Eating Disorders From Parent to Child: Mothers' Perceptions of Transgenerational Effect.

PhD Thesis

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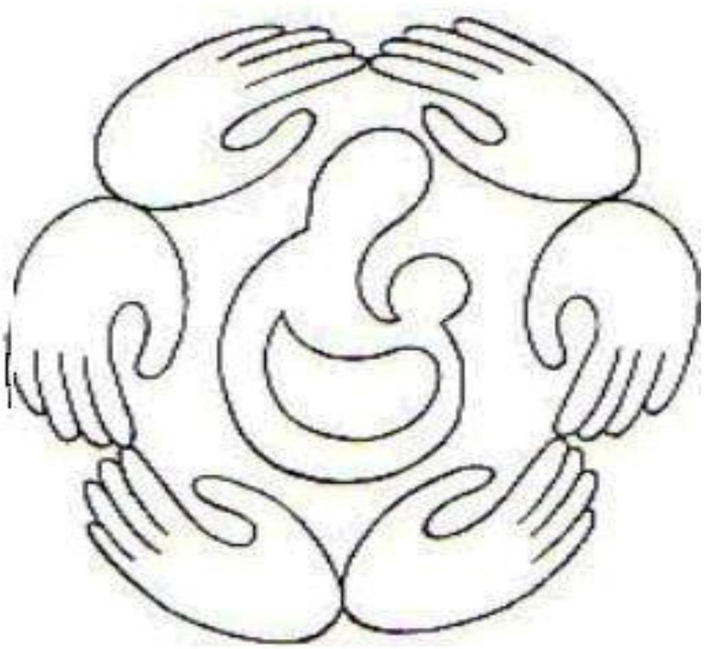

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Abstract

Introduction

There is now a greater understanding of the significance of attachment and the importance of the mother-child dyad in relation to Eating Disorders (ED). Mothers with this illness may not be able to offer their child the best environment to develop in a healthy way. Previous literature has indicated the probability of transgenerational effect and recognised that children of mothers with an ED are a high risk group. This research takes forward such awareness in relation to transgenerational EDs. It focuses on environmental factors and attachment. It explores the effectiveness of a group therapy intervention to prevent or mitigate the perpetuation of an ED through the generations. This study presents the outcomes of the group process, discussing the effects on the participants.

Aims

1. To conduct a group intervention.
2. To aid the recovery of the mother from her ED.
3. To investigate the possibility of primary prevention of an ED for the child.
4. To develop a transferable protocol from the group therapy that can be used by other therapists within a health care setting.

Method

Participants with an ED (AN, BN or EDNOS) as defined by DSM-IV, who had children under the age of 13 were recruited from NHS settings. Two hour sessions were conducted by a therapist at weekly intervals for 19 weeks; each session was recorded and transcribed. The transcriptions were thematically analysed using NUD*ST. The CORE and the EDI together with a semi-structured interview were administered at the beginning and end of the group and at the six and twelve month follow ups. The n=1 case study methodology was used to design and analyse the study, using the group intervention as the case investigated.

Results

At the end of the intervention and at 6 month follow up all participants demonstrated an improvement in their ED, but at 12 months this improvement was only sustained by 50%. At all points including the 12 month follow up all participants showed substantial improvement in the nurturing of their children. From this study we were able to complete a manual that could be disseminated to health professionals in order to replicate the organization of further groups for this particular client population.

Discussion

These results gave encouraging support to the hypothesis that group therapy can be a useful intervention for mothers with an ED in order to break the transgenerational cycle of dysfunction.

Chapter 1

Introduction

1.0

In my experience of treating ED (Eating Disorders) patients in the clinical context, the [1] mother-daughter dyad seemed to be a recurrent factor in the inception and continuation of the underlying emotional context of an ED. The transgenerational aspect became noteworthy in the majority of cases that I have been involved in during my clinical practice. At some stage of their treatment a significant proportion of these women manifested a pathological attachment history, with separation and individuation issues. Modelling and the repetition of dysfunctional behaviour, created by the internalisation of maternal behavioural patterns seemed endemic. The identification and reappearance of these features sparked my interest and led me to develop a pilot research project which was the main body of my MA thesis (Barnett 2000). This initial research study, my previous clinical experience and the copious literature on this subject, led me to believe that transgenerational transmission, particularly by environmental circumstances, plays a substantial role in the development and maintenance of an ED. These findings encouraged me to develop the main research study that is the body of this thesis.

I drew on my own clinical practice as an integrative psychotherapist and evaluated my experience of treating clients with EDs. While undergoing this introspection I recognised that a single therapeutic modality did not

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[1] For the purpose of this study the female will be used throughout.

exclusively encourage recovery. I was mindful of the inherent potential of different theoretical models that strove to understand human psychology and decided that it was important to draw on an integrative stance that amalgamated the different psychological theories for the best possible result.

As this research was developed to address the transgenerational transmission of EDs, it was hypothesised that mothers with an ED unknowingly and unwittingly pass on their dysfunctional behaviour, concepts and beliefs to their children. I will discuss later in this study the evidence that has established that the children of eating disordered mothers are at greater risk of developing the disorders themselves (Stein et al 2006, Park et al 2003, Hodes et al 1997, Stein 1995, Sourfield 1995, Stein et al 1993). It is understood by observation and research into child development that all children grow and develop by watching and mirroring their mother or main care giver (Kohut 1984, Winnicott 1960), so it seems evident that if the mother is lacking in her own autonomous states and her behaviour is overtly dysfunctional, that the child will internalise and eventually display this behaviour. A majority of ED sufferers have experienced attachment difficulties in their infancy (Ward et al 2000 b) and the aetiology of an ED includes low self esteem (Hartmann et al 2010). Therefore it seems quite probable that mothers with an ED will experience difficulties enabling their infants to become securely attached. Consequently it would seem plausible that positive support for the mother can play its part in reducing the pathological behaviour that becomes harmful to the child. This in turn can ameliorate and break through the cycles of insecurity and the inability to regulate feelings and behaviours that can be passed through the generations.

The consequences of EDs are far reaching and devastating and have been well documented. EDs are not just about the use and abuse of food; evidence suggests that there is co-morbidity with depression, obsessive-compulsive disorder, anxiety disorder, self-harm and other psychiatric illnesses. In all probability, taking into account the risk of suicide, EDs have become the major psychiatric killer (DSM-5 2013). It therefore seems likely that the prevention or alleviation of such a disturbing disorder is not only desirable but expedient.

There has been considerable work done in the field of prevention of EDs and I will discuss this further in a subsequent chapter. However interventions have been addressed at children no younger than eight or nine and this has been carried out in school based education programs (Piran et al 1999). There have been very few programmes targeted at mothers with the aim of supporting them with their own recovery and also educating them in the possible transmission of their EDs. With this knowledge and understanding an innovative method of treatment for this client group could address the present gap in treatment modalities.

After many years of research, it has been agreed that ED aetiology is multifactorial and cannot be attributed to any one cause. Consensus across the various different fields, confirms the belief that biological, familial, psychological and social factors are all prevalent in causation. This has been my findings in my clinical practice and although there are similar psychopathologies present in the different EDs that were presented, the causation can be diverse. In addition to a distorted body image and a dysfunctional relationship with food, it has been identified that ED patients suffer from deficits in attachment, social ineptitude, negative self-evaluation and submissive behaviour. There have also been several studies that have noted that EDs have been diagnosed in different generations of the same family (Park et al 2003, Strober et al 2000). The estimated heritability that previous research has suggested is between 41 to 72 per cent (Collier et al 1999).

When researching this study, I became aware that the prevalence of EDs and the availability of treatment displayed a shocking mismatch. Although this study draws on the vast amount of research literature that describes ED behaviour, it seems that the data produced from this literature has not been used sufficiently, to develop enough interventions. Nevertheless this study was guided by and incorporates very many aspects of the research literature and attempts to test their usefulness and validity by producing clinical evidence. It became clear that a high percentage of ED sufferers had little or no chance of accessing specialist or appropriate care. The NICE guidelines (National Institute of Clinical Excellence. 2004) were set up to address this issue and are seemingly not being adhered to, leaving professionals to ask why and sufferers in need of help. These are some of the statistics that fuelled my reasoning for this study.

- Eating disorders have become the biggest psychiatric killers of our time. With a mortality rate of between13-20%(DSM – 5 2013).
- The total figure for the number of diagnosed anorexics and bulimics was 1.6 million people in the UK. With many more not presenting to the NHS, the actual figure is deemed to be much higher (Beat 2007).
- In January 2014 total figures from the Health and Social Care Information Centre have shown a rise in hospital admissions of 8% from 2013 (Beat 2014). Only the most seriously ill patents are admitted for inpatient treatment. The majority of patients are treated in outpatients, within the community or in private treatment or not treated at all.
- Out of 500 people interviewed, 26% had to wait 6 months to start treatment in an outpatient unit. 8% waited longer than 1 year (Beat 2013).
- 32% were informed that local health authorities did not have a specialist service (Beat 2013).
- Beat did a report on the NICE guidelines in 2005 and it was identified that 42% of GPs did not make an early diagnosis as recommended.
- Out of 236 GPs interviewed only 9 reported using published protocols or guidelines when treating EDs (Currin et al 2007)
- Only 17% of young sufferers are being treated in an appropriate setting, most will be treated in an adult mental health unit (Beat 2005).
- Only 14 % were actually being treated within reach of their home (Beat 2005), so they were being sent away from their families and friends.

- The incidence of childhood onset eating disorders is growing; anorexic symptoms are identified in children as young as five or six (BBC News 2011, Bryant-Waugh & Lask 2002).

When EDs become chronic they are extremely difficult to treat; the illness and symptoms become persistent and embedded. In their report on waiting times for treatment (2013) Beat (Beat Eating Disorders) acknowledged that the quicker treatment is accessed the more likely a full recovery is achieved. Treatment if not accessed quickly can be a very lengthy and expensive process, often resulting in repeated hospitalisation (Schmidt et al 2004). Because of the life threatening implications of starvation the initial treatment in hospitals is based on re-feeding. When the patient's BMI is considered restored to a more stable level, then the psychological aspect of the illness is addressed. Because of financial and time constraints in the NHS the psychological component is very often not in depth enough or constant enough or lengthy enough so the patient often finds herself regressing into the illness on discharge or soon after. Support and treatment outside hospital can be difficult to access (as has been shown in the above statistics). Specialist centres are scarce and long waiting lists are an unwelcome reality in the NHS.

1.1 Funding

Rumsey and Marks (in Marks & Yardley 2004) describe the process of gaining research funding as follows:

“Applying for research funding, like research itself, is a pragmatic exercise that combines interpersonal skills, ethical awareness, political nous, scientific method, logic and sheer dogged determination, not necessarily in that order.” P 26.

Submitting an application for the funding of this study as the above quote states, was a lengthy and time consuming process, consisting of many reports, meetings and presentations, in total it took approximately 18 months to secure.

Both the pilot study submitted for my MA thesis and this more in-depth study that constitutes the basis for the thesis presented, were funded studies. It was important to gain a research grant, where the researcher has overall responsibility and control of the project and project funds, instead of a research contract where there is joint control with the funders. Fortunately a research grant was secured for both the pilot and the main study. The pilot being a smaller, less involved version of the final study, achieved £5000 funding from The Hertfordshire Early Years Development and Childcare Partnership. The main study which was far more complex in design and execution and involved a longer overall period of time represents the final body of my PhD submission. This was funded by a research grant to the sum of £81,416 by HertNet, which was the Hertfordshire network of Primary Care Trusts. HertNet received its funding directly from the National Health Service.

This introduction lays out the rationale for this research study encompassing some of the statistics that point to the need for an innovative treatment. The second chapter sets out to identify the concepts and beliefs presented within the framework of the literature, relevant to the core understanding of EDs and the theories under pinning them. The research questions and my chosen methodology are specified in the third chapter together with the description of the methods used in the process of establishing and executing the group. The statistical results are presented in the fourth chapter. The fifth chapter details the findings obtained from the qualitative analysis of the pre and post group interviews together with the six and twelve month follow up interviews. An analysis of the themes across all the cases is included at the end of the chapter. The sixth chapter details the progression of the group process, taking examples from the first, fifth, tenth, sixteenth, eighteenth and nineteenth group sessions. These particular sessions were included to give a representation of the clients' journey through the process of the group sessions. At the end of this chapter, an insight into the benefits and difficulties of the group for each participant is incorporated and a summary of the progress of each of the participants is included. Considering the research as a whole, a discussion in chapter seven analyses the findings of the project, returning to the main aims and research questions, relating them to the participants in the group. As a research project it would not be complete without reflecting on the limitations of the study, this is reviewed within the discussion, together with a reflection on the discrepancies between the qualitative and quantitative data and the rationale for using a group with a mixed ED sample. The conclusion demonstrates the potential for the use of the group therapy intervention and how it would sit within existing treatment modalities.

Chapter 2

2.0 Literature Search

In this chapter it is my intention to set the ideology and concepts of this research within the body of the considerable research literature. When my first hypotheses began to grow within my clinical work, my task became to locate their legitimacy within the wider context of previous research. The repetition and frequency of the emerging psychopathology that was endemic within the aetiology of my patients with EDs, led me to develop the emergent themes which were initiated and used in the pilot and finally utilised in this study. The first and most obvious theme and the main thrust of what brings the patient into treatment is ‘Food and Feeding’. The second theme identified was ‘Modelling’ which is the behaviour between mother and child and the internalisation of this behaviour by the child. The third theme, ‘Body Image’ is one of the more destructive elements of an ED and must be addressed when treating an ED. The fourth and penultimate theme looks at the developmental stages of ‘Individuation and Separation’ and the final theme addresses ‘The Mother and Daughter Relationship’.

It is my intention to discuss the context and origin of the themes in a later chapter. This literature study seeks to show how the themes were demonstrated in the research literature and is intended to identify the literature underpinning the understanding of the themes that have been presented.

In this modern era of research there has been an expansion in the field of genetics and neuroscience which is developing the understanding of the origins and maintenance of EDs. While these are fascinating areas to delve into and are certainly the way to broaden the perspective of EDs, they are not the main areas of interest in this study. It is important to note that the author recognises these alternative aspects of the aetiology of EDs. However as the developmental and environmental aspects of the aetiology are of paramount interest for this study, these are the areas that are dealt with more comprehensively.

The literature search, which is based on the themes set out above, commences by discussing the various risk factors that have been associated with the development of an ED. After identifying the risks I have touched briefly on the genetic and heritable aspects of an ED and continued with the psychological and familial risks which are the main thrust of this study. There is a considerable body of empirical evidence stating that attachment deficits contribute to familial psychopathology. As attachment and attachment theory is the bedrock of human relationships, I felt it was important to include some of the vast literature that examines the causes and effects of attachment deficits. Discussing the importance of attachment, the literature search goes on to elaborate on the equal value of the separation process which is also a crucial developmental stage and encourages individuation and becoming an autonomous being, which has been identified as a problem area within the aetiology of an ED. As the research focuses on mothers with an ED the next section identifies some of the literature that has looked at the effects that an ED has on mothers. We then move on to family pathology, in particular the relationship between mother and child which lies at the core of this research. A distorted view of body image frequently accompanies an ED and is one of the driving forces for maintaining it; some of the causes of the development of this dysfunctional ideology are presented. The literature discussed has a firm foundation and significance within the aetiology of an ED and wherever appropriate is linked to it.

As the research is carried out within a group setting, the derivation and benefits of groups are discussed. The pitfalls and advantages of using groups with an ED population are also examined and specific group interventions specifically aimed at EDs are discussed. When developing a treatment modality, the idea of prevention must undoubtedly be considered as this must be the ultimate aim. Some of the literature covering prevention and prevention programmes has been investigated and particular studies that have targeted parents are identified. EDs affect all aspects of the sufferer, so a brief look at the psychosocial affects of an ED have been included. Lastly the literature asserting that recovery is not only possible but achievable is considered, allowing some optimism for the success of this study and those suffering from this debilitating illness.

In writing this literature review it is inevitable that some papers will be not be included. It is hoped that the literature that is included will identify a broad enough understanding and confirmation of the subjects discussed.

2.1 Eating Disorders

Further descriptions of the presentation and aetiology of EDs will be elaborated upon at different stages of this thesis. At this time I will give a brief definition taken from the Diagnostic and Statistical Manual of Mental Disorders 5th edition (2013). Eating Disorders (EDs) are broadly categorised in three groups. Anorexia nervosa (AN) is characterised by extremely low body weight and a heightened fear of weight gain, which is controlled by starvation. Bulimia nervosa (BN) is characterised by a normal body weight and fear of weight gain which is controlled by purging after a binge episode. Eating Disorders Not Otherwise Specified (EDNOS), which has been re-defined to OSFED (Other Specified Feeding or Eating Disorder) by the DSM-5 (2013) is a variant of all the above symptoms. It is estimated that 50% of the community of EDs fall into the category of OSFED (Treasure et al 2010), although it is quite usual for clinical features to overlap one another. EDs are a multifactorial and complex illness and they are often accompanied by symptoms such as obsessive compulsive disorder, anxiety disorders, depression and some borderline traits. The co-morbidity and complexity of EDs increases the difficulty of accessing a generalised treatment programme; rather treatment has evolved through copious research and clinical experience.

2.2 Risk Factors

The only certainty that we can attribute when addressing risk factors for eating disorders are that they are multifactorial and combine biological, psychological, familial and sociocultural elements (Schmidt, 2002, Strober et al, 2000, Vandereycken & Noordenbos 1998). When trying to understand EDs we must be aware that the risk factors can combine at different stages of development to result in an eating disorder. The nature/nurture debate is progressively becoming more complex with the continuous development of genetic research and the expansion of information regarding environmental factors. Understanding the necessity of integrating both areas of research is essential. Rutter (1999) states:

> “Knowing that there is a genetic contribution or an environmental contribution is of very little use in its own right. Virtually all forms of psychopathology involve both and it is necessary to move on to the question of which genes have which effect and which psychosocial risk factors are more important and in both cases how they operate and how they combine or interact with one another.”
>
> (Rutter 1999 p489)

2.3 Heritability.

Throughout the history of mental illness, it has been determined that psychiatric disorders in parents have a detrimental effect on their children (Stein 1995, Rutter & Quinton 1984) and it has been established that children of mothers with an eating disorder are at greater risk of developing the illness themselves (Stein et al 2006, Hodes et al 1997, Stein 1995, Sourfield 1995, Stein et al 1993). As early as 1860, Louis Victor Marce noticed that inherited psychopathologies were prominent in families of young women with what was yet to be diagnosed as anorexia nervosa (Strober & Bulik 2002). During the 1990s the perception of the aetiology of EDs underwent a dramatic change, when evidence from twin and family studies showed a genetic component (Collier &Treasure 2004). Strober (1991) estimated that the prevalence of anorexia among sisters of patients is in the region of 6%, as against 0.1% to 0.7% in the general population. In a later study Strober et al (2000) using 1,831 relatives of 504 probands, found that both anorexia nervosa and bulimia nervosa aggregated in families and that cross-transmission suggested a common or shared familial diathesis. According to research by Holland et al (1988) 80% of the variance in liability to anorexia could be genetic. Collier et al (1999) posit an estimated heritability between 41 to 72 per cent. A twin study by Holland et al (1984) examined 34 pairs of twins and one set of triplets, where the probands had anorexia. Of the 30 female only pairs, 9 out of 16 (55%) monozygotic pairs were concordant for anorexia and only one out of 14 (7%) dizygotic pairs were concordant. Treasure and Holland (1995) did a controlled family study, where more than two affected members, spanning several generations were present. Their findings were that equal numbers of cases were found in both sides of the family, this suggested that the genotype can be passed through both maternal and paternal lines. However, in a later study Treasure (2005) felt that genetic vulnerability needed some sort of environmental, psychological or social stress to trigger an ED and believed that the environment accounted for 50% of heritability.

Identifying a genetic link can highlight the risk factors for the predisposition to an ED and provide an understanding of the psychopathology (Collier, 2002). Bailer (2005) did a study at Pittsburgh University into EDs and disrupted brain chemistry. She found that serotonin levels were higher in several parts of the brain in the women that suffered from bulimia. Although these findings are of great interest, the result of genetic research is as yet inconclusive and in the case of human behaviour, the correlation between what is inherited, learned, or a response to sociocultural conditions, is still a complex phenomenon. Genetic vulnerability by itself is not sufficient to cause disease but an accumulation of genes and environmental factors will increase the risks (Treasure 2005, Collier 2002, Hsu, 1990). It is acknowledged that many traits related to EDs have a heritable element and it is reasonable to suggest that they both contribute to the aetiology of an ED (Collier & Treasure 2004). Taking this into consideration the probability of transmission is considerable. What has as yet not been identified is to what extent the transmission of an ED is the result of adverse environmental conditions. Are the risk factors a combination of both nature as in a genetic link and nurture through internalising our environment and our unconscious processes?

Rutter (1982) believed that only treating the symptoms of the child and not taking the parents into consideration was unlikely to eliminate any disorder of the child. Even in severe biological child disorders, the parent/child relationship and the attachment process should be a particular focus for treatment. Gerhardt (2008) believes that the early life environment for an infant is the most influential factor in its growing development even if a genetic factor has been established. Genetic predisposition to an illness does not necessarily indicate the absolute certainty of developing that illness and it has been shown that environmental factors can combine to assist development of an illness, or work to prevent susceptibility (Strober et al, 2000). Gerhardt

(2008) believes that early care has a tremendous influence on the growth and development of the infant's nervous system and this determines how the later child and adult responds and interprets stress. The child's environment becomes embedded into the physiology and becomes a regulatory habit which then becomes hard to change (Gerhardt 2008). Schore & Schore (2008) in their paper 'Modern Attachment Theory: The Central Role of Affect Regulation in Development and Treatment' wrote that the infant internalises its somatic and social/cultural influences and the 'brain-mind-body-environment' operates at the psychobiological core. They go on to state that they thought early attachment experiences shape the human unconscious.

2.4 Psychological and Familial.

Although as we have discussed, there is now a proven link to the genetic vulnerability to an ED, the psychological and familial aspects are the pathways that are of most interest to this study in identifying a transgenerational association. The possible correlation between the care giving environment and feeding disorders in infants and children has been recognised to be directly linked to maternal depression and EDs, showing that the mother has difficulties in empathically recognising the child's affective states (Ammaniti et al 2010). Psychological and familial risk factors are linked to environmental influences. Consistent with Bowlby's (1973) theories (to be discussed in more detail later), if the child is not given the appropriate conditions for the development of a secure attachment, the child then becomes anxious, avoidant, introverted or insecure. Gerhert (2008) believes that vulnerability to mishandling could start *in utero*. The mother's dietary deficiencies and stress levels are passed on to the baby creating an oversensitised stress response. As they get older, their distress may be managed by the development of external symptoms such as eating disorders (Dozier et al 1999).

During the first few years of a child's life, her personality is developing (Greenberg 1999, Bowlby 1981). Winnicott (1989) argued the importance of the "good enough" mother, understanding that no situation was perfect but if a child is loved, admired, respected and nurtured in a continuous facilitating environment, she will grow into a secure independent adult. If there is a genetic predisposition to inherit a personality trait or disorder and the child is exposed and subjected to the dysfunctional behaviour of that trait, she is likely to internalise the negative behavioural influences which will work together with the genetic influence to develop into a dysfunctional personality. People with EDs exhibit a variety of different personality traits. Anorexics are usually described as obsessional, inhibited, compliant, restrained and perfectionist. Bulimics have been depicted as impulsive, interpersonally sensitive and anxious. Both anorexics and bulimics suffer from an acute lack of self- esteem (Collier & Treasure 2004, Wonderlich 2002). It has been found that negative family structure and interaction play an important role in the risk of developing an eating disorder (Benninghoven et al 2007). It has also been found that people with EDs report greater difficulties with emotional regulation and therefore have difficulties with social functioning (Harrison et al 2010), which encourages the cyclical nature of an ED. Alexithymic tendencies are frequently found in ED patients, which impairs their ability to distinguish bodily needs from emotional functions. These tendencies create a difficulty in communicating feelings, generating a sense of ineffectiveness (Montebarocci et al 2006). Hartmann et al (2010) believed that interpersonal problems are a ‘core’ component of EDs. Harrison et al (2010) also recognise that difficulties with emotional and social functioning are important components in the development and maintenance of an ED.

Stein et al (2006) have completed the only longitudinal study into the risks of developing eating pathology in the children of mothers with an ED. The original study of 1 year olds consisted of an index group of 34 mothers who had experienced an ED during the postnatal year and a control group of 24 mothers that showed no disturbance in eating behaviour (Stein et al 1994). The children were followed up at 5 years and again at 10 years. At the 10 year follow up the index group consisted of 33 first born children and the control group of 23 firstborn children. It was of concern that the study found at 10 years that the index children had developed raised levels of disturbed eating habits and attitudes, difficulties with weight and shape compared to the controls. The children whose mother had suffered from an ED for a longer period were more likely to have adopted eating psychopathology modelled by the mother. Kluck (2009) found that the parental modelling of dieting and disordered eating behaviours has been identified as a risk factor in EDs.

Bourmann and Yates (1994) in their study into risk factors for bulimia nervosa looked at the significance of parental psychiatric illness. Their sample was 25 women ranging from age 18-25, meeting DSM-III-R criteria for bulimia nervosa with a matched control group without bulimia. Their results were that 64% of the case probands group were classified with at least one parent with psychiatric illness, against 24% of the control group. Both major depression and personality disorder were found in significant numbers in the parents of the probands group. One limitation found in this study was the inability to determine cause and effect. There was the possibility that some psychiatric symptoms could have been caused or aggravated by the distress of having a bulimic daughter. Despite this, the study confirms the risks of parental psychiatric illness for bulimia nervosa. Ringer and Crittenden (2007) examined patterns of attachment in a cohort of 62 women with EDs. They found that most of their sample was struggling with attachment figures and that parents’ history and relationship problems were causal factors in the development of an ED. In the majority of cases the women were not aware of how parental behaviour was tied causally to their own behaviour.

2.5 Attachment

Having looked into the risk factors for EDs and having established the importance of the mother/child relationship, I feel it necessary to touch on the copious literature on attachment. The following section will attempt to describe the relevance of attachment to the understanding of EDs.

“Among the most significant developments of psychiatry during the past quarter of a centenary has been the steady growth of evidence that the quality of the parental care which a child receives in his earliest years is of vital importance for his future mental health.” (John Bowlby.1990 p13)

It is thought by many clinicians that the attachment relationship has a significant impact on mental health problems (Schore & Schore 2008, Sroufe 2005, Rutter 1977). It has also been identified that transgenerational transmission of attachment should be an area to pursue in further research (Ward et al 2000 b). Ward et al (2000 b) in their review believe that there is 'an overwhelming message' from the research literature that points to abnormal attachment patterns in the ED population. They hypothesise, that most anorexics have an avoidant/dismissive attachment and bulimics tend to have angry/dismissive attachment. Zachrisson & Skarderud (2010), in a later review of attachment and EDs, suggested that there is robust empirical evidence linking the quality of attachment to mental health. The review goes on to suggest that deficits in attachment are common in women with EDs.
It has also been noted in other research, that high levels of insecure and avoidant attachment have been identified in people with EDs (Harrison et al 2010). Given these observations it is probable that attachment deficits lie deeply imbedded in the aetiology of an ED.

The dictionary definition of attach is to join, fasten or connect, to attribute or ascribe. The infant-caregiver relationship is the core around which all other experience is structured (Sroufe 2005). When a baby is born the most vital job is the attachment of the baby to the mother for food, which ensures its survival. As we have evolved we have begun to recognise that to survive and develop the baby needs more than food, it needs to grow and develop in a caring, loving nurturing setting, so that it can achieve independence and autonomy and grow into a healthy adult both mentally and physically.

The essential task for the mother in the first year of life of her baby is a secure attachment (Bowlby 1981). Schore (2003 b) believes that as soon as a baby is born it uses its sensory capacities to interact with its environment. As the baby grows the mother needs to be attuned to and resonate with the baby's temperament to allow the development of attachment, which is inextricably linked to developmental neuroscience. The attachment relationship co-regulates the infant's developing central and autonomic nervous system, which create the states of positive and negative arousal. The ability to negotiate positive and negative arousal are the fundamental constituents of attachment and its associate emotions (Schore & Schore 2008).

There is solid evidence that the mothering environment influences the developing patterns of neural connections that underlie infant behaviour. The infant uses the mother's right cortex as a template for imprinting the circuits of her own cortex, which mediates her expanding affective capacities (Schore 2003 b). Bowlby (1990) argued that the baby should receive a warm, intimate and continuous relationship with the mother to ensure mental health and that the early experiences underlie the development of character. A secure attachment results from being able to model an available and responsive attachment figure (Cole-Detke & Kobac1996). The infant internalises models of emotional schemas in relation to others, based on her own experiences with her main caregiver (Wilkinson 2010).

Schore (2003 a) states “The most important aspect of the environment is the social environment, the relationship the infant has with its caregivers”(p.72). It forms the building blocks of secure mental health and allows the child to negotiate the further stages of development with a solid foundation (Holmes 2001). The key achievement of infant development is the capacity to experience, communicate (non-verbal then verbal) and regulate emotions (Schore 2003 a). Deprivation of maternal care, inadequate or dysfunctional care, can affect the physical, intellectual, emotional and social development of the child, the effects of which can become apparent as early as the first weeks of life (Bowlby 1990, Rutter 1977). Any disturbance in the mother/infant attachment can have significant long term consequences for future psychopathology (Thompson 1999). Green and Goldwyn (2002) believe that the child’s repeated experiences within the attachment relationship are the primary social experience and a template for later emotional regulation. At birth a baby has no sense of its own continuity, boundaries, space, or psyche and soma. It depends entirely on the maternal presence to develop its instinctual and primal needs (Sidoli and Davies 1988).

Schore’s work (2003 a) integrates developmental psychology, infant psychiatry and neuroscience. It looks at models of normal and abnormal emotional development

> “The central thesis of my ongoing work is that the early social environment, mediated by the primary caregiver, directly influences the final writing of the circuits in the infant’s brain that are responsible for

> the future socioemotional development of the individual. The "experience" that is required for the "experience-dependent" growth of the brain in the first two years of human life is specifically the social-emotional experiences embedded in the attachment relationship between the infant and the mother." (p73)

After much research it is now understood that if stress is experienced during the first months of life and even in utero, high levels of cortisol are released. This can be detrimental as high levels of cortisol affect the development of other neurotransmitter systems that are still being developed in the brain. If these systems become affected it may result in a regulation difficulty in later life (Gerhardt 2008). As stress is a common phenomenon in EDs it can now be understood how the stress of the mother with an ED can affect the attachment process between the mother and child.

Winnicott (1986) believed that the key to successful development is integration by the child of the mother's states and that a subsidiary task is "psychomatic indwelling" which is developed by the holding and handling of the child, facilitating the development of a healthy psyche-soma. Psychosomatic health refers to the individual's relationship to her subjective experience of indwelling within her own physicality (Turp 2001). The drive-related activities, namely eating, sleeping and playing are physically and psychically of great importance. From the repetition of these activities the infant can begin to construct a representation of feelings and emotions that are awakened from within herself (Stern 1998). These psychobiological experiences of attunement, misattunement and reattunement are imprinted in the early developing brain (Schore 2003 b). The infant by repeating or mirroring the mother can then begin to respond, therefore if the mother's actions and re-actions are inadequate or dysfunctional the infant will internalise and mirror the dysfunction and fail to develop in a natural way (Stern 1998, Kohut 1985, Winnicott,1965).

When the mother/child dyad is not attuned, the development of self-attunement for the infant cannot be achieved on its own (Schore 2003 a). If the infant fails to attach securely, the process of the emerging personality will be affected. The failures then become consolidated as the child matures and negatively influences the developing psychosocial functioning (Thompson 1999). As the growing child gradually starts to develop the conceptual skills she needs to make sense of and represent her own personal experiences, she is likely to appropriate behaviours, perspectives and understandings that she has witnessed from her main care givers (Fonagay 2001, Thompson 1999). This is due to the fact that during the early critical phases of development, organised and disorganised insecure attachment is affectively 'burnt in' to the infant's developing right brain (Schore & Schore 2008).

The attachment of mother and baby can depend on the attachment experiences of the mother (Holmes 1996). One of the main tenets of attachment theory is that the mother repeats her own maternal attachment representations which in turn affect the infant's attachment process, with the possibility of compounding dysfunction throughout the generations (Forbes et al. 2007). These internal representations are self-perpetuating because they create responses consistent with their relational experiences (Thompson 1999). The new mother's representation of her experiences with her own mother is thought to be the single best predictor of the patterns of attachment with her baby (Stern 1998). Ward et al (2000) believe there is a transgenerational aspect of attachment behaviour as parental attachment status is shown to predict attachment security in the infant. However attachment patterns can change according to the mother's circumstances. A child who has not had a secure attachment from birth can learn to develop one if the mother becomes aware of her behaviour and has the ability to change it. Although change is encouraged and developing an attachment late is better than not developing one at all, it is not known whether a late attachment can be as strong and stable as one that develops from birth (Bowlby 1981). Long-term follow-up studies have shown that if a child is classified at one year as being securely attached, it is likely that she will have maintained that security at school entry (Holmes 1996). Conversely, children identified as disorganised in infancy have been observed in pre-school years to be of a hostile coercive nature, or a solicitous reversal of care nature (Green & Goldwyn 2002). In later years the way in which a child attaches can affect the individual's internal belief system and influence self - esteem and relationships with others (Holmes 1996). As the literature identifies, it would seem that the relationship between mother and child during infancy and early years is one of the most important factors in the development of the child's personality (Greenberg 1999). Winnicott (1990) believed that the basis of mental health is actively being laid down during the course of every infancy.

Bruch (1974) wrote in relation to anorexia:

> "There is agreement on the fundamental issue that personality develops out of the dynamic interaction and experiences of the child with the people in his environment." (p74)

Research indicates that there is compelling evidence that early forming psychopathology results from attachment disorders and manifests itself in the failure of interactive regulation (Schore 2003 a).The conclusion drawn is that the experiences to which a child is exposed to in early life may be the determinant of maladaptive personality traits and psychopathology in latter life (Perris1994). It is an interesting point that Sroufe (2005) tested Bowby's theory, that variations of the attachment quality given to the infant were the foundation for later differences in personality. In conclusion he agreed with Bowby that attachment experiences remained vital in the formation of the person (Sroufe 2005).

The level of attachment depends on the ability of the mother to recognise the child's needs. The aptitude of the mother to respond adequately to her child's needs lies in her capacity to monitor her own internal signals (Schore 2003 a). If a mother's interaction with her child is withdrawn and dysfunctional, taking place only during routine care, then the attachment becomes insecure (Rutter 1977). If the mother is depressed or withdrawn and is not able to respond to her baby's needs, then her baby's needs will escalate and the child will be affected throughout her whole mind, brain, body experience (Wilkinson 2010). The missing ingredient is the incorporation of love, stimulation and the pleasure of being together. As has been indicated previously, these are necessary for a healthy development. If the mother is able to enjoy her child then the child becomes capable of developing a secure attachment. Infants are *supposed* to be highly dependent; it is a universal state in infancy. Seeking physical closeness and contact is normative and functional (Sroufe 2005) The inability of the mother to be emotionally and psychologically available for the child is as damaging as being physically removed (Rutter 1977) and neglect in early infancy is as traumatic as being abused (Schore 2003 a). Seifer (2003) acknowledges that children of parents with a mental illness have obvious differences from the first weeks of life. The child is more likely to develop an anxious attachment because of the discrepancy of the model. The mother is there, yet not there, loving outwardly, but giving messages of rejection and disapproval. Defensive strategies are likely to develop when the child perceives the attachment figure as unavailable, unresponsive or insensitive (Schore 2003 a). If the mother is unable to regulate her own feelings then this is perpetuated in the infant, resulting in the infant's inability to monitor or adjust its own states, leaving it with a sense that its feelings are of no consequence and should not be noticed (Gerhardt 2008).

These defensive strategies could present as deactivation or hyper activation of the attachment situation (Cole-Detke & Kobak.1996). An anxious attachment can lead a child to an excessive need for love, feelings of guilt and resentment culminating in depression and other mental disorders such as EDs. Alternatively, overprotective mothering can cause disturbances in the attachment process as the mother is not taking her cue from the child but fulfilling her own needs and compulsions (Bruch 1974; Bowlby 1981) leading to mental disturbances such as obsessive compulsive disorder, anxiety, phobia, addiction, or eating disorders in later years. As the growing child gradually starts to develop the conceptual skills she needs to make sense of and represent her own personal experiences, she is likely to appropriate behaviours, perspectives and understandings that she has witnessed from her main care givers (Thompson 1999). If the infant's model is one of loving responsiveness, she will develop a secure expectation that her needs will be met and feel loved and accepted. Alternatively, if her experience is rejecting or inconsistent and her expectation is that her caretaker is unavailable, she learns not to express her needs, as they are unlikely to be met. This results in the child developing a damaged self that believes she is unlovable and unacceptable and therefore deserves rejection (Dozier et al 1999). Stern (1994) believes that if the infant fails to involve the mother emotionally, the infant then tries to win her by ways of imitation and identification, thereby creating the transgenerational dysfunctional cycle. Trauma normally causes a child to seek safety by gaining proximity to the attachment figure; this causes dependency on the maltreating figure with a real risk of escalating the maltreatment, thereby increasing distress and an even greater inner need for the attachment figure (Wilkinson 2010).

2.6 Separation

We have investigated the difficulties of the lack of a secure and healthy attachment and now we consider some of the literature that helps us to understand the pitfalls of a dysfunctional separation, which can be as difficult for the mother to negotiate as it is for the child.

The sought after goal in child development, is to achieve adequate harmony between the mother and child in order to enable the child to become autonomous and achieve separation (Ringer & Crittenden 2007). Part of the aetiology of an eating disorder lies in low self-esteem, lack of autonomy, dependence and a failure to separate and become an independent person (Garner 2002). If the mothers have their own unresolved loss or trauma, it may negatively affect the ability to perceive and respond to the child's signals, resulting in the child's internal needs not being met (Out et al 2009). Separation and individuation are key components at the heart of an eating disorder (Vanderlinden & Vandereycken1997). In almost all adolescent and young adult cases of eating disorders, the separation-individuation process has not been negotiated successfully (Vandereycken 1994). Ward et al (2000,b) found that ED behaviour was associated with the lack of positive and emotionaly supportive parental relationships, together with poor parental fostering of autonomy. The following literature describes this argument.

As previously stated, the first phases of an infant's development are bound up in feeding and nurturing. The next stages involve introjecting perceptions and attitudes and learning to separate (Palazzoli 1985). Food and feeding can often become a battleground between the mother and child as a struggle for separation and independence (Buckroyd 2011). The capacities for self-care are not automatic, but evolve within the context of the handling of the infant by the mother; they depend on the mother’s ability to respond to the infant’s communication (Turp 2001). The task of the “good enough” mother is to facilitate age appropriate development within a safe environment; this involves understanding that the needs of the child are physical, behavioural and emotional (Duncan & Reder 2000).

Winnicott (1986) explains that the child has to perceive the mother as “not me” to be able to develop the concept “I am”, which involves the loss of the merged unit and the growth of the individual. If this has been absent, or distorted and the opportunity to internalise the functions of self-care has not been available, there is a likelihood of a damaged sense of knowing and understanding the body (Turp 1999). If these developmental stages have not been successfully negotiated and the infant has not been effective in having her needs adequately met, she then becomes unable to identify her own functions, needs and emotions, becoming deprived of developing her own “body identity” (Bruch 1985), or sense of self. The child’s development is related to the reactions to her external environmental failures (Gerhardt 2008, Winnicott 1965), causing delays or dysfunction in the ability to form an identity. Erikson (1950), states that in the child’s second year, autonomy becomes the essential goal of development. It has been argued by Hudson and Rapee (2001), in their research into anxiety disorder, that both controlling and rejecting parenting leads to psychopathology present not only in anxiety, but also in eating disorders, depression and other behavioural disorders. As anxiety and depression are symptoms conducive to eating disorders, it would seem that controlling or rejecting parenting is an important component in the development of an eating disorder. Previous research has generated considerable evidence that these disorders compromise maternal sensitivity during the interactions between the mother and child, giving rise to disturbances in the child's development and outcomes (Nicol-Harper et al 2007).

Ainsworth and Bell (1970) in their seminal work 'Attachment, exploration, and separation: Illustrated by the behavior of one-year-olds in a strange situation', devised a way of assessing attachment and separation in the child. This analysis became one of the foundations of attachment theory and is still used today. I will attempt to give a brief description but for a fuller explanation the reader should refer to the above paper.

Unless the child has achieved a secure attachment, the probabilities of negotiating a satisfactory separation are remote (Bowlby 1981). If a secure attachment has developed by the time the child is mobile, then the child uses the mother as a base to explore from, leaving her and returning for short periods of time. As the child grows she feels comfortable enough to be separated from mother for longer periods because having internalised the good mother, she feels safe in the knowledge that mother will return (Bowlby 1981,Wilkinson 2010). If the mother is unavailable to the child this causes the child to become anxious and manifests in the child needing to maintain a close proximity to the mother when the mother is available (Ainsworth & Bell 1970). This inhibits the child from separating and exploring her own identity, thereby creating the possibility of future problems with autonomy (Holmes 1996).

The bid for autonomy and individuation are synonymous with being accepted and understood (MacLeod 1981). To achieve these states successfully the separation process, including the psychological, as well as the physical separation, has to take place. In order to attain this both parties need to have negotiated the ability to become individuals, as opposed to being tied together emotionally as a single unit (Buckroyd, 1996). Bowlby (1973) suggests that if a child is given the message that she is inadequate and will be unable to function as an individual, the child is denied the confidence and security needed to negotiate the rigors of separation. She develops anxieties, feels out of control and cultivates avoidant strategies, such as withdrawal or disruptive behaviour that mask her internal distress. These avoidant strategies can evolve into external symptoms such as an eating disorder. If the child has difficulties with her primary attachment, it leads to a poor capacity for mentalizing, the development of poor self image and a drive towards perfectionism to boost that self-image. Within the framework of an ED, when the likelihood of separation occurs, the child retreats from adult development into self starvation and weight loss and the child fails to separate (Robinson 2009).

In the case of sexual, physical or emotional abuse, a cycle based on the attachment process is activated. Early relational trauma causes the child to seek safety by trying to cling more to her attachment figure. This creates a greater dependency on the abuser which generates increased maltreatment and escalates an even greater need for the attachment figure for fear of total isolation or rejection, opening up a cycle of abuse (Wilkinson 2010, Holmes 1996; Rutter,1977). This usually results in the child taking responsibility for the neglect or abuse, “I must be bad to be treated like this”. The child internalises the message of worthlessness and begins to develop her own dysfunctional psychopathology, which is compounded by modelling the dysfunctional behaviour of her parent. If the mother is unable to protect the child from abuse and sustained trauma is experienced, there are far reaching effects on the development of the mind (Wilkinson 2010). Total isolation results in the child preferring bad attention rather than no attention and to the child internalising this model of behaviour, with the possibility of repeating it during her own parenthood, thereby creating a cycle of dysfunction through the generations. When the child experiences the caregiver as the source of fear and also the solution to the fear, it places her in an irresolvable and disorganised paradox (Out et al 2009). The child will seek comfort, but experiences either further threat, preoccupation or unavailability of the parent. Such contradictory experiences will induce conflict in the child leading to disorganised behaviour (Green & Goldwyn 2002).

2.7 Mothers with an Eating Disorder

After discussing the probability of passing on dysfunctional and pathological behaviour to the next generation, I felt that I should explore the literature for the experiences of women who are mothers and are suffering from an ED.

Motherhood at the best of times can be beset with multiple emotions and challenges. Being a mother and suffering from an ED can exacerbate the feelings of isolation and guilt (Garfinkel & Dorian 2001), that are already present in an ED and can develop into in various complications regarding motherhood and parenting.

Pregnancy can be an overwhelming time for most women filled with a whole gamut of emotions, some joyous and some fearful. Women have to deal with enormous changes in their bodies, in their hormones and in their minds. The preparation for motherhood is a difficult road but for a woman with an ED, it can become a time full of conflict between what is best for their child and the unrelenting demands of an ED.

Tierney et al (2010) looked at this conflict and called it a ‘Tightrope between motherhood and an ED’. They recruited eight women with EDs who were either 16 weeks pregnant or over, or had a child within the past 2 years. All the participants were given a semi-structured interview which was taped and transcribed. Four main themes emerged; Fear of failure, transforming body and eating behaviours, uncertainties about child’s shape and emotional regulation. Fear of failure related to difficulties of breastfeeding and not being able to eat sufficient to produce enough milk. One mother talked of feeling free when she was advised to go on to formula milk, that she didn’t have ‘that physical attachment’ to her daughter and that they were now ‘two separate entities’. Some mothers went to great lengths to hide their ED behaviour from their partners and continued it throughout their pregnancies. They avoided socialising with other mothers as they were extremely anxious about being judged by other people and were concerned about society's lack of understanding behaviours such as binging, purging and restricting.

Theme two, 'Transforming body and eating behaviours' indicated that some participants were torn between their ED and their wish to be seen as a caring mother. Generally their fear of weight gain continued into their pregnancy with some being able to cope with their abdomen becoming larger, but not with the rest of their body. Some experienced a sense of disgust and became downhearted when they gained weight and felt relieved when they lost weight. Conversely a few participants altered their eating behaviour for the benefit of the child. The implication of this theme was that these mothers sense of self was strongly influenced by their appearance and their weight. 'Uncertainties about child's shape', theme three uncovered a fear that the children would become obese. The mothers tried to disguise their own anxieties concerning food and body image, but became agitated before a family meal. They were far more concerned about the weight of their daughters, rather than their sons. They compared their children's size to other children's and preferred them smaller, believing that boys were less likely to be affected by an ED. The authors (Tierney et al 2010) argue that the last theme, 'Emotional regulation' can be described as the purpose of an ED. They state that the behaviours of an ED such as binging, purging, restricting and exercise, inhibit the feeling of emotions and are used as a distraction. During pregnancy some of the mothers continued to use exercise but adapted what they did, for example swimming rather than running. Some continued to vomit saying that it was compulsive and that it brought them relief. One mother said that her negative feelings were so powerful after she had eaten, they only stopped once she had vomited. Self harm was also used as an outlet for their emotions with one participant cutting her stomach ‘trying to get the fat out’. On a positive note, one mother credited her children as a catalyst for stopping her ED. This paper suggests that there is a great deal of conflict for mothers, between doing the best for their child and the demands of an ED.

Rortviet et al (2009) explored the experiences of guilt in mothers with an ED. They interviewed eight mothers, seven of whom were outpatients and one who was an inpatient of a psychiatric unit. The study identified the main theme as ‘Experiencing guilt as a mother in the context of an ED’. This was broken down into six sub-themes; ‘Having a guilty conscience in relation to being a good mother’, ‘devaluing oneself as a mother’, ‘experiencing becoming a mother at a vulnerable period’, ‘being preoccupied about not involving the children in the ED’, ‘worrying about the influence of the ED on the children’ and ‘feeling incompetent to deal with issues connected to the children’s body shape’. They found that the main areas associated with guilt were; pregnancy and post-partum, being a role model and issues regarding information and advice about the ED to the children.

The mothers described worries about not being a ‘good enough’ mother. They feared that their relationship with their children would suffer as their lack of energy affected their ability to engage with their children. They feared that their ED related problems had influenced their relation with their children and they felt guilty about leading a double life. They were afraid that the children would notice their ED behaviour and they were uncertain of the expectations of being a mother and feared being judged by others. During the pregnancy and post-partum period there were mixed recollections. Some felt that it was a positive time and recalled feeling proud and others described negative experiences of weight gain and shock about being able to fall pregnant due to not being anorexic enough. Some reported the increase of self induced purging and restricting more severely. While other mothers reported being able to restrain from their ED behaviour during pregnancy, but relapsing at post-partum.

On reflection about whether or not the children were affected by their ED, the mothers reported a significant amount of guilty feelings in relation to meal times and body image. Great concern was felt regarding the internalising of their ED behaviour by their children and subsequently the possibility of passing on their ED. There were mixed feelings about telling their children about their ED, some felt it would damage the children at a young age and that they should be told when more mature. Others argued that the children would sense that there was something wrong and it was better for them to know the facts. All of the mothers felt incompetent when having to deal with anything to do with body image and were at a loss to know how to deal with their children’s weight issues.

These findings demonstrated that EDs have a powerful influence on motherhood and exacerbate the feelings of not being a good enough mother, that can be a common belief in many mothers. They highlight the difficulties that mothers with an ED have around mealtimes and body image and how their ED impinges on these areas.

Stitt and Reupert (2013) did a study of nine mothers with an ED, recruited from the community rather than clinics or hospitals. They conducted semi-structured telephone interviews which were taped and transcribed. Their findings focused on 2 main themes consisting of, ‘Impact of parents’ ED on children’ and ‘Modelling disturbed eating behaviours’. Each of these themes having sub-sections of; social isolation, emotional absence, problems setting boundaries, parentification of children, impact on younger versus older children, ‘food comes before anything’, children motivating recovery, secrecy around ED, treatment needs. Their findings showed that participants felt that they isolated themselves and their children socially, due to their fear of eating in public; that thinking and obsessing about eating and food meant that they were not emotionally present for their children and had no emotional energy left for them. Issues of discipline and setting clear boundaries were compromised, due to being caught up in their ED. Two of the participants were concerned about their children looking after them and taking on the parenting role and some felt that their ED impacted more on older children than younger children in their developing years. Most participants were aware that their ED came before the needs of their children and some were irritated that their children interrupted their ED rituals such as purging. All the mothers who participated felt that having children was a motivation for recovering from their ED, but some who had older children felt that when they left home it was easy to relapse. The majority of the participants thought that they hid their ED from their children and that although their children witnessed their ED behaviour, the children did not associate that behaviour with an ED. All the participants had been through treatment and they all felt that the treatment had not addressed the needs of mothers and that treatment was aimed at sufferers without children. Stitt and Reupert (2013) agreed with Rortviet et al (2009) and felt that their findings indicated that the mothers were caught in the overwhelming demands of their ED and the needs of their children.

EDs can be totally consuming and becoming a mother, especially for the first time can be extremely demanding. As we will see in the further sub section on attachment, the early years are of paramount importance and
the mother who is battling with an ED is indeed walking a ‘tightrope’ (Tierney et al (2010).

Sadeh-Sharvit et al (2015) did a study on the feeding perceptions of mothers with EDs. They interviewed twenty nine mothers who had an ED, with children between 18 and 24 months. The interview was designed to explore the effects of her ED on her maternal functioning and the feeding of her child. They identified four main themes, the child’s eating and controlled feeding practices, body weight and shape, avoidance of eating with the family and aggregated effects of the mother’s ED on the children.

The majority of mothers reported a concern with their child’s body shape and weight and a worry that their child would become overweight. These concerns correspond with the mothers own anxiety. Their concerns regarding the child’s weight led them to want their children to have a low calorie diet. Some mothers restricted their child’s intake and exploration of food, delaying autonomous eating and restricting any exploration of food. They were also anxious and found it difficult to decide how much and what food to give, when to introduce new food and when to change routines. Because of their own inability to recognise their own hunger states, they found it difficult to regulate and recognise their children’s hunger and satiety states. Because of the difficulties with their own ED, some mothers avoided handling food and feeding altogether. Activities outside the home which included eating, created tension for the mother. Family meals were a rare occasion, as the mothers ate different food at different times. Mothers acknowledged a disparity between wanting to model healthy eating behaviour for their children and being controlled by the problematic eating behaviour of an ED. It was recognised by the mothers that awareness and modelling of their ED behaviour was happening at a very young age and the mothers expressed a great sadness at the noticeable effect that their ED was having on their children. A unique focus on daughters rather than sons was found. Mothers who had both girls and boys reported more food restriction and more restraint with autonomous eating, with daughters rather than sons. Their daughters’ body shape and weight were discussed and commented on more than their sons’. Nevertheless these mothers also reported that having seen the impact that their ED was having on their children, it had motivated them to try their utmost to recover from their ED.

It can be seen by the literature presented that being a mother with an ED has many pitfalls and difficulties, but having a child also gives the sufferer a reason to recover.

2.8 Family Pathology and the Mother/Child Relationship

The scientific literature has indicated that maternal psychopathology is a risk factor in the development and maintenance of emotional, behavioural and mental health problems in children (Cimino et al 2012). The literature described in the following section will demonstrate the connection between the mother's pathology and the daughter's ED.

If the mother's pathology is dysfunctional or incomplete and the child is used to fulfil the mother's missing psychological states, the child in turn will develop her own dysfunctional pathology that bears a resemblance to the mother's (Farrell 1995). A dysfunctional mother/daughter relationship is often the starting point of an eating disorder and can create a repetitive cycle to fuel it (Colahan & Senior.1995).

As the treatment and research on EDs has developed over the years, many authors on the subject (Patel 2002, Riess 1992, Palazzoli 1985, Crisp1980, Bruch 1973) have agreed that part of ED aetiology is endemic in the family's dysfunction as the child internalises her environment. From the first recognised diagnoses of anorexia as an illness by Gull (1874) and Charcot (1889), the family's involvement has been acknowledged. Lasegue in 1873 wrote "that the patient and her family, form a tightly knit whole" (Hsu 1990). A common theme in the families of anorexics is “learned helplessness”, which is an integral component of the development of poor self esteem, an intrinsic part of anorexia (Waller & Hartley 1994). It is also said that these families are overly enmeshed and often have communication problems. Anorexia sufferers have high levels of social anxiety and view themselves as socially inferior (Hartmann et al 2010). They appear avoidant, not just of food but involvement in general; whereas bulimics appear to be angrier and more chaotic (Ward et al 2000 b). Bulimia nervosa is a variant of anorexia and was defined as a diagnosable illness by Russell (1979). However the earliest case that resembled modern diagnostic criteria was identified in the 1930’s (Parry-Jones & Parry-Jones1995). Bulimics have been depicted as impulsive, interpersonally sensitive and anxious (Wonderlich 2002). It has been argued that the common denominator in the pathogenesis of anorexia and bulimia is “vulnerability” (Silverman 1997). It was believed that the parenting style of bulimics was of ‘affectionless control’; that it showed more rigidity and disorganisation and an unwillingness to discuss disagreements with the child. Bulimic families were also described as conflicted, not cohesive and badly organised (Vandereycken 1994). Bulimics are found to have higher levels of negative interactions, in addition to perceived social incompetence (Hartmann et al 2010).

Having looked at the dynamics of anorexic and bulimic families and having discussed the psychological development of the infant and child. I feel it is important to delve further into this subject as it is essential for this research to appreciate how the care giving environment impacts on that development.

Orbach (1985) states, “that the psychological development of the infant is dependent on the relationship between it and its mother”. Winnicott (1960), believed that the infant and the maternal care formed a unit and that in health this unit was able to disentangle and resolve into the development of “unit status”, which is the infant becoming an autonomous individual. He states that an infant cannot reach its full potential without adequate maternal care which incorporates the total environmental provision for the infant. Without this the infant is at risk of impairment to the development of the orbito-frontal region of the brain, which leads to the high probability of externalising behavioural problems (Fonagy & Target 2001).

Associated with this is the infant’s psychosomatic existence, which Winnicott calls “the psychic indwelling in the soma”. The inability to integrate the psyche and the soma, leads to the development of the false self. The function of the false self is to hide the true self, which is thought to be unacceptable; the false self is activated by compliance with environmental demands (Winnicott 1965). Insecure and false patterns are developed to preserve a feeling of safety and comfort when the attachment figures are unpredictable or inconsistent (Zachrisson & Skarderud 2010). If the early relationship has not conveyed an acceptance of the full range of emotional feelings, these will be hard to tolerate and experience in later life (Gerhardt 2004).

An important function of anorexia and bulimia is the presentation of the false self, which is developed by the inability to integrate the psyche and the soma.

Winnicott (1978) states that where there is a reasonable adaptation to the needs of the infant, this gives the best chance for a firm establishment of the psyche and the soma. Where there is a failure of these adaptations, the psyche can develop without a strong attachment to bodily experiences, resulting in being cut off from physical feeling (Schore 2003 b). Deficits in attachment can lead to failures in the development of the right brain; this creates deficits in affect regulation and in the infant's physiological responses to stress (Schore 2003 b). These deficits link to the behaviour of the anorexic, who is unable to recognise the needs of her body. (Bruch 1973) Both anorexics and bulimics have learnt maladaptive ways of dealing with stress. Protinsky and Marek (1997) did a study of eleven college students between the ages of 18 to 22 who had disordered eating. Their findings were that the most prevalent problems that emerged were that of differentiation and connection. A subsequent theme related to these issues, was emotional recognition and difficulty in identifying their internal feeling states.

As a leading voice in child development Winnicott (1953) believed that to negotiate successfully the link between the internal and external states, the "me and not me concept", the child develops the use of a transitional object. The transitional object is chosen by the child and is the symbolic link between it and the mother. It is the child's first symbol and stands for the union of mother and child, based on the mothers' reliability and capacity for identification of the child's needs (Winnicott 1953). If the mother's own development has not progressed satisfactorily and the mother herself is unable to differentiate between her own internal and external states, she is in danger of using her child as her own transitional object. (Farrell 1995). McDougall (1989) suggests that if the baby is the mother's sole object of libidinal and narcissistic satisfactions, the adult-to-be will be predisposed to create pathological transitional objects, resulting in addictive patterns and psychosomatic tendencies to attempt to fill the void of the inner world. The mother who is herself anorexic and has not been able to accomplish her own autonomy, or is not able to recognise her own needs, will in turn find great difficulty in facilitating her own infant with her maturation processes (Lunt et al 1989). ED patients are known to have defects in self development resulting from failures in parent-child interactions. These defects impair the capacity to distinguish bodily needs from emotional experience and can result in alexithymic tendencies such as difficulties in communicating feelings, interoceptive confusion and a sense of ineffectiveness (Montebarocci et al 2006).

