Anorexia, Self Harm and Depression: Exploring Internal Worlds and Underlying Deficits

By

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Acknowledgements

I would like to thank all of those who have helped me both professionally and personally over the last two years. In particular I would like to thank my research supervisor Maggie, and my friends, family and soon to-be husband for their inspiration care and support.

A special thank you for all of those who agreed to participate in my study, without you I could not have done this, thank you also to the eating disorders clinic where my research took place.

Section A: Preface

Overview

This doctoral portfolio is divided into three sections; firstly an investigation into the most effective interventions used in the treatment of self harm; secondly a research component exploring the meaning of food for individuals with eating disorders; and finally a combined client study and process report which explores the challenges of working therapeutically with a client who has had a very emotionally deprived upbringing. The separate components of the portfolio are linked primarily by an overriding theme of lack of internal equipment. For they all explore whether explicitly or implicitly the impact that internal deficits or impairments as a result of misattuned caregiving can have on individuals and the regulation of themselves.

What follows below is a summary of each of the three main sections within this portfolio, this is then proceeded by a description of the evolution of this portfolio and its underlying focus on internal deficits and then finally by some comments on the evolution of this portfolio with reference to myself as a practitioner.

Sections of the portfolio

Section B: What is the most effective intervention used by clinicians in the treatment of self harm?

This section of the portfolio illustrates my ability to carry out original and critical evaluations on clinical literature. This critical literature review outlines and evaluates interventions both from the cognitive and psychodynamic fields used in the treatment of self harm. Within these evaluations the review also tries to identify what may be the effective mechanisms of change within these varied approaches and what stand out as being important characteristics of the therapist in the treatment of self harm.

Section C: The meaning of food for individuals with anorexia nervosa

This research study is the chief component comprising this portfolio. It explores the meaning of food for inpatients in an eating disorders unit. 8 participants from one inpatient unit with a diagnosis of anorexia nervosa were interviewed in the study. A semi-structured interview technique was employed and participants were asked to explore with the interviewer what they thought the meaning of food was for them. Following the interviews, Interpretative Phenomenological Analysis was carried out on the interview transcripts. Once analysis was complete prevalent themes emerging from the participants' narratives were explored.

Section D: How hard therapy can be for someone who has had "nothing"

This combined client study and process report demonstrates my abilities as a counselling psychologist. This makes up the practitioner component of this doctoral portfolio, and is intended to present to the reader with some of the work I have done with clients suffering from a lack of internal equipment or internal deficits. It is also intended to show the reader how internal deficits can manifest themselves in other ways, not just through anorexia. It also illustrates my work in my chosen specialism, psychodynamic therapy and explores the value and also difficulties that one can experience when working in this way.

How the portfolio evolved

Compiling this portfolio has been both a difficult and engaging experience. In keeping in tune with the ethos of counselling psychology throughout this portfolio I have tried to maintain a balance between the explorations of research, theory and practice. Additionally at all times I have adhered to the underlying humanistic principles of counselling psychology, which has

helped to inform the positioning of the participants and clients spoken about within this work.

The direction of this portfolio has very much evolved with my own interests. What follows below is therefore an account of its evolution, and the influencing factors within it. I hope that this will provide a clearer sense of the links between each of the individual pieces of work and how and why I consider them to sit well as both individual pieces of work in their own right and as part of a synthesis of a greater piece of work.

Early on in my training due to an interest that emerged after working with clients who self harmed I decided to explore the most effective interventions for clinicians in this area (section one) and what may be the effective mechanisms of change within these approaches. From exploring and researching in particular some of the risk factors associated with self harming behaviour I developed an awareness and growing interest on the effects that misattuned caregiving or invalidating environments could have on an individual's ability to regulate affect. From this I started to wonder whether there were any other illnesses which could be considered as "self harming", and whether affect regulation could be a component worth exploring within these illnesses too. This led me on to the topic of eating disorders, out of which developed my research (section 2). It is however important to note that although originally I felt that eating disorders, in particular anorexia was a form of self harm, that presently due to my research findings this is no longer my view. However the concept of affect regulation; the difficulties that individuals with anorexia have in regulating themselves, still stands strong as a central concept within the research which is expounded upon and explained further in relation to these individuals' perceptions of their experiences of their caregiving and the meaning of food for them.

Whilst carrying out my research, I came across a client who in many ways reminded me of an anorexic client. She often appeared "two dimensional" or "flattened", in a way that was synonymous with the "concrete attitude" of

the anorexic (as explained within my research) and struggled deeply to form an engaging and intimate relationship both with herself and with me. As I grew to understand her better within the sessions it became apparent how impaired her thinking and ability to regulate herself was and how this seemed to have grown out of her experiences of inattentive and neglectful caregiving when she was younger. For this reason I decided to write about this client and include this piece within my portfolio (section 3), feeling that it demonstrated from another angle again the importance of attuned caregiving and the impact that internal deficits can have on individuals. Furthermore I felt this piece of work illustrated well some of the issues that arise within clinical practice when working with clients with such internal deficits.

It is this evolving focus; the impact of internal deficits on individuals that is explored in relation to missattuned caregiving that I believe underscores the entire portfolio. Although clearly this emphasis is considerably lesser in the first piece of work, I feel that its inclusion is justified through the way that it acted as a springboard to my own developing interests in this area and in addition, through the way an interest in self harm inspired me towards an exploration of anorexia.

Counselling psychology

The evolving focus of this portfolio very much parallels my own journey into becoming a counselling psychologist and how I see and understand my role as a practitioner now. Within the portfolio there has been a clear and growing emphasis on psychodynamic theory, this is synonymous with the developing view and understanding of myself as a practitioner who works most comfortably within a psychodynamic framework. In addition the emphasis within this portfolio on the impact that misattuned caregiving can have on individuals has helped me to conceptualize further my own understanding and belief in the role of the counselling psychologist as an "attuned caregiver", someone who is responsive to the subjective needs and

worlds of their clients and in addition is able to engage with them in the individual and subjective manner that they require.

Section B: Critical Literature Review

"What is the most effective intervention used by clinicians in the treatment of self harm?"

This paper was originally written in 2008, however has recently been revised and updated for the purpose of this portfolio.

Introduction

Much research has been carried out into the phenomenon of deliberate self harm (DSH). Most of the literature tends to fall into one of two categories; the functions of DSH or the risk factors for DSH, both of which bear important implications for the treatment and prevention of self harm. Previous research has shown that counsellors prefer a multifaceted approach when treating self harm, (Suyemoto & MacDonald, 1995); however recent literature has seen more of an emphasis being placed on cognitive therapies as interventions. This review intends to identify the most effective and desirable forms of treatment for DSH (inclusive of treatments outside of the cognitive therapies), to give brief descriptions of these interventions and to identify what may be the effective mechanisms of change within these approaches.

Self Harm

DSH can be defined as the deliberate and direct destruction or alteration of one's own body tissue without conscious suicidal intent (e.g. cutting, burning), (Favazza & Conterio, 1988). DSH is listed as a symptom of borderline personality disorder (BPD) by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) however it is not specific to this disorder and roughly 4% of adults (Klonsky, Oltmanns & Turkheimer, 2003) and 14-21% of adolescents (Ross & Health, 2002) in the nonclinical population exhibit DSH.

Throughout the literature the terms *deliberate self harm*, *non-suicidal self injury*, and *self mutilation* are used interchangeably to refer to the same phenomenon. The term parasuicide is also used; however this term does not distinguish between self harm and suicide attempts (Linehan, 1993). Follow

up studies have shown that in the year following an episode of self-harm the risk of successful suicide is increased 50-200 times (Owens, Horrocks, & House, 2002). Despite the frequent comorbidity of these behaviours research has shown, however, that many individuals with a history of self-harm do not report a history of suicide attempts (Dulit et al., 1994), for this reason it is important for the term to distinguish between the two types of behaviours.

Patients who self harm describe feelings of isolation, alienation and of chronic emptiness (Orbach et al., 2003) in combination with overwhelming and intense negative emotions (Connors, 1996; Favazza & Conterio, 1988; Leibenluft, Gardner, & Cowdry, 1987). Consequences of self harming behaviour are believed to be negatively reinforcing, due to the reduction in tension that follows (Haines, Williams, Briain, & Wilson, 1995). However the guilt, shame and regret that often follow the act of DSH can intensify the negative emotional arousal of the individual and increase the likelihood of further isolation (Leibenluft, Gardern & Cowdry, 1987).

Risk factors for and functions of deliberate self harm

Most of the empirical research on the risk factors for self harm has focussed on childhood experiences associated with risk for DSH in adulthood. A lot of this research has focused in particular on sexual and physical abuse in childhood; as a result there is considerable evidence that suggests that there is a relationship between childhood sexual abuse and DSH (Boudewyn & Liem, 1995; Gratz, Conrad, & Roemer, 2002). Research also suggests that childhood physical abuse is related to DSH in adulthood, (Gratz, Conrad, & Roemer, 2002) although the extent at which it does so is unclear. Aside from the more extreme cases of sexual and physical abuse, childhood trauma, neglect, loss, childhood separation and invalidating environments (Linehan, 1993) have also been found to be good predictors of self harming behaviour. Attachment theory best explains why such associations occur.

Bowlby (1973) believed that children develop internal working models of the attachment relationship between themselves and their caregiver. A

secure working model helps the child to develop a sense of trust, which enables him to regulate affect, tolerate separations and mature in a healthy way. If the attachment is insecure such development will be impaired. An insecure attachment is believed to develop from insensitively attuned care giving interactions. The insecure attachment exists on a continuum from the traumatic attachment, which is associated with dissociation (Howell, 2005) and occurs from a trauma such as sexual abuse to avoidant and resistant/ambivalent attachments. Only clinical rather than empirical evidence, (Faber, 2007) is shown to associate ambivalent and avoidant attachments with DSH, however many who develop traumatic attachments are inclined to violent behaviour towards themselves and others (Farber 1995, 2000). This is because self harm is believed to develop when the child who has formed an attachment to those who inflict pain and suffering on them, maintain that attachment by causing pain to themselves.

Other environmental risk factors have been investigated by ecological studies that have examined the relationship between area characteristics and self harm. Higher self harm rates have been found to occur in areas of socioeconomic deprivation, especially amongst younger age groups and males (Hawton, Harriss, Hodder, Simkin, & Gunnell, 2001).

Less research has investigated the role of individual risk factors for DSH. However emotion dysregulation characterised by high levels of negative affect has been found to exist in individuals who self harm (Favazza, 1988) and emotional inexpressivity or alexithymia has also been associated with DSH (Zlotnick et al., 1996), this is consistent with the literature on the functions of DSH, which believes that one function of self-harm may be to express, release or communicate emotions that an individual feels unable to verbalise (Favazza, 1998); this is supported by Linehan, (1993) who primarily conceptualised self harm as a tool for emotion regulation. DSH is also thought to be associated with distorted body images or feelings of anger or disgust at one's own body (Muehlenkamp, Swanson & Braush, 2005) and to be associated with poor problem solving ability (McAuliffe et al., 2006).

The standard treatment approach for deliberate self harm

According to the National Institute for Health and Clinical Excellence guidelines (NICE), 2004, anyone who self harms should be offered a comprehensive assessment of needs, which should include the evaluation of the social, psychological and motivational factors specific to the act of self harm. Following this assessment the assessor is to make a joint decision, (where possible), with the service user whether to refer them for further assessment and/or treatment or to discharge them where possible. For those who self harm who also have a diagnosis of borderline personality disorder, dialectical behaviour therapy is to be considered. For those who have self-harmed and are deemed at risk of repetition an intensive therapeutic intervention is to be offered along with outreach. The type of intensive therapeutic intervention to be used is not however specified.

Also in accordance with the NICE guidelines, 2004, the service users' GP and/or psychiatrist should be involved in the writing of their treatment plan. This may lead to the introduction of pharmacological interventions as well. Tricyclic antidepressants and selective serotonin reuptake inhibitor (SSRI) are commonly offered to those who DSH.

The Rationale for this review

In view of the lack of treatment guidelines available for DSH, Muehlenkamp, (2006) wrote a paper which highlighted the studies of interventions that showed some success in treating DSH. Her review however focussed on cognitive behavioural interventions alone. Other reviews have considered the efficacy of a wider range of psychosocial treatments (Hawton et al. 1998 & Comtois 2002), however since these papers were written significant further studies have been carried out. This review intends to evaluate interventions from the cognitive therapies and interventions from a psychoanalytically orientated approach in order to bring the reader up to date on the most recent trials published in an another attempt to identify

the most successful interventions for treating those who DSH and the mechanisms of change within them.

Since the original writing of this paper Kerr, Muehlenkamp and Turner (2010) have written a paper which reviews and evaluates both interventions from the cognitive therapies and psychoanalytically orientated approaches, although this paper provides an effective and informative summary of the studies it includes what it does not do, is incorporate the extent of psychodynamic studies that this paper does (for instance Interpersonal Psychodynamic Therapy) and furthermore unlike this paper it does not try to identify the mechanisms of change within the interventions reviewed.

The Cognitive Therapies

Muehlenkamp (2006) supported Linehan's view (1993) that self harm is primarily conceptualized as a tool for emotion regulation maintained through negative and positive reinforcements, as such she reviewed only cognitive behavioural interventions. Such a conceptualization has meant that Muehlenkamp's (2006) review of empirically supported treatments is limited for it overlooks and fails to include other types of interventions such as brief psychodynamic interpersonal therapy (Guthrie et. al, 2001). In line with this it must be assumed that the recommendations for treatment she concludes to make must also be limited.

In reviewing the literature Muehlenkamp (2006) identified only two types of treatments that fell within the cognitive behavioural domain which focused on DSH; Problem Solving Therapy, (PST; D'Zurilla & Goldfried, 1971) and Dialectical Behaviour Therapy (DBT; Linehan, 1993). She tentatively concluded that both PST and DBT are effective approaches to treating DSH behaviours. Muehlenkamp reported that few well conducted empirical studies specific for DSH existed and that these rarely included

randomized controlled trials. Although her article appears comprehensive it is important to note that it is not made clear within the article what the inclusion and exclusion criteria were for her reviewed studies within the cognitive field. Another limitation of her review is that within the article she does not specify what the treatment as usual (TAU) consisted of for each of the individual trials, thus making it hard for the reader to critique the studies and make any kind of original evaluation about the work.

Problem Solving Therapy

PST is based on the assumption that dysfunctional coping behaviours are the consequences of behavioural or cognitive breakdowns in the problem-solving process (D'Zurilla & Nezu, 2001). Research has shown that those who engage in acts of DSH frequently exhibit poor problem-solving skills (Speckens & Hawton, 2005). PST aims to help clients to identify and resolve problems they encounter by teaching them general coping and problem-solving skills. This is done by teaching the different steps involved in problem solving such as problem identification, goal setting, assessing solutions and selecting and implementing solutions. Muehlenkamp (2006) states within her review that the efficacy of PST in reducing self harming behaviours is inconclusive. The studies she evaluated are briefly reviewed below.

Conflicting results were found in earlier studies which examined the effectiveness of PST against treatment as usual (TAU); Gibbon, Butler, Urwin & Gibbons, (1978) and Patsiokas & Clum, (1985) concluded PST was more effective than TAU where as Hawton et al. (1987) and Liberman and Eckman (1981) did not. Such results are unsurprising considering that these studies were limited by the fact that they were not randomised controlled trials, that different TAU were offered by the studies[1] and given the small sample

[1] Patssiokas & Clum (1985) assigned participants to either cognitive restructuring, problem solving or nondirective control treatment consisting of 10 hour individual therapy sessions. Gibbon, Butler, Urwin & Gibbons (1978) assigned patients between an experimental social work service and a routine follow up service. Liberman and Eckman (1981) compared a brief 10 day behavioural therapy programme including a problem-solving component against

sizes used. In 1998 a meta-analysis of 20 randomized clinical trials was carried out (Hawton et al.) assessing the efficacy of various treatments for parasuicide. PST appeared to be most effective in reducing parasuicide compared to standard care controls. These reductions, however, were not found to be statistically significant and were not specific to self harming behaviours as the results also included suicide attempts. In 2001, a further meta-analysis was carried out which examined the efficacy of treatments for DSH alone (Townsend et al.). This meta- analysis found that PST was effective in reducing comorbid depressive symptoms; problem levels among participants and hopelessness however with regards to reducing acts of DSH the results for PST were inconclusive.

Within her review Muehlenkamp (2006) also focussed on PST which had additional cognitive, behavioural or interpersonal elements within it known as manual assisted cognitive behavioural therapy (MACT). MACT is a short term intervention of 6 sessions which teaches clients to manage emotions and negative thinking. The first big study to test the efficacy of MACT in reducing self harming behaviours was carried out by Tyrer et al. (2003). This study was a multi-site, randomized clinical trial which compared MACT to TAU for 480 clients. Clients were assessed 6 months and 12 months post intervention. Although MACT showed promise in reducing self harming behaviours, (at the 12 month assessment point, 39% of clients from the intervention group reported repeated self harm against 46% from the control group) the results found were not statistically significant and Tyrer et al. had to conclude that brief CBT was no more effective than TAU in preventing repetition of self harm. It is most likely that the reason that this study failed to find any differences between the two groups was due to a limitation in its design for the TAU included individual problem solving therapy, seeing a general practitioner and individual and group therapy, thus confounding elements of MACT within the control group.

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an insight orientated therapy and Hawton et al. (1987) evaluated out patient counselling against general practitioner care.

Since Muehlenkamp's review significant research has come to light which suggests that PST could be an effective form of treatment for DSH. Slee, Garnefski, van der Leeden, Arensman & Spinhoven (2008), conducted a study which investigated the efficacy of a short cognitive-behavioural therapy intervention with 90 participants aged between 15-35 years who had recently engaged in self harm (patients were excluded if they reported a sever psychiatric disorder or had cognitive impairments) and who had visited their local health centre. Not dissimilar to Tyrer's (2003) MACT, Slee, Garnefski, van der Leeden, Arensman & Spinhoven used a manualised cognitive behavioural intervention for self harm which was modelled around the assumption that vulnerability to self harm can be changed by changing negative and suicidal thinking and problem solving deficits.

This study examined the short and long term efficacy of a 12 week intervention against the repetition of self harm. The primary outcome measure of the study was the number of episodes of self harm 3, 6 and 9 months after treatment and the secondary measure was the reduction in emotional problems such as anxiety, depression, suicidal cognitions and problem solving deficits. Slee, Garnefski, van der Leeden, Arensman & Spinhoven hypothesised that the rate of self harm of participants who received CBT as well as TAU, would be lower than those who only received TAU and that participants in the intervention condition would also have significantly lower scores for emotional problems and suicidal cognitions and higher scores for behavioural skills like problem solving ability. Their hypothesis was supported, and they attributed this to the effect of CBT.

This seems a fair assumption given the robust nature of their design which used random assignment and was absent of between-group differences with regards to demographic factors, history of self harm, psychopathology and use of healthcare services. The results of the primary outcome measure were also well founded. Repeat episodes of self harm were assessed using a structured clinical interview. To investigate the reliability of the number of episodes of self-harm reported in the assessment, results were compared with hospital records as well as with information from the treatment

sessions. The correlations between these measures were high ranging from 0.88 to 0.90.

One unexpected result was that effects on secondary measures were stronger than on the target variable, DSH. Changes in emotional problems and improved problem solving ability seemed to precede changes in DSH; this suggests that increasing problem solving ability or challenging suicidal thinking might be the mechanism of change for DSH.

One large limitation of this study was that due to ethical reasons participants in both conditions were free to pursue any form of TAU they wanted to. Three different forms of TAU were recorded within the study; psychotropic medication, psychotherapy and psychiatric hospitalisations. The study is unclear on which participants chose what type of TAU, it also failed to record the specific types of psychotropic medication or psychotherapy (whether it focussed on self harm or not) patients received in either condition; it is therefore unclear whether the conditions were equivalent in this respect. Furthermore as such differences are unclear it is difficult to assess whether the effects of those in the treatment condition were specific to CBT or due to the combination of CBT with the varying types of TAU available to the participants.

Slee, Garnefski, van der Leeden, Arensman, E & Spinhoven's recent study empirically validated CBT as an effective treatment for the reduction of self harm. The contribution of PST within this study is validated by the results of the secondary measures. However the specific impact of improved problem solving abilities is still confounded with the concurrent reduction in emotional problems; the efficacy of using PST exclusively in treating DSH is therefore inconclusive, however when combined with other additional aspects of cognitive therapy it has proved to be an effective way of reducing self harming behaviours. It is also important to note here, that due to the exclusion of people with cognitive impairments in this study, it is unclear how helpful PST is or can be for individuals with cognitive deficits, and that

furthermore it perhaps suggests that it can not be of help, thereby highlighting a limitation of the cognitive model.

Overall the research regarding the effectiveness of PST is inconclusive, although research indicates that PST has some therapeutic effect, it is not clear whether the effective component is the problem solving training or another factor within the treatment. For this reason it is not possible to identify PST as mechanism of change for individuals who self harm.

Dialectical Behaviour Therapy

DBT was developed by Linehan (1993) as a treatment for individuals with BPD of which DSH is a common symptom. Linehan (1993) proposed that if a child experiences an invalidating environment when they are young, (i.e. there are dissonances and discrepancies between the capacities and characteristics of the child and environmental opportunities and demands), then this was likely to result in maladaptive functions and distorted development which could facilitate the development of BPD. DBT combines general cognitive behavioural techniques with elements from Zen Buddhism. Behind DBT is the core dialectical principle of encouraging the client to accept him or herself and to change simultaneously. In line with the principles of CBT, emotion regulation, distress tolerance, interpersonal effectiveness, core mindfulness and self management skills are taught. In accordance with Zen patients are encouraged to develop a non-judgemental and alert attitude towards events, their own cognitions and emotions. It is this mindful attitude that is considered paramount in order to prevent impulsive, mood dependent behaviour which is associated with DSH. This non-judgmental and mindful attitude is also considered vital for the therapist as well as DBT focuses on validating the patient's experiences. A hierarchical stage model provides the structure for therapy. A number of treatment modalities are included within this model; group skills training, individual therapy and phone coaching.

At the time Muehlenkamp reviewed DBT only four randomised clinical trials had evaluated the efficacy of DBT; Koons et al., 2001; Linehan, Armstrong,

Suarez, Allmon, & Heard, 1991; Linehan et al., 2002 and Verheul et al., 2003. Each of these trials demonstrated significant reductions in DSH for individuals in the DBT condition compared to those in the TAU condition for up to 6 months post treatment. These differences however were not sustained past 12 months. Although these studies have positive outcomes they are limited by the way they group together instances of self harm and suicidal behaviour, making it unclear which results pertain specifically to self harming behaviour. Furthermore the participants of these trials were predominantly female and they were all diagnosed with BPD. It is therefore unclear how these results can be applied to those who self harm outside of the BPD population. In addition to the four randomized trials, a number of other studies have also reported that DBT is superior to TAU in reducing self harming behaviours, (Elwood et al 2002; Shearin & Linehan, 1994 and Low, Jones, Duggan, Power & MacLeod, 2001), these studies also suffered from the same limitations of the randomized trials, in addition however there was often no comparison group (Elwood et al. 2002).

Muehlenkamp concluded that collectively the reviewed studies suggested that DBT is effective in reducing DSH amongst patients with BPD. Since her review however a two year randomized controlled trial and follow up of DBT has been carried out, (Linehan et al., 2006) which compared DBT versus therapy by experts for suicidal behaviour and BPD. From a distance its findings replicated those of previous research, with DBT being reported as a successful intervention in reducing parasuicide, however on a closer look, the study, in contrast to previous DBT randomized trials (Koons et al., 2001; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan et al., 2002 and Verheul et al., 2003), reported no significant differences between conditions in the incidence or the frequency of DSH. An explanation provided by the authors of this study for this finding was that subjects in the comparison group may have underreported habitual self harm to a greater extent than those in DBT. Such an explanation however seems unlikely given the computerized adaptive minimization randomization procedure, (which looked at 5 primary prognostic variables), that the study employed to minimize between-group differences. Although the efficacy of DBT as a

treatment for parasuicide behaviour in particular for those with BPD is generally well established (Gratz, 2007) given the results of Linehan et al.'s study (2006), now more than ever, it appears necessary for research to explore the specific effects of DBT on DSH alone. Without such research it is still unclear how to reach anything more than a tentative conclusion, as Muehlenkamp makes, for the effectiveness of DBT as a treatment for DSH.

An absence of research has also been identified in examining the mechanisms of change in DBT (Gratz, 2007). Linehan et al.'s study (2006) was designed with the objective of identifying the specific elements of treatment which are sufficient and necessary for a successful outcome among individuals with BPD. Although they managed to prove the success of DBT as being grounded in elements of its approach rather than in other more general factors associated with receiving expert psychotherapy (by using a rigorously defined control condition), they did not manage to provide information about the mechanisms of treatment within their multi-component approach, their study is therefore of little help in developing more effective treatments[2]. However two studies have reported that mindfulness and dialectical techniques are most effective in reducing DSH (Shearin & Linehan, 1992; Miller & Wyman et al., 2000). Incidents of DSH significantly decreased when the therapist was rated as being nurturing, understanding, respectful, instructing, providing autonomy to the client and validating of them within the relationship (Shearin & Linehan, 1992; Perseius et al., 2003). Again such findings are limited as they have been based on participant samples of those with BPD. BPD is a disorder which has a range of symptoms beyond DSH; it is therefore unclear whether these mechanisms of change are appealing for those who deliberately self harm without a diagnosis of BPD.

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[2] Additional dismantling studies of DBT are currently underway by Linehan to determine what the essential components of DBT are and how much flexibility can be applied to treatment from the DBT manual whilst maintaining comparable success.

Muehlenkamp's more recent paper, Kerr, Muehlenkamp and Turner (2010) seems to address many of the limitations that this review has highlighted within Muehelenkamps's original paper (2006). For this paper provides more detail or information on the individual studies included, e.g. providing the reader with details of TAU and inclusion criteria of the studies, thereby making it easier for the reader to make an original evaluation of the work described. In addition this paper also raises important critical questions around the studies such as the often inconsistent and confounded definitions of self harming behaviours in outcome measures and what this may mean for comparing studies and their outcomes, e.g. Lineham, Armstrong, Suarez, Allmon & Heard, 1991 and Koons et al. 2001. Most importantly however this review includes the evaluation of treatment models outside of the cognitive field in particular psychodynamic psychotherapies, meaning that this studies recommendations for treatment are less limited due to the broader inclusion criteria of the review.

The Psychodynamic therapies

Although the majority of most recent research has focussed on cognitive therapies for treatment against self harm, there is evidence that psychodynamic orientated interventions are also an effective course of treatment. In fact it would seem by Kerr, Muehlenkamp and Turner's inclusion of the psychodynamic traditions within their recent review (2010) that the psychodynamic traditions are becoming increasingly more recognised as an effective form of treatment within the field of self harm.

It is interesting however that on a number of reviews and meta-analysis carried out on the efficacy of treatments preventing DSH (Hawton et al. 1998; Comtois, 2002; Crawford, 2007), psychoanalytically orientated treatments which have been successful in reducing self destructive symptoms in patients with BPD have been omitted. This stands in contrast to their inclusion of the many studies which have looked at the effectiveness

of DBT in reducing self destructive symptoms in borderline patients. Three studies emerged from reviewing the literature of the effectiveness of psychoanalytic treatment of personality disorders as providing evidence of the effectiveness of psychoanalytic psychotherapy in reducing self harming behaviours. Out of these three studies, two of them; Transference –focussed psychotherapy and Mentalization based therapy were included in Kerr, Muehlenkamp and Turner's review (2010), the third, Interpersonal psychodynamic therapy was not.

Psychoanalytically orientated treatments

Stevenson and Meares (1992) reported on 48 patients diagnosed with BPD treated with a twice weekly psychoanalytic psychotherapy for a period of one year. The treatment model was based on a psychology of self and carried out by trainee therapists; great effort was made to ensure therapists adhered to the treatment model. One of the outcome measures was the number of self harming episodes one year after the initial assessment and one year after the cessation of therapy. Significant improvements on self harm were found at the one year assessment and these improvements were maintained the following year after the cessation of therapy. Although this trial shows promise in the treatment of self harm by psychoanalytic psychotherapy its design was not strong and as such its results might be questionable. The trial was moderately sized and only 30 of the initial 48 patients completed therapy. There was also no control group included in this study and participants were not randomly selected. At the end of the year 30% of the patients no longer filled the criteria for DSM-III for borderline personality disorder, this in itself may have had an effect on the positive outcome for self harming episodes.

Bateman and Fonagy (1999; 2001) did, however, carry out a randomised control trial to investigate the effectiveness of psychoanalytically orientated treatment on patients with BPD. Their research into a mentalisation-based treatment (1999; 2001; 2004) showed that by increasing the patient's capacity to mentalise, the necessity to self harm decreases. Key tasks for the clinician giving this treatment include encouraging the patient to create a

meaningful and emotional narrative; to ask significant clarificatory questions; to encourage the patient to understand what was going on for them, at times when they have self harmed, (what pressures they were under, what may have got them angry and upset), and to provide a therapeutic framework by demonstrating an interest in the patient, within which the patient can make meaningful links about themselves in an attempt to manage and recognise their own feelings.

The treatment group in Bateman and Fonagy's trial (1999) consisted of individual, group and expressive psychoanalytic psychotherapy for 18 months. Outcome measures were self harm, suicide attempts and emotional problems (depression and anxiety). Assessments were made at 6 months and at 18 months and compared to a control group who followed the standard psychiatric care for patients with BPD which is exclusive of any form of psychotherapy. Incidents of self harming behaviour were found to decrease significantly over the course of treatment in the intervention group but remained constant in the control group. The median number of self mutilations at 6 months was reduced from 9-1 in the intervention group compared to 8-6 in the control group. Positive features of this study were the randomised control design, the use of semi structured interviews cross checked with hospital records to record the number of self harming episodes and the small number of patients who dropped out of the study. A follow-up of this study was carried out 18 months later by the authors (2001) who found that the decreasing incidents of self harming behaviour had been maintained 18 months post treatment by the intervention group. During the 18 month follow-up period the mean for mutilating acts for patients in the control group was calculated at 10.9 compared to the patients in the intervention group whose mean was 0.6, a difference that was reported as being highly significant (Mann-Witney $U=84$, $p<0.001$).

This study like many of the DBT studies mentioned earlier (Koons et al., 2001; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan et al., 2002 and Verheul et al., 2003) was also limited by the participant sample who were all diagnosed with BPD, again it is therefore unclear whether such

results can be generalised to a self harming population who do not have a diagnosis of BPD. Unlike the other studies that this review has reported on, this study involved the partial hospitalisation of patients. It is therefore hard to identify whether the mechanism of change within this study was the psychoanalytic therapy or the large amount of staff time received by patients in the intervention group. This criticism is shared by Kerr, Muehlenkamp and Turner (2010).

Recent research has come to light which believes DSH can best be understood when concepts of psychoanalysis are integrated with attachment theory (Farber, 2008) and it is within such research that the mechanism of change within psychoanalysis is best explored. According to psychoanalysis and attachment based treatments successful treatment of self harm depends upon the development of a secure attachment to the therapist, this is believed to help the patient explore and rework his/her internal working models (Farber, 2008). Bateman & Fonagy (2004) suggest that the capacity to develop reflective thinking can only take place within the context of a close interpersonal relationship. An emphasis on the attachment relationship being the mechanism of change within psychoanalysis is consistent with Lambert and Barley's finding (2001) from a review of the outcome literature for psychotherapy that the therapeutic relationship was the largest positive factor.

Despite the limitations described earlier surrounding Bateman & Fonagy's study (1999), due to the strong understanding and emphasis placed on their concept of what is the mechanism of change within the treatment the researcher believes it makes a convincing and directive starting point for the argument that psychoanalytic therapy is an effective treatment for DSH.

Transference-Focused Psychotherapy

Transference-Focused Psychotherapy (TFP) is an intensive treatment that was developed for patients with BPD. TFP aims to assist patients change their behavioural and affective responses to stress particularly in interpersonal contexts through dynamic reflections on the patient-therapist

relationship during frequent therapy sessions twice per week for one year (Kerr, Muehlenkamp and Turner, 2010). As of yet only one study exists that explicitly investigates the effectiveness of TFP in the treatment of self harm, Clarkin et al. (2001). This study found from a sample of 23 outpatients with BPD that after 1 year of TFP the severity of self harm and degree of medical care needed after self injury was reduced. However it also found that the frequency of self injury was not reduced (p=45) bringing into question the overall effectiveness of the intervention. Although further randomized clinical studies have investigated the effectiveness of TFP as a treatment of BPD against other treatment approaches such as DBT (Clarkin, Levy, Lenzenweger, Kernberg, 2007) and against an active placebo Levy et al. (2006) all of these studies failed to discuss the effect of TFP on self harm, as a result no further evidence has been found to suggest that TFP is an effective form of treatment for self harm. Interestingly however, Kerr, Muehlenkamp and Turner, 2010 highlighted the fact that what these studies did find, however was changes in for example attachment patterns, reflective function and improvements in impulsivity depression and anxiety all of which can be considered as related constructs within TFP. As a result even though it is clear that further research is needed to determine the effectiveness of TFP in the treatment of self harm, TFP clearly shows promise and potential as an effective intervention. It is also important to note here that further research which explored both these, related constructs and self harm specifically, could help to identify the mechanisms of change in the treatment of self harm such as increased reflective function.

Psychodynamic interpersonal therapy

Other forms of psychodynamic therapy have also been explored as effective treatments for those who DSH. Guthrie et al. (2001) conducted a randomised controlled trial to determine the effects of brief psychodynamic interpersonal therapy (PIT) versus TAU for patients after deliberate self poisoning. PIT is a derivative of psychodynamic therapy. Unlike the more traditional psychodynamic therapies PIT is a brief intervention, which, rather than focussing on the deep seated sources of symptoms emphasises the way in which current relationships and social context can cause or

maintain symptoms. The rationale behind using an interpersonal intervention for the treatment of DSH is that 70% of all episodes of DSH are precipitated by an interpersonal problem (Bancroft et al., 1977).

The goal of PIT is to resolve interpersonal difficulties on the understanding that this will have the knock-on- effect of alleviating psychological distress (Guthrie et al., 2001). The model used by Guthrie et al., (2001) was adapted from a model developed by Hobson (1985) which was proved to be effective in the treatment of depression (Shapiro, Rees & Barkham, 1995) and has also been shown to be cost effective (Guthrie et al. 1999).

Within this trial PIT was provided to the intervention group once a week for the period of four weeks, sessions were delivered by nurse therapists in the patient's home. Suicidal ideation was considered the primary outcome measure for this study, repetition of self harm and depressive symptoms were considered secondary measures. Patients were assessed on entry to the study, at the end of the four weeks of therapy and then 6 months later. The study showed that patients who received PIT showed greater improvement on the outcome measures at 6 months than patients in the control group. A significant reduction was found in the intervention group with regards to self harming behaviours; only five patients (9%) had harmed themselves again compared to 17 patients (28%) in the TAU group (P=0.009, Fisher's exact test).

This study has many positive features; the trial was efficiently randomised and there was a good participation rate of those randomised throughout the 7 months of study. However it was moderately sized and the only form of assessment of recurrent self harm was collected through retrospective self report. The study is also limited by its participant sample who were all from an in patient setting and only included those who had deliberately self poisoned. The article's definition of self poisoning is unclear; it has been interpreted as an act in which an individual deliberately ingests a substance in excess of the prescribed dosage. (Kerkhof, Schmidtke, Bille-Brahe, 1994). DSH is commonly considered to include acts of self poisoning (Slee,

Garnefski, van der Leeden, Arensman & Spinhoven, 2008) however self poisoning is not inclusive of all acts of self harm. This study therefore excludes those who engage in self harming behaviour of which cutting and burning is preferable to self poisoning.

Despite such limitations within the study the overall results are impressive. In the past decade focal psychotherapies have been proved effective treatments for various other psychiatric and behavioural problems (Guthrie et al., 2001) with this in mind, it is not surprising that it has been found to be an effective intervention against acts of self harm. To my knowledge, however, no previous or subsequent studies to this one have investigated the efficacy of PIT in relation to self harming behaviours as a primary outcome measure. Further research is therefore needed in this area in order to verify and reiterate the results found.

Within the research surrounding PIT limited research has also been carried out into the effective mechanisms of change within the approach. Guthrie et al., (2003), went on to explore which baseline factors predicted outcome following treatment for their 2001 study. However these results were limited to the patients' personal history and psychopathology and neglected to explore the successful elements within the therapy. Distinctive features of PIT have however been explored (Blagys & Hilsenroth, 2000) in an attempt to delineate techniques from cognitive behavioural treatment; seven interventions were listed including focus on affect and the patient's expression of emotions; an exploration of the patient's resistance to therapy and identification of patterns in patient's thoughts. It is possible that some of these techniques may provide us with the effective mechanisms of change within this theory, although further research would need to be carried out order to determine which one.

Conclusion

Problems with the research and ways forward

Results from the studies described show promise in providing ways forward for the treatment of DSH; at present, however, given the reasons outlined below it feels too premature to conclude with any certainty that any one of these treatments is more effective than the other in the treatment of DSH.

DBT has showed increasing success as a treatment for BPD, however results from Linehan et al.'s latest study (2006) question its ability to treat self harming behaviours alone. As mentioned earlier these latest results did not reflect the results from previous studies carried out; it is therefore recommended that this study be replicated in the future in order to clarify its effect on self harming behaviours. PST as an element included in a wider cognitive approach has also showed success (Slee, Garnefski, van der Leeden, Arensman, & Spinhoven, 2008) however results regarding it as a treatment in its own right have been ambiguous (Hawton et al., 1987). Psychoanalytically orientated treatments also showed success in treating self harming behaviours, but the treatments offered (Bateman & Fonagy, 1999) were considerably more intensive than the treatments offered by the cognitive approaches, furthermore there is a lack of research available in this area; future research is therefore needed to build greater support for its' efficacy.

Other difficulties have also come to light in comparing the literature. The difference in the volume of research carried out in the cognitive therapies compared to the psychoanalytically orientated approaches is quite striking. Such an imbalance of research between the two approaches could be suggestive of the promise of one theory over the other; however it could also be explained away by the increasing popularity of the cognitive therapies over the past decade or the possibility that psychoanalytic approaches apply less meaning to empiricist research. Either way the

imbalance between the literatures make it hard for an unbiased evaluation to be passed or a fair comparison to be made between the two.

Another difficulty that has emerged in comparing the studies has evolved out of the inconsistencies between the control groups of the randomised control studies. TAU within the studies has varied from psychotropic medication, partial hospitalisations, psychotherapy to no psychotherapy at all (Slee & Garnefski, van der Leeden, Arensman & Spinhoven, 2008; Bateman & Fonagy, 1999). Such differences in the control group makes it hard for any true comparison to be made between the studies for there is no one baseline from which all studies can be assessed as they all compare their treatment group to a different form of standardised treatment. A difference in the country of which the studies were carried out in, i.e. the USA (Linehan et al., 2006) Holland (Slee, Garnefski, van der Leeden, Arensman & Spinhoven, 2008) and England (Bateman & Fonagy, 1999), ethical reasons, and the fact that different TAU stand for a participant population diagnosed with BPD (Linehan et al. 2002, Linehan et al., 2006; Bateman & Fonagy, 1999) than it does for a participation sample whose selection criteria is only self harming behaviours (Slee, Garnefski, van der Leeden, Arensman & Spinhoven, 2008) can explain why this problem occurs. Similarly, there were also differences within the studies as to who carried out the interventions. For instance, Stevenson & Meares (1992) used trainee therapists, Guthrie et al., (2001) used nurse therapists and other studies used well trained experts in a specific field (Linehan et al., 2002). It is possible that the different qualifications of the practitioners could have had positive or negative influences on each of the individual studies. This again makes a fair comparison between studies difficult for there are external factors outside of the treatment specific intervention that might impact on the results.

