A portfolio of academic, therapeutic practice and research work including an investigation of "Maternal eating disorders: Adult daughters' reported experiences"

by

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INTRODUCTION TO THE PORTFOLIO

Introduction

This portfolio contains both theoretical and research papers and is the culmination of three years of doctoral study. The three dossiers contained cover different aspects of the course. Specifically, the Academic Dossier contains four essays; the Therapeutic Practice Dossier relates to clinical practice and contains a short description of my placements as well as the final clinical paper, which considers my development to date as an integrative practitioner. The Research Dossier contains one literature review and two research projects. Each of these dossiers will be considered in more detail in the sections below. Counselling psychology acknowledges that both therapy and research are dynamic processes, and that the therapist’s and the researcher’s interpretations will inevitably be coloured by their own experiences, conceptions and theoretical frameworks. I will therefore provide the reader with some information about my reasons for training and my stance with regard to counselling psychology as these have inevitably influenced my research and clinical interests.

Background

I have been passionate about psychology for as long as I can remember. As a child, I lived with a parent who has a mental health problem and I believe that this experience sparked my interest in psychology. I remember wanting to learn about human development and about the kind of crises and issues that people may encounter during their lifetime. Additionally, I wanted to learn how people in distress could be helped to improve their sense of well-being. In Sweden, my country of origin, professional training courses in psychology are very broad and include aspects of clinical, educational and occupational psychology. Such courses span over six years during which the first five years focus on the academic aspects of psychology whilst in the final year trainees undertake a one-year placement. The organisation of the Swedish psychology courses did not appeal to me as I believe that it is important that theory is embedded in practice, and that it is in practice that theory comes to life and starts to ‘make sense’. In 1995/1996 I spent a semester studying English as a foreign language
at an English university and during this time I learned about the organisation of English postgraduate training courses in psychology, which were more specialised than those in Sweden. This immediately appealed to me and in 1997 I started studying for a BSc in Psychology in England. Soon after starting this course I learned about counselling psychology, which I felt had an affinity with my own underpinning values and I decided that I wanted to pursue a career in counselling psychology.

Initially, the humanistic value system underlying counselling psychology, including the rejection of the medical model and the endorsement of the scientist-practitioner model, were important reasons for my attraction to counselling psychology. As I have progressed through my training, however, I have come to appreciate even more the special identity of counselling psychology. For example, my training in three different schools of therapy has provided me with a broad knowledge base from which I can assess, formulate and work with different clients. Although I was aware of the importance of this before I started training, it was only during the later stages of that training that I was able to fully appreciate how profoundly this has affected my approach to clinical practice.

In counselling psychology, great emphasis is placed on developing a sound and good therapeutic relationship. Indeed, this has been repeatedly reported to be one the most important therapeutic components in creating a positive change in clients’ mental well-being (Bergin & Lambert, 1978; Luborsky, Crits-Cristoph, Mintz & Auerbach, 1988; Roth & Fonagy, 1996; Safran & Segal, 1990). I have found attachment theory (Bowlby, 1969/1982; 1973; 1980) particularly useful in helping me to conceptualise the therapeutic relationship. Specifically, interactions with my clients have been guided and clarified by conceptualising the therapeutic relationship as an attachment bond, where the goal is to form a ‘secure base’ from which exploration and alliance rupture repairs can take place (e.g., Fonagy, 2001; Holmes, 2001, 1993). Working with the therapeutic relationship, however, requires that the therapist is aware of and understand their own psychological processes. I therefore believe that one of the strengths of counselling psychology is the requirement that counselling psychologists in training should undergo a minimum of 40 hours of personal therapy during the first
year of their course (Woolfe, 1996). Personal therapy allows the trainee therapist to examine and develop an understanding of their psychological processes; I know from personal experience what a significant affect this can have on clinical practice. In conclusion, my personal and professional experiences are reflected in the various papers in this portfolio and this will be elaborated upon below in relation to each individual dossier.

**Academic Dossier**

As mentioned above, the Academic Dossier contains four essays. The first examines the important psychoanalytic concept of the therapeutic frame. Although I was aware of the significance of the therapeutic frame on a theoretical level, it was not until my therapist started to be late for our meetings, which brought up very powerful feelings in me, that I started to appreciate just how important it is. The personal experience of breaks in the therapeutic frame encouraged me to undertake further reading on the topic, and this essay is the product of that reading. As outlined above, I believe that it is imperative that therapists pay attention to their own responses to their clients and/or their material. The importance of engaging in self-reflection was further brought home to me in the second year of my training when I undertook a placement in an eating disorders service. I experienced very powerful countertransference reactions to my clients and that encouraged me to write the second essay in this dossier, which considers psychoanalytic ideas of countertransference and how these can be used to inform practice when working with clients with eating disorders. In the third year of my training I was introduced to the theory and practice of cognitive therapy. This school of therapy has traditionally de-emphasised the role of the therapeutic relationship. As I consider the therapeutic relationship to be crucial, I was curious about how cognitive therapy conceptualises and works with difficulties that arise in the therapeutic relationship, and this is the focus of the third essay. Furthermore, during this year the course team urged us to consider the issue of integration more actively. This encouraged me to consider how attachment theory can facilitate efforts to integrate psychodynamic and cognitive theories when working with clients with eating disorders, and this is explored in the fourth essay.
**Therapeutic Practice Dossier**

This dossier relates to clinical practice and provides the reader with a brief overview of my placements and the client populations I have worked with. It also contains a ‘Final Clinical Paper’ discussing how I integrate theory and research into therapeutic practice.

**Research Dossier**

The Research Dossier contains one literature review, one qualitative research project and one quantitative research project. The literature review concentrates on the effects of parental eating disorders on offspring. My interest in this topic originated from my experience of living with a parent with a mental health problem in addition to someone close to my heart having suffered from an eating disorder. I believe that these experiences have affected the way I feel about myself and, how I relate to other people and, it made me wonder about the kind of experiences offspring of parents with eating disorders might have. Whilst reviewing this literature I was surprised to find that very little research had been carried out in this area. Furthermore, the majority of the research had been carried out on infants or young children and almost nothing was known about the experiences of older children and adolescents. In order to redress this imbalance, I carried out a qualitative research project in my second year of training which explored reports of the mother-daughter relationship provided by adult daughters of mothers with eating disorders. When I carried out the interviews for this project, most of the participants reported that they had not received any support from the mental health services involved in their mothers’ care and they felt that as children they would have benefited from some form of psycho-education in terms of ‘normal’ attitudes to food, body weight and shape. As a child, I also had a similar experience in terms of not receiving support from the mental health services involved in my parent’s care. In addition, my literature review indicated that mental health professionals in eating disorders services could have an important role in interrupting the intergenerational transmission of difficulties, although little was known about the
extent to which the children of parents with eating disorders are considered in the assessment and treatment process. All of these factors contributed to my decision to carry out my third year project which examined mental health professionals in eating disorders services clinical decision-making regarding the children of their female clients.

**Concluding comments**

This portfolio is the culmination of three years of doctoral study. The papers included reflect both my personal and professional experiences. I hope that my efforts to acknowledge and reflect upon my own processes are evident in throughout.

**NB.** Details of individual clients have been changed and pseudonyms have been employed throughout this portfolio in order to protect client confidentiality.
References


INTRODUCTION TO THE ACADEMIC DOSSIER

This dossier contains four selected essays that were submitted during the PsychD course. The first essay is concerned with the therapeutic frame and considers the significance of the therapeutic frame to the therapeutic process and the importance of maintaining it. The second essay discusses psychoanalytic ideas of countertransference and how these can be used to inform practice, with particular reference to the countertransference reaction commonly experienced by therapists with clients with eating disorders. The third essay discusses how cognitive therapy conceptualises and works with difficulties that arise in the therapeutic relationship. Finally, the fourth essay considers how attachment theory can facilitate efforts to integrate psychodynamic and cognitive theories when working with clients with eating disorders.
THE THERAPEUTIC FRAME: THE CORNERSTONE OF THERAPY

Introduction

The therapeutic frame is a very important concept in both psychodynamic and psychoanalytic theory and practice. In 1912, Freud set out a number of ground rules that he viewed as essential for establishing the analytic relationship. These rules included: free association, evenly suspended attention from the therapist, neutrality, set time and length for the sessions, confidentiality and a set fee. Freud (1912) postulated that if these rules were violated, the client\(^1\) will be less able to overcome deeper resistance. These ground rules were later named ‘the frame’ by Milner (1952), where the frame was a metaphor of an artist’s frame. Specifically, the frame contains the artistic creation and it was the idea of containing that was behind the thought of having a frame for the therapeutic process between client and therapist. Milner (1952) pointed out that by adhering to the therapeutic frame, the therapeutic relationship is significantly different from other relationships in the client’s life and this creates the opportunity for the development of transference. The therapeutic frame is therefore an essential component of the therapeutic process.

As the therapeutic frame is such an important concept in psychotherapy and psychoanalysis, it has been widely written about by many authors (e.g., Bleger, 1967; Cheifetz, 1984; Gray, 1994; Hoag, 1992; Langs, 1976, 1977, 1988; Milner, 1952; Viderman, 1974; Winnicott, 1965, 1986). It is beyond the scope of the present essay to engage in this topic in an extensive manner, and the interested reader is referred to the authors mentioned above. The aim of the present essay is to describe the therapeutic frame, its significance to the therapeutic process and the importance of maintaining the frame. Firstly, a general description of the frame and what constitutes the frame will be provided. Secondly, there will be a discussion of how the therapeutic frame in itself can be a very useful therapeutic tool. Thirdly, the implications of violations of the

\(^1\) Most writers in this field refer to clients as ‘patients’, however, the word ‘patient’ stems from the medical model of professional practice and is evocative of illness. Counselling Psychology arose from a concern with the fulfilment of potential rather than curing sickness (Woolfe, 1996). As the author is a trainee Counselling Psychologist it therefore seems inappropriate to use the word ‘patient’ and the word ‘client’ will be used in the present essay.
therapeutic frame instigated by the therapist will be explored. Where appropriate, examples of the author’s clinical experience, and experience as a client will be used to further illustrate the point(s). Finally, a brief discussion of how the therapeutic frame can be maintained in so-called ‘deviant frame’ settings will be provided.

Description of the therapeutic frame

During the first meeting between a client and a therapist, a therapeutic contract contact is made in which the practicalities of the therapy are agreed on. It is this agreement that constitutes the frame, though it is important to bear in mind that there is no consensus in the literature on what exactly constitutes the frame (Gray, 1994; Hoag, 1992). However, the frame generally includes; confidentiality, a private setting in which the therapist and client can meet, the total number of sessions or finishing date (sometimes an open-ended contract is offered; that is, no fixed time is agreed for termination), the length of each session, the regularity of the sessions, payment, arrangements for cancellations and breaks (Jacobs, 1999). If this is not made clear in the first meeting, misunderstandings and misconceptions are likely to occur. Thus, at one level the therapeutic frame is very similar to any other agreement made between two people. The client’s response to the therapeutic frame, however, is an important aspect of the work as violations of the frame instigated by the client, such as missed sessions, can have underlying meanings.

The idea of the continuity and consistency of the therapeutic frame have led many authors to argue that there are significant similarities between the early mother-child relationship and the therapeutic frame. Gray (1994), for example, claims that babies learn through the experience of their mother’s repeating actions that she will respond to their needs, and this leads the baby to be able to wait with hope. Furthermore, if the baby’s needs are responded to, he/she will internalise that he/she is of worth and that their needs can be met. However, if a baby does not have this experience of having their needs met, they may be predisposed to future psychological difficulties (Gray, 1994). The frame, like good-enough parenting, provides continuity and consistency through experience, and it is only through the experience of being contained in the
frame, that past failures can be re-experienced and worked through. Winnicott (1965, 1986), also viewed the frame as a representation of the early mother-child relationship. He perceived the frame as a symbol for maternal holding, which is required in order to help the infant through critical life events. In the same sense, the therapeutic frame is viewed by Winnicott as holding the client and enabling him/her to build sufficient ego strength to cope with the analysis of intrapsychic fantasies and conflicts. Both Gray’s (1994) and Winnicott’s (1965, 1986) accounts of the link between the frame and the early mother-child relationship underscore that not only is the therapeutic frame important on a practical level but is also has significant theoretical implications.

The therapeutic frame as a tool

The idea of continuity, that the therapist has a certain time set aside for each client each week (or several times a week in the case of psychoanalysis) is important. The client knows that a part of the therapist’s working day is set aside for them, irrespective of whether the client chooses to come or not. In that sense the therapeutic frame can also be used as a tool, as breaks in the frame instigated by the client can have an underlying meaning which can be explored in therapy. For example, I noticed that one of my clients, Mrs J, on two occasions cancelled the following session after a particularly important session where painful areas of her life had been explored, and where it seemed that she had gained important insights. This client was usually very reliable and she rarely cancelled. Following the second cancellation, I raised this matter with her. It then emerged that Mrs J had caught her husband reading her journal, and that she initially felt very upset and betrayed by him. Mr J had then explained that he felt jealous of her relationship with me as she did not talk to him like she used to before she began therapy. Mrs J described feeling very guilty about having excluded her partner. She then explained that she had cancelled the sessions after the ones where important insights had been gained, in order to compromise with herself as, by cancelling the session, she believed that she had showed him that it was not so important to her to attend her sessions with me. By doing so, she felt that she could still go on seeing me but at the same time she was appeasing her partner. That disclosure made me wonder whether her non-attendance also was an expression of her
finding therapy intrusive, i.e. she equated it as a sample reading of her journal, and this was explored in later sessions.

The firmness of the frame can also bring up powerful feelings in clients, which are often related to their past (Gray, 1994). The frame means something different to each client, and the experience of the frame can bring unconscious thoughts and feelings into awareness. For example, I noted that one of my clients, Miss A, seemed to struggle to end each session at the stated time. I maintained the firmness of the frame despite feeling very protective of her and wanting to give her a few extra minutes. I did, however, comment on my observation about her seeming uneasy at the end of sessions. She disclosed that she felt very anxious at the end of the sessions and following further exploration we gained important insights into her fear of rejection. In this way the firmness of the frame can bring up different issues for clients which then can be explored. The firmness of the frame also brings a sense of security, and can therefore bring up powerful feelings in the client if it is broken by the therapist. I have experienced this as a client in my personal therapy. I could feel myself getting agitated and anxious during a period when my therapist was consistently late for our sessions. When I finally brought these feelings to therapy, I realised that they were related to my anxiety of being let down and not being important enough to other people.

**Violations of the therapeutic frame**

Although violations of the therapeutic frame instigated by clients can be used as a therapeutic tool, the therapist is usually strongly discouraged from modifying the therapeutic frame. Langs (1977, 1988), for example, argues that not only does the breaking of one rule that makes up the frame encourage the therapist to break other rules, it also has significant implications for the therapeutic relationship. For example, the client may start to develop a sense of mistrust in the therapist and the personal boundaries in the therapeutic relationship can become unclear. It must, however, be pointed out that sometimes breaks in the frame can have a therapeutic effect as each client and their life situation are unique and sometimes it is necessary to break the frame. For example, when working therapeutically with clients with severe and
enduring mental health problems, a multidisciplinary team is usually involved in their care. This means that sometimes it is necessary to extend the boundaries of the usual dyad of the therapeutic frame to include other team members (Wright, 1996). One of my clients, Mrs G, had a 25-year history of bipolar disorder, and she had considerable difficulties in coping with the recurrence of mood episodes. My supervisor and I agreed that Mrs G was likely to benefit from having her care co-ordinator involved in some aspects of the therapy, for example, to provide support with homework. The client seemed very held by this arrangement and she made significant progress in therapy. Furthermore, when the therapy ended, Mrs G’s care co-ordinator continued to reinforce the skills that the client had developed in therapy, and thus the risk of relapse was minimised.

In my own experience as a client, I have found it helpful when the frame is broken from time to time. My personal therapist was very flexible with my appointments: we often booked only one appointment in advance, as my schedule was very busy and often changed from week to week. I found it extremely helpful that he could make allowances for this and break the frame. It made me feel that he lived in the ‘real world’ where at certain stages in a person’s life it can be very difficult to stick to the same appointment every week. On the other hand, I did not have the experience of safety brought about by knowing that a regular time was set aside for me each week, and therefore I do not know how this impacted on the therapeutic relationship. In summary, although violations of the therapeutic frame can be helpful, it is very important that the therapist uses their clinical judgement to decide whether it could be helpful and to ensure that it is not a ‘knee-jerk’ response to the client or their material.

The deviant frame

In some settings, such as General Practitioner (GP) surgeries or psychiatric outpatient clinics, it may be virtually impossible to maintain the frame. Langs (1988) describes these situations as deviant frames, where the therapist’s goal is to maintain as much as possible of the therapeutic frame. He claims that it is absolutely vital that the therapist maintain the frame as firmly as possible, because deviant frame clients tend to ask for
additional alterations in the ground rules. Langs believes that although the deviant frame clients ask for further breaks in the rules, they also indirectly direct the therapist to maintain the frame. Hoag (1992) describes an experience of working in a deviant frame in her paper. She worked as a counsellor in a GP surgery where the frame was consistently broken; she had to move between different consulting rooms, appointments were made through one of the 15 receptionist which often led to clients changing appointment days and/or times, messages from clients getting lost, and clients in crisis did sometimes not get an appointment or even contact with the therapist. As a result, there was a high non-attendance rate including failed first appointments and clients terminating the therapy prematurely. Hoag then made an attempt to secure the frame by acquiring a consistent room used by only the therapist, maintaining control of the appointment handbook and discussing at each initial session how the therapist functioned in relation to the structure of the GP practice in particular with regard to confidentiality. She also pointed out that the therapist was being paid for by the surgery. These changes led to a major drop in clients terminating the therapy prematurely, and an increase in the average number of sessions per client.

Hoag’s (1992) account of her experiences of the difficulties of working within a deviant frame highlights the importance of trying to maintain as much as possible of the secure frame when working in such circumstances. She also brings up another important aspect of the frame which is often unacknowledged; the set fee. Therapists working for the National Health Service (NHS) receive their payment through this organisation, and clients and therapists therefore do not exchange money, and this leads many clients to regard the service as free. Cheifetz (1984) argues that it is the set fee that establishes the intimate relationship between client and therapist as professional, and if the client does not pay a fee, feelings of guilt that the time could be used for someone more needy can arise. McRae (1986) conducted a study in a Community Mental Health Team (CMHT), and he found that it was a significant correlation between not paying a set fee and premature termination of therapy. It should be noted that this issue is of particular importance for counselling psychologists, as many find employment in the NHS, and it is clearly something that should be addressed. Hoag (1992) suggests that by letting the clients know in the
initial session that the therapist is being paid for by the NHS, it is possible to amend that break in the frame.