Several authors confirm the effect that ED mothers have on their child and the probability of transgenerational effect. The anorexic is in constant need of a close nurturing relationship with her mother, which is simultaneously feared and rejected (Colahan and Senior 1995). This fear and rejection can easily be repeated in the relationship with her own child, causing the child to introject these divergent messages. Stierlin and Weber (1989) believe that these messages and assumptions in the families of anorexics are characteristically found across a number of generations, causing complex cause and effect mechanisms that become a repeated cycle. In a study into parental factors relating to bulimia nervosa, Moreno and Thelen (1993) found that mothers directly related their attitudes about weight, dieting and exercise to their daughters and that there was a clear relationship between maternal factors and daughter's dysfunctional eating behaviour. Hodes (2000) states that mothers with disturbed eating pathology and body image serve as a role model for the child who then models and internalises the behaviour. Winnicott (1989) believed that the mother's mood could impinge upon an infant's growing psychic reality and could dislocate the child from finding its own character. If the mother is vulnerable to her own ED, she becomes withdrawn and self- preoccupied which renders her unavailable to the child both physically and emotionally, resulting in the child becoming anxious and depressed. This creates a vulnerable child, who is unable to distinguish between reality and distortions and exposes her to the risk of adopting her mother's behaviour. The child then becomes affected by the manifestations of the disorder and the consequences of it (Duncan & Reder 2000). Positive support helps to reduce the defensive behaviour that becomes harmful to the child and is the source of the cycles of insecurity and the inability to regulate feelings that pass through the generations (Gerhardt 2008).

2.9 Body Image

As body image forms such an integral part of the aetiology of an ED it was chosen as one of the themes to be incorporated into the group and as such some of the literature involving body image is discussed. Previous research has investigated the role of family factors in body image disturbance and disordered eating (Corning et al 2010, Rodgers & Chabrol 2009, Kluck 2009). A disturbed body image is one of the factors closely related to negative eating pathology (Benninghoven et al 2007) and as such is of great importance to the study described in this thesis. EDs can develop because of the relationship a woman/adolescent/child has with her own body. This relationship could have been based on her attitudes formed in early life (MacLeod 1981).

Girls' insecurities about their bodies are beginning earlier and it is thought that 20% of 9 year old girls have already been on diets (Good Housekeeping 2003). It has been demonstrated in the literature (McCabe et al, 2007) that girls as young as 5 are socially aware and strive for the thin ideology. In their study McCabe et al (2007) looked at the messages given to pre-school children about their appearance, diet and exercise. They ascertain that by the time girls get to primary school, 90% would like to be thinner. They claim that messages transmitted to pre-school children by mothers with distorted body image and eating behaviour predispose the children to develop disturbed body image and dysfunctional eating pathology. In an earlier study by Abramovity and Birch (2000) it was found that up to 65% of 5 year old girls were twice as likely to diet if their mothers had dieted. In addition, children's weight was found to be directly related to the degree of the mother's concern about her own weight and body image (Ammaniti et al 2010). These conclusions reveal the extent of the impact that mothers' behaviour has on the child. McCabe et al (2007) concluded that parents and teachers needed to be aware of and understand the dangers of communicating to children the messages of disordered eating patterns, which are then adopted by children as young as 4 or 5.

As with all risk factors, the biological factor is also being explored in relation to body image. In a recent study (BBC News 2010) scientists at University College London found that a sample of people had a distorted image of their hands, which was attributed to the way the brain receives information from different parts of the body. These findings were said to be relevant to the distorted body image found in EDs, particularly anorexia. It was thought that this brain study could give some insight into the reasons why dangerously underweight people truly believe they are larger than they are (BBC News Health June 2010). This study gives an example of the wider fields that are being researched with regard to EDs.

Benninghoven et al (2007) have directed their research towards the body image of patients who have eating disordered mothers and the role of family functioning. The paper highlights the correlation between mothers' preoccupation with weight and appearance and the daughters' negative body image. It goes on to report that the daughters' body dissatisfaction was directly linked to the mothers' lack of autonomy and the inability to facilitate autonomy in the daughter. This lends credence to a further study by Kluck (2009) which linked body image disturbance and maladaptive eating attitudes in the mother, with similar attitudes and dissatisfactions in the daughter. This study also identified the correlation between family emphasis on thinness and criticism of weight to the development of an ED (Kluck 2009). Corning et al (2010) recognised that the mother is the primary model for weight and body image issues. They developed an intervention targeted at mothers, with a view to preventing the transference of the mother's dysfunctional body image to the daughter. They found that the mothers, who participated in the study, gave their daughters significantly less pressure to be slim. The study confirmed that the mothers play a vital role in their daughter's developing body image and professionals should be cognisant of the influence that mothers have over their daughter's health.

2.10 The Use of Groups

The review so far demonstrates the extensive research literature which has shown the importance of the family environment and in particular the mother/child relationship in the development of an ED. The intervention to be described in the remainder of this thesis is an attempt to respond to this literature. The following is an account of the literature which supports the decision to adopt a group as the method of treatment.

Given that one of the aims of this study is the development of a protocol for a group to be used in therapeutic settings, it is of interest to examine some of the literature concerning the history and use of groups. Groups that address parenting, smoking cessation, anxiety and other common problems, are already well developed and successfully used as a reliable resource in primary care. Due to the ever present financial strain on the NHS and the overload of existing resources, time limited group interventions are a successful and sought after way to reach an optimum number of patients (Thomas et al. 1999).

The first group that we experience is the family group where we learn to relate and where we learn to play out any dysfunctional influences from our environment. However the experiential group, as we know it today first came into existence as the T-group, or training group in 1946. Since then the emergence of different groups, run for different reasons, using different approaches has burgeoned (Yalom 1985). Groups are an ideal delivery system for providing new learning and sustained behaviour change (Conyne & Harpine 2010). A therapeutic group can be seen as a forum in which we can replay our actions and analyse any unhelpful patterns. It provides an environment where we can repeat, explore and counter balance past experiences from our first group experience, that of the family (Tudor 1999). Gustafson and Cooper (in Bion 1992) believed that social life could be understood more deeply by “participant observation” in groups. Bion (1992) postulated that the group culture that develops in the group will influence each individual member and the individual member will influence the group, creating a cycle of contribution.

The literature found that having a specific focus for the group was beneficial for the client. If there was a specific purpose for the group it did not prevent other issues emerging, but enabled the group to minimise deviation (MacFarland 1995). If goals are not identified then the hidden agendas of individuals may sabotage the group (Benson, 2001). It is necessary for the group members to strive together for specific goals within the group, imbuing a sense of attachment and group achievement. To encourage the success of the group, there needs to be a mutual giving and receiving of information and support. This encourages the ‘the affective sharing of one’s inner world’. It is the very ‘shared nature’ of their problem, that can instil a sense of validation in the participants and dispel their isolation (Yalom 1985). If issues need to be confronted in one person, the same issues are indirectly confronted by the whole group (Stordeur and Stille 1989). Marmarosh et al (2005) found that group cohesiveness leads to greater collective self esteem and develops an atmosphere in which curative factors can thrive.

Yalom (1985) argues that the participants in groups should be at various stages of improvement, to instil hope of recovery and to intra-facilitate, that is, enable those who have been through certain stages to support others on the same ‘journey’. Such intra- support has been argued by some researchers to dictate homogeneity in sex and disorder (Butler & Wintram 1995, Yalom, 1985). Indeed, it has been found that the success of such group therapy has been directly connected to “group cohesiveness” and “general popularity” (MacFarland 1995, Butler & Wintram 1995, Yalom 1985). MacFarland (1995) found that cohesiveness formed more rapidly in a focused group, as everyone is bound by the same purpose and commitment. Running a women’s only group allows a safe place for support and shared experiences; it is also a source for examining different perspectives on similar problems (Butler and Wintram 1995).

The character of the group is an important facet and can either have a detrimental effect on the therapeutic outcome, or add to the group’s cohesion.

If one person takes on the role of scapegoat, this can have a damaging effect, causing the rest of the group to collude with one another against this person. On the other hand, if a person chooses to be the one to unburden herself, at the cost of using all the time available, this will allow the others to protect themselves from self exposure, threatening the cohesiveness of the group (Whitaker 1989).

Whitaker (1989) posits that it is more advantageous to have a group where the members hold the same belief systems, giving an example of the group collectively influencing an individual who disagrees. This in my opinion points to her earlier warning about the scapegoat, which the facilitator should be aware of and discourage. It has been suggested, that the group size is kept to a maximum of eight to ten, as larger numbers tend to become unmanageable, when focusing on interpersonal learning (MacKenzie and Harper- Giuffre 1992). In a manageable group all the participants will have the opportunity to take an active part and there will be less likelihood of exclusion.

Riess and Rutan (1992), found they had fewer dropouts in time limited groups, as they presented a clear boundary for the length of commitment that was expected and made completion more likely for the client. A closed time limited group can be experienced as a safe container which provides a physical and psychological space for exploration (Tudor 1999). Cummins (1996) found that she had a lower drop out rate when she prepared potential group members in advance for the group process, thus enhancing the cohesiveness of the group. Meeting the group members prior to the commencement of the group gave the participants a chance to be introduced to the facilitator and lessened the anxiety of going into the unknown. Harper-Giuffre et al (1992), recommend that attendance is made mandatory for acceptance into the group, giving the message that the group's importance is paramount and found that post group follow-up establishes a firmer commitment to the therapeutic work. MacFarland (1995), established that in a structured, solution-focused, time limited group, clients were able to see their success more readily, which gave them the encouragement to develop and compound it.

2.11 Eating Disorders and Groups

Having established through the literature that a group is an effective model for delivering treatment, I will now continue with some of the literature that gives an insight into how the patient with an ED responds in a group.

The structural and participatory requirements embedded within group therapy are particularly suitable for exploring the aetiology of eating disorders. These are a secret disorder and can often lead the sufferer to feel isolated; the use of a group can help to dispel the notion that the participants are alone and ensure awareness that other people suffer from the same problems (Protinsky & Marek 1997, Polivy 1981).

In 1988, Peter Yellowees realised that group therapy for EDs was not a commonly practised treatment and when it was used, it was more likely to be implemented as an adjunct to inpatient treatment. Since then it has become more widespread and is found to enhance the management of patients with EDs, at various stages of their treatment (MacKenzie and Harper- Giuffre 1992). A structured time limited group, helps to reduce the psychological chaos that accompanies EDs (Reiss 1992). McFarland (1995) posits that hope is one of the major benefits of group therapy and for the ED patients who develop the necessary ego strengths, by recognising the resources needed to make changes. As such, when the group works well, it can be the most successful form of treatment for EDs, offering members increased self awareness, leading to the ability to recognise and cope with emotions. This in turn leads to lasting change in relationships, increasing the prognosis for lasting recovery (Hall 1985).

People with eating disorders can be morbidly self- absorbed and have obsessive relationships with food, exercise and body image, to the exclusion of most other things. Polivy (1981) found that running a group for EDs seemed to facilitate the feeling of being understood without explanation, leading to the acceptance of feedback and criticism, expediting development. Brunori et al (2004) found that a small group mirrored the family group environment and having the same symptoms created a process of reciprocal identification. A group can reinforce communication by creating a space where ED sufferers can learn how to cope with otherness and can reinforce identity by the growth of the self (Segercrantz 2006). Hartmann et al (2010) designed a group programme for inpatient and day clinics that focused on interpersonal issues. They found that a group environment encouraged the examination of interactional patterns, leading to more assertiveness for the patients.

ED patients are often ambivalent and this increases resistance when starting treatment, increasing the possibility of higher drop-out rates (Gale et al 2006). However, Riess and Rutan (1992), found they had fewer dropouts in time limited groups, as they presented a clear boundary for the length of commitment that was expected and made completion more likely for the client. Smaller groups have been thought to be more containable and successful. The mixture of anorexic and bulimic clients can represent a meaningful exchange of education as they present similar aetiology, encouraging the group to become more cohesive (Dokter 1995).

2.12 Research into Group Interventions for Eating Disorders.

I would now like to explore the literature and address the effectiveness of different types of group interventions for EDs. I will endeavour to identify client population, structural aspects and processes identified and associated with good or poor outcomes and to identify studies that asked the participants to describe the helpful and unhelpful aspects of the group.

As discussed earlier several authors (Rotviet et al 2009,Tirney et al 2010, Sitt & Reupert 2013, Sadeh-Sharvit et al 2015) agree that mothers with an ED find parenting a difficult path to negotiate. Feeding especially can be beset with problems, therefore an intervention that can promote healthier routines and practices could be the path to supporting these mothers into a healthy lifestyle for their children.

Tuval-Mashiach et al (2013) in their study ‘Negotiating Maternal Identity’ identified 13 mothers with an ED which had been ongoing for an average of 15 years. They had been part of a recovery programme in a large hospital in Israel. The majority of the participants were inpatients at the time of the study, 12 were married and one was divorced. Of the different types of EDs, 3 were diagnosed with Bulimia Nervosa (BN), 4 with the restricting type of Anorexia Nervosa (AN) and the remaining 6 were diagnosed with Eating Disorders Not Otherwise Specified (EDNOS). The participating mothers ages ranged between 32 and 48 and the ages of the children were between 7 months and 24 years. The number of children that each mother had was between 1 and 7, with a mean of 2.5 children per mother.

While these mothers were hospitalised it was identified that the available therapeutic interventions that were offered did not meet the specific needs of mothers. This study was therefore set up to offer mothers a unique opportunity to access a group that would specifically discuss issues related to motherhood, in order to develop a protocol explicitly aimed at mothers with an ED. Two consecutive groups were set up, one with 7 participants and one with six participants. Two participants from the first group dropped out after two sessions. There were 10 sessions each session lasting one and a half hours, led by two experts in the field of EDs, each session was taped and transcribed. The purpose of the group was for the participants to express and explore their views and experiences of motherhood and EDs. In each session the facilitator presented one aspect relating to motherhood and EDs such as maternal self-perception, mother-child relationship, maternal modelling etc. The participants would then describe and discuss their experiences. The participants chose whether to continue with a topic for more than one session, therefore several themes were discussed over several sessions. Although there was a difference in the ages of the mothers and a difference in the ages of their children, all the mothers had similar concerns and appreciated a unique place to express the difficulties of motherhood with an ED. From the analysis the authors indentified two overarching categories relating to the distinctions between mothering practices and roles and motherhood as a defining aspect of a woman's identity.

Under the category 'Mothering Practices: Roles and Relationships with the Child' four themes emerged; Discussing the illness with the child; The child as caregiver; Concerns about bad modelling for the child; Strategies developed to manage the challenges of mothering:
'Discussing the illness with the child': An overarching question for these mothers was how much information they should reveal about their ED to their children. They agreed that ideally the child should be kept at a distance from their ED, but in reality it was extremely difficult to shield the child and they were aware of how much their children knew of their illness. In some cases involving older children, the mothers felt that it was justifiable to disclose their illness.

‘The child as caregiver’: As the children became aware of their mother’s illness the role reversal became very specific, predominantly focusing on emotional involvement targeting weight issues and eating habits. The mothers were aware how inappropriate their child’s involvement was and tried to re-assert the parental role. They acknowledged that their roles as mothers outside the ED were still satisfying, but that their ED was impacting on their overall ability to mother.

‘Concerns about bad modelling for the child’: the children’s awareness of their mother’s illness created feelings of guilt, sorrow, worry and disappointment in the mothers. They were concerned about passing on their eating problems and self-image, especially to their daughters. These mothers wished that their children were as different to them as possible and made a conscious effort to distance their children from their negative influence. The all consuming nature of the ED detracted time and attention from their children and the sense of frustration at being unable to provide a healthy role model for their children, was a cause for disappointment for all the mothers and threatened their sense of maternal competence.

‘Strategies developed to manage the challenges of mothering’: By building a solid and continuous support system for their children, these mothers were able to minimise the effects that the illness had on their children. This support was usually with their father or with grandparents. Some of the mothers felt that because of their illness they were far more aware of the need to support their children in positive ways for example trying to develop a strong self - image.

Three themes emerged, in the category of ‘Motherhood as a defining aspect of identity’: Motherhood as a normalising experience; the child as a motivation for recovery and experiencing oneself as a deficient mother.

‘Mothering as a normalising experience’: ED sufferers are perceived to be deviant, self-centred and responsible for their illness. Choosing to become a mother is a step towards normalcy and convention. Motherhood serves as a way of trying to improve their disordered behaviour and gives these women a chance of engaging in normal motherly behaviours. Some of the mothers found that while motherhood gave them a retreat from their ED, it did not eradicate the challenges of dealing with an ED. While motherhood was beset with difficulties, self-blame, shame and guilt, it also gave them a sense of meaning and satisfaction with a great deal of joy.

‘The child as a motivation for recovery’: All the mothers in this group had been suffering from an ED for 10 years or more. However even though they felt a great deal of hopelessness and despair, they saw their children as a source of future hope and as a motivation for recovery.

‘Deficient motherhood’: These mothers felt that their ED became a reason for being unavailable to their children which in turn led to feelings of inadequacy. A common aim for the participants was to try and become a different role model to their children than their mothers had been to them. They experienced difficult relationships with their mothers that were either too demanding or completely indifferent and felt that this dysfunctional modelling was the cause of their own difficulties in mothering their own children.

The mothers in this study reported that being a good mother, despite having an ED, was of great importance to them. However these mothers struggled to maintain a positive concept of themselves as mothers and spoke of themselves as being deficient and inadequate. They were aware of the social and cultural perception that EDs are self inflicted and therefore the sufferer's responsibility. Although this perception disturbed and frustrated them it was obvious that they had internalised these beliefs by displaying high levels of guilt, self-blame and fears of contaminating their children with their dysfunctional ED behaviour.

During the group discussions these women disclosed that although motherhood was a source of stress in trying not to influence their children by modelling their ED, it also brought empowerment which helped with the motivation needed to recover. These participants reported that being a mother helped them to improve their eating behaviour and encouraged them to put the interests of their children before them. They said that having children was an incentive to seek out treatment and that gave them hope to recover. The authors found that the mothers valued the group because it focused on the specific concerns of mothers with an ED. By doing this, it enabled them to develop some strategies to cope with their unique parental challenges and complications.

Sadeh-Sharvit et al (2016) developed the 'Parent-Based Prevention Programme', which was an intervention focusing on parental cognitions and behaviours associated with feeding practices. The programme stipulated the active involvement of both parents aimed at reducing the negative outcomes for children of mothers with an ED. They recruited 12 families with 16 children between the ages of 4 and 48 months. Their inclusion criteria were that the families were intact, mothers had been diagnosed by a health professional with either anorexia, bulimia or eating disorders not otherwise specified and had children under 5. Their exclusion criteria were if the mother required inpatient or day care treatment for her ED, major psychiatric disorder, acute ED or feeding symptoms of the child or if the child was undergoing any psychological or psychopharmacological treatment. Four families had 2 children and the remainder only 1. The mothers ages ranged between 25 and 35, fathers between 25 and 42. Seven mothers were diagnosed with OSFED, 3 with AN and 2 with BN. The average duration of the ED from onset to birth of first child was 13.2 years. Measures were taken at baseline, after 3 months of treatment and 1 month after the end of treatment. The Child Feeding Questionnaire was used and for children under 18 months the Unpredictable Temperament subscale of The Infant Characteristics Questionnaire-6 months Form was used (for details of these questionnaires please see the referenced paper). The programme was delivered by two psychotherapists, experts in the field of EDs.

This intervention was developed to target the environmental adversities associated with maternal EDs. The aim of this intervention was to reduce eating psychopathology and broader psychopathology in the children of mothers with an ED. The programme was made up of three components; a group intervention targeting the understanding by the mothers of the effects that their ED has on parenting; behavioural experiments related to the child's feeding which were then analysed for their execution and the goals that were achieved and the involvement of both parents. Three main areas of risk were indentified and targeted. The first was the disrupted division of responsibility of feeding, where feeding behaviours were modelled on the mother's concerns and not the child's cues. The second was the co- morbid psychopathology of mothers with an ED that compromise maternal functioning. Thirdly, the problems relating to the spousal communication over the daily routines and feeding of the child, which may aggravate the adverse effects of the maternal ED.

The study included two phases; the first consisted of 12, ninety minute group sessions for 6-8 mothers, these sessions focused on the effect that the maternal ED had on her parenting. This was a semi-structured, psychoeducational group, which invited discussion of the behavioural changes that were made in the home. The mothers were also encouraged to discuss their impressions of the group with their spouses and to involve their spouses in supporting these changes in order to get the required results. The second phase consisted of 12 family sessions for each individual family. Some of these sessions included the whole family and some only the spouses. The sessions lasted an hour, the first 8 sessions were weekly and the last 4 were held bi-monthly. These family sessions focused on providing information about EDs, assessing and intervening in the family's transactional patterns and facilitating communication in order to attain more support and collaboration in feeding. They addressed the family's routine, the number of family meals, the parents' eating habits and both parents' problems that affected their parenting.

The authors found that the data suggested that this intervention was linked to improved feeding practices in the child and more positive perception of the children among both parents. At baseline the mothers with the ED reported greater concern and took more responsibility for the child's eating than the spouses. Given the difficulties in feeding associated with maternal EDs, involvement and support by the spouse was important. The findings show that restriction of the child's eating and pressure on the child to eat were reduced in both parents after each phase of the intervention. It was thought that this intervention was associated with a change in parental behaviour that impacted on the child's ability to take a healthier developmental course. The inclusion of both parents strengthens the likely long term impact on the child's functioning and although the mother's eating and co-morbid psychopathology were not especially targeted they found that there was a decrease during the programme. Focusing on the mother's efficacy and strengthening the spousal communication may have enhanced the mother's psychological functioning. Maternal stress associated with child rearing did not change during the intervention. This was thought to be due to the increased knowledge of the potential damage that their ED has on their children. The authors acknowledge the limitations of their study but believe that this intervention could be adapted and could lead the children of mothers with an ED to a healthier life style and could minimise the reoccurrence of EDs in another generation.

While the above studies show the value of group interventions for mothers, groups have also been successfully used for many aspects of EDs, and also for patient satisfaction. The following studies are an example of this.

MacNeil et al (2016) undertook a pilot study to evaluate patient satisfaction of a group offered to adult ED patients in an outpatient clinic. The original sample consisted of 81patients, 78 female and 3 male. Out of these 81 patients, 36 attended the full group therapy programme. The full programme included a 16 session weekly two hour CBT group, a medical follow up with a nurse practitioner, ongoing psychiatric consultation and the option to attend nutritional groups. At the intake assessment group participants completed psychometric questionnaires and again after 12 sessions which was 75% of the group programme. The group was facilitated by health professionals with a minimum of 7 years history of treating EDs using CBT.

The group consisted of weekly self-monitoring of nutritional intake, ED behaviour, negative automatic thoughts, feelings and how to challenge these thoughts and feelings. Nutritional and behavioural goals related to normalised eating were dealt with first. The content of the group included psychoeducation on EDs, risk and medical complications, co- morbid concerns and the CBT model of treatment. During the education in the group, the participants were taught the links between thoughts, feelings, physical sensations and behaviour. Common cognitive distortions, thought challenging and cognitive restructuring and alternative coping methods were included and participants were also informed on lapse and relapse prevention.

During the course of treatment the participant’s weight was monitored by the interdisciplinary team and if they failed to reach the target 16 BMI they were given the option of a higher level of care. Participants completed the Satisfaction with life Scale, the Beck Depression Inventory, the Beck Anxiety Inventory and the Eating Disorders Inventory. At the end of the group the participants completed the Patient Satisfaction Questionnaire. Measurements were taken at pre and post group and the results signify that the group members reported higher life satisfaction after the group than they did at the initial assessment. Depressive symptoms were significantly lower following participation in the group but there was no difference in anxiety symptoms post group. ED symptoms indicated that drive for thinness was considerably lower post group but bulimic symptoms and body dissatisfaction were not lower. Self-esteem had been raised and the results for emotional dysregulation had not changed.

The authors felt that few studies to date have looked into the satisfaction of group therapy for patients with an ED and that their research provides some preliminary data of how satisfied the participants were of a CBT group format for adults with an ED. They go on to say that patient satisfaction is an important factor as it encourages the patient’s engagement and adherence to the group therapy offered. Although they felt that this study presented valuable data from the group that was evaluated, they felt that there were certain aspects that highlighted limitations in the study. There was no data collected in relation to the participants' medication and this could have had an effect on their depressive symptoms. Even though there are certain ethical considerations in creating a control group, the authors felt that the study would have benefitted from including a control group into the study for comparison. Overall the study was viewed as being useful in helping adult ED patients to reduce ED and depressive symptoms and to improve their general view of life. The evaluation supplied an important insight into the patient's experience and satisfaction with the group treatment that was provided.

Wnuk el al 2015 evaluated a pilot study using emotion focused therapy (EFT) for a group of 12 women with bulimic disorders. The women were recruited from an adult ED outpatient clinic in Canada. The inclusion criteria were that the participants were 18 years of age or older, female and had two or more binge eating episodes and/or one self-induced purging episode in the last 28 days. The exclusion criteria were any psychotic disorder, suicide risk, a BMI of less than 17.5, substance abuse, the intention to take part in any other treatment. All the possible participants took part in a brief phone screening. The participants who were eligible signed informed consent and completed a semi-structured interview focusing on their ED symptoms and they also completed questionnaires pre-treatment. The period of recruitment took 11 months during which 44 people were identified and 14 were recruited into the study. The outcomes being measured were; ED symptoms, psychopathology emotional regulation and self-efficacy. The Past 28 Days Eating and Symptoms Interview was administered to assess the binge/purge episodes.

The other measures used were; The Eating Disorder Inventory, the Difficulties in Emotional Regulation Scale, the Beck Depression Inventory and the Symptom Checklist-Revised-90 (for more information on these measures please see the original paper). At the conclusion of each session a two question self-report questionnaire was completed; the first question measured symptom self-efficacy: ‘If you decided to stop your eating disorder symptoms (binging, vomiting, strict dieting, over- exercising) how confident are you that you would succeed?’ The second question measured emotional self-efficacy: ‘How confident are you that you are going to be able to deal with your feelings in healthier ways?’ both were rated on a 10 point Likert scale 1= not very much and 10= very much.

Two groups consisting of 7 women each ran for 16 weeks. All the participants were monitored for their medical health by a family physician. The groups were facilitated by two female practitioners who were experienced in EFT and EDs, with one leading chair work and the other guiding discussions. The first session was based around introductions and psychoeducation about EDs and emotions; a manual was given to each participant with this information. The remaining sessions began with each participant summarizing the difficulties that they were currently experiencing, for approximately 15-20 minutes. During this initial time key themes were identified and were used as a starting point for chair work which the remaining group observed. This chair work lasted 15-30 minutes and 2-3 participants took part in each session. After each chair work exercise, the group discussed their feelings and related what fed into their own issues. Each group member took part in the same number of chair exercises over the 16 sessions (for full descriptions of the chair work please see the full text of the paper). Only five participants from the first group were included in the analysis and the full quota of seven from the second group. The mean age was 32.6 years, seven participants were diagnosed with BN, four with BED and one with EDNOS (for full demographic and analysis data please see paper).

To the author’s knowledge this was the first group to use EFT with an ED sample. The analysis shows significant decreases in binging episodes, improvement in ED symptoms and in depression, emotion regulation, psychiatric distress and self-efficacy. The data suggests that the key therapeutic goals of EFT could be achieved with a sample of women with bulimic disorders and could lead to symptom improvements by addressing the underlying emotional process.

As in previous studies included in this literature review this study also recognises the limitations of a small sample and of no control group and that future groups should include follow-up data. However the conclusion is that this study was an important pilot study in evaluating EFT for EDs.

Pretorious et al 2012 did a study that was supposedly the first reported study of the evaluation of a Cognitive Remediation Therapy (CRT) group for adolescents with AN and EDNOS-AN. The group was mixed because of the similarities in eating pathology and psychopathology. The paper reports on the specific changes in cognitive flexibility and the adolescents perceptions of taking part in the group. Twenty four female adolescents' completed the group and the questionnaires and therefore made up the sample for the final analysis. All the participants were attending a day care treatment centre at the Maudsley Hospital, London and were taking part in a six week intensive day treatment programme of which the CRT was a part. A motivational ruler was used to determine the participant's self-reported ability to change. Two questions were asked: 'How important is it for you to change and recover from your ED?' and 'How confident are you in your ability to change and recover from your ED?', a 10 point Likert scale was used with 0=not at all and 10= very much. The cognitive flexibility scale was used to determine the participants' awareness of alternate ways of behaving and their willingness to be flexible and a satisfaction questionnaire was developed for feedback as to the participants experience of the group (for full details of the measures used, please see the full text of the paper).

Seven groups made up of four to six participants ran for four weekly sessions of 45 minutes each session. Each group was run by two facilitators. The questionnaires were completed at the beginning of the first group and at the last group; the satisfaction questionnaire was completed at the end of the final group. The first group focused on the 'bigger picture' exercises, the second focused on set-shifting exercises, the third group focused on multi-tasking and the fourth summarised and consolidated what had taken place in the previous groups. The fourth group also focused on the real life application of the skills that they had learnt. Homework tasks were given in between the group sessions for practice and to try and adapt the exercises that had been learnt in the groups to real life situations (for full details of the exercises please see paper).

Taking into account the small number of sessions carried out, the results show a small improvement in the level of cognitive flexibility and almost no changes in the motivation to recover. The overall feedback from the group was positive and the adolescents found the group acceptable and helpful. Their comments were that they experienced the group as fun, interesting and that it helped them to reflect on their thinking styles in regard to changing their behaviour. The authors found this encouraging as it is generally difficult to engage with this age of client group. A similar intervention was used with adults in an in-patient setting for ten sessions twice a week with more positive results. It was therefore believed that cognitive flexibility would improve with the length and frequency of running the group. The other possibility put forward for the reason for minimum change in the adolescent group was that the questionnaires were self reported, which may not have been an accurate measure of change.

As with previous studies and my own study, the authors recognise that the limitations of this study are the small sample size, the limited sessions available and the lack of a control group. They suggest that future groups should compare CRT to other therapeutic modalities. The authors also report that the adolescents that took part in the study were at the same time taking part in other therapeutic groups as part of their out-patient treatment and therefore there was difficulty in attributing any of the cognitive changes to the CRT intervention exclusively.

2.13 Prevention Programmes

The intervention that was carried out and is described in this thesis constitutes an attempt to design a group therapy intervention that can be used in therapeutic organisations across the health spectrum. Its purpose is to facilitate the mother's recovery and by achieving this help the mother become more aware of the transgenerational pitfalls that affect her children, in an attempt to prevent the cycle of EDs. There is an abundance of literature on prevention and prevention programmes for all aspects of EDs, the following is a sample of that literature.

Schore & Schore (2008) believed that prevention programmes should be developed and used in early interventions for the infant's mental health, by addressing the linkage of early attachment deficits to neurobiology. In their special issue of 'Group Dynamics: Theory, Research, and Practice', Conyne & Harpine (2010), highlighted the future and effectiveness of prevention groups. In their introductory article they said:

"The purpose of prevention groups is to enhance members' strengths and competencies, while providing members with knowledge and skills to avoid harmful situations or mental health problems. Prevention groups occur as a stand-alone intervention or as a key part of a comprehensive prevention program. Prevention encompasses both wellness and risk reduction.

Preventive groups may focus on the reduction in the occurrence of new cases of a problem, the duration and severity of incipient problems, or they may promote strengths and optimal human functioning.” (Conyne & Harpine 2010 p194)

Catalano and Dooley (1980) in Austin (2000) suggest that primary prevention should be divided into two sections, reactive and proactive. Their definition of reactive primary prevention is an intervention to improve coping responses and to build up the resistance to harmful stressors. Their definition of pro-active primary prevention is an intervention to eliminate the cause of the problem. If we interpret this for eating disorders, reactive primary prevention would entail teaching people how to deal with symptoms when they arise. It would educate them about the harmful affects of stressors such as the model, music and film industries and to make them aware of the disastrous effects of dieting. On the other hand pro-active primary prevention would be to try and alleviate the possible causes of the problem.

Fingeret et al (2006) did a meta-analysis on the research into the prevention of EDs. They found that there were better results when focusing on a high risk population and that ED prevention programmes successfully increased participants knowledge into and about EDs. They also found consistent evidence of small improvements in general eating pathology and dieting behaviours. Their opinion was, that as EDs were associated with such a high mortality rate, even small improvements were of significance.

More research is needed to assess the period of greatest risk for the development of an eating disorder, as this would help in the design of prevention programmes (Stice et al. 1998). There is a growing incidence of childhood onset of eating disorders; anorexic symptoms are being identified in children as young as six or seven (BBC 2007, Bryant-Waugh & Lask. 2002). The increasing prevalence of this illness has led to an expansion of efforts in the field of prevention. Indeed the need for prevention programs addressing eating disorders has been identified since the early eighties (Shisslak & Crago, 1994).

2.14 Prevention Programmes involving Parents

A considerable number of prevention programmes have targeted schools, colleges and “at risk” groups such as dancers and athletes. The main areas addressed in these programmes are raising self awareness and self esteem, the sociocultural aspects of thinness, nutritional information, the consequences of dieting and the warning signs of an eating disorder (Piran et al 1999). It has been agreed that early intervention is essential. For example Thelen et al (1992) recognise that the foundations of an eating disorder are established long before eating disordered behaviours present themselves. Graber et al (1999) believe that girls would benefit from prevention and early intervention programmes addressing eating behaviours in a developmental context. If this is the case, then it would seem prudent to address prevention at the earliest opportunity within a proven “at risk” group. Graber et al (1999) go on to comment on the absence of parents in prevention programs and have found that prevention programs targeted at adolescents that include parents, have been linked to healthier eating attitudes and behaviours.

In recent years the importance of parent training interventions has become increasingly recognised. Primary prevention is an attempt to intervene prior to the disorder developing, by altering the risk factors (Slade, 1995). Prevention groups are gaining increased attention in mental health and are becoming an increasingly important component in health care (Coyne & Harpine 2010). Primary prevention has been successfully used in the U.S.A. in a project known as “Parents as Teachers”. This was a program based on the principles that babies are born learners and parents play a crucial role in moulding their children. Outcome studies have suggested that by supporting and educating the parents, the numbers of children needing special or remedial treatment has decreased considerably. (Winter & McDonald,1997). Borden et al (2010) developed a collaborative group approach with the aim of strengthening parenting competencies, to promote the prevention of conduct problems, substance abuse and violence and to encourage attributes such as emotional regulation, with positive results. The critical role of early parenting in the evolution of mental and social problems in later life, creates growing concerns in terms of individual, social and financial costs. Jansen et al (2011) did a study to tackle childhood obesity that dealt solely with the parents. They felt that parents were the key in treating overweight children as parental modelling stimulated the child’s eating behaviours. The intervention targeted parents by means of support and educational group sessions which were based on themes. Even though the children were not treated, the results showed that the BMI of the children whose parents engaged in treatment showed a significant decrease from pre-treatment to post-treatment. An added benefit that was found was that the siblings in the families who took part, also showed a healthier BMI (Jansen et al 2011).

Research has been able to recognise the significant part mothers play in the development of an eating disorder (Cimino et al 2012, Stein and Woolley, 1996, Evans and le Grange, 1995). Franzen and Gerlinghoff (1997) set up a mother and child group to offer therapeutic and educational support to mothers with an eating disorder. They found the mothers became more confident in their parenting role and that it had a positive effect on their symptoms, which in turn benefited their children. Bryant-Waugh et al (2007) designed a study for ED mothers with children under the age of 5. The study started with 13 women split into 3 groups but 4 dropped out. Each session explored a different theme but it was thought that the theme of ‘Fear of passing on traits’ was a pervasive concern that permeated into all the other themes, therefore could not be addressed in a single session. The study was only set up for 8 sessions and focused on the role of parenting. Although this was only a small pilot, it suggested that these mothers did benefit from being supported in an intimate group environment that focused on the difficulties of parenting while suffering from an ED.

Stein and Woolley (1996) suggest that the struggle for autonomy can start in the conflict during feeding and mealtimes. They have recommended that sensitive intervention and education may help these parents become aware of their behaviour, enabling them to implement important change. It has been argued that parents need to be included in prevention programmes targeted at EDs in adolescent girls. It was identified that parents need to address how they feel about themselves and their own development and how they transmit their unhealthy behaviour and concerns to their children (Graber et al 1999).

Jones and Briant-Waugh (2015) developed a pilot study for a group intervention that provided skills and support for mothers of children with feeding problems. Nine themes were identified from a literature review and by surveying six mothers whose child had been discharged from a feeding and ED service. They also surveyed six professionals working in the field of feeding problems. There were seven final themes decided upon: Food, preparation and provision; Mealtime interactions; Identity; Parental expectations and support; Impact on the general parent-child relationship; Concerns about the future; Stress and Need for control. The first six themes were the focus for individual group sessions while the seventh theme, ‘Need for control’, presented itself in all the sessions. The intervention consisted of six ninety minute weekly sessions, an individual follow-up and debriefing session. Measurements were taken at baseline, pre-intervention, post-intervention and follow-up. Feedback was collected weekly during the intervention and at follow-up phases.

The aim of the study was to evaluate the effectiveness of a group intervention for mothers of children with feeding problems. The results indicate that there was little change in the mothers mood and stress levels, but changes were demonstrated in maternal perception and rating of the severity and number of feeding problems. Feedback suggested that it provided mothers with the opportunity for emotional expression and helped to reduce the feelings of isolation and self-blame. At baseline and pre-intervention the participants were shown to have clinically significant levels of anxiety, depression and parenting stress. While a number of participants showed an insignificant decrease in anxiety and parental stress, a significant change was found in the whole group regarding parenting concerns relating to feeding. These changes were supported by positive trends in the child’s problematic behaviour and their feeding difficulties. The authors felt that the findings had the potential for the intervention to bring about positive change in the mothers concerns relating to child feeding, via a reduction in stress levels connected to their child’s eating behaviour. The participants found the group relevant and helpful and highlighted the isolation these mothers felt. The most commonly reported benefit was the opportunity to be with other people who shared similar difficulties. This gave them the possibility of empathising with one another, which reduced their isolation and increased their sense of identity. The sessions were structured and no individual clinical advice was given, making this an intervention that could be easily disseminated among multidisciplinary teams with limited psychological training. Although there were limitations to the design and execution of the group and that the group did not appear to achieve any change in the maternal psychopathology and stress, there were however indications that these mothers could benefit from a group that provides support related to feeding. The participants reported positive benefits of being supported and understood, which helped to dispel their feelings of isolation.

Hart et al (2015) did a systematic review of interventions for the prevention of body dissatisfaction and EDs, involving parents. They state that parents play a pivotal role in shaping the body image and eating behaviours of children and that research has been espousing the inclusion of parents in prevention programmes since 1996. They argue that parents are the primary source of information for pre-school children and should therefore be the main focus for primary prevention programmes. Unfortunately they found that small sample sizes of parents seemed to be pervasive in the literature studied and suggested that there needs to be more understanding into the reasons why.

One study noted that ‘a child’s perception of their parent’s behaviour is more important than the parents’ perception of their own behaviour.’ The review found evaluating a child’s at risk status and communicating that to the parent, did not improve the parent’s motivation to take part in a prevention programme. Hart et al (2015) felt that these findings highlighted a need for more education of parents as to the dangers of EDs. One new approach suggested in the review for overcoming poor parental engagement in ED research, is to provide parenting programmes designed to improve the relationship between parent and child.

Taking an overall view, the studies included suggested that parental behaviour can be effectively targeted to reduce the risks in children of distorted body image and EDs. They found that the specific substance of the programmes rarely contained a psychological model relevant to healthy behaviour or behaviour alteration. They therefore suggested that a stronger focus for the content of these programmes should be informed by psychological models relevant to behavioural change. Some studies suggested that targeting all the influencing factors relating to the child's environment would be relevant. The authors felt that this review demonstrated that prevention programmes for EDs targeted at parents are being conducted and show that these programmes can reduce the risk factors. The lessons identified in this study were applied to the study that has been presented in this thesis.

Spettigue et al (2016) developed a psycho-educational intervention for parents who had adolescents with an ED, using a family-based psycho-education model. The adolescents were waiting to join an ED program at a children's hospital in Canada. The parents were recruited into the study, out of 188 parents screened 51 were eligible; 27 were randomly chosen for the intervention and 24 went into the control group. Out of the original number 8 remained in the control arm and 17 in the intervention arm. The intervention consisted of a 2 hour psycho-educational session, followed by bi-weekly telephone calls made by a senior nurse experienced in EDs. Families were also offered free copies of three recommended books, a DVD and a list of other resourses (please see paper for full details). The topics covered in the session were; general information about EDs, definition of symptoms, risk factors for developing an ED and medical and psychiatric consequences. The goals were to educate the parents, externalise the illness, to increase empathy for the sick child, to help parents to see that the illness controls the child, to lift blame from the parents and empower them to take charge of their child's nutritional input.

The intervention group were asked to take part in a further telephone interview, six parents took part. Most of these said that the information given made them realize how sick their children were and how valuable that was. They found that some of the information was distressing but as this information was given by professionals in the field, they felt reassured that help could be provided. They felt that since the session they were more aware of ED behaviour and would be more equipped to recognise it. Parents felt that they were more empowered after the session, less guilty, less helpless and less hopeless. In general the six parents from the intervention group found the session helpful. The feed back from the parents provided several important factors for inclusion namely; describing the different types of EDs in more detail, providing information on what to tell the child's school, what to discuss with the GP who did not specialise in EDs, what the parents could say to their child in specific circumstances and information about the different types of medication that could be used. The authors felt that this study's strength lay in the concept of using this intervention for families on waiting lists for their child's ED. They felt that their findings were in line with previous research that demonstrated the effectiveness of psycho-educational interventions for parents who have a child with EDs. It was found that increasing the self-efficacy in parents predicted a decrease in ED symptoms for the child and although this did not prevent an ED it certainly aided the recovery from one.

It is important to look at repeating family interactions from a transgenerational perspective, as it has been found that eating disordered patients show serious parenting difficulties. (Woodside & Shekter-Wolfson,1990). This could have significant implications for future prevention programmes (Vandereycken 1994). Hodes (2000) believed that the screening of children of mothers with an eating disorder could have great clinical relevance in the development of primary prevention. He goes on to state that if any eating disordered patient currently in treatment has children, these children should be identified and enquiries made about their emotional, behavioural and physical health.

Further research has been called for into the significance that maternal eating disorders have for their child’s development and psychopathology and also into the effectiveness of interventions (Hodes 2000). The literature on the transgenerational transmission of psychopathology and the inclusion of parents in prevention programmes has had significant influence on this research study.

2. 15 Psycho-Social Affect

Barrueco Costa and Melnik (2016) did a systematic review of the effectiveness of psychosocial interventions in EDs. Their study criteria were; Randomised controlled trials, systematic reviews, meta-analysis and a review of the literature on the effectiveness of psychosocial interventions in EDs, covering any age and any sex and including any diagnosed ED. The psycho-social interventions identified were, self-help and guided self-help for general EDs, family therapy and individual therapy for AN, a combination of drug treatment and psychological treatments for BN and psychological treatment for BED. The most effective treatment for AN was short term family therapy, leading into individual CBT, focal psychoanalysis and supportive psychotherapy. For BN, CBT was shown to be the most effective treatment but the combined treatment of medication and psychotherapy compared to psychotherapy alone showed better remission rates. This was also the case for BED. They found that the effectiveness of psychosocial interventions varied depending on the chronicity and co-morbidity of the patient. Given the multifactorial etiology of EDs, they found that effective interventions increasingly addressed prevention by taking into consideration the individual, family and social risk factors. Some studies that focused on positive schemes for self- image were found to be effectual when included into the school syllabus, to help to prevent the development of EDs and dysfunctions of body image and self-efficacy.

2.16 Outcome and recovery

Having explored the multifarious risk factors that are likely to influence the onset of EDs, it is encouraging to note that suffers can and do recover. Robinson (2009) believes that one of the most remarkable aspects of treating EDs is that it is possible for patients to recover, sometimes after as long as a 20 year duration. However when assessing recovery, what also needs to be addressed is whether or not the underlying issues of attachment, autonomy, individuation, maturation and separation, have all been adequately dealt with, to support the physical aspects of recovery (Ringer & Crittenden 2007).

As EDs are a secretive and isolating illness (Garfinkel & Dorian 2001), with a great deal of shame and guilt attached, the demographics of EDs in the population are difficult to assess as many cases are unreported, therefore not diagnosed (Schmidt et al, 2004, Eating Disorders Association 2000). However, in 2004 it was estimated that 1% of women in the United Kingdom between the ages of 15-30 suffered from Anorexia Nervosa and 2% suffered from Bulimia Nervosa (Mind 2004). Yet The Eating Disorders Association (2000) suggested that there could be as many as 1.15 million sufferers in the UK.

The question remains as to the extent of recovery, as there is some disparity in the findings. At this stage it is important for this study to note that patients with a long history of ED have poorer outcomes than patients with a shorter history (Roth & Fonagy 2005). Some authors believe that the earlier the onset and the quicker the treatments are made available, the better the outcome (Roth and Fonagy 2005, Treasure & Schmidt 2005, Treasure 2000). This points to the importance of primary prevention which can deter the onset of the illness. It has been stated that within the AN population after 5 years only 50% will have been deemed to have recovered, 30% will remain severely affected and 20% will still be underweight with amenorrhoea (Treasure 2000). Even after several years of recovery Treasure (2000) believes that stressors such as childbirth can trigger relapses, pointing to the importance of supporting these mothers as early as possible.

Hsu (1990) found that disturbed family relationships were a poor prognostic indicator for recovery and agreed that the longer the duration of the illness the less likely full recovery was achievable, although not impossible. He believes the case for competent treatment improving outcome is strong, however he found that only one third of patients at follow up, had a regular eating pattern. These findings are still supported in a recent study by Maxwell et al (2011). This study found that the absence of family and social support typifies patients with persisting and long term illness. The authors also confirmed the belief that psychiatric and social impairment can exist long after the abatement of maladaptive eating behaviours.

Brinch et al (1988) did a seminal follow up study of 151 anorexic patients,11 of whom were males. Out of the 140 women, 50 had borne children. It was found that the group of mothers had a better all round functioning outcome than the group of non-mothers. This could lead us to surmise that motherhood is an incentive for recovery and possibly an incentive for addressing any issues that might be harmful to their child. Crisp (1980) states, that 40% of severely ill anorexics will recover naturally, or else be “much improved” after six years and that with treatment an overall of 70-80% will recover. We then have to ask, “What is meant by recovery?” Crisp (1980) goes on to say that 70% of females will recover menstrual function, 60% normal body weight and that 60-70% will have normal sexual relationships.

He believes that their body image at this stage of recovery will be commensurate with other females that have not had the condition. Crisp (2006) in a later study over a 35 years period, found that full recovery was possible and that three quarters of the patients that had effective treatment did recover. However, as yet there seems to be no clear consensus on the definition of recovery, leaving researchers and clinicians to make implicit assumptions as to the meaning of recovery (Noordenbos & Seubring 2006). Garner et al (1997) indicates that abnormal attitudes towards food and weight are common and persistent features in anorexia nervosa greatly interfering with full recovery. Though improved weight and cessation of purging are concrete signs of improvement, recovery would be better achieved by promoting better self-esteem, overall well-being and improved relationships (Mickley 2001). Noordenbos & Seubring (2006) found that the realization of psychological recovery took two years longer than the realization of criteria concerning eating behaviour and weight.

Berkman et al (2007) reviewed literature published from 1980 to 2005 on the outcomes of EDs. They identified 32 separate studies which yielded 62 articles. The final report was based on 28 studies compromising 56 articles. It was identified that a shorter duration of the illness was a significant predicator for recovery and that relapse was greater among those whose duration of therapeutic contact was less than a year. Poorer outcomes were associated with greater family hostility and disturbed family relationships together with significant co-morbid psychiatric or psychological disorders.

Although this paper was interesting and concluded that recovery is possible, there were considerable differences and inconsistencies in the study designs of the literature reviewed and substantial difficulties in drawing conclusions from a review of this nature.

High levels of EDs are of concern, given their prognosis and effect. EDs are reported to have a mortality rate of between 13-20% (Crisp et al 2006, EDA 2002, Crisp et al 1992, DSM - IV 1994). Anorexia is said to have the highest mortality rate of any psychiatric disorder (Bailer 2005). All EDs can lead to serious medical and psychological complications. Sufferers can develop osteoporosis, electrolyte imbalances, kidney, renal or heart failure (Treasure & Szmukler 1997, Goldbloom & Kennedy 1995). The psychological consequences can be anxiety, depression, self-harm, obsessive compulsive disorder and personality disorders (Halmi 1997). When EDs become chronic and embedded they result in repeated hospitalisation (Schmidt et al 2004) and prospects for recovery are poor (Hsu 1990). Treatment becomes long, difficult and expensive. The social effects include disruption to families, the inability to form or maintain relationships, problems with work and difficulty functioning in society. It has been found that EDs often become chronic and lead to substantial problems not only physically, but also in psychosocial functioning and that these problems could be a core component of the ED (Hartmann et al 2010).

This study was undertaken because, as stated, the incidence of EDs is rapidly growing (BBC News Health October 2012) and new treatment modalities are being sought. As yet it seems that within the treatment spectrum, there is still a paucity of treatment specifically aimed at mothers with an ED, although it has been recognised and identified that the children of these mothers are at high risk of developing their own ED. It is hoped that the intervention devised for this study will prove to be of benefit to this group and their children.

2.17 Using Mixed EDs

It is understood that EDs have become more prevalent in recent times and that the course and development of each specific ED can frequently become transferable (Fairburn & Harrison 2003). When undertaking this research from previous studies (MacNeil et al 2016, Wanlass et al 2005), it was understood that people with EDs have many common characteristics, such as feelings of isolation, low self-esteem, difficulties in identifying feelings, alexithymia and problems in communication. Fairburn and Harrison (2003) state that anorexia nervosa and bulimia nervosa have a distinctive core psychopathology. They believed that ‘mood intolerance’ was a critical variable that could be identified across the range of EDs. Patients overvalue their shape and weight and judge their self-worth by their shape and weight and their ability to control them. This core psychopathology manifests itself as mistaking certain physical and emotional states as being and feeling fat. They go on to describe atypical EDs namely Eating Disorders not Otherwise Specified (EDNOS) as closely resembling anorexia and bulimia and being virtually identical, although not meeting the precise diagnostic criteria. EDNOS as a diagnosis of EDs is believed to affect 50% of the ED community but proposals have been made to reduce the specificity of some of the diagnostic criteria for anorexia nervosa and bulimia nervosa which would reduce the proportion of cases that fall into the category of EDNOS (Treasure et al 2010). Across all EDs the sufferers are caught in a spiral of dichotomous thinking patterns, a disparaging concept of self image and a dysfunctional, destructive relationship with food (McMillan 2011). These criteria together with the criteria of distorted body image and the fear of weight gain (DSM 5, 2013) are all difficulties that ED sufferers in general are familiar with.

The diagnosis of EDs can be unstable, as specific EDs such as anorexia and bulimia often seep into the boundaries of each other. It is difficult and imprudent to categorically divide one ED from the other (Collier &Treasure 2004). In a mixed group it is possible to set up competition between the restricting anorexic and binge/purge bulimics who themselves feel that they are failed anorexics, but if there is enough common ground for the group to recognise feelings of familiarity as a source of identification, rather than competition with the other members of the group, the mix becomes productive. When the group described in this thesis first started, several participants admitted to the feelings of competition, of wanting to be the thinnest in the group, but these feelings soon dissipated once they made a connection to each other and understood that there was a specific focus to the group. It is precisely the feelings of familiarity and the ability to identify with one another that takes away the secrecy and isolation that is embedded in EDs and enables the participants of a mixed group to bond. This therefore makes a mixed ED group environment (not including obesity) no less advantageous and in most cases more advantageous than an exclusive group. A mixed group has the advantage of mirroring the real world that these mothers live in, as it is highly unlikely that they will come across fellow sufferers that have a definite fixed diagnosis of one ED, as against another or in fact have all the same symptoms. It is also a common phenomenon in the diagnosis of one form of ED such as anorexia nervosa, or bulimia nervosa to find different symptoms in each individual that will overlap the diagnostic criteria of one ED against another. As discussed previously in the paragraph on 'The Use of Groups', it is important for the group participants to feel understood by one another. This promotes a non judgmental environment and encourages the sharing of experiences, which in turn leads to greater group cohesiveness (Marmarosh et al 2005, Yalom 1985).**

2.18 Case Study Methods and EDs

Case study methodology plays an important role in the growth of knowledge in the field of counselling and psychotherapy, as it provides a source of narrative knowledge that contributes to the understanding of human emotion (McLeod 2010). As human emotion lies at the heart of most psychological disorders, it is fair to state that it plays a vital part in the development and maintenance of an ED. The case study method can be used as a valuable tool in the field of EDs, to communicate typical patterns or variations in behaviour, as well as revealing processes and connections that can only be divulged in the transmission of the narrative life history. The case study places emphasis on the signs of symptoms and the history of the psychological disorder, as well as the social aspect of the life histories (Bromley 1986).

Case study methodology addresses the questions that are of interest to the counsellor or psychotherapist who is interested in change, the change process and the therapy process. It looks at whether or not the client has changed and in what way, how they experienced the therapy and whether they find it helpful or not and whether the therapy was part of the process of change (Barker et al 1994). These questions are of direct interest when treating EDs and are relevant in being able to translate research findings into clinical practice.

Research into EDs often focuses on which modality of therapy and what sort of intervention shows any indication of improvement. The case study methodology for research focuses on four sets of questions: outcome questions, theory building questions, pragmatic questions and experiential or narrative questions (McLeod 2010). These questions are in line with the focus of inquiry into the development, function and recovery of EDs, making the case study methodology a realistic form of research that can be integrated into the psychological approach.

Chapter 3

3.0 Methodology & Methods

The relationship between therapist and client, researcher and participant is a privileged experience and facilitating the group allowed me to gain a very intimate and rewarding perception of the lives of the participants. I hope in analysing their data I have done justice to their stories.

The overarching desire when designing this research project was to inform and drive forward clinical practice by attempting to develop a group therapy intervention for future use with this client group. In attempting to achieve this, a research methodology that could amalgamate the research findings into clinical practice was desirable. My decision to choose the qualitative methodology of the case study, n=1 design was based on several factors which are set out below.

3.1 Qualitative Methodology

The all encompassing paradigm that sits within the phenomenological and hermeneutic principles that underline this research is a qualitative methodology. Qualitative research is an interactive process, in which the person or persons studied, teach the researcher about their lives and the researcher seeks to understand their experience (Sherman & Webb 1988). It is a sensitive method of opening up meaning and generating new insights that do justice to the experience of those participating in the research (McLeod 2001). Formal, empirical, experimental research is based on the idea of building and testing hypotheses according to the principles of induction and deduction (Higgins 1996). In this case the hypothesis was to investigate whether the protocol for the group intervention was effective in answering the research questions.

3.2 Research Strategy - Case Study

The single case study design was first developed in the 1950s and 60s, pioneered by Shapiro (Barker et al 1999). Fonagy and Moran (1993) believed that the case study approach was the dominant paradigm of psychological research until the twentieth century. The case study allows the researcher to delve deeply into the environment of sensitive material, producing a holistic understanding of the issues pertaining to the research questions (Marks & Yardley 2004). The rationale for developing a research strategy for any research project is linked to the identification of the type of research question, being asked (Yin 2003). In the evolution of the case study research questions, there need to be elements of outcome questions, theory developing questions, pragmatic questions and experiential questions (McLeod 2010). The case study was devised to understand complex social phenomena and investigate the meaningful features of real life events and people (Yin 2003). It provides a highly detailed analysis and an inductive support for theories by reporting measures of central importance. Focus is placed on observations of individual behaviours and the design favours a small number of participants

(Perakylia 2004, Yin 2003). McLeod (2010) believes that there are four factors that explain why case study research is important for building a knowledge base in therapy. Narrative knowing; representing and analysing complexity; generating knowledge in context, and understanding practical expertise in action, all of which play a part in the described study.

Case study research within the practice of clinical and counselling psychology refers to the written narrative that describes the treatment process of the patient /client (Chamberlain et al 2004). It gives a more human dimension that is lacking in the statistical findings from larger quantitative research. As the original rationale for this research study was the amalgamation of research and clinical practice, the single case study has been found to accomplish this requirement, as it enables the practitioner to integrate the findings of the research with the treatment process (Barker et al 1999). Case study as a research method covers the logic of design, data collection techniques and specific approaches to data analysis, confirming an all-encompassing research method (Yin 2003).

