Eating Disorder and the Experience of Self: An Interpretative Phenomenological Analysis

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1. ABSTRACT

Aims: *Quantitative research and clinical observations have long supported a link between the eating disorders and disturbances of self / identity. However, less is known about the process of how this comes about, and little qualitative research has been conducted in the area. The current study therefore aimed to gain an in-depth understanding of the experience of self and eating disorder, using a qualitative approach. The study focused upon the experiences of women, in order to keep the sample homogenous, and sought to explore the following: How women with an eating disorder view and describe themselves; their thoughts and experiences concerning why they view themselves this way; and their thoughts and experiences regarding whether they think there is a link between their view of themselves and their eating disorder.*

Method: *Semi-structured interviews were carried out with four women who had been diagnosed with, and were undergoing treatment for, an eating disorder. Verbatim transcripts of the interviews were then analysed using Interpretative Phenomenological Analysis (IPA).*

Results: *The analysis produced four master themes. These were,* '"I'm always questioning, who am I?": Experiencing a fragile sense of self'; 'The influences of others on self perception'; '"Just made me feel better about myself": Strategies employed to manage the sense of self'; and '"I can't rise above my childhood": The enduring influence of early experiences on self'. *A description of these master themes and the related subordinate themes is presented.*

Conclusion: *The results of the analysis are considered in light of existing theory and their clinical implications.*

2. INTRODUCTION

2.1 Overview

The current study is an Interpretative Phenomenological Analysis (IPA) (Smith & Osborn, 2003; Smith, Flowers & Larkin, 2009) of the experience of self and eating disorder. This introduction is set out in order to provide background information about eating disorders and existing literature highlighting the role of self and identity, and to explain the rationale and aims of the current study, including the decision to adopt an IPA approach.

2.2 Current clinical definitions of the eating disorders

The eating disorders have been characterised as having the following key feature (Garner & Myerholtz, 1998, pg 592):

> ...a persistent overconcern with body size and shape indicated by behaviour such as prolonged fasting, strenuous exercise, and self-induced vomiting aimed at decreasing body weight and fat.

The current Diagnostic and Statistical Manual of Mental Disorders (4th Edition; Text Revised; DSM-IV-TR) [American Psychiatric Association (APA) 2000] divides eating disorders into three diagnostic categories: Anorexia Nervosa (AN), Bulimia Nervosa (BN), and 'Eating Disorder Not Otherwise Specified' (EDNOS). The DSM-IV-TR criteria for AN are: refusal to maintain body weight at or above a minimally normal level for one's age and height; an intense fear of gaining weight or fatness; disturbed experience of body weight or shape; and amenorrhea for at least three consecutive menstrual cycles. The AN category is subdivided into either restricting-type, for individuals who primarily achieve their weight-loss through dieting, fasting, or excessive exercise; or binge eating/purging type, for individuals who regularly engage in binge-eating and/or purging (self-induced vomiting, misuse of laxatives, diuretics or enemas) (APA, 2000).

The DSM-IV-TR criteria for BN are: recurrent episodes of binge-eating (i.e. eating a larger amount of food than most people would eat during a similar period of time and

circumstances, accompanied by a sense of lack of control); the use of compensatory behaviours, such as purging, exercising or fasting, to prevent weight gain; that the binge-eating and compensatory behaviour occur at least twice a week, on average, for three months; and undue influence of body shape and weight on self-evaluation. These difficulties should also not occur exclusively during episodes of AN. The BN category is also subdivided into purging and non-purging types, the former involving compensation via self-induced vomiting or use of laxatives, diuretics or enemas, and the latter involving other types of compensatory behaviour such as fasting or excessive exercise (APA, 2000).

The EDNOS category includes individuals who do not quite meet the criteria for either AN or BN and those who fulfil the suggested category of binge eating disorder (BED), which involves binge-eating associated with emotional distress, but without engagement in compensatory behaviours. Binge eating commonly occurs within the context of a general tendency to overeat, a pattern which is linked to obesity (Adami, Gandolfo, Bauer, & Scopinaro, 1995; cited by Keville, Byrne, Tatham & McCarron, 2008). In practice BED has already come to be accorded the status of a diagnostic category in its own right (Palmer, 2005).

Although these diagnoses are construed as discrete categories by diagnostic systems, in clinical practice much overlap in symptoms is observed, with movement of individuals between the categories (APA, 2000; Palmer, 2005). This has led to the development of transdiagnostic theories of the eating disorders, which identify the causal and maintaining factors common to all forms of eating disorder (e.g. Fairburn, Cooper & Shafran, 2003), and to criticism of current diagnostic systems (e.g. Palmer, 2005; Waller, 1993, 2008).

It is also pertinent to note that there are postmodern critiques of these dominant discourses about eating disorder. For example, Hepworth (1999) has argued that the psychiatric definition of anorexia is socially constructed through language and the different forms of knowledge that have emerged throughout different historical periods in western society.

2.3 Estimates of incidence, prevalence and prognosis

The incidence of eating disorders is thought to have increased markedly in the last 50 years, although this may be the result of greater awareness and reporting (Wakeling, 1996; cited by Polivy & Herman, 2002). In 1993, Turnbull, Ward, Treasure, Jick & Derby (1996; cited by

van Hoeken, Seidell & Hoek, 2005) found an age- and sex-adjusted incidence rate of 4.2 for AN and 12.2 for BN per 100 000 population in the UK.

In terms of prevalence, The National Collaborating Centre for Mental Health (NCCMH) estimate that about 1 in 250 females and 1 in 2000 males will experience AN, and about five times this number will suffer from BN. Atypical eating disorders are thought to be more common still (NCCMH, 2004; page 7). Hay (1998; cited by van Hoeken et al. 2005) found a point prevalence for BED of between 1 and 2.5%, although this was from a study conducted in Australia rather than the UK.

Regarding prognosis, it is thought that about a third of patients continue to meet diagnostic criteria 5 years and longer after initial treatment, while 50% of patients show significant improvement more than 5 years after beginning treatment (Polivy & Herman, 2002).

Polivy & Herman (2002) estimate that mortality rates (including suicide) range from just over 5% to just over 8%. Standardised mortality rates (the fraction of the observed mortality rate compared to the expected mortality rate in the population of origin) cited by van Hoeken *et al.* (2005) are 9.6 for AN and 7.4 for BN. In a meta-analysis by Harris and Barraclough (1998; cited by Hoek, 2006) anorexia nervosa was associated with the highest rate of mortality amongst all mental health problems. This highlights the need for further research that may contribute to improving our understanding of eating disorders, which may thereby enhance their prevention and treatment.

2.4 Causes of Eating Disorder

Current understanding is that there is no single cause of eating disorders. It is acknowledged that they are complex and multi-determined by a combination of different factors (Garner & Myerholtz, 1998). It has therefore been argued that they remain poorly understood (Fairburn & Harrison, 2003), which would support the need for further research in this area. Relevant identified variables include both interpersonal factors (familial, cultural and social) and intrapersonal factors (individual psychological and biological / genetic factors), and it is thought to be an interaction between these that leads to eating disorder development and maintenance (Garner & Myerholtz, 1998; Polivy & Herman, 2002; Schmidt & Treasure, 2006).

It is beyond the scope of this chapter to provide a full review of research concerning the causes of eating disorder. Since the current study is concerned with the role of the construct of 'self' in eating disorder the following sections will present relevant background information about theoretical contributions and research in this area, highlighting the gaps that support the relevance and originality of this current study.

2.5 The self in eating disorder: Previous research and theoretical contributions

The following sections provide a selection of the relevant literature in the field of eating disorder and self. This is not an exhaustive review of the literature in the area; rather, contributions have been presented according to their relevance in informing the reader about the background and purpose of the current study. Literature in this area comes from a number of different theoretical orientations, which I have categorised in the following way:

- Psychoanalytic and developmental theories
- Feminist theories
- Cognitive and behavioural perspectives
- A Personal Construct Theory perspective

I have chosen not to adopt just one approach or model as a framework for the study, as I felt that this may have an undue influence on the analysis. That is, that the interpretation may be biased by an expectation that participant experiences would fit a certain model. Similarly, as the terms 'self', 'self-concept', 'identity' and 'sense of self' have come to be used interchangeably in the literature (Stein & Corte, 2003), I have included research and theories adopting each of these terminologies. It is often the case that authors and researchers in this field do not provided definitions for the terminology they use, leaving the reader to assume a 'commonsense' interpretation of terms (Epstein, 1973; Stein & Corte, 2003). Use of 'everyday' or layperson's language is appropriate to the approach of the current study, as use of ambiguous technical terms in interviews may hinder both participants' understanding and the researcher's interpretation. Additionally, academic definitions may not fit with participant's lived experience. However, in order to provide some context for the theories

discussed in the proceeding sections, the following definitions of self/self-concept may be helpful.

Epstein (1973) provided a useful review of theories of the self in his paper *The Self-Concept Revisited, Or a Theory of a Theory*. Although it is an old paper, I found it integrated thinking about the self in a way that is compatible with theories of self in eating disorder. Having reviewed previous contributions to theories of self and self-concept, such as those of Cooley (1902), James (1910), Mead (1934) and Rogers (1951), Epstein summarised the main characteristics attributed to the self-concept as follows (excerpt from page 407):

> 1. It is a subsystem of internally consistent, hierarchically organised concepts contained within a broader conceptual system.
>
> 2. It contains different empirical selves, such as a body self, a spiritual self, and a social self.
>
> 3. It is a dynamic organisation that changes with experience.
>
> 4. It develops out of experience, particularly out of social interaction with significant others.
>
> 5. It is essential for the functioning of the individual that the organisation of the self-concept be maintained. When the organisation of the self-concept is threatened, the individual experiences anxiety, and attempts to defend himself against the threat. If the defence is unsuccessful, stress mounts and is followed ultimately by total disorganisation.
>
> 6. There is a basic need for self-esteem which relates to all aspects of the self-system, and, in comparison to which, almost all other needs are subordinate.
>
> 7. The self-concept has at least two basic functions. First, it organises the data of experience, particularly experience involving social interaction, into predictable sequences of action and reaction. Second, the self-concept facilitates attempts to fulfil needs while avoiding disapproval and anxiety.

In response to this picture, of a structure that must be stable yet dynamic at the same time; and which assimilates and organises knowledge, yet is an object of knowledge itself, Epstein (1973) proposes that the self-concept is a 'self-theory':

> It is a theory that the individual has unwittingly constructed about himself as an experiencing, functioning individual, and it is part of a broader theory which he holds with respect to his entire range of significant experience. Accordingly, there are major postulate systems for the *nature of the world, for the nature of the self, and for their interaction*. (p.407)

Epstein argues that it is this self-theory that fulfils the purposes of facilitating the maintenance of self-esteem and organising the data of experience in a manageable way. In this respect he likens his theory to Kelly's (1955) personal construct psychology, which sees humans as personal scientists, gathering information about themselves and the world in order to predict and solve the problems of everyday living. The idea of "postulate systems for the *nature of the world, for the nature of the self, and for their interaction*" also appears analogous with cognitive models of core beliefs (e.g. A. Beck, 1964; cited in J. Beck, 1995) and schema (e.g. Young, 1990, 1999; cited in Young, Klosko & Weishaar, 2003). Epstein also refers to the self-concept as "the subjective feeling state of having a self", which seems compatible with definitions used in the psychodynamic literature in the following section.

2.51 Psychoanalytic and developmental theories

The emergence of selfhood has been described as a central interest of psychoanalytic and developmental psychology (Strober, 1991). Psychoanalytic theories addressing the development of self in eating disorder have drawn particularly on self-psychological perspectives, which originated with the work of Kohut (1971, 1977). Psychoanalytic stage theories of identity development (e.g. Erikson, 1959, 1980; cited in Stevens, 1983) have also been applied to an understanding of eating disorder, and literature emerging from these two approaches is considered in the following subsections.

2.511 Self-psychological perspectives

Within a self-psychological framework the phenomenology of self experience is emphasised (Strober, 1991; deGroot & Rodin, 1994), with the self defined as a subjectively experienced psychological structure (Kohut, 1977; cited by deGroot & Rodin, 1994). The centrality of self-experience is also demonstrated in the following definition by Atwood & Stolorow (1994, pg. 34; quoted in Strober, 1991, pg. 361) of the self as:

> a psychological structure through which self-experience acquires cohesion and continuity, and by virtue of which self-experience assumes its characteristic shape and organisation.

From a self-psychological perspective, healthy self-development depends upon there being sufficient attunement in early infant-caregiver experiences. The caregiver initially provides the 'selfobject functions' of a sense of cohesiveness, soothing, vitalization (sense of feeling alive), narcissistic equilibrium (sense of well-being and security), tension regulation and self-esteem regulation (Goodsit, 1997). If "good enough" parenting occurs, the selfobject is internalised and becomes part of the child's own mental structure. If caregiving is not sufficiently responsive to the infant's needs, then deficiencies in important functions such as cohesion, tension and self-esteem regulation are thought to follow, resulting in a disorder of the self (Goodsit, 1997). Goodsit proposed that disturbances in the parent-child relationship may be caused by parental stressors, mental health problems or other illness, and problems identifying and appropriately responding to the child's affect and needs. Strober (1991) proposed the additional theory that a genetically based personality style of high stimulus-avoidance, low novelty seeking and high reward dependence in the infant would inhibit the exploratory activities needed for normal identity development.

Similarly, Hilde Bruch has proposed that highly controlling and perfectionistic parenting limits a young person's opportunities for autonomous functioning, and therefore interferes with the development of a clear and elaborated sense of self. When faced with the challenges of adolescence, this lack of self-definition gives rise to feelings of incompetence, self-doubt, and fear of losing control. To compensate for this lack of a clear identity and associated negative feelings, the adolescent turns to the highly-salient (and culturally valued) domain of body weight for their self-definition (Bruch, 1981; cited in Stein & Corte, 2003).

Bruch (1973) thereby described anorexia nervosa as "a desperate struggle for a self-respecting identity" (pg 250).

The emphasis on infant-caregiver experiences in self-psychology has been linked with attachment theory and research (e.g. deGroot and Rodin, 1994), and there is a good deal of evidence for the role of insecure attachment in the eating disorders (e.g. O'Kearney, 1996; Ward, Ramsay and Treasure, 2000). It may be suggested that there are parallels between the internalisation of the selfobject and the formation of an internal working model of self and others (Bowlby, 1973; cited in Young, Klosko & Weishaar, 2003). Bowlby's notion of internal working models has also been proposed to overlap with the idea of 'Early Maladaptive Schemas' in Schema theory, and attachment concepts have been integrated into schema-based and other cognitive models of personality (Young et al., 2003). This therefore provides a conceptual link between the self-psychological theory considered in this section and the cognitive theories discussed in Section 2.53.

The key element of a self-psychological approach in therapy is the emphasis on the validation of the client's subjective experience, in order to help them rely more on their own inner experience and thus to achieve an enhanced sense of agency (Bruch, 1978; deGroot & Rodin, 1994). Support for self-psychological approaches comes from clinical material and case studies with both anorexic and bulimic women (e.g. Bruch, 1973; Strober, 1991; Sands, 1991), rather than research trials or empirical validation of the theory, leading to the criticism that confirmatory empirical data are incomplete and inconclusive (Polivy and Herman, 2002).

2.512 Stage theories of identity development

Auslander and Dunham (1996) have drawn upon the stage theories of identity development of Erikson (1968) and Marcia (1966) in hypothesising about the aetiology of bulimia. Erikson described the human life cycle in terms of eight phases of ego development; 'ego' being conceptualised as the synthesising function of personality (Stevens, 1983). Erikson theorised that during adolescence the individual is faced with the conflict of 'identity versus role confusion'. Given the right conditions of space and time to experiment and explore, the individual may develop a firm sense of who he or she is. However, difficulties resolving the problem of 'role diffusion' may continue to trouble a person into their maturity (Stevens, 1983), and it is thought that individuals who do not develop a clear sense of self may become "maladjusted and self-destructive" (Auslander & Dunham, 1996; pg 19). Marcia (1966)

postulated four different statuses of ego identity development: moratorium, foreclosure, achievement and diffusion. In moratorium the individual is in the identity crisis period, has rather vague identity commitments, and is engaged in an active struggle to commit, e.g. through weighing up their own wishes and those of their parents and seeking to make a compromise. In foreclosure, the individual has expressed commitment without having experienced the crisis, e.g. through conforming to parental goals and wishes. In achievement the individual has experienced the crisis and has arrived at a commitment having seriously considered several different choices (e.g. of occupation or ideology). Diffusion is considered the most immature of the ego-identity statuses, and describes an individual who has experienced little exploration of or commitment to personal values, goals or beliefs (Auslander & Dunham, 1996).

Having reviewed the literature, Auslander and Dunham concluded that there are similarities between persons with bulimia and persons who are identity diffused, in terms of familial descriptors, personality characteristics and interpersonal styles. Personal characteristics found to be common to both bulimic individuals and diffused adolescents included negative interactions, low quality relationships, external locus of control, low self-esteem and use of escape-avoidance behaviours to manage anxiety. Parental characteristics common to each group included ratings of mothers as controlling and domineering and fathers as withdrawn and distant. They suggest two main hypotheses emerging from these similarities. Firstly, that both bulimia and identity diffusion may originate from similar interpersonal processes within the family. Secondly, that bulimia may partly be a product of the diffused identity status. Given that other disorders have been linked to developmental and identity problems, this second hypothesis raises the question of what factors determine whether these difficulties are expressed in bulimia, rather than another disorder. More in-depth phenomenological research may be able to illuminate this process.

Auslander and Dunham acknowledged the limitations of their findings, for example, the discontinuity in the comparisons being made. That is, studies in the bulimic group were comparing individuals with bulimia with a healthy control group of the same age, whereas the diffused individuals were being compared to individuals of other identity statuses. There is also the criticism that ratings of familial characteristics may have been carried out some time after the bulimia diagnosis. The characteristics found may therefore represent changes that occurred in response to the stress of having a family member with an eating disorder,

rather than being characteristics that were present before onset and which may therefore have had a causal role.

2.52 Feminist theories

Feminist theory regarding eating disorder and the self fits within a psychoanalytic conceptualisation of the self. Feminist theorists have argued that whilst male development is characterised by recognition of the differences between self and caregiver, female psychosocial development is marked by ongoing identification to the mother or caregiver, such that the distinction between self and other is less clear for women. A consequence of this is thought to be greater internalization of cultural values and ideals regarding women, femininity and body weight, which may become integral to the self (Chodorow, 1978; Steiner-Adair, 1990; cited in Stein & Corte, 2003). Gender differences in capacity for empathy have also been hypothesised to account for a greater reliance on external sources for self-evaluation in women (deGroot & Rodin, 1994).

Many feminist theorists have linked eating disorder to cultural pressures which conflict with women's ability to develop a satisfying identity, necessitating reliance on the 'feminine ideal' as a way to cope with this lack of an authentic self (Malson, 1999; Piran, 2001; cited in Stein & Corte, 2003). Lester (1997) has put forward the alternative proposition that anorexia functions as a means of 'tailoring the self' in a culture in which thinness is equated with self-control and intelligence. She argues that through anorexia women are pursuing the mastery of the pure, intellectual mind (which is symbolically masculine) over the wanton, sexual and self-indulgent body (which is symbolically feminine). Of this symbolism she writes:

> Thinness comes to represent the hard-won triumph of the self over the flesh - "proof" that the self and the body can be dislodged from one another, and that her female body can be discarded as the anchor weight harnessing her otherwise brilliant self to a mundane and restricted existence. (p.486)

She suggests that the body becomes a metaphor for the self and so food, which when eaten crosses the boundary between "me" and "not me", assumes a symbolic significance in negotiating and establishing the boundaries of the self.

While empirical evidence for these theories is lacking, the relationship between body dissatisfaction and the cultural promotion and internalisation of a 'thin ideal' for women is well supported by research studies (e.g. Stice, Schupak-Neuberg, Shaw & Stein, 1994; Harrison, 2001; Groesz, Levine & Murnen, 2002; Cafri, Yamamiya, Brannick & Thompson, 2005; Grabe, Ward & Hyde, 2008; Dittmar, Halliwell & Stirling, 2009). Body dissatisfaction, in turn, has been shown to be a precursor of disordered eating (Thompson, Heinberg, Altabe & Tantleff-Dunn, 1999; cited in Dittmar *et al*. 2009) (See Section 2.533 below).

2.53 Cognitive and behavioural perspectives

This section draws on literature concerning the role of negative self-schema, self-esteem, body dissatisfaction and 'escape' hypotheses. The relation of these constructs to current models of the eating disorders will be briefly considered. Following this, consideration will be given to aspects of third generation cognitive approaches that draw on the construct of self (third generation, or 'third wave', meaning those approaches that developed after the first generation of traditional behaviour therapy and the second generation of cognitive-behavioural therapy, e.g. Acceptance and Commitment Therapy).

2.531 Negative self-schema

Vitousek and Hollon (1990) proposed a self-schema framework for a cognitive understanding of eating disorders, drawing on Markus' (1977) self-schema theory. The following definition of self-schema is quoted by Vitousek and Hollon (1990; p.195):

> According to Markus (1977), "self-schemata are cognitive generalizations about the self, derived from past experience, that organize and guide the processing of self-related information contained in the individual's social experiences" (p.64)"

An emphasis on the role of past experience in the development of self-schema provides a link between the more here-and-now emphasis of CBT models and the interest in the early experience of the infant found in more psychoanalytic theories. Vitousek and Hollon describe how schema are of particular relevance to clinical problems due to their tendency to privilege stability over change, and hence their role in perpetuating negative views of the self.

In the case of eating disorders, Vitousek & Hollon suggest that eating-disordered individuals develop schemata around the issues of weight and its implications for the self that influence their perceptions, thoughts, affect, and behaviour. They also propose that these schematic processes fulfil the valued roles of simplifying, organising and stabilising the eating disordered person's experience of self and the external environment. In this respect they link their theory to those of Bruch (1973; discussed in Section 2.51), and Button (1983, discussed below in Section 2.54).

Drawing upon evidence for the relevance of both low self-esteem and body image disturbance (see Sections 2.532 and 2.533 below), and Markus' (1977) self-schema model, Stein (1996) has put forward a cognitive model of the self-concept in eating disorders. This model proposes that the presence of few positive self-schemas, many negative self-schemas and high interrelatedness among self-conceptions is a cognitive vulnerability for eating disorder, as such women:

> ...will both lack the diverse array of interests, commitments, strategies and positive affects necessary to facilitate active and meaningful goal-directed behaviours in a diverse array of domains, and, simultaneously, will be more likely to experience negative affects, behavioural avoidance and inhibitions stemming from the negative self-views. [Stein & Corte, 2007; pg 60.]