Studies also included different lengths of follow- up periods. Bateman & Fonagy, (1999) had the longest follow-up period conducting another study to assess the decrease in self harming behaviours 18 months after their original study. Linehan et al. (2006) study included a one year post-

treatment follow up. Whereas other studies only included a 9 month follow-up (Slee, Garnefski, van der Leeden, Arensman & Spinhoven, 2008), or as little as a 6 month follow-up period, (Guthrie et al., 2006). For the studies which had a smaller follow up period (Slee, Garnefski, van der Leeden, Arensman & Spinhoven, 2008; Guthrie et al., 2006; Linehan et al., 2002; Verheul et al., 2003) further studies which include a longer follow-up period would need to be carried out in order to investigate whether these treatments have longer standing benefits, such studies would be important in investigating the cost effectiveness of treatments offered.

Individual limitations of the studies also create problems in evaluating the literature; for studies which had participant samples of patients diagnosed with BPD (Bateman & Fonagy, 1999; Linehan et al. 2006, Clarkin) there is no guarantee that their findings could be extended out to the general population and for studies which looked at parasuicide behaviour (Linehan et al., 2002; Verheul et al., 2003; Linehan et al., 2006) their results do not solely reflect the reduction in self harming behaviour. All the studies mentioned have used a clinical population in their sampling in order to verify whether the outcomes of these studies are extendable to the general population further studies would need to take place.

Self harming behaviour is complex and patients who self harm often have a variety of additional co-morbid psychological problems such as depression and anxiety. Difficulties have arisen within the studies identifying which part of therapy addressees which issue. For instance Slee, Garnefski, van der Leeden, Arensman & Spinhoven (2008) found that their manualised cognitive behavioural intervention led to a greater change in emotional problems, suicidal cognitions and behavioural skills than it did to self harm. This suggests the importance of looking at emotional problems and behavioural skills individually to see if they could be considered as variables which mediate the relationship between therapy outcome and self harming behaviours.

Identifying the mechanisms of change

Each intervention described has developed out of a belief in a particular risk factor(s) which leads to self harm, (for instance PST has come from the belief that poor problem solving and coping skills can lead to episodes of self harm). The mechanism of change within each theory, to a certain extent, can therefore be found in the way each intervention attempts to address the risk factor. It is important to note, however, that there is limited research available that discusses the elements of therapy within these individual treatments which are believed to be critical in reducing self harming behaviour. Nevertheless having reviewed the literature available there seems to be a general consensus that the therapeutic alliance is at the forefront of bringing about positive change; with both psychoanalysis and the cognitive therapies emphasising the need for a collaborative relationship and nurturing and secure attachment. Additional support can be obtained for this consensus from literature which has reviewed working with suicidal individuals; these highlight the importance of forming a collaborative and supportive therapeutic alliance where the therapist and client work as a team rather than expert and subject (Henriques, Beck, & Brown, 2003; Jobes, 2000).

Within this review different studies have identified similar aspects of the therapist which are paramount in creating a good therapeutic alliance. Shearin & Linehan, (1992) and Miller & Wyman et al., (2000) identified aspects of the therapist, such as validating the patient within the relationship and being understanding, (within DBT) as reducing self harming behaviours. The importance of these characteristics for the therapist is reiterated in Bateman & Fonagy's mentalisation based treatment (2004). This treatment moves away from the technical requirements adhered to by classical psychoanalysts such as transference interpretation and neutrality, and instead the clinician actively encourages the client and demonstrates an interest in them in order to help them develop an understanding of themselves. Nathan (2004), a psychoanalyst also moves away from the classic psychoanalytic form by emphasising a more productive therapeutic stance which requires that the clinician must, as an

absolute starting point, accept the self harming behaviour of the patient. This assertion is backed up by the presence of research which suggests that specific strategies such as acceptance and validation interventions may bring about positive behavioural change (Koerner & Linehan, 2000).

Counselling psychology

Although this review is informative for all types of clinicians trying to manage self harming behaviour, the reviewer as a counselling psychologist herself feels that it is important to note that an emphasis on a more productive therapeutic stance is particularly congruent with the ethos of counselling psychology which promotes the increasing awareness of the "importance of the helping relationship as a significant variable in facilitating the therapeutic endeavour" (Strawbrige and Woolfe, 2003; p.4). Similarly the assertion of the importance of the clinician's acceptance of the self harming behaviour of the patient lies in parallel with the counselling psychologist's "acceptance of the subjective world of the client as meaningful and valid in its own terms" (Strawbridge and Woolfe, 2003; p.8). As such the emphases on the core mechanisms of change in the treatment of self harm may be considered to be consistent with some of the defining concepts of counselling psychology.

Concluding Comments

The difficulty in establishing one standardised treatment for DSH is reflective of the heterogeneous population that carry out these acts and the belief in the many different risk factors that lead to DSH. In view of research findings on risk factors which lead to DSH, treatments need to include interventions which have been proved effective in treating particular aspects of the disorder like problem solving skills or maladaptive cognitions; yet at the same time be flexible enough to tailor the treatment to the individual needs of the client. Psychoanalytically orientated approaches stand out as being able to identify with and focus on the individual more in therapy, whereas the cognitive therapies seem to take a more prescriptive mode towards treatment focusing on restructuring previously defined cognitive deficits. Both approaches have shown promise in the treatment of

self harm, if future research could successfully identify and explore further the effective elements within each of these different treatments then these could be synthesized to provide another way forward for treatment.

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Section C: Research

"The meaning of food for individuals with anorexia nervosa"

Abstract

This thesis explores the meaning of food for individuals with anorexia. 9 female inpatients aged over 18 with a diagnosis of anorexia nervosa were interviewed. The participant interviews were analyzed qualitatively using Interpretative Phenomenological Analysis and four master themes were identified: Food as a container, food as a concrete representation of internal states and relationships, food as a separator and food as a control mechanism. Within this research these master themes were expounded upon and explained in relation to current theories and also in relation to two core concepts that also emerged from the research's findings: Loss of and broken sense of self and misattuned caregiving. In conclusion this study offers its readers a potential conceptual and theoretical model based around its findings of the meaning of food, for the explanation and development of anorexia. It is hoped that these findings will be useful in informing and developing clinical understandings of anorexia and new treatment approaches.

Chapter 1: Introduction

Overview

Much research has been carried out into the phenomenon of anorexia nervosa (AN). However despite there being a great wealth of literature within the area of eating disorders AN is still somewhat of an enigma and at present there is no clear explanatory model, biological or psychological for the development and maintenance of the disorder. The aim of this research is to further the understanding of the specific psychopathology of AN by using phenomenological methods to develop a theory about the possible symbolic and metaphorical use of food for individuals who suffer from AN and to investigate whether food for those who suffer from AN is or ever can be a concretised metaphor for something else.

In order to provide the reader with the context to understand and interpret where this research question has come from and the problem it wishes to address, what follows below is an introduction describing the theoretical perspective, framework and central concepts of the study followed by a review of the most pertinent literature surrounding it.

Introduction

Therapeutic and theoretical approaches towards Anorexia Nervosa

At present there is no standardized or agreed approach towards the psychological treatment of AN (NICE, Eating disorders, 2004). The Clinical practice recommendations by the National Institute for Clinical Health and Excellence (NICE GUIDELINES, 2004) states that therapies to be considered in the psychological treatment of AN include Cognitive Behaviour Therapy (CBT), Cognitive Analytic Therapy (CAT), Interpersonal psychotherapy (IPT), focal psychodynamic therapy and family interventions, (p.89). Irrespective of these varied recommendations for the psychological

treatment of AN, today the field of eating disorders seems to be dominated largely by the cognitive behavioural therapy traditions (Skarderud, 2009). Despite the prevalence of this one approach, treatment is considered to lack in effectiveness; in a recent article Skarderud (2009, p.83) stated that the "state of art for anorexia and eating disorders, and that goes for both theoretical understanding and therapeutic approaches is far from satisfactory." Similar conclusions have been drawn previously by Fairburn (2005, p.S29) who in response to the question "Is evidence-based treatment of anorexia nervosa possible?" replied "barely" due to the weaknesses of scientific trials and treatment programmes and by Woodside (2005, p, S41) who remarked on a series of overviews on therapy in this area that "there are more weaknesses than strengths in our understanding of the treatment of individuals with anorexia nervosa".

The strength of the cognitive behavioural therapy traditions is its practicability; the manualisation of treatment (Skarderud, 2009), however a significant weakness is theory (Skarderud, 2009). A limited focus on cognitions and self schemes means that the theory lacks a concept about the development of the personality (Skarderud, 2009), focuses too little on emotional life (Vanderlinden, 2008) and may undervalue the severity of eating disorders by reducing major psychopathology to cognitive dysfunctions, (Skarderud, 2009). It is for these reasons that this review intends to leave to one side the present day's overemphasis on the traditions of cognitive behavioural therapy. In a similar vein this study also intends to exclude the more main stream clinical and experimental data within the field of anorexia, believing it is not that helpful. Instead this review will outline some of the ways in which the psychopathology of AN has been explored by theory and conceptual models, and the influence these models have had on ways forward for the therapeutic treatment of this disorder.

Ways in which the psychopathology of AN has been explored is through the symbolic role of the body (Skarderud: 2007a; 2007b), the meaning behind the symptoms (Bruch, 1962, 1973, 1978 1988) and deficits in a sense of self

and mental processing (Bruch;1962, Bateman & Fonagy; 2004, Skarderud; 2007 and Buhl, 2002). Such explorations move away from the more traditional western thinking of philosophers such as Descartes whose dualism viewed the mind/body, person/world and subject/object as distinct entities towards the more modern and existential thinking of Philosophers like Maurice Merleau-Ponty who emphasised the importance of man as being in the world (1962) and introduced the concept of 'corps proper' (1962), the lived body. The lived body proposes that ones own body is more than its physical aspects, for it unfolds for you a world which is particular to you and different from the world which is disclosed through another's body. Similarly this research concerns itself with the unique subjective experience of the individual as they attend to their being-in-the-world and asks whether the external world can ever be more than its physical objects? Can food ever be more than something to eat?

Definitions of central concepts

Central concepts in this research are ' Anorexia Nervosa' 'symbolism', 'metaphor', 'concretised metaphor', 'projections' and 'introjections'.

Anorexia Nervosa

According to The Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM IV), the following criteria must be met in order to give an individual the formal diagnosis of Anorexia Nervosa (AN):

"A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected)."(p263)

"B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self evaluation, or denial of the seriousness of the current low body weight.

D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles."(p.263)

The DSM IV also differentiates between two specific types of AN:

"Restricting type: during the current episode of AN, the individual has not frequently engaged in binge-eating or purging behaviour (self induced vomiting or the misuse of diuretics, laxatives or enemas.

Binge-Eating/ Purging type: during the current episode of AN, the person frequently engages in binge-eating or purging behaviour." (p.264)

Symbols and metaphors

A symbol stands for or signifies something else. Symbols are often universal, stand for something concrete and represent institutions such as culture, family and religion; and tend to be represented and supported by generations of use. The metaphor is a subgroup of symbols (Skarderud, 2007a) it is a far more intimate concept than a symbol for it is not universal but often personal and unique. Aristotle (1984) in 'poetics' defines the metaphor as 'giving something a name that belongs to something else' (p.1457). A metaphor enables one to experience and understand one phenomenon through another phenomenon. Lakoff & Johnson (1999) define the metaphor as being grounded in similarity, a resemblance between the phenomenon in the 'target area' and 'source area'. Two explanatory models exist to explain the function of the metaphor; Black's model (1962, 1979) and the inter-actional model (Richards, 1936; Beardsley, 1958, 1962; Ricoeur, 1978).

Recent years has seen the use of the metaphor evolve from being a creative ornamental rhetoric to a model for the general function of mind Lakoff & Johnson (1980, 1999). Particularly in the world of psychoanalysis the mind is seen as metaphorising in a general sense (Arlow, 1979; Ogden, 1997; Melnick, 1997; Borbely, 1998 and Rizzuto, 2001). The use of the metaphor

as a working concept in psychoanalysis has led Campbell & Enckell, (2005) to suggest that "the psyche works through the medium of non-verbal metaphor to establish links and organize mental contents" (p.803) with the theories of dreams and transference being cited as examples.

Concretised metaphors

'Concretised metaphors' refer to instances when the metaphor is no longer understood or experienced as representing and containing an indirect expression of something else. Rather, concretised metaphors are perceived as "presentations stating a merciless reality which instead of being functioning symbols, concretised metaphors are experienced as immovable facts with which one cannot negotiate." (Campbell & Enckell, 2005; p.801). That is no distinction can be made between the metaphor and the phenomenon being metaphorised; the 'as if' of the metaphor becomes an "is". Campbell and Enckell, (2005) believe that concretised metaphors come about as a reaction against inner fragmentation or a threatened sense of self and are considered an impairment in reflective function. Other terms which explain such impairment in reflective functioning in reference to AN are 'concrete attitude' (Miller, 1991), 'concretism' (Buhl, 2002) and 'psychic equivalence' (Bateman & Fonagy, 2004). A vignette described by Kitayama (1987) illustrates well this collapse of functioning metaphors. A psychotic man complained about not being able to sleep due to a continuing light. The man called his former girlfriend 'my sunshine'. It was eventually apparent that the thought of the girlfriend kept the patient awake.

Projection and introjection

The term projection is used to describe the way people externalize their structures, contents or relations of their internal world. Introjection, however refers to the way people internalise into their ego qualities of objects from the outside world. Klein (1946) wrote that both projection and introjection are mechanisms of defence, which evolve against the overwhelming anxiety of annihilation. Here the ego strives to introject the good and project the bad; the function of such a split is to keep the ideal

object as far away as possible from the persecutory one whilst maintaining control over them both.

Overview of the Literature

Anorexia nervosa as conceptualized and understood by Hilda Bruch

> "Expressions of the deficiency in overall development are manifested by inaccuracy in perception and control of bodily sensations, confusion of emotional states, inaccuracy in language and concept development, and great fear of social disapproval. The relentless pursuit of thinness can be conceived of as an effort to camouflage these underlying problems." (Bruch, 1988; p. 4)

Dr Hilda Bruch is one of the most seminal figures in eating disorders; she is being used as a starting point for this review as despite some of her work dating back almost 50 years, she has been singled out as an inspiration for a stronger focus on conceptual and theory models (Skarderud, 2009); additionally it is intended that in giving a description of her work it will lay the foundations for the discussion to follow of more recent findings in the area of this research.

Bruch was the first to assert the necessity of delineating differences in the psychological manifestations and clinical courses of different forms of eating disorders as essential to effective treatment and the understanding of the disorder (Bruch, 1962). Bruch's paper "Perceptual and Conceptual Disturbances in Anorexia Nervosa" (1962) did just that and through the examination of clinical symptoms and multiple psychodynamic data of 12 patients over 10 years identified three areas of "functionally disordered psychological experience" for the individual with AN (Bruch, 1962).

The first area she identified was a disturbance in body image "of delusional proportions" (Bruch, 1962; p.188). Bruch characterised this by the extreme absence of concern by the individual over their emaciation, their stubbornness to defend their thinness and denial of their illness. The second area she identified was a disturbance in "the accuracy of perception or cognitive interpretation of stimuli arising in the body" (Bruch, 1962; p.189); chiefly the anorexic patients inability to recognise their own hunger, fatigue and weakness in correspondence with their malnourishment, a falsified awareness of the bodily state through over activity, lack of sexual feelings and a limited ability to identify, describe and verbalise their own emotional states and faulty language and concept development. The third area identified was an overwhelming sense of ineffectiveness, which permeates all the thinking, and activities of the anorexic patient, to the extent that the anorexic patient only ever perceives themselves as acting in response to the demands placed upon them from other people and situations and never as doing anything they might like to.

Much of her authorship which followed echoed these findings (1970, 1973, 1988) and over time Bruch consolidated her landmark contribution as a theoretical and descriptive model that defined AN and severe eating disorders as manifestations of underlying self disorders, in particular developmental deficiencies in the organisation of the psychological self.

Of particular interest to this review is Bruch's understanding of the origin of these developmental deficiencies as early faulty transactional patterns (1970). From detailed analysis Bruch concluded that even though on the outside the picture of the anorexic patient and their families is that of devoted parents who provide good care to their children, what in fact is present underneath is an all pervasive "attitude of doing for the child and superimposing the parents' concepts of his needs, with disregard of the child initiated signals" (1970; p.53). This attitude Bruch believed denies the child of an essential learning experience that is "the regular sequence of events, that of felt discomfort, signal appropriate response, and felt satisfaction."(1970; p.53). Without recognition or confirming responses to

the child initiated signals, Bruch believed that the child in time will fail to develop an awareness of their own needs and a sense of control over their impulses (1970); instead they may find themselves feeling that they are not in control of their functions and fail to recognise that they are living their own life and develop a conviction of their own ineffectiveness (Bruch, 1970). Due to such a falsified awareness of their own body and needs, when the anorexic patient reaches an age when they need to assert their own independence they may therefore "resort to rigid control over their bodies" as a way to establish "a domain of self hood." (Bruch, 1970; p.53).

In summary, for Bruch behind each anorexic patient lies an individual with an under developed sense of self. It is this personality deficiency that Bruch felt should be the focus point for psychotherapy. Consequently she set about formulating a psychotherapeutic approach which focussed on correcting these early faulty transactional patterns through "the setting of a new intimate interpersonal relationship" (1985, p.14), and emphasised the evocation of awareness of thoughts, feelings and impulses that find their origin in the patients themselves rather than the therapist' interpretations (Bruch, 1970, 1985). Her success with regards to this new approach, was documented by individual case studies (1970, 1975) and culminated in the writing of her last book "Conversations with Anorexics" (1988) within which she includes many case studies which unfold to present the reader with an effective and remarkable way of treatment.

Bruch's work was revolutionary, not only did she recognise the need to delineate the clinical manifestations of AN from other eating disorders but she acknowledged that the underlying disturbances of the condition were much broader than the thinking of traditional psychoanlysis had assumed (1988)[3]. The theoretical model she forged in response to these needs was not only informative and enlightening, but was also very practical, for out of it developed a new treatment approach which proved very successful and

[3] Previous psychoanalytic thinking understood AN as founded in conflicts over sexuality and fears of oral impregnation, (Bruch, 1988)

led to her being regarded as one of the most gifted healers for those with AN (Skarderud, 2009).

Despite singing the praises of Bruch, almost 50 years on from some of her earlier works it is important to recognise other theories which have emerged since this time and to review her work in the context of these developments. In general advances have been made in developmental psychology, attachment, personality development and in psychoanalysis (Skarderud, 2009), all of which have contributed to the emergence of an original and distinct concept of self-regulation and more specifically affect regulation (Skarderud, 2009). These concepts although superior to those of Bruch's are however consistent with her concept of interoceptive confusion (1973) and self deficits as experienced as an overwhelming sense of ineffectiveness, lack of control and an inability to regulate and recognise emotions. Many of the theories that explore and utilise this concept of affect regulation, this review will go on to discuss and so at this point it is only necessary to raise an awareness of aspects of Bruch's theoretical and conceptual model which now may be seen as out of date.

Changing focus and looking at Bruch's work in light of the clinical data she collected, it is perhaps necessary to put forward the idea that even though the data she gathered was collected consistently over a number of years, through detailed case studies, that these case studies were put together and presented in papers that were often only written by her (1962, 1970, 1973, 1975, 1978) and hence there is some possibility that these case studies were presented in bias towards the theoretical and conceptual model she had developed. In a similar respect the cases, which she presented in support of her new psychotherapy, were clients who had undergone therapy with her. Without wanting to take away from her remarkable success with these clients, the question arises as to whether this success was down to the structure of the therapy she employed or whether there was something else innate in her quality of character that was also a contributing factor to her success.

The self and anorexia nervosa – "The concrete attitude"

Following on from Bruch several other authors persuasively argued that a patient who suffers from AN is suffering from a disorder of the self (Geist, 1985,1989; Chessick, 1984/1985 and Goodsitt, 1985). These ideas were summed up in a coherent and persuasively written paper by Miller (1991) in which he clarifies and illustrates with the use of a case study the meaning of something called the "concrete attitude" and a new treatment approach which focuses on the acceptance and understanding of this "concrete attitude".

Previously used by Josephs (1989) to refer to a presymbolic developmental level where "things are no more than what they appear to be at face value" (p.495) the "concrete attitude" as expanded upon by Miller (1991) denotes the anorexic patients "tendency to focus concretely on their food and weight related symptoms" (Miller, 1991, p. 85). It makes reference to the observations made by Bruch (1973, 1978 & 1985), Geist, (1985) and Goodsit (1985) that the anorexic patient is notably out of touch with their emotional and bodily experiences, is "deficient in the ability to think abstractly about psychological issues, and singularly devoid of psychological insight" (Miller, 1991, p.85). In light of these observations Miller goes on to advocate a treatment approach in line with Bruch and many others who argue for the value of integrating a self-psychological perspective into the treatment of patients with eating disorders (Kohut, 1971, 1977, 1984; Geist, 1985,1989; Chessick, 1984/1985 and Goodsitt, 1985). These authors convincingly argue that a patient with anorexia nervosa is suffering from a disorder of the self, and that their anorexic symptoms have the function of maintaining the stability and cohesion of a greatly tenuous sense of self (Geist, 1985,1989, Chessick, 1984/1985 and Goodsitt, 1985).

Outlining the argument from the self psychological perspective Miller asserts the necessity of empathically attuned parents who are able to serve as selfobjects to their children as key in providing the developing child with a stable and cohesive sense of self and in permitting the effective integration

of the body-self, affective experience, self organization and inter-subjective relatedness (Stolorow, Brandchaft, & Atwood, 1987; Kohut, 1971, 1977). Such 'optimal integration' according to Miller is a far cry from what has happened in reality for individuals with eating disorders (Miller,1991; p.87). This can therefore leave them vulnerable to structural decompensation of the self- organisation (Stolorow and Lachmann,1980). During stressful times e.g. adolescence this decompensation may threaten such individuals with at the least severe level, a loss of self esteem and at a more severe level, identity confusion and even fragmentation (Stolorow and Lachmann,1980). As a consequence Miller (1991) asserts that individuals with a vulnerable self-organisation, attempt to bolster their sense of self by trying to enhance their experience of being grounded in their own body. These efforts have been called "concretization" by Atwood and Stolorow (1984) and defined as "the encapsulation of structures of experience by concrete, sensorimotor symbols" (p.85). In the case of individuals with AN their symptoms serve to concretize their self experience in the hope of minimizing their risk of a greater loss of stability and cohesion of the self, for example "the anorexic's constant activity and exercise are her attempts to feel herself within her body. They are attempts at feeling whole and cohesive" (Goodsitt, 1985, p.59).

In addition to concretising self experience, the self psychological perspective as laid out by Miller (1991) believes that the anorexic patient starts to see herself as how she views her body: "In seeing herself as fat the anorexic patient is concretizing her self-image of being "out of control" and imperfect" (p.87), furthermore "her feelings (often dissociated) of emptiness and of a self that is shrinking and dying are literally expressed concretely by her body, which is indeed empty, shrinking and dying."(p.87). Unfortunately however, Miller asserts that the anorexic patient lacks the conscious awareness to make symbolic connections between her underlying sense of self and her concrete symptoms, it is this incapacity that Miller believes is best explained by Josephs (1989) "concrete attitude" a presymbolic developmental level of thinking. Using the developmental framework of Piaget and Inhelder (1969), Josephs likened the transition from the concrete

operations stage to the formal operations stage to the transition from "Concrete attitude" to "abstract attitude"; with the "abstract attitude" representing an ability for the "contemplation of the non-present and the hypothetical: the past, the future the possible and the impossible" and "the capacity for symbolic interpretation" (Josephs, 1989. p. 490).

Given the emotional and cognitive limitations behind this "concrete attitude" Miller (1991) asserted that traditional analytic therapy which requires individuals to work at an abstract level with symbolic interpretations would not be an inappropriate form of treatment; better suited would be one which requires the therapist to enter the realm of the concrete rather than the patient to enter the realm of the symbolic.

Within Miller's article and the self psychological perspective anorexia is in a sense conceptualised and understood from the "concrete attitude". Although this concrete attitude is adequately described (in its manifestation and origin) and illustrated clearly within Miller's case report, it is not explored in relation to the theory of the metaphor. Therefore their lies little if any scope for a more detailed and introspective understanding of "concretization". As with much of the literature in this area, arguments seem to be built for theories from the author's own observations in his clinical work. Although this holds much merit, for it provides the most natural insight into the minds and behaviours of these individuals, it is however not the most robust way of demonstrating theoretical knowledge in this area as it is prone to bias in interpretation, for this reason there is some call for more controlled exploratory studies in this area.

Similar to Miller and the self psychological perspective, Buhl (2002) drawing on Killingmo (1989) also explores anorexia as deficit pathology, more specifically an expression of a "disturbed developmental process" (p.138). Unlike previous papers Buhl moves beyond a focus on the concretistic symptoms of anorexia and attends to more specifically their concretistic use of words. Within her article she asserts the anorexic's inability to use abstract concepts, words and verbal language in relation to

mental states, impulses and needs (p.138) and explains this as a result of a disturbed or dysfunctional psychological environment within the family. She equates these deficits to alexithymic traits and asserts the importance of understanding this in psychotherapy. In particular she asserts like Miller (1991) the importance of the therapist meeting the patient's "concretistic language directly and concretely" (p.144).

Buhl's (2002) article is coherent and informative. It places a clear and important focus on the concretistic use of language within the disorder and discusses it in the light of more evolved concepts such as alexithymia. Apart from this, however the articles' end goal is the same to Millers (1991) and others that have gone before, both in the sense of what this means for therapy and the origins of the deficits. One therefore has to ask the question aside from re-affirming what has been written before what new contributions this makes towards our understanding of anorexia.

Concretised metaphors and anorexia nervosa

Bateman and Fonagy (2004) and Fonagy, Gergely, Jurist, and Target (2002) in the development of their major theoretical concept of "mentalisation" draw on the notion of "psychic equivalence". Mentalisation is "defined as the developed ability to read other people's mind" (Skarderud, 2007b, p.248). It includes both an interpersonal and self-reflective component the combination of which provides a child with the ability to distinguish outer from inner reality. It is this ability that Bateman and Fonagy (2004) argue underlies the capacity for impulse control, self- monitoring, affect regulation and the experience of self agency. Psychic equivalence is defined as the equation of the internal with the external (Fonagy, Gergely, Jurist, and Target 2002), e.g. "what exists in the mind must exist out there" (Skarderud, 2007b, p.248). It is both characteristic of an infant's or young child's early awareness of mental states and both an older person's compromised mentalizing capacity.

Originally the concept of psychic equivalence was developed in relation to borderline personality disorders, however there is some reference of it in relation to eating disorders by the authors (Fonagy, Gergely, Jurist, and Target, 2002). Within these references they refer to how when psychic reality is poorly integrated, the body can take on an "excessively central role for the continuity of the sense of self." (p.405). In addition they state how psychic equivalence can lead to "specific physical states acquiring exaggerated significance in relation to the self," moreover "mental states unable to achieve representation as ideas or feelings, come to be represented in the bodily domain."(p.405). In this sense psychic equivalence can be seen as referring to a similar phenomenon such as concretised metaphors (Skarderud, 2007b).

The concept psychic equivalence further develops and enriches the idea of the "anorectic deficit" (Skarderud, 2007b, p.248). It also encourages a wider understanding of anorexia in the context of other disorders of the self such as borderline personality disorder. It is just a shame that this concept has not been further explored by the authors in direct relation to AN.

Concretised metaphors have been more widely understood and explored in relation to psychotic and borderline functioning. Campbell and Enkell (2005) describe the collapse of the capacity to use functioning metaphors as a "corollary of psychotic functioning" (p.805) and explore it in relation to the metaphor as a working model for psychic functioning. They propose that concretised metaphors "may be viewed as restitutional efforts" (p.805).

Returning to the field of eating disorders, Skarderud (2007a,b&c) is the only scholar to have explicitly explored the use of concretised metaphors within anorexia nervosa. Skarderud (2007a) carried out qualitative research on ten female participants with AN to investigate whether emotions are symbolised and concretised through the use of the body. The basic assumption of this paper was that aside from linguistic representations the body also functions as the source area for metaphors.

Skarderud was able to classify two main categories of concretised bodily metaphors; 'specific' and 'compound'; examples of specific metaphors include emptiness/fullness, purity and spatiality; here the metaphor equates emotion to one domain of the sensorimotor experience. An illustration of a specific metaphor, is that anorexics often have a low self esteem or negative self-evaluation, this can be linked to the sense of not being worthy of taking up space and explain why they try to shrink in size. In compound metaphors more and different domains of sensorimotor experience can interact with the experienced feelings; examples include control/vulnerability/protection and self worth. Skarderud's results demonstrated that "there is no unambiguous or closed relationship between food denial in anorexia nervosa and metaphorical content" (p172), however the main focus of these findings was their emphasis of a deficiency in the capacity for symbolic functioning which shows an impairment in reflective functioning and mentalisation.

Reflective function is the capacity to make mental representations (Skarderud, 2007b). It is a broader concept than mentalisation, which is only a part of reflective functioning. Mentalisation is also described by Skarderud (2007c) as being an important determinant of self organisation and affect regulation. Skarderud's concept of impaired mentalisation can be seen as an updated conceptualisation of what Bruch first described as deficits in mental processing (Skarderud, 2009).

Skarderud's research is heavily grounded in other theoretical and conceptual literature written around AN, (Miller, 1991; Buhl, 2002; Bateman and Fonagy, 2004) and his papers on the whole present a coherent argument and framework within which to understand AN. Skarderud's (2007a,b & c) exploration of the concretised metaphor in anorexia nervosa is pioneering on two counts. Firstly in the way that unlike previous literature it specifically considers the role of concretised metaphors within the illness, and secondly in the way that it assumes that not only is the mind a source area for metaphors but the body as well. For these reasons it makes a valuable and original contribution to the field of literature. In

addition to this an advantage of Skarderud's work is that he used his findings in a practical way to outline a new form of psychotherapy for patients with anorexia based on a model of mentalisation.

Difficulties the researcher has with his findings are located in his dual role of therapist and researcher. For despite his intention of aligning his therapeutic aims alongside his research aims, the question is raised as to whether the data gathered has been interpreted or influenced in light of pre-existing knowledge or assumptions about participants and also whether participants have construed their answers in the interviews to please their therapist or to appear compliant, a common character description of individuals with AN (Bruch, 1962).

Object-Relation Theory and anorexia nervosa

The last area of literature this review intends to discuss is object relation theory. Within the object relation's field eating disorders are understood as being grounded in unresolved conflicts caused by early deprivation in the child-parent bond (e.g. Castelnuovo-Tedesco & Risen, 1988; Lawrence, 2001, Williams, 1997; Winston, 2009). Similar to the self psychology perspective and the work around mentalisation the relationship between the child and mother is described as ineffective and unfulfilling (Williams, 1997; Winston, 2009) and the mother herself is described as unempathic and unattuned to her child's needs. Due to the breadth of work on AN in this area, this review has decided to focus on the work of two particular authors (Selvini, 1974 and Winston, 2009) within this field, the writings of which both seem to be particularly pertinent to the theme of concretised metaphors.

Having said that Skarderud (2007) was the first to explore the metaphorical role of the body within anorexia this is actually not the case; Mara Selvini Palazzoli's within his book "Self-starvation" (1974) asserts that "the body of the anorexic does not merely contain the bad object but that it is the bad

object" (p.87). Although clearly coming from a different perspective to Skarderud, that of object relations, and with the use of different terminology it is undeniable that for Selvini, like Skarderud (2007a,b&c), the "as if" of the body is no longer and instead it is concretised to the "is". That is the body acts as a concretised metaphor for something else, for Selvini the bad object.

Selvini (1974) describes the anorexic's fight against her body as a desperate fight against a bad object, which has been incorporated into the self due to defective emotional relations with the object. This is similar to other object relation theorists who have argued that self starvation is a way of controlling a "bad" object unless it becomes too over powerful (Boris, 1984, Newton, 2005). More specifically Selvini explains the body is experienced as "having all the features of the primary object as it was perceived in a situation of oral helplessness; all-powerful, indestructive, self-sufficient, growing and threatening." (p.87). For the anorexic the incorporated bad object cannot be split up. In order to spare her own ego she therefore projects the "unacceptable within the structures of her own personality, into her own body", thus her body becomes the persecutor, "but a persecutor on whom it is relatively easy to spy and impose controls." (p.93). This type of projection Selvini states becomes a way of protecting the patient from "interpersonal delusions and, in a way, preserves her ability to socialize and relate to the world" (p.93).

Essentially for Selvini in AN "the power motive frustrated in interpersonal relationships is shifted to the intrapersonal structure, that is to the rigid control of the patient's body" (p.94). Where other theories does not, this theory therefore manages to account for not only the impact that negative and misattuned caregiving relationships can have on an individual but also more specifically on how these individuals attempt to manage and protect themselves from these relational dynamics. In a sense where all other theories emphasise the "anorectic deficit" this theory emphasises the defensive and protective nature of AN, not only against a very tenuous sense of self but from an identified persecutor, the bad object. In both these respects Selvini's interpretation of AN therefore feels more inclusive of the

relational dynamics which all theories (Bruch; 1962, Miller 1991, Buhl, 2002, Bateman & Fonagy; 2004 and Skarderud; 2007) seem to agree contribute towards the development of AN.

Like many other authors within the psychoanalytic tradition, Selvini based his theories around AN on his own observations with his clients, therefore raising some questions surrounding the validity of his work. It is also quite apparent that since he wrote his book there have been significant developments within the attachment field as mentioned earlier. However having said this, Selvini's belief that the anorexic body becomes and is the incorporated object is implicit of a concretised metaphor, a concept that was ahead of his time, and provides us with a new angle from which to explore and consider the extent and functions of concretised metaphors.

Winston (2009) drawing on the works of the French psychoanalyst Andre Green (1986), in his article "Anorexia Nervosa and the Psychotherapy of Absence" looks to explore AN from the notion of absence and asks the reader to consider the role of the therapist as filling these absences. Within his paper he links the absence of feeling, fantasy and a secure sense of self" within the anorexic client to "the absence of containment, potential space and good internal objects" (p. 78). Of particular interest in his paper is his exploration of the impoverished fantasy life of the anorexic. Drawing on the works of Winnicott (2005) Winston asserts that the impoverished fantasy life of the anorexic can often be traced to "a failure to develop a potential space between mother and child" (p.81) where both symbolization and empathy develop. From this Winston asserts that:

"If there is no potential space, however, the "as if" quality is lost and only concrete reality remains. Metaphorical thought becomes impossible and symbolic equation (Segal, 1957) is the dominant mode of thought. In the content of anorexia, food is not experienced as though it were dangerous, it is dangerous" (p.82).

Quite clearly here Winston is alluding to the collapse of functioning metaphors within the anorexic client due to a lack of potential space. What is of note here is his reference to food as dangerous, implying that food in itself comes to be a concretised metaphor for something else, something that is perceived as dangerous. Earlier on his paper Winston suggests that food for the anorexic becomes equated with feeling, feelings they wish to retreat from due to uncontained early feeding experiences. However both this comment and the one before about food are fleeting and the nature of and the type of projections or meanings that food can or may contain are left unexplored and inadequately described. What is important however is the way this article provides a first glimpse or inference at food as being a potential source area for metaphors as well.

Summary

The absence of the exploration of food and its meaning within anorexia is present within all the models this literature review has explored. In failing to leave space for such an idea these models become limited by their epistemological framework for it only allows the body to become an extension of the mind and its thinking, a representation of what has gone wrong in the development of the self. The external world is only accounted for in a systemic way through the impact of the child's environment on their growth when they were younger. The reverse is not allowed, for the models cannot account for how the individual may think about and give meaning to their external world through their disorder.

If anorexics do have a deficiency in the capacity for symbolic functioning as the theoretical models this review has explored maintain then it is important to understand the extent to which the anorectic mind applies the concrete metaphor. Does it for instance extend out to food and if it does what does this mean for the therapies that this review has outlined which talk about engaging the patient on a "concrete level". For these reasons the

study that follows below aims to address this gap within the research literature by exploring the meaning of food for individuals with anorexia nervosa, in doing so it hopes to make a valuable contribution to the field of knowledge in this area.

Chapter 2: Methodology

Introduction

This chapter discusses the issue of epistemology and introduces the study's methodological approach and specific methods through which the study's goals are met.

Epistemological Framework

Hermeneutic tensions and phenomenology

This study's exploration of the subjective meaning and experience of food for individuals with Anorexia Nervosa (AN) incorporates a number of hermeneutic tensions. Critically it tries to account for the tension that arises from the hermeneutic spectrum as described by Ashworth (2003, p.19) which at the one end takes and understands accounts at face value, 'the hermeneutics of meaning collection' and at the other end does not, 'the hermeneutics of suspicion'. More specifically this study attempts to stay true to the conscious content and behaviour of individuals, which can be understood through shared meanings and social contexts but additionally intends to dig deep and try to make sense of through interpretative actions the not always fully conscious intra-psychic experiences of individuals.

The inclusive approach this study takes toward this hermeneutic tension is in line with Heidegger's (1927) understanding of phenomenology. Heidegger believes appearance has a dual quality (1927); that is things not only have distinct visible meanings for us but they can also have concealed meanings. Whilst these visible meanings are available to us through perception, the hidden meanings are illuminated analytically, thus whilst phenomenon appears a phenomenologist is needed to make sense of and understand that appearance (Smith, Flowers & Larkin, 2009). Meaning thus

becomes interweaved with the phenomenologist and their own fore-conception, that is prior experiences, preconceptions and assumptions (Smith, Flowers & Larkin, 2009). However just as Heidegger believed fore-conceptions precede our encounters with new things this does not mean that our understanding cannot be formed the other way. For example it may only become clear after engaging with a text what my preconceptions are. (Smith, Flowers & Larkin, 2009). In addition to this, this study also believes in accounting for what Schleiermacher (1998) calls grammatical and psychological interpretation. That is when studying phenomenon it is necessary to have a more holistic understanding of interpretation; meaning is not made in the isolation of the phenomenologist's own interpretation for it is contextual and is therefore also made by the expectations and conventions of an author's own linguistic community and the unique intentions and techniques of the author which will imprint a particular form of meaning upon the author's account.

Reflecting on my role as phenomenologist within this project and within this epistemological framework it has become clear that a further more personal hermeneutic tension is present. This is that within the interpretative framework that I employ that on the one hand although I may want as far as possible to remain true to my preferences towards the theoretical ideas and concepts of psychodynamic theory, that on the other hand it is important for me to stay flexible in my approach to the interpreting within the analytic process and give voice to alternative formulations should they make more sense. This tension is further couched in my own identity as both a researcher, seeking to forge new, independent and objective understandings about the world and as a counselling psychologist trying to make sense of individual's difficulties in line with the theories I have learnt and understood through my psychodynamic training and interests.

The Interpretative Stance

When reflecting in more detail on the type of interpretative stance this project takes, inline with Heidegger (1927) it believes this stance is grounded in the lived world, a world of people, objects, relationships and

language. This "worldly" perspective is of importance for as Smith, Flowers and Larkin (2009, p. 17) states it "affords the embodied, intentional actor a range of physically-grounded (what is possible) and intersubjectively-grounded (what is meaningful) options", that is, as individuals we use the world and our worldly context to make meaning.

> "Such entities are not thereby objects for knowing the world theoretically, they are simply what gets used, what gets produced, and so forth." (Heidegger, 1927:95)

Along with recognizing the importance of our worldly context this study also believes in Merleau Ponty's (1962) concept of 'corps proper' (1962) the lived body. The lived body proposes that ones own body is more than its physical aspects, for it unfolds for you a world which is particular to you and different from the world which is disclosed through another's body. The body for Merleau Ponty was no "longer conceived as an object in the world, but as our means of communication with it." (1962:106). As individuals therefore our perception of other is always our own embodied perspective.

In summary the epistemological framework within which this study is best contextualized is by a 'constructivist –interpretative paradigm' grounded in "a relativist ontology (there are multiple realities), a subjectivist epistemology (knower and subject create understanding), and a naturalistic (in the natural world) set of methodological procedures" (Denzin & Lincoln, 1994, p.13-14).

