Understanding Recovery from The Stories of Individuals with a Former Diagnosis of Anorexia Nervosa: A Narrative Approach to Lived Experiences.

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List of Abbreviations

AN – Anorexia Nervosa

ANT – Attachment Narrative Therapy

CBT – Cognitive Behavioral Therapy

ED – Eating Disorder

FBT – Family Based Therapy

NA – Narrative Analysis

PTG – Post Traumatic Growth

UREC – University Research Ethics Committee

Abstract

The main aim of this qualitative study was to understand recovery from the stories of individuals with a former diagnosis of anorexia nervosa. The overarching aim was to explore the link recovered individuals make between childhood experiences and the development of AN, and to gain a deeper understanding of the key therapeutic processes that are now part of the broader life experience of the individual. It aimed to examine the manner in which individuals perceive early relations to have impacted the development of AN and to identify any changes in their life-script after treatment. A qualitative approach was adopted to investigate this phenomenon. Three participants who have been remittance for a minimum of two years were recruited to participate in two one-hour semi-structured interviews. All interviews were transcribed verbatim and analyzed through the model of narrative analysis proposed by Dallos and Vetere (2016). The analysis was sub-divided into three types, namely thematic, structural and process analysis. The three dominant narratives that were elicited were "The illusion of control"; "From one system to another"; and the "The ever-evolving self". Possible frozen narratives were identified in the narrative structures as is suggested by the model proposed by Dallos and Vetere (2016). Process analysis was carried out to analyze the participant stories beyond content and focuses on the experiences of the 'in-between' as the story is being narrated. The findings of the study suggest that participants struggled with letting go of their extreme sense of control over food, difficulties with taking on the role of patient in their social context and maintaining closeness prior recovery. Notable findings included the imminent role of psychotherapeutic treatment that helped with shift in thoughts, decreasing control, increasing relational proximity post recovery, post-traumatic growth and evolved sense of self that occurred through the process. Recommendations for future studies were included and the study's implication for policy and practice were discussed.

Keywords: anorexia, recovery, attachment, narrative, self.

Dedication

In the hopes that this work may in some way strip off the shame surrounding eating disorders,

this dissertation is dedicated to those who had to suffer and live their story in silence.

If only we could listen to what you have to say!

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And last but not least, my mother Rita, whose love not only gave me roots but also wings to fly. Your absence is felt every day.

Chapter One - Introduction

"There is no magic cure, no making it all go away forever. There are only small steps upward; an easier day, an unexpected laugh, a mirror that doesn't matter anymore."

– Laurie Halse Anderson.

1.1 Preamble

The above quote by Anderson (2009), author of the best-selling book Wintergirls, highlights the painful path to recovery. The novel describes the continuous struggle an individual faces when experiencing Anorexia Nervosa (AN), and the significant attempt to hold on to the most important thing of all – hope.

In my role as a supportive therapist in a specialized eating disorder (ED) private clinic, I was entrusted with several stories that featured the patient's suffering and emotional distress. I believe the field of psychology in Malta has come a long way in fighting the stigma surrounding mental health. This has been especially significant with challenges like anxiety and depression, while not as much for other mental health difficulties such as ED. The difference in socio-cultural perspectives between these mental health difficulties may impact the individuals and their relatives from seeking help willingly (Martin et al., 2000).

As a trainee psychology practitioner, I have been trained to reflect on the impact diagnostic labels can have on the individual. Local psychiatric treatment is strongly rooted in a medical model – a stance which in my view contributes to the negative stigma surrounding mental health and may be separating the mind and body connection in its treatment modalities (Mate, 2008). Consequently, there is little importance given to the subjective narratives of individuals living with AN (Conti et al., 2016).

In recent years a significant increase in the rates of young people with an ED has been documented: even in Malta where recent statistics show that 5% of young individuals between the age of ten to sixteen have an ED (Calleja, 2020). Meeting clients in my role as trainee psychologist and listening to their stories has given me an understanding that goes beyond that provided by statistical reports, medical diagnoses and treatment. Therefore, I would like my research to focus on this particular point of view and allow participants to voice and share their stories and experiences with their own choice of words.

1.2 Aim of Study, Rationale and Issues to be Investigated

Early attachment experiences and the importance of understanding their contribution to the development of AN underlies my interest for the current study. A multitude of literature has considered healthy relationships at infancy to be vital for the healthy development of connections to self and others (Gander et al., 2015). In contexts where healthy relationships were not possible, it is argued that the individual develops connections with other sources possibly leading to an adverse obsession with body image and fixating on food in the case of AN (Delvecchio et al., 2014). Following the large amount of evidence on the effects of attachment on AN, my work will aim to investigate the narratives of patients who have been formerly diagnosed with AN.

The overarching aim of this research will therefore be that of exploring the link recovered individuals from AN make between childhood experiences and the development of their ED, and to gain a deeper understanding of the key therapeutic processes that are now part of the broader life experience of the individual. These research aims will be investigated by means of narrative interviews which will be conducted with three participants with a former diagnosis of AN. Data will be analyzed by means of a narrative analysis (NA) approach by Dallos and Vetere (2016).

1.3 Brief Historical Perspective to Anorexia Nervosa

Currently, AN is considered to be a mental health disorder affecting Western societies since the middle of last century. It is a modern-day concept emphasizing the thin ideal, and promoting starvation, weight loss and a perfect body shape. The DSM-5 (APA, 2013) describes AN as "*disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight*" (p. 307)

The meaning assigned to starvation and fasting changed throughout the ages. Most interesting is the history of Saints and the perceptions of fasting and self-starvation in relation to religion; where the practice of food abstinence promoted a sense of purification to Roman women (Dell'Osso et al., 2016). Abstinence from food was common practice in early Christianity, where the human body and sexuality were considered secondary to the will and spirit (Behar & Arancibia, 2015).

The connection between female saints and their control with starvation was used for purification of the soul and as glorification to God. Some scholars like Behar and Arancibia (2015) suggest that this lies at the originating roots of practicing extreme starvation in AN. However, it is important to highlight what was considered as starvation at the time is different from AN as we know it today. The main differentiation between concepts is rooted in the individual's motivation and internal drive for behaviour. In 'holy anorexia' as described by Sipila et al. (2017), the focus is on obtaining spiritual purity whilst in AN, the individual is obsessed with the thin ideal (Dell'Osso et al., 2016). The individual suffering from AN is concerned with a 'false-configuration' of the self, an uncontrollable obsession with thinness, overevaluation of body shape and weight, and fear of becoming fat. Even though the ultimate aim of fasting is significantly different between spirituality and mental health difficulties,

they both result in the same consequences – malnutrition, severe physical harm and death for many (Davis & Nguyen, 2014).

1.4 Theoretical Frameworks and positioning of the researcher

This qualitative study will consider the attachment narrative theoretical framework at the core because it adds emphasis to the importance of understanding how recovered individuals perceive their life events to have contributed to the development of their ED and how key aspect in their therapeutic journey have helped their recovery.

In order to capture the multifaceted nature of AN, I believe additional theoretical frameworks were necessary for this research. This is further discussed in chapter two, where the theories that inform my thinking throughout the process of this study are further described. I consider attachment theory (Bowlby, 1969, 73, 80) narrative theory (Bateson, 1972), self-psychology (Kohut, 1977), systemic theory (Dallos & Draper, 2000) and cognitive-behavioral theory (Beck, 1976) to play a critical role in the integrative conceptualization of AN. I also deemed it necessary to consider the paradigms behind some of most optimal evidence-based treatment modalities have been demonstrated as key movers of change in anorexia (Whyte, 2014).

As a researcher who comes from a counselling psychology background where the person's subjective truth and experience carry invaluable meaning, I consider postmodernism and social constructionism to be the main theoretical underpinnings of the applied narrative approach in this study (Gergen, 1998). Whilst I agree that a more realist approach to mental health difficulties facilitates diagnosis and interventions, I believe this is in line with the multiple movements promoting a transition from the medical model to an understanding that mental health difficulties stem from many factors including trauma, social and emotional deprivation (British Psychological Society, 2015).

The critical role of diagnosis in counselling psychology practice cannot be overlooked as this may provide a guide for professionals in their decision-making processes (Craddock & Mynors-Wallis, 2014). However, I also recognize a diagnosis may not always be helpful for individuals who do not recognize their identity is independent of the condition's symptoms. As cited by Foucault (1977), power is often exerted through the use of medical discourse and individuals who have been diagnosed may struggle to live their lives independently from the medical lens from which their truth has been categorized. I believe behind every diagnosis there is a collection of detail subjective to every individual and as a professional, I agree with Bracken and Thomas (2005) who argue that individuals should be given the opportunity to prioritize understanding themselves and, in this way, eschew" regimes of truth" (p.95) and the negative effects of being assigned a diagnostic label.

1.5 Clinical Relevance and Contribution to the Field

Moving forward in our approach to EDs appeals for new paradigms for research and practice to look into the narratives of individuals who have experienced AN (Conti et al., 2016). Through my dissertation, I believe I am providing an opportunity for the field of counselling psychology to explore further routes to conceptualizing and treating AN, both in terms of practice and the social structures that inform them. I hope this dissertation serves to challenge the medical model and its influence on the treatment of AN and to encourage scholars to invest in research studies look at alternative perspectives to AN that better resonate with the lived experience of those for whom the medical perspective has been unsuccessful.

I would also like this research project to promote the consideration of alternative conceptualizations to AN which can challenge the notion of heroic therapists and brave patients and mediate against acts of self-silencing. My aim is to sensitize the professional

community regarding the importance of active listening that goes beyond the randomized trials and manuals which form a large part of our training. I believe it is time for practitioners and scholars alike to listen to the people's voices and the realities of their suffering.

1.6 Conclusion

In this chapter I have provided a general introduction in which I declare my interest in conducting this research, outline the aims and research questions, the theoretical framework and the researcher's positioning, give a historical perspective to anorexia and the clinical relevance of this research. In Chapter Two I present the literature review in which I discuss the theoretical frameworks of this study and the different treatment modalities to AN in more depth. In Chapter Three I describe the methodological approach taken and outline the process of research. The results are presented in Chapter Four and further discussed in Chapter Five. The concluding Chapter Six will highlight the strengths and limitations of the research, and provide recommendations for further research, practice and policy-making.

Chapter Two – Literature Review

2.1 Introduction

The aim of this research is of understanding recovery from the stories of individuals who had a former diagnosis of Anorexia Nervosa. The core psychological features of AN include the over-evaluation of shape and weight with an excessive restriction of food intake leading to significant low body weight (Frank et al., 2019; Morris & Twaddle, 2007). Individuals with this ED will exhibit a distorted perception of body image, an intense fear of gaining weight, and the inability to comprehend the seriousness of this condition its interference with their lives (Attia, 2010; Gorwood et al., 2016).

2.2 Research Gap in the Literature

Studies have attempted to explore possible prevention and treatment methods for ED. However, there is a contemporary prevailing interest for research to address the current gap by understanding the role of attachment and relational difficulties in childhood and how these contribute to AN development.

Previous studies attempted to address this issue by conducting quantitative surveys with structured questionnaires as a primary data collection tool. Whilst such research methods are helpful in providing statistics on the prevention and treatment modalities necessary for ED (Nilsson et al., 2007), they often fail to explore the in-depth narrative and connections which recovered individuals make when retelling their experiences (O'Shaughnessy et al., 2012; Olson, 2000). Redenbach and Lawler (2003) suggest that such quantitative methods make it difficult for new insights to emerge in the literature, and Ponterotto (2005) affirms this limitation to inhibit the field of counselling psychology in extending its conceptual advancement of the condition – whereby highlighting the lack of qualitative research that looks at the contribution of relational attachments to AN development to be a major gap in the literature.

This study aims to address this gap by understanding the connections recovered individuals make when narrating their experience of how attachment and relational experiences have impacted their AN development and recovery. Narrative telling provides individuals with opportunity to make sense of their experience and create continuity between the past, present and future (Hall & Powell, 2011). Narrative and self are inseparable in that a crucial resource for communicating and shaping a 'whole 'experience requires socialization of emotions, attitudes and identities (Ochs & Capps, 1997).

In view of this increasing relational interest to AN development in literature, Garrett (1998) and Saukko (2000) explored the themes of dependency and conformity in the lives of recovered women however, they do not explore the connections individuals make when narrating their own story of recovery – a critical point of relevance addressed by the current study and its theoretical frameworks. Moreover, applying a qualitative approach that considers attachment narrative theoretical framework at the core, adds emphasis to the importance of including how individuals perceive their life events and their therapeutic journey to the literature. Through the use of semi-structured interviews, drawing of genograms and a timeline activity, this study aims to obtain a preliminary understanding of the participants' link between childhood experiences and the development of AN. In the process of narrating their story, individuals are reinstating their fragmented aspect of self in a context where they can be seen as a whole person (Rance et al., 2017).

2.3 Conceptual Frameworks

In order to provide a context for the research in question, a variety of theoretical frameworks are applied to inform my thinking throughout the process of this research. These frameworks include the attachment theory (Bowlby, 1969, 73, 80) narrative theory (Hermann et al., 2005), self-psychology (Kohut, 1977), systemic theory (Dallos & Draper, 2000) and cognitive-behavioral theory (Beck, 1976). The application of these theories was necessary for

an integrative perspective on conceptualizing AN, and to determine the understanding behind some of the most optimal evidence-based treatment modalities that affect therapeutic change (Whyte, 2014).

2.4 Research Strategy

The literature review undertaken has shown the limited amount of local research about AN and therefore, most of the literature cited in this chapter will be based on international studies. The following keywords were used; anorexia nervosa, attachment narrative, psychological treatment, self in anorexia. Most of the articles were retrieved from APA Psych Net, PubMed, ScienceDirect and Sage.

2.5 Overview of the chapter

In this chapter I highlight the criteria for AN in the Diagnostic Statistical Manual DSM-5 (American Psychiatric Association [APA], 2013), including the differences between the current and previous version of the DSM. I include the worldwide incidence, prevalence, and distribution rates of AN. I explain the aetiological perspectives that inform the underlying theoretical frameworks of the study. These theories were necessary to inform my thinking throughout the research and to consider the integrative element of different therapeutic modalities for AN. Treatment options and challenges are further discussed towards the end of this chapter.

2.6 The DSM- 5 Diagnostic Criterion for Anorexia Nervosa

There are three diagnostic criteria for AN in the DSM-5 (APA, 2013). Criterion A specifies the restriction of food intake that leads to significant low body weight in the context of the age, sex, developmental trajectory and physical health of the individual. Significantly low weight is described as a weight rank that is less than the minimal norm. Criterion B specifies the presence of an intense fear of becoming fat or gaining weight, or of any persistent behavior that may interfere with weight gain even though the individual is already

in a significantly low weight range. Criterion C indicates the presence of distorted views towards own body weight or shape without recognizing the seriousness of the current low body weight (APA, 2013). Moreover, the DSM-5 specifies between two subcategories of AN, namely the restricting type and the binge-eating/purging type.

2.6.1 Changes in definition

It is worth noting that there have been two major changes in the criteria for AN from the DSM-IV (American Psychiatric Association [APA], 1994) to the DSM-5 (American Psychiatric Association [APA], 2013). The first change is that amenorrhea, described as the absence of menstruation, was eliminated as a criterion. This elimination is important because it enables males to meet the criteria for AN (Zayas et al., 2018), whilst it also avoids the exclusion of a small minority of females who still experience menstruation despite extreme weight loss and malnutrition.

The second change involves the revision of the low weight criterion for more subjectivity and clinical judgement (Estour et al., 2014). This revised criterion highlights the crucial aspect that AN can occur in individuals who would not be objectively considered to be low weight on a BMI chart. This new criterion considers the subjective growth trajectory and weight history. In order to be diagnosed with AN, a person must meet all criteria in the current DSM-5 edition (APA, 2013).

2.7 Worldwide Incidence, Prevalence and Distribution of Anorexia

According to the World Health Organization (WHO, 2013), AN is witnessed in all developed countries with a global prevalence of around 0.3-1% in women, and 0.1-0.3% in men. Scientific evidence suggests that AN is increasing in our society with a marked rise in prevailing rates of the condition and with the age-of-onset to be as low as ten in females (Halmi, 2009; Currin et al., 2005).

Research on the rising epidemic brings together historical and cultural perspectives. Richard Gordon (1990) indicated high incidence of this condition can be traced to multiple factors including the increasingly challenging transition from adolescence to adulthood and the social importance that is attributed to the physical body – particularly, the common thin ideal that glamorizes anorexia in the media. In 2006, a meta-analysis by Hoek also documented a spike in AN with the most substantial increasing rates to be among females aged between 15-24 years. Similarly, van Son et al. (2006) reported increased incident rates in the number of severe cases of AN requiring hospitalization in females aged between 15-19 years.

In the revised section on ED in the DSM-5, the lifetime prevalence rate of anorexia amongst women is 1.7% whilst rates were relatively rare in men (APA, 2013; Smink et al., 2014). Contrastingly, findings from Kinasz et al. (2016) suggest that males tend to have an earlier age-onset of the condition and attend treatment at a younger age than their female counterparts – who, on the other hand, are more likely to present with severe symptoms of eating restraint, weight and shape concern (Striegel-Moore et al., 2009).

Interestingly, statistics indicate a higher incidence rate of AN in western countries than in non-Western countries, although it appears to be increasing. This distinction was reported in a study by Makino et al. (2004), where the rates for AN in western countries ranged from 0.1% to 5.7% and rates in non-western from 0.002% to 0.9%.

2.8 Etiological Perspectives

Considering the different dimensions that frame the construct of AN in the literature (Aquilina et al., 2014), the below section highlights the contribution of attachment, narrative, cognitive, systemic, socio-cultural, personality and self-psychology theory.

2.8.1 Attachment Theory

The core tenet of attachment theory is that individuals share a universal need to seek proximity to their caregiver when under stress or threat (Prior & Glaser, 2006). Bowlby (1958) proposes attachment can be understood within an evolutionary perspective i.e. the caregiver provides safety to the infant by secure base from which the child can securely depart to explore the world. In systemic terms, seeking proximity and protection from the caregiver when under stress represents an interactional process between the child and caretaker (Dallos, 2001). This interactive process indicates the human's biological predisposition to attach, and that the consistent presence of an affectionate parent is crucial for secure attachment (Dallos, 2001; Bowlby, 1969).

