JOINT NARRATIVES OF COUPLES LIVING WITH ANOREXIA THROUGH A FOUCAULDIAN LENS

By

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A thesis submitted to the University of Birmingham for the degree of DOCTOR OF CLINICAL PSYCHOLOGY

Centre for Applied Psychology

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The University of Birmingham

October 2022

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Overview

This thesis is submitted in partial fulfilment of the degree of Doctor of Clinical Psychology at the University of Birmingham and is comprised of four chapters. The first chapter is a meta-synthetic review of the literature on parents' experiences of family therapy around their child's anorexia. The second chapter is a qualitative empirical study of couples' narratives of navigating their relationship with each other and anorexia. The final chapters present a 'press release' for both the literature review and the empirical study, which outline the main findings of the papers in a manner suitable for public dissemination.

All identifying information has been removed or amended to ensure anonymity.

Acknowledgements

To my family and friends who have been incredibly patient and supportive – I couldn't have done this without all of you – thank you. Special shoutout to those in the trenches with me – Claire, Sarj, Alys, Cat, and Lisa – we had each other's backs on the darkest of days, lifted each other up, and made sure no one got left behind. You're all stuck with me now.

A huge thank you to my supervisors, Dr Gerard Riley and Dr Newman Leung, for their immense patience with my appalling inability to meet deadlines, interest in my mad ideas, and helping me take said mad ideas to the next level.

Above all – thank you to the brave couples who shared their stories with me with so much openness and vulnerability. I hope I have honoured your stories and done them justice.

Contents

Chapter 1 Systematic Literature Review: A meta-ethnography of parents' experiences of family therapy around their child's anorexia 1
1.1 Abstract 1
1.2 Introduction 2
2.1 Family Origins of and Family Therapy for Anorexia 2
2.2 Experiences of Family Therapy 4
2.3 Study Aims 6
1.3 Method 6
3.1 Noblit and Hare's (1988) Meta-ethnography 6
3.2 Systematic Literature Search 7
3.3 Quality Appraisal 12
3.4 Data Extraction 12
3.5 Data Analysis and Synthesis 13
1.4 Results 14
4.1 Repeated renegotiation of role and identity as parents while continuing to parent 15
4.2 Changes in navigating parent-child relationship 20
4.3 Connectedness and recognition 22
4.4 Therapy as containing or depersonalising 25
1.5 Discussion 27
5.1 Research Findings in Context 28
5.2 Clinical Implications 30
5.3 Research Implications 33
5.4 Limitations 34
1.6 References 36
Chapter 2 Empirical Paper: Joint narratives of couples living with anorexia 42
2.1 Abstract 42
2.2 Introduction 43
2.1 Women with anorexia's experiences of being in a relationship 43
2.2 Individuals' experiences of caring for a loved one with anorexia 44
2.3 Dyadic research on couples living with anorexia 46
2.4 Aims of the present study 47
2.3 Methodology 47
3.1 Ethics 47
3.2 Epistemology 48
3.3 Recruitment and Sample Description 48
3.4 Data Collection 53

3.5 Data Analysis 57
3.6 Rigour of Analysis 59
2.4 Results 60
Narrative Chapter 1: Gradual development of understanding of anorexia in the context of societal discourses around thinness, gender, and mental and physical health 61
Narrative Chapter 2: Anorexia as the interplay between power and powerlessness 63
Narrative Chapter 3: Navigating shifts in power and helplessness within the relationship: Shifting roles, communication, and conflict 68
Narrative Chapter 4: Resolution and rebalancing of power 75
2.5 Discussion 81
5.1 Research Findings in Context 83
5.2 Implications for Practice 86
5.3 Limitations of the Study 88
5.4 Future Directions for Research 89
2.6 References 90
Chapter 3 : Press release for the systematic literature review 94
Chapter 4 : Press release for the empirical paper 96
APPENDICES 99
Chapter 1 Appendices 99
Appendix 1A: Quality Appraisal of Studies Using Critical Appraisal Skills Programme (CASP) 99
Appendix 1B: Extraction Grid Analysed 100
Appendix 1C: Table of Translations 102
Appendix 1D: Identity translation which became the theme *Repeated renegotiation of role and identity while continuing to parent* 105
Chapter 2 Appendices 107
Appendix 2A: Ethical Approval Letter 107
Appendix 2B: Services' Research and Innovation Approval 108
Appendix 2C: Recruitment Poster 110
Appendix 2D: Participant Information Sheet 111
Appendix 2E: Interview Guide 116
Appendix 2F: Debrief Sheet 117
Appendix 2G: Sample Coding 119
Appendix 2H: Narrative Summaries 122

Chapter 1 Systematic Literature Review: A meta-ethnography of parents' experiences of family therapy around their child's anorexia

1.1 Abstract

Background

Anorexia often develops in adolescence. Family therapy has been shown to be more effective at addressing adolescent anorexia than individual therapy, but the remission rate following family therapy at 12-month follow-ups is only 49%. Some family therapy approaches such as Maudsley Family Based Therapy involve parents being tasked with assuming primary responsibility for the young person's weight restoration. The present study aims to gain a more in-depth understanding of parents' experiences of family therapy for their child's anorexia by synthesising existing qualitative studies on the subject, allowing for more generalizable theories to be formed, as well as providing insight into why interventions succeed or fail.

Method

A systematic literature search was conducted in accordance with PRISMA guidelines. From the search, 10 studies were found to have met the required criteria for inclusion into the synthesis. Data were analysed in accordance with Noblit and Hare's (1988) seven step approach to meta-ethnographic research.

Results

Four themes arose from the data, namely, *Repeated renegotiation of role and identity while continuing to parent*; *Changes in navigating the parent-child relationship*; *Connectedness and recognition with other families and within their own family*; *Therapy as containing or depersonalising*.

Conclusion

The results highlight several implications for research and practice centering around the importance of taking more integrative approaches to family therapy around a young person's anorexia and ways of furthering containment within the process of family therapy.

1.2 Introduction

Anorexia nervosa is an eating disorder characterised by restrictive food intake, resulting in low body weight. The individual may also experience a fear of weight gain, as well as changes in body image and perceptions (Herpertz-Dahlmann, 2009). Anorexia has a significant impact on the individual's mental and physical health, as well as having the highest mortality rate out of all mental illnesses (Herpertz-Dahlmann, 2009).

Anorexia often develops in adolescence, and is most common in the 15- to 19-year old age group (Eisler et al., 2007), most of whom tend to be living with their parents. For adolescents, treatment often involves helping their parents supportively monitor their meals in order to facilitate weight gain, which is often a distressing experience for parents and adolescents alike (Eisler, 2005). Studies (Lock et al., 2006, 2010) show that anorexia remission rates at 12-month follow-ups were significantly higher following family therapy (49% remission) as opposed to individual adolescent-focused therapy (23% remission). Family therapy has therefore been recommended by the National Institute of Clinical Excellence (2017) to treat adolescents experiencing anorexia.

2.1 Family Origins of and Family Therapy for Anorexia

Different understandings of anorexia and forms of family therapy have been developed and studied over the years.

Early understandings of anorexia, such as those espoused by Hilde Bruch (1982), conceptualised insecure attachment as being key in the aetiology of anorexia. Minuchin's concept of the 'psychosomatic family' (Minuchin et al., 1978) also influenced the development of family therapy for anorexia and is seen in Sargent and colleagues' (1985) conceptualisations of anorexia: "The syndrome of anorexia nervosa is associated with characteristic dysfunctional patterns of family interaction. The family therapist conceptualises anorexia nervosa in relation to the organisation and functioning of the entire family [….]". At

the time, Bruch (1982) also reflected on how treatment was then guided by one of two approaches, one with an emphasis on "weight gain only with complete disregard for psychological problems" or "psychoanalysis extending over several years with disregard for low weight" (as cited in Treasure & Cardi, 2017). As such, Bruch (1982) recommended that both physical and psychological considerations be taken into account in therapy, as well as the role of interpersonal relationships.

Eisler (2005) noted concerns that early research was focused on understanding aetiology and that this, and clinical accounts of family dynamics, were being used to form explanatory models for anorexia. These concerns were also highlighted in the Academy for Eating Disorders' Position Paper (Le Grange et al., 2009), which concluded that focusing on family influences in aetiologic models of anorexia implied that families were to blame for their child's illness, and that it is more helpful to consider how families structure themselves around the eating disorder. This highlights a shift towards looking at the maintenance of anorexia, as opposed to its origins. This is evident in Family Based Therapy (FBT), which attempts to address factors that maintain anorexia.

Family Based Therapy (FBT), also known as the "Maudsley approach", was authored by Lock and Le Grange (2001) and has been extensively evaluated and is the most widely used form of family therapy for anorexia (Wufong et al., 2019). This manualised approach has three phases, beginning with the parents being supported to take control over the adolescent's diet, before handing back control to the young person, then considering other developmental issues such as the young person's identity in therapy. The approach is rooted in behavioural, narrative, and structural family therapies, and uses a number of techniques, including psychoeducation, systemic formulations, the family meal, and challenging beliefs, to name a few (Lock & Le Grange, 2013). Notably, Lock and Le Grange (2019) state that "remission rates remain elusive for more than half of all cases" following FBT, with remission and

recovery often defined by such studies in terms of whether an adolescent has gained weight or not. Treasure and Cardi (2017) summarise that FBT is less effective if the illness has persisted for over 3 years, or if the onset of the disorder occurred after the age of 18, as per the findings of Russell and colleagues' (1987) study.

Alternatives to FBT for adolescent anorexia include non-manualised systemic family therapy and multi-family therapy, which have not been as extensively evaluated as FBT. Non-manualised systemic family interventions for adolescent anorexia revolve around similar principles as FBT, such as working alongside the family in a non-blaming manner, externalisation, and increasing parental agency (White & Epston, 1990). Non-manualised family interventions allow a clinician more flexibility in tailoring interventions to each family's circumstances and needs. Multi-family therapy (MFT) is similarly aligned with FBT principles, but involves five to seven families learning from and supporting each other through the therapy process. In addition to improved outcomes for the adolescent, families also reported feeling less helpless, isolated, and ashamed about their experiences. Following a review of the literature, Baudinet and colleagues (2021) concluded that there was emerging evidence to support MFT being effective in reducing eating disorder symptoms in adolescents with anorexia (Eisler et al., 2016; Gelin et al., 2015; Hollesen et al., 2013), as well as improving mood and self-esteem (Salaminiou et al., 2017), family functioning and communication (Voriadaki et al., 2015), and reducing carer burden (Denhag et al., 2019) and expressed emotion (Uehara et al., 2001).

2.2 Experiences of Family Therapy

Families' experiences of the interventions targeting the maintenance of anorexia described above have been studied extensively, with an emphasis on the adolescents' experiences of these family interventions. Medway and Rhodes (2016) conducted a meta-synthesis to understand adolescents' experiences of family therapy for their anorexia, and the

major themes highlighted included a) ambivalence at relinquishing control to receive authoritative care, b) improved family relationships characterised by increased openness, decreased conflict and structural issues, improved understanding within the family, and externalisation of anorexia, c) neglect of issues underlying the anorexia, as well as d) a failure to address deeper family issues. These findings were aligned with Conti and colleagues' (2021) study, which highlighted that adolescents found that the initial exclusive focus on weight gain and relative neglect of their psychological distress resulted in a loss of their voice.

Parents' experiences of family interventions for their child's anorexia have been studied less extensively. A meta-synthesis of adolescents', parents', and professionals' views of overall treatment for adolescent anorexia highlighted that parents often felt confused, frustrated, guilty, frightened, and powerless to help their child when confronted with the anorexia (Sibeoni et al., 2017). Family therapy was thought by professionals and observers to help parents play a more active role in their child's care, while parents stated that the intervention provided a space for reflecting on feelings, identifying and managing conflicts, and fostering a sense of trust. Parents reflected on the need for building trusting relationships with professionals, particularly as they often felt "de-skilled" as parents and had a lack of confidence in the professionals (Sibeoni et al., 2017). Notably, Sibeoni and colleagues' (2017) meta-synthesis included only two studies on parents' experiences of family therapy specifically.

A more comprehensive, in-depth understanding of parents' experiences of family therapy for their child's anorexia would be helpful for several reasons. Parents and family carers experience high caregiving burden and high levels of distress that may at times be difficult to regulate, which can result in them responding to the anorexia in an extreme manner, such as being critical or overprotective (Goddard et al., 2013), thereby inadvertently maintaining the difficulties. These factors are often addressed during family therapy, and

parents' experiences of this is likely to affect how they make changes outside of the sessions. Additionally, parents have a key role to play in treatment, particularly in FBT, as they are supported to assume control over their child's eating during therapy, which is often a distressing experience for them (Eisler, 2005). Parents' ability to successfully navigate the assumption of control over their child's eating is the strongest predictor of outcomes after FBT (Ellison et al., 2012), making it important to understand their experience of being supported to do so during therapy.

2.3 Study Aims

The present study aims to gain a more in-depth understanding of parents' experiences of family therapy for their child's anorexia by synthesising existing qualitative studies on the subject using a meta-ethnographic approach. Meta-ethnography allows for "holistic interpretations" (Noblit & Hare, 1988) to be made, allowing for more generalizable theories to be formed, as well as providing insight into why interventions succeed or fail (Atkins et al., 2008).

1.3 Method

3.1 Noblit and Hare's (1988) Meta-ethnography

Noblit and Hare (1988) described meta-ethnography as an approach that allowed for the synthesis of qualitative research by translating studies into each other. The process follows seven phases, detailed in Table 1.1 below.

Table 1.1

The Seven Phases of Conducting a Meta-ethnography

Phase 1. Getting started: This involves identifying an intellectual interest that qualitative research may inform. The intellectual interest is developed further as interpretative accounts and studies are read.

Phase 2. Deciding what is relevant to the initial interest: This involves identifying relevant studies or accounts for the synthesis.

Phase 3. Reading the studies: This entails a repeated reading of the accounts, including carefully noting details and metaphors in the accounts.

Phase 4. Determining how the studies are related: This entails determining the relationships between the studies, which may be done by creating a list of the key metaphors, phrases, ideas, and/or concepts used in each account and comparing them with each other.

Phase 5. Translating the studies into one another: This involves treating the accounts as analogies and drawing comparisons between them, while continuing to consider the wider context of the account when translating key concepts into each other.

Phase 6. Synthesising translation: This involves considering whether the translations encompass each other or whether competing interpretations are created.

Phase 7. Expressing the synthesis: This involves communicating the findings of the synthesis in a manner appropriate for the intended audience.

In line with Noblit and Hare's (1988) first phase of conducting a meta-ethnography, the researcher considered their intellectual interests as reflected in the empirical study, namely, anorexia, relationships, shared experiences, and meaning-making. Initial searches highlighted meta-syntheses describing how adolescents with anorexia experience family therapy, as well as stakeholder views on adolescent anorexia treatment. These studies highlighted a level of responsibility placed on parents in family therapy, which was reflected in individual accounts and studies of parents' experiences of engaging in family therapy for their child's anorexia. As such, following discussions with supervisors, it was agreed that parents' experience of family therapy for their child's anorexia would be the focus of the meta-synthesis.

3.2 Systematic Literature Search

Noblit and Hare's (1988) second phase of conducting meta-ethnographic research entails the identification of relevant accounts and papers. A systematic literature search was conducted to this effect and is described below.

The search terms were finalized at the end of an iterative process considering the trade-offs between retrieval (potentially relevant records found) and precision (actually relevant records found) when searching for qualitative literature, as recommended by Shaw and colleagues (2004). Consultations were sought with a librarian at the University of Birmingham in considering both free-text terms in the search, and in considering the indexing systems of various electronic databases to ensure that the most relevant thesaurus terms were used to locate relevant papers, as per Shaw and colleagues' (2004) recommendations. The final list of search terms, including truncations, is detailed below in Table 1.2.

Table 1.2

Free-text search terms used

Construct	Search terms derived from construct
Family	Family
Therapy	Therap* OR intervention OR training OR work
Anorexia	Anorexi* OR restrict*
Parent	Parent OR carer
Qualitative	Qualitative OR phenomenology OR interview OR focus*

A title and abstract search combining the sets of terms shown on each line of Table 1.2 joined by the operator "AND" was conducted in June 2021 across four databases, namely, Web of Science, Scopus, Ovid, & Wiley. The final search resulted in 1,897 records being identified, which were narrowed to 10 studies in accordance with the Preferred Reporting Items for Systematic Review and Meta-Analyses (PRISMA) model (Moher, Liberati, Tetzlaff & Atman, 2009) by the application of inclusion and exclusion criteria detailed in Table 1.3. The process is summarised in Figure 1.1.

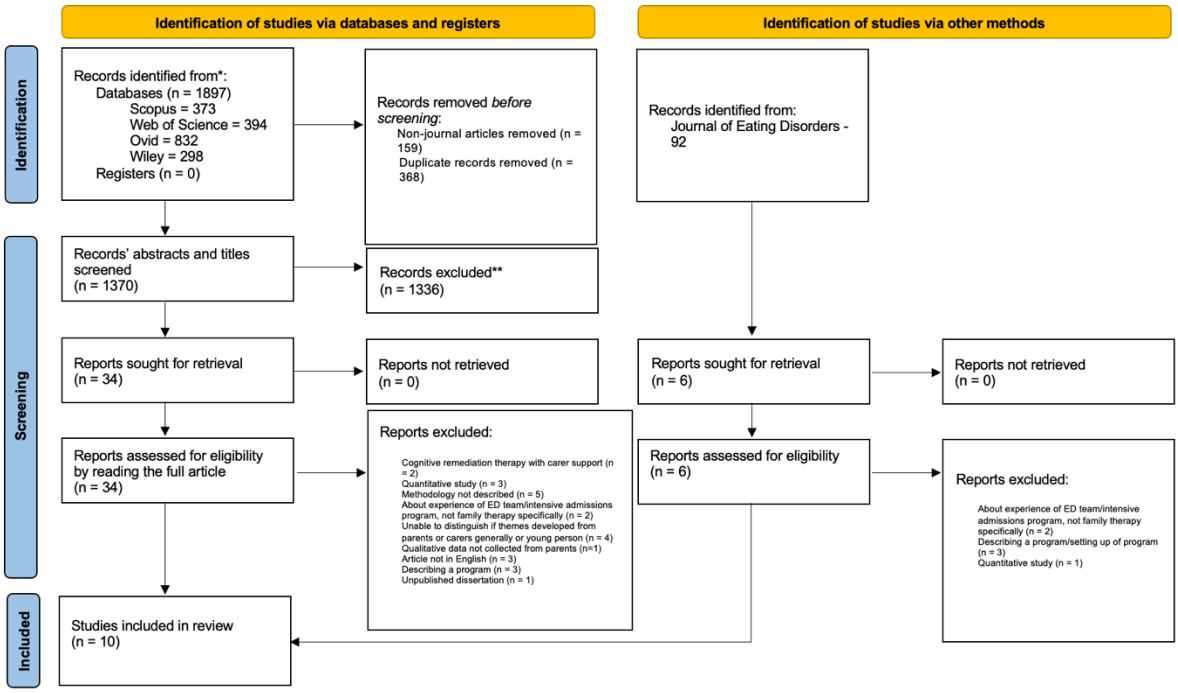
Table 1.3

Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria	Rationale
Papers published in English	Papers published in a language other than English	The ethnography is being completed in English. A layer of meaning would be altered and/or lost if the original papers were translated.
Peer-reviewed journal articles presenting original research	Review articles, theory articles, opinion papers, book chapters, and dissertations	Dissertations are not included as they have not been peer-reviewed to ensure that the research is rigorous.
Qualitative papers	Quantitative or mixed methods papers	Meta-ethnography is a synthesis of qualitative research.
Parents must have attended family therapy around their female child or young person's (under 25) anorexia	Parents attending family therapy for their male child or adolescent's anorexia; parents attending family therapy where a young person over the age of 25 has anorexia; parents attending an intensive admission program or therapies other than family therapy (such as cognitive remediation therapy) being the focus of the paper Parents' experiences of living with a young person with anorexia	Parents attending family therapy for a male child's anorexia are excluded from the study as anorexia in males is conceptualised differently than anorexia in females, and is less studied. The child being over the age of 25 is also grounds for exclusion from the study, because the role parents would have to play in the child's treatment and recovery would change based on age. Studies considering parents' experiences of an intensive admission program or therapies other than family therapy are also excluded as they are beyond the scope of the study.
Data must be gathered directly from parents	Data gathered about parents' experience from the perspective of the young person or therapist	This is to ensure that the parents' voices and experiences remain central to the study.
Quotes from parents must be used to support the findings	Absence of quotes from parents	This is to ensure that the parents' voices and experiences remain central to the study.

Figure 1.1

PRISMA Model Application of Inclusion and Exclusion Criteria



Five out of the 10 studies were conducted in Australia. The remaining five studies were conducted in Norway, Sweden, England, France, and China. The sample sizes in the studies varied, ranging from 2 (Conti et al., 2017) to 34 (Rhodes, Brown, & Madden, 2009) for a combined total of 160 parents included in the current review. Analyses used in the studies were thematic analysis (three studies), grounded theory (two studies), phenomenology (two studies), and critical discursive analysis (two studies). Further information about the characteristics of the studies is detailed in Table 1.4.

Table 1.4

Characteristics of Studies Included in the Review

Paper	Research Question/Aim	Epistemology	Data Collection	Analysis	Demographic Information	Therapy Information
Baumas et al. 2021	What are the experience of families who have completed Multifamily Therapy for anorexia and what are the mechanisms of change?	Not stated	Focus group with parents and focus group with children	Thematic interpretation (inductive analytic approach)	France 3 patients aged 14-19; 4 mothers and 2 fathers	Therafarmbest's Multi-family therapy 10 3-hour sessions over a year with 5-7 families Themes of the program: understanding and managing AN; family relations and identity; overcoming social isolation; values beliefs and perceptions.
Brinchmann & Kravac 2021	How do patients and families experience Multifamily therapy?	Grounded Theory	Group and individual interviews	Thematic analysis	Norway 12 families of young adult women aged 18-22 - parents siblings grandmother partner	Multifamily Therapy 6 group gatherings over a year each 2- or 3-days' duration with 12 families Themes of the program: relationships; communication; conflict management; interactivity; motivation; feelings of guilt.
Conti et al. 2017	What is the experience of MFT/FBT of an adolescent and her family?	Not stated	Individual and family interviews	Critical discursive analysis	Australia 1 family of an 11-year old girl; parents young person and sibling	Family-based therapy (FBT) manualized therapy based on Maudsley Family Therapy FBT not completed Themes of the program: orchestrating an intense scene to increase parental anxiety and responsibility; returning control over eating to adolescent; adolescent issues (development and autonomy anxiety depression and social integration)
Engman-Bredvik et al. 2015	What is the experience of MFT for AN treatment from a parental perspective?	Phenomenology	Individual interviews	EEP method thematic analysis	Sweden 12 parents of 6 girls aged 12-17 years old	Multifamily therapy (manual-based) Group treatment for 6-8 families with 10-whole day meetings spread throughout the year Themes of the program: symptom oriented phase; relationship oriented phase; future oriented phase;
Ma & Lai 2008	What is the perceived treatment effectiveness of family therapy in the eyes of patients with AN and their families? What are their experiences of family therapy?	Not stated	Unclear but likely family interviews	Not stated	China 24 recovered patients and their families	Family therapy based on Micucci's (1998) treatment model; non-manualized; addressed family issues in therapy (e.g. severe marital conflict family poverty) 90-minute fortnightly sessions; number of sessions ranged from 3 to 39 over a period that lasted from 2 - 18 months Themes of the program: negotiating a treatment contract by shifting family's focus from symptom to cycles/constricting family processes that maintained and escalated AN; encouraging parental collaboration in place of control; addressing unresolved conflicts and improving family relationships; handling relapses; supporting individual development; supporting transformation
Rhodes Brown & Madden 2009	To qualitatively evaluate the use of parent-to-parent consultation in the Maudsley model of family-based treatment by comparing parents' experience of standard treatment and other parents' experience of standard treatment with the consultations	Grounded Theory	Individual interviews	Axial coding (grounded theory)	Australia Parents from 20 families with children aged 12-16 who had anorexia and had been discharged from a recent hospital admission	Maudsley Model of Family-Based Treatment for Anorexia Nervosa with additional parent-to-parent consultations for half of the families Duration unclear Themes of the program: parents taking an authoritative stance against externalized anorexia; parents supported to refeed their child; siblings recruited to provide emotional support to patient; responsibility for eating handed back to patient as they reach a healthy weight; restoration of normal adolescence Parent-to-parent consultation involved new parents listening to therapist interviewing graduated parents with the aim of circulating liberative stories
Voriadaki et al. 2015	What are the experiences of a group of families during MFT and what changes were noted linked with these experiences?	Phenomenology	Researcher observations rating scales daily journals focus group between parents and focus group between adolescents	IPA	England 6 families with adolescents aged 15-16 years old with a diagnosis of AN	Multifamily therapy 10 full days of treatment over 9 how months however study was conducted after first 4 full days of intensive treatment Themes of the program: experiential and creative activities (including sculpting writing letters to anorexia etc) and psychoeducation and daily multi-family meals.
Wallis et al. 2017	The aim of this study was to understand the impact of FBT on family relationships and investigate this process of change for families with a good outcome in an attempt to generate new theoretical insights to guide future enhancements to treatment interventions.	Constructionist grounded theory	Individual interviews with young person and parents	Constructionist grounded theory	Australia 16 families who had completed 20-session FBT protocol and the young person (12-18 years old) had a weight greater than 85% estimated body weight at session 20	Manualized Family Based Therapy (FBT) 20 sessions Themes of the program; Not described
Williams Wood & Plath 2020	What are parents' experiences of engaging with AN treatment including both FBT and non-manualised systemic family treatment?	Interpretivist	Individual or joint (where both parents were interviewed together) interviews	IPA	Australia 9 parents of a young person (aged 12-18 at time of diagnosis) with anorexia who had experienced FBT	Manualized Family Based Therapy (FBT) or systemic family therapy Duration of therapy not stated Themes of the manualized program: empower parents to promote weight gain (including the family meal); parents negotiate new patterns of relating with child with autonomy being encouraged; consideration of developmentally appropriate tasks for adolescent and resolving other family issues Themes of the non-manualized systemic family intervention: adoption of nonblaming stance strong parental alliance parental agency as key externalization and working alongside the family
Wufong Rhodes & Conti 2019	What are parents' experiences of MFT/FBT in cases where treatment was discontinued and/or their child continued to experience distress post-treatment? To build a more comprehensive understanding of how these parents ascribed meaning to their experiences and negotiated their identities in the context of MFT/FBT which is important given the central role parents are assigned in this intervention to facilitate their child's weight and eating recovery	Not stated	Individual interviews	Critical discursive analysis	Australia 13 parents who experienced MFT/FBT for AN treatment for their child and dropped out or reported that their child continued to express distress and/or ED symptomatology	Maudsley Family Therapy informed manualized Family Based Therapy (FBT) Duration not stated Themes of the program: supporting parents to assume control over adolescent's food intake; transitioning control over food back to adolescent; adolescent's developmental needs

3.3 Quality Appraisal

The method of appraising the quality of qualitative research continues to be debated within scientific communities. Williams and colleagues (2019) posit that checklists such as the Critical Appraisal Skills Programme (CASP) were developed for assessing the quality of qualitative research, but tend to be based on positivist paradigms that have different underpinnings than interpretivist paradigms that underlie qualitative research. Yardley (2000) highlights key principles to guide the assessment of quality in qualitative research: sensitivity to context, commitment and rigor, transparency and coherence, and impact and importance.