Stein & Corte (2007) suggest that this vulnerability may therefore contribute to a focus on body weight and shape as a core source of self-definition, as in the cognitive models of Fairburn and colleagues (e.g. Fairburn et al. 2003). Having found support for this theory in their cross-sectional quantitative research (Stein, 1996; Stein & Corte, 2003, 2007), they propose that:

> Prospective studies that examine the unfolding of eating disorder symptoms and properties of the self-concept over time are necessary to gain greater insight into the nature of the relationship between the self-concept and the eating disorders. [Stein & Corte, 2007; pg 68.]

2.532 Self-esteem

Low self-esteem has been linked with a variety of mental health problems, including eating disorders (Fennell, 1998; Polivy & Herman, 2002). Fennell (1998, p.297) suggests that:

> ...the essence of low self-esteem lies in global ('me as a person') negative core beliefs about the self, which derive from an interaction between inborn temperamental factors and subsequent experience, for example, neglect, abuse, bereavement or an absence of sufficient warmth, affection and praise. Dysfunctional assumptions then function as 'escape clauses' which allow the person to feel more or less happy with him/ herself, so long as he or she is able to do as they require (be perfect, be loved, be in control, etc.).

Self-esteem is also thought to relate to how others react to the individual, hence actual or perceived rejection may cause lower self-esteem (Polivy & Herman, 2002). Heatherton and Polivy (1992; cited in Polivy & Herman, 2002) have suggested that dieting (which is prone to disruptions that result in overeating) produces a downward spiralling of self-esteem that would contribute more specifically to eating disorders, rather than to other disorders such as depression. Polivy & Herman (2002) also cite findings that shape- and weight-based self-esteem is reduced in eating disorder patients (Geller, Johnston, Madsen & Goldner, 1998) and that, in prospective studies, girls with low self-esteem are more likely to develop disordered eating in the next few years (Button, Sonugabarke, Davies & Thompson, 1996).

Self-esteem has been found to moderate perfectionism and feeling overweight in predicting bulimia symptoms, such that women high in perfectionism, and who consider themselves overweight, exhibit bulimic symptoms only if they have low self-esteem (Bardone, Vohs, Abramson, Heatherton & Joiner, 2000, Vohs, Bardone, Abramson & Heatherton, 1999; cited in Polivy & Herman, 2002). Additionally, a program aimed at increasing self-esteem in an ‘at risk’ group of teenage girls was found to result in a lower incidence of weight loss and eating disorder symptoms one year later (O’Dea & Abraham, 2000; cited by Polivy & Herman, 2002).

2.533 Body-image

Stein & Corte (2003) state that the majority of research on the role of the self in eating disorder has focused upon body image, the presence of disturbed body image being a requisite symptom for both anorexia and bulimia in the DSM-IV-TR (APA, 2000). Body image disturbances are thought to include two distinct dimensions, perceptual body-size distortion and evaluate dissatisfaction (Cash & Deagle, 1997).

Research has shown that women with anorexia and bulimia are more likely to describe themselves as fat and to be unhappy with their body weight (Cash & Deagle, 1997), and that these weight-related cognitions are predictive of the eating and weight-control behaviours characteristic of an eating disorder. Links have also been shown between cultural norms regarding female body weight and body dissatisfaction (BD) and overestimation of body size (Stice & Shaw, 1994; cited by Stein & Corte, 2003).

Most multifactorial models of eating disorders (e.g. Stice, 2001) assign BD a prominent causal role (Polivy & Herman, 2002) and it has been proposed that other hypothesised causal factors such family and peer pressure, teasing, and more individual psychological influences (e.g. general anxiety) operate via BD (Paxton et al, 1999; cited by Polivy & Herman, 2002).

Polivy and Herman (2002) propose that BD is probably a necessary factor in the emergence of eating disorders, although not a sufficient causal factor on its own (given that not everyone who is dissatisfied with their body develops an eating disorder). They suggest that what makes the difference is "whether or not the individual seizes upon weight and shape as the answer to the problems of identity and control" (pg 199). This indicates a need for further research illuminating the relationship between identity and body dissatisfaction, and the process of the hypothesised use of weight and shape to solve identity problems.

2.534 Escape and blocking hypotheses

The role of negative affect produced by negative self-schema is highlighted by research into models of eating disorder that see the eating disordered behaviour as providing a way of escaping from or managing aversive self-awareness.

Heatherton and Baumeister (1991) have proposed a process model of binge eating as a way of escaping from aversive self-awareness. The model begins with the proposal that

binge-eaters have extremely high standards and expectations of themselves. This includes both their own standards and what they perceive that others expect of them, and is thought to relate not only to standards for thinness, but also standards for achievement in other domains. These unusually high standards result in inevitable failure or shortfall at some point, resulting in an awareness of the self as inadequate. This perception of the self is associated with negative affect, such as low mood and anxiety. According to the model, this is managed through a process of cognitive narrowing, in which there is a focus on immediate stimuli, low-level or deconstructed thinking and rejection of meaningful thought. The consequences of this narrowing are proposed to be disinhibition and concrete thinking, which lead to bingeing. For example, thoughts may become more black-and-white, leading to a perception that a diet is either intact or "blown for the day" (Heatherton & Baumeister, 1991, p.94).

Other theories of the eating disorders as serving the function of emotional avoidance includes the 'blocking' model (e.g. Lacey, 1986; cited in Corstorphine, 2006), which proposes that eating behaviours (including restricting, bingeing and purging) are used to block out short-term awareness of emotions that the individual feels unable to tolerate. However, the effect of this relief is temporary and leads to an exacerbation of distress in the long-term (Corstorphine, 2006). Such models have support from a large amount empirical literature demonstrating links between emotions and eating disorder symptoms (e.g. Agras & Telch, 1998; Meyer, Waller & Walters, 1998; cited by Corstorphine, 2006).

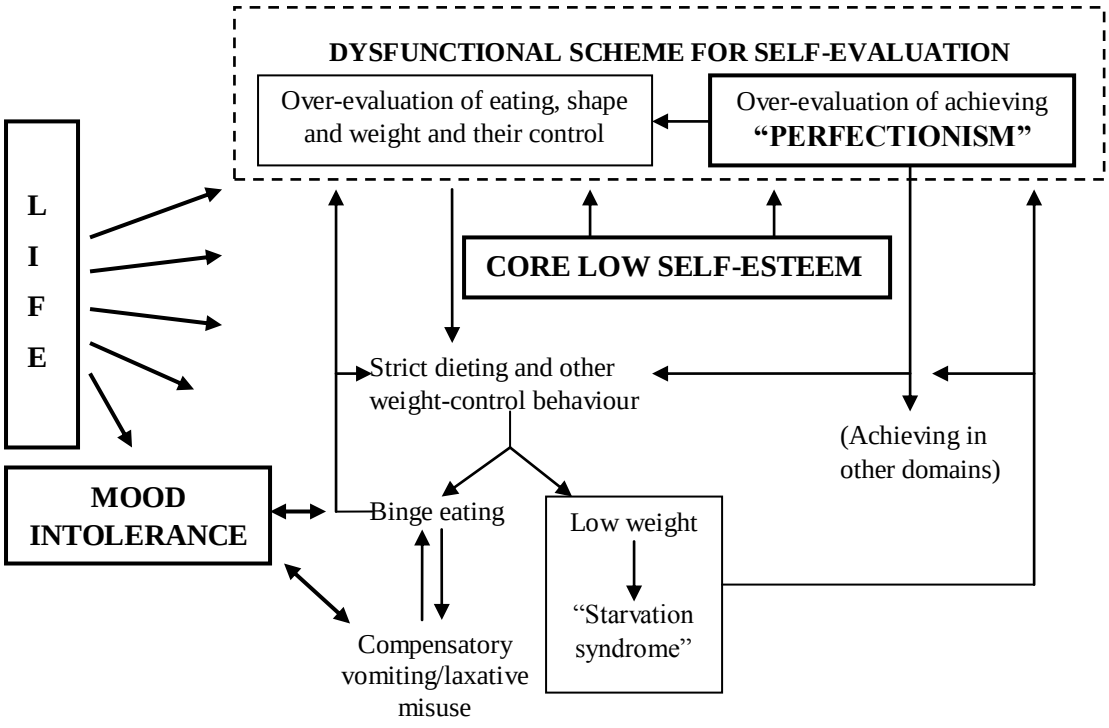
2.535 Cognitive-behavioural models of eating disorder

As reflected in the DSM-IV-TR (APA, 2000) diagnostic criteria for the eating disorders, a cognitive conceptualisation views the over-evaluation of shape and weight and their control as a 'core psychopathology' common to anorexia, bulimia and most cases of EDNOS (e.g. Fairburn, 2008). The models and treatment guidelines of Fairburn and colleagues have been fairly dominant in cognitive-behavioural therapy (CBT) for the eating disorders, for example their cognitive-behavioural therapy for bulimia (CBT-BN; e.g. Fairburn, Marcus & Wilson, 1993) and more recent enhanced CBT (CBT-E; Fairburn, 2008) which is developed for use with all eating disorders. CBT-E is based upon a transdiagnostic model of the eating disorders, which draws on the common mechanisms thought to be involved in their development and maintenance (Fairburn, Cooper and Shafran, 2003; see Figure 1). Both CBT-BN and CBT-E have proven effectiveness in research trials with bulimia and EDNOS (Fairburn & Harrison, 2004; Fairburn et al., 2009) and it is the treatment recommended by

NICE (2004) guidelines for bulimia and binge-eating disorder . There is 'modest' evidence for CBT with anorexia according to Fairburn and Harrison (2003), and it is one of a group of therapies suggested by NICE (2004) guidelines for anorexia.

The transdiagnostic model of the eating disorders includes emphasis on core low self-esteem, mood intolerance (some of which may originate in aversive self-awareness), and perfectionism as potential maintaining factors. In accordance with this model, CBT-E includes additional modules to address each of these, and also a module to address interpersonal 'life' difficulties.

Figure 1 – The 'transdiagnostic' model of the maintenance of eating disorders ('Life' is shorthand for interpersonal life) – From Fairburn *et al.* (2003)



In addition to CBT-E, other CBT-based therapies also have empirical support with the eating disorders, including an adaptation of Dialectical Behaviour Therapy (Safer, Telch & Agras 2001a, 2001b; Telch, Agras & Linehan, 2000; cited in Hayes, Masuda, Bisset et al., 2004)

and Cognitive-Emotional-Behavioural Therapy (Corstorphine, 2006), which both target mood intolerance, and thereby avoidance of affect related to self-awareness.

2.536 ACT and related frameworks

Theories considered in the previous sub-sections include hypotheses that eating-disordered individuals may lack commitment to personal values and goals (section 2.512) and that they manage negative affect, including emotions triggered by aversive self-awareness, through escape-avoidance behaviours. These ideas are consistent with an Acceptance and Commitment Therapy (ACT) framework (Hayes, Strosahl & Wilson, 1999), which proposes that psychopathology is the result of maladaptive control strategies directed towards emotional avoidance, cognitive fusion, and failure to act in accordance with chosen values (Hayes & Pankey, 2002).

ACT is underpinned by relational frame theory (RFT; Hayes, Barnes-Holmes & Roche, 2001; cited in Hayes, 2004) the main premise of which is that human behaviour is largely influenced through networks of mutual relations called relational frames. These relations are posited to form the core of human language and cognition, and permit learning without direct experience (Hayes & Smith, 2005). Hayes (2004) gives the following example of how relational frames work:

> Suppose a child has never before seen or played with a cat. After learning "C-A-T" → animal, and C-A-T → "cat", the child can derive four additional relations: animal → C-A-T, "cat" → C-A-T, "cat" → animal, and animal → "cat". Now suppose that the child is scratched while playing with a cat, cries, and runs away. When the child later hears father saying, "Oh, look! A cat," she may cry and run away even though scratches never occurred in the presence of the words "Oh, look! A cat." (pg. 11)

Although relational frames confer humans the ability to learn without direct experience, they are also seen as the basis for suffering, due to processes such as cognitive fusion and experiential avoidance. These processes are two major components of 'psychological inflexibility', which the ACT model sees as the origins of psychopathology. Cognitive fusion refers to the process by which behaviour comes to be over-regulated by verbal processes, for

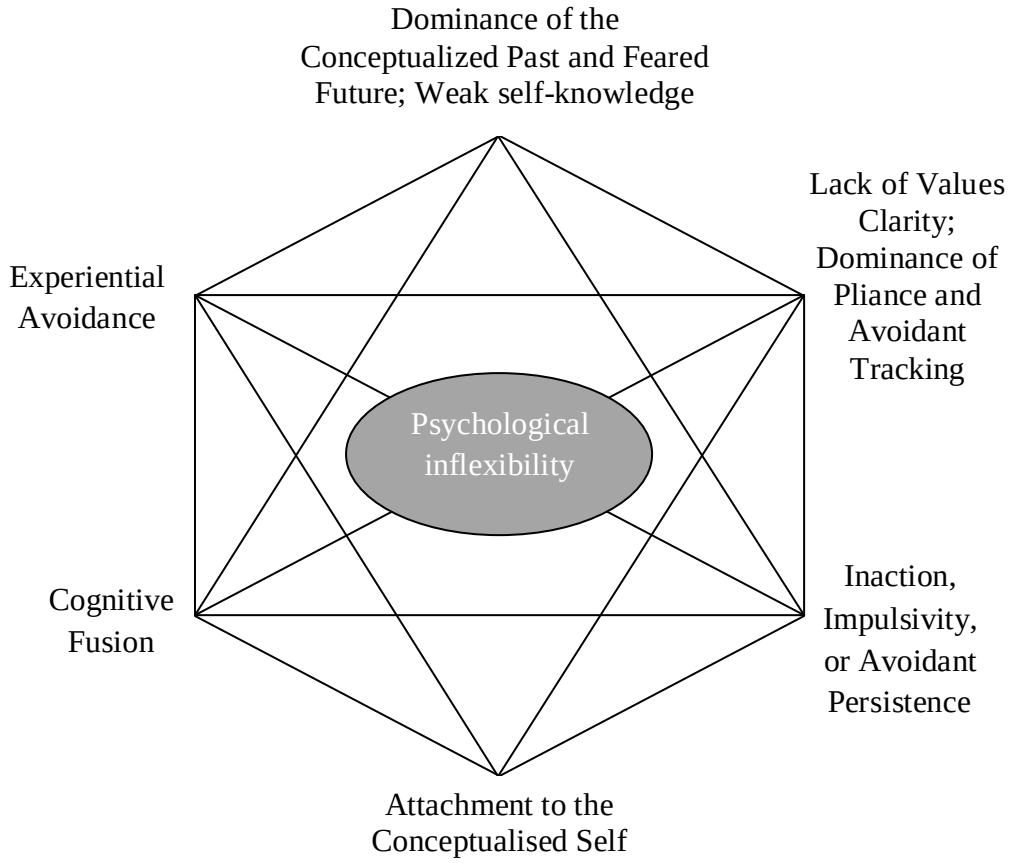
example, responding to the thought "life is hopeless" as one would to a truly hopeless life. This process can prevent people from acting in accordance with their chosen values and goals (Hayes *et al.*, 2006). The result of this domination of literal and evaluative language is experiential avoidance (Hayes, 2004):

> Experiential avoidance is the phenomenon that occurs when a person is unwilling to remain in contact with particular private experiences (e.g. bodily sensations, emotions, thoughts, memories, behavioural dispositions) and takes steps to alter the form or frequency of these events and the contexts that occasion them, even when doing so creates harm. (p.14)

The results of experiential avoidance are often unhelpful due to the verbal entanglement of private events (e.g. thoughts, emotions). For example, in order to deliberately avoid a negatively evaluated thought, a verbal rule must be followed specifying – and thereby containing - the thought to be avoided. Therefore, in what is known as the paradox of thought suppression, these deliberate attempts to suppress thoughts and feelings can actually increase their frequency and impact on behaviour (Cioffi & Holloway, 1993; Clark, Ball, & Pape, 1991; cited in Hayes, 2004). It is suggested that many forms of psychopathology are forms of experiential avoidance, including eating disorder behaviours such as a focus on eating and weight (Hayes & Pankey, 2002) and binge-eating (Keville, Byrne, Tatham & McCarron, 2008). However, it is not clear why this psychological inflexibility leads to eating disorders in some people and to other problems, such as worry or alcohol misuse, in others.

A related component of psychological inflexibility is 'attachment to the conceptualized self'. This occurs when people begin to "live in their heads", and have more attachment to the remembered past and feared future than they do the present moment. It can become more important for the person to defend a verbal view of themselves (e.g. being a victim, being broken) than it is for them to engage in more helpful forms of behaviour that do not fit this verbalisation (Hayes *et al.*, 2006). The ACT model of psychopathology is shown in Figure 2 overleaf.

Figure 2 – An ACT/RFT model of psychopathology, taken from Hayes et al. (2006)



Within an ACT framework, sense of self is conceptualised as a perspective arising out of relational frames such as I versus You, Now versus Then, and Here versus There. Self, or "I" is thought to emerge over large sets of perspective-taking relations (Hayes, Luoma, Bond, Masuda & Lillis, 2006). One of the six core processes of ACT, which are aimed at increasing psychological flexibility, is 'self as context' in which defusion and acceptance are fostered as alternatives to attachment and investment in experiences such as negative thoughts about the self. This is achieved through mindfulness exercises, metaphors, and experiential processes (Hayes et al., 2006).

Outcome data for the effectiveness and efficacy of ACT with eating disorders is still in progress (Wilson, 2004; Hayes & Pankey, 2002). There is a published case study of the successful use of ACT with an adolescent female with anorexia (Heffner, Sperry, Eifert & Detweiler, 2002). Wilson (2004) has also described how the third wave CBT concepts of mindfulness and acceptance can be used to augment a traditional CBT approach to all eating

disorders, using the illustration of CBT for bulimia. Keville et al. (2008) have also incorporated third wave techniques into a CBT group intervention for binge-eating disorder. Additionally, support for the role of ACT processes in eating disorder comes from Schmidt and Treasure's (2006) cognitive-interpersonal model of the maintenance of anorexia, which includes evidence for the role of experiential avoidance.

2.54 A Personal Construct Theory perspective

Personal Construct Theory (PCT; Kelly, 1955) sees people as scientists, who seek to anticipate their world based upon the formulation and testing out of 'constructs'. If the person is functioning optimally, their construct system will be revised in the face of invalidation. Generally speaking, PCT sees psychological disorders as involving a lack of such revision despite repeated invalidation (Winter & Button, in press). According to PCT, eating disorders are thought to occur when a person's construct system is constricted to the extent that food and weight take on a central importance, and other areas of their construing are much less well elaborated (Fransella, 1970; cited by Winter & Button, in press). Button (2005) has suggested that 'constriction' is the PCT concept that is most useful in understanding eating disorder as an attempt to make life more manageable. That is, the person's world is narrowed down to the area of eating or not eating, perhaps in an attempt to avoid the anxiety and unpredictability of other areas of life (Winter & Button, in press). A central idea emerging from empirical investigation of PCT and eating disorder (e.g. Button, 1980; cited in Winter & Button, in press) is that people with eating disorder are deficient in person-construing, that is, their ability to construe both themselves and others is relatively rigid and impoverished. Elaboration of the self-image and an increase in positive self-construing has been found to be associated with significantly better therapy outcomes (Button & Warren, 2002).

2.6 Why might more research into the self in eating disorder be clinically relevant?

Polivy & Herman (2002) and Stein & Corte (2003) have argued that although there is an established link between self-concept and eating disorder, the process between the two is not yet fully understood. As stated by Stein & Corte (pg. 65):

> Additional research that focuses on the psychoanalytic and feminist proposition that links self-concept disturbances to eating disorder symptoms may be key to the prevention and promotion of a full and enduring recovery from these debilitating disorders.

This provides support for the idea that further research is warranted in order to better understand the link between the self and eating disorder, and that this would potentially be clinically useful. Issues of self and identity are also often described in the literature as being particularly prevalent in a sub-set of individuals who are the most difficult to treat (Fairburn, 2008; Bulik & Kendler, 2000). Therefore, a better understanding of these processes may be helpful in informing treatment in these difficult cases. As Bulik & Kendler (2000) observe:

> ...for some individuals with long-standing illness, the eating disorder can develop into an integral part of their identity. A well-intentioned therapist, whose goal is to ameliorate the symptoms of an eating disorder, can unwittingly threaten a central integrating factor of his or her patient's sense of self. (pg. 1755)

As identified in the previous sections, the evidence-base for the role of self in eating disorder mainly comes from clinical observations and quantitative research. Nevonen and Broberg (2000) have described a particular need for more qualitative research into eating disorders, pointing out that research in this area is usually based upon self-report and structured interviews, which have the limitation that participants can only comment on what they are asked to respond to. In arguing for the need for more qualitative research in this field, particularly that which attends to the positive as well as the negative aspects of eating disorders, Serpell and Treasure (2002) have quoted Vitousek's (1997) call to:

> [Spend more] time <u>listening</u> to the voices of women telling us about their 'authentic lived experience' of the phenomena we seek to explain.

Qualitative approaches, such as in-depth semi-structured interviews, have also been recommended for studies of the self-concept, given that it is dynamic and changes over the life course (Demo, 1992).

2.61 Existing qualitative research of the self and eating disorder

Brooks, LeCouteur and Hepworth (1998) carried out a discourse analysis of interviews with ten women and one man with BN. Their aim was:

> ...to analyse the variety of versions of bulimia, and of the self, which are constructed in language" (page 194).

They identified various repertoires used by participants, most of which involved very negative versions of the self, such as 'victim', 'weak', 'childish', 'lacking will-power', 'abnormal', and 'freak'. However, participants' contradictions of the dominant repertoires provided some more positive descriptions of the self as 'in control' and 'special'. A dualist construction of the self was also interpreted during the analysis, "describing a *mental self* acting upon or punishing a *bodily self*" (page 197, my emphasis). However, the focus of discourse analysis is upon how meaning is socially constructed through language, rather than being upon the experience or individual cognitions of the participant. In addition to asking participants for their descriptions of themselves and their experiences of bulimia, the 50 to 90 minute interviews also covered: ideas about why bulimia is more common in females than males; comparisons between anorexia and bulimia; comments on the DSM-IV definition of bulimia and on the terms *bulimia, eating disorder, sufferer,* and *mental illness;* and descriptions of their recovery and experiences of professional help if this was applicable. Opportunity for participants to provide in-depth information about their experience of self may therefore have been limited by the number of other topics addressed by the interview schedule.

Another discourse analysis of eating disorder and self was carried out more recently by Surgenor, Plumridge and Horn (2003), this time with five women diagnosed with severe AN. During the interview, participants were encouraged to "fully describe their views of themselves and their circumstances in and before therapy" (pg 24). One participant presented

herself as "an essentially healthy person who had simply 'overdone it'" (pg 25) and who had been "stupid" for allowing things to get to the stage that she required hospital treatment. Another participant described her healthy self being continually wounded by social demands and critique, while her anorexic self was "impervious" due to the "protection" of AN. The discourses of the remaining four participants revolved around anorexia as the "perfect condition" and themselves as failing to achieve it, but in which state they would be "strong", "superior" and "healthy". Again, as a discourse analysis, this study did not address what the experience of self was like for participants.