The Strange Situation experiment (Ainsworth et al. 1978) illustrates reactions infants show when placed in temporary situations that are void of their caregivers' presence. The observed reactions were classified into three attachment styles, namely: secure, avoidant and anxious/preoccupied. According to Bowlby (1969), these early relational connections become internal systems of representation for the child that are linked to child's interactions with the external environment even as they develop (Main et al., 1985; Cole-Detke & Kobak, 1996; Fonagy et al., 1991). Since various studies report that individuals diagnosed with AN tend to have an insecure attachment style (Kuipers & Bekker, 2012) it was deemed necessary to apply such theoretical background to this study and explore the often-associated themes of lower identity differentiation and poor self-concept in cases of ED (Jacobi et al., 2004). Other scholars suggest insecure attachment to contribute to lower acceptance of their own body and self and an impaired recognition of hunger and satiety (Gander et al., 2015). Moreover, Brown (2009) argues that a deprivation of emotional connection in infancy may lead to adult connections seeks other sources for self-soothing, possibly increasing risk for developing an adverse obsession with body image and exercise behaviors. Thus, the application of

attachment theory (Bowlby, 1969, 1973, 1980) was considered important for the understanding of AN development (Mikulincer & Shaver, 2010).

2.8.1.1 Attachment and The Relational Self in Anorexia Nervosa

Northoff (2013) considers 'the self' as central structure of the mind that categorizes different functions towards internal and external stimuli within one's environment. In this way, the self can be considered to represent the individual's attribution of experiences at a particular point in time (Doering et al., 2012). Such attribution entails the arrangement of both neural and psychological activity, and alterations within such arrangements may consequently impact all the subsequent functions, including abnormal changes in cognitive, affective and social functions (Northoff, 2015a, b).

Decety and Somerville (2003) indicate that individuals with a healthy sense of self are able to conceptualize a clear distinction between the body, the emotions and the individual boundary when engaged in a connection with others. In this sense, the organizing function of the healthy self allows the individual to know what is one's own and what is of the other (Doering et al., 2012) and thus, the self can be considered to play a key role in distinguishing between one from the other in a relationship. Similarly, Erikson (1950) states that no true relationship can exist without a sense of differentiation. This is supported by Schore (1994) who considers the development of the self to be dependent on parental caregiving and attachment.

Bowlby (1969) describes attachment behavioral systems like crying and eye gazing to be inborn processes that increase proximal closeness between an infant and its caregiver especially when feeling distressed. The repeated interactions between an infant and the caregiver become encrypted as internal working models of attachment in the child and act as schemata for future relationships (Siegel, 1999). Although patterns of attachment are often formed in infancy and taken on to adulthood, changes can occur when the individual

encounters unexpected life events or changed interactions with its attachment figures during adolescence and adulthood (Pinquart et al., 2013). Since individual differences in the organization of attachment behaviour are related to the responses of the primary caregiver, it is understandable to consider the fact that individuals who experience inadequate security, emotional availability and attunement from their caregivers during times of distress may develop maladaptive dependency or detachment as defense strategies (Amianto et al., 2016).

2.8.2 Narrative Theory

Within a narrative theoretical framework, narration is considered main instrument through which individuals organize their experiences and attribute meaning to their life events (Di Fini & Veglia, 2019). According to Bateson (1972), narrating stories embodies the constructed patterns of objects and events in the social and cultural context they reside in (LeBlanc et al., 2017). The constructed connections are significant to this study since it seeks to understand the appraisals of recovered individuals with a former diagnosis of AN and how they give meaning in their conceptualization of reality.

A prevailing principle of narrative is that of drawing from postmodern concepts that view reality to have more than a singular interpretation of existence (Lyons & Cole, 2007). It is instead considered to include varying interpretations of reality to which meaning or appraisals are associated. In many respects, such an idiographic research method can be viewed to hold much in common with systemic practice. This is because it requires the researcher to be curious about people's lived experiences and understand "what it is like" for the participants to have experienced these life events (Dallos & Draper, 2010, p.88).

Moreover, deep descriptions of complex phenomena and of causation can be captured by comprehending how people think problems arise, how they resolve them and how they heal from them. With narrative the researcher is able to link phenomenology and social constructionism together (Berger & Luckmann, 1966), and as the story unfolds, the

individual's subjective sense of self and identity are also being composed (Clandinin & Connelly, 2000; Dallos & Vetere, 2014). Additionally, eliciting people's perspectives without much interruption when narrating their story eliminates the risk of gathering categorical data. The use of visual aids, such as drawing a family genogram can also assist the individual in articulating what is difficult to express verbally, touch on what is emotionally painful, suppressed, and/or defended (Vetere, 2016). As the current research aims to explore the life events and the attachment systems that were present in the participants' experience, narrative theory was deemed most appropriate for these themes to emerge.

2.8.3 Self Psychology

Whilst the attachment narrative framework is the core theoretical background for this study, I could not overlook the importance of the psychodynamic and its influence on understanding the concept of the self in AN. Self psychology was developed by Kohut (1971; 1977), a psychoanalyst who conceptualized the self "as a mental system that organizes a person's subjective experience in relation to a set of developmental needs" (Wolf, 1988 as cited in Banai et al., 2005 p.224).

Kohut (1977) considers the psychological self to emerge from the ego and made up of the individual's thoughts, attitudes, feelings and sensations towards oneself and the world. This concept of self is central to personal identity in psychoanalysis as it provides insight into people's experience of their developmental continuity over time. According to Kohut (1977), the development of the self begins in infancy and continues through the self-object experiences encountered across time. Kohut's theory emphasizes the infant's need for affection and connection from caregiver to sustain emotional survival. It notes the function of emotion regulation through self-object experiences in early life.

Kohut (1977) identifies three self-object needs, otherwise known as narcissistic needs, crucial to the healthy development of the self. These three self-objects need include

mirroring, idealization and twinship. An infant who experiences empathic lapses and disappointments to these narcissistic needs may develop pathological issues with feelings of self-worth (Kohut, 1977). Whilst the developing environment of a child can never be perfect, Kohut believes narcissistic needs can be met in a way that is 'good enough' to develop a sense of self without pathology (Arble & Barnett, 2014). When children are deprived of these needs and is met with rejection or criticism instead, they develop personalities that seek to obtain these needs from other sources (Kohut & Wolf, 1978). Particularly, due to their lack of self-esteem, these children grow into adults that feel hungry for affirmation and behave in ways that evoke attention and care from others.

The self is an active agent continuously seeking competence, resolution of internal and external conflicts, and mastery in the social world (Brown, 1998). It is a social product molded and shaped by early relationships (Mikulincer, 1998; Frome & Eccles, 1998) whose developmental changes in cognitive abilities and the requirements of specific life-events that are embedded in specific times and spaces (Moretti & Higgins, 1990). Thus, others' values and behaviour are significant to the development of one's sense of self (Oyserman et al., 2012). Moreover, what one remembers, how one remembers it, and the sense one makes out of one's experiences are shaped by one's concept of the self (Oyserman et al., 2012).

Practitioners working with AN often observe a disconnection between the patient's own internal experiences and those of others (Rothschild-Yakar et al., 2013, Tapajoz Pereira de Sampio et al., 2013) They also tend to witness troubling emotional responses such as anger and helplessness that is often present in the therapy room (Vitousek et al., 1998; Satir et al., 2011; Fassino & Abbate-Daga, 2013). Given the interpersonal nature of the disorder, the theory of the self in AN is important to apply in this study as it represents the organizing function of the mind, that when disturbed will lead to the onset and maintenance of the disorder (Amianto et al., 2016). A fundamental tenet of the psychodynamic approach with

AN is that it views psychopathology symptoms to be a way of managing internal painful experiences related to a deficit in the Self (Tasca & Balfour, 2014; Williams & Reid, 2015). Research has shown that such a deficit in the self of individuals with AN is related to attachment insecurity and thus to emotion dysregulation – a common predisposing factor to development of AN (Tasca et al., 2009).

2.8.3.1 The 'false-self' Configuration

Literature has reported a correlation between insecure attachment and poor self-concept (Jacobi et al., 2004). Similarly, prominent psychoanalyst Helen Bruch (1982), considers the core root of AN to stem from a deficit in the structure of the self. This deficit compromises a person's integrative capacity to coordinate functions and eventually develop a "false-self" to engage. This 'false-self' signifies the way or manner in which these individuals struggle to distinguish between their own and their caregiver's needs and expectations (Winnicott, 1964).

In his theory, Winnicott (1964) highlights the vitality of the psychological self that could be threatened by the interaction of parents, or other individuals who may negatively impact the inner world of fantasy of the child (Ehrlich, 2021). When these aspects are not well engaged, they undermine one's sense of psychological vitality leading to a higher risk of developing a false self when under pressure to comply with surrounding demands (Ehrlich, 2021).

The likelihood that the experience of the body in individuals with AN is not integrated into their sense of self is noticeable through the attitude of "objectification" toward their body (Tiggemann & Lynch, 2001). The body is no longer experienced in a subjective way but is rather considered to be a mere impersonal object (Greenleaf & McGreer, 2006; Fitzsimmons-Craft, 2011; Eshkevari et al., 2014). Bruch (1982) also suggests that individuals with AN have difficulty in both considering their future as well as perceiving and integrating their past

into the present narrative of the self. Hence it is possible that due to these difficulties individuals with AN struggle to integrate their own internal experiences with a meaningful narrative of the self. Over time, this struggle results in an unstable sense of identity that is considered to weaken associated functions like interpersonal effectiveness, emotion regulation and self-esteem (Amianto et al., 2016). Current psychoanalytic authors broaden the concept of the “false-self” by considering how nurturing issues in early mother-child relationships may lead to basic existential difficulties with recognizing feelings and integrating them into a sense of self (Granieri & Schimmenti, 2014).

In a way, one can expect a “false-self” to be born when the environment surrounding the infant does not welcome the self to be as it is (Amianto et al., 2016). Moreover, when infants are not nurtured into their capacity to deal with life, severe impairment in one’s ability to self-soothe is caused and it can lead the individual to have a chronic need for soothing to be experienced through external sources (Amianto et al., 2016).

Scholars argue that the very onset of AN can be considered to be one configuring example of a “false-self” in which the individual is obsessively seeking to self-soothe an insatiable amount of hunger which cannot be satisfied nor denied enough through the uses of ED behaviors (Amianto et al., 2016). Amidst the obsessive need to feed the “false-self”, it is likely that the individual becomes so consumed by it that the authentic form of self is forgotten. According to Winnicott, this refers to splitting and repressing from integrating both polarities of self in a concurrent manner (Boag, 2017). This is further supported by studies that depict the effective adaptive strategy of the “false-self” to protect the individual from exposure to the real self and from seeing who they really are (Winnicott, 1965). Additionally, the ego may become so invested in the false self that it begins to believe in its reality and any threat to its existence becomes perceived as a threat to life itself (Amianto et al., 2016).

In view of such deficits, it may not come as a surprise that ED have higher mortality and co-morbidity rates than any other psychiatric disorder (Nielsen, 2001). It also adds understanding to why individuals with AN often have lower motivation for change and resist treatment (Pike, 1998; Steinhausen, 2002). Arguably, such individuals would have been detached from their true self for so long, they may fear there would be no self at all without their "false-self". Hence why some individuals may cling to their ED as if their life depends on it, even though essentially it is taking their life away.

Weaknesses in the integrative functions of the self may shed light on why certain traits like perfectionism (Wade & Bulik, 2007; Hurst & Zimmer-Gembeck, 2015) and low self-directedness (Fassino et al., 2004, 2013) become rigid in individuals with AN. Wagner et al. (2006) considers these traits to play a key role in the maintenance of AN, and they often remain strong even after recovering. Such problematic attributes of the self often result in challenges with integrating current self-image and engaging in relationships with others that in turn, may generate social insecurity and feelings of insecurity that tend to maintain ED (Amianto et al., 2016).

In view of the psychoanalytic theories that consider the self to be the core organizing principle behind various aspects of mental functioning, it is plausible to consider deficits in the self's functioning to stem from attachment insecurity and to the root cause of AN (Tasca & Balfour, 2014a; Gander et al., 2015). These deficits may be further precipitated in sociocultural contexts that pressure the internalization of the thin ideal (Klump et al., 2009).

2.8.4 Systemic Theory

Systemic theory contributes a reflexive framework to map patterns, process, communication and meaning-making in relationships (Dallos & Draper, 2000). The theory describes relations, their consequent satisfactions and dilemmas, both ordinary and extraordinary (Vetere, 2016). It helps to conceptually separate the person from the problem,

and in this research, it can provide further insight to the other theories of relational content, including attachment and narrative theory. In my view, adding systemic theory to the conceptual framework can shed light on the individuals' intimate relationships in life and it also provides an integrative explanation to what is happening between one and the other in the context of an ED (Vetere, 2016).

Systemic theory views the development of AN as a natural consequence to dysfunctional interactions in a group, a family (Caille et al., 1977). It rests on the conceptualization that the welfare of individuals is related to the membership within the family, and if the family is dysfunctional the individual may become dependent on maladaptive mental or behavioral transactional patterns to stabilize the system and avoid disintegration (Caille et al., 1977). This theoretical insight provides a background for the critical treatment modality of family-based therapy (FBT) with a unique approach to understanding and treating AN (Lagos, 1981).

2.8.5 Cognitive-Behavioral Theory

Cognitive behavioral theory provides a transdiagnostic account that underpins an enhanced form of treatment for AN (Murphy et al., 2010). This theory considers the core psychopathology of AN to be cognitive were individuals experience an increased rate in over evaluating weight and shape (Fairburn et al., 1999).

CBT to psychopathology describes how people's perceptions and thoughts of situations influence their behavioral and emotional reactions (Beck, 1976). It is the foundation to one therapeutic approach within the larger group of CBT therapies (Beck, 2011). CBT seeks to overcome difficulties and change dysfunctional thinking, behavior and emotional responses (Beck, 2011) - and its exclusive focus to AN is with managing to regulate excessive control on eating (Fairburn & Cooper, 1999).

2.9 Treatment for Anorexia Nervosa

The following section considers the different treatment modalities that are found to be most effective in helping cure AN. The consideration of these modalities was necessary to address the multidimensional aspects of AN that may require more than one treatment approach for recovery.

2.9.1 Psychoanalytic Treatment

The psychodynamic practice strives to integrate insights derived from drive theory (Freud, 1920), ego psychology (Freud, 1927), object relations (Klein, 1923), self psychology (Kohut, 1977), intersubjectivity (Husserl, 1931), relational and attachment theory (Bowlby, 1969, 1988, 1980) to claim a thorough comprehension of the antecedents of the ED symptoms. As is also indicated in other treatment modalities, it is fundamental for psychodynamic treatment to prioritize the unique personal history of the individual and to provide a safe space in which one may process that same history (Zerbe, 2001).

Bruch (1982), a prominent psychoanalyst in the study of AN, states that it is imperative to create a safe space for these individuals to communicate and process their most salient emotions, as they arise in the therapeutic dyad. It is part of the process for the psychoanalytic practitioner to assess the transference and countertransference reactions that are interchanged within the therapeutic relationship. Through healthier identification with the practitioner, the individual is gradually more able to become autonomous and master their independent behavior (Zerbe, 2016; Bruch, 1982).

Throughout this process, the psychodynamic therapist attempts to understand and resonate with the deep internal anguish that is conveyed and manifested through the bodily sufferings of these individuals. Manetta et al. (2011) point out that psychoanalytic practitioners focus less on rapid symptom reduction and engage in confronting the profound

emotional pain in order to therapeutically assist these individuals in getting better. Prominently, psychodynamic focuses on exploring and restoring the characteristic deficits of self-conception, personality and body awareness that could be related to an absence of secure responses in early mother-child relations (Bruch, 1982). Moreover, patients with AN are encouraged to develop initiative and autonomy during psychoanalytic therapy (Bruch, 1982).

2.9.2 Family Based Therapy

One novel treatment for individuals with AN is Family-Based Therapy (FBT). This approach promotes the identification of the family's role in the development of the ED (Bodell & Keel, 2010). Whilst evidence suggests that no particular family style contributes to the development of AN (Darrow et al., 2017), they are effective in mitigating shame and stigma around the condition (Zerbe, 2016; Rienecke, 2017) – two prominent issues that are addressed as a first step to facilitate family therapy engagement (Kelly et al., 2014). FBT seeks to better understand what meanings are attributed within the family home to food, weight and body shape (Savage et al., 2007) and how these meanings are embedded in the complex familial and cultural systems (Banks, 1992; Chadda et al., 1987).

Research suggests FBT may be considerably advantageous over individual psychotherapy when it comes to resumption of menstruation, weight gain and with the decrease of cognitive distortions (Gardner & Wilkinson, 2011). This is further supported by Loeb and le Grange (2009) who argue that FBT challenges the practical factors maintaining the AN in the system; such as allowing the individual to make their own food choices and making no assumptions to what may have been the cause of AN from the system.

Moreover, FBT aims to externalize the illness from the intersubjective exchanges that occur in the system by reducing blame towards the individual with AN. This aids in correcting any misconceptions often held towards the individual with symptoms who may be

believed to be orchestrating an ED for attention (Vitousek & Gray, 2005). Supportive relationships within the system are further strengthened in treatment by assigning supportive roles in relation to recovery (Loeb & le Grange, 2009).

2.9.3 Attachment Narrative Therapy

Attachment Narrative Therapy (ANT) offers a useful link for systemic approaches in determining how early interactions in families not only promote particular emotional attachment patterns (Ainsworth, 1978) but they also shape the content and style of the narratives formed by the individual (Dallos, 2001). Research suggests that common patterns are observed amongst AN/ED sufferers including the avoidance of conflict and apparent difficulties in discussing relationships and feelings (Cerniglia et al., 2017). This adheres with the literature that reports trans-generational experiences of insecure/avoidant attachments within the family system (Cortes-Garcia et al., 2019).

Moreover, potential unresolved attachment insecurities of the mother are then activated by the child's anxieties, and feelings of rejection or unavailability within the caregiver may be reactivated (Doane et al., 1991). This may lead parents to re-enact with their child the conflicts they had experienced with their own parents. Parents who lack awareness regarding the fact that these emotional experiences from their childhood are being activated and transferred onto their own children and do not seek help, could inadvertently contribute to the development of ED in their child (Dallos, 2001).