For the current review, quality of papers were assessed using the Critical Appraisal Skills Programme (CASP) (see Appendix 1A). Yardley's (2008) principles, with an emphasis on considering sensitivity to context, were integrated into the Critical Appraisal Skills Programme (CASP) when assessing the descriptions of theory and previous research, participant characteristics, relationship between researcher and participant, and data analysis described in the papers. All ten papers were read and assessed in line with the aforementioned criteria, with criteria marked as having been met ("Yes"), not met ("No"), or partially ("Partially") met. A final column was added to summarise the overall methodological quality of each paper. This is illustrated in Appendix 1A. Overall, six studies were found to be of good quality, three studies of acceptable quality, and one of poor quality. All but two of the studies neglected to meaningfully consider sensitivity to context, including the role of the researcher during design and data collection and analysis.

3.4 Data Extraction

Phases three (reading the studies), four (determining how the studies are related), and five (translating studies into one another) of Noblit and Hare's (1988) approach were commenced. All ten studies were read several times, with an added emphasis on the results

sections of the studies. Data were extracted from the results sections of the various studies. The data consisted of the themes, subthemes, and key ideas discussed within the themes and subthemes of each study. This data was summarised in an extraction grid (see Appendix 1B). The extracted data were then read and re-read, words and ideas illustrating similar concepts across studies were colour-coded (see Appendix 1B), which formed the basis for the 15 initial reciprocal translations. The initial reciprocal translations are listed Figure 1.2.

Figure 1.2

Initial Reciprocal Translations

1. Role
2. Responsibility
3. Identity
4. Blame/shame/guilt
5. Power/helplessness
6. Conflict
7. Unity/isolation
8. Communication
9. Externalising
10. New understanding/growth/insight
11. Family dynamics
12. Emotional experience
13. Structure
14. Therapist/therapeutic relationship
15. Hope/optimism

3.5 Data Analysis and Synthesis

The translations and authors' interpretations surrounding these were considered in each of the papers, resulting in similar translations being merged (e.g. "role" and "responsibility" being subsumed by "identity") and broader translations being broken down and merged with other translations (e.g. elements of "family dynamics" being captured by "conflict", "unity/isolation", and "communication"). The final reciprocal translations as well as the authors that contributed to each of these can be found in Appendix 1C. This was done in accordance with Noblit and Hare's (1988) sixth phase, synthesising translations. Finally, four themes were developed from the translations (see Appendix 1D for a sample of this

process), following critical discussions with my supervisors as well as members of a meta-ethnography support group. The themes were then refined and are presented in the results section of this paper, in accordance with the final step of Noblit and Hare's (1988) approach to meta-ethnography.

1.4 Results

The studies synthesised in this review used varying analyses, including thematic analysis (3 studies), interpretative phenomenological analysis (2 studies), grounded theory (2 studies), and discursive analysis (2 studies). The themes resulting from the synthesis therefore appear to parallel that of a thematic analysis with both phenomenological and discursive elements. Four main themes were identified, namely, parents' repeated renegotiation of their role and identity while continuing to parents their child/ren, changes made in navigating the parent-child relationship, parents developing a sense of connectedness and recognition with other families and within their own families, and the overall experience of therapy being either containing or depersonalising. The themes and respective sub-themes are summarised in Table 1.5.

Table 1.5

Themes and Subthemes

Theme	Subthemes
Repeated renegotiation of role and identity while continuing to parent	
Changes in navigating parent-child relationship	New understandings of child, anorexia, and self
	Handling conflict
Connectedness and recognition	With other families
	Within the family
Therapy as containing or depersonalising	

4.1 Repeated renegotiation of role and identity as parents while continuing to parent

This theme appeared to underlie parents' journeys with their child's anorexia before, during, and after family therapy. It was discussed in most depth in Conti and colleagues' (2017) and Wufong and colleagues' (2019) papers.

Before therapy

Five out of the ten papers included in the synthesis made reference to parents' early renegotiations of their identities as parents when initially confronted with their child's anorexia. Anorexia appeared to bring up feelings of helplessness and inadequacy in the parents' perceived ability to carry out their roles, leading to feelings of guilt.

> *Margaret: Oh my goodness I was, I've never been so challenged in my life as a mother. I felt wretched. You know it's such a, a fundamental thing to feed and protect your child and anorexia has […] challenged that in its essence […..]* (Conti et al., 2017: pp. 414)

> *Jack: I just felt completely helpless on multiple fronts. My hardest hitting feelings were actually at the very beginning. That's when I felt most desperate and guilty. […] I just wandered in and I just crawled into the bed next to her, put my arms around her and then that's when I just felt her skin and bones and her cold skin and her just lifeless body. I sobbed and sobbed and sobbed that – how did it get, how did it get to this stage? On my watch?* (Conti et al., 2017: pp. 412)

Conti and colleagues (2017) made sense of Jack's experiences by drawing on discourses around fatherhood and masculinity, and the linked expectations of adopting the role of the protector within the family. In a similar vein, Margaret's quote highlights that she felt unable to fulfil feminine roles of woman, mother, and nurturer dictated by society.

Participants spoke of noticing a reduction in confidence in their approach as parents prior to engaging with family therapy, which manifested in several tangible ways. Parents spoke of "battling" with themselves alongside anorexia, to work out what to "value or prioritise as parents" (Williams et al., 2020). Parents struggled with concerns about their paid work due to caregiver burden and providing for their families (Williams et al., 2020). They also struggled to protect their other children from distress (Baumas et al., 2021) and to ensure

that their other children were not "neglected" (Engman-Bredvik, et al., 2015). Parents also spoke about struggling to navigate conflict with their child (Wallis et al., 2017).

Seven out of the ten papers included in the review made reference to parents' feelings of guilt and self-blame, and this was positioned as being central to parents' experience of navigating their role within the family when confronted with anorexia. Papers also appeared to position sensitivity to these feelings of guilt and self-blame as key considerations in family therapy for the child's anorexia. Notably, papers did not appear to report on parents experiencing feelings of anger and or resentment towards their child, which is worth further consideration, given that anger would have been an understandable and expected response in light of the challenges to their identity as parents as well as the increase in conflict that often accompanies anorexia.

During therapy

Upon commencing therapy, some parents spoke of initially experiencing hope and confidence in the approach, particularly when the structure of the Maudsley approach and its success rate was discussed with them. This led to them being open to relinquishing or sidelining knowledge they had previously accumulated as parents in favour of new ideas and expertise from professionals or therapies, as an antidote to the helplessness they felt as parents.

> *I felt helpless. I felt totally out of control. I had lots of people saying to me "Just—just make her eat. It's no big deal." Particularly [...] that generation who don't always get that this is a genuine mental illness. So, having a plan just made me feel like I had something secure to—to work on, to work with, to trust in* (Wufong et al., 2019: p. 5).

> *[…] the 95% Maudsley track record or whatever it was that rolled out gave me a high level of confidence "will this work?" So follow them, follow it consistently, don't deviate because we haven't got any of that expertise or experience they do* (Wufong et al., 2019: p. 5).

Most of the family therapies described in the studies included in this review included elements around re-feeding or a symptom-oriented phase in the early stages of therapy. During this phase, particularly in Maudsley Family Based Therapy, parents were told to assume responsibility for their child's eating. An excerpt from a parent focus group summarises some of the different perspectives parents held about this assumption of responsibility:

> *Ken: We are the treatment ... we can get our kids to understand that we are not the enemy.*
> *Mary: But we haven't got a lot of tools to do that, apart from coaching them to eat, which is very difficult ...*
> *Norma: It was a big realisation all of a sudden that you are the cure. It is a huge thing to accept.* (Voriadaki et al., 2015: p. 18).

These excerpts illustrate a process whereby parents' initial confidence in professionals and the approach led to them being willing to hand over responsibility, but later experiencing the weight of the responsibility being placed back on them during therapy. This was experienced as either empowering or furthering a sense of helplessness by parents.

The assumption of responsibility to re-feed their child was highlighted during the "family meal" component of Maudsley Family Based Therapy. This experience was found to be distressing by some parents, who found it akin to "force-feeding" their child , while other parents reflected that it supported them to do things they would otherwise find challenging (Williams et al., 2020). As such, it appeared that the "family meal" component was perceived by some parents as helpful in reinforcing their authority as parents, whereas others potentially received this as being against the values they held as parents.

During the re-feeding phase of therapy, parents' experience of therapy and views of themselves as parents appeared strongly tied to whether their child was able to put on weight.

> *Jack: In our case we were on trial. I'd be shocked if Margaret didn't even use that expression. [. . .] I felt like she was on trial in those sessions towards the end. And Hayley's failure to put on weight was Margaret's failure to feed her enough ultimately* (Conti, et al., 2017: p. 410).

> *Jack's narrative highlighted the extent to which this purported non-blaming approach inadvertently ended up blaming, with the pervasive and unspoken assumption that Hayley's struggle to gain was her mother's 'failure to feed her enough'* (Conti, et al., 2017: p. 411).

> *Alice: Yeah, and when things aren't going well you do kind of blame yourself. Like I really blame myself for her going backwards at Christmas. I should have been more watchful about what had happened" (Wufong, et al., 2019: p. 10).*

Ultimately, Wufong and colleagues (2019) concluded that despite Maudsley Family Based Therapy being designed to reduce blame directed towards parents, parents were given direct responsibility for their child's weight gain, which furthered experiences of self-blame and guilt when the desired weight was not achieved or maintained. In addition, parents being told that the therapeutic approach was 95% effective, while intended to increase hope and confidence at the start of therapy, ultimately implied that if the treatment were to fail, the fault would lie with them, as opposed to professionals, the treatment modality, or other external factors. It is understandable, therefore, that despite therapists absolving parents of guilt, all the parents spoke about struggling with self-blame when struggling with holding the responsibility for their child's eating restoration (Wufong et al., 2019).

Only one of the ten studies included in the review explored parents' experiences of handing back responsibility to the child for their eating following the re-feeding stage. In Wufong and colleagues' (2019) study, six of thirteen parents struggled with handing over responsibility to their child for their eating, in line with the second phase (handing back control over eating to the adolescent) of the Maudsley approach.

> *Emily: I actually have difficulty then again letting go, because it was then, okay I have to be in charge to be really the boss against this illness. [...] Kelly said to me, "Mum, don't talk about it anymore. I don't want to be that person with anorexia all the time. We have to let it go." [...] it's hard to not identify then [as] the mother of a child with anorexia* (Wufong et al., 2019: p. 11).

> *Shifting from an authoritarian stance in phase one of the intervention was troubling for these parents as they were faced with the fear of their daughter*

> *lapsing, greater uncertainty around their child's future, and renegotiating their roles and identities as parents* (Wufong et al., 2019: p. 12).

Parents' renegotiations of their roles and identities during family therapy happened alongside them still attempting to continue to fulfill their role as parents during the sessions. This was evident in parents' concern for their children's experiences of therapy:

> *However, I know that my daughter sometimes came out of the session worse than when she came in. […] It was violent for the little ones, at least for the younger ones. I wish my youngest daughter had not been there* (Baumas, et al., 2021: p. 6).

> *Parents' experience of clinician compassion for their circumstances and empathy for their child tended to shape their overall experience* (Williams et al., 2020: p. 8).

After therapy

Most parents continued to express feelings of significant anxiety after therapy had been completed, which appeared to be the case regardless of whether weight was restored or not. This linked with concerns highlighted by parents that the therapy had focused primarily on weight restoration, with their child's psychological distress being sidelined during the sessions (Conti et al., 2017; Wufong et al., 2019).

Parents spoke about worrying that their child might "bear the legacy of anorexia for the rest of their days", and a "sense of struggle about where to turn to next" (Wufong, et al., 2019: p. 9). Other parents, however, appeared to have gained a more hopeful, contained sense of acceptance over their child's future and the role they would continue to play in it from other parents:

> *Because I was still at the point where you just can't comprehend what the future holds at times. I think it confirmed that this isn't an overnight fix and it was going to be extremely hard to fight. I guess I took some encouragement out of it for myself to say, well, if these guys can do it and they made some progress, then perhaps I can* (Rhodes, et al., 2009: p. 188).

As such, parents continued to renegotiate their relationship with hope for their child's future with a sense of overwhelming anxiety or a sense of acceptance.

Parents' renegotiations of their identity and roles were linked with tangible changes they made in how they approached their children.

4.2 Changes in navigating parent-child relationship

New understandings of child, anorexia, and self

Parents spoke of new understandings they gained of their child, anorexia, and themselves in family therapy that allowed them to create changes in their relationships within the family. Most studies included in the review spoke about or made reference to externalising, which most parents appeared to find helpful. One paper described an emotional family sculpting exercise that helped parents understand the power anorexia had over their daughters and how isolated and powerless the girls felt, as well as how powerful their daughters then felt when declining food (Voriadaki et al., 2015). Parents spoke about how this understanding helped them shift their feelings of frustration towards anorexia, as opposed to their child, uniting them in their fight against anorexia (Wufong et al., 2019; Engman-Bredvik et al., 2015).

On the other hand, two parents spoke about how they found the sculpting exercise that enabled other families to externalise to be too distressing and were ambivalent about its usefulness (Voriadaki et al., 2015). In another study, one parent found externalising unhelpful and distressing:

> *Margaret: I accept that when she was very sick, you know, we talk in these beautiful terms of "it was the eating disorder and not Hayley in the room" and all those euphemisms but effectively Hayley was still in the room but she was treated as though she wasn't. [...] that was probably the most unnerving thing that the person who I believe has been the key to recovery, i.e. herself (emotional tone), was deliberately excluded from the process and talked about as though she wasn't even in the room* (Conti et al., 2017, p: 416).

Parents also spoke about how understanding their child differently allowed them to confront things about how they parented:

> *Her illness was partly caused by the fact that in the process of growing up, she felt that she couldn't control her life; so she controlled the amount of food to be eaten and controlled others' eating too. That's her way of mastering life. We (he and his wife) committed the same mistake. We controlled her to do this and to do that. Now we let go and relax. Let her manage her own difficulties. The effects of doing so are positive (*Ma & Lai, 2008: p. 68).

> *I was one of these people who didn't show my emotions much, very tough orientated, very much the job at hand. ... once I understood what anorexia was like for my son, it helped me change. Now I've let my guard down and let people in ... I think it's [AN] made me a better person and a better parent ... as much as it nearly killed me* (Williams et al., 2020: p. 9).

Handling conflict

Parents spoke about how new understandings of their children, anorexia, and themselves helped them set firm boundaries with their children in a calm and collected way (Rhodes et al., 2009; Engman-Bredvik et al., 2015; Wallis et al., 2017; Williams et al., 2020). Despite this, some parents spoke about how meal conflict continued to be quite difficult to navigate, despite being branded by the therapy as simple:

> *Alice: [...] they talked to us a lot about the re-feeding and it sounds easy in principle, in theory, but when you actually do it at home it's not that easy when a teenager's screaming at the top of her lungs and you're getting yoghurt thrown at you. I found it really distressing when she didn't want to eat [...] Because you can't really put someone's mouth in a vice and make them eat it, can you?* (Wufong et al., 2019).

Parents' improved understanding of anorexia also led to them to reflecting on the conflict they had between themselves:

> *Many recognised the phenomenon as a venting of frustration on each other rather than on the root cause […]: It starts with our daughter doing something, but it ends with me and my wife fighting . . . that is somehow what this disease does* (Engman-Bredvik et al., 2015: p. 8).

Several parents spoke of increased collaboration between themselves and their partners when navigating conflict, particularly with fathers becoming more involved in the process and mothers letting go of some responsibility (Engman-Bredvik, 2015):

> *Kiera: [...] we were a joint force. I think if you can work together really quickly it helps because an eating disorder can get around one of you, but if it knows that dad's there backing up everything that mum says and vice-versa, I think that helps* (Wufong et al., 2019: p. 7).

> *Father 8 narrated: "Our family relation was extremely poor mainly because she (P8) refused to eat and her mom forced her to eat. She (P8) didn't listen and they fought. During treatment, the therapist suggested me to help my wife. We (her daughter and him) ate outside. I lectured less, and gave her (P8) more time and space to take care of her health. Their conflicts lessened and vanished. She (P8) used to argue with me fiercely. Now she is more compromising* (Ma & Lai, 2008: p. 69).

However, some parents spoke of how both parents were encouraged but not required to be part involved in family therapy, and this resulted in more responsibility being placed on the parent who did attend, reinforcing a sense of isolation (Williams et al., 2020).

4.3 Connectedness and recognition

With other families

Shame, isolation, and not feeling understood by others around them characterised parents' experiences of having a child living with anorexia (Engman-Bredvik et al., 2015). "Several participants described the difficulty of explaining to outsiders how AN affects most aspects of life, so in many cases parents had even stopped to try" (Engman-Bredvik et al., 2015: pp. 5).

However, meeting other parents and families living with anorexia, either during multifamily therapy or parent-to-parent consultations reduced parents' isolation and feelings of guilt by fostering a sense of belonging. Participants spoke of how it was "freeing" and "painful" to meet other families with similar experiences (Brinchmann & Kravac, 2021: p. 6). Parents were ultimately connected by a shared experience of loneliness because others not living with anorexia struggled to understand what it was like to live in a home "dominated by an eating disorder" (Brinchmann & Kravac, 2021: p. 10).

> *Participants found meeting other families in a similar situation most valuable. They felt less lonely, as they realised how common the disease is, and that other, otherwise completely "normal," families were sharing the struggle. This yielded a comforting experience of fellowship and belonging* (Engman-Bredvik et al., 2015: pp. 4-5).

One parent who met other parents during parent-to-parent consultations, however, did not appear to have developed the same sense of connectedness with the other parent they spoke with: "I sort of saw those things that wouldn't work with us. Their relationship was so different to ours and how they approached it was very different" (Rhodes et al., 2009: p. 190).

Parents in multifamily therapy spoke of a sense of safety within the group, which was described as a "place tolerant of their need to cry or to be angry" (Brinchmann & Kravac, 2021: p. 6). Parents described the experience as "emotionally charged" when asked to put a name to their feelings and feeling other parents share in their pain (Engman-Bredvik et al., 2015).

> *The first time, the first meeting of the mothers` group, we sat in our group and as soon as we sat down, I began to cry. I was totally unprepared for that because I do not cry easily. It was a shock, but at the same time it was a signal that I had now come to some people who ... A strange experience, as I felt I wanted to scream. And I think that it was because I realised that at last there were people who understood what I was talking about ... . I understood that there was truth in that you said that you understood what I was talking about – and it was quite liberating – good and bad at the same time* (Brinchmann & Kravac, 2021: p. 6).

Within the family

Several parents spoke about how, prior to therapy, they had struggled to communicate openly with their child due to anxieties around triggering difficult feelings and the eating disorder and the distance created as a result of this avoidance:

> *Before we started in MFT it was just as if there was a wall between her and us in relation to the disease, but then something happened in the MFT which meant that the wall was broken down a bit. You knew what we could talk about, have some shared experiences around the illness that we could speak about – because we have been so scared – am I crossing a boundary here if I say .... or is it something I mustn't say. You become very watchful. This wall really set a limit in that she didn't really know what to say to us, because we didn't really understand what this was all about. And so, you sit on the other side of the wall, afraid that if you say this or that it might be wrong, or there again maybe smart. You sit and wonder what to do: should you try to tempt her with something? Should she get something if she does it? You sit there like a question mark. And you don't start to climb over the wall because you don't know what awaits you on the other side* (Brinchmann & Kravac, 2021: p. 7).

During therapy, emotional expression was encouraged, which parents felt facilitated changes in family interactions and relationships (Voriadaki et al., 2015).

> *At home we knew that we were unhappy with one another but we wouldn't discuss it. Here there were fewer barriers. We let others know our views. We communicated with one another during treatment. We learned from each other's views. We had mutual understanding and mutual support. Once she (P24) asked her mom not to force her to eat this and that. Afterward, her mom was less rigid* (Ma & Lai, 2008: p. 70).

> *Emily: [...] they actually kind of guided us through some of the very, very hard conversations. Hard as in about feelings, about guilt, about perceptions, and about the effects it had on us [...] I think as a family we've grown a lot closer [...] in a way that we can respect each other* (Wufong et al., 2019: p. 7).

As discussed in a previous section, sculpting exercises where participants had to step into the roles of other family members helped them empathize with each other better, bringing the family together in the fight against anorexia:

> *Mother 7 said: "Here she (P7) learned that she was not the only sacrifice and victim in the family; we (the parents) were too." The mother continued: "We began to know that it's a family affair; not an individual affair in fighting AN* (Ma & Lai, 2008: p. 68).

Some parents, however, felt this openness in communication ultimately "disrupted' their relationship with their child (Williams et al., 2020: p. 8) and was accompanied by an exacerbation in conflict and disconnection (Conti et al., 2017).

Other parents noted differences in their experiences of multi-family therapy compared to single family therapy and how these linked in with feelings of unity and connectedness within the family and with other families:

> *Mother 3: "For the single-family therapy we had to drag the children, they did not want to go. But, each time, it created something strong and we were quite united for two or three hours. It did not do that after MFT. Each time we would say "well, let's do something afterwards," but each time everyone went about their business. MFT has not the same effects afterwards. I think it takes both, in fact. We need spaces like this one where we actually highlight the resources we have. The disease has an effect on the family and our family and other families are the same; families are actually hurt by the disease. And then, sometimes, we also need other spaces where we can talk about what is difficult in a particular*

> *family. Because it might not be the same thing in our family and in another one, because I do not think that there is a typical anorexic child's family* (Baumas et al., 2021: p. 6).

This quote highlights that multi-family therapy was perceived as fostering a greater sense of connectedness and recognition with other families, while single-family therapy was perceived as fostering a greater sense of connectedness and recognition within their own family.

4.4 Therapy as containing or depersonalising

Parents appeared to view elements of the experience of family therapy as either containing or depersonalising.

Some parents described the experience of undergoing Maudsley Family Based Therapy (FBT) as like being given a "roadmap", in that there was a structure with regular set treatment sequence, goals being set, and progress being checked. These parents highlighted that this structure resulted in less uncertainty for them to have to contend with, thereby providing increased security and a high level of accountability (Wallis et al., 2017).

> *Some parents felt the treatment "pushed" them to "keep going" and this created a momentum that they found reassuring: "With Maudsley, you know each week it sort of just pushes you that bit further" (P5). One father (P9) described this momentum as giving "her and us something to manage"* (Williams et al., 2020: p. 7).

Other parents, however, experienced the provision of a "roadmap" (manualised therapy) as depersonalising: "Where I think we've gone off the rails is in hindsight, is when I feel as though we almost put her as a person to the side and followed, followed a process or followed somebody else's roadmap." (Conti et al., 2017: p. 416). This appeared to have had a distressing impact on some families:

> *With Maudsley therapy it's treatment, they don't really care about the person that's at the core of it all ... she (daughter) used to come out saying "nobody cares about me at all, I'm just nothing, I'm worthless so kill me". She never got spoken to. They should really structure a treatment around the family rather than saying, "this is how we treat you"* (Williams et al., 2020: p. 7).

Some parents appeared to struggle to disentangle their experience of a manualised approach to therapy from their experience of the therapist delivering the therapy, as illustrated by the quote below:

> *One parent (P6) described a sense that the manualised FBT clinicians were "saying what they were trained to say ... without caring". This parent explained receiving "textbook treatment", and that the inflexibility of the manualised FBT clinicians resulted in her terminating treatment at the service (*Williams et al., 2020: p 8).