Concluding comments

The aim of the present essay was to describe the significance of the therapeutic frame, and illustrate how the frame and breaks in it can be used as a therapeutic tool through which important insights can be gained. Furthermore, a discussion of the importance of maintaining the frame, and when it can be helpful for the therapeutic process to break it, was also provided. The frame is a unique and essential component of the therapeutic process, without which it would be near impossible to carry out any meaningful therapeutic work. It lays the foundations on which a therapeutic relationship can be built, in the best scenario the frame provides a safe space with secure boundaries within which the client’s anxieties can be contained and gradually understood. Breaks in the frame, by the client, can also be used in a meaningful way to facilitate the therapeutic process, and likewise, it can also be beneficial for some clients if the therapist, where they feel it is necessary, breaks the frame.
References


THE CONCEPT OF COUNTERTRANSFERENCE AND ITS IMPACT AND USE
IN THERAPY WITH EATING-DISORDERED CLIENTS

Introduction

Ever since Freud introduced the concept of countertransference (1910), it has generated a lot of controversy. This concept was initially viewed by Freud (1910, 1915) as a hindrance, which interfered with the therapist’s neutrality and therefore needed to be overcome. Freud’s definition of countertransference is not altogether clear though it did involve the client’s\(^1\) influence on the therapist’s unconscious feelings (1915). He believed that it was central for trainee analysts to work through their neurotic problems in their own personal analysis and as such reduce the possibility of countertransference based reactions intruding in future treatments. Freud’s lack of precision when he coined the term ‘countertransference’ has given rise to some confusion and difference of opinions in the literature.

Freud’s notion of countertransference was challenged in the late 1940s and 1950s and these new ideas brought about a change in the perception of the concept (Bateman & Holmes, 1995; Gorkin, 1987; Maroda, 1991). Over the last two decades, it seems that fewer therapists strive towards being a “blank screen”. Instead, there has been a growing consensus that the therapist’s emotional response to their client can provide useful information about the client’s inner world. One client group in which it is particularly important for therapists to manage their countertransference reactions is with clients with eating disorders, as they tend to evoke exceptionally strong countertransference reactions in their therapists (Baumann, 1992; Beattie, 1988; Burke & Cohler-Bertram, 1992; Franko & Rolfe, 1996; Goodsite, 1997; Hughes, 1997; Wuhrmann & Breechbuehl, 1999; Zerbe, 1998; 1996). These clients can present as superficially well motivated, but are often extremely ambivalent and resistant towards treatment, which can give rise to feelings of internal criticism and personal

\(^1\) Most writers in this field refer to clients as ‘patients’, however, the word ‘patient’ stems from the medical model of professional practice and is evocative of illness. Counselling Psychology arose from a concern with the fulfilment of potential rather than curing sickness (Woolfe, 1996). As the author is a trainee Counselling Psychologist it therefore seems inappropriate to use the word ‘patient’ and the word ‘client’ will be used in the present essay.
vulnerability in the therapist (Beattie, 1997). As a result, it is important that therapists working with this client group can implement a range of tools to manage their countertransference reactions.

The aim of the present essay is to discuss psychoanalytic ideas of countertransference and how these can be used to inform practice, with particular reference to the countertransference reaction commonly experienced by therapists of with clients with eating disorders, and to the author’s clinical experience with such clients. Firstly, there will be a brief review of the history of the expanding definition of the concept of countertransference, though it should be noted that it is beyond the scope of the present essay to provide an extensive review and the interested reader is referred to Gorkin (1987). Secondly, a definition of countertransference, as used in the present essay will be provided. Thirdly, there will be an outline of commonly reported countertransference reactions in therapists working therapeutically with clients with eating disorders. Finally, a discussion of how therapists working with this client group can usefully and successfully make use of their countertransference reactions as therapeutic tools will be provided. It is important to bear in mind that this list of guidelines is not exhaustive nor is it by any means exclusive to clients with eating disorders.

The development of the concept of countertransference

Freud’s definition and view on countertransference went largely unchallenged for nearly forty years after he coined the term (Gorkin, 1987). Ferenczi (1921) was the first to challenge Freud’s notion of countertransference, though, this was not a disagreement of the definition as such but instead with regard to Ferenczi’s ‘active techniques’ which advocated greater involvement between client and analyst than that which Freud proposed. He developed a technical approach in which the therapist interacts with the client in a direct way, whereby the therapist uses their emotional reactions in a manner radically different to Freud’s ideas. Ferenczi did, however, still view countertransference as part of the therapist’s own difficulties. Up until the late 1940s and early 1950s there were few attempts by psychoanalysts to explore
therapists' emotional response to their clients in a focused manner, and the Freudian position that therapists should remain neutral toward their clients - both inwardly and outwardly - at all costs, was maintained.

The British object relations school and the Sullivan interpersonal school began attacking the Freudian approach to countertransference through a number of articles in leading psychoanalytic journals in the late 1940s. Articles by Winnicott (1949), Heimann (1950) and Little (1951) are viewed by some contemporary writers to have represented most fully the challenge for a revision of the concept (Bateman & Holmes, 1995; Gorkin, 1987). Heimann (1950) expanded the definition of countertransference to include all of the therapist's feelings and fantasies about their client and further postulated that the analyst's emotional response to the client within the analytic situation represents one of the most important therapeutic tools. Despite the controversy that her definition of the concept fuelled, Heimann's (1950) thesis laid the foundations of contemporary thinking about countertransference. The challenge to Freud's original concept of countertransference was responded to by a number of investigators, though it seems that Reich (1951, 1960) was the most outspoken (Gorkin, 1987). Like Freud, she believed that countertransference was a hindrance that needed to be kept under control. Although she argued that countertransference as such was not helpful, she did, however, propose that the therapist's willingness to acknowledge and overcome it was.

At the same time as there was an intense interest in the concept of countertransference, seminal papers on work with clients with borderline personality disorder and psychotic clients were being published (Deutsch, 1942; Faribum, 1940; Little, 1951, 1957; Knight, 1953; Winnicott, 1949). In these papers the intense emotional reactions evoked in the therapists by such clients were explored, and this work contributed to the formation of the idea that different kinds of clients might be expected to evoke different types of expectable countertransference (Heimann, 1950). Since these early papers, there has been a steady and increasingly sophisticated exploration of the negative countertransference that often emerges in the work with these client groups.
There is still little consensus on the definition of countertransference, and the different definitions depend upon how narrow or broad a boundary is drawn around the term. In the present essay the term countertransference will be employed to include all of the therapist’s responses to the client (e.g. Heimann, 1950; Joseph, 1985). There will, however, be a differentiation between what, for example, Winnicott (1949) has called objective countertransference, which is the therapist’s response to the client’s projections, personality and behaviour in the session, and subjective countertransference, which is due to the therapist’s own personal conflicts. It is further assumed that any response to the client by the therapist is a mixture of objective and subjective countertransference and that it is the therapist’s job to tease out and weigh these aspects (Gorkin, 1987).

**Countertransference with eating-disordered clients**

*Eating disorders: diagnostic criteria and psychodynamic theories of aetiology*

The self-destructive behaviour manifest in clients with eating disorders is often enacted in the therapeutic relationship and can lead to difficult clinical management problems (Baumann, 1992; Beattie, 1988; Burke & Cohler-Bertram, 1992; Franko & Rolfe, 1996; Goodisit, 1997; Huges, 1997). There are two major groups of eating disorders, Anorexia Nervosa and Bulimia Nervosa. Eating disorders occur predominately among young western women, however, there is a growing awareness of eating disorders in males, but information is still limited (Carlat, Camargo, & Herzog, 1997). A period of dieting generally precedes the onset of an eating disorder. Anorexia is normally characterised by starvation due to an intense fear of becoming fat, whilst bulimia is characterised by binge eating and prevention of weight gain through misuse of laxatives, self-induced vomiting or both2 (Diagnostic and Statistical Manual of Mental Disorders [DSM-IV] American Psychiatric Association, 1994).

The aetiology of eating disorders, like many other psychiatric disorders, is generally considered to be multifactorial, and research has implicated a large number of

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2 More extensive diagnostic criteria for anorexia and bulimia are presented in DSM-IV.
predisposing factors. Psychodynamic theorists of different persuasions have attempted to explain and make meaningful the behaviours and complex inner lives of clients with eating disorders. Early psychoanalytic theory conceptualised eating disorders within Freud's (1923/1961) drive-conflict model in which the clinical features are derived from an internal conflict among the three agencies of the mind: id, ego and superego. Eating disorders, in particular anorexia, were seen as a way of managing the affects associated with the development of sexuality (Waller, Kaufman, & Deutsch, 1940). Later psychodynamic thought reconceptualised eating disorders within object relations theory (Fairbaim, 1944). Object relations theory encompasses two key processes: understanding and tolerating the separateness of individuals and accepting mixtures of good and bad within individuals (Nicolle, 1938). Consequently, eating disorders came to be understood as a disorder of interpersonal relationships and the organisation of the self (Kaufman & Heiman, 1964).

The range of countertransference reactions with eating-disordered clients

A number of investigators have explored the sometimes extraordinary countertransference experience commonly reported by therapists working with this client group. (Baumann, 1992; Beattie, 1988; Burke & Cohler-Bertram, 1992; Franko & Rolfe, 1996; Goodsitt, 1997; Hughes, 1997; Wuhrmann & Breechbuehl, 1999; Zerbe, 1998, 1996). There have been reports indicating that clients with anorexia tend to evoke more intense negative feelings in their therapists than clients with bulimia. For example, Franko & Rolfe (1996), investigated the emotional reactions of 32 therapists to clients with either anorexia, bulimia or depression and they found that the therapists reported feeling more frustrated, hopeless, helpless and less successful with clients with anorexia. This could possibly be due to clients with anorexia often being more in denial about their problem and therefore are more reluctant to engage in treatment than clients with bulimia (Franko & Rolfe, 1996).

Zerbe (1998) reviewed the literature on transference and countertransference paradigms of eating-disordered clients, and she reports that it is expected that the therapist will experience a range of countertransference feelings throughout treatment.
Furthermore, a number of investigators have underscored the importance of constantly reminding trainees and other professionals new to therapeutic work with this client group, that countertransference reactions are not indications of failure or lack of professionalism, and that managing them successfully and usefully can be challenging even to the most experienced clinician (Burke & Cohler-Bertram, 1992; Hamburg, 1990; Zerbe, 1998). Countertransference feelings can, however, impede on the treatment if they are acted upon or taken to extremes, and can thus become a powerful source that can undermine and ultimately destroy the therapeutic relationship (Burke & Cohler-Bertram, 1992; Hamburg, 1990; Zerbe, 1998).

When I first began my clinical work at an eating disorders service, I was quite unprepared for the intense feelings I experienced with my first client, Ms A. She was a 18-year old woman with anorexia who reported that she only wanted therapy to “shut her mum up” and she appeared very reluctant to engage in therapy. During the course of our work together I found myself experiencing powerful feelings of despair, helplessness and mourning which were strikingly different to anything I felt with previous clients. I was also constantly doubting my abilities as a therapist, and was worried that my being an inexperienced trainee was the cause of the lack of progress in therapy. In supervision, however, my supervisor always paid specific attention to countertransference difficulties as they arose, and her recognition of, and help with, managing these difficulties were invaluable to my work with this client.

One common countertransference reaction to these clients is anger, which can be an attempt to protect the therapist’s self-esteem from the client’s hatred, slow movement or castigation (Zerbe, 1998). In such situations, countertransference may be reflected as (i) repression: the therapist is trying to place the client’s difficulty out of awareness by daydreaming, fantasising, feeling bored, forgetting aspects of the client’s history etc., (ii) turning against the self: when the client resists therapeutic intervention, the therapist’s conscious desire to help turns into self-punishment, and (iii) reaction formation: when the client does not respond to therapy, instead of feeling anguish, the therapist engages in rescue fantasies and unrealistic involvement in the client’s life (Maltsberger & Buie, 1975).
Therapists working with this client group can also often experience an excessive need to change the client (Zerbe, 1998). This need is likely to reflect the underlying despair the client may be experiencing. Furthermore, these clients often bring their own tendencies to avoid addressing their pain by repression and denial. As these clients often appear reluctant and ambivalent to treatment, the therapist sometimes colludes with client by not addressing the specific symptoms, frequency or rituals of the disorder, or by not giving the client psychological space to share their emotional pain. This can be a reflection of the countertransference difficulties tuning into the anguish of these clients (Zerbe, 1998). In the early work that I undertook with Ms A, I caught myself avoiding usage of the word 'anorexia' and feeling uncomfortable when I enquired about the symptoms of her anorexia. When I realised that I was doing this, I attempted to change this behaviour and tried to encourage Ms A to explore aspects of her disorder. Some time later I noticed that Ms A appeared more comfortable and seemed more willing to share difficult feelings with me.

The type of countertransference evoked when working with clients with eating disorders can also depend on the therapist’s gender. Zunino, Agoos and Davis (1991) reviewed this literature and concluded that there are four treatment issues in which a therapist’s gender might affect the cause and content of therapy. These are: (i) problems of body image, (ii) the client’s overinvolvement with her mother, (iii) the client’s ambivalence about gender identity, and (iv) her need for a role model. They do not believe that any gender in particular would be more successful with treating these clients, but they do encourage therapists to be aware of the impact their gender can have on eliciting transference and countertransference feelings.

The countertransference as a therapeutic tool with eating-disordered clients

When treating clients with eating disorders, the therapist having strong feelings is the rule rather than the exception and working through the transference/countertransference paradigms can substantially alleviate the distress that they can evoke. Zerbe (1998) has made a range of recommendations regarding how the therapist can usefully work with their countertransference with this client group. She
states that clients with eating disorders require a deeper understanding of the meaning of the eating disorder in their life as anorexia or bulimia have become a way of life and a sense of identity and it will therefore not be relinquished easily. The countertransference can be used silently by the therapist as a source of information about the client’s inner world. This is made possible through the concept of projective identification (Klein, 1946) in which the client splits off unwanted parts of the self and projects them onto the therapist, and thus is able to evoke corresponding intense countertransference reactions in their therapists, i.e. the objective component of countertransference (Gorkin, 1987).

One of the therapist’s principal tasks is to contain the client’s projective identifications, and later to return them in a ‘detoxified’ version by means of an interpretation or emotionally modulated statement of the interaction (Langs, 1976; Ogden, 1979; Searles, 1979). It has been hypothesised that clients with eating disorders find it particularly difficult to contain their feelings, as they symbolically expel them through bingeing, vomiting, self-starvation, overexercising or laxative abuse, so if the therapist is then able to bear the dysphoric feelings of the client instead of acting on them, the client will be enabled to contain their own feelings (Baumann, 1992). Containing the client’s projections also serve the important purpose of proving to the client that the therapist is durable in the face of the client’s attack, a person who can tolerate separation and growth despite rage and devaluation.

Zerbe (1998) also recommends that the therapist pay particular attention to boundary issues, as many of these clients have a personal history of enmeshment and have enormous difficulties with separating and becoming autonomous. As the treatment progresses, the client is likely to attempt to blur the boundaries and increasingly challenge the therapist to be more ‘real’, for example, wanting physical contact, and it is therefore important that the therapist maintain appropriate therapeutic boundaries.
Concluding comments

The aim of the present essay was to provide a short review of the history of the concept of countertransference, to describe common countertransference reaction when working with clients with eating disorders and to illustrate how countertransference can be used in the therapeutic work with this client group. As it is more a rule than an exception that the therapist experience very powerful countertransference reactions when working with this client group, it is absolutely essential that the therapist seeks consultation or supervision frequently. This may enhance their professional development, bolster the therapist’s sense of professional efficacy and help to maintain appropriate therapeutic boundaries (Burke & Cohler-Bertram, 1992; Zerbe, 1998). Many clinicians feel discouraged when working with this client group as many such clients do not respond easily to treatment, and are consequently reluctant to take on these clients. By being aware of transference and countertransference issues the anxiety and distress that many therapists experience in therapy with clients with eating disorders can be alleviated, and countertransference is therefore an invaluable tool when working with these clients.
References


Introduction

The successful application of cognitive therapy in treating and reducing the risk of relapse in a range of depressive disorders (e.g., Depression Guideline Panel, 1993; Shea et al, 1992) has encouraged its application to a wide range of psychological disorders. Cognitive therapy has, however, been criticised for focusing more on therapeutic techniques than the therapeutic relationship\(^1\) (Jacobson, 1989; Safran & Segal, 1990). Traditionally, the therapeutic alliance has been taken somewhat for granted in cognitive therapy as it has been perceived as a necessary but not sufficient condition for client change (Scott & Dryden, 1996). In other words, the therapeutic relationship is important in that it sets the stage for the strategic and technical work that will follow but the therapeutic relationship \textit{per se} is insufficient to produce change. This assumption has led to a de-emphasis of this variable in the therapeutic process (Safran, 1990a).

In a review of the literature on the role of the therapeutic relationship in cognitive therapy, Waddington (2002) found that cognitive therapy has paid greater attention to the therapeutic relationship over the last decade. There seems to be two reasons for this growing interest in the therapeutic alliance. Firstly, there is research evidence to suggest that the therapeutic relationship predicts outcomes across therapies as diverse as cognitive, psychodynamic and gestalt. Roth and Fonagy (1996), for example, reviewed 100 research reports on the therapeutic relationship between 1976 and 1996 and concluded that there is a strong relationship between the quality of the therapeutic relationship and outcome of therapy. Secondly, cognitive therapy has had limited success in its application to clients with chronic interpersonal difficulties, such as personality disorders. Such clients often require treatment of longer duration which increases the importance of the role of the therapeutic relationship. These issues have

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\(^{1}\) The terms ‘therapeutic relationship’ and ‘therapeutic alliance’ will be used interchangeably throughout this essay.
encouraged cognitive therapy to re-evaluate their assumptions of and the importance that is placed on the therapeutic alliance.

The aim of the present essay is to discuss how cognitive therapy conceptualises and works with difficulties that arise in the therapeutic relationship. Firstly, there will be a brief outline of how the evolution of cognitive therapy has led to the development of new conceptual frameworks. Secondly, there will be a short description of the Therapeutic Belief System (TBS) (Rudd & Joiner, 1997), followed by an illustration from the author's practice. Thirdly, the concept of schema and its relevance to the conceptualisation of the therapeutic alliance will be discussed which will be followed by an illustration from the author's practice. It should, however, be noted that it is beyond the scope of the present essay to provide an extensive outline of TBS and schema theory, and the interested reader is referred to Rudd and Joiner (1997) and Safran (1990a, 1990b).

**Evolution of cognitive therapy: Some difficulties**

The success of cognitive therapy in treating Axis 1 disorders (Diagnostic and Statistical Manual of Mental Disorders ([DSM-IV] American Psychiatric Association, 1994) encouraged the development of new specific approaches for clients with more chronic problems, such as personality disorders. As a result, the importance of the role of the therapeutic relationship as a mechanism or vehicle for therapeutic intervention and change was increased (Rudd & Joiner, 1997). In the literature there was, however, an absence of a clear conceptual framework that defined the specific components of the therapeutic relationship, problems in collaboration and the mechanisms of change (Rudd & Joiner, 1997; Safran, 1990a; Safran & Segal, 1990). This absence has led cognitive therapists to resort to using concepts from other theoretical models in which the importance of the therapeutic relationship is more emphasised, such as psychoanalytic and psychodynamic models of therapy.