With ANT, it is possible for the therapist to take into account the attachment dynamics and the internal representations of each family member in the form of narratives or constructs (White & Epston, 1990; Dallos et al., 1996). This type of therapeutic approach consists of four stages, namely: i) creating a secure base, ii) maintaining it, iii) exploring the

nature of the early attachment narratives and iv) considering alternative factors that may have altered the attachments throughout the lifespan of the individual (Dallos, 2001).

2.9.4 The NICE Guidelines on Psychological Treatment

The National Institute for Health and Care Excellence (NICE, 2017) guidelines recommend treatments that address specific aspects of AN. These treatments are explained in Appendix I.

2.9.5 Non-adherence to Treatment

Resistance to treatment is a well-known phenomenon amongst patients with EDs and it is the principal reason behind relapses and poor outcomes (Berends et al., 2018). The main factors behind non-adherence to psychological treatment are included in Appendix J.

2.10 Conclusion

This chapter introduced the aims and objectives of the research and provided a rationale for the relevance of the study. It identifies a gap in the existing literature which this study seeks to address. Definitions of the phenomenon under study were presented, epidemiological data were considered and a rationale for drawing on specific theoretical frameworks is provided. The multifactorial etiology of AN is acknowledged and in addition to intra-psychic theories, this framework incorporates theories which emphasize the importance of relationships and of unique personal experiences of the individual. Different types of evidence-based treatments that can be applied from these theoretical frameworks were also discussed. The integration of these theories made it possible to view the phenomenon from a more integrative perspective against which the obtained results will be analyzed. The following chapter will provide a more detailed explanation of the methodology adopted to conduct my study.

Chapter Three – Methodology

3.1 Introduction

The first part of the methodology chapters presents the selected research method for this project. I outline the research questions, main aims and objectives. I discuss the rationale for using a qualitative approach as well as reasons for analyzing the data from an attachment narrative perspective. Furthermore, I will be stating and affirming my position as a researcher.

In part two of the chapter, I outline the research process with descriptions of the procedures followed to recruit participants, gaining access to the participants and the combined criteria for inclusion. An explanation of the process of data collection and analysis, ethical considerations, credibility and trustworthiness of the study is included along with a section on reflexivity.

3.1 Part One – Methodology

3.1.1 The research questions, aims and objectives

Individuals with AN are commonly distressed and often present a number of adverse medical morbidities, negative psychological consequences and considerable deterioration of quality of life (Sim et al., 2010). The severe consequences of AN has urged health care professionals to diagnose and treat AN as promptly as possible. Various aspects of AN have been investigated empirically, including the initial diagnosis, however as Sim et al. (2010) had identified, detecting ED at early stage is challenging for physicians given the barely noticeable psychological and physical symptoms manifested at that point in time.

Scholars like Nilsson et al. (2007) have tried to develop aids and clues which would enable early diagnoses. However, to date, limited attention has been given to the narratives of

people who have recovered from AN and how these individuals understand and interpret their experiences (Saukko, 2000; Olson, 2000; Redenbach & Lawler, 2003).

Therefore, this study aims to fill this identified gap in the literature, thereby exploring how individuals who recovered from AN make sense of the interplay between the symptoms of AN and the events that have occurred in their lives. It has been my intention as the researcher, to identify any changes in the life script, or selfhood, of the narrators as they construct the story of their past relational histories vis-à-vis their experience of AN. Moreover, there is limited available data on the reflective narrative that individuals make on their own treatment process and how that has helped them obtain a better quality of life (Cooper & Kelland, 2015).

Therefore, addressing this gap in the literature has shaped the second objective of this research study – exploring the key psychotherapeutic process that brought alterations to their life script and what aspects of the narrative, if any, they now carry as part of their broader life perspective. These insights could add to the richness of my study and provide critical awareness for the improvement of psychological interventions and service provisions.

3.1.2 The qualitative approach

The purpose of this research is that of giving a voice to individuals' stories, regarding the interplay of their life events and the development of AN. In addition to an analysis of the process and context of the individuals' life narratives, I also recount their idiosyncratic experience of key events during psychotherapy (Dallos & Vetere, 2016). For this reason, a qualitative approach was considered to be the most suitable method for this study, since it enables the researcher to obtain a deeper understanding of the complex phenomenon under investigation (Dallos & Vetere, 2005).

Qualitative research designs have the assumption that there are no universal truths or one objective reality (Lyons, 2007). In social sciences, understanding takes precedence over scientific explanations of nature. Brown (1976) states human studies are not mere facts of nature but rather objectified expressions of the human mind. It is argued that what one determines as his reality, is in fact a subjectively constructed worldview that has been schematized through a process of interpretation of events (Hawking & Mlodinow, 2010). This is what qualitative studies seek to understand.

Moreover, qualitative methods believe the production of knowledge is context-specific (Faber & Leon-Arauz, 2016). It is therefore my aim as researcher to take an active role and focus on interpreting the phenomenon under investigation in its most natural setting. In this research I seek to make sense of the meaning participants attribute to their context (Denzin & Lincoln, 2011) and any other related dynamics or social structures that form part of the context in question (Dallos & Draper, 2010).

3.1.3 Narrative research

As previously outlined, this research considers attachment and narrative theories to be insightful when seeking to understand the development and treatment of ED (Dallos, 2001). The close association between early attachment experiences and the coherence of the constructed narratives, seem to provide a useful link that indicates how early familial interactions not only promote particular emotional attachment patterns, but also influence the way in which the content and style of narratives are being formed (Cassidy et al., 2013). These implications are useful in understanding the life stories of individuals with a former diagnosis of AN, especially because a high number of researchers consider attachment disruptions between the child and the primary caregiver in the early years of life to play a central role in the development of ED (Bruch, 1975; 1990; Palazzoli et al., 1978).

Literature shows that insecure attachments developed during childhood are represented in the types of narratives individuals hold with regards to their life events (Di Fini & Veglia, 2019). Bruner (1990) argues that narration can be an instrument through which an individual organizes experience, attribute and share meaning in social interactions – and thus the application of ANT framework could not be overlooked. This provided the interviewees an opportunity to interpret and share eventful themes they consider central to their perceptions of social roles and relations (Singer & Bonalume, 2010). The connections individuals make in their narrative construction hypothesizes the existence of powerful indicators of meanings which can go beyond individual and cultural variations (Csikszentmihalyi & Beattie, 1979; Veglia, 2013; Veglia & Di Fini, 2017).

3.1.4 Rationale for Choosing Narrative Analysis

This study aimed to gather the participants 'constructed life stories of i) having a former diagnosis of AN and ii) any possible changes to the life-script after receiving psychotherapeutic treatment. Whilst quantitative methods are valuable in examining aggregates of information and generating statistics, they do not allow for a deeper understanding of one's sense of self, meaning, intention and experiences (Heron, 1992).

As a researcher, I considered other qualitative methodologies for this study however, the narrative approach was deemed to be the most fitting choice because of its striking features that match the question under investigation (Lincoln & Guba, 1994). Through a narrative perspective, the participants' phenomenological subjective meaning, sense of self and identity are formulated as the story is being unfolded (Clandinin & Connelly, 2000).

Husserl (1931) defines phenomenology as the analytical process of understanding the outside world through consciousness (Zahavi, 2003). For Heidegger (1927) consciousness is a construction of historical social context from which it arises and they cannot, nor should

they be separated. Consequently, reality and consciousness can be perceived as co-creations, a relationship between the two acting together to inform the individual's understanding of his world. In NA the researcher is able to link phenomenology and social constructionism together whilst depicting imagined potential futures, interpret events, outline intricate patterns and identifying descriptions of identity construction and reconstruction in the process (Sammut et al., 2016; Allen, 2017). As these factors are considered to be of significant importance for individual construction and creation of knowledge within a cultural context, NA was used to address the research questions and the related objectives of the study.

3.1.5 The Philosophical and Influential Roots of Narrative Research

In NA, the story becomes the object of study and the focus is set on how individuals make sense of actions and events in their lives (Reissman, 1993; Clandinin & Connelly, 2000). Studies show different perspectives to the theoretical underpinnings of NA, some of which include the theory of experience (Dewey, 1938), literary theory (Eagleton, 1996), ethnography (Geertz, 1973) and also psychoanalysis (Mitchell and Egudo, 2013.) However, for this research study the postmodernist and social constructionist theoretical underpinnings are applied (Gergen, 1998).

3.1.5.1 Postmodernism

Postmodernism criticizes the modernist view that the world holds one universal truth and that it can be applied in all situations (Engholm, 2001). It specifically criticizes the notions of truth, reason and rationality (Hollinger, 1994); and it "invites us to rethink the notions of self, society, community, reason, values and history that dominate modernity, and to do so without nostalgia or regret and without utopian aspirations for what we create under conditions of postmodernity" (Hollinger, 1994, p.170).

What Hollinger (1994) refers to as conditions of postmodernism, Ferrier (1998) further explores through his proposed seven prominent elements of postmodernism philosophy. These seven elements are namely; (i) the construction of knowledge by individuals or groups, (ii) contextual construction of meaning and validity of multiple perspectives, (iii) the grounding of truth in everyday life and in social relationships, (iv) reality being composed of multiple perspectives, (v) life as a text, whilst thinking being an interpretative act, (vi) science and other forms of human activity are full of value, and (vii) values and facts are inseparable.

These philosophical principles provided the underlying paradigms for this research. NA subscribes to these principles by considering people's narratives to be a source for constructing identity that also contributes to the process of meaning making (Czarniawska, 1997). Moreover, stories can act as groundwork for deeper understanding into one's lived phenomenon that communicates meaning and share knowledge (Gabriel, 1998).

3.1.5.2 Social Constructionism

Social constructionism is a useful perspective towards collecting data and generating meanings from that data (Crotty, 1998). Within this paradigm, researchers believe the process of understanding to be a resulting product of surrounding cultural and historical contexts (Burr, 2015). It challenges knowledge that is considered to be taken for granted and it adopts a critical stance toward the individual's observations of the world. This is because in themselves, the observations and sustained social processes in the world can bring about several constructions and interpretations of events that contribute to different actions (Gergen, 1998).

The process of NA is conducted in a similar way to the process outlined above. The researcher has to first understand the participant's identity and subjectivity. It is only then that

the researcher would be able to comprehend upon which foundations the story is being constructed, grounded upon (Bruner, 1990; Mitchell & Egudo, 2013). From a social constructionist position, one's story and narration style, can indicate the individual's values and beliefs, which in turn are formed through cultural and historical elements (Rosenwald & Ochberg, 1992). This type of individuality to lived experiences highlights the idiographic approach of this qualitative method (Salvatore & Valsiner, 2010)- one that seeks to analyze generalized knowledge through the unique lens of an individual in his context (Ponterotto, 2005).

3.1.6 Epistemology and epistemological reflexivity

Epistemology is the discipline that deals with the nature, origin, validity and limits of knowledge (Marcos, 2010). In this field of knowledge, one is concerned with understanding the process of knowing and of gathering information through one's own specific principles, assumptions and beliefs (Held & Pols, 1985; Dougherty, 2009).

For this reason, the discipline of epistemological reflexivity postulates questions that elicit the researcher's reflexive process on whether the applied research questions could have been investigated through the perspective of different approaches (Willig, 2013). It encourages the investigator to reflect on assumptions made during the course of the research and examine whether the question under investigation could have adopted a different design and method of analysis (Willig, 2013). Moreover, Willig (2013) states the researcher should reflect on the implications of such assumptions and whether applying different approaches could have led to alternative findings.

According to Andrews (2004), a constructionist approach to NA provides the researcher with useful tools to comprehend the diversity and the differentiating aspects involved in people's narratives. It accentuates that this approach seeks to understand the

complexities of personal and social relationships (Esin et al., 2014) and that most of the individual's perception of experience is rooted in history, culture and linguistics (Willig, 2013). Although the interpretation of such conditions may not reflect the true environment, the interpretations have to be understood as a singular, specific interpretation to each condition (Willig, 2013).

Linguistics play a crucial role in the process of constructing social knowledge (Gimenez, 2010). Hence, one can further understand the relevance of applying NA to this study because the same phenomenon might be described by different individuals in different narratives. In their own right different narratives capture different types of individual perceptions without the need of categorizing any of them as right or wrong (Willig, 2013). Therefore, I understand that as a researcher I am not to make any judgement on the cause and effect of the factors that construct the individual experience (Willig, 2013). I am to instead focus on gathering phenomenological knowledge of the participants 'perceptions, feelings, thoughts and experience. Furthermore, it is imperative that as a psychology trainee and researcher I hold a social constructionist stance that embraces the position discussed by Cohen et al. (2007), whereby "the social world can only be understood from the subjective point of view of the individuals who are part of the ongoing action being investigated" (p.19).

I believe individuals create personal constructions and meaning when they interact with their social and environmental context (Burns, 2000). They are free to decide which life events, and which aspects thereof, should their life narrative constitute of (Boyatzis, 1998). Consequently, they describe the important events in their life according to the belief that different aspects of the self are in an interdependent relationship to different features within the environment. This is in line with the Field Theory from Gestalt psychotherapy (Lewin, 1951).

Furthermore, adopting NA allowed to engage fully with participants as they narrate their experiences. In doing so, I relied on the phenomenological experience of what and how the life events have been narrated (Francesetti & Roubal, 2020; Hycner, 1991). In this study I took a therapeutic stance and sought to understand, actively listen, contain, and emphatically attend to what the interviewee, as a client, brought without any judgement to the unique recounting of each experience, and without attempting any form of therapeutic intervention (Kvale & Brinkman, 2009; Clarkson, 2014). As stated by Joyce and Sills (2010), the experience of others can only be understood if approached with an open mind and genuine sense of curiosity that seeks to discover each individual experience.

Together with being fully present, I am aware that my own cognitive processes and interpretations may have largely influenced my work as it is not always entirely possible to eliminate my values from the research process. This adheres to Ponteretto (2005) who argues that values of the researcher are at the core of a constructionist perspective and therefore, one would need to acknowledge, describe and bracket them in the process. This is important because as a researcher I had to maintain interpersonal contact with the participants to support their construction of 'lived experience' (Ponteretto, 2005).

3.2 Part Two – The Research Process

3.2.1 Recruitment of Participants

3.2.1.1 Inclusion criteria

Several measures were taken to ensure the inclusion criteria safeguards the participants 'safety and psychological wellbeing. Participation was open to individuals of any gender over the age of eighteen and proficient in both English and Maltese. In order to minimize the risk of harm, potential participants were required to have been in AN remittance for a period of two years prior to attending the interview.

These measures were also discussed with the gatekeepers to ensure that eligible participants are able to engage reflective activities, to integrate aspects of the past in the present and of being adept at talking about emotions with minimal risk to experience dissociation.

3.2.1.2 Access to participants

Following approval from the University Research Ethics Committee (UREC) (Appendix E), I contacted the Malta Chamber of Psychologists (MCP) and several psychologists who could help me with finding potential participants for my study. A recruitment letter (Appendix A), Participant Information Sheet and a Consent Form (Appendix B) were sent to the respective gatekeepers to assess whether interested participants were eligible for participation as per the above criteria.

The gatekeepers forwarded to me the contact details of interested participants after they agreed to participate voluntarily. In order to avoid coercion, I only contacted them upon their expression of interest in participating. During my initial telephone call with participants, I provided a comprehensive description of the study and a brief overview of the interviews. I also addressed any concerns they had and agreed to email them a copy of the information sheet prior to our first meeting. Although no one contacted me prior to our first meeting, I made myself available to answer any possible queries.

The table below includes the demographic information of the three participants that participated in two interviews each. In order to protect the participants anonymity, I have used pseudonyms for each individual.

Table 1: Table of Participants

Name	Age	Gender	Occupation	Relationship Status	No of Years Attended Therapy
Alison	36	Female	Self-employed	Married	Ten years and still ongoing
Ivy	27	Female	Nurse	In a relationship	Ten years and still ongoing
Daisy	35	Female	Community Worker	Married	Twelve years and terminated.

3.2.2 Constructing the interview guide

The first interview was based on two fundamental points. Firstly, the participants ' understanding of early mother-child bonds that may have added risk for adult psychopathology (Mikulincer & Shaver, 2012) and second is the narration of family composition, hereditary patterns and psychological factors that punctuate relational dynamics in the system. The first interview guide (Appendix C) was adapted from the Adult Attachment Interview (George et al., 1985). The questions pertaining to the family unit were collaboratively represented in the drawing of a genogram between the participant and researcher. The participants were also asked to carry out a timeline exercise to help them engage in a meta-cognitive stance and be conscious of their thoughts as they speak. In this way they continue to promote recovery and heal the self (Marland et al., 2011). All three participants engaged well with these activities.

The second interview (Appendix D) aimed to elicit key psychotherapeutic events in the participants' recovery. The participants were asked about their experience of therapy and

what aspects they believe may have positively or negatively contributed to their process of recovery. The interview guide consisted of semi-structured questions that aimed to generate stories and stimulate meaning when narrating them (Wengraf, 2001). Participants engaged well with the interviews overall, however there were some instances where the individuals struggled to provide coherent details of their emotional processes. The presence of fragmented sentences was noticed primarily around instances where descriptions of extreme events caused stressful emotional reactions to the individual.

3.2.3 Data collection and analysis

Data was gathered from two, semi-structured interviews which were audio-recorded and transcribed verbatim. To prioritize the safety of participants and to help them feel at ease, all candidates were offered the possibility of carrying out the interviews online via Zoom and/or to meet on the premises of the service from which they were recruited. The participants opted for the latter arrangement and preferred to meet in person. I ensured that all the Covid-19 safety measures were adhered to; including the use of a face mask at all times, hand sanitizer upon entry and exit of premises; as well as maintaining enough distance between the participant and the researcher for the entire time of the interview.

During the whole process of data analysis, I went through the transcripts and the audio-recordings several times in order to immerse myself in the participants' recorded experiences. I adopted the model proposed by Dallos and Vetere (2016) for data analysis which is divided into three parts – thematic, structural and process analysis. These scholars propose that the presence of incoherent memories, lack of detail, verbal connection and clarity are potential responses to unprocessed trauma – a concept otherwise known as "frozen narratives" in which the individual is considered to be in a traumatized state of mind (Dallos & Vetere, 2005).