Some parents, however, reflected on how their experience of the therapist helped them regain confidence they had lost as parents to anorexia. They found it helpful to receive reassurance and clear directives from their therapist (Wallis et al., 2017), but also appreciated it when the therapist "did not try to take the role of the parent away in standing up to the anorexia, but encouraged the young person to see her parents as the people who were responsible for her recovery" (Rhodes et al., 2009: p. 186). On the other hand, some parents were able to reclaim their roles as parents by advocating for their children in the face of a depersonalising and marginalising experience of therapy:

> *Merrum: [...] when I said, "we're at the point now where we need to move on. When's the psychology part of this come in?" Cause I knew it was going to come. And "oh not yet. We're not ready for that yet" and I'm saying, but Kate is and I think Kate needs to speak* (Wufong et al., 2019: p. 8).

Like Merrum, other parents expressed concerns over the lack of space offered to the child's psychological distress in favour of prioritising weight restoration via behavioural intervention. This was summarised in the following quote:

> *Although these parents understood the rationale for this symptom focus, they also expressed concerns including the implicit neglect of therapeutic focus on the broader contexts of their child's distress and the substantive impacts of being allocated the primary role of refeeding their child* (Wufong et al., 2019: p. 8).

They further discussed substantial distress continuing to be present in the family system after the young person's weight had been restored: "Within the narratives of the parents who

reported that their child's weight was restored through MFT/ FBT, there was a parallel process between their daughter's ongoing psychological distress and their own distress and worry [....]" (Wufong et al., 2019: p. 9).

1.5 Discussion

This meta-ethnography has drawn together qualitative studies that have aimed to explore and understand parents' experiences of family therapy around their child's anorexia. The findings of this review illustrate parents' repeated renegotiations of their role and identity as parents while continuing to parent their children. The studies highlight this as a difficult and "confronting" process shrouded in guilt and shame (Williams et al., 2020). The renegotiations began to occur when they are first confronted by their child's anorexia, which led to them questioning their ability and worth as parents, while experiencing feelings of helplessness, guilt, and self-blame. Parents appeared to experience some degree of relief from these difficult feelings when they initially started family therapy, leading them to be open to putting aside the expertise they had previously accumulated as parents in favour of new ideas and approaches. This may have been experienced as them handing over an anxiety-provoking responsibility over to professionals. During therapy, however, parents were confronted with needing to assume responsibility for their child's eating, which was described as a "big realisation" and a "huge thing to accept" (Voriadaki et al., 2015: p. 18) and brought up feelings of guilt and self-blame. This assumption of responsibility was received differently by different parents, some of whom found that it helped them reclaim their role as parents, while others (particularly those whose children continued to struggle with weight gain) experienced this as a repetition of their failure as parents. At the end of the therapy, the parents continued to experience feelings of anxiety, particularly as they felt that the distress underpinning their child's anorexia had not been addressed sufficiently in the sessions. Some parents appeared to experience significant anxiety about the future and their child's difficulties, while others

appeared to have come to a sense of acceptance about this process not being an "overnight fix" (Rhodes et al., 2009: p. 188).

The results highlighted that these renegotiations appeared linked with parents developing a better understanding of themselves, their children, and anorexia, enabling them to handle conflict with their child and within the family more effectively. Parents also spoke about how the process of therapy enabled them to build a sense of connectedness and recognition with families outside their own, as well as within their own families. On the whole, parents appeared to have varying views about whether the different aspects of family therapy were ultimately containing or depersonalising.

5.1 Research Findings in Context

The results can be situated in the context of the development of family therapy for anorexia. Bruch (1982) reflected on how, at the time, there appeared to be a dichotomy in the treatments offered for anorexia, with there being either a focus on "weight gain only with complete disregard for psychological problems" or "psychoanalysis extending over several years with disregard for low weight". Bruch emphasised the need for a more holistic approach that encompassed physical, psychological, and interpersonal considerations. The findings of the present synthesis indicate that parents experienced a coming together of the physical (weight restoration) and interpersonal (family interactions and dynamics) considerations in Maudsley Family Based Therapy (FBT), but appeared to find the psychological or emotional aspects to address distress lacking due to an over-emphasis on re-feeding. This highlights that the dichotomy in therapies identified by Bruch in 1982 continues to exist in therapies today.

Maudsley Family Based Therapy (FBT) was designed to focus on factors around the maintenance of the difficulties, specifically, how the family reorganised itself around the anorexia (Eisler, 2005). Le Grange and colleagues (2009) reflected that FBT centred itself around addressing the maintenance, as opposed to the aetiology of anorexia, in an effort to

reduce blame towards families. The findings of the synthesis, however, highlighted that high levels of guilt and self-blame continued to exist for parents who underwent FBT, despite explicit attempts by therapists to absolve them of guilt (Wufong et al., 2019). Some aspects of the therapy, such as highlighting the 95% effectiveness of Maudsley Family Based Therapy and re-feeding being spoken about as if it were a "simple" process (Wufong et al., 2019), served to allow parents' feelings of guilt to turn inwards, particularly when their child was unable to achieve or maintain the desired weight.

An alleviation in guilt and self-blame appeared to be more prominent in the studies where parents engaged with other parents or families living with anorexia (Baumas et al., 2021; Brinchmann & Kravac, 2021; Engman-Bredvik et al., 2015; Voriadaki et al., 2015). These approaches appeared to include a space for parents to "sit" with and name their feelings, and have these validated and understood by others undergoing similar experiences, leading to a sense of connectedness and recognition that may have alleviated some guilt and self-blame. This highlights a potential paradox: attempts to avoid considering or reducing blame and guilt appeared ineffective, whereas acknowledging and have these feelings acknowledged inadvertently appeared to make these more tolerable. This aligns with neuroimaging studies that show that affect labelling reduces distress (Lieberman et al., 2011) and research highlighting that attempts at suppressing thoughts and feelings may serve to increase distress (Wegner, 2011). This also aligns with research highlighting that experiences of similar emotions between two individuals fosters a sense of connectedness (Cheong et al., 2020) that may be linked with a reduction in self-blame.

In addition to feelings of guilt and self-blame, parents experienced continuous renegotiations of their identity and role before, during, and after therapy, which can be thought of as a time of multiple and repeated transitions. In systemic therapy, transitions can be thought of as "radical experiments with different ways of behaving and believing" that

further disrupt the balance in the family, particularly when there are differing attitudes towards change in the family (Burnham, 1986: p. 35). Parents appeared to continue to experience distress at their children's suffering and were concerned about their child's experience of therapy, while navigating the stress of repeated transitions of their own. This overwhelming experience raises the possibility of it becoming difficult for parents to contain their own anxieties, making it difficult for them to contain (Bion, 1962) their children and foster a trusting and secure relationship with them (Wallis et al., 2017), which ultimately maintains anorexia. Wallis and colleagues (2017) reflected that the process of family therapy and the structure of Family Based Therapy (FBT) allowed the parent/therapist to take the intolerable feelings and return them to the child/parent in a way that felt manageable. This sense of containment was positioned by Wallis and colleagues (2017) as what allowed for parents to be able to understand their children's experiences through a new lens, improved family communication, conflict being navigated with more confidence and care, and a sense of connectedness within the family. Notably, however, the synthesis highlighted that some parents experienced therapy as uncontaining when they experienced their child's voice not being held at the centre of the therapy. Others parents who had a more positive overall experience of therapy also appeared to experience uncontaining anxiety when therapy was brought to a close. This was illustrated in the results by them continuing to experience overwhelming anxiety and a "sense of struggle about where to turn to next" at the end of the therapy (Wufong et al., 2019: p. 9) as opposed to coming to a sense of acceptance that addressing anorexia would not be an "overnight fix" (Rhodes, et al., 2009: p. 188).

5.2 Clinical Implications

The clinical implications are centred around developing more integrative approaches to family therapy and ways of ensuring that manualised single-family therapy approaches for anorexia are made as containing an experience as possible for parents, and by extension, their

children. First, care must be taken in how the Maudsley approach is initially discussed with participants, as this affects how parents' expectations are built, as well as how endings are navigated. The Maudsley approach is often discussed as having a "95% track record" with participants, which can give them a high level of confidence in the approach initially (Wufong et al., 2019: p. 5). However, this and the responsibility assigned to parents for their child's eating, positions the child's unsuccessful weight gain as due to parent fault, thereby potentially increasing the self-blame and guilt parents are already overwhelmed by at the start of therapy. In addition, after the therapy, regardless of whether their child's weight is restored or not, parents are left feeling anxious and uncontained about their child's underlying distress not being addressed in the sessions. Much of the research on Maudsley's effectiveness is based on recovery and remission being defined as weight restoration, which is not aligned with how parents and children with anorexia cited psychological wellbeing the most frequently in conversations about recovery (Richmond et al., 2020). Furthermore, it may be helpful dedicating more time to setting up endings in therapy (Webb et al., 2018), to help parents contain their anxieties of their children's continuing difficulties. Normalising the idea of therapy being both helpful and disappointing may help contain parents' anxieties.

Second, it may be worth helping parents notice and name their child's and their own feelings and to sit with these feelings with compassion, alongside the behavioural elements of the Maudsley approach in order to provide more holistic therapy that addresses the distress experienced by the child and the family. Doing so may help parents feel more contained and may aid them in containing their child's distress, particularly as Williams and colleagues (2020) concluded that "unmanaged guilt tended to distract parents from the challenging tasks associated with recovering from AN." A concrete way this sense of containment can be built into family therapy was described in a paper by Robinson and colleagues (2015) wherein FBT was integrated with emotion-focused therapy, as summarised in the Figure 1.3.

Figure 1.3

Integration of emotion-focused therapy in Maudsley Family Based Therapy as proposed by Robinson and colleagues (2015)

	FBT	+EFT
Phase 1	Parents are experts on child and therapist is expert on eating disorders.	Parents are experts on child and therapist is expert on emotion.
	Parents are supported to refeed and interrupt symptoms as if tending to a younger child.	Parents are supported to become child's emotion coach and identify miscues.
	'Feed the baby'	'Rock the baby'
Phase 2	Parents gradually return control of eating over to their child.	Parents develop an increased ability to be their child's emotion coach, including 'speaking the unspoken.'
	Therapist explores child/adolescent issues and the development of ED.	Parents share the responsibility for past injuries/losses to free the child from her own crushing self-blame.
Phase 3	Therapist assists the family to return to normal life cycle.	Parents continue to respond to the child's emotions/soothe. The child's capacity for self-soothing continues to emerge.
	Therapist assists the family in supporting child's journey towards development of healthy identity.	Therapist supports the parents in processing their own emotional reactions to the child's individuation and identity development.

Third, having a safe environment where parents could share experiences and feelings with other parents appeared containing and it would be helpful for this to be integrated into FBT. Notably, parent-to-parent consultations with a parent who had already undergone FBT appeared to provide a sense of containment for parents in their anxieties about the future:

> *Because I was still at the point where you just can't comprehend what the future holds at times. I think it confirmed that this isn't an overnight fix and it was going to be extremely hard to fight. I guess I took some encouragement out of it for myself to say, well, if these guys can do it and they made some progress, then perhaps I can* (Rhodes et al., 2009: p. 188).

The aforementioned clinical implications can be set within the wider context of the National Health Service's (2019) Long Term Plan, which pledges to increase funding around child and young people's mental health, as well as to recognise the

burden carried by carers and to improve support around this. The findings of the present study highlight the weight of the responsibility thrust upon parents in navigating their child's anorexia, as well as adequate time not being given to consider and hold the psychological distress both they and their children carry. Ultimately, the idea of holding space for distress alongside weight restoration requires an acknowledgement that these processes take time and therefore, funding. As such, this will require a radical shift in the orientation of health services alongside substantial increases in funding, to allow for movement towards providing care that is holistic and addresses underlying distress in children and their carers, aimed at promoting wellbeing, as opposed to the absence of symptomatology.

5.3 Research Implications

It may be helpful for several research avenues to be explored further. First, Williams and colleagues (2020) concluded that "unmanaged guilt tended to distract parents from the tasks of recovery", but do not expound further on this. It may be helpful for further research to be conducted on how guilt impacts on parents' abilities to carry out their roles, in an effort to provide appropriate support for this, particularly as parents appeared to experience a high level of self-blame and guilt. Second, there is a lack of understanding of how parents and children alike experience responsibility for eating being handed back to the adolescent, and how this transition is navigated, and the support required during this stage. In line with this, it would be helpful for a better understanding of how this process is navigated in accordance with the young person's age. Third, studies evaluating outcomes after family therapy need to expand the outcomes being measured to include factors outside of weight restoration, particularly as recovery for parents and children alike is not conceptualised as weight restoration alone (Richmond et al., 2020).

5.4 Limitations

The studies included in the review appeared to be around different types of family therapy (primarily FBT and multifamily therapy), but most studies did not describe the therapies with sufficient depth to provide adequate context to how parents experienced family therapy, making it difficult to make definite conclusions about how different therapies with substantial overlaps in content are experienced. Some papers included in the review also interviewed parents alongside other family members. For the purpose of this review, data were only extracted where parents' experiences were clearly featured. In doing so, however, some quotes and experiences may have been stripped of a layer of context. The studies included in this review all also appeared to lack reflexivity sections and at least half of the studies did not include sufficient quotes. These limitations meant that it was difficult to understand how the authors' lenses allowed them to make sense of the data they collected, due to the lack of transparency in the process. These concerns were amplified by authors at times being in the same teams as the therapists conducting the therapy or authors also facilitating family therapy sessions, as well as authors not discussing how their therapeutic leanings may have influenced how they made sense of parents' experiences of the therapy they had undergone. In reading and reviewing these papers, the researcher noticed they appeared particularly drawn to two papers (Wufong et al., 2019; Conti et al., 2017) and appeared to lean more heavily on their findings. This may have been due to the process of how the authors made sense of the data being more transparent compared to the other studies, as the two papers heavily quoted participants to illustrate their points. However, the reliance on the two aforementioned papers in the present review may have also been due to the researcher's values as a therapist – I lean away from more structured and manualised approaches to therapy in favour of more person-centred and psychoanalytic approaches to therapy, and the aforementioned papers appeared to be the most critical of the manualised

nature of FBT, and therefore already aligned with my own opinions. I therefore made a concerted effort to clearly represent the voices of participants from papers that were less critical of FBT and instances where participants found containment in the structured nature of FBT.

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Chapter 2 Empirical Paper: Joint narratives of couples living with anorexia

2.1 Abstract

Background

Existing literature on women with anorexia points to romantic relationships with their partners as an important factor to examine, as relationships are thought to either contribute to the maintenance of the anorexia or to serve as one of the key factors that contributes to recovery. Control and power have emerged as key issues in the literature on anorexia and romantic relationships. The present study aims to understand how couples' sense-making of anorexia impacts on how they relate with each other and with the anorexia, and how this evolves over time. The study also aims to do this in the context of dominant discourses in society around eating disorders and relationships.

Method

Five couples where a female partner has been diagnosed with anorexia were jointly and individually interviewed using an unstructured, narrative interview. Data were analysed using Foucauldian-informed Narrative Analysis (FNA).

Results

Four narrative chapters arose from the data, namely, *Gradual development of understanding of anorexia in the context of societal discourses around thinness, gender, and mental and physical health*; *Anorexia as the interplay between power and powerlessness; Navigating shifts in power and helplessness within the relationship; Resolution and rebalancing of power*.

Conclusion

The results highlight several implications for research and practice centring around the importance of acknowledging the powerlessness that underlies the need for control in an effort to combat shaming dominant discourses around anorexia and control.

2.2 Introduction

The research literature on women with anorexia points to romantic relationships with their partners as being an important factor to examine. A review on eating disorders and romantic relationships concluded that concomitant difficulties in marital or intimate relationships are thought to maintain eating disorders, although the direction of causality is unclear (Arcelus et al., 2012). On the other hand, Tozzi and colleagues (2003) assessed 70 women's perceptions of factors that contributed to their recovery from anorexia 10 years after initially being treated, and having a supportive partner was the most commonly cited factor associated with recovery. Existing evidence, therefore, appears to suggest that eating disorder symptoms and relationships dynamics reciprocally influence one another, whereby individuals who felt more stable in their relationship reported both lower eating disorder symptomatology and a lower impact of the eating disorder on their relationship than those who felt less stable in the relationship (Linville et al., 2016).

2.1 Women with anorexia's experiences of being in a relationship

Women living with anorexia do not differ from those without a diagnosis of anorexia in desiring committed relationships, as well as engaging in these (Maxwell et al., 2011). Findings from a study where 11 women with anorexia were interviewed about their experiences of romantic relationships highlighted that their experiences were characterised by dialectical engagement and distancing, in a way that is aligned with generalized theories of relationships (Newton, et al., 2005). Participants in Newton and colleagues' (2005) study conceptualised engagement as a state of emotional and physical connection characterised by trust, which appeared to facilitate disclosure around the anorexia, providing an opportunity for the women to feel safe at seeing the relationship maintained following disclosure, as well as to receive emotional support from their partners, ultimately increasing trust in their partners and safety within the relationship. Distancing, on the other hand, was described as a state of

emotional and physical disconnection, and was characterised by self-preservation and protection, fears around rejection linked with reduced (ongoing) disclosure around the eating disorder, inward focus on eating disorder, reduced physical intimacy linked with low libido and body image concerns, and disparaging reactions from partners during vulnerable moments. All participants interviewed in the Newton and colleagues' (2005) study experienced oscillations between engagement and distancing to varying degrees, which reflects a common conflict in many romantic relationships – maintaining an individual identity and fostering an identity as a couple (Rusbult & Arriaga, 1997). Notably, however, distancing tended to be in the context of maintaining secrecy around their eating disorder, and the degree of flux between engagement and distancing appeared inversely linked with their wellness (Newton, et al., 2005).

2.2 Individuals' experiences of caring for a loved one with anorexia

Research on those supporting loved ones with anorexia have largely revolved around parents' experiences of caring for their adolescents' difficulties around anorexia (Zabala et al., 2009), which highlighted that parents experienced high levels of caregiver burden and distress. However, Graap and colleagues (2008) found substantial overlap in both parents' and partners' experiences of caring for a loved one with anorexia or bulimia, in that both experienced significant distress.

A meta-synthesis summarizing parents' and partners' experiences of caring for an individual with an eating disorder highlighted that carers' sense-making of the eating disorder affected how their interacted with their loved ones with EDs, which was then thought to mediate the impact of the eating disorder. Carers' understanding of eating disorders was found to be fluid, resulting in a process of changing approaches to supporting their loved one that was repeatedly re-evaluated over time (Fox et al., 2015).

Partners of individuals with eating disorders (henceforth referred to as "partner^{B}")[1] have been found to experience significant distress, often linked with a struggle to understand their partners with anorexia (henceforth referred to as "partner^{A}") declining to eat (Fischer et al., 2015), as well as navigating their own sense of identity, and physical, emotional, and mental health (Fox et al., 2015). Partners^{B} tended to experience feelings of anger, anxiety, sadness, and guilt (Bulik, et al., 2012), as well as a sense of powerlessness (Antoine et al., 2018), while attempting to understand their partners^{A}' experiences. Partners of women with bulimia, which was found to similarly be characterised by secrecy like anorexia, described finding it difficult to trust their partners^{A} and to understand the secrecy around their eating difficulties, which partners^{B} felt conflicted with their desire for openness and communication in a relationship (Huke & Slade, 2006). Partners^{B} spoke of feeling powerless in response to their partner^{A}'s secrecy and unwillingness to discuss their difficulties, which often left partners^{B} frustrated at their inability to influence their partner^{A}'s behaviour (Huke & Slade, 2006). This frustration manifested in either a power struggle (often represented via conflict) or detachment (often represented by an avoidance of conflict) (Antoine et al., 2018). This is thought to maintain the eating disorder, in line with Schimdt and Treasure's (2006) cognitive-interpersonal maintenance model for anorexia. As per the model, restrictive behaviour is used as a means to exert control, and those around the individual commence a "battle" over food during mealtimes, which is eventually lost by those around the individual with an eating disorder. This "victory" allows the individual with an eating disorder a sense of control and success, thereby reinforcing the individual with anorexia's behaviour. As the anorexia worsens, the carer often becomes hostile or over controlling, furthering the individual with

[1] Partners with an eating disorder will henceforth be referred to as partner^{A}, while partners who have not been diagnosed with an eating disorder will henceforth be referred to as partner^{B}. Mentions of the word "partner" without a superscript attached to it refers to a partner within the relationship more generally. This has been used to facilitate the flow of the paper and to enhance its readability.

anorexia's sense of isolation, resulting in them avoiding further interactions and becoming more entrenched in the anorexia (Schmidt & Treasure, 2006).

2.3 Dyadic research on couples living with anorexia

The dynamic nature of the aforementioned interactions around anorexia between partners were researched by Antoine and colleagues (2018) and Linville and colleagues (2016) using dyadic methodologies. Antoine and colleagues (2018) separately interviewed each partner in 5 couples living with anorexia to understand the couples' difficulties in the context of their relationship, as well as ways of coping with anorexia. The study highlighted individuals with anorexia continuing to maintain secrecy around the anorexia and most of their partners[B] being aware of this, partners[B]' experiences of powerlessness in navigating how to respond to their partners[A] in interactions around the anorexia, resulting in either a power struggle or partners[B] detaching themselves from responsibility for their partners[A]' eating, and partners[B] ultimately adopting a "paternalistic" role where they comfort and protect their partners[A] to prevent the relationship from ending, ultimately facilitating the individual with anorexia's control over the symptoms, thereby maintaining the anorexia.

Linville and colleagues' (2016) study, on the other hand, involved joint and individual semi-structured interviews with couples where one partner lives with an eating disorder in an effort to clarify the reciprocal relationship between couple dynamics and the eating disorder and recovery processes using grounded theory. Key themes highlighted included individuals with an eating disorder feeling like they had to choose between their relationship and the eating disorder, partners[B] feeling like they had to monitor their partners[A]' eating behaviour, validation and empathy from partners[B] being helpful, the relationship being affected by decreased intimacy and increased stress and conflict, navigating recovery ultimately strengthening the relationship, and coping strategies for recovery as a couple.

2.4 Aims of the present study

The present study aims to build on past research in several ways. First, power and control have emerged as key issues within the literature around couples living with anorexia. In order to further explore this, the present study adopts a Foucauldian approach to understand how mechanisms of power shape knowledge and interactions (Foucault, 1991). Second, only Linville and colleagues' (2016) paper has previously conducted joint interviews to understand couples' experiences of living with anorexia. The advantage gained by joint interviews is that it allows researchers to understand the shared narrative held by two individuals, and to obtain a sense of the (power) dynamics inherent to the relationship (Ummel & Achille, 2016), which may inform systemic interventions in the field. However, Linville and colleagues' (2016) study did not illustrate how couples made sense of the anorexia as individuals or as a unit, which is linked with how couples ultimately relate with each other (Fox et al., 2015), nor did the study capture the rich and dynamic nature of interactions between the couple to highlight how the interactions and relationship ultimately evolved over time.

Thus, the present study aims to understand how couples' sense-making of anorexia impacts on how they relate with each other and with the anorexia, and how this evolves over time. The present study also aims to do this in the context of dominant discourses in society around eating disorders and relationships.

2.3 Methodology

3.1 Ethics

This research study was reviewed and received full ethical approval from the NHS Health and Research Authority (HRA) (Appendix 2A) and the Research and Innovation departments of two NHS Trusts (Appendix 2B).

3.2 Epistemology

Foucault's (1991) ideas around mechanisms of power (including societal discourses) producing different types of knowledge and meaning-making, and constructing subjectivity and power relations are central to the study. Therefore, the epistemological stance taken in the study was critical constructivism, whereby the researchers critically considered sociocultural landscapes that influence individuals' sense-making and storying of themselves, others and the wider world, i.e. "knowledge is constructed in the mind of the knower, and those minds are constructed by the world around them" (Newton-Braithwaite & Parry, 2022). This epistemological stance was selected for the present study due to the wider discourses around eating disorders, control, and relationships that exist in society and how these contributed to how participants engaged in their relationships with anorexia and their partners.

3.3 Recruitment and Sample Description

Females who had been diagnosed with anorexia and had been in a romantic relationship with a partner for over 2 years were eligible to participate in the study. The full inclusion and exclusion criteria as well as the rationale for these are described below in Table 2.1.

Table 2.1

Inclusion and Exclusion Criteria

Inclusion/Exclusion Criteria	Rationale	Inclusion/exclusion criteria amendments during the study

Inclusion: Couple where a female partner has been given a diagnosis of anorexia nervosa	The partner with a diagnosis of anorexia must be female, as anorexia in men is thought to present differently than anorexia in women (Wooldridge & Lytle, 2012). A diagnosis of anorexia was required as opposed to individuals who restrict their food intake more generally, as the latter may include those diagnosed with Avoidant/Restrictive Food Intake Disorder (AFRID), which may present differently than anorexia and may not include a fear of weight gain (Cañas et al., 2020).	Not amended
Inclusion: Female partner must have received the diagnosis of anorexia prior to entering into the relationship	Antoine and colleagues (2018) conclude that there are likely to be substantial differences in relationships of couples where a partner was diagnosed with anorexia before entering into the relationship. There is likely to be a larger number of individuals who have been diagnosed prior to entering into a relationship, and as such, this was selected as the criteria to ensure a balance between facilitating recruitment and recruiting a reasonably homogenous sample.	Amended – participants who had been diagnosed with anorexia both before and after entering into a relationship were included in the study, due to difficulties in recruiting an adequate number of couples to the study.
Inclusion: Partners must be in a committed relationship with each other and must have cohabitated for the last two years at a minimum	Cohabitating couples would be more likely to have shared experiences linked with food, such as sharing groceries, cooking and eating meals together, and the like, that are often affected by anorexia. Furthermore, research highlights partners sometimes needing to assume caring responsibilities, including monitoring (Huke & Slade, 2006), which may be impacted by whether couples live together or not. The impact of the changes resulting from anorexia may, therefore, manifest differently in non-cohabitating couples.	Not amended

Inclusion: Both partners must be between the age of 25 and 65	The age range used as inclusion criteria was selected by considering Erikson's (1982) stages of psychosocial development, where adulthood is thought to span the ages of 25-65.	Not amended
Exclusion: Individuals who do not have a sufficient command of the English language to engage meaningfully with the interview	The research is qualitative, and experiences may be described in abstract terms. Individuals' lack of fluency in the English language may impact on the richness of the data gathered and the researchers' ability to meaningfully capture the participants' stories.	Not amended
Exclusion: Other partner is not aware of their female partner's diagnosis of anorexia nervosa	The research requires that both members of the couple make sense of their experience with their partner's anorexia together, which requires that both partners be aware of the diagnosis of anorexia.	Not amended

The researchers attempted to recruit from two Eating Disorder services from two NHS Trusts, but were unsuccessful. The sample was recruited by advertising the study on several virtual platforms, namely, Reddit anorexia forums (1 couple), Facebook anorexia groups (2 couples), and Wednesday's Child's (eating disorder charity) Instagram page (2 couples). Publicity materials used to advertise the study can be found in Appendix 2C.