3.3 Generalisability

The case study shares research methods with other qualitative methodologies such as grounded theory, action research and ethnography. It differs in that the case is clearly defined as an individual or group and can be examined through a variety of different methods of data collection and analysis (Chamberlain et al 2004). **T**he benefits of smaller numbers, allow the case study the space to examine the influence of contextual factors, in ways that are not possible when a large number of subjects are being studied (McLeod & Elliott 2011). In case studies it can be difficult to determine if the results can be generalisble and whether there is wider relevance to the outcomes. Although case studies are restricted due to the size of the subjects, it is still possible to produce generalisble results by allowing further research to adhere to the original protocol (Perakyla 2004). In the instance of this research study, the reinforcement and development of the findings of the pilot study, the use of standardized measurements pre and post group and at six and twelve month follow ups, the design of the semi-structured interviews, the protocol of the group and the taping and transcribing of the interviews and group sessions, all contribute to the possibility of extracting generalisble findings and of replication.

3.4 Multiple Sources of Evidence

The disparity and complexity between the units of analysis can be controlled through the use of multiple sources of evidence (Windle 2005). The case study proliferates rather than narrows and is best used for adding to existing experience and humanistic understanding (Stake 2000). It excels in the intimate ‘lived-in’ experience of the client and it attempts to explore the meaning and understanding of their world. Mitchell (2000) talks of the “extended case study” that traces the events in which the same set of main actors are involved over an extended period of time. Yin (1994) stated that to increase the reliability of the evidence of a case study, it is important to maintain a chain of evidence. This is compatible with tracking the experiences and responses of the participants during the groups and the follow up interviews that were incorporated in the design of this research. Continuing to collect data during a follow up period after the intervention has ended, can give strong indications as to the fundamental change that has occurred and if that change has survived the absence of the therapist (McLeod 2010).

McLeod (2010), identified 11 principles that could be taken as guidelines for carrying out case study research in the field of counselling and psychotherapy. I would like to attempt to link these guidelines to the research study in this thesis.

1. “Creating as rich a data set as possible, based on multiple sources of information, including description of the context within which the therapy took place.”

This study collected data from the pre-group interview, the 19 sessions of the group, the end of group interview together with the six and twelve month follow up interviews. The amount of data that this produced was too great to be able to include it all, so relevant portions that gave a flavour of the overall project were chosen to be included. All the interviews and the beginning, middle and end groups were analysed and described, to give an understanding of the context within which the therapy took place.

2. “Engaging the interest of the reader by telling the story of what happened within the case.”

A detailed history was taken from each of the participants at the initial interview and each participant’s story was recounted throughout the group sessions and continued through to the 12 month follow up. The reader of this study was able to ‘get to know’ each participant and was able to follow their stories through the lifetime of the group and into the subsequent year.

3. “If possible, using standardized process and outcome quantitative measures that allow comparisons to be made with data from other cases.”

Two outcome measures were used at all the interview stages of the study. Clinical Outcomes in Routine Evaluation (CORE) (Mellor-Clark et al, 2001) and the Eating Disorder Inventory (EDI) (Garner 1991) were completed. CORE was specifically designed for the psychological therapies. It assesses global distress and risk factors, so it can be used both as a screening tool and for evaluation. It is user friendly and easy to score and has also been extensively validated (Evans et al 2000). The EDI is a widely known questionnaire designed to measure the attitudes and psychological features of AN and BN. Both the EDI and the CORE were self-report questionnaires which the participants filled in themselves at the different interview stages.

4. “Provide enough information within the report, or in the appendices, so that the reader can make up their own mind about the interpretation of the case.”

All the group sessions were taped and transcribed, but not all the group sessions were analysed. A number of the group sessions were analysed, namely the 1st session, the 5th session, the 10th session, the 16th session, the 18th session and the 19th session. It was felt that the analysis of this sample of the group would give the reader enough information to be able to form an adequate opinion of the process and progress of the group. All the interviews were taped, transcribed and analysed, adding to the overall understanding of the participants and their ‘journey’ through the group.

5. “Use multiple analysis, rather than depending on a single perspective on the data. Also, if possible, more than one person should be involved in the data collection.”

As all the interviews were analysed it gave the research a different dimension than just taking the data from the group sessions. This gave the study multiple sources of analysis. There were two other trained qualified counsellors who carried out all the interviews and collected the data from them.

6. “Do some kind of time-series analysis, to enable the process of change to be explored in a systematic manner.”

The interviews spanned the lifetime of the group, with the first interview at the beginning of the group and the next one at the end of the group, with the two follow-ups at 6 and 12 months. This enabled the analysis to document the course of change that the participants made in a systematic manner.

7. “Critically examine alternative interpretations of the data- be critical and scholarly, rather than using the case study to ‘sell’ an approach to therapy.”

The reader of this thesis will have to make a judgement on this point. Although it was very enticing to just ‘sell’ the case study, I have also pointed out the limitations of the research. I hope that in doing so I have been critical and scholarly. During the analysis of the group sessions I have lent heavily on the literature and used it to either criticise the relevant point, or to back it up.

8. “Take theory seriously, on the grounds that generalization is based on the establishment of cross-case theoretical principals.”

The literature study shows that I take the theory of groups in this population seriously. I have also considered all sorts of other principles concerning the group, such as; should the group be mixed in illness, life stages, gender and motherhood. The main drive of this study was based on reference to the underlying theory.

9. “Try and find out what the client thinks about the therapy he or she has received and about the analysis of the case data.”

During the end of group interview and the 6 and 12 month follow-up interviews, the participants were asked what they felt about being in the group and what if anything they would have liked to change. They were also asked what points they found to be most useful and which situations they found to be most difficult. The participants were asked to comment on the size of the group, the duration of the group and the length of each session. Due to my illness the analysis was not completed till some years later and by that time contact had been lost. Unfortunately because of this they were not able to read the analysis and we were not able to get their opinion on it.

10 “Be reflective- provide relevant information about the author(s), to allow readers to take potential sources of bias into account.”

During the introduction I discussed my clinical practice and the experiences that had influenced me that were relevant to the research and had led me to undertake this study. Also included in the methodology chapter there is a section outlining my therapeutic approach and the reasoning behind the incorporation of this approach into the study.

> 11 "Use a standard format (e.g. the one recommended by the Pragmatic Case Studies in Psychotherapy journal), to make it easier for future scholars to conduct meta-analyses and for current readers to find their way around your case report."

Unfortunately the format recommended by the Pragmatic Case Study in Psychotherapy journal was not used. It is hoped however that the format that has been used is easy to read and understand.

3.5 The Small-N (n=1) Approach

Within the overall design of the case study method there are a series of different approaches that can be used, the one most suited to my research study was the n=1 approach. The n=1 approach is aimed at testing hypotheses and answering questions that evaluate the usefulness of the study. It makes it possible to measure change within a specific intervention (McLeod 2010) such as the group. A "case" can be whatever is under investigation and it can be singular or multiple (Stake 2000). Within this research, a "single case" analysis has been undertaken, with "The Group Therapy Intervention" being the "case". This design exemplifies a way of looking at individual complexity while giving a viable method of research to clinicians. This approach attempts to identify and quantify the individual differences of the basic characteristics and it delves into the origins and development of these characteristics within the individuals experience, looking into the effects on behaviour and psychological process (Bromley 1986).

3.6 The Research Question

The hypotheses i.e. the research questions (Fig 2) were formulated at the inception of the pilot study and were originally triggered by the author's clinical practice. They were then consolidated by the literature which is discussed within the literature review (Chapter 2). After the analysis of the pilot study (Barnett 2000), the research questions were revised and refined for the main study of the research. However it is felt that the research questions formulated are really too big to be addressed in one qualitative study, but it is hoped that this study can in a small way begin the process.

Fig.1 The Research Question

The Research Questions

1. Are deficits in attachment and separation in this group, linked to EDs
2. Can it be demonstrated from this group that EDs get passed through the generations?
3. Can this group therapy intervention aid recovery and help the prevention of transgeneralisation EDs by altering the mothers' behaviour to their children?
4. How did the participants experience the group and research process?

Fig 2 The Case Study Inquiry

The Case Study Inquiry

- Copes with the technically distinctive situation in which there will be many more variables of interest than data points, and as one result.
- Relies on multiple sources of evidence, with data needing to converge in a triangulating fashion, and as another result.
- Benefits from the prior development of theoretical propositions to guide data collection and analysis.

Yin (2003) p13

3.7 Analysis and Coding

Once the transcriptions of the interviews and group sessions were completed each transcript was read through meticulously, to allow immersion in the data. When interviews are recorded and transcribed the meaning of the sentence structure can often be misinterpreted, as the use of punctuation can change the meaning. This can be avoided by listening to the audiotapes while reading and analysing the transcripts (DiCicco-Bloom & Crabtree 2006). This method was used during the analysis of the transcripts in this study.

It was particularly necessary to read and re-read the transcripts whilst listening to the audio tape of the group sessions, as it was important to be able to distinguish and identify who was speaking at any given time. All the interviews were analysed: pre, post and both follow ups and the group sessions chosen for analysis were decided upon. The group sessions chosen for analysis were the first session, the fifth session, the tenth session, the sixteenth session and the last session which was the nineteenth. A brief analysis of the eighteenth session was included as it contained important and relevant information and insight into the process of the group. The identification of the codes and the subsequent category development was completed by examining the multiple sources of data such as the initial interviews, the group sessions and the follow up information.

In addition to the final main themes, information that was relevant to the study as a whole was also coded and used for the final analysis. Information such as personal details, medical history and treatment history, pregnancy, general family dysfunction connected to other relationships in the family and information on the children was originally coded. This information was deemed important to complete the general understanding of the lives of the participants and to gain an insight into their feelings and behaviour. These were also a vital component in being able to tell the story and give the reader the ability to immerse themselves in the therapeutic process. Data concerning the participant's experience of the group was also extracted from the end and follow-up interviews. This was important for the study as it enabled me to gain an understanding of what aspects of the group process worked and which did not. This would be important information if the groups were to be repeated.

The coding then began by taking each sentence and identifying which theme the material was relevant to. This was then entered into the NUD*IST programme that was used (Richards 2002). The first round of coding that was used were the 'free nodes', this was any material that could be connected to the main themes or the additional codes, for example; if the participant was talking about what others were doing in comparison to something she was or was not doing this would be identified as 'comparing with others', this could then be connected to attachment issues, which could then be connected to the main theme of the 'mother /daughter relationship'. Or if the sentence contained information about the participant's medical history or their personal history, this was then put into the relevant codes.

Once the free nodes for each interview and group session were completed, the computer programme categorised the free nodes into tree nodes. This meant condensing the information down into the main codes that were used which included the main themes and the added categories mentioned above. The tree nodes were then crossed checked back to the original free nodes and then the tree nodes were used in the breakdown for the final reporting of the findings that were used in Chapters 5 and 6. **

3.8 Themes

Deciding what to code can be one of the most challenging tasks of the research. (The themes are highlighted in bold). The first seeds of a research project began to materialise, when my interest was fired by the repetition of certain themes in the life histories of the clients that I was treating. When delving into their backgrounds and analysing their past relationships, it became clear, as the therapeutic process began to unfold, that attachment was one of the predominant issues that was at the core of each of the clients presenting with an ED.

In all the cases that I dealt with, the client was female and the mother was the main care giver. The difficulties with attachment were developed from a problematic relationship with the mother. This could have been from birth or could have developed as the infant grew, but by the time these women came into therapy the effects of a dysfunctional attachment were apparent. Therefore my initial interest for the themes of this research was into the early signs and development of an ED and I began to focus on the primary relationship between **mother and daughter**. Once I had affirmed that attachment issues were an integral concern, I widened the search for more themes into the wider connections that emanated from this relationship.

In most cases that presented with an attachment issue, it became noteworthy that the developmental stages of separation and individuation were also problematic. These women had low self worth and separation was dogged with fear and trepidation. Separation and individuation are the final achievements of a healthy attachment, so understandably if a healthy attachment has not been achieved then **separation and individuation** cannot be negotiated in a satisfactory manner. These then became two of the themes.

The literature was all too clear that mothers unwitting and unknowingly allowed their children to mimic and absorb their habits. When I started looking more closely at the clients in front of me, I recognised what the literature was saying. Neither the mother nor the child seemed aware that the child was modelling and internalising the mother's behaviour and cognitive preoccupations. This therefore became another theme…**Modelling**.

Of course **food and feeding** are one of the most central and conscious parts of an ED. They are the modus operandi that are used to bring control into the ED sufferer's life. So one of the themes had to be about food and feeding. The other most conscious part and indeed one might say the most idealised part of an ED is **body image**. This indeed the anorectic cannot hide from and the bulimic hides behind so it is in the forefront of the ED sufferer's mind and as such too important not to be included.

I ran my pilot study to confirm that these five themes were indeed relevant to the development and continuance of an ED and that they were significant in the lives of the participants of that study. The findings of that study were in favour of the hypothesis (Barnett et al 2000). Those findings and the relevant literature led me to include these themes in my main study. That is the rationale for this thesis.

3.9 Limitations Reflexivity and Validity.

The case study as a qualitative methodology can be a valuable piece of research as long as the limitations are understood. The case study allows us to derive what is possible, not what is typical; it can provide a suggested cause or connection but cannot provide strong evidence (as in large statistics) to substantiate the findings (Barker et al 1999). Yin (2003) argues that case study as a research strategy is one of the most challenging in social science but is used when the need for the research arises out of the desire to understand complex social phenomena. A qualitative case study attempts to develop an understanding of the perspective of the person or persons being studied and lends itself to experience meanings from the observed disparity of the participants. The case study approach sits comfortably with these objectives (Chamberlain 2004). This methodology tests hypothesises or causal explanations that investigate validity and reliability (Elliott et al 1999). The case study research can involve subjectivism and bias toward verification but it is felt that there have been more discoveries stemming from the type of intense observation made possible by the case study than from statistics applied to large groups (Flyvbjerg 2006). Whilst acknowledging that bias is inherent in any researcher/therapist role and accepting that it is improbable that you can set aside your own perspective (Elliott et al 1999), I believe that awareness of this phenomenon leads the researcher to question the credibility of the analysis in order to keep bias to the minimum. The use of multiple sources of data collection gives a basis of reliability to the information that is retrieved and commonalities can be identified from other studies in this area (Elliott et al 1999).

From the original concepts of this study my ideas and thoughts were discussed with my supervisor who is a renowned expert in the field of EDs. She has also been involved in numerous research studies into EDs. Her knowledge when overseeing my work was an invaluable component in supporting and validating my data and analysis. I met with her each week after the end of each group session and weekly throughout the lifetime of the study. During these meetings I was able to reflect on my thoughts, feelings and ideas about the research. Although this group was small it consisted of a group of fairly sick women who had been ill with an ED for a considerable amount of time. Facilitating this group as well as being the researcher for the study became a very taxing experience and these meetings with my supervisior were a place that I could reflect on my own process and discuss in a safe and confidential environment the process of the group participants.

As my theoretical stance stems originally from the psychodynamic orientation, my overriding interest when designing this study was to investigate the lifelong experience of the patient. My belief is that understanding the causation of the initial dysfunctional exposure will in turn help to enable the patient to accept their emotional situation and facilitate them in moving forward into recovery. In my treatment of ED patients in my clinical practice I have used this method together with other orientations with a considerable amount of success; therefore it seemed prudent to incorporate this understanding into the design of the group and the formation and hypotheses of the research questions. The process of the treatment and the patient's perception of the helpfulness of the treatment became a vital component of the study when designing the protocol, as this would be a necessary element if the protocol were to be of any value if repeated.

There has been previous debate discussing the merits of using qualitative and quantitative methods together and whether or not the two methods complement each other (Elliott et al 1999). It has been seen from this study that the use of the two methods did not in fact complement one another. I would say that the use of the quantitative methods on such a small sample only confused the results, instead of supporting them. The qualitative data that emerged from this study was so rich and in depth that I felt it represented in full the meanings of human experiences and actions and that it was able to stand alone (Elliott et al 1999). By illustrating the data and giving verbatim examples of it, the reliability of the data became more credible. Also the input of my supervisor for the purpose of editing and checking for discrepancies and errors kept the data reliable and on track.

This study draws on the vast amount of research literature that describes and discusses ED behaviour. However, the data that this literature produced has rarely been used to develop interventions or treatment models that could be offered to ED sufferers. This study drew on the findings of the literature to develop this group therapy intervention. It attempts to test the usefulness and validity of the research study by producing clinical evidence from the vast amount of data that has been analysed, that could be incorporated into future clinical practice, with the aim of improving treatment methods for this client group.

3.10 Methods

3.10.1 Recruitment

Recruitment proved to be a difficult and protracted process. Given the statistics on the need for specialist treatments, our initial expectation was that there would be an abundance of referrals as there was no other treatment modality targeted at this group. Unfortunately this proved not to be the case. There was one referral from a GP, who later dropped out. GPs did not seem to be interested even though the group offered was free for the clients. I feel very strongly that the reasons for the sparse referrals should be further investigated and researched.

The recruitment process consisted of contacting every practice manager and senior practice nurse in all the PCTs in Hertfordshire. A letter and a flyer (Appendix 6&7) were sent describing the research, outlining the key points and asking for referrals from their practice. A group e-mail (Appendix 8) was sent to all Hertfordshire PCT Network (HertNet) members. Flyers and information were also distributed to health clinics, counselling services and voluntary services. Alongside these activities, presentations were made to the Primary Care Trusts (PCT) meetings, health visitors, speech therapists, parenting services, home start, community adult mental health units, community child and adolescent mental health units, hospital specialist in-patient and out patient eating disorder units. However, the response was extremely poor and as mentioned only one referral came from a GP and one from a community mental health unit, the others came from the specialist hospital in-patient units on discharge. This was unexpected as the research was initially targeted at Primary Care not Secondary Care. The hospital in-patient units were interested as there was no specialist follow on care available for these patients and very little or no support for them. The majority of cases continued to suffer with their illness, creating the revolving door scenario (repeated hospital admissions).

3.10.2 Participants

The group started with eight mothers (All the names have been changed for confidentiality). All were white British aged between 24 years and 44 years (mean 33.5 years). Their BMI ranged from 15 to 22.5 (mean 18.4). The age onset of their ED ranged between 13 years and 18 years (mean 15.75 years) making the average duration of the ED 17.75 years. The total number of children was 15, 10 girls and 5 boys, ranging in age from 1 month to 12 years (mean 7.75 years). There were four mothers identified too late to be processed for the start date of the group and we had to exclude them.

3.10.3 Ethics

Ethics are always of great concern when dealing with people. It is necessary to keep the participants of research informed and safe at all times. As a therapist I abide by the ethical framework instituted by my professional body, The British Association of Counselling and Psychotherapy and was very aware of the necessary steps to take in order to protect the participants. These steps are set out in the description of the methods below. In addition, as the principal researcher and the principal therapist, clinical supervision was a crucial element in keeping the participants safe, trying to minimise any bias within the analysis and ensuring my own equilibrium (McLeod 2010). However it was also necessary to gain official ethical approval from the relevant authority. Ethics approval was granted in 2002 from the Hertfordshire NHS Health Authority (Appendix 15). Research Management and Governance was granted in 2003 (Appendix 16) and a successful audit was undertaken in 2004.

Having identified that taking part in a psychological group could impact on the participants’ well being at any time, I as the main researcher and the group facilitator, made myself available for contact at any time from the start of the research to the final follow ups and beyond. For added precautions the details of the participants GPs and health workers or key workers were taken, so that they could be contacted if the need arose.

3.10.4 Initial Meeting

As the participants had been recruited from in-patient units and community mental health units, it was understood that the client group identified was an extremely vulnerable group. An initial meeting was arranged with me, as the facilitator of the group and also the lead researcher. The meeting was set up in the participant's home as it was important to put each participant at her ease. A further reason for this meeting was to "set the scene" for the forthcoming interviews and to allow the participant to meet the facilitator prior to the commencement of the group (Cummins 1996). In meeting the facilitator prior to the commencement of the group, it was hoped to alleviate some of the anxiety that the clients were experiencing and give the client an opportunity to ask any questions before agreeing to participate (Cummins 1996). As an experienced and qualified psychotherapist specialising in EDs, I tried to draw on my therapeutic training to enter the client's space in a non threatening manner. At this meeting an information pack (Appendix 9) was given to the participants and the purpose of the group was explained. Informed consent was also explained and they were told that it would be obtained at the initial interview. All the original 8 clients seen at this initial meeting agreed to attend the interviews and to take part in the research.

3.10.5 Interviews

The next meeting that the participants would have, was the initial interview carried out by a colleague who is also an experienced counsellor. The use of a different counsellor to conduct the interviews was to minimise bias for the research. After this first meeting the participants and the facilitator would not meet each other again until the group started. At the initial meeting an interview date was set up. This would be with one of the trained interviewers from the research team. The participants were given the choice of having the interviews at their home or in the community centre where the group was to be held and where the crèche was available. Each interview was scheduled for between one and one and a half hours. As the success of the interviews rested on the skill of the interviewer (Mason 2002), the interviews were conducted by qualified and experienced counsellors.

Interviewing is an effective way of producing empirical data and can be used in several ways (Holstein & Gubrium 2004). The qualitative interview is topic centred, biographical and uses themes as a starting point for discussion. It is designed to have a fluid structure to enable the researcher and the interviewer to develop and uncover information that may lead to unexpected data (Mason 2002). Mason goes on to suggest that the qualitative interview is chosen if the knowledge and evidence that is needed to be extracted should be as contextual as possible and focus on the experiences and processes of each specific interviewee. The data that was explicitly required for this study could only be generated by extracting the stories and accounts by listening to the individual expressing themselves.

The semi-structured interview is a set of predetermined open-ended questions that allows the interviewer to delve into the social and personal experiences of the interviewee (DiCicco-Bloom & Crabtree 2006). The decision to have a semi-structured interview rests with the openness and flexibility of an interview. It relies on advanced preparation and the skill and intuition of the interviewer. The interviewer has to decide which will be more valid to the research, whether or not to follow the flow of the interviewee or to move onto the next question (Kvale1996). If the interview is non directional and unbiased it is hoped that the interviewee will respond with the facts and details of their experience. Mason (2002) agrees with Kvale (1996) that it is important for the interviewer to take their cue from the interviewee and to follow up the specific responses which are relevant to them and their context before going onto the next question. This would not be possible in a more structured format or in questionnaire form.

Two counsellors were briefed and trained by the principal investigator of the research before the interviews took place; each counsellor interviewed the same participants at each interview point. In the case of this study it was essential to train the interviewers not to stick to a rigid structure when administering the questions supplied and to apply prompts that would encourage the interviewee to expand on their responses. It was important to emphasise that the job of the interviewer was to anticipate the areas that were of interest to the research and to be able to explore them in detail when they arose in the interview (Mason 2002). As the interviewers were all trained therapists it fell to them to draw on their therapeutic experience to develop an atmosphere conducive to open and undistorted communication (Holstien & Gubrium 2004). The therapeutic training allows for intense listening, remembering to keep a balance between talking and listening, picking up verbal and non-verbal cues and mentally recording visual cues (Mason 2002). This training added a much needed dimension to the art of interviewing as the subjects were a hard to reach group.

In all interviews the image of the research plays a role in the understanding and validity of the information received (Holstien & Gubrium 2004). Therefore it is acknowledged that the interview process is invasive and it rests on the interviewer to be reflective and conscious of the differences that lie between the interviewer and the interviewee (DiCicco-Bloom & Crabtree 2006).

Holstein & Gubrium (2004) believe that there are two conventional approaches to interviews. The first is the rational question that looks for the facts and it focuses on the statements, explanations and the reasons for the interviewee's experience. The second approach is deeper and focuses more on the feelings of the interviewee. This study has used both approaches to gain the maximum information from the interviewee's experiences. To be able to fully understand the different aspects of the interviewee's experience the questions asked need to be facilitative or open ended questions in order to draw out the uniqueness of the personal information (McLeod 2001).

At this interview the overall research, confidentiality and rights of the individual were explained again and informed consent was taken (Appendix10). All the interviews and the group sessions were taped, transcribed verbatim and thematically analysed using NU*IST (Richards 2002). Permission was sought for the taping and transcribing at the initial interview. The standardised measures of the Clinical Outcomes in Routine Evaluation (CORE) (Mellor-Clark et al, 2001) and the Eating Disorder Inventory (EDI) (Garner 1991) were also completed. CORE was specifically designed for the psychological therapies. It assesses global distress and risk factors, so it can be used both as a screening tool and for evaluation. It is user friendly and easy to score and has also been extensively validated (Evans et al 2000). The EDI is a widely known questionnaire designed to measure the attitudes and psychological features of AN and BN. It has been argued that the EDI (Garner 1991) should be used more often in clinical work (Vanderlinden & Vandereycken 1997). Both the EDI and the CORE were self-report questionnaires which the participants filled in themselves at the different interview stages.

Following these preliminaries, a semi-structured interview (Appendix 11) was carried out. All the interviews were constructed around the themes that were used for the group sessions, and the interviews were developed to create an understanding of the participants' history. This included their family of origin, their illness, their present family, particularly their children and their lifestyle. The interview was also used to ascertain their behaviour and beliefs in regard to the themes. Other than the initial interview, interviews were carried out after the final group session (Appendix 13) then again at 6 months (Appendix 14) and 12 months (Appendix 14). For all the interviews the participants were given the choice of their home or the community centre and the crèche was offered every time.

3.10.6 Phone Calls

To enable the participants to gain the maximum benefit from the group, follow-up phone calls were arranged to start after the final group, to support the group members until the six month follow-up interview. The facilitator was to make the calls at a mutually designated time on a weekly basis. A limit of half an hour per call was adhered to. It was anticipated that this would help the participants with the ending and the letting go process.

3.10.7 Inclusion Criteria

The inclusion criteria for the group were as follows:

- Mothers with an ED who had children under the age of 13. This age for the children was chosen as it was posited that by the age of 13 the transgenerational dysfunction would have already been internalised.
- The mothers had to be diagnosed or recognised as having an ED by an appropriate health professional.
- The mothers had to be over 18.

3.10.8 Exclusion Criteria.

Participants were excluded from the group for the following reasons:

- Drug or alcohol problems
- Severe depression

- Major psychiatric disorder, e.g. schizophrenia, bi-polar disorder, severe personality disorder.

3.10.9 The Group.

The group ran for 19 weeks with 2 breaks of 1 week, each session was weekly for 1.5 hours. There were 3 sets, 1st set ran for 6 sessions, 2nd set ran for 6 sessions and the 3rd set ran for 7 sessions. The group sessions took place at a Community Centre and crèche facilities were offered at the Woman's Resource Centre a few doors away.

3.10.10 Therapeutic Approach

As an integrative psychotherapist, I incorporate different theoretical approaches within my clinical practice, therefore it seemed expedient to maintain this approach when conceptualising the delivery of the group. My initial training was in psychodynamic theory; these core beliefs and strategies will always be the underpinning of my understanding and approach to therapy. However, during my years in practice I have studied the benefits of other modalities and have seen the advantages of incorporating them into my therapeutic delivery. Being cognisant of the wide spectrum of society that ED sufferers come from and that one modality could not possibly fit all and given the difficulties of engaging with ED sufferers and maintaining that engagement, the significance of offering them the 'right fit' seemed vital. The importance of maintaining their commitment to therapy was paramount for the continuation of the group, therefore the mix of therapeutic approaches was considered carefully. The psychodynamic approach was relevant for understanding the psychological development of the individual and gaining a perception of the foundations of their relationships (Jacobs 1996). Self psychology is closely linked to psychoanalytic/psychodynamic theory but focuses on the restoration of the damaged self by using the empathic therapist/client relationship (Siegel 1996). These two approaches both incorporate attachment theory into their theoretical foundations. Cognitive therapy attempts to alter the dysfunctional and distorted ideation associated with the illness and addresses how these distorted ideas affect behaviour (Beck et al 1979). All these theoretical approaches deal with awareness, understanding and change, therefore were recognised as a suitable fit for the delivery of the group. The protocol of the group was then finalised and a semi-structured format, using a psycho-educational and psychotherapeutic format was delivered, incorporating self-psychological (Kohut, H. 1985, Goodsitt 1997), psychodynamic (Herzog 1995, Jacobs 1996) and cognitive therapy (Beck et al 1979, Garner et al,1997) approaches.

3.10.11 Protocol of the group sessions

Each session was allocated a theme which was developed from the previous pilot study (Barnett 2000, Barnett et al 2006) and the research literature. Some themes extended into two sessions, some themes were re-visited and some sessions were left blank to discuss the effects that the group was having on the participants. On two occasions when only one participant attended they were each given a single session to discuss the groups content and its effects. Each session commenced with either an exercise or a video; some exercises included art therapy (Dokter 1995). After each exercise or video the session was then opened out to allow the participants to explore their responses. The group was a closed group to encourage the members to feel safe with one another (Wanlass et al 2005, Reiss 1992).

The protocol of the group was developed prior to the commencement of the group although adapted during its lifetime. The adaptation took into account circumstance and attendance. The relationship to the research and the research methods needed to remain flexible throughout, responding to the different developments in the way therapy responds to changes in the demands of the client (Higgins 1996).

A group manual has been designed from this study, that can be used by a psychologically trained health professional to run similar groups (please see Appendix 20).

Chapter 4

4.0 Quantitative Results

4.1 Interpretation of Data

The data collected from the quantative studies is hard to interpret given the small number of completers in the study. The rationale for using multiple sources of data is to minimise the researcher bias that often accompanies case study research. Had the original eight participants in this project all continued, the statistical data might have been more reliable, but a sample of only four participants and only three with complete data, presents anomalies that reduce the value of the results. However in the results that follow, an attempt has been made to derive some benefit from the statistical data that was available, continuing to be aware of its limited validity.

The statistical data was collected from the Eating Disorder Inventory (EDI) (Garner 1991) and Clinical Outcomes in Routine Evaluation
(CORE) (Mellor-Clark et al, 2001). Both the EDI and CORE are self report questionnaires and as such rely on the honesty and reliability of the person completing them at the time.

The EDI consists of 64 items in a multiscale measure designed for the assessment of psychological and behavioural traits common in EDs. It consists of eight subscales:

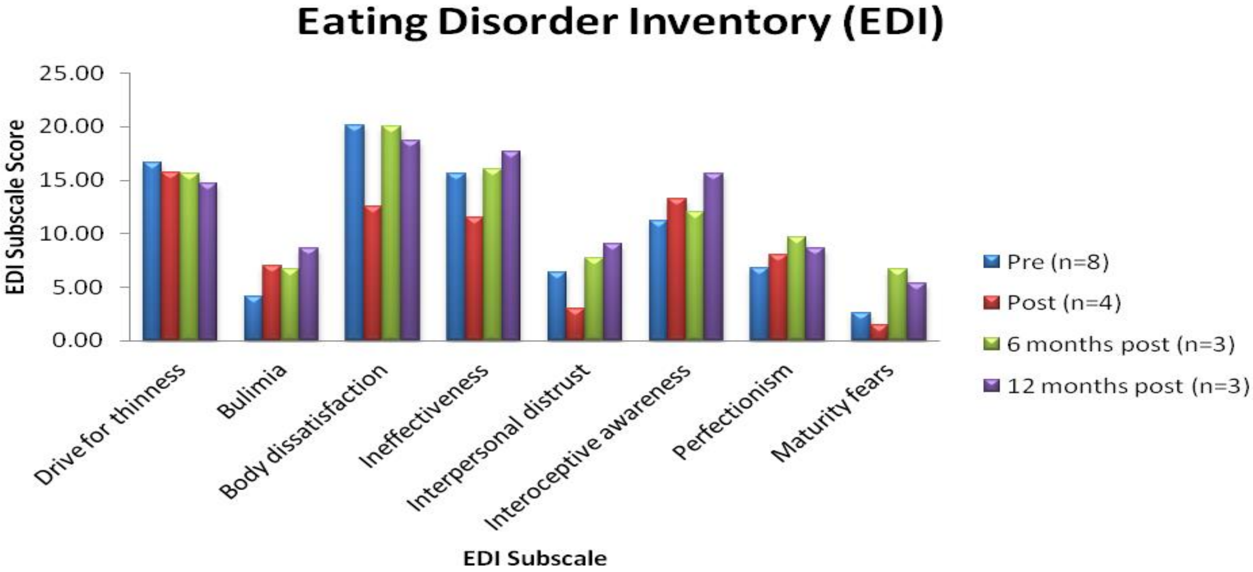
1. Drive for thinness, an extreme preoccupation with dieting and a morbid fear of weight gain.

2. Bulimia, frequent incidents of binge eating and then purging by vomiting or laxative abuse.
3. Body dissatisfaction, a negatively distorted view of the body.
4. Ineffectiveness, feelings of inadequacy, insecurity, worthlessness and lack of control over life.
5. Perfectionism, having to be perfect in all aspects.
6. Interpersonal distrust, an inability to form close relationships through low self esteem.
7. Interoceptive awareness, the ability to be self aware and to be able to discriminate between sensations and feelings.
8. Maturity fears, the fear of facing adult life.

Each subscale ranges over 6 points from ‘always’ to ‘never’ (Garner 1991).

When looking at the overall EDI results and taking each subscale separately, they correspond in general to the qualitative data but have significant anomalies. Drive for thinness shows a steady decrease and corresponds to the qualitative data whereas Bulimia shows an increase after the group which is then maintained at 6 months only to rise quite considerably at 12 months. An explanation for this could be the detrimental life events that took place at that time. Body dissatisfaction shows a marked improvement at the end of the group which then rises at 6 months with a further decrease at 12 months. There seems to be a miss match with the bulimia results and the drive for thinness and body dissatisfaction, as it is arguable that the three categories are closely linked and should present a similar pattern. It is interesting to note that interpersonal distrust fell significantly after the group ended, then increased dramatically at 6 and 12 months. This shows us that the group had a positive effect on the participants but they were unable to sustain this after the group finished. Interoceptive awareness and perfectionism were the only two subscales that showed an increase after the group, which again does not correspond with the qualitative data. The participants state clearly that they had a greater understanding of themselves and were able to let go of some of their more perfectionist behaviour. Maturity fears show a marked increase at 6 months and this is also likely to be connected to their life events.

4.2 E.D.I. Graph



The graph and table above show the results of the EDI at the pre (n=8), post (n=4), 6 month (n=3) and 12 month (n=3) interviews.

4.3 Eating Disorder Inventory Table

Table 1. Means and standard deviations for EDI subscale scores for all four time points (pre, post, 6 month post, 12 month post).

EDI Subscale	***Mean before intervention (SD) n=8***	***Mean after intervention (SD) n=4***	***Mean 6 months after intervention (SD) n=3***	***Mean 12 months after intervention (SD) n=3***
Drive for thinness	16.63 (4.93)	15.75 (9.25)	15.67 (10.97)	14.67 (11.93)
Bulimia	4.13 (3.04)	7.00 (9.70)	6.67 (8.33)	8.67 (10.97)
Body dissatisfaction	20.13 (8.08)	12.50 (7.68)	20.00 (9.64)	18.67 (9.24)
Ineffectiveness	15.63 (7.29)	11.50 (8.35)	16.00 (14.53)	17.67 (15.70)
Interpersonal distrust	6.38 (5.24)	3.00 (5.35)	7.67 (10.02)	9.00 (10.82)
Interoceptive awareness	11.25 (6.41)	13.25 (10.40)	12.00 (9.64)	15.67 (13.65)
Perfectionism	6.75 (5.63)	8.00 (7.07)	9.67 (8.08)	8.67 (7.57)
Maturity fears	2.63 (2.77)	1.50 (1.91)	6.67 (4.73)	5.33 (4.62)

4.4 The Clinical Outcomes in Routine Evaluation (CORE)

The CORE measurement was developed to obtain an outcome benchmark for psychological therapies. It was designed to be suitable for a wide variety of services and includes the measurement of risk and global distress. As such it can also be used as a screening tool. The CORE is made up out of 34 items measuring 4 dimensions:

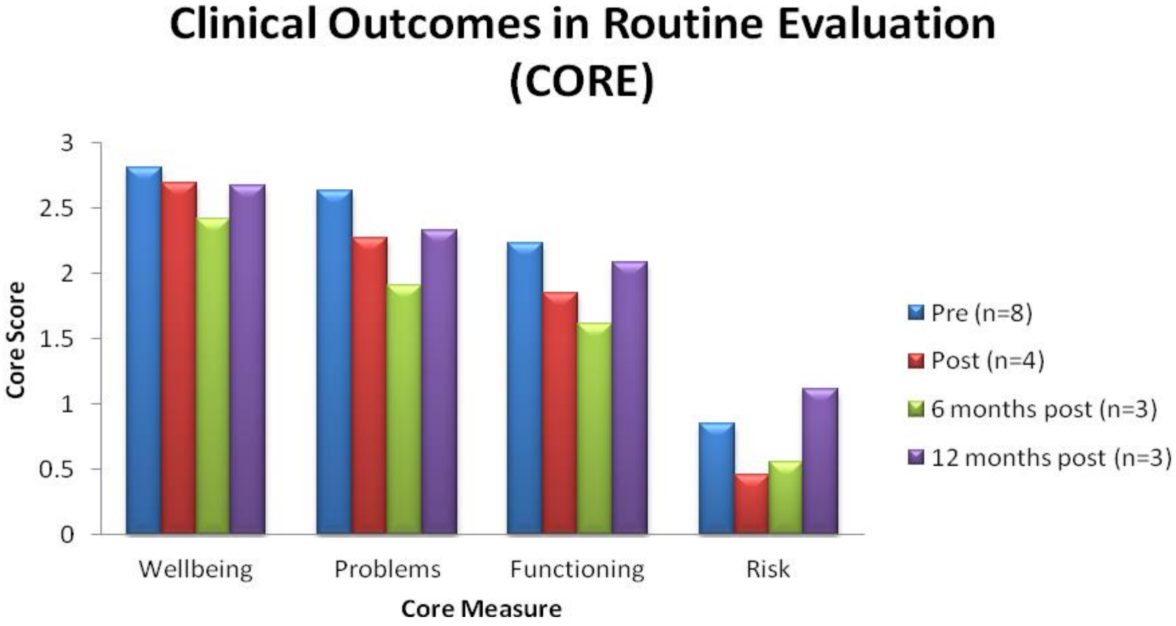
1. Subjective well-being.
2. Problems/symptoms.
3. Life functioning.
4. Risk/harm.

(CORE Systems User Manual 1998)

Taking the CORE measurement of Risk, the benefits of the group can be clearly assessed. The slight rise at 6 month and the significant rise at 12 month undoubtedly correspond to the qualitative data and highlight the major life events happening to the participants. However Wellbeing and Functioning seem to be at odds with Risk, the expectation would be that if Risk goes down, the Wellbeing and Functioning would increase and this is clearly not the case with these measurements. Problems seem to correspond with the qualitative data indicating the benefit of the group.

4.5 C.O.R.E. Graph

The following graphs and tables measure the results of the CORE evaluation at pre (n=8), post (n=4), 6 months (n=3) and 12months (n=3) interviews.



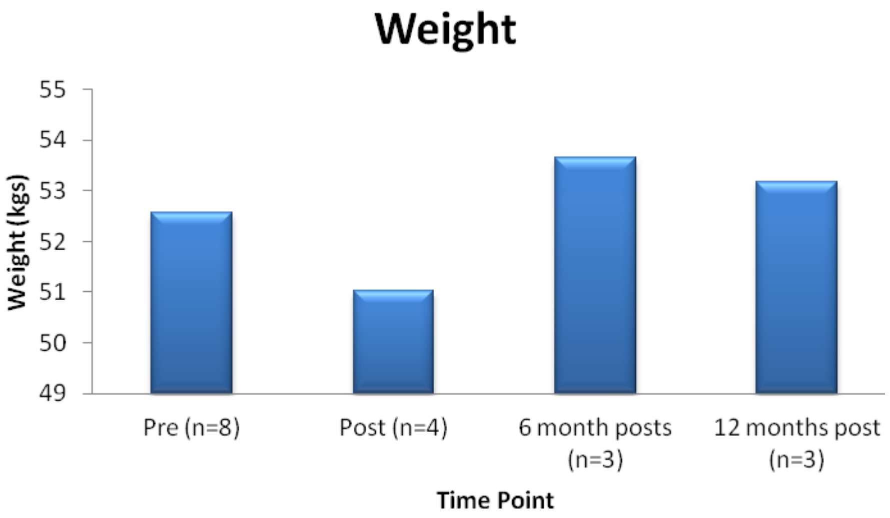
4.6 Clinical Outcomes in Routine Evaluation Table

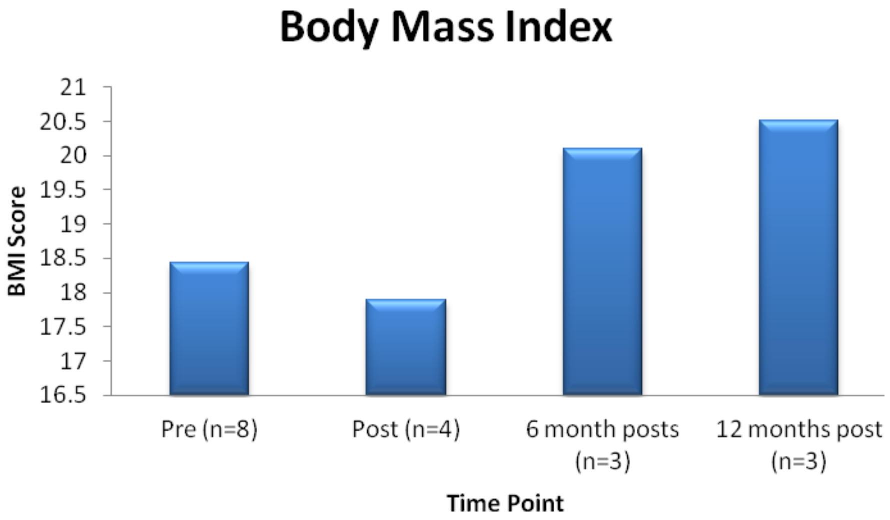
Table 2. Means and standard deviations for CORE scores for all four time points (pre, post, 6 month post, 12 month post).

CORE Measure	*Mean before intervention (SD) n=8*	*Mean after intervention (SD) n=4*	*Mean 6 months after intervention (SD) n=3*	*Mean 12 months after intervention (SD) n=3*
Wellbeing	2.81 (0.82)	2.69 (0.63)	2.42 (0.88)	2.67 (1.89)
Problems	2.63 (0.76)	2.27 (0.57)	1.91 (1.17)	2.33 (1.81)
Functioning	2.23 (0.57)	1.85 (0.43)	1.61 (1.07)	2.08 (1.59)
Risk	0.85 (0.75)	0.46 (0.31)	0.55 (0.69)	1.11 (1.02)

The weight and BMI were encouraging and seem to match the qualitative results. Although the weight went down after the group, there seemed to be an improvement which the participants who concluded were able to maintain at the 12 month follow up.

4.7 Weight and Body Mass Index (BMI)



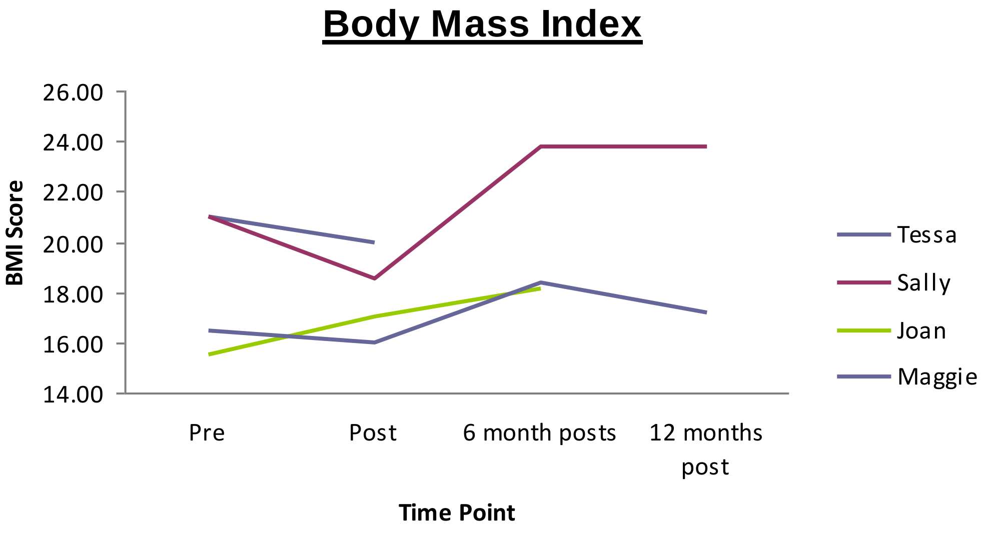


4.8 Table 3. Means and standard deviations for weight (kgs) and BMI for all four time points (pre, post, 6 month post, 12 month post).

Health Measure	***Mean before intervention (SD) n=8***	***Mean after intervention (SD) n=4***	***Mean 6 months after intervention (SD) n=3***	***Mean 12 months after intervention (SD) n=2***
Weight (kgs)	52.56 (9.79)	51.02 (9.52)	53.64 (3.28)	53.18 (5.78)
BMI	18.44 (3.21)	17.88 (1.75)	20.10 (3.21)	20.50 (4.67)

The statistical information was unfortunately bound by one moment in time when the participants filled in the questionnaires. This is the case for the missing data in the graph and table below. Joan did not fill in her BMI in the last questionnaire and this was not picked up at the time. Tessa was unable to complete any information for the 6 and 12 month questionnaire due to her diagnosis of EDS. As the numbers were small anyway this leaves us with a considerable gap in the results, although the remaining data does show a small but steady increase in the participants BMI.

4.9



4.10 Time Point Table

Patient	Pre	Post	6m post	12m post
Tessa	21.00	20.00		
Sally	21.00	18.50	23.80	23.80
Joan	15.50	17.00	18.10	
Maggie	16.50	16.00	18.40	17.20

The intention behind the statistical measures was to provide an alternative method of evidence charting the progress of the participants, from that provided by the narrative analysis. The narrative data provided an in-depth account of the participants experience of the group intervention. Since the inception of the intervention and the assessment of its validity and usefulness by the participants, the narrative data has been extremely useful and gave a sensitive and introspective account of the participant’s lives. It was anticipated that the statistical data would provide a parallel account of the participants progress but this has not always been the case. The quantative data represents an inconsistent match to the qualitative data giving food for thought for future research. A possible explanation for this miss match is the participant's difficult life events after the completion of the group but at a time when the follow up measurements were taken.

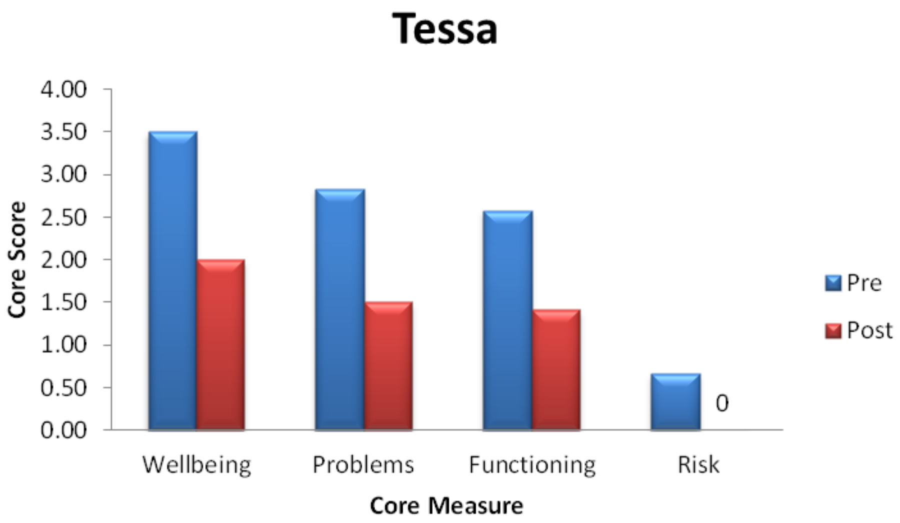
The progress made by the four completers will now be reviewed, comparing the qualitative and the quantative data.

4.11 Tessa

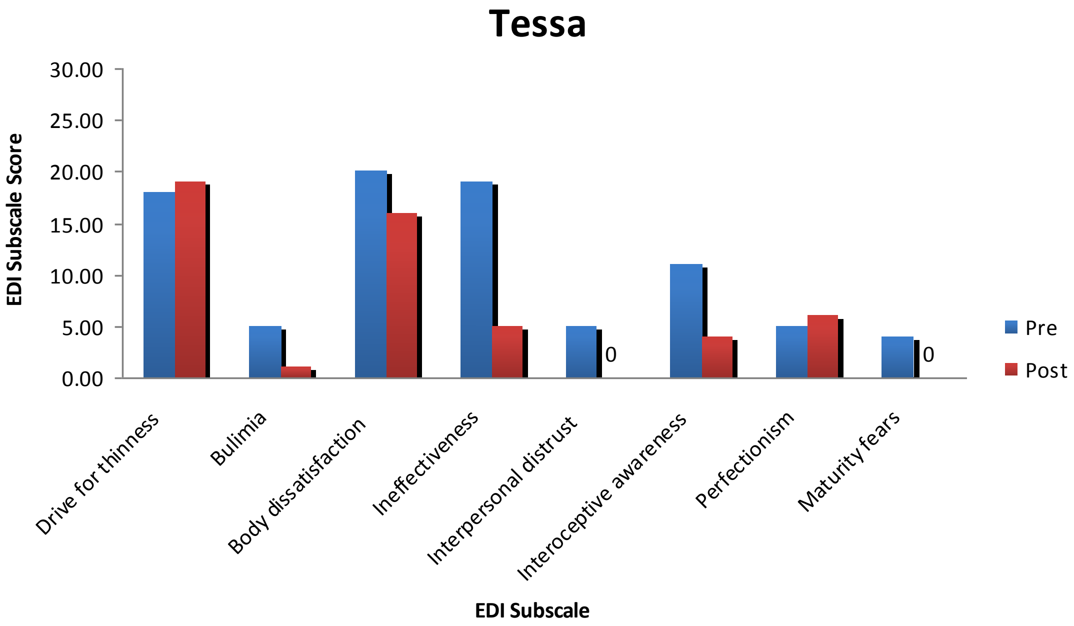
Tessa was unable to complete her 6 and 12 month follow up because after the group ended, she had a confirmed diagnosis of Ehlers-Danlos Syndrome (please see http://www.ehlers-danlos.org), and she felt she could no longer participate in the research. Tessa suffered from co-morbid depression, for which she was on medication and attended the group with opposition from her husband, which created a considerable amount of anxiety. The analysis of the qualitative data that was available, suggested that during the group intervention Tessa gained an insight into the effect that her relationship with her mother had on her ED. She was also able to acknowledge that her children had imitated some of her behaviour around food and body image (please see Findings Chapter 6).

Using the data that was derived from the EDI, Tessa showed improvement in 5 of the 6 scales for which the data is available. Her BMI data which was only available pre and post intervention, shows a minor change from 21-20 which however remains within the healthy range. Tessa's CORE data was less encouraging in that Wellbeing and Functioning decreased, but this might have been due to her problems regarding her Ehlers-Danlos Syndrome. It was however interesting to note that her Problems reduced considerably and Risk reduced to nil at post group.

4.11.1


Tessa
4.00
3.50
3.00
2.50
2.00
1.50
1.00
0.50
0.00
Core Score
0
Wellbeing
Problems
Functioning
Risk
Core Measure
Pre
Post

4.11.2

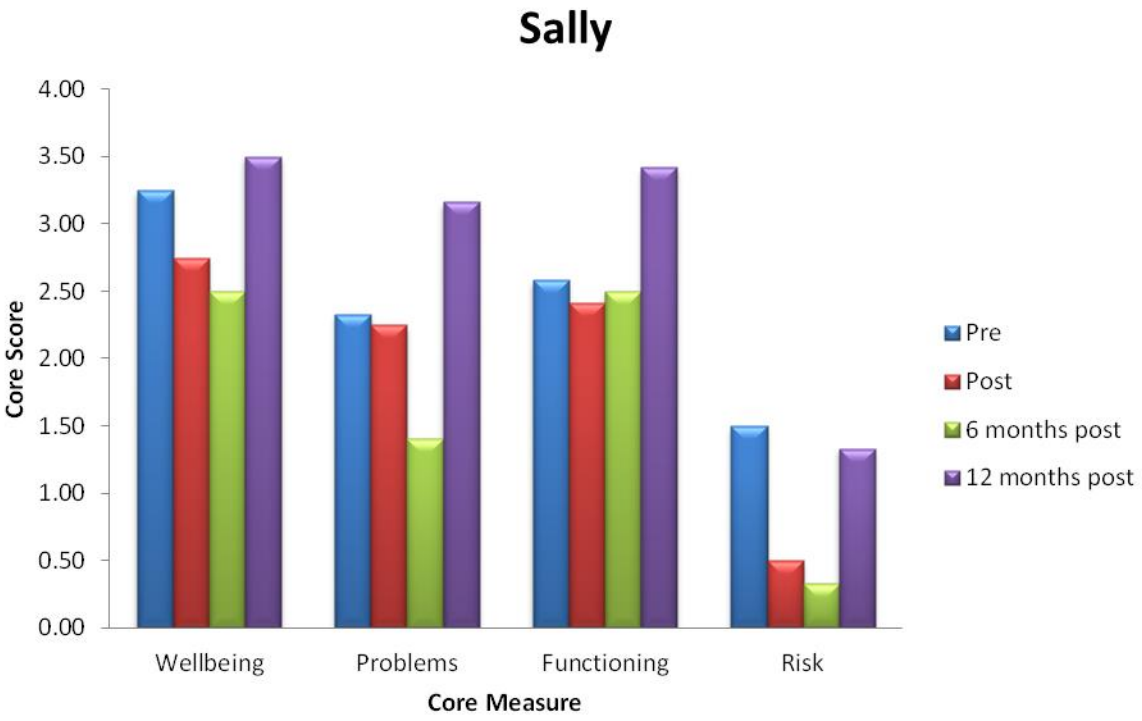

Tessa
30.00
25.00
20.00
15.00
10.00
5.00
0.00
EDI Subscale Score
0
0
Drive for thinness
Bulimia
Body dissatisfaction
Ineffectiveness
Interpersonal distrust
Interoceptive awareness
Perfectionism
Maturity fears
EDI Subscale
Pre
Post

4.12 Sally

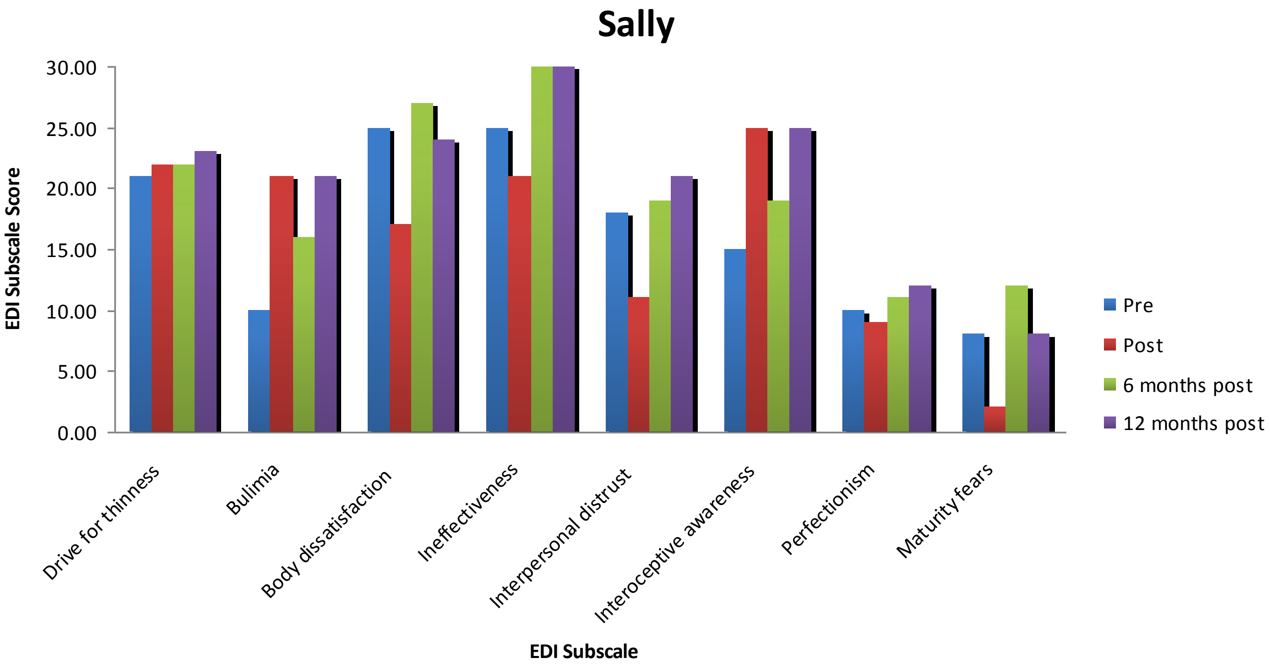
The qualitative data in Sally's case showed marked improvement in her relationship with her daughter, which was at grave danger at the commencement of the group. Sally's co-morbidity was depression and self-harm; she had been abused as a child by an uncle. At the completion of the group Sally had stopped self-harming and had not relapsed by the 12 month follow up. She was able to relate to the group members in a more positive way providing her with a constructive model for relating outside the group. Although her mother died before the 12 month follow up she was still able to recognise the benefits the group had given her (please see Findings Chapter 6).

The data derived from the EDI indicates a less positive picture in that 6 out of the 8 scales show a worsening of her scores and in the remaining 2 there was minor improvement. The EDI however, measures different aspects of the pathology from that revealed by the qualitative data, so there is not necessarily a contradiction in these results. In addition Sally's BMI had declined during the intervention, but by the 6 and 12 month post intervention she had reached a more stable and healthier weight. The data from Sally's CORE measurements showed a decrease in Wellbeing at post and 6 month, a decrease in Functioning at post but a small increase at 6 months, but these 2 scales showed a marked improvement at 12 month, which is surprising as this is when Sally's mother had died. Her Risk and Problems on the other hand went down at post and 6 month and increased at 12 month. The CORE scores corresponded more accurately to the qualitative data.