Through the conduction of thematic analysis, I drew out three dominant narratives and their subsequent themes (Dallos & Vetere, 2016). By means of a structural analysis the narratives were then summarized in terms of coherence, clarity and details around the timing of when the event happened. Instances where these characteristics were absent, I considered the possible presence of a frozen narrative and/or that the individual may be potentially directing conscious thoughts on how to manage current difficulties and/ or resolve future anticipated issues (Dallos & Vetere, 2016). In the process analysis I evaluated the individuals' style of interaction with the social world by assessing how they communicated and interacted with me. Furthermore, I applied a phenomenological framework when analyzing these narratives, and paid attention to the participants 'idiosyncratic experiences, including how, as a researcher I experienced our 'in-between' process (Yontef, 1993).

3.2.4 Ethical Consideration

Measures to preserve the safety of the participants', their anonymity and wellbeing were taken. Interviews were conducted only after receiving approval from UREC and participants were identified by a professional who was sure that these individuals were in a safe position to recount their experiences and understand the implication of their consent. Preserving the participants 'emotional wellbeing was of utmost priority for me, hence the reason for specifying that AN needed to be in remission and recovered in order to be eligible.

Prior to starting the interviews, I allowed enough time for the participants to go through the information sheet and discuss any concerns. They were also asked to read and sign a consent form which provided reassurance for anonymity and of their right to withdraw from the study at any point throughout the research process (Lee, 2010). In order to ensure confidentiality, participants were also informed that pseudonyms would be used and thus their identity is protected. Participants were also informed that audio-recordings would be destroyed once the dissertation assessment processes came to completion.

Finally, I believe it was crucial to maintain an empathic, neutral and non-judgmental stance in my position during the interviews. Whilst I am aware that I could not administer any therapeutic interventions in my role as researcher, I sometimes needed to empathically reflect back to the participants and elaborate further on the information they were providing (Brinkman & Kvale, 2008). This applied skill had significant benefits when obtaining insights on sensitive issues (Coyle & Wright, 1996).

3.2.5 Reflexivity

Having worked in the area of ED before could have influenced my process of data collection and analysis. Psychopathology, and perhaps more specifically ED is an area in psychology practice which intrigues me and it often fuels my interest in obtaining a better understanding about the subjectivity of the self and one's means to defend it. Throughout my experience so far, I have come to understand that the values of an individual are part of his personality and possibly the source of his problems too (Scalabrini et al., 2018). Having such insight from my previous work experience could have benefitted the participants in some ways. However, I am aware that at times this insight may have also allowed me to over-empathize with the participants even though my main role was that of a researcher. In order to remind myself of this position in the process, I took a meta-cognitive position as a reminder that I was not assuming the role of therapist in this process and to prevent further chances of engaging in a semi-therapeutic relationship in this qualitative research (Brinkman & Kvale, 2008).

Through my work experience I have also developed the bias that AN is often the result of early relational deprivation. My inclination to think this way could also impact the interpretation of results and admittedly, I found it challenging to suspend interpretation in the first part of the data analysis process. However, I realize that this suspension was necessary to remain as faithfully close to the participants 'experience as possible. Therefore, I kept a

journal with process notes after every interview and I reflectively evaluated the co-construction of the ongoing process between the participant and myself (Denzin & Lincoln, 1994; Dallos and Vetere, 2016).

Despite the meaning I attribute to this area of work, my enthusiasm was sometimes challenged during the process of this research. This was partly due to increased concern that this unforeseen reality of Covid-19 might cast additional difficulties in the research process. However, my motivation was rekindled as soon as I started meeting the participants who shared their stories so willingly. Towards the end of each interview all participants expressed their gratitude for the opportunity to make their voice heard and their stories known.

3.2.6 Credibility and trustworthiness of the study

I have tried to strengthen the credibility and trustworthiness of my qualitative research by adhering to various principles proposed by Yardley (2000; 2011). These principles are in line with my position as researcher that was articulated in previous sections, and with the constructionist position of narrative research too. Yardley (2011) proposed four core principles for evaluating the validity of qualitative research including; (i) sensitivity to context, (ii) commitment and rigor, (iii) coherence and transparency (iv) impact and importance

Credibility was ensured by providing a detailed step-by-step log of the research process that allows the reader to follow a clear path when reading through the chapters. The majority of this process is outlined in the aims and objectives, theoretical frameworks and my positioning as researcher described in the first part of this chapter. Even though I did not involve an independent auditor to examine the credibility of the research process, I engaged in respondent validation by checking with every participant the obtained data resonates with their experiences.

Consistent sensitivity to context was crucial aspect to maintaining dependability in the study. ED and the associated psychological challenges often evoke negative emotional reactions of fear and pity – two types of reactions that further perpetuate mental health stigma in society (Hinshaw, 2007). Given Malta's highly dense population rate where multiple relationships are possible to develop (O 'Reilly Mizzi, 1994), I believe I needed to be extra sensitive to this contextual factor and ensure that the participants' anonymity was completely safeguarded.

My sensitivity to all narratives was provided by a safe space, and by maintaining confidentiality and using pseudonyms to protect true identities. To remain as faithful as possible to the profound data gathered, I made use of several verbatim quotes in the results chapter – giving the reader the opportunity to determine whether the presented results may be transferable to other individuals in similar clinical contexts (Meyrick, 2006).

Coherence was retained by ensuring the underlying theories are in uniform with the aims of the research question – namely that of uncovering the individuals' phenomenological meaning to their experiences. Moreover, my positioning on the epistemological continuum is also in line with the theories I chose to inform my thinking throughout – namely the phenomenological, attachment narrative and field theory perspectives described in the previous section of this chapter.

3.2.7 Conclusion

This chapter presented the research process. The first part of the chapter outlined the research questions and the main aims and objectives. I presented a comprehensive account of the selected research method for this project. I discussed the rationale for a qualitative method and reasons for analyzing the collected data from an attachment narrative perspective. I described and affirmed my position as a researcher.

In the second section I outlined the research process, the recruitment process and the interview guide. I outlined the method of data collection and analysis, ethical, credibility and trustworthiness issues of the study. Finally, I included a section on reflexivity. The following chapter presents the results obtained from all six interviews.

Chapter Four – Results

4.1 Introduction

This chapter presents the data obtained from the interviews. An introduction for each participant can be found in Appendix K. The names of the participants were changed to pseudonyms and some of their demographic details were adapted. These amendments were necessary to conceal their personal identity especially as multiple relationships are more likely in the Maltese community, which might facilitate identification of participants (O'Reilly Mizzi, 1994). The thematic, structural and process analysis are presented as proposed by Dallos and Vetere (2016).

4.2 Part One: Thematic Analysis

Table 2 represents the three dominant narratives and their subsequent themes that were obtained from the participants' interviews.

Dominant Narratives	**Themes**
The illusion of control	It's not about image
	Attached to the grip
	Losing and letting go
From one system to another	The self at home
	Moving from home to home
	Breaking through the systems
The ever-evolving self	The self at birth
	Becoming
	The broader self

Table 2: Table of Dominant Narratives

The illusion of control.

The dominant narrative of 'The illusion of control' emerged in all interviews. Subsequent themes include 'It's not about image', 'Attached to the grip' and 'Losing and letting go'. These themes capture a sequential flow of events and trace the journey from the participants' realization that the ED problem lies in the need for control, to then understanding that getting better meant losing and letting go of that grip.

It's not about image

In all interviews, participants spoke of their battle with issues of self-image. Alison described how her "relationship with the body was always negative" and she could never be happy. Even though she knew she was smaller than the size of her clothing, "no matter what size I was I used to see myself as fat". Alison says the negativity towards herself is what allowed her to "blame issues on the weight or the body image but deep down it wasn't truly that".

Similarly, Daisy recalled of a when "no matter how much weight" she lost she could not be happy. She described even when "she was wearing size 6" and her "clothes fell off" still she saw herself as "not good enough and wanted to lose more weight". However, Daisy explained her struggle with body image was not impacted by media but rather due to a "problem with control".

She adds "I needed to control something […] I'm not even a vain person where all clothes have to be perfect and match […] so I had bad body image because other issues where there".

Ivy also described struggle with body image issues that were fueled by an intense need to "feel in control and not something else controlling me". Everything she was going through at the time she "showcased it physically because I was not someone who would

display emotion from the outside or talk about them". She believes she had to "suppress it" through her image and "yes it was a control mechanism. It was the only thing in my life that I could control, the food".

Attached to the grip.

The participants recounted descriptions about attachment to the grip of control. They recognize this kind of attachment could have been at the root of their anorexia. Alison's account on this theme was one of the most powerful as she explained

"The more you feel in control, the more you want to be in control and no one can stop you […] it is a common tendency in anorexia […] it's an addiction at the end of the day". (Alison)

Moreover, "when you start going down in weight you feel like in full control of yourself of your body, whatever, of everything […] it's just that there's so much emphasis about the food and what comes with it that your full control and purpose in life is that, not the people around you that you love, just this" (Alison).

Similarly, Daisy also shared her experience with needing "feel in control by cooking things I like but not eating it […] it used to come very naturally to me". She acknowledged that similarly to Alison, "having the full control was everything […] and when there was a lot going on, the only way to be in control and to handle it was to control the eating".

The theme of control featured strongly in Ivy's narrative too as she describes "at the worst part of the eating disorder no one could touch my plate, […] before putting food on it I wash it because I would be scared that there are extra calories […] I always wash my teeth too […] had a ritual." She explained this fear had "become her character" and she became "very different […] so on edge when someone touches your plate after you had just cleaned it or weighed your food that others wouldn't dare touch it […] I had a lot of obsessions […]

started becoming more restricted and rigid around food […] this was my world and it's a very competitive one unfortunately, it's scary to be honest" (Ivy).

Her family members noticed this behaviour in her but were tolerant and chose to "let her be at least she eats something today". She states her boyfriend "used to wash a plate for her sometimes because he knew I would be anxious so he tried to help me in this way […] but I still gave it a wipe myself after".

Losing and letting go.

In the process of recovering from AN, Ivy explained how she began to make effort to "lose the ideal" and "go to a nutritionist to eat healthy […] my dad used to come with me to make sure I go in for the appointment and my mum started to adapt her cooking". She explained her father's support was helpful and "he used to tell me; 'look you follow the meal plan and I reduce my alcohol consumption and we eat healthy". Together with therapy, his presence and will to get healthier himself encouraged Ivy to "change" her "relationship with food".

Contrastingly, Daisy's story depicts the challenge in "letting go" of what was always normal for her. Starting therapy helped her change ED practices that were "normal" for Daisy and "even though I was anxious I was not aware at all, no idea". Through therapy she had to "let go" of what she was used to perceive as "normal" and had to start "realizing that it was something bigger" than herself.

From one system to another

In this section I include data from themes of 'The self at home', 'Moving from home to home' and 'Breaking through the systems'. These subordinate themes follow a sequential order in highlighting the participants' perception of moving from one system to another. Participants first speak of themselves in relation to their systemic family dynamics and the food environment within, then of having to move from one home system to another, to then

realizing that both systems were dysfunctional and their sense of self is what dominated their recovery in helping them break through both systems that were oppressing them.

The self at home.

'The self at home' describes the significant relationships in the family, the atmosphere that was experienced during mealtimes and the meaning that was given to food. In order to remain faithful to the individual experience as much as possible, I present the participants' narratives and their respective genograms in separate subsections.

Alison.

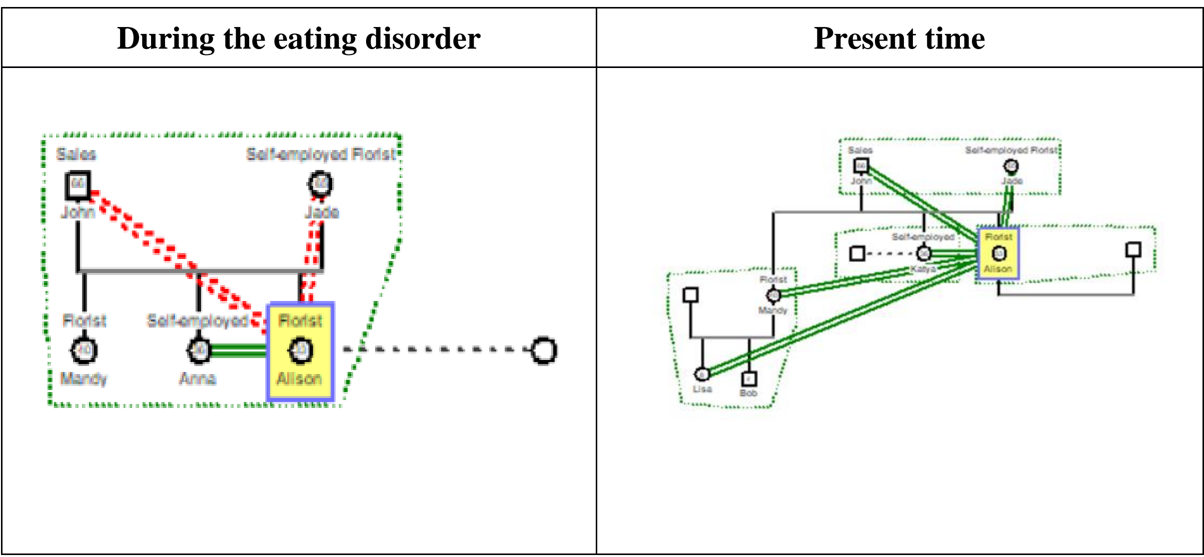

Figure 1: Alison's Genogram

Figure 1 illustrates Alison's considerable difference in her family genogram during the time of her eating disorder and the present. In her narrative, Alison explained that during AN she did not feel close to her family members as she was "convinced" that they "could not understand". She had a good connection with her sister and her girlfriend at the time – whom she considers to have been of good support to her. During meal times, the atmosphere was rather tense because "food was scary" even "if it smelt good". She explained her family is "fond of cooking home-made meals and enjoy gathering round the table to eat together […] it was meaningful". However, it was "uncomfortable" for Alison to "sit there and not eat with

the rest", she felt "frustrated for not being able to engage with others" and discomfort when others looked at her and passed comments on being "underweight".

Moreover, Alison described her family as "struggling to find suitable help and guidance" to support her in what she was going through. I could feel her sense of frustration as she explained some "professionals disregarded" her struggle and tried to "persuade" her that her "symptoms are stress-related that can be outgrown". Alison's frustration however was mixed with a degree of consideration towards that these professionals did not have "specialized awareness" on AN and who cannot "understand and help" her "communicate the depth of struggles when fighting the battle". This added to further feelings of isolation and distant relationships at home.

Presently it appears that she is able to form closer bonds with both parents, all siblings and her niece. She is also married and maintains a central position in her family of origin. Being at the center of these relationships allows her to be in close proximity with several members of this social system. Nowadays Alison is also able to control her emotions around food, has associated new meaning to eating and enjoys cooking for others while they share meals together as well.

Daisy.

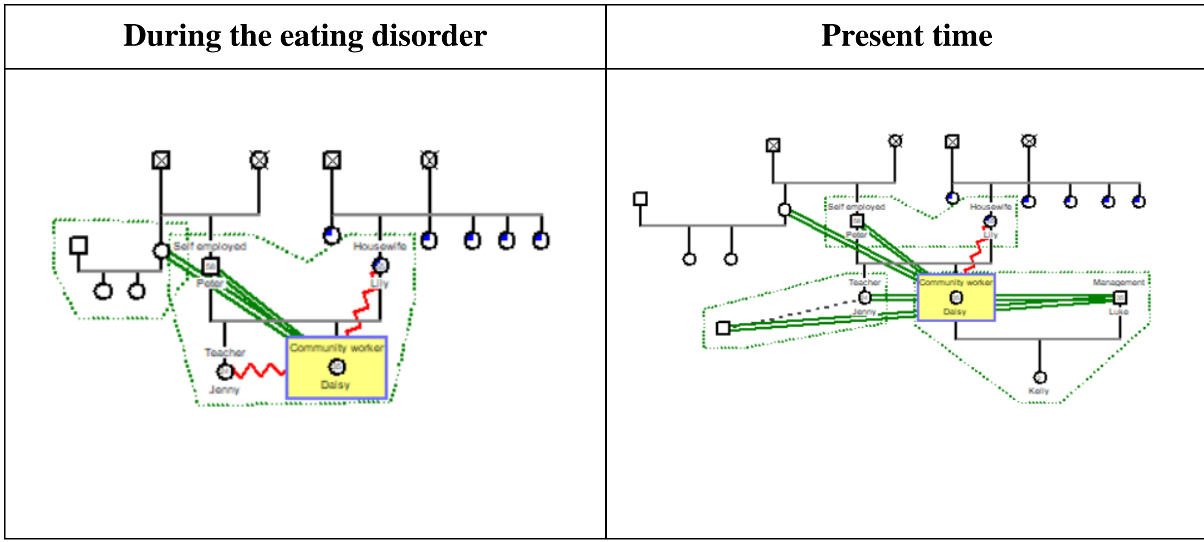

Figure 2: Daisy's Genogram

Figure 2 shows the substantial difference in Daisy's support network and the level of closeness with her significant others. She spoke of the support she found from her dad, her paternal aunt and from her relationship with her husband. She explains how the "atmosphere" at her aunt's house is the "typical Maltese kind where food is prominent" to their culture. In contrast, in her home of origin there was "no freedom and flexibility around food" and we did not "enjoy cooking a variety of meals or eating together". Daisy explained that during childhood she felt her mother "pushed" her away and "preferred" her younger sister. This created a "hostile dynamic" between the mother, Daisy and her sister and "did not find support in each other" whilst growing up.

In the second genogram, it is evident that Daisy's relationship with her sister shifted to a positive one, possibly indicating that they moved closer to each other and formed a friendship. However, her relationship with the mother remains "conflictual, insecure and unsafe even as the mother has mental health difficulties for which she does not wish to receive treatment". However, the support from her father when she was admitted to hospital and his encouragement to get better meant a lot to her. She finally highlighted his "challenges with understanding the condition" and the psychological pain he felt when visiting her at the psychiatric unit; impacting their connectedness to some degree.

Ivy.