Individuals who saw the publicity materials and were interested in participating in the study contacted the researcher directly via email. The researcher provided individuals who expressed interest in participating in the study with a participant information sheet (see in Appendix 2D) via email. Individuals who continued to express interest in participating in the study after reading the participant information sheet independently contacted the researcher via email. The researcher followed up on individuals who had been given the participant sheet

and had not contacted the researcher via email at least 5 days after the participant information sheet had been sent. Email communication clearly stated that if individuals were no longer interested in participating in the study, they did not need to respond to the email, and the absence of a response within a week would be understood by the research team as the individual declining to participate in the study. Participants who elected to proceed with the study were screened via a telephone call to ensure they met the inclusion and exclusion criteria detailed in the participant information sheet. If individuals did not meet the criteria for participating in the study, they were thanked for their time and interest and informed that they were not eligible to participate in the study, and their contact information would be deleted.

Individuals who met the criteria for participating in the study were asked to confirm they had discussed participating in the study with their partners, and had asked their partners to contact the researchers via email if they were interested in participating in the study. When the second partner contacted the research expressing interest in partaking in the study, they were furnished with copies of the participant information sheet. When partners independently contacted the researcher to state their continued interest in participating in the study, they were screened via a telephone call to ensure they met the criteria discussed in the participant information sheet.

Five couples were recruited to participate in the study. This was considered appropriate for the study, which required an in-depth analysis of each couple's context and multiple interviews with each couple and each member of the couple. All five women who had been diagnosed with anorexia had male partners. Couples had lived together for between 2-12 years. Participants were in varying stages of their journeys with anorexia, and had experienced varied interventions. Four couples resided in the United Kingdom, while one couple resided in Canada. Participants were assigned pseudonyms to ensure anonymity. Participant characteristics are detailed in Table 2.2.

Table 2.2

Participant Characteristics

Partner 1 (Gender, Age, Ethnicity) and Partner 2 (Gender, Age, Ethnicity)	Length of time living together	Anorexia diagnosed before or during relationship	Treatment received	Stage in ED journey at time of interview	Country
Elaine (F, late 20s, European Caucasian) and Russ (M, late 20s, British Caucasian)	2 years	During	None – intending to pursue psychological therapy	Attempting to increase weight	England
Sophia (F, early 30s, British Caucasian) and Benjamin (M, early 30s, British Caucasian)	10.5 years	During	Day treatment	In recovery	England
Carina (F, late 30s, British Caucasian) and Harry (M, late 30s, British Asian)	11 years	Recovered from anorexia as a young person; anorexia in adulthood during relationship	Inpatient admission, day treatment, psychological therapy	In recovery	England
Thea (F, late 30s, British Caucasian-Asian) and Adam (M, late 30s, British Caucasian)	12 years	Bulimia before relationship, transformed into anorexia during relationship	Inpatient admission, day treatment, psychological therapy	In recovery	England

Daniela (F, early 40s, Canadian Caucasian) and Liam (M, early 40s, Canadian Caucasian)	6 years	Childhood anorexia; anorexia in adulthood during relationship	Psychological therapy	Attempting to increase weight	Canada

3.4 Data Collection

Participants were asked to read out the consent form (see Appendix 2E) individually and were asked to state their consent to each point on the form. This process was audio recorded using an encrypted Dictaphone.

Data were collected in one unstructured joint interview with each couple, and a semi-structured individual interview with each participant, for a total of fifteen interviews between the five couples. All interviews were conducted using a video conferencing platform recommended by the University of Birmingham and were audio recorded using an encrypted Dictaphone.

The joint interview conducted with each couple was guided by the principles of narrative interviewing as outlined by Jovchelovitch and Bauer (2000). Narrative interviewing is a form of unstructured, in-depth interview that aims to encourage the interviewee to tell a story about events in their lives. It deviates from the "question-response mode" in most qualitative research, in an effort to obtain a more "valid" rendering of the informants' perspectives and what is important to them.

Table 2.3 summarises the phases of the narrative interview as considered by Jovchelovitch and Bauer (2000), which emphasises several key stages, namely, understanding the field, formulating a topic about which a story will be told, narrators sharing their stories uninterrupted, and those listening to the story asking questions.

Table 2.3

Narrative Interview Phases

Phases	Rules
Preparation	Exploring the field Formulation exmanent questions

1 Initiation	Formulating initial topic for narration Using visual aids
2 Main narration	No interruptions Only non-verbal encouragement to continue story-telling Wait for the coda
3 Questioning phase	Only 'What happened then?' No opinion and attitude questions No arguing on contradictions No why-questions Exmanent into immanent questions
4 Concluding talk	Stop recording Why-questions allowed Memory protocol immediately after interview

The researchers adapted the above process outlined by Jovchelovitch and Bauer (2000) in a manner summarised in Table 2.4, which formed the basis of the joint interviews held with participants. The joint interviews focused on how participants navigated their relationship with each other and with anorexia, and an unstructured narrative approach to interviewing was selected so as to allow the participants' joint sense-making and interactions to unfold in an organic way, unhampered by the formality and leading nature of a semi-structured interview. The aim of adopting the aforementioned approach was to provide a window into the couples' world of shared experience and meaning. The interview guide can be found in Appendix 2E.

Table 2.4

Adapted Narrative Interview Process

Phases	**Procedure**	**Rationale for deviation from Jovchelovitch and Bauer's (2000) approach**	**Amendments to procedure during study**

Preparation	Exploring the field by surveying relevant literature Formulating exmanent questions	N/A	None
Initiation	Formulating initial topic for narration Using visual aids (timeline)	N/A	Use of visual aids was discontinued during the first interview, as the interview was conducted virtually and the use of visual aids made it difficult for the researcher and participants to see each other, which appeared to hamper the storytelling process that is central to narrative interviewing.
Main narration	Non-verbal encouragement to continue story-telling Interruptions only if participants start to drift substantially from the topic of the interview or to ask "what happened then?"	The researchers incorporated elements from Jovchelovitch and Bauer's (2000) questioning phase into the main narration phase. This was done due to the study having been designed to allow for only one 2.5-hour joint interview given the constraints of a professional doctorate thesis, whereas a more traditional approach to narrative interviewing would have required multiple joint interviews over time that would have allowed for more drift.	None

Questioning phase	Why, opinion, and attitude questions linked with what was shared during the main narration Exploration of contradictions	The researchers incorporated aspects of Jovchelovitch and Bauer's (2000) "concluding talk" phase into the questioning phase.	None

During the joint interview, the researcher ensured only marginal intervention to allow the informants' stories to unfold in an organic manner. Due care was taken during the interview to ensure that the researcher played the role of an impartial, but engaged listener to the story being shared, occasionally intervening to move the story along or to manage substantial drifts from the main narrative.

Following the joint interview, participants were asked whether they preferred to continue on with the individual interview on the same day or to complete the individual interview on a different day. The individual interviews were semi-structured interviews aimed at allowing participants to share aspects of their experience that they were unable to share during the joint interview, as well as to allow them to reflect on the process of the joint interview. The individual interviews were amended after data had been gathered from the first two couples, due to the lack of richness in the data gathered. The amendment involved the interviewer explicitly asking individual participants to reflect on more sensitive and contentious moments that occurred during the joint interview.

Following the joint and individual interview, female partners were asked to complete the Eating Disorder Examination Questionnaire (EDE-Q 6.0) (Fairburn & Beglin, 2011) to provide further context to the narratives about the eating difficulties they had been struggling with. At this stage, participants were reminded that they could decline to answer this

questionnaire or to decline to answer questions from this questionnaire that they felt uncomfortable with. All five female participants completed the EDE-Q 6.0.

Participants were then asked to answer demographic questions. Data collection was completed. Participants were debriefed, asked about their emotional wellbeing upon completing the study, as well as directed towards support if required. Debrief sheets (see Appendix 2F) and 25 GBP vouchers were emailed to participants. Participants were reminded that they had a period of two weeks in which they could withdraw their data from the study, and that the data would be destroyed.

Interviews had been recorded on an encrypted Dictaphone, and were transcribed verbatim. Consent and interview transcripts were transferred to the secure University server by the researcher. Data were then deleted from all other locations to ensure compliance with data protection requirements.

3.5 Data Analysis

Parry et al., (2020) described Foucauldian-informed narrative analysis (FNA) as a form of critically informed narrative analysis sensitive to both personal sense-making, as well as wider sociocultural narratives that surround experiences. The underpinnings of the approach combine complementary aspects of Interpretative Phenomenological Analysis (Smith, Larkin, & Flowers, 2009), critical narrative analysis (Souto-Manning, 2012), narrative analysis (Gee et al., 1992), and Foucauldian discourse analysis (Willig, 2013). Parry et al., (2020) developed a six-step FNA framework presented in Figure 2.1.

Figure 2.1

Six-step Foucauldian-Informed Narrative Analysis

Foucauldian-Informed Narrative Analysis
1: Origins at the Individual Level This stage is about individual narratives around the research topic and how stories change over time, what they mean to participants, and their interpretation of their experiences in their stories.

2: Orientation in Relationships and Construction

This stage focuses on the effects of the narrative the individual holds in relation to their dynamic relationships with others.

3: Language and Power in Relationships

This stage is about analysing the language used around the subject topic by the storyteller – language that is theirs and language they have internalised from others, while also thinking about what this language could mean for the individual, for those around the individual, and on a wider societal level.

4: Individuality and Commonality

This stage looks at how people develop meaning within their personal milieu and how that meaning can transcend further than the individual, for example, across peer groups, across professions, and genders through the formation of a narrative summary.

5: Constructing a Resolution

This stage is about perception and how this leads to the construction of identity.

6: Phenomenological and Emancipatory Narratives

This stage reflects the connections between narrated lived experience, interpreted experience, commonality and difference synthesised into chapters.

The FNA approach was selected as the analytic framework of the present study as it allowed societal discourses around eating disorders, relationships, and control to contextualize the couples' experiences of navigating their relationships with each other and with anorexia. The FNA approach and how it was applied in the present study is summarised in Figure 2.2.

Figure 2.2

Foucauldian-Informed Narrative Analysis as Applied in the Current Study

1. Reading and re-reading: this involved familiarization with the data by reading each transcript in its entirety.

2. Line by line coding: this involved three levels of coding applied to the transcript (see Appendix 2G for samples), in accordance with the first three steps of Parry and Varese's (2020) six-step FNA framework:

    · Origins at the Individual Level: the researcher highlighted data where the narratives and participants' interpretations changed over time (narrative focus)

    · Orientation in Relationships and Construction: the researcher highlighted sections of the data that highlighted how the events discussed and/or narrative held impacted on relationships with others (phenomenological and narrative focus)

    · Language and Power in Relationships: the researcher coded the language used around anorexia, their relationship, and their partner, and considered what the language used might mean for the individual, the relationship, or wider society (discourse focus)

3. Narrative summaries: this involved developing a summary of each couple's story (see Appendix 2H), considering commonality and difference across the five couples' stories, and considering how identities were constructed given their experiences, in line with the fourth and fifth steps of Parry and Varese's (2020) six-step FNA framework.

4. Phenomenological and emancipatory narratives: this reflects the connections between narrated lived experience and how these were constructed by societal discourses, and are synthesised in the "Results" section as analytic chapters. This in line with the sixth and final step of Parry and Varese's (2020) FNA framework.

The analysis resulted in four chapters, presented in the *Results* section.

3.6 Rigour of Analysis

After the first two interviews, the researcher and supervisor (GR) reflected on the quality of the interviews conducted. This involved considering the appropriateness of the level and nature of intervention by the researcher during the main narration and the questions asked during the questioning phase. The researcher also discussed with supervisors concerns navigating seemingly opposing views held by couples during interviews.

To ensure that the analysis of the data and chapters developed were coherent and grounded in the data, a number of processes were employed. First, the chapters were

constructed and refined in consultation with both supervisors. Second, a qualitative researcher and trainee clinical psychologist was given the chapters and the narrative summaries of each couple, and asked to consider whether the chapters captured the narratives presented in the summaries. Feedback given was incorporated into refinement of the chapters. Third, ample quotes have been incorporated throughout the chapters to ensure transparency in the process of data analysis.

Supervision and feedback throughout the process of data collection and analysis assisted with reflexivity. The researcher has had personal relationships with individuals living with anorexia, and encountered both conflict and avoidance of conflict around anorexia. These experiences brought up feelings of anxiety when couples' stories brought opposing views or conflict to the forefront. The researcher noticed in herself a desire to intervene as a clinician during some joint interviews, as opposed to maintaining the role of researcher, due to concerns that bearing witness to what she initially perceived as harmful narratives between couples without intervening would serve to legitimise these. However, the researcher transcribed these joint interviews and reflected on her own feelings and why these had come up in a reflective diary prior to conducting individual interviews, which allowed her to engage in the individual interviews and formulate questions from a more curious standpoint. The researcher continued to update the reflective diary throughout the analytic process.

A lay summary of the findings was sent to the participants upon completion of the study.

2.4 Results

The *Results* section is structured into four chapters, in line with the final step of Parry and colleagues' (2020) six-step approach to Foucauldian-informed Narrative Analysis (FNA). The first two chapters illustrate the development of couples' understanding of anorexia in the context of wider societal discourses, while the latter two chapters highlight shifts in the

partners' relationships with each other and with anorexia in the context of power. The four chapters ultimately highlight the couples' journey in their relationship with each other and with anorexia in a linear manner.

Narrative Chapter 1: Gradual development of understanding of anorexia in the context of societal discourses around thinness, gender, and mental and physical health

All five couples situated the beginnings of anorexia within significant stressors faced by the female partner.

All female partners, including Carina and Daniela who had lived with anorexia as children, spoke of gradually coming to an understanding that experiences they viewed as "normal" had progressed into something concerning - anorexia. Daniela spoke about how it took her years to acknowledge that her not eating in response to stress was concerning, before coming to accept that the label of an "eating disorder" characterised her experience:

> *[…] I didn't recognise nor would I admit that I had an eating disorder, because to me, it was just I am not eating because I am stressed out. It wasn't until probably two years ago that I actually admitted that it is anorexia – as a teenager too, I never would've admitted that I had an eating disorder. People would say I did and I would just get really mad at them.*

Similarly, Carina spoke about how she had managed to "safely" lose weight following the birth of her children, but a few months after, noticed she had lost 20 kilos and at this point acknowledged "[…] actually, I think it's a bit of an issue".

All male partners except Benjamin came to understand that their partner was living with anorexia after their partner had become aware that they were living with anorexia and informed them of this. All five male partners stated that they initially understood eating disorders to be related to body image and thinness, as highlighted in the quote below:

> *Adam: I guess I had the standard view on eating disorders that they were just body image related and people want to be thin and like those kind of things and not really understanding the importance of it and how serious it was – people are dying from it.*

In referring to the "standard" view of eating disorders having to do with thinness, Adam illustrated how he had initially drawn upon wider discourses in society around eating disorders being centred around thinness to inform his understanding of anorexia, which he later viewed as both him and society trivialising the experience. Roehrig and McLean (2009) highlighted the different ways in which lay participants in their study held more stigmatising and trivialising attitudes towards individuals with eating disorders than depression, often viewing the eating disorder as being a means of garnering attention from others and something the individuals were responsible for. In line with this, Gowers and Shore (1999) contended that the public tended to perceive anorexia nervosa as partly motivated by narcissism linked with a desire to be thin due to this being socially desirable.

Notably, Russ, while drawn into wider discourses conceptualizing anorexia as being about thinness, resisted understanding his partner within these discourses from the beginning of their journey with anorexia:

> *Russ: I don't think it ever even after hearing…finding out you've got the diagnosis, it hadn't occurred, I didn't think Ohh, she wants to be thin, even though that was my understanding of anorexia was girls who want to be thin. It just didn't occur to me that that might be your mindset, because I know that that you're not (inaudible).*

During the interview, when considering how they were made aware of the anorexia, all the male partners reflected on moments they now recognised as the beginnings of anorexia, but at the time, had not attributed these to anorexia, in part due to wider discourses and understandings around anorexia, and thinness being socially desirable.

> *Carina: And so to start with, he was like, wow you're looking amazing. Like, how have you lost all the weight? And then I think he started to get a bit worried. He was like, are you taking diet pills? But unfortunately, because he was so naïve to it, it made it really easy for me to just not eat in front of him, didn't it? Harry: Yeah, I'm pretty clueless about stuff, so yeah.*

With the exception of Russ, all male participants' early trivialised understandings of anorexia appeared to influence how they initially viewed and responded to their partners'

difficulties. Couples spoke of how the male partner adopted a "practical" approach in wanting to "fix the problem", without then appreciating how difficult this was for their female partners. This was received as unhelpful and dismissive by female partners, leading to conversations being shut down:

> *Liam: I probably wasn't the most supportive in it because I didn't really know much about it, for me it was like "eat something". Daniela: I think one of the biggest problems and probably with most couples with this is that men tend to be very logical thinkers. And they tend to be the protectors and when they see their woman hurting, they want to fix it, fix it, get it over with and make it happy.*

> *Sophia: He's like, well, you just need to do XYZ or what? What do you want me to say about it? And then that leaves me feeling really either like, oh well, I should just get on with it or that kind of unimportant feeling […]. Benjamin: I'm certainly not unique, definitely around the male population. I think there are a lot of people that just don't understand mental health and don't get it. Yeah I made it very, very difficult. Yeah, which I understand why, Sophia, it took so long for Sophia to actually say something to me because, you know, you would have been afraid of just being dismissed.*

In the excerpts above, participants appeared to draw on societal discourses around gender roles and stigmatising views towards mental health that had been internalised in an effort to understand and reduce blame.

Chapter summary: This chapter highlighted how anorexia developed in the context of significant stress. Both partners in the relationship needed time to recognise the gravity of the situation, with society construing thinness as desirable and male partners internalising unhelpful discourses around anorexia, gender, and mental health, resulting in male partners responding to their female partners' refusal to eat in a way that was received as dismissive.

Narrative Chapter 2: Anorexia as the interplay between power and powerlessness

All couples with the exception of Russ and Elaine discussed conversations around anorexia after it was known to male partners as involving elements of secrecy, where the extent of female partners' difficulties was not fully known to the male partners.

Besides female partners fearing being dismissed by their male partners as described in the preceding chapter, female partners also found it difficult to be completely open with their

partners around the anorexia due to female partners not wanting to be stopped from restricting food intake by their male partners, as well as due to feelings of shame:

> *Carina: I think there's a lot of deceit - anorexia thrives on secrecy, but I think equally, some of the things I was doing, I was so ashamed of and I think partly I didn't want him to know because I didn't want him to be able to stop me from doing those things, and partly I didn't want him to know because I was ashamed of them. I think it's really hard because it was that it was the elephant in the room that ended up not being talked about, and yet it was the thing that was you know it was causing this massive wedge, but at the same time, I think if he'd tried to address it, I would've just met it with lies and deception.*

In the quote above, Carina acknowledged the secrecy around anorexia being a way to continue to hold on to a sense of perceived power where she could not be stopped by her partner, while also acknowledging the powerless position Harry held in attempting to battle anorexia while not knowing what it was due to the secrecy around it.

Harry attempted to make sense of his partner's secrecy by drawing on medical discourses, and in doing so, highlighted the stigma and shame surrounding mental health. The construction of stigma and shame as having the power to isolate also allowed him to shift blame away from his partner:

> *Harry: I mean just a random example - if you had like breast cancer, you'd say oh I've got a lump I'm going to the GP or and then the GP would refer you and then I'll maybe come with you to the appointment and you know and you'd be involved and you'd get advice and then you know what's going on, but with anorexia you can go for like a year of living with anorexia, but not knowing if they've got anorexia or not, really being sure, until they're really sick. So there is that like pressure on the relationship that you are hiding something and you're not telling me, and I'm supposed to know what it is. And and and that's different, isn't it?*
> *Carina: Like you said, if I'd had breast cancer, I would have shared each stage along the way. You'd know what we're doing with it - it would have felt like we were dealing with it together, whereas this was like this monster that you were dealing with that you didn't even know what it was.*

During interviews, all couples brought control and/or power into the conversation around anorexia. A desire for control was constructed as a response to powerlessness, which underlay anorexia:

> *Elaine: That was the thing I was surprised by, cause I didn't realise that anorexia could be anything other than to look skinny. I didn't realise… because it's a*

control thing, we think. Primarily a control thing. So all the stresses feed into it. It was always, when I have good days, so I'm already happy, I just automatically eat more and then sometimes the depression comes back and then I'll be, I don't know, thinking, yeah, at least I can control how much I eat and what I eat.

Daniela, however, appeared to struggle with anorexia being conceptualised as being about control:

Daniela: The main thing it is called an eating disorder, but it really has very little to do with food. Researcher: Could you tell me more about that, what would you say it is more to do with? Liam: Control. Daniela: No. Liam: No? Daniela: Lack of self-worth, no and that is another thing actually, the misconception that makes me really mad is that it is a sign of control. Liam: Because that is what it looks like. Daniela: It does. Liam: I understand where you are coming from and I know that is not it, but it is 99% of the time what it looks like. Daniela: […] Yeah for me with my parents a big part of it was, "you want to lecture me about this? Well fuck you, you can't force me", like that is what it was, but it wasn't the control that started it, it turned into a control issue because they made it turn into a control issue […] Liam: Yeah for her, it is a self-worth issue, but admittedly, if you look at it and everything we have said, it actually does look like a control thing, but she is right, it is self-worth, and I am not arguing that, but it does look like more of a control thing because if you think about it, every time something spirals out that she really doesn't have control over, whether it was like the separation or the court and the social workers and stuff like that, she has no control over those situations, and those are always the situations that spiral out.

In the quote above, Daniela highlights her frustrations with the dominant discourses around anorexia being about control, and that these discourses do not capture her experience of powerlessness that underpinned a need for control. Liam appeared to attempt to integrate his experience of anorexia being linked with control with Daniela's experiences of powerlessness, by making sense of the events as Daniela aiming to attain a sense of control in the face of powerlessness.

Daniela: Control and weight loss – everybody accused me of trying to be skinny to look like a model or caring about what I looked like or trying to get attention or yeah like trying to be in control – all of these stupid misconceptions that were put on me really just drove it home even more that 'Alright, I am a piece of crap […..]'

In the quote above, Daniela makes reference to stigmatising wider discourses in society around eating disorders and thinness. She further construes discourses around "control" as having negative connotations in its ability to reinforce the disparaging views she

holds of herself. Thea similarly struggled with being understood as holding the power within the relationship due to the sinister implications of this, as well as perceiving it as negating her powerlessness:

> *Thea: It was power and it is powerful, anorexia is powerful, but it just makes me uncomfortable. Adam: Because you feel like you were the bad guy and you were doing it to me. Thea: Yeah! I was having the worst time of my life. I wanted to kill myself. Like, that's not power. I was very vulnerable. Like the anorexia had the power. I wasn't in a position of power, because if I was, I would've done something about it.*

Thea's partner, Adam, however, struggled to discuss with her that he had experienced this differently – that he had experienced his partner and the anorexia being in a position of power within the relationship:

> *Adam (during the individual interview): I think Thea is more able to kind of separate herself and the anorexia as kind of two separate things, whereas I think I find that more difficult, so I would probably sort of group them together, so her with the anorexia was the powerful person in the relationship and I appreciated it – she wasn't possibly fully in control of that and it wasn't a conscious choice. And I know that Thea doesn't want to come across as kind of controlling or she was, you know, dominating the relationship, and it it wasn't like that.*

Surgenor and colleagues (2002) discuss Crisp's (1995) conceptualisation of anorexia as a lack of mastery over biological and psychological experiences being influential in the past 30 years, in the following quote:

> *In order to maintain this control over a changing internal self, it becomes both necessary and efficient to directly exert control over the environment, and this includes control over others by explicit relationship domination.* (Surgenor et al., 2002, p. 87)

In the quote above, individuals living with anorexia are construed as wanting a sense of control over their selves, but this being accompanied with a desire to control others in a sinister manner, as construed by the word "domination". Discourses around relationships in society at present emphasise equality in relationships, as evidenced by coercive or controlling behaviour in intimate relationships being made illegal in the UK since 2015 (Home Office, 2015). These dominant discourses around control construct a desire for any form of control as

sinister, as opposed to allowing for nuance within the discourse around control, where it is understandable up to a point for someone who has been rendered powerless to seek some degree of autonomy and power, as these are basic psychological needs (Ryan, Ryan, Di Domenico & Deci, 2019).