Rich's (2006) qualitative study, which applied "what might loosely be termed a feminist post-structuralist form of analysis" (pg 288) to ethnographer's field notes and narratives from semi-structured interviews with anorexic women, also touched upon views of the self. This study aimed to explore how young women 'manage' the complexities of the presentation of an anorexic identity, focusing on stigma and relationships with other sufferers. Rich (pg 298) found that:

> Many of the young women in our study attempt to manage their selves and to minimise the damage of the negative social positioning they experience. To do so, they present alternative narratives within which they construct themselves not as irrational, seeking attention or 'abnormal', but as in some ways embodying extraordinary strength and finding 'empowerment' through anorexia.

In her conclusion, Rich suggests that attempts to better understand such experiences as "feelings of euphoria, control, 'specialness', independence and efficiency" (pg. 302) will illuminate the active role that women have in understanding their identities through anorexia.

Norbo, Espeset, Gulliksen, Skarderud & Holte (2006) applied a descriptive phenomenological approach in a study of eighteen young women aged between 20 and 34 with anorexia. The aim of this study was to explore the meaning that the participants attributed to their anorectic behaviour. The results of the analysis were eight constructs, two of which are relevant to the self-concept: "Self-confidence", which involved participants feeling better about themselves through receiving compliments on their weight-loss, and "Identity", which described participants using AN in order to help them achieve a new more likeable identity through becoming weaker and more vulnerable. A descriptive form of

phenomenological analysis was used for this study, so further layers of meaning may have emerged had an interpretative form of phenomenological analysis such as IPA been used. Also, as this study was carried out on a Norwegian sample, it may be that different constructs would have resulted from a UK sample. For example, the notion of becoming more likeable through being weak and vulnerable is in contrast with the themes emerging from the other studies, of becoming 'impervious', 'empowered', 'in control' and 'strong' through eating disorder. This may reflect greater cultural similarity between the samples in the other three studies, which were conducted in South Australia, New Zealand and the UK respectively.

2.7 Argument for the Current Study

Whilst existing qualitative research into eating disorders has explored views of the self, this has largely been secondary to other aims such as exploring 'experiences of bulimia' (Brooks *et al*., 1998) or the meanings of anorectic behaviour (Nordbo *et al*., 2006). The predominant use of discourse analysis (DA) in these studies, an approach which focuses on the social construction of reality through language, suggests that additional understanding may be gained by adopting a different qualitative approach. Interpretative Phenomenological Analysis (IPA) is a qualitative approach which aims to "explore in detail how participants are making sense of their personal and social world" (Smith & Osborn, 2003; page 51). IPA has similarities with DA, in that it is a qualitative approach that places an emphasis on the importance of language. However, the two approaches differ in their perception of the accessibility of cognitions (Smith, Flowers and Osborn (1997), therefore an IPA approach, which aims to explore the thinking and experience of participants, may be able to contribute more to an understanding of the processes between self and eating disorder. The decision to adopt an IPA approach is discussed further in the Method chapter.

A search of existing literature indicates that there are as yet no published studies applying an IPA approach to the exploration of the experience of self in eating disorder.

2.8 Aims and research questions

The aim of the current study was to gain an in-depth understanding of the experience of self for women with an eating disorder, using an Interpretative Phenomenological Analysis (IPA) (Smith & Osborn, 2003, Smith, Flowers & Larkin, 2009). The main research question was therefore:

What is the experience of self for women with an eating disorder?

Related to this main research question, the following areas of interest were explored:

1) How the participants currently view/describe themselves
2) Whether participants experience changes in their view of themselves across different situations and with different people
3) How the participants have viewed themselves throughout their past (including before the onset of their eating disorder)
4) The participants' views regarding why they see themselves that way, and associated experiences relevant to this
5) The participants' views and experiences regarding whether there is a relationship between how they see themselves and their eating disorder

3. METHOD

This section explains the rationale for the chosen method, describes participant recruitment, data collection and analysis, and outlines how I have aimed to meet research quality guidelines.

3.1 A qualitative approach

The value of qualitative research in eating disorders has been highlighted by Hepworth (1994, p.179; quoted by Colton & Pistrang, 2004), who described the lack of such research at the time as 'a weakness in developing theory and clinical practice'. Since this time a growing number of qualitative studies of eating disorder have been carried out (e.g. Newton, Boblin, Brown & Ciliska, 2005; Nordbo, Espeset, Gulliksen, Skarderud & Holte, 2006; Mulveen & Hepworth, 2006). However, these remain relatively few in number compared to the volume of quantitative studies. Nevonen and Broberg (2000) have argued that whilst quantitative research has enabled a great deal of progress, it also has limitations. For example, since such research often utilises structured reporting methods, participants can only comment upon what they are asked to respond to, and this may produce a 'fragmented picture'.

With this in mind, and considering how the particular research question of this study may best be addressed, it was decided to adopt a qualitative methodology. Such approaches have the advantage of allowing in-depth and detailed study of phenomena that are not easily quantifiable, as in this study of 'the experience of self'. A further advantage was that such an approach allows for the emergence of unanticipated findings (Barker, Pistrang & Elliott, 2002).

3.2 Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) (e.g. Smith & Osborn, 2003; Smith, Flowers & Larkin, 2009) was the chosen qualitative approach for the following reasons.

Firstly, IPA is consistent with the research aims, in that it is committed to the examination of how people make sense of their major life experiences (Smith *et al*. 2009). It is a phenomenological approach in that it is focussed on 'exploring experience in its own terms'

rather than attempting to reduce it to 'predefined or overly abstract categories' (Smith *et al.* 2009, pg 1). IPA is also interpretative, and employs what is known as a 'double hermeneutic' in which the researcher is trying to make sense of the participant trying to make sense of their experiences (Smith & Osborn, 2003; Smith *et al*. 2009).

Secondly, IPA is both phenomenological and social constructionist, in that it is concerned with personal experience but also involves interpretation, involving a consideration of context. It is therefore in keeping with my own epistemological position, which I would describe as somewhere between critical realist and social constructionist. Cosgrove (2000) has also argued that in studying women's experiences of distress, one should adopt an approach that is both phenomenological and social constructionist

Thirdly, IPA's idiographic nature is in keeping with the aims of the study. That is, IPA is concerned with the particular, with revealing something about the experience of each of the individuals involved, and being able to say something in detail about the participant group. Smith et al. (2009; pg 29) describe how IPA's commitment to the particular operates at two levels. Firstly, there is a commitment to detail, and depth of analysis. Secondly:

> "IPA is committed to understanding how particular experiential phenomena (an event, process or relationship) have been understood from the perspective of particular people, in a particular context."

The aim of IPA is not to make premature generalizations about larger populations, but rather to arrive at more general claims cautiously, and only after the painstaking analysis of individual cases (Smith & Osborn, 2003; Smith *et al.* 2009). Smith (2004; pg 42) cites Warnock (1987) as having made the point that 'delving deeper into the particular also takes us closer to the universal'.

Lastly, although IPA is an approach that has initially gained momentum within the field of health psychology, its utility has since been demonstrated within clinical psychology research (e.g. Rhodes & Jakes, 2000; Pearce, Clare & Pistrang, 2002). IPA has also been used to address other questions in eating disorder research, such as Colton and Pistrang's (2004) study of experiences of inpatient treatment for anorexia nervosa, and Mulveen and Hepworth's (2006) study of participation in a pro-anorexia internet site.

3.21 Why not a different qualitative method?

In this section a rationale is presented for choosing IPA over three other types of qualitative analysis that were considered as possible alternatives: Grounded Theory, Discourse Analysis, and Narrative Analysis.

IPA was chosen over Grounded Theory as this may be considered more of a sociological approach (Willig, 2003), which draws on convergences within a larger sample to support wider conceptual explanations. IPA by contrast is more psychological, concerned with giving a more detailed and nuanced account of the personal experiences of a smaller sample (Smith *et al.* 2009), which was felt to be more in keeping with the study's aims.

Discourse Analysis (DA) was ruled out, as whilst IPA is concerned with cognitions and sense-making, DA is sceptical regarding the accessibility of cognitions and focused on language more in terms of its function in constructing social reality. While IPA recognises that cognitions are not transparently available from verbal reports, it engages with the analytic process in the hope of being able to say something about the sense- and meaning-making involved in such thinking (Smith, Flowers & Osborn, 1997; Smith *et al.* 2009).

Narrative Analysis was considered as it is also a social constructionist approach concerned with meaning-making. However, narrative is only one way of meaning-making (others including discourse and metaphor), and so it was felt that IPA could include consideration of narrative in the sense-making of participants, without being constrained by this focus (Smith *et al.* 2009).

3.3 Design

The study employed a cross sectional qualitative research design. A purposive sample of participants was used, in keeping with IPA requirements to have a small and fairly homogenous sample. Semi-structured interviews were employed, which were audio-recorded, transcribed verbatim, and then analysed using IPA (Smith & Osborn, 2003; Smith *et al.* 2009).

3.4 Participants

3.41 Recruitment

Clinicians working in an NHS adult Eating Disorder Service were provided with copies of the inclusion and exclusion criteria below, and a summary of the research protocol, so that they would be aware of what taking part would involve, and which of their clients may be suitable. They were asked to pass the names of any potential participants to the service administrator, who then sent the identified individuals copies of the Participant Information Sheet (see Appendix 1). The Participant Information Sheet contained my contact details, and invited the recipient to contact me if they wanted to take part. Potential participants were able to take as long as they liked in considering whether or not to take part before they made contact. Participants were not contacted directly by me unless they had contacted me first to indicate that they were interested. On making contact, participants were asked if they would like any further information, or if they were happy to arrange a meeting to go through the consent form and be interviewed.

Response to this recruitment strategy was slow. This may have been a reflection of using the Participant Information Sheet (PIS) as a recruitment tool. The PIS needed to be lengthy in order to incorporate all the information necessary to allow participants to give informed consent. It is likely that many individuals simply did not read it as it was too long, and therefore sending a shorter invitation letter with a brief outline as a first step may have been preferable.

Given the poor response to recruitment, I approached another NHS eating disorder service, who agreed that I could also recruit through them. At this point I had only completed two interviews, with one further person who had expressed interest. As I had originally proposed to recruit between six and eight participants (based upon numbers adopted for previous IPA projects by D.Clin.Psy students at the University of Hertfordshire), At this point, I decided to widen recruitment in order to complete the project.

However, by the time I received approval from the ethics committee to widen recruitment, I had increased my sample to four. At this point I decided to stop recruiting, a decision which was supported by my primary supervisor, for the reasons outlined below.

Firstly, the project had suffered major delays even before the recruitment problems, and so the time left until the project deadline was very limited. Waiting for Research and

Development approval to recruit from the second site would have left me without the time to analyse further interviews in sufficient detail.

Secondly, Jonathan Smith (the originator of IPA) and his colleagues had recently published *Interpretative Phenomenological Analysis: Theory, Method and Research*. In it they reflect on the maturation of IPA, and how researchers are now adopting very small sample sizes, and even single case studies. They emphasise that this is because IPA's primary concern is with a detailed account of individual experience, which benefits from a concentrated focus on a small number of cases (Smith *et al.* 2009). As such, they recommend that between three and six participants is reasonable for a student project using IPA, and they observe that the typical number of interviews analysed in professional doctorate projects (between four and ten) "seems about right", with emphasis that it is "important not to see the higher numbers as being indicative of 'better' work" (pg. 52).

3.42 Inclusion and exclusion criteria

Participants had to have a diagnosis of an eating disorder (Anorexia Nervosa, Bulimia Nervosa, Eating Disorder Not Otherwise Specified or Binge Eating Disorder). This would have been narrowed to just diagnoses of Anorexia Nervosa had the sampling pool contained enough individuals of this diagnosis to make recruitment of a sufficient sample likely, as this would have increased the homogeneity of the sample.

Participants had to be female and of working age (between 16 and 65). The decision to focus on one gender was made in order to keep the sample homogenous in this respect, and women were chosen due to the far higher prevalence of eating disorders amongst women. It was felt that an adult sample would have the advantage of having longer life histories from which to draw self narratives, in addition to being able to give consent for themselves.

Being non−English speaking was set out as an exclusion criterion, as due to qualitative research relying heavily on language there was a concern that the richness and meaning of language may have been lost if using a translator. However, as all of the clients at the service in which recruitment took place were English speaking, it was not actually necessary to

exclude anybody for this reason. Similarly, it was planned to exclude individuals if they were unable to give informed consent, but nobody actually needed to be excluded for this reason.

I had commenced a placement with the service in which I was recruiting by the time that I had ethical approval to start inviting participants (it was originally anticipated that data collection would have been completed before this placement started). The exclusion criterion that individuals on my caseload should not be invited to take part was therefore introduced, as it was felt that there may be an ethical concern should my clients feel obliged to take part to please me.

3.43 The sample

Participants were four women currently in treatment for an eating disorder, whose ages ranged between 29 and 40 years (see Table 1 below; alias names have been used to protect participant confidentiality). The sample was varied according to ethnic origin, but all of the women had been born and brought up in Britain. For each participant the approximate length of their eating disorder has been given according to their own reports (from either their research interview or their initial assessment report in their clinical file).

3.431 Table 1 – Participant characteristics and demographics

Participant Alias	**Age**	**Diagnosis**	**Approximate length of eating disorder**	**Marital status**	**Ethnic origin**
Kerry	32	Anorexia	21 years	Married	White and Asian
Angela	40	Binge Eating Disorder	23 years	Single	Black Caribbean
Charlotte	29	EDNOS	14 years	Married	White British
Nicola	33	Anorexia	2 years (but problems with eating since childhood)	Married	White British

3.5 Context

Participants were recruited from an Adult Eating Disorder Service in Bedfordshire which provides treatment for individuals aged between 16 and 65, with a range of eating disorder diagnoses. It is a small service staffed on a part-time basis by a multi-disciplinary team comprised primarily of clinical psychologists (three qualified and one assistant), a nurse specialist, two dieticians and a consultant psychiatrist.

Referrals are taken from across Bedfordshire, which had an estimated population of 403, 900 in 2006, and a population forecast for 2009 of 138,600 women between the ages of 15 and 64 (Bedfordshire County Council, 2009). Although Bedfordshire is largely rural, 60% of the population live in larger towns such as Bedford and Dunstable. People from Black and Minority Ethnic groups represented 11% of the county's total population in 2001, with the largest ethnic groups being of Asian and Italian descent. Bedfordshire is described as a county of contrasts, being only 134th out of 149 counties in the 2007 Index of Multiple Deprivation, yet having three areas in the top 10% of the most deprived nationally (Bedfordshire County Council, 2009).

3.6 Ethical considerations

Ethical approval was granted for the study by the Essex 2 Research Ethics Committee. Supporting documentation can be found in Appendix 2.

3.61 Informed consent

Informed consent to participate was ensured through providing a Participant Information Sheet (Appendix 1), which clearly set out information about the study, including the purpose of the research, what taking part would involve, who would have access to the data and how it would be stored. As the information sheet was used as the basis for invitations to take part, potential participants could take as long as they liked to consider this information before deciding to contact me.

On meeting, I ensured that participants had read and understood the contents of the information sheet, and they were given the consent form to read (see Appendix 3). If they wanted to continue they were asked to give written consent before being interviewed. A signed copy of the consent form was given to the participant and a second copy was placed in their clinical file.

To ensure that participants did not feel obliged to take part, it was emphasised that they were under no obligation to do so, and that whether or not they decided to participate, it would not effect the treatment or quality of care they received from the eating disorder service. Participants were also informed that they could withdraw from the study at any time, without needing to give a reason for doing so. Individuals unable to give informed consent were excluded from the study (see exclusion criteria above).

3.62 Confidentiality

Participants were fully informed about confidentiality and its limits. They were aware that professional transcription services may be used, and that any such services that were used would also have signed confidentiality agreements. They were aware that although quotes would be used in the write-up for the thesis and journal article, all identifying information about themselves (such as names and places) would be removed from the transcripts and write-up. They were aware that my supervisors and representatives from academic and professional bodies would look at the anonymised transcripts. Part of the consent process also included agreement for me to have access to their clinical file.

Participants were also informed of the limits of confidentiality, that is, that I would share information with appropriate services if I thought that somebody was at risk of harm.

3.63 Affiliation of the study

The information sheet highlighted that participant's decisions about whether or not to take part would not affect the service they received in any way. This was particularly important to establish given that I had commenced a placement with the service through which recruitment was conducted. As described in the section on inclusion and exclusion criteria,

this ethical issue was managed by not inviting individuals to take part if it was planned that I would work with them therapeutically.

3.64 Potential distress

There was a risk that taking part may be potentially distressing to participants. This was addressed by providing a lot of information beforehand about what taking part would involve and the topics that would be covered, so that potential participants could make informed decisions about taking part. Participants were made aware that they could ask for a break at any time, and had the right not to answer particular questions if they did not want to. They were also informed that it was their right to withdraw from the study at any time, without having to give a reason for doing so. Informed by my experiences of working with people in distress and my clinical psychology training, I endeavoured to conduct the interviews as sensitively as possible. A debrief period followed each of the interviews, in which I checked with each participant how they had found being interviewed, and a debrief sheet was given that detailed sources of support should they require them following the interview (see Appendix 4).

3.7 Data collection

3.71 Semi-structured interviews

A semi-structured interview schedule was developed (see Appendix 5), which was relevant to the study aims. This was informed by relevant literature, discussions with my supervisor, and guidance on interview development sought through published guidelines (e.g. Smith & Osborn, 2003) and attending a workshop run by IPA experts Richard de Visser and Virginia Eatough. The schedule was used flexibly, in order to allow probing of unanticipated areas that emerged.

Participants could choose where they wanted the interview to take place, either in one of the services' clinic rooms, or in their own home. Three chose to be interviewed at the clinic and one chose to be interviewed at home. The interviews lasted between 55 and 117 minutes, and were audio recorded and later transcribed verbatim, with all identifying information removed.

I transcribed two of the interviews myself, and sent two to a professional and confidential transcription service.

3.8 Data analysis

As detailed above Interpretative Phenomenological Analysis (IPA) (Smith & Osborn, 2003; Smith, Flowers & Larkin, 2009) was the approach used to analyse the data. Supervision was gained from one researcher with experience in eating disorders and qualitative methods, and from another experienced at using IPA. The analytic process was also informed by guidelines for ensuring quality in qualitative research (Yardley, 2000; Spencer, Ritchie, Lewis and Dillon, 2003).

3.81 Individual case analysis

In keeping with IPA's idiographic commitment, each interview was first analysed in-depth individually (Smith *et al.* 2009). Each recording was listened back to at least once, and the transcript read several times. Initial annotations were made in one margin, with exploratory comments describing initial thoughts about the content, language use and more conceptual, interrogative comments (Smith *et al*. 2009).

Each transcript was then re-read and the second margin used to note emergent themes, drawing on both the transcript and the initial analyses. Each interview was analysed in this way until all four interviews had been analysed to this level.

3.82 Emergent themes

At this stage the emergent themes were listed chronologically and then moved around to form clusters of related themes. Smith *et al.* (2009) detail how super-ordinate themes can be identified through *abstraction* (putting like with like and developing a new name for the cluster); *subsumption* (where an emergent theme itself becomes a super-ordinate theme as it draws other related themes towards it); *polarization* (examining transcripts for oppositional relationships); *contextualization* (identifying the contextual or narrative elements within an

analysis); *numeration* (the frequency with which a theme is supported) and *function* (themes are examined for their function).

3.83 Cross case analysis

The next stage involved looking for patterns across cases. This was achieved by drawing up a list of themes for the group, and clustering these into master themes representing shared higher-order qualities. The master table of themes for the group is shown in Table 4.2 in the Results section.

3.9 Validity and quality

Assessing the quality of qualitative research requires different criteria than those for assessing the validity and reliability of quantitative work (Barker, Pistrang & Elliott, 2002). There are a number of available guidelines for doing this (e.g. Elliott, Fischer & Rennie, 1999; Yardley, 2000; Spencer *et al*. 2003). Since Smith *et al.* (2009) particularly recommend the Yardley (2000) guidelines, and have described how they apply to an IPA study, I have chosen to present the quality issues for this study according Yardley's four principles: sensitivity to context, commitment and rigour; transparency and coherence; and impact and importance.

3.91 Sensitivity to context

Sensitivity to context may be established through demonstrating sensitivity to the existing literature and theory, the socio-cultural setting of the study (Yardley, 1999) and the material obtained from the participants (Smith *et al.* 2009). I have endeavoured to demonstrate these aspects through the theory included in the Introduction section; descriptions of the sample characteristics and study context in sections 3.43 and 3.5 above; and through the manner in which I collected and analysed the data. For example attention was paid to issues of power between myself and the participants, consideration of my role in the interaction throughout the interviews, and attention to ethical issues during all phases of the study. I have aimed to demonstrate sensitivity to the data through conducting and describing an in-depth analysis and supporting my arguments with verbatim extracts. Smith *et al*. (2009) argue that this gives

participants a voice in the project and allows the reader to check the interpretations being made.

3.92 Commitment and rigour

Yardley describes that commitment involves in-depth engagement with the topic and through developing competence and skill in the method used. Smith *et al*. (2009) suggest that this may be demonstrated through attentiveness to participants during data collection and taking care over the analysis, which I have endeavoured to do and hope will demonstrated through my interview example in Appendix 6 and an example audit trail of an analysis in Appendix 7. Although I am new to qualitative research and IPA, I have sought to develop my skills, not only through attending lectures on these methods as part of my clinical training and conducting reading on the topic, but through attending an IPA workshop which covered the development of interview schedules, honing interview skills through role-play and also developing our analytic skills through practicing on examples. Peer review was also carried out in the form of two audits of analysis carried out by my supervisors, one of whom is an eating disorder specialist, and the other an IPA specialist. My supervisors agreed with the themes produced and could see how they had emerged from the transcripts.

By rigour, Yardley refers to thorough data collection and the depth and breadth of analysis. Whilst the rigour of this study will have been affected by my status as a novice qualitative researcher, and also practical constraints in terms of time and the available sample, I have at all times aimed to carry out the study in a thorough and careful way drawing on available training and supervision.

3.93 Transparency and coherence

Smith *et al*. (2009) state that transparency refers to how clearly the stages of the research process are described in the write-up, and that there should be coherence between the research that has been carried out and the underlying theoretical assumptions of the approach being utilised. I have aimed to enhance the transparency of my analysis by including an audit trail in Appendix 7. Yardley also includes consideration of reflexivity within the principle of transparency, and a discussion of this is presented below in section 3.95.