In the existing literature, a number of authors have discussed the importance for cognitive therapists working with clients with personality disorders to understand, recognise and manage the psychodynamic construct countertransference (e.g., Beck &
Freeman et al, 1990; Layden et al, 1993; Linehan, 1993). Countertransference can loosely be defined as the therapist’s emotional reactions to the client and/or their material (e.g. Heimann, 1950; Joseph, 1985). In a recent paper, however, Rudd and Joiner (1997) argue that the fundamental principles of cognitive therapy are violated when psychodynamic constructs, such as transference and countertransference, are applied to cognitive therapy. Specifically, they claim that when psychodynamic constructs are integrated into cognitive therapy, the fundamental assumptions underlying this approach, such as the idea of an unconscious, are inherited as well. Rudd and Joiner (1997) claim that the fundamental assumptions underlying psychodynamic therapy are inconsistent with the fundamental principles of cognitive therapy as summarised by Clark (1995): “(a) that individuals actively participate in the construction of their reality, (b) that cognitive therapy is a mediational theory, (c) that cognition is knowable and accessible, (d) that cognitive change is central to human change, (e) that cognitive therapy adopts a present time frame” (Rudd & Joiner, 1997, p.234).

So where does this leave the conceptualisation and understanding of the therapeutic relationship in cognitive therapy? Authors, such as Rudd and Joiner (1997) and Safran (1990a, 1990b), have attempted to develop alternative conceptual frameworks, which are still consistent with the fundamental principles of cognitive therapy, that can guide the use and understanding of the therapeutic relationship in cognitive therapy. A description of these frameworks and how the therapist can use them to work with difficulties that arise in the therapeutic relationship will follow.

**Conceptualisations of the therapeutic relationship in cognitive therapy**

*The Therapeutic Belief System*

The TBS was put forward by Rudd and Joiner (1997) as a conceptual framework to identify the therapist’s and the client’s cognitions about the therapist, the client and the therapeutic process. The TBS allows the therapist to work on the therapeutic
relationship on two levels: on the deeper cognitive structures such as core beliefs, and on the more peripheral cognitive structures, such as automatic thoughts and assumptions. Thus, the TBS acknowledges both tacit and active beliefs and the related emotional and behavioural responses. In practice, separate TBS diagrams are completed for the client's and the therapist's active and tacit core beliefs, assumptions, compensatory strategies, automatic thoughts, emotional and behavioural responses in relation to the client, the therapist and the therapeutic process. The TBS diagrams will thus provide the therapist with rich clinical material that can in itself be used to identify therapeutic goals. One of the advantages of using the TBS as a framework to conceptualise the therapeutic relationship, is that it facilitates the therapist to become more aware of their own TBS. As a result, the therapist may be able to, respond to and manage their own TBS more effectively and thus prevent or minimise counterproductive interactions on their part.

The active beliefs about the therapist, the self and the therapeutic process vary from client to client but in some Axis 1 and 2 diagnoses common themes may be encountered. Rudd and Joiner (1997) identified themes regarding suicidal clients' active beliefs about the therapist as shifting along a continuum from potential victimiser, to collaborator/partner, to saviour. The client has beliefs about themselves and the treatment process as well which are also shifting along a continuum, and TBS can be completed for each. For cognitive therapy, the ideal is for the client to view themselves and the therapist as collaborators. As each theme has related emotional and behavioural responses, however, any shift along the continuum(s) may be useful as the these responses can be addressed in therapy. For example, if the client viewed him/herself as a victim, his/her emotional response may be one of anxiety and their behavioural response may be to miss sessions. The TBS framework could be used to either complete TBS diagrams or as a source of generating hypotheses that the therapist could explore. The client's belief that he/she is a victim could then be targeted in therapy, resulting (hopefully) in a shift to collaborator. As mentioned above, the TBS may also be completed for the therapist and when working with suicidal clients, the therapist's beliefs about the client may shift along a continuum.

2 In this essay, the terms 'schema' and 'core belief' are used more or less interchangeably as they both refer to the cognitive structures that organise experience and behaviour (Padesky, 1994).
from hostile aggressor, to receptive collaborator, to helpless victim. An example of how the TBS can be used in practice will follow below.

TBS in action

Mr J is a 37-year old man whom I was seeing for symptoms of Post Traumatic Stress Disorder (PTSD) following a serious road traffic accident (RTA) two years ago. Mr J has been married for 15 years and has two children. He used to own a haulage company with his father and brother, but they had to sell the family business owing to Mr J’s inability to return to work following the RTA. He described therapy as his last resort and if it could not “cure” him, he will suffer for the rest of his life. In therapy, Mr J seemed very hopeful and enthusiastic but he was making little progress. He attended the sessions very regularly and every time we set a homework task he stated that he “wanted to try anything to get better” but he rarely completed it. I had tried to address the discrepancy between the enthusiasm he was communicating to me and his lack of commitment with regards to the homework, but with little success. I had had frequent discussions about this client with my supervisor but nothing seemed to help to shift us from this “stuckness”. As a result, I had been beginning to doubt my abilities as a therapist and was considering referring him on to another, more experienced, therapist.

In the last session before the Christmas break, Mr J brought me an extravagant Christmas gift. My emotional response was one of anger, having automatic thoughts such as “he’s trying to manipulate me” and I wanted to confront him with this. In other words, I viewed the client as a “hostile aggressor”. TBS would suggest that my anger and urge to confront Mr J may be a behavioural response to my active core belief about the treatment, that he was a threat to me professionally. The strength of my emotional reaction reminded me about this, and I did not confront the client but instead used guided discovery in order to explore the meaning behind his bringing me a gift. It transpired that Mr J viewed me as his “saviour” and bringing a gift was a means to seek reassurance that I would not give up on him. Furthermore, his struggle with completing homework tasks may be a result of his active assumption of me as a “saviour” in which his compensatory strategy allowed him to attend the sessions
passively, expecting me to do the necessary work to “cure” him. I, however, interpreted this as evidence of him being a “hostile aggressor” and my compensatory strategy was to consider referring him on. By bringing the client’s beliefs about me, the therapist, into the therapy, we were able to incorporate them into our work and use it to tackle issues such as non-compliance with homework. This seemed to help to move the therapy forward.

It is quite interesting that our conceptualisations of the TBS were not complimentary. This could perhaps be a result of not having completed TBS diagrams for the tacit beliefs yet. It is possible that a range of tacit beliefs and associated emotions may have been triggered in both myself and the client by the therapeutic process itself, which could have contributed to our differing conceptualisations. In other words, my response to the client may have been a result of my own less functional schemas that had been activated during our work. With my supervisor’s guidance I completed TBS diagrams of both mine and Mr J’s potential tacit beliefs and related responses. It was my hope that I would be able to respond to my client in a more clinically effective manner as a result. I found this framework very helpful when working with Mr J as I was able to use it to conceptualise what was happening in therapy rather than pathologising our reactions. I do believe, however, that it can be quite difficult for a therapist to elicit their tacit beliefs as they are by definition less accessible. It may be particularly difficult to do so for a therapist who has not undertaken personal therapy, and this could limit the usefulness of TBS. Schema theory provides another framework to conceptualise and work with difficulties in the therapeutic relationship and this will be discussed below.

_schema theory_

_the concept of schema_

The concept of schema has for a long time been integral to cognitive therapy, though it is only fairly recently that approaches that focus more on the development and maintenance of schema have been developed (James, 2001). In cognitive therapy, the term ‘schema’ refers to a cognitive structure that helps us organise our experiences
into categories and attach meaning to events, thus helping to make sense of the world. Different types of schemas have different functions, for example, cognitive schemas are concerned with interpretation whilst affective schemas generate feelings (Beck & Freeman et al, 1990). As schemas determine our perception and interpretation of new information, they are maintained through the processes of attending to information that is consistent with the existing schemas or by trivialising or ignoring contradictory information (Nelson, 1997).

*Using schema theory to conceptualise the therapeutic relationship*

Safran (1990a, 1990b) proposes that there are specific interpersonal schemas that are based on previous self-other interactions. He suggests that there is a wired-in propensity for maintaining interpersonal relatedness, and that infants learn from past experiences how to maximise the possibility of maintaining interpersonal relatedness to others. In other words, interpersonal schemas are formed to help the infant to maintain interpersonal relatedness with their caregivers. The interpersonal strategies that are employed by an infant, however, may not be adaptive for an adult. Individuals with interpersonal difficulties are hypothesised to employ interpersonal strategies that are no longer adaptive in the current context, but were so in the past (Safran, 1990a). As interpersonal schemas are supposed to help a person to maintain interpersonal relatedness with others, it is puzzling as to why a person would carry on employing interpersonal strategies that are maladaptive. Safran (1990a) suggests that a person’s maladaptive interpersonal patterns persist because they are reinforced by the interpersonal consequences of the person’s behaviour. In other words, as a schema determines a person’s perception and interpretation of information and thus influences the individual’s actions, the environment will be shaped by the individual’s actions in a manner that reinforces the interpersonal schema. Safran (1990a) calls this a cognitive-interpersonal cycle.

Safran (1990a) further suggests that individuals with interpersonal difficulties have a limited range of interpersonal behaviours as their interpersonal schemas are rigid and constricting. As a result, the more severe an individual’s interpersonal difficulties, the more likely they are to produce a similar response in a range of different people.
(Kiesler, 1986). If a person has very rigid and constricting interpersonal schemas and thus difficulties with interpersonal relationships, it is likely that there will be difficulties in the therapeutic relationship too. Safran’s (1990a) framework, however, can help the therapist to conceptualise these difficulties in terms of their client’s cognitive-interpersonal cycle. The therapist can then use the therapeutic relationship to attempt to identify, in situ, the client’s interpersonal style that is part of their cognitive-interpersonal cycle. The therapist can then intervene in a manner that is not consistent with the client’s schema, and thus provide the client with a new experience which can elicit new and adaptive interpersonal behaviours from the client (Kiesler, 1982; 1988). An example of how, in practice, the therapeutic relationship can be used to identify parts of the cognitive-interpersonal cycle will be given below.

**Mr E’s cognitive-interpersonal cycle**

Mr E was a 47-year old unemployed man who had been suffering from depression for the last four years. He had been married for 17 years, and had three children. Mr E ascribed part of his depression to his feelings of loneliness as he had a very limited social network and the friends he does have tend to “boss me around”. The client’s younger twin brothers died at birth and he remembered his mother as always being very overprotective and making all the decisions for him as a child. Mr E described his relationship with his wife as “difficult” and that they would have separated a long time ago had they not had children. He stated that he was doing everything he could to please her, but she was never happy with his efforts and treated him “like a child”, for example, by booking his doctor’s appointments for him (indeed, she also arranged for his therapy referral). Mr E reported that he always withdrew when his wife treated him “like a child”, which made his wife furious, and then he tried to please her again.

In therapy, Mr E seemed very eager to please me and was constantly seeking reassurance that he deserved therapy. He did his homework very conscientiously. In the first few sessions of therapy I became increasingly aware of my feelings of discomfort, and how I tried to distance myself from Mr E by being very directive in the sessions and when setting homework. This behaviour seemed uncharacteristic of me and I therefore brought this to supervision. Through discussions with my
supervisor, I came to realise that the pattern occurring in therapy - Mr E trying hard to please me and my responding by pulling away and being directive - may be an example of the interpersonal pattern that creates difficulties in his marital life. Additionally, my response to him provided him with information consistent with his early maladaptive schemas which, on the basis of his constant attempts to please others, seemed to include beliefs about himself as helpless and inadequate, and others as critical and undermining. The full cognitive-interactional cycle that was occurring with his wife was not as yet occurring in therapy, but as Mr E’s tendency was to withdraw when people become too directive, he might have terminated therapy prematurely. As soon as I realised that I was responding to the client’s interpersonal pull, I used guided discovery to explore with Mr E how his attempts to please me was a repetition of patterns that occurred in his other relationship and what he might need from therapy in order to help him to modify this pattern. I found Safran’s (1990) framework invaluable in my work with this client as it provided a clear conceptual framework for understanding the dynamics of the therapy. It does not, however, acknowledge the potential of the therapist’s less functional schemas interfering with therapeutic process and how to address that.

Concluding comments

The aim of the present essay was to discuss how cognitive therapy conceptualises and works with difficulties that arise in the therapeutic relationship. A brief outline of how the evolution of cognitive therapy encouraged a re-evaluation of assumptions about the therapeutic relationship was provided. That was followed by a short description of how TBS and schema theory conceptualise and utilise the therapeutic alliance accompanied by illustrations from the author’s practice. As discussed, TBS and schema theory can potentially be very useful frameworks in cognitive therapy. It is, however, important to bear in mind that therapists can also have less functional schemas that may be activated during therapy. The therapist’s schema could interfere with the therapeutic process and the therapeutic relationship. The importance of supervision must therefore be emphasised as it can bring such issues to the forefront, and thus allow the therapist to prevent or minimise counterproductive interactions. It is hoped that this essay has demonstrated that the therapeutic relationship is an
invaluable therapeutic tool as the therapist’s reactions to the client can provide a wealth of information about the client but also the client’s reactions to therapist “open windows into the patient’s private world” (Beck & Freeman et al, 1990: p. 65).

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References


HOW ATTACHMENT THEORY CAN ASSIST EFFORTS TO WORK INTEGRATIVELY WITH EATING-DISORDERED CLIENTS

Introduction

Clients who are suffering from eating disorders are often found to be very challenging by clinicians (Zerbe, 1998). Specifically, such clients often have great difficulties with interpersonal relationships (Stein & Woolley, 1996), which can hinder efforts to engage them in a therapeutic relationship. Furthermore, the self-destructive behaviour manifest in clients with eating disorders is often enacted in the therapeutic relationship and can lead to difficult clinical management problems (Baumann, 1992; Beattie, 1988; Burke & Cohler-Bertram, 1992; Franko & Rolfe, 1996; Goodsitt, 1997; Huges, 1997). In addition, many clinicians experience powerful feelings of failure when working with this client group as many such clients do not respond easily to treatment (Zerbe, 1998). For these reasons, it would seem that schools of therapy in which the importance of the therapeutic relationship is emphasised, such as psychodynamic approaches, would be indicated for this client group. Eating disorders are, however, associated with significant medical complications and the mortality rate for these disorders is high (Goldbloom & Kennedy, 1995; Mitchell, 1995). Therefore, it is important that specific symptom management strategies form an integral part of any therapeutic intervention undertaken with this client group. Cognitive therapy is an approach that has traditionally focused on symptom reduction. It has, however, been criticised for focusing more on therapeutic techniques than the therapeutic relationship (Jacobson, 1989; Safran & Segal, 1990). Owing to these issues, it can often be rather difficult to plan therapeutic intervention for clients with eating disorders.

Integration of psychodynamic and cognitive approaches may be one solution to the difficulty in choosing a therapeutic approach with this client group. Such integration would allow for a focus on both the therapeutic relationship and on symptom management strategies. The assumptions underlying psychodynamic and cognitive therapies are, however, fundamentally different which would suggest that integration could be very difficult indeed (Rudd & Joiner, 1997). Attachment theory (Bowlby, 1969/1982, 1973, 1980) was derived from psychodynamic theories, but some of its
concepts are perhaps closer to that of cognitive therapy (Holmes, 1993). As a result, attachment theory has the potential to act as a bridge between psychodynamic and cognitive theories. The aim of the present essay is therefore to discuss how attachment theory can facilitate efforts to integrate psychodynamic and cognitive theories when working with clients with eating disorders. Firstly, there will be a short outline of the different assumptions underpinning psychodynamic and cognitive theories. That will be followed by a brief description of attachment theory. Common ground between attachment theory and psychodynamic theories, as well as attachment theory and cognitive therapy, will then be explored. Finally, there will be a short outline of how attachment theory can be used to bridge psychodynamic and cognitive theories when working with clients with eating disorders, and an example from the author's clinical practice will be provided to illustrate how this can work in practice.

Psychodynamic and cognitive theories: points of divergence

Clinicians working with clients with eating disorders may need, for the reasons outlined above, to integrate psychodynamic and cognitive therapies. This could, however, be rather difficult to achieve as the assumptions underlying these approaches seem inherently different. Psychodynamic therapy, for example, is a non-directive therapy which emphasises the importance of emotion, past experiences, unconscious processes and intrapsychic structures (Bateman & Holmes, 1995). The therapeutic relationship is of paramount importance as it is viewed as a vehicle for therapeutic intervention and change. Although the phenomena of transference and countertransference frequently occur during normal social interactions (Anderson & Miranda, 2000), they are brought to the foreground in the therapeutic relationship as they can be used to guide therapeutic intervention and thereby encourage change. Transference can loosely be defined as the process through which the client’s perceptions of, and response to, the therapist are influenced by their early relationships (e.g. Kahn, 1997) whilst countertransference can be defined as the therapist’s emotional response to the client and/or their material (e.g. Heimann, 1950; Joseph, 1985).
Cognitive therapy, on the other hand, is directive and emphasises the importance of cognition, the present time frame, the individual's active participation in the construction of their own reality and the accessibility of cognitions (Clark 1995). The therapeutic relationship is viewed as necessary, but not sufficient, for change. In addition, cognitive therapy lacks a framework in which specific components of the therapeutic relationship are defined and where relationship dynamics can be understood or addressed (Rudd & Joiner, 1997; Safran, 1990; Safran & Segal, 1990). Attachment theory (Bowlby, 1969/1982, 1973, 1980) offers a framework for thinking about relationships, but also acknowledges internal models of the world in the form of mental representations. It could therefore offer a potential solution to this predicament by providing a bridge between psychodynamic and cognitive approaches. A short outline of the main features of attachment theory will follow.

**Attachment theory**

Attachment theory was put forward by Bowlby (1969/1982, 1973, 1980) and has common roots with psychodynamic theories, but evolved in epistemologically distinct ways with attachment theory being far closer to empirical psychology. According to this theory, infants have a wired-in propensity for maintaining relatedness to others in order to ensure protection from danger, the supply of food and social interaction that provides opportunities to learn about others, relationships and the self. Although the basic goal of maintaining interpersonal relatedness is biologically wired-in, the infant has to develop efficient behaviours to obtain this goal through learning from past experiences with, and expectations of, the caregiver (Bowlby, 1980). In addition to behaviours that are designed to maintain interpersonal relatedness with the principal caregiver, the infant also develops an emotional link - attachment - to them (Holmes, 1993). Depending on the main caregiver’s availability, ability and willingness to respond to the infant, they will develop different types of attachments (secure, anxious, avoidant or disorganised) to their caregivers (Ainsworth, Blehar, Aters, & Wall, 1978). As development proceeds, the attachment experience with the principal caregiver becomes represented mentally by the child in the form of an internal working model. Different attachment experiences will generate particular internal working models (Sroufe & Waters, 1977). Internal working models organise
expectations and behaviours in all other significant relationships, and they tend to be self-fulfilling and self-confirmed as others react to the individual’s expectations of how they will behave.

**Attachment theory as a potential framework for integration**

*Attachment theory and psychodynamic theories: points of contact*

As argued above, an understanding of and ability to work with the dynamics of the therapeutic relationship is of paramount importance in working with clients with eating disorders. As attachment theory may share more with some psychodynamic traditions than others, the focus of the following section will therefore be on similarities relevant to the therapeutic relationship. Both psychodynamic theories and attachment theory emphasise the importance of the first years of life in their consideration of the relationship between social environment and personality development (Fonagy, 2001). For example, both Bowlby (1969/1980) and Klein (1935) focus on the first year of life as a crucial determinant of later developmental outcome. Attachment theory and psychodynamic theories (e.g. Erikson, 1950; Kohut & Wolf, 1978; Winnicott, 1962) also have a more specific common focus on maternal sensitivity as a causal factor in determining the quality of object relationships and consequently psychic development. Furthermore, the notion of internal working models, and the idea that they can elicit behaviours from others that maintain and perpetuate early attachment patterns, can be linked with that of transference (Eagle, 1999). In other words, the therapist becomes an important attachment figure for the client, and the client’s experience of this relationship will be re-created in light of their internal working model, i.e. transference. The therapist may feel the urge to react to the client’s behaviour in a manner that is expected from the client’s internal working model, i.e. countertransference.