In the quotes above, Thea and some of the other female partners in the study externalised the power as being with anorexia, as a means of highlighting their powerlessness and reducing self-blame. Notably, in the study, some male partners struggled with externalising – "I was doing it for her. I wasn't doing it for the anorexia or anything like that."

The dynamic of the flux of power and powerlessness in the relationship led to male and female partners being positioned against each other in the relationship. Participants reflected how it often felt that female partners were choosing between their male partner or anorexia, which furthered a sense of isolation within the relationship:

> *Thea: I was protecting the anorexia. I didn't feel like I could say I'm really struggling today, cause he'd ask like what I've eaten, and then I hadn't eaten enough, and then I feel shit about not eating enough and letting him down and then he'd make me eat more. I literally explained it to him that I was either gonna have an argument with him or I'm going to have an argument with IT in my head. And then I just chose. It was easier to have an argument with him every night….But obviously it's not a choice. We know that now.*

Carina reflected on how her partner perceiving it as a choice she had to make between her family and anorexia had the potential to create feelings of blame – "I was getting better and I think it felt to you like I was choosing to be sick again and that I didn't want to be well and that I didn't I didn't value our family enough to prioritise being well."

One couple, however, appeared to position themselves on the same side against anorexia and by communicating openly about anorexia from early on in their journey:

> *Elaine: I've sometimes had sneaky thoughts, like I've worked very early in the morning, 7:00 in the morning. Sometimes you think, oh yeah, they wouldn't notice if I didn't eat anything now. But I just don't. Like it wouldn't occur to me because I know Why would I lie to my partner that wants me to be better, like that would be horrible. I couldn't do that. I just. I wouldn't do that to him.*

Chapter summary: Some female participants at times struggled to acknowledge the relative power they held in the relationship due to wider disparaging societal discourses around control, as well as perceiving holding power as invalidating their experiences of powerlessness. It located the source of the problem within themselves and implied that they had the power to change at the time, which contradicted their experience at the time of feeling powerless to change. Externalisation was used by some participants as a means of highlighting their powerlessness and reducing self-blame while trying not to invalidate their partners' experiences of powerlessness. The flux between power and powerlessness (as seen in conversations about secrecy and control) linked with the anorexia in the relationship led most couples to position themselves against each other, and female participants as choosing anorexia over their partners.

Narrative Chapter 3: Navigating shifts in power and helplessness within the relationship: Shifting roles, communication, and conflict

Carina and Harry reflected on how shifts in "control" occurred during their journey with anorexia. They reflected that Carina experienced a greater desire to hold on to "control" alongside the development and progression of anorexia, which peaked and nosedived when she was admitted into an inpatient unit, at which point, Harry had to assume "control":

> *Carina: I think I kind of held control of most things at home anyway. And then when the anorexia came, that kind of got more and more. And then when I was admitted, that's when Harry took over. Harry: So as she was approaching the anorexia, she became more controlling of everything. And everything to be more perfect. And and then until everything reached the peak and then took a nosedive and then I had to sort of like take over.*

All five male partners highlighted varying degrees of additional responsibilities that they had to take on when their partners had become unwell, contributing to shifts of power within the relationship. Russ, for example, spoke of needing to "restrict" his partner to one walk per day and having to monitor his partner's food intake, which he described as "not micromanaging, but making sure you don't slip up, which I don't think I've had to do very

often. I think you're just as concerned about getting better as I am". He further spoke of wanting to do more to "not force you to eat more, but do more to encourage it". His discomfort at using words such as "micromanaging" and "force" to describe his experiences, as well as highlighting him rarely having to assume this responsibility, illustrate his attempts to attenuate the inherent power imbalance involved with this assumption of responsibility, in an effort to create a sense of shared ownership over recovery with his partner. Harry highlighted his similar discomfort with his assumption of responsibility and desire for a shared ownership in his partner's recovery in the quotes below:

> *Harry: I wanted you to feel… I didn't really want to be like. Carina: You didn't want to be my parent. Harry: Your parent. It's like being a teacher, isn't it? And monitoring you all the time. You know, I've really felt that. You know, I can only do so much, but really the change has to come from you. I didn't wanna be the headmaster making sure you were doing your homework all the time, you know? And making sure you're eating.*

> *Harry: I feel like we're like a team, we're like equals, right? So I don't like… you're not a like a child. Like obviously, if I have a child, you always like kind of check on them, making sure they're okay, making sure they're well, making sure they're fed, check, you know, make sure they're growing or stuff like that. But when you're married, you don't have to do that with your partner normally, so you don't have to think about necessarily, you know, their health in the same way you would do like a child or something.*

Harry's metaphors of being a headmaster and his partner being a child illustrated the extent that anorexia impacted on the power dynamic of their relationship in a way that was not aligned with his understanding of relationships between partners and their roles, which he felt required a more balanced distribution of power.

Harry and Benjamin and their partners all expressed discomfort at the prospect of Harry and Benjamin adopting the role of becoming their partners' carers.

> *Benjamin: Neither of us wanted me to be your parent. Yeah. Sophia: Oh God, no or carer. Benjamin: No. But that. No, that Sophia: That's not our dynamic. Benjamin: That's not our dynamic. That would have been weird. We wouldn't have liked that. Sophia: No. Benjamin: If that was what was needed, then that would have been fine. But I think that would have fundamentally changed the relationship.*

Benjamin, while having to take on some additional responsibilities, felt once his partner had commenced day treatment, he "always felt she'll be fine", which he attributed to his partner liking rules, saying "If someone sets a rule for her, she won't break that rule anyway. So I always had a lot of faith that like if they told her not to walk, she wouldn't walk the dogs." This prevented Benjamin's role as a partner from blurring into carer.

Harry, on the other hand, found himself needing to adopt some responsibilities that he felt caused a blurring between his roles as a husband to his wife and a doctor to his patients, despite his best efforts to keep these as "separate as possible":

> *Harry: I remember this there was a period of time when she needed to have like bloods every week and she didn't like going to the practice in her surgery to take a arterial sample, so she would ask me to do it. So I used to do it first thing in the morning before work and I didn't really feel comfortable with this because I'm I'm a doctor, so I see patients and I don't wanna see I don't wanna see Carina as a patient. You know, I don't wanna treat her as a patient. She's my wife and so I tried to keep it as separate as possible.*

In a similar vein, Adam noticed he had fallen into what he retrospectively recognised as "carer mode", which he felt overshadowed his identity as an individual and identity in the relationship as Thea's husband:

> *Adam: It was like it was my responsibility as a husband to to look after my wife and make sure she's okay and make her happy. Because of the eating disorder the focus of it all was around food and Thea's physical health. That's what I was worried about and I would put myself out and I guess not pay attention to any of my needs or my mental health. It was just everything around Thea, so monitor eating, check on partner.*

The shift in roles and responsibilities for the male partner were accompanied by an increase in conflict and difficulties navigating this for four of five couples. Male partners often experienced fear and frustration at their female partners' refusal to eat, which sometimes translated into how they communicated with their partners:

> *Adam: I think I was probably just probably a bit more forceful with things and trying to be rational with it. I guess probably even also probably quite angry. I think I probably argued more with Thea and got cross cause… Thea: because you're frustrated. Adam: Also I knew how serious it could be as well. I think it probably made me… Thea: Freak out a bit. Adam: Yeah, I think so.*

Adam and Harry spoke of attempting to find alternative means of communicating with their partners that they needed to eat, in an effort to navigate the conflict caused by these conversations. Adam attended a Maudsley Family Therapy group attended by parents for their child's anorexia to help him navigate conversations around encouraging his partner to eat, which he stated helped him navigate some conversations around food, but also triggered anxiety around the security of their relationship:

> *Adam: They did courses for carers which I found really useful. So they were aimed more at parents than partners but there were transferable skills there and I found that really helpful. Again, just how to talk to Thea and encourage her to eat without causing the fights or well, trying to anyway.*

> *Adam: I think they were talking about the relationship dynamics as well, which I think I found tough because kind of the parent child dynamic is based around… Thea: not equal. Adam: Yeah and it's based around the premise that kind of the love is unconditional, like that the child can be rude or whatever, and you know still the parents are going to love them, whereas as a partner, it's more conditional, it's you know, it's a choice in a relationship. It was that danger that if I did something that upset Thea, then she could just go well, that's it, it's over, and there's kind of nothing you can do about it. So I think that made me much more cautious about kind of what I said, whereas most of the work that we did in the workshop was like, you can do these, try these things out. Give them a go. If they don't work, it won't be the end of the world – that's still your child. You're still gonna have that relationship. Whereas, yeah, I think I felt more… Thea: a lot of pressure. Adam: Pressure that I probably didn't have as many chances, and if I did mess it up, then that could be it.*

Harry similarly sought support to navigate communication and reduce conflict with his wife, stemming from a sense of guilt and feeling inadequate in his role as a husband. However, he eventually came to the conclusion that the conflict was unavoidable:

> *Harry: You are a really bad husband because you feel like all that's going on is your fault, and so you take the blame on yourself. I would ask the carer support lady you know what to say, like to the point where I would would write, she would give me a sentence to say, and I would write it down and I would repeat that sentence at that time. But then I think I figured out that it didn't really matter what I said because it wouldn't, it wasn't going to be received in the helpful way it should've been. So yeah, I think it took me a while, cause I thought maybe it was the way I was saying it, the word I was using was triggering you… Carina: whatever you said wouldn't have helped. Harry: It would've triggered your dragon Carina to come out.*

Male partners' attempts at monitoring their female partners' restrictive behaviours and encouraging their partners to eat were often not received well by their partners. Female partners often experienced this shift in the power dynamic within the relationship as frustrating and an impingement on their independence by their partners:

> *Carina: You don't want to be… An eating disorder sort of person never wants to be told that they should have more, but also, for your husband to tell you to have more, it's so patronising. And so I was like, don't patronise me. I can work out if I like. I'm an independent adult, I don't want to be told what to do. It's one thing coming from a nurse on the ward and it's quite another thing coming from your husband, where you're like, hmm, piss off.*

Sophia spoke of experiencing resentment at seeing her partner do things that she was not "allowed" to do, such as exercising and walking the dog, while simultaneously feeling "guilty" for the responsibility her partner had to take on:

> *Benjamin: I think Sophia sets rules for herself almost like the dogs need two walks a day. Sophia: Two exciting walks (laughs). Benjamin: I've decided that the dog needs two walks a day. Now we both know that the dog does not need two walks a day. But the problem is Sophia's rules for herself will then be projected onto me. Sophia: Yeah. Benjamin: So it was like, you haven't walked the dogs twice today. And I could sense that it was because Sophia wanted to do it.*
> *Sophia: It didn't cause like a rift or anything, but it was definitely upsetting for me. Benjamin: I could definitely sense the resentment. Sophia: Yeah, because you were allowed to do the things that I wasn't allowed to do.*

Sophia reflected that they "never really argued" over this friction, "it was just this like bubbling". Benjamin reflected that he understood where his partner had been coming from at the time, and "bit my tongue" due to this. He stated that he made a conscious effort of showing his partner that he was not resentful, while Sophia reflected that at the time, this furthered her feelings of resentment.

> *Benjamin: There was never any resentment coming from me. But I did try to make a point of showing no resentment and whether I was successful in that or not, I don't know. Sophia: Yeah, you were, but I was more resentful for it.*

In a similar vein to Benjamin, some male partners spoke of avoiding conflict where possible by taking the "path of least resistance" and apologising instead of agitating their

partners. They also spoke of attempts to find discreet ways of encouraging their partners to communicate:

> *Liam: I tried the whole pushy thing, and it doesn't work, it makes things worse, so I have got to let her come out by just being supportive and by being there. Okay, well now there is definitely something wrong - she is just not telling me, which is where I would eventually have to start just being the shoulder to lean on or the ear to listen and not come straight out and say, you know like a psychologist does with a kid, they would sit and play and they would just sit there and talk with them and eventually they can kind of steer a conversation to the way they want it, but very discreetly without the person knowing.*

At other times, some partners spoke of a willingness to be seen as the "bad guy" and to do "what needed to be done" - Russ: "As long as you eat something, as long as you're doing better eating-wise, you can think I'm an asshole – that's fine. (Elaine laughs) As long as you eat it."

Male partners, however, recognised that the added responsibility they had to take on and the shift in power within the relationship was accompanied by a sense of powerlessness within:

> *Adam: I was trying to look after Thea and be careful, but I wasn't in control of anything. I couldn't, like if Thea didn't want to do it, then I couldn't make her do anything. I couldn't force her to do anything. And I found that really difficult, because I obviously wanted to help as much as I could, but I also felt completely helpless.*

> *Russ: But I feel a bit powerless. I think, I suppose, because you'll have a bit of a breakdown. You'll be upset about something. And all I can do is say the same, it's not a speech that I have about it, like the same points I'll make over about how we need to put weight on for all the reasons.*

As such, some male partners' experiences appeared to partially mirror their female partners' experiences of outwardly attempting to hold on to a degree of control in the face of powerlessness.

Shifts in power within the relationship and discomfort with this appeared most prominent in Harry and Carina and Thea and Adam's stories, reaching a peak around the time Carina and Thea commenced inpatient treatment. Adam and Thea reflected on the discomfort

and power imbalance in the relationship in the lead up to Thea's inpatient admission and the wedge this drove in their relationship:

> *Adam: I think that was really difficult – knowing that Thea didn't want to be there and was hating it and was adamant and I felt like I was forcing her to be there, knowing that it was the right place for her to be. Thea: Yeah, I just felt Adam was just going along with what the doctors were saying. And I felt quite betrayed and I felt it was meant to be me and him against the world, and now he's turned against me and I'm all on my own.*

Carina similarly reflected on times when she was "really unwell", perceived Harry as being controlling but retrospectively recognised that he was acting in her best interest, while Harry reflected on the discomfort he felt at Carina perceiving him as controlling:

> *Carina: And I think that was the thing when I was admitted, Harry took my car keys away and wouldn't let me drive because my BMI was under 15 and the like DVLA says that you shouldn't. It took him quite a long time, my BMI always well over 15 before he gave me my car keys back. And at that time, that felt controlling like he was trying to take my freedom away. He was trying to control what I could do and couldn't do with the kids. Like he obviously at that point had complete control over when I did and didn't see the kids because I was in hospital and and he could choose what access I had. But I think that was more. I don't think he was controlling me. I think he was watching out for the kids and making sure that they were cared for and that actually, he was doing what he had to do retrospectively, but at the time it felt like control. Harry: Yeah, I mean that was basically just looking out for you really because I didn't think you were in the right position, although you couldn't see it at the time.*

> *Harry (during the individual interview): I was becoming the embodiment of everything that she has, all the issues going on in her mind, because I think part of the anorexia is the control and that's because of the previous trauma you've had in the past is someone controlling you. And so when she said those things, I felt like I'd become the embodiment of that person who had done that to her in the past, and that was really hard.*

Chapter summary: This chapter highlights how the male partners experienced discomfort at having to assume varying levels of responsibility for their female partners. Female partners often experienced resentment and betrayal at their partners' assumption of control. Male partners' experience of assuming control often occurred alongside and in response to helplessness, which appeared to mirror their female partners' experiences of anorexia described in the preceding chapter. In assuming control, some male partners experienced

shifts in their roles from husbands to carers, as well as difficulty navigating communication and conflict with their partners.

Narrative Chapter 4: Resolution and rebalancing of power

This chapter primarily features the stories of couples where the female partner was in recovery at the time of the interview, namely, Sophia and Benjamin, Carina and Harry, and Thea and Adam.

Navigating recovery

Theme summary: Navigating recovery involved shifts in the distribution of power within the relationship towards more equality. Benjamin and Sophia's recovery process was characterised by Sophia feeling anxious about being monitored and "called out", but feeling reassured by Benjamin not being risk averse and encouraging her to be spontaneous, which helped her feel more confident. Carina and Thea, on the other hand, appeared to have more tumultuous experiences of navigating recovery, leading to their partners experiencing increased anxiety and keeping their feelings to themselves. Harry continued to downplay his feelings, leading to more defensive interactions with his partner, while Adam became more open with his partner, re-opening lines of communication within the relationship.

Couples reflected on shifts in the relationship once the female partner either transitioned from inpatient to outpatient/day treatment or transitioned out of day treatment. Benjamin and Sophia shared that after Sophia left day treatment, she had a conversation with Benjamin re-establishing boundaries in the relationship:

> *Benjamin: It was kind of you setting your boundaries and going, I need you to call me out if something happens and I trust that you will call me out if something happens. But you were saying kind of, I've got… I have this under control, but if you think (sic), call me out, and there have been occasional times where I have kind of said stuff to you and I made you think about stuff occasionally, it turns out that probably wasn't an issue. But I think just occasionally calling things out as, it's almost like uhm electroshock therapy, it just uh just shakes you a little bit and makes you think about it again and think about what you're doing. But I haven't done it very often and I haven't felt like I've needed to.*

Sophia reflected on how she experienced Benjamin's "calling out" as being both helpful and unhelpful at different times. It either helped her reflect on her actions and whether it was an "ED thing" or when it was unrelated to anorexia, she would start to wonder "how much do I have to prove myself?" or "he's watching everything I do and picking up on it". Sophia reflected that either way, she would become defensive when "called out". Sophia appeared to be experiencing anxiety about regaining her partner's trust and her independence within the relationship, as demonstrated by the quotes above. Benjamin appeared to be able to contain his anxiety over Sophia's recovery, instead choosing to take on the role of encouraging her to push herself outside of her comfort zone:

> *Benjamin: I know that Sophia is gonna be very, very strict on rules, and very, very strict on herself. My role as such was to be the devil and go, ahhh why don't you just try something different or have something different […], bring a bit more spontaneity back into what you were doing.*

Sophia reflected this as being helpful, as it built up her confidence in herself:

> *Sophia: I think if you'd been all very risk averse and feary and like ohh don't do that, do you think it's too soon? I don't think that would've built my confidence. Because you were just like, well, why don't you just try it and see how you get on, it did give me the confidence to do it.*

Carina and Harry and Thea and Adam, on the other hand, experienced a more tumultuous recovery process, with Carina needing to revisit day treatment after being discharged from it the first time and Thea speaking about how she did not attend day treatment as regularly as she had communicated to her partner, which she made sense of as her "ED abusing the increase in responsibility and trust" that accompanied her care being stepped down. Both Harry and Adam experienced significant anxiety at their partners being stepped down in care and struggled to contain this:

> *Carina: His sort of expectation was that I'd come home and I was better and I wasn't. I was a lot better than I had been, but I obviously wasn't good, and I think that was hard for you? Harry: Well, I didn't think you'd be better, but I just thought I didn't, it's hard to know how much it improved, isn't it?*

Adam: Obviously when she was an outpatient and things, she had a meal plan, so I had to make sure she ate all those. And then when the meal plans stopped, I still felt like […] I still need to make sure she's eating enough, so that's my role. And the same with like, exercising like when she was part of the services, they were like quite structured on what she should and shouldn't do, how much she should do a week and again, even though that finished, I still felt that was my role to then kind of monitor that and check that side. I was always checking in on Thea and even if it wasn't asking Thea, because I was well aware that would be a trigger for her and put strain on the relationship – it was just then trying to observe it. Can I see other signs that I can notice that you know, she's doing this or she's doing that. And then if she skips one meal, you know, those kind of things would panic me and I would be all, it's happening again, you know, she's just gonna end up back in the services, back in the hospital, you know?

Thea and Adam further reflected that Adam had been "stuck in caregiver mode rather than husband mode", where Thea reflected that Adam had become "really good at hiding his emotions". While she was "starting to enjoy life for the first time as an adult", in hindsight, she reflected that "Adam just sort of got left behind and was still in panic mode every single day".

They reflected on the impact of the anxiety on their relationship together:

Adam: I was scared of the relapse, but then obviously that meant not trusting in Thea to be recovered or in recovery and be safe, and then she couldn't trust me because I wasn't being honest with her. Thea: I felt really hard done by. I was like, well you, they're telling me to tell you everything. Well, you're not telling me anything!

Thea spoke of navigating the anxiety by extending an "olive branch" by trusting Adam with thoughts like she still had the urge to purge, which re-opened the lines of communication within the relationship.

Harry, on the other hand, spoke of continuing to protect his partner's feelings by downplaying his experiences during the joint interview and speaking more openly about these during the individual interview:

Harry (during the individual interview): I mean, I think you've caught us at a time where I think Carina's in a good place. So I think it makes less of a difference, but if you were to interview us as a couple when Carina was maybe in a worse place, then I'd probably having to be very. [...] So you end up having to you know, protect her in a way, without… cuz you don't want to upset her if she's going through treatment and things like that, I guess. Interviewer: What sorts of things

might you have held back on talking about if she had been an inpatient? Harry: Probably the effects it was having on our family, and the effects it was having on our relationship and those sorts of things. Interviewer: Did you feel during the joint interview we did have that you were able to speak very openly about the kind of impact it did have on your relationship and the family, or did you feel like there was a part of you that still tried to protect her? Harry: Definitely protected her from the guilt.

When asked to expand more on what Harry held back on speaking about during the joint interview, he described experiences shrouded in guilt, shame, and pain he felt at the time, with regards to Carina becoming poorly:

Harry: I think from my point of view it's like you feel like the reason why she's like that is because I'm not a good enough husband or I'm not doing my job properly or why does she hate me so much all the time, so that does really have an impact on your relationship, uhm you know because you're, in your mind, thinking why is she ill why is she upset, why is she like this, and you think it's because I suppose as a husband you feel like you're not providing enough or you're not doing something properly or or whatever, so you sort of internalise that.

Harry: I was becoming the embodiment of everything that she has, all the issues going on in her mind, because I think part of the anorexia is the control and that's because of the previous trauma you've had in the past is someone controlling you. And so when she said those things, I felt like I'd become the embodiment of that person who had done that to her in the past, and that was really hard.

During the joint interview, however, he at times appeared to become defensive when he experienced his partner as suggesting the improvement in their relationship was linked with changes they had both made in light of marital issues. It appeared he received this as implying he and the marital issues they had experienced had contributed in some way to his wife's deterioration, which may have triggered the overwhelming feelings of guilt and shame around the development of his wife's eating disorder:

Carina: [...] we got really encouraged to do couples therapy again, which had been mentioned quite a few times by both Harry's individual therapist and by mine, and because of our previous experience, we'd sort of not been keen and so we entered it very… I think Harry was probably even less keen than I was, but I think it's made a big difference. Harry: I dunno, I don't think so particularly. Carina: See, I think it has. Harry: I think you've been better, that makes the most difference.

Becoming a team again

Theme summary: Becoming a team again was ultimately made possible due to female partners reappraising past conflict around the eating disorder, male partners becoming more attuned to female partners' needs, both positioning themselves as a team against harmful narratives around them in society, and developing trust in their partner. Ultimately, all couples described feeling their relationship had been strengthened following their struggles with anorexia.

Female partners looked back on their experiences when they were unwell and reflected on the times their partners undertook actions that they then viewed as "controlling" or a "betrayal" with a different lens and viewed these actions as "what needed to be done". When asked what helped them shift their views, Thea and Carina both spoke about being able to see things differently now that they weren't as "entrenched in it":

> *Carina: I think also the sicker I got, I couldn't see it. I was so entrenched in it, that I couldn't see how and when I was. And it didn't just affect food and what I was eating, but I needed to control everything.*
>
> *Thea: Oh just being in it. So I felt that betrayal because I was so in it, and I was all about my eating disorder as my priority in life. I felt to survive in this world, I had to look after this eating disorder and I had to do everything it said and so I was really entrenched in it and I couldn't see anything else, whereas now I'm not in it as much and I can see 100% like if it happened again, I'd be like, yeah, do what the doctor says, like it's not even a question.*

All five male partners became more attuned to their partners' needs in the process as a whole:

> *Benjamin: Looking back on it, I suppose I tried to give that kind of reassurance, but realised very quickly that wasn't what was needed and stopped doing that. (Sophia and Benjamin laugh)*
>
> *Carina: I mean the obvious one for me, where I really noticed it is my mood's been quite low since kind of Christmas time and I texted him and said I'm really struggling to concentrate at work. I've got no motivation and he texts back and said come home, ditch, work, it doesn't matter and I did. And then he was like, what's up? Why can't you just be happy with what we've got? You know, you just need to smile more and stop being so grumpy. And then for like 2 weeks, he didn't talk to me and which, at the time, when my mood was low, kind of had the effect of me feeling like I wasn't good enough for him and he didn't love me and all of that kind of crap. Whereas when my mood then dipped again near Easter time and I said, in fact I didn't even tell him my mood had dipped, he just noticed. And rather than shutting me off, he would do little things like saying, ohh, why don't we just*

sit and do Jigsaw for half an hour? Or do you want to watch half a movie me with me because I know that a whole movie will be too much for you to cope with. Like if I'd say to him I I just need an hour out […], he was much better at being, like, actually, Mum's having her time now and I go off and have a coffee for an hour and I'll look after the kids and kind of helping to make sure that I got that time rather than, rather than expecting me to carve it out, which I would find really hard when my mood was really low. Like they might not sound like massive things, but they made a big difference. Rather than feeling like it was my fault and that I wasn't good enough.

All five couples spoke about eventually feeling more like a team. They all positioned themselves as either a team against anorexia or a team against harmful narratives in society.

Sophia: Like when we have friends or family, say stuff that's just so inappropriate and really weird when you think about it. We do just, yeah, look at each other and go. Mmmhm, that's weird. And just carry on. Benjamin: It's almost when something comes up that is triggering or is potentially damaging, just that little acknowledgement that somebody else is hearing it too, I think that helps just a little kind of almost a nod to, yeah I know what's going on in your head.