4.12.1


Sally
Core Score
4.00
3.50
3.00
2.50
2.00
1.50
1.00
0.50
0.00
Wellbeing
Problems
Functioning
Risk
Core Measure
Pre
Post
6 months post
12 months post

4.12.2

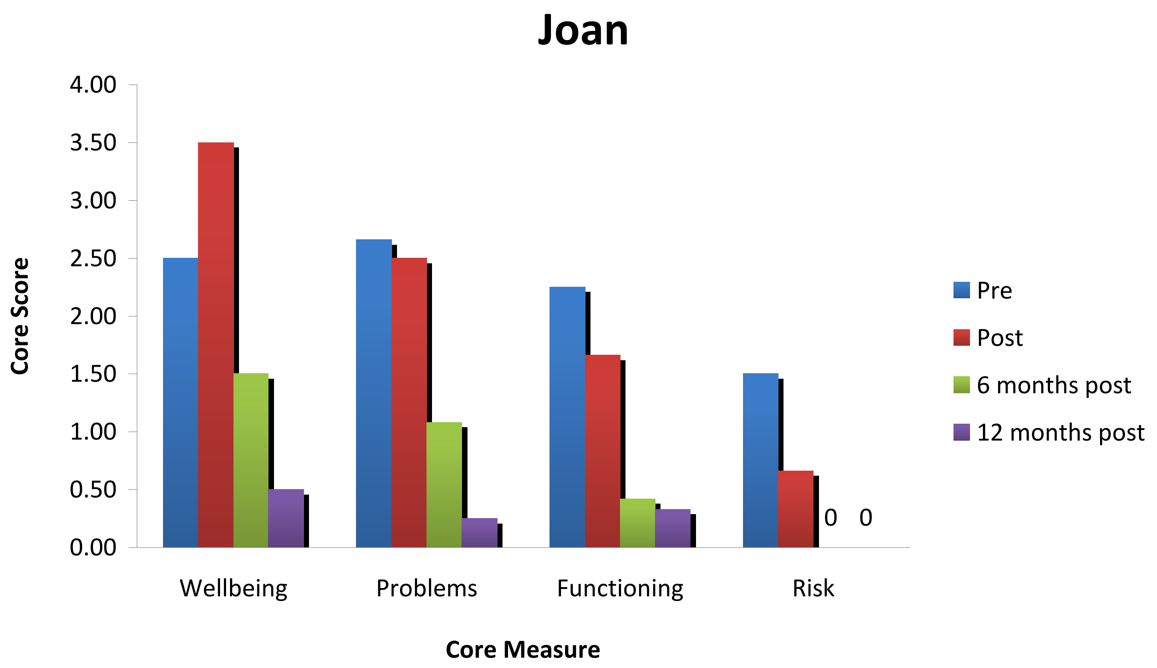

Sally
EDI Subscale Score
30.00
25.00
20.00
15.00
10.00
5.00
0.00
Drive for thinness
Bulimia
Body dissatisfaction
Ineffectiveness
Interpersonal distrust
Interoceptive awareness
Perfectionism
Maturity fears
EDI Subscale
Pre
Post
6 months post
12 months post

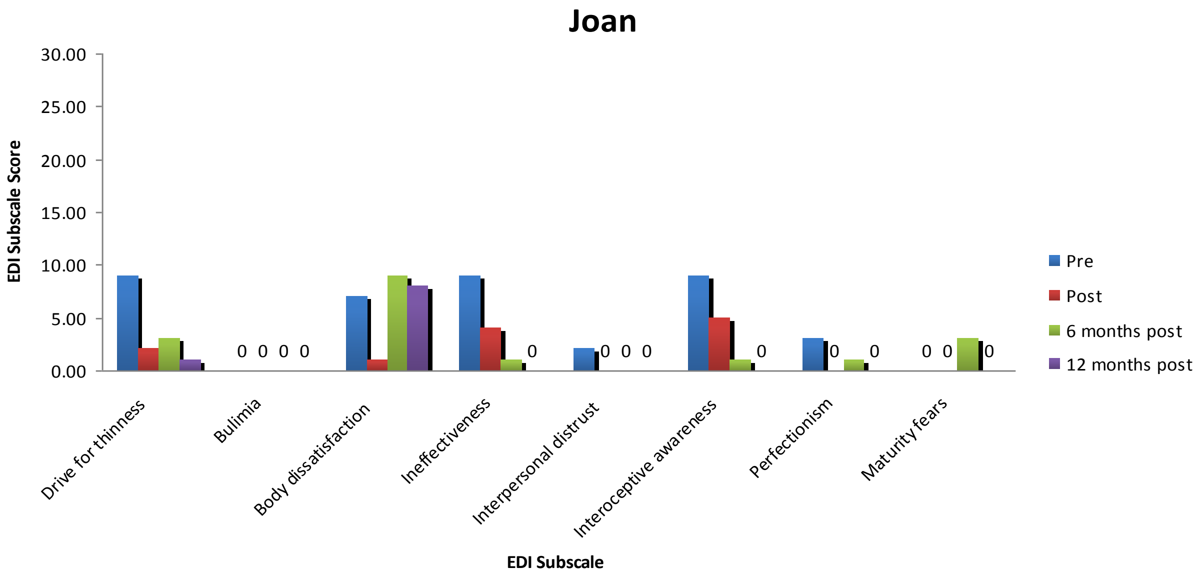
4.13 Joan

The qualitative data shows that Joan had made a marked improvement while attending the group and seemed able to sustain these improvements at post, 6 and 12 month follow up. She had increased her weight, was managing to eat with her family on a more regular basis and had stopped self- harming. Her relationship with her children was much improved and her understanding of the causes and maintenance of her ED had increased considerably. By the 12 month follow up she had resumed full time work and was maintaining her improvement (please see Findings Chapter 6).

The statistical data arrived at in relation to the EDI, shows that she is by far the least disturbed and pathological of the participants. Of the 5 scales for which there is continuing data, 4 show great improvement. The scale that does not improve, that of body dissatisfaction contradicts the qualitative data and her BMI scores. Joan's BMI was 15.5 when the intervention began and at 6 month follow up had reached a far healthier level at 18.1.This corresponds to the qualitative data but is not compatible with the statistical results. The missing data for the 12 month follow up for Joan was because she did not complete the 'present weight' section of the questionnaire.

The CORE on the other hand produced mixed results that contradict the qualitative data on the Functioning scale, which falls continuously up to the 12 month follow up. Wellbeing rises considerably at post intervention, but drops down at 6 month and then again at 12 month. Problems take a continuous downwards path falling considerable at 12 month and Risk becomes nil at 6 and 12 months which is more in line with the qualitative data. The only explanation for the inconsistencies in the data is that Joan had serious problems that did not relate to the group, which she was having to deal with. These problems might have had a bearing on the way she filled out the questionnaires and no bearing on anything relating to the group.


Joan
4.00
3.50
3.00
2.50
2.00
1.50
1.00
0.50
0.00
Core Score
0
0
Wellbeing
Problems
Functioning
Risk
Core Measure
Pre
Post
6 months post
12 months post


Joan
30.00
25.00
20.00
15.00
10.00
5.00
0.00
EDI Subscale Score
0 0 0 0
0
0 0 0
0
0
0
0 0
0
Drive for thinness
Bulimia
Body dissatisfaction
Ineffectiveness
Interpersonal distrust
Interoceptive awareness
Perfectionism
Maturity fears
EDI Subscale
Pre
Post
6 months post
12 months post

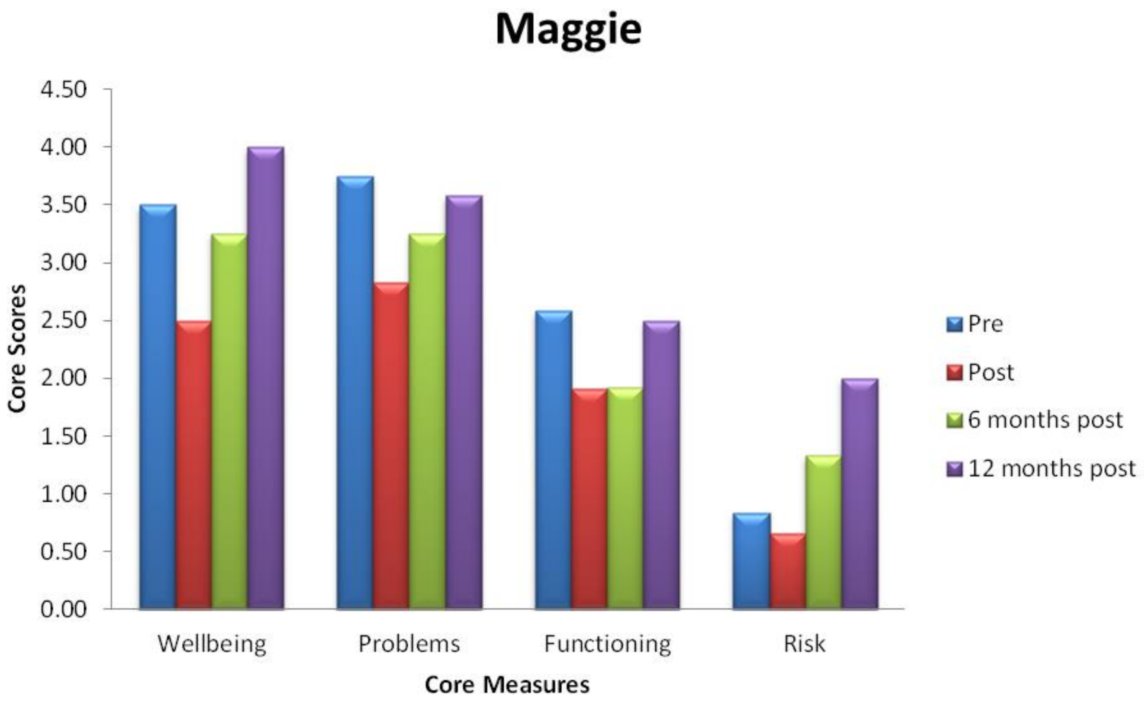
4.14 Maggie

Maggie’s qualitative data showed that she had made remarkable progress in her sense of self. She became more assertive and was able to enter into part time employment. She was able to participate in family activities and understood her dysfunctional mother/daughter relationship. She recognised the transgenerational links of an ED and she identified the dysfunctional behaviour around food and body image that her grandmother and mother presented. She was also able to acknowledge that her children were modelling and displaying the dysfunctional behaviour she was engaged in because of her ED. At 12 month follow up, Maggie was trying to adjust to several life changing events and acknowledged that her eating behaviour and bulimic symptoms had not improved (please see Findings Chapter 6).

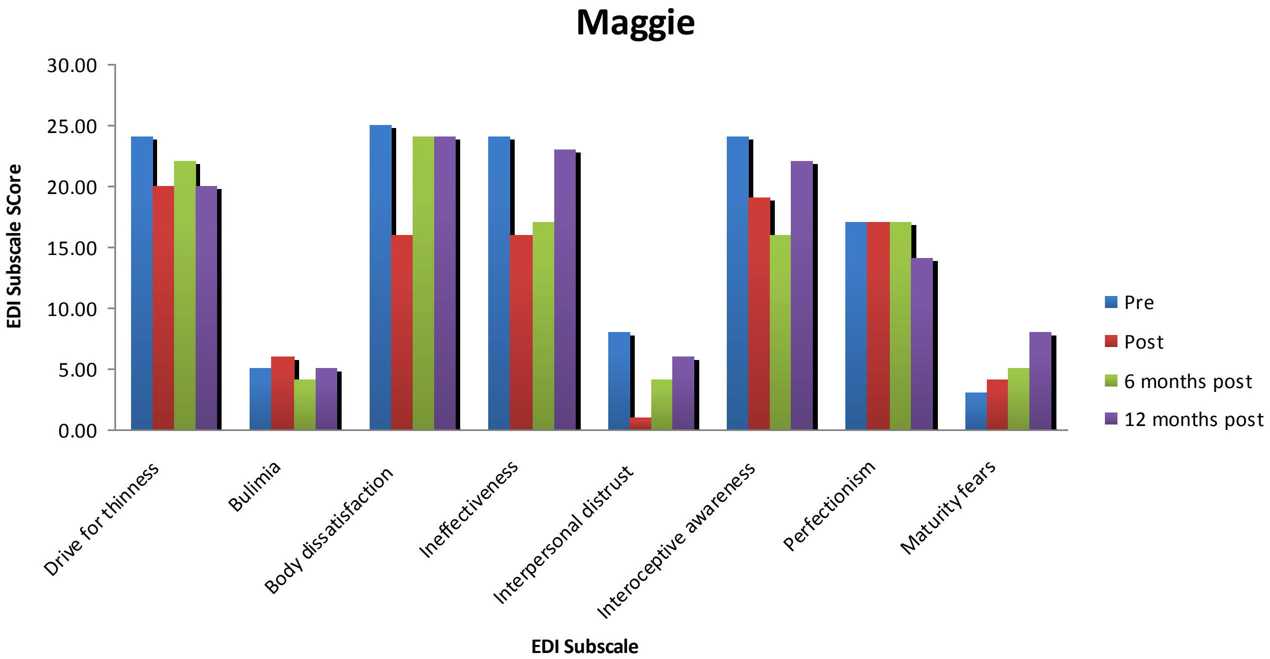
From the EDI, Maggie demonstrated an improvement on 6 out of the 8 scales. On 1 scale there was no change and on 1 there was deterioration. In this case the qualitative data which proved that her bulimic symptoms were virtually unchanged supported the quantative data. In terms of BMI, she similarly shows little or no change and is the only one of the four that at 12 month follow up was still within the anorexic range. In the CORE data it shows that her Wellbeing scores went down at post intervention but rose considerably at 6 month and again at 12 month, a similar result is found in the Functioning. It is hard to correlate these 2 scores with that of the qualitative data. However her Problem score went down at post intervention but rose again at 6 and 12 month, finishing just below her starting score. Her Risk score showed a drop at post intervention and a considerable rise up to the 12 month follow up.

These 2 scores seems to match the qualitative data.

4.14.1


Maggie
4.50
4.00
3.50
3.00
2.50
2.00
1.50
1.00
0.50
0.00
Core Scores
Wellbeing
Problems
Functioning
Risk
Core Measures
Pre
Post
6 months post
12 months post

4.14.2


Maggie
30.00
25.00
20.00
15.00
10.00
5.00
0.00
EDI Subscale SCore
Drive for thinness
Bulimia
Body dissatisfaction
Ineffectiveness
Interpersonal distrust
Interoceptive awareness
Perfectionism
Maturity fears
EDI Subscale
Pre
Post
6 months post
12 months post

Chapter 5

5.0 Findings (Interviews)

5.1 The Research Group

As described before the group started with eight mothers (All the names have been changed for confidentiality). All were white British aged between 24 years and 44 years (mean 33.5 years). Their BMI ranged from 15 to 22.5 (mean 18.4). The age onset of their ED ranged between 13 years and 18 years (mean 15.75 years) making the average duration of the ED 17.75 years. The total number of children was 15, 10 girls and 5 boys, ranging in age from 1 month to 12 years (mean 7.75 years).

5.2 The Drop Outs

There were four participants that dropped out of the group. Linda was the eldest of the group at 44. She was divorced and lived with her two children, both girls, of 11 and 13 years of age. Her younger child was diagnosed anorexic. Linda had an older brother and a younger sister and both parents were alive. The age onset of her ED was 17, so she had been suffering from an ED for 27 years. At the time of the group her BMI was 22.5. She had been referred by the ED clinic of her local hospital, which she had been attending. Throughout her life she had been very ambivalent about treatment and had sought help in a variety of different ED centres but had dropped out of all the treatment she was given for various reasons. Although she sought treatment, she kept her ED and her daughter's ED secret from friends and family. Her eating was very irregular, she vomited, took laxatives and anti-depressants.

The relationship with her mother had always been strained and she did not get on with her father or her siblings. Linda never remembered being cuddled resulting in feelings of not being ‘good enough’. There was enormous dysfunction with food in her nuclear family. Food was used as a bribe and a punishment and her mother was always on diets. In her family today, her older daughter is a ‘finicky’ eater and her younger was diagnosed with anorexia a year ago. Mealtimes were difficult as they would each only eat certain foods and all ate at different times although Linda tried to make a family meal at Sunday lunch. Her ex husband was very weight conscious and encouraged the children to be excessively active in sports. Achieving her own independence had been a problem for Linda and resulted in arguments with her parents. Having gone through this experience, Linda was conscious of allowing age appropriate independence for her children. Making friends and fitting in was a problem for her, which resulted in a feeling of isolation. She found it very difficult to help her daughter because she was still in the throes of her own ED and felt overwhelmed by her problems, but she felt that there was no adequate treatment available and would have been an ideal candidate for the group. She did not attend the first session but came to the next two sessions and then made excuses of work commitments and child care. She was contacted by phone and e-mail several times and after each contact promised to come to the next session but never did. She eventually sent an e-mail to say she was unable to attend.

Jenny was 30 and lived with her partner who was 22 and one child, a little girl of three months. She had a twin brother and a younger sister. The duration of her ED was 15 years with age onset of 15 and her BMI was 15. She was referred by the doctor of the specialist ED unit of a mainstream hospital where she had previously been an inpatient. Before she had become pregnant she was vomiting regularly and taking a packet of laxatives a day. She did not know she was pregnant until she was 13 weeks as she was taking the contraceptive pill. She was 7 stone at 13 weeks. When she found out she was pregnant she stopped taking laxatives and vomiting, but since she had the baby her weight had dropped considerably again. Her baby was considered to be undernourished and she was told to stop breast feeding, as she was not eating enough to make enough milk. She felt that she was a terrible mother and that her baby hated her. Feeding time for her was a ‘nightmare’ and she hated it. When she fed her baby, the baby screamed and brought it back; when father fed her, she was quiet. Jenny hated anything to do with food and left what she could to her partner. Her partner tended to take over everything when he was home, which she translated as her not being capable. Her sister had a baby 3 weeks after Jenny and her mother kept comparing them, which also undermined her confidence. When she was pregnant she wanted a boy, because she feared that a girl would ‘be like me’. During the interview, when asked her opinion, she always referred to her partner’s views. She had no friends and relied totally on her partner. She felt her mother smothered her, which she thought affected her relationship with her siblings. Jenny had no self confidence and was very anxious about starting the group. She found it very difficult to connect to the discussions about children as her child was still a baby; also her partner was not supportive of the group and she was very frightened of losing him. She attended sessions one and two, missed session

3 came to session 4 and 5 then dropped out. She was also contacted by phone and e-mail but did not respond.

Mel was 27, married with one daughter of two and a half. She was the middle child and had an older brother and a younger sister. Her ED started at the age of 18 when she went to University and she had been suffering for 10 years, her BMI was 15. She had been referred by a health professional of a local ED charity. She had become greatly attached to this health professional to the exclusion of anyone else. During the initial interview she gave monosyllabic answers and was very difficult to engage with. When asked if anyone else in the family had a weight problem she said ‘Yes’, but would not be drawn. She was very reclusive and found it very difficult to communicate with anyone. She answered ‘Yes’ when asked if she was taking antidepressants and if she used laxatives or diuretics. Mel hated her body and had to be tube fed when she was pregnant. When her child was a baby she had no idea if she was hungry or not but kept her on a ‘tight feeding schedule’. At the time of interview Mel had her child on a strict diet and got anxious if she didn’t eat what she should and got cross if she wanted more. She felt that her child was fat. During the initial meeting, before the initial interview, she told me that she watered down her daughter’s milk and allowed her one Smartie a day, so the child would not get fat. Mel felt that as a child she had been very reliant on her mother who ‘took over’, and was not able to make her own choices. She said she had always had a problem with her weight but had started vomiting when she went to University. She was very fearful of the authorities taking her child from her and felt anything she said would incriminate her. She remained completely silent for the duration of every group she attended, even though she was encouraged to participate by the group and the facilitator. Mel continued to attend without participating in any of the exercises or discussions for four sessions. She then did not return and did not reply to any phone messages.

Sue was the only participant to be referred to the group by her GP. She was the youngest of the group at 24 and lived with her partner, her father of 79 and her one month old baby girl. Her father had 5 children from his first marriage and she was the only child from his second marriage; her parents were quite old when they had her. Sue had suffered from an ED for 10 years with age onset at 14, her BMI was 21. Her mother had died from anorexia when she was 11 after developing it soon after Sue was born. Sue's mother was in and out of hospital and she only remembered her mother as 'a woman in a room' not as her mother. Sue says her father did everything for her and she was spoiled by her siblings. She always felt that her mother's illness was her fault. Sue had been raped when she was 13 and that was the trigger for her ED. At 15 she was taken to an in-patient unit but ran away and threatened to commit suicide if she was sent back. She was then taken round a high dependency psychiatric ward to frighten her before she was admitted to another in- patient unit. This unit gave her the responsibility to eat which she responded to and she was there for approximately 6 months. After she had her baby she went from 11 stone to 8 and a half stone in five weeks. Sue remembered her mother's dysfunctional eating habits and was very aware of her own and therefore did not want her daughter continue the cycle. She recognised that although her baby was only 4 weeks old she was very 'clingy to her’, she never remembers being close to her mother. Sue felt good when she was pregnant and felt ‘empty’ after she had given birth which made her feel depressed. During the sessions she attended Sue also found it difficult to absorb discussions about children as she was a first time mother with such a young baby. Just before she had the baby her father had been ill and when the group started she was finding it very difficult looking after her father and a new baby. Her partner was young and not much help. Sue attended four sessions before she dropped out and would not answer any phone messages or letters.

All the people who referred the drop outs were contacted to inform them that the people that they had referred had dropped out and they were asked to intervene if possible.

5.3 The Findings

The findings in this chapter will be of the four participants who attended the group from commencement to conclusion and completed the follow-up interviews. This includes Tessa who was unable to complete the 6 and 12 month follow-up interviews due to being diagnosed with Ehlers-Danlos Syndrome (please see history). These four mothers were at various stages of their ED with co-morbidity of depression and anxiety which was being controlled by drugs. Together with their ED there was a history of self-harm and laxative abuse. The transcripts of these interviews were analysed thematically from themes that were identified from the literature search and the pilot study (Barnett et al 2000). This has been discussed more thoroughly in the methods chapter.

The end of group interviews were carried out within 2 weeks of the final session of the group. This interview as well as the 6 and 12 month follow up interviews were carried out by a qualified counsellor who was not the group facilitator. The main purpose of the end of group and the 6 and 12 interviews, was to ascertain the participants' experience of the group and whether they had received any benefits from attending it. All the interviews were conducted individually and analysed in the same manner as the initial interview. The participants were again asked to complete the EDI and the CORE for statistical evaluation of change. The end and follow-up interviews had identical questions to the initial interview in order to evaluate the participants' perception of any change that had occurred. The only addition from the initial interview was to ask whether any change had occurred and if this was due to the group.

5.4 "Tessa"

These findings are derived from the initial and end of group interviews.

5.4.1 Personal Details, ED and Medical History

Tessa was 34 and lived with her second husband and four children. Two boys aged twelve and nine by her first husband, a girl aged four and a boy aged 19 months by her second husband. She is the middle child of her original family and has an elder sister and a younger brother whom she sees but is not close to. Both her parents are living. She had an ED since she was 13 and was on Prozac for depression. Tessa was severely ill as a child and suffered major dislocations of her shoulders, hips and knees. Before the commencement of the group she had her gall bladder removed. Just before the six month follow up interview, Tessa and her youngest son were diagnosed with Ehlers-Danlos Syndrome (http://www.ehlers-danlos.org) and she was unable to complete the six month or the twelve month follow up interviews.

5.4.2 Suitability for the Group

When Tessa was approached to join the group she did not think she was a suitable candidate, as she felt it was for anorexics and she felt that she suffered from bulimia. When the group was explained in more detail she agreed to participate. She decided to attend the group not for herself but to help her children avoid the transgenerational effect of her ED.

"I thought I'd give it a try 'cos I'd do anything for the kids."

Even though Tessa saw a psychologist once a week and had a CPN attached to her she felt there was not enough support available. She was referred to the group by her CPN who was concerned about her weight issues after her last child was born.

One of the traits of an ED is perfectionism and sufferers very often compare themselves to others. Tessa had quite a competitive nature which was heightened in connection to her ED. Understandably when she was put in the position of being together with other ED sufferers, it brought out her feelings of insecurity and not being slim enough. This is always a risk when you put ED sufferers together but it can nevertheless be worked with and overcome.

“At the beginning of the group, I went through a starvation period ‘cos I thought I was too fat compared to the other girls here…. It’s like a competition, that’s what it felt like when you came in….Like who’s the thinnest and you’d look at somebody else and look see how thin they were and think you wanted to be like that, you know. ”

At the beginning Tessa had been quite a resistant member of the group and at one point her husband had tried to dissuade her from continuing. It took a considerable amount of persuasion to help her carry on and although she found it extremely difficult at times, she remained in the group until the end.

“It’s been hard to see it through. There was several times I didn’t want to come. Some of it was extremely difficult for me to come but I still did.”

5.4.3 Referral and Onset of ED

Tessa was being seen weekly by a psychologist attached to her local Adult Mental Health Unit and was seeing a CPN. She was referred by her CPN. She felt let down by the Doctors that were caring for her but had managed to make a strong attachment to her psychologist.

As a result of taunts about being overweight from her mother when she was 13, Tessa stopped eating and developed anorexia. Since then she has had an intermittent eating problem which developed into bulimia and binge eating. She uses laxatives sometimes and on a bad day a whole jar of Andrews.

5.4.4 Family Pathology and the Mother/Daughter Relationship

At the initial interview, Tessa felt that she had a good relationship with her mother and was very dependent on her. She felt that her relationship with her father had been more problematic, but felt she was always living up to her mother's expectations. She didn't have many friends and is not close to the rest of her family. Her father has always referred to her as the "pig in the middle", so this is how she describes herself.

"That's how I see myself, the piggy in the middle."

During the group sessions Tessa was able to recognise the dysfunctional behaviour of her mother and was able to discuss it with the other members of the group. It was remarkable to make a comparison between what Tessa had allowed herself to acknowledge whilst participating in the group and what she acknowledged during the end of group interview. It was as if outside the safety of the group she didn't feel able to accept the negative aspects of her mother/daughter dyad. Maybe because her mother played a vital role in helping Tessa cope with her daily life, she felt guilty thinking of her mother in a negative way; it was as if she could not verbalise her true feelings outside the safety of the group whereas she had been able to do so within the group.

"I've got quite angry at times when it was suggesting that a lot of it was passed through the mother line and mine wasn't."

It was difficult for Tessa to accept that the relationship with her mother was flawed, as she depended a great deal on her. But she acknowledged that she had uncovered in the group the feelings of not being good enough and that these feelings went back to an early age and were still very prevalent.

"I've learnt that even though I'm very close to my mum I feel that I'm trying to live up to her expectations, up to her standards. I didn't realise that, which definitely came out from the group".

5.4.5 Food and Feeding

At the initial interview Tessa felt that her eating was erratic and out of control, she either eats nothing at all or binges and uses Andrews to purge herself.

"I think, I don't need to eat and I don't. Then I eat and then I take Andrews."

Because Tessa had four children ranging in age from two to twelve she found it very stressful to sit down and eat with them. She was relieved to have the excuse of eating later with her husband so that she did not have to eat the same food as them.

“I’ll eat afterwards and that’s usually a salad, something different to what they eat.”

The choice of what to eat was problematic for Tessa and she felt that food ruled her life.

“I used to hate choosing everything all the times. I never want anything fattening and I don’t know what to do… It does rule my life a lot of the time.”

Tessa vacillated from starvation to over eating. Eating frightened her as she had an abnormal fear of weight gain.

“And then I’m scared to eat ‘cos of putting weight on”.

At the end of group interview, feeding her children was still a problem for Tessa; she felt that if she deviated from her perception of a healthy diet even in a moderate way, they would become “fat” and unacceptable to her.

“I’m still very conscious of what they eat. I hate doing their food because I want them to eat healthy stuff, when I give them the other stuff I’m thinking, oh god I’m going to end up with the fattest, ugliest children.”

5.4.6 Modelling

Usually the only meal the family had together was the occasional Sunday lunch and then the children noticed that there was a rule for them and a different rule for her.

"If I do Sunday lunch and I don't eat my dinner, it's like well we have to eat all ours but you don't have to eat all yours."

Tessa was unaware that her attitude to food impacted on her children. Even when she acknowledged the similarity in her eldest son, she was reluctant to make the connection.

"Well [my eldest son] moans if there's a little bit of fat on his meat. I don't buy anything with fat on anyway so."

Tessa was a tall woman and kept comparing herself to women who were much shorter. She felt she was fat and constantly said this to her family; her husband frequently spoke to her in a derogatory manner which she accepted as she felt she did not deserve anything different.

"I say, I feel fat. I look fat 'cos my face is fat… He says to me, 'You're a minger'."

Her eldest son imitated this opinion and treated her in the same derogatory manner as her husband. She gave way to this and accepted it as she felt they were conveying the truth. She found it difficult to accept that her son's behaviour was a direct response to her own behaviour and that of his step-father and allowed herself to become the object of his bad conduct.

"My eldest son still calls me fat. That's because I think I am 'cos I say that I'm fat so I just agree with him…[my eldest son] will say in front of his friends, that I'm his 'minger mum' his 'fat, minger mum' so it doesn't bother me. 'Cos I agree with him. I know he does think that I'm fat. I think I'm fat."

Tessa was more aware of her daughter's eating habits and recognised that her daughter often modelled her choice of food on what Tessa was eating herself.

"I think [my daughter] picked up on that a few times because she's asked for salad instead and I know she doesn't really want it."

When Tessa was asked if she treated her sons differently to her daughter, when allocating food, she was surprised to recognise that she did.

"I do treat her differently, to the boys, in packed lunches. She doesn't have crisps and biscuits".

Tessa had such a low opinion of herself, it made her feel that she did not want any of her children to be like her in any way.

“Hopefully none of them would be like me. That’s what I would hope for anyway.”

Tessa had four children, three boys and one girl. As mentioned previously, she used to denigrate herself in front of her children all the time. In the groups on modelling we were able to address this and she felt that the group had made her more aware of how her children, especially her daughter, responded to her.

“ She gets quite upset if I call myself fat ‘cos I say I’m fat all the time. She gets quite upset and she says ‘you’re not fat mummy’….Yeah, I’m more aware. I try not to say things like that in front of her….I suppose it’s made me a bit more aware.”

Tessa did acknowledge that the group had made her aware that her daughter was modelling her eating habits. Instead of being able to use this in a positive manner and allowing this awareness to help her modify her own behaviour, she saw it in a negative light and felt guilty.

“I don’t know whether she’s got it from the fact that she always sees me eat salad. The group made me think, is that because of me? So it’s made me feel more guilty sometimes about the children.”

Modelling was an important theme of the group as this was the key to transmitting dysfunctional behaviour. Unfortunately it seemed that Tessa was not willing to grasp the modelling aspect of her relationship with her children and felt that she could still tell her children how to behave rather than lead by example. She felt uncomfortable with the thought that her behaviour had any impact on her children.

"I would hope that none of my children were like me….I want them to be more confident in themselves, happier about themselves."

5.4.7 Body Image

Tessa was well aware that she often spoke of the negative feelings that she had about her weight and body image, but did not believe it affected the children.

" I do speak about my weight in front of the children and they do know that I think I'm fat."

Tessa felt despondent about her weight and felt that there was no way out. She had a morbid fear of weight gain and distorted view of her size.

"In my head, I have got this fixation that I have got to be a size ten and that I've got to stay there."

Tessa’s fear of weight gain transferred itself to her children. She was as concerned about them gaining weight as she was herself and feared being ridiculed.

“Well all you hear is about children being obese these days and I don’t want my children to be obese. I don’t want the ridicule. .”

She was particularly concerned about her second son and felt guilty that her revulsion against weight gain encroached on her ability to nurture and mother him in an unconditional manner.

“[My second son] got a bit chubby; he had a rash on him and I felt absolutely ashamed ‘cos I didn’t like putting the cream on him ‘cos he was fat. I was absolutely devastated that I felt like that.”

Tessa felt that her eldest son had to keep up with peer pressure to conform to expectations as he was tall like his mother. She held him up as an example to her second son and implied that if he was overweight he would be an embarrassment to his brother.

“He feels he’s got to live up to that reputation and he doesn’t want to be embarrassed by his brother.”

Tessa didn’t believe in herself and her self worth was so low that she was unable to consider that there were any positive aspects to her.

“Cos if anyone says anything nice to me I don’t believe them… I can’t see what they’re talking about. ”

Even after the group, body image was still very problematic for Tessa. She kept tight control over her children’s weight by the food they were allowed and their body image was an extension of her own.

“[My second son] is a bit chubby so I was watching what he was eating and he was aware of that as well.”

Because Tessa had no self-worth she allowed her husband and children to denigrate her. This was an area that she acknowledged the group had boosted for her; it had enabled her to improve her self-image and she felt she accepted herself more.

“I think maybe I accept myself a little bit more but I don’t like anything of me still. It was coming to the group that helped.”

5.4.8. Separation/ Individuation

Tessa was the middle child and grew up feeling that she was never good enough. She had the nickname of ‘Miss Piggy’ and was referred to as the ‘Pig in the middle’.

“My dad used actually used to call me Miss Piggy… even to this day I still feel totally inferior to them.”

She felt so isolated from her family that she believed she was adopted
“I used to believe that they weren’t my parents.”

Her ED began when she was 13/14 after her mother’s encouragement to diet. Her feelings of inferiority made it difficult for her to gain any sense of her own self and to separate in any way from her mother. This continued throughout her life.

5.5 “Maggie”

These findings derive from the initial interview, the end of group interview and the 6 and 12 month follow ups.

5.5.1 Personal Details, ED and Medical History

Maggie was 36 and lived with her husband and 3 children, 2 boys aged 8 and 10 and a girl of 6. She is the middle child and has two sisters. Both parents are living. She has had an ED since she was 15. She was on a high dose of Prozac for depression; sleeping pills; iron tablets for low haemoglobin; and analgesics. Due to the severity and length of her ED she lost the fat and muscle around her internal organs causing a bowel and bladder prolapse.

“I had sort of like a multiple prolapse really. They had to put my bowel in a sling and attach it to my back, there’s no muscle left inside me”.

She had a hysterectomy before the group and had the bladder operation during the group, missing three sessions. There had been two hospital admissions for the ED and she had been recently discharged when referred to the group. The ED and having children had taken a terrible physical toll. Even so the possibility of relinquishing the ED was remote; vomiting had become a natural bodily function.

"It's like sneezing. It's an automatic thing that my body does now. It's actually hard for me to hold it in, I can just bend over and it will come straight out of me even an hour later".

5.5.2 **Suitability for the Group**

Other than inpatient treatment Maggie had not received any treatment on a regular basis. On discharge from hospital her support was limited and sporadic. She felt that treatment had "topped her up" but there was no continuity and no back up when she most needed it. She was on waiting lists to see mental health professionals but appointments had not materialised. She felt that the in-patient treatment she had received was structured around younger patients who did not have children and that it did not take into consideration that her needs differed.

"Being in that hospital made me realise when you haven't got children how selfish you are with the illness. When you've got children you can't just think about yourself and decide you're not going to eat. You are

with people that are still playing a game and not trying, which wasn't very easy".

Maggie's attitude to recovery had changed and she found herself in a different position. She was at the stage where her past was coming back to her and she was open to the possibility of recovery.

"To be honest I feel like I've had so many different stages in my life I think there's quite a lot that I've only just started to let myself remember."

5.5.3 Referral and Onset of ED

Maggie was referred by her CPN who she was seeing after discharge from a specialist ED hospital unit. She had been suffering from an ED for 20 years, since the age of 15. Maggie's first hospitalisation was at 18 for several months but on reflection she realised that she was not ready to be helped.

"I would be dropped off at the hospital and just go walk abouts; I was still trying to cheat the system".

5.5.4 Family Pathology and the Mother/Daughter Relationship

She felt that her mother "played games" with her and realised that this had always been the case ever since she could remember.

"I used to hope that she didn't know what she was saying but it became blatantly obvious that she was playing games with me".

When Maggie was about 13 she developed quite quickly. This was the time that her mother taunted her with weight issues and added to her fear of weight gain.

“Constantly going on about how I’m going to be like her side of the family, like my Nan twenty-odd stone and my dad’s side’s really thin. My two sisters were my dad’s side”.

The transgenerational transmission of dysfunctional eating seems to be evident in the grandmother/mother/daughter triad of this client. Maggie’s maternal grandmother was a compulsive overeater and weighs in excess of twenty stone. It was evident that weight was a huge issue in this family as her mother always made negative comments about weight and made comparisons.

“***I was going to be just like her. She was up to eleven stone something when she left school and so I had that constantly told that to me. And even one day she got a tape measure out and measured my legs against hers and I can remember thinking, I’ll show you. I’ll show you”.***

Maggie’s family did not give her any support during her illness and there was a great deal of friction with her mother, especially during the early years of her illness. This resulted in her having to leave home at a time when she was most vulnerable. Maggie felt that there was no closeness or empathy from her mother and that her mother manipulated and controlled the other family members against her.

"My mum used to say, "Oh either she goes or I go." So my dad'd drive me into London ….. But some of the accommodation that I was left in I can't believe my dad left me in it. It was horrendous. My mum would always say, that the illness was worse for her than it is for me. And it was always about her it was never about me. So every time if I tried to get help and it didn't work, all I ever got was anger from mum. She never once put her arm round me and said she loved me.

When Maggie was turned away from the family, she became suicidal. She was alone and separated from her family even during holiday times when most families gather together. She felt unable to make friends because of her ED and led a reclusive existence between work and her inadequate living accommodation.

"I was living on my own and I really don't know how I didn't commit suicide. I've been close a few times. I was still living the reclusive life of the illness and going to work and coming back and living in this tiny little room and none of my family talking to me. I didn't make any friends there".

Maggie realised that her mother gave her mixed messages and understood that what she told other people was a put on show of concern and that her true feelings portrayed her total lack of concern for her daughter's mental and physical well-being.

"She makes out she's desperate for me to get better. I know that they've told everybody that my bowel's prolapsed, that I got incontinent and I'm the anorexic one".

During Maggie's last inpatient treatment, one of the most important aspects of the treatment was contact with the family. Subsequently a group for the families to meet was provided and family members were encouraged to participate. Maggie invited her parents to attend and was devastated when they refused. Her mother was frightened that blame would be attached to her.

"They're going to end up blaming me. No. I really can't be bothered and anyway I'm going down to the quiz night."(her mother said). "So she could do it to go to the pub but she couldn't do it for something that was really important for me, so that really hurt."

Since Maggie's marriage she has been able to experience and witness a different sort of relationship and level of care from her in-laws. This has enabled her to compare her childhood and the way her parents still related to her, to an alternative more positive model.

"The comparison of mum since I've been with [my husband] for like thirteen years and the way their family operate has really highlighted my family".

Because her ED had resulted in severe medical complications she felt it put an extra burden on the ability of her husband and his parents to continue their empathy and support and was fearful of losing it.

"'Well the last time I went in everyone gave up on me. 'Well it's your fault because we still know that you're not eating properly'. So it was almost like just get on with it, even [my husband's] family."

Maggie relied entirely on her husband. She felt that he was the only person that understood her and she trusted him implicitly to always be there for her. All the other people in her life had at some time rejected and abandoned her and made no attempt to understand the complexities of her illness.

"He's always stood by me no matter what. He's the only person. Every one at some point in my life has pretty much walked away from me. "

Maggie realised that her husband was the main source of support for her and the thought of pushing him too far or loosing him was intolerable. Although this was an ongoing source of fear and anxiety, it was not enough to stop her ED.

"He realised that I was still being quite ill and he got to a point where he couldn't take any more and it's the first time he's ever doubted staying with me because of the illness. He's always been rock solid and that was a real kick up the backside for me… . I am so lucky but I feel so guilty because I'm risking all of that."

5.5.5 Food and feeding

Maggie’s grandmother was a compulsive overeater; her mother was continually on “faddy” diets and was obsessed with weight and size issues. Maggie’s experience with food as a child was not a pleasant one and she remembers her mother being very punitive and humiliating with her.

“If ever I took anything from the cupboard at home I was called a thief and you weren’t even allowed to have a bit of orange juice. If you did you would be made to look really stupid in front of everybody. My mum would say the best way to deal with things is to humiliate you.

Maggie’s relationship with food was determined by how “scary” food was and she set up a system of eating by consuming less contentious food first, so if it was in any way digested she would be less likely to gain weight from it.

“I always eat vegetables first so that if I have a panic later on and something’s started digesting it will be the vegetables. I’m very frightened of meat and sauces and potatoes.”

The thought of food being inside her was a frightening prospect. She also ate by colour as this enabled her to recognise when vomiting if she had managed to rid herself of everything she had eaten.

“You’ll eat carrots first ‘cos they are bright orange so you know when you’ve got to the bottom of your stomach.”

She found it very hard to eat when she was on her own as she did not seem to be able to organise herself enough to feed herself adequately. She relied heavily on her husband even if she would secretly get rid of it later.

"I just feel such a sense of relief when my husband is here because he'll make it and I'll sit down and have it with him even if I throw it up half an hour later. I don't ever make myself a coffee or a cup of tea on my own."

This inability to organise herself with food affected her ability to feed her children satisfactorily. When they are home she finds it difficult to adjust to their need to be fed in the middle of the day.

"But with lunch, to be honest, sometimes I forget all about lunch."

When Maggie did make meals for the family she tended to give them larger portions than was necessary. When they did eat together she very rarely ate the same food as they did and gave herself small portions of what she called "safe" food.

"I tend to overfill plates. I tend to make far too much I always have something completely different to them."

In retrospect Maggie was ashamed to realise that while she was denying her ED, her need to purge after food was so great that she used the children as decoys and vomited while she was with them.

"Well I am ashamed and I do wonder whether they remember but when they were toddlers I'd take the child to the loo and whilst they would dry

their hands I would be sick in the loo while they're in there and I'm really ashamed of that…."

Although vomiting had become a reflex action for her and she would try and hide it from her children, if her children would witness it she would make what she felt was a plausible excuse to them.

"Sometimes if they caught me 'cos I would do it so quick and quietly but sometimes if they did catch me I would say, "Oh mummy's got a bit of tummy ache."

Maggie admited that she has an abnormal fear when talking about food especially to her children. Diets were never mentioned in front of the children and she believed that the children did not know she had an ED. She avoided talking about weight gain or loss and talked instead of growing muscles.

"I'm always frightened to even go on to the subject of food. They never mention about weight but they say, "It's for muscles." It's like when they visited me in hospital. They'd say, "How are your muscles? ......So I'm very conscious, I never mention diets in front of the kids. They don't know I've got an eating disorder".

One of the main purposes of the group was to increase the mothers' awareness of their own eating behaviour in order to modify their children modelling their dysfunctional conduct regarding food.

"It's pointed things out to me where I could be sending the wrong signals so I'm more aware of that, of how I am around food in front of

them and to try and be more positive with food…. Yeah it's made me more aware that I'm sending mixed messages by saying, 'You've got to eat it but I haven't.' I'm trying to sort of change that a little bit."

5.5.6 Modelling

Looking back on her childhood Maggie remembered that her parents were unloving and cold, but she was able to understand that this was a dysfunctional model which had caused a great deal of hurt and anguish.

"I never felt I could go up and cuddle and kiss my mum and dad"

Due to the environment of Maggie's childhood she understood what she had missed and felt a great deal of guilt about what she was unable to do for her children. She was so anxious that her behaviour would not mirror her mother's that she became overtly apprehensive when dealing with her children and over compensated.

"I don't say the hurtful things my mum used to say, I'm just so worried about saying the wrong thing. I had so much that I remember from my mum that I'm scared, so I probably could go on about something more than I need to 'cos I'm worried".

Maggie recognised that her responses to her children had been unsure, which gave them weak messages. Even though she was determined not to abuse her children in any way, she was brave enough to realise that some of her responses had been abusive.

"I think it's made me believe in myself a bit more which has to be a good thing 'cos I didn't trust anything I did so I wasn't confident in everything I told them to do and I think they picked up on that. I feel a little bit more in control. I think when things have got too much, I've gone 'If you loved me you wouldn't do this,' which isn't right. That would be my last straw and then they would go, 'Yeah, mummy we do,' which is emotional blackmail, I suppose, which isn't good."

Maggie became anxious and stressed about her responses to her children. She tried to rely on her instinct but because her model was a dysfunctional one, she found it hard to trust herself.

"When you've had completely extremes at home it's hard to know whether you are doing it right or wrong".

She had felt a failure as a mother and as a person and realised that her attitude to everything had been tinged by her expectation that she would fail. But after the group, her approach to facing her problems was changing. The ability to change was increasing her confidence and in turn building her self-worth. She was beginning to understand that failure was not the end and to fail was human.

"I think if I prove to myself I can do it that will make me feel a better person. I've realised as I've achieved certain things it's made me feel better….My attitude to everything was, oh I can't do it. I've started to think, well I can have a go; I'm allowed to fail more."

Maggie was obsessive about keeping the house clean and tidy, it had to be perfect at all times. She found it very difficult to leave the house unless everything was just the way she wanted it. She felt that the state of the house reflected how good she was as a wife and mother.

"I find it really hard to leave the house unless everything's perfect …. panicking constantly that I can't go out 'cos their bedroom's not straight. I can't go out because their uniform's not perfect."

5.5.7   Body Image

At the beginning of the group, the competitive nature of the ED surfaced but after a while she felt more secure. She felt the realisation that it was not a competition was one of the positive components of the group.

"You are just constantly comparing yourself to everybody else but as time's gone along and we've all got to know each other we've realised that it's not a competition and that's been really helpful."

Even though Maggie on one level, knew she was too thin and was aware that her husband did not find her attractive, her inner anorexic voice kept telling her she was too fat and needed to lose more weight.

"It's such a mixed thing 'cos you can lay in bed and you can feel your bones and you know it's horrible and you're aware when your husband touches you, you feel horrible and he says how awful it looks but it's like I'm sorry that it looks really painfully thin, but all I keep telling myself is that my trousers are tight."

After Maggie’s last discharge from hospital, she continued to struggle with her weight and her body image was still distorted. This was making her feel quite depressed and despondent and causing her to panic. She was fearful that her thoughts were persistently about loosing weight.

“I’m feeling really fat. Everything’s feeling tight on me. I am panicking about being a bit heavier. I’m trying to lose it again which isn’t the answer”.

Maggie felt paranoid that other people were looking at her and judging her to be overweight. This presented itself when she had to pick the children up from school making her feel particularly stressed and vulnerable.

“I get a bit paranoid that everybody’s looking at me and judging my weight every time I walk out… up the school. I found it so hard I couldn’t cope with everybody looking at me. I just hated it.

Before the group her paranoia about other people looking at her, encroached badly on her life. She did not participate in family games outside the house or family outings as her fear was more powerful than her desire to be with her family. She was unable to socialise with friends and spent most of the time alone.

“I didn’t really interact much with the family….I didn’t want to go outside and see other people. The pressure of just going for a walk yeah, I’d be on my own…. I do really have to push myself to go out of the house.”

Recovering from an ED involves taking risks and recognising imbedded negative behaviour. During the group Maggie realised how much she had isolated herself.

"I've been taking quite a few risks, for me and realising that they're not as bad as I thought they would be….It made me realise how much I'd been missing out on being part of the family. I used to separate myself. I would feel isolated but I would always put myself in that position so it's made me realise as I've joined in more that it's far more rewarding. It doesn't matter too much to anybody else what I look like. It only matters to me."

Although Maggie felt that her children were age appropriate weight and thought she did not differentiate between her sons and her daughter, she displayed concern over her daughter's weight in the future as she was maturing. She was aware that her image of "normal" was distorted and relied on her husband's judgement.

"It does worry me, if she goes through that puppy fat stage, she's changing now she's getting a little taller and changing but I don't want her to have the panic. [My husband] He's kind of like a measure".

5.5.8 Separation/Individuation

Maggie was extremely nervous of the outside world and isolated herself most of the time.

“I’m very nervous going out. Even to just go up the school is a major feat.”

When she was younger her mother compared her to other members of the family and called her derogatory names. Her mother seemed to enjoy the fact that she was anorexic. Maggie felt that her illness defined her and she had no sense of being able to be autonomous.

“And even one day she got a tape measure out and measured my legs against hers.” “I’m the anorexic one… I’m labelled before I even meet anyone… she lives through the drama of my illness.”

Maggie was made to leave home at a young age and was not able to separate in a healthy way, which made her very unsure of herself. She found it difficult to trust herself in any way and was full of doubt and insecurities.

“I just find it very hard to make the decisions for myself…Because I don’t know whether I do things right or wrong. When you’ve not had, you’ve had completely extremes at home, it’s hard to know whether you are doing it right or wrong.”

5.5.9 The 12 month interview.

This was the final interview and the last contact with research team. The main purpose of this final interview was to ascertain the ability of the participants to maintain any changes that had been made during the group process.

In the six months that had elapsed since the last interview, life changing trauma had occurred to Maggie. At the six month interview Maggie was having difficulties with her marriage, but she was in a fairly positive state of mind that the situation would improve. This unfortunately was not the case and by the 12 month interview, Maggie's husband had left her. Maggie had a difficult relationship with her own family but since she was married she had forged a close bond with her husband's family. Therefore it was understandable that the situation Maggie found herself in was enormously traumatic. Not only had her husband left her but her father-in-law had died and her mother-in-law had tried to commit suicide.

"Yeah he's gone, my father-in-law's died; my mother-in-law's tried to commit suicide, and my husband on top of all that has left. So things aren't wonderful at the moment."

As it has been documented previously, Maggie depended a great deal on her husband, who had stood by her through years of illness, so his loss was making her feel devastated. It seems that any progress she had made with her eating was difficult to continue.

"It's just blown all of my positivity out of the window at the moment. I can't see the point in anything much at the moment. Find it hard to eat anyway now, again. To be honest if I didn't have the kids I'd quite

happily top myself, that's how I feel at the moment, if I'm honest. But I can't because they can't lose everybody."

Her familiar support structure had disintegrated and she was feeling frightened and alone. It was reminiscent of her adolescence, but she had the responsibility of her children now.

"It's just so frightening. I've never stood on my own two feet, completely on my own. Well years ago I did, before I had children. And on top of that I haven't got the support of my mother in law, who I'm really close with because she's so ill…. I just feel really alone."

The group and the continuing counselling had helped Maggie to be less emotionally dependent on others and to look after her own needs more. At the six month follow up Maggie had managed to get a job as a waitress in a café which was a great achievement. At the 12 month follow up she was working at the school and trying to build up her time as a Teaching Assistant. She was trying to maintain this through her difficult time.

"I did well this week because I made myself go to work, but it's when I stop still it hits me again….I was just getting my confidence and then….."

At the beginning of the group Maggie was unable to speak to her children's teachers for fear of their judgement. A year after the ending of the group, she was able to conquer her fears to such an extent that she was working at the school.

"I'm getting a bit stronger. Before I probably went along with whatever they said; I didn't have the confidence to disagree. But now, the fact that I'm even working in the school is completely beyond me because I couldn't even go and talk to a teacher without feeling like the naughty little school girl that I've always felt like."

During the twelve months since the group had ended, Maggie had managed to improve her eating behaviour and had increased her weight. This was a great achievement for her but unfortunately she was unable to maintain this because of her situation.

"I'd just started to get quite good, not perfect by any means but the odd meal was staying in me and I'd managed to maintain a higher weight. I was starting to get less frightened of food….I suppose part of me can't see the point of putting myself through having to keep food in me at the moment. I can feel that I've lost weight already and I find it hard to eat"

One of the important points that the group tried identifying was for the participants to become aware of their feelings and to understand the reasoning behind them. Maggie had worked hard to achieve this and had been acting upon her newly acquired awareness.

“I was becoming aware. I never used to understand this aware thing but I had started to understand when my illness was talking to me and when it was shouting, ‘Get rid of it!’ I could be aware that it was my illness and tried to override it….I tried to think, I do deserve to eat something. I was doing so well.”

With EDs it is not unusual that when the ED sufferer gets better and becomes more assertive the spouse finds it difficult. This is thought to be because there is a change in the dynamics of the relationship. The spouse can play an important part in keeping the sufferer ill by not condoning change. Maggie thought it was difficult for her husband to adapt to her being more assertive and less dependent.

“I think he has found it hard that I’ve tried to be more assertive and stronger…. I’m trying not to be so needy. I’ve tried to be a stronger person and be more assertive and stuff but, and he said to me, he doesn’t like that.”

After the group, Maggie fought hard to recover and to bring back some normality into her family’s life. She tried to integrate as much as she could of what she had been taught but was astute enough to understand that her changes affected her husband in an adverse way.

"I think what he found hard was because he had control; I handed over control of everything….And when I tried to take back a little bit of control, I think he saw it as a criticism."

Gaining her autonomy was a struggle for Maggie as she had been in the past a passive observer in the family. When ED sufferers start to change it is often very difficult for the spouse or partner to adapt to the new emerging self that is a vital part of an all encompassing recovery from ED. It is not the person that they have been used to.

"I was, trying to shout out, 'I am my own person' and I think that's what he found the difference, whereas before I was just a doormat. He did say to me in a heated discussion, 'For goodness sake, take some responsibility for your life' and I said 'Ok I will' and I did. He doesn't like it."

Taking part in the group had helped Maggie to find her sense of self and to start being more autonomous. This in turn gave her the strength to be able to cope with her present situation as a stronger person.

"A year or two ago I wouldn't have been as strong as I have been. I would have just done something stupid. So the group and the counselling have helped me to be a bit more assertive."

At first most of the participants attended the group for the sake of their children, but by the time the group ended they had come to the realisation that if they were to recover, it had to be for themselves. They could only help their children if they could help themselves.

"You can't always do it for yourself at the beginning; that comes later. When I first went to the group I felt as long as I'm doing it for any reason at first. And then it did start getting to the stage where I though well actually I do deserve this. Why have I got to punish myself; it does help me to help the children because it gives me a purpose. I'm re-educating myself at the same time or trying to."

The whole nature of her situation was making her feel undervalued, but even in the midst of this hardship Maggie was able to recognise the improvements she had been able to make. She had in the past suffered from such low self-esteem that she was frightened of her children's judgement, but she was now able to value herself which in turn helped her to feel valued by others.

"I've stopped being quite such a skivvy. So, I think they value you more when you stand up for yourself. I was always too scared to stand up for myself in case they didn't like me for it."

Maggie's life was filled with emotional and mental abuse from her mother. She was scapegoated from an early age. As she did not have the resources to fight back, instead she developed an ED. Her mother's abuse has continued into the present day but since Maggie had attended the group she had become stronger and had learnt to understand what the underlying issues were. This enabled her to deal with her mother in a stronger and more determined way.

"She used to say the way to reprimand children was to humiliate them… I have to keep my guard up because at any time she can quite easily humiliate me. The only difference is I fight back more now which I never had the skills or the nerve to….That's something I have learnt from the group. When she feels insecure about herself she puts it onto someone else to make them feel bad about it too."

At the conclusion of the interview Maggie was asked again to give her opinion of the size and length of the group and if she felt it was a beneficial and positive experience. Even in all the turmoil that Maggie was going through she was able to connect to her feelings about the group and she recognised that she was strong enough to retrieve everything she had learnt.

"I wouldn't have wanted any more people. I think it was about right really…. But yeah, it's very frightening once the group ends….You feel you need more. It would need to be longer, personally I think to make huge improvements, I think to complete the work, because I feel we were just all getting into it….. I think it's a worthwhile group. I still feel I benefited from the group, I definitely do yeah….It's made me stronger, it's given me coping skills. It's made me more confident. But although

this has really knocked my confidence for the moment, that confidence will come back, it's there. It's gone in."

5.6 "Sally"

5.6.1 Personal Details, ED and Medical History

Sally was 39 and a single mother living with her daughter of eight. She has two older sisters, one older brother and one younger sister. One brother and one sister live abroad. She does not get on with her younger sister and occasionally sees her other sister. At the time of the group both parents were living and her mother was a great source of support for her. Sally had an ED since the age of 18 and was taking Lithium and Respiridon for depression. She felt her ED and depression were due to being abused as a child by her uncle. Although Sally was able to acknowledge her abuse in the privacy of her interview, she did not directly mention it during the group sessions.

"When I was at school, I can remember, I can sort of remember not eating…. An uncle, I was abused by an uncle. So that's where that's come from….. I said that didn't come out until I was in my twenties. No one found out about that until I was in my twenties because I've managed to cover it up and keep it. It was almost like you'd locked it away, it was gone".

5.6.2 Suitability for the Group

When Sally was referred to the group she was not having any regular treatment and she was finding it difficult to adjust to the inconsistency of her care. Because of her trust issues she needed to feel safe before she was able to confide in someone, but the unpredictability of the CPNs allotted to her, made her feel wary and ambivalent. She had previously had a CPN to whom she had been able to form an attachment, but his tenure ended and he was moved.

‘Cos I saw [my CPN] and he left and then it took a while before the next one came and then she came and now she’s left. The last one, she introduced me to the next person and she hasn’t phoned me and made an appointment or anything yet....He got to know me and I got to trust him. I could open up.”