*Attachment theory and cognitive therapy: points of contact*

Cognitive therapy and attachment theory share a commitment to science. In addition, Bowlby’s (1969/1982, 1973, 1980) notions of internal working models are not far
removed from the basic assumptions of cognitive therapy (Holmes, 1993; Safran, 1990). In cognitive therapy mental structures are conceptualised in a hierarchy with schemas, which are formed in early childhood, at the top of the hierarchy. Schemas help to organise experience and behaviour. Schemas determine our perception and interpretation of new information, and they are maintained through the processes of attending to information that is consistent with the existing schemas or by trivialising or ignoring contradictory information (Nelson, 1997). Dysfunctional schemas are believed to underlie the development of psychiatric problems. Likewise, Bowlby (1985) conceptualised internal working models as a set of guiding affective and cognitive models of the world. People with psychiatric difficulties are believed to have rigid internal working models which are struggling to revise themselves in light of new experiences. Such individuals are therefore basing their relationship to the world on outdated assumptions. Both cognitive therapy and attachment theory propose that an important part of therapy is to elicit and modify schemas/ internal working models.

**Bridging the gap: attachment theory as a potential framework**

It was argued at the beginning of the present essay that the dynamics of the therapeutic relationship are of particular importance when working with clients with eating disorders, as well as the implementation of symptom management strategies. Attachment theory provides a bridging language between psychodynamic and cognitive approaches, in particular through the notion of internal working models (Holmes, 1993). Owing to the medical risks involved when working with this client group, it is important that the focus of the early stages of therapy is on symptom management strategies. This usually involves taking an essentially cognitive-behavioural approach which includes psycho-education, stimulus control techniques and cognitive restructuring (Fairburn & Cooper, 1989). Cognitive techniques can easily be incorporated into an attachment framework, as internal working models are very similar to the concept of schemas. Indeed, internal working models have been viewed by some as interpersonal schemas (Safran, 1990).

Once symptom reduction has occurred, attachment theory can be used to explore the meaning and function of the symptoms. For example, it has been found that three
differentiate individuals with bulimia from non-clinical controls (Waller, Ohanian, Meyer, & Osman, 2000; Waller & Luck, 2002). These schemas could be understood as internal working models generated from ambivalent attachment patterns to their primary caregiver. It is characteristic of individuals classified as ambivalent to have deep anxieties about the lovability and value of the self (Howe, Brandon, Hinings, & Schofield, 1999). The assumptions underlying the symptoms of bulimia, such as “I am special if I am thin” (Fairburn & Cooper, 1989), could be recast in attachment terms. For example, the self is unworthy of love but being thin is a way in which the self can become worthy of significant others’ love and attention. These assumptions, preconceptions and beliefs generated from the internal working model are likely to be brought into play in relation to the therapist, and can be modified through the new experience with the therapist. This is similar to the ideas of some psychodynamic theorists, such as Gill (1982) and Sandler (1976, 1981), who suggest that the main therapeutic opportunity provided by the transference is to provide the client with a response significantly different from the original one. It can also be helpful for the therapist to use attachment theory to understand their countertransference feelings in terms of the response expected from the client’s internal working model.

One of my clients, Miss L, was a 20-year old lady who suffered from bulimia, whom I saw at an outpatient eating disorders service. I assisted in the delivery of the dynamic programme which was of eclectic orientation. The theoretical approach was primarily psychodynamic (object relations theory) but cognitive behavioural strategies were also integrated in the treatment (Lacey, 1985). During the first stage of therapy we focused on reducing her bulimic symptoms by using cognitive behavioural strategies. Miss L’s bulimic symptoms reduced significantly although she was becoming increasingly depressed and tearful. Those feelings were explored in therapy, and it emerged that the client was having significant concerns about the possibility of putting on weight following the reduction of her bulimic behaviours and that putting on weight would have a negative impact on her worth and lovability. Through the ‘secure base’ of the therapeutic relationship, Miss L was able to explore these painful feelings, in particular her desire to ‘merge’ with other people and how being thin was a mean to make herself wanted to other people. Her desire to ‘merge’ with other people was also
enacted in the therapeutic relationship, and she seemed to struggle to cope with the ending of sessions and breaks in the therapy. It would appear, on the basis of her continuing efforts to keep other people involved with her, that she had a history of ambivalent attachment. The experience of coping with the rhythm of attachment and parting in the therapeutic relationship, in addition to gaining insight into the function of her bulimic symptoms, seemed to help Miss L to start modifying her internal working models.

**Concluding comments**

The aim of the present essay was to discuss how attachment theory can facilitate efforts to integrate psychodynamic and cognitive theories when working with clients with eating disorders. The different assumptions between psychodynamic and cognitive theories have been outlined, and attachment theory has been briefly described. The utility of using attachment theory as a framework in order to integrate aspects of both psychodynamic and cognitive theories when working with clients with eating disorders has been outlined, and a clinical example form the author’s own practice was provided.
References


INTRODUCTION TO THE THERAPEUTIC PRACTICE DOSSIER

The Therapeutic Practice dossier relates to clinical practice. It contains a short description of each of my placements including the clinical populations that I worked with. Furthermore, the 'Final Clinical Paper', which provides an overview of how I integrate theory and research into clinical practice, is also included here.

In order to preserve confidentiality, details of individual clients have been changed and pseudonyms have been employed whilst placement locations and placement supervisors have been omitted.
DESCRIPTIONS OF CLINICAL PLACEMENTS

Placement I (a): Children's charity

This placement was with a charity that provides emotional support to children aged 4-11 years in a number of primary schools in deprived inner-city areas. The children in these schools come from diverse ethnic backgrounds, typically as many as fifty different cultural backgrounds may be found in each school. The clients had either self-referred or were referred by their teachers for disruptive or withdrawn behaviour. There was a team leader in each school who was responsible for referrals, and for communication with teachers and parents. Furthermore, it was the policy of the charity to disclose as little information as possible about the clients to the therapists, in order to prevent the therapists from forming preconceived ideas about their clients. As a result, the information I had regarding my clients' backgrounds was sparse.

The charity offered both individual and group interventions, though I was only involved in long-term, one to one therapy. The therapy sessions took place in a purpose designed room in the client's school. Weekly supervision was provided by a psychodynamic psychotherapist.
Placement I (b): Psychological Therapy in Primary Care Service

This placement was in a primary care context in a large city where the clients were referred directly by General Practitioners (GPs). Clients were seen in a health centre which has several facilities including a child and family psychotherapy unit. Sometimes there were cross referrals, as was the case with one of my clients, who was referred through her GP from the child and family clinic. The clients suffered from mild to moderate mental health problems. The client group was a varied one but most commonly clients presented with any of the following; depression, anxiety (including panic attacks and/or phobias), post traumatic stress, physical illness related stress, bereavement, and relationship problems. The non-attendance (DNA) rate for the first appointment was significant at this centre. The clients were initially offered between 6 and 12 sessions with the possibility of renewing the contract.

I conducted psychological assessments (initially under the supervision of my supervisor) and provided one to one, time-limited therapy. I was also required to write assessment and discharge reports for GPs. Furthermore, there were liaison meetings with counsellors working within GP practices in the area and I attended these on a monthly basis. I received weekly supervision from a chartered counselling psychologist who is also a member of the UKCP Psychoanalytic Psychotherapy section, and so the main focus of the supervision was psychodynamic.
Placement II (a): Adult Outpatient Eating Disorders Service

This placement was an eating disorders service at a tertiary level in a large city and it accepts both local and national referrals by GPs or Community Mental Health Teams (CMHTs). The clients were seen in purpose designed accommodation which forms part of a larger hospital. The service receives approximately 350 referrals per year for inpatient or outpatient assessment and treatment, and is able to take referrals across the age span, both female and male. The referrals include clients with: anorexia nervosa (restricting sub-type), anorexia nervosa (binge-purge sub-type), bulimia nervosa, multi-impulsive eating disorders, binge eating disorders and Eating Disorders Not Otherwise Specified (EDNOS). All adult clients were initially referred to the outpatient department where they were assessed by a member of the team. The referrals were subsequently discussed at the weekly allocation meeting where a decision regarding the individual needs of a given client was made, i.e. inpatient or outpatient basis, dynamic or cognitive therapy.

I worked in the outpatient department as part of a multidisciplinary team which consisted of psychiatrists, psychologists, psychotherapists, clinical nurse specialists and dieticians. Specifically, I worked on the dynamic/behavioural programme, which utilised a combination of psychodynamic, cognitive and behavioural approaches. I provided one to one therapy for clients with anorexia, bulimia or binge eating disorders on a medium-term basis. I was required to write discharge reports to the referrers and I attended the fortnightly business meetings as well as the weekly referral and therapists’ meetings. At the therapists’ meeting a member of staff presented a case or their research for discussion. Indeed, I presented my second year research project entitled “Maternal eating disorders: adult daughters’ reported experiences” at the therapists’ meeting. I found the therapists’ meeting a particularly valuable learning experience. Additionally, I was supervised by a psychotherapist on a weekly basis.
Placement II (b): Psychological Therapies Service

This placement was with a psychological therapies service department in a secondary care context in a large city. The clients were referred by their GP or by one of the two local CMHTs. The service aimed to assess a client within 4 weeks of referral and clients were subsequently placed on a waiting list for 3-6 months. The clients were seen in purpose designed accommodation. The department offered Cognitive Behavioural Therapy (CBT), Cognitive-Analytic Therapy (CAT), Family Therapy, Art Therapy and Dance & Movement Therapy. The difficulties that the clients brought were varied but were perceived to be too complex for a primary care setting. The most common presenting problems included: history of trauma including sexual and/or physical abuse, depression, anxiety (including panic attacks and/or phobias) and interpersonal difficulties.

I provided individual psychotherapy on a medium-term basis and I was also required to write discharge reports for the referrers. Specifically, the main theoretical approach that I used was CAT, in which the clients were offered between 12 and 16 sessions and a follow-up where another block of 6-16 session was offered if needed. As this Trust provides mental health services to a diverse range of cultures and ethnic groups, I gained significant experience of working with clients from diverse cultural backgrounds. I received weekly supervision from a psychotherapist who also is an accredited practitioner of the Association of Cognitive Analytic Therapists.
Placement III: Community Mental Health Team

The placement was in a CMHT within a large inner city National Health Service (NHS) Trust. I provided a psychology service to the CMHT as part of the multidisciplinary team which consists of psychiatrists, psychologists, community psychiatric nurses (CPNs), occupational therapists (OTs) and social workers. The team sees people aged between 18 and 65 and focuses attention on clients with common or severe and enduring mental health problems. The clients were referred from a number of sources including General Practitioners (GPs), other members of the multidisciplinary team, self-referrals etc. Following assessment, the team made a decision during the weekly allocation meeting whether to offer the client treatment in this service, and if so where in the team the client would be seen (i.e., psychology, OT etc.). Clients were offered either short-term or long-term contracts depending on the complexity of their difficulties.

I undertook initial assessments of clients’ psychological function and needs in order to formulate suitable interventions which were then discussed with the team during the weekly referral meeting. In order to develop my range of assessment skills I was given the opportunity to use psychometric tests, such as the WAIS and the WASI. Furthermore, I also carried out individual therapeutic interventions on short, medium and long-term basis. The client group was a varied one but most commonly the clients presented with any or a combination of the following: schizophrenia, bipolar affective disorder, obsessive-compulsive disorder, post-traumatic stress disorder, anxiety or chronic unipolar depression. Additionally, I gained significant experience of using the Care Programme Approach (C.P.A) including case management, care co-ordinating and co-working. I attended the weekly referral meetings and was supervised by a chartered counselling psychologist on a weekly basis. The main focus of supervision was cognitive behavioural.
Introduction

Within this paper, the way in which I integrate psychological theory and research, supervision and personal therapy into my practice as a counselling psychologist will be described. The relevance of integrative therapy over single brand names of therapy will be discussed briefly before my personal approach to integration will be outlined. It is hoped that by addressing my personal and professional development throughout my three years of training, my continuing development as an integrative practitioner\(^1\) will be demonstrated. Furthermore, vignettes of my clinical work with clients will be used throughout this paper in order to further illustrate this point. Details of individual clients have been changed and pseudonyms have been employed in order to protect client confidentiality.

Integration issues

Evidence base and integration

At present, there is an emphasis in the National Health Service (NHS) on offering clients a treatment of choice as suggested by the evidence base (Department of Health, 2001). This means that psychological therapies have to be standardised and evaluated in terms of their efficacy in reducing symptoms of a specific mental disorder as defined by the Diagnostic and Statistical Manual-IV ([DSM-IV] American Psychiatric Association, 1994) (Holmes & Bateman, 2002). Cognitive behavioural therapy (CBT) has received the greatest proportion of support due to its ability to perform to quantitative standards. As a result, findings from other forms of therapy, which may have been seen to be effective within everyday practice, have been largely ignored. However, when meta-analyses (quantitative reviews of a large number of psychotherapy outcome studies) on different approaches to therapy have been carried

\(^{1}\) The terms practitioner, therapist and counselling psychologist will be used interchangeably.
out, sufficient evidence to believe in the superiority of any type of therapy over another has not been found (Roth & Fonagy, 1996; Stiles, Shapiro & Elliott, 1986).

Indeed, in recent years there has been a move towards enhancing therapeutic efficiency through integration rather than through single traditional brand name therapies (e.g., Clarkson, 1995: 1996; Dryden, 1996; Holmes & Bateman, 2002; Norcross & Goldfried, 1992; O'Brien & Houston, 2000; Palmer & Woolfe, 1999). This move seems to have been fuelled by the argument that a single brand name of therapy limits the flexibility of the number of ways in which an individual client’s complex need may be met (e.g., Owen, 2001). The terms ‘integration’ and ‘eclecticism’ are often used interchangeably, even though a clear distinction between the two the concepts has been put forward. McLeod (1993) has suggested that in eclecticism “the counsellor chooses the best or most appropriate techniques from a range of theories or models, in order to meet the needs of the client. Integration, on the other hand, refers to the somewhat more ambitious enterprise in which the counsellor brings together elements from different theories and models into a new theory or model” (p. 99).

Eclecticism has been considered by some authors as “a pick-and-mix approach that draws on the best aspect of a variety of approaches and applies them piecemeal to patients, without worrying about theoretical unity of approach” (Holmes & Bateman, 2002: p. 3). From this viewpoint integration is seen as somewhat superior, at least theoretically. On the other hand, other authors, such as Lazarus (1995), do not believe that integration is at all possible as he considers the integration of theoretical viewpoints irreconcilable. My own standpoint is somewhere between these two positions, and I do believe that there is room for both, which I hope to demonstrate in the present paper.

**My personal account of integration**

One critical question for the training course in counselling psychology at the University of Surrey is how to facilitate adequate knowledge of and competence in the three main therapeutic schools (humanistic, psychodynamic and CBT). The approach of the course was to provide one year of theoretical and practical training in each of the three schools, whilst simultaneously drawing attention to theoretical and practical
issues of integration. This approach allowed me to gain an understanding of the approaches but also to question their exclusive claim to the 'truth'. Practising a different approach to therapy each year also highlighted to me the rivalry between different therapeutic traditions, which I found both in the literature and at my placements. In many ways I can identify with the need for the security that a single therapeutic approach can offer. Each year I found the transition from using one therapeutic approach to another very difficult and I felt deskillled and ineffectual as a therapist. As I progressed through my training I realised that although the transition each year was difficult, the advantage was that I had started to develop a wide knowledge base from which I could formulate - a provisional hypothesis or attempt to explain how and why a particular client is experiencing these particular difficulties in this particular way at this particular time - and work with different clients. Although my professional identity is still being consolidated, my approach to integration corresponds to the 'wholistic integrative approach' (Owen, 2001). This perspective suggests that different theoretical frameworks are not mutually exclusive but instead important parts which in a complementary manner provide a more complete picture of the 'whole', i.e. human functioning. For me, integration is about being flexible and being able to offer a range of interventions according to different abilities and life situations, whilst being mindful of the real distinctions between techniques and philosophies of the different therapeutic modalities. I see integration as a career long process of continually evolving my repertoire of theoretical knowledge, therapeutic techniques and relationship styles in order to meet my client's diverse needs.

*The therapeutic relationship*

In counselling psychology, great emphasis is placed on developing a sound and good therapeutic relationship. Indeed, this has been repeatedly reported to be the most important therapeutic component in creating a positive change in clients' mental wellbeing (Bergin & Lambert, 1978; Luborsky, Cris-Cristoph, Mintz & Auerbach, 1988; Roth & Fonagy, 1996; Safran & Segal, 1990). The emphasis that has been placed on the therapeutic relationship throughout my training, in addition to having been an anchor through the transitions between different therapeutic approaches, has led me to believe that integration takes place in the context of the this relationship. I
believe that a crucial aspect of therapy is to engage the client in the therapeutic relationship and that it is within this relationship that therapy takes place. Of course, with many clients establishing and maintaining the therapeutic relationship is the therapy. Attachment theory (Bowlby, 1969/1982, 1973, 1980), in particular, has been invaluable for me in terms of providing a theoretical underpinning for my experience but also for the research findings that the quality of the therapeutic relationship is a good predictor of outcome of therapy. To conceptualise the therapeutic relationship as an attachment bond, where the goal is to form a ‘secure base’ from which exploration and alliance rupture repairs can take place (e.g., Fonagy, 2001; Holmes, 2001, 1993) has helped to clarify and guide my interactions with complex clients.

Personal therapy

One of the hallmarks of counselling psychology is the emphasis on self-awareness (Woolfe, 1996). It has been argued that in order to be able to contribute effectively to the establishment of a therapeutic relationship with a client, the therapist needs an understanding of their own psychological processes (e.g., Woolfe, 1996). Specifically, the therapist needs a high level of self-awareness in order to reflect on the process of the therapeutic encounter and their own responses. My personal therapy has been invaluable for both my personal and professional development. My experience of being a client and all that it entailed; feeling safe and being accepted, feeling scared of coming into close contact with disowned parts of myself, feeling vulnerable and taking risks, has led me to be able to empathise more with my clients’ experience and admire their courage. To experience theoretical concepts such as transference, countertransference, resistance and projection from a client’s perspective has been extremely important to me from both a personal and a professional perspective. I remember my surprise the first time my therapist interpreted her countertransference reaction as I had been completely unaware of my ability to elicit such feelings in another person. Furthermore, personal therapy has also made me more aware of my own material and thus helped me to separate it from that of my clients.
In counselling psychology the link between science and practice is a crucial one. Counselling psychologists are expected to research their work, and as a discipline counselling psychology is integrative in that it acknowledges the interdependence of theory, practice and research (Woolfe, 1996). In this section I hope to demonstrate that the research I have undertaken has informed my practice and development as an integrative practitioner. In my second year I carried out a qualitative research project in which I explored reports of the mother-daughter relationship provided by adult daughters of mothers with eating disorders. The study was informed by attachment theory (Bowlby, 1969/1982, 1973, 1980). The findings gave me some important insights into how mental health problems in parents may impact on offspring, for example, on the quality of the parent-child relationship and on the offspring’s mental representations of themselves. Specifically, the findings offered insights into the emotional needs and range of psychological difficulties that offspring of parents with mental health problems may face.