Sophia: It was that kind of that sort of unspoken thing between us, say we had a friend, if he suddenly said to me like ohh, you've eaten loads well done or oh gosh, look what's in this (social media) feed. And we have that look at each other, that felt quite protective because I knew he knew what I was thinking and I knew what he was thinking and it felt like somebody was, even though you weren't doing anything, it was like you have my back, I guess.

Carina: Rather than feeling like it was my fault that I wasn't good enough, it felt like he was supporting me and we were a team.

Partners reflected that they had become better at trusting each other, communicating their needs, listening to their partner without needing to "fix", becoming better at asking for help, and being more able to "lean" on their partner:

Carina: We've always, this sounds ridiculous having just told you how deceptive I was when I was ill but, we've always trusted each other in our relationship like I've never, I've never not trusted Harry. But I feel like how I trust him now is different like I share more with him, I'm not frightened to be dependent on him in the way that I was, and so that makes me feel closer to him. I feel like there's more stuff we can talk about that we can have an argument and we can repair from it, whereas in the past we would have an argument and then that would become another of the increasing growing list of topics we could no longer talk about without it turning into an argument. Harry: Mmhm. Carina: And I would never, ever wish an eating disorder on anyone or any family, but I do feel like the healing process has actually really grown our relationship and brought us closer together.

Carina additionally reflected on how the process and Harry's support throughout ultimately helped her feel more secure within their relationship:

> *Carina: While I had the anorexia, he really proved that in sickness and health bit [that] he promised when he made his wedding vows because he would never have expected having to support me through that, but I think… Actually, that was quite healing for me that I could see, yes, he loved me when I was the all singing, all dancing Carina, but he's still loved me when I was the totally broken, emaciated, nonfunctional Carina too, and that he would support me through both. I didn't want to be that nonfunctioning version of myself. I wanted to be the best version of myself that I could be, probably first of all for the kids, but then later for Harry and I think now just as much for Harry as the kids.*

Lifelong struggle

Partners were able to reflect on how they now understood that this would be a lifelong thing they would need to navigate.

> *Harry: I think that maybe anorexia is a bit like alcoholism, in the fact that, you know, even if you've been sober for 20 years, you're still an alcoholic. It's just that you haven't drunk. And that's what I think. But I previously strongly believed that when I met you, you were, like, cured.*

Thea for example, reflected that she does not like the term "recovered" and prefers to think about herself as "in recovery"- an ongoing process with ups and downs, with lapses and "full-blown relapses".

Some female partners reflected that ultimately, they were motivated to navigate recovery for their partners, while others were motivated by a desire to never be in such a powerless position again:

> *Elaine: If I didn't have someone with me everyday that would tell me or show me that very, very, deep want for me to be better… I've just never liked myself very much, so I don't think I'd have the drive to improve.*

> *Sophia: It was almost that commitment to trying really, really hard to staying well because I never wanted to be in a position where I can't do something I want to do again.*

2.5 Discussion

The study aimed to explore how couples' sense-making of anorexia impacts on how they relate with each other and with the anorexia in the context of dominant discourses in

society, as well as how these evolve over time. The findings indicated that anorexia developed in the context of significant stress. Early understandings of anorexia appeared to be situated within unhelpful discourses around thinness, anorexia, gender, and mental health, which contributed to male partners responding to their female partners' refusal to eat in a way that was received as dismissive. Anorexia eventually came to be understood as a desire for control in the face of helplessness and powerlessness. However, some female participants struggled to acknowledge the relative power they held in their relationship due to wider disparaging societal discourses around control, as well as perceiving holding power within the relationship as invalidating their experiences of powerlessness. The flux between power and powerlessness within the relationship led most couples to position themselves against each other, and female participants as choosing anorexia over their partners. Male partners eventually had to assume varying levels of responsibility for their female partners, which was not received well by their female partners. Male partners' experiences of assuming control often occurred alongside and in response to helplessness, which appeared to mirror their female partners' experiences of anorexia. Throughout this process, male partners experienced shifts in their roles, as well as difficulty navigating communication and conflict with their partners. Navigating recovery from anorexia came alongside shifts in the distribution of power within the relationship towards a more balanced position. The transitions brought up considerable anxiety in both partners, with male partners relating to their own anxieties in either a contained or uncontained way. Male partners who were overwhelmed by their anxiety downplayed their needs and feelings within the relationship, leading to either more defensive interactions with partners, or them eventually becoming more open with their partners, resulting in lines of communication within the relationship being re-opened. Ultimately, partners reflected that they felt themselves become a team again following these difficult experiences and perceived their relationship as having been strengthened following navigating

these difficult experiences. Couples also appeared to come to a sense of acceptance that living with anorexia would be an ongoing journey for them over the course of their lives.

5.1 Research Findings in Context

The findings of the current study largely appeared to coincide with existing research on couples and eating disorders. Huke and Slade (2006) studied partners' experiences of supporting an individual with bulimia, whereby the partners struggled to understand bulimia and their partner due to the secrecy in the relationship. Thus, partners oscillated between believing the eating disorder was a separate entity that controlled their unwell partner or that their unwell partner was causing their difficulties. The former understanding resulted in blame being directed at the eating disorder and partners engaging in excusing/avoidance behaviours that resulted in the maintenance of the eating disorder. The latter understanding resulted in blame being directed towards their unwell partner, resulting in critical and hostile confrontation. Partners were thus left feeling powerless over something they did not understand. Huke and Slade's (2006) findings were aligned with male participants in the present study initially being dismissive or critical and blaming of their partners' experiences due to their early understandings of anorexia being shaped by unhelpful societal discourses in society, as described in the first chapter of the *Results* section, as well as male partners' varying degrees of conflict avoidance, as described in the third chapter of the *Results* section. Furthermore, Huke and Slade's (2006) study highlighted the power of information and how secrecy within the relationship can result in an experience of powerlessness for the partner without an eating disorder, which was aligned with the findings of the present study as described in the second chapter in the *Results* section.

Linville and colleagues' (2016) study involved interviewing couples where one partner had an eating disorder both jointly and individually to understand how the eating disorder affected the relationship and vice versa. Their findings appeared to map on to the

findings in the third and fourth chapters of the *Results* section, whereby participants in both studies described partners[B] feeling pressure to monitor their partners[A]' restrictive behaviours, while not wanting to take on the role of policing their partners. Participants in both the present study and the one conducted by Linville et al., (2016) highlighted partners perceiving this power imbalance as adults in a partnership as uncomfortable. Participants in both studies also highlighted an increase in stress and conflict within the relationship around the eating disorder, which was construed as being the "third person" in the relationship. Participants in both studies also described the relationship having been strengthened after navigating difficulties around the eating disorder, including improved communication, and trust that partners[A] could lean on their partners[B] in difficult times, and be loved even as they struggled, and ultimately wanting to recover for their partners[B].

Furthermore, Antoine and colleagues' (2018) study highlighted that the male partners of women with anorexia ultimately became part of a "petrified system", whereby they comforted and protected their partners in a way that allowed them to avoid conflict, thereby maintaining the disorder. This appeared aligned with how Liam appeared to approach Daniela's anorexia, whereby he avoided conflict in a way that allowed the anorexia to continue to take up substantial space within their lives. Although both Carina and Thea were in recovery at the time of the study, both Harry and Adam (their respective partners) at times minimised their feelings and experiences in an effort to protect their partners in a manner that appeared aligned with the "paternalism" (to a lesser extent) described in Antoine and colleagues' (2018) study. In Harry's case, the substantial minimisation of his feelings and experiences appeared to contribute to blaming conflict between him and his partner in a way that may have contributed to the maintenance of his partner's difficulties.

The findings of the present study, as well as the aforementioned studies, thus appear to lend further support to literature that states that relationships and eating disorders reciprocally

influence each other in a way that can either promote recovery or maintain the eating disorder (Linville & Oleksak, 2013; Schmidt & Treasure, 2006).

The findings of the current study appeared to build on existing literature in two main ways. First, the study highlights why it may be difficult for women living with anorexia to acknowledge the power they hold within the relationship, which has the potential to invalidate their partners' distress. It was difficult for some female partners in the study to acknowledge some of the power they held due to sinister discourses in society around control and domination in relationships, as well as concerns that it would invalidate their own feelings of powerlessness when they were unwell. Discourses around anorexia are often centred around the control (Holmes et al., 2017), but they often neglect to highlight the powerlessness that underlies and understandably accompanies a desire for a sense of control. Conversations around control and power and the manner in which these are had, have the potential to trigger the high levels of shame and low self-esteem already present in those who live with anorexia (Goss & Allan, 2010). Therefore, an acknowledgement of an understandable desire for power in the face of powerlessness needs to be had when anorexia is conceptualised as being about control. This may allow conversations around power and powerlessness to be had in a sensitive and compassionate manner that may be less likely to elicit a defensive response. This is particularly important as women with anorexia are likely to have been exposed to highly critical interactions with others, that results in them avoiding interactions with others (Schmidt & Treasure, 2006), ultimately maintaining their difficulties.

Second, previous research has highlighted that partners[B] experience feelings of powerlessness (Huke & Slade, 2006; Antoine et al., 2018; Linville et al., 2016), and have alluded to partners[B] mirroring their unwell partners' feelings of powerlessness and desire for control. However, the present study has highlighted that this mirroring of their unwell partners' experiences can extend to partners[B] choosing not to share and/or to downplay their

own feelings during recovery, akin to their unwell partners' secrecy around anorexia prior to recovery. This has the potential to close down channels of communication within the relationship, which both participants and the research literature (Karney & Bradbury, 1995) cite as being key to relationships flourishing.

5.2 Implications for Practice

The findings of the present study give rise to several implications for practice. First, couples in the present study's experiences of living with anorexia appear similar with previous research around couples and partners[B] living with bulimia and eating disorders more generally, which lends support to transdiagnostic ways of understanding eating disorders. Second, it may be helpful for elements of compassion focused therapy (CFT) to be integrated into couples' therapy in conversations around anorexia. CFT highlights that individuals' difficulties are not their fault, but they are responsible for working on these, and the importance of directing compassion towards both oneself as well as others (Gilbert, 2010). Such an approach would allow individuals with eating disorders and their partners to acknowledge and hold the seemingly opposing feelings of power and powerlessness they experience in themselves and witness their partners experience, as shaming societal discourses appear to contribute to making it difficult for women with anorexia to acknowledge their need for control. Conversations around control and power will no longer need to be shaming for the partner with anorexia nor invalidating for the carer, allowing both parties to take a non-blaming approach to understanding their interactions and reflecting on what they would do differently, allowing them to take responsibility for hurt and harm that has been caused without blame and shame. This may further open communication between couples. Ideas around compassion-focused therapy for eating disorders may, therefore, be integrated into existing interventions for couples around anorexia, such as Uniting Couples (in the treatment of) Anorexia Nervosa (UCAN), that aim to position both members of the couple

being on the same side (Bulik, Baucom, Kirby, & Pisetsky, 2010). Third, it may be helpful for psychoeducation around the impact societal discourses around anorexia, power, and control, to be considered in couples therapy and to encourage discussions between the couple around this. This may allow couples to consciously appreciate the impact of these discourses and take a non-blaming approach to understanding their interactions with each other. It may also enable couples to position themselves as being on the same side against harmful narratives in society.

Ultimately, the present study highlights how difficult it can be for both partners living with anorexia to navigate their relationship with each other and with anorexia. Despite this, the relationship has the potential to ultimately be hugely protective for partners[A]. In order for this to occur, partners[B] must receive adequate support to cope and feel contained, in order for the relationship to flourish and serve as protective for partners[A]. This is in line with the NHS Long Term Plan (2019), which aims to recognise the difficulties experienced by "carers" and for adequate support to be provided around this. NICE guidelines (2020), however, still only references "carer" involvement for adult anorexia treatment in terms of how the partner with caring responsibilities can support the individual with anorexia, as opposed to considering what support the individual with caring responsibilities may need to maintain their own wellbeing. A shift is required where partners[B]' own needs are considered, in recognition that doing so indirectly allows for the provision of more holistic, systemic support for partners[A].

Lastly, research is currently being done on the impact of mental health recovery narratives on those experiencing mental health difficulties. Early studies show that mental health recovery narratives have the potential to create change for the individual struggling with mental health difficulties when the recipient develops a connection to the narrator of the events experienced, learn how recovery happens, or experience an emotional release (Rennick-Egglestone et al., 2019). Such narratives also have the potential to reduce stigma

and shame (Rennick-Egglestone et al., 2019). The emancipatory narratives developed as part of the present study attempt to honour the voices of the couples, and may therefore, resonate with those who live with anorexia and their partners. Following further research around how such emancipatory narratives are received by those who live with anorexia and their partners, such narratives being shared with couples navigating their journeys with anorexia may facilitate recovery by fostering a sense of connectedness, hope, and stigma reduction (Rennick-Egglestone et al., 2019).

5.3 Limitations of the Study

The study has several limitations. First, the present study would have benefited from a more homogenous sample, with all couples having a female partner who had been given a diagnosis of anorexia either before or after the relationship commenced, as well as a female partner who was either actively trying to achieve a healthy weight or a female partner who was in recovery. Furthermore, participants who were willing to partake in the dyadic nature of the interviews for the study were likely to already be relatively open with their partners, relative to the population of women who live with anorexia and their partners more generally. Second, the researcher had to conduct all interviews virtually due to the COVID-19 pandemic, which may have impacted on the relationship built between the researcher and participants, which is a key element of narrative interviews. Furthermore, interviews were not video recorded due to ethical limitations, which meant that participants' body language could not be interpreted alongside audio data. Third, the unstructured approach to narrative interviewing allowed participants to only share as much of their experiences that they were already consciously aware of. The interviewer also did not ask as many relevant follow-up questions as would have been helpful, only realising this upon analysing the data. Lastly, researchers were unable to ask participants to read back the results of the study and get feedback on this

due to ethical limitations. Participants' feedback on the results and whether they captured their experiences would have been particularly important due to the lens used in the study.

5.4 Future Directions for Research

The present qualitative research used small idiographic samples to explore specific experiences, which means that the study lacks generalisability. It would be interesting to understand whether males living with anorexia and their partners experience similar difficulties as the participants in the present study as they navigate relationships, and whether they are affected by wider societal discourses around eating disorders and mental health in the same way as the participants in the present study. In addition, as described in the preceding section, future research exploring the utility of emancipatory narratives in clinical practice may lead to further insights.

Overall, the study has highlighted how couples appear to be affected by societal narratives around eating disorders, gender, and mental health, which impacts on how they understand and make sense of anorexia and their experiences of power and powerlessness. This in turn drives how they position and engage with each other.

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Chapter 3 : Press release for the systematic literature review

University of Birmingham News Release

Parents' Experiences of Family Therapy Around their Child's Anorexia

Anorexia is an eating disorder characterised by restrictive food intake, resulting in low body weight. Anorexia has a big impact on an individual's mental and physical health, and has the highest mortality rate out of all mental illnesses. Anorexia often develops in adolescence. Family therapy has been shown to be more effective at addressing adolescent anorexia than individual therapy, but the remission rate 12 months after family therapy was completed still remains at 49%.

Parents are expected to play a significant role in their child's recovery from anorexia. Family therapy around adolescent anorexia often involves exploring and understanding family dynamics and how family systems adjust to accommodate the anorexia. Certain types of family therapy such as Maudsley Family Based Therapy emphasise the importance of parents assuming responsibility for the adolescent's eating.

Researchers at the University of Birmingham wanted to gain a more in-depth understanding of parents' experiences of family therapy for their child's anorexia by comparing and summarising all previous studies on the subject, with the hope that it might provide us with more insight about ways the intervention can be improved.

The study highlighted that parents are continually renegotiating their roles and identities as parents before, during, and after family therapy, which tends to be a stressful experience. At the same time, parents continue to parent their kids and are constantly aware of how their kids experience family therapy. Parents also held a lot of guilt and self-blame for their child's difficulties, and therapists telling them these difficulties were not the parents' fault did not appear to be effective at reducing their feelings of self-blame. However, being

around other families and parents undergoing similar experiences helped them to not feel alone in their experiences, as well as reduced their feelings of guilt and self-blame. Parents also developed new understandings of their children and themselves through family therapy, which allowed them to handle conflict within the family in more helpful ways. However, when family therapy came to an end, most parents found themselves feeling anxious about their children needing further support, particularly focused on their emotional wellbeing, as many parents felt some family therapies focused too much on restoring the young person's weight and not their emotional wellbeing.

The findings of the study highlight the importance of a) family therapies finding a balance between restoring the young person's weight and addressing their emotional wellbeing and b) parents having a space where they can reflect on and share their feelings with others going through the same experiences.

ENDS

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Chapter 4 : Press release for the empirical paper

University of Birmingham News Release

Joint Narratives of Couples Living with Anorexia: How Couples Understand their Relationship with Each Other and with the Anorexia

Anorexia is an eating disorder characterised by restrictive food intake, resulting in low body weight. Anorexia has a big impact on an individual's mental and physical health, and has the highest mortality rate out of all mental illnesses.

Previous researchers have found that women with anorexia's romantic relationships can either help or hinder recovery from anorexia, and that control and power are key issues in understanding anorexia and relationships. Researchers from the University of Birmingham wanted to understand how couples make sense of the anorexia together and how the understanding they develop of anorexia impacts how these relate with each and with the anorexia, and how this evolves over time. The researchers were also interested in understanding how discourses in society around anorexia, control, and relationships impacted on the understanding of anorexia developed by the couple.

Researchers interviewed the partners from five couples jointly and individually using narrative interviewing techniques. Data were analysed using Foucauldian-informed Narrative Analysis (FNA), which gave rise to four narrative chapters. The findings are summarised below.

Narrative chapter 1: Gradual development of understanding of anorexia in the context of societal discourses around thinness, gender, and mental and physical health

This chapter highlighted how anorexia developed in the context of significant stress. Both partners in the relationship needed time to recognise the gravity of the situation, with society construing thinness as desirable and most male partners internalising unhelpful societal discourses around anorexia, gender, and mental health, resulting in male partners responding to the female partners' refusal to eat in a way that was received as dismissive.

Narrative chapter 2: Anorexia as the interplay between power and powerlessness

This chapter highlighted how some female participants struggled with the conceptualisation of anorexia as being about control and acknowledging the relative power they at times held in the relationship. This was due to sinister societal discourses around control (as opposed to an understandable need for a sense of control and mastery in the face of powerlessness), as well as perceiving holding power as invalidating their experiences of powerlessness. It located the source of the problem within themselves and implied that they had the power to change at the time, which contradicted their experience at the time of feeling powerless to change. Externalisation was used by some participants as a means of highlighting their powerlessness and reducing self-blame while trying not to invalidate their partners' experiences of powerlessness. The flux between power and powerlessness (as seen in conversations about secrecy and control) linked with the anorexia in the relationship led most couples to position themselves against each other, and female participants being positioned as choosing anorexia over their partners.

Narrative chapter 3: Navigating shifts in power and helplessness within the relationship: Shifting roles, communication, and conflict

This chapter highlights how most male partners experienced discomfort at having to assume varying levels of responsibility for their female partners. Female partners often experienced resentment and betrayal at their partners' assumption of control. Male partners' experience of assuming control often occurred alongside and in response to helplessness, which appeared to mirror their female partners' experiences of anorexia described in the preceding chapter. In assuming control, some male partners experienced shifts in their roles from husbands to carers, as well as difficulty navigating communication and conflict with their partners.

Narrative chapter 4: Resolution and rebalancing of power

This chapter highlights how navigating recovery was a time of significant anxiety for one or both partners in the relationship. Some female partners spoke of feeling uncomfortable with continued monitoring and wanting to rebuild trust within the relationship, and with some male partners feeling anxious about relapse. Anxiety around recovery appeared to be highest in couples where the female partner had experienced at least one inpatient admission. Couples highlighted how navigating their struggles with anorexia ultimately left them feeling more like a "team" again, with male partners becoming more attuned to female partners' needs, female partners being able to communicate their feelings and needs more openly, and both partners positioning themselves as a team against anorexia and against harmful societal narratives.

The findings of the study highlight the importance of the way we as a society understand and speak about anorexia – it needs to be spoken about in a way that acknowledges the power and powerlessness that co-exists for understandable reasons. This will allow conversations to take a more compassionate, less shaming approach for women diagnosed with this, while not invalidating their partners' experiences, which has implications for interventions aimed at supporting couples through their journey with anorexia.

The author would like to acknowledge the brave couples who gave their time to take part in the study and shared their stories with so much openness and vulnerability – thank you!

ENDS

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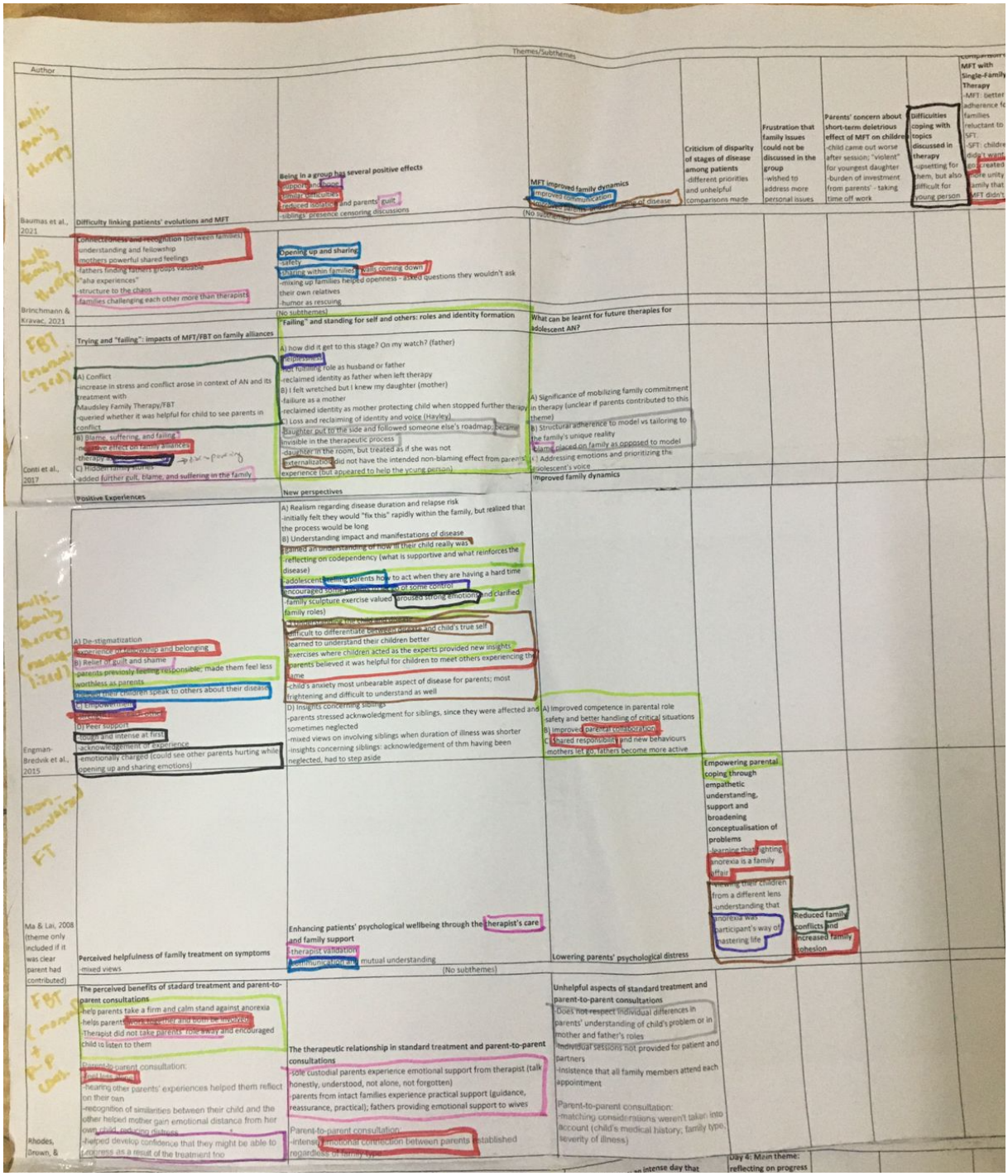
APPENDICES