3.94 Impact and importance

This final principle reflects that however well or sensitively a piece of research is conducted, the most decisive way it may be evaluated is in whether or not it tells the reader something interesting and useful. To this end I have included a consideration of the clinical relevance of this study in the Discussion section.

3.95 Reflexivity

Reflexivity involves reflecting on the impact of the researcher on the research process (Spencer *et al.* 2003; Yardley, 2000). Since it is acknowledged in qualitative research that the beliefs and assumptions of the researcher will influence how they collect and analyse the data, it is important to be as clear as possible about what these beliefs and assumptions are, and to 'own one's perspective' (Elliott et al. 1999). The following section therefore comprises a personal statement, written with these aims in mind.

3.96 Self-reflexivity

I am a twenty-nine year old white British woman and have lived in England all my life. I was born in a 'working class' area in a town north of London, but during my childhood moved to a more 'middle class' area in the Midlands, where I have lived for the majority of the time since. I am heterosexual and currently cohabit with my fiancé. I have not been married before, and do not yet have any children.

I have worked in the field of mental health for the last seven years, the last five of which have been in the area of clinical psychology. I am currently a Trainee Clinical Psychologist in my last year of training at the University of Hertfordshire, and am undertaking a specialist eating disorders placement.

In terms of epistemology, I disagree with the tenets of positivism, and during the last three years of my training I have become progressively more influenced by social constructionism (Barker et al. 2002; Burr, 2003). I see mental health difficulties, including eating disorders, as existing on a continuum. I believe that they are phenomena that anyone may experience

depending upon what has happened in their life and an interaction between psychological, social and biological factors.

In terms of theoretical orientation I would describe myself as integrative, and would acknowledge the influence of a wide range of models and theories on my thinking, including cognitive, psychodynamic, systemic, feminist, narrative and constructivist.

I have never had an eating disorder. However, for most of my life I have certainly been aware of the prevailing societal discourse that promotes thinness as an ideal, and the associated pressures this can place on women, myself included. My interest in eating disorders, and in psychology more generally, started when I was about seventeen years old, and two close friends disclosed that they had bulimia. In the following months one of these friends became very anorexic and frighteningly underweight. At the time I felt overwhelmed and frustrated at not knowing how to help these friends, and this was influential in my later decision to pursue a clinical psychology career. Whilst I hope I have moved on from a naive motivation to 'fix' people, I have retained an interest in eating disorders and this has influenced my decision to develop the current study.

4. RESULTS

4.1 Overview

Interpretative Phenomenological Analysis (IPA) of the four semi-structured interviews resulted in the emergence of four master themes. These were as follows:

- **"I'm always questioning, who am I?": Experiencing a fragile sense of self**
- **The influences of others on self-perception**
- **"Just made me feel better about myself": Strategies employed to manage the sense of self**
- **"I can't rise above my childhood": The enduring influence of early experiences on self'.**

Exploration of these master themes and their constituent superordinate themes (see Table 2 overleaf) will form the basis of this chapter, with each theme illustrated by verbatim extracts from the interviews.

It is recognised that these themes are one possible account of the experience of self and eating disorder. They do not cover all aspects of the participants' experience, and were selected due to their relevance to the research questions. It is acknowledged that they are a subjective interpretation and that other researchers may have focused on different aspects of the accounts. While these were themes common to the four accounts, there were also areas of divergence and difference, some of which are also commented upon.

In presenting the verbatim extracts some minor changes have been made to improve readability. Minor hesitations, word repetitions and utterances such as "erm" have mostly been removed. Missing material is indicated by dotted lines within brackets (...), and where material has been added (e.g. to explain what a participant is referring to) it is presented within square brackets. Dotted lines at the beginning or end of an extract indicate that the person was talking prior to or after the extract. All identifying information has been removed or changed, and the alias names used in the Method chapter have been maintained to protect the anonymity of participants.

4.2 Table 3: Master Themes and related Superordinate Themes

Master Themes	Superordinate Themes
"I'M ALWAYS QUESTIONING, WHO AM I?": EXPERIENCING A FRAGILE SENSE OF SELF	Uncertainty about self
	Negative experiences of self
	"I will never feel that it's good enough": Sense of self is undermined by perfectionism and self-criticism
THE INFLUENCES OF OTHERS ON SELF-PERCEPTION	"They make me feel like a nothing": The influence of (actual or perceived) negative judgements by others
	"It felt so wonderful": Feeling good about the self through positive feedback from others
"JUST MADE ME FEEL BETTER ABOUT MYSELF": STRATEGIES EMPLOYED TO MANAGE THE SENSE OF SELF	"It takes me away from the way I feel about myself": The function of eating disorder in avoiding or improving the sense of self
	Additional strategies of disconnection and avoidance to protect the fragile self
	"I always remember feeling like I needed to please people": A source of self-worth, yet also a drain on the self
"I CAN'T RISE ABOVE MY CHILDHOOD": THE ENDURING INFLUENCE OF EARLY EXPERIENCES ON SELF	"I think it's my parents that drummed it into me": Criticism from others becomes internalised as self-criticism
	"You and your siblings slot into a certain role": The influence of siblings in defining self
	"Being unable to stop the violence made me feel that I was useless at everything": The negative effect of traumatic early experiences on self

4.3 "I'm always questioning, who am I?": Experiencing a fragile sense of self

This master theme aims to capture the idea that participants' sense of self was fragile; that they experienced a lack of certainty regarding themselves and that their experience of themselves was negative. Participants also described high levels of perfectionism and self-criticism to which their 'self' seemed vulnerable.

4.31 Uncertainty about self

All participants either commented upon having trouble describing themselves, or demonstrated that it was difficult by giving a fairly limited reply to the question, 'How would you describe yourself?' Kerry, who had restricting type anorexia nervosa, gave an account that conveyed almost a complete absence of sense of self, as highlighted in the following interview extract:

Amanda: *How would you describe yourself?*
Kerry: *Not really anything special.*
Amanda: *Ok. Is there anything else you'd add to that? So maybe, what your most important characteristics are, do you think?*
Kerry: *Don't really have any.*

Nicola, who at the time of the interview was recovering from restricting type anorexia nervosa, also repeatedly described having difficulty answering this question:

...That's quite a hard question actually [laughs] (...) For a first question, very difficult... (Nicola)

She was able to describe more about herself than Kerry, such as being 'bubbly' and family and relationship oriented, but hesitated and seemed unsure about her reply. She later repeated, '*It's a really hard question*' and then ended with '*I don't know what else to say actually'*, as if she felt that her answer had not been adequate.

Charlotte, who was recovering from an Eating Disorder Not Otherwise Specified (which she described as starting with anorexia but then later becoming mostly bulimic), gave an answer that actually didn't provide much information about herself at all:

Amanda: *How would you describe yourself?*

Charlotte: *Probably an everyday sort of person [laughs], I guess.*

Amanda: *Can you sort of tell me a bit more about what that means to you?*

Charlotte: *It just means the sort of person you'd walk past in the street, say hello to without any problems. You know, you wouldn't feel intimidated or put, you know, uneased by basically.*

She delivered this in a matter-of-fact way, but her use of qualifiers such as '*probably*' and '*I guess*' conveyed an uncertainty about her self-view. The content in her description of being 'everyday' and not intimidating, also suggests more of absence than it does substance. When asked to describe what she liked and disliked about herself, she gave only two qualities, that she was caring but also self-critical.

Angela, who has Binge Eating Disorder, gave a great deal of descriptive information about herself, but conveyed an experience of finding it hard to define a 'real' self within this:

Who am I? I'm always questioning, who am I? From day to day. Am I that person that I see when I look in the mirror? Or am I more than who I see? Am I still that little, that child, that unhappy child, or am I now the grown-up with, with a say, you know, who's in charge of their life and in charge of their choices? (Angela)

4.32 Negative experiences of self

This superordinate theme addresses participants' accounts of experiencing themselves in an extremely negative or distressing way. The theme was represented by three of the four participants, rather than all four, but was a strong one. Charlotte was the one participant whose account did not include this theme, which was felt to be the result of her disconnection from herself (see sections 4.51 and 4.52).

Kerry's account of herself was the most pervasively negative. She stated, "*I dislike everything about myself"* and also described the experience of being her as, *"Horrible and disappointing".*

Although Angela initially described qualities that she liked about herself, such as being tenacious and intelligent, she also explained:

I don't like myself that much other than those few things... (Angela)

Although Angela's view of herself was not as overwhelmingly negative as Kerry's, she also talked about not liking being herself ("*I don't like being me...*") She was able to give a great deal of detail about the aspects of being herself that she did not like, and the nature of this experience. For example, there was a clear theme within her account of feeling fragmented, as demonstrated in the following extract:

> *If I could just [inaudible; demonstrates bringing her hands together], that would make me (...) in my mind, a better human being, as opposed to I feel fragmented now, that's what I'm trying to think. (Angela)*

As part of this fragmentation she also described '*compartmentalising*' and having '*buried*' or '*submerged*' aspects of her 'real' or '*inner*' self. Having compartmentalised herself in this way, there was a sense almost of 'mourning', captured in her descriptions of the loss of these parts of herself and her imagery of her 'real' self being buried or in a box:

> *I buried myself then (...) I compartmentalised parts of myself to the point where I didn't know who I really was... (Angela)*

> *I've lost it and it's just, it's that aspect of my own personality that I wish I could get back. (Angela)*

Nicola's account was more similar to Charlotte's in the sense that she seemed unaware of being disconnected from negative experiences of herself at times. She described that, *"at the moment it's good. Yeah, lovely being me"* and she credited therapy and the support of her husband as having helped her to feel better about herself. However, unlike Charlotte, she was still able to connect with aspects of herself that she still found negative. These tended to arise through comparing herself with others, particularly her sister, in comparison with whom she tended to feel '*stupid*' and '*boring*'. She also described feeling very negative about herself in comparison with two friends, who she described as being particularly beautiful:

> *They are stunning and when I was away with them I felt really inadequate (...) they're lovely girls, but yeah certainly being with those two makes me feel really inferior and ugly and you know, (...) not great at all. (Nicola)*

4.33 "I will never feel that it's good enough": Sense of self is undermined by perfectionism and self-criticism

This superordinate theme aims to address the extent to which participants' sense of self seemed vulnerable as a result of their tendencies towards perfectionism and self-criticism. This was most pronounced in Kerry's account. Kerry spoke of her ideal self being '*perfect in every way*' and '*the best at every single thing'*. Unsurprisingly, in comparison to this ideal she found that nothing she did was good enough:

> *I know that whatever I do, it's never going to be particularly good and I will never feel that it's good enough. (Kerry)*

There was an emergent theme within Angela's account of 'Time-consuming perfectionism':

> *I like things to be done 'just so' so I will spend hours perfecting something to the point that I, to the point that I, I irritate myself. (Angela)*

As demonstrated in the above quote, Angela was conscious of there being downsides to her perfectionism. She spoke of avoiding doing things as a consequence of feeling that she would not be able to complete them to her own high standards, and that she had therefore been '*fighting against*' this perfectionism.

Nicola's perfectionism and self-criticism was mainly related to her appearance, leading to her feeling '*inferior and ugly'* in comparison with her friends:

> *I do like to make an effort most of the time in my appearance. Probably quite self-critical about my appearance, particularly [my] skin. (Nicola)*

There was also a sense within her account of self-criticism regarding non-physical aspects of herself, which emerged in descriptions of comparing herself to others, for example, experiencing herself as '*boring*' and '*a bit stupid'* in comparison with her sister.

Charlotte also described being very self-critical:

I can be very self critical as well (...) You know if I do something wrong it's probably ten times worse than if somebody else did it, because I've done it... (Charlotte)

She initially presented self-criticism as her worst quality, but on further questioning did not seem sure, suggesting that it was a mark of trying to do one's best. Later in the interview she talked of the consequences for her view of herself of not doing what she perceived as her best:

I would see myself as a failure, yeah. I would beat myself up about it... (Charlotte)

4.4 The influences of others on self-perception

This second master theme aims to capture the strong influence of other people in participants' perceptions of themselves. This included responding to negative assumptions that they made about the thinking of others, feeling worse about themselves due to the way they were treated by others, and also feeling better about themselves in response to positive feedback and support from others.

4.41 "They make me feel like a nothing": The influence of (actual or perceived) negative judgement by others

This superordinate theme represents the negative influence that participants described others having. The theme includes both the effects of overt expressions on the part of others, i.e. things that have actually been said or done towards participants, and also to covert expressions, such as gossiping behind the participant's back, or their private judgements, in which most participants acknowledged there was an element of 'assuming' (Angela), 'blowing things out of proportion' (Nicola) or 'paranoia' (Charlotte) on their part.

Within Angela's account there was a very powerful theme addressing the terror and shame she experienced when feeling judged by others, although she acknowledged that this was based mostly upon her assumptions about what people were thinking if they looked at her. An example of this terror is illustrated in the extract below, in which she describes her reaction to breaking a chair in a public place:

> *...it was having all these people looking at me, it was like no, no, no, it was like a moment of sheer and utter terror, that's the only way I can describe it. I was mortified (...) everybody is looking at me, everybody knows that I am big, everybody is thinking insulting thoughts about me. (Angela)*

Asked what this incident had meant for how she thought about herself, she replied: "*I thought I was a bad person, a failure."*

Within Nicola's account she described how other peoples' reactions to her anorexia led to her feeling differently about herself:

...they started to treat me quite differently. You know I was like this kind of poor person, poor [Nicola], you know, a bit of a sad case [laughs]. (Nicola)

She felt that this then had an effect on her behaviour, over and above the physiological effects of the eating disorder:

...I suppose I sort of started acting a bit more weak and feebly. It wasn't just from a physical perspective, 'cause obviously I was weaker and more feeble, because of my size, but I definitely think there was a psychological element there, because I was being treated like that. (Nicola)

Kerry's perception was overwhelmingly that others did not like her, which led to her feeling hurt and angry:

It makes me feel angry, because I want to be liked but I'm not and because I feel hurt and upset about not being liked, that makes me feel angry. (Kerry)

This was most tragically pronounced in how her family made her feel about herself, to the extent that she described feeling like "*a nothing*":

My mum and dad make me feel like a nothing, and that I'm unimportant, and they don't really care about me. And my sisters and brother make me feel the same way. (Kerry)

Charlotte also referred to being influenced by concerns about what others would think of her:

Amanda: *What was it that used to make you nervous do you think, with strangers?*
Charlotte: *It used to be what people would think of me.*
Amanda: *Uh-mh.*
Charlotte: *(...) Used to be paranoia really (...)*
Amanda: *Did you have an idea of what they would think of you?*
Charlotte: *No, not really, but that was the worrying part.*

As can be seen from the example above, she described this in the past tense. During her interview she described feeling more confident now and not being anxious with strangers anymore. However, this seemed to be based more upon a resolution she had made to "be a lot more confident" when she returned to work (following a period of absence due to her eating disorder), rather than being based on changes that she had already experienced. She described a recent attempt to return to work in the following way, which suggests that at least until quite recently she had continued to be negatively affected by her perception of how others were judging her:

> *I tried to go back (...) about two months ago and that didn't work out well, 'cause I was just paranoid about what people were going to be gossiping about (Charlotte)*

4.42 "It felt so wonderful": Feeling good about the self through positive feedback from others

This subordinate theme addresses the positive side of the influence of others, including improvements in the sense of self (although these may be transient) provided by both support and positive feedback from others.

Despite having a pervasively negative view of herself, Kerry described feeling 'wanted' and 'loved' with her husband, and also described feeling more hopeful about herself, through the support of two recent friendships:

> *Because I've got my two friends now, they make me feel that maybe I can be different, that it doesn't have to be like this. (Kerry)*

Charlotte and Nicola also talked about how their husbands made them feel good about themselves:

> *...my husband always makes me feel good about myself. Never gives me any reason to doubt myself at all (Charlotte)*

> *...on the whole he really exerts a really positive (...) influence on me. Makes me feel (...) good about myself... (Nicola)*

Both participants also described the positive effect of support from their friends:

> *I feel very valued when I'm with her, like she's got time for you. She's not one of these people that will just, you know you can tell they're not really listening to you when you're talking to them, they're not really that bothered. (Nicola)*

> *I'm lucky at the moment that I've got like a really good community of friends... (Charlotte)*

Angela's account of the positive effect of others was the most striking, as illustrated in the following quote, in which she is describing entertaining other guests on a work social:

> *I was basking in all this wonderful glory, and laughter was pouring out of these people. It felt so wonderful, and at the same time I was sort of like radiating this, it was, I can't describe it, but it was joy. And I was getting the joy back and I felt all-powerful. (Angela)*

Her use of the words 'glory' and 'all-powerful' suggest the unusually powerful and transforming effect produced upon her by the positive responses of the other guests.

4.5 "Just made me feel better about myself": Strategies employed to manage the sense of self

This master theme draws upon the common ways in which participants were coping with or managing their perceptions of themselves. The theme includes the relationship between the eating disorder and the sense of self that participants described experiencing; an interpretation that participants were disconnecting (for example through avoidance) in order to protect their fragile sense of self; and finally that participants derived self-worth from pleasing or caring for other people, although this could be a drain on their own sense of self.

4.51 "It takes me away from the way I feel about myself": The function of eating disorder in avoiding or improving the sense of self

Angela, who as stated previously had binge-eating disorder, described how over-eating was a way that she could escape the unpleasant feelings she had about herself:

> *I look in the mirror I see this horrible big person, and when I eat I kind of almost get euphoric, is the only way I can describe it. I get the sense of euphoria and it takes me away from that way, the way I feel about myself. (Angela)*

Kerry also described how her eating disorder (anorexia) helped her to manage her sense of self, in that restricting food and losing weight gave her a feeling of self-accomplishment and made her feel better about herself:

> *It makes me feel happy because I can manage to do something and if I lose weight with it I just feel that there's at least one thing I'm good at. (Kerry)*

Charlotte's account mainly suggested a need to maintain her sense of self through being successful academically. She described being regimented in her eating, exercise and studying, as a way of maintaining a control which, it was interpreted, protected her from fears of failure (at this time she had anorexia):

> *If I could control everything then I knew I'd succeed sort of thing, so I was just controlling all my academic stuff and that helped me control it by being addicted to the gym sort of thing (...) you know it was all regimented and that's the only way I*

could cope with I guess the degree and kind of being poorly at the same time (Charlotte)

Nicola described how she felt that her eating disorder (anorexia) was the result of stress and low self esteem, and that its function was as follows:

Just made me feel better about myself. It made me feel I suppose that that was something that I had control of. While there was all these other things in my life that were going on at the time, you know I just felt like I had no control over them. (Nicola)

4.52 Additional strategies of disconnection and avoidance to protect the fragile self

In addition to the eating disorder being a means to avoid or improve the sense of self, there were themes of other forms of disconnection and avoidance throughout participants' accounts. It was interpreted that this helped participants to protect the more positive or familiar aspects of their fragile self-concepts.

Here, Nicola describes how she avoided acknowledging her difficulties during the worst phase of her eating disorder:

I guess I never really gave myself a chance to sit down and think about it too much. I didn't want to, 'cause I think I thought if I did sit down and really think about it, I would know this isn't right, but that would have really thrown me and (...) I would have been in all sorts of trouble really. (Nicola)

Angela, who described liking her mind but not her body (which she saw as a shell for her 'real' self) gives this account of avoiding looking at her physical self, in order to avoid the emotions associated with seeing herself as overweight:

If I walk towards a door and I see my reflection I will do anything to avoid looking at the reflection: I will look at the top of the door, I will look to the side, but I won't look directly at myself. (Angela)

The extent to which she avoided looking at herself was apparent from another description she gave of not recognising herself when she accidentally caught her reflection in a shop doorway after losing weight.

Charlotte's account suggested that she was engaging in a great deal of disconnection. This was likely the result of needing to protect her idea of herself as successful (in academic and occupational terms). She was very focused on getting back to work after a period of absence due to her eating disorder, and it seemed that she was therefore not motivated to acknowledge her problems in anything but a superficial way, in case it complicated her return to work. The following extract illustrates how quick she was to dismiss problems:

Amanda: *(...) How do you respond to unpleasant or negative ideas about yourself?*

Charlotte: *Um, I mean that's a difficult... I mean if you're talking about body image, that's a difficult one for me to answer, because I don't really get that (...) I react to circumstances rather than body image, if you know what I mean. (...) 'Cause my stress it usually makes me not eat or I just switch off sometimes when I'm stressed. (...) I can't really answer that question. I don't think I really have that problem.*

The above extract was edited for readability and to present the most salient aspects, and in the actual interview she actually talked around the topic, without addressing the question, for longer. Although 'unpleasant or negative ideas about yourself' are something that everyone experiences at times, Charlotte interprets the question in a way that she feels she can dismiss as not relevant to her.

By contrast, Kerry seemed very connected with her problems and with the things she did not like about herself. In fact, she described disliking everything about herself, so it seemed that she may in fact have been disconnected from her positive qualities. Having had an abusive childhood (see section 4.6) and having viewed herself with what she described as 'absolute hatred' and 'disgust' for so long, it seemed that she may have been motivated to maintain a view of herself which, although extremely negative, was at least predictable and therefore perhaps safer. It may have seemed a great risk to contemplate herself being better than she had previously thought, as this may entail hurt and disappointment should she later be

disabused of this more positive opinion (at the time of the interview she was still living with the parents that had emotionally abused her and so this would have been a real possibility). Kerry also talked about deliberately disconnecting from what she described as the 'real me', in order to protect herself from feeling rejected by her peers at school:

> *I just thought they wouldn't want to know the real me and that I was better off pretending that the real me didn't exist. (Kerry)*

4.53 "I always remember feeling like I needed to please people": A source of self-worth, yet also a drain on the self

This superordinate theme aims to capture the participants' strategy of deriving self-worth from pleasing or caring for others. While participants conveyed a strong motivation to continue doing this, they also reflected upon the downside of using it. For example, Angela expressed her fears of being 'drained' by others in her efforts to make them happy:

> *...if I see somebody is miserable my first reaction is I want to bring them out of that misery, but (...) I keep thinking (...) are they going to cling to me? Is my way of making them happy going to cause them to make me almost like a drug, that they have to keep having a fix of me and that way drain me... (Angela)*

Charlotte talked with some pride about being someone that people go to with their problems. However, she also suggested that this situation led to her not always getting her needs met:

Charlotte:	*...people would always come to me. I mean not so much for advice, but just to talk to me, 'cause I'd just sit there and listen (...) And you know yourself the odd word you put in to make people feel better (...)*
Amanda:	*(...) What's it kind of like being that person, the person that people always come to?*
Charlotte:	*It's nice.*
Amanda:	*Uh-mh.*
Charlotte:	*But then also sometimes you wonder, where do I go if I need some advice or someone to talk to?*

Nicola described always wanting to please people in her childhood:

> *I do always remember being a happy child (...) but I always remember feeling like I needed to... wanted to please people. (Nicola)*

She talked of wanting to please her father especially, through behaving well and trying really hard at her schoolwork, and the sense of feeling '*superior*' that this provided her with. However, she acknowledged that this had involved '*suffering*', and also that her control of her eating had potentially been a way to maintain a sense of being rewarded for her suffering, as illustrated in the extract below:

Amanda:	*...you were talking about that sort of a feeling of superiority that you got from the fact that you always worked hard and tried to please your dad.*
Nicola:	*Yeah.*
Amanda:	*Even though there was suffering you kind of in some way felt good about that?*
Nicola:	*Yeah, yeah.*
Amanda:	*I wondered sort of what happened with that? Did that continue throughout the rest of your life or did that stop at any point?*
Nicola:	*Yeah, yeah definitely. I think the whole suffering with the whole food side of things, and the exercise...*
Amanda:	*Uh-mh.*
Nicola:	*(...) Food was like a reward to me I suppose, (...) that's why I never had breakfast or never used to have breakfast, because I'd feel I needed to get a lot done before I'd had it, you know, looked upon it as a reward.*

Lastly, this theme is manifested in a slightly different way within Kerry's account. She did not actually describe trying to please or make others happy. However, this was interpreted as possibly being due to her having such a negative view of herself that she did not believe that she could make others happy. She indicated that caring for others was an important quality to her, by describing the caring behaviour of a friend who she had described as 'pretty much

perfect', and she also gave an account of the negative effect upon her of thinking that she had disappointed or let down her husband or friends:

> *I feel complete disgust and I just feel like I'm going to explode (...) I feel like that pretty much at any time if I feel that I have disappointed people or not done well enough. (Kerry)*

This extract suggests that pleasing others (or at least not disappointing them) helps her to feel less badly about herself. However, as she described her friend not entirely understanding her difficulties and therefore having unrealistic expectations of her, it seemed that disappointing others had become an inevitable and frequent occurrence.