The findings from my research were particularly useful in my work with a 19-year old girl in the context of a specialist eating disorders service. The client had been suffering from binge-eating disorder for the last six years and she was obese. Her father had been diagnosed with a personality disorder before she was born. He seemed to have difficulties with interpersonal relationship and the client described him as acting in a sexually inappropriate manner around women. At the time of therapy, he was awaiting trial for sexual assault. In therapy I aimed to provide conditions in which she could explore painful feelings relating to the relationship with her father and her experience of his difficulties. Although the findings of a study that explored reports of the mother-daughter relationship provided by adult daughters of mothers with eating disorders may not immediately seem relevant to the therapeutic work with a client whose father suffered from a serious mental health problem, I was, as a consequence of that study, more aware of some of the difficulties that the client might be experiencing. I could therefore use this awareness to encourage her to reflect upon how her relationship with her father has affected her sense of self and her behaviour in intimate relationships, including the therapeutic relationship.
Integration of theory and research in my practice

I will now provide an account of my work with clients during my three years of training with a particular focus on how I integrated theory and research into my practice. I also hope to demonstrate how I used the therapeutic relationship with my clients and the ways in which supervision and personal therapy have enriched my practice.

Year 1

In my first year I undertook a split placement which meant that I spent one day a week in primary care in a General Practitioner (GP) service and one day in a primary school providing individual interventions for children referred for disruptive or withdrawn behaviour. In my primary care placement I saw clients on both short and long-term basis whilst in the primary school I only saw clients on a long-term basis. Although the teaching on the course was mainly focused on humanistic models of therapy, both my supervisors’ orientations were psychodynamic. In practice this meant that I used the person-centred approach (Rogers, 1951, 1961) in my clinical work but used psychodynamic theories to conceptualise my clients’ presenting problems. In other words, from the very beginning of my career as a counselling psychologist I was encouraged to think about my clients and the therapeutic work from different theoretical perspective. It was, however, a challenge to trying to reconcile these different approaches as the assumptions they made about human nature were often conflicting. To illustrate how this worked in practice I will present a vignette of my therapeutic work with Miss A, whom I saw in my primary care placement.

Miss A was a 25-year old woman who presented with difficulties with managing her anger towards her partner. The client reported that during her angry outbursts she became physically violent towards him and that he often retaliated so that she ended up bruised. These angry outbursts seemed to be triggered when Miss A felt rejected or ignored by him. During the assessment it emerged that the client’s mother had been suffering from clinical depression throughout her childhood. She remembered how she used to get very angry with her mother for not paying her attention and that her mother
used to respond by locking her in her room for hours. This is consistent with research findings which indicate that children of mothers with depression often display aggressive and disruptive behaviours (Greenberg, Speltz & DeKlyen, 1993). Miss A had had two sessions of therapy prior to the assessment with me, but had been referred on to our service as the therapist was leaving. Following a discussion with my supervisor, I decided to offer the client 16 sessions of therapy (including the assessment).

At the beginning of the therapy, Miss A seemed very angry with me and reluctant to engage in therapy. She challenged my trainee status and informed me that she preferred male therapists to female. Working from a psychodynamic perspective, I could have used Menninger's (1958) 'triangle of insight' in order to make an interpretation that linked what was happening in therapy and in her relationship with her childhood experience of her relationship with her mother. It seemed that as a child, Miss A developed an ambivalent attachment style due to her mother being emotionally unavailable to her, as a result of her mother’s depression. Ambivalent attachments are characterised by deep anxieties about the lovability of the self and doubts regarding other people’s ability to be emotionally available in times of need (Bowlby, 1973). In other words, her being very angry with me may have been in response to a fear that I, like her mother and indeed the previous therapist, would reject her in a time of need. This seemed to be an *in situ* example of how she responded to her partner in light of potential rejection. By using psychodynamic theories to inform my conceptualisation of Miss A’s difficulties, I was able, with my supervisor’s help, to understand what was occurring in therapy and also to contain my own anxiety regarding her angry outbursts.

As I was working from a person-centred perspective at the time, it was more significant for me to acknowledge the reality of her concerns about my gender and qualifications as a therapist through the use of empathy and unconditional positive regard. By my accepting and giving value to the client’s experience, i.e. her anger, a relationship developed in which Miss A felt safe and supported as demonstrated by her increasing openness and willingness to take risks. As therapy progressed, she was able to reflect on her present situation and achieved a heightened awareness of the relationship between her past and present experience. Towards the end of therapy,
however, Miss A once again became angry and hostile towards me. It was then that one of the shortcomings of the person-centred approach became clear to me. Although a productive therapeutic relationship had been established through the core conditions of empathy, acceptance and congruence, this 'healing encounter' (Rogers, 1951) alone was insufficient to promote change in this client. According to Gill (1982), understanding the roots of the difficulties is not enough as the difficulties were acquired through experience and they must therefore be transformed through experience of the therapeutic relationship. In psychodynamic terms, insight and containment had been provided but not a 'corrective emotional experience' (Kahn, 1997).

This issue was discussed in supervision, and I also used my personal therapy to explore the meaning of my feelings of vulnerability elicited by Miss A's angry attacks. The insights I gained from using supervision and personal therapy enabled me to give Miss A the space and encouragement she needed to become aware of and explore her feelings of my abandoning her by the therapy coming to an end. By allowing her to 'work through' her anger and by not reacting with rejection or retaliation, she was provided with a 'corrective emotional experience' (Kahn, 1997). At the end of therapy, Miss A reported that she was able to express anger in an assertive, as opposed to aggressive manner, and her score on the General Health Questionnaire (GHQ) had dropped to a 'sub-clinical' level. In conclusion, although my therapeutic practice was primarily person-centred, my understanding of this client and of the therapeutic relationship was significantly enhanced by the integration of psychodynamic ideas.

Year II

In my second year I once again undertook a split placement. I spent one day per week in a psychological therapies service in a secondary care context, and one day per week in a specialist eating disorders service in a tertiary care context. In the latter I worked in the outpatient department as part of a multi-disciplinary team on the dynamic/behavioural programme devised by Lacey (1985). The programme was of eclectic orientation: the theoretical approach was psychodynamic but CBT techniques were incorporated in order to promote symptom reduction. At this placement I became
acutely aware of how important eclecticism can be. Specifically, as eating disorders are associated with significant medical complications and the mortality rate for these disorders is high, it is imperative that specific symptom management strategies are incorporate into any given model of therapy when working with people suffering from eating disorders (Goldbloom & Kennedy, 1995; Mitchell, 1995). Whilst I experienced how eclecticism can work in clinical practice at the eating disorders service, I also experienced how integration can work in practice at the psychological therapies service. This placement offered a range of short and long term therapies to clients with common mental health problems whose difficulties were considered too complex for a primary care setting. My supervisor’s main theoretical orientation was Cognitive Analytic Therapy (CAT) (Ryle, 1991). This is an integrative approach which aims to unite ideas from developmental and cognitive psychology with psychodynamic approaches, in particular those from the object relations school. I will now provide a clinical illustration of how I used this integrative approach with a client who suffered from depression.

Mrs C was a 30-year old divorcee who, for the last ten years, had been suffering from symptoms of depression, such as low moods, feelings of hopelessness, fatigue and low self-esteem. During the assessment she revealed that she had been estranged from her family for the last ten years. The client reported they had not believed her when she disclosed that she had been sexually abused by an older brother throughout her childhood, and that she had cut herself off from them after this incident. She reported that she had difficulties with maintaining interpersonal relationships as she “lets people walk all over” her and was deeply fearful of trusting others. This is consistent with research evidence that suggests that victims of older brother-younger sister incest commonly develop mistrust of men and women (Laviola, 1992). I was aware that the difficulty to trust people was likely to be re-enacted in the therapeutic relationship. Therefore, it seemed that a model of therapy in which the importance of the therapeutic relationship is emphasised, such as psychodynamic approaches, would be indicated with this client. It has, however, been suggested that a multimodal approach, in which therapeutic interventions focus on cognition, affect and behaviour in combination rather than in isolation, is the most appropriate treatment of survivors of sexual abuse (Sanderson, 1995). In discussion with my supervisor, we agreed that
CAT would be an appropriate approach to take with this client. As CAT is a time-limited psychotherapy (Ryle, 1991; Ryle, Spencer & Yawetz, 1992), Mrs C and I agreed to meet for 16 sessions with the possibility of renewing the contract.

Although the early weeks of therapy seemed very painful for Mrs C she was able to use the therapy to explore the difficult feelings around the sexual abuse she was subjected to as a child. We used the Psychotherapy File (Ryle, 1991), which describes different maladaptive procedures called traps, dilemmas and snags (Ryle, 1979), to identify the maladaptive procedures relevant to Mrs C. A ‘procedure’ is defined as “the sequence of perception, appraisal, aim formation, choice of means, action and evaluation of the efficacy and consequences of the action which is linked in a circular fashion and which maintains intentional action” (Ryle et al., 1992: p.401-402). A maladaptive procedure is a procedure that is not revised in light of negative feedback. In the fifth session I presented Mrs C with a reformulation, which was written as a letter to her and contained an account of my understanding of her history and how the strategies she employed as a child to survive were now operating as maladaptive procedures. The reformulation was checked with the client and revised as necessary. Mrs C’s particular dilemma revolved around either getting close to people and getting hurt or stay in charge but remain lonely (Ryle, 1991). It appeared that the reformulation presented Mrs C with visible evidence of being understood, which seemed particularly important with this client as it laid the foundations for a trusting relationship. The reformulation also provided a framework for therapy in terms of providing an ‘exit’ from her maladaptive procedure.

Mrs C’s dilemma was inevitably re-enacted in the therapeutic relationship. Over the first eight sessions, she worked very hard in therapy and she disclosed the sexual abuse to her best friend. This was one possible ‘exit’ from her dilemma that had been suggested in the reformulation. Half way through therapy the client did not attend three sessions in concession. I was feeling hurt, let down and bewildered by this behaviour. My supervisor was very helpful as this point by helping me to view this occurrence as an example of Mrs C ‘acting out’ her dilemma. By reflecting upon my feelings in supervision we were also able to hypothesise that I may be in part experiencing these emotions within the countertransference. This helped me to use my
own feelings to inform me about what Mrs C might be experiencing in close relationships. I found that by using the reformulation in therapy as a 'blueprint' we were able to collaboratively make sense of what had happened, and thus the therapy moved forward. At the end of therapy, Mrs C described feeling more confident and comfortable in her close relationships and her symptoms of depression had significantly decreased. Specifically, she had developed more trusting and supportive relationships with her partner and her best friend. We had a follow-up appointment two months after ending the therapy, and Mrs C reported that she had been able to maintain the gains she had made in therapy. I found CAT particularly useful in my work with this client due to the psychoanalytic understanding it offers including the crucial focus it lays upon the therapeutic relationship, through which she was provided with a 'corrective emotional experience' (Kahn, 1997). Additionally, the incorporation of behavioural and cognitive methods seemed to have empowered her by allowing her to convert passive suffering to active engagement in problem-solving.

Year III

In my third year I undertook a placement in a Community Mental Health Team (CMHT). I worked as part of a multidisciplinary team and I saw clients with common or severe and enduring mental health problems on both short and long term basis. Although I had incorporated CBT techniques whilst using CAT and on the dynamic/behavioural programme at my previous placements, I found the transition to practising CBT to be challenging indeed. The structure and practical application of CBT was appealing to me but adjusting to a more protocol driven, directive therapy was difficult on a personal level. This was because my perfectionistic attitudes and related concerns about 'doing the right thing' were brought to the forefront by following protocols and being more directive in the sessions. As a result, I felt very deskilled and ineffectual as a therapist. I was significantly helped by bringing some of these issues to supervision where my supervisor would model specific interventions, such as guided discovery, which allowed me to obtain more realistic appraisals of their usage. Personal therapy was also invaluable in exploring and 'working through' the feelings that surfaced from the experience of using CBT.
At the CMHT I was allowed considerable flexibility to work integratively, and I drew on psychodynamic, humanistic, and schema-focused ideas when conceptualising clients’ presenting problems and was also able to incorporate some of these concepts and techniques into a CBT framework in my clinical practice. Indeed, seeing clients with such complex and often longstanding difficulties highlighted to me the shortcomings of a ‘pure’ CBT approach. Specifically, I noted, like other authors before me (e.g., Douglas, 1989; Safran & Segal, 1990; Young, 1994) that some clients describe difficulties that seem to lie outside the scope of a CBT model. As a result, my awareness of the importance of having a wide knowledge base to assess, formulate and plan therapeutic interventions from was further increased. My experience of seeing clients with severe and enduring mental health problems helped me appreciate even more the unique contributions that counselling psychologists can make in this type of setting through their systematic training in different models of therapy, research and attention to process. I shall now provide an example of my work with a client that illustrates this.

Mr T was a 40-year old man who presented with symptoms of Obsessive Compulsive Disorder (OCD) and a fear of being contaminated by certain foods. He had an extremely restrictive diet, and approximately 1 to 2 days per week he avoided food altogether. At the assessment Mr T weighed 55 kg and his height was 185 cm giving him a Body Mass Index (BMI) of 16, which was significantly below the normal weight band (19.5-25). Both the symptoms of OCD and the fear of being contaminated by foods were of a long-standing nature. In addition, the client had a history of aggression and as a teenager he had been convicted for violence related crimes a number of times. During the assessment the client seemed very hostile towards me as demonstrated by his monosyllabic yet confrontational responses. He informed me that he was very sceptical about the benefits of therapy as he had found previous therapies very unhelpful and had subsequently discontinued them. I had initially planned to use a CBT approach (Beck, Emery with Greenberger, 1985; Salkovskis, 1996) as it provides a comprehensive account of obsessional problems. As Mr T seemed so hostile, however, it seemed more pertinent to concentrate efforts on establishing a working alliance as this cooperation between client and therapist underpins all effective helping (Clarkson, 1995). I therefore acknowledged the reality of his...
concerns through the use of the core conditions of person centred therapy: empathy, positive regard, genuiness and warmth (Rogers, 1951, 1961). This seemed to reduce Mr T's hostility and he appeared to gradually feel secure with me as indicated by his willingness to share his thoughts and feelings with me.

I carried out an extended assessment and at the end we seemed to have established an effective working alliance as we had been able to agree on goals of therapy, the necessary tasks to achieve the goals and Mr T was engaged in the therapeutic relationship. Bordin (1979) has suggested that these three aspects of the working alliance are required for any form of therapy to be successful. Research findings on the effects of semi-starvation suggest that it can have profound physical, psychological and social effects (Keys, Brozek, Henschel, Mickelsen & Taylor, 1950). As the client's BMI was very low, which was likely to have an effect on his ability to engage in therapy, we decided to firstly focus on the food avoidance. Psychoeducation is an integral component of CBT (Olmsted & Kaplan, 1995), and I employed research findings on the effects of semi-starvation to promote attitudinal and behavioural change to his diet. Two months on, following the collaborative construction of a graded hierarchy of food types, Mr T had regained one stone and had begun to enjoy eating again. The work of our sessions was consistently focused in the relationship during this process. Specifically, although the client employed the hierarchy in-between sessions, the sessions themselves were focused on his perception of himself as 'weak' and 'out of control'. Thus, a maladaptive schema, 'I'm powerless' was elicited.

As Mr T was regaining weight, his obsessive compulsive neutralising behaviours reduced but he was becoming increasingly aggressive outside sessions and was struggling to manage his angry outbursts. At this point Young’s (1994) concept of schema processes, in particular schema compensation, was particularly useful in assisting me to conceptualise the client’s difficulties. It seemed that Mr T had compensated for his powerless schema by being in control of his diet and through neutralising behaviours. When these strategies became less rigid through therapy he then used anger as a means to compensate for this schema. Following this, the therapy shifted its focus to a more schema-based approach which incorporated experiential and
interpersonal techniques within a CBT framework (McGinn & Young, 1996). During this phase of therapy I became even more aware of the necessity of a good working alliance. In schema-focused therapy the basic stance of the therapist is that of 'empathic confrontation', which involves empathising with the underlying schemas while confronting the client with the need to change (McGinn & Young, 1996). If a significant portion of the therapy had not been spent in engaging the client fully in the therapeutic relationship, I believe that Mr T’s powerlessness schema would have contributed to his feeling very threatened by this approach and he would probably have discontinued therapy.

As I progressed through my third year I noticed that there had been a qualitative change in my use of supervision. Although supervision was a space during which I could engage in a process of self-reflection, I had become more confident in trusting in my own ability when conceptualising clients' difficulties and planning therapeutic interventions. I believe that I was arriving at a place where I felt more comfortable in my role as a counselling psychologist whilst still being aware of my limitations and thus recognising when I could benefit from my supervisor’s experience. For me, this was a major shift from my second and particularly first year when I had relied heavily on my supervisors’ guidance and experience.

**Concluding comments**

In this paper I have presented an account of how I have used theory and research to inform my clinical practice during my three years of training. I have demonstrated how supervision, personal therapy, and my own research has assisted me in the process of becoming an integrative practitioner. I believe that integration takes place in the context of the therapeutic relationship and, for me, integration is a process of developing a wide theoretical knowledge base from which I can apply therapeutic techniques and develop relationship styles that meet the diverse needs of my clients. Thus, I view integration as a career long, continuing process of self-reflection, personal and professional development to which I look forward to.
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INTRODUCTION TO THE RESEARCH DOSSIER

This dossier consists of a literature review and two pieces of original research. The literature review examines psychological literature relating to the effects of parental eating disorders on offspring. The second paper explores reports of the mother-daughter relationship provided by adult daughters of mothers with eating disorders. The third paper examines clinical decision-making by mental health professionals in specialist eating disorders services, regarding the children of their female clients.
THE EFFECTS OF PARENTAL EATING DISORDERS ON OFFSPRING: A REVIEW OF THE EMPIRICAL LITERATURE

Abstract

This paper reviews the existing literature on offspring of parents with eating disorders. In order to gain a deeper understanding of these findings, the present review draws on research and knowledge of children and adult children of alcoholics, as there are superficial similarities between alcoholism and eating disorders. From the research to date, it is possible to deduce three broad mechanisms by which a parental eating disorder can affect offspring, and each of these mechanisms is discussed. The evidence from the present review seems to suggest that the most serious consequences of a parental eating disorder on offspring are a direct result of the parent’s eating disorder symptomatology. Further research on the possible intergenerational transmission of eating disorders can expand the knowledge of the aetiology of eating disorders. Implications for treatment are discussed and suggestions for future research are made.
Introduction

The last four decades have seen an immense rise in the prevalence of eating disorders, and about 20 per cent of sufferers are chronically affected (Garfinkel, 1995). Although anorexia nervosa and bulimia nervosa are regarded as distinct disorders, there is a substantial overlap in their defining features, including an intense preoccupation with weight and shape, and a morbid fear of becoming fat\(^1\). Both disorders are associated with significant levels of comorbidity, such as major depression, several anxiety disorders including panic attacks and social phobia, and particularly in the case of bulimia, alcohol dependence (Cooper, P.J., 1995; Lilenfeld et al., 1998; Pyle, Mitchell, & Eckert, 1981; Sullivan, Bulik, Fear, & Pickering, 1998). There is, however, an important difference between them, as anorexia nervosa has a much lower rate of full recovery (Herzog, Dorer, Selwyn, Ekeblad, & Flores, 1999) and has the highest mortality rate of any psychiatric disorder (Eckert, Halmi, Marchi, Grove & Crosby, 1995; Harris & Barraclough, 1998; Herzog et al., 1993; Sullivan, 1995). Even when sufferers of anorexia have met the criteria for full recovery, it has been found that a relatively low body weight and cognitive features of anorexia (perfectionism and cognitive restraint) still persist (Sullivan et al., 1998).