The first session of the group made Sally feel very anxious but when she realised that in fact she was similar to the other members, it made her feel more comfortable. EDs are a secretive illness and people that suffer from them tend to isolate themselves. Sally was no different to other sufferers.

“Nervous, although you know there are people out there doing what you do, sort of actually meeting them makes it a bit more real. You feel very alone the rest of the time.”

The competitive nature of an ED came to the surface with Sally and she found that the others felt the same.

“It didn’t make me not want to lose weight ‘cos I still felt fat. Sort of knowing there were other people who had similar feelings to what I had, if anything I think it might have helped.

While Sally was being interviewed for the group it became very clear that she had classic ED tendencies. She used food as a way of soothing her emotions, which made her suitable for the group.

“S***ometimes you just need it [food]. You do, you’ve just eaten, you’ve binged… I can then go in the cupboard and sometimes you’ve got to eat but you know you don’t want to eat so you eat then you have to get rid of it.”***

Most of the participants of the group were unsure if they fitted the criteria for the group. They found it difficult to describe themselves as anorexic or bulimic and did not know that EDs had many different symptoms. One of the main benefits of the group was meeting other people with similar symptoms and circumstances.

“I wasn’t sure whether I was right for the group because I’m not anorexic….I always class people with bulimia as they eat and then they vomit and I can’t do that…. Well you’re not really bulimic but what I do, I take laxatives. There was another girl who also couldn’t make herself sick so it made me feel a bit better thinking, oh yes I should be there”

5.6.3 Referral and Onset of ED

Sally’s depression had been the main focus of her treatment in the past and her ED was left untreated. She felt that she had not received any acknowledgement of it, or help for it. It had only recently been taken notice of by a Community Psychiatric Nurse (CPN), with whom she had managed to form a tenuous relationship but unfortunately was no longer seeing.

“It’s sort of come out with [my CPN] and so it wasn’t really seen as an eating disorder concentrated on. It was just like funny eating habits.”

The onset of Sally’s ED was in her adolescent years when she remembers not eating. She feels it has been with her in varying degrees since that time.

“When I was at school. I can remember, I can sort of remember not eating…. And then it’s sort of just been on and off.”

Sally had never had any formal treatment for her ED as it was never formally diagnosed. Yet she had used eating, laxatives and self-harm as a way of controlling and soothing her feelings since she was a child.

“I will hurt myself. As well as the food….though the cutting, the cutting has actually calmed me down…. It helps. It helps you to blot it out…And sort of like punishing me.”

Even though Sally knew that taking laxatives in excessive amounts would not control her weight, it had become so habitual that she was unable to stop. She reassured herself that taking laxatives was better than vomiting, as the damage couldn’t be seen.

“And so it’s the laxatives I do. Yet I also know that doesn’t make you lose weight…. I can’t vomit because I have this thing about my teeth.”

5.6.4 Family Pathology and the Mother/Daughter Relationship

Sally felt she was devoid of any physical or emotional attention from her parents. Her father was a surgeon and not at home for a great deal of the time and her mother was a nurse who worked nights.

"She worked nights so she'd sort of like be in bed during the day and work in the night…. When she'd worked Friday nights she'd be in bed Saturday. So we had to be quiet during the day so we didn't wake her up."

Sally had never been given the opportunity to experience a close loving relationship. The lack of any closeness from her parents and the sexual abuse from her uncle together with the abandonment of her partner had a profound effect on Sally's ability to mother and nurture her own child. Although she did not have a good relationship with her mother as a child, she relied heavily on her mother to help her maintain her equilibrium in her relationship with her own daughter.

"That is one of the reasons why I do go round there because I do know at least [my daughter] won't have me shouting at her. If I do start I can normally control myself at mum's. When I start shouting I do lose it."

The abuse from her uncle was a very tightly guarded secret and it was not until the secret was revealed in later life, that Sally found out that she was not the only one in the family that had been abused. She had been the youngest one to have been abused and it had been going on since her earliest memory. Sally knew precisely when it stopped, as the uncle died.

"Yeah, as young as I can remember. I know exactly when it stopped because he died but I can't remember when it started…. Probably about ten or eleven. He died; it was just before I'd had started secondary school."

Sally had been robbed of her childhood and the trauma and damage continued to influence her whole existence. It was only when she became severely depressed that the secret came out.

"I don't really remember other things about childhood. That didn't come out until I was in my twenties because I've managed to cover it up and keep it. It was almost like you'd locked it away, it was gone…. And then, I just found that I was getting depressed."

When the abuse stopped Sally felt completely alone and unable to confide in anyone. The fact that she was not the only victim in her family did not surface for many years.

"We did find that out afterwards. The only difference was they all had someone to talk to. So it wasn't a secret like it was for me. Except there was no one for me."

Sally’s abuse happened in the perceived safety of her home with a trusted family member who was everyone’s “favourite uncle”. This destroyed her ability to trust anyone, which in turn had a detrimental effect on her capacity to allow her child the freedom for age appropriate separation.

‘Cos I don’t like her doing, you’re just so worried, you don’t know what’s going to happen and I don’t want her to do things.”

Sally’s self esteem was non existent; she had no self belief and was suspicious of everyone and everything. She could not believe that anyone could be nice to her, let alone love her.

“And then if they tell me something that’s nice I don’t believe them. And it’s, they’re lying….They’re not without a motive?”

The relationship with her father was very strained and distant. He had never been told of the abuse she suffered and still did not know. She felt he was distant and uncaring and treated other people better than his own family.

“Yes, my dad, he’s very selfish. He just thinks of himself. He’s very religious. He goes to church. He treats other people better than his own family. ”

As the relationship with her parents was strained, Sally felt unable to relax in their company and was not a willing visitor. Unfortunately she was finding it difficult to maintain a stable relationship with her daughter and needed her mother’s help in order to manage.

“But it’s sort of like you can’t be yourself there and I’m finding it hard I don’t want to go round there any more….It’s only recently that mum’s realised how bad I do get.”

Sally spent a great deal of time at her mother’s. Nevertheless, because of the dysfunctional relationship she had with her mother, she found it hard to be in her mother’s company so often.

“We go round to my mum’s, which is fine but sometimes I don’t want to be there either, so that makes me feel worse ‘cos I’m not where I want to be.”

Although Sally was second youngest in a family of five, she always felt an outsider, unwanted at family get togethers and she tended to isolate herself.

“I always feel like I’m outside looking in. Like when everyone is there together, it’s I just don’t fit in. I just feel like I’m just sitting looking in. It’s like you’re outside.”

Sally was aware of her inadequacies and her inability to cope with her child, but the level of her mental distress and depression made it extremely difficult for her to control her moods. This was the cause of a constant irritability and a “short fuse” in dealing with her daughter.

“Once I’ve calmed down I tell her how much I do love her and she knows that mummy’s been poorly and I sort of say sometimes I can feel it coming on and I will say to her, “Look, mummy’s not feeling too good today and so please when I ask you to do something, please do it.”

Behaving as she did to her daughter caused Sally a great deal of pain. There was an enormous need for reparation and a great deal of guilt attached to her actions. There were times that she wanted to self harm and contemplated suicide.

“Because I really don’t want to have to shout at her, I say horrific things to her, I mean, afterwards, that’s when you really sort of want to harm yourself and things like that…. I can’t, I can’t end my life because [my child] would be the one to suffer, because she would probably think it’s her fault.”

Sally’s overwhelming fear of getting close to anyone, presented itself in the tragedy of not being able to express the love she had for her daughter.

“The worst thing I do to her, is tell her that she can go and live with her dad and not to come back to me, ‘cos I don’t want her. And that is the complete opposite to what I want.”

Coping with mess was an indicator of anxiety, perfectionism and life stressors. In the group we took notice of how the participants dealt with mess generated by their children and mess in general. Sally responded to mess in the same way that the other participants did. This is the general response of other ED sufferers. Mess is difficult for ED sufferers to tolerate, as it is an indicator of the loss of control and control is the bedrock of an ED.

"I just won't let people come in. You literally could not see the floor because of the state it was in, and you literally climbed over everything. I hate mess but it takes a lot for me to get the oomph to do it…. I just think oh I've got to do that. I don't like mess but sometimes I can't cope with it. I just shut the doors on everything."

5.6.5 Food and feeding

When her child was 9 months old Sally went back to live with her parents because her relationship with her partner broke up. She went back to work and left all the domestic care of her child to her mother. This included feeding her. Even when Sally and her child moved into their own home, she avoided preparing meals for her and continued to take her child to her mother's for meals.

"I've probably managed to avoid feeding her, because I left her dad when she was about nine months and I was living with my mum. I had

to go to work then so mum sort of done all that. I very rarely do the food for her."

Sally had a difficult relationship with food and given the choice would have preferred not to eat. Because she very often relied on her mother to provide food for her daughter, she felt trapped into having to eat to maintain a semblance of normality in front of her mother.

"I feel guilty when I eat. Because we're at my mum's quite a lot she does dinner and so you feel you've got to eat it"

When Sally was at home she rarely ate with her daughter and if she did she ate reduced portions.

"Where I'm at home, I very rarely eat with [my child]. If I do I have half of whatever she's got. You can fit mine on a little plate. So I'm eating something in front of her or I say I'm having it later."

Sally's eating depended greatly on her mood and she easily got into the cycle of eating because she felt bad and then feeling bad because she had eaten.

"Sometimes I'm feeling really depressed. Then I need to eat but then I don't want to eat because I find, that makes me more depressed because I've eaten more and I put on more weight.

Sally was not aware of her hunger states or the reasons why she abused food.

“Sometimes I don’t feel hungry but you eat anyway and sometimes I just don’t bother. I don’t know, there is no, there isn’t a straightforward reasoning why I eat and when I eat.”

She denied herself food until her body craved it but would only give in to her body if she knew she could purge.

“Sometimes you think to yourself, well, I can have that because I’ve got laxatives at home and sometimes I haven’t got any so I’ve really got to avoid having that.”

Mealtimes were still a problem for Sally and although the group discussed the value of eating together and making mealtimes more of a social event, she was as yet unable to do this.

“[My daughter] always eats on her own, or she’s at my mum’s.”

5.6.6. Body Image

Sally was very conscious of her weight which constantly fluctuated. She had a completely distorted body image and felt she looked unacceptable, even though on some level she knew this was not the case. She worried about how people saw her and what their opinion was of her.

"I go up and down…The sensible part of me knows that my weight isn't overweight. But when I look in the mirror, I see the stomach bulging and thighs out here and that's what I see. You just feel like everyone's sort of looking at you."

There were certain foods that Sally loved, such as chocolate. But she would not allow herself to have them, so they became "forbidden foods". These issues extended to her daughter and Sally was worried about any perceived weight gain. She restricted the child with her "forbidden foods" and watched her carefully.

"I do worry about her putting on weight. I do worry that if she wants sweets and cakes and biscuits…."

As Sally had never received any treatment for her ED, it would have been quite unrealistic to expect substantial changes in her eating behaviour and body image in the short amount of time that the group was running. She found it difficult to change her dysfunctional habits or to view herself in a more normal way.

"No because I still look and see all this fat, I look in the mirror and I just see bulges and I can't see how they can't see it."

Distorted body image is an integral part of the aetiology of an ED and this had become severely imbedded in Sally, due to the lengthy duration of her ED.

"***I always see fat I don't see slim or anything like that….I just feel uncomfortable because I just feel so fat…. I take the laxatives."***

An important aim of the group was to prevent the children from internalising their mother's dysfunctional ED habits. This included a distorted body image and it was essential to imbue the mothers with a sense of what was normal for the sake of their children.

"Sometimes I look at her and think, Oh god, it looks like she's putting on a bit of weight and whatever, but I don't tell her that and usually she's having a growth spurt."

5.6.7 Modelling

Because Sally's childhood was so devoid of love or affection, she never had the experience of a close loving relationship. Because of this her own abilities to nurture and love her child were grossly impaired. Added to this, her traumatic experience of the abuse she suffered, made it even more difficult to be tactile and loving to her child, although she knew that she needed to be for her child's sake.

"She comes down for a cuddle. Sometimes I find it hard and she puts my arm round her and you know you think, just give her a squeeze, I

can’t do that. When she’s really upset I can do it then. I don’t class myself as a good mother at all. I don’t give the love. I find it hard to give the love, because I never had the love.”

Although Sally intrinsically knew what was needed to mother her child, she found it extremely difficult to be available to her child and express the love she felt for her. This was due to the lack of her own mothering.

“I really do love her. I love her so much, but I can’t show her. I want to be able to just grab her and hold her and hug her, but I can’t… Because I want her so much, ‘cos I love her so much. I just don’t seem to be able to. When she’s gone to bed, she’s gone to sleep, I go to her room and I cry and I sort of stroke her head and I tell her I’m sorry. When I tell her I’m sorry and I explain to her that mum’s poorly, once I’ve stopped shouting and I’ve calmed down, so she knows. But it can’t be fun for her really.”

Sally was aware that she was unable to give her child what she needed. She acknowledged that she was frustrated about this, which made her more volatile than she would have liked.

I’m finding it very difficult with [my daughter] she wants me, but sometimes I can’t give her what she needs of me and I lose it a lot. I get cross and shout a lot. I know she’s desperate for me, but sometimes I

can't. She'll come like and want a cuddle but I can't hug her. I find it hard to hug her."

Sally was used to isolation; she had experienced it from an early age. As with her family she never felt fully accepted or acceptable with her peer group and found it difficult to make friends.

"***I have difficulty making friends, I find it very hard to trust…. These feelings of being a little girl, that's how I feel. I don't feel like I'm thirty-nine. You feel like you've never grown up."***

The group spent a considerable amount of time discussing the uselessness of giving mixed messages by saying one thing and doing another. That it was vital to lead by example and that children would model behaviour, rather than listen to verbal instructions. Unfortunately it seems that Sally had been unable to implement this with her daughter.

"I found I have been saying, 'Oh do I look fat? And mummy's eaten too much and she's feeling fat.' So I'm conscious of not letting her fall into the same trap. But she thinks that you can't do anything like this, 'until I'm mummy's age' and she thinks it's something you only do when you're older. Maybe that will help now. "

5.6.8 Separation/Individuation

Although Sally had a large family she did not feel a part of it.

"I always feel like I'm outside looking in…I just feel like I'm just sitting looking in."

Because of the abuse she had suffered and the absence of her mother, she found it very difficult to build any self-worth. Her relationship with her father was virtually non-existent and added to her isolation.

"Yes my dad he's very selfish. He just thinks of himself. He doesn't treat you, he treats other people better."

She was a single mum and was completely reliant on her mother, to help with the care of her child, so being able to separate and become an autonomous adult was an almost impossible task. Because of her experiences she found it difficult to trust and still felt like a child.

"I find it very hard to trust and if people say oh no we are friends and whatever. It's hard to believe in them… And to be honest, these feelings of being a little girl, that's how I feel."

5.6.9 12 month interview

At the time of the group and up to the 6 month interview, Sally's mother had been her main source of support and Sally had depended almost completely on her. At the twelve month follow up Sally's mother had died. She had a stroke while Sally and her daughter were staying with her before their move into their new flat. The stroke happened when Sally was out and her mother was looking after her daughter. Her mother was taken to hospital and died three weeks later.

This had a profound affect on Sally and her daughter. Sally's mother and Sally's daughter had a special bond between them. Her daughter spent the majority of her time with her grandmother and treated her as a second mother.

"[My daughter] is affected a lot. It's definitely affected her school work. I'm not pushing it too much…. Mum was there right at the beginning 'cos she was there right at the birth and she looked after her near enough the whole time."

When Sally joined the group she was under the care of her local mental health team on an ongoing basis. At the first interview Sally complained of the irregularity of her care and now at the 12 month interview she was still in the same position. She was unable to make a relationship with any of her CPNs as none of them were there long enough.

"***I just got a new one start again. I've seen him twice….You see them a couple of times and they say, 'Oh I'm going to be here for a long time, I'm not going anywhere'. And the next thing you know, 'Oh I'm leaving'. So now when they come along I'm quite negative about it. Because I think you have to go right through it from the beginning, through everything, you get to the same point and then they leave."***

When Sally's mother died she became more depressed and started to comfort eat without thinking if she needed or wanted the food. This unfortunately led her back to her old cycle of dysfunctional eating.

"I've put on a lot of weight. Then you get depressed because you put on weight. The harder you try to lose the weight the more you put on….. I was buying bars of chocolate and I was just eating just for the sake of eating. I don't think I was hungry….Yeah this is since mum's died."

As it has been noted previously, a large portion of time in the group was spent on modelling behaviour. It was important to impress on the participants how their behaviour influenced their children. Sally had understood this and tried to incorporate what she had learnt when dealing with her daughter.

"I try not to say too much to [my daughter]. I do actually say to her, if I put something on, which one doesn't make me look so fat. But I try to be careful how I say things…. I do try hard not to in front of [my daughter] because I don't want her ending up the same."

Loosing her mother so suddenly was such an enormous trauma for Sally and her daughter, it was hard for Sally to find the right balance for her daughter. The group had helped Sally with her relationship with her daughter and at the 12 month interview she was still able to use the information she had learnt from the group. Sally put this to use and was able to manage her own feelings enabling her to help and support her daughter.

"I do think about the group. Then I think to myself, I'm probably still anxious in the way I deal with her. I've managed to, sort of, put it aside, I'm still sort of, it's still there, but I've managed to control it a bit more. Be there because she's so unsettled."

Sally's mother was unable to love and nurture Sally, whether by intent or absence is unknown. This had the effect of Sally's childhood being full of trauma and neglect, creating a cycle of dysfunction reaching down to Sally's daughter. Sally knew that she found the normal features of motherhood difficult to show to her daughter, creating an atmosphere that was not nurturing for her child.

"I regret that I couldn't give her a proper childhood. Sometimes she's the adult not me…. I probably don't listen to her and talk to her as much as I should do and I come in and I don't really want to be involved. I just want to basically curl up on the settee there and switch the telly on and just block everything out, that's what I want…. I don't class myself as a good mother at all. I don't give the love; I find it hard to give the love because I never had the love."

Fortunately Sally's mother was able to love her granddaughter where she had failed her child. Sally knew that with the death of her mother she was the only source of love and comfort for her daughter and tried to give it to her. She knew she was unable to give the physical love she knew her daughter needed from her. Sally had been able to bring this to the group and was in turn helped by the other mothers. Since the ending of the group she had been able to draw from this help at different occasions and felt these coping strategies were of great use.

“Since mum died the group probably has helped me, in that taking more note when she says she’s got no one to play with, no friends and how upset she is and how distressed she is. It’s helped me to take note and try and help her and love her and give her the cuddles and tell her, no it’s ok, don’t worry….I think it did help me.”

As the final interview was drawing to a close, Sally was asked her opinion of the size of the group. She was comfortable with the size and voiced her opinion about not being given the space or the time in a larger group.

“I think it was ok size; it wasn’t too many. It was a comfortable size. There was enough people so that you all got a chance to talk and listen and, sometimes if you have too big groups, there’s not enough time for people, but I think it was a good size.”

Her overall observation of the group was that she had found it helpful and had managed to absorb enough of the information she had learnt to be able to draw on it in later stages. She especially felt that it had helped her with her relationship with her daughter. She had also enjoyed it.

"I enjoyed it, it was good. Things that were said were useful. Something will happen and you suddenly think, oh yes. So it has come in useful at times and it has helped a lot with [my daughter], thinking about it."

5.7 "Joan"

5.7.1 Personal Details, ED and Medical History

Joan was 35 and lived with her husband and two children both girls, aged 7 and 9. She is the eldest and has one brother and one sister. Both parents are living. She had an ED from the age of 18. She had gone to live with a friend for 2 years, who she refers to as a surrogate mother. At that time she had 3 years of counselling for her ED. For the preceding year and at the start of the group she had been on Cipromil, for depression. At the time of the initial interview, she was drinking over the recommended amount of alcohol and she was also self-harming quite badly.

"It's like a release valve for me, if it doesn't sound silly. Otherwise I just go round with, round and round in circles with things in my head and I've got nowhere for it to get out".

5.7.2. Referral and Onset of ED

Joan was referred by her psychologist, who she was seeing every 6 weeks for depression. She felt that this was too infrequent to be helpful. Although she had a BMI of 15.5, she was not being treated for an ED but her psychologist was aware that she had been diagnosed with anorexia in the past and thought the group might help her. The onset of her ED was when she left school at 18.

She was unsure how it evolved, but knew that she was unhappy at home and felt that not eating helped her to control her situation.

“I don’t know how it started, I just hated being at home and I felt that I was resentful that I had to be at home with my parents. I didn’t like it there. And I don’t know how it happened, but I just did stop eating”.

The only therapy Joan had received for her ED, was at 18 when she was diagnosed and this was for 2/3 years. On her own admission she did not feel that she was able to make full use of the therapy provided, at that time

“Half didn’t know why I was doing what I was doing and part of me didn’t want to talk either, so it was helpful but I didn’t know myself then as well as I do now.”

5.7.3 Suitability for the Group

At the initial interview for the group, Joan found it difficult to admit that she was still anorexic and had anorexic tendencies. While she was reflecting, with the interviewer, she began to realise that her behaviour around food was not natural and in fact was very controlled.

“I’m not anorexic now and I wouldn’t stop eating because of my children but….. My eating at the moment is sporadic. I don’t eat a lot at the moment. I’m underweight at the moment. I do think about what I eat every day and at the end of most days I do tot up on a pad. ”

5.7.4 Family Pathology and the Mother/Daughter Relationship

Although Joan was the eldest of two siblings she was not close to either of them and did not see them often. She did not have a good relationship with her parents whom she came to resent. As an adolescent she felt herself retreating further and further into her own world. Joan managed to build up a relationship with someone outside the home, who she refers to as a “surrogate mum”. When the situation with her parents started to escalate, she went to live with this person.

“Yes I just used to shut myself away in my bedroom. Got to the point where I really didn’t want to speak, or see my mum and dad at all. And I hated it if they did try and talk to me. Someone that I became close to, who’s like a mum to me now, I eventually went to live with her. My eating didn’t particularly get better living there but emotionally I was better”.

Joan’s only source of support for many years was her surrogate mother, but she felt she had recently pushed her away. Joan found it difficult to deal with emotion and felt that her surrogate mother was being too emotional when dealing with Joan’s issues.

“I’ve been unable to cope with that recently. And she is in either floods of tears or shouting at me and I don’t want to be dealing with either, so I have consciously on purpose shut myself away from her recently.”

Joan struggled with remembering a great deal of detail connected to her past, but recognised that she reached a stage when she did not care what her parents felt. Her experience was that her parents had not nurtured her and she felt unloved and uncared for.

“I really didn’t care what they felt. You know, they didn’t really care about me, so why should I care about them.

One component of the group was to help these women to understand and recognise the reasons why their ED had started. Understanding how it started contributes to the recovery process and helps those with EDs to come to terms with the past. At the 6 month interview Joan had a better understanding.

“I think a lot of how I am, is because of the lack of a relationship that I had with my mum…. I don’t know whether that’s why I was anorexic to begin with. It probably was; I know I was unhappy at home.”

5.7.5   Food and Feeding

When Joan first became anorexic, she used food as a powerful weapon against her parents. She felt it was a way she could take control away from them and as she felt rejected, she wanted to reject them and food became the way she could do this.

“And at that time, it’s hard to remember back now, but at that time, I just didn’t want any food in me. I just didn’t want anything and I hated it.

I didn't want people to force me to eat and I felt that it was a way of saying, "Up yours," if I didn't eat because I could control …."

Joan did not have any happy memories of eating in the family home with her parents. This affected her ability to relax and enjoy eating at home with her husband and children. As a consequence mealtimes were stressful for her and she avoided them as often as she could.

"Over the last year or so, I've hardly sat down and eaten with them at all ….It's just I prefer eating out and not in my home. I don't know why. I've had bad memories of eating at home, when I was growing up and I don't know if that's why I find it hard to relax in my own home"

As a child and adolescent Joan felt isolated from her parents and siblings. Although she worked as an adult, she felt that she still led an isolated life. Even though her parents lived near to her, she found it stressful to go back to her old home and had very little contact with her them. Her in- laws lived quite a distance from her and she recognised that she had only one close friend.

"I'm not close to my mum and dad at all, so I don't have them for support and they don't really know much about me".

The only time Joan felt relaxed enough to eat and socialise with her children, was when she went out to eat. She felt stressed about mess at home and always wanted eating to be over as quickly as possible without any delay by "chattering".

“Yeah they sit and chat. It’s funny I can’t let them chat loads and eat, ’cos I think their dinners getting cold and I want them to eat it and hurry up. It’s like I can’t; I don’t, I never thought about it before…. I never thought that before but it’s like I’m wanting it to finish….Yes, in fact when I’m out I don’t tell them to stop chatting..”

Joan’s eating depended on her emotional wellbeing; if she felt bad she didn’t eat. Even when Joan was in the house at mealtimes, she tried to avoid eating by busying herself with other things. She often made excuses to be out of the house during mealtimes.

“If I’ve had a bad day, I really don’t want to eat ….I have hardly sat down at all over the past year….I get busy doing other things….”

Even when Joan did eat with the family, she restricted her intake and only ever had one course.

“Sometimes, I’ve recognised that I’ve eaten no more than the children…. [My husband] will sometimes have a pudding with them, but I never, ever have pudding.”

After attending the group, Joan had been trying to make more of an effort to eat with her family. But she recognised that she did not eat the same food as the rest of the family. Her eating was still very secretive and she fooled her husband into thinking she ate more than she did.

“But I’ve been trying to make a bit more of an effort more recently, just

to sit down with them at the table, but last week I sat down, had soup. I didn't have what they had. [My husband] has been making me sandwiches recently, for me to eat at lunchtime. I've sort of taken them out to town with me and chucked them away, so he doesn't know about that…"

The group had been able to help with her anxiety, which had enabled her to be more relaxed during mealtimes. She was able to be quite reflective as to the reasons why she found mealtimes such a trial.

"I am less anxious than I used to be, actually when I am eating with them, definitely, so that has changed. I suppose I don't want to look back on memories about eating at home."

Restricting her food had become a habit and a normal way of life for Joan. Most of the time, it was not even in her conscious thoughts. As discussed previously, she was unaware of her emaciated appearance.

"No it's just a way of life for me really. It's become the 'norm' for me."

Before the group, Joan's eating was connected to her emotional well being and if she was feeling anxious or depressed she would not eat. Since the group, she had been able to understand her feelings more and had been able to disconnect her eating from her mood. This had enabled her to gain a more stable weight, which she had been able to maintain.

"Well my eating is a lot better than it was and I'm the heaviest now for probably three or four years. I don't not eat when I'm down or fed up and

that used to be a really big thing with me, which is why I lost the weight because I just didn't eat….I used to feel like I was in control by not eating, but I don't feel like that now that's probably why I am able to maintain my weight now."

One of the main factors in the formation of the group was to raise awareness in several areas of these mothers' lives; this in turn decreased anxiety. Any improvement in awareness and reduction in anxiety was seen to be a positive outcome. Joan was able to recognise that she had become more aware of her dysfunctional eating habits and this was making a considerable difference to her well being.

"I would say my anxiety levels have gone down since the group…. It's also made me realise though, that my eating habits aren't normal, it has raised my awareness of that, as well I think."

5.7.6 Modelling

Joan never ate breakfast and found it the most stressful meal of the day, as it was the one she couldn't avoid with her children. She was totally unaware that the battle to get her daughters to eat breakfast, stemmed from the model she gave to them.

" I don't have breakfast, but yeah, I feel that breakfast is very much a chore. You know, I think that they have to have breakfast because it's important, at the end of the day, so I give them breakfast. Quite often, it's a battle with my two as to what they want because [my daughter]

quite often doesn't want anything and I battle with her saying, you need to have something really.'

Joan's experience of eating a meal was a very dysfunctional model. She has no memory of ever eating together with her parents and mealtimes were never a relaxed sociable occasion. When she came to the group, she still believed that meal times were not for conversation. She had taken her model of mealtimes as a child and repeated it during mealtimes at home with her children.

"I never used to eat with my mum and dad as a child. They never used to eat with us….I've always thought that whenever you're eating you don't really talk, maybe, but people do talk though don't they?..... I just feel awkward sat at the table at home, a lot of the time, I feel awkward."

During the group the issue of modelling was stressed and repeated as an important component. It was felt that it could not be repeated enough that children will absorb the behaviour that they are exposed to and it will make a difference to them now and in the future. Joan found this aspect of her eating behaviour particularly difficult to change.

"[My youngest daughter] actually said "You don't very often eat with us and I'd really like you to". I think maybe I ought to try and eat a couple of times with them….It's just a habit I've got into, I just tend to say no."

Joan did not feel comfortable with herself and this led to her putting barriers up when playing with her children. She felt awkward and was unable to join in with their games.

"I don't enjoy it, but there again I feel like I'm the odd one out. I feel awkward. I don't play with them. And if [my daughter] says, "Will you come and play with this with me?" I just say, 'No, ask daddy to'. I don't play with them".

On reflection Joan realised that when she was younger, her behaviour was quite obsessional. But she acknowledged that her husband was an important influence, in helping to normalise her activities. Although she felt that she had improved, she still found mess a problem.

"I'm pretty fastidious around the house…It used to be a real issue for me, and my car particularly. I used to hate anyone getting into the passenger seat of my car. I'm not like that now. I clean the house to how I want it and I just do it regularly. I'm not one to let it get messy."

5.7.7 Body Image

Joan had a deluded view of her body, on the one hand she felt contented with her body, but she also recognised that her body image was distorted. She felt weight is acceptable on other people, but not for herself.

"My body, I'm okay with my body. There might be bits of it I don't like but I don't think I'm abnormal, different from anyone, in that respect.

I think maybe I have a distorted view of what I look like. I don’t particularly want to put any weight on…”

Looking back at photographs of herself, confirmed Joan’s distorted body image. It shocked her to recognise that she was so underweight. Even though she had irrefutable proof of it, she was unable to allow herself to see herself in this way.

“Maybe, I don’t see myself as other people see me, I don’t know. Sometimes when I’ve looked at photographs of me, I thought I looked absolutely terrible.”

Joan kept a tight control on her weight and although she knew she was underweight, she had an irrational fear of gaining weight. When she gained only slightly, it panicked her into wanting to lose it.

“Sort of, if I get on the scales and I’ve put on two or three pounds, I want to go back to losing it again, which I know I shouldn’t think that. I know I should put the two or three pounds on and put more on.”

During the group, she had managed to readjust her maladaptive thoughts in connection to her body image and since the conclusion of the group, she was working hard to maintain that change. It was a great achievement for Joan to gain weight and it took great courage to maintain it.

“***I try to take on board what people say and to believe it, because I’ve put on over a stone, and people say to me you’re looking really well. I try and think well they’re right and, I’m wrong. So, it’s getting used to maybe, not being able to see your hip bones quite as much and just accepting that’s how you’re supposed to be and not how I think I was supposed to be.”***

5.7.8 Separation/Individuation

Joan was the eldest of three children and felt she was ignored and not cared for. She started to isolate herself because she hated being at home.

“I didn’t like being at home and I felt that I was resentful, that I had to be at home with my parents.”

Joan used her ED as a way of rejecting her mother after years of feeling rejected herself. Her ability to separate and become an autonomous individual became the basis of her ED. Not eating became the only way she felt she could take control.

“I didn’t want people to force me to eat and I felt that it was a way of saying, “Up yours,” if I didn’t eat because I could control … they didn’t really care about me so why should I care about them”.

Her life at home became so intolerable for her that left home to live with a friend, but she held on to her ED which became who she was.

“Just got home from school and shut myself in my bedroom. And someone that I became close to, a lady, who’s like a mum to me now…I eventually went to live with her…. My eating didn’t particularly get better living there.”

5.7.9 12 Month Interview

At the twelve month interview, Joan’s circumstances had not changed and she was still living with her husband and two daughters. In the previous interviews Joan had recognised that the group had enabled her to be more conscious of responding to her daughters as children not adults. She felt that before the group, she had not tried to understand them and her natural reactions had been to expect far more than her children were capable of. Because of this new understanding, Joan was building a stronger and closer relationship with her children, which she was continuing to develop.

“I would say that I am probably closer to my children, but I am much more aware of, how things are different from a child’s point of view and I spend much more time with them now. I’m better now anyway, in myself. I remember that they’re a child and not an adult.”

When Joan was attending the group, she was spending a great deal of time off work. At this interview she was feeling much better and stronger in herself. This was making it possible for her to do well at work.

“In fact, I would probably say, that this year is the best year I’ve had at work for quite some time. Things at work are going really well at the moment for me.”

Part of the characteristics of an ED, is low self-esteem and heightened anxiety with various levels of depression. Joan felt that the group had helped her in all these aspects and she had been able to maintain her new found strengths.

“Well since the group generally, I’ve become less anxious over time and a lot less depressed, ….I think that made me become gradually better anyway. My own strength, I think has probably gone up, which is part of it. A lot of what we were talking about was accepting yourself and, so I think it did help.”

One of the aims of the research was primary prevention of an ED for the children. One of the keys to success in this area was to improve the relationship that the mothers had with their children. This would enable the mothers to be more aware of their children’s needs, leading to a better all round understanding of them. Joan seemed to adapt to and retain this. Since she was able to respond in this way at the final interview, it could be hoped she would continue to maintain these changes, in the future.

“The way I approach them and talk to them, is with more understanding. A lot of what we talked about in the group, you have to see things from their perspective and they need reassurance, they’re not adults. Before

I went to the group, I used to say, ' Oh don't be so silly', if they're upset. Now I'll try and understand why they're upset and so I think just always try to remember that they are children and they've got a long way to go before they are adults."

The group helped Joan to realise that children internalise their environment even if they don't acknowledge it to us. To Joan, this was an important part of what she had learnt from the group and it felt that she was determined to make the necessary changes to the way she related to her children.

"I think that's something I've learned about, their level of awareness of how I am. They are aware of it and do take it in. It's just raised my awareness, of how children think and act in response to what you do, or say, or don't do, as the case may be."

Awareness was one of the key components of the protocol of the group. Awareness helps you to get in touch with your feelings, which leads to understanding why we are having these feelings and what causes them. Without understanding and awareness there cannot be any change. Joan had benefited from this aspect of the group and at 12 month, had integrated it into her present life.

"I think I'm more aware, because I don't confuse how I feel with where my life might be going. Things are as they are and I sort of separate the

things. I am aware of my own feelings…. Only you really know how you feel.”

Understanding your feelings, opens up the possibility of choice and choice gives you control. Recovering from an ED, is not just about weight gain and better eating habits. It is important to address all the aspects of low self esteem and to allow the sufferer to take control of their lives, which in turn gives them the confidence to trust their own judgement once again.

“ It has made me feel more confident about the way that I am raising my children and made me less worried that, despite how I’ve been, that they’re still going to be okay, so long as I listen to them and are aware of things.”

A vital part of recovering from an ED is regaining self-esteem and feeling confident. If you regain these facets of who you are and you value yourself, being valued by others begins to follow. Joan had been able to do this.

“I value myself as a mother, I think they value me, I think I do a good job and I think both the girls know what I do for them…. I think I probably learned why mums are important and other ways to fulfil your children. I think probably, I do feel more valued as being a mother for them.”

As this interview was the last contact of the research, it was important to get a final assessment of the group process as a whole. Joan was asked if the she had received any benefit from the group and what in particular she had felt had helped her the most. Joan talked of the group being better than any other counselling that she has had, that it helped her eating and the support it gave her made her feel less isolated. She felt it was a safe, non judgemental place to disclose her feelings and that being with other people with similar problems, helped her to feel understood.

"I think that I found the group far more helpful than anything else that I've ever been to. It's been more useful than any of the one to one counselling I've had. I just think it's good to talk to other people in a similar situation, and even from the eating point of view, I'm really glad that I did. Lots of other things that the other girls were talking about, I could identify with and probably vice versa, so it makes you feel less isolated. I took an awful lot away each time. It felt like a really good way to get support…You're discussing your problems and your issues and thinking about ways to resolve them. Why you are like you are, or how you might do something different and if that would be better, or not? It's not saying to someone, you've got to start eating, this is ridiculous, it's not like that….It was very open and discussing things and by the mere fact that we had that discussion time, you would just go away and think about those things as well. So I think it's a really good approach….a very safe place and very non judgemental. Nothing's being rammed down your throat. You're just there to discuss things and listen to approaches to help you, to reflect, and to decide for yourself, but there for you to think about."

It seems that the group was a significant experience in Joan's life. When she came to the group she was off work, anorexic, depressed, drank too much and self-harmed. Twelve months later she had gained weight and retained it, she was back at work and doing well. She cut down her drinking and self-harm was a thing of the past. She had learnt strategies and coping mechanisms that she felt she was not going to forget.

"I'm doing so well at work now and things are going alright. The thought now of cutting myself would feel, I couldn't do it now. So that must say a lot….And I thought I really hope that I don't ever go back down that route again, because things like, cutting yourself and stuff, I could hide that away from my children because they were younger and I could just say, 'Oh I cut myself cleaning the car'. They're that much older now, that if I were to get depressed again and do that sort of thing, it would be more noticeable to them. They wouldn't be stupid, you couldn't hide it…. I'm just happy that I am where I am and I don't want to get ill again. I think I've wasted, certainly a lot of my younger years, being ill and I don't want to do that. So I know I'm determined to stay well….It's funny, I mean I didn't really write down anything but, it's just like ingrained in there and….you practise it, don't you, every day, with the children."

The size of the group was very important to Joan, as she felt that she was able to feel safer with a smaller number of people. She felt she would have liked it to continue, because it was helping her and she felt supported by it, but accepted its ending.

"Yes, I think, having a smaller group we came to know each other better, so more of us opened up more, I think. I think, if the group had been the original size, I think it would have taken a lot longer for everyone to fully open up and I think, that being the case we wouldn't perhaps have been able to discuss all the issues and get as far as what the group did. I suppose it's like anything, if you think it's helping you and it's beneficial, then you obviously want it to continue. It was beneficial and it would have been nice for it to have gone on for longer, but that's just because you've got that support line. But I think, in terms of the length of the course itself, it was okay."

Joan's overall view of the group was positive and she had gained a considerable amount of helpful information from it, which she could access for the rest of her life.

"My overall view of the group is very positive….very positive, yeah, and helpful….It's definitely helped me and I'm sure it's helped the others as well. All of us are very different, but I'm pretty sure, that it's helped all of us. So I'm just very pleased that I agreed to go."

5.8 Analysis of Themes Across all Cases.

5.8.1 Mother/Daughter Relationship

During the group two of the participants, namely Tessa and Sally, had a strongly reliant relationship with their mothers. They depended heavily on their mothers for help with their children and every day life. Maggie found a similar dependency with her mother-in-law and although Joan found a surrogate mother, at the time of the group their relationship was strained and Joan was more self-sufficient. All the participants had a long history of dysfunctional relationships with their mothers.

Sally and Joan experienced their mothers as absent contributors to their lives. Sally's mother was a nurse and worked nights which meant she slept during the day and took no interest in Sally, leaving her with feelings of abandonment. Although Joan's situation was very different to Sally's she also felt that her mother took no interest in her and felt alone, rejected and abandoned, resulting in her leaving home.

Tessa and Maggie experienced their mothers as controlling and manipulative. Maggie's mother called her names and was blatantly hostile towards her and made her feel unloved and unwanted. In one situation her mother left her in a bed-sit and would not allow her to return home. Although at the onset of the group Tessa reported a close relationship with her mother, on further examination of the relationship she recognised that her mother called her derogatory names and Tessa felt she was always having to live up to her mother's expectations of her. Both Tessa and Maggie were constantly being compared unfavourably to their siblings by their mothers.

Maggie felt that her mother had never supported her or nurtured her but had belittled her and scapegoated her. By the end of the group she had come to realise how big a part her mother played in her becoming ill. Tessa had the added disadvantage of having an abusive first husband and this compounded her feelings of insecurity. The abuse from her first husband had also taught her eldest son to verbally abuse her, which she felt she deserved. Sally had felt invisible in her family and had always felt an outsider. The abuse she suffered at the hands of her Uncle engendered such a fierce self loathing, that she was unable to show affection to her own daughter.

5.8.2 Food and Feeding

All the participants found food and feeding a problem, from being able to know what food to buy, to deciding what portion sizes to give their children and feeding themselves. They were all frightened of weight gain and used laxatives and purging to various degrees. Tessa and Sally used copious amounts of laxatives after they had eaten and Maggie had used vomiting so regularly that it became an instant reflex. Joan was the only one that did not use purging or laxatives but restricted her food intake severely. Food restriction had been Joan’s way of rejecting her mother as she had felt rejected by her. This had started in her late teens and was the onset of her ED. Mealtimes with the family were avoided as much as possible for all the participants. Sally sent her daughter to her mother for most of her meals which meant that Sally could say she had eaten and go without; she kept very little food in the house. This form of deceit was also used by Joan who would sit with her family while they ate, having said that she had already eaten. Maggie and Tessa did not eat meals with their children so that they could more easily eat a different meal to the family. They also used diversionary tactics to evade eating, such as telling their husbands that they had eaten with the children. They were all very conscious about what they gave their children to eat such as ‘healthy’ foods with no fat. Treats such a sweets or biscuits were a rarity and to be avoided.

5.8.3 Modelling

When the group first started, none of the mothers thought that their children modelled their behaviour. They were in complete denial and were under the misconception that they hid their ED from their children and that their ED and their children were completely separate. As the group progressed and the sessions for modelling were completed, the participants recognised that there certainly was a link and that they had not wanted to acknowledge it. As the concept of modelling began to be understood, the group began to realise that some of their behaviour had come in turn from their mothers.

The participants looked back on their childhood and realised how devoid of physical contact it had been. They didn’t remember cuddles or comforting of any sort. This had a devastating effect on Sally who found it very difficult to give her daughter the affection she needed. Indeed, at the beginning of the group Sally’s relationship with her daughter was in imminent danger of breaking down completely. At the end of the group, Sally had understood that because she had not had any nurturing from her mother, she found it very difficult to nurture her daughter. The input from the group had helped her to adapt her behaviour and the relationship became stronger. Maggie, Tessa and Joan had tried to use their mothers' behaviour as a lesson in how not to do things and tried to nurture their own children differently.

By the end of the group the participants all recognised that they had to lead by example and that their children did notice and internalise the behaviour that they were shown. They all gave examples of comments that their children had made regarding their behaviour, which they had not wanted to acknowledge before.

5.8.4. Body Image

All the participants had a morbid fear of weight gain at the start of the group. They all had a distorted view of themselves and felt very conscious of what they looked like. They were frightened of other people's judgement of how they looked and believed that other people saw them as 'fat'. This fear impinged on their ability to lead a normal life, as it stopped them from going out and mixing socially. During the group only Sally was working and she found this very difficult. She did not go out socially for fear of how she looked. Maggie felt picking up her children from school particularly difficult as she felt the other mothers were judging her weight and how she looked.

It was commonly discussed in the group that the mothers regularly asked their children if they looked fat. As it was discussed, they came to realise how damaging this could be to the children and how they were passing on a pervasive dissatisfaction with their body image and their fear of weight gain. All the mothers in the group were very conscious of the weight of their children and were not able to tell if they were a normal weight for their age and height. They all stated that they feared that their children would become fat and watched their food intake to control this. Tessa and Maggie were the only ones to have boys and girls and admitted that they watched what their daughters ate more than their sons.

By the end of the group Joan had managed to put on a stone in weight and was able to feel positive about it. The rest of the group were keeping to a stable weight and recognised how distorted their body image had been in the past.

Because of the adverse life experiences the participants had experienced, when the group ended, it was difficult for them to hold on to any inroads they had made into improving their self-worth, which would have in turn increased their self image and helped with their feeding problems. Joan was the only one who was able to maintain her increased weight.

5.8.5. Separation / Individuation

The whole group suffered from a complete lack of self worth and this affected their ability to take notice of their own feelings, trust their judgement and generally believe that they were of any value. Sally and Joan both self harmed while Maggie vomited as an automatic reaction and Tessa overdosed on laxatives. This lack of self worth meant that their capacity to become autonomous adults was greatly impaired. Sally and Tessa both had a dependent relationship with their mothers which made separation virtually impossible and Maggie had a more dependent relationship with her mother-in-law, but longed to be accepted by her mother. Joan had physically separated from her mother when she left home to live with her surrogate mother and was more independent than the rest of the group. She had a responsible job, but at the time of the group was off work for reasons of stress and depression.

Chapter 6

6.0 Findings (The Groups)

6.1 The Analysis of the Groups

The analysis presented will be of the first session, session 5, session 10, session 16 and the last session, session 19. A brief description of the penultimate session18 is also included as it opened some important material that was relevant to the final session. It is hoped that from these abstracts the reader will get a feel of the content and process of the group as a whole

These abstracts show the progress of the group, the difficulties the participants had during the lifetime of the group and the resulting drop out population. The hypothesis of the research was that a group therapy intervention would help mothers with an ED to improve and by achieving this goal it would in turn help to reduce the likelihood of transmission of their ED to their children. It has been found by previous research (Lask 2009, Bryant-Waugh & Lask 2002, Collier et al 1999) that there is a genetic component to EDs, but this need not necessarily lead to the development of an ED. The environmental climate that the child is exposed to could be a greater risk.

Several studies have found that people with ED suffer from alexithymic tendencies and that there is a co- morbid likelihood of depression and anxiety. Because of this ED sufferers often present a diminished capacity to articulate their experiences and are disconnected from their emotional functioning

(Motebarocci et al 2006). The reader will appreciate this as the analysis unfolds and the verbatim transcripts are presented. The full protocols of the group sessions that were analysed and used in the findings chapters are shown below. The full protocol for all the groups are to be found in the Appendix 3.

The first group was the base line of the intervention and as such laced with anxiety. The group members were anxious at meeting one another and the facilitator was anxious that everything possible had been done to create a welcoming and safe environment. The participants had all been suffering from an average duration of their ED of 17.75 years, qualifying them for the diagnosis of Severe and Enduring Eating Disorders (SEED Robinson 2009). Having had a ED for this length of time meant that the ED had become severely embedded and as such made it far harder to treat.

Fig.3. The protocol of the first session.

1st Session.

Introduction and getting to know one another.

Large name tags are given to each participant as an ‘aide memoire’. The facilitator begins by thanking them all for attending and reiterates the purpose of the group. Introduce them to the six categories that will be focused on: **Food and Feeding, Body image, Modelling, Individuation, Separation and the Mother/Daughter relationship** and say that each category will be addressed over two sessions. The remaining sessions will be left open and used for discussion and to re-cap. Remind them that the group is being used for research purposes and therefore the taping is necessary. The importance of regular attendance needs to be stressed and the dates of all the sessions together with the breaks are distributed. The benefits of using each other between sessions for support, is to be discussed. Remind them of availability of the crèche. Confidentiality within the group and outside the group is to be stressed and the confidentiality form is to be given to each participant to sign. The facilitator’s contact numbers and names and contact numbers of the group to be distributed.

Going around the group, asking each of them to tell what they want about themselves at this stage only e.g. what they do, their family of origin, brothers/sisters, where they come in the family, parents.

Going round the group, asking each of them to tell what they want about their current family, e.g. significant others, how many children, what ages/sex, if at nursery/school, partners, pets, what is their favourite thing that they like doing with their family.

Going round the group asking each of them to talk about the problem that they have with eating and food, e.g. when did it first start, how long they have been suffering.

Encourage interaction.

When coming to the end of the session summarise and ask for any questions. Ask what their expectations of the group are. Reiterate that the facilitator is available, if needed, in between sessions. Thank them again for attending and look forward to seeing them next week.

6.2 1st Group Session

There were seven participants present, Maggie, Joan, Sally, Tessa, Sue, Jenny and Mel. Linda was absent (Please see histories in previous chapter).

As we gathered for the first session of the group there was a great deal of tension. A crèche for the children had been provided for the mothers who had been unable to secure childcare for the time of the group session. Nevertheless some of the mothers found it difficult to separate from the children even for this short period. Jenny's child sat outside the room with a relative. This consequently became a disruption for Jenny who began to excuse herself from the session.

After the group was welcomed, an explanation of the purpose of the group and how the group would progress was given. We then went round with the initial introductions. It was thought that at the first session the participants should get to know one another before the themes were introduced. The initial function of a group that consisted of individuals with similar pathology was for them to be able to voice their problems and concerns without the risk of judgement (Brunori 2004). During the first session of the group, the benefits of homogeneity within the group became rapidly evident. The first commonality to be disclosed was the belief that they would never be able to have children.

Sue "I was suffering with anorexia from when I was fourteen and then I was told that it was very unlikely that I could ever get pregnant and then one day, oops-a-daisy, I got pregnant."

Maggie "I was told also that I would never have children. I've been anorexic since I was fifteen."

Jenny "I was anorexic since I was fifteen and I was told I'd never have children, never.

It has been acknowledged that mixing adolescent and adult ED clients is detrimental to the progress of the group and that neither party feel that their needs are met (Wanlass et al 2005). The commonality of a mutual illness and also the reality that they were all mothers seemed to play an enormously important part in the ability to understand one another.

Maggie "I don't think I'd be here now if I hadn't had the children."

Joan "Yeah! It's the children that keep me alive. Especially quite recent, I've had periods of hurting myself and stuff."

Maggie "Coming out of hospital I almost got quite angry. When you're not a mum a lot of the teenage girls in there…. I've been in there as a teenage girl. You can be incredibly selfish 'cos you've got no one else."

Women with eating disorders are often consumed with guilt and shame which leads to isolation (Garfinkel & Dorian 2001). Although there is an increased risk of foetal abnormalities in women with EDs, the mother's body appears to prioritise the nutrition of the baby over the mother (Robinson 2009).Their amazement at being able to fall pregnant and then their accompanying guilt about harming the baby, started to spill out. The group very quickly became the place where they were able to compare and share the experiences related to their illness without the accompanying feelings of being judged (Brunori 2004).

Jenny "I mean everyone was just in complete shock that I was having a baby 'cos I was never meant to be a mother."

Maggie "I found when I was pregnant, I'm ashamed to have been sick. so I told them I had an eating disorder and he just said- I think to try and scare me- but it didn't, 'The only person you're going to hurt is yourself, 'cos your baby will drain every last bit of stuff from you'. And I thought, oh that's okay then, so as long as the baby's all right. And then he said, 'Oh, some people are sick all the way through pregnancy' and I thought, Oh well, that's okay. So I justified it in my head that I could naturally be sick and then I'd eat an apple for the baby."

Sally "I've heard stories and things and when I first found out about it, I started to bleed. I was making myself sick in the beginning and when I had the bleed and they took me into hospital to have the emergency scan, is when I suddenly thought, I can't do this."

Joan "I was anorexic when I fell pregnant with [my daughter] and to this day I still am. She was born at thirty weeks and she was like a tiny premature baby and I still feel that's my fault 'cos even when I fell pregnant, I decided well, I know I've got to eat now 'cos I'm pregnant. She was premature and that's because I couldn't provide properly for her because of what I was like."

Maggie "That's it. I know what you're saying. I'd had a miscarriage after my first baby and I put that down to the anorexia."

They started to find out about each other's treatment for their ED and three members of the group discovered that they had been treated at the same hospital. This led them to compare notes and to understand how completely different they felt to the patients who were not mothers. In Maggie's case she describes how angry she felt that there was no recognition of the added problems that face mothers with an ED.

Maggie "I've been in there as a teenage girl you can be incredibly selfish 'cos you've got no one else. Everyone has walked away from you and had enough so the only person who you're hurting is yourself so you don't care about yourself so you just go on self-destruct….When it's affecting your whole family you've got the added guilt but not just the guilt of the food and the guilt of feeling fat and the guilt of all that. You feel guilty 'cos you're wrecking other people's lives and pulling them down and you're not being a good mum. It might be affecting them. The

guilt's incredibly hard to cope with and then your low self-esteem gets lower and lower 'cos you're a bad person for doing this to your family.

Sue "I was an inpatient at [that hospital]… It was six months…. I was nineteen, I went there when I was pregnant and I felt completely different to what I did before. You feel so much responsibility towards your child. You just feel so guilty about having the thoughts that you have."

Jenny "The first time I went to [the hospital] I had about three weeks to go before [my daughter] was born. I looked, I was, huge and walking around I just thought I did stick out like a sore thumb. I just hated going there then, "She doesn't have an eating problem she's nine months pregnant". I just didn't find it comfortable going there at all…. a bit intimidating really."

The group was then asked to talk about their histories and their understanding of how their ED came about. Having a specific focus was found to benefit the clients, but it did not prevent other issues emerging (MacFarland 1995). The group members were able to empathise with each other and began verbalising their own feelings of inadequacy. Part of the aetiology of an eating disorder lies in low self-esteem and a lack of autonomy (Garner 2002).They felt different to the other family members, which intensified their feelings of isolation and separation. As they progressively felt safer with each other they were able to disclose emotions and thoughts that they had felt were too emotive to be revealed.

Tessa "That's how I see myself, the piggy in the middle. I've got an older sister and a younger brother and I was always quite a chubby child. My dad used actually used to call me Miss Piggy as a joke. I wasn't as academically able as they were and even to this day I still feel totally inferior to them. I had to have quite a few operations on my joints and things when I was eleven, twelve. I ended up in hospital with plasters and obviously my weight must have started to become an issue. My mum would say, "Well go on a diet", not realising then that was the beginnings of when all my issues really started from."

Maggie "You feel like you have to apologise all the time. That's how I've felt all my life, that I'm a pain in the backside to everybody."

Maggie "Did you basically think you was adopted?"

Tessa "Oh yeah! I used to believe that they weren't my parents and that I used to have some strange beliefs about them."

Joan " I think that my eating issues started with two things. I was eighteen; I was with really attractive young women and I felt very inferior to them. I can't remember much of when I wasn't eating but I know that I didn't want to be at home and I used to come home from school and just

go upstairs and lock myself in my bedroom and sometimes I thought, 'Am I really part of my mum and dad?' Because I can honestly say now that they really don't know anything about me. They don't know how hard I find things. They never ring up. I feel that really I'm a stranger to them."

If the mother's support is inadequate or absent and the child's internal needs are not met, the child's development is affected by external environmental failures (Gerhardt 2008, Winnicott 1965) causing delays or dysfunction in the ability to form an identity. The group began to talk about the mother/daughter dyad and at this stage began to recognise what an important role the mother/daughter relationship played in the onset of their illness.

Joan "I don't think my mum knows anything about it. I don't think she understands or doesn't want to understand…. I think my eating habits got bad then because I felt unloved. I didn't feel particularly good about myself and I wanted to be loved. I so much wanted to be loved. You know I'd never been cuddled… I've been self-harming myself and they've seen that and so you just think why can't I just be normal?.... However hard I try I just don't feel complete and I don't feel whole."

Maggie "You feel like you have to apologise all the time for all the hassle of it. I always start my conversations, 'I'm sorry to be a pain.' That's how I've felt all my life, that I'm a pain in the backside to everybody… I can remember being thirteen and all I've ever wanted is my mum and

dad's approval and never getting it. No matter what I did, I didn't dare argue with my mum. Even now she frightens the life out of me."

Sue "My mum was anorexic so I grew up around my mum not eating a lot of food. I was always quite a plump little girl 'cos my dad used to give me sweets and chocolates, trying to make up for the fact that my mum couldn't take me out, or she couldn't even brush my hair, 'cos her hands were so bad with arthritis… So by the time I was eleven, I was ten and a half stone and my mum died. Everyone spoilt me even more to make up for the fact that she wasn't there and that's when I thought to myself, I don't want all this attention any more and I just shut everyone out and you go on a diet like you say and you just think it's I'm just going to go down to that weight and when you get down to that weight, 'Oh that was easier I think I'll just go down to that weight'. I'll just carry on 'til I got down to four and a half stone."

The conversation turned from their nuclear family experiences to how they behaved with their children. When the mother's own developmental stages have not been adequately dealt with and the mother herself is unable to distinguish between her own internal and external states, she is in danger of using her child to compensate for her losses (Farrell 1995). This can be clearly seen in the transference of the need for approval from parent to child.

Maggie "I think that's why these issues have come up more. Now I'm a parent myself trying so hard not to make the same mistakes and probably overcompensating, over cuddling, over loving."

Tessa "And over buying everything you can think of, to get the children's approval".

Problem solving, enmeshment and conflict avoidance are all present in disturbed interactive patterns in the families of ED sufferers (Lattimore et al 2000). These together with a lack of adequate mirroring and an inability to communicate can all be re-enacted within the group environment (Segercrantz 2006). The group can help to resolve these issues in a more constructive and positive way. This allowed the women, probably for the first time in their lives, to feel validated by others (Hudson et al 1999) which takes them back to the first stage of building the sense of self which is so deficient in them (Segercrantz 2006, Kohut 1985).

Jenny " I'm glad you said it, that you can't remember your childhood 'cos I was so nervous about coming today 'cos it's all I think all the time. Okay, I know I don't eat normally but I don't look like someone who's got something wrong about eating but everything you say is how I feel as well, you know. It's just made you feel that bit more normal I suppose that you're not the only one that's not normal."

Tessa " I don't remember hardly anything".

Maggie " I feel like I've had lots of different lives."

Joan "It's funny my mum is ever so good with the two girls and she loves them to bits and I think, well why wasn't she like that with me? But I still hate going over there."

The therapy group provided the space and containment that the participants needed to divulge and experience feelings that were previously too dangerous and overwhelming for them (Segercrantz 2006, Hudson et al 1999). They admitted that this was the first time that they had felt safe enough to divulge their secrets. They were now able to talk about the abusive behaviour they had suffered and the isolation that they felt.