4.6 "I can't rise above my childhood": The enduring influence of early experiences on self

This theme aims to capture three sorts of early experience that recurred in participants' accounts, and which appeared to have had a significant effect upon how they construed themselves as adults. These were: criticism from others; differentiated sibling roles, and traumatic experiences.

4.61 "I think it's my parents that drummed it into me": Criticism from others becomes internalised as self-criticism

All the participants described experiences of being criticised as children. This was most extreme in Kerry's case, as her family had been emotionally abusive and neglectful of her:

> *...nobody ever gave me hugs or cuddles or told me nice things about myself, and whenever they did say things it was always criticism. (Kerry)*

When asked how she dealt with unpleasant or negative ideas about herself, Angela reflected that in adulthood such ideas came from herself, rather than from others. She described how this had been different in childhood and that criticism she received from an older sister had a lasting effect upon her body image, suggesting that she had internalised her sister's criticism:

> *...the only negative thing I get really, is really from myself as an adult. As a child growing up, that's different. My, my other older sister she had a thing about weight (...) That was another influence in my life about my body image. If you put on a pound (...) you were made to feel that small, because of the fact that you put on a pound. (Angela)*

In Nicola and Charlotte's cases, the criticism they received as children appeared to be more subtle, and largely the result of their parents having high expectations of their academic ability. Charlotte described how her tendency toward self-criticism and perfectionism had been instilled by her parents pushing her academically:

> *Amanda:* *...the one that you said that you didn't like was the being self-critical.*
> *Charlotte:* *Uh-mh. Yeah.*
> *Amanda:* *What's it like to be like that?*

Charlotte: *I've done it since I was a kid. (...) I think it's my parents that drilled it into me though. (...) I grew up when there was like grammar schools (...) So you know it's all the eleven-plus and all that sort of stuff.*

Amanda: *Yeah.*

Charlotte: *We did you know tests leading up to that and (...) if you got 99% well they'd be like, "What happened to the other one percent?", not "well done".*

Amanda: *Right.*

Charlotte: *It was like (...) perfectionist type of thing. 'Cause they, they didn't have that luxury of having that sort of education available to them, so they wanted to push me*

As described in 4.32, she seemed uncertain as to whether this self-criticism was a good or bad thing, suggesting that it had led to her doing well, but also describing it as her 'worst' characteristic. It was also apparent from her account that she saw herself as a failure if she did not meet her perfectionist standards.

Similarly, Nicola remembered her father's impatience with her if she took longer than he thought she should to understand her homework:

> *I always remember him getting really impatient with me when I was trying to get my homework done (...) and I used to end up in tears loads, loads and loads, because (...) I wasn't getting it quick enough really for him (Nicola)*

Like Charlotte, Nicola also seems to want to avoid placing blame on her parents for this, explaining that her dad '*never did it in a really horrible way*' and that '*I was just really sensitive to it*'.

4.62 "You and your siblings slot into a certain role": The influence of siblings in defining self

This superordinate theme is about the lasting impact of the roles that participants took, or were forced into, in relation to their siblings.

Nicola described a long history of comparing herself with her sister, and characterised her sister as 'the mischievous one'. In contrast, she had worked hard to be 'the good one', being careful to behave herself and work hard. In the following extract she describes the effect this had upon how she saw herself as a child:

> *It kind of made me feel a bit self-righteous, that although I was suffering, because I was getting upset all the time, I was the better child, because (...) I was not being naughty and I was doing my work and I really cared about my work and I think I probably thought deep down that my dad liked me better, because of that and so I was gonna carry on doing that and be as (...) as good as possible. (Nicola)*

It seemed to be relevant to Nicola's difficulties that these roles had changed in adulthood and her sister was now very close to their parents, since having children of her own. Perhaps in a way she may have felt that she had lost her role, and that since her eating problems had escalated she had found herself in the role of 'the bad one', having distressed her family with the extent of her anorexia.

Charlotte also described adopting the opposite role to her sister:

> *I mean for me it's always been about family. If I compare me and my sister we'd be completely different things that we want to be. She's two years older than me, but she just wants to go out all the time. (Charlotte)*

Within Charlotte's account there were further clues as to how her role relative to her sisters may have influenced her idea of herself. In the extract below I am probing for more information about her being a perfectionist:

Amanda: *Can you (...) looking back think of any reason why (...) you would have been more perfectionist (...)?*

Charlotte: *I don't know, I think probably comparing myself to my sister was my guess, cause she was always... she was good at art and all that sort of stuff...*

This comparison with her sister, and its potential consequences, seemed to be difficult for Charlotte to think about. In my next question I ask if being good at art was something that was particularly valued in her family, to which she replied 'Not really, no', before giving her parents' (non-artistic) occupations and changing the subject without considering the comparison or its possible meaning any further. I interpreted this as indicating that the comparison with her sister was a complex issue that she was not ready to think about.

Kerry's role relative to her siblings appeared to be that of scapegoat, as her account describes her being singled out for abuse that was not directed at her sisters and brother (her father would try to make her choose whether he should kick or punch her mother). The following quote suggests something of a hierarchy amongst her siblings, in which they have her parent's tacit approval to bully her:

> *[My sisters] would just call me ugly and stupid, and my parents would never say anything to them and so I thought, well they must be right if my parents aren't saying anything. (Kerry)*

As described in the extract above, the fact that her parents do nothing to protect her from her siblings' insults gives them an added weight, and it may be hypothesised that they therefore had more influence on how she consequently saw herself.

Angela's account had a strong theme of being a nurturer, and early in the interview she describes how she became the '*nurturer*' compared to the '*tormentor*' role taken by her siblings. In the following extract she talks about feeling that this role should not have continued into adulthood, and of how she would like to escape it:

> *...because I had the role of nurturer all the time, 'Big Sis', (...) that's just sort of carried on into adulthood. And I don't want to be Big Sis' anymore, I don't want to be a nurturer, I just want to be [pause] equal. (Angela)*

4.63 "Being unable to stop the violence made me feel that I was useless at everything": The negative influence of traumatic early experiences on self

This superordinate theme represents the effect of early traumatic experiences on self development. This was described very explicitly by two of the participants, Kerry and Angela, with regard to domestic violence and childhood sexual abuse:

> *Being unable to stop the violence made me feel that I was useless at everything. (...) Because it was my dad who used to be violent against my mum, and he would always single me out and ask me if I wanted him to punch or kick her, and because I wouldn't answer he would do both and tell me it was my fault. So I felt that all the beatings were because of me and because I wasn't able to stop it made it even worse. (Kerry)*

> *I'm basically afraid of intimacy. I was abused as a child and I'm scared of intimacy. (...) deep down I think the more unattractive I am the less attention I would garner. (Angela)*

The above quote was Angela describing what she felt her 'core issues' were. Angela conveyed a sense that the abuse had robbed her of the person she might otherwise have been, which for her was represented by her favourite sister:

> *She's who I aspire to be and she really is theperson that, if I hadn't had the issues I had, I would have been. I sincerely believe it. (Angela)*

The sense of loss captured in the above quote was very prevalent in Angela's account, in which there were a number of emergent themes relating to a '*lost self*'. There was a sense that the very salient comparison provided by her sister, who she said was very similar to her in many respects, really emphasised this sense of loss in Angela's mind.

An effect of trauma was also interpreted in the other two accounts. For example, Charlotte described how her father died when she was still relatively young. Typically for her account, she did not give much detail and did not link this to either her self-concept or her eating difficulties. However, from the account below it can be seen that this was a traumatic experience for her, and as she was present when it happened and was unable to save him it

can be interpreted that this may have had an effect on how she viewed herself subsequently, which was the period in which her eating disorder worsened:

> *...because I've been through what I've been through, I understand how... you know cause my dad died at home and I had to give him CPR [cardio-pulmonary resuscitation] and try and bring him back and all that sort of stuff. So people know that I've been through probably the worst thing you can possibly go through. (Charlotte)*

Unlike the other participants, Nicola did not describe having been through a traumatic event or childhood abuse. However, she does describe her father's temper in a manner that suggests she experienced it as traumatic, and presents this, combined with her being '*sensitive*' as the origin of her needing to please him:

> *...my dad, although he was always a... he's a wonderful, wonderful man, he was always very, very uptight (...) you know he used to lose his temper so quickly. Had a really bad temper (...) He was always a very loving dad, as I say he just, he was really fiery tempered and so I always wanted to please him... (Nicola)*

Nicola also did not describe what this loss of temper consisted of, and so it is possible that what is presented is a minimised and partial account of experiences that may have been very distressing.

5. DISCUSSION

5.1 Overview

The aim of this study was to gain an in-depth understanding of the experience of self for women with an eating disorder. This was carried out through analysing semi-structured interviews using an Interpretative Phenomenological Analysis (IPA). Few qualitative studies have examined the construct of self in eating disorders, and it was therefore hoped that the current study would add to existing knowledge in this area, which to date has primarily come from quantitative research and clinical observations. The main research question was:

What is the experience of self for women with an eating disorder?

The following areas were explored in relation to the main research question:

1) How the participants currently view/describe themselves
2) Whether participants experience changes in their view of themselves across different situations and with different people
3) How the participants have viewed themselves throughout their past (including before the onset of their eating disorder)
4) The participants' views regarding why they see themselves that way, and associated experiences relevant to this
5) The participants' views and experiences regarding whether there is a relationship between how they see themselves and their eating disorder

5.2 What is the experience of self for women with an eating disorder?

In the following section the key findings will be considered in light of the questions above, and discussed in relation to the existing theory and evidence base. The significance of the study, clinical implications of the results, methodological issues, suggestions for future research, and reflections on the study will then be explored.

5.21 Current views of self

This subsection addresses the first area explored in relation to the research question: How the participants viewed themselves at the time of the interview. Overall, the findings were that participants had quite fragile 'selves', with self-perceptions that were mostly negative, and which seemed vulnerable to their high levels of perfectionism and self-criticism.

5.211 Fragile selves

It was found that participants' self-concepts were quite fragile, due to experiences of feeling uncertain about themselves (Nicola, Charlotte and Kerry), and even feeling fragmented (Angela). This uncertainty and fragmented experience may have been the result of using avoidant coping strategies and disconnecting from self-awareness (Heatherton & Baumeister, 1991; Hayes, Strosahl & Wilson, 1999), a strategy which is discussed further in Section 5.24 below. These processes are similar to dissociation, a 'mental state of absence' which ranges from daydreaming in its mildest sense to extreme incidents of 'blacking out', flashbacks or out of body experiences (Kennerly, 1996, p.325). It has been found that dissociating (for example as a way of coping with trauma) can be linked to the fragmentation of identity, such as is found in dissociative identity disorder (Kennerly, 1996; Mollon, 2001) A milder form of this process may be explanatory for any of the participants, but is particularly congruent with Angela's description of herself as 'fragmented'. It may also be that participants' fragile self-concepts were due to other problems with identity development, such as controlling parenting (Bruch, 1973) or other toxic childhood experiences (Young, Klosko & Weishaar, 2003). The potential origins of participants' fragile self-concepts is elaborated and explored more in Section 5.23.

In Charlotte and Nicola's cases it also seemed that there may have been an element of them presenting a 'social self' (James, 1983; cited in Striegel-Moore, Silberstein & Rodin, 1993) of being someone who had recovered from all of their difficulties. The inauthenticity of this presentation would then account for the vagueness and hesitancy of their initial descriptions of themselves. In Nicola's case this lessened as the interview progressed, perhaps as rapport was built and she became less anxious about the interview, but in Charlotte's case this need to totally minimise any difficulties persisted throughout the interview. This hypothesis is congruent with theories that women with eating disorders feel insecure about themselves and therefore suffer from high levels of social anxiety (Striegel-Moore et al., 1993). This is thought to be managed through a focus on body image (Gross & Rosen, 1988) and the presentation of a 'false self' (Winnicott, 1965; both cited in Striegel-

Moore et al., 1993). In addition to the focus on body image increasing vulnerability to developing an eating disorder (Polivy & Herman, 2002), this is thought to lead to distressing feelings of fraudulence. The focus on pleasing others rather than themselves also further inhibits the development of a satisfactory and authentic sense of self (Striegel-Moore et al., 1993). This links with the findings that participants attempted to feel better about themselves through pleasing others, but that they ultimately found that this was a 'drain' on the self.

5.212 Predominantly negative views of self

The finding that participants had largely negative current views of themselves is consistent with previous findings, from Bruch's (e.g. 1973) clinical observations to empirical studies seeking to identify the core beliefs and schema of individuals with eating disorder (e.g. Vitousek & Hollon, 1990; Woolrich, Cooper & Turner, 2006). The findings are also consistent with previous qualitative studies, such as Brooks, LeCouteur and Hepworth's (1998) discourse analysis with bulimic women, which found mostly negative views of self, such as 'weak', 'lacking will-power' and 'abnormal'.

The prevalence of negative views across the accounts made this stand out as a group superordinate theme, but within the accounts there were also positive aspects that were not all related to egosyntonic aspects of the eating disorders. For example, there was a theme within Angela's account of 'valued self characteristics' including the fact that she saw herself as tenacious and naturally joyous. However, it was notable that having started out on a positive note, the views expressed in the interview became progressively more negative, and so this became the dominant theme. Similarly, Nicola presented positive aspects of herself first, e.g. being 'bubbly', but (as described in the previous section) she did not seem sure about these answers. As with Angela's interview her descriptions also became more negative as the interview progressed. It may be that this was a reflection of the ordering of the questions, as there is a question towards the end of the interview that specifically asks how participants respond to unpleasant or negative ideas about themselves. However, this is unlikely since most of the questions have either been neutrally worded or balanced out with another question (e.g. Can you tell me about a time when you felt the best about yourself? followed by, Can you tell me about a time when you have felt the worst about yourself?), and in both Angela and Nicola's cases the transition to more negative descriptions happened very early on before the focus of the questions became specifically negative. As suggested in the previous section, the fact that some interviews became progressively more negative may

represent a reduction in anxiety and correspondingly reduced need to present a positive, more socially acceptable self. However, another hypothesis is that participants may have had difficulty holding on to positive aspects of their self-experience, perhaps due to cognitive biases such as disqualifying the positive. The Self-Regulatory Executive Function model (S-REF; Wells & Matthews, 1996) may also be drawn on in explaining this pattern. For example, negative self-perceptions are seen as more threatening, and so they may occupy more 'processing resources' and thereby reduce the ability of participants to attend to and integrate more positive views of self.

Charlotte was the one participant whose account did not fit the group superordinate theme of 'Negative experiences of self', but this seemed to be a result of her disconnection from herself and her difficulties, particularly as she was unable to elaborate the things she liked about herself beyond characteristics relating to caring for and pleasing others (e.g. being academic). A significant area in which some positive aspects of self emerged was in relation to support from friends and husbands, which is discussed in Section 5.22.

Participants' attachment to negative aspects of themselves was most pronounced in Kerry's account. Her view of herself was overwhelmingly negative, with the exceptions of feeling a little better with friends and her husband, and feeling a sense of achievement through her anorexia. It seemed that this globally negative view had been present for so long, and had been so cruelly reinforced by her parents, that she had little ideas of who she was beyond it and this may account for her inability to challenge her habitual negative view of herself. This seems to echo the ACT principle of 'attachment to the conceptualized self', in which it can become more important for a person to defend a verbal view of themselves (e.g. in Kerry's case, being disgusting and weak) than it is for them to engage in more helpful forms of behaviour that do not fit this verbalisation (Hayes *et al*., 2006).

5.213 Perfectionism and self-criticism

Another finding was that participants' views of themselves were affected by their strong perfectionist and self-critical tendencies. The link between perfectionism and eating disorders is long established, particularly with anorexia and bulimia, and, more recently, evidence has also emerged supporting the role of perfectionism in binge-eating (Bardone-Cone *et al*. 2007; Sherry & Hall, 2009).

Hewitt and Flett (1991) have proposed that perfectionism involves

three dimensions: Socially Prescribed Perfectionism (SPP; i.e. perceiving that others are demanding perfection of oneself); Self-Oriented Perfectionism (SOP; i.e. demanding perfection of oneself), and other-oriented perfectionism (i.e. demanding perfection of others). SOP, which may be argued to be related to self-criticism, has been found to be weakly related to psychological distress, and in some cases to positive outcomes (Chang, 2006b; cited in Sherry & Hall, 2009). This may account for Charlotte's ambivalence about whether her self-criticism was her 'worst' characteristic or a positive way to ensure that she was doing her best. SPP has been consistently found to be linked with psychological distress (Hewitt & Flett, 2002; cited in Sherry & Hall, 2009), and the literature has found links between both SOP and SPP and the eating disorders (Bardone-Cone et al., 2007). Some have argued that there are differential relationships across the eating disorders, with SOP more related to anorexia, and SPP more related to both bulimia and binge-eating (e.g. Shafran, Cooper & Fairburn, 2002; cited by Sherry & Hall, 2009), however, these results are not conclusive (Sherry & Hall, 2009). The role of perfectionism in the eating disorders is addressed in cognitive models of the eating disorders, such as Vitousek & Hollon's (1990) model of negative self-schemas and Fairburn et al.'s (2003) transdiagnostic model. Conditional 'if..then...' assumptions, which act to defend the individual against negative self-schema formed during early experiences, may include examples such as, "if I am perfect, then I will be loved". The unrealistic demands posed by pursuit of perfection provide a rationale for the narrowed focus (or 'constriction' in personal construct language) onto food and weight in an attempt to make life more manageable. Sherry & Hall (2009) have developed and found support for a model that explains why perfectionism is linked to binge-eating, and this is considered in the next section.

5.22 Changes in self across different situations and with different people

This subsection addresses the second area explored in relation to the research question: Whether participants experienced changes in their view of themselves across different situations and with different people.

The findings were that participants' sense of self was influenced by their interactions with others, both positively and negatively. This is consistent with general theories about the self, that is, that the self is experienced relationally (e.g. Mead, 1934), and so is not a feature of the self in eating disorder specifically. However, the extent of the influence described in participants' accounts seemed to be of a larger magnitude than may usually be the case. For example, Angela's feeling of being "*all-powerful*" when eliciting a positive social response

from colleagues, and Kerry's feeling of being "*a nothing*" in relation to her family. Both negative and positive implications are considered in the subsections below.

5.221 The negative influence of others

In terms of the instances of negative influence described by participants, it seemed that, at least in adulthood, this largely occurred in response to negative interpretations made by the participants, rather than overt behaviour or comments from others. For example, Charlotte talks of feeling "paranoid" about what other people will think of her, and Angela comments that she "assumes" that others will be thinking negatively of her. These findings fit within cognitive models of low self-esteem (e.g. Fennell, 1998) and social anxiety (e.g. Wells, 1997), which have both been linked with the eating disorders (Polivy & Herman, 2002; Striegel-Moore et al., 1993). Negative early experience leads to the formation of negative core beliefs, and to the activation of assumptions and negative automatic thoughts in trigger situations (e.g. being with strangers). The accounts given by participants were also in keeping with a personal construct theory of eating disorder, which suggests that people with these disorders are "deficient in person-construing" (Winter & Button, in press). That is, they have a limited ability to predict the constructs of others. This was particularly indicated by Charlotte's reply when I asked her what she thought strangers would be thinking about her. She said that she just "didn't know", and that was "the worrying part". In one sense I felt that this may have been a disconnection from her negative ideas about what people may think of her, i.e. that these worries were too difficult to be acknowledged and so needed to be avoided. However, it may be that a deficiency in person-construing could also provide an explanation.

Sherry & Hall (2009) have developed and empirically validated a perfectionism model of binge eating (PMOBE). The PMOBE posits that Socially Prescribed Perfectionism is a personality trait, which predisposes an individual to four main triggers for binge eating: interpersonal discrepancies (i.e. viewing oneself as falling short of other peoples' expectations), low interpersonal esteem (low feelings of self-worth tied to the social domain), depressive affect and frequent but unsuccessful attempts at dietary restraint. Theories of the role of SPP may be argued to extend to other types of eating disorder, which may also have a self-regulatory role (e.g. restricting), and provides an explanation for the finding that participants in this study attempted to improve their sense of self through seeking approval of others and trying to please them

Changes in self-concept across different situations did not emerge as a group theme, although to the extent that different situations may be more likely to involve different people,

it may be inferred that they would have an effect upon the experience of self. Where different situations were talked about, it was more in the context of the differing levels of stress that they would produce, and the effect that this would then have on their eating.

5.222 The positive influence of others

All of the participants talked about positive influences of others in their self-construing. It seemed that being accepted by others was a particularly powerful positive influence, which fits with theories that individuals with eating disorders are particularly motivated by a need to gain social approval (e.g. Striegel-Moore, Silberstein & Rodin, 1993).

Although others had a positive influence on self-perception, this was not always positive in terms of the consequences for the participant's eating disorder. For example, Charlotte described how compliments from others regarding her weight-loss had encouraged her eating disorder when it was at its worst, and that now she was beginning to recover she disliked such comments because she recognised that they may have a detrimental effect. The reinforcing effect of praise for slenderness and self-control has long been recognised as a perpetuating factor (e.g. Branch & Eurman, 1980; cited by Polivy and Herman, 2002).