Qualitative Research

Qualitative research tends to be concerned about meaning, in particular "how people make sense of the world and how they experience events" (Willig, 2008, p.8). Unlike more quantitative methods which tend to focus on finding out about causal relationships and variables, qualitative research

endeavor to discover and learn about the quality and texture of experiences people have and the meaning these individuals themselves are able to prescribe to their experiences. Unlike quantitative research the role of the qualitative researcher is never to predict, but only to possibly explain and describe experiences and events (Willig, 2008). The qualitative researcher does this by attending to people in their own natural settings recognising that it is this setting and the interpretation of both the researcher and participant that create the process of meaning.

Rationale for a qualitative study

Within the literature on eating disorders, nothing to the researcher's knowledge has been written on and about the meaning of food for individuals with anorexia nervosa. Given the researcher's desire to investigate this phenomenon using an inductive method which allows the exploration of complex emotions and meanings without restricting participants to preconceived constructs (Smith, 1995b) and the researcher's own epistemological standpoint Interpretative Phenomenological Analysis has been chosen as an appropriate method of inquiry.

Interpretative Phenomenological Analysis

This study will use interpretative phenomenological analysis (IPA) methodology. IPA looks to give a detailed examination of the unique intersubjective experiences of the individual, as a 'being-in-the-world' (Spinelli, 1989:108) and how individuals make sense of that experience (Willig, 2008); although it seeks to explore the research participant's experience from their own perspective it understands that the exploration cannot exclude the researcher's own view of the world and the interaction between researcher and participant, as a result the phenomenological analysis is always an interpretation of the participant's experience. This is a seen to be an attractive feature of IPA as following the experience of carrying out the pilot study the researcher became aware of the difficulty in reviewing data without imposing her own understandings and interpretations of the world upon them.

Given the researcher's own epistemological framework, study objectives and primary ways of thinking (psychodynamically), IPA's grounding in phenomenology and hermeneutics make it an appropriate method of research for the following reasons:

1. At the heart of this research is the existential thinking of Merleau Ponty, (1962) who introduced the concept of "corps proper" the lived body. This fits well with IPA, as IPA's starting point is the unique intersubjective experience of individuals as they attend to the body as it is lived and experienced.

2. This research asks whether for individuals the external world can ever be more than its physical objects; can food ever be more than something to eat? Aside from the emphasis IPA places on the importance of the body, it also attends to the hermeneutics of factical life. That is, IPA emphasises the inescapable, contingent yet worldly aspect of human existence (Moran: 2000) and looks to understand the objects and events we are directed towards through the way they are experienced and given meaning by the individual. This study looks to understand the meaning of food by the way it is experienced and given meaning by the individual.

3. IPA and Psychodynamic literature both aim to explore an individual's personal perception of account of an event. For psychoanalytic phenomenology "centres on the acquisition of reflective knowledge of participants' lived experience by making sense of their perceptual world and the influence of that inner world on their organization. It looks into the subjective perceptions of the world achieved by using reflective analysis of their experience and meaning" Diamond (1990, p.34).

4. Just as the researcher questions the limitations of the cognitive revolution (as detailed in chapter 1) so too does IPA believing that "emotion theorists have reduced the often messy and turbulent

process of making sense of emotional experience to the internal cognitive activity of hypothesized causal relationships." (Eatough & Smith, 2008, p.183). From the IPA perspective cognitions do not stand in isolation as separate functions but rather are an aspect of our being-in-the-world; "thinking is not detached reflection but part of our basic attitude to the world" (Mingers, 2001:110). The IPA method is therefore consistent with the researcher's more holistic understanding of cognitions as being only a component part of our meaning making.

The Analysis

IPA works with texts generated by participants through semi-structured interviews (Smith, 1995b) or through asking a participant to produce their own account of their experience through various forms of writing (Willig, 2008). IPA takes an idiographic approach, texts are analysed one by one and insights produced as a result of intensive and detailed engagement with individual cases. It is only during the later stages of the research that these individual insights are integrated into an inclusive list of master themes that reflect the experiences of the group of participants as a whole (Willig, 2008).

For the purpose of this study the researcher has decided to employ IPA analysis as advocated by Eatough & Smith (2008). Their method of analysis consists of two levels; the first level is a descriptive level, this privileges the participant's own accounts of their experiences. Only after such attention has been paid to the participant's account does the analysis progress on to the second level of analysis, which is interpretative and informed by theory; the emergent analysis is examined in the light of the extent of the literature and theoretical relationships are then established. The researcher has selected this particular method of IPA as it is felt that its second stage of analysis is able to account for and include the researcher's primary ways of thinking interpretatively (within a psychodynamic framework). Furthermore the researcher believes that the emphasis placed on the first level of analysis within this method will help the researcher maintain a flexible approach towards her primary ways of thinking, encouraging

alternative conceptualisations outside of the psychodynamic model to be given a voice should they be a better fit towards the participant's account.

A brief description of the methodological practice of IPA according to Eatough & Smith (2008, p. 187) is as follows:

- "Research questions are directed towards aspects of lived experience
- The idiographic commitment encourages the study of small homogenous samples
- Semi-structured interviews are the exemplary data collection method for IPA
- Other methods include diaries, unstructured life history interviews
- Data collection is dialogical with the participant taking a significant role in determining what is said
- Analysis is an iterative inductive process, beginning with several close detailed readings to provide a holistic perspective, noting points of interest and significance
- Step-by-step analysis then proceeds to the description of analytic themes and their interconnections, taking care always to preserve a link back to the original account
- Analysis continues into the writing-up stage and finishes with a narrative of both participant's and researcher's meaning making of the topic under investigation
- Ideally the final narrative should move between levels of interpretation: from rich description through to abstract and more conceptual interpretations."

Evaluation of Analysis and Maintaining Quality

Just as IPA recognises the impossibility of exploring the research participants experience from his or her own perspective (Willig, 2008),

without implicating the researcher's own view of the world, it also recognises that understanding cannot take place without us making some preliminary assumptions about the meaning of what we are trying to understand, this is referred to as the 'hermeneutic circle' (Schleiermacher, 1998). To a degree, the exploration carried out of recent findings in this area of research has led the researcher to have her own preliminary assumptions about the meaning of food, IPA recognises the importance of these presuppositions about the world and recommends that the researcher works with them and uses them to advance understanding, this is made possible through the second level of analysis. IPA also however emphasises the importance of testing these presuppositions in the light of the evolving meaning of what we are attempting to understand (Willig, 2008) by moving back and forth between presupposition and interpretation.

It is this back and forth motion of IPA that I believe has helped me to maintain a flexible interpretative framework, and that has ensured that the conclusions of my analysis are not rigidly bound by my own primary ways of thinking psychodynamically, but have been free to reach conclusions that may be conceptualised and understood better outside of my own interpretative framework should they fit best.

In order to ensure this research is of a good quality the analytic procedure has adhered to the generic qualitative 'good practice' guidelines laid down by Elliot, Fischer and Rennie (1999) and Yardley (2008). These are transparency of the results, triangulation, reflexivity in the interpretation processes, sensitivity to context, commitment and rigour and impact and importance.

Reflexivity

Within this thesis the researcher has chosen to interweave her own reflexive thoughts, written in the first person (and highlighted in italics), throughout the main body of this project. In order to help the researcher recognise, collect and understand her own thoughts throughout the process of this research, a reflexive diary has been kept and a reflexive interview

was carried out before meeting with participants in order that the researcher became aware of her own preconceptions.

What follows below is a more detailed reflexive account of the context of the research, the researcher's background and the emphasis of importance the researcher places on understanding and recognising the use and role of "herself" within this project.

Study Context

This research has been completed as part of my journey towards becoming a chartered Counselling Psychologist.

Counselling Psychology

Counselling psychology is concerned with the integration of psychological theory and research with therapeutic practice. The aim of counselling psychology is to help individuals live in a more satisfying and resourceful way (Dryden & Mytton, 1999). This is done by emphasising the client's own capacity for self determination through a collaborative and exploratory relationship which aims to help the client build an understanding of themselves and reflect on and come to terms with difficult events that may have happened to them in their life (Strawbridge & Woolfe, 2003).

The Researcher – who am I?

I am 28 years old and am working towards gaining my chartership as a Counselling Psychologist at City University. Throughout the last few years of my training I have had a variety of experiences working with different client groups individually within and outside of the NHS. I have had the experience of working both within the cognitive and psychodynamic fields, and have found that I have a natural preference towards working psychodynamically, perhaps in part I believe due to my initial undergraduate training in philosophy. One thing that has particularly struck me from all my experiences is how influential our early experiences and particularly early attachments can be upon our lives. In particular I remember thinking towards the end of my first year of training, when I was working with two adolescents who had

neglectful and abusive parents, how significant and important the role of the mother is in the promotion of good mental health. These experiences encouraged me to take an active interest in the field of attachment, where a great wealth of literature has been written specifically within the tradition of psychodynamic theory.

Alongside my clinical experiences I have also had the opportunity for personal development through personal therapy. One of the things I found most interesting to explore within these sessions was the very restrictive eating pattern I adopted when I was small. In my search to think about why I might have been this way, I started to develop a wider interest in eating disorders. In particular thinking about the role of the mother in eating disorders, thereby attending to my interest in the attachment field. Whilst surveying the literature in this area it became apparent to me that no one seemed to have explored the meaning of food for individuals with eating disorders, specifically anorexia nervosa, for me this felt like a gap that needed to be filled, and so I set about trying to make this the topic of my research.

The impact of myself on the research

When reflecting upon how my interests and background have influenced the direction and undertakings of this research, I have come to realise that my preference towards psychodynamic theory has led me towards putting aside (for now), the more cognitive traditions. Instead I have chosen to focus on and explore more theoretical and conceptual models to rationalise and understand eating disorders. This has meant that some of my secondary research questions may be best understood or grounded in the psychodynamic tradition, and therefore my analysis has lent itself towards being interpreted within the psychodynamic tradition. I myself do not view this leaning as a limitation on my research, but at the same time I understand the possibility that others may.

Transparency: paper trail

In line with good practice in qualitative research a paper trail of all the data involved in building the codes, themes and super-ordinate themes for

analysis has been kept, so as to ensure transparency in the analysis results. Field notes of the researcher's own developing ideas, conceptualisations and reflections of the research process and additionally impressions of the research process for each individual interview have also been kept in a reflective diary, as mentioned above. (Henwood & Pidgeon, 1992; Willig, 2008).

Triangulation

Triangulation was employed in order to validate the researcher's findings further. One interview was chosen at random and its results reviewed by the project supervisor and then discussed with the researcher.

I found this a very useful process, as it highlighted to me how important it was to have a strong grasp and understanding of my findings, in particular how important it was for me to be able to justify my choices in the analytic process. Furthermore it helped build my confidence in the analytic process I was adopting and my emerging findings.

Sensitivity to Context

Throughout the study the researcher demonstrated sensitivity to context through an appreciation of the interactive nature and method of collecting data (Smith, Flowers, Larkin, 2008) as shown later in 4.7. It also tried to account for and support at all times its analytic claims by referring back to the raw material and by providing adequate, appropriate and frequent verbatim extracts from participants account, (Smith, Flowers, Larkin, 2008).

Rigour and Commitment

Rigour relates to the thoroughness of the study and the quality of the interview and analysis undertaken. At all times the researcher tried to conduct in-depth interviews with candidates who were appropriately matched to the inclusion criteria and more generally with a sample group who could sufficiently serve to answer the research question (Yardley, 2008). Furthermore at all times the analysis tried to maintain sufficient

ideographic engagement with the texts while simultaneously being sufficiently interpretative (Smith, Flowers, Larkin, 2008).

Impact and Importance

This principle refers to the point that for Yardley (2008) the real test of the validity of a piece of work lies in "whether it tells the reader something interesting, important or useful" (Smith, Flowers, Larkin, 2008; p. 183). Through the inductive fashion and lack of prior research in this area, the researcher hopes that this study through its very nature offers the reader something not only interesting, important and useful, but novel and forward thinking as well.

Limitations of IPA

IPA relies on the ability of participants to verbalise their experiences. Given the sample group being used in this project this limitation needs to be considered further and will be discussed in line with the results of the study. However at this point it is of importance to note that from the outset the researcher had an awareness of the difficulties that this client group is renowned to face in expressing themselves and also in opening up to people e.g. family, friends, therapists. In order to help minimise this limitation, throughout the research process the researcher emphasised the confidentiality of the data being collected, emphasised her identification as a researcher, not a therapist or Doctor and more specifically introduced an introductory section to the interview schedule which was specifically designed to help build a rapport between the researcher and participant to help facilitate the more exploratory and open ended questions which would be asked later on.

Study methods

Based on the epistemological framework of this study, the lack of prior research in this area, and the general literature reviewed, it became clear

from the outset that the design of this study must engage participants in an in-depth investigative process of both inter- and intra-psychic meanings. In order to do this the researcher quickly became aware that the study design had to allow for and include the exploration of the researcher's own ideas and concern for relational, emotional and developmental themes (in line with her psychodynamic curiosities) yet at the same time be flexible enough to allow for contradictory themes to emerge and for the participants own thoughts and stream of consciousness to emerge and be heard. Thus producing an evolving investigative process that could be modified by either researcher or participant.

Piloting

In order to inform the design of this study further a pilot study was carried out on 8 participants. The participants of this study were known to the researcher and the researcher was therefore aware of the different relationships the participants had towards food. In particular three of the participants had had problematic relationships with food whilst growing up either through self-starvation, over exercising or use of laxatives. Participants were asked to complete a questionnaire containing 22 questions (see appendix 1), which were designed with the intention of exploring the meaning, feelings and associations behind food. A detailed summary of the responses to these questions can be found in appendix 1. The most interesting finding of this study was however the implication that food embodies more than its physical aspects; that is it represents something more than its physical form. For some of the participants this was expressed through their understanding of food as representing "life", "love" and "wellbeing", but for a few food seemed to embody something more personal and less abstract such as "a relationship –like a lover"; "love for people"; or an "enemy".

Following my experiences of carrying out the pilot study I became aware of the difficulty in reviewing data without imposing my own understandings and interpretations of the world upon them, this reinforced my decision for a phenomenological method which understands analysis as always an

interpretation of a participant's experience. Furthermore my experience of conducting this pilot study also impacted upon my choice of data collection within this project. Within the pilot study I asked participants to give short answers to 22 different questions. Although the numbers of questions were useful as they allowed me to explore a variety of aspects behind food, the answers felt at times disjointed. Participant's answers also felt restricted for there seemed to be an imbalance between my own intention to explore certain aspects of food, (demonstrated by the directive questions), and the ability of the participants to express in full a meaningful account of food for them as they live and experience it. This reinforced my decision for a study design, which was both directive yet flexible in its nature.

The Sample Group

Aware of the complexity, sensitivity and variation of the severity of the illness for those with Anorexia Nervosa and of the varying support people with this disorder may have access to, this study wanted to include a homogenous sample group who would not only be able to provide this research project with rich data that could give a fair representation of the complexity of the experiences of food for those individuals but more importantly who would have access to the support and containment for their illness outside of the research environment. This would be an essential part in safeguarding the participants of this study within and outside of the research process and in maximising their comfort and sense of safety within the research interviews, which in turn could help the researcher to facilitate more exploratory thoughts.

Inclusion Criteria

The inclusion criteria was that participants were female, aged over 18, had a diagnosis of anorexia nervosa according to the DSM- IV and were currently being treated in an inpatient facility.

Exclusion Criteria

The exclusion criteria were that participants should not have a co-morbid diagnosis of bulimia, were not male or less than 18 years of age. People who

could not speak English fluently were also excluded as due to the researcher's intention to explore complex and emotional themes verbally it was felt that some of the meanings and understandings could get lost in translation.

Sample Size

IPA keeps an idiographic focus and challenges the traditional linear relationship between number of participants and the value of research (Reid, Flowers & Larkin, 2005). 10 participants have been considered at the higher end of recommendations in sample size (Smith, Jarman and Osborn 1999). For this reason the researcher set about trying to recruit between 8-10 participants for the study. The final number recruited was 9.

Recruitment

The researcher contacted various inpatient eating disorder units within and outside of the NHS to ask them to consider letting the researcher invite their inpatients to take part in the study. Eventually the researcher received permission from the Service Manager at the Phoenix Wing, St Ann's Hospital, Barnet Enfield and Haringey Mental Health Trust, subject to NHS ethical approval, to invite patients from this ward to take part in her study. Once the researcher received permissions from the NHS Ethics committee, the researcher provided the relevant clinical and nursing staff on the ward with information sheets about the study. Following this the researcher spoke with the Lead Mental Health Nurse on the ward to discuss potential participants for the study. These participants were then introduced to the researcher through the lead nurse and were invited to come and talk to the researcher about taking part in her study. Following contact with the researcher potential participants were given an opportunity to discuss the study and to ask questions. All participants who wanted to engage with the study were then asked to sign a consent form, following which a time was agreed for when the interview would take place. Altogether 9 participants from the inpatient ward opted to take part in the study, (only 8 of the participant interviews, however were used in the process of analysis as explained later). All interviews as sanctioned by Wandsworth Research

Ethics Committee were conducted on site at the Phoenix wing. More specifically in line with the Lead nurse's suggestion and contingent upon the participant's agreement all interviews were conducted in the participants own bedroom on the ward.

The process of recruitment and inclusion and exclusion criteria had to be adhered to at all times in line with the ethical guidelines. This at times could feel frustrating and difficult. At one point I was approached by a 17-year-old girl who wanted to take part in the study, she had heard from a friend on the ward of the study and seemed very interested by it. It felt hard for me to turn her down, aware that I did not want her to feel excluded, and also being aware that her interest in the study could mean that her interview could be very insightful and interesting. Another difficult part of recruiting was the way I felt it happened in a bit of a whirlwind. The sense I got from participants was that they were interested in taking part in the study if it was done almost then and there, as if they were only happy to do it, if that was what everyone else was doing. This mixed with my own fear around participants losing interest in my study meant that the interviews were scheduled quite closely together. In fact on the day of recruitment much to my surprise 4 participants asked to talk to me then and there, which I agreed to. Four participants were booked in for the following week and one the week after.

Another difficulty I found in scheduling the interviews was that the structure of the day at the inpatient unit was very limiting, in the sense that patients on the ward had to attend 3 meals a day and two snacks a day at all at designated times. On top of this patients also on occasions had to attend group meetings and individual appointments whether with a therapist or doctor. For obvious reasons our interviews had to be scheduled around these times. This meant that often the interviews were being framed by meal times and that there was already a time restriction imposed upon the interview before it had started.

The Sample Group: Background information

Out of the 8 participants who took part in the study 7 out of 8 of them were aged between 18 – 24 years old and one of them (Kim) was 39 years old. Out of the 8 woman only one of them (Dianne) had obtained an undergraduate degree; 3 of the 8 girls, (Wilma, Sally and Ellie), had not yet completed their A levels due to their illness; Caroline and Lilly were taking a break from their university courses and Liv and Kim had not gone.

Interviews

Participants were invited to take part in a digitally recorded semi-structured interview, which on average lasted around 50 minutes. Semi structured interviewing is one of the most common methods used in IPA (Smith, 1995b). In accordance with the aims of IPA questions posed within the interview process were non-directive and open ended (Willig, 2008) and focused questions were only used to encourage a participant to elaborate on their account rather than to check whether they agree or disagree with a particular claim or statement (Willig, 2008). At the end of the interview participants were given an opportunity to ask questions, and were given a £20 book token to say thank you for taking part in the study. Participants were informed that if at any point they wanted to withdraw from the study they could so by contacting the researcher. All interviews were then transcribed for analysis.

During the interview procedure a semi-structured interview schedule was designed and used as a guide during the interview process (see appendix 2). In order to help build a connection between the interviewee and interviewer, and to help put the participant at ease and settle them into the interview the researcher began with a more structured line of questioning which asked the researcher to talk them through any encounters they may have with food on an average day, asking them to explore the emotions, meanings and thoughts they may have behind these encounters. Following this introductory period the nature of the interviewing schedule opened up allowing the researcher more flexibility to follow the participants line of thinking, whilst maintaining an overview of her own objectives within the

interview process. The researcher also kept a reflective diary throughout the process of the data collection in order to record her own reflections and thoughts of the process. At the end of the interviewing process the researcher made a decision not to include for analysis one of the participant's interviews, as the content of her interview indicated that at this time she saw herself as more bulimic than anorexic. This meant that overall only 8 participant interviews were used within the analytic process. Some of the most important and interesting reflections of the researcher are detailed below.

Overall I was pleased with how the interviews went and I was encouraged by the frankness and openness that some of the participants seemed to display. The interview process itself however did not always run as smoothly as planned. On occasions I could feel frustrated by the time limitations that were imposed upon some of the interviews by the meal times on the ward and other appointments, as despite the interview having to end, I often found I still had a number of questions that I wanted to ask. I also found that frequently the interviews were interrupted by knocks on the participants bedroom doors, this was particularly significant twice, when on one occasion the interview had to be postponed until the following week (the participant had forgotten she was supposed to be at group therapy), and on another occasion the interview had to be suspended for 10 minutes while the participant collected their medication. Another complication arose within the interview process when on one occasion the presence of two nurses was deemed necessary within the room, as the participant was on "watch", this I found created a whole new dynamic within the room and within the interview process. At one point the two nurses fell asleep during her interview and this seemed to agitate and distract her quite significantly, something that I interpreted within the room at the time as a transference reaction from her early object relations.

During the interview process I tended to spend whole days on the wards, from this experience I noted that it seemed that the participants moods seemed to deflate, and that tensions increased on the ward as the day progressed. Often in interviews conducted towards the end of the day participants could be

distracted or interrupted by screaming in the corridor from another patient who was upset or arguing with one of the staff. Similarly I became aware early on that my interviews were framed by meal or snack times, and that depending on how the particular individual I was talking to had experienced that meal time or was feeling about the next one seemed to bear some relevance on the content discussed and the atmosphere between us in the room.

Of particular interest were a couple of interviews where I was quite taken aback with how difficult the participants seemed to find the interview process. It appeared they had little to say or little that they wanted to say about their experiences; indeed it demonstrated (I felt), how dramatically the ability of introspection and reflection could vary between interviews. Just as the participants' presence in the interview process varied dramatically so too did I find my presence; during some of the interviews I found myself feeling quite relaxed, whilst in others I felt significantly anxious and once even out of breath, these feelings I have reflected upon as countertransference reactions, (for example I often believe I was made to feel like I was being judged, evaluated or even perceived as "the competition"), and as a result of projective identification, a way of communicating to me how they were feeling within the interview room. Even so this has made me consider what impact the varied presence and sense of myself that I had in each interview, had on the participants and in turn on the content of the interview, thus demonstrating my sensitivity to context (Yardley, 2008).

Transcriptions

Interviews were transcribed in order of the interviews. Interviews were given a number to identify the participant e.g. P1 for participant 1, and then for the purpose of the transcripts and analysis were given a new name, (the researcher found this to be a more personal way of managing confidentiality). Within the transcripts the interviewer referred to herself by use of her initials, KC. Unlike conversational analysis IPA does not require that speech rhythms are recorded, however it does require that all words spoken and incidental features within the dialogue such as false

starts, laughs and pauses are recorded (Smith, 2003). The transcripts were then engaged with in line with the process of analysis and interpretation as outlined above by Eatough & Smith (2008). Due to the sensitive nature of the transcripts and in line with the ethical guidelines given by Wandsworth Research Ethics Committee, they will only be made available to the examiners.

I found the process of transcribing the interviews to be surprisingly time consuming and quite laborious at times. However I also found the process to be quite rewarding for it provided me with an opportunity to move closer towards building a greater understanding of the interviews not only in themselves but in relation to one another. One thing of note that came out of the transcribing process was that often the way I chose to interpret and understand the interview within the interviewing process was quite different to how I chose to reflect on and interpret the interview in hindsight. This at times made listening to the tapes frustrating as on reflection I felt in some instances there were more preferable questions to have asked or lines of thoughts to follow up on. On a more positive note I also found listening to the tapes helped to reproduce within me some of the feelings I felt at the time within the interview and alerted me once again to the individual nuances of each participant.

Thematical Analysis

The Individual analysis of transcripts

Once the interviews were transcribed, the researcher, in line with Eatough & Smith's guidelines (2008), engaged with several close and detailed readings of the text, many of which involved listening to the digital recordings of the interview simultaneously and started making notes on the transcript of her initial thoughts. Following this process the researcher moved on to note down more exploratory comments on a fresh version of the transcript. In order to represent the participant's view of their world as accurately as

possible the researcher, as recommended by Willig (2008) was careful to make sure that the exploratory commenting was closely tied to the original text whilst also being "sensitive to the complexities of behaviour and the meaning in context" (Henwood & Pidgeon, 1994, p. 227). The exploratory comments were broken into three different focuses as recommended by Willig (2008):

- Descriptive comments – These focused on describing the content of what the participant had said and the subject of the discussion within the interview.
- Linguistic comments – These focused on exploring the participant's use of language within the transcript.
- Conceptual comments – These focused on engaging at a more inquisitive and conceptual level.

These exploratory comments were marked down in the right hand margin of the transcript and were colour coded so as the researcher was aware which comments alluded to which focus, (Descriptive-black, linguistic-red and conceptual- blue).

In order to develop emergent themes, the researcher moved from attending solely to the data itself, as above, to working primarily with the exploratory comments. This process as Willig (2008) asserts, requires both maintaining a focus at the local level and also keeping in mind what was learnt through the whole process of the initial noting and exploratory comments. Within the emergent themes the researcher tried to capture what was of particular importance in the various exploratory comments attached to a section of the transcript; these were noted in the left hand margin of the transcript.

In order to aid the next step of analysis once the emergent themes had been noted down throughout the transcript, the researcher set about recording them chronologically on a spreadsheet. Beside each emergent theme the researcher placed in brackets the page number of where this theme could be found. See appendix 6. Using this list the researcher then set about trying to group or cluster connected emerging themes using the process of

abstraction (Willig, 2008). This is where like is put with like and a new name, the super-ordinate theme, is developed for the cluster. At this point the researcher often found that some emerging themes could fit under two differing super-ordinate themes, for this reason the researcher put an asterix (*) at the end of the emerging theme to mark that the emerging theme was being accounted for under two different super-ordinate themes. At the end of this process the researcher produced a new spreadsheet, which contained a list of all the developed super-ordinate themes with their emerging themes underneath them (See appendix 7).

In order to help focus the findings further, at this point the researcher also subjected the super-ordinate themes to another level of abstraction, from which the researcher produced individual master themes. These individual master themes were then presented on a table (see appendix 8) with their component super-ordinate themes listed (with additional informative and reminding notes for the researcher). In addition the researcher then presented these individual master themes diagrammatically (see appendix 9) in an attempt to start building a conceptual and theoretical understanding of how they all might fit together. This process was then repeated across all participants' transcripts.

I found this process of analysis surprisingly timely, yet very involving. In particular I was struck by how some of the interviews (Ellie, Kim & Sally) seemed to take considerable less time to analyse than others, this I rationalised was due to the content of the interviews and the level and depth of discussion within them. In addition I was quite struck by how similar I found the individual master themes to be for each of the individual transcripts. This awareness came following the development of the individual master themes for the second participant (Liv) where it became apparent that the individual master themes were similar, if not at times only different by name, to the ones that I had developed from the first transcript. After I found the process of the third transcript to have come together in a similar way to that of the first and second I started to wonder whether I had created a model and set of individual master themes which could work for the remaining transcripts. Wanting to

retain the idiographic focus necessary for each of the remaining texts. I tried as much as possible to ignore the model template that seemed to be emerging and to develop the master themes from each of the individual themes on their own merit.

Towards the end of this process I became aware of how similar the individual master themes of each transcript were to each other. Wanting to make sure that it was not the bigger picture that I had started to build in my head that was influencing the development of the individual parts, as it were, I decided to take a step back from the analysis and to return to it after a 3 week break, in order to analyse the final transcript at a distance from the previous ones. This I did and still a similar list of individual master themes was produced from the final transcript.

Bringing it all together

The next stage of the analysis involved looking for patterns across the individual interviews. In order to facilitate this, the researcher compiled a table (see appendix 10) listing all of the individual master themes for each of the participants. This table helped the researcher to identify which themes were most potent and what connections there were in between cases. Once the master themes had been identified they were placed in individual tables (see appendix 11) each of which illustrated which individual master, super-ordinate and emerging themes from the participants corresponded to the master theme itself (corresponding transcript page numbers and comment numbers were indicated). Each transcript was then re-read with this list of master themes in mind so as to highlight any discrepancies and connections between participants and to pick up on any data that might have been overlooked.

Due to the similarity of the individual master themes for each of the participants the process of bringing the analysis altogether was perhaps easier than I had anticipated. One thing that I found particularly helpful at this stage was re-reading the transcripts in light of the developed master

themes. This was because on occasions I found emerging themes within the interviews which I had accounted for elsewhere within the individual analysis of the text (due to there not being enough other similar themes within the text to produce a super-ordinate theme) which now seemed to fit and contribute towards the master theme itself.

Participant Feedback

Once the analysis was complete, the researcher composed a feedback sheet for all the participants who took part in the study, which explained to them in a generalized form the findings of this study. The participant feedback sheet was approved both by the researcher's supervisor and the consultant Doctor on the inpatient ward before being distributed. The participant feedback sheet was sent out by email to all the participants along with a covering letter thanking them again for their participation, a contact email was also supplied should they have any further questions. See Appendix 12.

Ethics and confidentiality

Ethical Approval

Ethical approval was sought and granted on 13th October 2009 by Wandsworth Research Ethics Committee and by the Research and Development Department of Barnet, Enfield and Haringey Mental Health Trust on 21st October 2009. This research was also granted ethical approval by City University in April 2009.

This study was conducted in line with the NHS Research Governance Framework; more specifically it was guided by and adhered to the requirements laid out by Wandsworth Research Ethics Committee's and Barnet, Enfield and Haringey Mental Health Trust policies. The researcher

also complied with the ethical and good practice guidelines of the British Psychological Society and at all times with the Data Protection Act of 1998.

Informed Consent

Participants were given an information sheet (see appendix 3) which contained information about the research objectives, the researcher, participant requirements, risks and benefits of taking part in the study, results, confidentiality, the right to withdraw, complaints procedure and funding. The participant information sheets had been prior approved by Wandsworth Research Ethics Committee, the Research & Development Department of Barnet, Enfield & Haringey Mental Health Trust and City University. Participants were given the information sheets and given the time to read through them on their own and also with the researcher, they were then given the opportunity to ask any questions they may have around the research process. For those who decided to take part in the study, they were asked to sign a consent form (see appendix 4), before doing so however all the points on the consent form were discussed with the researcher to ensure that they were making an informed decision. These points included an understanding that their participation in the study was voluntary, that they could withdraw at anytime, that their care team knew of their involvement in the study and that the researcher, researcher's academic supervisor and regulatory bodies had access to any of their data collected in this study.

Confidentiality

Data

Code numbers and made up names were used to identify individual participants and their transcripts. No references to their real names or identifying details about the participants were disclosed. All data digitally recorded, typed or written was kept in a locked filing cabinet or in a password protected computer when not in use, with only the researcher having access to them.

Transcriptions

Where identifying or personal information was disclosed during the interview this was removed within the transcriptions by replacing it with a row of XXXXXX. Participants were made aware that quotes from the transcriptions may be used in future published material, however that all identifying information would be removed beforehand. Participants were also informed that they had a right to withdraw from the study and for their data to be removed and destroyed at anytime before its completion should they so wish. They were also informed that after 5 years all their transcripts would be destroyed in line with ethical approval.

Managing distress and the safety of the clients

Due to the sensitive nature of the phenomenon being investigated in this study, the researcher was aware at all times that through taking part in the study problematic feelings or emotions may arise for participants that cause feelings of upset or discomfort. For this reason the researcher at all times consulted the inpatient care team at the Phoenix wing for their approval before approaching any of the participants. At all times the researcher used her skills as a trainee Counselling Psychologist to help contain and support the individual through the interviews. Participants were given the opportunity to stop the interview at any time, and the researcher when detecting signs of distress gave participants the opportunity to take a break or finish the interview. The researcher was also flexible in rearranging some of the interviews and allowing breaks in the interview process following interruptions. During the interview process only one interview was stopped prematurely by the researcher due to an awareness of the discomfort and difficulty the interviewee was having in the room towards the researcher and towards answering the questions. This was a clinical judgment made by the researcher, the participant was not alerted to this decision, as it was felt this would cause unnecessary stress and so the interview was rounded off as usual, thanking the participant for their participation.

At the end of each interview participants were given the opportunity to share their thoughts on the interview process. Participants were then reminded that should they wish to contact the researcher at any time with any questions that they may do so, by the contact details they had been given. They were also made aware that their care team were aware of their involvement in the study and would be happy to talk through with them any issues that may arise or have arisen for them through the process of the interviews.

Throughout the experience of interviewing participants on the ward I had an awareness of their fragility and their vulnerability. In some cases, I felt the participants were more vulnerable than others, for example there was one particular participant who at the time was being tube fed on the ward, and mainly bed bound. When speaking to her, her voice was so quiet and child like that I found the tone of my own voice changed quite significantly and that the degree to which I encouraged some of our discussions to be explored was perhaps moderated to a lesser extent than usual. When reflecting on the fragility of these clients on a whole I felt that I grappled with the tension between seeing them as strong minded, wilful individuals (demonstrated on a daily basis through their illness) and paradoxically as very vulnerable and insecure individuals. It came to feel at times that the more wilful they were the more fragile they were too. My interviewing process, i.e. the way in which I asked some of the questions, or encouraged the explorations of certain items, timings of the interview etc. on reflection I feel varied significantly with each individual interview. Although some of these variations were undoubtedly a conscious decision on my part, I feel that a lot of how I felt and the manner in which I spoke within the interviews was an unconscious reaction from me. Both of which I believe reflects positively upon my individual attention to each participant and their needs within the study; an important part of safeguarding participants through the research process and sensitivity to context (Yardley, 2008).

Chapter 3: Results Section

Introduction

This Chapter will present the researcher's findings from the participants' interviews. The chapter will first give an overview of all of the researcher's findings and then will continue on to explain them in more detail, illustrating component themes and examples of these with quotes from participants. Where it is felt necessary and informative for the reader the researcher has footnoted her own reflections on the processes she went through within the analytic procedure.

Overview

After carrying out Interpretative Phenomenological Analysis on 8 of the participants' interviews, 6 master themes emerged. Of these emerging 6 master themes only 4 of them were directly related to answering the researcher's question of "The Meaning of Food for Individuals with Anorexia Nervosa". For this reason only these four will be referred to as Master Themes while the remaining two will now be referred to as core concepts. The 4 master themes and 2 core concepts were identified as:

The Master Themes:

1. Food as a container
2. Food as a concrete representation of internal states and relationships
3. Food as a separator
4. Food as a mechanism of control

The Core Concepts:

1. Loss of and broken sense of self
2. Misattuned Caregiving

The component themes emerging from the master themes were:

1. **Food as a container**
    - Food as a safety mechanism
    - Food as meaning making
2. **Food as a concrete representation of internal states and relationships**
    - The implicit Argument
    - Food as a concrete representation of Internal States
    - Food as a concrete representation of Relationships
3. **Food as a separator**
    - Food as a means to disconnect from the self
    - Food as a means to disconnect from others
    - Food as a distinguisher
4. **Food as a mechanism of control**
    - Food as a means to find control within the world outside
    - Food as a means to find control within the self
    - Food as a manipulator

The component themes emerging from the core concepts were:

1. **Loss of and Broken Sense of Self**
    - Lack of reflective function
    - Lack of internal validation
    - Low Self Esteem
    - Lack of Agency
    - Punitive and intolerant attitude towards the self
    - Disengagement

Rigid thinking

The split self

2. **Misattuned Caregiving**

Lack of containment

Responsibility

Imposition and control

Master Theme 1: Food as a container

This theme is clearly evident within 3 of the participants' accounts, Liv, Wilma and Caroline and is more subtly evident within some of the other participant accounts such as Ellie and Dianne. In order to best explain what is meant by the phrase, food as a container, the presentation of this theme has been organized under two headings; Food as a safety mechanism and Food as meaning making.

Food as a safety mechanism

Food is described within the participants' accounts as providing "safety" and "comfort" from life and all its problems. Wilma (113)[4,5] in reply to the question of what food represents for her states that it is a "bomb shelter" that is, it is her "comfort and safety zone amongst all those other things out there." Similarly Liv (66[6]) also describes her use of food as a "way of creating a safety" when she feels unsafe and Caroline (161[7]) too, similarly describes food as "a retreat" from things that are overwhelming.

These comments alone seem to conjure up images of an unsettling world from which the participants need protecting from. As shown above the way they seem to do this is by falling back on their relationship with food. Of

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[4] All numbers next to the participant names reference the comment number from which the quote was taken not the page number of the transcript.
[5] Taken from the super-ordinate theme of Food as a protector/safety zone.
[6] Taken from the super-ordinate theme of Food as a safety mechanism.
[7] Taken from the super-ordinate theme of Food as a safety and comfort.

note there seemed to be 3 different ways in which the participants' use their relationship with food in order to feel safe and protected.

The first is through a sense of isolation:

> Wilma 89: "Um, so I use food to, to well yeah, my obsession with food actually just say seems to, is what I bubble myself in, encage myself in."[8]

> Caroline 47: "Um, and I have to say going back to the food and what it does for me, that's another thing that food does for me, the food is a real escapism, its like a real way of locking myself off into my own little world."[9]

The second is through a sense of dependability or stability:

> Liv 110: "That whole moving on to the unknown created a lot of anxiety so by controlling the food again, it was creating that safety, something stable that I knew wouldn't then change."[10]

And the third is through companionship or the development of an ally.

> Caroline 53: "I don't feel guilty over enjoying mushrooms, because there is nothing in them, and it was almost like, agh, I do feel a bit silly saying this but it was almost like they were friends or something."[11]

As well as food acting as a safety mechanism in terms of protecting the self from the outside world, it also emerged that restricting food acted as a safety mechanism in terms of protecting the self from the self.

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[8] Taken from the super-ordinate theme of Food as a protector/safety zone.
[9] Taken from the super-ordinate theme of Food as a safety and comfort.
[10] Taken from the super-ordinate theme of Food as dependable.
[11] Taken from the super-ordinate them of Food as a safety and comfort.

> Caroline 69: "It's avoiding the experience, its avoiding the experience of taste which would then trigger the feelings of guilt, which would make me feel like I needed to punish myself, umm."[12]

Similarly to Caroline, Wilma (36-38[13]) also describes how she associates food as feeding her the energy to feel more emotions, in particular self - hatred, which can then actually lead her to harm herself. Not eating for Wilma therefore transpired in some capacity to be a way of protecting herself from her aggressive and angry feelings towards herself.

It is of significance here to note that although at this point the focus is on restricting food as a way to avoid self-punishment, there simultaneously emerged an element of restricting food as a form of self-harm within the participants' account. The emerging themes of self-harm appeared for Wilma, Caroline and Lilly as illustrated below[14]. This suggests that this is not such a straightforward concept as it initially appears to be and furthermore is indicative of and reflects well the ambivalence that was continually present within all of the participant's interviews.

> Wilma 5: "Yeah, well um, I've been having problems with food for since like, towards the end of A-levels where, I just chose not to eat, I think it was a way of punishing myself."[15]

> Lilly 21: "Um, its, I don't know sometimes, I think it can be a way of like depriving myself of something that, that would, that would mean, that I wanted it, and I don't, but it's a different way of hurting myself almost."[16]

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[12] Taken from the super-ordinate theme of Food as a safety and comfort.
[13] Taken from the super-ordinate theme of Food as a protector/safety zone.
[14] *During the analysis process however, due to questions I had about how perverse their intention was to self harm I decided only to give Wilma the individual master theme of Food as a mechanism for punishment and for the others to include these emerging themes under the individual master theme headings of Loss of and Broken sense of self.*
[15] Taken from the super-ordinate theme of Food as a mechanism for punishment.
[16] Taken from the super-ordinate theme of self-harm.