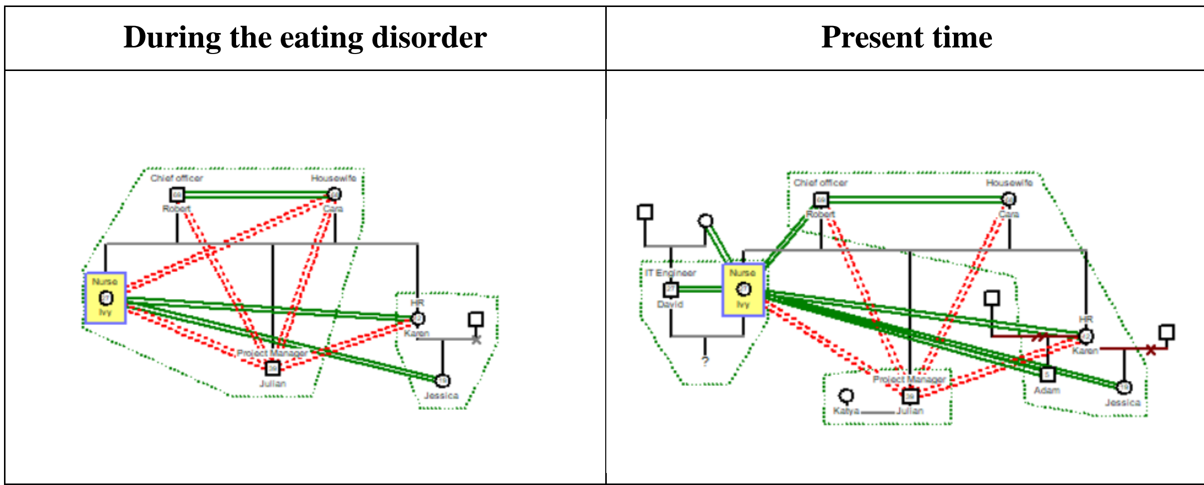

Figure 3: Ivy's Genogram

Figure 3 represents Ivy's relational bonds at the time of the ED and those that are at present. At eight years old Ivy was quite distant from most of the family member, yet closest to her sister and her niece. She felt her older sister was like a "second mother" to her, even as her birth mother was already "very advanced in age". She explained growing up she "struggled to fit in" and felt like she "needed to bridge the age gap" and meet older expectations of herself; possibly contributing to her struggle with accepting her true self.

In contrast, the second genogram portrays the number of close relationships Ivy built with the people in her social context on recovery. She explained how throughout her recovery her "significant others became much closer" – including her parents, her sister, her niece and especially her boyfriend. At present, Ivy also enjoys "eating with others, trying new recipes, going to restaurants and sharing recipes or photos on WhatsApp" with her significant others.

Moving from home to home.

The theme 'Moving from home to home' narrates stories of the challenging experiences participants had with having to leave their former social environment to a residential setting that offered treatment for AN. Alison's description of the local medical and mental health services was very critical and she complained that "the lack of specialized services" made her situation "worse".

"[…] there were certain psychiatrists who told my mum, with me being there, you can prepare her casket. That scared me" (Alison)

Alison emphasized her mother wanted to help but "no one helped her to try and understand me, so I all saw in those years was frustration […] she felt helpless as she couldn't help me".

Similarly, Ivy remarked how the local residential treatment for ED was "difficult" for her since she felt it was "therapeutically unhelpful".

"It was difficult for me, I spent a month and left […] there was a mixture of patients. […] I was exposed to some types of body figures and I was still very weak to deal with it […] I found it very difficult, the lack of contact you would have with family especially. I was already in a relationship and it was important for me […] my parents, I used to drive them crazy, if I ate something extra, I called my dad, my mother was scared that something scary is going to happen […] it was a relief to leave" (Ivy).

As a qualified nurse she now looks sat the service from two perspectives "that of a nurse and that of a patient". She explained as a patient she felt "like an outsider because there were many people that were in very different body shapes from mine, it was mixed […] and as a nurse nowadays I say there is still more to be done in general, even with the type of treatment offered."

Similarly, Daisy explained her "problem was to go there and eat what they give me, because I always wanted to cook my own food and keep it. That was a big issue for me." However, she explains that "deep down" she was not ready to "get better". She adds she "really wanted to get better" when she met her "husband at age 27, otherwise I always used to find some type of excuse for feeling unwell […] but when things started going well in my relationship with him and I realized that I want to do something, and that's why I went […] that's when I started to feel better" (Daisy).

Breaking through the systems.

The participants' narratives share their experiences with "choosing" and "managing" recovery as a process that for many started soon after their first hospitalization or residential setting. This theme highlights the participants explanation of how their personal sense of self dominated their process of recovery as they broke through the barriers of systems.

Daisy explained choosing not to go back to live with her mum helped a lot because she realized that her original family system would not aid her recovery process. During her

time in residential care, she recognized recovery as a "choice" and she needed take one for herself. She "began realizing" that when her mum went to visit, she would "change and start throwing tantrums and crying and no one knew what's gotten into me".

She explained, "even nowadays I get anxious when we are to visit my parents. My husband notices […] I would need to prepare myself for the lack of freedom to eat what I like when I'm around her. My relationship with food is different around her but with therapy I learned how to control it – that is my recovery, still getting the eating disorder thoughts but I am capable of controlling them for myself in the context that I'm in".

Ivy outlined that after leaving residential care she continued personal therapy to increase her "self-awareness" and learn "how to not only notice" her behaviour but her "thought process" in the family system as well. Her story provided a strong narrative of how her ED recovery was influenced by her personal and social context.

"The disorder itself turns you into a bit of a self-centered person […] and your only aim is to obey the voice of the eating disorder […] but when I began therapy, I chose not to remain self-centered and became more involved with family life and with taking care of my parents" (Ivy).

She explained her thoughts in recovery shifted from "not wanting to eat with others", to finding "it helpful to eat with someone else". She describes it "an experience of sharing with the other". She "learned a lot of techniques on how to deal with the ED thoughts" that go back on days when she is stressed.

Similarly, Alison explained how "people who go through recovery still encounter some issues in their lives". She explains "that you can never be fully recovered […] you learn how to live with it […] I see the fluctuations." She adds "choosing recovery" involved the "acceptance" that "some things can never change" but she can "choose what to do with

them”. She highlights her personal choice was dominant over the surrounding contextual systems:

“[…] many people are not aware, because it is not something that the family can do to actually help […] I say this as well, no one can help you, only you can help yourself no matter what they try to do” (Alison).

Even though she recognized the benefits of having family support in treatment, Alison explained “it’s more me who needed to help myself […] most of the time my therapy is to strengthen myself to get better”.

The ever-evolving self.

The dominant narrative of ‘The ever-evolving self’ includes three themes; “The self at birth”, “Becoming”, and “The broader self”. These themes capture the meaning these individuals have attributed to their sense of ‘self’. The themes flow a sequential order within a prominent existential issue about who they were at the start of this journey, who they have become and who they will continue to be.

The self at birth.

The participants spoke of previous ‘false-configuration’ of the self that was mostly constructed through their education and the family context they were born into. Daisy shared a strong narrative on her family culture and dynamics that “dominated” her relationship with herself and food. She explained her mother’s “controlling character” conditioned the family dynamic and her sense of self at birth. She described her “mother had the eating disorder herself […] and from when I was young at home, food was always with strict measure”. When at the age of 11 she “had a virus and lost some weight” her mother offered praise and “for the first time” Daisy said “ok I can be appreciated by her […] and then I remained that way”.

Similarly, Ivy explained her family placed high emphasis on educational achievements. She described her father "was quite absent" because of his "demanding role at work". She remembered "waiting for him at 10pm and my mum too waiting for him downstairs to check my homework. He was very involved in my education but I didn't enjoy him as a father very much" (Ivy).

She explained "at age 10 my mother stopped me from dancing because she said it's time to focus on school. I had nowhere to express myself apart from school and so I began to close off in myself. Here I had an over-the-counter pill abuse, at age 12, to cope with feelings of loneliness […] I needed stuff with codeine to sleep." Ivy explained that she "could not easily reach out for help" because "my sister was also going through her first divorce" and the "family's attention needed to be all on her".

In similar fashion, Alison described her family led a fast-paced life dominated by a demanding family business. She describes that as a toddler "apparently" her "mother was very busy […] my aunt had a restaurant and we were there 24/7 so she wasn't present […] her attention was not all on me." She explained her mother "was a very strict person and very religious where all hell would break lose if you didn't go to mass every day." Alison explained she "changed her a lot, my mother, she's not strict anymore." Alison was the only participant who shared details about the painful times she put her mother through "especially in the bad days […] no one will stick with me like she does, no matter what".

Becoming.

Ivy gave a detailed narrative of several changes in self to be fundamental aspects to her recovery – her journey of becoming. She described sports as a strong source to her development of a healthier "sense of identity". Throughout her recovery she noticed sports was her "me time and at the same time it was my motivator to eat, in the sense that I have to

fuel myself otherwise I won't manage my run or the gym, and I used to enjoy it. It gets me excited" (Ivy).

Furthermore, Daisy shared that in her process of becoming she began to improve her narrative around food with family. She explained therapy was helpful in helping her become aware that her true self loves food.

"I love food, I love to eat and to cook […] cooking food for my family is the nicest thing for me […] cooking for them and for me has helped me a lot and my relationship with food too […] I explore food, I go food shopping…" (Daisy).

Daisy's interview was characterized by details of how having to become more adept at controlling emotions without food.

"For example, if I have an exam my mind starts thinking not to have lunch […] which in reality is counterproductive because without food my performance would be less optimal […] so yes with therapy I had to learn and become aware that food and emotions don't mix together" (Daisy).

Similar to Ivy and Daisy, Alison explained her process of becoming required shifts in perception towards herself. She spoke at length about how important it was for her to "praise" herself and "boost self-esteem" and accept "who I was becoming".

The broader self.

Ivy described the changes in herself made her more "aware" of her "need for self-care" on a broader scale. She became aware of her "limits" and how she needed to "speak out to others if something bothers" her and not "suppress it" instead.

Similarly, Alison described her broader sense of self to be an ongoing process where "whatever I learnt throughout the therapy I still apply them each and every day and in everything I do in life".

Daisy outlines significant changes in herself "since then" and how "happy" she feels with her "achievement". She explained being a mother to a two-year-old motivates her to "keep improving" on how to relate to her own daughter when it comes to food and eating.

"I learned from my own experience and […] I don't want to pass this on to my daughter" (Daisy).

4.3 Part Two: Structural analysis.

Alison.

Considerable parts of the interview with Alison were characterized by short-answer responses. Although the interview was semi-structured with open-ended questions, Alison often responded with "yes", "that's right" or "yes exactly". Her narrative flowed more fluently when she illustrated her support network through the genograms however there were some incongruent sentences as we spoke about her proximity with significant others.

Alison's narrative highlights the significant presence of her mother and sister; two prominent characters in her story. She elaborated on her close relationship with both of them and expressed gratitude for the care and support they provided in her times of struggle. Sentences on this subject flowed naturally and conveyed rich detail.

"When I feel like giving up the relationship is so meaningful that she makes everything possible" (Alison referring to her mother).

"Actually, we are very connected. On my bad days my sister calls me and she gives me a lot. We are in sync." (Alison referring to her sister)

Alison described herself as "quite outgoing when I was a child, happy go lucky". A dominant shift in the structure of her story occurred as she spoke of "something that happened to me when I was young." Consequently, fragmentation of sentences was noticed. She explained this childhood event had taken a toll on her and her character "never came

back. I'm not happy go lucky. I was bubbly. I'm not now. So, what I can say, that it ripped off my character".

As Alison explained her issues with body image, she gave incoherent details and switched from stating "as such it's not about body image" to later stating that "but yes when you get the disorder it becomes somewhat, because let me tell you at the end of the day no matter what size I was I used to see myself fat." Alison seemed to be fully aware that "nowadays it doesn't make sense" and she would like to face future challenges in this regard with more strength and support.

Daisy.

The structure in Daisy's narrative was highlighted by events in her childhood that were described as "insecure and anxiety-provoking". She described marks on the timeline with extreme detail, perhaps indicating the significant impact the ED had on her life trajectory. For instance, she described several qualities she believed distinguished her from her family, qualities described as "challenging to accept." While describing the timeline, she stated the process of recovery from AN gave her a broader sense of identity that is separate from, but still linked to the ED.

"I think nowadays that's my identity, not the eating disorder. Probably I don't know how to live without it, I've gotten used to it so much. It became a huge part of my life." (Daisy).

Her story structure reflects her overall awareness and ability to recognize and resolve issues that are pertaining to her recovery. She described her ways of "managing" the disorder in its recovered stage. Despite an unstructured pattern in the narrative, her story was somewhat coherent and included clear descriptions of the event, any thoughts or feelings she experienced in relation to the event and the way she managed this.

"I start feeling anxious when I'm about to go visit my mother I would need to talk to my husband but I think you would need a mother who could be safe to you. Instead of safe, mine is the opposite" (Daisy).

Ivy.

In Ivy's narrative a lack of coherent sequence of events was evident. Her descriptions started with a detailed account of present aspects to her life, such as her passion for sport. When Ivy shared some short childhood stories, she rushed through the description and when I probed about this time in her life, she quickly shifted to discussing her recovery from the ED.

The plot of her story maintained an unorganized sequence of events which was characterized by a continuous back and forth movement on the timeline. Ivy shifted her thought every time she remembered or felt comfortable sharing further details about an experience. Her story took a striking shift and appeared to be more coherent when she spoke about her older sister and the good rapport they share. However, there were several instances where she could not remember events from her adolescence. She described this time-period as "isolated" from others and she engaged in an over-the-counter substance abuse at age 12 "to sleep". She explains that her memory from this time-frame is "deleted" and her sentences became somewhat fragmented. She was unsure of the details and she explained that "from here it's like my mind doesn't remember a lot of things".

Furthermore, when I invited Ivy to elaborate more on her experiences during the time gap, she seemed confused and stated that she would not be sure from where to start. Her sentences became further fragmented but she gradually began to remember instances as she moved to the themes of insomnia and bullying at the time. She divided this part of the story into short narratives as if she were speaking of two different sides to the same coin. As she moved on to narrate details of becoming aware of the ED, her manner of narrating followed a

more coherent flow. She shared the following statement to highlight the extent of dysfunction she had reached when she started to realize she was not well:

"My life became all about: eat, sleep, exercise, repeat" (Ivy).

Finally, Ivy seems to have reached a positive sense of resolution in which she acknowledged her past difficulties and commented about possible future ones. She was aware that the current pregnancy may "trigger the eating disorder" and she said she was "tackling this issue in therapy". She explained "the fact that I'm working on preventing a relapse gives me hope that I would not go through it again." She concludes that the people around her "know more about the disorder now" and what "she has been through" and this provides her with "strength and support".

4.4 Part Three: Process analysis

Alison.

To facilitate a flowing conversation with Alison I used several prompts that could have supported her in eliciting details of her life story. Out of care for the participant, I conveyed these prompts through a sensitive tone of voice that possibly helped her shift her shy and withdrawn position to a more comfortable one.

At times, Alison gave long descriptions and I actively listened without intervening much. This was especially observed when she was explaining her former difficulties with the ED. I could see the pain in Alison's eyes as she spoke and the suffering her family experienced with her. I was touched by her sense of love and care towards them and although her narration was fluent, I could understand that there were unfinished stories and possible trauma memories from her childhood.

"I'm not open to something that happened to me when I was a young girl" (Alison).

Despite acknowledging her difficulty with trusting others, Alison seemed to trust the research process and engaged well with sharing delicate details of her life experience. There

were several instances where she digressed somewhat, however, she still managed to keep me engaged in story-telling.

Daisy.

Daisy narrated experience in a comfortable pace which allowed me to take a step back and only intervene when necessary. I could sense that Daisy extensively worked on processing her story in therapy because of how composite and fluent her narration was. My hypothesis was eventually confirmed when at a later time in the interview Daisy confirmed the extensive journey she had embarked on in psychotherapy.

When narrating her relationship with her mother, our ‘in-between’ was marked by a sense of anxiety. This atmosphere was possibly a parallel process to what she feels in the presence of her mother. This was described by her saying she becomes “anxious immediately” on mentioning meeting her mother. She spoke about this relationship in a fast-paced manner and I noticed her sentence structure was fragmented too.

When she changed the subject to that of her husband’s support, the energy between us changed to a lighter, less tense one. She spoke at a much calmer pace when referring to the motivation and support she derives from these relationships.

“He’s like able to realize if there’s something and he supports me a lot, we talk a lot about it” (Daisy).

Speaking of these relationships I could felt a sense of security that created a strong presence of positive energy between us. She sat straight as she spoke and her sentence structure was coherent. Although she acknowledged the various challenges that may continue to surface in the future, Daisy expressed determination at remaining focused on her recovery.

Ivy.

A critical part of the interview with Ivy was when she narrated her story about being unwell in the midst of several delicate family issues. Immediately, her perseverance in

remaining resilient amidst the "chaos" was extremely admirable. However, there were other instances where she struggled to remember what happened. She tried her best to describe the events with precision, however due to frequent moments of silence, I felt the need to reassure her and to invite her to take all the time she needed.

Ivy described her experience of AN as "a challenge every day". I wondered whether the feeling I got in touch with was shame whilst she explained how she "could not handle the weight gain. The reason for the sleeping pills was that I just wanted to rest, I never wanted to die or commit suicide, but I just wanted to take a break".

The atmosphere between us changed again when Ivy shared how "scary" going out in society was after spending long time at home. Moreover, I felt her fear when she explained "the shift in weight was the main challenge". I also felt her pain when she explained the people around her did not realize how difficult this was for her.

"People used to comment on this sudden weight gain and they wouldn't know what I'm going through […] their words were hurtful and sometimes they used to trigger me […] it's my body it's my business" (Ivy).

Another significant point in our process was when Ivy explained how "proud" she feels about her recovery.

"I've been through a lot of things […] I don't have a reason not to, because I could have been worse, I could have died" (Ivy).

Whilst going through the transcripts, I became intrigued by Ivy's level of insight and awareness, her appreciation for healthy coping strategies and her continuous determination to manage the thoughts that were specific to her ED; explicitly referring to the fact that "it is still there but I learn how to compromise."

4.5 Conclusion

In the first part of this chapter, I presented the findings obtained from the narrative interviews. I first presented the raw data that resulted from the through NA. This was done and written in three main parts pertaining to themes, structure and process. Three dominant narratives were elicited, including: ‘The illusion of control’, ‘From on system to another’, and ‘The ever-evolving self’. Respectively, each narrative has three subordinate themes. Direct quotes from the transcriptions were presented in English, the language in which the participants opted carry out their interviews.

In the second part, I included a structural analysis of each narrative. In this section the presence of potential trauma, or ‘frozen narrative’, was highlighted and shall be discussed in further detail in the following chapter. Consequently, in the last section of this chapter, I included the process analysis of each narrative. The following chapter will include a critical appraisal and a reflective discussion of the results included above.