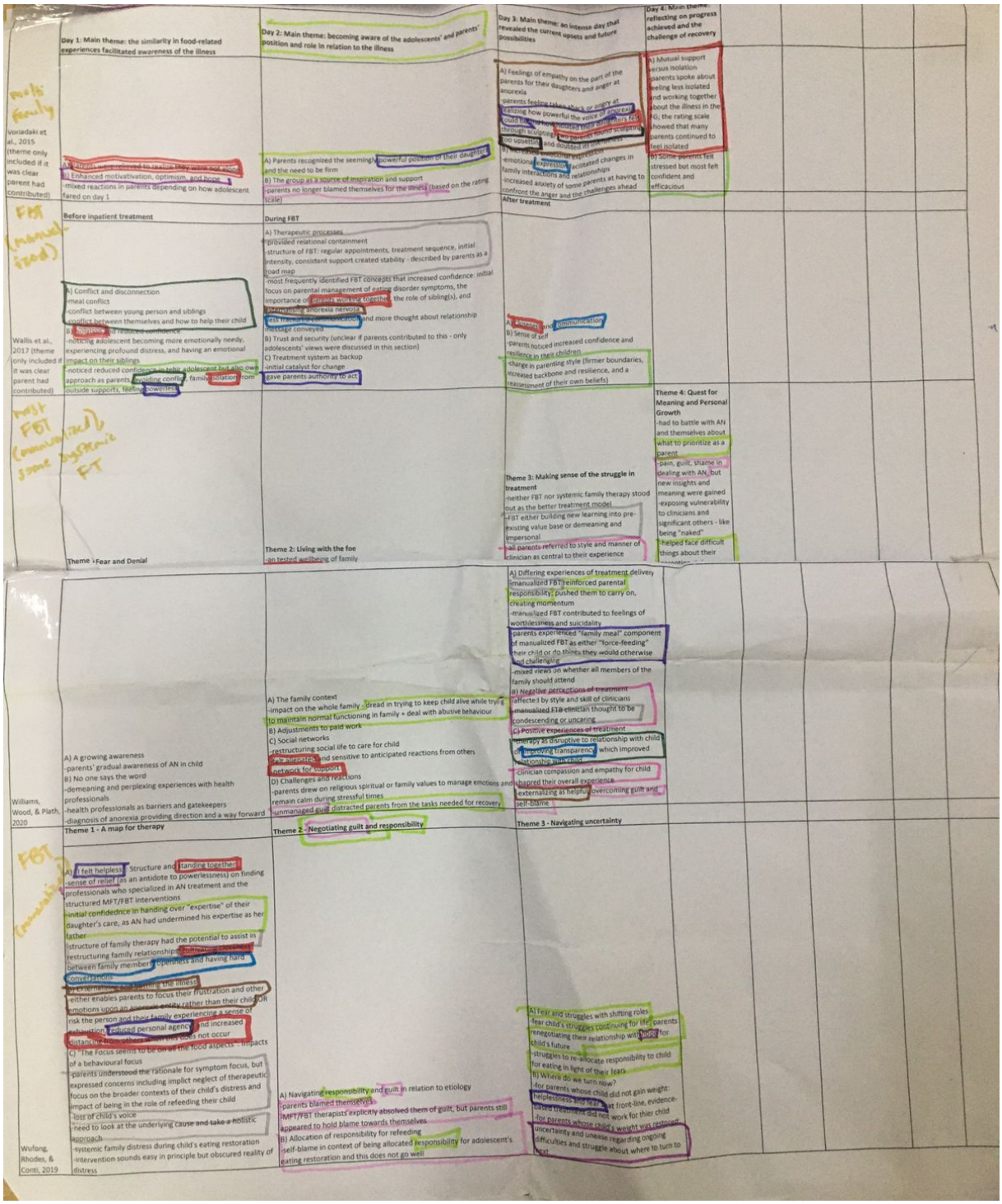
Chapter 1 Appendices

Appendix 1A: Quality Appraisal of Studies Using Critical Appraisal Skills Programme (CASP)

Paper	Clear Statement of Aims	Qual method appropriate?	Research design appropriate for aims?	Recruitment strategy appropriate for aims?	Data collected in a way that addresses question?	Relationship between researcher and pax considered?	Ethics considered?	Data analysis rigorous?	Clear statement of findings?	Valuable research?	Overall Methodological Quality
Baumas et al., 2021	Partially	Yes	Yes	Yes	Yes	No	Not beyond obtaining ethical approval	No	Partially	Yes	Substantial weaknesses identified: Rationale for the study unclear; insufficient discussions around recruitment; insufficient information around nature of intervention; relationship between researchers and participants not considered - bias identified during quality review; lack of transparency in data analytic process; insufficient quotes supplied; lack of reflexivity
Brinchmann & Kravac, 2021	Yes	Yes	Yes	Unknown - not addressed	Yes	Yes	Yes	Yes, but lacking reflexivity.	Yes	Yes	Few weaknesses identified: Recruitment strategy not described; relationship between researchers and participants considered; lacking reflexivity; slightly lacking transparency in data analytic process
Conti et al., 2017	Yes	Yes	Yes	Yes	Yes	No	Not beyond obtaining ethical approval	Partially	Yes	Yes	Few weaknesses identified: lack of consideration of relationship between researchers and participants; data analytic process significantly lacking transparency, lacking reflexivity
Engman-Bredvik et al., 2015	Yes	Yes	Yes	Yes	Yes	Partially	Not beyond obtaining ethical approval	No	**Yes**	Yes	Substantial weaknesses identified: lacking consideration of relationship between researchers and participants; insufficient quotes; lacking reflexivity
Ma & Lai, 2008	Yes	Yes	Yes	No	Yes	No	No	No	Yes	Yes	Study of questionable quality: lack of consideration of relationship between researchers and participants; lack of discussion of ethical considerations; lack of transparency and rigor in analysis; insufficient quotes
Brown, & Madden,	Yes	Yes	Yes	Yes	Yes	Partially	Yes	Yes	Yes	Yes	Minor weakness: Some lack of transparency in data analytic process
Voriadaki et al., 2015	Yes	Yes	Yes	Yes	to assess with information provided	No	beyond obtaining ethical approval	Yes	Yes	Yes	Few weaknesses: Some lack of transparency in data collection process; lack of consideration of relationship between researchers and participants; lack of reflexivity
Wallis et al., 2017	Yes	Yes	Yes	Yes	Yes	Yes	Not beyond obtaining ethical approval	Partially - lacking quotes and reflexivity	Yes	Yes	Substantial weaknesses identified: significantly lacking quotes; lacking reflexivity (although considered relationship between researchers and participants)
Williams, Wood, & Plath, 2020	Yes	Yes	rationale behind design	Yes	Yes	Partially	Yes	Yes	Yes	Yes	Few weaknesses identified: lack of reflexivity; could have justified inclusion/exclusion criteria further
Wufong, Rhodes, & Conti, 2019	Yes	Yes	Yes	Partially	Yes	Partially	Yes	Yes		Yes	Few weaknesses identified: manner of recruitment could have been improved; could have considered relationships between researchers and participants further

Appendix 1B: Extraction Grid Analysed




Day 1: Main theme: the similarity in food-related experiences facilitated awareness of the illness
Day 2: Main theme: becoming aware of the adolescents' and parents' position and role in relation to the illness
Day 3: Main theme: an intense day that revealed the current upsets and future possibilities
Day 4: Main theme reflecting on progress achieved and the challenge of recovery
Voriadaki et al., 2015 (theme only included if it was clear parent had contributed)
Wallis et al., 2017 (theme only included if it was clear parent had contributed)
Before inpatient treatment
During FBT
After treatment
Theme 1: Fear and Denial
Theme 2: Living with the foe
Theme 3: Making sense of the struggle in treatment
Theme 4: Quest for Meaning and Personal Growth
Williams, Wood, & Plath, 2020
Theme 1 - A map for therapy
Theme 2 - Negotiating guilt and responsibility
Theme 3 - Navigating uncertainty
Wufong, Rhodes, & Conti, 2019

Appendix 1C: Table of Translations

Translation	Common themes/references	Authors contributed
Identity (encompassing role and responsibility)	Standing for self and others: roles and identity formation; not fulfilling or "failing" role of mother or father; worthless as parents; clarifying family roles; reflecting on codependency – what is helpful and what reinforces the disease; children acting as experts – telling parents how to act when they are struggling; improved competence in parental role; empowering parental coping; parents take firm stand against anorexia; parents' role not taken away by therapist; becoming aware of adolescents' and parents' role in relation to illness; confident and efficacious; reduced confidence in approach as parents; change in parenting style; what to prioritise as a parent; parenting style; undermined expertise as father; responsibility; fear and struggles with shifting role	Conti et al., 2017; Engman-Bredvik et al., 2015; Ma & Lai, 2008; Rhodes, Brown, & Madden, 2009; Voriadaki et al., 2015; Wallis et al., 2017; Williams, Wood, & Plath, 2020; Wufong, Rhodes, & Conti, 2019
Blame/guilt/shame	Guilt; blame, suffering, and failing; blame placed on family instead of model; relief of guilt and shame; parents blaming themselves for the illness; pain, guilt, and shame in dealing with anorexia; unmanaged guilt distracting from recovery; externalising helping overcome guilt and self-blame; therapists absolving parents of guilt; self-blame in context of refeeding; externalisation not having intended non-blaming effect	Baumas et al., 2021; Conti et al., 2017; Engman-Bredvik et al., 2015; Voriadaki et al., 2015; Williams, Wood, & Plath, 2020; Wufong, Rhodes, & Conti, 2019
Power/helplessness	Therapy as disempowering; helplessness and powerlessness before treatment; empowerment from other families; control; anorexia as a way of mastering life; powerful position of daughter; anorexia's voice as powerful; treatment gave parents authority to act; family meal as "force-feeding" or doing things they would otherwise find challenging; helplessness before treatment and relief at treatment; helplessness persisting after treatment	Conti et al., 2017; Engman-Bredvik et al., 2015; Ma & Lai, 2008; Voriadaki et al., 2015; Wallis et al., 2017; Wufong, Rhodes, & Conti, 2019
Conflict	Increase in stress and conflict; reduced family conflicts; conflict and disconnection; meal conflict; conflict between young person and siblings; conflict between parents; therapy as disruptive to relationship with child or improving transparency, which improved relationship with child;	Conti et al., 2017; Ma & Lai, 2008; Wallis et al; 2017; Williams, Wood, & Plath, 2020
Unity/isolation	Support; similar difficulties; reduced isolation; unity in family; connectedness and recognition; shared feelings; walls coming down; negative effect on family alliances; fellowship and belonging; parental collaboration; shared responsibility; fighting anorexia is a family affair; family cohesion; work together; less alone; emotional connection; isolated; mutual support versus isolation; closeness; working together; alienated; network for support; standing together; distancing from others	Baumas et al., 2021; Brinchmann & Kravac, 2021; Conti et al., 2017; Engman-Bredvik et al., 2015; Ma & Lai, 2008; Rhodes, Brown, & Madden, 2009; Voriadaki et al., 2015; Wallis et al., 2017; Williams,

		Wood, & Plath, 2020; Wufong, Rhodes & Conti, 2019
Communication	Communication; opening up and sharing; helped children speak about disease; adolescents telling parents how to act; emotional expression; less fractured communication; improving transparency; openness and having hard conversations	Baumas et al., 2021; Brinchmann & Kravac, 2021; Engman-Bredvik et al., 2015; Ma & Lai, 2008; Wallis et al., 2017; Williams, Wood, & Plath, 2020; Wufong, Rhodes, & Conti, 2019
Different understanding of child; including externalising?	Understanding of how ill child really was; difficult to differentiate between disease and child's true self; child's anxiety most frightening and difficult for parents to understand; viewing child from a different lens – anorexia as participant's way of mastering life; feelings of empathy for daughters and anger at anorexia; externalising not having intended non-blaming effect; externalising as helpful to overcome guilt and shame; Parents focus frustration on anorexic entity rather than child or reducing personal agency or increased distancing	Baumas et al., 2021; Conti et al., 2017; Engman-Bredvik et al., 2015; Ma & Lai, 2008; Wallis et al., 2017; Williams, Wood, & Plath, 2020; Wufong, Rhodes, & Conti, 2019
Therapy as an emotional experience	Difficulties coping with topics discussed in therapy as upsetting; therapy as disempowering; tough and intense; emotionally charged; aroused strong emotion (family sculpture); too upsetting (family sculpture)	Baumas et al., 2021; Conti et al., 2017; Engman-Bredvik et al., 2015; Voriadaki et al., 2015
Therapy as structured/rigid	Daughter put to one side and followed somebody else's roadmap; structural adherence to model vs tailoring to the family's unique reality; does not respect individual differences in parents' understanding of problem or parents' roles; structure of FBT created stability and a road map; FBT either building new learning into pre-existing value base or demeaning and impersonal; manualised FBT clinician thought to be condescending or uncaring; structure of family therapy had potential to assist in restructuring family relationships; implicit neglect of therapeutic focus on broader contexts of child's distress; need to look at underlying cause and take a holistic approach	Conti et al., 2017; Rhodes, Brown, & Madden, 2009; Wallis et al., 2017; Williams, Wood, & Plath, 2020; Wufong, Rhodes, & Conti, 2019
Experience of therapist	Families challenging each other more than therapists; Enhancing patients' psychological wellbeing through the therapist's care and family support; therapist validation; therapist did not take parents' role away and encouraged child to listen to them; sole custodial parents experiencing emotional support from therapist; parents from intact families experiencing practical support from therapist; parents referred to style and manner of clinician as central to their experience;	Brinchmann & Kravac, 2021; Ma & Lai, 2008; Rhodes, Brown, & Madden, 2009; Williams, Wood, & Plath, 2020

	clinician compassion and empathy for child shaped overall experience; condescending and uncaring manualised FBT clinician	
Hope and optimism	Support and hope being in a group; parent-to-parent consultation helped parents develop confidence they might be able to progress as a result of treatment too; enhanced motivation, optimism, and hope; parents renegotiating relationship with hope for child's future; uncertainty and unease regarding ongoing difficulties and struggle about where to turn to next	Baumas et al., 2021; Rhodes, Brown, & Madden, 2009; Voriadaki et al., 2015; Wufong, Rhodes, & Conti, 2019

Appendix 1D: Identity translation which became the theme *Repeated renegotiation of role and identity while continuing to parent*

Paper	Authors Interpretations of Common References for "Identity" translations
Conti et al , 2017	Within their narratives, each family member engaged in a process of identity negotiation and within their role within the family Jack: Ijustfeltcompletelyhelplessonmultiplefronts Myhardesthittingfeelingswereactually at the very beginning That s when I felt most desperate and guilty I guess and you know (Interviewer: Guilty? In what way? What did you feel guilty about?) [ ] she just didn t seem herself at all and I got up in the middle of the night, just, I felt sick to my stomach and sweating that something was wrong with her A feeling I d never ever had before I just wandered in and I just crawled into the bed next to her, put my arms around her and then that s when I just felt her skin and bones and her cold skin and her just lifeless body I sobbed and sobbed and sobbed that – how did it get, how did it get to this stage? On my watch? [ ] I thought I was going to lose her And I looked at her, and I just said, "[ ] You want me to hand her over, that we can t care for our child?" And she looked at me and she said, "Well we re at that point" [ ] I didn t see her again [ ] I ve thought about it many times since, it s one thing for me to say to myself, "I can t provide for my daughter I m not providing I should ve seen this coming I can t help her" [ ] but to have someone else basically tell me you re not making it as her father struck a real chord and that s how I took it, was "you can t be her father so maybe the state can " But then that wasn t true Within the context of terror that he might lose his daughter, Jack s positioning of himself within the masculine provider/protector discourse deprived him of his identity as a father and a man – 'How did it get to this stage, on my watch? (extract 4a) In assuming the primary responsibility to both provide for and protect his family, AN posed a challenge to his identity as a male and father and ultimately contributed to a profound sense of 'helplessness that in some way he had fallen short of his own expectations of himself in his role as husband and father (extract 4b) Oh my goodness I was, I ve never been so challenged in my life as a mother I felt wretched You know it s such a, a fundamental thing to feed and protect your child and anorexia has already challenged that in its essence and then to, on a weekly basis, be in a context (emo- tional tone to voice) where your failings are on show and also on show to your children Margaret experienced inadvertent blame where therapy became an audience to the growing narrative of her failure as a mother to (re)feed her daughter with devastating effects – 'I felt wretched The public shaming she experienced in the context of ther- apy further undermined her sense of herself as a good mother that had already been challenged by AN itself In this stretch of text Margaret highlights the extent to which this purported non-blaming therapy became blaming, despite the anti-blame rhetoric of the model
Engman-Bredvik et al , 2015	During MFT they met "nice families," who had nevertheless also ended up in a similar situation, and this recognition was comforting and it made them feel less worthless as parents The parents started to reflect on co-dependency, for example, on being able to distinguish between what is truly supportive and what just reinforces the disease, which was a new perspective to many parents The particular exercise, "family sculpture" was valued, as it aroused strong emotions and clarified family roles Improved competence in parental role MFT gave participants a new perspective on their children s behaviours Seeing and hearing examples from other families made them more able to distance themselves from pathologic behaviours, becoming safer in their parental role, and thus able to handle critical situations in a better way Some of the parents became calmer and more patient since they knew that there were other families who had been through the same or worse In several cases MFT had a positive effect on the collaboration between the parents They became more "on the same page," and also improved their understanding of their partner Shared responsibility and new behaviours Participants reported that MFT led to a more shared responsibility towards the disease In several families it was primarily the mother who had taken responsibility of the disease, but after MFT fathers became more active Some mothers believed that the fathers gained a more profound understanding of the seriousness of the condition and the importance of their active involvement in the child s recovery At the same time, the mothers had to learn how to let go of some of the control in order to facilitate the cooperation between the parents
Ma & Lai, 2008 (theme only included if it was clear parent had contributed)	N/A
Rhodes, Brown, & Madden, 2009	In particular, they described how treatment encouraged them to be strict with their daughter and that separating their child from the anorexia helped them to do this in a calm and col- lected way I tend to be very weak when it comes to battling with the illness I think I realise even though it s hard at times that you have to be strict with her, very strict, and (therapist) reiterates that Parents also spoke of their appreciation for the fact that the therapist did not try to take the role of the parent away in standing up to the anorexia, but encouraged the young person to see her parents as the people who were responsible for her recovery Parents also described how the therapist helped both parents to be involved and to work together One thing that stands out is helping me to let Ashlee s dad be more involved It s like we had to make it work together we couldn t get her weight to go up (Marie, Code 21) Parent-to-parent consultations had a more emotional and reflective quality, helping parents to feel less alone, to reflect on roles and interactions that were relevant to the task of dealing with the anorexia, and to develop confi- dence that they also might be able to succeed in treatment
Voriadaki et al , 2015 (theme only included if it was clear parent had contributed)	Ken: We are the treatment we can get our kids to understand that we are not the enemy Mary: But we haven t got a lot of tools to do that, apart from coaching them to eat, which is very difficult Norma: It was a big realisation all of a sudden that you are the cure It is a huge thing to accept Ken: We know we are in the same boat, so we get a bit more strength out of the 4 days Just being together [has helped] and gelling it together So, we are the tools (FG-P)

Wallis et al , 2017 (theme only included if it was clear parent had contributed)	They also noted reduced confi- dence not only for their adolescent but also in their own approach as parents describing, avoiding conflict, family isolation from outside supports and feeling devastated and powerless with a problem that was beyond instinct and common sense, with one mother saying "I just think that we were all just really sad like and just feeling help- less" (M16) Most families noted an overall change in parenting style such as having firmer boundar- ies, and intrapersonal change described as increased backbone, resilience or reassessment of their own beliefs For example "I think going through this journey with (young person) has made me more resilient" (M12)
Williams, Wood, & Plath, 2020	They expressed "dread" in their task of keeping their child alive, whilst trying to maintain normal func- tioning for the whole family For those parents who continued in employment, adjustments to paid work created stress at work and at home, with one parent explaining that AN not only impacted her personal life, but also everyone she worked with: Sometimes it would take two to three hours for [son s name] to eat his lunch I d be sitting there thinking, "I ve got to get back to work somebody s doing my job" With all this stress I thought that I was jeopardizing my job I m going to have to give it away (P3) When at work, parents described worrying about their child, and when at home worrying about their paid work These parents felt burdened and exhausted This was particularly the case for single parents and those lacking the support of their partners Manualised FBT reinforced par- ental responsibility for their child s wellbeing and entailed significant challenges along the way Parenting an adolescent with AN had a profound effect upon participants They not only had to battle with AN but with themselves about what to value or prioritise as a parent While most parents described pain, guilt, and shame in dealing with AN, many gained insights and meaning P1 described how the experience of being in family treatment: "really helped me face up to really hard things that I probably wouldn t have faced up to in my parenting" One participant described how she became more attuned to her emotional wellbeing that ultimately reconnected her with her child I was one of these people who didn t show my emotions much, very tough orientated, very much the job at hand once I understood what anorexia was like for my son, it helped me change Now I ve let my guard down and let people in I think it s [AN] made me a better person and a better parent as much as it nearly killed me (P3) One parent, however, felt they were all trapped in a meaningless situation: You know that your daughter is seriously sick and she needs help in a way that she doesn t know she needs There is no meaning how long you can tolerate this? (P2) This father endured AN as a trauma and, unlike other participants, could see no personal gains from the experience
Wufong, Rhodes, & Conti, 2019	Diagnosis for Janice legitimated her daughter s experi- ence as a "genuine mental illness"—and confirmed her insider knowledge of the complexity of her daughter s experience—that was not simply attributable to parental incompetence in not being able to "just make her eat" The high evidence of success of MFT/FBT cited to Jack contributed to an initial confidence in handing over of "expertise" of their daughter s care, as AN had under- mined his own expertise as her father All of the parents recounted experiences of systemic family distress as they took up the responsibility for their child s eating restoration Terry: [ ] we d failed as parents It s simple, you know? Parents are supposed to look after their kids and particularly in, in the traditional sense fathers are supposed to look after their families [ ] I felt that I d failed in that For these parents, the reallocation of responsibility to their daughters for eating and self-care, and their transi- tion to autonomy in the later phases of MFT/FBT, were troubling to negotiate, especially in the context of their child s ongoing psychological distress and/or ED symptomology Emily: I actually have difficulty then again letting go, because it was then, okay I have to be in charge to be really the boss against this illness [ ] Kelly said to me, "Mum, don t talk about it anymore I don t want to be that person with anorexia all the time We have to let it go " [ ] it s hard to not identify then [as] the mother of a child with anorexia Jane: To some extent you just have to say, "Well look, what else can I do?" Just what will be will be, to a little extent [ ] it s the same as you can lead a horse to water but you can t make them drink and they re growing up and you have to let them go eventually A turning point for Emily in rethinking her role as "the boss against this illness" and renegotiating her iden- tity as "the mother of a child with anorexia" was when her daughter resisted totalisation of her identity as "that person with anorexia" Jane was also faced with knowing that she had done everything she could as a mother— which she depicted through metaphor ("lead a horse to water")—to mark out the limitations of the extent to which parents can make their child eat, particularly as they get older and to allow for uncertainty to "a little ex- tent" Kiera talked about the necessity of taking respon- sibility for her daughter s eating when she lapsed at age 19 as she sought to continue to be strong for her daugh- ter with the hope that one day she will have the "strength" to do this for herself Shifting from an au- thoritarian stance in phase one of the intervention was troubling for these parents as they were faced with the fear of their daughter lapsing, greater uncertainty around their child s future, and renegotiating their roles and identities as parents

Chapter 2 Appendices

Appendix 2A: Ethical Approval Letter

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Miss Suchika Kumar
Clinical Psychology Doctorate Candidate
University of Birmingham
School of Psychology, 52 Prichatt's Road,
University of Birmingham, Edgbaston,
Birmingham
B15 2TTN/A

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

09 December 2021

Dear Miss Kumar

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Living with anorexia: Joint narratives of couples' experiences in the United Kingdom**
IRAS project ID:	**294265**
Protocol number:	**RG_20-199**
REC reference:	**21/IEC08/0030**
Sponsor	**University of Birmingham**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Appendix 2B: Services' Research and Innovation Approval

IRAS 294265 – Living with anorexia: Joint narratives of couples experiences in the UK – Confirmation of Local Capacity and Capability at [redacted]

[redacted]

Wed 2/16/2022 11:27 AM

To: Suchika Kumar (ClinPsyD Clinical Psy FT (NBF)) [redacted]

[redacted]

1 attachments (315 KB)

Agreed OID.pdf;

Dear Suchi

Re: IRAS 294265 – Living with anorexia: Joint narratives of couples experiences in the UK – Confirmation of Local Capacity and Capability at [redacted]

This email confirms that [redacted] has the capacity and capability to deliver the above referenced study. Please find attached the agreed Organisation Information Document as confirmation.

Start and end dates:

We agree to start this study with immediate effect.

We understand that the study will end on 01/09/2022. We are aware that at this point, archiving is the responsibility of the Sponsor.

Recruitment figures:

We note that you wish to recruit 4-8 couples at this site.

Please note that you will be contacted by the R&I department periodically to obtain your current recruitment figures.

During your study:

During the study, researchers are required to fulfil the following duties:

- Inform R&I of any amendments to the study, both substantial or non-substantial
- Inform R&I when the study has completed at the Trust
- Inform R&I of the total recruitment number at the Trust
- Submit a final report to the R&I department.

All of the above can be submitted to [redacted]

If you wish to discuss further please do not hesitate to contact me.

Finally, we would like to wish you all the best with your research!

Best wishes

[redacted]

CONFIDENTIAL CAPACITY AND CAPABILITY (NON PORTFOLIO STUDY): Living with Anorexia

[redacted]

Mon 12/13/2021 9:15 AM

To: Suchika Kumar (ClinPsyD Clinical Psy FT (NBF)) [redacted]

1 attachments (125 KB)

IRAS ID 294265 OID Non+Commercial.docx;

Dear Suchi

Living with anorexia: Joint narratives of couples' experiences in the United Kingdom

This email confirms that [redacted] has the capacity and capability to deliver the above referenced study. Please find attached the completed Organisation Information Document as confirmation.

Recruitment activities for the study can commence at [redacted] with immediate effect and I would be grateful if you could keep me informed of the study's progress from time to time and also advise when the study has ended. Please note that study amendment documentation should be shared with me as and when they occur. Could you also please forward a copy of the study conclusions/final report in due course?

Good luck with this study, and please do not hesitate to contact me if you have any queries throughout the conduct of the study at [redacted].