Caroline 142: "When I was in Cambridge, um, one of my obsessions was to, um, eat a really large orange last thing at night and I would even eat the peel, and the peel did not taste nice and, (slight laugh), and I think it was probably two things, I think it was probably because I was really hungry so I was just st-, you know, I don't know, um, but there was some kind of weird perverse enjoyment in eating something that actually was horrible, um."[17]

Food as meaning making

From many of the transcripts there was a sense that food helped to "contain" the individual, not only in the sense that it provided a sort of protection for the self, as explained above, but in a way that helped them to restore an understanding in themselves and the world. One of the most significant ways it helped "to contain" the individuals was through helping them to understand and justify their own feelings.

Dianne 19: " I just feel within myself that I'm more controlled that I know how I'm feeling, I know why I'm feeling the way I am, and it makes things easier for me, it makes things more tangible for me knowing that I'm tired, well its because I'm not eating, its not because of something else, or I'm upset because I haven't eaten and I'm just like really moody and its not because of some other deep seated issues and it makes me feel like I know, I know why."[18]

Wilma 102: "Cos then I can swear, oh I'm feeling this cos I'm not eating, and it seems to justify my emotions and it just yeah,"[19]

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[17] Taken from the super-ordinate theme of Punitive and intolerant attitude towards self.
[18] Taken from the super-ordinate theme of Need for something concrete.
[19] Taken from the super-ordinate theme of Food as something that can explain and define the self

When reflecting on these quotes and a further one from Wilma:

> Wilma 110: In my terms it would be um, to, something to put something concrete into something that's not concrete."[20]

What stands out here is how having something "tangible" as Dianne suggested, or something "concrete" as Wilma suggested, in this case food, is of great importance in helping them to understand their emotions, something more abstract.

Another way in which food helped participants to restore their understanding in themselves and the world was through the way it appeared to provide them with an identity:

Caroline (53) talks about restricting food as comforting "because this is what I do."[21] While Wilma states:

> Wilma 101: "I feel it gives me my identity, as well food."[22]

This is similar for Ellie (30)[23] who talks about how restricting her food helps her to feel more herself.

Furthermore Wilma also asserts how food gives her a focus or a sense of purpose in life, which in turn helps things to feel more manageable:

> Wilma 43: "Yeah, more containable, yeah and its about, its just like instead of having 8 lessons like GCSE I just focus on one special lesson which is this food, and maybe see what things that what associate with that, which is weight, calories and all that."[24]

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[20] Taken from the super-ordinate theme of emphasis and importance of concreticity
[21] Taken from the super-ordinate theme of food as meaning making.
[22] Taken from the super-ordinate theme of Food as something that can explain and define the self.
[23] Taken from the super-ordinate theme of Restricting food as alleviating the self
[24] Taken from the super-ordinate theme of Food as something that can explain and define the self.

> Wilma 111: "in that sense it gives me identity, it gives me an aim in life, like, so before that I got so lost when I was ju-, obeying orders, with wh-, developed anorexia I realized oh my goal was to lose weight, I had a goal in my life, I saw, it gave me, it kind of gave me a meaning to, to carry on living"[25]

This is not too dissimilar from Caroline and the way in which she talks about her relationship with food as something that creates some sort of sense and order in a world that for her does not have either:

> Caroline 53: "Its like the food is, is a comfort, because it's a comfort knowing that I'm treating myself the way I feel I should be treated."[26]

> Caroline 127: "I haven't eaten enough I come to the hospital, the nurse weighs me, my weights gone down, that makes sense."[27]

Master Theme 2: Food as a concrete representation of internal states and relationships

This theme in comparison to the other master themes is the largest and most pervasive theme within the participants' account. This is because it contains not only a number of super-ordinate themes, which are explicitly linked to the theme in question, but also a number of super-ordinate themes within the accounts, which are implicitly linked to the theme as well.

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[25] Taken from the super-ordinate theme of Food as something that can explain and define the self.
[26] Taken from the super-ordinate theme of Food as meaning making.
[27] Taken from the super-ordinate theme of Food as meaning making.

The implicit Argument

Throughout all the participants account there is a sense that food embodies or evokes negative emotion. For example it can be a stressor, causing anxieties and fear:

> KC 105: "When you think about food how does that make you feel?"
>
> Wilma 105: "It scares me"... 107: "Well yeah it does fear me. Cause lots of anxieties."[28]
>
> Kim 7: "Um, I always dread going to the dining room, because I've picked up certain behaviours, and I eat slowly, so um, it's always a bit stressful."[29]
>
> Ellie 9: "Um, just like seeing it makes me feel scared and worried"

It is also viewed as something, which is overwhelming:

> Liv 10: "What's going to be in it what's it going to be, will I be the only one having that, um, what if I really don't like it, I still have to eat it, um, like just everything about it is like AGH!"[30]
>
> Caroline 24: "I'd rather not be staring at my plate the whole time, I find it too overwhelming."[31]

And something, which is confronting for the self and can create friction with others as well:

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[28] Taken from the super-ordinate theme of Food as provoking negative emotion.
[29] Taken from the super-ordinate theme of Pervasive and overwhelming nature of food.
[30] Taken from the super-ordinate theme of Food as a stressor and Ubiquitous entity.
[31] Taken from the super-ordinate theme of Food as provoking negative internal states

Liv 20/21 " Well I find it hard because like when I'm at home, I don't know exactly what I'm going to have for dinner, here there and how much its going to be, but because here you know its like "oh god, I'm going to be faced with all of that" and its harder when you think of it as a lump sum to accept it."[32]

Dianne 59: "I don't know it's, just with food at the moment, well not recently but for quite a long while it's just been, created arguments constantly, it's a battlefield, just like shouting "you need to eat that" being made to sit at the table, like until everything has gone for hours."[33]

Furthermore it is seen as something that within itself is bad:

Ellie 87: "Um, for me food is something bad, something wrong, something that I shouldn't be having."[34]

Dianne 84: "When I'm eating it, it's just all bad, its disgusting, its horrible, umm, it's the most awful thing."[35]

And also powerful:

Liv46: "I think its not so much the physically putting it in my mouth, that's the problem, its more when its in me, I don't know what it will do, like will it make me gain weight, will I end up with diarrhoea will I be sick and diarrhoea..."[36]

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[32] Taken from the super-ordinate theme of Food as a stressor and as an ubiquitous entity.
[33] Taken from the super-ordinate theme of Food as confronting.
[34] Taken from the super-ordinate theme of Food as bad.
[35] Taken from the super-ordinate theme of Food as embodying negative emotion.
[36] Taken from the super-ordinate theme of Food as a powerful entity.

> Lilly 10: "Um, just sort of thinking about, how it makes me feel, how, how I'm going to feel afterwards, how I'm going to feel about myself, what's it going to do to me, just like its too much".[37]

All of these statements about food, started to raise questions about what had happened to food, something that is in its very essence is no more than something to eat, in order for the participants to have such strong and adverse reactions to it. It therefore felt that implicit in these statements was the idea or thought that there must be something more invested in food.

What this investment then is leads on to the exploration of the more explicit super-ordinate themes under the heading of this master theme, which can be organized into two categories, concrete representation of internal states and concrete representation of relationships.

Food as a concrete representation of internal states:

> Dianne 86: "I don't know its like swallowing guilt, that's what it is because that is what I associate with food, so its just like gaining more and more guilt with it, really and it just feels unbearable"[38]

Indeed many other participants like Dianne expressed that they felt food had become associated with or transformed into difficult feelings belonging to the self. These internal states varied from participant to participant within the interviews. For example with Lilly (85-93)[39] it was almost as if food had come to represent her need or want of dependency, something which she loathed so much and wanted to keep at arms length, with Dianne (as above) it was her feelings of guilt and with Caroline (below) it was her feelings of sadness:

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[37] Taken from the super-ordinate theme of Food as a powerful.
[38] Taken from the super-ordinate theme of Guilt.
[39] Taken from the super-ordinate theme of Food as provoking/representing negative emotions.

Caroline 65: "I don't know, its almost like all the feelings of sadness and everything, gets kind of, because the way that, because the way that you're dealing with that emotion is through the food, then it seems, it seems inevitable to me that, its almost like all those bits of lettuce and mushroom or whatever you're eating, or the bowl of soup, its as if that is the emotion and you're taking control, because you're taking control of the emotions by, um, by doing something with food, its almost like that food itself is the emotion that you're controlling, you're saying I'm no, I'm not going to sort of let myself feel that emotion, and the way I'm not going to let myself feel that emotion is by restricting and so then, its almost like that bowl of soup is like a bowl of tears or something, and you're just drinking it down and you're saying that's not, I'm not even gonna, you know."[40]

One thing common for all the participants however seemed to be the way that by restricting food they were preventing themselves from assimilating, or taking on these difficult feelings. Furthermore if at times they were not in a position to restrict their food (such as on the ward) they attempted to disconnect from themselves so as to only "physically" eat the food and not to experience it. Again suggesting what powerful and emotive contents could be found invested in the food. Below is a quote from Dianna talking about her experiences of mealtimes:

Dianna 9: "Um yeah because its quite robotic your just going through the motions and you don't have to really think or feel anything its when things start changing that your hit with it, your like oh my god (*slight laugh*) but yeah at the moment I'm just literally doing it just hand to mouth action until its gone."[41]

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[40] Taken from the super-ordinate theme of Food becoming emotion.
[41] Taken from the super-ordinate theme of Cognitive and Emotional Disengagement

Caroline 67: "And I think, there have been many times when the only way I can get through um, a meal is by thinking, a meal here, is by thinking of it as a purely mechanical procedure um and um, certainly at the beginning of my admission before I, while I was still struggling a lot more, I would do thinks like hold my nose while I was eating, or I tried to do it really discretely so the nurses didn't realize, anyway to not taste it, so it felt like just an activity."[42]

Another facet to this component part of the master theme is the way that not only does food become a concrete representation of internal states for the individual but that it also becomes a concrete way of the individual trying to represent their internal states, how they feel about themselves, to others. This facet is referenced within the analysis and included in the master theme under the title of Food as a means of communication:

> Liv 66: " I think it is a way that I used to communicate with those around me, um, wherever it be in the sense to get attention to show I'm unhappy, I'm happy, or whatever its just a way of communicating."[43]

Similarly Caroline also expressed that she used food as a way to communicate her difficult feelings:

> Caroline 98: "I think that's the thing about what, what happens with the food, is, is that often its, its just a kind of concrete way of showing people how it is that you already feel, its not a way of creating a feelings, umm, its like I feel rubbish about myself, I'm not quite sure how to let you know that, so I'm going to show you by wasting away or I, I really don't know how to be with people, so I'm going to show you that by, by not being with you, because I don't feel like I can be with you when I am there, but you don't

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[42] Taken from the super-ordinate theme of Disengagement from and denial of self.
[43] Taken from the super-ordinate theme of Food as a means of communication.

> realize that so I'm just going to remove myself from the situation and then maybe you'll see that I really find that difficult all the time."[44]

And Lilly, that she restricted her food as a means to communicate that she does not want/need to depend on anyone (Lilly 23)[45].

Concrete representation of relationships

This component part of the theme in particular was influenced by the emerging themes from the text, (that were touched on earlier), that suggested or implied that food was seen as having and holding power over the self. The very word "Power", even though it is conceded that this is a word that has been interpreted from the content and choice of words of the participants' accounts, seems to suggest something relational. This in turn is now seen to support the interpretation that for some of the participants their relationship with food mirrors the relationship they have with other significant figures in their life and their self.

For some of the participants, some more implicit than others, there was a sense that their relationship with food mirrored the relationship they had with their parents in these two instances below, their Father:

> Dianne 41: "Well I kind of blame things that have happened with my dad um as responsible for the way I have turned out and the problems that I have with food."[46]

In this quote Dianne is talking about her relationship with her Dad, although in this passage Dianne is talking about her Dad as responsible for her difficult relationship with food, in taking the concept of blame or culpability out of this extract it appears as though she is implying that her turbulent relationship with her Dad has ran parallel to her turbulent relationship with

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[44] Taken from the super-ordinate theme of Food as a communication/expression of internal states.
[45] Taken from the super-ordinate theme of Restricting food as a communication of independence.
[46] Taken from the super-ordinate theme of Food as representing Mum and Dad.

food. The extract from Caroline's transcript below more explicitly alludes to how for her she feels her relationship with food was more intrinsically tied up with her relationship with her dad and his relationship with food.

> Caroline 72: " and the relationship between me, food, my dad, food and me and my dad has been something that's sort of cropped up quite a lot, particularly on my last admission here."[47]

The theme of Food as a rebellion also supports the idea that food comes to mirror or represent the relationships they have with other significant figures in their life. For when considering rebellion as a way of acting out, it is necessary to think about what or who are they acting out against? This question can be answered by returning to the participants account. Liv, after she was asked as to why she restricts food replied on two separate occasions that it was a way of rebelling, in her case against her Dad (Liv 70/85[48]). Similarly for Wilma (96)[49] she also commented that restricting food was a "way of rebelling, rebellion to them", meaning her parents. This suggests that food in these instances start to come to represent for these individuals a significant figure or figures in their life, i.e. by rejecting food they are rejecting their parents. Furthermore that the individual's relationship to food therefore seems to take on their relationship with their parents.

Another very important relationship that food appears to represent from the participants' account was the relationship that the participants have with themselves:

> Caroline 43: "You know actually if something good does happen, if I actually feel a moment of genuine wow I've done something, a

[47] Taken from the super-ordinate theme of Food as representing relationships.
[48] Both taken from the super-ordinate theme of Food as a rebellion
[49] Taken from the super-ordinate theme of Restricting food as a rebellion.

genuine sort of pride or something, sometimes that has made me try a little bit harder with food, and do a bit better with it."[50]

This quote illustrates nicely how the individual's relationship with food, in particular how much they restrict is comparative to what and how they think and feel about themselves, their relationship to themselves. In another sense their relationship with food comes to represent or be a symbol of their sense of self worth. Another example of this can be seen through Lilly where it seems that a loss of interest in herself seems to parallel a loss of interest in food:

Lilly 34: "Its about during my first year at Uni, and um, don't' know, I just lost interest in food, I couldn't' be bothered, I couldn't find the energy to feed myself, it wasn't that important."[51]

And through Dianne who after she was asked what it would mean for her if she did eat, replied this:

Dianne 70: "Um, probably that I meant something like in this world, where I don't think I am, I think I'm so insignificant that I think it wouldn't matter if I wasn't here anymore, and I don't know by kind of feeding myself or doing anything really positive for myself, says that I think I'm okay, and I don't think that I'm okay, yeah, I don't think that I'm a nice person, I don't think anything good about myself and um, if, because I don't feel that anyone else feels that about me, I don't feel like I should feel that about myself."

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[50] Taken from the super-ordinate theme of Food as a communication/expression of internal states.
[51] Taken from the super-ordinate theme of Restricting food as an expression of low self worth.

Similar to the above it is also apparent that for Ellie food starts to represent for her an image of a failing self, something that by not eating she strives to avoid (Ellie 88-90).[52]

Finally, something that ties this master theme together further is the interpretation that food as a very pervasive, concrete and ubiquitous matter/part of life, makes for the participant a very obvious and tangible medium through which to hold and communicate their internal states and relationships, which are also at times exceedingly pervasive and ubiquitous. This is illustrated in general by the emphasis from most of the participants about the pervasive, ubiquitous and overwhelming nature of food,[53] and is more subtly but clearly illustrated through the following extracts. Firstly Dianne's reply (46)[54] to the question of whether she felt able in any other way apart from food to express herself, that no she didn't because "food was such a big thing it seemed" and a "quite natural" way to express herself; and secondly through Caroline's comment (80) that "food just seems to have made the most sense" in terms of the way her problems have manifested themselves.

Master Theme 3: Food as a Separator

This theme explores how food is used by all the participants in some shape or form to separate themselves from themselves and/or those around them. Although in parts this theme may feel repetitive and as though it is drawing on component themes that already belong in other master themes, it is important to understand that the main emphasis of this master theme of Food as a Separator is the disconnection or withdrawal from intimacy from themselves and others in its own right.

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[52] Taken from the super-ordinate theme of Food as a representation of the failing self.

[53] Super-ordinate themes of this kind can be clearly found under most of the participants' analysis.

[54] Taken from the super-ordinate theme of Need for something concrete.

Food as a means to disconnect from the self

Within the transcripts many of the participants spoke about how restricting food enabled them to distance or disconnect themselves from their thoughts and feelings:

Wilma 36: "Without food I have the sense of numbness, I don't, I can't think."[55]

Caroline 49: "And that was certainly true when I was out, and living at home and you know, I might be feeling really, really, really down and then I would kind of just prepare my dinner and as I'm preparing the food my mind was actually blank, there was nothing going through my head, it was like was just like that kind of ritual."[56]

Caroline 44: "When I'm becoming unwell outside I don't really cry very much, I don't really umm, as I become more and more unwell I start feelings less and less and I know that to some extent that's a sort of um, physical symptom of becoming more malnourished, I know that, but at the same, it's a bit more than that because I just, it is a way of cutting off from emotions."[57]

Lilly 45: "Um, I suppose when I'm not eating I don't' really feel anything, so suppose it might be a way of controlling it but,"
KC 46: "When you say feel anything, do you mean you don't really feel emotions or?"
Lilly 47: "Just feel numb or cold."[58]

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[55] Taken from the super-ordinate theme of Food as a separator from self
[56] Taken from the super-ordinate theme of Food as a separator from the self and world.
[57] Taken from the super-ordinate theme of Food as a separator from the self and world.
[58] Taken from the super-ordinate theme of disengagement from thoughts and feelings through food.

Within these comments the words "numb", "blank", "cutting off" and "cold" stand out and illustrate well how almost clinical or absolute their intention is to be disconnected and avoid intimacy with themselves on any level.

In addition to this there was also a sense that restricting food allowed them to disconnect from their own body. This was particularly the case for Lilly as highlighted below:

> Lilly 54: "I don't want to be conscious of my body and like, um, when I've just eaten I feel full, makes me feel like more there, more present and I feel, when I'm sitting down I can feel the chair against me or I feel the floor and I don't want to be reminded of my body like that."[59]

However it is also highlighted more subtly within the super-ordinate themes of mind over body for various participants, (under the title of loss of and broken sense of self) whereby food becomes something that distinguishes the mind from the body for although the body needs it, the mind does not. (E.g. Caroline, Dianne, Sally).

Returning to Lilly's quote (above) now and thinking of it in relation to the quotes that went before it, what ties them together seems to be how becoming disconnected or separated from themselves seems to be a way of feeling less "present", i.e. less in contact with life. This idea is echoed in Liv's interview when towards the end she answers the question of what she thinks, in summary, food means for her. It is important to keep in mind as you read this quote that for Liv unlike many of the other participants there was a sense of recovery within her interview, therefore although she talks positively about the meaning of food for her now, it is apparent that this was not always the case and that for her previously by restricting food, she was restricting life:

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[59] Taken from the super-ordinate theme of Disengagement from the body by not eating

Liv 168: I think its everything about what living is, because the worse bit about anorexia is you don't' feel alive, you feel you're just, just this object that casts a shadow there is nothing inside you, I don't just mean food, um, but there is no soul, there's nothing, you just kind of sit with your friends and its like, you could, you might as well just be a ghost, and not there at all."[60]

Food as a means to disconnect from others

Not only does food seem to be a way for participants to separate themselves from themselves, to disconnect, but as Liv's quote suggests it also provides them with a means to disconnect and withdraw from others as well. Within many of the participants' accounts there was recognition of the sociable aspect of eating, in particular how it was a way to connect or spend time with the family:

Kim 48: "For meals, yeah, we always, like as a family, we used to sit down."[61]

Caroline 97: "Food has always been, played a big part in our family as something which is about our family coming together."[62]

Sally 17: Yeah, I think, I've always as a young child and before I became obviously ill I've really enjoyed my food and it was something which I would eat for pleasure and be with my family and it would be family occasions."[63]

From such recognition it therefore started to become apparent that just as eating and enjoying food could be seen and understood as a means of bringing people together, restricting and denying food could be seen and understood as doing the opposite. The following quotes below illustrate the

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[60] Taken from the super-ordinate theme of Equation of internal states to food.
[61] Taken from the super-ordinate theme of Association of mealtimes with connectedness.
[62] Taken from the super-ordinate theme of Food as a connector
[63] Taken from the super-ordinate theme of Food as a connector (to family/ life)

way in which Dianne's and Liv's relationship with food encouraged them to withdraw from those around them.

> Dianne 51: "But it was difficult because, they love getting food (Auntie and Uncle), where as because my sister loved having it, the food, it was quite difficult when I didn't want anything, um or wanted less or wanted something slightly different, um, so it was hard, so I think I probably when I spent, I'd start spending less time with them, in order to get out of it."[64]

> Liv 93: "Since I've been ill I don't like sitting altogether cos I feel like its everyone is just staring at me and my plate and its like please stop."[65]

Just as restricting food could be seen within the transcripts as encouraging participants to withdraw from those around them, so too could an initial feeling of withdrawal or isolation encourage a restriction of food:

> Caroline 98: "I mean obviously it was a way of probably withdrawing, but it think it was more reflecting how I already felt withdrawn."[66]

Similarly for Lilly it also became apparent that restricting food for her was caught up in her desire to become unnoticed:

> Lilly 72: "I don't want to be sociable anymore, I don't want to, again I don't want to be noticed by anyone."[67]

In the case of the last two quotes this then leads on to the idea that food becomes a way to communicate to others an internal state, as discussed in

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[64] Taken from the super-ordinate theme of Withdrawal from food mirroring withdrawal from others.
[65] Taken from the super-ordinate theme of Food as a separator.
[66] Taken from the super-ordinate theme of Food as a separator from the self and the world.
[67] Taken from the super-ordinate theme of Restricting food as a way to disconnect.

the master theme of Food as a concrete representation of internal states and relationships. Nevertheless the relationship with food that is adopted for these individuals, in both the two ways described above, seems to both enhance and facilitate the participants' disconnection/withdrawal from those around them. Furthermore the use of food as a separator/disconnector is also illustrated by the way in which, (as previously discussed under the master theme of Food as a container) the participants use their relationship with food as a way to isolate themselves from the world and those around them:

> Wilma 89: "Um, so I use food to, to well yeah, my obsession with food actually just say seems to, is what I bubble myself in, encage myself in."[68]

> Caroline 47: "Um, and I have to say going back to the food and what it does for me, that's another thing that food does for me, the food is a real escapism, its like a real way of locking myself off into my own little world."[69]

Here the use of the words "encage myself in" and "locking myself off" clearly illustrate how their relationship with food is almost used as a weapon to keep other people at bay and avoid any real relational intimacy.

Food as a distinguisher

The final way in which food seemed to act as a separator for participants was in the way that they tended to view their relationship with food as special or different from other peoples. That is, it distinguished them, for example, from other members of their family, setting them aside as different.

The quote below illustrates well how important it was for Dianne to feel like her relationship with food was something different, something more

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[68] Taken from the super-ordinate theme of Food as a protector/safety zone.
[69] Taken from the super-ordinate theme of Food as a safety and comfort.

"extreme" than her mother's, which in turn has the effect of setting her apart from her mother.

> Dianne 48: "Um, I think I'm, no, slightly extreme really, I mean mum's always on a diet or something, um, she's always going on about how, like she needs to loose weight, don't, yeah, but it was never to the extreme or anything and the fact that she didn't really actually need to loose any weight it didn't, it was just something, I don't know."[70]

Similarly for Lilly, this quote highlights how vastly different she feels her relationship with food is to other people's, again suggesting how this sets her apart as different:

> Lilly 18: "Um, like at the moment its quite like a dominant role because my life is, everything in this place is around food, about putting on weight and I don't know its not, for some people, like its a social thing its what you do with other people, you share it with others, and at the moment its just something that terrifies me so I don't.[71]

A similar theme also emerged in the case of Liv, however this time not only did it seem that she wanted to differentiate herself from her sister through her relationship with food but that she also wanted to better herself from her sister through her relationship with food.

> Liv 106: "I prefer to cook, but I think that that's as well like, an anorexia tendency but I think like me and my brother and sister, all don't mind cooking, my sister is the laziest git on this earth though *(laughs)* and she will not, I'm sorry I forgot that was

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[70] Taken from the super-ordinate theme of Desire for relationship with food to be special
[71] Taken from the super-ordinate theme of Sense of Difference through food.

recording, um, but she like won't wash up afterwards, she's so lazy."[72]

Master Theme 4: Food as a mechanism of control

The theme of control is very much embedded in or intertwined with the idea of food as a "coping mechanism" (Wilma, 89; Liv, 108; Caroline, 45) throughout most of the participants' interviews. Indeed it soon became clear during the analysis that what burned behind this "coping mechanism" was the way in which restricting food could help the participants to restore or find a belief of or sense of control.

Of note there were two areas in which restricting food helped participants to feel more in control; their self and the world outside.

Food as a means to find control within the world outside

Throughout the interviews there was very much a sense of the world being an unsafe, unpredictable, unstable and scary environment:

Sally 61: "I know before exams and things like that I always feel like I don't know enough and in the sense that, it is out of control, like I can't control the exam and what's going to be in the exam and can't control what the weather is going to be like or, you know, the mood the teacher's going to be in the lesson and things like that and the unknown I find scary, I think."[73]

Moreover it was a world that they felt completely out of control in:

Wilma 45: "But sometimes there's nothing overwhelming at the time, it just seems that as it goes on it just seems like I have to stay that way cos you don't know when, its like well I can control

[72] Taken from the super-ordinate theme of Isolation and separation of self
[73] Taken from the super-ordinate theme of World as unpredictable and Scary.

that, but then comes a problem I can't control so you might be okay one minute, it might not be, but I should still stick to it because it could be the next minute so"[74]

The meaning of restricting food in such a world therefore emerged to be about finding some sort of control:

Caroline 49: "I think it was because, it's like being able to control something, nothing else you can control and this is something you can control."[75]

This sense of control in turn could help the individuals to feel safer and as if things were more solvable. Furthermore it could help them to increase their own sense of agency within the world by feeling, for example, more in charge, more empowered and freer.

Liv 110: "I didn't want to leave school at all and, that whole moving on to the unknown created a lot of anxiety so by controlling the food again, it was creating that safety something stable that I knew wouldn't then change."[76]

Caroline 161: And I think that sort of sums up what, in a way, the food, the food, it feels like a way of solving something."[77]

Caroline 126: "And I think that is the other thing about the food when, it's a way of really feeling like you are in charge of something."[78]

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[74] Taken from the super-ordinate theme of Lack of Containment
[75] Taken from the super-ordinate theme of Food as a mechanism for control.
[76] Taken from the super-ordinate theme of Food as a control mechanism
[77] Taken from the super-ordinate theme of Food as a coping mechanism for emotions.
[78] Taken from the super-ordinate theme of Food as a mechanism of control

Ellie 30: "And it helps me to feel more empty and lighter and like, like a great weight has been lifted off my shoulders so I can think clearer, I can do more things and be more myself."[79]

Dianne 18: "When I restrict food I feel a lot more in control, which is ironic because I'm really not (laughs), but yeah I feel I'm able to do things that I wasn't able to do when I am eating."[80]

Wilma 8: "But um, it was yeah, I think I chose to because I suppose its like mealtimes when I felt like, it was more free for me."[81]

Food as a means to find control within the self

As well as restricting food helping participants to find a sense of control within the world around them it also helped them to find a sense of control within themselves, more specifically it helped them to feel more in control of and cope with their own emotions and also the way they felt about themselves.

Many of the participants suggested throughout their interviews that they found it very difficult or hard to express, understand and therefore control their emotions:

Wilma (111) on restricting food states: "Of course I didn't want it to kill me but it just kind of made my day go by a lot easier rather than dealing with these uncontrollable emotions, I was dealing with something that was more controllable."[82]

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[79] Taken from the super-ordinate theme of Restricting food as a mechanism to alleviate the self.
[80] Taken from the super-ordinate theme of Rejection of Food as a coping mechanism.
[81] Taken from the super-ordinate theme of Restricting food as a mechanism of control.
[82] Taken from the super-ordinate theme of Food as a vehicle for emotions.

Caroline 40: "Its another way as well, of dealing with emotions that I don't know how else to deal with."[83]

See also Dianne (38/39)[84] and Liv (158)[85].

The quotes below illustrate how controlling or restricting food becomes about finding a way to control or cope with emotions:

Caroline 65: "Its almost like all those bits of lettuce and mushroom or whatever you're eating, or the bowl of soup, its as if that is the emotion and you're taking control, because you're taking control of the emotions by, um, by doing something with food."

Liv 70: "Cos its always been like a way as well that I've tried to deal with my emotions is through food"[86]

Although these quotes return us back to the idea of food becoming a concrete representation of an internal state (emotions) as discussed previously, what is important here is the sense of control that is restored in the individual over their internal states from their choice to restrict food, which is already understood as having an association with emotions. For example Wilma (111) talks about food as a way "to make thing um, seem more controllable, so, um food, I associate my emotions with food so I can be able to control my emotions as well."[87]

The way, in which restricting food helps these individuals to feel more in control of their emotions, is by increasing their sense of agency through the belief that through food they now have the capacity to deal with or cope

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[83] Taken from the super-ordinate theme of Difficulty in affect regulation
[84] Taken from the super-ordinate theme of difficulty in emotional communication
[85] Taken from the super-ordinate theme of Lack of Internal validation.
[86] Taken from the super-ordinate theme of Food as a Coping mechanism
[87] Taken from the superorinate theme of Food as a mechanism of control.

with these emotions. Examples of how they manage to feel more in control of their emotions are given below.

> Lilly 86: Food is "a way of like, like, repressing my emotions."[88]

> Caroline 164: "So say the fear was located in some particular aspect of my life, I think what I was thinking at that moment was well, dealing with it through the food might temporarily just suppress the feeling."[89]

> Ellie 30: Not eating helps "me to block out all those bad feelings um, associated when, when I am having food."[90]

This last quote illustrates how for Caroline food even helps her to express release emotions that she wouldn't otherwise know how to manage:

> Caroline 40: I'll often take, take out anger towards someone else by restricting on my food or by doing something with my food, so I don't know how to get it out properly, so I'll just sort of use, sort of take it out on myself by not having enough."

In addition to restricting food helping the participants to feel more in control of their emotions, it also helped them to manage or control their own opinion of themselves:

> Lilly 86: "Yeah, I suppose its something that I need to control in order to control the way I feel about myself."[91]

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[88] Taken from the super-ordinate theme of Disengagement from thought and feelings through food.
[89] Taken from the super-ordinate theme of Disengaging from emotions.
[90] Taken from the super-ordinate theme of Restricting food as a way of avoiding negative feelings about the self.
[91] Taken from the super-ordinate theme of Disengagement from thoughts and feelings through food.

Similarly Sally described using food as a way of providing her with a sense of achievement, which in turn suggests helping her to control/improve, her own opinion on herself:

> Sally 43: "Restricting my food helped me feel like I was able to control something in my life, um, and controlling the shape of my body was something that made me feel like I had a se-, when I started to lose weight and perhaps was enjoying the feeling of feeling hungry and not responding to that hunger it helped me feel like I've sense of achievement, like, I'm actually achieving something doing this um."[92]

Furthermore this idea of restricting food helping participants to control the way they feel about themselves is fortified by reflecting back on the master theme of Food as a container, where one of the roles of restricting food was to protect the self against the self. That is by not eating, it in someway prevented individuals from taking on more negative feelings towards themselves.

Food as a manipulator

The final way, in which restricting food acts, as a mechanism of control is through the way that it was seen as a means to manipulate other people. This idea was only explicitly mentioned within Liv's transcript:

> Liv 82: "I think it has been a way of kind of, control, um, in a sense of my brothers vegetarian, I became vegetarian when I became anorexic really, um, my sister is very large, so all three of us are very different, and it was a way of us like kind of, manipulating mum to do what we want."[93]

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[92] Taken from the super-ordinate theme of Food as a mechanism of control.
[93] Taken from the super-ordinate theme of Food as a control mechanism.

However after closer attention it became apparent that this idea was implicit in many of the other interviews through the way in which they considered food as a means to get attention. [94]

> Dianne 43: "Previous before I actually had a problem if I didn't want to eat anything I could see, I could see how it made people react, like my parents react and it would get their attention even though, at that point in time, it wasn't purposefully done or anything, and I think that kind of stuck in my mind."[95]

Similarly within Caroline's transcript she also shows awareness of how food within her family was used to manipulate family dynamics (74/75)[96] in particular as a way of "trying to get praise". This was not dissimilar to Wilma who states:

> Wilma 54: "When I, when its by myself I just feel like I don't have to ea-, I don't want to eat and its scary eating, cos I think if no one will, yeah, I su-, I see I think that's why, that's why I think its more attention seeking cos I'm thinking no one will know that I've eaten, and never see what I've done, no one will take recognition of it, so why do I need to eat?"[97]

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[94] *As I feel that this too could be considered as a communication that they need help I have included this theme also under the heading of Food as a means of Communication, which was discussed under the master theme of Food as a concrete representation of internal states and relationships.*

[95] Taken from the super-ordinate theme of Need for something concrete.

[96] Taken from the super-ordinate theme of Food as a communication/expression of internal states.

[97] Taken from the super-ordinate theme of Restricting food as a way to get attention.

Core Concept 1: Loss of and Broken Sense of Self

This core concept refers to a very strong theme, which seemed to run throughout all of the transcripts. This was that the participants had a very fragile sense of themselves; that is they found it very difficult to know, understand and own themselves, and their place in the world. This in turn led to a very low sense of self worth and to broken ways of relating to themselves which in turn enhanced their sense of fragility.

The quote below is taken from Wilma's transcript and I believe illustrates well the main premises of this core concept:

> Wilma 98: "No, I don't really know who I am, I don't' know why, I don't know why I exist, I don't know, yeah seriously, I remember someone my family asks me the other day, I said someth-, um cos I said I hate myself, why do you hate yourself, describe the things you hate about yourself, and I couldn't, I just didn't know, couldn't even begin to describe why I hate myself, didn't know who I was, and I was saying things like because my parents hate me, because these people seem to dislike me, I feel that they hate me, like no-no, you, what do you and I couldn't, I just cou-. I still can't, and there....yeah, I have no, cos I can't justify all these feelings."[98]

As this is quite a large and pervasive concept that is present throughout all of the participant's account, and a lot of the time, in order to present it succinctly only some of the more prominent component parts of the concept theme have been selected to present and illustrate.

[98] Taken from the super-ordinate theme of Loss of sense of self.

Lack of reflective function

Throughout the participants' accounts there was very much a sense of participants having a very limited ability to reflect on know and understand their own thoughts, intentions and emotions.

> Caroline 5: "We kind of know when to expect food to be happening and then, its difficult because sometimes its late and I think that can, that stirs up a lot of feelings in me, because its like we're expecting it at a certain time and then when its late, its like, you then, you then become more aware that you're anticipating the meal, because its like well its, its ten past eight and it should have been here at eight and then you start feeling guilty because its like well what does that mean, does that mean I really want the food because now that, now that its late there's that little moment where there's a sort of, your then getting impatient because of the lateness, but then you think what does that mean that I'm kind of greedy, wanting the food."[99]

> Liv 80: "Um, I've always been fussy, so I guess in a way it always got att-, like I always got attention for it, um, I don't know whether or not I wanted that or not, but now its kind of like you still get the attention."[100]

For some of the participants this became evident through the "reduced" way they answered questions within the interview:

> Kim 11: "I cut my food into small pieces, um, I take a really long time in eating, um, I eat, things separately,"
>
> KC 12: "Okay, and do you have an understanding of maybe why you've picked up those habits?"
>
> Kim 12: "It's part of the Anorexic."[101]

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[99] Taken from the super-ordinate theme of Lack of reflective function.
[100] Taken from the super-ordinate theme of Lack of reflective function
[101] Taken from the super-ordinate theme of Limited Reflective function

KC 38: "Do you have any understanding of what maybe triggered the loss of interest in food or?"

Lilly 38: "No, not really, just stopped."

KC 39: "What do you think, I know we've spoken about how its like kind of saying you don't need anyone, sort of, do you think there was any other message in the food, at all, by not eating at all?"

Lilly 39: "I don't know, I haven't really been able to think of any reasons."[102]

Lack of internal validation

Intertwined with this sense of limited reflexivity was the lack of internal validation participants had towards themselves. This manifested itself not only through an inability to validate their own thoughts and feelings but also through a constant need for external validation whether it be through comparison or external praise.

Dianne 25: "we argue quite a lot, but over silly things and I'm not sure if that is mainly to do with the fact that I have been ill, that I have taken things the wrong way, or been easily wound up or if its just because, I don't know I was justified in being angry with the things she said to me."[103]

Dianne 70: "I get told things that, like I should like myself before anyone else will, but for me I kind of judge myself by other people's views and opinions."[104]

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[102] Taken from the super-ordinate theme of Lack of reflexivity

[103] Taken from the super-ordinate theme of Loss of sense of self

[104] Taken from the super-ordinate theme of Lack of internal validation.

Caroline 22: "Its not just limited to the dinning room I compare myself to people al the time, I don't think there is ever a time I'm not doing it, umm, I can be consciously engaged in something completely different and still be doing it, umm and it will be in terms of everything, appearance, intelligence, conversation, how much people are interacting with one another, am I liked, am I not liked."[105]

Wilma 64: "My parents always taught me things with punishment, they were never there to praise or anything, my teacher would see, recognize, what I do and maybe yeah little thing like a sticker or award of a sticker, and I feel recognized, and I had, my self, self esteem was higher with them and I felt, I felt more worthy of myself and I saw, saw qualities within myself that they kind of shown through their praises or whenever."[106]

Low self esteem

Coinciding with or running parallel to the lack of internal validation that participants seemed to have was a very low sense of self worth, or low self-esteem. This was clearly evident throughout all of the participant's transcripts for example:

Dianne 93: "Um, it just amounts to the fact that I think I'm like an awful person, that I'm undeserving,"[107]

Liv 143: "I'm struggling a lot at the minute with self worth and my place on the ward, I don't deserve to take up the staff's time and things like that."[108]

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[105] Taken from the super-ordinate theme of Lack of internal validation
[106] Taken from the super-ordinate theme of Lack of internal validation
[107] Taken from the super-ordinate theme of Lack of internal validation
[108] Taken from the super-ordinate theme of Low Self Esteem

See also Wilma 97[109]; Ellie 64[110] and Caroline 24[111]. As the quotes above illustrate their low self-esteem was often evident through the way they talked about what they did or didn't think they deserved. Other ways in which the participants' low self esteem manifested itself was through the way they viewed themselves as weak, powerless and with a limited ability to cope:

> Liv 14:"When you're already trying to eat and its already taken up a lot of head space a lot of anxiety and stuff, and then something else happens its like okay I can't deal with both of these."[112]

> Wilma 95: "But I'm used to be quite a passive person, and this anger I feel, I don't feel like I should be experiencing this stuff, I've always been a person too scared to express that, so kind of just let it, and then I let the, what they-, I kind of rather believe what they say, for they seem so much stronger and powerful than me."[113]

Such a view of the self seemed to encourage two things, the first a sense of lack of agency and the second an unaccepting punitive and intolerant attitude towards the self.

Lack of agency

A loss of agency or a sense of themselves having little choice in or responsibility for their situation was apparent in varying degrees for all participants. For example, for Dianne her lack of agency manifested itself in

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[109] Taken from the super-ordinate theme of Low Self Esteem
[110] Taken from the super-ordinate theme of Low Self Esteem
[111] Taken from the super-ordinate theme of Low Self Esteem
[112] Taken from the super-ordinate theme of Low Self Esteem
[113] Taken from the super-ordinate theme of Low Self Esteem

the way she clearly blamed her parents for how she is now (41)[114], almost as if she was collateral damage in her parents relationship. For Liv her lack of agency seemed to manifest itself in the way she felt she had no choice in her recovery (28, 32, 150)[115] and through the way she experienced her relationship with her Father:

> Liv 84: "It feels like he's trying to control me and what I'm putting in my mouth but yet it's my body and I should be able to decide what I want."[116]

Whereas for Sally and Lilly their lack of agency manifested itself through the way they both asserted the lack of conscious intent behind their illness (Sally 46[117] and Lilly 49[118]).