Eating disorders most commonly start to develop in adolescence, and therefore, many of the chronic sufferers are of child bearing age. Low fertility often accompanies eating disorders but despite this, children have been born to women with such conditions. There is now good evidence that psychiatric conditions among parents put their children at risk of developing problems, and this literature has been brought together through a series of reviews (e.g., Beardslee Bemporad, Keller & Klerman, 1983; Cassell & Coleman, 1995; Cleaver, Unell & Aldgate, 1999; Cummings & Davies, 1994; Downey & Coyne, 1990; Falkov, 1998; Hall, 1996; Oates, 1997; Pound, 1996; Puckering, 1989; Rutter, 1989; Rutter & Cox, 1985; Rutter & Quinton, 1984). It is only recently, however, that research into the effects of parental eating disorder on the offspring has been instigated. This research was sparked by two major concerns

\(^1\) More extensive diagnostic criteria for anorexia and bulimia are presented in Diagnostic and Statistical Manual of Mental Disorders ([DSM-IV] American Psychiatric Association, 1994).
(Stein & Woolley, 1996). Firstly, as the core symptoms are exceptionally pervasive and disruptive in daily life, they are likely to conflict with the parent’s ability to respond to and understand the child’s needs. Secondly, people suffering from eating disorders often have great difficulties with interpersonal relationships, and this may extend to them having difficulties with building a relationship with their children. Despite these concerns, there has been surprisingly little research carried out in this area. Most reports to date have consisted of case studies, although in recent years a small number of controlled studies have been carried out.

**Children of parents with eating disorders and children of alcoholics**

A number of researchers have argued that there are many superficial similarities between eating disorder pathology, and alcohol and drug abuse (e.g. Goldbloom, Naranjo, Bremner & Hicks, 1992; Hudson, Weiss, & Pope, 1992; Krahn, 1991; Wilson, 1995; Wilson, 2000). The similarities between eating disorder pathology and drug and alcohol abuse have particular reference to the pathology of binge eating, which is frequently a prominent feature of eating disorders. For example, both disorders include strong cravings for the substance, a loss of control over their consummatory behaviour, using the substance to cope with stress and to regulate their emotional state, secrecy of the pathological behaviour, denial of the problem, and a tendency for the illness to cluster among relatives. The two disorders seem further related as there is a significant comorbidity between them (Bushnell et al., 1994; Garfinkel et al., 1995; Kendler et al., 1991; Schukit et al., 1996; Suzuki, Higuchi, Yamada, Mitzutani & Kono, 1993; Wilson, 1993).

Due to the similarities between eating disorders and drug and alcohol abuse, it is possible that offspring of such parents have more similar psychological experiences than offspring of parents with other psychiatric conditions. The psychological experiences of children of parents with eating disorders and children of alcoholics (CoAs) may be more similar, however, than those of children of drug misusers. Specifically, there is a greater tendency for both parents to be drug misusers whereas problematic drinking, as with eating disorders, is often confined to one of the parents.
allowing the child to have a more stable relationship with the other care taker (Drummond & Fitzpatrick, 2000). From a child’s perspective, the adverse impact of illicit drug misuse by parents therefore seems to be qualitatively different from the effects of parental alcoholism and parental eating disorders. Furthermore, although there are striking similarities between eating disorder pathology and alcohol abuse, it is important to bear in mind that there are some significant differences between the psychological experiences of children of parents with eating disorders and CoAs. For example, the alcoholic parent often has an impaired consciousness as a result of the effects of alcohol, and this leads children of alcoholics to be at a greater risk of both physical and sexual abuse (Drummond & Fitzpatrick, 2000).

**Objectives**

As counselling psychologists and other clinicians are likely to encounter both clients with eating disorders and their offspring in their dual roles as therapists and researchers, it is critical that they are aware of the research that supports or refutes the assumptions that there is a relationship between parental eating disorders and disturbed child development. The aim of the present paper is therefore to review the empirical literature on eating disorders in parents and the implications for their children. As the effects of parental alcoholism on the offspring has been heavily researched, and the psychological experiences of children of parents with eating disorders and CoAs may be similar, research and knowledge of CoAs and adult children of alcoholics (ACoAs) will be employed. It is hoped that this will provide a broader perspective from which to view the findings of the effects of parental eating disorders. Such comparison could help to ascertain whether the findings from offspring of parents with eating disorders are domain specific, or related to the general psychiatric disturbances present in the parent.

This review will start with a preamble regarding the employment of psychiatric diagnostic categories in the present paper. That will be followed by a short outline of what constitutes ‘good-enough’ parenting in order to recognise the impact that a parental psychiatric disorder can have on a child. Furthermore, from the research to
date, it is possible to deduce three broad mechanisms by which a parental eating disorder can affect the offspring, and each of these mechanisms will then be discussed. Firstly, there will be an outline of the evidence regarding how eating disordered parents' disturbed attitudes toward food, body shape and weight may have a direct effect on their children. Secondly, there will be a summary of the literature on how the parents' eating disorder may interfere with their general parenting functioning. Thirdly, the research that has investigated how the parents' eating disorder may act as a poor role model for their children will be discussed. That will be followed by a brief summary of the evidence for the intergenerational transmission of eating disorders. Finally, there will be a discussion of the limitations of the current research, as well as a brief outline of the clinical implications of this research, and this paper will conclude with some directions for future research.

**The use of psychiatric diagnostic categories**

The majority of the research carried out on offspring of parents with eating disorders has employed a medical discourse and utilised psychiatric diagnostic categories. Psychiatric diagnoses are commonly used to describe, define and distinguish clinical characteristics. They are also used to facilitate research and communication between different professional disciplines (Walsh & Garner, 1997). The process of diagnosis is a medical task that essentially divides individuals into categories of sick/healthy, and stereotypes an individual within a given diagnostic category. Furthermore, it has been argued that psychiatric diagnoses pathologise ordinary human distress and developmental difficulties and that it locates the difficulties within the individual and distracts attention from contextual factors (Strawbridge & James, 2000). Psychologists, on the other hand, commonly employ psychological formulations which assume a continuity between the normal and the abnormal and are client and context specific. There are a number of issues associated with the usage of diagnostic categories (e.g. Blashfield, 1996; Kutchins & Kirk, 1999; Pilgrim, 1983; Pilgrim, 2000; Pilgrim & Bentall, 1999; Strawbridge & James, 2001), including the implications of psychologists utilising these, but it is beyond the scope of this paper to engage in such a discussion. It is worth noting, however, that the reason for the present...
paper's employment of psychiatric diagnostic categories from DSM-IV (American Psychiatric Association, 1994) is the nature of literature that will be reviewed.

'Good-enough' parenting

In order fully to appreciate the impact of a major parental psychiatric disorder on a child, it is important first to define what constitutes 'good-enough' parenting. Kelmer Pringle (1986) identified a number of basic needs that children in Western cultures need to have satisfied by their caretakers; the satisfaction of these needs constitutes the core components of 'good-enough' parenting. Reder & Lucey (1995) built on these principles and put forward the following as essential needs of children that must be satisfied by 'good-enough' parenting: physical (nutrition, warmth/shelter, health/cleanliness, safety and contact), behavioural (stimulation, exploration/learning, socialisation/role models, and rest) and emotional (affection, availability, consistency, reality testing, building of self-esteem, and attachment/autonomy). According to Duncan and Reder (2000) there is reciprocity between these requirements, in that "parents who support their child in their early steps are simultaneously encouraging their physical maturation, social exploration and learning, as well as facilitating development of their self-esteem, personal identity and sense of safety" (p.84). Throughout this review the components of 'good-enough' parenting will be considered in light of the research evidence on the effects of parental eating disorders on offspring.

The effect of parental eating psychopathology on offspring

Parental concerns regarding their children's body shape

From the limited number of studies to date, it seems that eating-disordered parents' preoccupations with eating, body shape and weight have a direct effect on their children. For example, the parents' morbid fear of getting fat can in some cases extend to their children, which may cause them to underfeed their children. Their concern with weight, shape and food intake may also lead to conflict during mealtimes, as well
as causing them to be critical of their children’s eating habits, weight and appearance. The implications of conflict during mealtimes will be explored further in the ‘feeding and mealtimes’ section. Smith and Hanson (1972) documented the first case of the effects of anorexia nervosa on offspring. They reported a case study where an anorexic mother starved to death her 10-week old daughter. This is, however, the only case in the literature in which such serious consequences of parental eating disorder have been identified. Following Smith and Hanson’s (1972) article, several researchers began to investigate the effects of eating disorders on offspring. Lacy and Smith (1987), for example, conducted a study on the effects of bulimia nervosa on motherhood. They found that 15 per cent of these mothers had actively been reducing their babies’ weights within their first year of life. Later research and case studies have supported this finding (Hodes, Timimi & Robinson, 1997; Russell, Treasure & Eisler, 1998; Scourfield, 1995). There is also evidence to suggest that mothers with eating disorders express significantly higher concern for their young daughters’ weight and shape than non eating disordered mothers, but this difference is not reported for sons (Agras, Hammer & McNicholas, 1999).

Growth

Restricting of food can have serious adverse physical consequences for children. From the research to date, a relationship between anorexic mothers and children with stunted and/or low weight-for-height has been demonstrated. The entire population of clients diagnosed with anorexia in Denmark were followed up by Brinch, Isager and Tolstrup (1988), and of those who had children 28% reported that their children had had eating and weight problems in their first year of life. In 1989, Van Mezel-Meijker and Wit found that seven children from three families where the mothers had a history of anorexia presented with both stunted and low weight-for-height. Similarly, Hodes et al. (1997) investigated the extent of abnormalities of weight and growth amongst children of mothers with eating disorders, and they found that 32 per cent of these children had abnormalities of weight or growth. These findings were also supported by Russell et al. (1998). However, Stein, Murray, Cooper and Fairburn (1996) found evidence that suggests that the growth disturbances observed in these children are not
a direct extension of their mothers' psychopathology. They compared the growth of infants of mothers with eating disorders with infants of mothers suffering from postnatal depression. They found that although the infants of mothers with eating disorders were smaller in terms of both height and growth, there was little evidence that these mothers preferred their infants to be smaller or that they were dissatisfied with their babies' weight or shape. Instead, it seems that a general difficulty with feeding was a more important mechanism in the causation of disturbances in weight.

Feeding and mealtimes

A number of studies have observed food-related difficulties among children of eating disordered parents. Stein, Woolley, Cooper and Fairburn (1994) conducted an observational study with two groups of primiparous mothers and their infants. The index group consisted of mothers who had been suffering from an eating disorder during the postnatal year whilst the control group had not. The two groups were observed at home during play and at a mealt ime when the infants were 12-14 months old. The main finding from this study was that the index mothers were more intrusive with their infants during both mealtimes and play compared to the controls. The index group also expressed more negative emotion towards their infants during mealtimes but not during play. Furthermore, the index infants tended to be lighter than controls and infant weight was independently and inversely related to both the amount of conflict during mealtimes and the extent of the mother's concern about her own body shape.

Stein et al's. (1994) findings have generally been supported. For example, Waugh and Bulik (1999) reported that, in comparison to a control group, eating disordered mothers made significantly fewer positive comments about food and eating to their infants during a mealtime observation. They also found that the index infants had significantly lower birth weights and lengths than controls. Other food-related problems that have been documented among eating-disordered mothers include considerable difficulties with both keeping food in the house, and feeding the children, due to fears of provoking binge eating attacks (Fahy & Treasure, 1989; Franzen &
Gerlinghoff, 1997; Stein & Fairburn, 1989). There is also some evidence to suggest that mothers with eating disorders feed their children on a less regular schedule than controls and that they use food for non-nutritive purposes such as rewarding or calming the offspring down (Agras et al., 1999). Evans and le Grange (1995), however, found that mothers with eating disorders fed their infants on schedule whilst controls fed on demand, and more research is clearly needed to clarify this issue.

It has also been found that that eating-disordered mothers' eating psychopathology can interfere with their ability to recognise and respond to their infants' cues during feeding, particularly with potential antecedents to conflict (Stein, Woolley & McPherson, 1999). These antecedents to conflict most commonly involved the infant making a mess when eating or trying to feed itself. Stein et al. (1999) suggest that, as a result of the mother's eating disorder, she found mealtimes especially stressful, and this stress might have been heightened when she had to sit and patiently feed an infant, and cope with her own preoccupations with food at the same time. As a result, the mother's attention was impaired and she missed the infant's cues, which often led to conflict. It is still not clear, though, why these mothers found the infants making a mess, and attempts to self-feed, so stressful. However, one of the characteristics of sufferers of both anorexia and bulimia is perfectionism (Cooper, Z., 1995), and it is possible that it is this need to stay in control and have the environment perfect that causes the infant's attempt to self-feed to be so stressful for the mother. The research reviewed in the 'maternal concerns regarding their children's body shape', 'growth' and 'feeding and mealtimes' sections seem to suggest that some parents with eating disorders fail to provide parts of the physical dimension, i.e. nutrition and health, that constitutes 'good-enough' parenting. This failure can, however, have implications other than inadequate weight gain and growth in infancy and childhood, and this will be discussed below.

**Attachment and eating disorders**

Daws (1997) suggested that feeding and weaning problems are related to issues of closeness and distance between the infant and the caregiver. She conducted a study of
infants who failed to thrive in a baby clinic at a general practice and noted that those who have problems with feeding are often held at a distance from the caregiver when fed. Daws (1997) hypothesised that this distance is a necessity for the caregiver in order to cope with emotional issues. She further suggested that it is necessary to look at attachment to understand why some children are unable to take food when it is readily available. In other words, it seems that caregivers of infants with feeding problems have problems managing the complexities of intimacy, and this would result in the formation of a poor quality attachment between caregiver and infant. As many individuals with eating disorders have great difficulties with interpersonal relationships, they may form poor quality attachments with their children, which in turn may affect the feeding situation and this eventually leads to a feeding problem.

Although children of parents with eating disorder may be at risk of forming a poor quality attachment with their parent due to their interpersonal difficulties, they may also do so for other reasons. Zahn-Waxler and Radke-Yarrow (1990) have argued that a caregiver who is preoccupied with an illness is unlikely to be able to separate her/his own needs from the child’s; hence his/her capacity to understand and respond to the child’s need is impaired. This could have negative implications for the process of forming an attachment between infant and caregiver. Miller (1981) argues that if a parent’s needs are dominating at the expense of the child, the child will have difficulties in developing an independent sense of self. In order for a child to separate, he/she needs the foundations of secure attachment and dependency which will have developed from the centrality of the child’s needs and the parent’s accurate response to them. Studies of ACoAs have demonstrated that they have a distinct dysfunctional attachment profile (Brennan, Shaver & Tobey, 1991; El-Guebaly, West, Maticka-Tyndale & Pool, 1993), but no study to date has investigated the possible effects on attachment for offspring of eating disordered parents.

**Parental eating disorder and general parenting functioning**

A parent’s eating disorder may interfere with their general parenting functions; for example, parents’ preoccupation with body shape, weight and food may impair their
concentration and they may become unresponsive to their children's emotional and physical needs. This would indicate a deficiency on the emotional and behavioural dimensions of 'good-enough' parenting. As a result, it is possible that these children are at risk of developing behavioural and emotional problems, and other psychiatric disorders. Moreover, the majority of eating disorder sufferers are female. This may be a particular disadvantage for the offspring, as there is evidence from studies of CoAs that suggests that it is particularly damaging for children to have an alcoholic mother. For example, Moser and Jacob (1997) compared parents and children from alcoholic and non-alcoholic families, with regard to quality of interactions and child outcomes. They found that the most impaired interactions were exhibited in families where both parents were alcoholic, or where only the mother was alcoholic. They suggest that the more negative impact on parent-child interactions exhibited in the families with an alcoholic mother reflects the excess stress experienced by these families. In other words, in most families mothers have many unique roles and have more contact with the children than fathers, and therefore alcoholic mothers may have a particularly negative impact on the family members. It would be useful to investigate whether the gender of the eating disordered parent relates to different child outcomes. It may be difficult to explore this possibility, however, as only a small proportion of all sufferers are male and within this group, approximately two thirds define themselves as either gay or asexual (Carlat, Camargo & Herzog, 1997) and so are less likely to be parents. Furthermore, in the remaining heterosexual third, there seems to be only a few that have children of their own. So far, Woodside and Shekter-Wolfston (1990) have reported the only study to date that involved fathers with eating disorder, and that involved only two cases.

*Development of psychological difficulties*

Bearing in mind the relative paucity of the research to date, already a relationship between maternal eating disorder and emotional and psychological problems in their offspring has been demonstrated. Evans and le Grange (1995) compared the attitudes of eating disordered mothers towards their children with controls. They found that 50 per cent of the index children were described by their eating-disordered mothers as
displaying difficulties of varying types and severity. These problems included hyperactivity, avoidant behaviour, enuresis, insecure attachment, childhood depression, alcohol abuse, personality problems and violent temperament. Likewise, Hodes et al. (1997) found that 50 per cent of their sample of children of mothers with chronic eating disorders had a psychiatric disorder, including severe conditions such as anorexia nervosa and obsessive-compulsive disorder.