Kind regards

[redacted]

[redacted]
Research & Innovation Governance Manager

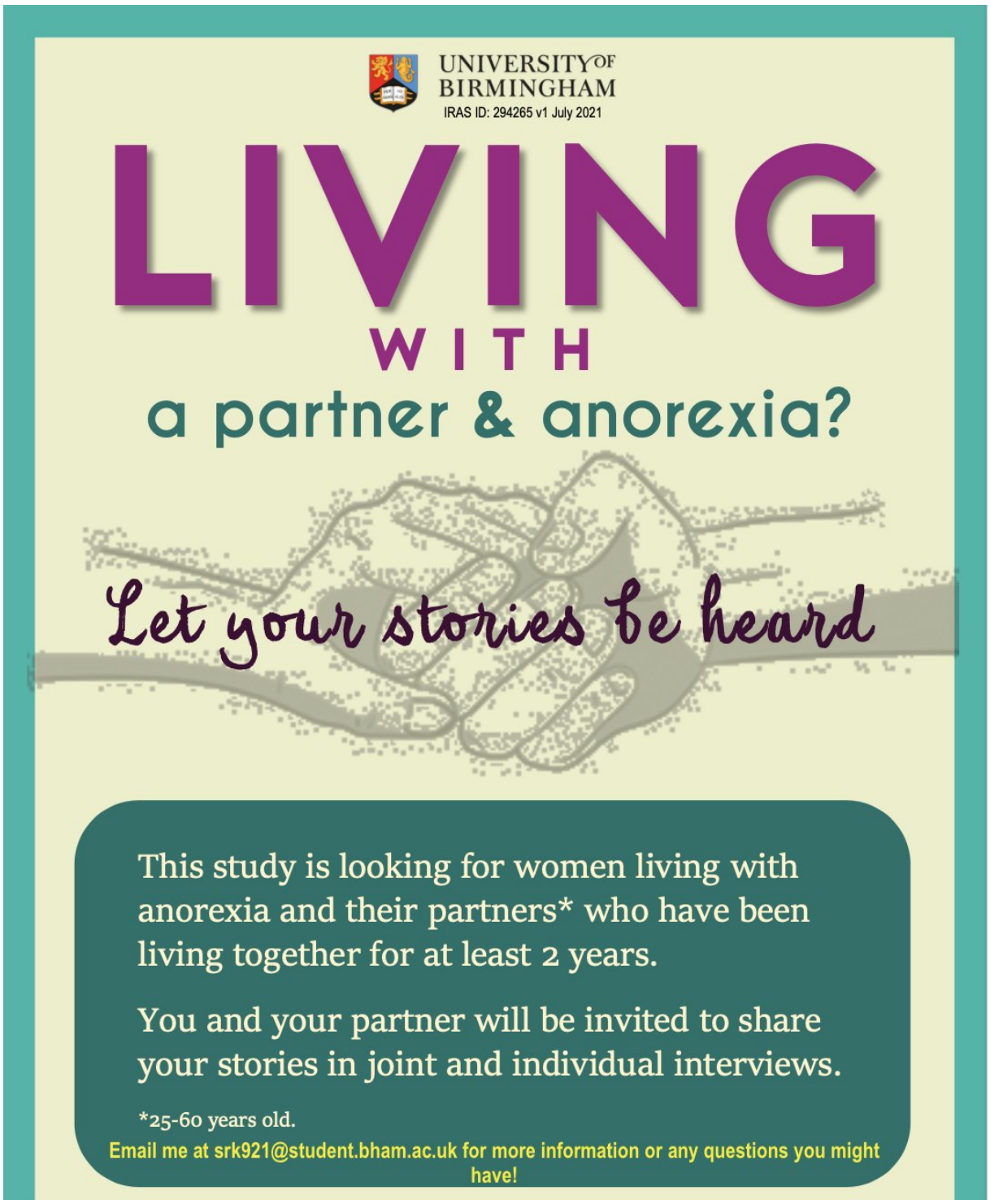
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[redacted]

[redacted]

Appendix 2C: Recruitment Poster



Appendix 2D: Participant Information Sheet

IRAS ID: 294265
Ver 1.5 8 March 2022

Participant Information Sheet

Study title

Understanding anorexia in romantic relationships: Joint narratives of couples

Invitation paragraph

We would like you and your partner to help us with our research study. You have been invited to take part in this study because either you or your partner has a diagnosis of anorexia nervosa and you are in a committed relationship together. Please read this information carefully and ask the researchers if anything is unclear or if you want to know more about the study.

What is the purpose of the study?

The study wants to understand how couples make sense of the role anorexia plays in their relationship and how this understanding affects them and their relationship. We want to understand the effect anorexia has on your relationship and vice versa, and to what extent you agree on these issues.

Why have I been chosen?

You have been chosen to participate in the study because it is thought that:

1. You are in a relationship and have been living together for at least two years;
2. A female partner in the relationship has a diagnosis of anorexia;
3. Both you and your partner are between the ages of 25 and 65.

Do I have to take part?

No. It is entirely up to you! You can decide not to take part in this study even if your partner wants to.

If both you and your partner agree to take part, you will each be asked to complete separate consent forms. If the interview will take place virtually, you will be given the option to either sign consent forms that will be emailed to you or you may choose to verbally consent to participating in the study, which will be audio recorded and securely stored and deleted by the end of the study.

What will I have to do?

You will first speak with one of the researchers over the phone for around 10 minutes, who will ask you a few questions about you to see if you are eligible to participate in the study. The researcher will have a similar conversation with your partner. This will also be an opportunity for you to ask any questions you might have.

Both you and your partner will then be asked to sit in an interview together with the interviewer (either in your home, at an NHS site, or over an online platform like Zoom), where you will talk about anorexia and your relationship. You will be compensated for travel expenses between you and your partner if the interview is conducted at an NHS site. The interviewer will ask very few questions – we will just want to listen to your story! This joint interview will last anywhere from 1.5 – 2.5 hours.

Within a week of your joint interview, the interviewer will speak with you and your partner separately to hear your thoughts on the joint interview. Whatever is discussed during this interview will not be shared with your partner and whatever your partner shares will not be shared with you. This solo interview will last anywhere from 30 minutes to an hour and a half.

For the female partner, you will be asked to complete some questions at your solo interview about your difficulties with anorexia in the last 28 days. This will take less than 20 minutes. If the interview is completed online, the interviewer will put the questionnaire up on the screen while you state your responses.

The interviews will be recorded using an audio device. If the interviews are conducted on-line due to the COVID-19 pandemic, the interviews will take place via Zoom or Microsoft Teams and will be recorded.

What will happen if I don't want to carry on with the research?

You can choose to withdraw at any time during the study. You can also contact any of the researchers (contact details at the end of this sheet) up to 2 weeks after the interviews are completed to have the data withdrawn.

If either you or your partner withdraw from the study, both of your data will need to be excluded due to the joint nature of the project.

Will I be compensated for taking part in the study?

You will be compensated with a 25 GBP voucher of your choice to thank you for your time in participating in the study. You will still receive the compensation should you decide to discontinue the interview once it has started, and will still receive the compensation should you decide to withdraw your data from the study.

What are the possible disadvantages and risks of taking part?

There is a chance that the interview or questions may cause either you or your partner distress, as you may speak about emotive subjects during the interviews. We can discuss ways we can reduce this before the interview. The debrief sheet you will be given at the end of the study will also contain information on support available to you and your partner.

The University has in force a Public Liability Policy and/or Clinical Trials policy which provides cover for claims for "negligent harm" and the activities here are included within that coverage

What are the possible benefits of taking part?

There are no direct benefits of taking part, but the research may help us improve treatment, care, and support for those with anorexia and their partners in the future.

What will happen after the interviews have been completed?

When the interviews have been completed, the recordings will be transcribed and the recordings will be deleted. The transcriptions will be securely saved on the University of Birmingham's Research Data Store. The results of the study will be written up and submitted as part of Suchika Kumar's doctorate degree. The findings will also be presented to other psychologists and published in journal articles. Any details that will identify you or your partner will be omitted or changed. You and your partner will be sent a copy of the results.

How will we use information about you?

We will need to use some information about you for the research project, including your name, contact details, and your affiliated clinical team member (if applicable).

People will use this information to do the research or to check your records to make sure that the research is being done properly.

People outside the research team will not be able to link you to the interviews or the study. They will not see your name as we will use a code name for you and will remove all identifying data about you from the results.

We will keep all information about you safe and secure.
Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

You can stop being part of the study at any time, without giving a reason. You can withdraw your participation or data from the study up to two weeks after the interviews are conducted. We will then destroy all data we have collected relating to you.
We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?

You can find out more about how we use your information:

- At www.hra.nhs.uk/information-about-patients/
- Our leaflet available from http://www.hra.nhs.uk/patientdataandresearch
- By asking a member of the research team

- By sending an email to dataprotection@contacts.bham.ac.uk

Will the data be kept confidential?

The data will be kept confidential unless you say something that suggests you are at risk of harming yourself or someone else. If this happens, we will need to inform relevant authorities to keep those involved safe. In most cases, you will be informed before confidentiality is broken. The exception to this is if doing so is thought to increase any risks.

Who is organizing the research?

This research study is sponsored by the University of Birmingham (UoB) and will be conducted by researchers affiliated with the university.

Who has reviewed the study?

Before any research begins, it must be evaluated by a Research Ethics Committee to ensure that the study is okay to do. This study has been given approval to commence by an NHS ethics committee.

What happens next?

You will be contacted by a member of the NHS team who gave you this sheet to see if you consent to being contacted by the researchers of the study at least 72 hours after being given this sheet.

Alternatively, you may get in touch with me, Suchi Kumar, at 0736645416 or via email at srk921@student.bham.ac.uk to discuss participating in the study or any questions you may have.

Contact for support

If you need support at any point during or after the study, you can contact the following:

Samaritans on 116 123 (open 24 hours)

SANELINE on 08457678000 (open from 13:00 to 23:00 daily)

Birmingham Carers Hub on 033300697111

Contact for further information

If you would like any further information about this study, please contact one of the following:

Dr Newman Leung (Clinical Psychologist and UoB Lecturer) – [redacted]

Dr Gerard Riley (Clinical Psychologist and UoB Lecturer) – [redacted]

Suchika Kumar (University of Birmingham Trainee Clinical Psychologist) –

Complaints

If you would like to make a complaint, you should contact (redacted to ensure anonymity).

Appendix 2E: Interview Guide

Interview Schedule

Demographic questions

1. How old are you?
2. What is your gender?
3. What is your ethnicity?
4. What is your nationality?
5. How long have you been in a romantic relationship?
6. Do you and your partner live together?

Joint interview

"We are interested in understanding how your relationship has influenced how you have dealt with anorexia and how anorexia has influenced your relationship. We want to know your story. I will mostly listen as you share your story together and will ask you some follow up questions based on what you have shared at the end."

"Tell me about your relationship before you knew about the 'anorexia'".

The participants will then be allowed to narrate their story uninterrupted, with the exception of probes from the researcher such as: "and then what happened?", " "tell me more."

Individual interview

1. Please think back to the joint interview. What was the joint interview like for you?
2. Were there aspects of the discussion that you wanted to clarify or expand on?
3. Was there anything you wanted to add during the joint interview but were unable to?

Appendix 2F: Debrief Sheet

Participant Debrief Sheet

Thank you for participating in this study entitled "Understanding anorexia in romantic relationships: Joint narratives of couples"!

What was the purpose of the study?

The purpose of the study was to understand how couples make sense of the role anorexia plays in their relationship and how this understanding affects them and their relationship, and to what extent you agree on these issues. It will help us understand what aspects of people's relationships are helpful and/or unhelpful in supporting someone with anorexia.

What will happen if I want to withdraw my interviews from the study?

You can contact any of the researchers (contact details at the end of this sheet) up to 2 weeks after the interviews are completed to have the data withdrawn.

If either you or your partner withdraw from the study, both of your data will need to be excluded due to the joint nature of the project.

What will happen now that the interviews have been completed?

The recordings will be transcribed, then deleted. Any details that will identify you or your partner will be omitted or changed. The transcriptions will be securely saved on the University of Birmingham's Research Data Store. The results of the study will be written up and submitted as part of Suchika Kumar's doctorate degree. The findings will also be presented to other psychologists and published in journal articles. You and your partner will be sent a copy of the results.

Contact for support

If you need support at any point, you can contact the following:

Samaritans on 116 123 (open 24 hours)

SANELINE on 08457678000 (open from 13:00 to 23:00 daily)

Birmingham Carers Hub on 033300697111

Contact for further information

If you would like any further information about this study, please contact one of the following:

Dr Newman Leung (Clinical Psychologist and UoB Lecturer) – [redacted]

Dr Gerard Riley (Clinical Psychologist and UoB Lecturer) – [redacted]

Suchika Kumar (University of Birmingham Trainee Clinical Psychologist) –
[redacted]

Appendix 2G: Sample Coding

Foucauldian Narrative Analysis Stage	Samples from Data
1: Origins at the Individual Level This stage is about individual narratives around research topic and how stories change over time, what they mean to participants, and their interpretation of their experiences in their stories.	That was the thing I was surprised by cause I didn't realise that anorexia could be anything other than to look skinny. I didn't realize.. cuz it's a control thing, we think. Primarily a control thing. So all the stresses feed into it. You're not going to the point where you're losing weight, still no, but I think putting weight on is still too much of an obstacle without therapy. Or. Yeah, I think that is all become. The same. Well sort of in the last few months, we've hit like the point where this is anorexia now, this is what you're dealing with. We need something to get you over the the hurdle of being able to put weight on Well, you know, because it has made a lot of stress Is it at the same time of it strengthening our relationship It has made the relationship a lot about, it's now about me, you, and anorexia or me, you and food, which is a bit Frustrating I mean I I used to think that maybe anorexia is a bit like alcoholism in the fact that, you know, even if you've been sober for 20 years, you're still an alcoholic It's just that you haven't drunk And that's what I think But I Strongly believed that when I met you, you were, like, cured You were You didn't have any Like, I never say at all, you know, genuinely genuinely believed that
2: Orientation in Relationships and Construction This stage focuses on the effects of the narrative the individual holds in relation to their dynamic relationships with others.	I've asked you to be more open about things since the anorexia I think I'm I'm being Very, very careful now to be even more honest with (male partner) just because I realized how much it hurts him to see me like that, and I have to say without (male

Commented [SK(CPF(1]: Transition - change in how anorexia is now understood

Commented [SK(CPF(2]: Transition – recognizing limitations of what they can do without more professional input

Commented [SK(CPF(3]: Transition – how relationship has changed over time

Commented [SK(CPF(4]: Transition – change in understanding of anorexia

	partner), I'll probably be worse Because even though you should probably aim to recover for yourself knowing that my friends and my partner and my family want me to recover as well That for me, that just helps me big time " Sorry, I think she's she's still does this sometimes where she will have a meal. And then still think you need to go for a walk after. (Female partner mmhms). Or like because I tried tried to restrict you to (Female partner chuckles) to 1 Walk a Day just have 1/2 hour walk And I can't help you unra.. I mean, I can help you, but I can't. Sort through that for you because. If I didn't have someone with me every day, that would tell me or that would show me The very, very deep want for me to be better Because I you know, with all the depression, anxiety and all the things we just talked about, I've just never liked myself very much So I don't think I'd have the drive To improve, Kind of weird that at my age I need constant supervision But I have completely embraced it at this point
3: Language and Power in Relationships This stage is about analyzing the language used around the subject topic by the storyteller – language that is theirs and language they have internalized from others, while also thinking about what this language could mean for the individual, for those	Or he always found out and made me tell (*Male partner laughs)* and then I just understood - All right, I just tell him, and then I just told him and it just took like an assuring word or something And then it was good So I think we grew with each other I always feel like I could Not force you to eat more, but do more to encourage it. But it's. Yeah, it's just, yeah, wanting to do more

Commented [SK(CPF(5)]: Saw how secrecy hurt partner, and has changed in how she relates to her partner – has become more open.

Commented [SK(CPF(6)]: Partner taking on role of having to monitor and restrict partner

Commented [SK(CPF(7)]: Wanting to help, but recognizing limits of this – powerlessness

Commented [SK(CPF(8)]: Partner is motivation to recover – struggles to recover for self – powerlessness

Commented [SK(CPF(9)]: Accepting partner's role of supervising her – coming to terms with changes in power/powerlessness within relationship

Commented [SK(CPF(10)]: Partner had to take initiative and make her tell – element of power dynamics; partner laughing – potential discomfort with having had to take a position of power (?)

Commented [SK(CPF(11)]: Redistribution of power, from making me tell to growing together

Commented [SK(CPF(12)]: Discomfort with being conceptualized as being about force (as opposed to encouraging) and power dynamics of this – wanting to do more for partner + helplessness

around the individual, and on a wider societal level.	Yeah. And that it always When I have good days so I'm already happy, I just automatically eat more and then sometimes the depression comes back and then I'll be. I don't know. Thinking. Yeah, at least I can control how much I eat and what I eat and only eat healthy and don't eat too much junk food In my mind, that's the next big step to progress Because we got to the point where you're eating enough to put on weight, but we don't think you are well, I think a lot of it you point out to me that I need to. Stop you from doing things or you point out to me that I need to. Make sure you have enough granola in your lunch. Yeah, a lot of. Not micromanaging, but making sure that. You don't slip up Which I don't think I've had to do very often. I think you're. Just as concerned about getting better as I am As long as you eat something, as long as you're doing better eating-wise, you can think I'm an asshole – that's fine (Lisa laughs) As long as you eat it

Commented [SK(CPF(13]: Brings it back to external factors which they feel they can't control, so they control their response to it – passive/powerless position held by speaker.

Brings it back to how helplessness/powerlessness underlies the need for control in latter half.

Commented [SK(CPF(14]: Partner taking control firlmy, my mind – interestingly, uses we in conversations about her gaining weight – we got to the point where.... We don't think you are – shared responsibility and positioned on the same side

Commented [SK(CPF(15]: Male partner having been handed power; discomfort at assumption of power ("not micromanaging") – shared ownership over recovery

Commented [SK(CPF(16]: Willingness of partner to be seen as the "bad guy" – in response to assumption of responsibility

Appendix 2H: Narrative Summaries

Narrative Summary Couple 1:

-Relationship was a change for F partner, who was encouraged by M to be more open
-F partner having a gradual awareness that something was wrong; M partner not noticing initially, then assuming it was to do with depression
-Diagnosis was an "oh shit" moment for M partner, but both jumped into tackling the problem; both felt relief at knowing what the problem was – it gave them a "starting point"
-Their understanding of anorexia changed from being about thinness to being about control
-Partners positioned themselves as being on the same side against the "monolith" that was anorexia
-There was a desire from M partner to protect F from blame by externalising while holding partner accountable; externalising to protect relationship as well
-There was a desire from F partner to protect M from self-blame and the weight on him by validating his distress; validation of distress to protect the relationship as well
-M partner feeling uncomfortable with assumption of "control"(while still feeling powerless and recognising limitations of what he could do to help) but a willingness to be viewed as an "asshole" if necessary
-M partner supporting via helping with sense-making and validating distress while being firm in the need to eat and planning next steps in recovery
-F partner recognising need for control in the face of helplessness, but has come to a sense of acceptance about needing "constant supervision" from partner
-Recognition that there is shared ownership of recovery and shared recognition of this
-F partner feels guilt for the impact on her partner and partner M feels sadness over F partner's guilt
-F partner finds it hard to want to recover for self, but wants to recover for partner
-Partners evolve in understanding how to navigate conflict and communication with each other, which has strengthened the relationship despite the added stress
-Partners recognise further progress will require professional help

Narrative Summary Couple 2:

-Relationship was quite settled; respect for each other's independence and need for space
-M partner had a very practical way of looking at difficulties – wanted to fix – but often viewed difficulties as a choice; "emotionally neutral"
-F partner struggled to raise concerns for fear of being dismissed and struggled to ask for help
-F partner was good at hiding things and M partner was not very observant
-Both partners knew something was wrong, but struggled to raise the conversation – both felt relief once the anorexia was spoken about
-M partner thinking background in mental health would help F partner cope; F partner experienced more shame around difficulties due to mental health background
-F partner felt resentment towards M partner for being able to do things she couldn't, but also guilt for what he had to take on
-M partner cooked to show love, but could no longer do this; showed love by taking on practical tasks needed to be done
-M partner needing to adapt to F partner's needs – making decisions, listening, not becoming overly validating
-Both partners not wanting a carer dynamic to form

-M partner had to take on some added responsibilities, but trusted things would be alright once F partner was in day treatment
-F partner having a conversation with M partner about re-establishing boundaries after day treatment
-F partner anxious about being watched after recovery or needing to prove herself; M partner initially being anxious about whether to "call out" behaviour that was concerning or not
-M partner voicing concerns being met with defensiveness from F partner, but providing her with food for thought
-M partner encouraging F partner to leave her comfort zone did not add anxiety to F partner already feeling anxious
-It became easier to become a team against a visible rather than invisible enemy
-Unspoken understanding developed between partners
-M partner became more protective of F partner in some ways, which was appreciated by F partner but also felt uncomfortable at times
-M partner became better at listening and F partner became better at being assertive
-More emotionally close as a couple and better at communicating needs and not being dismissive, but unsure if would attribute this to anorexia per se, or the natural progression of their relationship

Narrative Summary Couple 3:

-F partner had anorexia as a young girl; had been recovered for years
-F partner and M partner met and got married, had three children
-F partner and M partner talked about childhood anorexia, M partner viewed her as being "cured"
-F partner liking things done a certain way, preferred to take responsibility for things on her own than having M partner do things
-Both experiencing difficulties in the relationship during a stressful time and going to couples' therapy, where a "can of worms" of the F partner's past was opened; F partner coped by restricting
-M partner not realising what was happening, being complimentary of weight loss
-F partner taking on more control as anorexia progressed
-F partner not wanting to share what was happening due to not wanting husband to keep her from restricting and feeling ashamed, but then doing so following a conversation with her GP
-M partner initially took a very practical approach and spoke of wanting to "fix" – "you need to eat, so just eat", "why can't you just be happy?"; M partner felt very out of his depth and not understanding or knowing what he was dealing with
-M partner not wanting carer role to overshadow identity as husband, but also feeling guilt and wondering if he was not fulfilling his role as husband well and whether he had caused his wife's distress
-F partner felt like M partner was against her – conflict was very difficult to navigate
-F partner had to go into inpatient treatment, then day treatment – disrupted the power within the relationship
-M partner had to take on responsibility and control, which was received as being controlling by partner at the time
-M partner experienced relief at female partner getting help, but anxiety when she was coming out of treatment
-F partner became unwell again – M partner became very distressed and was quite blaming in his approach; F partner felt she was letting everyone down and bought into wider stigmatising discourses in society

-Relationship improved due to F partner's recovery and M partner being more gentle when partner was struggling (attunement)
-Redistribution of power and responsibility in relationship – F partner now able to trust M partner and lean on him and trusts that if there is a rupture, there will be a repair
-M partner wanting to protect F partner from his own guilt and pain, but also feeling angry and becoming defensive when his experiences were minimised during the interview

Narrative Summary Couple 4:

-F partner had bulimia and told M partner of this when they started seeing each other
-In ED treatment, bulimia developed into anorexia, which was more visible
-M partner initially frustrated and angry with F partner for not eating; tried to become "forceful" with eating or trying to be rational
-F partner became more secretive about anorexia in an attempt to "protect" it
-F partner then viewed it as a choice between having a fight with anorexia or M partner
-M partner "pushed" F partner to engage with doctors and therapy
-M partner felt like he was "forcing" F partner into inpatient treatment; F partner felt "betrayed"
-M partner assuming responsibility but feeling helpless
-M partner lonely and isolated, but relieved; F partner secretly relieved
-M partner taking a course for carers aimed at parents – strategies not received well by F partner
-F partner stepping down into day treatment – given more freedom and responsibility, but decreased care and increase in weight was distressing; M partner feeling anxious
-F partner wanting to recover for partner and their relationship, but ED voice sometimes made her wish she was single
-M partner struggling to transition out of carer mode into husband mode, while F partner improved
-M partner wanting to protect F partner from worry; F partner not knowing M partner was struggling
-M partner sought help for himself
-F partner extended olive branch to rebuild trust in relationship
-Relationship more balanced now
-F partner reflected how she could not "see" the anorexia and the effect it had in the same way because of how entrenched she was in it at the time
-Anorexia put strain on the relationship, but ultimately, both partners came out as improved versions of themselves and a closer couple
-F partner feeling pressure to maintain progress
-Power/control was seen as being accompanied by a sense of helplessness for both partners
-M partner being protective of F partner and not wanting them to be perceived as controlling because this is something partner is uncomfortable with

Narrative Summary Couple 5:

-F partner had anorexia since the age of 10, but did not accept the diagnosis she eventually received at age 13
-M partner began to notice the physical changes a year and a half into their relationship, then noticed emotional elements; F partner only acknowledged that this was anorexia 4 years into the relationship
-Increase in arguments in the relationship

-M partner initially took a very practical approach to anorexia – "just eat something" – felt helpless and expressed this as anger and frustration; F partner became anxious and ate less
-Secrecy of anorexia made it difficult to build intimacy in the relationship – F partner kept things from M partner due to not wanting M partner to worry
-F partner gave M partner book about a carer's experience of supporting someone with anorexia, which helped M partner understand
-F partner learned to communicate her experiences with M partner
-M partner's understanding changed, learned what worked through trial and error, became more caring in approach instead of pushing F partner, communicated differently
-F partner felt anorexia is not understood by others – conceptualised anorexia as having to do with a "lack of self-worth", M partner conceptualised anorexia as being about control; M partner integrated the two different understandings
-Ultimately, anorexia put a lot of strain on the relationship, but the process of navigating this has brought both partners together as a couple
-F partner acknowledges there are still secrets; M partner acknowledges that F partner has become more open and has come to an acceptance that F partner won't be completely open, but recognising F partner is working on this