Punitive and intolerant attitude towards the self

This attitude manifested itself throughout the participants account with varying degrees of severity. For example within Wilma's interview there was a definite sense at times that she had wanted to harm herself and that she found it very difficult to do anything good for herself, 86 and 87[119]. For Ellie, however there was a sense that she was very critical towards herself and blamed herself a lot for "bad things" happening (64)[120]. Whereas for Caroline there was a sense of disgust towards her own needs (139)[121] and for sally a sense that she felt compelled to put others needs before her own:

> Sally 38: "I just, I like helping people and I like the feeling that I'm helping them ease their load or um, making sure they're feeling

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[114] Taken from the super-ordinate theme of Loss of Agency
[115] All taken from the super-ordinate theme of Lack of Agency
[116] Taken from the super-ordinate theme of Lack of Agency
[117] Taken from the super-ordinate theme of Lack of Choice
[118] Taken from the super-ordinate theme of Lack of Intention Behind Illness
[119] Taken from the super-ordinate theme of Lack of Introjected Good Object.
[120] Taken from the super-ordinate theme of Punitive Attitude towards the self (own needs).
[121] Taken from the super-ordinate theme of Punitive and Intolerant attitude towards the self.

well and stuff, like if my Dad's ill or something I'd help him, look after him and on the weekends I go home and try and help out as much as possible cos I feel like its their weekend and they shouldn't be working and doing too much."[122]

This neglectful and intolerant attitude towards the self is not the only example of the broken or maladaptive ways in which the participants tended to relate towards themselves. Other ways in which this was apparent was though their disengagement from the self, rigid thinking and a split sense of self.

Disengagement

This refers to the way in which within the participants' accounts they seemed to express a sense of wanting to avoid or disengage from themselves and their experiences.

Dianne 14: " No I don't want to think about it at all, that is why the evenings are quite difficult because from having dinner from the night snack is quite a gap and its hard because there isn't anything to do, there are no groups either and its quite quiet, everyone is a lot more relaxed and you can kind of hear the thoughts in your head a lot clearer, which I'd rather not."[123]

Sally 8: "I find it very uncomfortable, um, the atmosphere there (dining hall) doesn't help either because everyone's so focused on their fears and their desire not to eat the food, it becomes very tense which obviously makes it harder, um, I don't tend to think much about it now I've got into a kind of routine of doing it."[124]

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[122] Taken from the super-ordinate theme of Inattention to self and own needs.
[123] Taken from the super-ordinate theme of Cognitive and Emotional Disengagement.
[124] Taken from the super-ordinate theme of Disengagement from Self.

This disengagement was also present through the way in which they could be quite non-committal or ambivalent in answering or exploring some of the questions within the interview. For example at one point Liv was encouraged to think about what impact she felt her relationship with her sister had on her eating. Her reply below illustrates the ambivalence and or difficulty she felt in answering this question through the way she moves from talking about herself to "people":

> Liv 127/8: "Um, I think it perhaps did, but now I'm more aware of it, I have to make sure it doesn't. So I think that how you're feeling, I think its like any kind of human, though if you're feeling, well I suppose some people like to, turn to comfort food but you might lose your appetite if you've had an argument." [125]

Other similar examples include Kim 54 and 107[126] and Caroline 97[127].

Rigid thinking

Rigid thinking is present throughout all the participants' accounts and refers to the way in which participants seemed to construct very rigid rules around how they thought they should live their lives. [128]

The quotes below have been selected to illustrate the type of rigid rules and ways of thinking that the participant's imposed upon themselves, both around food and other areas of their lives.

> Kim 87: "So I just don't eat in front of people at all."
> KC 88: "Okay"

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[125] Taken from the super-ordinate theme of Ambivalence towards Self, Own Needs and Relationships.
[126] Taken from the super-ordinate theme of Ambivalence.
[127] Taken from the super-ordinate theme of Ambivalence towards self.
[128] Often many of these rules were orientated around food, for this reason at one point I considered accounting for this theme under Food as a container, (as I felt these rules could help to provide individuals with a sense of containment in their lives). However on further reflection I decided that the rigidity of the rules around food were more indicative of cognitive dysfunctions and therefore would better be accounted for under the concept of Loss of and Broken Sense of Self.

Kim 88: "When I'm on the outside."

KC 89: "What, what kind of things don't you like about the thought of eating in front of people, cos I know you also mentioned that you don't like that kind of watchfulness in the,"

Kim 89: "It's just that I don't do it, I don't eat in front of people."[129]

Ellie 24: "Um, cos I already feel like I'm too big and I'm a bit all or nothing."[130]

Lilly 61: "I don't need the food, I shouldn't, shouldn't need to eat it, I don't need it, shouldn't."[131]

Dianne 87: "U, it's a general rule, like as little fat as possible, umm as little carbs as possible,"[132]

The split self

The Final area in the exploration of this concept, is the theme of a split self. This was evident throughout the interviews through the way in which participants seemed to demonstrate a battle between their rational and irrational sides and similarly between their mind and their body.

The quotes below highlight well the internal conflict/tension that was created within the participants due to the conflict between their rational/healthy and irrational/unhealthy sides.

Dianne 11: "Especially because I'm, no I'm not sectionable, I'm hear voluntarily and I feel that anything I do now, any meal that I have, every mouthful that I have is purely down to me cos no one

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[129] Taken from the super-ordinate theme of Rigid Thinking.
[130] Taken from the super-ordinate theme of Cognitive Dysfunctions and dysfunctional beliefs
[131] Taken from the super-ordinate theme of Rigid Rules
[132] Taken from the super-ordinate theme of Development of Rules and False beliefs.

is insisting that I have to do it so I do feel quite angry with myself because its my choice."[133]

Caroline 103: "I have to admit that particular story with my family makes me feel quite sad, because actually I do like olives and I pretty much never eat them now because of my eating disorder because I'm scared about the calories and um... and I hardly ever drink alcohol now, and I do sometimes think, oh I fancy a glass of wine, oh I fancy a pimms in summer and I don't, and I don't, I don't do it, you know."[134]

The next two quotes show not only how participants started to view their mind as above and beyond almost as superior to the body, but also how the body is viewed as working against or in opposition to the mind.

Wilma 9: "I never received psychological help until I got here, cos in the general ward in the mental, they weren't specialized in this, they were just more like saying "do you know why we need to feed you?" And I said no I do, I'll say no I don't, I really don't and I was, I was saying you maybe you maybe thinking your healing me physically but every feed you're putting into me, do you know how much pain your put-, pu-, like putting me psychologically, you're actually making my psychological illness worse."[135]

Lilly 52: "Like the body needs food, so the body is dependent on it, but, there's kind of dependent relationship with it, but I don't, I don't know its (sighs) I need it but I hate it."[136]

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[133] Taken from the super-ordinate theme of Split Self
[134] Taken from the super-ordinate theme of Ambivalence towards self
[135] Taken from the super-ordinate theme of Mind over Body Split
[136] Taken from the super-ordinate theme of Mind over Body.

This battle is further enhanced by a strong sense of ambivalence that runs throughout all of the participants' accounts. This ambivalence can be seen in the above quotes and is similarly present under the theme of Disengagement, as touched on earlier

Core Concept 2: Misattuned Caregiving

This core concept refers to the participants' experiences of their upbringing, past and present and how at times it seemed/ seems not to be conducive with or in tune to their needs and wants. The first component part of this concept to be explored is Lack of Containment.

Lack of containment

Within all of the participants' accounts there was very much a sense of them having difficult or strained relationships with their parents or other family members, similarly there was also a sense of their being other difficult or strained relationships within the family, often between the parents. Lack of containment refers to the way in which the dynamics of these relationships could result in the participants feeling for instance overlooked, unloved, misunderstood, unsupported and rejected.

> Kim 60- 63: "Um, well when she got a husband, um, she didn't really, she just let us go out when we wanted to, do what we wanted to, she was never interested in what we was up to and never took part in our lives really...At the time I supposed it was really good, but now I look back and it we should have had boundaries and... I wish she had more part in our lives, took more of a mothering role, made us fell wanted."[137]

[137] Taken from the super-ordinate theme of Lack of Containment

Wilma 61: Because it was just very a cold atmosphere, it was, there was no, no one spoke to each other, my mum was so busy my dad was never at home, and me and my brother even when we were at home, we never, like he has his own room, I have my own room. Its just,"

KC 62: "So it felt very isolating or very kind of,

Wilma 62: "Yeah, and its weird having that feeling of loneliness when you're around people, its like okay I'm with people, but I'm still feeling lonely, what's wrong with me?"[138]

Dianne 42: "Umm, there are probably a few things, really, one was that my Dad was a drug addict and he was kind of never really around, he wasn't ever there and I didn't, I don't know, mum's attention was always distracted with him and like be caught up in arguments the whole time. I think it was partly a way of trying to get their attention (restricting food), not in like a negative kind of attention seeking way, but just as a child growing up, just wanting her parents around"

Sally 26: "But on the weekends my mum would still be very much talking about work, you know what she's got to be doing the next week and stuff she's very dedicated to her work and I'd, I'd still find it hard, because when I go home on the weekends, she's obviously still talking about school and things and"

KC 27: "How does that make you feel I guess, when she's talking about work?"

Sally 27: "Makes me feel quite sidelined I suppose."[139]

Caroline 123/4: "I woke up in the night hearing them arguing, I'd go and sit on the stairs so I could hear what they were saying, and looking back you know that was such an unhelpful thing to

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[138] Taken from the super-ordinate theme of Lack of Containment

[139] Taken from the super-ordinate theme of Lack of Containment

do, cos I heard things I shouldn't have heard really, um, but I felt like it was, almost like it was negligent of me not to listen."[140]

Responsibility

The last quote from Caroline leads on to another component part of this core concept that through their experiences of their upbringing, often the participants felt responsibilities or pressures in life that were perhaps inappropriate for them to feel. In the quote above Caroline refers to herself as "negligent" implying that she felt a certain responsibility within her parents relationships. Similarly to this Ellie in her interview when talking about her parents' relationship expresses that at times she felt responsible for their difficulties as if she could have done something to help them:

Ellie 61: "Um, I felt protective towards my mum and annoyed towards my dad. Towards me I felt a bit, annoyed with myself, cos I felt like, well, maybe if I had been wearing something like a dress, or if I had, done something differently or, then it wouldn't' have, he wouldn't have his anger wouldn't' have overflowed like that."[141]

The following quote from Liv, illustrates how she felt she had other types of responsibilities at home in her mother's absence.

Liv 125: "With Alex (her brother), me and him are like two peas in a pod, we're like inseparable basically and we're so alike, and I was like his mum really, cos my mum was, like been at work or out at the weekend and I'd look after him."[142]

This final quote from Sally illustrates how she felt a constant sense of responsibility towards making sure that others were okay, in particular her parents:

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[140] Taken from the super-ordinate theme of Lack of Containment
[141] Taken from the super-ordinate theme of Lack of Containment
[142] Taken from the super-ordinate theme of Demands and Expectations upon self.

> Sally 38: "On the weekends I go home and try and help out as much as possible cos I feel like its their weekend and they shouldn't be working and doing too much."[143]

Imposition and control

The final component part of this core concept is the theme of imposition and control. Within some of the participant's interview there was a strong sense that they could feel quite controlled or imposed upon by others. This could lead them to feel like there was little space or allowance for them to be themselves, which in turn could lead them to feel unaccepted.

This theme was explicitly evident within Liv's interview, where she talks about how unaccepting she found her Dad's behaviour towards her growing up:

> Liv 86: "But obviously in the time period of leaving school, I was growing up I was going to be starting driving lessons, I was going to start going clubbing and all of these things that my dad wanted to hold on to, his little girl and didn't want me to do and he was always quite against me growing up basically, he was always like no, no, no, you can't have alcohol and everything like that and where are you going, who you meeting and everything and its just like he was trying to control every part of my life and keep me little."[144]

It was also present within Wilma's interview, where her experience of the controlling nature of her parents seemed to present her with a feeling of being untrustworthy:

> Wilma 68: "Yeah, and I was never allowed to even eat out with friends to eat because my, like my mum was quite against me

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[143] Taken from the super-ordinate theme of Sense of Responsibility.
[144] Taken from the super-ordinate theme of Imposition and Control by Others.

going out with friends, or especially with Dad actually, "Oh Wilma, you're going to smoke or somet-".[145]

This theme was also implicit in Lilly's interviews through her description of what she wanted for herself:

Lilly 63: "I don't know, I don't really want people to its not that I want people to understand me or, I'd rather that they just felt nothing, that they, that they didn't have any feelings about me rather than them misunderstanding or trying to make me into something that I'm not."[146]

[145] Taken from the super-ordinate theme of Lack of Containment
[146] Taken from the super-ordinate theme of Sense of Self as being controlled/overlooked

Chapter 4: Discussion

Overview

This chapter will first review and explore the themes which have emerged from the participants' interviews, noting any connections between them and making reference to the literature which supports the interpretations of their narratives. Each master theme will be explored in the order that they are presented in the results chapter. As this chapter intends to go beyond the actual data offering more interpretative and reflective comments the master themes will be explored as a whole rather than through their component parts, individual quotes however will be included in order to add richness to the discussion. Due to space limitations within this research, core concepts 1 and 2 will not be explored individually but instead when appropriate they will be made reference to and explored within the discussion of the master themes.

Following the discussion of all of the individual master themes next will come a discussion of the master themes as a whole. Subsequently this chapter will go on to explore both the implications of this study for clinicians working with individuals with anorexia and the wider implications of this research for the counseling psychology field. Finally this chapter will evaluate the strengths and weaknesses of this study and look forward to what useful future research could be carried out within this area.

Individual Discussion of the Master themes

Master Theme 1: Food as a container

Implicit within this master theme was very much a sense of the participants feeling unsafe, insecure or uncontained. This sense fits quite clearly with the lack of containment experienced by these individuals as described in

Core Concept 2, Misattuned caregiving, (it is important here to note that the data supporting core concept 2 is not observational data, that is it is the participants perception of or the participant's own memories and attitudes towards their experiences of their caregiving). It is the researcher's thought that as a result of feeling "uncontained", that the participants set about trying to create for themselves a feeling of containment, and that the way that they did this was through their relationship with food.

The feeling of containment is said to grow out of a child's relationship with a parental object, who can receive, contain and digest its child anxiety and projections, returning them in a form with which the child can manage (Bion, 1962). Repeated experiences of such containment leads to the development of the child's own internalized function, or introjected object, to deal with his own anxiety; the alpha function (Bion, 1962). The alpha function not only helps manage anxiety but it also makes feelings understandable, thinkable and therefore more tolerable. Within the participants' interviews it was clear throughout (see core concept 1) that the participants did not posses what Bion calls the internalization of an alpha function. More specifically, that they had not had the experience of a containing relationship and therefore were left feeling very uncontained.

The description in the results section of food as both a safety mechanism and food as meaning making for the participants gives rise to the idea that food for these individuals creates within them a sense of containment. Furthermore that the individual's relationship with food tries, in a very concrete way, to fill the gap that is left from the lack of experience of a containing relationship. Two examples that support this interpretation of the text are described below.

In this first extract from the participant's narrative Liv expresses here quite clearly not only how uncontained (anxious) she can feel, but also how she tries to remedy this feeling by creating for herself her own sense of safety:

> Liv 110: "That whole moving on to the unknown created a lot of anxiety so by controlling the food again, it was creating that safety, something stable that I knew wouldn't then change."

It is this sense of safety and stability that the researcher believes should be available to Liv through her relationship with her parental object, however as it appears not to be, Liv is left trying to fill this gap herself.

The second extract from the participants' interviews is from Dianne:

> Dianne 19: "and it makes things easier for me, it makes things more tangible for me knowing that I'm tired, well its because I'm not eating, its not because of something else, or I'm upset because I haven't eaten and I'm just like really moody and its not because of some other deep seated issues and it makes me feel like I know, I know why."

In this extract Dianne firstly seems to suggest how hard it is for her to know and understand herself, thereby suggesting that she hasn't internalized a good object or an alpha function, from which to help her understand, think and tolerate her own feelings. She then goes on to explain how food and not eating, helps her to manage these feelings of not knowing by providing her with an explanation and an understanding of her own feelings. Thus again we see how through food the participants try to fill the void that is left from being uncontained.

Another interesting angle from which to explore this interpretation is from Winston's (2009) article on the theory of absence within anorexia. Winston writes that the idea of absence is intrinsic in anorexia. Certainly implicit within the above examples is a sense of absence or a sense of not having the right equipment to help experience understand or deal with feelings. In particular Winston talks about the absence of potential space between mother and child (Winnicot, 2005) something, which is synonymous to the absence of an internalized alpha function, (both refer to the lack of a

developed capacity or space to think) and is reminiscent of the psychological absence of the mother as described by Green (1986). This leads us on to a possible explanation as to why food steps up to fill this absence, why food becomes the container.

Winston writes (p.82): "If there is no potential space, however, the 'as if' quality is lost and only concrete reality remains." It is the researcher's belief however that without the 'as if' or the internal space to think about and understand things then not only does the concrete reality remain but the concrete reality is what is turned to in order to give meaning to experiences. For instance food as something tangible or concrete for Dianne provides meanings to her feelings. From this view it is not so much as Winston states that the collapse of the 'as if' means that "metaphorical thought becomes impossible" (p.82) but that something concrete has to step up to fill this potential space, and in these instances it is food.

Master Theme 2: Food as a concrete representation of internal states and relationships

As shown within the results section powerful and emotive contents such as internal states and relationships could be seen within the participants' narratives to be invested in food. It is the intention of this discussion to review and explore these results in light of an interpretation that asserts both that food in these instances could be considered as containing projections and additionally that food in these instances could be seen as acting as a concretised metaphor.

AN has been conceptualized within the object relations field as a defensive structure midway between shizo-paranoia and depression (Selvini, 1974). In addition it has also been likened to Winnicot's (1956) notion of the 'false self' (Winston, 2009). What is clear for both interpretations and many others within the object relations field is that defenses employed by the anorectic client are splitting, projection and disassociation (Goodsitt, 1969, Charles, 2006).

Up until now the most accepted and explored areas for hosting projections has been the body (Selvini, 1974, Skarderud, 2007) and other persons (for example the therapist as evident within most psychoanalytic literature). It is clear however from the participants' interviews that it is the food and not the body or some other person that comes to represent internal states:

> Caroline 65: "It's almost like that food itself is the emotion (sadness)."

Selvini (1974) writes, "that the body of the anorexic does not merely contain the bad object but that it is the bad object" (p.87). In a similar vein to this the researcher asserts that food in these instances does not merely contain the emotion but that it is the emotion. This leads us on to the concept of a concretised metaphor. A concretised metaphor, as explained earlier is when an internal state is given external equivalence, i.e. an emotion is concretised (Skarderud, 2007a). Dianne's words (86): "I don't know its like swallowing guilt... so its just like gaining more and more guilt with it," illustrate well the concretization of emotions into food. Furthermore it illustrates well how eating food is seen as taking on or internalizing that externalized emotion. In light of this, restricting food could thus be seen as a way of disassociating from or disconnecting from one's emotions. (This is something that is explored further in the following master theme, food as a separator). It could also be seen as a very concrete way of trying to manage emotions which feel so abstract, when there is a deficiency of internal equipment to deal with them from within, e.g. when there is a lack of an introjected good object. Wilma 91: "maybe because food is more concrete stuff where, and emotions aren't, by controlling my food I feel like I'm controlling my emotions."

Indeed, when, (as mentioned before), it is likely that the participant's do not possess the potential space (Winston, 2009, Williams, 1997) within themselves to think about, manage and understand their own complex feelings, it is clear enough that something has to be done with these feelings,

they have to go somewhere, for they themselves cannot contain them. Food as a tangible and concrete entity provides this space that they do not have, a safe harbor for their feelings, one that they can still impose some control over. However due to the lack of internal space which provides the capacity for symbolization (Winston, 2009, Williams, 1997, Bion, 1962) an understanding of food as if it were the emotion is not an option instead it becomes the emotion.

An understanding of food as if it were, or is, the emotion is congruent with Williams' (1997) idea of a no-entry system of defenses. Williams (1997) drawing on Bion's concept of the alpha function developed a concept she called the omega function. The omega function sits at the opposite end of the spectrum to the alpha function. It refers to the internalization of an impervious and disorganizing object, which is overflowing with projections that is introjected as a result of lack of containment and when in fact the child becomes a 'receptacle' for her mother's anxieties. For Williams the attempt to reject the introjection of this disorganizing 'omega function' can lead to what she describes as a no-entry system of defenses something which she believes is manifest within individuals with serious eating disorders, she writes:

> "A pervasive symptomatology with a 'no-entry' quality can represent a defensive system developed by a child who has perceived himself/herself (early in infancy), to have been invaded by projections. These projections are likely to have been experienced by him or her as persecutory foreign bodies. The 'no-entry' syndrome performs the defensive function of a blocking access to any input experienced as potentially intrusive and persecutory." (Williams, 1997, p. 121)

Within the participant's narratives it was clear that at times not only did they feel uncontained but that they also became the receptacle of their parents anxieties. For instance Caroline who described often having to give relationship advise to her mother or Sally who worried that her mother was

more ill than she was. Within anorexia the 'no- entry' syndrome is clearly or concretely evident within the refusal of food. It is therefore logical to deduce from this that food for the anorexic is (or is at least part of) the persecutory foreign body. By not ingesting food they therefore avoid taking on and allowing entrance to dangerous projections, which could cause chaotic and fragmenting feelings. That is the rejection of food within this "no-entry" system of defenses is synonymous with the interpretation of food as a concrete representation of internal states.

In a recent paper Ruangsri (2009) explored the psychodynamics of the use of food in eating disordered clients. Reflecting too on the absence of symbolization within the eating disordered patient he concluded from an analysis of recent literature (Winston, 2009, Newton, 2005 & Borris, 1984) that for these individuals food, understood as the first bridge between a mother and her child is perceived as a "representation of the mother together with her love and care" (p.5). Rejecting food is therefore a rejection of the maternal relationship. This understanding of food is not too dissimilar to the interpretation of food within this paper as food also being a concrete representation of relationships, more specifically, as illustrated within the results section, food as a rebellion or the relationship with food as mirroring their relationship with their parents. In respect of this there already seems to be some support for the idea that food can come to represent relationships. However, what is of significance here is that within this study, as illustrated within the results chapter, for the most part the relationship being represented within the food was the paternal relationship, or the parental relationship (mother and father).

Within the literature around AN there seems to be a strong emphasis on the impact that the mother and her relationship with the child can have in the development of the illness (Williams, 1997, Lawrence, 2001, Winston, 2009, Newton, 2005 & Borris 1984). Quite logically this seems to have derived from a combination of the perception of the mother as the most common primary caregiver and the mother's involvement in early feeding experiences. However the results from these participant's interviews, (in

particular Dianne, Caroline, Liv and Wilma), seem to suggest that just as the mother can have a strong and perverse impact on their child and the development of anorexia so too can the father.

Within much of the literature written around the importance of attuned caregiving, whether thinking of it in the context of attachment (e.g. reflective functioning and mentalisation, Bateman and Fonagy, 2004) object relations theory (e.g. Bion, 1962, Williams, 1997 & Winston 2009) or even the self psychologist perspective (Miller, 1991), the emphasis is on the importance of the presence of an available, loving and empathic caregiver. Within most of the participant's interviews there was an emphasis of one parent over the other being more attuned to their needs. For instance Liv, Dianne, Caroline and Ellie all emphasized problems with their relationship with their father, whereas Sally and Lillie expressed feeling closer to their father than their mothers. The question that this provokes is can you have attuned caregiving when you experience it from only half of your parental objects? This is not to say however that for Dianne, Liv, Caroline etc that they did receive adequate parental attention, care and containment from their mothers, as it was evident within their interviews that at times they did not. Irrespective of this however the question still remains can you ever receive enough attuned caregiving from one parent to negate the neglect of the other? The answer to this question the researcher is unsure of, however she believes that there is an argument for the importance of attuned caregiving from both sides of the parental object, and more specifically that it is not just misattuned caregiving from the mother that can play a big part in AN but misattuned caregiving from the father as well.

In asserting that food not only represents the maternal relationship but the paternal relationship as well this inevitably calls into question how and why food is chosen to represent such an internal structure. Within the context of the maternal relationship food is seen as an early symbol of intimacy or bridge between mother and child. Collapsed symbolic functioning/ lack of space however means that the maternal relationship becomes the food. But how does this transfer to explain the investment of the paternal relationship

within the food? The researcher believes there are two possible answers in reproach of this question. The first is that just as food can represent an early symbol of maternal intimacy for a child so too can it symbolize paternal intimacy if the child has had experiences of being fed by her father. The second answer is that this explanation does not necessarily need to transfer. This is because there is no reason why something in the external world such as food cannot or should not act or function as a source area for metaphors or symbolic thought as well. Such a thought is backed up by the knowledge that we can all when reflecting on our own lives find that we may attribute a part of ourselves or our life to something very physical. For instance a meal may come to represent or remind you of someone who has once cooked it for you, a song may make you cry as you associate it with certain memories or you may grow very attached to an item of clothing because of who gave it to you or because you passed an exam into it. All of these examples illustrate how we invest bits of ourselves into everyday items all the time. Thereby with the collapse of symbolic functioning there is no reason why these "as ifs" would stand strong while others did not.

Master Theme 3: Food as a separator

Within the results section this theme, in part, described the way that the participant's relationship with food seemed to provide them with a way of disconnecting from themselves on a cognitive and emotional level. This idea relates back to and supports what was discussed in master theme 2, whereby restricting food, (food understood as containing and becoming projections), could be seen as a way of disassociating from or disconnecting from one's emotions. Within this theme the notion of or sense of disconnection that the participants could feel as a result of restricting food is clearly exemplified; the words "numb", "blank", "cutting off" and "cold" were singled out to illustrate the disconnection that they experienced. This disconnection sits well with the interpretation that food can contain and represent emotions, for with food holding all the feelings, what is left for them to feel inside except for a sense of nothingness – the "numb"-ness or "blank"-ness they describe.

Moving on from this there was also a strong sense within the participants' interviews that by restricting food they not only disconnected from themselves on an emotional and cognitive level but on a physical level as well, in particularly from their body. Within the self psychology perspective it is thought that the anorexic tries to bolster her sense of self by strengthening her own experience of her body through the concretization of her symptoms (Atwood and Stolorow, 1984 & Miller, 1991). This interpretation feels quite opposed to what is being suggested here as within the participants' interviews it seemed that the participants' relationship with food allowed them to disconnect from their body and help them to feel less present in the world, thereby almost diminishing their own sense of self:

> Lilly 54: "I don't want to be conscious of my body and like, um, when I've just eaten I feel full, makes me feel like more there, more present."

This is not to say that this paper like the self psychologist perspective and many others (Bruch, 1970, Miller 1991) does not conceptualize anorexia as a disorder of the self, for it does. In fact core concept 1: Loss of and broken sense of self, clearly illustrates the ways in which the participants were seen to suffer from deficits (in particular reflexive and affect regulation deficits) and fragmented and disorganized perceptions and understandings of themselves. It is just at this point the meaning of food for these individuals seems to be a way of disconnecting or withdrawing from the very broken sense of self that they feel exposed to rather than as a way of enhancing their own sense of self. It is perhaps pertinent to note here that although at this point I am highlighting how food is used to withdraw from the broken sense of self that they experience, that in the first master theme it was discussed how food seemed to represent a container for individuals with anorexia. That is how food seemed to provide the participants' with a solution for their uncontained and confused selves. Thus food seems to hold a dual role, both as a mechanism to help contain the individual whilst

simultaneously helping them to become more disconnected and disparate from within. Both of which illustrate how truly dominating food is in the world of anorexia.

Just as food could be seen as a way of withdrawing from the self so too could it be seen as a way of disconnecting from those around you, as illustrated within the results section. The combination of the both of these it is believed had a large impact on the interviews themselves. This is because in a sense the researcher was asking the participants' to do the very two things that food seemed to encourage or help them not to do; to start to explore and understand themselves and to engage with another on an intimate level. What is of note here is that the amount that the researcher felt engaged by a participant seemed to echo the amount that the participant was able to reflect upon and understand themselves. For example, for Caroline, her interview seemed to reflect a growing and insightful understanding into what the meaning of food was for her and in turn the interviewer found her forthcoming and engaging, whereas for Kim, the interview felt stilted and very superficial, with limited insights and the researcher felt strongly that the interview was not something that she had felt comfortable doing.

The implications of this seem to be twofold. Firstly that the two types of disconnection, from the self and others, seem to run in parallel to one another, that is the disconnection experienced within the self is similar to or equivalent to the extent of the disconnection between the self and others. And secondly that the extent of the withdrawal of the self both from within and from others into the anorexia seems to connect to the extent of or the severity of the illness suffered by these individuals. For example out of all of the participants Ellie and Kim seemed to be the most severely affected by the illness at the time of the interview, (Ellie was being tube fed and Kim described having anorexia for over 20 years) in turn their interviews seemed to provide little insight into themselves and into the meaning of food for them. Of particular interest was the way in which it seemed hard for them to see the meaning of food for them as anything beyond something

that made them put on weight. That is they showed what the researcher interprets as the most reduced capacity in reflective functioning.

The final area this discussion wishes to address is the way that food seemed to act as a distinguisher for many of the participants', that is their relationship with food was something that helped them to feel different from other people. Although in part this idea can be understood in the sense that food acts as something to create more distance or a perception of distance between themselves and others, another interpretation is, is that the relationship that these individuals have with food helps them to feel more special or different from others, it provides them with an identity. Within the participants' interviews there emerged a definite sense of low self esteem as illustrated by core concept 1, and also a strong sense of lack of containment (see core concept 2). Both of these themes seem to suggest that at times maybe the participants questioned their role, place or worth within their family. Adopting a relationship with food in some respect could then be considered as trying to give them a role or find a place for them within the family, e.g. the one who has difficulty with food. In this sense food as a distinguisher could be seen as closely related to food as a container for in this light it helps to provide the individuals with an identity, something that as a result of their very tenuous sense of self they have little of.

Master Theme 4: Food as a mechanism of control

Within this master theme, like master theme 1, there was very much a sense of the world being an unsafe, unpredictable, unstable and scary environment; again this sense fits quite clearly with, or is a symptom of the lack of containment that these individuals perceived themselves as experiencing whilst growing up (see core concept 2). Perceived as such a place, the world could at any time approximate a generalized multi-factorial set of circumstances that could feel threatening and push the individual into feeling out of control. Food, or restricting food, within this context helped participants to feel more in control. This was because the rigid control they

imposed on their food helped them to bolster their own sense of self, in particular their feelings of self-efficacy, self-agency and self-esteem.

Caroline 126: "and I think that is the other thing about the food when, it's a way of really feelings like you are in charge of something."

Dianne 18: "When I restrict food I feel a lot more in control, which is ironic because I'm really not (laughs), but yeah I feel I'm able to do things that I wasn't able to do when I am eating."

Whereas the self psychologist perspective talks about individuals with anorexia using their bodies to bolster their own sense of self (Miller, 1991), this research believes that it is not the concretized focus on the body that bolsters the self, but more a sense of control that can be achieved through the food (as illustrated above) that enhances their own self image. This is not to say that the importance of the "concrete attitude" as asserted by Miller (1991) is undermined, for it is not, it is only being interpreted in a different light. Within the participants' interviews it became clear that the participants found it hard to regulate, understand, express and therefore control their emotions, this is something that is clearly highlighted in core concept 1, and it can be understood as being born out of the lack of an introjected good object (Bion, 1962, Williams, 1997). One way in which they felt more able to assert control over this area of their life, their internal states, was by controlling food. It is within the assertion, that by controlling food participants could find control of their emotions, that this paper believes lies the "concrete attitude". Here the concrete attitude being referred to is the understanding of food as a concretised metaphor for emotions. For it is only through such a concretised metaphor that participants would start to believe they did indeed have such control over their emotions.

An understanding of the collapse of symbolic functioning, i.e. the concretised metaphor in this instance can be seen not only as a symptom of an impairment or a deficit in reflexive functioning (Skarderud, 2007b) but also

as a defensive strategy brought around to increase the participants' own sense of self-efficacy and self-agency:

> "Clinging to the concrete attitude is then a means of maintaining one's sense of reality, of possessing an ordered and orderly existence" (Josephs, 1989, p. 492).

Other ways in which controlling food seemed to help bolster the participants" sense of self was through the impact it could have on relationships, both with the self and with other people. For instance in a similar way that food helped the participants to find control over their emotions it also helped them to find control within their relationships with other people, through an increased sense of self agency. Within the results section food is described as a mechanism of control through the way that it can help individuals to manipulate other people and also as a means to get attention. In these instances food is used as a tool to enhance the sense of control the individuals feel they have within their significant relationships in their life thereby bolstering their own sense of self through an enhanced sense of self agency. In addition controlling food also seemed to help the participants to control their own self -image. As shown within core concept 1, many of the participants had very low self esteem and lacked any internal validation, this meant they were constantly seeking validation from external means, whether it be for example from other people or academic success. Controlling food in this context therefore could be seen as a very concrete or tangible way of the participants trying to validate themselves. Sally within her interview talks about how restricting food and not responding to her hunger helps her to feel a " sense of achievement" (43). This, again like before, highlights how something external, in this instance food is used as a means to bolstering the sense of self, this time through self-esteem.

In consideration of why food is chosen in these instances as a mechanism to find control, or why food becomes a concretised metaphor for emotions, this research draws on the notion that food according to the self psychologist perspective is not only the first bridge between the mother and the child

(Geist, 1989, Krueger, 1997) but that from a young age it is also a very "real, tangible and soothing substance which physiologically and emotionally regulates affect and tension states, hence providing selfobject functions" (Ruangsri, 2009). From a self psychology perspective eating disordered symptoms represent frantic struggles to supply missing selfobject functions (Brenner, 1983, Goodsitt, 1969).

The idea that food provides selfobject functions is similar to the idea of what was discussed in Master theme 1: Food as a container, whereby participants set about trying to create for themselves through food their own feelings of containment. The use of food in both these instances (as a controller and as a container) is suggestive of arrested development. In particular it reinforces the idea that the participants had not managed to move on from a presymbolic developmental level of thinking – the" concrete attitude" to the development of an "abstract attitude" (Miller, 1991) or as Buhl (2002) wrote had not developed an inner language, a "prerequisite for the ability to use words and abstract symbols as soothing and controlling functions." (p.138). This in turn meant that they had not managed to move on from the early functions or role that food played within their lives. Instead, they have clung to it as a way of grounding, bolstering or controlling their own sense of self, for they lack the capacity to do this from within.

Overall Discussion of the Master Themes

Caroline 159: "I think food had become something to me which is just, chocofull of meaning, its quite difficult in a way to answer your question, because I think for me, depending on my mood, depending on my situation, depending on all sorts of things my day, anything, it will be just embedded with all sorts of meaning or feeling or something, "

This quote from Caroline sums up nicely the polysemic nature of food that has been explored within the individual discussions of the master themes. It asserts unequivocally, that yes food does carry meaning for individuals with anorexia, something that has been illustrated within the results section and the discussion of the master themes, and it reflects well the difficulty of the task in really ever understanding the extent of the different and varied meanings that food can carry for individuals with anorexia.

This paper's interpretation of the meaning of food for individuals with anorexia has been organized into four master themes. On further reflection however and after the individual discussion of each of the master themes, it feels important to note, that even at this stage it is possible to make further groupings or clusterings within these 4 master themes. That is, master theme 1: Food as a container, master theme 3: Food as a separator and master them 4: Food as a control mechanism seem to sit together nicely, for they all express how food is employed as almost a coping mechanism, something which helps them to manage themselves and their situation in the wake of their internal deficits. Master theme 2, however is set apart and different from the other three master themes for it expresses something different that is, that food comes to be a concrete representation of internal states and relationships.

When considering one of the initial aims of this study, to investigate whether food is or ever can be a concretised metaphor for something, this master theme stands out. For it is within this master theme that a clear relationship between food in anorexia and metaphorical content is illustrated. That is food is shown to be a concretised metaphor for both internal states and relationships. This interpretation goes a step beyond Miller's (1991) understanding of the "concrete attitude" and similarly a step beyond Skarderud's (2007a) understanding of concretised metaphors, for it asserts that the external world can act as a source area for (concretised) metaphors as well. This interpretation therefore provides further evidence for the theory of metaphor as a general function of mind (Lakoff & Johnson, 1980, 1999) and encourages a more inclusive epistemological approach that

looks beyond the living body, (Merleau-Ponty 1962) to a living body and living world. Within this context it is therefore the meaning that comes to be embedded or concretised in food that makes eating so hard for individuals with anorexia:

> Caroline 159: "when I know that I need to get through someth-, get through a meal, when I'm really het up or when I'm really stressed out or something, some advise that other people have given me or that I then try to give myself is, um, the food doesn't mean anything it its just food."

Within the interviews not all the participants were able to make or see a connection for themselves between food and emotions, in fact the ability to make associations within the interviews varied quite dramatically between the participants. The question is raised therefore is it right to assert that for all individuals with anorexia that meaning becomes concretised within the food. After considerable reflection on this point the researcher has come to an understanding as to why and how such an assertion can be made. Within the participant's interviews Kim, Ellie, and Sally stand out as the three individuals less able to make associations between food and emotions, what is interesting here is that the immediate association made for these three with food was weight gain, or getting "fat". (Whilst talking about weight, it is important to observe at this point that fear of weight gain as a result of eating was hardly mentioned at all by the other participants). Returning to what was spoken about in master theme 3: Food as a separator, it was these participants that seemed to be the most disconnected from themselves (and from the researcher) within the interview, therefore showing a reduced capacity in reflective functioning, and these participants which in turn seemed to be the most severely affected by their illness at the time of the interview. From this it can therefore be interpreted or argued that for Kim, Ellie or Sally it is not so much that food has not become a concretised metaphor for internal states and relationships but that they do not have the capacity or internal equipment to understand or make such an association themselves. This is because their thinking has become so reduced that it is

impossible for them to see or understand much beyond their rejection of food as an attempt to lose weight.

This argument invites further thinking around an understanding of the psychopathology of anorexia in respect of impaired reflective functioning. For it encourages us to think about the level of reflective impairment of an individual with anorexia as sitting on spectrum in accordance to the severity of their illness or vice versa. Furthermore it invites us to consider whether the level of an individual's impairment could be understood or translated onto a developmental trajectory and whether this in turn could help us to predict how severe their disorder is and how hard or difficult it might be for them to recover?

Within previous literature anorexia and the "concrete attitude" has been seen as representing a presymbolic developmental level of thinking (Josephs, 1989) which is comparative to what Piaget and Inhelder (1969) called the concrete operations stage. Within these theories there is very much a sense of either having the capacity to think symbolically or not, there is not much space for anything in between. Within the participant interviews the researcher developed a sense that it was not so much an either or, or "as if" "is" situation for the participants but that more that their level of reflexivity could be understood as resting somewhere along a continuum with one end of it representing immature and non-symbolic thinking and the other end of it representing mature and symbolic thinking. Appendix 13 illustrates how, why and where the researcher conceptualized each participant on this continuum drawing from not only the content and meaning provided by the participants within the interview but from the process as well.

Returning to the argument; that impaired reflexivity can explain the absence of associations made by participants that are consistent with master theme 2. The question is raised as to whether this argument can transfer to explain the absent associations from participants pertaining to the other three master themes, e.g. for those participants who did not describe food as a

safety mechanism is this just because they just did not possess the insight to. The researcher believes that this argument does not transfer in a large part down to the qualitative difference of the themes being described between master theme 2 and master themes 1, 3 and 4. For whereas master theme 2 is explicitly linked to the notion of reflexive impairment through the collapse of symbolic functioning illustrated through the concretised metaphor, the others are not. So how can it be explained that for some of the participants food held a certain meaning for them when for others it did not. The researcher believes one possible explanation for this could be found by returning to core concept 2, misattuned caregiving, which quite clearly has been shown to be a factor in the development of anorexia (Bruch, 1970, Selvini, 1974. Miller 1991, Winston, 2009). Misattuned caregiving is a term used within this research to refer to the many ways in which participants did not experience "attuned" caregiving, that is they did not experience an empathic, containing and loving object (Williams, 1997). Misattuned caregiving, in the researcher's eyes, is a multifaceted term for there are many ways in which caregiving can be misattuned. For instance where as one parent may be neglectful another may be too controlling, where as one parent may not be supportive of their child another may apply to much pressure, or alternatively whereas a mother for one child may be loving and their father not, for another this could be the other way around. It is the researcher's understanding that for individuals with anorexia that the individual nuances or experiences of their own caregiving could possibly impact upon the meaning that they attribute and impart upon food.