Chapter Five – Discussion

5.1 Introduction

In this chapter I discuss the findings from the participant interviews. The dominant narratives, subordinate themes, structural and process analysis presented in Chapter Four were carried out in line with the narrative model proposed by Dallos and Vetere (2016). The findings are mostly discussed in view of the literature presented in Chapter two. The discussion of the same findings is divided into three segments; whereby first segment addresses the dominant narratives, the second addresses the narrative structure, and third segment provides analytical and reflective review of the process analysis.

5.2 Part One – Dominant narratives and subordinate themes

5.2.1 The illusion of control.

'The illusion of control' included descriptions of the extreme need to maintain control over weight, body image and eating patterns. It highlights the participants' common tendency to increase control with food to feel good. Their subjective process towards realizing that their experienced tendencies were not similar to others in the world around them is discussed in light of existing literature.

5.2.1.1 It's not about image.

Froreich et al. (2016) suggested that in order to understand the etiology and maintenance of ED, the underlying psychological issues of control need to be considered. Bruch (1978) considered AN symptomology to be rooted in a personal "struggle for control, for a sense of identity, competence and effectiveness" (p.251). In her view, these four factors contribute to the individual's attempt to compensate for an internal sense of lack of control that is experienced even in other areas in life. Similarly, Slade (1982) suggested control of

weight allows individuals with AN to control their surrounding context, especially close family members through their behaviour (Schmidt & Treasure, 2006); and to also avoid negative states of affect that are commonly correlated with life dissatisfaction and interpersonal issues (Slade, 1982).

These factors were highlighted by all participants as contributing elements to their ED. Participants narrated how controlling food became the primary focus in life because being in control was perceived as “successful behaviour in the context of perceived failure in all other areas of functioning” (Slade, 1982, p.173). Similar to various other scholars, e.g. Fairburn et al. (1999), the participants also noted that the use of control in ED goes beyond the over-evaluation of shape and weight because the main preoccupation is with an overall index for self-worth and self-control. Hypothetically, this need for control was illustrated by participants through the themes of self-consciousness, fear of gaining weight and obsessive restrictions.

5.2.1.2 Attached to the grip.

Although representations of control within the participants’ accounts vary to some extent, most express the underlying premise of feeling attached to the grip of control as a coping strategy with generalized feelings of ineffectiveness. This is further supported by Froreich et al. (2016) who suggests that this attachment to the grip of control is manifested through obsessive conditions that reinforce the individual’s fear of deficient control and worthlessness – two conditions that are high risk factors for developing and maintaining AN (Lee et al., 2005; Wade et al., 2015). The findings of these studies could be seen as similar to the life experience narrated by one of the participants who explained the absence of healthy adaptive personal strategies were driven by obsessions to enact rituals and associate them as good control mechanisms.

In AN, another common conceptualization of control is the individual's desire for control in life. Studies have found that individuals with AN tend to have lower levels of interest to obtain mastery over life events when compared to healthy ones (Tiggemann et al., 1998). Some of the participants narrated stories that are congruent with the above literature, whilst other dimensions of control were based on a sense of guilt, self-punishment and remorse for not living up to the mother's expectations and feeling rejected in return. The participants explain that therapy was helpful with shifting these thoughts to more positive ones, and to learn to acknowledge, allow and accept the flow of their emotions without controlling them with food. (Reichenberger et al., 2020).

5.2.1.3 Losing and letting go.

Some participants outlined several challenges they encountered in journey of recovery – including the challenge of losing the grip of control and letting it go. Data gathered from the interviews highlighted complex dimensions of self-awareness and gave insight into the several challenges the participants had to experience.

Neuroscience indicates that conceptualizations of awareness are built around various areas of the nervous system which derive from the concept of the 'self '(Segarra Echebarria et al., 2010). The notion of awareness incorporates a complex mental faculty that may be influenced by social and cultural factors (Segarra Echebarria et al., 2010). Some participants highlight their lack of immediate awareness of AN symptom and they explained the fruitful work psychotherapy has done in increasing their level of self-awareness.

Moreover, psychotherapy seems to had accompanied the participants' fluctuating levels of awareness; that varied from complete denial to increased conscious awareness across the different stages of AN. The psychodynamic perspective argues that a poor level of awareness is indicative of an involuntary defense mechanism which may support the person

in coping and adapting to the distressing event of AN diagnosis (Vaillant, 2011). Prominent psychoanalyst Melanie Klein (1946) considers denial a common unconscious defense mechanism. This is in adherence to other scholars who argue denial could serve as a protective factor against the experience of negative emotions that may result when individuals understand the subconscious consequence behind their ED (Waska, 1999). Indeed, most participants expressed feelings of pain when talking about their experience of working through denial in order to “let go of issues of control”. Participants explained attending therapy was helpful with toning down their defenses, gaining awareness and integrating it with their lived experience. Therapy was also helpful with gradually letting go of the denial and subsequently gaining increased ability to “let go of control and choose to get better”.

5.2.2 From one system to another

‘From one system to another’ is a dominant narrative across all participants’ stories. Their process of recovery was portrayed in the subordinate themes of ‘The self at home, ‘Moving from home to home’ and ‘Breaking through the systems’. The most salient features of these subordinate themes will be discussed in view of the dominating presence of the personal self within different social contexts, including the family and the institution, the encountered shame and stigma, fear of relapse, and the challenges with the local mental health services for AN.

5.2.2.1 The self at home

As outlined in the previous chapter, there seemed to be a significant shift in the proximity of significant relationships between the participants and their relatives from before and after their ED. Hypothetically, this significant shift could be indicative of increased level of connectedness between the participants and their significant others after treatment.

Studies indicate that the diagnosis of an ED impacts the entire family as well as the individual (Gilbert et al., 2000). Literature states the mother, often assumed to have the role of the main caregiver, has the biggest influence on how individuals perceive themselves (Allen et al., 2014). However, most participants seem to believe that whilst their maternal attachment may have contributed to the development of EN, it was not the main focal point in their recovery. Whilst repairing their relationship with the mother was important, the notion of the self dominated their therapeutic journey (Williams et al., 2016). Thus, this central dimension to their process could not be overlooked in this research and even though I considered the possibility of having the participants' maternal relationship to be a potential dominant theme in this study, on a conscious level I reasoned that I needed to remain faithful to the participants narratives when drawing out the results and therefore I decided to focus on aspects of the self as they related it to their AN.

In view of the several studies that indicate maternal relationships to be a significant risk factor for AN (Allen et al., 2014), it was also my intention as researcher to delve deeper into this aspect in my interviews. However, most participants seemed hesitant to speak at length about this. As a result, I felt compelled to be very empathic and stay with their process even if it may have protected the potential outcome of a relational injury or trauma in their attachment with the main caregiver. I now realize however that I may have colluded with their defenses. My countertransference to their defenses may have compelled me to protect myself from being in touch with feelings of loss due to my mother's demise a couple years ago.

Additionally, studies show that extreme maternal feeding practices enhance the individual's chance of developing ED such as low appetite, pickiness and low enjoyment in food (Rigal et al., 2012). Under other conditions, where exposure to food was more flexible

in attitude and various in options, may enhance one's motivation to eat (Gorwood et al., 2016). One participant highlighted parental excessive control and restriction with food limited her eating autonomy and negatively influenced her food choice in later life (Easter et al., 2013; Micali et al., 2009). For this participant, maternal intrusiveness and other strict parental behaviour around food were interpreted as not recognizing the needs of the child and promoted the risk of ED development as a reaction (Gahagan, 2012).

Parker and O'Reilly (2012) argue that families often have a linear, causal attribution to their difficulties and they identify the person with the 'problem' as the source of their difficulties. However, Patrika and Tseliou (2016) argue against this notion of blame and emphasize the importance of eliminating such a pathologizing approach to any presented difficulty This is in adherence to the concept of scapegoating, in systemic theory that conceptualizes the person with ED to be the one perceived as not good enough (Warner, 1972). In fact, the obtained genograms provide a visual representation of the participants distant relationships with most of their family members during their ED. Some participants explained that they felt misunderstood, and hypothetically, this could indicate how excluded the participants may have felt in the midst of their difficulties with AN (Levine, 2012).

More specifically, the participants' narratives highlighted that negative affect at mealtime, struggles with food and eating conflict in their childhood may have added risk for subsequent symptoms of AN in adolescence. Some participants express that they needed to distance themselves from the rest of the family during meal times. Despite the positive meaning that most of the families associated with food, most participants seemed to experience an "uncomfortable" atmosphere of fear and distress around the dining table. As their subjective experience to food was often different from other members in the family,

participants felt secluded from experiencing a meaningful activity that was seemingly bonding the family together.

These features reinforced the significant cultural aspects that are often common with eating experiences among families (de Wit et al., 2015). Although generational disparities may exist in view of what rules and rituals must be followed during mealtimes, these disparities could complicate boundaries around food in the family system (Ramalho et al., 2021). The data gathered from the participant interviews indicates that the re-organization of boundaries around food was often necessary yet missing (Minuchin, 1974). Participants highlighted how their families were either enmeshed, rigid and/or conflict avoidant – a relational attachment style that models the psychosomatic type of system that is often encountered in families with a member presenting with AN (Minuchin et al., 1978) Consequently, in line with findings from Ramalho et al. (2016) participants' autonomy in view of the family setting and their identity related to food appeared to be missing. Similarly, the participants indicated that their struggle to achieve eating autonomy was marked by a loss of control on themselves and on others due to an autonomy-dependence struggle that occurs between the individual and the rest of the family (Ramalho et al., 2021).

5.2.2.2 Moving from home to home.

The experiences of some participants on leaving their home of origin for residential care reflected a disruption to their sense of self and posed additional challenges to their recovery. Such statements were indicated with the use of delicate words that differentiated themselves from "other body figures" when referring to other individuals at Dar il-Kenn or the psychiatric unit. Hypothetically, one can argue that the participants' integration of this differentiation into their narrative may be indicative of their current broader sense 'self 'that would not wish to trigger any thoughts of the previous false 'self'. It may also be

hypothesized that much of the participants' anger towards the service system may be a projection of the internal hatred towards the mother (Waska, 1999).

A common theme within most of the participants 'stories of moving from the family home to residential home was that of shame. One participant stated that even in this present day she barely speaks to anyone about her ED, because "many people are not aware […] and they don't understand". Shame is defined by Miller (1983) as a state of distress that the individual experiences when defining the concept of their own 'self 'in being convinced that it is defective and not good enough. This sense of shame is felt at the core of the self and in order to understand it, one must first conceptualize the damage that would have been sustained by the self as a result of previous psychological structural deficits (Morrison, 1989 as cited in Darmanin Kissaun, 2017).

Research outlines that stigma is commonly experienced by individuals who experience AN (Zwickert & Rieger, 2013). Stigmatizing attitudes from others have allowed some participants to internalize the shame that is often associated with AN (Stewart et al., 2008). Shame from the family was induced to the individual's experience when their attachment inhibits or is autonomous from the normal attachment in the family. Nevertheless, all participants shared that when they were in a residential system, they all turned to their family for support, possibly indicating the important aspect of connection to the biological caregiver for emotional survival and in feeling supported by the family of origin during such vulnerability – a novel concept that is pivotal to FBT for AN (Loeb & le Grange, 2009) as was described in chapter two.

5.2.2.3 Breaking through the systems.

A significant point of issue in relation to recovery is the conceptual element of having a "choice". This theme was prominent in all narratives, even as most emphasized that full

recovery does not exist but it is rather a matter of "learning how to live with it". More prominently, was the fact that all participants linked their process of recovery with their success of breaking through the barriers in the systems and paving their way out of them predominated a focus on their sense of self. This emerged in all their narratives.

All participants have expressed that "managing" recovery required their constant, conscious effort to apply what they learned in therapy and maintain a healthy sense of self by practicing good self-care, healthy coping strategies and taking control of their ED thoughts especially when in the presence of fear for relapse (Berends et al., 2016). Some participants expressed that they do not know a life without their ED and therefore, one may question whether not finding the right support from social contexts, or systems, may be posing a negative impact on their broader sense of self (Khalsa et al., 2017).

Participants explain that life following an ED diagnosis will never be the same for them, especially if their fear of relapse poses any threats or negative impact to their broader sense of self (Khalsa et al., 2017). Reflecting on the possibility of AN always remaining part of the life-script of the individual, one may wonder how fully accepting of "forever" aspect can one individual be, and if so, to what extent can the individual tolerate the chronic negative cognitive dysfunction that results from loss after psychological trauma (Ehlers & Clark, 2000). Participants explain that part of the process in accepting these aspects of the self was through therapy, which helped them break away from the internalized negative influences of systems they were in. Additionally, therapy helped them to engage in a process compassionate self-love and acceptance that nurtures the emerging broader self.

5.2.3 The ever-evolving self.

The concept of the self refers to the organized structure that frames the individuals' thoughts and feelings about their self and the other (Leary & Tangney, 2011; Vazire &

Wilson, 2012). Individuals able to think about their concept of self in relation to other 'objects' (Oyserman, 2012), are also able to include reflexivity in their narrative (Kihlstrom et al., 2003). Although some of the participants provided profound reflexivity in their narrative, I was unable to evaluate whether the processing of their experiences had been fully integrated with their self-identity. Despite the fact that all participants were highly self-aware, well-informed and reflexive about AN and their experience of it, there was a striking fear of relapse in all participants. Hypothetically this could be indicative of a potential fear in disintegrating their new sense of self if they become in touch with their previous 'false' self even in their broader life narrative.

A common feature within this dominant narrative was the evolving process of the self that each participant spoke of. Various theories argue the concept of self to be fluid (Oyserman, 2012) even as it protects itself from the changes that occur as a result of surrounding circumstances (Swann, 1985). Participant interviews indicate their awareness on the "ever-evolving" sense of self by describing the various changes they experienced following their AN diagnosis and treatment. The participants spoke of this process in three distinct time-frames; who they were as children (referred to as the birth self in chapter four), who they became through the process of recovering from AN and who they will continue to be in their broader life-story.

Some of the participants explained how through therapy they became more sociable, more flexible with food and less conscious about their body shape and weight. Such shifts in the self were amplified when some of the participants remarked how therapy helped them realize how "strange" and "illogical" their ED patterns were. They added that narrating their story through the use of the timeline-activity in the interview was a meaningful process of integration of the past into the present for them.

Although recovering from AN was a unique process for each participant, it was highlighted by all that "maintaining" recovery remains an ongoing process. Most participants suggested recovery to require a number of different factors to keep it going in the present; including having hope, finding meaning and purpose, taking responsibility for their well-being and maintaining their new sense of self (Andresen et al., 2003). Some participants also highlighted the important role therapy had in their psychological growth. Elements of post-traumatic growth (PTG) in the aftermath of their traumatic experiences were described by having a greater sense of appreciation towards life and towards a strong support network with close relationships (Wagner et al., 2016). Furthermore, most narratives included a description of the change in self that emerged through psychotherapy, including a more mature, resilient self who has become more adjusted in life and learned how to turn its mess into a message (Wagner et al., 2016).

5.3 Part Two- Structural analysis

In the structural analysis I analyzed the participants 'stories for coherence and clarity in detail and timing of events. The methodology in this study followed the model proposed by Dallos and Vetere (2016) who proposed that verbal disconnection, incoherent memories, lack of detail and clarity are responses to the individual's unprocessed trauma.

Unprocessed traumas are otherwise referred to as 'frozen narratives 'in which the individual exists in a trauma state of mind (Dallos & Vetere, 2016). Most of the narratives provided by the participants included fragmentation and were not completely coherent. However, one needs to also consider the affect trauma has on episodic memory and on the individual's ability to recall the sequence of events (Bremner, 2006). Literature indicates that trauma memories, like all memories, are prone to distortion (Strange & Takarangi, 2015). Growing evidence shows that trauma can prevent information from different parts of the

brain to integrate semantic memory (Bremner, 2006) and individuals experience difficulties with retrieving a complete, coherent recollection of the event. Therefore, one's recollection may be expressed in a poorly organized manner, fragmented in structure, missing in details and lacking sequence of events (van der Kolk & Fisler, 1995).

5.3.1 An evaluation of the frozen narratives.

Frozen narratives are defined as traumatic memories that are unconsciously inaccessible for recovery (Janet, 1925). Such frozen narratives contain flashback memories of highly stressful situations from the person's life (van der Kolk & Van der Hart, 1991; Kleim et al., 2015). Although some participants experienced memory fragmentation with a certain level of clarity, others resisted the integration of traumatic memories into existing mental structures. Despite this distinction in recalling memories, all participants shared an element of distress when narrating their stories. The presence of this distress was not too severe and it did not cause any traumatic stress-like symptoms however it may have affected their ability to remember details.

Additionally, the presence of shame in disclosing particularly challenging times may have also impacted the participants' ability to remember and disclose full detail in their narrative. Whilst incoherencies that are portrayed through fragmented and incomplete sentences could be considered to reflect the presence of a frozen narrative (Dallos & Vetere, 2016) one might need to consider other factors too, such as one participant who described herself as shy and reluctant to retain conversations at length. Arguably, some of her fragmented sentences may have been due to this.

There were also incomplete sentences and several pauses in the narratives of some other participants. Hypothetically, they may have felt uncomfortable in sharing these experiences from go as the more I stayed with them in those moments, the more comfortable

they seemed to feel comfortable to provide further details. My hypothesis may be strengthened by the narrative of one participant who experienced a complete black out when attempting to remember a particular traumatic time-frame in her ED. By time she remembered that she had engaged in an over-the-counter substance abuse as a way to ease or control emotions when they were stressful or confusing. This can be further understood through Khantzian's (1977) theory of self-medication which hypothesizes that self-medication occurs in contexts where the individual experiences self-regulation vulnerabilities – primarily with regulating emotions, esteem, relationships and self-care. With gradual time, she was able to remember more detail beyond the substance abuse incident and gave vivid descriptions of her story.

Finally, veering away from talking about their mother may have been another form of frozen narrative. This deviation in narrative may suggest the potential presence of an unresolved emotional trauma that has not yet been well processed or well-integrated into the participants' lived experience (Dallos & Vetere, 2016). Such frozen narrative may have caused difficulty for the participants to come up with details of the relationship in their story, thus not having enough security to talk about it (Overbeek et al., 2019).