The findings also linked to literature emphasising the importance of social supports in recovery (Rorty, Yager, Buckwalter & Rossotto, 1999; D'Abundo & Chally, 2004), as three of the participants talked about the valuable role friends, family members and their husbands had in helping them to feel better about themselves. Angela, who was unmarried and tended to withdraw from her friends, described having no support since her mother died, which fits with findings that people with eating disorders have less support than healthy comparisons (Marcos, Cantero & Sebastian, 2003).

5.23 The self over time and origins of self-concept

This subsection addresses the third and fourth areas of exploration in relation to the research question: How the participants have viewed themselves throughout their past (including before the onset of their eating disorder), and; the participants' views and experiences regarding why they see themselves the way they do. The findings regarding the factors that account for participants' experiences of themselves fall into three main categories: Internalised criticism from caregivers; the different roles taken by family members; and the influence of trauma.

5.231 Internalised criticism from caregivers

It was found that criticism from key caregivers was construed by participants as having been internalised, leading to self-criticism. In the case of most participants this came from their parents, but for Angela her caregivers included an older sister who did the majority of the disciplining, and this sister was very critical about any weight-gain. In Kerry's case family criticism was extreme and came from her parents in addition to her siblings. In Charlotte and Nicola's cases, the criticism was more subtle and related to the high academic expectations (or perceived expectations) of their parents. These results link to findings that eating disorder patients generally describe a critical family environment, featuring coercive parental control (Haworth-Hoeppner, 2000). They are also consistent with Bruch's (1981) clinical observations that perfectionistic parenting limits a young person's opportunities for autonomous functioning, and therefore interferes with the development of a clear and elaborated sense of self.

5.232 Family roles

It was found that family roles had a lot of influence on the development of participants' self-concept, and was therefore related to their eating behaviour. For example Angela's conceptualisation of herself as a 'nurturer' to the 'tormentor' role taken by her siblings, and Nicola's need to be the good, hardworking or 'superior' one in relation to her sister's 'mischievous one'. It seemed that difficulties with respect to these relationships seemed to stem either from the unhelpful perpetuation of these roles into adulthood (e.g. as with Angela) or from an unanticipated change of roles within the family. The latter was apparent in Nicola's case, in which it seemed that her sister had become the 'good one' by remaining living close to their parents and making them grandparents while Nicola pursued a career and struggled with fertility problems due to her years of restrictive eating. These findings fit with a family systems view of the eating disorders (e.g. Dare & Eisler, 1997), and also with more recent research into the nature of sibling relationships, e.g. Bachner-Melman's (2005) narrative study of women with anorexia and their relationships with their sisters, which were characterised by rivalry.

5.233 The influence of trauma

Previous research indicates that sexual, physical and emotional abuse are risk factors for eating disorders (Wonderlich, Brewerton, Jocic, Dansky & Abbott, 1997; Polivy & Herman, 2002; Kent, Waller & Dagnan, 1999; Grilo & Masheb, 2001). However, Schmidt, Humfress

and Treasure (1997) found inconclusive results and concluded that greater focus on general family functioning is warranted. They also suggested that more research into mediating/moderating factors between abuse and eating disorder should be carried out, given that not all survivors of abuse go on to develop eating disorders.

The findings of this study indicate that abuse and trauma may have a negative effect on self-concept and that this is a factor in eating disorder development. The link between adverse early experience and negative self-schema is well supported in the literature (e.g. Beck et al. 1979; Vitousek & Hollon, 1990; Fennell, 1998; Young, Klosko & Weishaar, 2003). Dalgleish et al (2003) found that people with eating disorder tend to produce more 'overgeneral' autobiographical memories than controls, and also that self-reported parental abuse was positively correlated with the tendency to produce overgeneral memories in response to negative cues. Although the results were not conclusive, it may be that abuse leads to this 'overgeneral' processing. For example, the authors cited Williams et al.'s (1997) suggestion that traumatic experiences in childhood lead to the encoding of memories at a more general level, in order that the individual be protected from painful activation of specific memories. This more general level of processing may lead to a discontinuity and negative bias in experience of the self, characteristic of the findings of this study.

Theories of the association between dissociative symptoms and trauma (Kennerley, 1996) also provide an explanation for why trauma can lead to self-concept disturbances. It is theorised that dissociation to cope with early trauma can have a deleterious effect upon identity. Kennerley (1996) cites Steinberg's (1995) five core dissociative symptoms as amnesia, depersonalisation, derealisation, identity confusion and identity alteration. The majority of these symptoms relate directly to identity difficulties, and symptoms such as amnesia may contribute due to gaps in autobiographical memory producing an experience of a discontinuity or fragmentation in sense of self.

5.24 The relationship between self and eating disorder

This subsection addresses the fifth and final area of exploration in relation to the research question: The participants' views and experiences regarding whether there is a relationship between how they see themselves and their eating disorder.

It was found that participants' sought to escape from self-awareness through their eating behaviour. In Angela's case this was a function provided by binge-eating, which in her words, *"takes me away from the way I feel about myself."* It was also interpreted that other participants' eating behaviours were functioning to help them avoid emotions, particularly

those related to self-awareness. For example, Kerry described restricting and cutting to cope with negative thoughts about herself, and Charlotte and Nicola both described using eating and exercise to manage stress. This seemed particularly in the context of events involving a high degree of self-evaluation (by the self and others), such as degree exams and their weddings. These findings fit with emotion 'blocking' and escape hypotheses discussed in the Introduction (Heatherton and Baumeister, 1991; Lacey, 1986; cited in Corstorphine, 2006). Heatherton & Baumeister's model begins with the individual's high standards and perfectionism, and so these findings link with the perfectionism theories described earlier in Section 5.213. The findings are also congruent with the third-wave CBT concept of experiential avoidance (e.g. Hayes, 2004).

There were clear themes in Charlotte and Nicola's accounts of using eating and exercise regimes in order to achieve a sense of control and self-efficacy in the face of uncontrollable and therefore stressful circumstances. This fits with Slade's (1982) theory that individuals who are high in perfectionism but low in self-efficacy have a need for absolute control over at least one area of life, a proposition that has been included in subsequent models of the eating disorders, e.g. Fairburn et al (2003).

Kerry described a real sense of self-accomplishment through weight-loss, which was the only sphere of life in which she felt this, and her account seemed to have the most in common with Bruch's (1973) description of anorexia nervosa as "a desperate struggle for a self-respecting identity" (pg 250).

5.3 Significance of the study

This study provides a contribution to an understanding of the phenomenon of self in eating disorder, and appears to be the first study of this sort to have been conducted (searches of the literature showed there had been no published IPA studies conducted on this topic previously). This study also appears to have been the first to have included a qualitative analysis (of any sort) of the experience of self and binge-eating disorder, as other qualitative studies in this area used samples of individuals with either anorexia or bulimia. Searches of the literature indicate that there is a paucity of qualitative research into binge-eating disorder generally. Therefore, although this study included a sample of mixed diagnoses, the findings do provide a contribution to an understanding of binge-eating disorder, as the idiographic nature of IPA allows the voices of individual participants to be heard.

5.4 Clinical implications

The current research highlighted the difficulties experienced by participants in maintaining a coherent sense of self, the role of the eating disorder in helping them to either avoid or improve their sense of self, and the influence of traumatic events in the development of self. The findings of IPA studies, which utilise small samples, should not be generalised without caution. However, as discussed in section 5.2, the findings are consistent with previous theory and research, and therefore provide additional support for the following clinical practices.

Firstly, the results have implications for the importance of interventions aimed at prevention. For example, education for parents and any professionals who play a significant role in children's upbringing and development (e.g. teachers). This may include suggestions praise and promote qualities in girls that are not just to do with physical appearance or conformity to adult expectations. Angela's experience would also caution against putting children on diets, and would suggest that an approach that did not make the child feel so singled out would be preferable, e.g. introducing increased activity rather than cutting out calories. The findings would also support education for parents and teachers on identifying signs that a child may be regulating their emotions through food, or that they may have suffered abuse, and would support the use of guidelines for responding sensitively to disclosures.

In terms of treatment, the results support interventions aimed at improving self-esteem and elaboration of the person's sense of self, such as CBT and PCP. However, the link between participants' reports and models of self-regulation and emotional processing such as the S-REF model (Wells & Matthews, 1996) would emphasise the need for interventions to address the processes surrounding self-related cognitions and emotion, rather than just the content of the thoughts/beliefs themselves. The S-REF and ACT processes indicated by the findings provides additional support for the use of techniques based on third-wave principles, such as the mindfulness, defusion and distress tolerance techniques practiced in meta-cognitive therapy, ACT and Dialectical Behaviour Therapy (Heffner, Sperry, Eifert & Detweiler, 2002; Safer, Telch & Agras 2001a, 2001b; Telch, Agras & Linehan, 2000).

The strong theme of the role of the family in self-development, and the subsequent effect upon eating found in the results, would also provide some support for the rationale for family therapy, which is currently recommended by NCCMH (2004) guidelines for adolescents.

5.5 Methodological considerations

A strength of the methodology was in the use of an approach that allowed in-depth exploration of participants experiences. Each interview was analysed carefully and in a lot of detail, as it was considered that this would improve the rigour of the study, and would help both to ensure that participants' experiences were captured, and to facilitate a good level of interpretative engagement with the text. The small sample size, which may be seen by some as a weakness, was actually a strength in allowing time for this depth of analysis and ensuring that the voices of all participants were heard, thus meeting the idiographic commitment of IPA (Smith et al., 2009). It was also a strength of the study that the sample was composed of women with eating disorder diagnoses, rather than a 'sub-clinical' sample.

Although I was new to IPA, and to qualitative analysis generally, I endeavoured to ensure the quality of the research by conducting a lot of reading about IPA, seeking supervision with an experienced IPA researcher, and by attending a conference and an advanced workshop on IPA, which was in addition to the teaching on qualitative methods that I received as part of my doctoral training. As described in the Method chapter, the quality and transparency of the analysis was supported by peer review in the form of two audits of analysis undertaken by my supervisors, who are both clinical psychologists, one with IPA expertise and the other with expertise in the field of eating disorder. It is recognised that there is a 'double hermeneutic' in IPA, that is, it involves the researcher trying to make sense of the participants trying to make sense of their experience. For this reason it was considered unnecessary to conduct member-checking and due to the time constraints on the project it was not carried out.

A major criticism of the methodology of this study is that a small sampling pool was used. Clients from only one service were invited to participate, and it is likely that this was a factor in the recruitment difficulties experienced. This decision was made due to time constraints, as it would have taken much longer to apply for and gain ethical approval for multiple recruitment sites. As IPA only requires a small number of participants, and it had been originally intended to recruit six to eight, it was initially thought that one service would be ample to meet this need. However, in retrospect it is now apparent that a much bigger sampling pool would have made recruitment a lot easier and would perhaps have afforded the opportunity to recruit a more homogenous sample, using participants of only one diagnosis. The heterogeneity of diagnosis within this study's sample is defensible in terms of transdiagnostic conceptualisations of the eating disorders. The finding that there were several

consistent themes between the accounts provides support for the idea of transdiagnostic processes. However, more divergent themes emerged within Angela's account, which often seemed related to her obesity compared to the other women being either underweight or at the slim end of the healthy range (having all had restricting anorexic presentations either currently or in the past), and this would indicate the different experience of overweight women with binge-eating disorder.

Use of the Participant Information Sheet as an invite to participate may also have been a factor in the recruitment problems. This information sheet needed to be long in order to satisfy the ethical requirements for informed consent to participate, and in retrospect use of a shorter letter as an initial invitation to participate would probably have elicited a better response. Such a letter would have been quicker to read, thereby increasing the likelihood that recipients would take the time to do so, and also it would have been less overwhelming than the three-page information sheet. There is also the possibility that potential participants were deterred by the topic under investigation, given the findings of this study (and previous research) that individuals with eating disorders are often motivated to avoid thinking about themselves.

An improvement to the methodology may have been to conduct a pilot interview to develop the interview schedule further. The question "How do you respond to negative or unpleasant ideas about yourself?" elicited a small amount of confusion in two participants, who wanted to know if I meant negative ideas coming from other people or negative ideas coming from themselves. I actually meant both, and although this was easily clarified in both cases, it may be that the question could have been better worded, and that this could have been achieved through a pilot interview. However, given that I had difficulties recruiting, this would have reduced the sample size further. In actual fact the first participant did not express any difficulty with any of the questions, so in the event that her interview had been treated as a pilot, it would not have led to revision of the interview schedule.

A further criticism of the interview schedule is that the first question, "How would you describe yourself?" might be a difficult one for anyone to answer, because 'self' is an abstract concept. An extension of this criticism would therefore be that interpreting an 'absent' or 'fragile' sense of self from the answers given would be invalid. However, given that the participant interview sheet was very detailed about what would be expected from participation and what would be asked about in the interview, it can be considered that the

context of this study is markedly different than, say, a situation in which such a question would be asked 'out of the blue'. Participants were also given as long as they needed to answer and additional, more specific, prompting (e.g. "What do you like / dislike about yourself?"; "Could you tell me a bit more about what X means to you?"), and every effort was made on the part of the interviewer to give participants ample opportunity to give as full an answer as they were able.

It is recognised that the interview schedule will have had some effect on the themes interpreted in the analysis, as it was the basis for the structure of the interview. However, sincere efforts were made not to use leading questions, and the interview schedule was used flexibly, with additional questions formulated in response to participants' answers to previous questions. Additionally, all participants were given the chance to comment upon things that were not asked at the end of the interview. This allowed unanticipated areas to be followed up, and also, any questions asked by me that did not elicit participants' experiences would not have had an influence on the analysis, because although an interpretative method was used, the themes were rooted in the words of the participants themselves.

In terms of the validity of the findings, it should be noted that all of the participants were either currently engaged in, or had recently completed, psychotherapy for their eating disorder. It is acknowledged that this will have had an effect upon how participants interpreted their past experience and the link between their perception of themselves and their eating disorder.

Another point regarding the validity of the findings is that due to participants' strategies of avoiding and disconnecting from their self-experience, it is likely that they were unable to tell me the full extent of their thoughts about themselves, and thus it was not possible to access some aspects of their experience.

5.6 Suggestions for future research

The findings of the current study have demonstrated strong support for the link between self-concept and eating disorder, and have illuminated the lived experience of this for four individuals. It would therefore be informative for this study to be repeated with other individuals, potentially using more homogenous groups of just one type of diagnosis.

The current study has highlighted the particular need for more qualitative research into the phenomenology of binge-eating disorder. Angela, the one participant in this study with a binge-eating disorder diagnosis, gave a particularly multi-faceted account of her experience, which was at times contradictory, but was fascinating in the vivid imagery and

metaphors she employed to describe her experience. It may be that this was a characteristic peculiar to Angela in being a very articulate, imaginative and verbally expansive individual, rather than being an indication that all experiences of binge-eating would be similarly complex. However, it would be interesting to see the results of analyses of other accounts of binge-eating disorder, which, if similar in length and multi-layered quality, may be suited to a case-study approach.

A way of addressing the concern that interview accounts are retrospective, and may not accurately capture the nature of past experience, would be to conduct longitudinal studies of the experience of self. It is acknowledged however, that this would be expensive and extremely difficult to organise, particularly if a prospective design was used.

A further area of research suggested by this study would be for quantitative research in to the potential mediating or moderating effect of self-perception in the relationship between trauma and eating disorders.

5.7 Study reflections

During the process of carrying out this research I was mindful of any issues that may arise through confusion about my clinical versus my research role, either for myself or for participants. As I had commenced a placement with the service from which I was recruiting, it was necessary to be particularly aware of these differing roles, and as stated in the Method, my clients were not invited to take part in the research for ethical reasons. However, I was aware that my participants were all in the process of attending the service for either dietetics or psychotherapy, and that for those participants who chose to be seen at the clinic rather than in their own home, this may mean meeting in the same room they were used to having therapy in. I was keen that participants be aware that the research was separate from the treatment they were receiving from the service, and endeavoured to convey this through the participant information sheet. However, on reflection I could have been more explicit about the differences between a research interview and a therapy session, as whilst participants seemed to have realistic expectations about what the interview would involve, it may be that they had different anticipations of the interview that they did not verbalise.

It was also a new experience for me to be undertaking research rather than therapy interviews, having not conducted any qualitative research previously. I had to put a lot of effort into trying to ensure that I asked questions based upon a research focus and didn't begin to act like a therapist.

A further reflection was that I wondered if assumptions based upon my gender, appearance, and status as a doctoral student may have influenced how participants responded to my questions, and what they may have chosen to disclose or keep to themselves. This may have arisen as much through our similarities as our differences. I was aware that I was very similar in age to three of the participants, and also that two of them were employed in healthcare professions, which may have resulted in them drawing comparisons and making assumptions that could have affected the process of the interview and thus the answers they gave. Angela was the participant with whom there seemed the greatest degree of difference between us (at least in terms of overt differences like age, ethnicity and body shape). Although she was born and brought up in the UK, the same as myself, we were ethnically and culturally diverse. She mentioned during the interview that her older sister had spent her formative years in another country with poorer nutrition, and also that her beliefs had been affected by being raised as a Jehovah's Witness, so it seemed that her family background was very different to my own. Given her expressed desire to reach a healthy weight (my weight is in the healthy range, and this is evident from my appearance) and to be thirty again (around my age, which again would be indicated by my appearance), I wondered how these factors may have influenced the process and her interview experience.

6. CONCLUSIONS

The primary aim of this study was to gain an in-depth understanding of the experience of self for women with an eating disorder. In relation to this broad research question, the following more specific areas of interest were explored: participants' current perception of themselves; participants' experiences of themselves across different situations and with different people; participants' views of themselves throughout their past (including before the onset of their eating disorder; participants' views and experiences regarding why they see themselves the way they do, and; participants' views and experiences regarding whether there is a relationship between how they see themselves and their eating disorder. The use of Interpretative Phenomenological Analysis allowed the in-depth and idiographic investigation of participants' lived experiences.

The analysis resulted in four master themes, the first of which was *"I'm always questioning, who am I?": Experiencing a fragile sense of self,* which related to participants' current perceptions of themselves. The second master theme was *The influences of others on*

self-perception. The third master theme, *"Just made me feel better about myself": Strategies employed to manage the sense of self*, included the relationship between self and eating disorder. The final master theme to emerge from the analysis was *"I can't rise above my childhood": The enduring influence of early experiences on self.'*

The results were found to be consistent with existing theory and literature and were discussed mainly in relation to the fragile self-concepts found in participants' accounts; escape and avoidance models of the eating disorders and the role of socially prescribed perfectionism.

Overall, this study aimed to provide a more in-depth and idiographic approach to the exploration of the established link between self and eating disorder, in an attempt to illuminate the processes involved in a clinically useful way. As qualitative studies in this area are few, and rarely include participants with binge eating disorder, it is hoped that this study has contributed something novel to the evidence-base.

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8. APPENDICES

Appendix 1 – Participant Information Sheet

Appendix 2 – Ethics approval documentation

Appendix 3 – Consent form

Appendix 4 – Debriefing Sheet

Appendix 5 – Interview Schedule

Appendix 6 – Interview Example

Appendix 7 – Audit trail

University of Hertfordshire

Appendix 1
Version 2.0 (23rd March 2009)

Eating Disorder and the Experience of Self

Participant Information Sheet

Introduction
You have been invited to take part in a piece of research exploring how women with an eating disorder view and describe themselves. Before you decide whether you would like to give consent to take part, please take the time to read the following information, which I have written in order to help you understand why the research is being carried out and what it will involve.

The researchers
My name is Amanda Nunn. I am a Trainee Clinical Psychologist, and I am carrying out this study as part of a Doctoral qualification in Clinical Psychology. The research is being supervised by Mr John Rhodes (Academic Tutor and Consultant Clinical Psychologist at the University of Hertfordshire) and Dr Faith Russell (Consultant Clinical Psychologist at the Eating Disorders Service).

What is the purpose of the research?
This study aims to gain an in-depth understanding of how women with eating disorders see themselves; what it is like for them to view themselves in this way; their thoughts and experiences regarding why they see themselves this way; and their views regarding whether there is a relationship between how they see themselves and their eating disorder. Whilst existing research has established a link between eating disorder and factors such as low self-esteem and body dissatisfaction, there has been little investigation of how this process comes about. It is hoped that this study, which aims to emphasise the voices of women with eating disorders themselves, will enhance healthcare professionals' understanding, and thereby contribute to promoting prevention and recovery.

Why have I been invited to take part in the study?
All female patients from the Luton and Bedford Eating Disorders Service have been invited to take part. I am hoping that between six and eight women will agree to take part and share their experiences for this study.

Do I have to take part?
You are under no obligation to take part, and even after agreeing to do so you may change your mind *at any time*, without having to give a reason. Participation is entirely voluntary and your decision will not affect the standard of care you receive in any way. In making your decision you may wish to seek advice from somebody independent. For example, a friend, family member, or trusted professional.

What is involved?
If you decide that you would like to take part, please contact me using the details below. You can ask me some more about the research if you would like, after which you can take some more time to think about it, or we can arrange a time and place to meet. This can

either be at one of the Eating Disorder Service's clinic rooms (Dunstable or Bedford), or in your own home if this is more comfortable for you.

During this meeting I will first check to see if you have any further questions, or if you have changed your mind. If you are still happy to go ahead I will ask you to sign a consent form to say that agree to take part in this research. I will then carry out an interview with you for around 1 hour to 1 ½ hours. During this time we will discuss: how you currently view yourself; what you do and do not like about yourself; why you think you view yourself this way; what it is like for you to view yourself in this way; how you would have described yourself before your eating difficulties started; if there have been any changes in how you see yourself over time; and if you think there is any relationship between how you see yourself and your eating. The interview will be audio-recorded.

After the interview you will have an opportunity to ask any questions and raise any concerns you may have.

What will happen to this information?
The recording of the interview will be typed out so that the information can be looked at in detail. The aim of this is to uncover common themes that are important in understanding the experiences we have discussed. A professional transcription service may be used; in this case, confidentiality agreements will have been signed. Both the recordings and the typed out transcripts will be made anonymous and kept in a locked storage facility. In addition to the information collected from the interview, I will also ask consent to collect some background information from your records (e.g. your age, your current diagnosis, previous eating disorders you have experienced and what treatment you have had).

Anonymised sections of the information collected from the interview will be looked at by my supervisors, and may also be looked at by representatives from academic and professional assessment bodies in order to assess the quality of this doctoral research project. If you give additional consent, I would also like to discuss anonymous parts of the transcript with a group of my colleagues who are interested in this type of research and may assist me in the analysis (they are all Trainee Clinical Psychologists like myself and have the same duty of confidentiality towards all participants).
As part of the doctoral programme, I will write up a report of the research. Within this report I may include anonymous extracts of the interview to illustrate themes that have been discussed. These extracts will not include any information that could identify participants. I will also write a shorter article for publication in an academic journal, this may also include brief anonymous extracts of the interview. There is the potential that the research findings may be presented at conferences in the future, but again this would not include any information that could identify participants.