This idea draws upon the self psychologist perspective that believes eating disordered symptoms represent struggles to supply missing selfobject functions (Goodsitt, 1969, 1997, Miller, 1991). Within the self psychologist perspective it is believed that only a responsive selfobject environment can provide the experiences of living that facilitate the structure of a cohesive sense of self (Kohut, 1971, Bachar, 1998). The self object functions are initially perceived to be provided by the mother, who provides in particular three types of self object functions (Goodsitt, 1997; Banai, Mikulincer & Shaver, 2005). Firstly the mother functions as a mirroring selfobject,

whereby, by admiring and valuing the infant she contributes to the development of a healthy sense of "grandiosity" (Kohut, 1971). Secondly she provides or is an idealized object towards which the child can identify with thereby helping the child to develop a secure sense of self and to internalize the capacity to hold ideals and set realistic goals (Banai, Mikulincer & Shaver, 2005). Third and finally the mother provides a twinship selfobject function to whom the child feels an alikeness with and therefore comes to feel protected and validated (Kohut, 1971). Failures in either of or any of these three provisions, mirroring, idealizing and validating needs could therefore be seen to contribute to particular deficits (e.g. lack of internal validation, insecure sense of self) within the capacity to maintain a cohesive sense of self. In light of this, the varied meanings of food could thus be explained by the individuals attempt to counteract their own particular deficits as a result of their unique experience of their mother's provision of the selfobject function.

It is difficult to explore, relate and illustrate this argument from the participants' interviews as firstly the interviews were too short to provide any detailed insight into the individual's real experience of their caregiving, (furthermore the data that was gathered was from their perceptions and was not observational data) and secondly this was not the focus of the interview. However in an attempt to explore and support this argument by returning to the texts it has come to light that for example for some of the participants who spoke about feeling particularly controlled by others, e.g. Wilma by her parents, Liv by her Father and sister, food for them was very much used as a mechanism of control to regain a sense of self agency. Furthermore for those who spoke about food helping them to provide their feelings with meaning and understanding, e.g. Wilma and Dianne, they often also spoke about how misunderstood they felt by their parents. To conclude in these examples the meaning of food as suggested within the argument can be seen to mirror (in the positive) the absence of the self object function.

Turning now to reflect on the data gathered as a whole another point for discussion is something that was touched on earlier within the

methodology, which was the similarity of the data between participants (See appendix 10). As mentioned before the researcher was quite struck by how similar the findings for each participant were to one another. However after further consideration and reflecting on this observation in light of what has been discussed within this chapter, in particular the concrete or impaired level of thinking that has emerged as present within individuals with anorexia, this observation no longer seems surprising. In fact the researcher believes that this observation and in turn, perhaps also the very stereotypical experience that clinicians can have with individuals with anorexia, can be explained by this very concrete level of thinking. For it is this thinking that disables the anorexic of any variety of thought thereby restricting their individuality and confounding their presentation as a stereotype of their client group.

Again looking at the data as a whole a final point for discussion is the difference that can be perceived between all of the participants' accounts of the meaning of food for them and what we may conceive of as a more "normal" account or explanation of meaning of food for individuals without anorexia. The researcher would consider a normal response to the meaning of food as one that would describe it in relation to appetite, hunger, fuel weight and sociality. It is pertinent to note that the notions of appetite, hunger, and fuel were rarely if ever drawn upon by the participants. The notion of weight was only mentioned within three interviews and at these times was perceived or interpreted as representing limited reflexivity, and the sociality of food was remarked upon as something they wished not to be included in. The fact that the meaning of food for these individuals is not consistent with a more "normal" response, provides further evidence for the meaning of food for individuals with anorexia as explained and illustrated within the master themes. For if it is not one thing, (the normal response) it must be another and it is this other that the study has tried to illustrate, describe and explain throughout.

Discursive Reflections on the Results

Within this section I would like to reflect upon my own thoughts around the results and some of the processes I went through. As inevitably my own reflexive thoughts have helped to form the discussion of the results, it is possible that there may be some repetition within this section. It is hoped however that at these points my reflexive comments will help to ground my decisions and my discussions of the results further.

A significant change that occurred during the analytic process

Originally I thought about having a fifth master theme entitled Food as weight. However as I sat down to write about it I realized I had fairly little to say about it aside from the fact 4 out of the 8 participants identified food strongly with weight gain. As I tried to dig deeper to find more to say about this theme I became aware of the way that these participants used quite sensational language when talking about weight gain (see bolded text).

Kim 7: "And after I've eaten I always ***feel*** *big and fat"*[147]

Ellie 10: "And when they're putting it in me, its almost ***like I can feel myself*** *gaining weight or can feel myself growing bigger."*[148]

Sally 8: "I've got into a kind of routine of doing it, I've been here so long, but still have the feelings afterwards which are feeling of hating myself I suppose for, for eating the food and the physical feelings of like be- bloated and makes me feel uncomfortable and then draws on the aspects of my body which I don't' particularly feel comfortable with"[149]

It was almost as if the experience of eating encouraged them to make a sensual connection with their own body, and as Sally suggests it is this

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[147] Taken from the super-ordinate theme of Preoccupation with external effects of eating.
[148] Taken from the super-ordinate theme of Association of food with weight.
[149] Taken from the super-ordinate theme of Food as Weight gain.

connection that they did not like. This then led me to think that rather than food representing weight in this instance this was another argument for food as a way of withdrawing and disconnecting from the self.

When reflecting on what made me initially want to create this fifth master theme, I realized that it was actually the strength of the participant's pre-occupation of weight gain within the interviews (see quotes below) combined with possibly a primitive assumption of mine that yes rejecting food must be about weight loss. However after reflecting on the interviews and the participants as a whole I started to realize that the interviews within which there had been an emphasis on the body and/or weight gain that these were the individuals who seemed to be more severely affected by the Anorexia, that is they were being tube fed, or they had been battling with anorexia for over 20 years, and indeed these were the interviews within which I struggled to engage them on a more deep and meaningful level. For this reason I started to believe that that although for them it might feel like the meaning of food is heavily tied up with weight gain in fact there is more to it than that, (as found through the other participants) and that perhaps this confusion came from the varying levels of reflective function within the interviews.

> *Lilly 11: "Well I know that, the food is making me put on weight,"*[150]

> *Sally 15: "I just feared that I would put on weight because of food and I suppose that's what food represented for me."*

Surprises within the results

One of the things that surprised me within the results was the lack of emphasis I found to be placed upon food as a form of self-harm. Although it was definitely alluded to at times by the participants, that restricting food was a way of harming themselves, this was not by any means a main focus of the meaning for them (aside from Wilma, that is, who did seem to place enough

[150] Taken from the super-ordinate theme of Food as identified with weight

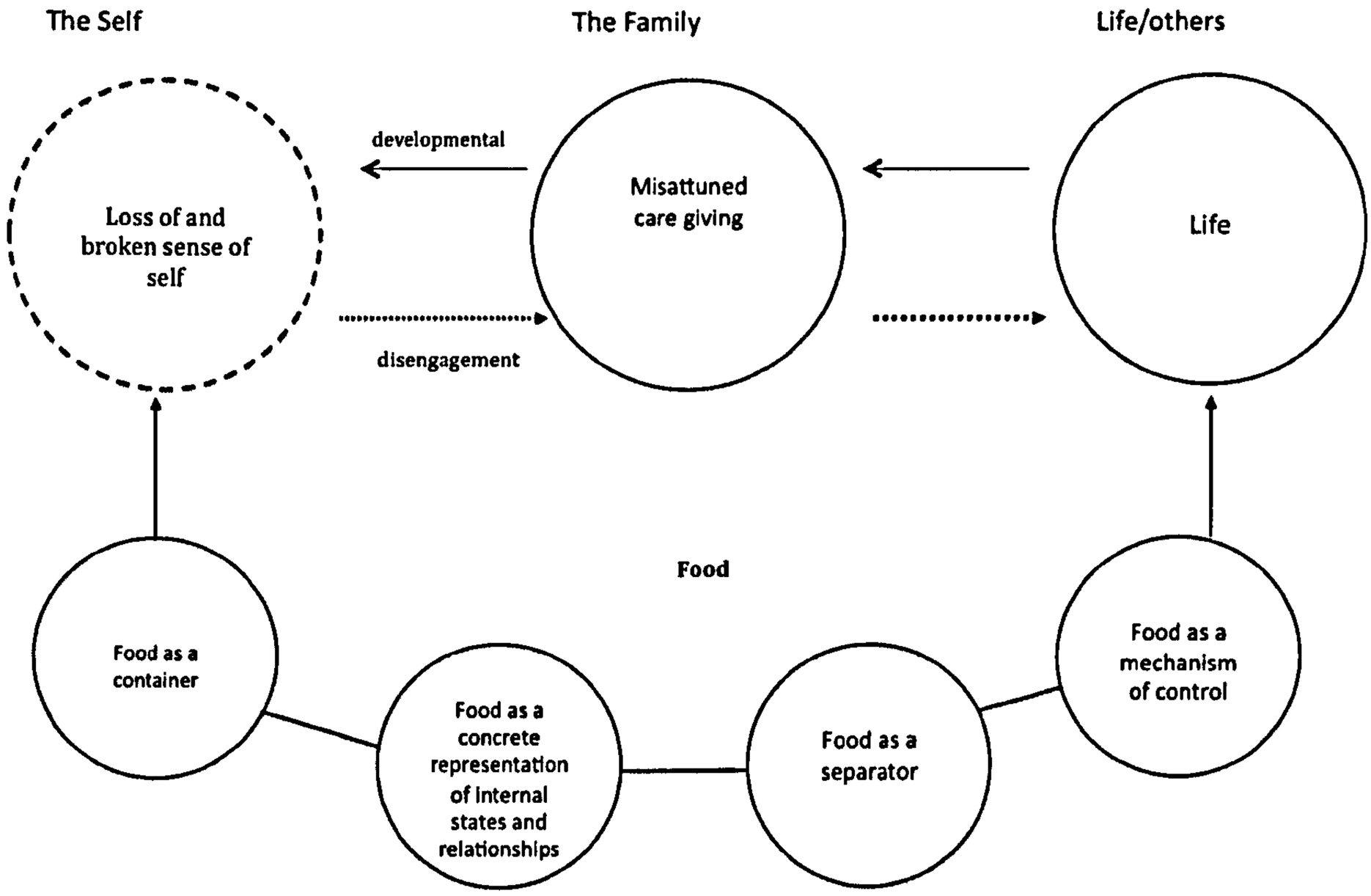
focus on it for it to evolve into its own individual master theme). My surprise over this seemed to indicate to me that somewhere along the line I had made an assumption that the rejection of food represented a malignant desire of self-destruction. The fact that this assumption was not validated through my interpretation of the data I believe is key, as for me this says that individuals with anorexia, regardless of the severity of their illness, do not reach such a perverse and destructive stage that they will not give anyone else or themselves the satisfaction of recovery, thereby suggesting that individuals with anorexia are perhaps more helpable than I originally thought.

Another thing that I was struck by through the interpretation of the results was just how similar the list of individual master themes came out for each of the participants, on reflecting on this with my supervisor it became clear that this was perhaps not surprising giving the stereotypical nature of the illness that is well documented within the literature in this area (Miller, 1991, Skarderud, 2007, Bruch 1970, Selvini, 1974).

The final thing to surprise me within the results was just how different the way that the participants spoke about food was to how individuals like myself without anorexia may talk about food. Although this may sound like quite a strange comment to make given the very premise of the study, it is just that perhaps the meaning and associations that were embedded in food far exceeded my expectations of what they may be. Furthermore the rich language used by the participants in particular Caroline, and the assertiveness or knowingness placed behind some of their comments e.g. Wilma and Dianne enhanced the depth of or experience of the meaning of food for these individuals, far more than I had anticipated. The different ways of understanding and talking about food that these individuals demonstrated has inevitably awaken within me a sense of difference that lies between a person with anorexia and a person without anorexia, a difference in a level or engagement of thinking, one that I had perhaps not expected to find in so many uncertain terms.

Formal Theory Building and Conclusion

The contents of the participants' interviews demonstrated the very concrete and direct nature of the many meanings or metaphors of food for individuals with anorexia. In doing so it pointed to the presence of a very basic relationship that can exist between the internal mind and physical objects, such as food. This relationship is one of direct translation within which internal states come to be represented (concretised metaphor) and internal needs or deficits come to be compensated for. Either way something very concrete, tangible or physical like food evolves to take on a more living or intra-psychic meaning, something, which it is then, held accountable for by the individual. The diagram that follows below is a conceptualization of a theoretical and descriptive model for anorexia based around these findings of the study.



The theoretical model above proposes how life and family, in particular an individual's experience of misattuned caregiving (core concept 1), can have a negative impact (as illustrated by the solid arrow) on an individual's sense of self (core concept 1). In particular it suggests how the disparity or

misattunement that is felt between an individual and their caregiver can come to be mirrored within the individual by their disconnection to themselves and the family and world around them, (as illustrated by the broken circle around the self and the broken arrows leading from the self to family and others).

In order to help manage these broken relationships (to the self, family and life) this theory argues that food is employed by the individuals as something that can help manage and bridge the perceived gaps within the self, between the self and others and simultaneously enforce them (master themes 1, 2, 3 and 4).

Another theory that has arisen out of this study is the idea that the level of impaired reflexivity for individuals with anorexia can be seen as lying on a continuum in parallel to the severity of the disorder. Although this theory is not illustrated within the diagram above it is relevant for it indicates how entrenched an individual may have become in bridging their gaps with food.

Implications for Further Research and Implications for Clinical Understanding and Treatment of Anorexia Nervosa

Within the study it would have been useful to have had more time to investigate and explore more of the meanings behind the core concepts and how these may relate to the study's findings. In particular the researcher would have liked to have had more time to carry out further research into the suggested link between the participants perceived experience of their caregiving, that is their experience of the self object functions provided by their mother and the meaning that food provided for them. This could be a beneficial area to research in the future as not only would it consolidate a better understanding of the meaning of food for individuals with anorexia

but it could also have important clinical applications. For if the varied meanings of food for individuals with anorexia could be explained by the individuals attempt to counteract their own particular deficits as a result of their unique experience of their mother's provision of the selfobject function, it brings to light the question that in understanding the meaning of food for individuals with anorexia can we therefore understand more clearly what the role of the therapist should be?

It is a basic premise within psychodynamic therapy that there are "related processes coming into being between the infant and caregivers, and later between patient and therapist. Former and actual relationships are reciprocal metaphors." (Skarderud, 2007c, p. 329). Understanding the role of the therapist in such a context asserts the importance of understanding the nature of the client's experience of their mother's provision of the selfobject function. For in understanding this, the therapist can start to understand the ways in which he/she needs to make up for the particular deficits experienced by the client, thereby deciphering her role better and molding it to be more in attune to the needs of the individual client.

Another similar and useful study that could be carried out within this area is one that uses observational data of parents' interactions with their child from an early age and tracks the development of the child into young adulthood to see if they develop anorexia. For this could help us to develop a more sophisticated understanding of the impact that types of misattuned caregiving could have on individuals, in particular individuals with anorexia and furthermore what impact the types of misattuned caregiving have on the meanings of food for individuals with anorexia.

In a similar vein the studies suggested above could also help to investigate further the role of the father within anorexia, more specifically his role in attuned caregiving and help to qualify what exactly attuned caregiving comprises of, i.e. can it for instance be supplied by only one parental object, with a marked absence from the other? All questions which have been raised within this study.

A final useful study that could be carried out within this area is one that looks to explicitly explore and qualify the levels of impaired reflexivity within individuals with anorexia on a developmental trajectory (one more sophisticated than the one included in appendix 13). For a study like this could help provide a scale which clinicians could then use as a tool to think about and try and conceptualise their formulations of their clients. In addition it could also help clinicians to predict what kind of a recovery period could be expected for each individual and what type of therapy could be best suited to them in accordance to their level of impairment.

All explorations of the four master themes have highlighted a core psychopathological trait of anorexia to be impaired reflective functioning. This in itself is nothing new, for Skarderud (2007a,b &C) through his exploration of the meaning of the body in anorexia drew the same conclusion. What is different however is the means by which this study came to the same conclusion that is through an understanding of food in itself as having the capacity to hold internal meanings. In response to Skarderud's findings (2007a,b &c) he outlined a new model of psychotherapy for persons with anorexia based on a model of mentalisation, here he described a relational process where concretized metaphors will be turned into genuine linguistic ones. This study in building support for existing evidence that the core psychopathological trait of anorexia is impaired reflective functioning increases the evidence for such a mentalisation based treatment. At the same time however it takes a step back from the findings of Skarderud and asserts the importance of understanding the extent to which the anorectic mind applies the concrete metaphor. This study has made an interpretation that food is and can come to be a concrete representation of internal states for those with anorexia. This interpretation needs now to be accounted for within clinical understandings of anorexia and models for treatment, for it is only after an understanding is developed of what holds what meaning can the therapeutic space be used to help then turn this concrete meaning into a more linguistic

concept, one that will help the patient to understand/mentlalise their feelings properly (Skarderud 2007c).

In a similar vein this paper also builds support for many of the other treatments which have been outlined (Bruch 1978, Miller, 1991, Buhl, 2002) that encourage the therapist to engage with the anorexic client on a "concrete level". The importance of such a level of engagement was made particularly clear through the researcher's experience of interviewing some of the more severely ill participants. Often these participants were unable to answer with any insight or even understand some of the questions that were being asked of them, it was clear from this that any interpretative associations that may be offered to them within a therapeutic session, would not only go way above their head but may also strengthen their tendency to disconnect from others (the therapist) and themselves as a result of feeling misunderstood. Again however the results of this study also require that the level of concrete engagement is reviewed, for again if food in this process is overlooked as holding such substantial meaning as it was revealed to, then again there is still a danger that the client may feel misunderstood and may withdraw from treatment.

Although for the large part this paper has been interested in finding out about content and meaning, when thinking about the clinical applications for the work it is necessary too to think of in terms of process as well. From the researcher's experience within the interviews she encourages clinicians to consider the qualititative experience of the therapeutic relationship within the room as mirroring or in proportion to how connected the individual is to their inner self (how reflexive they can be). This could be a good guide for gauging interventions and also in helping the therapist to manage any frustrations they may experience within the counter transference. On a more speculative note this study also invites clinicians to consider whether in accepting and understanding the distinct meanings that something external to the self like food can hold for individuals with anorexia whether this could be advantageous or helpful for the therapeutic process. This is because food as something external to the self unlike the

body or the mind provides a bridge or almost a shared reality where both the therapist and the client can meet. Furthermore talking about the meaning of food may feel less invasive or persecutory for individual's with anorexia than a focus on their feelings towards, for example, their body might. Similarly talking about food and what it may mean for the individual may feel less confronting than trying to talk to them directly about their inner feelings and experiences, something perhaps akin to a more a mediatory experience.

Wider Implications for Counselling Psychology

This study, as consistent with the ethos of counselling psychology has tried to assert throughout the importance of the empathic engagement of the therapist with the world of the client and "the acceptance of the subjective world of the client as meaningful and valid in its own terms." (Strawbridge and Woolfe, 2003 p.8). In this context, the implications of this study for counseling psychologists can therefore be seen to be consistent with the general implications for the treatment of the illness as outlined above. Having said this there is one area or priority of counseling psychology that needs further discussion, this is the assertion of the importance of a "developing focus in the work of helpers on facilitating well-being as opposed to responding to sickness and pathology" (Strawbridge and Woolfe, 2003, p8).

Within this research there has been an emphasis on uncovering the psychopathology of anorexia, more specifically there has been an emphasis on the need to understand the nature of and extent of the impairment or deficits of the anorectic mind, and for the therapist to respond to this by engaging with them on their concrete (impaired) level. As such some might argue that this focus goes against the grain of counseling psychology for it encourages a response to pathology and not well being.

Counselling psychology as a discipline however clearly recognizes the importance of clear conceptual frameworks from which research and practice can develop and be evaluated (Strawbridge and Woolfe, 2003), as such a conceptual and theoretical model of anorexia as rooted in an understanding of internal deficits becomes warranted. Yet can the encouragement of the counseling psychologists' direct engagement with the client's pathology be justified within the discipline? This paper believes that it can and that it must be in order to allow for the development and growth of both the therapeutic alliance and client. Whilst this paper recognizes the importance that the counseling psychology model places on not pathologising clients as is done so within the medical models, it wishes to highlight that the concept of pathology should not be neglected all together for it still holds a use for the counseling psychologist. This is because pathology as illustrated within this study can be understood as a theory of deficits, and deficits in turn can represent what the clients need, and it is these needs that the counseling psychologist should be trying to respond to within the therapeutic space.

Strengths and Limitations of the Study

One considerable strength of this study was its epistemological framework, for this encouraged an investigation of meaning outside of the lived body, something that has not been done before within and around the literature on anorexia. In doing this, this research has brought new and valuable insights into how anorexia can be conceptualized and understood, (from the meaning of food) and in turn has also provided additional support for existing literature within the field that believes that a core trait of anorexia is impaired symbolization or reflective functioning (Skarderud 2007a,b &c, Miller, 1991, Buhl, 2002).

Methodological weaknesses of this study were perhaps its exclusion of males. Understanding the meaning of food for individuals with anorexia means understanding it for all of those who suffer from anorexia including males. Although the researcher's decision to exclude male participants was based on IPA's preference for homogenous sampling (Smith, Flowers & Larkin, 2009), the results of this study should be analogous or representative for the whole client group (individuals with anorexia), regardless of gender, it would therefore have been more inclusive to have extended this investigation out to male participants as well. It is also possible that the study may have provided stronger results if it had interviewed recovered anorexics, for where at times the researcher had to rely on her own interpretations of the interviews, due to limited insight or reflexivity from the participants, this may not have been the case had she interviewed recovered anorexics, for they themselves might have been able to make the interpretations. Having said this however the need of the researcher to make her own interpretations has been a valuable process within itself for this study.

The greatest strength of this study as indicated before is its originality, epistemological framework and (in addition as referred to within the implications section) the developments that this demands for in treatment, in particular a more extensive understanding of the client's subjective world. Another important strength of this study is that it encourages the investigation of food within other disorders such as bulimia and obesity from a similar standpoint, which similarly could lead to new insights and understandings. Like any new findings this study's results, in particular food as a concretised metaphor for internal states, could benefit from further substantiation from studies in the future, however at present these findings are new and exciting and the researcher believes could be considered as a true development or move forward towards a more accurate and inclusive conceptualization and understanding of anorexia nervosa.

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Appendices

Appendix 1: Pilot Study

A pilot study was carried out on 8 participants. The participants of this study were known to the researcher and the researcher was therefore aware of the different relationships the participants had towards food. In particular three of the participants had had problematic relationships with food whilst growing up either through self-starvation, over exercising or use of laxatives.

A list of the questions asked to participants are detailed below:

1. What does food mean for you?
2. What comes to mind when you think of food... (Images, thoughts, feelings etc?)
3. How much time in the day do you think about food?
4. What kind of role does food play in your life?
5. In what kind of ways do you enjoy (if you do) food?
6. What comes to mind when you think about eating?
7. What does eating mean for you?
8. Do you organize many events/ activities around food?
9. What are the functions of food?
10. What are the functions of eating?
11. What did food mean for you when you were growing up?
12. What kind of role did it play within your family?
13. How has it changed for you over the years?
14. Do you associate food with people if so anyone in particular?
15. How do you feel when you think about food?
16. How do you feel when you think about eating?
17. Do you associate any types of emotions with food?
18. Are these different to or similar to the types of emotions you experience with eating?

19. Are there any textures, flavours or physical structure appearance in food that you favour more than others?
20. Has food developed a meaning for you through use or practice through time?
21. Has food developed a meaning for you through association in fact or thought?
22. If you were to describe food as symbol for something what would you say?

Participants are numbered from 1-8. Participants 6,7,8 to the researcher's knowledge all had problematic relationships with food whilst growing up, however their present relationship to food is unknown, participant 5 also had a questionable relationship with food, but this is less known to the researcher.

From the answers given, food for all seemed to have an association with "family and lovers". Almost everyone connected thoughts about food and their enjoyment with it with their partners. More interestingly sisters or other female friends, were also seen to have a strong connection with food; "Charlie and my sister" (p6), "Maxine and my lover Thomas" (p7) and "all family particularly mum as she is the only other female in the family and we think about food differently (p5)".

For most of the 8 participants it was seen as a pleasure and an enjoyment however for a couple of them this was only the case if they were sharing food with someone else; preparing or eating food for themselves alone was considered a "chore (p4)", "a hassle" (p8) or "inconvenient" (p8). Eating was frequently connected with social activities and an opportunity to bond with friends and family over a creative and shared activity.

Everyone seemed to have an awareness of the functions of food as fulfilling our biological needs, and it seemed common for people to associate different types of food with different moods. For example certain foods were considered as more comforting than others such as "beans on toast" (p1)

and "ice cream" (p3). One of the participants who had a problem with food when younger said that she feels "the need to eat more when feeling hormonal" (p7).

Only a couple of participants did not associate food with any negative feelings (p1&2). For others however guilt was a common feeling to have following the feeling you have overeaten or eaten unhealthily. More Interestingly the impact that food can have on the body in terms of gaining weight was only mentioned by one participant, (p1) who mentioned she was not able to eat as much as she used to without putting weight on, but otherwise the notion of the body in terms of shape or size was not explored in any of the answers, aside from the idea that "food provides your body the nutrients and energy".

The most interesting finding from the study came from the answer to the last question asked; if you were to describe food as symbol for something what would you say? 6 of the 8 participants answered either or both of "life", "love" "happiness" and "wellbeing". More interestingly however food for the two remaining participants who had both suffered from eating problems growing up, seemed to have an underlying tone of embodying something more; "A relationship, like a lover- indulgent and exciting but sometimes guilty" (p6) and "love for people" (p7). In both these quotes food seems to stand for something more tangible than the abstract notion of love itself, rather they appear grounded in the person's experience of something else. The idea that food can embody something else was also echoed in the responses to the question "What did food mean for you when you were growing up" where for one participant they described it as their "enemy" (p6) another participant said they "hated it for a while" (p8); both answers implying that food embodies more than its function of fulfilling a biological need.

Appendix 2: Interview Schedule

Warm up: Introductory section

To help us both settle into the interview what I thought I would do for the first ten minutes is to ask you to take me through a normal day for you, describing and explaining all of your encounters with food. By encounters I mean any interactions you may have with food through: thoughts, eating, cooking, shopping, TV, feelings.

Was yesterday a typical or normal day for you?..... Perhaps we could start there then.... Lets start from when you wake up..

e.g. Why did you have coffee, did you have any thoughts about having anything else... why didn't you... Probe for feeling...
If you weren't feeling so good what would you do..

Main body:

For the next part lets talk about and try and explore what the meaning of food is for you.

What role does food play in your life?

- Outside of nourishment any significant other role?
- Prompt around friends, family (mother)
- Does or has this role changed for you over time... why is this?
- Does this role change throughout the day or at different times of day, or when you experience different emotions?

How would you describe your relationship with food?

- Is it similar to or different to how you see other people's relationship with food (significant others, friends, family, especially mum).

What kind of associations do you make with food?

- Positive or negative
- Emotions, people, events, memories,
- Do you have any different associations with different food?
- Do you have any favourite foods?
- Have these associations changed over time or have they always been the same?
- Do you have any good experiences of food, perhaps you could tell me about your best?
- Do you have any bad experiences with food, perhaps you could tell me about your worst?

How does it make you feel when you think about food?

- Is this different to when you think about actually physically eating something?
- Do you get pleasure out of food?
- At times when you limit your food/or have limited your food, what would you limit yourself to and why (apart from maybe the calorie content of food, is there any reason why you limit yourself from particular foods and allow yourself to eat other ones.

Given all that we've discussed could you sum up for me what you think food means for you?

If you were to describe food as representing something else (a symbol for something else) what would you say that was?

Thank you so much for your time

Ask if have any feedback - interview style, did you ever feel lead, ease of interview.

Appendix 3: Participant information sheet

Participant Information Sheet

Research Title: The Meaning of food for individuals with Anorexia Nervosa

Researcher's name: Katie Cooper

I would like to invite you to take part in my research study. Before you decide I would like you to understand why the research is being done and what it would involve for you. Please take the time to go through the information sheet with me and ask any questions that you may have. I would suggest this should take about 10-20 minutes, however please take the time to talk to others about the study if you wish. Part one tells you the purpose of this study and what will happen to you if you take part. Part two gives you more detailed information about the conduct of the study. Please ask if anything is not clear.

Part one

Purpose: I am currently working towards a practitioner's doctorate in Counselling Psychology. Aside from having to gain experience of working with clients on a one-to-one basis I am also required to carry out doctorate level research. The title of my research is as told above and the aim of my study is to explore the meaning of food for individuals who have a difficult relationship with food. No previous research has explored this phenomenon so this research will be original. It is hoped that in uncovering the meaning behind food it will promote a better understanding of the use and importance that food can have for individuals, thereby helping the individuals themselves and the people who may be working with them around this problem.

Why me? This study requires the participation of 8-10 participants. Individuals will be invited to take part in this study following a

recommendation from their care team that they may be interested. It is up to you to decide to join the study. I will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive.

Participant requirements: Participants who take part in this study will be asked to take part in an interview which will be digitally recorded and last no longer than one hour. During the first ten minutes of the interview participants will be asked to describe to the researcher their encounters with food on a normal day. Following this they will be invited to explore with the researcher what they think the meaning of food is for them. Following the collection of data from participants the digital recordings will be transcribed and I will carry out qualitative analysis on all the data. On completion of this participants who have taken part in the study will be offered feedback of what I have found. This feedback can either be given in a written format or delivered verbally at a time of mutual convenience. Similarly all Participants will be interviewed at a time convenient for them and the researcher in a private room on site at the phoenix wing, St Ann's Hospital. All interviews will be completed by the end of January 2010 and participants will receive feedback of this study's findings before the end of July 2010. A £20 book token will be given to all participants who take part to thank them for their involvement in the study.

Risks and Benefits: Please be aware that if you decide to take part in this study you may find that some of the questions asked are of a sensitive nature and may cause possible upset, on the other hand taking part in this study might provide you with an opportunity to reflect on and think about in your own terms the importance of food for you helping you to have a better understanding of your problem. It may also help improve therapeutic treatments for those with a difficult relationship with food in the future. Please note that your care team at the hospital will be aware of your involvement in the study and will be on hand to discuss with you any issues that may arise for you from the interviews.

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2. Your participation in this study will be confidential and all information which is collected about you during the course of this research will be kept strictly confidential. I will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

Part Two

Right to withdraw: Should you decide to take part in this study but change your mind at any point, you are able to withdraw from the research, no questions asked at any time. Any information gathered from you will be securely destroyed and will no longer be used as part of the study. Withdrawing from this study will **not** affect your therapeutic care here at the Phoenix wing.

Complaints: If you have a concern about any aspects of this study, please contact the researcher who will do their best to answer your questions (coops25@hotmail.com). If you remain unhappy and wish to complain formally you can do this by contacting the researcher's supervisor Maggie Mills; maggiemills@hph.easynet.co.uk.

Confidentiality: All information which is collected about you during the course of this research will be kept strictly confidential. Any information about you which leaves the **Russell Unit**, will have your name and any other identifying details removed so that you cannot be recognised from it. All digital and raw material from the interviews will be kept on a password secured file on a password secured computer or in a locked filing cabinet accessible only to the researcher.

Please note that someone else will be asked to look over the anonymous transcripts at a later date to validate my findings and that the care team here at the phoenix wing will be informed if your involvement in the study if you decide to take part.

Results: It is possible that the results of this study may be publicised, however just to emphasise again all participant involvement is anonymous. As explained earlier all participants will receive feedback about the general findings of this study.

Participants will be given a choice of receiving written feedback either by post or email or receiving feedback verbally at the **Russell Unit** at a time convenient both for the researcher and the participant.

Funding: This research is being privately funded by the researcher; however the research is being sponsored by City University.

Who has reviewed the study: All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Wandsworth Research Ethics Committee.

Further information and contact details: should you have any questions regarding general or specific information about this research please contact the researcher; Katie Cooper; coops25@hotmail.com. Should you require advice on whether you should participate, please contact either the researcher, as above, or maybe talk to a member of your care team. If you are unhappy about any aspects of this study, please approach the researcher, as above or alternatively her supervisor; Maggie Mills; maggiemills@hph.easynet.co.uk

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

Appendix 4: Consent form

Centre Number:
Study Number:
Patient Identification Number for this Study:

Consent Form

Title of project: The meaning of food for individuals with Anorexia Nervosa

Name of Researcher: Katie Cooper

	Please initial box
1. I confirm that I have read and understood the information sheet dated ..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care rights being affected.	☐
3. I understand that relevant section of my medical notes and data collected from this study may be viewed by the researcher's supervisor, from regulatory authorities or by the NHS trust, where it is relevant to me taking part in this research. I give permission for these individuals to have access to my records.	☐
4. I agree to my care team being informed about my participation in this study.	☐
5. I agree to take part in the above study	☐

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Name of person taking consent	Date	Signature

When completed 1 for participant, 1 for researcher site file, 1 (original) to be kept in medical notes.

Appendix 5: Emerging themes list for Dianne

Emerging themes
Loss of self in story (1)
Disengagement from self (1)
Timeline (1)
Wilfulness (1)
Stuckness (within illness and recovery) (1)
Living but not present (surviving & Psychological absence) (1)
sep of mind and body (1)
Food as confronting (2)
Food as ubiquitous (2)
Desire to avoid thoughts on food (2)
Food as a stressor (2)
Eating as having negative affect on thinking – (thoughts of guilt) (3)
Sense of isolated self within ward
Disengagement from self and thoughts whilst eating (3)
Change as difficult (3)
Sense of self as a robot (3)
Disengagement from life (3)
Anger towards self after eating (3)
Conflicting self, unhealthy vs healthy (4)
Anger towards self for having to take responsibility of self (4)
Choice vs involuntary eating (4)
Food as something you take inside (4)
Eating as neverending (4)
Avoidance of thoughts around eating (switch off/robot) (4)
Admission of not wanting to think (4)
Guarded self (5)
Sense of fragile self (5)
Feeling saturated by food (5)
Staying power of food on self after eating physical and psychological (5)
Ambivalence in exploring food role in her life (5)
Understanding of food as integral part of life (5)
Food as confronting (5)
Food as ubiquitious (5)
Food as an obstacle to being in "normal" world (6)
Obsession with food (6)
Restriciting – feeling in control vs not being in control (6)
Restricting food as empowering (6)
Battle between rational and irrational self (6)
Separation of mind over body (6)
Fragile sense of self (6)
Desire to know self (6)
Loss of sense of self (6)
Affect of food as something concrete from which to understand and explain self. (6)
The concrete meaning food gives diverts attention from real feelings – coping mechanism (7)
Sense of Loss of control over own life (7)
Relationship with food acts as a separator of self from family (7)
Food within her family as a coping mechanism...plaster (7)
Association of food with mum - Rejection of food as rejecting mum (7)
Sense of being misunderstood (8)
Volatile relationships within family (8)
Search for blame (8)

Uncertainty of cause and effect (8)
Lack of knowing self (8)
Stuckness – inability to move on from past (8)
Anger towards Dad (8)
Avoidance to deal with feelings (8)
Difficult relationships within family (9)
Perception of mum as "stuck" within relationship with dad (9)
Illness mirroring relationships within family (mum manage dad, she manages illness) (9)
Perception of impact on feelings towards dad on other relationships (10)
Sense of self validation only through shared feelings (10)
View of Sep of self from family (10)
"Stuckness" within relationships (10)
Disbelief towards change (10)
Perception of self causing problems for mum (blame) (10)
Perception of mum as buffer within her relationship with dad (11)
View of sep of self/identity from family (11)
Perception of need to outwardly ignore own feelings/self (not shared) (11)
Perception of own difficulty in expressing self to others (11)
Need of something concrete or actual to validate her own feelings (11)
Perception of self as someone different and misunderstood (11)
Sense of relationship with food mirrors relationship with dad (12)
Need to blame (mum and dad) (12)
Absolution of self blame, shift of responsibility of self onto others (12)
View of self as collateral damage in parents relationship... an effect of the cause (12)
View of self as helpless (no agency) (12)
Sense of parents being physically and mentally absent (12)
View of restricting food as attention seeking (12)
Ambivalence towards exploring meaning in her experience (12)
Food as a means of communication (13)
Not eating expressing she wants more from parents (13)
Food as only means to express herself (13)
Conscious vs unconscious choice to use food (13)
Food as an obvious concrete medium through which to get attention (13)
Restricting food as a learnt behaviour (13)
Intent vs non intent (13)
Restricting food as a provoker/reactive (creating negative attention and aggression) (13)
Perception of illness evolving from focus on food to weight (13)
Development of false beliefs (towards weight) (13)
Fight for concrete communications, solutions and beliefs (13)
Ambivalence in exploring self (13)
Food as a means by which to sep herself from family (14)
Perception of her own relationship with food as different to family (14)
Perception of control within other family members relationship with food (14)
Sep of her relationship with food to others (14)
View of her relationship with food as "special" (14)
Dismissive attitude towards mums identificatin of having issues with weight and food (14)
View of mum's relationship with food not as significant to her own (14)
Need to separate herself from mum (15)
Need to keep her relationship with food as "special" (15)
Rejection of food represents a desperate need from within her (15)
Perception of mum not eating properly (15)
Memory of meal times as very separate/individual for all the family (15)
Disconnection of family emphasised and illustrated through meal times (15)
Sense of happier times being outside the immediate family (16)

Belief of self would eat normally when happy (16)
Absence of attention from parents (16)
Idea of life with parents, past and present not "normal" (16)
Sense of comfort found being with Aunt and Uncle (16)
As illness evolved loss of comfort amongst others (16)
Isolation of self through relationship with food (17)
Withdrawal from food mirroring with- drawal from others (17)
Sense of own development of relationship with food as difficult and hard (17)
Relationship with food causes social and relational awkwardness (17)
Food as negative (17)
Food creates friction a "battlefield" (17)
Food creates battle of the wills – aggressors (feeling attacked) (17)
Feeling of being misunderstood (17)
Intended communication through food often not heard (17)
Restriction of food as a means to express "care for me" (18)
Understanding of use of food as counter productive, a provoker (18)
Sense of intention behind illness (18)
Rejection of Food expressing unhappiness (18)
Rejection of food expressing no self esteem (18)
Rejection of food expressing a belief that no one cares (18)
Rejection of food expressing a want for someone to care (18)
Rational vs irrational self/ healthy vs unhealthy (18)
Overpowering strength of unhealthy side (18)
Sense of guilt over what not eating causes (18)
Not eating as her only coping mechanism (18)
Not eating has evolved to have a life of its own (18)
Meaning of restricting food transforms/evolves (19)
Restricting food as attention vs isolation
Restricing food as control vs no control
Restriction of food as means of distraction vs coping mechanism
Restricting food controls/ copes and distracts from emotion
Food as guilt
Guilt towards self, undeserving to eat (low self esteem)(19)
Guilt towards others, for restricting food as reactive (19)
Sense of loss of self and identity in world (20)
Concept of feeding expressing positive feelings towards self and life (20)
Sense of having strong negative beliefs towards self (20)
Importance of external validation (others views, to take in, and eating to take in) (20)
Projection of own self onto others (20)
Lack of self knowing (20)
Inability to trust others (20)
Idea that not believing in self means she does not deserve to eat (20)
View of self as not special (20)
Food hinders making friends (21)
Difficulty in expressing feelings (21)
Desire not to explain self (21)
Constant need for comparison (21)
Underweight as holding a status position (21)
Lack of internal validation (21)
Constant failing in comparisons (21)
Perception of self as not deserving, unworthy of help (21)
Relationships with other inpatients as double edged sword (21)
Belief that to be thinner is better , something concrete that is personally validating(22)
Double meaning of less you eat – more deserving vs less you think of yourself (22)
Inability to see self (22)
Less deserving vs more deserving (22)
Sense of never being good enough (22)