5.4 Part Three – Process analysis

The below section provides a reflective analysis of the 'co-created 'process between the participant and myself, the researcher. The analysis includes comments on how our relational process was relevant to our interaction as it examined and determined whether process mirrored content and vice-versa.

Alison.

Alison was the first participant who attended the interview. Her narrative was characterized by moments that triggered profound counter-transference reactions. I felt a strong sense of care and compassion towards her, and heart-break while she described the pain she had experienced. I could see this pain through her eyes and even though she was not able to verbalize all of it, I connected with a sense of longing for love and security. I found it difficult to comprehend how these emotional reactions were being triggered while she is explaining how special and profound her relationship with her mother is. She seemed to be narrating this relationship with a smile on her face, however given the emotional counter-transference I was feeling I believe that the content and the process were incongruent. This is in line with the earlier mentioned hesitation from the participants towards speaking on their maternal relationship at length. Moreover, incongruence was also visible when Alison described the experience of her close sister moving abroad and when she had her first break-up. Hypothetically, Alison's previous relationships may not have provided her with the security she describes.

When describing her therapeutic process, she continuously made a before-and-after distinction in her ED behaviour. However, the more we progressed into the interview, the less detail she provided about her experience. I could sense her hesitation from delving into emotional depth and intellectualizing content instead - possibly indicating the presence of alexithymia or a frozen narrative that is not well processed or integrated. Therefore, I wondered how genuinely comfortable she was with the changes that occurred.

Daisy.

Daisy's interview was strong in descriptions of how her mother's rejection to the way Daisy behaved around food was the root cause for her ED. As Daisy described the reasons behind her mother's approach towards her, I connected with a sense of longing for safety and protection. I felt that this might have resonated with similar emotions that I experienced when my mother passed away and evoked a profound sense of loss in me.

The co-created space between Daisy and I was a secure space that perhaps allowed her to trust the process and recall painful experiences. She seemed confident and strong in her narrative and as a consequence, I took a passive stance in my position as I felt that she was recalling sufficient, specific detail in her narrative without needing further prompting from my end. This position in the narrative from Daisy may have mirrored how well processed the content in her story is in knowing and communicating the significant impact the ED had in her life-script. As I sat with her and watched her fill in the time-line activity, I felt the strongest sense of transference during the 'From one system to another' narrative where she described her move to Dar il-Kenn. However, I am aware that my bias in considering insecure attachment styles to be a prominent risk factor for ED and psychopathology in a general, may influenced my interpretations of her experiences. There were moments where I needed to distance myself and take a meta-position in my stance so that I could observe what was happening between us from a more objective point of view. Daisy's friendly personality and high awareness of the subject may have contributed to my profound engagement in the story.

Ivy.

Ivy's interviewing process highlighted a unique aspect to the narrative. There were specific instances where Ivy could not recall painful experiences throughout her adolescent years. It seemed like Ivy was not ready to trust the process yet and consequently she may have blocked her memory due to frozen narrative or alexithymia (Brewin, 2018). In that moment I resonated with a sense of caution and concern, and I did not wish to invade her privacy. There was an immediate shift in the atmosphere which was perhaps fueled by themes of fear and self-exposure. I am aware that my biases may have influenced my interpretation of the intensity of such experiences.

This fragile atmosphere dissipated as Ivy began to feel safer in our co-created space. This was translated through a flowing type of narration that had less pauses and the addition specific details in the story. Her narration became quite fast-paced and it resembled a sensation of panic. Possibly this presence of emotion reflected how she felt at the time. I observed that her choice of words described a parallel process and consequently, I stayed with Ivy to support her in our interacting process. Moreover, I felt captivated by Ivy's level of processing, insight and circular reasoning.

5.5 Conclusion

In this chapter I presented a detailed discussion of each narrative, the narrative structure and the process analysis. The outlined narratives were discussed in view of scientific literature, some of which were presented in Chapter Two. It is significant to mention that although literature considers the mother-daughter attachment to be dominant in the recovery process of AN, in this chapter I have presented the participants' narratives of recovery in view of the 'self' and how they relate it to their AN. I have highlighted a counter-argument to the concept of frozen narratives as mentioned in the methodology, by drawing on

cautionary points of consideration when interpreting trauma memories. In the following chapter I present a conclusion to the study.

Chapter Six - Conclusion

6.1 Introduction

In this chapter I summarize the main findings that emerged from this research and I outline some of the strengths and limitations of the study. Additionally, I present a few recommendations for future research and discuss implications for policy and practice. Finally, I present a few concluding thoughts.

6.2 Summary of findings

NA was applied to all six semi-structured interviews, from which the dominant narratives and their subsequent themes were elicited. The structure of the narrative and the process which was co-created between each participant and the researcher were evaluated. The three resulting dominant narratives were 'The illusion of control', 'From one system to another' and 'The ever-evolving self'.

'The illusion of control' was a dominant narrative which highlighted the participants' stories of issues of control during their ED. Their narratives were rich in detail that at times their descriptions seemed like a scripted tale. The stories within this dominant narrative flowed logically; realizing that AN it's not about image was followed by a state of awareness that their attachment to the grip of control was not shared by those around them in the social world. In line with literature, participants indicated control exertion over food intake was dominating their existence, and having poor insight about it maintained their defense mechanism in times of distress. Choosing to let go of their attachment to control was a stepping stone for their process of recovery.

The dominant narrative of 'From one system to another' describes a critical timeframe in the lives of participants. The family genograms represented the relational connections of the participants before and after their ED closer connections to significant others once their ED was under healthier control was noted. Issues around eating autonomy and around

boundaries and structure in the family home were elicited to be necessary yet missing. Furthermore, participants highlighted their challenges when they moved from family home to a residential home. The most common themes included shame, mental health stigma and how these impacted their personal agency. They also highlighted the process of growth in their sense of 'self' as they spoke of what they been through. This gave rise to reflections around how achieving a healthier sense of self requires a process of adjustment, of maturity and change in perspective where defects are no longer considered as flaws but are now accepted and integrated into a broader sense of self.

This process in the participants' stories gave rise to the dominant narrative of the 'The ever-evolving self'. This narrative dominated most participant stories and they frequently referred to their selfhood according to who they were at birth, who they became and who they wish to continue to be. The resultant data showed that the participants' choice to recover required a process of meaning-making and redefining their sense of self above all else. In the end, some narratives also mentioned an element of PTG – a type of growth that reflected the resilient aspect to their sense of self as it became better adjusted at dealing with life.

The way which participants described their story led to unique co-created processes with each individual. Rich narratives transmitted and elicited different transference and counter-transference reactions. At times participants were emotionally distant and described their painful experiences with a smile on their face. This possibly indicated the shame underlying their thoughts which questioned how they were being perceived. Consequently, process analysis enabled a better understanding of the participant's experience by evaluating whether process mirrored content, and to speculate on possible reasons where it did not.

6.3 Strengths of the study

Utilizing a qualitative approach is a main strength of study because the elicited data is a true reflection of the participants' choice of words, details and sequencing of life-events as

they occurred in their reality. Speaking with the participants in person helped me get in touch with different aspects of what they went through and this offered a rich narrative of their experience. All participants expressed that these interviews were their only opportunity so far to narrate their AN experience in such detail and with someone who is not their significant other or in therapy. NA, particularly the model proposed by Dallos and Vetere (2016) assisted the process of a thorough analysis from which data on three dominant themes, structure and process was elicited.

The resulting data might be especially relevant to professionals and researchers in the field as it provides greater insight into how understanding the self in therapy has helped individuals come to better terms in processing what they are going through, their emotions and their growth. The theme of 'The ever-evolving self' highlights the importance that is given to the individual's sense of agency in the process of recovery. It implied that a substantial part of their recovery included good care of the self rather than just reducing the symptoms of the condition. Moreover, reflecting on the way individuals engaged in interviews highlights the importance of listening to individual life stories and to appreciate the richness and complexity that comes out from their narration. This further signifies the strength in applying a qualitative approach to understanding and evaluating individual stories of recovery because it adds experiential value to the literature base on ED.

The adults in this study seemed to highlight that recovery is an on-going process that one learns to live with. A key characteristic to maintaining recovery seemed to include understanding one's own underlying thoughts and emotions. Through psychological treatment participants learned that food does not have to be an emotion regulation strategy. They also learned that there is meaning in the process of recovery and life should not be all about weight and body image. They argue that this insight from therapy has helped them feel autonomous and of a separate mind from their ED and therefore, this could be considered as a

strength that implies the crucial element of fostering psychological growth in terms of mood regulation, cognitive restructuring and attributing meaning to the recovery process of AN. Engaging in conversation with the participants on these issues in the interviews may have strengthened and further sustained their broader level of autonomy, and therefore supporting their recovery in the process as well.

Since all interviews were conducted in English, the direct excerpts included in the results chapter did not require translation. This eliminated the possibility of having nuances of meaning to become lost in translation, and it exacerbated the chances of remaining faithful to the participants' original narratives as much as possible. All participants chose to speak English throughout the interviews and they did not seem to find it challenging to use adequate words to articulate their story – adding further richness to depth and detail that was provided.

6.4 Limitations of the study

This research was based on the lived experience of individuals who recovered from AN and thus it relied on their thought process, mood, feelings and ability to reflectively integrate the past with the future. Some participants found it challenging to talk about certain life-events, which is understandable given the traumatic effect this may have had on their sense of self. The process of talking about their experiences required the individuals to remember what happened to them and how therapy helped them recover from it. Thus, their memories may have been affected by the trauma and led to fragmented, 'frozen narratives' at times (Dallos & Vetere, 2016).

In my opinion, considering incoherence in sentences, pauses and unclear sequence of events to be just indicative of an underlying trauma is limiting our understanding of what may lead to a frozen narrative. Undoubtedly, it may well be the case that the presence of

intense emotions evoked by the interview like shame and anxiety; and personality factors like shyness may also contribute to lack of coherence. Throughout the interviewing process I noticed that some participants found it challenging to talk about their relationships and focused most of their narrative on their ED recovery and its impact on the self and thus, this may have impacted the data. As was highlighted in the literature review, the focus of this study was to explore how early relationships may have impacted the development of AN. Despite my efforts to make the aim and focus of study explicit to the participants before interview, perhaps more explanation was necessary to further clarify what the study was investigating.

Another limitation to the study is the lack of detail about the therapeutic process that the participants engaged in. The resulting data indicated the participants' meaning to psychotherapy – mostly that it provided them with a range of tools for coping and adjustment; an increased level of awareness, and a safe space where they could transform the meaning of their experiences and symptoms in such a way that it helped participants feel better and function more adaptively (Locher et al., 2019). However, the lack in defining their experiential process of psychotherapy may be a limitation. More specifically, perhaps the relational experience to the psychologist and the changes the participants went through as a result of the client-professional relationship. In this view, future research could follow-up this study by observing directly the individuals' experiences of the therapeutic process and obtain detailed descriptions of the process, context and differences that may occur.

Moreover, all participants in study were females and thus the generated data does not represent the experience of other genders, binary and non-binary alike (Holdcroft, 2007). Whilst having all female participants may reflect the female-gender bias in literature were rates of AN are reportedly higher than males (Striegel-Moore et al., 2009), this may pose a

limitation to generalizing findings to a larger population scale that is inclusive of more than just female individuals along the gender spectrum in society.

Narrative research emphasizes the individual perception of the experience and the unique manner in which the participants recount their stories. Because of this only the participants' accounts of the therapeutic process were considered. Perhaps interviewing the participants' respective psychologists may have shed further light on the participants' understanding of their therapeutic journey. This could be an avenue for further research, as mentioned in the subsequent section.

6.5 Recommendations for future research

The understanding of ED recovery from an attachment-narrative perspective is, to my knowledge, the first of its kind in Malta, and therefore it is being recommended that future research continues to focus on obtaining the subjective lived experience of individuals who recovered from AN. Research in this field should include the voices of the family members, significant others, psychologists and psychiatrists who specialize in the field. Similar to Clark and Rossiter (2008), I argue that "… believing in narrative, we must also believe that the story is not finished, that there are other possibilities, and that other voices will enrich and expand it" (p.69). Thus, replicating this study in other countries and with a larger sample size can continue to shed light on other multi-layered stories.

The dominant narrative 'From one system to another' highlighted the difficulties participants experienced with local residential treatment for ED. Further research on the residential setting would better explain the link between the difficulties in retaining treatment and its impact on the individual's sense of self which featured prominently in the narratives of participants who attended Dar il-Kenn. The impact of the stigma these individuals experienced and the repercussions this might have had on their recovery and sense of autonomy also merits further investigation.

Given that my participants mentioned the sometimes-turbulent relationships with their mothers, it would be interesting to unpack further the link between mother-daughter attachment and parenting methods in early development and how this links to the development of AN. This could be explored with a larger sample size and that is inclusive of binary and non-binary genders.

Most participants described how their recovery process required them to let go of the self at birth and grow into a broader sense of self that is characterized by resilience and greater maturity. It would thus be beneficial for research to obtain a better understanding of PTG in relation to AN recovery. Further research on participants' process with regards to PTG could help to shed light on the different therapeutic modalities or perspectives that influenced autonomous resilience in their journey.

6.6 Implications for policy and practice

The lack of specialized treatment services for ED in Malta was highly emphasized by all participants. A study by Grech (2013) indicated that 34.3% of the participants suffered from AN at one point in their life. 1.3% of these participants were adolescents who still live with their families - the context where eating habits and relational dynamics are more likely to maintain or exacerbate eating issues. These statistics may indicate that the current local response to address AN for familial and adolescent client group is not comparing to the urgency of the problem. A number of implications for practice and service development may be brought forward in light of this research.

According to Gander et al. (2015), AN needs to be considered as an issue rooted in the relationship that the infant has with the primary caregivers from early years. In this respect, psychologists need to understand and implicate the crucial value of nurturance for the child's emotional regulation and that this regulation goes beyond controlling food intake. In view of this conceptualization, there needs to be a rise in integrative discussions across

different professional disciplines, better implementation of nutrition and parenting education interventions. This approach may need to be linked to systems outside the family home, like Dar il-Kenn, that mutually shape the stories of individuals.

The provision of specialized training in supporting and intervening with problematic eating habits needs to be further addressed. Following the resulting data of this study, investing in educational programs that inform and support family members, especially mothers, on optimal parenting approaches and feeding habits could provided. Educating parents and fostering reflexivity for higher self-awareness can aid better understanding and support in how to regulate themselves and their children in the face of challenges too.

Finally, the need to give a voice to the professionals working on these sensitive topics. The psychologist has a prominent role in supporting these individuals and thus proving a safe space where challenges of the practice can be brought out in the open may help unpack the pervasive matters that are kept in silence. Matters related to ED problems may sometimes be related to shame and stigma in society, and therefore the need to break this ongoing cycle by further training and/or shame-sensitive supervision could be useful to consider in future policies and practice protocols.

6.6 Concluding thoughts

At the end of this journey, I am in awe of the amount of personal and professional growth I have achieved throughout the research process. The idea of researching this area was present prior to beginning my Masters in Psychology. My previous work experience in ED and witnessing my friend’s immense suffering with recovering from AN motivated me to carry out this research. The lack of literature on the individuals' perspective to AN recovery further fueled my motivation and enthusiasm, to the extent that when my tiredness became figure, I leaned on these incentives for a boost. Each participant’s story had unique aspects

that resonated with me and my process – and this rekindled my enthusiasm throughout the process too.

In conclusion, I believe this research and the contributed understanding of the lived experience of these participants will prove to be invaluable even in my clinical practice. This study has helped me see the many layers there is to AN and its recovery and I would like to extend my interest by conducting further research in this area. As a future Counselling Psychologist, I would like my practice to follow a relational-developmental perspective that considers attachment, trauma, narrative and psychodynamic theory to be central frameworks in my conceptualization. I believe this research was an eye-opening experience in understanding that my role as practitioner should give main priority to the deepest vulnerabilities that lie at the core of the problem, and to how these vulnerabilities impact one's sense of self when struggling with ED.

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Appendix A

Recruitment letter

Dear Sir/Madam,

My name is Marie Claire Agius and I am postgraduate student with the Department of Psychology at the University of Malta. As part of my Masters of Psychology in Counselling Psychology dissertation, I am conducting a research study to "Understand Recovery from The Stories of Individuals with a Former Diagnosis of Anorexia Nervosa". I am recruiting participants who have been recovered for a minimum of two years before the time of interview (in order to reduce the likelihood of distress); are of eighteen years of age or older; and are able to communicate in good English and/or Maltese.

Participation in study will require the person to be interviewed twice, for approximately one hour every time. In the first interview I will ask about childhood experiences with particular focus on attachment representations. In the second interview I will then ask questions that explore the experience of the participants' therapeutic process as part of their broader life story. Interviews will be audio-recorded for data analysis purposes.

Participation is voluntary and there are no consequences and/or benefits for choosing to participate or withdraw from the study. Confidentiality of all participants will be strictly maintained. The data will be kept secure and password protected.

Any further questions regarding the project can be directed to me;
Marie Claire Agius on marie.c.agius.12@um.edu.mt
or my supervisor, Dr. Greta Darmanin Kissaun on greta.darmanin-kissaun@um.edu.mt.

Looking forward to your reply. Kind regards,

Marie Claire Agius

Appendix B

Participant Information Letter and Consent Form

Information about the study

My name is Marie Claire Agius and I am a postgraduate student at the University of Malta. I am reading for a Masters of Psychology in Counselling Psychology, and am currently conducting research as part of my dissertation. This project is titled as "Understanding Recovery from The Stories of Individuals with a Former Diagnosis of Anorexia Nervosa: A Narrative Approach to Lived Experiences".

The aim of my study is to understand and represent the experiences of people who have been diagnosed with anorexia nervosa in the past and their process of recovery. The current research study will also seek to explore the experience of the participants' therapeutic process as part of their broader life story.

Your Participation

Any data collected from the research will be used solely for the purposes of this study. Should you choose to participate, you will be asked to take part in two, one-hour long interviews. The first interview will focus on the impact of childhood experiences and attachment representations. The second interview will look at key events in the course of psychotherapy that have been helpful in the process of recovery. Interviews will be audio-recorded for purposes of data analysis.

Data gathered will be collected through respective gatekeepers, a psychologist or psychiatrist. The role of the gatekeeper is to ensure that the potential participant fits the inclusion criteria.