I will also ask if you would like me to send you a summary of the research findings when the study is complete.

What are the possible disadvantages and risks of taking part?
You will be asked to discuss your views about yourself in some detail, the experiences you have had that have contributed to how you see yourself, and how you think this has affected your eating. This could be potentially distressing, and every measure will be taken to minimise the risk of distress. If during the interview you are asked a question that you are not happy to answer you can skip it, and if you do become upset, you will be given the option to take a break or stop the interview altogether. Following the interview, I

will be available if you feel you need some time to talk about any issues raised. I will be able to advise you of who you can talk to if you need further support, and will give you an information sheet with details of sources of support.

What are the potential benefits of taking part?
I cannot promise that the study will help you, but the information we get from this study will help improve understandings of eating disorder and may therefore help improve treatment in the future. You may also appreciate having the opportunity to talk openly about your experiences.

What will happen if I don't want to carry on with the study?
If you decide you want to withdraw from the study please let me know by contacting me on the email address or phone number given at the end of this information sheet. If you have completed the interview you will be asked what you would like to happen to the data. It can either be included in the study, or destroyed. Either option is perfectly acceptable. Your decision of whether to take part or withdraw from the study will not affect the care you receive from the Eating Disorder Service.

What if there is a problem?
If you have a concern about any aspect of this study, you can contact me and I will do my best to answer your questions. Alternatively you could can contact my research supervisor, John Rhodes, through the University of Hertfordshire (see contact details below). If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure.

Will my taking part in this study be kept confidential?
All information which is collected about you during the course of the research will be kept strictly confidential, and any information about you which leaves the NHS premises will have your name and address removed so that you cannot be recognised.

As with any health professional, there are limits to confidentiality. If you disclose any information which suggests that either you, or someone else, is at risk of harm then I am obliged to breach confidentiality and inform someone (this is likely to be a clinician from the Eating Disorders Service and/or your GP). I will do my best to discuss this with you first.

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 safety, rights, wellbeing and dignity. This study has been reviewed and approved by the Essex 2 Research Ethics Committee.

Contact Details:
Amanda Nunn (Trainee Clinical Psychologist)
A.L.Nunn@herts.ac.uk
(Telephone messages can be left for her through the Course Administrator, Jean Thomas, on 01707 286322)

Mr John Rhodes (Consultant Clinical Psychologist)
Academic Supervisor, University of Hertfordshire
j.1.rhodes@herts.ac.uk
01707 286322

University of Hertfordshire

Appendix 2

NHS

National Research Ethics Service

Essex 2 Research Ethics Committee
Terminus House
9th Floor
The High
Harlow
Essex
CM20 1XA

Telephone: 01279 419312
Facsimile: 01279 419246

31 March 2009

Miss Amanda Nunn
Trainee Clinical Psychologist
Cambridgeshire and Peterborough Mental Health Partnership NHS Trust
D.Clin.Psy. Course
The University of Hertfordshire
Hatfield
AL10 9AB

Dear Miss Nunn

Full title of study: **Eating Disorder and the Experience of Self. An Interpretative Phenomenological Analysis.**

REC reference number: **09/H0302/31**

Thank you for your letter of 23 March 2009, responding to the Committee's request for further information on the above research and submitting revised documentation]

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). The favourable opinion for the study applies to all sites involved in the research. There is no requirement for other Local Research Ethics Committees to be informed or SSA to be carried out at each site.

Conditions of the favourable opinion

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

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
CV for supervisor		10 February 2009
Interview Schedules/Topic Guides		
Protocol	1.0	10 February 2009
Investigator CV		10 February 2009
Application		13 February 2009
Debriefing sheet	1.0	10 February 2009
Letter from Sponsor		10 February 2009
Response to Request for Further Information		23 March 2009
Participant Consent Form	Version 2.0	23 March 2009
Participant Information Sheet	Version 2.0	23 March 2009

Statement of compliance

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

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review –guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

09/H0302/31	**Please quote this number on all correspondence**

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

Yours sincerely

pp

Mr Jon Gould
Chair

Email: suzanne.emerton@eoe.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to:

Professor JM Senior
Pro Vice-Chancellor for Research
University of Hertfordshire
College Lane
Hatfield
Herts AL10 9AB

Ms N Stokoe
The Bedfordshire & Luton Mental
Health & Social Care NHS Trust
Disability Resource Centre
Poynters House
Poynters Road
Dunstable LU5 4TP

Bedfordshire and Luton NHS
Mental Health and Social Care Partnership NHS Trust

Research Governance Approvals Group
Bedfordshire and Luton Partnership Trust
Disability Resource Centre
Poynters House
Poynters Road
Dunstable, LU5 4TP

Miss Amanda Nunn
The University of Hertfordshire
Hatfield
AL10 9AB

26th February 2009

Dear Miss Nunn,

Re: *Eating Disorder and the Experience of Self. An Interpretative Phenomenological Analysis.*

Thank you for submitting your research proposal to the Research Governance Approvals Group. The group felt that this was an interesting and worthwhile subject, and I am pleased to confirm research governance approval for the above study.

If you make any changes to your proposal please inform the group of these. If they are substantial changes you will need to resubmit your full proposal for review.

In receiving this letter you are accepting that your study must be conducted in accordance with the research governance framework and in line with health and safety and data protection guidelines. If you are unsure about your obligations in relation to these three areas, please contact me immediately. Throughout the course of you research you will be sent monitoring forms and audits. It is important that you fill these in and return them. A failure to do so may result in your approval being withdrawn.

Additionally, brief details of your project (title, aim and project lead), may be posted on our internal website to give other staff a flavour of the research currently taking place in the organisation. Details of research funded by pharmaceutical companies will not be added but all others may be used, unless you notify me of your objection.

Please inform me of any amendments to the approved research proposal / protocol, participant information sheet or consent form and use the usual incident reporting channels to report any adverse events relating to your study.

At the end of your study, please forward a copy of the final report to me, together with presentations or publications relating to the project so that I can keep an accurate record of the outcomes of research in our area.

I look forward to hearing about the progress of your proposal,

Best wishes,

Nicole Stokoe
Research Assistant to
Prof G A Kupshik
Chair of Research Governance Approvals Group

Cc

Mr John Rhodes, The University of Hertfordshire

University of Hertfordshire

Appendix 3

Version 2.0 (23th March 2009)

Eating Disorder and the Experience of Self

Participant Consent Form

Title of Project: Eating Disorder and the Experience of Self. An Interpretative Phenomenological Analysis.

Researcher: Amanda Nunn, Trainee Clinical Psychologist

		Please tick box
1)	I confirm that I have read and understand the information sheet (dated 23.03.09) for the above study. I have had the opportunity to consider the information and if needed ask questions that were satisfactorily answered.	☐
2)	I understand that participation is voluntary and that I am free to withdraw at any time, without giving any reason.	☐
3)	I understand that my information will be filed in a locked cabinet and the information I provide will be anonymised for the use of the study.	☐
4)	I give consent to the audiotaping and transcription of the interview, and the use of direct quotes in the write-up of the study (which I understand will be anonymised).	☐
5)	I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from The University of Hertfordshire, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	☐

.....	.....	.....
Name of participant	Date	Signature

INVESTOR IN PEOPLE

POSITIVE ABOUT DISABLED PEOPLE

THE QUEEN'S AWARDS FOR ENTERPRISE: INTERNATIONAL TRADE 2004

A charity exempt from registration under the Second Schedule to the Charities Act 1993

Optional additional consent:

Please tick box

I give consent for anonymised sections of my interview transcript to be seen by a group of the researcher's colleagues who are part of a special interest group for this type of research. I am aware that they are also Trainee Clinical Psychologists, and bound by a professional duty of confidentiality towards participants. ☐

.....	.....	.....
Name of participant	Date	Signature

University of Hertfordshire

Appendix 4
Version 1.0 (10th February 2009)

Eating Disorder and the Experience of Self

Debriefing Information Sheet

Thank you very much for making this study possible.

This study aimed to explore how women with an eating disorder perceive themselves. I was interested in:

- how you see yourself currently
- what it is like for you to view yourself in this way
- how you have previously viewed yourself, and how this may have changed over time
- where you think your ideas about yourself have come from
- whether or not you think that there is any relationship between how you see yourself and your eating difficulties, and if so, what your experiences and views are about how this relationship works

Existing academic literature supports the idea that there is a relationship between how women perceive themselves and their eating behaviour, with factors such as low self-esteem, body dissatisfaction and identity disturbances being linked to eating disorders. However, there is little research looking into the processes that may be involved in this relationship, or what this experience is like from a personal perspective. Researchers have argued that further research into these processes may be helpful in promoting prevention of and recovery from eating disorders.

Sources of comfort and help

Talking about your experiences may have left you feeling low or upset. This is quite normal and should pass within a few days. However, if these feelings persist there are local sources of support and comfort which may already be familiar to you.

1. The most immediate sources of comfort and help are likely to be your own family and friends.

2. As you know, your clinician at the Eating Disorder Service is aware of this study, and you have the option to talk to them about how you feel following participation.

3. There are also a number of national organisations who can also offer you support. For example:

- ***beat*** (tel. 0845 634 1414; www.b-eat.co.uk; help@b-eat.co.uk). *beat* (the working name of the Eating Disorders Association) is the leading UK charity for people with eating disorders and their families, providing information, help and support. Their helpline staff have received a comprehensive training programme, and are there to listen. They will offer information about treatment and other sources of help available, encouraging callers to make their own decisions about a way forward. They will also be able to give information about beat resources, books, leaflets etc., and can post out a basic information pack. The helpline is open from 10.30am to 8.30pm Mon-Fri;

1pm to 4.30pm on Sat, closed on Sun and open 11.30am to 2.30pm on Bank Holidays.

- ***The Samaritans*** (tel. 08457 909090; www.samaritans.org). The Samaritans is a helpline which is open **24 hours a day** for anyone in need. It is staffed by trained volunteers who will listen sympathetically.

4. You are welcome to contact me again to discuss any aspect of your participation in this study, to share any concerns you might have or to ask questions.

Contact details:

Name: Amanda Nunn
Email address: A.L.Nunn@herts.ac.uk
Telephone number: 01707 286322
Postal address: Doctorate of Clinical Psychology Training Course
University of Hertfordshire
Hatfield, Herts. AL10 9AB.

5. If you have further concerns that you would like to raise with the University of Hertfordshire, you can contact my Academic Supervisor:

Name: John Rhodes
Email address: j.1.rhodes@herts.ac.uk
Telephone number: 01707 286322
Postal address: Doctorate of Clinical Psychology Training Course
University of Hertfordshire
Hatfield, Herts. AL10 9AB.

Thank you again for taking part

Appendix 5

Interview Schedule:

1. How would you describe yourself?
   Prompt: What are your most important characteristics? What do you like / not like about yourself?
2. What is it like to be you?
   Prompt: What is it like to experience yourself this way?
3. How would you describe your ideal self?
   Prompt: What do you want to be like? Why are these good characteristics?
4. Can you tell me about a time when you felt the best about yourself?
   Prompt: When was it? How did you see yourself? What was it like? Stage of eating disorder? Weight?
5. Can you tell me about a time when you have felt the worst about yourself?
   Prompt: When was it? How did you see yourself? What was it like? Stage of eating disorder? Weight?
6. Does the way that you see yourself change in different situations, or when you are with particular people?
7. Has the way that you see yourself changed since the time before your eating difficulties started?
   Prompt: What are these differences? What do you think caused them? What was it like to be you before your eating difficulties?
8. Where do you think your ideas about yourself come from?
   Prompt: particular events (own memories and stories told by others)? Comments? Particular people in your life? Family? Peers? Media? Positive and negative influences.
9. How do you respond to unpleasant or negative ideas about yourself?
   Prompt: What do you do? How do you deal with thoughts/feelings?
10. Do you think that there is any relationship between how you see yourself and your eating difficulties?
    Prompt: Why / Why not? Can you tell me about experiences you have had that support this idea? What would need to happen to address this?

Appendix 6 - Interview One Transcript

Emergent themes	Original transcript	Exploratory comments
	I: Ok, so it's the 29th of May 2009 and this is [interviewer] speaking to [P1]. Ok, [P1] you can take your time with these and remember, if there's one that you don't want to answer just let me know. Ok, question one: How would you describe yourself?	
	P1: Not really anything special.	Nothing special.
	I: Ok. Is there anything else you'd add to that? So maybe, what your most important characteristics are, do you think?	
Absence of self-concept.	P1: Don't really have any.	No important characteristics. Absence of self-concept.
	I: Is there anything that you particularly either like or dislike about yourself at the moment?	
Total dislike of self.	P1: I dislike everything about myself.	Everything about the self is disliked.
	I: Ok. So everything?	
	P1: Hmn.	
	I: Is there anything that you dislike less, or feel ok about?	
	P1: [*Pause*] Not really.	Black and white thinking – either self is perfect or is totally disliked.
	I: Ok. Well, question two: What is it like to be you?	
Horrible and disappointing to be me.	P1: Horrible and disappointing.	Horrible and disappointing to be herself.
	I: Can you tell me a bit more? So, in what way…so describe, did you say 'horrible'?	
Only good at losing weight.	P1: Hmn. I'm not really any good at anything except losing weight.	Not good at anything except losing weight.
	I: Ok.	
Never good enough.	P1: And even if I try to do other things it's never good enough.	Never good enough.
	I: Ok, so what was the 'disappointing',	

	can you tell me a bit more about what that's like?	
Hopelessness about self.	P1: I know that whatever I do, it's never going to be particularly good and I will never feel that it's good enough.	Hopelessness / helplessness.
	I: So, you wouldn't feel that it's good enough? Or other people?	
	P1: I wouldn't feel that it's good enough, and I don't think other people would either.	High standards or low estimation of own ability?
	I: Ok. And how would you describe your ideal self? What would you like to be like?	
The ideal self is perfect.	P1: Perfect in every way.	Ideal is to be perfect in every way.
	I: Ok, so what would perfect be? What would…	Unrealistically high standards.
Unattainably high standards.	P1: Being the best at every single thing.	Perfect is being the best at everything.
	I: Is there anything in particular that you'd want to be the best at?	
	P1: I want to be the best at martial arts because I do, I used to do martial arts.	Martial arts – protecting the self?
	I: Ok.	
Wanting to be the best person that I can be.	P1: I want to be the best person that I can be. Whatever I chose to do, I'd want to be the best at.	Wants to be the best person she can be, the best at everything she chooses to do.
	I: Um. Are there other characteristics of somebody who is the best that they can be, or what would you be like if you were the best that you could be? Apart from excelling at martial arts and things like that.	
Seeing friend as perfect.	P1: I have a friend who helps me with all of this and I see her as pretty much perfect.	Seeing friend as perfect.
	I: Ok. Could you describe her a bit for me? Sort of, sort of as much detail as you can.	

Ideal is kind and funny.	P1: She's kind and funny. I: Um-hum.	Ideal is being kind and funny.
Ideal cares for others.	P1: And she's always got time for me. She cares about me, and she tells me that she loves me. She's a black belt in martial arts, and she never rejects me when I came to her for help. I: Could you tell me why those are good or important characteristics? So you were saying, 'being the best at everything' being 'kind', being 'funny': Why are those things good?	Having time for others. Caring. Loving. Not rejecting.
	P1: Just, if other people are like that to me it makes me feel happier.	Ideal is making others feel happy.
Ideal is making others happy.	I: Ok, so when people are like that to you [*pause, looking at one of the digital recorders*] Sorry I'm just fiddling with this recorder because it's not recording. [*Pause, looking at other recorder*] It's ok, that one's recording, we're alright. Ok, so people being that way makes, is good for you, or makes you feel good? P1: Um-hum. I: So you would like to be that way to other people? Is that right?	Would like to make others happy.
	P1: Um-hum. I: Ok. Can you tell me about a time when you felt the happiest about yourself? So, the best you've ever felt about yourself.	
Happiness with self through weight loss.	P1: [*Pause*]. I always feel that if I've lost weight. I: So would that mean that the more weight you lost, the better you would feel about yourself? Or is it more complicated?	Happiness with self through losing weight.
Pleasure with self is fleeting.	P1: A bit more complicated, because my initial reaction is being pleased for myself because I've lost the weight. But then it gets to the point where I think, well, I've got to lose more weight to feel	Losing weight initially leads to feeling pleased with self, but it is never enough.

	happy again because it never seems enough weight that I've lost.	
	I: Ok, so, in the initial reaction, when you are pleased, what's that like for you?	
	P1: It feels like freedom.	
	I: Would you use any other words to describe it?	
Weight-loss means self-accomplishment, freedom and relief.	P1: Relief.	Freedom and relief from having managed to do something.
	I: What does that mean for you?	
	P1: That I've managed to do something.	
	I: Ok. So when was the last time you felt like that? Was this, are we talking recently, or was it further in the past?	
	P1: It feels like a long time ago because I've been trying to put weight on. I think that the last time I lost weight was probably about April I suppose.	
	I: Ok. So, next question, question five. Can you tell me about a time when you have felt the least happy, sort of the worst about yourself?	
	P1: My childhood.	Felt worst about self in childhood.
	I: And how would you describe how you felt about yourself then, or how you viewed yourself?	
Absolute self-hatred in childhood.	P1: Absolute hatred.	
	I: Ok.	Absolute hatred and anger towards childhood self.
	P1: Anger towards myself.	
	I: And is this before your eating disorder started?	
	P1: Um.	
	I: Um. Ok. So you said hatred and anger towards yourself. Would you describe it in any other ways, how you viewed yourself?	
Anger & disgust at childhood self.		

	P1: Disgust. I: Ok. So what was that like for you?	Disgust towards childhood self.
Wanting to punish or obliterate the self.	P1: I just wanted to hurt myself all the time, or kill myself. I: If you were asked to describe why it was that you felt that way, or kind of what it was like for you to have those feelings, how would you describe that?	Wanted to hurt or kill herself.
Domestic violence instils ineffectiveness.	P1: Being unable to stop the violence made me feel that I was useless at everything. I: Ok. [*Pause*] Ok. Is there anything else that you wanted to say about that question, sort of about that time?	Felt useless as a result of being unable to stop domestic violence.
Being made to feel responsible for violence towards mother but powerless to stop it.	P1: Because it was my dad who used to be violent against my mum, and he would always single me out and ask me if I wanted him to punch or kick her, and because I wouldn't answer he would do both and tell me it was my fault. So I felt that all the beatings were because of me and because I wasn't able to stop it made it even worse. I: So he put it on you and made you feel it was your fault? P1: Um-hum. I: Ok, question number six. So, thinking about at the moment, or over the past years or so, does the way that you see yourself change in different situations or when you are with particular people? Can you maybe feel better or worse about yourself depending on where you are or what you are doing or who is there?	Father singled her out during violence against mother, made her feel it was her fault. Being unable to stop it made it worse.
Mother figure brings safety but also rejection.	P1: Sometimes if I'm with my friends who help me with this I feel safe and loved. But if her other daughters are there I feel very lonely because I know that she could never really love me in the same way as she loves them. I: So who was that with, sorry?	Can feel safe and loved with friend. 'Other daughters' – friend is seen as a mother-figure. Feels lonely when comparing herself to friend's children.

	P1: That was with my friend who helps me with this. I: Ok. And who was it you were saying if you are with, you feel lonely with them? P1. If um, because she's got other children... I: Ok.	
Feeling like an imposter in surrogate family.	P1: ...and if her other children are around as well I just feel very lonely and I feel that I shouldn't be there. I: And did you say sort of you feel that she wouldn't love you as much as she loves them? P1: Yeah. I: Are there any other people in your life that can sort of influence how you feel about yourself? P1: My husband does. I: Um-hum. What sort of effect does he have? P1: He makes me feel wanted.	Feels like an imposter in surrogate family? Husband makes her feel loved and wanted.
Feeling loved and wanted with husband. Expecting to wreck things ruins the moment.	I: Are there sort of any other differences about when you are with him that you could describe? P1: I feel loved with him in a special way. I: So what's that like, when you are experiencing that feeling of being wanted and being loved? And also the feeling that you described with your friend, what are these experiences like for you? P1: Just waiting for it to end. I: Why is it that you would be sort of anticipating the ending do you think? P1: Because I'll probably wreck it and lose them.	During positive experiences she is waiting for it to end, expecting that she will wreck it and lose them.

	I: Are there any other situations or people that can change how you are looking at yourself? I wondered perhaps about the martial arts you mentioned earlier? What about when you are doing that? P1: Because I'm not able to do it at the moment... I: Ok.	
Feeling like a failure.	P1: ...it just makes me feel like a failure. I: What about when you could do it?	Not being able to do martial arts makes her feel like a failure.
Never good enough.	P1: I never felt that I was good enough. I: Is it that way with all activities that you might do? Is there anything that you can do that you would think you are ok at or might change how you feel? P1: Not really good at anything. I: Um, just kind of while we are on that question still, is there anybody that we have missed out that you think has an influence on how you view yourself? P1: Not a positive influence. I: Ok. P1: Other people have a negative influence, but that's all there is for the positive. I: Are you ok to talk about the people that have, like who they are and what the negative impact is? P1: Yeah. I: Ok.	Never feels that she is good enough.
My family make me feel like a nothing.	P1: My mum and dad make me feel like a nothing, and that I'm unimportant, and they don't really care about me. And my sisters and brother make me feel the same way.	Family make her feel like a nothing.