Furthermore, the backgrounds of these children have generally included high levels of parental separation, family discord and poor maternal social functioning. These background factors are highly relevant to the high rate of psychiatric disorder, as it has been documented that discordant marital and family relationships have their own adverse effects on children (e.g., Barnes, 1999; Buchanan, Maccoby & Dornbusch, 1991; Buehler, Anthony, Krishnakumar & Stone, 1997; Cummings & Davies, 2002; Cummings, Davies & Simpson, 1994; Holroyd & Shepard, 1997; Johnston, Kline & Tschann, 1989; McCabe, 1997; Nomura, Wickramaratne, Warner, Mufson & Weissman, 2002; Rutter, 1994; Rutter & Quinton, 1984). Research has shown that eating disorders are often associated with interpersonal difficulties (Fahy & Treasure, 1989, Stein & Woolley, 1996) and it is therefore likely that the mothers’ eating disorder contributes to the high rate of marital discord and separation found in this sample, which in turn may contribute to additional adverse effects on the children. The high rates of divorce and separation amongst families with an eating-disordered parent may also have the additional effect of reducing possible protective effects. There is evidence from studies of CoAs that suggests that a warm and nurturing relationship with one parent can compensate for the potentially damaging effects of the dysfunctional parent (Moser & Jacob, 1997). If the children live with the eating-disordered parent after the separation (which seems to be the case in most studies to date), it may be difficult to maintain such a relationship with the other parent due to their physical absence, and the protective effects could therefore be reduced. Furthermore, in many cases, separation has already taken place at the time of the child’s birth.
Social learning and eating disorders

The third documented adverse effect on children whose parents suffer from an eating disorder is that parental eating disorder can act as a poor role model for children. It has been noted that a number of children whose mothers are suffering from an eating disorder show behaviours that are remarkably similar to their mother’s symptoms. For example, Timimi and Robinson (1996) observed a 2½-year old girl, whose mother suffered from bulimia, mimic vomiting over waste paper bins at home. Likewise, they also noted that a 4-year old boy whose mother suffered from anorexia - including a history of retching when she eats - displayed similar retching behaviour when eating. This has been explained as a form of social learning, where the child is modelling the mother’s behaviour. This phenomenon has also been found in the ACoA literature (e.g. Sher, Walittzer, Wood & Brent, 1991). In her review of the recent ACoA literature, Harter (2000) concluded that ACoAs were more prone to use alcohol to cope with stressors, and to expect beneficial effects from alcohol use, than non-ACoAs and individuals from other high risk groups. This may seem rather remarkable at first sight, as it might be expected that ACoAs would be less likely to use alcohol to cope with stressors and not to expect beneficial effects from alcohol than non-ACoAs, as they presumably have had first hand experience of the negative effects of alcohol.

Both alcoholics and individuals with eating disorders have reported using alcohol/food to regulate their emotional state and cope with stress (Wilson, 1995). Bearing the above finding in mind, it seems possible that the eating-disordered parent models eating disorder symptomatology as a means of coping with stressors. This could cause the offspring also to employ this non-optimal method of coping with stress. Furthermore, this is another indication of problems on the behavioural dimension of ‘good-enough’ parenting. It is, however, rather unlikely that the process of modelling could solely cause an eating disorder, as most researchers on the aetiology of eating disorders agree that the pathways to symptom formation are multiple and interactive (e.g. Hoek, 1995; Vitiello & Lederhendler, 2000; Whitehouse & Harris, 1998). In addition, over the last century there has been increasing cultural pressure on women in western societies to be thin, and in parallel, the incidence of eating disorders has vastly
increased since the 1960s. It has therefore been suggested that socio-cultural factors play a large part in the onset of an eating disorder in a person who is already vulnerable due to risk factors (Dorian & Garfinkel, 1999; Garfinkel & Gamer, 1982; Gordon, 1990). It therefore seems worth considering whether children of mothers with eating disorders may be a high risk group for developing eating disorders due to the additive effects of a possible genetic susceptibility to eating disorders, having eating disorders symptomatology modelled at home and the promotion of the thin beauty ideal by the Western culture.

The intergenerational transmission of eating disorders

There is some evidence to suggest that there is an intergenerational transmission of eating disorders. Pike and Rhodin (1991) conducted a comparative study of mothers’ attitudes and behaviours that relate to disordered eating, between mothers and their eating-disordered daughters, and mothers with daughters who did not suffer from such psychopathology. They found that the mothers of the eating-disordered daughters were themselves more eating disordered and differed in their dieting history in that they had a longer dieting history compared with the mothers whose daughters were not eating-disordered. These findings have been supported by research on early childhood feeding problems (Whelan & Cooper, 2000; Whitehouse & Harris, 1998). Whitehouse and Harris (1998) compared the eating behaviour of a group of nursery school children whose caregiver showed evidence of abnormal eating attitudes as demonstrated by their scores on the Bulimic Investigatory Test, Edinburgh (BITE) (Henderson and Freeman, 1987), and the Eating Attitudes Test (EAT-26) (Garner, Olmstead, Bohr & Garfinkel, 1982), and that of a control group drawn from the same population. Food refusal was higher - but the difference was not statistically significant - in the children of caregivers with disordered eating attitudes.

Whelan and Cooper (2000) did find a strong and specific association between childhood feeding problems and maternal eating disorder in a community sample. They compared three groups of four-year old children: children with a feeding problem, children with a non-feeding form of disturbance (e.g. shyness, fearfulness, or
behavioural disturbance), and children without disturbance. Maternal current and past affective disturbance and maternal current or past eating disorder were systematically assessed. They found that mothers of the children with feeding problems had a markedly raised rate of both current and past DSM-IV eating disorder. There is some evidence of a continuity between childhood feeding problems and frank eating disorder in later childhood, adolescence, and early adulthood (Jacobs & Isaacs, 1986; Marchi & Cohen, 1990). There is also compelling evidence that there is a genetic component to eating disorders (Kendler et al., 1991; Kipman, Gorwood, Mouren-Simeoni & Ades, 1999; Pieri & Campbell, 1999; Vitiello & Lederhendler, 2000; Wade et al., 1999). The association between maternal eating disorder and childhood feeding problems may be mediated by either genetic or environmental variables, or both.

**Genetic factors**

The results of studies of genetic factors in eating disorders seem to indicate that there is a genetic susceptibility to the development of eating disorders, but a genetic susceptibility *per se* is not enough to develop an eating disorder. For example, Lilenfeld *et al.* (1998) reported a high degree of familial aggregation for eating disorders; they found a total rate of eating disorders of about 8 per cent among the first-degree relatives of sufferers of eating disorders. These findings have generally been supported. Kipman *et al.* (1999) conducted a review of the genetic factors in anorexia, and they reported an estimate of heritability to be 0.72 of all published familial studies and 0.71 of all published twin studies. Moreover, there is evidence to suggest that additive genetic and non-shared environmental variables best explained variance in liability to develop disordered eating, with about 60 per cent of the variance explained by genetic factors (Wade *et al.*, 1999). However, none of these studies have included children of mothers with eating disorders. It would seem possible that a parent's eating psychopathology contributes to an environment in which a genetic predisposition is more likely to be activated (Stein & Woolley, 1996), and therefore these children might be at an even higher risk of developing an eating disorder than family and twin studies would indicate.
Critical reflection on the existing literature

Methodological considerations

It should be noted that the research on offspring of parents with eating disorders suffers from major methodological shortcomings. These include small sample sizes, which are known to result in inadequate statistical power to detect small effects reliably, and this can lead to inconsistency in findings. Most of the research to date consists of case studies, which are in-depth studies of one individual (usually) and therefore lack generalisability (Al Rubaie, 2000). Only a small number of studies have compared eating disordered mothers with non-eating-disordered mothers. The former group most commonly consists of a mixed group of mothers with either past or present eating disorders (e.g. Evans & le Grange, 1995). Consequently, the results may not be reliable as it is quite possible that a mother with a past eating disorder may behave in a different manner towards her children than a mother with a current eating disorder.

Furthermore, due to the difficulty in finding participants, the index group often consists of mothers with either bulimia or anorexia. These two disorders are qualitatively different in many ways, and they are differentiated in DSM-IV (American Psychiatric Association, 1994). The premorbid personality characteristics for the two conditions are also distinct. For example, individuals with anorexia tend to be perfectionists, introverted, have poor peer relations and low self-esteem (Beumont, 1995). Likewise, individuals with bulimia tend to be perfectionist and have a history of disturbed interpersonal relationships but unlike individuals with anorexia they tend to have difficulties with impulse control and substance abuse (Beumont, 1995).

Anorexia and bulimia are also different with regards to treatment success. There is no consistently effective treatment for anorexia, and a recent longitudinal study found that only 33 per cent of sufferers reached full recovery (Herzog et al., 1999). Furthermore, the same study found that approximately 40-50 per cent of the weight-restored anorexics relapsed after achieving full recovery. Factors that seem to influence the risk of a relapse for sufferers of anorexia are: the client's motivation for treatment, degree
of insight and severity of symptoms (Eckert et al., 1995). It has also been found that clients who were discharged in more stable physical and psychological condition were less likely to relapse (Baran, Welzin & Kaye, 1995). Conversely, treating bulimia has been more successful, with a 50 per cent recovery rate after a 12-week course of Cognitive Behavioural Therapy (CBT) (Mitchell et al., 1990). It is possible that offspring are affected in different ways depending on the whether the parent has anorexia or bulimia, and that possibility has not yet been explored. Likewise, only one of the studies to date (Stein et al., 1996) has included an additional high risk group for comparison, in order to find out whether the disturbances in parenting relate to the specific cognitions and behaviours of eating disorders or to the general psychiatric disturbance present in mothers.

There is also a complete absence of research on adolescents whose parents have eating disorders. Most research has been carried out on infants or young children and research on pre-school CoAs has found an absence of psychopathology in these young children, and increasing rates of disturbances among older children (Luby, Reich & Earls, 1995). This may indicate that pre-school children are insensitive to some aspects of their environment due to their developmental immaturity, but older children are affected with increasing severity. Reviews of biological, psychological and family research on CoAs and ACoAs (Harter, 2000; Searles & Windle, 1990, Sher et al., 1990) have also noted a need for increased attention to life span developmental factors in considering the outcomes of parental alcoholism. It seems possible that the effects of both parental alcoholism and parental eating disorder can differ, depending upon the child’s developmental stage at the time of active parental drinking or active parental eating disorder. As the majority of current research has concentrated on very young children, there is a growing concern that the disturbances that have been found in children of eating-disordered parents may only be the tip of the iceberg.

Though the findings to date have contributed to the formation of a critically important evidence base regarding the impact of parental eating disorders on offspring, no investigation has attempted to apply existing theories, or develop new domain-specific theories to describe the totality of the experience including the psychosocial effects on
offspring. A theory can be defined as something which: “explicates a phenomena (sic), specifies concepts which categorize the relevant phenomena, explains relationships between concepts and provides a framework for making predictions” (Charmaz, 1990, p. 1164). It seems that each piece of research in this field is building on previous findings in a rather unsystematic manner. As the evidence base is still very small, it may not be surprising that no one as yet has attempted to build a new, domain-specific theory. The absence of the use of existing theories to attempt to explain the findings to date, however, is perhaps more remarkable. This field would benefit from the application of theories as they can provide a framework for future investigations through the identification of variables and the generation of hypotheses. This could lead to a better understanding of the underlying processes by which offspring of parents with eating disorders respond to their experiences. Furthermore, theorising could contribute to the improvement of the care of this client group, as it could suggest pertinent factors necessary in the education of practitioners (Sque & Payne, 1996). It could therefore also help improving risk assessment, clinical formulations and interventions. Theorising is particularly important with regards to the latter, as empirical data are often lacking, and theory can enable therapists to make informed decisions about treatment (James, 1994).

Reflections on implications for practice

The implied connection between childhood feeding problems and maternal eating disorders in addition to the other difficulties that these families seem to encounter, suggest that preventative treatment of these families would be fruitful. The present review has found evidence to suggest that offspring of parents with eating disorders appear to be at a particular risk of developing eating disorder symptomatology. Eating disorders pioneers, such as Crisp (1988), have emphasised the need for primary intervention in childhood to prevent the development of eating disorders. Indeed, it has been found that early identification and treatment of eating disorders can result in a better outcome than those who had a longer interval between the onset of symptoms and beginning of treatment (Russell et al., 1987).
A very small number of studies have offered suggestions on the management of children with varied problems whose mothers have eating disorders (Griffiths et al., 1995; Russell et al., 1998; Stein & Woolley, 1996; Woolley, Wheatcroft & Stein, 1998). Stein and Woolley (1996), for example, have built on their research regarding infant development and maternal-infant interactions and developed a clinical approach to families with young children where a parent has an eating disorder. This approach uses careful observation together with sympathetic and sensitive support to help parents recognise the way their own overriding attitudes and concerns about food may interfere with their perceptions of and their ability to meet their children’s needs. Furthermore, Russell et al. (1998) offered guidelines on the management of mothers with anorexia who underfeed their children. They highlighted the importance of forming a good relationship with the mother and other involved relatives as well as providing nutritional counselling regarding the children’s dietary needs. Likewise, Griffiths et al. (1998) also emphasised the importance of nutritional counselling in their suggestions for treatment of adolescent anorexic girls whose mothers suffered from the same disorder. It is worth noting, however, that all of these suggestions are descriptive and to date no controlled trials have been carried out.

It is rather surprising that, in the existing literature, there is a general lack of extensive or in-depth discussion of the clinical implications of the findings. Most commonly the clinical implications take the form of recommendations that “clinicians assessing eating disorder patients who have children should routinely see the children and assess any parenting difficulties” (Timimi & Robinson, 1996: p.187), which is rather nonspecific. This may, however, be a result of the relative paucity of research. Evidence based practice is crucial and it has the potential to inform excellent client care, but it is also important for political reasons. In the current health care climate there is a strong emphasis on evidence based practice, and a need to demonstrate efficacy and cost-effectiveness, and this is another reason why it is imperative to have reciprocity between research and practice (Corrie & Callahan, 2000).
Recommendations for practice

This review has found evidence to suggest that parental eating disorders increase the risk of parenting difficulties and adverse developmental outcomes for children. Although there are some indications that parental eating disorders impact on general parenting, it does seem to be specifically related to growth, feeding, body shape and weight concern. It is important to bear in mind, however, that very little is known about the long term effects of parental eating disorders on offspring as most of the research to date has focused on infants and young children. It is worth noting that research findings on long term effects on children of alcoholics indicate that this group have difficulties with interpersonal relationships, and have higher rates of psychopathology than the general population (e.g. Bidaut-Russel, Bradford & Smith, 1994; Black, 1981; Hadley, Holloway & Mallinckrodt, 1993; Kashubeck & Christensen, 1992; Wright & Heppner, 1991). Given the superficial similarities in the psychological experiences of these two groups of children, together with the existing evidence base that indicates that children of mothers with eating disorders may be at high risk for developing psychological and physical difficulties, it does seem likely these children are at risk for a variety of negative outcomes.

Clinical recommendations on how to most effectively treat CoA commonly suggest that targeting high-risk children for early intervention may be important in terms of good outcomes for the children but also in terms of cost-effectiveness (Hill, Locke, Lowers & Connolly, 1999; Hill & Muka, 1995). There is, however, a paucity of treatment outcome studies for CoAs and ACoAs (Harter, 2000). Owing to the paucity of research on the effects of parental eating disorders on offspring and on treatment outcome studies for CoAs and ACoAs, it is difficult to make any firm clinical recommendations at this stage. It is likely, however, that early intervention will be important in order to interrupt the intergenerational transmission of difficulties. Since children of parents with eating disorders may have varied difficulties, a range of interventions may be needed. Interventions, such as those proposed by Stein and Woolley (1996) and Woolley et al. (1998), could be very useful at reversing the interactional processes associated with the onset of problems. Although family
systems therapy is often recommended for families who experience difficulties, there is evidence to suggest that a maternal eating disorder can reduce the effectiveness of family therapy if the offspring too have food-related difficulties (Griffiths et al., 1995). Specifically, it can be very difficult for the mother to support her children in overcoming their concerns with food if she has her own preoccupations with food. Clearly, more research is needed, including evaluations of the effectiveness of existing accounts regarding interventions, before firm recommendations for early interventions can be made.

If early intervention is to be made possible, it is important that mental health professionals involved in the parents’ care ask to see, weigh and measure the children. In recent years there has been a rapid growth of specialist eating disorders clinics in the UK, and mental health professionals in such clinics would be in a good position to consider the impact of a disorder on the children and to refer children who have difficulties for appropriate help (Hodes, 2000). There is, however, evidence to suggest that health care professionals working with mothers with eating disorders have little knowledge of these risks for adverse developmental outcomes for the children (Berg & Hodes, 1997). It should, however, be pointed out that not all children of parents with eating disorders are adversely affected. Some parents seem to manage well, and their children develop without any apparent problems (Stein & Woolley, 1996). Likewise, research on ACoAs have found that although many individuals in this group suffer negative emotional consequences, others do remarkably well (Drummond & Fitzpatrick, 2000).

**Directions for future research**

In order to ascertain whether a domain-specific theory is needed, and at the same time expand the evidence base, there is an urgent need to gain information about the experiences and perceptions of the offspring themselves. By making the experience of the offspring explicit, it could contribute to an understanding of the psychosocial effects on the offspring of parents with eating disorders. Such information could then be used to ascertain whether the offspring’s experiences are qualitatively different.
from those of offspring of parents with other mental illnesses. In the literature to date, eating-disordered mothers have been interviewed about their offspring, but the offspring themselves have not been interviewed. It would be valuable to supplement the quantitative work that has been undertaken so far, with qualitative research on the experience of having an eating-disordered parent. By using a qualitative method, such as interpretative phenomenological analysis (IPA) (Smith, 1996; Smith, Flowers & Osborn, 1997; Smith, Jarman & Osborn, 1999), it would be possible to obtain richer and more detailed information of the phenomenon under investigation which can be retained in the subsequent analysis. Although such research would involve a small sample, which would limit the generalisability of the findings, it could provide important insights into the psychological challenges faced by offspring of parents with eating disorders. This is a particularly pertinent issue, as the incidence of eating disorders is on the increase and many chronic sufferers are of child bearing age and clinicians are therefore likely to come across increasing numbers of sufferers and their offspring.

It would be very useful if future research would concentrate on potentially protective effects. This would have implications for both treatment and potentially, preventive treatment of children of parents with eating disorders. Research on ACoAs have indicated that protective factors are very important as many ACoAs do remarkably well. This group of ACoAs have been deemed as resilient (e.g., Rydelius, 1997), and resilience has been described as a capacity for successful adaptation to challenging or threatening circumstances (Zvirbulis-Levine, 2000). It still is not clear, however, what factors contribute to the development of a resilient ACoA, though it seems that the presence of a large and/or satisfactory social support is important (Williams & Corrigan, 1992). Both protective factors and risk factors could be investigated through longitudinal studies of the development of offspring of parents with eating disorders over time and across different life demands. At this point in time, when the evidence base is still rather small, such studies would be particularly valuable as they could contribute a wealth of information. Additionally, as mental health professionals in adult eating disorders services could play a particularly important role in identifying and referring children who experiences difficulties for help, it may be valuable to carry
out a survey in order to ascertain whether Berg and Hodes (1997) findings are supported in such services. This could help identifying areas where further training regarding the risks to these children may be needed.

In order to facilitate the process of expanding the existing evidence base, it would be helpful if future studies would include additional high-risk groups. By doing so, it would be possible to compare the disturbances in parenting by eating-disordered parents with other potential parental high risk groups, and hence find out if the disturbances relate to the specific cognitions and behaviours of eating disorders or to the general psychiatric disturbance present in the parent. The existing literature indicates that the disturbances found in the offspring result both from the general psychiatric disturbance present in the parent and the more specific cognitions and behaviours of eating disorders. The implied connection between maternal eating disorder and childhood feeding problems is particularly worrying and warrants further investigation. It would also be helpful to compare possible disturbances in offspring of parents with either a past or a present eating disorder. There is evidence to suggest that the cognitive features of eating disorders are extremely persistent and that they continue to be present among individuals who no longer meet the criteria (Sullivan et al., 1998). Therefore, it seems possible that offspring of recovered eating-disordered parents may still be at some risk.