Joan "I just feel very isolated and I feel that I don't have anyone to talk to about things. I've been upsetting her [my surrogate mother], so much with my cutting and my eating that it's got to the point now where she'll just have a go at me, so that I just don't feel that I can talk to her now either."

Sally "I can't make myself sick. I have to take laxatives and sometimes you haven't really eaten something, or even a little bit of apple sometimes. You've eaten that and there's too much in me and I just empty it out. When she's [my daughter] in bed, that's when I get the knife out, especially if I've had a bad time."

When children have experience of rejection or unreliability, their expectation is that their caretaker is unavailable. They learn not to express their needs as they are unlikely to be met. People that suffer from an ED have a diminished capacity to articulate their experiences and are disconnected from their emotional functioning (Motebarocci et al 2006). This results in the development of a damaged self that feels unlovable and unacceptable, deserving of rejection (Dozier et al 1999). The group spoke of their fears of being rejected and abandoned by their spouses. They believed that they were not good enough and their expectation was that they would inevitably be deserted.

Tessa "I fear all the time that maybe he won't be there 'cos that's what I feel like. Why does he have to put up with me and the way I am, you know? You know, I think to myself it makes me feel insecure if he finds somebody else who can eat normally, can enjoy life normally. Doesn't do things to themselves. Doesn't take pills in the morning just to get out of bed in the morning and stuff like that you know. That's how I feel".

Joan "He doesn't understand why I cut myself or why I don't eat. He's very black and white you know, 'if you want to eat, you love the girls, you'll eat won't you'… And if you say 'well it's not as easy as that,' he'll say 'Well it's just what you want isn't it?' I find it very hurtful and feel bad about myself so then probably cut myself 'cos he's made me feel bad about myself. 'Cos I'm angry with him."

Jenny "I suppose I always feel that [my partner's] going to leave me because he's eight years younger. I think he could have somebody his own age, glamorous, gorgeous and normal. Cos I think if I go out on my own he's not going to be there when I come home…. I think it's my own fault if he does leave. I can't seem to do anything to make myself better to make him stay."

Having a homogeneous group with motherhood as the common denominator in addition to the ED, helped the participants confront the possibility of a transgenerational link. The group allowed them to deal with the fear of passing on their ED to their children. They recognised that children mirror their main attachment figure and mimic negative as well as positive behaviour. This led them to acknowledge that their behaviour around food in front of their children was dysfunctional and could be repeated by the children.

Jenny "I didn't want my little girl to be like me. I just don't want [my daughter] to go through what I've been through.".

Tessa "He's twelve now and it's very, although they says now, it's not so common in boys. He's twelve, he's starting the teenage bit so he'll say, 'Mum I'm not eating today 'cos I'm getting fat.'

Maggie “They’re aware that I don’t eat meat so they think that’s because of my last operation. It’s all getting very complicated. They’re picking up on things you know.”

Tessa “They’re constantly saying to me you know, ‘Mum don’t eat that ‘cos you’ll only say something about it.’ They know what I’m going to be like if I do eat something. I’ll say that in the main, he is very aware of it so it is the same with boys.”

Sue “Well I’ve actually been through it because my mum was anorexic so I grew up around my mum not eating a lot of food. ‘Cos I used to be jealous of my mum’s figure when I was younger. She was so skinny and I was always quite a plump little girl. But it was only since I’ve had the baby now that I realise I don’t want this to pass on to her ‘cos it was passed from my mum to me and I don’t want it to carry on. I want to do something about it before she gets too old to actually realise that mummy’s not eating her meals and having her ask, ‘Why aren’t you having your dinner?’ I don’t want that to carry on.”

Sally “I look at her and I worry because I think to myself, you eat that, you’re going to get fat. And I’m biting my tongue not to say that to her because I’m so worried that she’s going to get fat and start worrying and things and I don’t want her to get fat.”

People with eating disorders can be morbidly self- absorbed and have obsessive relationships with food, exercise and body image to the exclusion of most other things. Inclusion within a group can teach them to become more altruistic and enable them to recognise that they have the ability and the capacity to help others, thereby providing them with a new counter-solipsistic perspective (Yalom 1985). As the group progressed the participants relaxed and felt that they were in a non judgemental space. This encouraged them to talk about their own experiences with their ED.

Maggie "I've got to the stage where I'm being sick so easily that I can't eat, can't control the reflux happening it's just like coughing."

Sue "I was like that….I remember when I was at my worst even if I have a cup of coffee or a little drink you feel so full that you had to get rid of it so even fluid. When it becomes so easy to get rid of, it's too easy."

Maggie "If I'm made to eat, then I'll just bring it up, but if I don't have to eat I don't bother…. And of course they're plonking food in front of me and say you've got to sit and eat that meal. But it's not then I need the help it's an hour later or half an hour later when I'm sitting there and I can still feel it coming up…. For me being sick can vary from eight to ten times a day."

Tessa "I don't actually get sick but I take enough laxatives to try and flush, make it feel okay that I've eaten, to get rid of it. I use Andrews and have used half a pot of it."

Sally "That's it! So you sort of have to eat it and so you then, that makes you feel bad and then I can go one of two ways. I'll either go over the top and then I'll eat and eat and eat or I'll go the complete opposite and not eat anything."

Joan "If I have cake, like that's the only time I make myself sick really…. so I've made sure there's lots of noise going on and I bring it up."

If the mother is suffering from her own eating disorder, her ability to feed her child may become distorted as a result. The child then becomes affected by the mother's incapacity to understand their correct nutritional needs and is indirectly affected by the manifestations of the disorder and the consequences of it (Duncan & Reder 2000). Mel who was present during the group but not participating, had spoken in her first meeting of watering down her child's milk. She was very concerned that the social services would find out and take her child from her. It was my feeling that this concern was the reason she would not take part in the group and eventually dropped out. She was encouraged to participate several times but after giving the basic information she would not interact. After the rest of the group talking about their own eating behaviour they moved on to how they felt about feeding their children and allowing them to have treats.

Sally “My mum is probably the one who gives her cakes and sweets because I don’t. I say ‘at the weekend you can have a sweet’ and if she forgets about it I don’t give it to her.”

Maggie “That’s what I’m sort of like with my boys. If they’re outside playing football, lunchtime will come and go and I’ve not thought about lunch.”

The combination of both pregnancy and an ED can be detrimental to both maternal and foetal well being (McNicholas et al 1996). Maggie started to disclose what an enormous physical toll she had paid for her ED. This led on to the group discussing how they felt when they were pregnant. For some the ED was so embedded that even the risk to their unborn child could not deter them.

Maggie “I’m paying the price now ‘cos I’ve got multiple prolapses ‘cos I’ve got no muscles left to hold my insides in. Now I’ve got to have an operation to have my bowel put back in a sling attached to my back. I’ve got my bladder put in a sling and attached to my back and all these things are going wrong now which won’t ever go right again and I’m sort of half incontinent as well. I can’t walk very far without feeling like I’m going to have a baby, so paying the price. You think you’re getting away with it, but you don’t get away with it, it catches up.”

Sue "I've heard stories and I started to bleed and that's when I started thinking 'cos I was making myself sick in the beginning and when I had the bleed and they took me into hospital to have the emergency scan is when I suddenly thought, I can't do this, it's not fair. So that's when I put it on hold for nine months and as soon as the baby was born it was like 'Right back down to business again' and you start doing the exercise and making yourself sick and I just want that to stop. I don't want that to carry on as she gets older. I don't want her to be looking at me and thinking that's normal and for her to do it. I've been through too much to want it to carry on."

Tessa "I was anorexic when I fell pregnant with [my daughter] she was born at thirty weeks and she was like a tiny premature baby and I still feel that's my fault 'cos even when I fell pregnant I decided I've got to eat now 'cos I'm pregnant. But I still feel that she was premature and that because I couldn't provide properly for her because of what I was like."

Maggie "That's it. I know what you're saying. I'd had a miscarriage after my first baby and I put that down to the anorexia."

The most common co-morbid disorders that are associated with EDs are self-harm, depression, obsessive compulsive disorder, anxiety disorders and some personality disorders (Fishman 2004). The majority of the group had definite incidents of depression and some were on medication. Tessa initiated the subject of treatment and how she felt about it. The main members of the group seemed to agree that treatment was not forthcoming or that it was delivered on an ‘ad hoc’ basis.

Tessa “Now that they’ve changed medication and done whatever again and I’ve had a couple of better days so all of a sudden they don’t want to know. Unless you say to somebody, ‘I want to kill myself,’ nobody takes any notice of you.

Maggie “Yeah I think that.”

Tessa “I mean unless you sort of really scream and shout and say things like that, you feel nobody listens.”

Joan “I think the NHS is really bad in being there to support people who are depressed. I feel really strongly about that, same as you do, and I see an outreach ‘cos I had to go to A & E ‘cos I cut myself worse than I usually do and so they came out and they were saying to me do I have suicidal thoughts? And I said, ‘No not really’. And I said to them there, that I need to speak to someone every week. I feel isolated and that’s one of the reasons that I cut myself.”

Maggie “It’s almost a relief when you’re taken in because you haven’t got to make the decision. I’m dreading this operation but part of me is going, ‘phew’ I don’t have to make any decisions again for a while. But

it's true you kind of have to be at death's door before they seem to do anything."

Sally "I had one good CPN and he left. Then eventually I saw someone in September. When I saw that CPN, 'Oh I'm retiring at Christmas'. And I'm still trying to get an appointment with the other CPN that's taken over from her. I've given up 'cos I'm seeing a psychiatrist in a couple of weeks time."

As mentioned previously some of the group had been treated in the same hospital. This specialist ED unit was the main source of referral to the group and had been instrumental in helping these women find some sort of relief from their ED. Before being referred to this unit, this tranche of the group had experienced inadequate or damaging treatment. Before Sue had been referred to this unit she had been an in-patient at an adolescent specialist clinic and was aggrieved by her treatment which she felt had not addressed the causes of her ED.

Jenny "Our GP used to say to my mum and dad, 'Try sprinkling some stuff on her food that might encourage her to eat more'. So I used to go there once a week, get weighed. That would be it. This went on for years. So it was my midwife actually referred me to [the hospital]. I had to wait 'til I was pregnant for somebody to send me to the right place."

Sue "You're out of control of what they're putting inside and your weight just shoots up and they're discharging you and expecting you to be better. So I just went home and lost all the weight and lost even more. I was in [adolescent clinic} for seven months and their treatment there was if you didn't eat you got force fed. And I didn't find the therapy there very good. I was in hospital, out of hospital and once potassium got so low my heart started going funny in there. I was on heart monitors and drips and I still didn't really care. I liked the attention when I was in 'cos everyone seemed to love me when I was ill, but as soon as you get better it's like everyone goes and leaves you and you have got the weight on, you're better. So the way to get them all back again was just to get ill again. And that's when I went to the [Adult Hospital]. That's the place that saved my life because the treatment there was if you want to get better then you eat. No one forces you to eat."

The success of the group is dependent on the mutual giving and receiving of information or "the affective sharing of one's inner world" (Yalom 1985). Even though this was the first group session it is to be noted that the majority of participants felt safe enough to be able to reveal a great deal about themselves. Sue was able to talk about what made her eventually decide that she wanted to try and recover and how even after having her baby she was spiralling back into her old learned behaviour.

Sue "Then my friend that I was in there with, she died of a heart attack and she was only twenty, twenty-one. I went to her funeral and it was

when I saw her mum and dad and all her family and I can remember sitting there feeling so guilty about what I'd been putting my dad through and my family through and that was the point in my life where I decided ... It's funny 'cos some days you just wake up and think, right that's it, I'm going to get better and you just make the effort and I've been doing it ever since. Now I've had the baby, you think why. I don't really want to eat now. I mean my weight went right up to eleven stone but I loved it. I loved being pregnant. I had a nine pound five baby a massive baby. But now it's gone; the weight is dropping off me. I'm back down to eight stone which is not, it's pretty good weight to be but the thing is the thoughts are coming back where I just want to carry on losing it and that's why the group has started at the right sort of time for me."

Tessa made a comment about how difficult it was for her to communicate on some days. This I felt was her way of reaching out to Mel who had remained silent throughout the session.

Tessa "I started off this morning not too bad and but some days I wouldn't be able to talk or anything. Some days I can't even get my words out and so it depends on what the circumstances are as well. Some days I just can't communicate, full stop."

Towards the end of the session, the group were invited to give their opinion of the session and to share any feelings that had arisen for them.

Sue "I always find it, if we talk to anyone and tell them that you've got an eating disorder that they look at you funny. To me, it's like people treat you completely differently when you're ill. It's nice to know that you come to a place like this and you're not on your own you've got other people who feel the same way as you, you're not a freak. But I plucked up the courage to come and I'm glad I did."

Maggie "There's not a lot that I can achieve these days but I can do something by coming. It's for yourself, isn't it?"

Joan "Well I'm glad 'cos as you know I did have reservations, but yeah, I have identified with a lot that's been said, so yeah, I'm glad.

Tessa "When I had the interview I found that very distressing because I don't like talking about myself."

It has been theorised that ED sufferers have difficulty in interoceptive awareness, communicating feelings and have a sense of ineffectiveness, (Montebarocci et al 2006). Mel was the one participant who had only taken part to reveal her identity. Even though she had been invited to participate several times, she remained silent and would not take part. She was encouraged to participate on various occasions throughout the session, but she remained silent. The atmosphere and mood of the group dictated that I move on and I decided not to press her for fear that she was finding the session too difficult and hoped she would feel more able to participate in future sessions.

When working on the protocol of the group it was felt that the group should be encouraged to interact with each other during the intervening period between each session. The idea was to build a source of support between the participants while the group was in progress. Once the connection was made between them, it was hoped that this would encourage them to use the support of each other when the group finished. When presented with the idea, at the end of the first group, it was treated with mixed feelings, but generally with enthusiasm at this stage. It is to be noted though, that this idea was never implemented by the participants and they did not contact each other either during the group or after it. They talked about it but never implemented it. The first session of the group was brought to a close by explaining the content of the subsequent sessions.

Other than Mel, they had all taken part at one stage or another although some had participated more than others. But generally, I felt that the group had opened in a positive way.

6.3 5th Group Session

There were 4 participants present for session 5, Tessa, Joan, Jenny and Sally. (Please see Initial Interviews Chapter 4 for case histories).

Wallier et al (2009) report a high drop out rate of 20.2% to 49.6% amongst in-patient in specialised ED units. They warn that these high drop out rates pose a serious obstacle to successful treatment and a greater risk of mortality. The group was experiencing similar problems to the in-patient departments in reference to drop outs. Session 5 was at a very troubled period, as many of the group were experiencing difficulties with what the group was bringing up for them. Some of the spouses/partners of the participants had been encouraging them to leave, as supporting them through this stage was becoming too complex and maybe too threatening. Women with EDs have mixed feelings on recovery; there may be substantial advantages in remaining unchanged. Change involves building a new personality (Treasure 2005) which might be detrimental to their existing relationship.

I was having trouble contacting Mel, Sue and Linda, as they were not answering phone calls or letters. Maggie had to take time out for surgery and it was uncertain if she would be returning. She was a particularly valued member as she was one of the leading voices and found it less difficult to express herself. The previous session had been expressly targeted at looking into their feelings around the group and helping them to voice their fears and uncertainties as a way of minimising drop out.

Fig.4. The Protocol of Group 5.

Session 5 . BODY IMAGE

Welcome them back. Go through any problems that they are having and then introduce them to the category of body image. Give them pen and paper and slowly give them the questions with enough time to write down their answers.
Be aware that this is a very sensitive subject.

1. Body Image Exercise
What do you feel about your own body image?
How did you view your body at different ages, 4/5, 10/11, 15/16, 20/21?
What messages did you get from other people about your body, at those ages?
How do you feel about your looks when you are with a group of people?
How do you feel when you walk into a room on a social occasion and people are already there?
How do you feel about buying new clothes?
How do you feel about having your photo taken?
Do you talk about your body?
If you do, under what circumstances and to whom?
Are you preoccupied with losing weight?
If so, why? What would losing weight do for you?
Do you have a particular part of your body that you dislike?
Why do you dislike about this part of your body?
What is the function of this part of your body?

Do any other members of your family share the same concern about this part of their body?
How do you feel about that part of **their** body?
What part of your body do you think can't be changed?
What part of your body do you think can be changed?
Do you fantasise about changing your body?
Do you have an ideal body image and if so how does it differ from your actual body image?
How do you think you would feel in your ideal body image?
How does that differ from what you feel about yourself now?
How often do you think about your body during the course of a day?

How were you when you had to change or shower for games at school?
What do you feel like at a beach or swimming pool?
Would you consider yourself a clumsy child?
Were you good at sport or dancing?
Are you proud of your body or are you ashamed or embarrassed about your body.

What did your mother say to you about your body?
What does your mother say to you about your children's bodies?
What did your mother say to you about their own body?

What messages did you get about your mother's body?
How did your mother feel about her body?
Did your mother allow you to see her body?
How did you feel about your mother's body?
Do you think that the messages you were given about your mother's body affected your view of your own body?
Do you think that the messages you were given about your mother's body affects how you view your children's bodies?
Do your children make any comments about your body?
What do you say to your children about your body?
Do you allow your children to see you undressed? How undressed, fully nude, bra and pants?
How do you see your children's body?
How do you think others see your children's body?
What do you say to your children about their bodies?
What do other people (e.g. Grandmother / Father) say about your children's bodies?
Do you compare your children's bodies to other children's bodies?
How do your children feel about their bodies, e.g. at school changing for gym/ swimming?
How did you feel about your body when you became pregnant?
What did you feel about your body growing?
Did you breast feed; for how long?
How did it make you feel?

After the exercise open the session up for discussion.

Some of the participants seemed to be very conscious of their body image and felt very competitive with one another's weight. This came out at the commencement of the session when they were asked to voice their feelings and any problems they might be having. The fact that they themselves brought up their own issues with body image, led the facilitator seamlessly into the chosen category for this session, of body image. At this stage of the group (Session 5) Jenny, whose partner was not supporting her was feeling very pressurised by the group and the subject matter.

Jenny "I'm reluctant to come back to the group because I'm probably not good at coping with the things we're talking about. I'm not good with other people. I'm making this a bit competitive, I'm trying to lose weight."

Joan "There's not much more of you to lose, is there? When I look at you I think you're painfully thin."

Jenny "Well, that's what I think when I look at you. It's like we're going in circles here, to be honest."

Cognitive distortions with regards to body image and weight are a common factor in EDs (Benninghoven et al 2007, Dobmeyer & Stein 2003). In the group the women recognised the distortions about their own bodies but their view of the other members was relatively normal. The positive effects of the group were beginning to take effect and they were able to reassure each other from their own previous experience.

Tessa "You know I was saying that I have a distorted view of myself; maybe we all do?"

Joan " I know I'm not as thin as you. See, I can see that and probably you can see that as well."

Jenny "I would say that you're slim, very, very slim. To me, I'd love to look like that."

Tessa "But it does feel like a competition in a way, and it shouldn't do. Last week I felt a lot worse than I do this week. I felt I'm the fattest or whatever, but then this week I've been thinking it isn't a competition and actually this week I've eaten. I need to eat to stay alive so I have been eating. So I think it has slightly altered the way I've thought. So maybe this is your bad week."

The facilitator started to slowly ask the questions and embellished them as she went along. There was a lot of good natured bantering and clarifying points going on while the questions were being asked (For the full description of the session please see Protocol in Appendix 3). At the end of the questions they were asked to discuss how they felt and what the exercise had brought up for them. They all said that they felt uncomfortable and that they had found it difficult.

Joan "Horrible. Just like you don't want to talk about it all or think about it really… Yeah, it just reminds me of things I don't like about myself and that I find it difficult to deal with…. Something you said about when you were at school and changing and I hated that. I hated having to go in the shower. I dreaded having games. I did everything I could to get out of it. I didn't want my body to be seen by anyone. I found it very

embarrassing…. I let my children see me naked and [my husband], I do. It took me ages and ages to feel comfortable with [my husband].

Jenny "I was worried a bit at school, the showers bit. They just used to pull the towel from you and just shove, push you in the shower in front of everyone. You were standing there naked in front of each other and the teachers just used to think it was funny."

It has been found that maladaptive eating and dieting, can be instigated by the influence of family teasing about weight and size (Jones et al 2005). Rodgers & Chabrol (2009) established that parental attitudes towards their children's shape or weight communicated by teasing, criticism or encouragement to lose weight, has been found to be a predictor of disordered eating pathology. This became exemplified by Jenny's story.

Jenny "That's when I started losing weight 'cos I obviously wasn't comfortable with it at all, really. I compared myself with my sister a lot. I was never as slim as my sister. My sister's lovely, and of course I'm not. I don't look anything like that like my sister, remotely. …. And 'cos my sister, this time around, was pregnant the same time as me, I had it right through pregnancy that I was bigger than her and overweight…. I didn't like being told, you're bigger than your sister.

Jenny revealed that a great deal of comparison and criticism was a regular feature in her family ever since she could remember. As she was talking, she realised that the babies were also being compared.

Jenny "[My nephew] sort of doesn't weigh as much as [my daughter] does and that's such a big thing…."

Jenny realised that her family had responded to her child in the same manner that they had responded to her, thereby giving a clear example of the dangers that transgenerational dysfunction can perpetuate.

Jenny "They said '[My daughter] is starting to look like her mother in the face, chubby.'…. Yeah, my parents are doing to their grandchildren what they did with the three of us. As much as I try and scream and yell at them, they're doing it."

It was a good opportunity to link what Jenny was feeling about her own circumstances, to how competitive she was feeling in the group. The group was repeating her family situation and bringing out her learned behaviour. Underlying maladaptive core beliefs have been found to be an important variable in the aetiology of EDs (Jones et al 2005) and Jenny had internalised that she was not good enough. She was not able to compete with her sister, so this created a problem with her ability to relate to other females.

Jenny "Yeah 'cos if I just can't relate to my sister, I can't relate to anybody else…. cos I don't relate to girls, All I just do is compare myself and think that they're just better than I am….But I do all the time think, she's thinner than me, she's prettier: all the time. "

Yalom (1985) talks of "the affective sharing of one's inner world" and Jenny's grief and obvious pain prompted the group to respond. Joan asked her what happened if she saw women that were obviously bigger than her.

Joan "What about if you're out and you see bigger women, or fatter women?"

Jenny "I think they're slimmer than me, all the time. I know I'm embarrassed to say it, I've no doubt you'll laugh at me. But I do, I think everyone's sort of slimmer than I am."

Tessa "It's all right for them to be bigger and it suits them. That's how you see it, but for you and you think, 'Oh no, I'm bigger than they are."

Jenny "I know everybody's slimmer than I am; prettier; cleverer, all the time, yeah…. I know, until I get over that I'm not going to get over anything. I don't know how long that's going to take.

Tessa obviously empathised with Jenny and Jenny's revelations must have triggered memories and experiences for Tessa, which she then started to share with the group.

Tessa "I always compare myself to my sister. My sister's older than me, always done everything bigger, better, even when it's come down to having the children…. I never done anything first, then I had [my son] first and then I discovered that she had to have IVF treatment. She still managed to get pregnant by the IVF with triplets. So straight away she's better than me and it's always been like that for me as well. Even now I feel totally inferior to her…. always been better academically than I have. She came round a few weeks ago. She's about three stone heavier than I am and I still think she looks better than me."

If the individual's sense of self is insecure, they will find it hard to cope effectually with stressful situations. They will find it difficult to think well of themselves and if other people offer them positive feed back, they cannot accept it, as their care has not been well regulated as a child (Gerhardt 2008). This was often brought into the group at different occasions relating to different presenting problems.

Tessa "Everywhere I go, what people are thinking about me, 'Look at her, she looks fat'. And then I think to myself why am I worrying about what other people think about me, but I do. It's just a constant thing, what other people are thinking about what do I look like?.... I don't

believe what anybody says. I find it totally destroying that [my husband] looks at me and thinks it's nice to look at."

In this instance self esteem was connected to body image. Tessa felt so bad about her body that she wanted to hide it and couldn't bear it to be looked at. This was exacerbated by the many operations that she had to have through her life.

Tessa " I've always hated what I looked like, even more so since I've had the children and I've had surgery. I'm all cuts and scars there, but even before that was there, I've always hated it…. I know when I was fourteen and I had operations on my knees, I put on weight then and my mum actually helped me diet. So it was obviously, it started, it affected me."

It is important to recognise when an ED began, as it can give insight into the reasons that triggered it. Tessa could recall that overweight child who felt unloved and isolated. This was compounded by her mother who helped her to diet, thereby giving her the direct message that she was unacceptable, encouraging Tessa's insecurities.

Tessa "Well, she obviously thought I was overweight otherwise she wouldn't have helped me diet…. I would be the fat, ugly one….I've always been a bit of an outsider to everybody else's little group…. They had all nice clothes and everything and I could never fit into the clothes that they could wear. I was always too big."

Body image disturbance is a diagnostic criterion for ED (DSM-5 2013) and it is thought perfectionism is related. The characteristics of perfectionism within the ED spectrum seem to focus on fear of others' scrutiny, unrealistic expectations and intense self-criticism (Sherry et al 2009). These characteristics were all present in the participants of the group and were well illustrated by their conversation. Body image was obviously a very emotive subject for Sally and although she had been silent in the session so far, Sally knew what the others were saying and felt moved to talk.

Sally "Usually I still feel fat and ugly and my clothes are too tight and things and it doesn't matter how, what size the other people are. You can see, the sensible part of you says that they're bigger than you but they look all right. But you look at yourself and you don't look all right. And I know quite a lot of the time I am half the size of what they are, but that's them and not you."

Joan " I wish I could be like that and feel good about myself and be happier but for some reason I prefer to see myself more straight. Sometimes when I get really bad I'll like lie flat in bed and I'll see my hip bones …. I'm as straight as, and probably look more like a boy than a woman. I have seen pictures of me and I probably don't want to look like that but it's like, I just find it so hard to just put that amount of weight on, to actually have curves."

All the group had a problem with weight gain and a fear of changing their bodies but Joan seemed to be the one who was able to voice her fears and share them with the others. The fear of weight gain was synonymous with losing her identity.

Joan "Because your body changes, so my tummy will get bigger; my hip bones won't be so prominent and I suppose, you know some of my clothes will get tighter…. It's like I'm frightened of letting go of that and becoming something else or being a different size. … It's like saying I'm different. If I do it, it's like I'm not me."

At this point I probed for a transgenerational link and I asked the group what size and shape their mothers' were. Joan was again the one to speak up. At first she did not recognise that her mothers' size had had an impact on her, but as she continued speaking about it she realized that it had affected her. Her fears about having curves and looking like a woman were directly linked to the feelings she had about her mother's shape.

Joan "Fat! She is; my mum's fat. She's got huge boobs as well and I was dreadfully, dreadfully frightened that I was going to end up like this…. Oh god no. I don't think I would though…. I know my mum's big but I don't think I sort of made note of that all the time…. Oh my god, because people used to say that you take after your mums…. So I suppose yeah, when I was growing up I was worried about it, I suppose."

Joan’s focus on her mother brought out the anger she felt. As it was Mothering Sunday that week it highlighted the mother/daughter relationship. While Joan spoke of her mother, her distress regarding both her parents emerged and led her into how she first became anorexic.

Joan “I hate Mother’s Day, you know, this Sunday, like it’s a real stress thing for me…. If I had a choice I don’t think I’d bother ‘cos I just think you’re paying lip service and why give a person, who’s not in my life very much now, a card that calls her my mum when she’s not been as a mum should be in my own eyes…. Same with my dad really. If I didn’t see him on Father’s Day, I wouldn’t be spoken to for a year yet, but they never pick up the phone to ring me. They never do that, you know, never, ever. I always ring them. They never come over to see me…. I think that’s why, that’s one of the reasons I became anorexic and my mum and dad didn’t know how to deal with it. I just used to shut myself away in my bedroom. They didn’t really do anything. Well, they didn’t do anything so much so, that in the end I ended up going to live with someone else.”

Research suggests that those closest to an individual may have a particularly powerful influence on what the individual perceives as normal (Kluck 2010). Joan’s perception of herself was that she didn’t matter and was the forgotten child, that no one took any interest no matter what she did.

Joan "I used to play trumpet and the organ….. I never got any feed-back from my mum and dad…. She's like, never really took any interest."

I tried not to let one person dominate the group, so at this stage I made a point of trying to encourage the others to talk about their impressions. Jenny felt she had been linked to the paternal side of the family who were on the large side. She was teased and compared to her sister a great deal. This set up the competition that was discussed earlier.

Jenny "***Well, according to mum; well, mum says I take after dad's mother. They were big, which is not very tactful to say to me really, take after dad's side…"***

Sally suffered from an extremely distorted body image, as her intellectual self acknowledged that she was smaller than her siblings. Yet her low self esteem and feelings of inferiority led her to believe that she was bigger than they were.

Sally "Although I know they're bigger than me, I still feel I'm bigger. You still feel; like if you're going out somewhere, I feel so big and just see them and they all look nice and I just felt fat, so fat among them, but I couldn't have been."

Although Sally's daughter was only eight, Sally had already begun to ask confirmation of her body size from her child.

Sally "I just put something on and as a rule I just ask her, 'Does that make me look fat?' That's as far as I'll ask her."

One of the risk factors for EDs is dieting. Researchers have explored the link between being exposed to the parental modelling of dieting and the child's disordered eating (Kluck 2010).Tessa seemed to remember her mother as having a problem with her weight, as she dieted. At one time she encouraged Tessa to loose weight together with her and this could have been the trigger for Tessa's ED. There had always been competition with weight in Tessa's family and this resulted in her feeling different to the rest of the family.

Tessa "My sister's over six foot and my brother's six foot five and they've always been taller and slimmer than me…. That's why I've always been the odd one out."

By describing their childhood and adolescence in this way, the group had uncovered a commonality between them. They all felt different, alien to their families. They felt that they didn't belong. Family influences and the role parents play in the development of the child, extends into early adult years and beyond (Kluck 2010, Rodgers & Chabrol 2009, Jones et al 2005). The message they got from their families was that they were not good enough and they introjected these maladaptive thoughts, which stayed with them. They had internalised the shame. They had stepped into the dysfunctional cycle of pursuing perfection which is unobtainable. Their self worth was inextricably linked to their appearance and body image.

Jenny "That's why I think now I look horrible. I look fat, 'cos I know I can weigh less and I have felt happier in myself and I think I looked better when I weighed less. I'm sure I probably didn't but I thought I did."

Jenny began to understand why she became anorexic. She realised the secondary gain that she achieved by doing so. To her, gaining an ED was nothing compared to gaining peace from her family. She had finally excelled in something.

Jenny "Yeah, they couldn't call me fat and they weren't trying to make me eat food or anything then, 'cos there was no point….Yeah, they just left me alone at that point and I'm happier….Yeah, I think one thing that my brother and sister couldn't have done. So I know it's wrong to say it was an achievement but to me it was."

As the session was drawing to a close I did a sweep of the group members to assess how they were feeling. Tessa was feeling better than last week and better than she had felt at the beginning of the group. Joan was stuck in destructive thoughts about herself. Not wanting her to leave on a negative, I went back to one of the questions about finding the points they liked about themselves. Jenny had linked into feelings that had been expressed last week, thereby normalising her thoughts and Sally was feeling better but at the end of the session wanted to start to talk. We had two sessions to go before the Easter break and I began preparing them for that. At the end of the group I was feeling more positive and held more hope for the group to continue.

6.4 10th Group Session

By session 10, Sue, Jenny, Linda and Mel had dropped out. It has been acknowledged in previous research (Segercrantz 2006) that the beginning stages of a group are be-set by terminations and this group was no exception. All the women that “dropped- out” except for one were influenced by their partners. By the middle of the group the remaining participants settled down and became comfortable with one another. It is interesting to note that the literature identified that family dynamics stand a greater chance of being elaborated in a small group which is a closer model of the nuclear family (Brunori 2004). The participants felt that a smaller group was more intimate and safer and that the “drop-outs” could not have been committed enough to their recovery to complete the course. At this stage of the group I was feeling more settled and I think this was reflected in the group. They felt that they were the committed ones and they settled into the task at hand.

The previous session we had watched a video that was related to the category of Modelling, showing how children viewed their mothers. It was more to do with mothers and their children than anything else. The first part of it was connected with how children pick things up from mothers even though mothers didn’t think that that was happening. The second part was how the children dealt with society, the pressures of their peers and the pressure of the media. It showed how young teenagers, particularly girls, dealt with the pressures of being thin and what society presented to them and how they dealt with that. It ended on an important point of how not to bring up your children, where mothers just gave their children anything they wanted and how damaging, in fact that was to the children. The children had no boundaries whatsoever, which gave them an extremely distorted worldview. The strength of the film was that it interviewed the mothers and the children separately, which highlighted the discrepancies between what the mother wanted to believed was going on and what the child could actually see. For example the mothers were asked if they dieted or restricted food and if they were explicitly conscious of their body image. All of the mothers said they did not diet and were not excessively bothered about their body image. The children on the other hand said that the mothers were always dieting and took dieting aids, did not eat with the family and were explicitly conscious of their image. Maggie had not been present for the video session as she had been in hospital and had asked to borrow it, which was agreed. During this session, there were four people present, Maggie, Sally, Joan and Tessa. Group 10 was the second session to incorporate the theme of modelling.

Fig. 5. The protocol of group 10.

Session 10. Modelling

Welcome them back. Go through any problems that they might have had during the last week and then introduce them to the category. Give them pen and paper and slowly give them the questions with enough time to write down their answers. Make sure they are all ready for the next question.

2. Modelling

Do you remember as a child copying the things that your mother did? What sort of things were they?
Write down all the things you do that your mother did or does. Anything that stands out in your memory.
Write down all the things that your mother did with you that you do with your children.
Write down all the things that you consciously **do not** do with your child that your mother **did** with you.
How alike do you think you are to your mother?
Are you aware of your child copying the things that you do? What sort of things do they copy?
How alike do you think your child is to you?
Did your mother weigh herself? How often?
Were you aware of it and what sort of feelings and comments did you have about it?
Do you weigh yourself and how often?
What sorts of feelings come up for you when you weigh yourself?
What sort of comments do you make about yourself?

Do you think your child is aware of you weighing yourself and does he/she comment on it? If they do, what do they say?
Does your child weigh him/herself?
What sort of comments do they make about themselves with regards to weight/appearance?
What sort of comments do you make about them?
How did your mother use a mirror? Did she avoid them or rely on them?
How do you use a mirror?
How does your child use a mirror?

When this exercise was finished it was then opened out for discussion. Maggie found it hard to contain the feelings that had emerged surrounding her mother. She was very conscious that the comments her mother had made to her had a deep and lasting effect and she did not want to do the same to her children.

Maggie "I found it hard to stop… I know I've got lots of issues there…. a lot of anger as well. .it still gets to me…. She must have been bad to deserve such awful children, things like that…. Always brought up to think we were the worst children."

The thoughts that emerged seemed to take Maggie back and enabled her to re-examine what her mother had made her feel. She was then able to look at how this affected her relationship with her children.

Maggie "I'm never positive about me. I'm always the butt of my own jokes… I know they [my children] humour me. It's a bit embarrassing sometimes."

Stern (1994) believes that if the infant fails to involve the mother emotionally, the infant then tries to win her by imitation and identification. This pattern then becomes repeated, creating the dysfunctional transgenerational cycle. Sally had been abused by an Uncle for many years; she kept it well hidden until her mid twenties. While she was with the group, she was unable to bring that information into the group but had been able to talk about it during her interviews. Her pain was palpable and her comments were very much connected with her early experiences. Sally had blocked out most of her childhood and could only remember her mother as absent. This seemed to affect her ability to nurture her own child and presented itself as the mother pushing the child away. In this way she was repeating the behaviour she had been subjected to when she was a child. She found herself unable to express love.

Sally "Mum was in bed asleep or she was going to work so I hardly ever saw her… I've lost touch with being a mum. [My daughter] may be there but I'd take no notice and I know that's horrible…. I want to take notice, I can't…. I've managed to say something, do something nice but you can guarantee that before the end of the weekend I've pushed her away, saying something horrible."

Sroufe (2005) believed that variations in attachment quality with the infant were the foundation of later differences in personality. The inability of the mother to be emotionally and psychologically available for the child is as damaging as being physically removed (Rutter 1977) and neglect in early infancy is as traumatic as being abused (Schore 2003 a). Some of the other participants also felt that their mothers had either been neglectful, abusive or absent. One was described as "nondescript". In their cases the negative experiences influenced them to manage motherhood in a converse way.

Joan "I suppose it sounds funny if you live with your mum and your dad, but she was there and wasn't, if you know what I mean. Most things that I do remember about my mum were how impatient she used to be and particularly how she used to tell us off….I was starting to tell my children off in the way that my mum did; I don't think at the time I was conscious of it …. I make sure I give them lots of cuddles and tell

them how lovely they are, which my mum never did…. I didn't think I had much of a relationship with my mum and I think what I can remember is that she didn't really have a lot of patience for us. She just didn't want to see us sometimes, so that's what I remember."

Weston (1999) talks of the "empty matrix" which is the emptiness that the anorexic and bulimic creates, because of the denial of their devouring needs. There was a realisation that their illness was connected to the lack of love and nurturing that had come from their mothers. It was indeed hypothesised (Jones et al 2005), that the more negative perceived parental rearing behaviours would be associated with more severe eating pathology.

Maggie "She never showed anything positive, she never took part in anything. She didn't ever say, 'I love you,' never anything like that. All you'd get was 'You're really stupid' or whatever. I did need cuddles and things, I really wanted it, cuddles. It does seem wrong even now*….I*t's almost made me kill myself to get her to say that she does actually care …. They were only happy when I was unhappy, at my worst. She wants me to be ill. She wants me to be constantly struggling 'cos that makes her feel better about her life. ….That's my way, I suppose, of getting my mum to notice me, is to have an ongoing crisis."

A synergy began to take place within the group as the group came to recognise that they had all come from backgrounds that were deprived in one way or another. Some of them began to realise that they had at one time or another looked outside the parental bond for surrogate love.

Maggie "I get so many surrogate mums, other people's mums that have mothered me all my life."

Joan "[My surrogate mother] is like a mum to me and I think probably why I am like I am now, I'm so clinging to some people, is because of that, probably."

In a study into sexual abuse and bulimic behaviour, Murray and Waller (2002) found that internalised shame played an important yet complex role in the relationship between interfamilial sexual abuse and bulimic psychopathology. When Sally was asked when her ED started, it opened up a torrent of concealed hurt and neglect which took the listener into her perceived shame.

Sally "When I was a teenager mum was a nurse. She doesn't know about the laxatives I take. It's not for attention from others it's a punishment for me… For years I was in total denial. I wouldn't have admitted that there was anything wrong. You know, if I was the last person in the world, to say anything to my mum, because that would control me and I wouldn't want her to know, to take my control away…. ***My brother already told me that when mum dies 'It's your fault'. I don't want any of them to know. I hide it all at home."***

Once exposed to sexual abuse, the consequences can be that an individual's identity becomes associated with feelings of inferiority, worthlessness and self- contempt (Murray & Waller 2002). Sally's inferiority and worthlessness surfaced whatever she talked about. Normality and self-worth were not attributes she acknowledged in herself.

Sally "I hate being told off. If I see a note at work saying, 'See me', I think it's 'Oh god what have I done now?' No one knows. Well I've got a friend and she knows about the eating but apart from her no one knows what I do…. No one's ever known that when I was at school, when I wasn't eating and I'd say to mum that I'd eaten stuff at school and at school I'd be saying I'll probably go home for dinners, but then I wouldn't I'd go somewhere else and not bother. My weight just goes up and down. So if I want it to go down and down and it didn't seem to want to go down and it just gets out of control. Then I start wearing baggy clothes and no one can see."

Sally's pain seemed to swamp the group at this time and I felt it was important for Sally, as well as the group, to try and help her make sense of what had been said, by linking back her behaviour. Repeating her description of her mother being absent or asleep, I pointed out that she didn't have a mothering model either to emulate or in the negative model to be able to do the opposite, as some of the other members had. Her mother's ineffectual mothering had for Sally confirmed all the shame and worthlessness she already felt, which rendered her unable to nurture her own child. It was time for Sally to realise she could break the negative cycle of dysfunctional mothering and to try and start a new cycle with her own daughter.

As the group was a tool to help to educate the participants, it was important for them to understand the maladaptive thoughts that fuelled their ED and that there were multiple reasons that maintained it. We talked about how they either denied themselves food because they thought they did not deserve nourishment or, they ate and vomited because they did not think they were good enough to keep it. Either way it became a form of self punishment.

Maggie "It's been so long now in my mind that it isn't easy to put the food in. For me now is the holding the food in. I know it's supposed to be doing me good, but I've trained myself so much to think that everything that goes in there is so bad, that I'm not allowed to have that."

Once again we started to get into the realms of the pros and cons of an ED (Gale et al 2006, Serpell et al 2004).The reason that Tessa was so frightened to come to the group was the fear of change. She had become her ED and her ED had become her.

Tessa "I'm also scared too, 'cos I've been like it all my life, that people won't like me if I change. I'm scared. Will my husband fancy me if I change and I keep on saying, for reassurance, 'Are you still going to

love me when I'm fat?' You know, if I eat this meal; and it's very hard to believe it, that he will still love me."

In previous sessions Tessa had commented on being unable to compare with the others regarding her mother. She had suffered from physical health problems (please see medical history in initial interview) since an early age and had always relied on her mother for support. While she was talking she uncovered some truths about her relationship that she had not realised before.

Tessa "I've always needed doctors 'cos I've always been ill. So it's hard for me to relate to what they're saying about their mums because my mum's always …. I suppose, the way I feel is that I've got to be ill for my mum to still be there but I always expect it. Since I was about nine I've always been sick. I always expect my mum to be there. She's always been very loving and caring with me and worried about me but that's the only way I know that she would be there for me."

As I have mentioned before, Yalom (1985) believed that the success of a group depended on "the affective sharing of one's inner world (Yalom 1985)." This seemed very relevant at this point in the group. The benefits of sharing feelings, thoughts and situations certainly had the effect of including the other participants and encouraged them to do the same. Tessa's realisation that her ED was bound up with her relationship with her mother brought up a great deal of empathic feelings for Maggie. This led her into her feelings of isolation.

Maggie "For me it's the only way I can get my family to show any emotion for me….For them that's the only part that I fulfil, is once a year while I'm in hospital. I get moments now when I think I'm not going to play this game anymore. The only person they've hurt is me and why am I doing this?"

Bowlby (1969) proposed that the individual forms expectations of attachment experiences in the future, based on earlier experiences. By this stage of the group the participants started to gain a better understanding of how much the family dynamics and their relationship with their mothers played a part in the continuation of their ED. It was a surprise to them that they still needed their mother's approval and they realised how intense the sibling rivalries were in their family. Being in the group was helping them to uncover what they were feeling and they were confirming the realisation that being ill was the only way they retained their mothers' attention (Gale et al 2006)

Tessa "It is a constant battle because I still need her approval, which is so stupid. My oldest sister shines. My younger sister shines, and my only way of shining I suppose is by being ill. I think that's what I've realised…I didn't think until, it was the last week. The way that I am, certain things have just stuck, 'cos I want my mum to think the best of me … I didn't realise that I was doing it really. Didn't realise until I was with you last week when we was talking last week with the people I was with [the group]."

The group sessions were obviously having a great effect on Tessa. In one of the previous sessions about modelling we had talked about how much mess they could tolerate in connection to the children. This had also sparked recognition for Tessa.

Tessa "We was talking about the kids being clean and stuff and it comes from my mum. So I'm doing it to get my mum's approval, although that's what I automatically do, that's the way I am. 'Cos I know that my mum will be pleased you know. 'Tessa can keep her clothes, keep her children's clothes, better than [my sister] can'. About all I can do…. My mum was there every day but she's not there now and I think I'm not ill enough."

As the group felt more comfortable with each other, they were able to bring the fear and anger related to their partners. They felt their partners did not understand their illness; this fed their insecurities and self-loathing. What became evident was that most of them had similar feelings which they had been containing for a considerable time. One suggestion from the group was to have a meeting of the partners as this had helped one of them previously.

Tessa "Do you ever think that it would be good for the partners to get together and talk….When I was in hospital after [my son] was born; I was in there for four months and they used to do meetings for the dads …. And it used to be really good because they don't understand that

other people experiencing it [ED]…. I was talking to [my husband] about it and he wants to know. He just wants reassurance that what, that everything was fine here and that it does help and probably that's what he wanted to know."

Maggie "The similarity to other people's problems, not just all the weird things that you do. Other people do it as well and it's part of the nature of the illness. It's not me being a selfish person trying to hurt, for god's sake, it doesn't matter, you've got your children. The feelings are too powerful…. When you feel like that you've got no answer."

Joan "[My husband] is very black and white, you know. He'll say, well it's up to you. You choose to do something or you don't. I don't even know if he'd come. It probably would help him if you got him there and got him to talk to someone. It's just getting him there. 'Cos when we have tried to talk he gets very angry, which isn't his fault. Also as you say, it's very hard for men to understand."

It was disclosed that the partners felt excluded and threatened by the group. As this point in time led to the greatest percentage of "drop-outs", it would be expedient to consider how to deal with this in future groups. It became clear that Tessa's partner did not want her to have any difficult feelings that might upset her equilibrium and was obviously not willing to see the benefits of supporting her through these difficult feelings.

Tessa "'I'll say to him it's good 'cos it makes you say things in your head and makes you sort them out and he doesn't know how….'Cos I can't always say to him we've talked about so and so and it's really been. 'Cos I say to him we've talked about something that's really upset me and his immediate reaction is, 'Oh don't go any more….Don't talk about things that upset you', and I say to him, 'Oh no 'cos it's sometimes by talking about them. Yes, they upset you, yes they bring out feelings that you don't want brought out again, but it's the only way you've brought them out, that then you think about a little bit more; a bit differently perhaps."

Nearing the end of the session they returned to modelling which was the original theme of this group. Many authors (Patel 2002, Thompson 1999, Kohut 1985, Winnicott's,1965) writing on the mother/daughter dyad, have recognised that the infant, by repeating or mirroring the mother, can then begin to respond to her. If the mother's actions and re-actions are inadequate or dysfunctional the infant (and later the child) will internalise and mirror the dysfunction and fail to develop in a real and natural way. The mothers began to realise that saying the right things to their children was not enough. They started to understand that children learn by example and if their mothers are saying one thing and doing another the message is flawed.

Tessa "I'm always telling them off for leaving their dinner, I'm not eating it. I'll be sat there with half my plate. We don't sit there often and eat together 'cos the boys go to bed. Very occasionally I do a Sunday dinner

and I sit there and say, 'You've got to eat your dinner.' 'But you're not going to eat all yours.' 'Yeah', I said 'well I put too much on my plate.'

In summing up this session I acknowledged the painful feelings that had surfaced for them. I encouraged them not to push their feelings away that even if they had painful feelings it was better to understand them and discover what they were connected to, rather than allowing them to surface in dysfunctional ways. We touched on how all of them gave their children mixed messages and how their behaviour impinged on their children. On the whole I felt we had reached a great deal of understanding and I felt more positive that the remaining four were fully committed and would continue the group until the end.

6.5 16th Group Session

The intrapersonal attachment process is closely connected to the task of separating intrapsychically from the caregiver in order to develop an autonomous self (Rodes & Kroger 1992). Bruch (1974) wrote that if the infant/child's needs and impulses remain poorly differentiated, this would result in a lack of separateness and a pervasive sense of ineffectiveness, which is evident in the aetiology of an ED.

Session 16 was attended by three of the remaining participants, namely Joan, Sally and Maggie. By this time we had settled into a comfortable group and the members looked forward to meeting one another. This feeling of composure enabled us to proceed into the session more rapidly. After a quick recap we went straight into the exercise which was on the theme of separation. Again the questions were asked slowly with enough time for reflection. When the written exercise was completed the participants were asked to do some images which we subsequently displayed and discussed.

Fig.6. The protocol of group 16

Session 16

Welcome them back. Go through any problems that they might have had during the last week and then introduce them to the category. Give them pen and paper and slowly give them the questions with enough time to write down their answers. Make sure they are all ready for the next question.

Separation
Do you have trouble knowing what you want?
Are you afraid to explore when you go to new places?
Are you afraid to try out new experiences?
If you try them do you wait until someone has tried them first?
Do you have great fears of abandonment?
In difficult situations do you long for someone to tell you what to do?
If someone gives you a suggestion do you feel you ought to follow it?
Do you have trouble enjoying your experiences?

Are you a big worrier?
Do you worry about something else happening all the time?
Do you have trouble being spontaneous?
Do you worry about being embarrassed?
Do you find yourself in frequent conflict with people in authority?
Do you fear anger in other people?
Do you fear anger in yourself?
Will you do almost anything in order to avoid conflict?
Do you feel guilty when you say no to someone?
Do you sometimes go berserk and inappropriately let go of all control?
Are you often excessively critical of other people?
When you achieve success do you have trouble enjoying or even believing in your accomplishments?

Now think about this exercise with regard to your children.
Do you see these traits in them?
What is your response to these traits?
Take each child separately.

Separation. Part two.
Make sure they have large pieces of paper and markers or pens.

Using circles for you and your mother, draw where you think your mother is and where you were when you were a child, adolescent / young adult, now.
Use separate pieces of paper for each age and label which age it is.

Using circles for you and your child/children, draw where you think you are and where you think your child/children are. Name which circle represents which child.

Pin them up and discuss.

Making images may facilitate the unconscious or undifferentiated state into concrete thinking and the beginnings of the separation process (Schaverien 1995). Working with the images was very powerful and as a group they all seemed to find the stark reality quite shocking.

Maggie "The circles make me realise how distant mum is from me. How none of her daughters have never been close."

Sally "I just didn't feel like I was close. I can't think, no reasons. I don't get on that well now. I don't think she ever is willing to listen to my point of view but I think as a child and teenager and I suppose now as an adult as well, as she never got to know me or take an interest in me. So therefore she doesn't really deserve to be on the page anyway. I actually put on that last one that she isn't on the page."

This brought the group to a morose silence unable to go forward and I made the decision to go back to the questions that had been asked. This decision was based on the prior knowledge that I had of Sally's past abuse and I felt it was wrong to allow Sally to get into a difficult place if it was not forthcoming from her. Maggie took the diversion and the group moved on to discuss conflict. It is possible that poor conflict resolution is compounded by frequent destructive exchanges coupled with a lack of positive communication (Lattimoreet et al 2000). Joan found it interesting that she was able to find self belief when dealing with her children or people younger than herself.

Joan "I think I find it hard to maybe think that sometimes, well that sometimes conflict is okay. I always think of it as something that's very, very negative and that if I am in a conflict with someone then it's me that's been wrong, unless it's the children. In conflict with the children I'm confident to think I'm right. (Laughs) Actually that bit is interesting."

Maggie "I said yes to practically everything and just do anything so that people like me, very non-confrontational. I'm too frightened to give my own opinions in case people think badly of me. I would just agree with anyone."

This brought into acute consciousness the restricting, dogmatic and isolating upbringing they had experienced. It is probable that this accounts for the inability to apply the effective listening skills that are necessary to achieve compromise in conflict negotiations (Lattimore et al 2000). The majority of the group found it difficult to negotiate or confront authority figures, which included teachers and medical personnel.

Sally "I don't like confrontation, I'd avoid it…. I feel frightened. I always feel like a little girl again and I'm frightened of getting into trouble. You're thinking you're talking to someone adult to adult, but I'd feel like I was a school girl, frightened if I do something which they're not going to like, but it's how I feel."

Joan "I suppose I've always been brought up with the belief that anyone that is older than me, I should respect them and therefore I'm not entitled to argue with them. Most people I argue with are older than me. I always tend to think, well am I in the wrong or right? I don't have the right to make someone unhappy or argue with them."

Maggie "Especially at the point even when I'm cross with the teacher, I still can't confront them 'cos I don't, I don't want the teacher to think badly of my son's mother. Or if I have an issue with them, I find it really hard to approach somebody in authority. Even though I'm really upset about something. Even though I'm angry inside, I can't…"

As stated in the literature search, Bowlby (1981) found that individuals formed expectations of attachment experiences in the future, based on their earlier experiences. Insecure attachments have been found to be common in women with eating disorders (Zachrisson & Skarderud 2010). The line of discussion that was beginning to surface within the group, led us into attachment patterns which confirmed what has been found in the literature.

Sally "I think as a child I was too frightened to get into trouble ….I wouldn't do anything wrong just in case…. I was frightened of what anyone was going to say."

Maggie "My mum's a very strong, dominant person. My dad has to do more or less everything she wants…. When I was growing up everyone did what mum said…. Saturday was housework day, not for my other two sisters but for me. They would go riding and they would tread straw through the house…. You just have to live with that. And if I wanted to go out half an hour or an hour I was always made to feel really, really guilty that I would have to make up a reason….. I do it even now. I feel I

have to explain to everybody…. I felt like I needed to explain, justify what I've done.

Maggie's story linked into the exercise we had been doing. Although previously she had not connected her fear of life and the world to her earlier experiences, the exercise and now telling her story were piecing the two together.

Maggie "I would go into hospital and I wouldn't get better so they would kick me out, the only way I could show how angry I was…. And then I would hit a new low again and end up going back and then having to leave again…. I have to really psyche myself up to go out. I couldn't just be spontaneous, I would be just petrified. I can't even bear the thought of getting on a bus or train. It absolutely petrifies me.

She was asked by the rest of the group, what she found so frightening***.***

Maggie "Doing it wrong, doing it wrong….. With everybody I just don't ever make the decision myself…. I never believe anything I do is good enough. I always point out where I could have done better before they do…. It's made me realise how much I really don't believe in anything. I don't have confidence in anything that I do.

People with EDs show extreme personality features of emotional dysregulation and inhibition which include social avoidance, anxiousness and affective liability (Harrison et al 2009). These features were clearly present in the members of the group and added to their self doubt and feelings of worthlessness.

Joan "I guess I just always think that 'cos I feel like I'm making a mess of my life. I just think why can't I be, if you like, normal."

Maggie "I just think that the things that they take for granted are things that I find very difficult…. My mum and dad abandoned me several times probably and I've had none of my family talking to me just because I'm anorexic…..I still can't forget all of that. I try to but I can't."

Women with EDs have been found to have a lower emotional awareness and defects in emotional regulation. It has also been suggested that eating pathology is used to regulate affect and functions as a block to painful emotional states (Harrison et al 2009). All her life Maggie had been unable to express her emotional states and had used her ED as a way of releasing the tension within her. She even uses the words "She can bring it up" when describing her mother, not realising that this was how she used food to deal with her emotions. Her ED began at the age of 15 and she seems to have remained at that age emotionally.

Maggie "She can beat me with words. I get tongue-tied if someone shouts at me. She can bring it up and just go off like a cannon at me and I never get a chance to reply.

The moment I start talking about it, it's so painful I'll just burst into tears…. I don't feel like an adult….I don't ever feel like an adult. I still feel like I'm fifteen."

Joan was able to pick up how using food was always linked in to her mood and emotions, but she observed how she had recently been able to avoid returning to her past repetitive and destructive cycle.

Joan "Yeah and I guess I haven't been feeling that good recently but I haven't taken that out on food and I am still eating and I haven't lost any weight. I haven't lost the weight I've put on so it's probably quite a big achievement for me really. …To keep trying to eat and keep it separate from emotionally how I feel, to keep feeding myself even if I don't feel like eating. And I suppose not get into that whole circle really because it's just a downward spiral.

It is recognised that emotional problems lie at the core of EDs (Harrison et al 2009) and the group were beginning to understand that it was essential to deal with these problems before they could address their eating pathology. How to deal with emotions came up repeatedly within the group, as they started to recognise how they used their ED to express the emotions they found difficult and to start to find new and less harmful ways of expressing themselves. Maggie's ED was brought about by the fear of other people's perceived judgement of her, which was fuelled by her fears of abandonment and rejection from her mother.

Maggie "I don't know why I'm so frightened of her not approving of me and yet I know even when I'm trying really hard to please her she would still always find the bad anyway. I know there's no win situation."

Joan "I find it really hard to know how to cope with my feelings and I didn't go to work this morning. I was really stupid, I know but all this morning, I so wanted to cut myself and I really had to fight not to do it. But for me, I don't know what to do with my feelings. So for me it's a release that I don't know what else to do. Just thinking about it but I didn't do it. Then I ran out of time 'cos I had to come here so then I thought I'd take my knife with me and I don't want to get like that again because I did that before and I don't want to do that. I don't want to do it again."

ED behaviours are likely to manifest when an individual is experiencing negative emotional states (Meyer et al 2010). It was difficult for the group to understand that that their ED constituted a form of control and when they felt out of control, they reverted to their previous destructive learned behaviour.

Joan "I don't know what to do with my emotions. I don't know how to deal with the feelings I have….By changing my life, by doing something, to change the situation that I'm in so that I don't keep feeling the way I feel, I suppose, is the answer to that."

One of the major aims of the group was to break the cycle of dysfunctional behaviour from mother to child. Meyer et al (2010) suggested that negative attitudes toward emotional expression act to block the cognitive processing of emotional information. The development of these attitudes is often as a consequence of invalidating environments during childhood. This was very apparent in the way the group learnt to block off emotion from their children, giving a very clear message that negative emotion was not to be dealt with, which is what they had learned from their own childhood.