Irrationality (22)
Sep of self from others (22)
Conflicting standards for self and others (22)
Desire for concrete cause and effect (23)
Dependence on thinness for creating better life (false belief) (23)
Sense of things falling apart (23)
Desperate need for something concrete to tie life together (23)
Projection of self beliefs onto others (23)
Sense of shame around eating (23)
Disconnection between getting bigger and feeling better (23)
Belief in being bigger embodies more guilt (23)
Sense of food never being important within family (24)
Food as only fodder (24)
No emotional investment within food whilst growing up ?? (24)
Importance of food in jewish tradition/ mum vs lack of importance within her family (24)
Food as not even necessary fodder – not worth food ? (24)
Rational vs irrational self (24)
Food as something to eat is bad (24)
Disconnection of food on its own and for others and for her self (24)
Food as having an identity of its own in relation to her (25)
Eating as swallowing and assimulating guilt (25)
Food as embodying emotions (25)
Rules of Restriciton (25)
not eating as representing desire not to be here, opt out of life (passive aggressive suicide) (26)
Lack of care for self vs self maintenace (26)
Sense of being in purgatory – just surviving (26)
Healthy vs unhealthy side (26)
Taking from self through food as only means to communicate (26)
Using food as cry for help (27)
Food becomes embodiment of negative emotions around the experience of being anorexic (27)
Intense negative feelngs towards food – view of food as evil (27)
Sense of self as bad person (27)
Sense of self as undeserving (27)
Forced eating as representative of a communication from others as being a bad person (28)
Self hatred (28)
Projection of self views onto others (28)
Irrational beliefs about food (28)
Food as dangerous, hazardous (28)

Appendix 6: Dianne: Table of Super-ordinate themes

Dianne Super-ordinate themes	Emerging themes
Relationship with food as a separator	Isolating of self through relationship with food (17)
	Relationship with food causes social and relational awkwardness (17)
	Food as a means to separate herself from her family (14)
	Food as an obstacle to being in a "normal" world (6)
	Withdrawal from food mirroring withdrawal from others (17)
	Food hinders making friends (21)
	Relationship with food acts as a separator of self from family (7)
	Disconnection of family emphasised and illustrated through meal times (15)
	Sense of own development of relationship with food as difficult and hard (17)
	As relationship with food evolved loss of comfort amongst others (16)
Perception of separateness	View of self as different identity to the family (11)
	Need to separate herself from mum (15)
	View of separate self from family (10)
	Sense of isolated self within ward (13)
	Sep of self from others (22)
Desire for relationship with food to be special	View of mum's relationship with food not as significant to her own (14)
	View of her relationship with food as "special" (14)
	Need to keep her relationship with food as "special" (15)
	Food as having an identity of its own in relation to her (25)
	Dismissive attitude towards mum's own identification of having issues with weight and food (14)
	Perception of her own relationship with food as different to family (14)
	Separation of her relationship with food to others (14)
Cognitive and emotional disengagement	Disengagement from self (1)
	Psychological absence (1)
	Desire to avoid thoughts on food (2)
	Disengagement from self and thoughts whilst eating (3)
	Avoidance of thoughts around eating (4)
	Admission of not wanting to think (4)
	Ambivalence in exploring food role in her life (5)

	Avoidance to deal with feelings (8)
	Ambivalence towards exploring meaning in her experience (12)
	Ambivalence in exploring self (13)
	Desire not to explain self (21)
Mind over body	Sep of mind and body (1)
	Wilfulness (1)
	Separation of mind over body (6) *
	Sense of intention behind illness (18)
Disengagement from life	Sense of being in purgatory - just surviving (26)
	Not eating as representing desire not to be here, opt out of life (26) *
	Living but not present just surviving & psychosocial absence (1)
	Disengagement from life (3)
Loss of sense of self	Loss of self in story (1)
	Loss of sense of self (6)
	Desire to know self (6)
	Lack of knowing self (8)
	Sense of loss of self an identity in world (20)
	Lack of self knowing (20)
	Inability to see self (22)
Loss of agency	Sense of self as robot (3)
	Anger towards self for having to take responsibility for self (4)
	View of self as collateral damage in parent's relationship.... An effect of the cause (12)
	View of self as helpless (no agency) (12)
	Absolution of self blame, shift of responsibility onto others (12) *
	Not eating evolving to having a life of its own (18)
	Overpowering strength of unhealthy side (18)
Lack of internal validation	Sense of self validation only through shared feelings (10)
	Perception of need to outwardly ignore own feelings/self that is not shared (11)
	Sense of having strong negative beliefs towards self (20)
	Emphasis of the importance of external validation (others views as something to digest like food) (20)
	Constant need for comparison (21)
	Constant failing in comparisons (21)
	Lack of internal validation (21)
	Perception of self as not deserving, unworthy of help (21)
	Sense of never being good enough (22)
	Sense of self as undeserving (27)
	Sense of self as bad person (27)

	Self hatred (28)
Split self	Conflicting self, unhealthy vs. healthy (4)
	Battle between rational and irrational self (6)
	Separation of mind over body (6)*
	Rational vs. irrational self (18)
	Irrationality (22)
	Rational vs. irrational self (24)
	Healthy vs. unhealthy side (26)
Feeling misunderstood	Sense of being misunderstood (8)
	Perception of self as someone different and misunderstood (11)
	Feeling of being misunderstood (17)
	Intended communication through food often not heard (17)
Difficulty in emotional communication	Perception of own difficulty in expressing self to others (11)
	Difficulty in expressing own feelings (21)
Uncertainty and volatility	Sense of fragile self (5)
	Fragile sense of self (6)
	Sense of loss of control over own life (7)
	Uncertainty of cause and effect (8)
	Sense of things falling apart (23)
	Change as difficult (3)
Food as a means for communication	View of restricting food as attention seeking (12) *
	Not eating expressing she wants more from parents (13)
	Food as a means of communication (13)
	Food as only means to express herself (13)*
	Communication of mental state (unhappiness) through eating (16)
	Restriction of food as a means to express "Care for me". (18)
	Rejection of food expressing a want for someone to care (18)
	Rejection of food expressing a belief that no one cares (18)
	Rejection of food expressing no self esteem (18)
	Rejection of food expressing unhappiness (18)
	Concept of feeding expressing positive feelings towards self and life (20) *
	Taking from self through food as only means to communicate (26) *
	Not eating representing desire not to be here, opt out of life (passive aggressive suicide) (26)
	Taking from self through food as only means to communicate (26)*

	Using food as a cry for help (27)
	Forced eating as representative of a communication from others of being a bad person (28) *
	Rejection of food representing a desperate need (15)
Rejection of food as a coping mechanism	Restricting food as empowering (6)
	The concrete meaning food gives diverts attention from real feelings (7)
	Food within her family as a coping mechanism... a plaster (7)
	View of restricting food as attention seeking (12) *
	Restricting food as a learnt behaviour (13)
	Food as only means to express herself (13) *
	Not eating as her only coping mechanism (18)
	Restricting food controls/copes and distracts from emotion (19)
	Restriction of food as a means of distraction (19)
	Taking from self through food as only means to communicate (26)*
Food embodying negative emotion	Food as a stressor (2)
	Food as negative (17)
	Food as embodying emotions (25)
	Food as something to eat is bad (24)
	Food becomes the embodiment of negative emotions around the experience of being anorexic (27)
	Food as dangerous, hazardous (28)
Food as confronting	Food as confronting (2)
	Food as confronting (5)
	Restricting food as a provoker, a reactive (creates negative attention and aggression) (13)
	Food creates friction, a battlefield (17)
	Food creates battle of the wills - aggressors (feeling attacked), (17)
	Understanding of use of food as counter productive, a provoker (18)
Pervasive nature of food	Food as ubiquitous (2)
	Eating as never-ending (4)
	Understanding of food as integral part of life (5)
	Food as ubiquitous (5)
	Obsession with food (6)
Insignificance of food	Sense of food never being important within family (24)
	No emotional or social investments from family in food whilst growing up (24)
	Food as only fodder (24)

	Food as not even necessary fodder (not worth food) (24)
Negative psychological and physical impact	Eating as having negative affect on thinking (thoughts of guilt) (3)
Of eating	Anger towards self after eating (3)
	Feeling saturated by food (5)
	Staying power of food on self after eating, physical and psychological (5)
	Sense of shame around eating (23)
Need for something concrete	Affect of food as something concrete from which to understand and explain self (6)
	The concrete meaning food gives diverts attention from real feelings (7) *
	Need of something concrete or actual to validate her own feelings (11)
	Fight for concrete communications, solutions and beliefs (13)
	Food as an obvious concrete medium through which to get attention (13)
	Belief that to be thinner is better, something concrete that is personally validating (22)
	Desire for concrete cause and effect (23)
	Desperate need for something concrete to tie life together (23)
Food as a representing mum and dad	Association of food with mum - rejection of food as rejecting mum (7)
	Illness mirroring relationships within family (mum manage dad, she manages illness) (9)
	Sense of relationship with food mirrors relationship with dad (12)
Guilt	Sense of guilt over what not eating causes (18)
	Guilt towards others, for restricting food as reactive (19)
	Food as guilt (19)
	Guilt towards self, undeserving to eat (low self esteem) (19)
	Belief in being bigger embodies more guilt (23)
	Eating as assimilating and swallowing guilt (25)
Development of rules, false beliefs	Development of false beliefs towards weight (13)
	Concept of feeding expressing positive feelings towards self and life (20)*
	Idea that not believing in self means she does not deserve to eat (20)
	Underweight as holding a status position (21)
	Dependence on thinness for creating better life (false belief) (23)

	Rules of restriction (25)
	Irrational beliefs about food (28)
	Forced eating as representative of a communication from others as being a bad person (28)*
Stuckness	Stuckness within illness and recovery (1)
	Stuckness - inability to move on from past (8)
	Perception of mum as "stuck" within relationship with dad (9)
	Stuckness within relationships (10)
	Disbelief towards change (10)
Blame	Search for blame (8)
	Perception of self causing problems for mum (buffer) (blame) (10-11)
	Absolution of self blame, shift of responsibility onto others (12) *
	Need to blame mum and dad (12)
Defences	Guarded self (5)
	Inability to trust others (20)
	Projection of own self onto others (20)
	Projection of self beliefs onto others (23)
	Projection of self views onto others (28)
Broken and absent relationships	Volatile relationships within family (8)
	Difficult relationship within family (9)
	Perception of impact on feelings towards dad on other relationships (10)
	Sense of parents being physically and mentally absent (12)
	Memory of meal times as very individual for all the family (15)
	Absence of attention from parents (16)
	Idea of life with parents, past and present not normal (16)
	Lack of comfort found from parents (16)
	Sense of happier times being outside the immediate family (16)
Contradictions	Choice vs. involuntary eating (4)
	Restricting - feeling in control vs. not being in control (6)
	Conscious vs. unconscious choice to use food (13)
	Intent vs. non intent (13)
	Restricting food as control vs. no control (19)
	Restricting food as attention vs. isolation (19)
	Conflicting standards for self and others (22)
	Double meaning of less you eat more deserving you are vs. less you think of yourself (22)
	Less deserving vs. more deserving (22)

	Disconnection between getting bigger and feeling better (23)
	Disconnection of food on its own and for other and for others and for her self (24)
	Importance of food in Jewish tardyon/mum vs. lack of importance within her family (24)
	Lack of care for self vs. self maintenance (26)
Discarded Emerging themes	Timeline (1)
	Food as something you take inside (4)
	Perception of control within other family members relationship with food (14)
	Anger towards dad (8)

Appendix 7: Individual Master Themes for Dianne

Individual Master Themes	Super-ordinate themes
Loss of and Broken sense of Self	Cognitive and emotional disengagement
	Loss of sense of self
	Loss of Agency
	Lack of internal validation
	Feeling misunderstood
	Difficulty in emotional communication
	Uncertainty and volatility
	Defences
	Stuckness
	Blame
	Development of rules and false beliefs*
Mind and body split	Mind over body
Ambivalence	Split self
	Contradictions
Disengagement	Disengagement from life
	Perception of separateness
Absent and broken relationships	Absent and broken relationships
Separator	Relationship with food as a separator
	Desire for relationship with food to be special
Communication	Food as a means for communication
Coping mechanism	Rejection of food as a coping mechanism
Concrete representation of internal states and relationships	Food as representing mum and dad
	Food embodying negative emotion
	Food as confronting *
	Pervasive nature of food *
	Insignificance of food*
	Guilt
	Need for something concrete

Notes to self:

Food as confronting * - These battles although perceived as interpersonal also represent the battle that exists within the self.

Pervasive nature of food * This makes it something obvious and more concrete tool to use to represent the internal states and relationships, additionally the pervasive nature of food is reflective of the pervasive nature of the illness and the symptoms underneath it personal and interpersonal.

Insignificance of food* - reflects the belief of her own insignificance within the family.

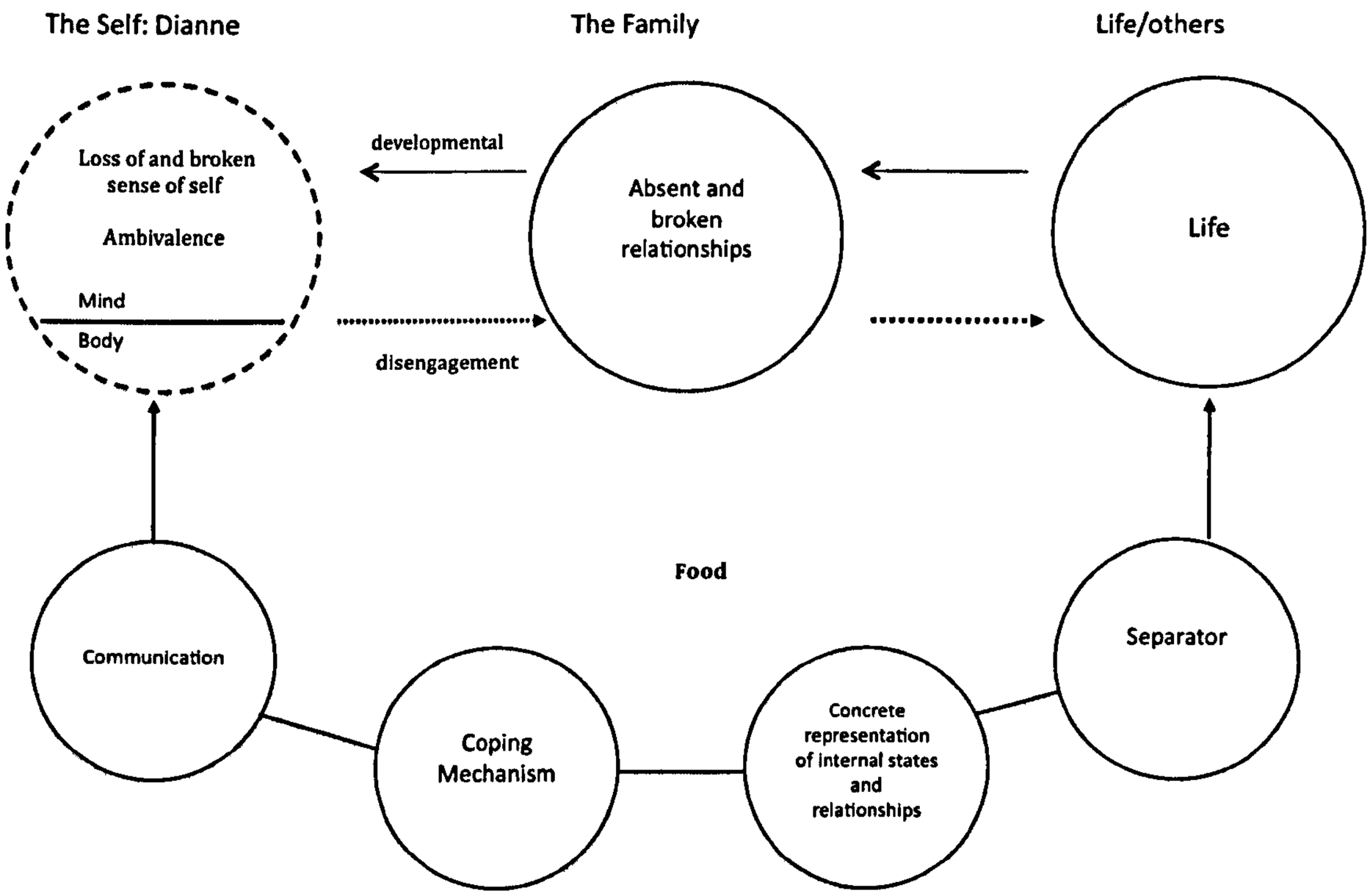
Appendix 8: Master Map for Dianne

This map illustrates how food becomes part of a system that manages the self and its relationships to others and life.

In particular the map shows:

How life and family impacts on the development of the self, and how this effects the self's relationship to itself (mind body split, ambivalence), the world and others around them (disengagement).

In order to manage these relationships to the self, family and life food is employed as something that is believed to help manage and bridge the perceived gaps, (between self and other, and self alone) and simultaneously enforce them (separator).



Appendix 9: Individual master themes table

Individual Master Theme	Dianne	Liv	Wilma	Kim	Ellie	Caroline	Sally	Lilly
Loss of and Broken Sense of Self	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ambivalence	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mind and body split	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Misattuned Caregiving	Yes (1)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Disengagement	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sense of a demanding and punitive world	No	No	Yes	No	No	Yes (2)	Yes (3)	Yes (4)
Developmental	No	No	Yes	No	No	No	No	No
Food as a separator	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Food as a means of communication	Yes	Yes	No	No	No	No (5)	No	Yes
Food as a coping mechanism	Yes	Yes	Yes	Yes	No	Yes	No	Yes
Food as a concrete representation of internal states and relationships	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Food as a safety mechanism	No	Yes	No (6)	No	No	No (7)	No	No
Food as a control mechanism	No	Yes	Yes	No	No	Yes	Yes	Yes
Recovery	No	Yes	No	No	No	Yes	No	No
Food as a container	No	No (8)	Yes	No	No	Yes	No	No
Food as representing weight	No	No	No	No (9)	Yes (10)	No	Yes	Yes
Limited recognition of restricting food meaning something deeper than weight	No	No	No	No	Yes	No	No	No
Food as a mechanism to alleviate the self*	No	No	No	No	Yes	No	No (11)	No
Food as chocoful of meaning	No	No	No	No	No	Yes	No	No
Food as a mechanism of punishment	No	No	Yes	No	No	No	No	No

1. Within the list of master themes for Dianne this is actually labelled as **Absent and Broken relationships**, something that I now believe better fits under the label of **Misattuned caregiving**.
2. Within the list of master themes for Caroline this is actually labelled as something very similar; Sense of world as demanding and unreliable, both of which are meant to allude to a similar perception of life (maybe with individual nuances).
3. Within Sally's individual master theme list this theme is labelled as **Sense of the world as unpredictable and scary** the explanation as to why I have listed it is here is as above in footnote 2.
4. Within Lilly's individual master theme list this theme is labelled as **View of life as unfair**. Explanation as to why this has been detailed here as above.

5. Within this transcript **food as a means of communication** is not listed as its own master theme but is named as a superordinate theme under the master theme of **Food as concrete representations of internal states and relationships.** I believe it has a place under both these headings and so for the purpose of maintaining an idiographic focus on my original analysis of this text I have chosen not to adjust my original list of master themes so as to make a better fit now, rather to just draw attention to what has occurred. Another reason that I have chosen not to adjust my original list of master themes at this point is that I believe that this process of arrangement and alteration is what I will contend with in the next stage of analysis.
6. **Food as a safety mechanism** is however included as a super-ordinate theme under the heading of **Food as a Container**.
7. **Food as a safety and comfort** is however included as a super-ordinate theme under the heading of **Food as a Container.**
8. As explained earlier there is however some crossover between this theme and the individual master theme of Food as a Safety Mechanism (as listed earlier). In light of this although I have said no in this box there is an element that one is perhaps indicative of the other.
9. An aspect of this theme **Preoccupation with external effects of eating** is however present within this participant's account and has been included as a super-ordinate heading under the individual master theme of **Loss of and Broken Sense of Self.**
10. Within this individual's list of master themes this has been given the similar title of **Food as a means to put on weight.**
11. However, this theme seems similar to the super-ordinate theme of **Avoidance of food,** which is included as a super-ordinate theme under the individual master theme of **Food as a Separator** in the analysis of this individual's account.

Appendix 10: Master Theme Table

Master Theme 1: Food as a container

Particip-ant	Individual Master Theme	Super-ordinate theme	Emerging theme (page number)	Comment number
Liv	Food as safety mechanism	Food as a safety mechanism	Food as a safety mechanism (15)	66
			Food as a safety mechanism (15)	68
			Food as a safety blanket (16)	73
			Food as a safety blanket (25)	108
		Food as dependable	Food as consistent (17)	75
			Food as something to rely on (17)	77
			Self stabilisation through diet (17)	74
			Importance of finding stability in food when things change around her (17)	75
			Food as a means for stabilising self (25)	110
Wilma	Food as a container	Food as a protector/ safety zone	Not eating as a shield against problems and the world (10)	36
			Not eating as a way of protecting herself from herself (11)	37
			Relationship with food as a buffer to life (12)	42
			Food as something that isolates and protects the self (28)*	89
			Food as a shield (33)	113
			Food as a "bomb shelter"/ safety zone (33)	113
			Food as a comfort (33)	113
			Sense of developing a dependence on food (13)	45
		Food as something that can explain and define the self	Food gives her a focus (simplifies things) (12)	43
			Food as something that gives her identity (30/31)	101
			Food as something that can provide her with explanations for her feelings (31)	102
			Restricting food helps her to justify her emotions (32)*	111
			Food gives her an identity (32)	111
			Food gives her a purpose in life (32)	111
		Emphasis and importance of concreticity	Importance of the concreticity of food (28)	91
			Distinction of food as something concrete, emotions as not (28)	91
			Food as a tangible way to control things (29)	91/2
			Restricting food helps her to justify her emotions (32)*	111
Caroline	Food as a container	Food as a safety and comfort	Food as a comfort (16)	53
			Food as a friend (16)	53
			Avoiding feelings as a way of avoiding self punishment - protection (22)	69
			Safety in food (46)	156
			Food as a friend/partner (47)	156
			Food as a retreat (50)	161
		Food as meaning making	Relationship with food as putting back order or sense into the world (16)	53
			Sense of purpose/ or assertion of self through food (17)	53
			Food as something that makes/provides sense (25)	80
			Sense of food having big role within family (29)	97
			Relationship of food to self as something that makes sense (40)	127
Ellie	Food as a mechanism to	Restricting food as alleviating the	Restricting helps her to feel more herself (6)	30

	alleviate self	self		
Dianne	Food as concrete representation of internal states and relationships	Desire for something concrete	Affect of food as something concrete from which to understand and explain the self (6)	19
			Need of something concrete or actual to validate own feelings (11)	38

Appendix 11: Participant Feedback

"The Meaning of Food for Women with Anorexia Nervosa"
By Katie Cooper

20th October 2010

Dear

Thank you so much for taking part in my study, "The meaning of food for individuals with anorexia". Your involvement was greatly appreciated and I felt very privileged to have you talk to me about your experiences of your illness first hand. Just to remind you that everything we spoke about within the interview has been kept completely anonymous and confidential.

What I have tried to do in the process of analysis of all the participant interviews is to extract from the data some generalized ideas of what might be going on in clinical samples of people who suffer from anorexia, please see attached feedback sheet which outlines my findings. I hope that these findings will help clinicians to have a better understanding of anorexia and therefore improve the help that is offered to individuals who suffer from the illness.

If you have any queries about the participant feedback, please feel free to contact me on katierosecooper@gmail.com.

Thank you again for your participation

Best Wishes

Katie Cooper

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

Participant Feedback Sheet for the study:
"The Meaning of Food for Women with Anorexia Nervosa"

Researcher: Katie Cooper
Supervisor: Maggie Mills

Thank you again for your participation in this study, please find below an outline of the findings of these study.

From the analysis of the participant interviews there seemed to emerge four different themes or ideas as to what the meaning of food may be for individuals with anorexia. These four themes are outlined and described below.

Theme 1: Food as a container
Within the interviews it appeared that food seemed to help some of you by providing you with a sense of safety and comfort and in addition by helping you to understand and justify your own feelings.

"A container" is a concept which describes a person, (usually a mother), who has the capacity to help another (usually their child) to regulate and understand what may be confusing feelings and to help them feel safe. From some of your interviews it appeared that food seemed to play a similar containing role, thus the development of this theme of food as a container.

Theme 2: Food as a concrete representation of emotions
It also appeared within the interviews that for some of you, you strongly came to associate your emotions with food. In this light, not eating almost seemed to be a way of avoiding contact with your own emotions, which may have felt too difficult or hard to manage or understand.

Theme 3: Food as a separator
This theme describes the way in which for some of you not eating was almost a way of disconnecting from your self, (both from your body and from your own thoughts and feelings) and from others as well (it helped to remove yourself from social situations).

Theme 4: Food as a mechanism of control
Within the interviews it appeared that often some of you referred to controlling food as a way of helping you to feel more in control of yourself and your life, both of which at times could feel out of your control and unmanageable. Similarly some of you also described food as a way of

sometimes trying to get attention from others and as a way of regaining a sense of control within relationships where you maybe felt little.

I hope you have found these findings interesting should you have any further questions about the results please feel free to contact me at katierosecooper@gmail.com. Thank you again for your participation.

Appendix 12: Reflections on participants and developmental trajectory.

Participant	Summary of Reflections	Development trajectory[151]
Dianne	Seemed quite together and quite knowing about her illness, yet no mention of recovery within her interview. Seemed nervous within interview, "huddled in her pyjamas on her bed" I felt aware of this and aware of being in her space. Felt as though even though she was forthcoming within the interview that perhaps she did not want me there. When I encouraged her to think beyond her first response to a question she was often receptive to doing this and could show good insight.	6
Liv	Spoke a lot and quickly (nervous), felt needed little prompting from me. Sense she wanted to play the "good client" with me. Felt at ease with her in the room. Strong sense of recovery and looking forward within her interview. Good awareness from her as to what food meant for her and what role it had played.	7/8
Wilma	She seemed very eager and keen to talk to me, at end she asked to give me something she had written about anorexia for me to read. This made me feel quite comfortable when interviewing her. At times she was hard to understand and her thoughts seemed jumbled. However she spoke with good insight into her problems and about the meaning of food for her, she also seemed to have a good awareness of the difficulties she faced within her family. Her problems seemed to have been ongoing for sometime. Although no theme of recovery was mentioned within her interview, the sense of knowing about the difficulties she faced and the insights she had into them, seem to suggest that her functioning was not too impaired.	7
Kim	Struck by how closed off she was in the interview and how much it felt like she didn't want to be there. Yet she had approached me for the interview. I felt very anxious within the interview, almost as if i was the car and she was the rabbit in the headlights. Struck by how little she seemed to reflect on her illness and food and the meaning it had for her. Also quite taken aback when I found out how long she had been in and out of inpatient wards and how long she had been battling with AN. Very much a sense of illness as being a disease you have no control over, no theme of recovery at all within interview. I was also surprised at the news that she had a daughter, as I found it very hard to imagine her in the role of a "mum" as it felt for me she was able to give so little/ didn't feel emotionally mature enough or knowing of herself.	2
Ellie	Felt very anxious within the room, very aware of the two nurses, and I could see how preoccupied Ellie was with their attention to the interview or lack of. Spoke very gently and quietly, almost like she was an 8 year girl. Looked very fragile and small hard to imagine her as an 18 year old. Seemed unsure of herself at times.	2

[151] (Conceptualised as on a scale of 1-10, 10 representing the most mature and symbolic level of thinking) "is" (0) ----------(10) "as if"

	Interview broken up for her to collect medicine. No sense of recovery within her interview and a very difficult interview to carry out in the way that she didn't seem to be able to be that reflexive within the interview, and encouraging her to be more seemed to confuse her.	
Caroline	She had approached me to do the interview seemed very intelligent and spoke eloquently and meaningfully about her experiences. I felt very comfortable within the interview with her apart from at one point when I felt she was weighing me up, as competition. Seemed to have good insight into her experiences. She told me she was allowed exit from the inpatient ward to go to Uni, she was the only one who had this and also spoke about therapy a bit, seemed to suggest she had got quite a lot from it. Strong sense of recovery and moving forward at the end.	8
Sally	Seemed very nervous and very young, she looked and acted young. During the interview strong sense that she didn't want to be there, she avoided eye contact with me at all times. Felt she did not want to explore or answer my questions, this felt dangerous for her. Sense of her wanting to be the "good child" not make a fuss about anything, not express how she really felt. At one point she got upset within the interview due to an argument outside, reflected to me her fragility and her vulnerability. Seemed very hard for her to focus on or talk about her emotions. No theme of recovery within her interview	4
Lilly	I felt instantly that she felt quite angry whether that was with me for interviewing her or just how she felt. However she presented as very closed off within the interview. Was very hard to get her to identify any emotions. Spoke very quietly and looked down twiddling with her bracelet at all times. I felt anxious within the interview, not wanting to upset her. Some sense of knowing about what restricting food meant for her – desire to be independent, but hard for her to explore beyond this as to why this might be. Felt there was some anger towards her parents, but this was hard for her to look at. Surprised to hear within the interview she was a twin, wondered what this would mean for her within a family, the competition she may feel. Did not want to talk much about her twin. Sense of her having developed, matured yet now being stuck, or on outside seems emotionally mature and okay about things but on inside screaming, having a tantrum.	5

Section D: Combined Client Study and Process Report

"How hard therapy can be for someone who has had "nothing": Client Study and Process Report Combined"

Introduction

Overview

I chose to present this client and this transcribed section due to the challenge I faced in forming and maintaining a therapeutic alliance within this work, the exploration of which has taught me something particularly important about psychotherapeutic practice. This is how hard therapy can be for someone who has had "nothing".

Summary of Theoretical Orientation

Relevant theoretical background to this case is an understanding of object relations theory as presented by Wilfred Bion (1962a/1962b); in particular his understanding and theory of thinking "as one of the fundamental links between human beings, a link which is fundamental also for the forming and functioning of a normal mind" (O'Shaughnessy, 1981, p.181).

Bion (1962a) assumes that as infants we are born without the apparatus for thinking we therefore require the use of another human mind (container) to help accept, absorb and transform our overwhelming impressions of the world into meanings (Fonagy, 2001). This meaning-making process by which the container makes overwhelming impressions more thinkable, understandable and tolerable is known by Bion as the alpha function (1962a/b).

The alpha function transforms what Bion calls Beta elements into alpha elements (Bion, 1962a). Beta elements are concrete undigested facts, sensations and impressions that cannot be metabolized; "they are not amenable to use in dream thoughts but are suited for use in projective identification. They are influential in producing acting out" (Bion, 1962a, p.7). Alpha elements however give meaning and structure to our experiences and sensations and can be stored and made available for conscious and unconscious thinking. The process of this alpha function is first modeled through the child- mother dyad, where the mother uses her

own mental equipment and 'reverie' or empathy to metabolize in herself and give meaning to what the child projects into her as a result of not yet being able to metabolize, and understand her/himself (William, 1997, p26). After repeated experiences of this process the child is able to take inside him the repeated experience of being understood and of having space in somebody's mind thus enabling him to develop his own apparatus to think and to develop a space for himself in his mind (Williams, 1997. p27). This experience of the internalization or introjection of an alpha function is not dissimilar to Klein's emphasis on the importance of the "introjection of an object who loves and protects the self and is loved and protected by the self" (Klein, 1957; p.19) in creating a feeling of integration, inner security and steadiness.

For Bion a key factor in the normal development of a child is the experience of this interactive meaning making process or projective-introjective cycle between caregiver and infant. If this process fails to occur then a massive defensive structure is thought to arise (Fonagy, 2001), this can lead to the continued and increased evacuation, of both the modified more tolerable elements returned to the infant by his mother and of the containing mother herself, and in more severe cases to an aggressive attack on his/her own mental capacities (O'Shaughnessy, 1981, p.183).

For the therapist working within Bion's object relations framework, she is concerned with understanding and developing the capacity of the client to "think"; that is "thinking" as a human link; "the endeavor to understand, comprehend the reality of, get insight into the nature of, etc., oneself or another" (O'Shaughnessy, p.181). The progress of analysis therefore requires "an analyst with a mind that can, in the same way (to a mother), contain reasonably flexibly, the patient's distress and thus think about it." (Hinshelwood, 1999). Additionally the therapist needs to be open, receptive and aware of all "the configurations of projections and introjections that make up both the communication and also the defensiveness in the analytic setting" (Hinshelwood, 1999); this is achieved through successful analysis of the client's transference and the therapist's own countertransference.

The Work context and referral

Lucy[152] is being seen in a secondary care, NHS service, which provides psychodynamic counselling for patients for 12 months. Lucy was referred from the Short Term Assessment and Recovery Team (START) whom she had been in the care of since attempting to take her life 18 months previously. After an assessment by my supervisor Lucy was referred on to see me.

Client profile and background information

Lucy is 35 years old. Her mother is from Finland and her father is from Italy. Lucy spent the first few years of her life living in Italy with her mother, father and sister (who is 10 years older). At the age of 5, Lucy's parents divorced and she moved to Finland with her mother and her sister. Since leaving Italy Lucy reported not having had much contact with her father. To begin with Lucy said she used to visit him in the school holidays, however she described feeling 'bad' in his company finding him to be judgmental and undermining and therefore stopped going to see him.

Lucy reported never feeling like her home in Finland was her home. She described never fitting in and explained that at school she was bullied and had no friends and at home she felt unwanted, sensing that her mother preferred the company of her sister. When Lucy was 9, her sister moved back to live with her father to study in Italy. When her sister moved away, Lucy said her mother got depressed and started to drink. Additionally she said her mother started to work late, which meant that every day after school she returned home to an empty house. As a consequence Lucy said she often felt scared in the evenings and would turn on all the lights and the TV and wait anxiously by the window staring at the train station waiting for her mother to return, (who often did not until past her bedtime). Additionally Lucy said that everyone seemed to complain about her, her

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[152] In order that my client remains anonymous, for the purpose of this study I have called her Lucy.

sister called her a horse, her mum said that she was too active and her school thought she was a problem child (for she was always getting into trouble). She reported that from a young age this meant that she constantly worried whether she was doing things right.

Lucy lived in Finland until 2005 when she moved to England to pursue a career in the fashion industry. Soon after moving she met and married her husband who she now lives with. Lucy stated she has not had sex with her husband for two years and is currently thinking about divorcing him. Over the last few years Lucy has had a number of design jobs in the fashion industry. Two years ago Lucy found herself unemployed after she was let go from a number of fashion jobs in quick succession, following this Lucy reported feeling "terrible" as if she had "failed" and attempted suicide. Lucy was found by her husband and was admitted into hospital, where she was looked after by the crisis team and then START. After some time Lucy reported feeling better and felt able to go back to work. Lucy currently has a job as a designer in a fashion company.

Presenting problems and Impressions of Client

Lucy's physical appearance is more typically Scandinavian than Italian; she has blonde hair and pale skin. Lucy dresses quite fashionably and speaks with a strong Finnish accent, which at times I find difficult to understand.

When I first met Lucy I was struck by how tired and drawn she looked, she had big bags under her eyes and her hair was quite messy around her face. Lucy spoke about having felt unhappy for a long time, which she described as a feeling of emptiness inside. Additionally Lucy said she found it very difficult to know how she was feeling, she compared herself to a baby, saying "it is easier for you to tell from my face what I feel as I can't describe my feelings". Lucy did however manage to say that she thought she felt quite angry as a child growing up, however she felt too scared to express this and felt as if there was no-one to express it to, her mother was never there.

Lucy described having little confidence in herself, saying that she constantly worries whether she is doing things right or saying the wrong thing, for this reason she says that she often finds it uncomfortable being in the presence of others, fearing that they are judging her or forming an opinion on her like she so often felt people did when she was younger. This in particular she said made her work life very difficult, for she constantly worried about her ability and whether she would be able to keep her job. Additionally Lucy reported feeling like she lived in her own world or bubble. Towards the end of our first session Lucy reported finding the silences in the room almost unbearable, she said she found them uncomfortable and felt as if I was checking her out, observing her behaviour and judging her.

Throughout the first few sessions I was struck by how much Lucy avoided eye contact with me. At times when she did make eye contact she appeared scared and quickly moved her glance away from mine. Additionally I noticed that Lucy had a tendency to mumble or talk very quickly towards the end of her sentences, as a consequence often what she said was inaudible to me and left me with the impression that she was talking to herself or that she did not want me to hear what she had said. Another important feature I noticed about the way Lucy spoke, was the way in which she often answered my questions about her experiences or explained aspects of her past using generalizations, e.g. "everyone finds life in London hard, it's an unfriendly city", "Everyone would find talking to a therapist hard" and "Finnish people don't hug". At times when I tried to question her own experiences about the statements she had made by trying to show an expressive interest in her she would often reply, "no I'm just telling you how it is". This left me with the impression that not only was it really hard for Lucy to own and trust her own feelings and thoughts, but that it felt safer for her to mediate herself to me through statements that would be harder for me to question or explore, suggesting from the outset a strong ambivalence in our therapeutic relationship. Additionally when in the room with Lucy I could often feel quite sad over some of the stories she was recounting, I could also feel misunderstood, particularly by the way she could respond to my interpretations in quite an aggressive way, as if they had been attacking

towards her. Probably the most distinctive impression I started to develop over our first few sessions however was how hard it was to get a sense of who Lucy was and what her personality was like, almost as if I was seeing her in a very flattened or two dimensional way.

Initial Formulation

From Lucy's description of her childhood I started to develop a strong sense of what a lonely and sad child she had been whilst growing up and how there had felt no place for her in the world around her. In line with Bion's emphasis on the importance of a sensitively attuned caregiver in the process of "thinking", the physical and emotional absence of her mother stood out for me and I wondered how 'contained' she had felt as a child and furthermore how she had managed or regulated the negative affective states that she often described feeling. When reflecting on this in light of my experience of her in the room, in particular how she felt 'two dimensional' or 'flattened' and how she had referred to herself as "like a baby" I started to wonder whether what I was picking up on was the lack of internal space or capacity to "think" that Lucy had. This would make sense given the repeated failure she experienced of not having a space in somebody's mind whilst growing up and her deprived experiences of an alpha function.

Bion (1962b) suggests that internal space that is not occupied by a good internal object does not remain vacant; instead it becomes haunted by internal persecutors (Williams, 1997). From my experience of Lucy's fear of judgment from others and importantly at times from me, I started to wonder whether these fears/anxieties were as a result of projective identification, that is Lucy split off those parts of herself that felt too intolerable and hostile, her internal persecutors, and projected them into others. This was her only means (projective identification) to dealing with the concrete and indigestible Beta elements (Bion, 1962, p.7). Furthermore I wondered whether at times when these anxieties seemed too intolerable that this led her to revert to a two-dimensionality which could be seen as an attack on her self; "the defensive obliteration of an internal space, perceived not only as a receptacle for painful thoughts and feelings, but also for nightmarish

tenants that need to be evicted" (Williams, 1997, p. 30), and furthermore in the past had led to an even more direct attack on her self through her attempted suicide.