Participation in this study is entirely voluntary; in other words, you are free to accept or refuse to participate, without needing to give a reason. You are also free to withdraw from the study at any time, without needing to provide any explanation and without any negative repercussions for you. Should you choose to withdraw, any data collected from your interview will deleted/stored anonymously. Your participation does not entail any known or anticipated risks, however suggestions for psychological support services can be provided if the need arises.

Data Management

The data collected will be treated with strict confidentiality and pseudonymized. Data will be stored in a safe place that is locked with a coded password. Only the researcher and her supervisor will have access to it. All data collected will be erased after three years upon completion of the study.

Please note also that, as a participant, you have the right under the General Data Protection Regulation (GDPR) and national legislation to access, rectify and where applicable ask for the data concerning you to be erased.

Participant's consent

- ☐ I hereby declare to have read the information about the nature of the study, my involvement and data management.
- ☐ I have had the opportunity to ask questions about the study and my questions have been satisfactorily answered.
- ☐ I declare that I am 18 years or older.
- ☐ I understand that should I have any further queries, I can contact the researcher; Marie Claire Agius (marie.c.12@um.edu.mt), and/or her supervisor Dr. Greta Darmanin Kissaun (greta.darmanin-kissaun@um.edu.mt).
- ☐ I agree to participate in this research study.

MARK ONLY IF APPLICABLE

- ☐ I agree to be identifed in the research records.
- ☐ I agree to be identifed in the research publications.

______________________________ ______________________________

Participant's name (in block) Researcher's name (in block)

______________________________ ______________________________

Participant' signature Researcher's signature

____

Date

Appendix C

Interview Guide One – The interplay of childhood experiences and life events

I'm going to be asking you a few questions about your childhood experiences, and what you think about the way they may have affected you. This interview is expected to last between 45 minutes and 60 minutes. We will start by talking about your family composition and then we will look into events from the past that had an effect on the development of Anorexia Nervosa. To help you remember details from your past, I have prepared an A3 sheet with a timeline on it. The timeline is divided into 5-year periods according to age.

Ice-breaking questions for us to ease into the interview.

- Can you tell me a little bit about yourself?
- Where do you live at the moment?
- What do you do for a living?
- What activities do you like doing in your free time? Do you have any hobbies?
- Who forms part of your family now?

Interview Guide

1. Can you tell me about your family composition at the time? (Interviewer and interviewee draw a
genogram together that will map out details of the family members and describe their relationships)
2. I would like you to start by marking your weight at every mark on the timeline.
3. Can you mark any significant major life events, your age when these happened, and whether they
were accompanied by weight fluctuations?
Prompts: (e.g. school transitions, losses, major illness etc)
4. How do you think these events interacted with the development of anorexia?
5. Can you mark at what age the anorexia emerged on the timeline?
6. Can you mark significant events that happened throughout the course of this condition?
7. How do you describe your relationship with your body throughout the course of the condition?
8. What was your relationship with food before and after the onset of anorexia?
9. What was your parents' relationship with food?
10. How was the family atmosphere at home during mealtimes?
11. What meaning did food have in the family?

Thank you for your time and for participating in this interview. Your input is greatly appreciated. I will see you again next time for the second interview where we will be focusing more on the therapeutic process and what was helpful about that.

Appendix D

Interview Two – Key Psychotherapeutic events that helped with recovery.

In this interview, I will be asking you questions related to your experience of therapy and the factors related to your therapeutic journey that contributed to recovery. Take as much time as needed to respond to the questions as detailed as possible.

1. Could you tell me your story of how you recovered from anorexia nervosa?
2. What were the key events in psychotherapy that you felt have helped you to recover?

Prompts:

• Which aspects of psychotherapy have helped you develop a different relationship with your body?

• Which aspects from psychotherapy have been of benefit to your family in the process?

• How has psychotherapy helped you develop a different relationship with food?

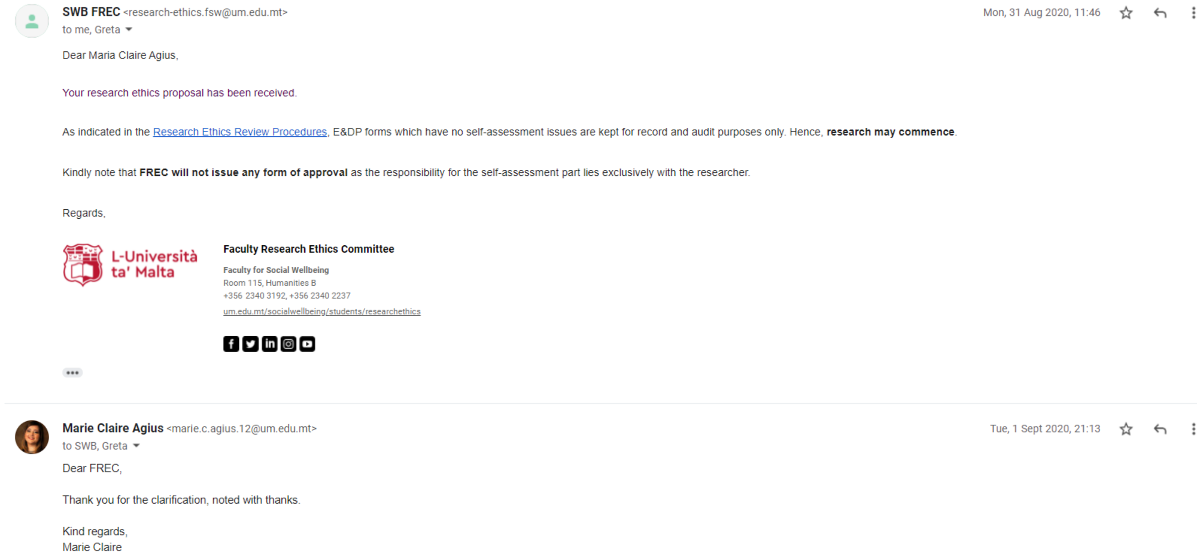
3. What does recovery mean to you?

4 What is the meaning your family gives to your recovery from anorexia?

5. Did anyone else support you during the process? If so, who?
6. Can you describe an aspect of therapy that you found challenging?
7. And lastly, what aspects from your psychotherapeutic process have you carried into your current life?

We have come to the end of today's interview. I wish to thank you for taking the time to participate in these interviews. Your input is of great value to my research and I am very appreciative for all that you have shared with me

Appendix E



SWB FREC <research-ethics.fsw@um.edu.mt>
to me, Greta
Mon, 31 Aug 2020, 11:46

Dear Maria Claire Agius,

Your research ethics proposal has been received.

As indicated in the Research Ethics Review Procedures, E&DP forms which have no self-assessment issues are kept for record and audit purposes only. Hence, **research may commence**.

Kindly note that **FREC will not issue any form of approval** as the responsibility for the self-assessment part lies exclusively with the researcher.

Regards,

L-Università ta' Malta

Faculty Research Ethics Committee
Faculty for Social Wellbeing
Room 115, Humanities B
+356 2340 3192, +356 2340 2237
um.edu.mt/socialwellbeing/students/researchethics

Marie Claire Agius <marie.c.agius.12@um.edu.mt>
to SWB, Greta
Tue, 1 Sept 2020, 21:13

Dear FREC,

Thank you for the clarification, noted with thanks.

Kind regards,
Marie Claire

Appendix F

Transcript Sample

Transcript	Structure	Thematic	Process
P: The more, when you start going down, the more you feel in control, the more u want to be in control and no one sort of can stop you.	Detailed description of issue		
I: Ok. Can you tell me more?			
P: As such, well it is an addiction at the end of the day. You like what you see, you start losing more, but the difference is that who has anorexia has the tendency to want to be in control, you see, a lot. When you start going down down down, and you see the scale going down down down, you feel like in full control of yourself, of your body, whatever, of everything. Because so much is about the food and what comes with it that your full control and purpose in life is that, not the people around you, that love you, just this.	Vivid, descriptive details Resolution to purpose in life	Frustration	Sensing anger
I: Mhm controlling the food and how you look in a way.			
P: Exactly			
I: How would you say your relationship with your body was throughout this time?			
P: No I always hated my body, I'm not saying I hated it when I was young, as I said before something happened in my life I was quite a bubbly person, I didn't care if I was big or short			Sensing shame

or whatever, but then yes… I just actually…you know… the first time I lost weight I just used to hate my body and the fact, that as much as you feel in control you are never happy.	Vivid details, fragmented sentences	Not feeling well, like a sense of suffering	
I: Was it unsatisfying?			
P: Yes exactly			
I: Ok. And do you believe that maybe back then you began to feel more self-conscious of your image?			
P: Not really, the main aim of anorexia, well in my case it wasn't as such body image but yes when you get the condition and sorts it becomes somewhat, because at the end of the day no matter what size I was I used to see myself fat. Somehow there was that reflection in the mirror that made me fat.	Fragmented sentence when speaking of body size and weight	Frustration Anxiety	The frustration felt real when she outlined difficulty with body image The more she spoke the more I felt like she was alone through all this
I: OK			
P: I mean I knew my trousers size was falling off	Went back to the time of the event – clear memory to recall event in narrative	Shame	Distancing the emotion and going to cognitive – defence mechanism?
I: OK			
P: Nowadays it doesn't make sense	resolution		Outlining the difference between then and now – protection of self?
I: Mhm it's like now you see it differently			
P: Yes exactly			
I: And back at the time, during the condition, how you describe your relationship with food?			
P: Before I can say I used to love food, ok there was always something I didn't like but other than that I used to love food.	Vivid details, coherent sentence	Happiness	Story felt real
I: Ok			
P: They love food in my family too			Sensing warmth and containment

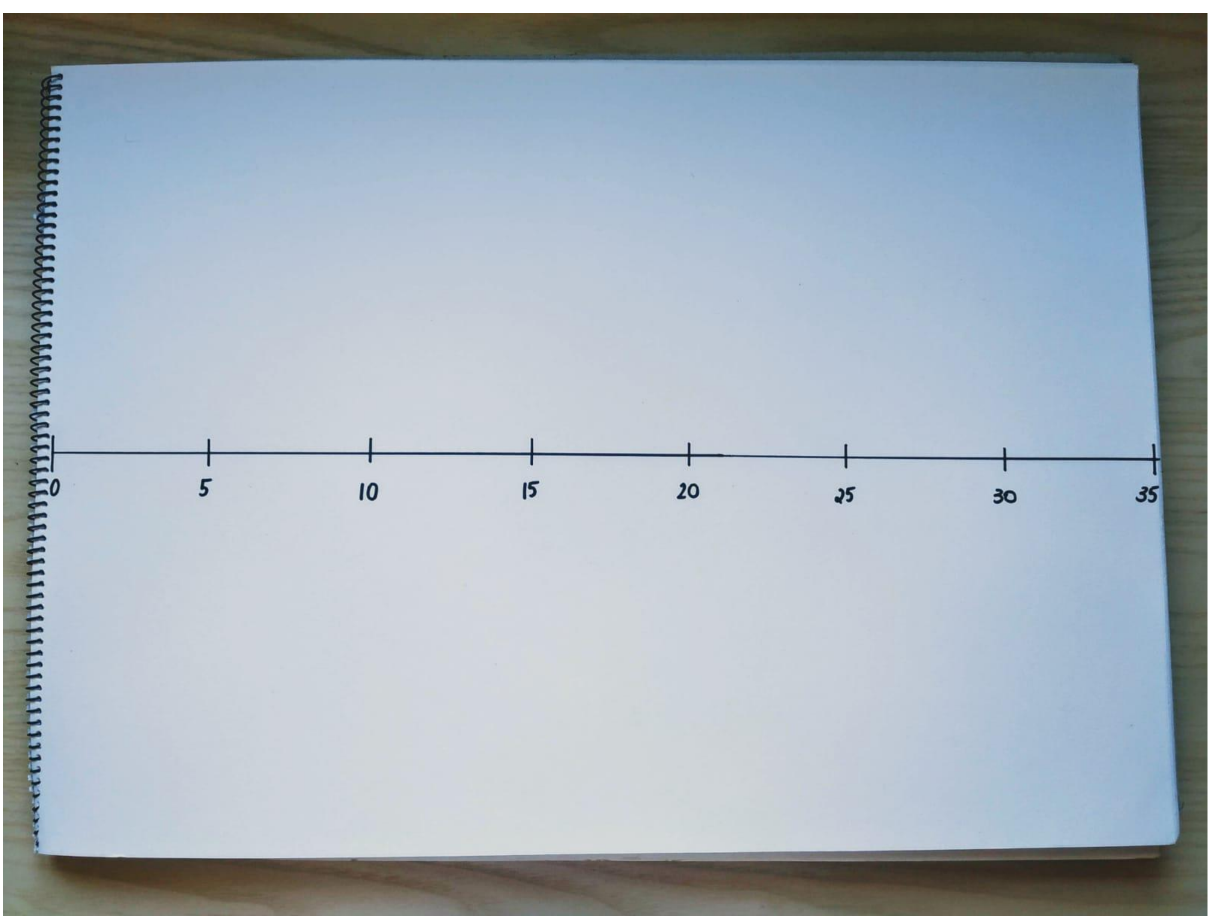
Appendix G

Table of Illustrative Qoutes

Dominant Narratives	**Themes**	**Quote**
The illusion of control	It's not about image	"It's not really, […] well in my case it wasn't as such body image but yes when you get the condition and sorts it becomes somewhat […]" (Alison)
	Attached to the grip	[…] it's an addiction at the end of the day" (Alison)
	Losing and letting go	"[…] lose the ideal and go to a nutritionist to eat healthy […] my dad used to come with me to make sure I go in for the appointment and my mum started to adapt her cooking" (Ivy)
From one system to another	The self at home	"During meal times, the atmosphere was rather tense because food was scary, even "if it smelt good" (Alison).
	Moving from home to home	"It was difficult for me, I spent a month and left […] there was a mixture of patients. […] I was exposed to some types of body figures and I was still very weak to deal with it […] I found it very difficult, the lack of contact you would have with family especially […]" (Ivy).
	Breaking through the systems	"[…]t is not something that the family can do to actually help […] I say this as well, no one can help you, only you can help yourself no matter what they try to do" (Alison).
The ever-evolving self	The self at birth	"At age 10 my mother stopped me from dancing because she said it's time to focus on school. I had nowhere to express myself apart from school and so I began to close off in myself […]" (Ivy)
	Becoming	"[…] so yes with therapy I had to learn and become aware that food and emotions don't mix together" (Daisy).
	The broader self	"Whatever I learnt throughout the therapy I still apply them each and every day and in everything I do in life" (Alison)

Appendix H

Visual Representation of Timeline of Events



Appendix I

The NICE Guidelines on Psychological Treatment for Eating Disorders

The National Institute for Health and Care Excellence (NICE, 2017) guidelines recommend treatments that address specific aspects of AN, including disordered thoughts regarding food and body image, dysfunctional behaviors such as restrictive eating, binging and purging; as well as interpersonal and intrapsychic issues (Bodell & Keel, 2010). The three main treatment approaches recommended by NICE (2017) are:

Individualized Eating-Disorder-focused Cognitive Behavioral Therapy (CBT-ED).

A program of twice-weekly sessions over a period of forty weeks or more. The aim is to reduce the risk of physical health and any other symptoms of the disorder by addressing nutrition, body image concerns, self-esteem and relapse prevention by means of cognitive-restructuring, mood regulation and by practicing social skills (NICE, 2017).

Maudsley Anorexia Nervosa Treatment for Adults (MANTRA)

The main objective in MANTRA is to encourage the individual to develop a 'non-anorexic identity'. The patient's family members or caregivers are involved to support the person in understanding and linking their condition with the problems it has caused to their wider social context, whilst assisting them in changing their behavior (NICE, 2017).

Specialist Supportive Clinical Management (SSCM)

The aim of SSCM is to assess, identify and regularly review the key problems and as a result help the patient recognize the link between their symptoms and their abnormal eating behavior. Providing psychoeducation and nutritional advice is aimed to encourage the patient reach a healthy body weight and to adopt healthy eating practices (NICE, 2017).

Appendix J

Resistance to treatment is a well-known phenomenon amongst patients with EDs and it is the principal reason behind relapses and poor outcomes (Berends et al., 2018). The main factors behind non-adherence to psychological treatment include the sustained ego-syntonic symptoms that reinforce the conditions (Nordbo et al., 2011), which often lead patients to perceive the consequences of AN as positive and adaptive (Nordbo et al., 2006). The patients' unwillingness to recover from an ED is also underpinned by personality, general psychopathology, environment and the treatment itself (Abbate-Daga et al., 2013). Cluster C personality traits such as intense anxiety and fear seem common in AN restricting type (Diaz-Marsa et al., 2000). Indeed, high scores of persistent traits, cognitive rigidity, perfectionism and fear of losing self-control are also commonly comorbid with AN (Buzzichelli et al., 2018; Froreich et al., 2016).

On the other hand, for many individuals with a binge eating-purging type of AN, a co-morbid borderline and avoidance type of personality disorder (Martinussen et al., 2017) is often noticed. A poor relationship between the therapist and client is also a potential barrier to treatment adherence. According to Sibeoni et al. (2019), a positive therapeutic alliance that supports patients and attends to their emotional needs is one of the most important aspects to ensure treatment engagement. In instances where the therapeutic alliance is considered too weak to provide compassionate care and containment of negative emotions, poor adherence and to treatment is noticed (Graves et al., 2017).

Appendix K

Participant Introductory statements.

Alison.

Alison, a thirty-three-year-old Maltese female who lives with husband of three years. She is youngest of three sisters and obtained a university degree. Although described to be a shy person, she seemed to be very approachable upon my first impression and engaged easily in the interview. She experienced her first ED symptoms at thirteen yet was unaware that her behaviour was symptomatic of a mental health condition. At age twenty-two that she sought psychological support and has been attending therapy since then, on an on and off basis.

Ivy.

Ivy is a twenty-seven-year-old Maltese nurse. She cohabits with her boyfriend and they are expecting their first child. Ivy is the youngest of three siblings and she considers herself to be very determined and hard working –highly honorable characteristics in her family of origin. Ivy appeared to be very intelligent and well-informed about the topic of ED and she was very transparent during the interview.

Daisy.

Daisy, a thirty-five-year-old Maltese female who leads a very busy life as she works two job roles at a homeless shelter. She has been married for three years and has a two-year old daughter. She describes herself as a joyful person who tries to maintain a good balance between work, family and leisure in life. One of her greatest qualities seems to be her strength and perseverance in furthering self-development.