Joan "I'll be miles away sometimes and I can tell [my children] want to say something. They want to ask me but they don't and they probably pick up that I don't want to sit and talk about it either but….I don't block them off. I always say 'I'm okay' and certainly my eldest daughter, she'll know that I'm not…So she knows that I'm not being truthful with her but I don't discuss that with her…"

Eating disorders are a secret and isolating illness and the sufferers often feel a great deal of guilt and shame (Treasure,J. 2005, Garfinkel & Dorian 2001). Joan sometimes found the emotion so intolerable that she reverted to self harming which only served as a downward spiral into more guilt and loneliness. The benefit of being in a group became evident when Maggie understood completely and was drawn in to support Joan.

Joan "I was like thinking back to when I used to cut myself last year and I kept sort of saying to them, 'I was cycling past a car and I scraped it on

the window'. I used to say that a lot. I'm trying to make the marks that I've got to go away. I don't want to give myself any more. But it's just very difficult really. You know you said about feeling alone. And that's how I feel. I feel so alone. That's why it's hard to deal with sometimes."

Maggie "It's a very lonely condition don't you think?"

Joan "Yeah, and I suppose if you do feel down then you do feel isolated so…. thoughts just don't go away."

We started to talk about diversionary tactics to help the group cope with their emotions, giving them a practical base of different coping mechanisms. They had become experts at being devious and lying and had become convinced that if others didn't know what they were doing, it was acceptable. What they were beginning to realise was, that they were lying to themselves.

Maggie "It's the moment when I eat something, I feel so gross that I don't want anyone to see me and I think the only way I could maybe hold it in is maybe go for a walk, but then I know if no one was with me I would find a bush for myself and I would always be finding a loophole in the situation as much as my intentions are good before the meal. I've tried it with my husband. He can just sit with me until you're going to feel OK and then after a few days when the novelty of watching me has sort of worn off a bit and sort of think well no one's watching, so I'll go and get rid of it and no one will know. But if I could find a way . .

Sally "Just explode and shout and if I can go down the gym…. It's not always possible to do. Just stop and do it. But if it just coincides with a day that I'm due to go down and I can sort it to go down, but I just end up screaming at [my daughter]."

The use of a group can help to dispel the notion that sufferers are alone and, encourage the realisation that other people suffer from the same problems (Protinsky & Marek 1997). At this stage of the group it seemed that the members were feeling safe enough with each other to talk about their worst behaviour. Joan had opened up the hidden behaviour.

Sally "One time [my daughter] kept following me into my room, I tried to tell her not to do it but she kept coming in. And when she came in she couldn't find me because I just sat curled up at the bottom of my cupboard. She found that worrying, sort of 'cos she didn't know where I was and she thought that I had gone out of the flat and she was left in there by herself. I usually just end up shouting. I used to cut but I haven't done that now for a few months, so that was the other thing I'd do, as soon as she went to bed out comes the knife. I used to sit there. As I say touch wood, I haven't done that."

Individuals who have a negative reaction to their own emotions tend to avoid them because they are perceived as too painful to negotiate (Harrison et al 2009). This in turn creates new divergent strategies. The interaction of the members of the group with each other was another example of feeling safe together, especially after such a difficult exposure. Maggie felt able to do this and Sally responded.

Maggie "When you've calmed down do you go back and sort of say sorry."

Sally "I try and say to her, 'You can see when I'm not, when mummy's feeling poorly', 'cos she can see and I'll say, 'If you see mummy like this just try and do what she says, so just be good', but she's not really old enough to really take it in. But what she does now is, the other week she tells me and she asks me, why am I being horrible? I was nice a minute ago. She says she has a new mum and an old mum

Maggie "Is the new mum since you've been coming here?"

Sally "The last couple of weeks, about a month, a couple of weeks to a month she's said it. Yeah, she said 'I've got a new mum'.

Maggie "That must make you feel you've achieved?"

Excessive physical activity is a common feature of EDs, affecting up to 80% of patients (Bratland-Sanda et al 2010). Sally shows the excessive behaviour that is part of the symptoms used to diagnose ED (DSM 1994). When used less excessively, exercise can be a valuable component of the recovery process, as it can be used as a diversionary tactic. The guilt attached to any amount of food eaten, leads ED sufferers to resort to any kind of behaviour in order to expunge it.

Sally "If I have eaten too much then I'll try and get down the gym. Like last night I spent an hour and a half on the stepper on the high levels and I kept saying it's 'cos I ate too much at the weekend, 'cos I need to burn the calories off, so I've just thought I've got to keep going. And some nights I end up doing thousands of them so I burn calories. If I haven't been to the gym I feel guilty. If I've eaten I feel guilty."

It has been frequently observed that ED sufferers have a discrepancy between their perceived body size and their actual body size (Lemma-Wright 1994, Beumont et al 1997). As with excessive exercise, distorted body image is one of the criteria for diagnosing ED (DSM-5 2013).

Sally "The sensible part knows that I must have lost weight because of the size[of my] clothes but when I look in the mirror I can't see that. I probably am becoming more obsessed with the gym because I go about five times a week now and if I could go the other two days I would, but I can't, I just can't fit it in."

During the winding up of the session we recapped on finding diversions when their feelings became overwhelming. We talked about setting small manageable goals and acknowledging their achievement when they had accomplished the task, thereby progressing one stage at a time. I pointed out that attending the group was an accomplishment which would help them achieve their final goal of recovery.

Maggie "I really shock myself when I do come because in the past I would have found an excuse not to….I do feel proud of myself that I have….I'm hoping that this is the turning point for me, this week and the week that's gone and I hope that today's session will be the turning point so I can start working on some things."

At the conclusion of group sixteen I felt very aware that there were only a few sessions left to the completion of the group. I was disappointed that even at this stage there had been an absentee and did not take for granted that there would be a full attendance for the rest of the sessions. On reflection I was satisfied with the session and believed that we had covered a substantial amount. There was a feeling of safety and mutuality which encouraged the depth of work that we had been able to reach.

The Final Groups

6.6 18th Group Session

As the end of the group sessions were drawing nearer it became evident that the participants were only just starting the therapeutic process and needed to be supported for a longer period if they were to maintain their recovery. This could have been as a result of the length and severity of their ED, as there is evidence of markedly different outcomes from treatments given in the early stages of an ED as compared to the later more embedded phases (Treasure & Schmidt 2005). The NICE (National Institute of Clinical Excellence) guidelines for EDs have been published since 2004, yet it is unclear whether Primary Care physicians routinely use or are aware of these guidelines (Currin et al 2007). Nearing the end of the group, a great deal of time was spent trying to find suitable alternatives to the existing group, for the participants to continue with their recovery. This search highlighted the knowledge that there are few specialist services available in out-patient care. Indeed it has been noted that less than half of ED sufferers in the UK are receiving specialist treatment and there is a recognised lack of specialist ED services (EDA 2005). The ending of a group is a time for the participants to identify strategies for supporting themselves beyond the group (Tudor 1999). The mothers themselves recognised the difficulty of getting care and also the frustrations of continuous care never being available to them.

Tessa "I wanted someone to talk to and there was nowhere to go….There was nothing else I could do 'cos I've been in a crisis like this before. You might as well just kill yourself anyway…… But it's just so, you know, you get the help and then you get to trust in somebody and then they're taken away and all they say to you is that the NHS can't provide. You know, they can't keep the people."

The final group went through the procedure of recapping and ending, so I have included the penultimate group as an example of the therapeutic process of ending the therapy. It is not unusual that coming to the end of a group catapults the members into “getting on with the business” (Tudor 1999). This proved to be the case at the end of Session 18.

The group consisted of Maggie, Tessa, Joan and Sally. The participants were asked to write a letter to each other that they would read out in the final session. The group were quite taken aback by this but after some protestations they agreed. They suggested that they would like to bring in photos of their children and this was approved. The group was then asked to do an exercise about thinking back, not necessarily remembering back, putting themselves back in a situation at different stages of their lives.

The first stage was as a toddler. They were asked what they thought they would have wanted from their mother as a two/three year old. Instead of writing it down it was thrown open for discussion. This was an exercise in re-capping the mother/child dyad (For full details of the exercise used please see Appendix 3).

Maggie “Lots of love and cuddles.”

Joan “Fun. You know to have your mum play games with you. To take time to be with you and to enjoy my company so I can enjoy hers.”

Sally “I would have wanted mum to be around.”

We then progressed in age to six or seven. Some of the group found it difficult to imagine what they wanted from their mothers as they could not remember their childhood and looked towards what they gave their children.

Maggie "'Oh give us a kiss, we love you'. It's like that all the time. Every time it happens I think I'd love that to be how my mum was. And tell her all the time how precious and things and the boys every night we always. It's very kissy, cuddly and every time that happens I always get that stab in the heart thinking that I wish my mum could have done that to me. I don't ever remember her doing that to me."

Joan "No, I don't either. I don't remember her reading stories or anything."

We moved further on, to puberty. Tessa recounted her many hospitalisations and remembered that her mother was always there but her father was not. This led her to believe that her mother was emotionally present as well as physically, until she recalled how her mother handled her fear and bad dreams at night.

Tessa "She always used to take me up to bed and she had to say, 'Goodnight, god bless. See you in the morning'. 'Cos if my mum didn't say that to me I believed I wouldn't wake up; I'd be dead in the morning, I would. So she would always say that to me…. On some nights she'd have to come up and tell me off 'cos otherwise I couldn't sleep because I

was too worried about it. The only way I'd get to sleep is I'd be too scared, more scared of my mum than what I was . .

Maggie felt that her mother was always angry and that she was hated.

Maggie "'Why do you hate me so much?' Why are you so angry? "

We moved onto the present and how they felt about the relationship with their mother. By this stage, the group knew each other's stories and felt comfortable with one another, so their conversation flowed.

Joan "My mum doesn't give me support. My mum only ever rings me because there's a reason to ring me. She won't ring me to say, 'How are you?' And she probably comes to my house twice a year if that. So to me she has no interest in my life and has no time for me and I guess I just accept that 'cos I think I have too much hurt inside me to let me be close to her. She just jumps down your throat, loses her temper very quickly and I don't like being in her company really. And when she is nice to me it just feels really strange.

Maggie "You feel like you're heading for a fall every time you.... Like my mum sitting next to me when she's being nice.

Joan "I don't have a relationship with my mum and she really doesn't know the person that I am and I don't think she ever will."

The anorexic adapts to not being taken notice of or understood by withdrawing and consequently by starving (Farrell 1995). The feelings that Joan could not get her mother's attention or love drove her into the anorexic state and eventually away from the family. A very similar experience happened to Maggie.

Joan "There was no interest from my mum and I think that's what….I don't know, I wanted my mum to notice. I just hated the situation that I was in. I hated being there. I hated the way my mum and dad were with each other and I just didn't want to be in the same house and I have felt like that for a number of years and I just needed to get out."

Maggie "I can't remember feeling loved by my family at all. My mother never showed it. I felt very alone, I think."

It has been documented that the quality of attachment is closely linked to mental health problems (Zachrisson & Skarderud 2010, Sroufe 2005). In a study by Ward et al (2000) it was shown that ED patients displayed a mixed pattern of insecurity, reflecting both anxious/ambivalent and avoidant patterns. Most of the group felt that they were not wanted by their mothers and they had felt rejected and abandoned by this.

Joan "I can actually remember my mum saying to me that she wishes that she never had me."

Tessa "And I can remember actually getting upset about that…. I can remember. I don't know why that's suddenly come to me".

Maggie "That must have been my mum's favourite phrase, 'I wish I hadn't had children. What have I ever done to deserve these children? I can remember once getting really upset and I was really shocked. Then my dad who doesn't normally talk like that, he actually came out and said it to me in a normal conversation going along in the car and he said, 'No, I have to admit if we had our time again, we wouldn't have had children 'cos it's just been too much hassle.' And it made me feel so shit you know.

Joan "I still feel alone because I haven't had a relationship with my mum that I feel I should have had. And so even when I, with my own children I can give them love and I do get something back from that. But I suppose, in what Maggie said, I don't feel but I quite often think, well why wasn't my mum like this with me?.... It does make you feel unwanted because the two people in your life that should love you and that you should be able to go and feel comforted by are your parents and I don't have that."

In families that neglect their children, the child can develop a fundamental uncertainty about the worth of the self, developing an inner working model of worthlessness and even badness (Gerhardt 2008). The group felt that this was the case for them and only came to realise there was an alternative way of relating to children when they experienced their own.

Maggie "'Cos I look at my family and think how, how can you treat children that way? How? I could never treat them that way. And then you think there's something wrong with me 'cos it's not normal to treat kids like that is it, you know? I didn't realise how abnormal it was until I had children of my own and I learned from [my husband].

Joan "I just don't understand why, why things went so wrong. I guess, I suppose…. I see [my friend] with her mum and her mum's so loving…. I want my mum to be like [my friend's mum] is but she's not.

Even though everyone in the group had siblings, they all felt excluded from their families. They felt alien, different and on the outside. Sally talked of how she felt in her family and how isolated she felt even though she came from a large family. Although she made no explicit reference to the abuse she suffered there was something in her voice and how she expressed herself that gave the underlying feeling of it. The room was filled with Sally's loneliness and pain and this must have been felt by Maggie as it led her to disclose her own abuse, which she had never talked about to anyone. Maggie had chosen to divulge this important, painful experience, which up until now she had kept well hidden, at the end of the penultimate session.

Sally "He's the one that told me that if mum ever died then it would be my fault basically…. They don't talk to me when they come. The fact that the age I am, even though you think that I'm coming up to forty so they'd treat me like an adult, but they don't. They talk to you as if you don't know anything and you're just a child still….. but I just feel like I'm not there. I'm not part of it. I am literally outside looking in."

Maggie "When I was sixteen I remember, and a friend of the family, he was actually one of my older sister's ex-boyfriends. He's thirty-two said he was going to give me a lift and I ended up in the forest and he raped me. I told my mum and she laughed and said, 'Lucky you'…. And I was made to feel like I should be grateful that I've been raped, now so I hadn't even done a thing. I didn't do anything to have brought to a boy to start things…Just turned sixteen and she didn't even do anything about it. It took ages to tell her and she shrugged it off and said, 'Lucky you'…. No I'm just embarrassed. Once again, it must be something to do with me, mustn't it 'cos why would it happen to me?.... When I really needed my mum and dad to be there and they just never have. It was soon after that that I had to leave home. I just used to wonder…. Don't know why I got to say it, I just wanted to.

Maggie's unconscious timing assured her that it would not be able to be possible to deal with her revelation in the time available before the end of the group. Although she intimated that there was more underneath the surface, it was impossible to delve further at this time and open wounds that would be too painful for her to negotiate without support.

Maggie, "Seems to me, 'cos as soon as I start letting stuff out I'm scared of what else is going to come to the surface. Scared of what's been there for so long….You know I have done a lot coming here and it does, has really helped."

There was also the rest of the group to consider at this late stage and I opened it out to see the effect on the others. There was a great deal of shock and anger in the room and it was important for the group to express some of it before ending the session and even more importantly ending the group completely.

Tessa "I just hope I never meet her mother ....It's got me quite angry really…. And to think that your mother would just laugh at you over something like that is just …. I just don't know."

Joan "For me personally, a lot of stories that you've told I've found quite shocking and I'm really sad…. You've shocked me with a lot of things you've said."

Maggie "I've shocked myself telling them."

Tessa “You know, it’s good in a way that you felt comfortable enough perhaps to say it.”

The only one who could not speak at this stage was Sally. We ended the session by looking at the options for further treatment. We had identified earlier that the group were taken from secondary care and therefore had a much longer duration of ED than they would have had if recruited from primary care. It was to be expected that they would need further ongoing treatment to be able to consolidate any changes they had been able to make. Taking that into consideration and recognising the paucity of specialist outpatient care, it was an extremely difficult task finding any available treatment that understood EDs and was offered on a weekly ongoing basis. The participants recognised the benefit of having had a regular weekly group to attend.

Maggie “It’s just that I’ve never had any treatment for every week…. Its usually once a month before they get back and see you again.”

In the last minutes of the session Tessa asked me a personal question, which I decided to answer. This had been a really difficult session and I felt it would not be in their best interests to avoid this.

Tessa “Can I ask you a question? Have you got children?”

It was important for them to know that I was a mother like they were and I answered the question truthfully. There seemed to be a feeling of relief and acceptance from the group and I felt that I had made the right decision in answering Tessa's question.

6.7 19th Group Session

Fig.7. The protocol of group 19

19th Session

Ending

During the penultimate session they were encouraged to write a letter to each of the other participants, which they would read out during the last session.

Discuss the phone contact.
Re-cap what we have done.

Food/feeding,
What and how much you give your children to eat
Mealtimes
How you use food reward/ punishment
Eating different meals

Body image
How you view yourself
What messages you received about your body
What messages you give out about your body
How you view your children's bodies
Is there is a difference between boys/girls?

Modelling,
Repeating behaviour you have experienced with your mother
Modelling behaviour that your children might pick up and copy, eg with food, body image, touching ,loving, dealing with situations, anger ,fear, low self worth.

Individuation
Becoming an individual, believing and trusting yourself.
Helping your children become individuals.

Separation
Being able to separate from your mother and significant others.
Allowing your children to separate from you.

Mother and daughter relationship.
How this has and still is affecting you.
How it affects the relationship with your children.
What has changed for you?
What still needs to change.
How do you see yourselves progressing?

Read out letters.

What do you feel about ending?

What you will do to continue the process?

Exchange personal details if you want to.

How have you been able to use the group?
What did you find valuable?
What did you find difficult?
What if anything would you have liked to change about the group?

Remind them of phone contact with me and the follow up interviews with colleague.

In the protocol of the group it was decided that when the sessions were completed, I would remain in weekly telephone contact up until the 6 month follow up interview. I had managed to secure ongoing weekly therapy for Maggie and Sally, Tessa already had her psychologist that she went to every 2 weeks and she wished to continue with him and Joan had decided not to continue with therapy.

It was important to see how Maggie was after her revelation at the end of last week’s session.

Maggie “At the end I was upset and a little bit shocked that I came out with it. Not feeling that I’d talked to [my husband] about it. Started trying to tell him and something happened. The kids and we got distracted, so he hasn’t said anything to me.”

Although I felt that Maggie’s revelation had not been dealt with adequately, I felt that it was too big to be addressed within the final session of the group. I suggested that she brought it to her future therapy sessions.

During the first part of the final session we recapped what had been done, going over the themes. The mothers were surprised at how much the group had made them aware of their behaviour and how much change had occurred during the lifetime of the group.

Maggie “I feel a little bit more confident, a lot more than I was. I’m trying to trust the decisions that I make, a bit more. It’s made me realise that I can do more than I thought I could do.”

Joan “I think I am much more aware of why I am like I am. I think that certainly, coming to the group’s helped me realise more how much the

children do take in even when you think they don't…. I have learned more about myself."

Tessa stated that before the group she had not realised that she made a distinction between her sons and her daughter. The group made her aware that she definitely fed her children in a different way and Sally acknowledged that her relationship with her daughter was much better.

Tessa " But I was doing that sub-consciously. I wasn't really aware that I was making such a distinction.

We looked at how they wanted to progress after the group and how they could hold on to what they had managed to learn from the group.

Maggie "Well, I want to carve out a bit of a life for me…."

Sally "I'd like my relationship with [my daughter] to improve even more."

The letters that the group wrote to one another showed a remarkable depth of empathy and perception. Being able to understand one another so completely helped them to understand themselves, as they were able to see a mirror image. Although they were well prepared for the ending they were frightened of letting go, but believing that maybe for the first time they were capable of completing their recovery.

Maggie "I feel quite sad. A bit scared actually. I think it's the first time I've ever felt something working for me and it's ending…. I hope that I've hit a point where I can change something."

Tessa "I think sometimes I've come quite pessimistically believing that it's not helping me but underlined sort of things that have been there unconsciously and coming out. Although I don't think that at the time that maybe I have related to it as I've dealt with issues and certain things at home, that more of it's gone in than I realised….."***It's 'cos it's, you really want to do this and you want to do it and you've got to believe in that you will do it."***

As the group were recapping their experiences, they mentioned the drop outs and wondered if they were still in the denial stage of the illness. They talked about how well they had connected with each other in the group, even though they came from an assortment of different backgrounds. The strain of dealing with opposition from partners and the fact that sometimes father's behaviour and treatment created the problems. During last week's session they had suggested bringing photographs of their families for the ending and this was how the group finally came to a close. They were all quite emotional and none of them wanted to leave.

I felt quite emotional my self at the ending of the group. As always in therapy, you share such intimate details of the clients. I feel it is an enormous privilege and a tremendous responsibility. I felt generally that the group had been a success and that in retrospect my idea of running a larger group was not a viable proposition. A smaller more intimate group offered a safer more contained space. My feelings of contentment were overridden by feelings of frustration that the work was only just starting with these clients and the difficulty in finding them follow on treatment did not bode well for ED clients in general. For them as well as for me the work was only just beginning.

** 6.8 Benefits and Difficulties of the group.

6.8.1 Tessa

All through the group and the interviews Tessa was very defensive and did not want to recognise the commonalities between her life and what was discussed in the group. Although she found it difficult to recognise the basic premise of the group, during the lifetime of the group she was reflective enough to recognise the dysfunctional aspects of her family relationships. It is possible that she was able to do this because she felt safe and contained within the group. She could then adapt that reasoning to her own children.

"Most of what I've got from the group has been more subconscious than conscious; I didn't think I was getting anything out of it. I was finding it quite annoying at times. Some of these ideas of where it's come from and stuff but then as I've been at home with the kids I've seen some of it coming out and I have been a bit different towards them."

There had been a turning point in the group when Tessa had felt that the group had helped her to handle a situation with her son in a different way. She seemed quite surprised that the group could have a positive effect in how she related to her children.

"I dealt with something completely differently to how I would have done normally and got a good result from it."

She knew what it felt like to be left out and to perceive that you are different from your family so when a similar situation presented itself with her son, she was able to think about her previous reaction and to change it, with an encouraging result.

"I think I deal with things slightly differently now. I know how I feel sometimes you don't want to be left. I tried to reassure him a bit more. He says he doesn't want to be part of the family but when I make sure he is, he's pleased, and that is something I think I have learned from the group."

Separation and age appropriate independence were themes in the protocol of the group. To help the mothers release the tight control that is a symptom of an ED was an important aspect of the group. The separation process was often a problem and was fraught with self doubt for the entire group. Tessa felt that the group had helped her with this.

"I don't question myself so much. I make my decision and stick to it…. I think I'm a bit more comfortable about them. I do let them make their own choices to a degree, what I feel is appropriate at their age."

Tessa felt that she had subconsciously picked things up from the group and until she acted upon them didn't realise that they had made an impact on her.

"I have done things and thought where's that come from and then I know it, that it's something that I've thought of from the group."

When Tessa was asked her overall opinion of the group she was quite negative, but it was fairly obvious that she felt this way because she did not want to admit that her behaviour could be internalised by her children as it then brought up guilty feelings. It was far easier to believe that her behaviour had no impact on her children, in which case it was only she that was suffering and she could justify that. The thought that she was damaging her children was far too distressing to contemplate, even though the evidence was discussed by her in the group. As the safety and security of the group had ended so Tessa's defences had been firmly put back into place.

"To be quite honest with you, I found it a bit manipulative, to a degree…. I don't see how my kids can pick up my eating habits when they're not around when I eat. So I'd like there to be some evidence showing to me, that it's down to me that my children are getting the wrong vibes. I'm not

convinced that they are. That's what I've struggled with all the way through, that your children are picking it all up."

The group was established especially for mothers to help them with all the elements of an ED. Tessa's expectation of the group was that it would help her with her eating and she felt that this had not happened. Nevertheless she did feel that it had helped her in other ways.

"I thought that it would have helped me a bit more with my eating but it hasn't….I know it sounds like I don't think that the group's done very much but I think it has. I'm just not totally aware of it and more may come out as the time goes by."

Change in an ED is a difficult and daunting prospect and far more onerous without the support of the partner. It is sometimes possible that the partner can sub-consciously collude in maintaining the ED as a form of control. Tessa attended the group without the support of her husband and therefore it is quite probable that she was far more fearful of change than she would have been with his support.

"I mean, my husband didn't like me doing it all really, he was totally against it."

At the conclusion of the end interview, Tessa referred to the letters that they were asked to write and read out in the final session of the group. As other peoples' judgement of her was important she found this rewarding and enjoyed doing it for the other members. She displayed a great deal of insight and empathy with the letters.

"Yeah, the letters bit was really nice. It was nice to hear what other people thought. When you're like me, that's all you worry about is what other people think about you….And when somebody sort of writes down what they've been thinking about them, I suppose it was quite nice and I liked doing it to the other girls. I liked giving the other girls their letters 'cos you feel you've built up this relationship with them."

6.8.2 Maggie

Maggie felt that the group had imbued her with hope for the future and given her the tools to access her emotional states and she would have liked the group to have continued.

"I'm less depressed now 'cos I'm looking toward the future more, whereas before I couldn't see a future. The group has taught me how to recognise my feelings, to be more aware…. I'm a lot more honest I used to say what I thought people wanted to hear…. I just think we just hit a stage where I think it would have been beneficial for me to have carried on a bit longer."

Maggie admitted that she usually does not complete treatment but this time something shifted in her and she realised that she needed to do this for herself. Maggie exemplified the importance of being ready to face the fear of recovery and the importance of dealing with the underlying reasons for the ED as well as the symptoms of the illness.

“***Yeah, I’m really surprised that I completed it. I don’t normally manage to complete many things, which is a sense of achievement.”***

None of the previous out-patient treatment that had been offered to Maggie was weekly and she felt that it was not constant enough to be useful to her. She felt that because the group had been weekly it had been able to hold her enough for her to embark on change. Now that the group had ended she was concerned that there would be no other treatment or support available and that she would loose any progress she had made.

“What I’m scared of; it’s only just stared to change and now everything’s ending….It’s the only thing I’ve done regularly every week.

As EDs are filled with shame and guilt it creates isolation for the sufferer who becomes convinced that no one else has similar feelings. Maggie felt that the group was a constructive and validating experience.

“Whereas before I never felt validated, it’s helped to make me realise that it’s still quite an important problem.”

The group had helped Maggie to be more assertive and gave her the coping strategies to deal with her anxiety, reclaiming her ability to make decisions and take responsibility.

"It's helped me to control some of the anxiety when I feel it coming on; to sort of realise that it's happening rather than just let it take over. I think I've learned to be able to speak and not be frightened of speaking….I think because we worked through quite a lot of different things and it made me take some responsibility again and I'd given up all my responsibilities, basically."

Maggie felt at ease in the group, she thought that the space was non-judgemental and did not feel overburdened by guilt. This environment encouraged change brought about by learning and understanding.

"Yeah, I think the biggest thing with the group is how aware of your actions it makes you. It doesn't do it in a way that makes you feel guilty and judged but it just seemed to gently put thoughts into your mind that actually that probably isn't a good idea and that's what's good; you're not being preached to."

Homogeneity within the group was an important factor when indentifying the specific needs of mothers with an ED. It was hypothesised that the success of such group therapy would be directly connected to the group's cohesiveness.

Having been in groups during her inpatient stays Maggie felt that this feature of a group was of great significance.

"I think its of huge importance to have been with other mums. I felt very alone when I was in [hospital] because everybody else was like a teenager with no responsibilities. It's very easy when you're anorexic, you haven't got to do it for anybody else. So it's very hard when you're battling with trying to do it for your family's sake. There wasn't anything that dealt with that, whereas when you go to the group other mums are struggling and you can bounce ideas off each other….That's what I think was the thing that really helped; is talking to other mothers."

One of the aims of the group was primary prevention of an ED for the child. The belief upholding this rationale was that if you helped the mother overcome her ED and made her aware of her dysfunctional behaviour, then there was a chance of blocking the transgenerational sequelae. Individuation was one of the themes of the research and it was important not only to help the mothers with their own individuation but also that of their children. Individuation is closely linked to separation which was another theme of the research.

"I never realised how un-individual I was making them. I used to always dress my boys exactly the same, to the point that from behind even I couldn't tell them apart and I've started separating them a little bit more. I used to have to feel in control with all of that."

Maggie was very anxious about letting her children separate from her. School represented a huge problem for her and anything associated with it fed straight into her low self worth. She was nervous about fitting into the normal routine of school life and found relating to the teachers as an adult and parent a problem.

"I don't want him to pay the price for me being disorganised and stuff….I do have trouble with people in authority. I do tend to slip back to being a little girl when talking to teachers and don't stand up for myself very much."

Maggie appreciated the ethos of the group that EDs are not just about food and that without dealing with the underlying issues, recovery is not possible. Previous treatment that she had undertaken was centred around a re-feeding programme, which was necessary when presenting with a low BMI; but while the BMI is brought up to acceptable levels, it is vital that the underlying issues are brought to the fore.

"My eating is still a huge problem but it's changing…. I just thought I would sort the eating out and everything else would fall into place and it's kind of like I've had to work inwards from the ripples to get to the eating…..That's what it feels like and I'm just getting to the centre now, hopefully the last stage of getting over it."

The difference between the group and previous treatment was the relationships Maggie was able to build due to the weekly contact. The group had exceeded her expectations, but now she was back to uncertainty about her treatment.

"People seem to genuinely care. That's what comes from going weekly you build up a rapport with someone….It was better than I thought it was going to be… I'm more open to other help. Things haven't worked in the past. I am feeling different but I am worried now it's stopped. How will I continue to keep making progress?"

Maggie spoke highly of the group and felt that it had helped.

"Yes, actually it's the best thing I've ever done…. I'm really quite sad that it's ending because it's the only thing that's ever helped."

The most difficult session for Maggie was the penultimate session when she had disclosed her rape for the first time (please see group findings). Being in a group of empathic people gave her affirmation that her experience and the way her mother had dealt with it was as traumatic as she felt it was.

"Yeah, actually the last but one was very upsetting. A lot of stuff came out that I'd not told anyone before and it sort of shocked me how much I'd buried really….when I tried to confide as a child or teenager to my mother about the fact that I was raped. It took me by surprise, but I

suddenly… she laughed it off and said, 'Lucky you' and I've never really told anybody because I always felt that they might just dismiss it out of hand again, like it doesn't really matter… Yeah, it's came out of nowhere. It took me by surprise but I suddenly felt that I could…. It's the only time I felt safe enough to say it."

At the conclusion of the 6 month interview Maggie was asked to give her opinion of the group and add any further comments. She returned to the homogeneity of the group and how much benefit she had derived from it. She compared what it felt like to have an ED with and without children and that until the group there was nowhere for mothers to go specifically and what a difference it made to be with other mothers.

"I think personally, from having lots of different treatment over the years, that this has been the best one that I've had personally and maybe it's because I've come to a stage where I want to get better, as well and I've got children but since I've had the kids there didn't seem to be any niche for me…. That's been, 'cos you feel terribly guilty when you've got something like a mental illness or eating disorder 'cos you feel like you're just going to be the worst mother and the worst wife and it's affecting everybody else and not just you. When there's just you, you don't care about you….So hearing other mothers saying how they feel and seeing that you're not the only one struggling with those thoughts is reassuring, especially when you think, well they're doing it really well and they seem really confident but they're having the same

inward feelings….So you don't feel so alone. No, I think it's been really good. I think it could be really helpful."

6.8.3 Sally

EDs have a stigma linked to them and because of this there is a great deal of shame and guilt attached to them. It becomes difficult to seek help for the ED and also for any issues arising from it. Sally had great difficulty with nurturing her child and being in a group with other mothers helped her a great deal. As Sally felt she was unable to divulge her ED to anyone, she was in a very vulnerable and isolated position.

"A couple of times I know I ended up crying, lots to do with my daughter and how I listened to the others. No one knew I came to this [group]. I hadn't told my mum or anyone. They knew I went to a group, but not that it was for an eating disorder, 'cos they don't know."

By the end of the group Sally felt that her anxiety had not improved, although she did feel that the group had helped her with the relationship between her and her daughter. When she first started the group the relationship was so bad that her daughter was spending most of the time at her mother's.

"That's probably improved that has, 'cos I don't have a really hard time with her any more. I can cope with her and she stayed with my mum a lot of the time and that has, I say, improved….They [the group] were

quite supportive and they could see that I was struggling and so I think that they did help me."

Sally felt that the group had helped her get through the difficult time she had experienced before the commencement of the group. She was able to understand that the problem lay with her, not her daughter and was trying to deal with the consequences of her outbursts.

"I think they've helped me get through an awful lot since the beginning of the year; the problems I was having coping with [my daughter] I am more aware and try not to, do and say things. But if I do, I try and do something to counteract it."

At the beginning of the group Sally was unaware that her dysfunctional relationship with her daughter was a component of her ED, but as the group progressed she started to understand the far reaching complexities involved with an ED.

"I didn't know what to expect, the supportive aspect of it's been quite important. Talking about [my daughter] and me, I've sometimes felt it's not really for a group with eating disorders. It has actually made me more aware and careful not to let [my daughter] see what's going on."

The fact that the group was run on a regular weekly basis was a very positive factor for Sally.

"I think the group; it probably was more useful because it was every week."

When the group ended, Sally thought that she had made certain changes but was unsure if she would be able to maintain them when she was on her own again.

"At the moment I'd say yes, because it's still fresh…..I'd like some more help. It's what was important about the group that it was regular, that it was every week….That's the kind of support that would feel useful."

It became evident from Sally's comments about the group, that the relationships with the other members, were an integral component. This allowed her to build trust, leading to a feeling of safety, enabling a certain amount of disclosure.

"I felt welcome and at ease and you could open up. I mean, I opened up and I've never, ever thought I would do, it was possible for us to talk in front of other people."

The main change for Sally was her relationship with her daughter. Due to her depression, she had in the past, long periods of anger and rejection. This she found was becoming more manageable.

"I'm able to control myself a bit more now. I still, sometimes, just don't want to do anything and things haven't changed completely, but they don't occur as often."

6.8.4 Joan

The subject of mess was again brought up at the 6 and 12 month interview, to ascertain the changes that had been made in this area. It was looking quite positive, that the changes that Joan had been able to make in one or two areas, were being taken on as permanent changes.

"I'm not as bad about mess as I used to be….I think it's got better, I'm more patient and less strung up. If something goes flying on the floor, where it perhaps used to upset me, now I sort of say it doesn't matter."

All though the group Joan was learning that her behaviour might have an impact on her children. As the group progressed the realisation that her children could question her actions became apparent to her.

"I haven't ever thought about it. I guess through talking in the group, I suppose I've thought that, when they get older they're going to be more in tune, ask more questions about why I'm not eating something. It doesn't go unnoticed now, but it's easier just to say, 'No I don't feel like it.' But when they're older it worries me."

Her children were an important area in Joan's life; after the group it was a key recognition for her, how much children internalise what they experience.

"The group's certainly changed my understanding of my children, and the time I give to them and for me to be aware of how they pick up on things, that I maybe didn't think they would. It's made me much more aware of that."

When people suffer from an ED, their relationships are affected. All the mothers in the group, failed to realise how much their ED disrupted the relationship with their children and how the ED interfered with the time they should be spending with their children. On recognising this, Joan was able to redress the situation and had made a considerable improvement to the overall connection with her children. This connection seemed to be a lasting one, as Joan was aware of it at both the 6 and 12 month follow ups.

"One of the key things the group did do, was raising your awareness. I think it has changed, through listening to what was said. Not just about what they pick up with your eating, but in terms of being there for them, my relationship has probably got better. I do give them much more time now and I try to understand they don't think like an adult because they are a child. It's just helped me to realise things like that and I spend a lot more time with them and I'm enjoying them, actually."

At the 6 month interview, Joan was able to reflect on her unhappy childhood and felt very positive that the group had taught her how to relate to her children in a more open and constructive way. This led her to understand their needs in a more compassionate manner, leading to a closer and happier relationship with them.

"I'm really glad I went to the group and I think that I am different with my children and, my whole awareness of, what I do and don't do and how they pick up on things, is there now and so I really think it's helped my relationship with them…. I can be a better mum to them."

Over the 6 months since the group had ended, there had been a great change in Joan and she felt that the understanding and awareness that she had learned in the group, would stay with her and help her to maintain her new behaviour.

"It's there with me now. I've learned it. I will always be different to how I was. Be there more for them, understand their needs more or, understand what they're asking for, or why they might be upset….I will continue because I am now aware of it and so, I act differently."

6.9 Progress of the Participants

6.9.1 Sally

On completion of the group and at the 6 month follow up, Sally had stopped self-harming, had reduced her laxative abuse considerably and was much more aware of her eating behaviour. Her relationship with her daughter had improved significantly as she was able to control her emotions more, which allowed her to develop a more loving bond between them. By the 12 month follow up Sally unfortunately had lost her mother. This was a big blow for Sally and her daughter as her mother had been their only source of support and Sally's daughter had been very close to her grandmother. Even through this trauma Sally was still able to maintain and continued to build her relationship with her daughter and was capable of fulfilling her role as mother. Although she was still struggling with her eating, especially since her mother's death, she had not self harmed and continued to reduce her laxative abuse. Sally had felt that the group had given her more confidence and had helped her with her relationship with her daughter, both of which she felt would be continuous.

At the beginning of the group, Sally was a quiet introverted member. It took quite a few sessions for her to feel safe enough to let some of her defences down. When she started to speak and tell the group about her life, it became clear that although she needed help with her ED, her relationship with her daughter was in imminent danger of breaking down completely. During Sally's initial interview, she divulged that she had been abused by an uncle in her childhood. Although she was able to disclose to the group intimate details of her life and her relationship with her daughter, she did not talk about the abuse. Rustomjee (2009) talks of shame as the 'most personal and private feeling', she goes on to say that people experiencing shame 'can feel extremely vulnerable and overwhelmed at the thought of sharing an unresolved experience of shame.'

When Sally started the group her eating was extremely erratic, she would follow periods of non stop eating and binging by periods of starvation, she would self-harm and continued with severe laxative abuse. She hardly ever cooked and would never eat with her daughter. The only normal meals she and her daughter ate had been at her mother's house. This had improved after the group and she was able to provide more meals for her daughter. At the 12 month follow up, after her mother's death she was able to provide full care of her daughter.

Throughout the group, Sally spoke movingly of her inability to nurture her daughter. This took great courage on her behalf and by her own admission was the first time she had ever spoken about this in such depth. She took a great personal risk in doing this as her expectation was that she would be shunned, but the group empathised with her and accepted her. Yalom (1985) found that the success of group therapy was directly connected to "group cohesiveness" and the support of the group members. This support helped Sally to address her feelings of inadequacy and enabled her to put into practice the advice that the other members gave her.

6.9.2 Maggie.

When Maggie was referred to the group she had been an inpatient for her ED on several occasions. She was unable to work and found it difficult to leave the house. At this stage her motivation for recovery was high and she viewed the group as a last chance; she was a willing and responsive participant. At the completion of the group and at the 6 month follow up Maggie had managed to get a job and was far more independent. She was able to tolerate more food and was vomiting less; she was going out more and taking part in family activities and family decisions. Although by the 12 month follow up Maggie had bettered her job, she was struggling, as seriously adverse life events had overtaken her. Her husband had left her, her father-in-law had died and her mother-in-law had had a breakdown. Her in laws had been a great source of support for her during her illness and her husband was everything to her.

Maggie informed the group when she first started, that she would have to miss one or two sessions as she had to undergo surgery. It subsequently transpired that she only missed one session as she was extremely committed to attending. Maggie's ED was very severe and had been extremely long term, resulting in many physical problems. Her eating was minimal and virtually everything she did eat she vomited. Eating with her family was very problematic and she avoided most meals. She was extremely anxious and found going out and mixing with other people a great strain. She was entirely dependent on her husband, physically, financially and emotionally. She was enthusiastic about the group as she felt that this was the first time anyone had offered her treatment taking into consideration that she had children. Despite her anxiety she was an integral part of the group from the start and made a valuable contribution to it.

Maggie found that the interaction with other mothers who had an ED a valuable part of the group. She felt an affinity with the group which led to a greater understanding; the group gave her the unconditional support she needed and had never received. As the group progressed she started recognising behaviour that her children had learned from her and this upset and worried her. Maggie not only gained support from the group, she played a great role in supporting others. The fact that others respected her judgement increased her self worth immeasurably, which in turn improved her confidence. As Maggie had played such an active role in the group it was surprising that she was only able to reveal that she had been raped when she was a teenager, in the penultimate session. This precluded any help that the group might have given her but she revealed that the mere fact of being able to disclose it was cathartic and the response of the group gave her a positive and accepting experience.

Maggie was an excellent example of how an ED can be associated with a dysfunctional relationship. While she was severely ill and wholly dependent on her husband, the relationship survived. While attending the group she became more empowered and the dynamics of the relationship changed which unnerved her husband and prompted his departure. By her own admission the group gave her the self esteem and confidence to survive.

6.9.3 Joan

When Joan joined the group she admitted that she had an ED when younger but felt she had now recovered from it, although she recognised that her eating was erratic. Joan was emaciated and extremely underweight; she found it difficult to eat at home, therefore avoided mealtimes. She went through long periods of eating minimally (an apple a day) and self harmed; she had also been off work for a considerable amount of time due to severe depression. While she was attending the group she started to ease her way back to work part time. By the 12 month follow-up she was back full time, taking an active and responsible role. She had also managed to maintain her increased weight and had continued to refrain from self-harming.

Joan was a regular member of the group and took an active role. She valued the input from the other members and they valued hers. There was one particular session that resonated with Joan and that was session three, where we did an exercise on mealtimes (see Protocol of Group). This exercise made her recognise how dysfunctional mealtimes had been with her family of origin and how she was repeating the same patterns with her children. After that she worked very hard on understanding where her ED had its roots and how she needed to change her dysfunctional behaviour to stop any transgenerational effects being passed on to her children. For the first time since she was seriously ill she allowed herself to gain weight and started to make a tremendous effort to make sure she ate with the family. She also stopped self-harming which she had been doing for years. She spent more time with her children and took a far more active role in their care and progress.

At the initial contact for the group, Joan had felt that she did not fit the criteria for the group but would attend as she had been recommended to do so. When she ended the group she had found that it had been an ‘eye opening’ experience and was sure that she had benefited from it and would continue to put what she had learned in to practice. She was aware of the pitfalls that her children could fall into and was determined to keep a watchful eye on her own and their behaviour.

6.9.4 Tessa

Tessa was unable to finish the 6 and the 12 month follow-up interviews because she was diagnosed with Ehlers-Danlos Syndrome (http://www.ehlers-danlos.org). The diagnosis was confirmed after the end of the group and her youngest son was also confirmed to have the syndrome. After the diagnosis, she felt that she could no longer continue with the research.

When Tessa first joined the group she had been off work for some considerable time with severe depression. She had been suffering with an ED since her early teens and abused laxatives. She over exercised to the point of self harm as her joints would dislocate and muscles become stretched and swollen. This was due to her Ehlers-Danlos Syndrome which was unknown to her at this point, but she used exercise to compensate for eating, to keep her weight down. She was obsessive about calories and cleanliness.

Tessa’s husband made it very difficult for her to attend the group and encouraged her to stop. Due to this she nearly dropped out but managed to gain enough inner strength to continue. At the beginning of the group she did not believe that her children could internalise her behaviour and insisted that she kept her ED separate. Tessa took an active role in the group and felt safe enough to divulge a great deal of intimate detail about her life. During the lifetime of the group she began to see the significance of the group and was able to use what she had learned in the group with her children. Although Tessa was able to use the group with her relationship with her children, she found it very difficult to change her self image and her eating habits but she was able to stop her abuse of laxatives. She believed that the group had given her a better understanding of her relationship with her family of origin and that overall she had had a positive and beneficial experience.

Unlike Maggie, Tessa was unable to use the benefits of the group to her advantage in her relationship, as she was too frightened of change. She admitted that her husband had been against the group from the start. Just attending the group took a great deal of determination. Her inability to change could have been due to her diagnoses of EDS or to the fact that this was her second marriage, but this is supposition.

At the beginning, all the group participants attended the group for the sake of their children. During the lifetime of the group they all realised that the only way to help their children was to help themselves first. It became very clear how important the role of support is to anyone suffering from an ED. Without a strong source of support, these women struggled with their EDs for many years and it was very clear how hard they worked to initiate and maintain any changes. Whatever the reasons for the onset of an ED, without support in dealing with the onslaught of this debilitating illness, recovery becomes an extremely difficult mountain to climb. **

Chapter 7

7.0 Discussion

The following chapter presents a general reflection on the findings of the study as a whole. This research set out to design and develop a new and innovative treatment for mothers with an ED. From developing and implementing the pilot study and taking note of the relevant literature, it was felt that a group would provide the best possible environment to give these mothers a safe and non-judgemental space to explore their behaviour and uncover the unconscious meanings behind it. The sample was made up from women who had suffered from an ED for a lengthy period of time and were recognised as a difficult to treat sample (Robinson 2009). However once they were able to explore and examine their own lives and their own unconscious processes, they could begin to examine and observe how their behaviour was having an effect on their children.

While delving into the literature and examining my own clients' histories, it became apparent that ED sufferers are prone to attachment deficits and parenting difficulties. As this study has indicated throughout, the children of these mothers, either by genetic inheritance or environmental exposure, or a combination of both, are a high risk group or are very likely to develop their own ED (Stein et al 2006, Hodes et al 1997, Stein 1995, Sourfield 1995, Stein et al 1993). Yet through the examination of the literature and my own research into the availability of treatment, I found that this is a group of ED sufferers that has not yet been adequately catered for by the treatment presently available.

7.1 Aims

Fig.8 Research Aims

AIMS

1. To conduct a group intervention.
2. To identify if deficits in attachment and separation are linked to EDs
3. To aid the recovery of the mother from her ED.
4. To investigate the possibility that the mother's recovery will facilitate the primary prevention of an ED for the child.
5. To develop a transferable protocol from the group that can be used by other therapists within a health care setting.

The first aim of the study (see Fig 10) was to conduct a group intervention that could answer the research questions (see Chapter 5). While carrying out the interviews and facilitating the groups, the second aim of the study was clearly fulfilled. All the participants of the group and also the drop outs had difficult and dysfunctional attachment histories which had played an important role in the development of their EDs. While examining their poor attachment histories, it became clear that they had come from dysfunctional families that had amongst other things, a troubled relationship with food and body image. What was also identified from the participants' histories was a direct link with transgenerational behaviour. During the process of the group, it became clear that the mother’s and in some cases the grandmother’s dysfunctional behaviour was being passed on to their children and their grandchildren, even though at the start of the group the group members all denied that this was happening. The children were appropriating their mother’s behaviour by internalising the dysfunctional model that they were being presented with. In all cases the mothers felt it was sufficient to give the children the message “Do what I say not as I do”. By the end of the group the realisation that this was not an adequate message was really understood.

The third aim of this study was to examine if a group intervention could aid the mothers’ recovery from their own ED, which would enable them to nurture their children in a more effective way. It was hypothesised that if we could achieve this objective, it would help us on the pathway to alleviating the transgenerational nature of EDs and would also support the primary prevention of an ED in these children. It was felt that this third aim was met, as all the completers reported some positive change in their behaviour. All the mothers who completed the group felt that they had learnt and benefited from the group and that the group had made a difference to their lives. The positive effects of the group were that they felt they were able to learn from one another and gained confidence and self-esteem from being able to give and receive advice.

The fourth aim, investigating the possibility of the primary prevention of an ED for the child was unable to be met fully in this study as the children were not measured and the only results were the reports from the mother. It was decided at the onset of the research that the children would not be monitored as that would have taken a much bigger study, requiring more funding and more researchers qualified in working with children. It was also acknowledged that this was a much damaged client group and the risk of them becoming overly anxious about their children and their mothering, was too unsafe. This was confirmed during the group sessions when the mothers became very protective of their children. However, when the mothers began to feel safer, they were able to discuss during the group sessions, how the children had appropriated their mother's behaviour and beliefs with regard to food and body image (Please see Findings Chapters 4, Food and Body Image, for each participant).

The last aim of this study was to develop a transferable protocol from the group intervention that could be disseminated and used by other psychological practitioners, within a health care setting. A smaller version of the protocol was devised for the pilot study and tested during it. This was then expanded before the main study commenced and was developed during the lifetime of the group to gain maximum benefit from the themes. This aim was completed as 'The Group Manual' (Appendix 20).

7.2 Protocol

I have discussed my own stance as an integrative psychotherapist and my understanding that one theoretical position does not fit all. While constantly leaning heavily on the relevant literature, I also delved deeply into my own professional experience to amalgamate the different theoretical paradigms that seemed to fit well with this particular client group and the wider purposes of the group. The final decision that the group should be based on a semi-structured psycho-educational format using self-psychological (Goodsitt 1997), psychodynamic (Herzog 1995) and cognitive (Garner et al,1997) theoretical ideology seemed to work well with the delivery of the group.

As attendance sometimes fluctuated, the protocol was adapted during the lifetime of the group in order to gain maximum benefit from the themes. The themes were used to structure the session and give each session a focus which was then opened out for discussion. Each session was allocated a theme; some themes spanned two sessions. These themes were not entered into lightly and each theme was researched very intently and linked to the relevant and current literature, to make sure they were pertinent to the group and to the research. The themes were then tested on the pilot study to ensure their relevance to the clients and the study. The themes were then cross matched to the research literature and were then chosen for the main study. The themes covered during the group were as follows:

- Food and feeding.
- Modelling.
- Body Image
- Individuation and Separation
- The Mother/Daughter relationship.

It became evident from the end of the group interviews that were administered, that the protocol that had finally been devised and used, was a good working model that could be taught and repeated within the remit of a therapeutic setting (Please see Group Manual Appendix 20). All the participants commented on the benefits of the group and how it had helped them in various different ways (Please see Chapter 6, Benefits and Difficulties of the Group for each participant).

7.3 Deficits in Attachment

The literature search was significant in revealing all the nuances and intricacies of the aetiology of an ED. It gave very clear indications as to the validity and usefulness of themes that would be helpful in the treatment of EDs. From the literature, it was apparent that attachment issues were at the heart of the environmental causation of an ED. Because of attachment issues, the mother/daughter relationship was flawed and dysfunctional which often leads to low self-esteem which can then spiral into a full blown ED. The sufferers from EDs have problems with food and feeding themselves and commonly have difficulties in appropriately feeding their children. They have usually experienced difficult or no separation and have problems becoming self-confident individuals. They have an extremely damaged and distorted body image and seldom recognise how they have internalised behaviour that they were exposed to. In fact they have difficulty in recognising how children in general internalise and appropriate their environment.

Fig.9 The Research Questions

The Research Questions

1. Are deficits in attachment and separation in this group, linked to EDs?
2. Can it be demonstrated from this group, that EDs gets passed through the generations?
3. Can this group therapy intervention aid recovery for the mother and help the prevention of transgenerational ED, by altering the mothers' behaviour to their children?
4. How did the participants experience the group and research process?

The areas of research interest generated by the group were as in Fig.10. The deficits in attachment became clearly linked to the participant's EDs. Even Tessa who felt that she was securely attached to her mother and became upset at the insinuation that the attachment was not as secure as she wanted to believe it was, started to recognise problem areas and admitted that she was always living up to her mother's expectations. She recognised that when she was 13 her mother encouraged her to diet and loose weight telling her she was 'too fat', indeed her father always called her 'the pig in the middle' of her siblings and that's how she thought of herself. While going back exploring her past she became more aware of the roots of her ED.

Maggie and Joan both recognised from the outset, that their attachment to their mothers and indeed to both parents was problematic. Maggie recognised that from an early age her mother 'played games with her' and gave her mixed messages. She remembers her mother being very punitive and humiliating to her, as her mother always made negative comments about weight and made continual comparisons. She became convinced that her mother's attitude to her was the cause of her ED. Joan's experience was that her parents had not nurtured her and she felt unloved and uncared for. She spent long hours alone in her room and did not want to speak to anyone; she resented her parents and 'just stopped eating'. She left home at 17 and went to live with a surrogate mother and has a very estranged relationship with her mother to this day.

Sally's mother was unable to love and nurture her. She felt she was devoid of any physical or emotional attention from her parents. Her father was not at home for a great deal of time and her mother was a Nurse who worked nights and slept during the day. Sally had never been given the opportunity to experience a close loving relationship and she was abused for several years by an uncle. These events had a profound effect on her ability to mother and nurture her own child. These childhood experiences had the effect of Sally's childhood being full of trauma and neglect, creating a cycle of dysfunction reaching down to Sally's daughter. She knew that she found the normal features of motherhood difficult to show to her daughter, repeating a dysfunctional attachment for her child.

(For further details of each of the interview transcripts please see Findings Chapter 5 Interviews).

7.4. The Group Process

It was felt that all the themes used were relevant to all the participants, their histories and their on-going problems. Each theme brought up deficits across three generations within the triad of grandmother, mother and child and each theme flowed into the others. The semi-structured format allowed us to concentrate on a theme and look into all the aspects related specifically to that theme. The discussion time was extremely valuable, as it enabled the participants to explore wherever they wanted to go. This discussion time invariably brought up exploration of their past lives and relationships and in doing this they flowed seamlessly into all the themes. This included their nuclear family dynamics; they recognised how different and alien they felt from their families, some even felt as if they had been adopted. They often felt that they were the focus of family taunts and jibes, which led them to recognise how isolated and disassociated they felt. Each session without fail, always brought up the relationship with their mothers. They looked at how that relationship impinged on their relationship with their children. They reflected on the similarities between their mother’s behaviour and their own behaviour and began to understand that the deficits in their attachment process had a great deal to do with the development of their ED. In turn, they came to the realisation that children were very aware and internalised behaviour presented to them. This gave them the determination that they did not want their children to appropriate their dysfunctional behaviour.

7.5 **Transgenerational Effect**

The study was able to demonstrate that EDs are passed through the generations, but was unable to categorically prove that EDs were passed on to the children of this study, as the children themselves were not tested, although the indications were that the children did internalise and repeat their mother's behaviour and picked up the underlying dysfunctional cognitions. The genetic disposition of heritability was investigated in the literature review (Collier & Treasure 2004, Strober et al 2000, Collier et al 1999, Treasure and Holland 1995), revealing a large body of research that indicates that there is a high probability of genetic inheritance. Further research into genetic transmission is ongoing. This together with the environmental internalisation that was indicated in this study makes the likelihood of transgenerational EDs a strong possibility, and supports the likelihood that the children of mothers with an ED are a high risk group that need to be provided with appropriate treatment.

Maggie was a prime example of disordered eating and disturbed body image being passed through the generations. Maggie's grandmother was a compulsive overeater and about 20 stone; her mother was continually on "faddy" diets and was obsessed with weight and size issues (Please see Findings Chapter 4 Initial Interviews). Maggie's experience with food as a child was not a pleasant one and during the group she became conscious of the fact that her son was far more aware of her eating habits than she thought, saying 'Why is it that we get told to finish our plate but mum never does?', demonstrating the ineffectiveness of the 'Do as I say not as I do' message. She also recognised that he was very conscious of his body, with comments like, ‘Oh my tummy looks a bit fat.’ (Please see Findings Chapter 6 Groups).

Two of the participants that had dropped out had definite transgenerational links. Sue’s mother had suffered from anorexia since she was born and died of it when Sue was 14. In the group she talked about how good if felt to be amongst people who understood her and didn’t judge her, how frightened she was of coming and how glad she was that she had plucked up the courage. She talked in detail about her illness and treatment, but then she dropped out. Linda had been suffering from an ED for 27 years, since she was 17. Her daughter had been diagnosed with anorexia at the age of 11. She talked of having a great deal of past treatment and nothing had helped her. She spoke of how difficult it was to help her daughter when she suffered herself, yet she also dropped out (Please see Findings Chapter 5).

7.6 **Mother’s Recovery**

During the lifetime of the group, it became evident that the group process itself was the catalyst for helping these mothers become aware of their own behaviour. They all agreed that the most important aspect of the group was being with other mothers. This was something that they had never experienced in all their years of previous treatment. They commented on how difficult it had been for them to participate in groups while they had been hospitalised. They felt that they could not connect to the other in-patients without children, as without children they had different agendas and did not understand the implications of motherhood.

As they began to feel safe and accepted enough in the group they became able to talk about their past experiences and they were then able to link these experiences to their present behaviour and cognitions. For the first time they were in a position to understand their actions and to realise that other people felt as they did and that most of their actions were driven by their illness. Being in a homogeneous group (Butler & Wintram 1995, Yalom, 1985) enabled them to feel accepted enough to make their thought processes conscious. When this happened they found that they were able to offer suggestions which were of help to others. This gave them the confidence to contemplate the difficult task of changing their embedded dysfunctional thoughts and behaviours. It became clear that if the mothers could change their behaviour and their children were presented with a healthier less dysfunctional model, there would be less likelihood of transmission. This leads us to believe that the group offered could play an important role in the prevention of transgenerational EDs.

7.7 Primary Prevention

While researching this study, a great many statistics came to light, some of which I felt highlighted my concerns about treatment in the area of EDs. In the introduction to this study there was an invitation to digest some statistics on EDs. Those statistics were formulated a few years ago, yet it seems very little has changed. It has been recently stated that one in three people admitted to hospital for EDs are children, some under the age of 10 (*Nursing Times Net*

2010). The number of girls under the age of 16 who have been hospitalised with AN has increased by 80% (BBC News 2009). In a survey carried out into the age of onset in EDs , 20% stated that they were 11 or younger when their problems first started and the youngest was just 6 years old (BBC News 2010).