Another way in which Bion (1959) conceptualized the attack on the self was as one "specifically directed at the capacity to make links- links within the mind, such as in 'putting two and two together'; or links between one mind and another" (Hinshelwood, 1994, p. 112). Reflecting further on my experience of Lucy in particular how hard she could make it for me to hear her at times, the way she avoided eye contact and the manner in which she could speak to me, by using generalizations and removing herself from the sentence, I started to wonder whether what underlay all of these experiences was a destructive attack on a link; something that was also mirrored in her life outside of the therapeutic room through her description of how she tended to live in her own world and felt uncomfortable in the presence of others. I started to realise that it was this destructive attack on linking which in part created such an ambivalence in our therapeutic relationship.

Bion (1957) also believed however that as well as their being an unhealthy part of the patient who destroys their world and meaning there is another part of the patient that seeks to make links. This part of the patient I felt was present in Lucy through the way she brought herself to therapy, appeared to speak honestly and openly about her experiences and most importantly allowed herself to sit through and tolerate the unbearable feelings of anxieties she experienced with me in the room during our first session and return the next week. Furthermore through my experience of feeling attacked or misunderstood in the room, I wondered also, in line with Bion (1962a/b), whether she used projective identification not only as a way of evacuating feelings but as a means of communication; in particular communicating to me how at times she felt misunderstood or attacked. This form of communication, a way of inserting one thing inside of another, I understood as coming from the healthy part of Lucy, the part that wanted to create a link between us.

The Contract and Therapeutic Aims

My choice to work psychodynamically with Lucy was partly based on the understanding that I was able to offer her long term counselling. It was also based on the emphasis that psychodynamic theory places on the importance of internalised early relationships (especially with the mother) and the ability of such relationships, if secure and adequately containing (Bion, 1962a/b) to help create an internal working model which has the capacity to understand feelings cognitions, intentions and meaning in oneself and in others (Fonagy, Gergely, Jurist & Target, 2002)[153]. Due to Lucy's presentation and the inattentive and neglectful relationship she described with her mother I wondered whether she had managed to reach this level of functioning. Psychodynamic therapy emphasises the emotionally corrective experience individuals can have through the experience of being held or contained whilst in therapy, in particular its ability to support the re-acquisition and re-integration of projected parts of the self necessary for self and mutual affect regulation and intra-psychic conflict (Howell, 2005; Faber, 2008). I felt this should be an important part of my work with Lucy believing it could help her to develop her capacity to "think"; more specifically her ability to understand herself and others and find a place for her own thoughts and feelings, (something she had not had whilst growing up). Additionally I wanted to facilitate the "internalization of a benevolent object which can provide support from within when facing panic and anxiety and increase the capacity to tolerate psychic pain." (Williams, 1997; p. 31). This felt important especially considering her previous attempt on her life.

From the outset Lucy was aware of the boundaries of the counselling session; the frequency of our meetings (once weekly) and that counseling was available to her for a period of 12 months. In my first meeting with Lucy

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[153] This is often known as reflective functioning, or mentalisation

I carried out a risk assessment; this indicated that she was at no current risk to herself or others.[154]

Development of Therapy and the transcript

Therapeutic plan and main techniques used

After discussing with my supervisor Lucy's history and presentation we decided that an important step in reaching my therapeutic aims would be to establish between Lucy and myself an attachment relationship or interpersonal context out of which Lucy could develop an understanding and toleration of her own mental states and experiences. In order to help produce such an understanding from our relationship it would be important to continuously provide Lucy with the experience of "containment" or "linking"; that is to perform for her the "alpha function", the original role of the mother.

Hinshelwood (1999) highlights three important aspects of Bion's container-contained relationship (1970) all of which I have tried to model within my relationship with Lucy;

1. An infant/patient needs a mother/therapist who can feel the infant's/child's disturbance and become disturbed herself.
2. The relationship is flexible; the contained is allowed to enter in and impact upon the container, while simultaneously the container modifies the contained. "The knack is to feel the dread and still retain a balance of mind".
3. The container needs to be strong enough to retain its form and function so that the contained does not overwhelm it and break it to pieces, and so that the infant/patient does not receive back their own

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[154] Mindful of Lucy's history however and the exploratory nature of our sessions I agreed with Lucy that should her suicidal feelings re-emerge that she bring them to the session for us to discuss. Furthermore I informed her she could contact this service at any time between our sessions should she need to, gave her the number for the Samaritans and reminded her she could ring her GP or go to A&E as well. I then agreed with my supervisor to provide regular updates of our sessions.

projection with the implicit message that it is intolerable and to be feared.

In addition to the container-contained relationship other important techniques for me to employ in the room, as discussed with my supervisor, would be the successful detection and analysis of transference and countertransference feelings and an ability to reflect on and sustain these feelings (rather than discharging them like the patient), (Heimann, 1960, pp.9-10) so that they may be used to help inform my interpretations and model again the process of the alpha function.

Key content issues and the pattern of therapy leading up to the presented session; Sessions 1-13.

During our first few sessions Lucy told me of her family history and what had brought her to therapy in particular the events preceding her overdose. Throughout Lucy's descriptions I tried to listen attentively and to reflect back an empathic understanding of her experiences, hoping that this would help her to feel contained. Although at times Lucy was forthcoming in her descriptions and explanations of her thoughts and her past it quickly became apparent that there was a great distance between us; this manifested itself implicitly through Lucy's sometimes inaudibility, her tendency to avoid eye contact with me and her often monosyllabic answers to any exploratory questions I might invite of her. As our sessions progressed this distance or perhaps better conceived as resistance/ ambivalence within our therapeutic relationship became more explicit through her tendency to arrive late for our sessions or on one occasion, session 8 not turn up.

As I became more familiar with Lucy and our sessions together, it started to become apparent that the content of our sessions was rather repetitive. Lucy would continuously tell me of stories from her childhood and in her present life of people letting her down, attacking her, misunderstanding her and judging her. Through the repetitive nature of these stories I started to develop a sense of Lucy being "stuck"; more specifically stuck in her own

rigid and unforgiving view that you can't trust anyone. This, as she was able to identify meant that she had started to "live in her own bubble" and felt increasingly lonely.

All of these experiences, feelings and patterns of relating I started to understand as contributing to and maintaining the distance in the room between us; that is they were being transferred onto our therapeutic relationship. After reflecting upon this with my supervisor it was decided that seeing as I had given the time to allow for this resistance to develop, an important part of confronting and analyzing resistance within a patient (Greenson, 1985, p.105), it would be important for me to reflect on the resistance I experienced within the room between us and to try and interpret it in light of her previous experiences, thereby offering her a meaning as to "why" she was resisting. Offering Lucy interpretations or meanings would be an important step in developing my role as a "container" (Bion, 1962a\b, 1970) and in trying to improve our therapeutic alliance.

Interpreting the resistance or ambivalence in our relationship has been an important reoccurring theme so far in my work with Lucy. The way in which Lucy has received these interpretations about our relationship has varied underlining again the ambivalence within our sessions. For instance, at times Lucy has responded well to my interpretations surrounding her ambivalence and has been able to explore it in terms of the difficulty of a "push and pull" she feels in all relationships; how she wishes to get close to people, but then feels overly anxious and overwhelmed and so pushes them away. Other times Lucy has even felt able to explore what this ambivalence means for our relationship in the room; that she wishes there was a wall between us, or that she is experiencing me as very judgmental. However at other times Lucy has rubber stopped any interpretations I have offered by replying things such as "Anyone would find it hard coming to therapy and talking to a stranger" or "I don't know". At all times whilst making these interpretations I have tried to reflect an empathic appreciation of how difficult it is for Lucy to be in the room with me and how divided this may make her feel. In particular highlighting the internal struggle she faces of on

the one hand having an impulse feeling of longing for emotional closeness and for her needs to be met; Bion's (1957) healthy part of the patient that seeks to make links, yet on the other hand having a character defence of self sufficiency under the aegis of the superego; Bion's (1957) unhealthy part of the patient that specifically directs attacks at the capacity to make links.[155]

Another important part of my work with Lucy has been analyzing the countertransference. In particular it has been important for me to understand the role of projective identification within the room, understanding it both as a form of evacuation and affective communication (Hinshelwood, 1994), and to respond to it appropriately.

One way of protecting oneself from the pain of being treated badly is to identify with the aggressor and to treat another in that way, thereby inducing in them the unwanted pain or feelings from that experience (A. Freud, 1966). Often within the room with Lucy I can feel misunderstood, for at times she has misinterpreted some of my interpretations or observations and perceived them as being judgmental or unkind when this has not been there intention at all. This can leave me feeling anxious, confused and attacked. From using my internal supervisor (Casement, 1985) and from reflecting on this feeling in external supervision I have come to realize that these persecutory feelings I am experiencing are most likely a form of affective communication from Lucy of what it felt like for her growing up, and how she can feel now in the presence of others. That is she is unconsciously recreating in me feelings that belong to her own experience as a way of communicating them and getting rid of them (Casement, 1985). Recognizing my feelings as a result of an interactive pressure from Lucy enabled me to understand what it was like for her as a child. My response to these interactive pressures has varied in accordance to the context of the sessions. At times it has felt more appropriate to hold on to and to tolerate this feeling within me, demonstrating my ability to be a container (Bion, 1970), (this at times has felt very difficult because I desperately want to leap

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[155] A defence or kind of object relationship that Hinshelwood (1995; p162) would argue has developed in order to evade the point of maximum pain.

to my defence). Other times however I tried to interpret the experience in the room as a way of telling me how misunderstood and unrecognized she felt as a child. This in turn has helped her to identify with and explore her experiences of her childhood and their impact on her ability to form relationships in the present.

Other important themes/issues that have emerged during our work so far together has been Lucy's inability or resistance to exploring her feelings surrounding her experiences or conceptions of herself as being judged, attacked or misunderstood. Although at times she has fleetingly identified affects such as "I suppose anger", or "sad, I don't know". Her inability to stay with these feelings, to claim them as her own and express them within the room has stood out and heightened within me not only this idea of a "flattened" self but that just like when she was little she feels that there is no-one there to express them to, I am not present to her yet. In the face of this at all times I have tried to stay alert and receptive to her communications through projective identification, thereby trying to build the link between us, and to emphasize our sessions as a space for her to start recognizing herself and her feelings.

Finally within the sessions through the way Lucy talks about her life and through her responses to some of my interpretations it has become evident that she finds it hard to experience any good, or allow any good for herself. Again this has heightened my awareness of how deprived she was as a child and how the lack of experience of an internalized benevolent object has deprived her of a template or an ability to internalize within herself any good (Williams, 1997). This theme I have now started to try and interpret within the room as also contributing to the ambivalence around our relationship and our sessions, which may represent something good.

Lead into transcript

The transcript is taken twenty four minutes into session fourteen. At the beginning of this session Lucy and I spoke about how hard it felt for her to be in the room with me today, of particular importance was Lucy's comment

that maybe she didn't want anyone to help her. Following this Lucy's phone rang twice and she expressed annoyance with the caller for not respecting she could not answer the phone. Knowing that I had tried to call her twice the previous week, I felt anxious that maybe she had experienced a similar feeling towards me and therefore made an interpretation to this effect. Lucy misunderstood this interpretation and felt that I was judging her and jumping to conclusions about her. This left me feeling quite anxious and attacked. Following this Lucy went on to say that she doesn't know how to be when things are "nice" and that she finds it difficult to take good feedback; she then went on to talk about Finland and her experiences of people there - "that they don't hug" and her memories of growing up.

Transcript

KC 1: So I guess, it sounds like maybe on the one hand you're saying how you can maybe understand why your mum moved you to Finland

Lucy 1: Yeah I understand the facts, you know

KC 2: But at the same time, it didn't feel like your home

Comm 1: Moments before Lucy had been telling me how she had felt 'totally alien' when her mum moved her to Finland, for she didn't feel like she fitted in anywhere; at school or at home. After this she went on to list many practical reasons as to why her mother might have made the decision to move them as if she was seeking an explanation or an understanding around her mother's actions. By linking apparent disparate sentences in her story here my comment (KC 1 &2) tried to reflect an understanding of some of the conflicts she was experiencing on an unconscious level; of understanding but feeling so confused, thereby bringing together split off or separate feelings which the client has been unable to acknowledge (Jacobs, 2004).

Lucy 2: No, I don't know how well I would be in Italy either, I can't really remember, I think I had lots of friends there.

Comm 2: Initially Lucy's response, in particular the "No", felt quite rejecting or dismissive of my reflection, as if she didn't want me to make a connection with her or to identify and understand the struggle within her, thus illustrating the unhealthy part of the client that wants to be destructive towards linking (Bion, 1959). However as Lucy continued to speak her words softened and it felt like she was slowly starting to let me back in or open herself up to me once more. This moment, I felt, highlighted the ambivalence in our therapeutic relationship and how hard it was and would be for her to allow me to identify with her, but more specifically the "push and pull" that Lucy had spoken of experiencing in relationships.

KC 3: Hmm,

Lucy 3: And also I think in Italy I was a little bit special because, you know, I was blonde child, you know, and they really, you know, quite like that you know, you know?(*mumbling)* We left my dad (*didn't hear this in the session*), you know, and its just go to Finland and, just didn't fit in with anyone.

KC 4: Hmm, and maybe didn't feel special anymore?

Comm 3: The capacity to think, that is the ability to reflect on your own mind and on other's and to understand intentions in yourself and in other's are born out of the context of early containing/attachment relationships (Fonagy, Gergely, Jurist & Target, 2002). Listening to Lucy speak again it really felt as though she was searching for meaning or an understanding of her own experiences, again suggesting what little experience of containment she had had. The idea that what made Lucy feel special in Italy was her blonde hair stood out for me and it made me feel sad, for I started to understand how little Lucy must have felt internally validated or appreciated by her parents. Additionally in line with Fonagy, Gergely, Jurist & Target, (2002)who writes of the meaning of physical attributes being given such a weighting as to reflect internal states such as self worth how poorly Lucy's psychic reality was

integrated. My comment here therefore intended to try and reflect an understanding in me as to how she felt she had lost something in the move to Finland; a sense of herself as being special. Additionally it felt important for me to pick up on and reflect back the word 'special' sensing in the moment that behind this was a feeling of being loved or of worth.

It was only after listening to this section on tape that I heard Lucy's words "We left my Dad" something that I had missed within the session. Not understanding or hearing everything Lucy said was quite common for me in the sessions as I often found the way she spoke and her accent quite unclear. I was quite shocked when I heard this, firstly because I had missed it and secondly as their seemed to be a sense of loss in her voice over leaving her Dad, something that I had not heard before. In hindsight, I wish that I had heard these words and that I had responded to them by reflecting back to her that yes they did leave her Dad behind and I wonder how that felt for her? Something that I doubt anyone ever asked her when she was little.

Lucy 4: Well I suppose like every child is supposed to be special for their parents anyway, (*pause,)* I don't know, I'm unsure what happened, what was in Finland, alright, but I know that I got like, maybe little bit, like for example there was where we lived, there was this, um, older woman, who had children and she brought me stuff you know, I'm not sure (*mumbling off),* for, I suppose she, (voice gets louder) and I remember when I went to visit my Dad, and then some of the people's houses they quite liked me because you know, I was blonde. But from just saying that, I don't know.

I don't think the kids in Italy are that ju- judgment, judgmental like. Kids are always judgmental, I think a little bit. But I don't know its just, I don't know what is the reason that I feel misunderstood, maybe because they go, they go the kindergartens already when they like, 11 month, 1 year and they just, cos peo-, parents working, so they don't really get out of all this family thing you know. Then countries where the kids stay home with the family,

in which they getting a bit warmer because you know its, maybe its not that tough you know, or its not that tough at home like somewhere like school or kindergarten you know or? In kindergarten, you know the teachers they haven't got time for every child, you know?

KC 5: Hmm,

Lucy 5: They sort of have to survive, and then at home you've got always someone who looks after you, if you hurt yourself, you know, your mum is there you know, or your grandparents.

Comm 4-5: The length of Lucy's response to my comment suggested to me that she felt responded to (KC 4) and that my comment had offered her a link within her story; a more simple kind of interpretation (Jacobs, 19?) one that she could take on board and reflect on further.[156] The way Lucy spoke was vague, disjointed and chaotic. She seemed to swap quite rapidly from talking about herself in the first person to thinking about and rationalizing her own experiences, in particular how she felt so misunderstood, judged and unloved in light of how the family system is set up in different countries. These features of her discourse highlighted to me the internal confusion that she felt and how hard it was for her to use words as a means of thinking about her real thoughts and wishes, a sign of poor early containment (Fonagy, Gergely, Jurist & Target, 2002, p.15). Additionally her use of language, which felt quite sterile through its use of generalizations about "kids" and "countries" and use of clichés such as "you know" and "I suppose" in accordance with Greenson (1985) suggested that she was "isolating affect and evading emotional involvement" (p. 66) and furthermore was within the room "withholding personally revealing communication" (p.66). This again emphasized for

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[156] In hindsight this has made me wonder whether perhaps she even noticed that I had failed to pick up on what she had said about her father, or whether she had not intended me to hear, or was consciously aware of it herself. Either way, I realize now that this is an area important for me to pick up on and help her to explore in the future as this could help her in recognizing and linking together her own experiences and mental states, an important part of the meaning making process (Williams, 1998).

me the ambivalence within our relationship and emphasized for me how hard it was for her not to "flatten herself" and to allow herself to hold on to and recognize her own thoughts and also how much easier it felt for her to look for meaning and an understanding of her experiences outside of herself.

As Lucy spoke I felt confused at times as to what she was trying to convey to me and also quite anxious as to whether I would respond appropriately to her. These feelings in part I understood as a result of projective identification, for Lucy often spoke about feeling anxious and confused, especially in the presence of others. Within the room I realized in this moment with more certainty that it was my role as a container to tolerate and receive into myself these chaotic input of feelings and sensations (Williams, 1997), her projections and to metabolise them and feed something manageable and meaningful back to Lucy, thereby performing for her what Bion calls the 'alpha function' (1959). I therefore tried to focus my thoughts and sieve through the confusion and chaos. I started to ask myself in line with Bion[157], what exactly it was Lucy was trying to communicate to me at this point. This was when I started to sense an absence or loss in her communication; that is she was trying to tell me about what she had not had. My comment that followed was intended to reflect this understanding of her communication.

When reflecting on this response I found it really hard to know where to start and what to comment on , for it felt like there was so much going on within it, yet no obvious starting point from which to comment and build on from. After spending time reflecting on this issue I now realize that this in so many ways mirrors Lucy's own experiences. Lucy starts this comment by conveying such a tenuous and uncertain understanding of what she thought she did have in Italy; essentially how uncontained she was there; "well I suppose", "I'm unsure", "maybe little bit", "I'm not sure" etc; that's its almost as if she's describing how she has no solid

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[157] Unfortunately I was unable to find which text of Bion's this quote has come from. I originally became familiar with this quote through the teachings of one of my tutors, it stuck with me.

foundations from which to build an understanding or sense of herself from. This in turn is almost how it feels for me trying to present effectively my understanding of her response; that like Lucy I have no starting point/ a foundation from which to build my comments on. Having no starting point, has led me to feel frustrated, confused and overwhelmed, all feelings that are easily identifiable with Lucy and her situation. Waska (1999) writes that "certain aspects of the intrapsychic and interpersonal communications between therapist and patient can continue beyond the hour or even past termination"; this certainly seems to be the case with Lucy.

KC 6: I guess it feels like you're telling me a lot about what you didn't have in a way, I guess you didn't have grandparents or the mum to look after you if something went wrong or it didn't feel like that anyway?

Comm 6: I felt comfortable whilst making this interpretation believing it to be quite sensitive and attuned to Lucy's communication. Almost instantly Lucy's eyes started to well up in response to my interpretation suggesting to me that it had been. However almost as instinctively as she had started to cry, Lucy stopped herself and turned her head away even further from me and wiped a tear from her eye. I felt really sad in this moment, sad for Lucy that she would allow herself so little in the room. In hindsight I now realize that this feeling of sadness was also in part as a result of projective identification, but this time as a form of defence; a way of externalizing, evacuating and modifying her negative affect (Fonagy, Gergely, Jurist & Target, 2002).

This moment I also think illustrates well the internal conflict that Lucy faced between what Bion (1959) conceptualized as the healthy and unhealthy part of the client. For there is a part of her that wants to reach out and forge links with another and within herself thereby increasing her capacity "to think", yet simultaneously there is another part of her that makes destructive attacks "on anything which is felt to have the function of linking one object with another" (Bion, 1959, p.

308). Again this brought to mind the ambivalence or the "push and pull" within our relationship, and also made me start to consider how hard it could be for me to establish a link with her if these destructive attacks continued.

(*Lucy eyes well up, turns away from me, she breathes in deeply*)

Lucy 6: umm, I don't know it doesn't help though, my sister she lived with me and she had mum home until she was 13,

KC 7: Sorry?

Lucy 7: I don't know if it helps though, but you know it would, it would have been nice you know just to, its probably the reason because I would never want kids, because what you going to do? You could be off of work for one year and then you have to put them somewhere, come home at 8 0'clock at night you know, not even going to get to see your kids. If you don't decide to stay home.

Comm 7: I didn't quite follow or hear Lucy's comment (6) and so asked her to repeat herself (KC 7). As she repeated herself I couldn't help but think that her words were a diversion from the affect she was close to experiencing underneath, for again they felt quite sterile and full of clichés; "I don't know", "What you going to do?" thereby suggesting she was evading emotional involvement with herself and with me (Greenson, 1985, p.66). Not wanting to collude with this resistance to connect to herself and with me in the room, thereby advocating for Bion's (1959) healthy part of the patient I decided to try and bring her back to that short moment of emotion that she seemed so intent on moving away from so quickly.

Looking back now, it feels as though her comment 6, which referred to her sister, was possibly heading in a different direction to her comment 7. Although I still recognize that prior to her comment 6, Lucy appeared

to have already moved away from the emotion that was starting to well up within her, I do now wonder what kind of impact not "hearing" Lucy in the room had, and whether perhaps this in a way might have pushed her further away from her feelings in her comment 7.

KC 8: I guess I, I ju, you know, I just noticed that you were, you seemed to come close to tears just then, and then how quickly it felt like you tried to stop yourself and to move on from that feeling.

Lucy 8: I suppose its just old stuff you know,

KC 9: Hmm.

Lucy 9: I can't really help what happened, you know, I can't change the past,

Comm 8-9: Lucy's comment 8 although it felt softer and more in touch with herself than her previous comment 7, still felt dismissive and negative towards her feelings and the importance of them. Furthermore her comment 9 felt quite defeating not only of herself but of our sessions and what impact either of them could have on her life. In this moment I started to recognize where that sense of "stuckness" that I experienced with Lucy came from; it was from the weight of words from her own internal persecutors and monsters (Williams, 1997) telling her that she was powerless or helpless (this could also be conceptualized as the introjection of the aggressive attitude she experienced when she was younger, of never being able to do anything.) that had filled the space of the vacant good object (Bion 1962b).

KC 10: Hmm, I think, you know, that's right, I guess we can't change the past, but, you know, we're here to kind of, you know help change how you're feeling now, and what's going on for you at the minute, and maybe looking at some of those feelings that you had in the past and that you still have now, might help, might help do that.

Comm 10a: Quite often within the room I experienced Lucy as being very negative, as if there was no internal space within her for anything good[158]. During these instances I often felt compelled to try and become ultra positive as if to try and counteract her negativity. Aware that an important part of being a container is to "retain balance of mind" (Hinshelwood, 1999) it felt important here not to do this but rather say something that could create not only a bridge between us, but her own polar/black and white ways of thinking.

Lucy 10: Hmm (29-27 – 29.35) I can't remember what I feel to be honest Katie, I suppose angry.

Comm 10b: Lucy's use of my name, made me feel very connected to her, as if she was starting to recognize me and the relationship that was building between us within the room. In this moment I felt a certain amount of peace, for it really felt as though she had let her guard down, let her defences slip and "the push and pull" between us was no longer. Although this felt positive and I was pleased with her response I couldn't help but feel anxious as well, for I was worried now that I felt let in by her, I would let her down. Although I believe this anxiety was in part an anxiety of my own, that comes from my desire to want to do well for my clients and not let them down, I now realize in hindsight that this anxiety was also as a result of projective identification. For given all Lucy's experiences of being let down by others in the past, this was another opportunity for the pattern to repeat itself; this most likely made her feel very anxious and possibly start questioning my ability to contain her, something that I now see I was starting to do in the room.

Not wanting to overwhelm her in this moment (something that she said she often experienced in relationships), by jumping into this moment

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[158] This I understood as due to her defensive obliteration of her own internal space, (William, 1998) which can feel overwhelmingly persecutory, and as a result of splitting, (whereby in order to keep the ideal object (good) safe she must project it in order to keep it as far away as possible from the persecutory one (the bad objects) that she has introjected, (Klein, 1946)).

headfirst and clinging on to the anger she was starting to recognize within her as something for us to explore, I decided it was important for me to sit back and show my interest and attention in her implicitly through my facial expressions (I smiled sympathetically and nodded my head) and to wait for her lead.

KC 11: Hmm, (*Pause 29.38 – 30: 38*)

Lucy 11: Yeah,

KC 12: What's on your mind?

Comm 11-12: As the silence continued I started to wonder whether I had done the right thing in sitting back and whether in fact this might have been perceived by her as neglectful or inattentive; something she so often complained of her mother being. I started to try and think of things I might say to bring us back to that moment and struggled. Even in hindsight I struggle now reflecting on possible options of what I might have said, suggesting either that perhaps it was important for me to say nothing and that this was her space to think or perhaps that I was responding more to "the push" within the relationship than I realized that is I was being drawn into a re-enactment of Alex's own internal drama and as Casement (1990) suggests was starting to "become like one or other of the parents in ways that are typical of the patient's experiences" (p.166); Which one it was I am still not sure and this is something I will take to supervision. I felt relieved when Lucy finally spoke, although her comment was small her tone was soft and I felt like it gave me permission to inquire after her once more (KC 12).

Lucy 12: I just try to think how I felt when I was a kid, but I can't really remember,

KC 13: Hmm,

Lucy 13: I don't' know I can't remember if that was just, not very happy, was always something, always some troub-, problems.

Comm 13: Lucy's comments 12 and 13 started to feel resistant again, her words "I can't really remember" and "I don't know" suggested to me that not only was she pulling away from me in the room, but also from making a connection with herself, linking up her own memories and feelings. On reflection I now wonder whether she did experience too much space within the silence and whether this felt neglectful or that her communication was not manageable, perhaps I had responded too easily to the "push"; consequently she developed a sense of her own self and feelings as being unmanageable which resulted in a new state of hopelessness and despair (Bion, 1967). Sensing in the moment that I did not want her to think I had ignored her earlier recognition of anger (something that would not be very demonstrative of a good container) I decided it was important for me to show that I had heard what she had said and to try and bring that recognition of her self back into the room again.

KC 14: Hmm. *(Pause 31.05 – 31.18).* But I guess noticing and recognizing that you felt angry as a child seems, seems,

Lucy 14: Well I think so, I think that I was quite angry when I was a child

KC 15: Hmm

Lucy 15: And sad, and lonely and like I always felt that I couldn't do anything right but, but then, I don't know, my mum said I pushed people away, so I don't, or my sister said I pushed people away, so I can't remember.

Comm 14-15: The way in which Lucy almost jumped into my sentence (KC 14) before I had finished speaking, made me realize how much she had needed me to recognize within the room the feeling of anger she had

started to recognize herself and maybe how hard that silence had felt for her. In hindsight I now wonder whether as well as saying that she felt "quite angry" when she was a child, whether she was also saying within her response that she felt "quite angry" with me in the room for not recognizing her sooner. However in spite of this Lucy's response seemed to give more of herself, for she started to allow herself to attend to other thoughts and emotions that she had felt when she was younger, like sadness, and also showed a spontaneous link or understanding of what impact this might have had on her, that she pushed people away, thus in line with Davanloo, (1990) suggesting a fluidity in her unconsciousness and a willingness to engage once more with herself and me in the room; a mobilization of the therapeutic alliance.

KC 16: Hmm, well, you know I wonder sometimes people push people away when they, you know, when they are feeling sad and angry sometimes pushing people away can be a way of protecting ourselves.

Lucy 16: Hmm,

KC 17: And I guess sometimes, sometimes that, you know that way of dealing with something can be functional for some time, but quite often, we can grow out, you know, it can change from being a functional defence to something that maybe isn't helping us anymore,

Lucy 17: Hmm,

KC 18: and, and I wonder if maybe that's, you know, something that's happening now for you sometimes is that, you know, you've got used to pushing people away and maybe in here that's what, that's what makes it so hard in here to try and, or for us to sometimes work together is because, the most natural thing for you is to, is to not to want to let me in and to help you.

Comm 16-18: I felt pleased when Lucy brought into the room herself, (albeit indirectly through reporting that this was what her mother or

perhaps sister had told her), her tendency to push people away, as I had felt for sometime that had I made this interpretation myself that she would have been quick to reject it. Understanding and interpreting repetition within the relationship, the transference is an important part of psychoanalytic technique (Hinshelwood, 1994). "Transference may consist of any of the components of an object relationship" (Greenson, 1985, p. 152). In this instance I understood that Lucy's defences, of pushing people away or alternatively self- sufficiency under the aegis of the superego was being repeated within the room, with me. It felt important in this instance to offer her an interpretation of what was happening with the room between us, as not only would this be offering her a meaning to a process in the room, which otherwise might remain meaningless, an important role of the alpha function, but that this might help us to explore the ambivalence within our working alliance, something that at this stage I felt was holding us back. In particular I hoped it would help her to identify and separate her "relatively nonneurotic relationship" towards me from her "more neurotic transference reactions" for "a patient must be able to develop both types of relationships in order to be analyzable" (Greenson, 1985, p169).

Aware that in the beginning of the session Lucy had misinterpreted something I had said and felt it to be quite attacking, combined with her comment that she often felt that she "couldn't do anything right", it felt important for my response here not to be too quick or forceful in agreeing with her, as I worried she would feel attacked or blamed by me. Looking back now although I understand this concern in part as coming from my own wish to try and preserve the therapeutic alliance that at this point I felt was building between us, I realize that this anxiety was also as a result of my own countertransference feelings; like Lucy, I do not like being misunderstood and earlier on the session when this had happened I had felt very uncomfortable. This is perhaps why in this instance my response is over tentative, hesitative at times, and even avoidant through its talk of what people do, as suppose to what Lucy does. Something that I now see mirrors Lucy's earlier use of sterile

language as a means of evading emotional involvement. (Greenson, 1985). In hindsight I realize that I would have been a better container for Lucy had I managed to tolerate and withstand the anxiety within me around this interpretation better for this would have demonstrated my ability to retain a balance of mind (Hinshelwood, 1999) and to metabolise her chaotic input of feelings and sensations, an important role of the alpha function (Bion, 1962a/b). This could have been demonstrated through a more succinct and clear interpretation of the process between us in the room.

Lucy 18: Hmm (33.04 -33.12)

KC 19: And you know, I guess I want to say I understand that and I know that it is very difficult but I'm here to, here and, you know, want to help and be with you through this.

Comm 19: My decision to make this last part of the intervention came from an anxiety within me that previous to this (KC 18), I had said "you" too much, which again might have made her feel like I was blaming her, and also that I was removing myself from the situation and the relationship. Given these concerns it felt necessary at this point, not only to show containment through an understanding of how conflicting it felt for her to be in the therapy room with me, thereby demonstrating that she had a space in my mind, an important part of modeling the alpha function (Williams, 1997) but also to show my willingness to respond to her impulse longing for emotional closeness, something that she felt no-one had done for her when she was younger and to make myself present in the room, something that I had previously felt I was not.

Lucy 19: Yeah. (*Pause: 33.26 – 33.40*) I just sometimes feel it's too late.

KC 20: Hmm, I wonder if there is another part of you that thinks something else?

Comm 20: Lucy's response felt quite rejecting towards me and the link I was trying to build between us. Not wanting to give up on her and our relationship my next comment was intended to try and explore and strengthen her "nonneurotic relationship towards" me (Greenson, 1985, p.169) or what Bion calls the healthy part of the patient.

In hindsight I realize that perhaps my intervention (particularly KC 19) had felt too overwhelming for her, something that she had previously explained experiencing in relationships and that this had meant she instinctually became more resistant/ made a destructive attack on linking (Bion, 1959). In saying that although I think the words I used to express myself here (KC16-19) might have been more succinct as suggested earlier, I do believe that the content was valid. I now believe that it was perhaps too ambitious for me to expect anything more from Lucy at this point, for she had already given me so much (Lucy 10) and that an important part of the development of our work together and of our relationship will be my consistent and continual demonstration of my ability to be with her in the room. An alternative intervention at this point might have been one that reflected an empathic understanding of "how maybe our time together doesn't feel enough for you at times".

Lucy 20: Well I just think it would be nice to have a life, when I was younger, these little things like, it would have been easier for me to do the other stuff you know, go in the school and, you know?

KC 21: Hmm,

Lucy 21: I didn't see anyone, or anything and I don't' really understand why, you know, because I think, I suppose I was quite difficult when I was a child, I don't understand why no one really cared.

Comm 21: Within Lucy's comment (20) there seemed to be a glimmer of her wanting more for herself, ("it would be nice to have a life,")

something that would be so important in her becoming "unstuck". This suggested to me that my comment had had some impact on her and momentarily given the healthy part of her a voice again. As Lucy continued to speak I felt an overwhelming sadness within me, for once more I felt as though she was telling me how little she had had, how no one really cared. Having had time to reflect on this moment further I now understand what Lucy was trying to convey to me was how coming from having nothing makes "other stuff" so hard, more importantly how coming from having nothing, not even an internal space of her own, makes being with me and our relationship so hard.

What Happened Next

At present I am still working with Lucy. After the session above Lucy came for our next two appointments, within which we discussed further the ambivalence within our relationship and she shared more stories from her childhood of being let down by people and more instances in her present life where she felt judged and attacked by people. Within these sessions, although progress was slow as anticipated, I had started to feel as though Lucy was slowly starting to open up to me more. One important development in particular was her recognition towards the end of these two sessions that she had no idea who she was. In the moment I was quite taken aback by this comment for I felt it was particularly honest, open and undefended. Following this Lucy cancelled our next four sessions. Each cancelled session Lucy made telephone contact with me to tell me she would not be able to make it but wanted to come the following week.

Lucy recently returned from this unexpected break questioning whether our sessions together would help her and whether CBT could be an alternative form of treatment for her. These questions helped me to interpret the meaning behind her absence as rooted in the ambivalence she experienced within our relationship (in particular how it might have felt quite dangerous becoming closer with me in the room), and within herself; i.e. the internal struggle she faces between having an impulse longing for emotional closeness and a defence of self sufficiency under the aegis of the superego.

Lucy responded to these interpretations well and was able to link this to the existence of her own personal mantra of "you have to do things on your own" and her experience of feeling so un-helped in the past. Lucy attended our following session (which brings us up to present day), this session, more so than any other one, felt very hard as I started to feel within me that she thought I was not good enough for her and that these sessions were not enough. This feeling I understand as a result of a strong countertransference pattern between us. After reflecting upon this with my supervisor, it was decided that the development of this countertransference pattern between us was potentially positive, as it came from a place within her that was not only infuriated by me, most likely a transference reaction, but with the side of her that wants and needs. Uncovering and analyzing this anger would be an important step in moving forward together and in helping her and our sessions to become "unstuck".

Although at this point, the ending of therapy has not been explicitly addressed within the sessions, given the ambivalence within our relationship and Lucy's history it has become increasingly clear how important it will be to start exploring the ending of our sessions sooner rather than later. This will then hopefully provide her with an experience of a "healthy" ending within which she feels contained and understood rather than reinforce her previous experiences of endings as rejecting and abandoning. Given the importance of this task, yet also keeping in mind the negative impact that addressing the ending too soon may have on the therapeutic alliance, it will be important to reflect on and discuss this matter with my supervisor thoroughly before engaging Lucy with it.

Discussion

Liaison with other professionals

Lucy's GP was contacted at the beginning of her treatment to inform him of the start of our treatment and of the boundaries of our sessions.

Difficulties in the work and use of supervision

Working with Lucy has and continues to be very challenging. Primarily the difficulty I have experienced within the work has been due to the ambivalence within our relationship and consequently how hard it has been for us to form a good working alliance. A working alliance is formed between the patient's reasonable ego and the analyst's analyzing ego (Sterba, 1934). However as Greenson writes (1985, p.46) a patient's ability to form a relatively reasonable and rational relationship to their analyst stems from his capacity to have formed such "neutralized relationships" in his past. When reflecting on Lucy and all of our sessions together it is clear from the numerous stories she has told me of being let down what little experience she has had of such relationships, and therefore how hard this has made it for us to work together. Additionally when reflecting on what little internal space or capacity "to think" (Bion, 1962a/b) I perceived Lucy as having what little room this means there is for us and the reflective and connective nature of our relationship within her.

The use of supervision has been incredibly important in helping me manage and understand this ambivalence within our relationship. In particular it was very helpful in helping me to process and reflect upon the meaning and nature of Lucy's cancelled sessions. During Lucy's period of absence a part of me was worried that this was down to my analytical skills, however after further reflection with my supervisor and considering Lucy's telephone contact during this time, I came to understand her absence as more of a reflection of the internal struggle (as mentioned above) she faced within her and the "push and pull" she explained experiencing within relationships. Additionally I also came to wonder whether this break although perhaps a defensive reaction towards the relationship that was starting to develop between us just prior to her absence, was in fact a test for me. That is, would I, unlike her teachers, family and friends from when she was younger notice her absence, notice she was not being a "good client" (like she was not a good girl when she was younger). Would I care? Would I follow up on what was behind it? Would I recognize her and her struggle? Or would I like the others neglect and reject her because of it and move on. This idea that she is

asking me to prove myself and my intentions to her, although frustrating, has been helpful in helping me to tolerate and withstand not only the struggle of our relationship but also the repetitive nature of our sessions and my sense of her being "stuck". It has allowed me to re-assert within myself the importance of my role as a container within the room, and more specifically to understand what being a container means for Lucy at this time; that is to contain reasonably flexibly her distress (the ambivalence) and thus think about it. (Hinshelwood, 1999).

Other difficulties I have experienced within the work has been tolerating, managing and understanding the countertransference as a result of projective identification. Due to Lucy's diminished capacity "to think" much of what is shared and experienced within the room between us is through this unconscious communication (Bion, 1962a/b). Given the intensity of this however this at times can leave me feeling overwhelmed confused and even defeated. Again supervision has played an important role in helping me to internalize these feelings, to process and find meaning within them and to feedback where appropriate my interpretations of this thereby hopefully providing Lucy with the experience of being understood and of having a space in somebody else's mind.

Evaluation of work

The difficulty I have experienced in writing this report, focusing my comments and providing clear and un-jumbled explanations of our work together, has reemphasized to me not only how hard and confusing it can feel at times for me to be with Lucy but furthermore how hard and confusing things most likely feel for Lucy all the time. This coupled with the difficulties I have faced in establishing a therapeutic alliance between us has inevitably meant that progress within our sessions has been slow. Although at times moving forward slowly can feel frustrating I feel that this is an important part of our work together, and is in the best interests of helping Lucy to feel safe and contained within our relationship. Although there are areas of my work with Lucy that I feel could be improved, for instance managing my countertransference feelings within the room (Comm. 16-18.)

I think that the very fact that Lucy is still attending our sessions is testament to the growing relationship between us and the importance of the work that we are doing together.

What I learnt about psychotherapeutic practice and theory

Writing this piece of work has had quite a big impact on me, for it has really helped me to understand what an arduous task therapy is for someone who has had nothing. When I say nothing, I am speaking of experiences of containment. Williams (1997) in her book "Internal Landscapes and foreign bodies" writes of something called "double deprivation". This is an understanding of their being firstly a deprivation that can be imposed upon individuals by external circumstances and secondly a deprivation imposed upon individuals from internal sources; the quality of the internal object and crippling defences. It is this "double deprivation" that I now realize has made therapy so hard for both me and Lucy. For not only is Lucy contending with the force and weight of this "double deprivation", but the impact or pressure that this "double deprivation" can have on an external object to give up (Williams, 1997), in this case me, can be so forceful that even at times it can be hard not to wonder myself, how and when will we move forward?

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