	I: Ok. And what is that like? Being with them and experiencing that kind of, that feeling of being a nothing?	
	P1: It makes me feel hurt and angry.	Feeling like a nothing makes her feel hurt and angry.
	I: Is there anyone else that you sort of wanted to add to that list?	Then turns that anger inward?
Feeling hurt and angry believing that others do not really like her.	P1: I find it hard to get on with my husband's parents because I don't really feel they actually like me.	Feels that important others don't really like her.
	I: Does that have an effect on how you like yourself or how you see yourself when you are around them?	
	P1: It makes me feel angry, because I want to be liked but I'm not and because I feel hurt and upset about not being liked, that makes me feel angry.	Feels hurt and upset about not being liked, which leads to anger.
	I: Ok, so next question is number seven, and you've touched on it already but I'll ask again and maybe there is some more that you would add. Has the way that you see yourself changed since the time before your eating difficulties started?	
	P1: Some things have changed.	Some aspects of how she sees herself have changed since before the ED.
	I: Could you describe what the differences are?	
Friends bring the hope that she can change and feel better.	P1: Because I've got my two friends now, they make me feel that maybe I can be different, that it doesn't have to be like this. But before that I thought that how I felt was the best that I'd ever feel.	Friends make her feel that maybe she can be different, give her hope.
	I: Can I just check what order things happened in? Um, so when you were feeling that how you felt was the best that you could ever feel, when was that? Kind of in relation to 'before the eating difficulties', 'after', and then also there's this time when these friends came into your life. Where would you place that?	
	P1: When I was at college I was able to just pretend to be a different person to	Pretending to be a different person.

	the outside world and keep myself to myself because I thought, well, if I show people the real me then nobody's going to like me at all, so I thought, that's the only person I can be.	Nobody will like the real me.
Pretending to be a different person to protect the self from rejection.	I: Ok. What was this different person like, the sort of person that you showed to the world?	
	P1: Just very quiet and didn't really say much to people, but just kept myself out of harms way by not letting people in, because I thought that if I don't make friends, and have people around me that like me then I can't wreck that and I can't feel really hurt.	Showing a false self to keep others out, protect herself from rejection.
	I: What would have been the 'real you' that you were not wanting to show?	
Real self is weak.	P1: [*Pause*] Weak.	Real self is weak.
	I: So, in what ways weak?	
	P1: Very delicate over little things. Not being the best at everything, not being able to overcome all my difficulties.	Real self is not the best, unable to overcome difficulties.
	I: So at this time you were, I mean I don't know kind of what language you prefer to use. Would you say 'eating disorder' or 'anorexia', how would you describe what the eating difficulties were?	
	P1: I think they were probably developing then because I used to exercise excessively and withhold food, but at the time I just thought it was normal because I had always done it.	Thought that restricting and over-exercising were normal as they were so habitual.
	I: Ok. So you'd always done it, but you were feeling like it was developing. Was it kind of getting worse, you were doing it more?	
Comparisons with others.	P1: I think because I was around other people I was aware of the sort of things that they would do and noticed that I didn't really do things the way they did.	Comparisons with others revealed that she was different.
	I: What were the things that you did	

	differently? P1: Walk to college and back, but I lived in [town 1] and I went to [town 2] college, and I would walk there and back a couple of times a week. I: Quite a long way then. P1: I wouldn't have breakfast or lunch and for dinner I'd like to have the same thing. I went to aerobics classes at the weekend as well. I: So, this noticing that you did things differently from other people, is that, is that what made you feel that you needed to hide the real you?	
Denial of real self.	P1: I just thought they wouldn't want to know the real me and that I was better off pretending that the real me didn't exist. I: Ok. So that was the keeping quiet and not going into friendships? P1: Um. I: Ok, so that was, um, that was when things were developing, and it seemed that later on you made some friends that helped you to feel that maybe things could be different? P1: Um. I: So what, with regards to your eating, you said that you had always not ate very much and exercised a lot. Was there ever a time before that when you didn't do those things?	Others won't want to know the real me. Better off pretending that the real me didn't exist. Avoidance of rejection through social withdrawal.
Shame and hiding.	P1: When I was a child I would like to eat sweets but I had to use my dinner money to buy sweets and then so I could afford them I used to save my dinner money for the week and I wouldn't bother to eat during school time, and at the weekend I would go out and buy sweets but hide them in my cupboard. I: Ok. So, were you not allowed sweets by your parents then?	Hiding sweets, is ashamed.

Eating means fat and greed.	P1: I was, but if I ate I felt like I was fat and greedy so I didn't like to eat in front of them. I: [Inaudible]... I asked quite a similar question earlier, you were talking about your childhood and how you viewed yourself with hatred and anger and disgust you were saying. Was that through all of your childhood, or can you remember an earlier time when you felt differently?	Eating means you are fat and greedy.
Consistent anger and disgust at self throughout childhood.	P1: I always felt like that. I: And was that consistent through all of your childhood? P1: Yeah. I: Ok. So, since your friendships, these important friendships that you are having more recently, you've talked about how your friend can make you feel a bit differently, and help you feel loved. Um, can you describe sort of a bit more for me how you have been viewing yourself since you have met these friends?	Consistently felt hatred, anger and disgust for self throughout childhood.
Breaking free then being pulled down again. Pessimism.	P1: Up and down, because sometimes I think that I can do it and I can break free from everything, but then little things pull me down again and I think, oh what's the point because in the end everyone will reject me anyway and I know I'm going to fail. I: [*Pause*] Ok. I'm just sort of looking over the questions because they cover quite similar things and I think you have answered quite a lot of them. Ok. So, next question: Where do you think your ideas about yourself come from?	Breaking free but then pulled down. Learned helplessness. Pessimism.
	P1: My family. I: Can you sort of tell me a bit more about that? Whether it was particular events in your family, or particular..? I mean you've touched on some of them, but maybe particular things they would say or do?	Ideas about self come from the family.

Family were unaffectionate and critical every day.	P1. It's how all of them were with me every day and nobody ever gave me hugs or cuddles or told me nice things about myself, and whenever they did say things it was always criticism.	No affection or positive comments. Criticism, never good enough.
	I: Ok.	
	P1: Things were never good enough, and they used to make comments about how I looked.	Negative comments about appearance.
	I: What sort of comments?	
	P1: My mum would tell me that I had bad skin and that I had fat thighs, and my sisters would make comments about the way my face looked.	
	I: Did they say anything specific, or...?	
Being bullied by siblings and not protected by parents.	P1: They would just call me ugly and stupid, and my parents would never say anything to them and so I thought, well they must be right if my parents aren't saying anything.	Called ugly and stupid by sisters. Parents did not stick up for her.
	I: Ok, so because they didn't contradict then you felt they must think it too?	
Mother criticised appearance and weight.	P1: Hmn. My mum used to say I was fat and ugly as well but she didn't use those words she would say things like I had awful skin and she would say I had big thighs and everything and she would say I seemed to struggle with my weight even though I was always the thinnest out of everybody.	Mother criticised appearance. Told that she seemed to struggle with weight, in contradiction of evidence.
	I: Ok. And at the time did you realise that actually you were the thinnest or...?	
	P1: I thought I was the fattest.	
	I: Ok. And how have you realised since? Was this from photographs or other people telling you different?	
Perceiving self as	P1: I still see myself as being fatter than them but I know that I wear smaller sizes than them so although I see that I am fat and feel that I am fatter I know in	Feeling fat.

fat despite reality.	reality I can't be. I: Ok, so you have got sort of objective evidence since that that's not the case. P1: Um. I: Ok. Where else do you think um, were influences that impacted on how you see yourself, so family was...	
Rejection and bullying by peers at school attributed to being boring.	P1: At school nobody bothered to try to make friends with me. If I did make friends then they always get bored of me and go off with somebody else. I: And what did you put that down to? P1: That I was a boring person. [*Pause*] And sometimes people would make fun of me there as well. I: So at school? P1: Um. I: Ok. Did you see anybody else your own age outside of school? P1: No. I: So it was just family and school were the main people you saw. What about extended family, did you ever see them?	No friends at school. Abandoned / rejected self. Feeling like a boring person. Bullied.
Unable to trust.	P1: I saw my Nan occasionally, but [*pause*] with her I got cuddles, but I couldn't really talk to her because I didn't feel able to. I: What was stopping you, do you think? P1: I didn't trust her. I: Whose mum was she? Was she..? P1: My mum's mum. I: Ok. So this feeling of not trusting her, um, did she have any effect on how you felt about yourself or how you viewed yourself?	Physical affection from Nan, but didn't trust her.

	P1: No. I: Were there any positive influences at all or, benign influences, kind of neutral? P1: No. I didn't really like anybody in my childhood. I: Ok. Were there, kind of, any other erm areas that you used to kind of make erm, not decisions, but kind of that influenced how you thought about yourself, so television or magazines, anything like that? P1: Not in a positive way. I: What was the negative way?	
Comparing self to women on TV and in magazines.	P1: Just, if I'd see people on the TV I would think, well I'm not as thin or as pretty as them or I'm not as good as them. And if I saw, if I read magazines I think the same. I: Are there any other influences that we haven't talked about for that question? P1: I don't think so. I: Ok. Two more questions. P1: Ok. I: Um, so next question, number nine: How do you respond to unpleasant or negative ideas about yourself?	Negative comparisons to others on TV and in magazines.
Coping through restricting and cutting.	P1: Usually I either cut myself or restrict eating even more. I: Ok. So the, can you sort of tell me a bit more about that experience, about erm, you know what the thoughts about yourself are?	Experiential avoidance? Dissociation? Cutting and restriction to deal with unpleasant ideas about self.
A self deserving of punishment.	P1: They are just, if it's with my husband or my two friends, I feel like I have let them down and I feel I need to be punished for it...	Feeling that she needs to be punished for letting others down.

	I: Ok.	
Feeling stupid to have thought that anybody could actually love me.	P1: ... and I feel that I was stupid to have ever thought that anybody could actually love me, so I [inaudible] get my knife out, which I see as a friend and I just cut.	Feeling stupid to have thought that anybody could actually love her.
	I: So the knife is like a friend?	
	P1: Um-hum.	
	I: Ok. What effect does that have on how you view yourself, so sort of before you do it you feel that you have let people down, that "I was stupid to think that anybody would love me" and "I should be punished", so after, after the cutting, do you feel that you have been punished, do you feel that, you know, is anything is different about how you feel about yourself?	
Cutting reduces anxiety and improves mood.	P1: When I'm doing the cutting I feel less low, and it makes me feel safer and happy as well, and...	Feels happier and less anxious for having cut.
	I: And what, sorry?	
	P1: And happy as well. And when I've finished the cutting I feel pleased that I have done it, but then I feel guilty because I think if anybody sees that I've	Feels guilty about effect on others.
Predicting abandonment.	cut again then they will get to a point where they will get sick of it, and they will just walk away.	Fears / predicts abandonment.
	I: Do you feel afterwards that you are absolved at all of the guilt that you have that you felt you should be punished? Do you feel any differently, better or worse about yourself?	
Negative prophecies about self disappointing others.	P1: I feel less guilty but I know that I will feel like it again so I just wait for next time when I disappoint people.	Negative prophecies about herself. Predicts she will disappoint others.
	I: Ok. So you feel sort of a bit less guilty about yourself but then feel guilty about um you know, what happens if other people get sick of it?	
	P1: Yeah.	

	I: Ok.	
Guilt at letting others down, but anger at having been made to feel guilty.	P1: And I feel guilty because other people tell me I shouldn't be doing it, so I feel that I've let them down if I have. But on the other hand I feel angry because I think if it makes me feel better and I'm not hurting anybody else by doing it so there's no reason why I shouldn't.	Guilt about letting others down, but anger about being told what she shouldn't do.
	I: Ok. And when you feel angry, you've talked about anger a couple of times, in relation to, erm you know if you feel that other people don't like you, you feel sort of angry, and also um you know the sort of the pressure not to cut yourself you feel angry about that as well. If you think about kind of the experience of feeling angry like that: how do you, do you look at yourself in any different a way when you're angry than the other, sort of ways you were describing?	
Self-disgust. Cutting releases emotional pressure.	P1: I feel complete disgust and I just feel like I'm going to explode, but there's nothing to release the pressure except the cutting.	Complete disgust. Release of emotions through cutting.
	I: Ok, and this, you know this feeling of anger and wanting to explode, does that come along with any other different feelings about yourself than sort of the more usual ones you seemed to describe of feeling sort of weak and feeling a bit nothing? Does the anger and wanting to explode have other things that come with it, kind of about you and how you see yourself?	
	P1: I feel like that pretty much at any time if I feel that I have disappointed people or not done well enough.	Feeling angry at herself if she feels she has disappointed people or not done well enough.
	I: Ok.	
Others don't really understand and expect too much.	P1: Because my friend doesn't really understand, or I feel that she doesn't understand, the difficulties I have around food and so, she erm, I feel that she expects me to be able to eat normal things quicker than I am...	Others don't really understand / have expectations that are too high.

	I: Ok.	
	P1: ...because I feel that I'm not happy doing that at the moment it makes me feel weak again, and [*pause*].	Feels weak
Feels weak and a disappointment for not meeting expectations.	I: So is feeling that...	
	P1: ...that I'm a disappointment.	Feels like a disappointment for not meeting expectations.
	I: Ok. So feeling very high expectations from your friend?	
	P1: Um.	
	I: Ok so going back to um how you, how you respond or what you do when you are feeling very negative about yourself, you were saying obviously you, as well as maybe cutting you would start restricting what you eat more and, and you've talked a little about it already but perhaps we should just go over it again. What sort of effect does reducing your food have on how you feel about yourself or what does it do to those negative thoughts about yourself?	
Happiness with self through weight-loss. One thing I'm good at.	P1: It makes me feel happy because I can manage to do something and if I lose weight with it I just feel that there's at least one thing I'm good at.	Feels happy there is one thing she is good at.
	I: Ok. So on to the last question, which might seem a little bit strange because we have erm, you've talked about, you might feel that it's a bit of an obvious one but I will ask it anyway. Do you feel that there is any relationship between how you see yourself and your eating difficulties?	
Changing how one feels about oneself by changing how one eats.	P1: Yeah. Because if I was able to eat like other people then I would feel less weak.	Relationship between self and eating is that eating like others would make her feel less weak.
	I: Would it have any other effects do you think?	
Self is disliked with the eating disorder, but might be worse without	P1: I don't really know, because even if I don't have the eating disorder I don't know that I would still like myself and I don't know that I would be happy still.	Even if I didn't have the eating disorder, I don't know that I would like myself.

it.	I: I was going to ask actually when you were saying, so you were saying that you, you are not sure but perhaps if you were able to eat more then you would feel less weak. I was wondering if you had any experience of that? Can you tell me about times when you might have experienced that even just a little bit? P1: I can't really remember being able to eat without having issues about it. I: You were saying earlier that you had been trying to eat more recently. P1. Um. I: Ok. Have you been at all successful in eating a bit more compared to what you used to? P1: I used to just eat salads and cracker bread. I: Um-hum. P1: And so I stopped doing that and I do eat, I generally have the same thing every day, and then [*pause*] I had a bit of an upset with my friend over it, so I started lying to her but then I felt bad about lying to her so I would try little bits of new food, but now I've cut down on things like having breakfast and then I do more exercise to compensate. I: Ok, so little bits of new food have come in, but you've been compensating in other ways. P1: Yeah. I: Ok, and you said that you had just been eating salad and cracker bread, but you stopped doing that... P1: Yeah. I: ...and you were eating the same thing usually, what was it that you would..? P1: It would always be peanut butter on	Eating the same thing – reduction of anxiety? Feeling bad about being dishonest.
Feeling bad about being dishonest to friends.		

	toast for breakfast. A cucumber sandwich for lunch and a cucumber sandwich for dinner. I: Ok, that sounds like more than the salad and cracker bread, is that right? P1: Um I: Ok. So, eating that bit more, did that have any effect on how you felt about yourself and your 'identity' I suppose? P1: Not really. I: Ok. So there was sort of no difference? You didn't feel better or worse?	
Eating more means feeling worse about the self.	P1: In some ways I felt worse because I thought, I'm wrecking the only thing that I've ever been good at. I: Ok. [*Pause*] So this, sort of feeling about yourself that the only thing you are good at is sort of restricting and losing weight, um, what do you think would need to happen for that to change, to sort of address that?	Eating leads to feeling worse about herself, wrecking the only thing that she has ever been good at.
Needing to feel good at other things to address eating.	P1: If I feel that I am good at things, and I don't need to lose the weight to feel that I am good at anything. I: And at the moment can you see any ways that that might happen, like other things you might feel better about how well you do them? P1: No, not really. I: Ok. What about in sort of the future? Is there anything you think that, kind of given time, you would feel better about?	Needs to feel that she is good at things.
Could learn to like myself through finding another skill.	P1: I might be able to learn to like myself in the future, and I might find something that I'm good at, other than losing weight. I: Are there any other ways that you might learn to like yourself, other than finding something that you are good at?	Might be able to learn to like herself. Finding something she is good at other than losing weight.

	P1: I don't really know. I: Ok. But that would help. Ok. Is there anything that, um, that I haven't kind of given you a chance to talk about that you think is kind of relevant to the questions I've asked you so far? P1: I don't think so. I: Ok. Well thank you very much for taking part in the interview.	

Appendix 7 – Audit Trail

Chronological List of Themes – Interview One

Absence of self-concept.
Total dislike of self.
Horrible and disappointing to be me.
Only good at losing weight.
Never good enough.
Hopelessness about self.
The ideal self is perfect.
Unattainably high standards.
Wanting to be the best person that I can be.
Seeing friend as perfect.
Ideal is kind and funny.
Ideal cares for others.
Ideal is making others happy.
Happiness with self through weight loss.
Pleasure with self is fleeting.
Weight-loss means self-accomplishment, freedom and relief.
Absolute self-hatred in childhood.
Anger & disgust at childhood self.
Wanting to punish or obliterate the self.
Domestic violence instils ineffectiveness.
Being made to feel responsible for violence towards mother but powerless to stop it.
Mother figure brings safety but also rejection.
Feeling like an imposter in surrogate family.
Feeling loved and wanted with husband.
Expecting to wreck things ruins the moment.
Feeling like a failure.
Never good enough.
My family make me feel like a nothing.
Feeling hurt and angry believing that others do not really like her.
Friends bring the hope that she can change and feel better.
Pretending to be a different person to protect the self from rejection.
Real self is weak.
Comparisons with others.
Denial of real self.
Shame and hiding.
Eating means fat and greed.
Consistent anger and disgust at self throughout childhood.
Breaking free then being pulled down again.
Pessimism.
Family were unaffectionate and critical every day.
Being bullied by siblings and not protected by parents.
Mother criticised appearance and weight.
Perceiving self as fat despite reality.
Rejection and bullying by peers at school attributed to being boring.
Unable to trust.
Comparing self to women on TV and in magazines.
Coping through restricting and cutting.
A self deserving of punishment.
Feeling stupid to have thought that anybody could actually love me.
Cutting reduces anxiety and improves mood.
Predicting abandonment.

Negative prophecies about self disappointing others.
Guilt at letting others down, but anger at having been made to feel guilty.
Self-disgust.
Cutting releases emotional pressure.
Others don't really understand and expect too much.
Feels weak and a disappointment for not meeting expectations.
Happiness with self through weight-loss.
One thing I'm good at.
Changing how one feels about oneself by changing how one eats.
Self is disliked with the eating disorder, but might be worse without it.
Feeling bad about being dishonest to friends.
Eating more means feeling worse about the self.
Needing to feel good at things to address eating.
Could learn to like myself through finding another skill.

Theme Table for Interview One

Themes	Page	Key words
An overwhelmingly negative self-view compared to a 'perfect' ideal:		
Absence of self-concept	1	Don't really have any
Total dislike of self	1	I dislike everything about myself
Horrible and disappointing to be me	1	Horrible and disappointing
Never good enough	1	it's never good enough
Hopelessness about self	2	Whatever I do, never going to be good
The ideal self is perfect	2	Perfect in every way
Unattainably high standards	2	Being the best at every single thing
Wanting to be the best person that I can be	2	I want to be the best person that I can be
Seeing friend as perfect	2	I see her as pretty much perfect
Ideal is kind and funny	3	She's kind and funny
Ideal cares for others	3	always got time for me. She cares about me
Ideal is making others happy	3	makes me feel happier
Feeling like a failure	7	makes me feel like a failure
Never good enough	7	I never felt that I was good enough
Real self is weak	9	Weak
Comparisons with others	9	didn't do things the way they did
Perceiving self as fat despite reality	12/13	feel that I am fatter, in reality I can't be
Comparing self to women on TV and in magazines	14	TV, not as thin or as pretty
Self-disgust	16	I feel complete disgust
Fleeting happiness and self-accomplishment through weight-loss:		
Only good at losing weight	1	not good at anything except losing weight
Happiness with self through weight loss	3	I always feel that if I've lost weight
Pleasure with self is fleeting	3	it never seems enough
Weight-loss means self-accomplishment, freedom and relief	4	freedom, relief, managed to do something
Happiness with self through weight-loss	17	feel happy, manage to do something
One thing I'm good at	17	at least one thing I'm good at
Changing how one feels about oneself by changing how one eats	17	if I was able to eat, I would feel less weak
Self is disliked with the eating disorder, but might be worse without it	17	I don't know that I would still like myself
Eating more means feeling worse about the self	19	felt worse, wrecking the only thing good at
Needing to feel good at other things to address eating	19	good at things, don't need to lose the weight
The possibility of learning to like the self through finding another skill	19	learn to like myself, find something good at
Abusive early experiences: Bullying, lack of affection, and being forced to feel responsible for domestic violence:		
Absolute self-hatred in childhood	4	Absolute hatred
Anger & disgust at childhood self	4&5	Anger, disgust
Domestic violence instils ineffectiveness	5	unable to stop the violence, useless
Being made to feel responsible for violence towards mother but powerless to stop it	5	my fault, I wasn't able to stop it
My family make me feel like a nothing	7	make me feel like a nothing
Consistent anger and disgust at self throughout childhood	11	I always felt like that
Family were unaffectionate and critical	12	nobody gave me hugs, always criticism

every day		
Being bullied by siblings and not protected by parents	12	call me ugly, parents never say anything
Mother criticised appearance and weight	12	mum used to say I was fat and ugly
Rejection and bullying by peers at school attributed to being boring.	13	nobody bothered, get bored of me

Strategies for coping with the self-view: Cutting, restriction, and hiding the 'real' self:

Wanting to punish or obliterate the self	5	hurt myself...or kill myself
Pretending to be a different person to protect the self from rejection	9	show people the real me, nobody's going to like me
Denial of real self	10	pretending that the real me didn't exist
Coping through restricting and cutting	14	cut myself or restrict eating
A self deserving of punishment	14	I feel I need to be punished for it
Cutting reduces anxiety and improves mood	15	makes me feel safer and happy
Cutting releases emotional pressure	16	release the pressure, cutting

The role of current important relationships: Feeling loved and hopeful vs. feeling like a disappointment and predicting abandonment:

Mother figure brings safety but also rejection	5	I feel safe and loved. But...very lonely
Feeling like an imposter in surrogate family	6	I feel that I shouldn't be there
Feeling loved and wanted with husband	6	feel wanted, loved with him
Expecting to wreck things ruins the moment	6	Just waiting for it to end
Feeling hurt and angry believing that others do not really like her	8	don't, feel they, like me, angry, hurt
Friends bring the hope that she can change and feel better	8	make me feel that maybe I can be different
Feeling stupid to have thought that anybody could actually love me	15	I was stupid to have ever thought that
Predicting abandonment	15	they will get sick of it, just walk away
Negative prophecies about self disappointing others	15	wait for next time when I disappoint people
Guilt at letting others down, but anger at having been made to feel guilty	16	feel guilty, but on the other hand I feel angry
Others don't really understand and expect too much.	16	my friend doesn't really understand, expects
Feels weak and a disappointment for not meeting expectations.	17	makes me feel weak, a disappointment
Feeling bad about being dishonest to friends	18	I felt bad about lying to her