7.8. Treatment

It has been previously stated on a number of occasions that early intervention is essential for a speedy recovery (Treasure & Schmidt 2005, Treasure et al 2005, Roth & Fonagy 2005, Hsu 1990), but it would still seem that GPs, as the primary source, are still failing to recognise, treat or even to understand EDs (BBC News 2009). The NICE guidelines clearly state that the key to successful recovery is that GPs listen and act quickly, but a previous study by the Nursing Times (2009) reported that out of 59% of patients presenting to their GP with concerns of an ED only 15% felt their GP understood and more importantly knew how to help (Nursing Times Net 2009). Although it is recommended that specialist care is sought as soon as possible, EDs span the transition between child and adult mental health services; the specialist treatment needed becomes problematic and sufferers often get caught in the changeover (Treasure et al 2005). What this study also found was that ED sufferers who are also mothers were a neglected and misunderstood category and that they also fell into a treatment abyss that was not catered for.

Once the illness becomes long term, both the medical and psychological risks become more multifarious and severe and are far more difficult to treat. Some of the medical complications include electrolyte imbalances, impaired liver functioning, osteoporosis, amenorrhoea and cardiac problems all of which increase the risk of mortality with the length of illness. The psychiatric and psychological disturbances that become more imbedded include depression, obsessive compulsive disorder, anxiety and self-harm. The psychosocial aspects of the illness such as work, shopping, dealing with teachers/people of authority and general living become overwhelming and are avoided. All these increase the cycle of cognitive impairment that fuels an ED (Robinson 2009). If the correct treatment is difficult to access or completely unavailable the sufferer can become disillusioned and retreat further into her illness. This creates a sure pathway to severe and enduring EDs (Robinson 2009).

The group that was offered to the participants was a form of treatment that was specifically designed to address some of the areas of treatment that were currently unavailable. The participants all felt that the group which was offered to them certainly filled a gap in treatment that had previously not been accessible to them. The participants commented that even when they get the courage to seek help, they are not understood and not offered suitable treatment. This was certainly a theme that presented itself during the interviews and the group sessions. None of the participants felt that they had been given the right treatment by the right people for the right amount of time, at the right period. As most clinicians agree, there is a need for further research into treatments.

7.9 Drop Outs

The complex psychopathology and ambivalence of these subjects creates a high probability of drop outs (Willis 1999). During the lifetime of the group there was unfortunately a 50% drop out rate. This seems to link with the argument that when EDs become embedded it is more difficult for the sufferers to accept help (Schmidt et al 2004, Slade 1997). Although there were a high percentage of drop outs in this study, this was in line with the drop out rates for the majority of treatments for EDs (Sly 2009, Campbell 2009, Waller 2009, Gale et al 2006). If we are to improve on the treatments offered to ED sufferers, we must endeavour to understand the reasons behind the high drop out rates.

Research has identified that drop out rates have increased over the years, even in studies that have taken great care to retain patients (Campbell 2009). It has been suggested that before patients are offered specific treatment they should be screened. This screening should assess the level of motivation, as in an individual's desire and drive to change, and the readiness to change, as in an individual's capacity and skills to achieve change (Geler et al 2001). In their research into how people change, Prochaska, DiClemente and Norcross (1992) looked into the stages of change that people go through. By their own admission they realised that they originally misinterpreted the data and had only recognised four stages namely: precontemplation, contemplation, action and maintenance. It took them seven years to recognise that preparation was a vital stage that influenced the next stages of action and maintenance. (Prochaska et al 1992). Price-Evans & Treasure (2011) found that for AN sufferers, the use of motivational interviewing in the initial stage of treatment guided the patient towards commitment to change by invoking their intrinsic motivation to do so. They acknowledged that reluctance and ambivalence to recover poses a major challenge to treatment (Price-Evans & Treasure, 2011).

A study by Treasure & Schmidt (2001), found that the majority of anorexic inpatients were in the precontemplation and contemplation stages, making the possibility of change difficult to negotiate. But motivation is difficult to assess in the clinical procedure for treating EDs, as emotions and therefore motivation can change rapidly for the client during a session, or they can be severely de-motivated by situations or family members in between sessions (Treasure & Schmidt 2001). This was found to be the case for a number of the participants of the group, for whom the de-motivation from their families was too great, causing them to drop out.

Motivation and high drop out rates were considered when this study was being designed and with this in mind the initial meeting with the group facilitator was introduced (Please see Methods Chapter 3). This was done with a view to avoiding the pitfalls of high drop out rates. In this study, it was felt that one of the reasons for the high rate of drop outs was the complexity, severity and length of illness in the cases that were referred. The original study was designed for referrals from Primary Care where the severity and length of illness was not as extreme. Poor motivation to change contributes to the continuation of the disorder and increases resistance; it is a predictor of drop out (Gale et al 2006). Some were faced with strong disapproval from their partners and were unable to negotiate the possibility of change without their support. This inability to support change in the partner was identified in the case of Maggie at the follow up interviews. When she started to change and assert herself, the dynamics of her relationship changed and her husband left her (see Findings Chapter 5). Mel, who was one of the drop outs, was purposely watering down her child's milk and was very frightened that social services would become involved, therefore she never participated in any of the groups she attended and after a few sessions did not return. At the end of the group a letter (see appendix 12) was sent to all the participants who dropped out in the hope that we could gain valuable information as to why they felt unable to continue and what if anything would have helped them to complete the intervention offered. We did not receive any replies and when followed up with phone calls we were unable to make contact.

In retrospect it was very difficult to anticipate drop outs, as only Mel and Jenny were reticent about joining the group. The others looked upon it as a source of help. Low motivation of the people who dropped out should have been taken into consideration and they should not have been asked to join the group, although it was hoped that their motivation could have been 'fired' during the lifetime of the group. It was felt that this hard to reach group could have been affected by the previous treatment they had or had not been offered and that they had become the long term sick.

7.10 Limitations

The main source of recruitment was the specialist in-patient units and community mental health units where the expected length of the illness and co-morbidity of patients is greater than those found in PCTs (Barnett et al 2005). The recruiting of the participants was far more onerous than first anticipated. Due to the difficulties in recruiting, the start date of the group had to be put back. In the original design of this project, recruitment was aimed at Primary Care. The lack of referrals from PCTs was unexpected as according to statistics from the Beat (2007), a typical GP's list in the year 2007 could expect to have 1 or 2 anorexics and 18 bulimics. In the year 2007, Beat believed there were approximately 90,000 anorexics and bulimics receiving treatment, with many more undiagnosed. Their total figure is 1.15 million people. GP's identified 56.7 cases per 100,000 in the 20-39 age group. Not all will have children, but it is probable that some may have. Since that date the incidence of EDs has risen and the onset of EDs is occurring in a younger age group (BBC News 2011).

We started the group with 8 mothers who had 15 children between them (see Findings Chapter 5). Two of the mothers had babies less than 1 year and they were their first children. They both dropped out. Although a crèche was provided one of the mothers, Jenny, showed serious difficulties with separation and wanted to check on her baby during the session. It was felt that as their babies were so young they could not relate to the general discussions on children that occurred. It is now understood that it is not enough for the group to be all mothers it is important that the children be of comparable age. In the design process we had believed that having a larger group would cover for any absences that might occur, but when the drop outs did not come back and we were left with the core of the group, which was a much smaller number, absences did become a problem. However, in general it was found that a smaller group was far more acceptable and led to greater cohesion amongst the participants. This enabled them to be more open and disclose more on a personal and intimate level.

Although the results of this study can only be suggestive, due to the small numbers, the indications are that it would be beneficial to repeat it. The understanding that we now have of these groups, would be put to greater use in replicating this study. We would run several small groups of participants who are less seriously ill, in conjunction, to see how far we could go in treating these patients. A longer time frame for the group would be more favourable in helping the participants to secure and consolidate the changes they were able to make. In view of Maggie's disclosure of rape in the penultimate session and the fact that Sally did not disclose her abuse in the group, it could be deduced that they needed more time to feel able to do this. Continuity was an important aspect to the participants; this was something that none of them felt that they had in any of their previous treatment. As soon as they began to feel safe and move towards an attachment with a particular professional, the professional would leave and the process of trying to attach had to be started from the beginning again. This would have been difficult to negotiate for someone with a stable attachment history, but for these women it was an impossible task. The need for continuity seemed to give support to the idea of a longer time frame being more beneficial. This would give them the advantage of building a more secure and continuous relationship with the facilitator. We would therefore recommend a time frame of not less than 6 months but preferably 1 year. In replicating this research for a larger study, the use of usual care controls would validate the findings further. Nevertheless the feedback that we received from the participants was very positive which leads us to deduce that the group as it stands could play an important role in forming a usable treatment modality for this patient group.

In this study the children were not monitored, but it is thought that in future studies it would be beneficial if the children could be monitored in some way, as it has been found that there are quite considerable discrepancies between what the mother tells and what the child experiences (BBC 2, 2005) . But for this study there were not enough resources for this to be a viable possibility. It is also felt that it would have been quite difficult to obtain consent from the mothers to administer measure to the children as they were very protective of them. In replicating this study as outlined above, it would be of interest to develop a way of reaching the children in order to ascertain if the benefits that the mother was achieving were in fact filtering down to the children. A further way of expanding the study would be to follow up the children in a longitudinal study spanning five or ten years. If a study incorporating the children were to be possible, it must be made clear that the problem of the mother's protection of their children would have to be overcome. For the purpose of this study it was sufficient to acknowledge the mothers' improvement and to take the mother's word for the effect that their improvements had on their children. It was anticipated that if the mother changed then it would be probable that the children would have a healthier model and ultimately benefit from that change.

This study focused solely on the mother, but it has been shown in a study by Sadeh-Sharvit et al (2016) that the involvement of the father can encourage positive outcomes. They found that given that the mothers with EDs found mealtimes and feeding problematic the participation of the father reduced the pressure on the situation and strengthened the likely long term impact on the child's functioning. The mothers in the group commented that they could not discuss the group with their partners as they would not understand. By including the fathers in some way it would serve to educate them in EDs and would elevate any feelings of exclusion that they felt and allow them a positive role in supporting their partners.

7.11 Discrepancies between the Qualitative and Quantitative Data.

The qualitative data that was collected in this study was very rich and full of information about the thoughts, beliefs and environments of the participants that took part in this study. This data was taken over a 19 week period which gave the participants plenty of time to reflect and convey their thoughts and beliefs and to be able to give detailed information about their lives and their environments both past and present. The interviews added a more in-depth knowledge of their personal details and histories and the end interview and the follow up interviews added the information about their views on the group and how the group had affected them. Their opinion on how helpful or how difficult they felt the group had been, was valuable information that could be used in the running of further groups in the future. Even though there were only four completers to the study this was an advantage to the qualitative analysis as it was able to produce an abundance of rich in-depth valuable data which had to be condensed. The advantage of the qualitative data was that it was taken over a period of time and was able to deliver a more rounded picture and understanding of the participants.

In contrast to the qualitative analysis the quantitative analysis is taken at a specific time and gives a window into what is happening for the participant at that particular point. It relies on the honesty of the participant and what they feel at that singular point in time. Quantitative analysis responds better when the numbers are greater as it is able to give a more robust finding with larger numbers. It cannot give an in-depth view of the overall situation covering a period of time; it cannot penetrate the underlying feelings behind the answer to the question, it can only link one time point to another.

In my opinion there were some questions that the participants were not fully honest with and there was one participant who did not fill in her BMI. My thoughts on this are that it must have been difficult for them to put something down in writing, as once it is written down it is the stark truth staring back at you. When the questionnaires were taken for the quantitative data the participants were at very vulnerable stages. At the time of the first questionnaire at the initial interview, before the group had started, they could have been worried about being judged, as they were not sure what to expect. The next questionnaire was at the end of the group, this was when they worried about being abandoned and coping on their own. At the time of the follow up interviews, both at the six month and the twelve month, all the participants had experienced extraordinary life events which must have had a tremendous impact on them.

7.12 Mothers with an ED

As was discussed earlier in the literature review, being or becoming a mother while living with an ED can be an overwhelming and daunting experience. Tierney et al (2010) talked about the conflict that occurred and called it a ‘tightrope between motherhood and an ED’. This conflict starts at pregnancy with the joy and disbelief of finding out they had managed to become pregnant and then dealing with the fear of damaging their unborn child. The mothers in this study were no exception and we can recognise this by looking at the relief that Maggie felt when she was told by the doctor that she would not harm her baby only herself if she didn’t eat and that many mothers vomit all through their pregnancies. This gave her the permission she needed to continue her ED behaviour regardless if this was true or not. Tessa gave birth to a premature low weight baby and felt that this was due to the continuation of her ED.

Guilt was an experience that was found to be endemic in mothers with an ED (Rortviet et al 2009) and was found to invade all the aspects of motherhood; from being a good mother to worrying about the influence that their ED was having on their children, to being unable to deal with issues concerning their children’s body shape. Being a good mother was a major concern for Sally when she joined the group. Her relationship with her daughter was in serious jeopardy of breaking down completely as she felt that she was unable to cope with her ED and her daughter. She would send her daughter to her mother for meals so she was able to skip them, she would not keep sweets or biscuits in the house in case she was tempted so her daughter had to do without and was not allowed any treats. Tessa felt a great deal of guilt giving birth to a low weight baby. This baby was her third child and she was pregnant when she was in a difficult place with her ED. She also had a problematic situation with her middle child who was a boy, when she felt repulsed having to put cream on his body because she felt that he was ‘fat’. All the mothers in the study felt guilty about leading a double life and expecting their children to be unaffected by their behaviour. Although in their paper Rortviet et al (2009) spoke about the mixed reports that the mothers gave about telling their children about their ED behaviour, none of the mothers in this study spoke openly to their children on the subject of having an ED.

The subject of isolation was discussed in the group and the mothers spoke of the difficulties they had in going out and being part of anything social, to the detriment of their children and most of all themselves. They could not join in family outings or even playing games with their children and they found disciplining the children difficult. This was all due to being caught up with the obsessions of the ED. Stitt and Reupert (2013) reported similar findings in their study. It was interesting to note that the mothers in the Stitt and Reupert study thought that they hid their ED from their children and that although their children witnessed their behaviour, they did not think that the children associated their behaviour with that of an ED. This was similar to the beliefs of the group participants in this study as they all felt that they hid the typical behaviours of their ED from their children, even though for example, at one point Maggie’s son asked why he had to finish his meal when his mother never did.

The study that Sadeh-Sharvit et al (2015) did on mothers who had children between the ages of 18 to 24 months had a striking resemblance to one particular mother in the present study. They reported that the mothers in their study were concerned with their children’s body shape and were worried that the children would become overweight. These concerns translated into the mothers restricting the child’s food intake and wanting them to have low calorie diets. In the present study Mel had reported that she had watered her child’s milk down so she would not be having too much fat intake. She also restricted solid food and rationed the child’s food.

The similarity with the present study and with the other studies that have been mentioned, points to the difficulties in socialising, modelling their ED behaviours and understanding that the children internalise this behaviour, taking part in family meals and recognising their children’s hunger states. It is also notable that in these studies the disparity between how these mothers behave to sons and daughters is extremely recognisable. A unique focus on their daughters was found and it was reported that the mothers restricted the food intake of their daughters rather than their sons. Also their daughter’s body shape was commented on and discussed far more than their son’s. This was a factor that was also uncovered in the present study with the mothers who had different sex children, namely Tessa and Maggie who both recognised this fact during the course of the group.

The guilt that the mothers in this study experienced undermined their ability to feel positive and secure in their role as mothers. They doubted their ability to parent and leant heavily on their husbands or mothers. The findings of this study have corroborated the findings of previous and current studies that have been identified in the literature.

7.13 Group Interventions for EDs

There are many different theoretical approaches and many different ideas that are being used in the treatment of EDs. Out of these diverse treatments, group interventions have been found to be one of the most effective forms of treatment, either as a stand alone treatment of in combination with other treatments. Group interventions for ED sufferers have incorporated many of the different theoretical modalities but the universal benefits of insight, cohesion and interpersonal growth do not alter. A group offers a non-judgemental space and a common understanding of the feelings endemic to an ED. A small group can mimic the situations of the family and might be able to trigger repressed memories. A group also helps the participants to learn from one another and this in turn helps the individual with their self-esteem issues, which is a large factor in the aetiology of an ED.

Group interventions have been used to treat many different aspects of EDs. They have been found to be an effective and cost efficient form of treatment as they reach several different people in one treatment session. In the group used for this study, the participants found the ability to give and receive advice from each other a valuable and integrating part of the group experience.

It was found in a study by Tuval-Mashiach et al (2013) that during hospitalisation the therapeutic interventions that were offered to mothers who were inpatients, did not meet the specific needs of these women. Therefore a specific group was set up for these mothers to discuss the explicit needs of mothers with an ED. This was the reason that the present study was developed as it was felt that a group specifically for mothers would give mothers a unique place to express the concerns that arose from being a mother with an ED. The Tuval-Mashiach study has several similarities to the present study; there were 10 sessions set up and each session dealt with a specific area related to the effects of an ED on motherhood. Some of the themes that were discussed were similar to the present study, such as the mother/child relationship and modelling. A group consisting of only mothers would give them an ideal opportunity to identify with others in a similar situation which would enable them to discuss their distinctive fears and problems. Maggie talked about the difficulties she experienced as an inpatient when she was confronted with other patients who were not mothers. She felt women and girls who were younger and did not have the responsibility of having children, had a completely different agenda and that it was not helpful for them to be put together. She felt the need to talk about the problems that she was experiencing, that were connected to her children and found it impossible to do so within the group environment she was placed in, with patients that were not mothers. This was something she mentioned quite frequently in the group and felt very strongly about. The mothers in the group studied by Tuval-Mashiach echoed the same responses as the mothers in the present study by saying that a specific group focusing just on mothers with an ED helped them to develop strategies to cope with the unique challenges of parenting with an ED.

Sadeh-Sharvit et al (2016) used a group successfully in their intervention for a Parent Based Prevention Programme for EDs. In this study the involvement of both parents was stipulated. The aim of the intervention was to reduce the eating pathology and broader pathology of the children of mothers with an ED. The similarity between this study and the present study is the group that was conducted for 12 ninety minute sessions just for the mothers; the fathers were involved in the study at a later date. The group was a semi-structured, psychoeducational group that focused on the effects that the maternal ED had on parenting.

Although prevention of an ED is an enormous undertaking the Sadeh-Sharvit et al (2016) study and the present study both recognised the potential of targeting mothers with an ED. Both studies recognise that if you can help the mothers in their recovery and give them the tools to understand the possibility that their damaging behaviours could be internalised by their children, there is a chance that the ED will not be passed on. Both these studies were developed with the intention of addressing the environmental dysfunctions associated with maternal EDs with the intended possibility of avoiding the transgenerational effects. It was thought by the authors of this study (Sadeh-Sharvit et al 2016) that the intervention was associated with a change that impacted on the child's ability to take a healthier developmental course.

A group was offered to adult ED patients at an outpatient clinic and MacNiel et al (2016) undertook a study to evaluate the patient's satisfaction with the group. The content of the group was CBT based and consisted of self-monitoring, psychoeducation on EDs, risk, medical complications and co-morbid concerns. Measurements were taken at pre and post group and the participants of the group reported higher life satisfaction after the group. Depressive symptoms were lowered and ED drive for thinness were lowered. The authors of this study (MacNiel et al 2016) acknowledge that patient satisfaction is an important aspect as it encourages the participants to engage in the group that they are attending. In the present study presented in this thesis, at the end of group interview and at the six and twelve month follow ups the participants of the group were asked their view of the group. This was reported in the findings under 'The benefits and difficulties of the group'.

Pretorious et al (2012) did a study that reported on a group that consisted of adolescents with different types of EDs as it was recognized that all the different EDs had similar eating pathology and psychopathology. The present study was also made up of participants with different types of EDs and because of the similar pathology it was not found to be problematic. The fact that they had the common link of all being mothers was found to be a powerful connection. In the Pretorious et al (2012) study, the common link was all being adolescents. The adolescents found the group fun and interesting which helped them to reflect on their behaviour; this was viewed as encouraging as this is a generally hard to reach group. A similar group was conducted with adults for a longer period which had far more positive results. The reason put forward for the minimum change in the adolescent group was that the questionnaires administered were self-reported which might not have reflected an accurate measure. This was also a possible reason put forward for the discrepancy in the quantative and qualitative results in the present study. This study also showed differences in an adolescent group and an adult group, which indicate that mixing the two age groups would not be advisable. By separating the age groups they were able to adapt the group content and focus on the correct age, with better results. This was similar to the present study, which took the common denominator as motherhood.

The similarities in the studies of groups set up for EDs that have been cited in the literature search and the present study encouraged me to believe that a group format with a specific focus on mothers, was the correct modality in which to present this study. The literature also provided me with the knowledge that all studies have pitfalls and limitations and if these are correctly acknowledged and addressed, a stronger and more robust study could emerge.

Chapter 8

8.0 Conclusion

This study has confirmed that EDs have multifactorial risk factors and their development is greatly influenced by the transgenerational effect of both nature and nurture. (Schmidt, 2002, Strober et al, 2000, Vandereycken & Noordenbos 1998). The study has focused on the nurture aspect of the risk factors, namely the emotional and environmental circumstances. At the conclusion of this study we are in agreement with previous literature, that children of mothers with an ED are more likely to develop an ED themselves and are considered a high risk group (Stein et al 2006, Hodes et al 1997, Stein 1995, Sourfield 1995, Stein et al 1993). However, although it is now understood that it is highly likely that mothers play a significant part in the development of an eating disorder (Stein & Woolley 1996, Evans & le Grange 1995) enough treatments have, it seems, not incorporated that understanding. The hypothesis that mothers can play a significant part in the primary prevention of an eating disorder for the child has not been adopted in a sufficient number of treatments.

If we are to gain long term benefit from treating this illness, we must look at the illness holistically. EDs are not just about symptoms, they are about how the symptoms arrived. It is of vital importance to inquire into the sufferers' family histories and the experiences of their environment. It has been recognized in this study that there is a paucity of treatment specifically for this client group. Although the treatment modality investigated in this study needs improvement; it could become a recognised and beneficial treatment that might fill the existing gap.

Rodgers and Chabrol (2009) found evidence that parental focusing on weight and appearance is conducive to increasing body image disturbance in children. The effect is particularly strong regarding active criticism but is also present in relation to parental behaviour. This strengthens the argument that if the parent is helped with their own behaviour and attitudes to their children, then the children will reap the benefit. A controlling family environment with negative communication together with discrepancies on values and norms are shown to be a risk factor for the development of body image related problems such as EDs (Benninghoven et al 2007). Understanding the cause of the symptoms can have immeasurable benefit for the mother who can then, instead of passing on the dysfunction of an ED and all that goes with it, pass on to her child a healthier model which will encourage them to lead a life free of dysfunctional ED behaviour.

Greater knowledge of the manner in which family attitudes can act as risk factors will enable future prevention programmes to better target their actions and become more effective (Rodgers & Chabrol 2009). Stein et al (2006) in their longitudinal follow up study into the children of mothers with EDs found that at 10 years of age these children had a raised level of disturbed eating habits and attitudes compared with the controls. The children of mothers who had a more severe and long term ED manifested a greater level of ED psychopathology. Their recommendation was that more longitudinal research is needed to follow these children in to adolescence. This would determine whether identifying and treating these mothers reduces the risk of transgenerational EDs, but their results at this point confirmed the risk factor (Stein et al 2006). We have touched briefly on attachment theory, but have highlighted enough to relay how important the early mother/child relationship is.

The ever present financial strain on Primary Care and the overload on existing resources may mean that limited group interventions can be a successful and a financially expedient way to reach an optimum number of patients (Thomas et al. 1999). Nevertheless such interventions would need to be adapted to the structure of primary care. The needs of primary care and the demonstrated success of groups for EDs were taken into account during the developmental stage of this group intervention. If by running these groups we can prevent even a small proportion of cases, then we are not only preventing physical and emotional damage and pain but we will be reducing the financial burden for the health authority in treating cases individually. In a recent report released under the Freedom of Information Act, it was shown that more than 2,000 children received treatment for EDs over the past 3 years, 600 were under the age of 13, 197 of those were aged between 5 and 9 and it was thought that this was an underestimation (Linden 2011).

As we found out in this study, gaining referrals from GPs was a difficult task. This points to a whole new research programme, as to why the referral process is so fraught with difficulties. We have seen the figures and on paper there should be no difficulties at all, but the reality is different …. Why? If GPs identify these patients at the earliest opportunity and refer them on, we stand a far better chance of success with this client group instead of leaving them to become the severe and enduring long term ill (Robinson 2009), where they have little or no hope of change. GPs play a crucial role in the identification and treatment of EDs. Although there is a considerable body of research stating that early diagnoses and specialist treatment is crucial for EDs (Treasure & Schmidt 2005, Treasure et al 2005, Roth & Fonagy 2005, Hsu 1990) and the NICE guidelines recommend early referral to specialist treatment, 20% of patients with AN and 40% of patients with BN are still being treated exclusively in Primary Care (Currin et al 2007). We need to encourage clinicians to address the severity of EDs and make speedy referrals to whatever specialist services are made available to them.

Harrison et al (2009) in their study of emotion recognition and regulation in AN, found evidence of difficulty in recognition of emotion in these women and suggested that interventions should focus on psycho education. This would highlight the importance and usefulness of emotions, thereby decreasing the secondary emotional responses and social avoidance. Towards the conclusion of the group, it was evident that the participants' alexithymic tendencies had improved and there was progress in their emotional language.

Recognising behaviour and thoughts are the first stages in being able to change them and the sufferer needs to understand and feel reassured that their maladaptive thoughts and behaviours are shared by others. This allows them to understand that they are not isolated cases, which validates their suffering and encourages them to speak. During the life time of the group, the difficulties that people with attachment deficits have in feeling safe became clear. This should be taken into consideration when preparing for a future group. Women with EDs find it extremely difficult to acknowledge that they need help (Slade 1997). As with most mental illness, there is a great deal of stigma attached and fear of not being understood. For mothers there is also the fear of their child being removed. Motherhood at the best of times can be daunting and problematic; mothers faced with having to cope with an ED simultaneously, can easily become overwhelmed. Once in the grip of an eating disorder, it is difficult to think of anything else, let alone the damage the individual’s behaviour might be doing to her child. Instead of looking after herself and trying to recover, the mother now feels her main task is to look after her child, not realising that the two are interlinked. Seeking help becomes more difficult as having problems feeding and nurturing a baby seems an admission of failure and laced with more shame and guilt. Orbach and Rubin (2014) in their report “Two for the price of one” stress what a vital role Midwives and Health Visitors play in the health of new mothers and their babies and what little training these health professionals have in the effects of an ED. They believe that early intervention post-partum gives the opportunity of reaching new mothers who are receptive to help at this time and gives them the chance to optimise their own health and therefore the added well being of their baby. If the Health Visitors were trained more extensively in EDs and recognised the benefits of early referral to specialist care, maybe referral would take place at the first signs of problems, rather than when the ED reaches a crisis point. If early referrals were to be instigated, the mother stands a better chance of recovery and the child stands a good chance of not inheriting this damaging and destructive illness.

This was a pioneering study attempting to address the severe problems inherent in an ED, in order to alleviate these problems for the next generation. Although the group consisted of patients with long term EDs, all the participants managed to gain some benefit at some stage of the project. The fact that they all experienced major traumatic life events when the group finished had an adverse bearing on their ability to hold on to some of the changes they had been able to make, for example improvements connected to food and behaviour around food. In spite of all the problems they had to go through, they still felt that the group had been beneficial and the things they had learned would stay with them. With the ever increasing demands of society today, if we can help mothers with an ED identify the problem areas and help them with parenting, we can endeavour to restructure their sense of self, imbuing them with added confidence for their own benefit and that of their child.

It is important that mothers with an ED are made aware of the possible dangers to their children, with regard to the risks that surround the impairment of the natural and healthy development of their infant (Van den Broucke et al 1997). If a child develops an ED there are long term risks involving, growth, fertility and osteoporosis, to be considered (Bryant-Waugh and Lask 1993). It is hoped that when mothers are confronted with the possible transmission of such a damaging illness, they will welcome help aimed at this area. The role of the mother is at best, a role filled with pitfalls, prohibitions and obligations. The power a mother holds over her young child is undeniable and I have talked about Winnicott's theories of "the good enough mother". However as the act of childrearing is becoming more psychologically focused, there is an argument that mothering can never be "good enough" and that the child will become damaged in one way or another, what ever the mother does, due to her unconscious defective instincts (Grunebaum and Smith 1996). My feelings are when dealing with mothers who have an ED, we need to address the issues of the "good enough" mother and stress that the "good enough" experience is sufficient for the well being of the child. It is important not to allow the feelings of inadequacy that are already a prominent feature in the aetiology of an ED sufferer to be exacerbated. Mogal (1989) viewed parenthood as a powerful developmental challenge and a second chance to extract major restitution of childhood emotional deficits, allowing a restructuring of their identity as an individual and a parent and forming a new positive mother/child relationship.

It is hoped that the readers of this thesis will understand that the study has not been about apportioning blame but about trying to understand the multiple intricacies of this destructive illness with a view to finding a treatment modality that will benefit the sufferers and help a new generation to be free of it.

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Group Manual

Mother's with an Eating Disorder. (To address the prevention of transgenerational eating disorders.)

Recruitment

For the recruitment process you are advised to contact every practice manager and senior practice nurse in all the (Primary Care Trusts) PCTs in the areas you intend to hold the group. A letter and a flyer (enclosed) should be sent describing the research, outlining the key points and asking for referrals from their practice. Flyers and information should also be distributed to health clinics, counselling services and voluntary services. Alongside distributing the information, it would be helpful to make presentations to the Primary Care Trusts (PCT) meetings, health visitors, speech therapists, parenting services, home start, community adult mental health units, community child and adolescent mental health units, hospital specialist in-patient and out patient eating disorder units. The hospital in-patient units could be a good source of referrals as there is very little specialist follow on care available for these patients on discharge. However, it is advisable to be aware that the patients referred from Secondary Care inpatient units are more severely ill than those referred from Primary Care.

Inclusion Criteria

The inclusion criteria for the group are as follows:

- Mothers with an ED who have children under the age of 13. The age for the children was chosen as it was thought that by the age of 13 the transgenerational dysfunction would have already been internalised; younger children may have a better chance of avoiding an ED themselves.
- The mothers need to be diagnosed or recognised as having an ED by an appropriate health professional.
- The mothers need to be over 18.

Exclusion Criteria.

Participants should be excluded from the group for the following reasons:

- Drug or alcohol problems
- Severe depression
- Major psychiatric disorder, e.g. schizophrenia, bi-polar disorder, severe personality disorder.

Ethics

Having identified that taking part in a psychological group could impact on the participants' well being at any time, the group facilitator should make themselves available for contact at any time from the start of the group to the final follow ups and a period beyond. For added precautions the details of the participants GP's and health workers or key workers should be taken, so that they can be contacted if there is any worry as to the wellbeing of the participants.

Initial Meeting

As sufferers with EDs are known to be an extremely vulnerable group, an initial meeting should be arranged with the facilitator of the group. The meeting could be set up in the participant's home, or somewhere of the participants choosing, as it is important to put each participant at her ease. A further reason for this meeting is to "set the scene" for the forthcoming group and to allow the participant to meet the facilitator prior to the commencement of the group.

In meeting the facilitator prior to the commencement of the group it is hoped to alleviate some of the anxiety that the clients could be experiencing and give the client an opportunity to ask any questions before agreeing to participate. It is important to enter the client's space in a non threatening manner and to put the participant at her ease. At this meeting the participants' history is taken, including their family of origin, their illness, their present family, particularly their children and their lifestyle. Their beliefs in relation to the themes of the group should be discussed.

The Group.

The group will run for 19 weeks with 2 breaks of 1 week. Each session will be weekly for 1.1/2 hours. There are 3 sets, 1st set for 6 sessions, 2nd set for 6 sessions and the 3rd set for 7 sessions. The breaks that are taken should coincided with school holidays if possible. It is advisable that the group sessions take place at a facility that offers a crèche either on site or very near.

Therapeutic Approach

It is important to be cognisant that the group will incorporate people suffering from different varieties of EDs who will be at different stages along the range severity and recovery. They will all have had different experiences of a wide range of diverse treatments and come from a wide range of society. Taking this into consideration one modality of therapy could not possibly fit all and given the difficulties of engaging with ED sufferers and maintaining that engagement, the significance of offering them the ‘right fit’ is vital. The importance of maintaining their commitment to therapy is paramount for the continuation of the group, therefore the mix of therapeutic approaches was carefully considered. The therapeutic modalities used are self-psychology (Kohut, H. 1985, Goodsitt 1997), psychodynamic (Herzog 1995, Jacobs 1996) and cognitive (Beck et al 1979, Garner et al,1997) therapies.

The psychodynamic approach was relevant for understanding the psychological development of the individual and gaining a perception of the foundations of their relationships (Jacobs 1996). Self psychology is closely linked to psychoanalytic/psychodynamic theory but focuses on the restoration of the damaged self by using the empathic therapist/client relationship (Siegel 1996). These two approaches both incorporate attachment theory into their theoretical foundations which lies at the heart of every ED. Cognitive therapy attempts to alter the dysfunctional and distorted ideation associated with the illness and addresses how these distorted ideas affect behaviour (Beck et al

1979). Cognitive therapy has a proven track record in helping the client deal with the symptoms of the ED. These three main theoretical approaches deal with awareness, understanding and change and are recognised as suitable for the delivery of the group. The protocol of the group should be delivered using a semi-structured format, incorporating psycho-educational and psychotherapeutic methods.

It is important to answer questions as honestly as possible and where necessary to give information that could inform participants. It should be emphasised that the group is about learning and understanding and not about apportioning blame. It is important to make sure that each member is heard but to maintain a balance and an understanding if a member does not want to talk or disclose at any given time.

Do not make participants feel that they are being pressured to talk but facilitate them in feeling supported enough to do so. Be inclusive.

Underlying Issues

There is a great deal of shame attached to any eating disorder as it is viewed as a self destructive illness. Because of this ED sufferers tends to isolate themselves and the illness becomes shrouded in secrecy. There needs to be a great awareness of shame when bringing the participants together. Even though they are with likeminded people in a non judgemental environment there is an underlying fear of the consequences of their behaviour towards their children. For example during the initial interview one of the members of the group had admitted to watering down her baby’s milk and then restricting her food intake, so she was very concerned that her child, who was then 2, would be taken away from her. The consequence of this was that the mother did not speak at all in the group. This affected the group dynamics and began to upset the other members of the group. When she finally dropped out the other members were pleased as they felt aggrieved that they were disclosing things about themselves and she was not. Shame can be approached in the first session maybe when confidentially is addressed. This would help the participants to have a stronger feeling of safety. It is important to be aware that shame can occur at different stages throughout the lifetime of the group. The times to watch are when disclosing incidents and relationships relating to their nuclear family and self-disclosure and relationship and behaviour with regard their own children.

The Anticipated Change

It was difficult for the mothers to recognise and thereby admit that they played a part in their children's relationship with food, body image and the wider dysfunctions of a possible ED. Again it is important to stress understanding as change occurs and not apportioning blaming is essential to convey. If participants could understand the messages that they had internalised from their upbringing they could start to understand how the transgenerational problems occur. As they started to disclose, the similarities and recognition brought cohesiveness to the group, it was then appropriate for the facilitator to point out the unconscious process that they had experienced. Once there was an understanding of the unconscious modelling process it became a great deal easier to accept that it could be occurring with them and their children. When the understanding occurred it then became possible for changes to be implemented. This process needed to be repeated throughout the different stages of the group. At the start of each session when asking if the group want to bring anything up regarding last week, encourage them to bring to the group any changes they might have implemented throughout the week. This opens up support and encouragement from the other members.

The Themes

Food and feeding.

Modelling.

Body image.

Individuation and separation.

Mother/daughter relationship.

The evidence in the literature led to the themes that were eventually decided upon. The **mother/daughter relationship** seemed in most instances to be the earliest source of the ED. From this starting point some of the other themes were linked and intertwined with this relationship. **Individuation and separation** are the consequences of a dysfunctional attachment and can become problematic developmental stages. **Modelling** is how all babies and young children learn and is a vital component of our growth and development; a dysfunctional model can lead to a dysfunctional child. A distorted **Body Image** is one of the foremost diagnostic criteria in EDs and the way ED sufferers use **food and feeding** is one of the main concerns when trying to treat them. In the prolific literature on EDs these themes became readily identifiable and presented themselves in a majority of papers. They were then tested in the pilot study (Barnett 2000) which confirmed their relevance. (For additional information on these themes please consult this study.)

Protocol of the group sessions

Each session was allocated a theme. Some themes could extended into two sessions, some themes can be re-visited and some sessions should be left blank to discuss the effects that the group is having on the participants. If there are sessions that are attended by only one participant due to other absences, this session should be used to discuss the groups content and its effects. Each session commences with either an exercise or a video; some exercises include art therapy. After each exercise or video the session is then opened out to allow the participants to explore their responses. The group is a closed group; this is to encourage the members to feel safe with one another. The time and day of the group and the breaks should be agreed upon before the commencement of the group and a definite end date given. This is done to help with the containment of the participants.

The protocol of the group has to be open to amendments as it has to be flexible and take into account the overall attendance. The relationship to the group needs to remain flexible throughout, responding to the different developments in the way therapy responds to changes in the demands of the client (Higgins 1996).

Full Protocol for Groups

Total of 19 sessions.

First set 6 weeks

Break 1 week

Second set.. 6 weeks.

Break 1week

Third set 7weeks.

End

First set to comprise of six sessions.

1st Introduction. 2nd. and 3rd Food/feeding. 4th and 5th Body Image.
6th Modelling.

Second set comprises six sessions.

7th. Welcome back and modelling 8th and 9th Individuation.
10th and 11th Separation. 12th Relationship with their mothers.

Third set comprises of seven sessions

13th. Welcome back. Mothers and daughters. 14thVideo on modelling
15th Attachment video 16th Food and feeding 17th Individuation
18th Open
19th.Ending.

Session. 1

Ask them to wear large name tags for first session. Housekeeping etc.

Introduction and getting to know one another.

The group is being set up to help mothers with their own problems but also to help them with any problems that their children might be experiencing. The idea is to give them a safe place with people that are experiencing similar things to each other. Introduce them to the six categories and the format of the sessions, Tell them that it’s important to be honest and that no one is judging them. The idea is to help them and support them.

Talk about the importance of regular attendance; suggest that they use each other between sessions for support. Leave paper and pen on table and tell them to fill in names and numbers if they wish to do so. It will be photocopied for next meeting. Remind them of availability of the crèche.

Talk about confidentiality within the group; give them confidentiality form to sign. Talk about shame and disclosure. (Important)
Give them paper with dates and breaks, facilitator's contact numbers and remind them facilitator can be contacted at any time. Telephone numbers of the place that they are meeting at.

Any Questions

What are their fears and anxieties about being in the group?

Going around the group, each telling what they want to about themselves e.g. what they do, their family of origin, brothers/sisters, where they come in the family, parents, grandparents, any other significant people in their lives when younger, school.

Going round the group, each telling what they want to about their family, e.g. partners, how many children, what ages/sex, if at nursery/school, pets.

What is their favourite thing that they like doing with their family.
What is the thing they dislike most doing with their family.

Going round the group talking about the problem that they have with eating and food, e.g. when did it first start, how long have they been suffering, what treatment if any they have had or are having.
What is it like for them now?

Encourage interaction.
Any questions.

End the session and remind them of the next session.

Session.2

Welcome them back.
Acknowledge how difficult last week was for them, as it was the first session.
Leave contact sheet on table to fill out at any time. No pressure to put name on.

Talk about the exercises, that all their experiences count and that they will each have their own space and will all be included. Each one is a valuable member of the group.

1st Session Food and Feeding.

Give out paper and pens.

Introduce the subject and explain what it means eg. Mealtimes, preparation of food, shopping, their ideas and thoughts around food, good / bad food.

Food and Feeding Exercise.

Who does the shopping in the family?
Who chooses what food to buy?
Are fat and calorie content taken into consideration?
Who does the cooking?
If you cook how do you feel when cooking. Enjoy it, tolerate it, hate it.
Are any foods forbidden / encouraged.
How do you feed your children .e.g. at the table, on the floor, on your lap?
What do you feed your children?
Does it vary?
Who chooses what your children eat.
When do you feed your children? E.g. at regular times.
How often do they eat?
How much do you give your children to eat?
Who chooses how much your children eat.
What do you feel like when you feed your children?
What do you feel like when your children refuse food?
What do you do when your children refuse food?
What do you think of waste?
How do you deal with waste, eat it, save it, re-cycle it, throw it away.
What do you think of mess?
How do you deal with mess?
Does the family eat together?
Do you eat different meals than the family?
Do you go out to eat as a family?.
How do you manage food when you are out?
How do your children manage food when they are out?
What were mealtimes like at home?
Do you ever use food as a reward or punishment?
Was food ever used for you as a reward or punishment at home?

Open out and discuss try and include all members of the group.

Session.3

2nd Session Food / Feeding

Welcome them back. Ask how the week has been for them and are there any comments or questions regarding last week. Deal with anything that comes up but be aware of time constraints for the exercise.

Give out paper and pens.

Introduce them to the exercise. Talk to them calmly and succinctly and let them take their time with each question. Make sure they have all finished answering before going on to the next question.

MEALTIME EXCERSISE

Think of yourselves at an age that you can remember.
Draw a diagram of the room you used to eat in, with all the furniture and show where the family sat while they were eating.
Who was responsible for preparing the food?
How did they view it, did they enjoy it, was it a pleasure, did they find it a burden, were they resentful?
What place in the family budget did food take, did it come before anything else, was it plentiful, was it rationed, was it affordable, was it skimped on, was it hard to come by?
Who was the food made for emotionally, Mother, Father, Children?
Drawing lines and arrows, draw in who speaks to whom during the meal.
Is there any typical conversation, if so what and to whom is it addressed to?
What is the emotional purposes of the meal. Is it a chance to meet the family, to exchange what has happened during the day, to exert power, to punish, to argue, to be silent?
Is everybody allowed to speak, or are some forbidden to speak are they only allowed to speak when spoken to?
Is everybody allowed to address each other?
What can and can't be said?
What emotional memories do you have of mealtimes?
Do you think your memory of mealtimes is an accurate reflection of the dynamics of the family?
How are mealtimes for you now?
What have you done with your experiences?
What effect do you think your experiences had on your eating behaviour?

Open it out and discuss.

Message... The experience of eating with the family is extremely powerful. How much more are mealtimes than just being fed.

Session 4

Welcome them back. Ask how the week has been for them and are there any comments or questions regarding last week.

This is an open session to talk about their fears and anxieties about what the group has brought up for them so far.

It is important no to go too quickly for the participants. Having an open session at this stage would give the participants a space to discuss anything that the group had opened up for them. An open session will give the participants time to consolidate their trust and strengthen the cohesiveness of the group.

Session.5

First session on Body Image

Welcome them back. Ask how the week has been for them and are there any comments or questions regarding last week. Deal with anything that comes up but be aware of time constraints for the exercise.

Introduce them to the category of body image. Be aware that this is a very sensitive subject.

Give out paper and pens.

1st. Body Image Exercise

What do you feel about your own body image?
How did you view your bodies at different ages, 4/5, 10/11, 15/16, 20/21.
What messages did you get from other people about your bodies, at those ages?
What do you most like/dislike about your body?
How do you feel about your looks when you are with a group of people?
How do you feel when you walk into a room on a social occasion and people are already there?
How do you feel about buying new clothes?
How do you feel about having your photo taken?
Do you talk about your bodies?
If so under what circumstances and to whom?
Are you preoccupied about losing weight?
If so why? What would loosing weight do for you?
Do you have a particular part of your body that you dislike?
Why do you dislike this part of your body?
Do any other members of your family share the same concern about this part of their bodies?
If so how do **you** feel about that part of **their** body?
What part of your body do you think can't be changed?
What part of your body do you think can be changed?
Do you fantasise about changing your body?
Do you have an ideal body image and if so how does it differ from your actual body?
How do you think you would feel in your ideal body?
How does that differ from what you feel about yourself now?
How often do you think about your body during the course of a day?
How were you when you had to change or shower for games?
What do you feel like at a beach or swimming pool?
Were you good at sport or dancing?

How do you feel about other people looking at you?

Are you proud of your bodies or are you ashamed or embarrassed about your bodies?

What did your mothers say to you about your body?
What did your mothers say to you about their own bodies?
What messages did you get about your mothers bodies?

How did your mothers feel about their bodies?
Did your mothers allow you to see their bodies?
How did you feel about your mother’s bodies?
Do you think that the messages you were given about your mother’s body affected your view of your own body?
Do you think that the messages you were given about your mothers body affects how you view your children’s bodies?
What do your mothers say to you about your children’s bodies?

Do your children make any comments about your bodies?
What do you say to your children about your bodies?
Do you allow your children to see you undressed. How undressed, fully nude, bra and pants?
How do you see your children?
How do you think others see your children?
What do you say to your children with regards to your children’s body?
What do other people (e.g. Grandmother / Father) say with regards to your children’s body?
Do you compare your children’s bodies to other children’s bodies?
How do your children feel about their bodies, e.g. at school changing for gym/ swimming?

How did you feel about your body when you became pregnant?
What did you feel about your body growing?
Did you breast feed, for how long?
How did it make you feel?

Open and discuss.

<u>Session. 6</u>

<u>Second session on Body Image.</u>

Welcome them back. Ask how the week has been for them and are there any comments or questions regarding last week. Deal with anything that comes up but be aware of time constraints for the exercise.

Tell them for this next exercise it is not important if they can draw or not.

Bring large paper, pens, crayons and markers. Use as many different pieces of paper as they need.

Body Image Exercise

Draw yourself as you see yourself.
Draw yourself as you think others see you.
What, if any, are the differences.

Draw your mother as you saw her when you were a child.. adolescent… adult.
Are there any differences.

Draw your children as you see them.
Draw your children as you think others see them.
What if any are the differences.

Put all drawings on wall. Talk about them what feelings do they bring up and why.

Talk about what the group say to their children about their bodies and what the children say to them about their bodies and what the children say about their own bodies.
What their mothers say to them about their bodies and their children's bodies and if they talked about their own bodies.

Think about what the differences are and why there are any differences.
Think about what you feel about how you see yourself.
Think about what you feel about how others see you.

What do you say to other people about your bodies?
What messages do you give them about how you feel about your size, shape, appearance?

What do you see when you look into the mirror?
What do you say to other people (e.g. partner) about what you see in the mirror?

Session 7

Welcome them back. Ask how the week has been for them and are there any comments or questions regarding last week.

This is an open session to talk about their fears and anxieties about what the group has brought up for them so far.

This session is again an important stage to have a break from the exercises. The two body image exercises were very powerful and it is important that the participants should be given extra time to reflect on the feelings and emotions that have been aroused.

Session 8

First Modelling Session

Welcome them back. Ask how the week has been for them and are there any comments or questions regarding last week. Deal with anything that comes up but be aware of time constraints for the exercise.

Show them the video "Bingers Battling Bulimia" (BBC 2, 2005)

Tape from the TV programme. Approximately I hour.

Open up and discuss.

Session 9

2nd. Modelling Session.

Welcome them back. Ask how the week has been for them and are there any comments or questions regarding last week. Deal with anything that comes up but be aware of time constraints for the exercise.

Give out paper and pens.

Modelling Exercise

Do you remember as a child copying the things that your mother did. What sort of things were they?
Write down all the things you do that your mother did or does anything that stands out in your memory.
Write down all the things that your mother did with you that you do with your children.
Write down all the things that you consciously do not do with your child that your mother did with you.
Are you aware of your child copying the things that you do? What sort of things do they copy?
How alike do you think you are to your mother?
How alike do you think your child is to you?
Did your mother weigh herself? How often?
Were you aware of it and what sort of feelings and comments did you have about it?

Do you weigh yourself?
How often?
What sort of feelings come up for you when you weigh yourself?
What sort of comments do you make about yourself?
Do you think your child is aware of you weighing yourself and does he/she comment on it. If they do what do they say?
Does your child weigh him/herself?
What sort of comments do they make about themselves?
What sort of comments do you make about them?
How did your mother use a mirror?
How do you use a mirror?
How does your child use a mirror?

Open up and discuss

Session 10

Welcome back. Ask how the week has been for them and are there any comments or questions regarding last week. Deal with anything that comes up but be aware of time constraints for the exercise.

1st Session on Individuation

Ask them what they think individuation is. Use flip board. Use their suggestions and elaborate on the meaning of individuation.

Individuation Exercise

What are feelings?
What are feelings for? (Guides to actions)
How do you know when you have a feeling?
What happens to you when you have a feeling?
Do you take any notice when you have a feeling?
What sort of feelings were you aware of having when you were a child / adolescent / young adult?
What happened when you displayed feelings, when you were a child / adolescent / young adult?
Were there feelings that you thought you shouldn't have as a child / adolescent / young adult?
What were the main feelings you remember being displayed by members of your family, when you were a child / adolescent / young adult?
Were there any forbidden feelings in the family?
Are there any feelings that you don't like?
Are there any feelings that you think you shouldn't have?
How did your mother deal with anger, determination, rejection.
What sort of feelings are you aware of displaying with your children?
Are there any forbidden feelings in your family?
Are there any feelings that you don't like or find difficult in your children?

Are there any feelings that you feel your children should not have?
What happened when you were difficult or disruptive when you were a child.
What happens if your child is difficult or disruptive?
Are there any feelings that you feel you shouldn’t have as a mother?
How do you deal with anger, determination, rejection?

Open it up. Discuss.

Session 11

Welcome back. Ask how the week has been for them and are there any comments or questions regarding last week. Deal with anything that comes up but be aware of time constraints for the exercise.

2nd Session on Individuation

Give out paper and pens.

Individuation Exercise.

Do you often compare yourself to other people and find yourself inferior?
Do you wish you had more good friends of both sexes?
Do you frequently feel uncomfortable in social situations?
Do you feel uncomfortable being part of a social group?
Do you feel most comfortable when you are alone?
Are you sometimes told that you are excessively competitive?
Do you feel you must win ?
Do you have frequent conflicts with people in your family?
Do you have frequent conflicts with people you work with?
In negotiations do you give in completely or insist in having your own way?
Do you pride yourself on being strict and literal, following the letter of the law?
Do you procrastinate a lot.
Do you have trouble finishing things.
Do you believe you should know how to do things without instructions?
Do you have intense fears about making a mistake?
Do you experience severe humiliation if you are forced to look at your mistakes?
Do you frequently feel angry and critical of others?
Do you spend lots of time obsessing and/or analysing what someone has said to you?
Do you feel ugly or inferior?
If yes do you try to hide it with clothes, things, money or make-up?
Do you lie to yourself and others a lot of the time?
Do you believe that no matter what you do its not good enough?

Think about what you feel.…… think about your childhood…….think about your Mother……. how could things have been different for you.…..
Now think about this exercise in relation to your children.
Do you see these traits in them?

Do you recognise what they have learned from you.
Would you like things to be different for them? If so in what way.

Open it up. Discuss.

Session 12

Welcome them back. Ask how the week has been for them and are there any comments or questions regarding last week.

This is an open session to talk about their fears and anxieties about what the group has brought up for them so far.

This session is again an important stage to have a break from the exercises. The two modelling exercises were very powerful and it is important that the participants should be given extra time to reflect on the feelings and emotions that have been aroused.

BREAK for HALF-TERM

Session 13

Welcome them back. Ask how the week has been for them and are there any comments or questions regarding last week. At this point an inquiry into any changes that they have been able to implement, could be added. Deal with anything that comes up but be aware of time constraints for the exercise.

Give out paper and pens.

Motivation for change.

Do you experience your eating disorder as a friend or a foe?

What do you think are the good things about your ED and why do you think they are good?
How do they affect your life?
How do you think they affect the lives of your children?
If you want to stay as you are what do you think the benefits will be?

What do you think are the bad things about your ED and why do you think they are bad?
How do they affect your life?
How do you think they affect the lives of your children?
If you want to change what do you think the benefits will be?

Who do you think should be responsible for your change and why?

How do you think you can access change?
By being aware
If you are aware of what you do, you can begin to change it.
What is awareness?
Awareness is the capacity to see, feel and hear things in one's own way, **not in the way we were taught by others.**
Awareness requires living in the here and now. Not elsewhere, not in the past, not in the future.
The aware person knows how she feels, why she feels it and when she feels it.
Awareness is truth and belief in one's self. Truth about what you are feeling and belief in what you are feeling and why you are feeling it.
Awareness of yourself is the first step in being your own person, in understanding yourself, in accepting yourself.
If you accept yourself then you are not frightened of other people's judgement.
If you accept yourself you can live by your own choices not other peoples.

Open it up. Discuss

Session 14

Welcome back. Ask how the week has been for them and are there any comments or questions regarding last week. Deal with anything that comes up but be aware of time constraints for the exercise.

Give out paper and pens.

1st Separation Exercise

Do you have trouble knowing what you want?
Are you afraid to explore when you go to new places?
Are you afraid to try out new experiences?
If you try them do you wait until someone has tried them first?
Do you have great fears of abandonment?
In difficult situations do you long for someone to tell you what to do?
If someone gives you a suggestion do you feel you ought to follow it?
Do you have trouble enjoying your experiences?
Do you worry about something else happening all the time?
Are you a big worrier?
Do you have trouble being spontaneous?
Do you worry about being embarrassed?
Do you find yourself in frequent conflict with people in authority?
Do you fear anger in other people?
Do you fear anger in yourself?
Will you do almost anything in order to avoid conflict?
Do you feel guilty when you say no to someone?
Do you sometimes go berserk and inappropriately let go of all control?
Are you often excessively critical of other people?

When you achieve success do you have trouble enjoying or even believing in your accomplishments?

Now think about this exercise with regard to your children.
Do you see these traits in them?
What is your response to these traits?
Take each child separately.

Open it up. Discuss

Session 15

Welcome back. Ask how the week has been for them and are there any comments or questions regarding last week. Deal with anything that comes up but be aware of time constraints for the exercise.

2nd Separation Exercise.

Explain that they do not need any drawing ability.

Give them large pieces of paper.

Using circles for you and your mother, draw where you think your mother is and where you are when you were a child , adolescent / young adult, now. Use separate pieces of paper for each age and label which age it is.

Using circles for you and your child/children, draw where you think you are and where you think your child/children are. Name which circle represents which child.

Pin them up and discuss.

Session 16

Welcome back. Ask how the week has been for them and are there any comments or questions regarding last week. Deal with anything that comes up but be aware of time constraints for the exercise.

1st Session Mother/Daughter Relationship

Show them the Attachment video.

Discuss

Session 17

Welcome back. Ask how the week has been for them and are there any comments or questions regarding last week. Deal with anything that comes up but be aware of time constraints for the exercise.
Give out paper and pens.

Mother / Daughter Relationship.

Think of yourself as a 2 year old what would you have wanted from your mother.
Were you told what you were like as a baby? By whom?
What would you have liked to say to your mother at 6/7, 11/12, 16/17
What was your emotional experience of your mother as a child / adolescent / young adult. Were you frightened, confused, angry, hurt, happy contented, safe?
How much did you have to conform to be who your mother wanted you to be?
What is your emotional experience of your mother now?
What would you really like to say to your mother now?

What do you think your child would really like to say to you and how do you think you would respond.?
How do you think your experience of being mothered affects your mothering of your own children?

In what emotional circumstances were you conceived were you planned.
Were you conceived quickly or were there problems conceiving?
Into what emotional circumstances were you born. E.g. single mother, divorce, unhappy relationship, happy relationship?
What was your mother's reaction to you?
What sex did your mother want?
What sort of baby / toddler / child / adolescent did your mother want you to be?

Open it up. Discuss

Session 18

Welcome them back. Ask how the week has been for them and are there any comments or questions regarding last week.

This is an open session to talk about their fears and anxieties about what the group has brought up for them. Talk about the ending. Remind them this is the penultimate session.

This session is again an important stage to have a break from the exercises. The two mother/daughter exercises were very powerful and it is important that the participants should be given extra time to reflect on the feelings and emotions that have been aroused.

Homework for end session.

Write a letter to each other, what they have learnt from each other, what they feel about each other.

To be read out at last session.

Session 19

Ending

Re-cap what we have done.

Food/feeding,
What and how much you give your children to eat
Mealtimes
How you use food reward/ punishment
Eating different meals

Body image
How you view yourself
What messages you received about your bodies
What messages you give out about your body
How you view your children's bodies
If there is a difference between boys/girls.

Modelling,
Repeating behaviour you have experienced with your mother
Modelling behaviour that your children might pick up and copy, eg with food body image, touching ,loving dealing with situations, anger ,fear, low self worth.

Motivation for change.
ED friend or foe.
Change and awareness

Individuation
Becoming an individual, believing and trusting yourself
Helping your children become individuals

Separation
Being able to separate from your mothers
Allowing your children to separate from you.

Mother and daughter relationship.
How this has and still is affecting them

How it affects the relationship with their children

What has changed for them?
What still needs to change?
How do they see themselves progressing?

Get them to read out the letters they have written to each other.

What they feel about ending.

What they will do to continue the process.

Exchange personal details if they want to.

How have they been able to use the group.
What did they find valuable.
What did they find difficult.
What if anything would they have liked to change about the group.

Thank them for taking part in the group.

END

Phone Calls

To enable the participants to gain the maximum benefit from the group, follow-up phone calls can be arranged to start after the final group, to support the group members for a six month period. The facilitator can make the calls at a mutually designated time on a weekly basis. A limit of half an hour per call is a reasonable length. This would help the participants with the ending and the letting go process.