Conclusions

The aim of this paper was to review the existing literature on offspring of parents with eating disorders and, where appropriate, to draw on findings from CoAs and ACoAs in order to ascertain the influence of parental eating disorders on offspring. The three broad groups of mechanisms, deduced from the research to date, by which parents with eating disorders may impinge on their children's development have been reviewed. This review indicates that there is a relationship between parental eating psychopathology and disturbed child development. Specifically, the evidence suggests that these children are at risk of disturbed physical development, such as stunting and/or low weight-for-height. There are also indicators of intergenerational
transmission of eating disorders as a result of both environmental and genetic factors, and this is a cause for major concern. Furthermore, the findings of this review indicate that parents with eating disorders may not satisfy all of their children's essential needs, i.e., the core components of 'good-enough' parenting.

There is evidence to suggest that eating disorders are more prevalent than official figures would indicate (Whitehouse & Harris, 1998). Beglin and Fairburn (1992) found that women who choose not to participate in surveys on eating disorders had a high rate of eating disorders, and it therefore seems that many individuals with eating disorders do not seek treatment. It is therefore imperative to carry out more research in order to establish common patterns that would help to increase health professionals' awareness of how these children may present. Hopefully this review has helped to underscore the importance of further research and the utility of applying existing theory or/and developing new, domain-specific theory specific to the field of offspring of parents with eating disorders.
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MATERNAL EATING DISORDERS: ADULT DAUGHTERS' REPORTED EXPERIENCES

Abstract

The aim of the present study was to explore reports of the mother-daughter relationship during childhood, adolescence and adult life, provided by adult female offspring of mothers with anorexia nervosa or bulimia nervosa, and their perception of the possible effects of the maternal eating disorder on this relationship. Five participants, from the UK and the USA, between the ages of 19 and 39 were recruited. All the participants had or were themselves suffering from eating disorders. The participants were interviewed and the data were subjected to interpretative phenomenological analysis. The analysis highlighted some of the difficulties that such offspring may face. In particular, the mothers' eating disorders were reported to have impacted on how the participants perceived themselves and their own worthiness. These findings support previous suggestions for interventions built on research from infant development and maternal-infant interactions.

Keywords: maternal eating disorders, qualitative research
Introduction

The last four decades have seen an immense rise in the prevalence of eating disorders. Although the majority of individuals with eating disorders recover, approximately one quarter continue to be symptomatic and a sizeable minority are chronically affected (Sullivan, 2002). Although anorexia nervosa and bulimia nervosa are regarded as distinct disorders, there is a substantial overlap in their defining features, including an intense preoccupation with weight and shape, and a morbid fear of becoming fat (more extensive diagnostic criteria are presented in Diagnostic and Statistical Manual of Mental Disorders [DSM-IV], American Psychiatric Association, 1994). There is, however, an important difference between them, as anorexia nervosa has a much lower rate of full recovery (Herzog, Dorer, Selwyn, Ekeblad & Flores, 1999), and has the highest mortality of any psychiatric disorder (Eckert, Halmi, Marchi, Grove & Crosby, 1995; Harris & Barraclough, 1998; Herzog et al., 1993; Sullivan, 2002). Even when sufferers of anorexia have met the criteria for full recovery, it has been found that a relatively low body weight and cognitive features of anorexia (perfectionism and cognitive restraint) persist (Sullivan, Bulik, Fear & Pickering, 1998).

There is good evidence that psychiatric conditions among parents put their children at risk of developing problems, and this literature has been brought together through a series of reviews (e.g., Beardslee, Bemporad, Keller & Klerman, 1983; Cassell & Coleman, 1995; Cleaver, Unell & Aldgate, 1999; Cummings & Davies, 1994; Downey & Coyne, 1990; Falkov, 1998; Hall, 1996a; Oates, 1997; Pound, 1996; Puckering, 1989; Rutter, 1989; Rutter & Cox, 1985; Rutter & Quinton, 1984). Research into the effects of parental eating disorders on children was sparked by two major concerns (Stein & Woolley, 1996). Firstly, as the core symptoms are exceptionally pervasive and disruptive in daily life, they are likely to conflict with the parent’s ability to respond to and understand the child’s needs. Secondly, people suffering from eating disorders often have great difficulties with interpersonal relationships, and this may extend to them having difficulties with building relationships with their children. Despite these concerns, there has been surprisingly little research carried out in this
area. Most reports to date have consisted of case studies, although in recent years a small number of controlled studies have been carried out.

From the research conducted so far, it is possible to deduce four broad environmental mechanisms through which parental eating disorder psychopathology may impinge on childrearing and on their children’s development (Stein, 2002). Firstly, there is evidence to suggest that parental eating psychopathology can have a direct effect on offspring. For example, the parent’s morbid fear of getting fat can in some cases extend to their children, which may cause them to underfeed their children and also lead to conflict during mealtimes (Agras, Hammer & McNicholas, 1999; Hodes, Timimi & Robinson, 1997; Lacy and Smith, 1987; Russell, Treasure & Eisler, 1998; Scourfield, 1995; Smith & Hanson, 1972; Stein, Woolley, Cooper & Fairburn, 1994; Stein, Murray, Cooper & Fairburn, 1996; Stein, Woolley & McPherson, 1999; Stein et al., 2001). Secondly, parents’ disturbed eating behaviour and attitudes may serve as a poor role model for their children (Scourfield, 1995; Timimi & Robinson, 1996). Thirdly, the high levels of marital discord and separation commonly found in this sample may have their own adverse effects on child development (Fahy & Treasure, 1989; Rutter & Quinton, 1984). Finally, a parent’s eating disorder may interfere with their general parenting functions, as a caregiver who is preoccupied with an illness may find it difficult to separate their own needs from the child’s; hence their capacity to understand and respond to the child’s needs may be impaired. This could have negative implications for the process of forming a secure attachment between infant and caregiver (Evans & le Grange, 1995; Hodes et al, 1997; Zahn-Waxler & Radke-Yarrow, 1982).

Attachment theory provides an overall framework for thinking about relationships (Bowlby, 1969/1982; 1973; 1980). According to this theory, the infant develops a set of strategies for organising emotional experience and dealing with negative feelings based on the principal caregiver’s responsiveness to the infant’s signals of distress (Sroufe & Waters, 1977). The early experiences of sensitive or insensitive care are thought to be incorporated into inner working models of attachment that reflect memories and beliefs that developed from the experience of caregiving (Bowlby,
Berlin and Cassidy (1999) reviewed attachment theory and research on the development of relationships, and they found good evidence that early attachments influence later relationships. Insecure attachment is common in eating disordered populations, and there is some evidence to suggest intergenerational transmission of these patterns (Ward, Ramsay & Treasure, 2000; Ward et al., 2001).

It should be noted that the research on offspring of parents with eating disorders suffers from major methodological shortcomings. These include small sample sizes, which are known to result in inadequate statistical power to detect small effects reliably, and this can lead to inconsistency in findings. Only a small number of studies have compared eating-disordered mothers with non-eating disordered mothers. The former group most commonly consists of a mixed group of mothers with either past or present eating disorders (e.g. Evans & le Grange, 1995). Consequently, the results may not be reliable as it is quite possible that a mother with a past eating disorder may behave in a different manner towards her children than a mother with a current eating disorder. In addition, most research has been carried out on infants or young children and very little is known about the experiences of these offspring later in life. The majority of the research to date have come from specialist adult eating disorder services (e.g. Fahy & Treasure, 1989; Hodes et al., 1997; Lacy & Smith, 1987; Russell et al., 1998; Woodside & Shekter-Wolfson, 1990). These services may be more likely to treat sufferers with particular characteristics and considerable difficulties, and the offspring may therefore be more adversely affected than others (Hodes, 2000). Furthermore, interview-based qualitative studies provide researchers with the opportunity to obtain richer and more detailed information of the phenomenon under investigation which can be retained in the subsequent analysis. There is, however, a complete absence of such research in the existing literature which seems a serious oversight as it could provide important insights into the psychological challenges faced by offspring of mothers with eating disorders. This is a particularly pertinent issue, as the incidence of eating disorders is on the increase and many chronic sufferers are of child bearing age and clinicians are therefore likely to come across increasing numbers of sufferers and their offspring.
The aim of the present study was to expand the existing evidence base by producing an initial, in-depth analysis of reports of the mother-daughter relationship during childhood, adolescence and adult life in order to offer insights into some of these offspring's experiences. These reports were provided by adult female offspring of mothers with anorexia nervosa or bulimia nervosa, and included their perception of the possible effects of the maternal eating disorder on this relationship. A qualitative approach was used in order to obtain rich and detailed information on how these individuals perceive and respond to their experiences. The present study was informed by attachment theory in order to provide a framework for future investigations which could lead to a better understanding of the underlying processes by which offspring of parents with eating disorders respond to their experiences.

Eating disorders is a topic that has been of great interest to me for many years. It is near impossible to be a young woman in a Western society and not be aware of the societal ideal of a thin body image. This societal pressure in combination with one of my sisters developing anorexia during my teenage years sparked my desire to learn more about eating disorders. I have always been particularly close to this sister but I found myself being unable to understand the reasons for her preoccupation with food, body weight and appearance. I could not understand why this had happened and where it had come from. Furthermore, my particular interest in offspring of parents with eating disorders was brought about by two experiences; my sister having suffered from anorexia and my own experience of being a child of a parent with a psychiatric disorder. I believe that that experience has affected the way I feel about myself and how I relate to other people. That made me wonder about the kind of experiences offspring of parents with eating disorders have. Would their parents' preoccupation with food, body weight and appearance have a direct effect on them and how they feel about themselves? I remember how difficult I found it with my sister's close scrutiny of my weight: what would that be like if she had been my mother? With these kinds of questions in mind, I began my literature review last year, and to my surprise there was very little research done in this area. In addition, most research to date consisted of studies of infants and young children, and almost nothing is known about the experiences of older children and adolescents. I therefore believed that if I were to
undertake a piece of research that explored the experiences of adult children of parents with eating disorders, I could really make a contribution to this field.

Method

Participants

It was decided to focus on female offspring only as there is some evidence to suggest that mothers with eating disorders express significantly higher concern for their young daughters' weight and shape than non eating-disordered mothers, but this difference is not reported for sons (Agras et al., 1999). This maternal concern could have a negative impact on the mother-daughter relationship (Haworth-Hoeppner, 2000). Furthermore, it was decided not to recruit from specialist adult eating disorders services for the reasons previously described. This decision was likely to impinge on the recruitment process and it was therefore decided to include female offspring of mothers with either anorexia or bulimia, despite them being distinct disorders.

Information about the present study was posted on an eating disorders support organisation's internet website, in local universities and as an advertisement in a psychology magazine. Three criteria for choosing participants were used. Firstly, the participants were to be females over 18 years of age whose mother, according to the participants, had been clinically diagnosed with bulimia or anorexia by a therapist, psychiatrist or medical doctor when the participant was aged between 0-17 years (17 is generally defined as the end of adolescence [Cooper, 1996]). Secondly, the mothers would not have experienced drug or alcohol dependencies at anytime during the participants' childhood. This was because there is a significant comorbidity between eating disorders and substance abuse (Bushnell et al., 1994; Garfinkel, 1995; Kendler et al., 1991; Schukit et al., 1996; Suzuki, Higuchi, Yamada, Mitzutani & Kono, 1993) and such comorbidity in a parent may have a different effect on offspring than an eating disorder alone. Thirdly, the mother was to have been the primary caregiver.
Subsequently five of the women (three from the UK and two from the USA) who contacted the researcher by e-mail were judged to fit the criteria and agreed to participate. According to their reported diagnoses, three of the participants’ mothers suffered from bulimia nervosa, one of the mothers suffered from anorexia nervosa of the restricting subtype and the remaining one suffered from anorexia nervosa of the purging subtype. Two women were interviewed face to face, one in the participant’s home and one in the interviewer’s home. The remaining three, who all lived in locations which were geographically distant from the researcher, were interviewed over the telephone.

Interview Schedule

The interviews were semi-structured in order to allow the participants to tell their story in their own words as far as possible. The interview schedule (see Appendix A) began with demographic and background questions, followed by questions about events relating to their mother’s eating disorder that they believed were significant, the mother-daughter relationship during childhood and the mother-daughter relationship at present. Due to the nature of the topic, a sensitive method of interviewing was used which was based upon an interactional style derived from counselling (Coyle, 1998; Coyle & Wright, 1996). The interviews lasted between 45 minutes and 1 hour 45 minutes and were audio recorded and transcribed verbatim. After the interview, the participants were given information about suitable support groups that they could contact. Furthermore, the interviewer telephoned each participant the following day to ensure that the interview had not breached defence mechanisms - as far as they were aware - or led to delayed distress.

[As a trainee counselling psychologist who works therapeutically with clients, I found it very challenging indeed to conduct these interviews. When I work therapeutically with clients, we have agreed on a contract which states the number of sessions, how often, and when. Difficult experiences can (hopefully) be worked through and more often than not the client is less distressed at the end of the therapeutic work. When I set out to conduct these interviews, I was not prepared for how much they would affect...]

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me. During the interviews, all of the participants disclosed some painful childhood experiences and conflicting feelings about their mothers. I felt extremely inadequate in that I desperately wanted to help them, but was of course unable to intervene in an explicit therapeutic way in my role as a researcher. Although I have dealt with similar distress previously, it has been in my capacity as a therapist where there is a clear framework to work from. I felt myself getting very confused and unsure of how to respond. On the one hand, I was supposed to use the counselling interview in my interviews but on the other hand this was not a therapeutic relationship. I found the telephone interviews particularly challenging as it was difficult to gauge the level of distress in the participants when I could not see them in person. In addition, the dynamics of those interviews seemed different as well in that I felt more removed from the situation and less able to connect with the interviewee. I was, however, amazed at how openly and willingly the participants disclosed sensitive and difficult information. I felt very grateful that they were able and willing to share this with me, and it felt somewhat unsatisfactory just to leave at the end of the interviews. In addition, I felt quite ruthless at times in how I was controlling the direction of the interviews with my questions, as I am more used to working in a client centred manner with my clients.]

Analytic Strategy

The data were analysed using interpretative phenomenological analysis (IPA) (Smith, 1996; Smith, Flowers & Osborn, 1997; Smith, Jarman & Osborn, 1999). According to Smith et al. (1999), IPA aims to explore participants’ personal perceptions, accounts and their meaning making of the topic under investigation. In other words, it is concerned with cognitions, and not with attempting to produce an objective account of the event. However, IPA does not assert that these cognitions are transparent from language. Instead the researcher engages in the analytic process in the hope of inferring some of these cognitions from language. This method also acknowledges that research is a dynamic process, and that the researcher’s interpretations of the participants’ stories will inevitably be coloured by the researcher’s own conceptions and interpretative framework.
The interviews were transcribed using wide left and right hand margins. The first stage involved reading and re-reading the transcripts a number of times, whilst making note in the left hand margin of initial thoughts and observations in response to the text. Some of those comments included associations, questions, summary statements or descriptive labels. The transcripts were then re-read again and emerging themes, i.e. key words that captured the essential quality of what was represented by the text, were noted in the right hand margin. The themes were then listed on a separate sheet in order to look for connections between them. During this stage, it is often found that some themes cluster together and some may be described as superordinate concepts. A table of themes and subthemes found in all transcripts was produced, and the links between these themes and the data set were checked again. Finally, the themes were ordered in a ‘logical’ way and, alongside each theme, a note was made of where, and in which transcript, instances could be found. At this stage, some themes were dropped if there was little evidence to support them.

Such an analysis involves a high degree of subjectivity as it is shaped by the researcher’s interpretative framework. In order to obtain a rich analysis which would hopefully be sensitised to different aspects of the data, the emergent analysis was discussed and checked with a male social psychologist who is experienced in qualitative research, a female counselling psychologist who is experienced in working with families with eating disorders, and an individual whose mother is suffering from an eating disorder but who did not meet the inclusion criteria. Moreover, as the analysis will involve the researcher’s interpretations, traditional methods of evaluating research, such as validity and reliability, are inappropriate criteria for evaluating the present study. This is because they are based on an assumption of researcher objectivity and disengagement from the analytic process (Henwood & Pidgeon, 1992). Instead, the focus should be on the persuasiveness of the interpretations of the data through grounding in examples (Elliott, Fischer & Rennie, 1999; Smith, 1996). In this article, the interpretations are exemplified by quotations from the data. The participants have been given pseudonyms to ensure confidentiality. Information that has been added for clarification purposes is signified by square brackets, a pause in the interviewee's speech is indicated by a bracket containing three fullstops, information
that has been omitted is manifested by empty square brackets, and words that are underlined indicates emphasis.

**Analysis**

*Background Information*

The participants' mean age was 25.8 years (range 19-39; SD 8.3). In terms of ethnicity, four participants described themselves as “white” and one participant described herself as Native American. One participant had been educated to GSCE levels, two had A-levels (or equivalent qualifications) and two had Master degrees. Using the International Standard Classification of Occupations (International Labour Office, 1990), three were classified as holding professional jobs, and two were students. In terms of parental marital status, three of the participants' mothers were divorced and two were married. None of the participants had children themselves. The mean duration of mothers’ eating disorder was 22.4 years (range 8-45; SD 14.5). All of the participants had been or were suffering from an eating disorder themselves. Specifically, three participants were suffering from bulimia (Chloe, Jo and Zoe), one from anorexia (Julia) and one had recovered from anorexia (Natasha).

The analysis of the data revealed a variety of themes, and a summary of these are presented in Table 2 below.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Participants</th>
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<tr>
<td>1. A family culture of disordered eating</td>
<td>Julia, Jo</td>
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<td>2. Awareness of the mother’s disordered eating</td>
<td>Natasha, Chloe, Julia, Jo, Zoe</td>
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<td>3. The family’s management of the mother’s disordered eating</td>
<td>Natasha, Chloe, Jo, Zoe</td>
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<td>4. The mother as a role model</td>
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<td>5. Betrayal</td>
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<td>Natasha, Julia</td>
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Four of the themes will be presented in the present report: a family culture of disordered eating, awareness of the mother's disordered eating, the family's management of the mother's disordered eating, and the mother as a role model. The themes presented here were selected on the basis of being highly relevant to the experience of living with a mother with an eating disorder, and how such a disorder can affect the mother-daughter relationship. Some themes and subthemes will be reported in more detail as they offer insights that were not expected from the existing literature or they are important in contextualising the participants' experiences. Other themes or subthemes that reflect more common themes in the literature will only be reported in outline.

A family culture of disordered eating

Some of the participants described a general familial difficulty around food and eating. One of them, Jo, whose mother suffers from bulimia, reported that all the members of her family binge eat, whilst Julia, whose mother suffered from anorexia, described her whole family as having disordered eating.

I knew she [her mother] had problems with food erm (...) and my father is obese and there was not a time when there wasn't any (...) any (...) I mean (...) always we knew that everyone had problems with food. (Jo)

I was always very secretive with my eating and me and my whole family have (...) they (...) we don't all have eating disorders but we all got disordered eating in one way or another. (Julia)

Both Jo's and Julia's accounts seem to suggest that difficult feelings and practices associated with food and eating have been normalised. This normalisation is further illustrated by the participants' descriptions of how certain food behaviours were undertaken together as a family, without anyone questioning or talking about it. These behaviours included familial bingeing, and being very secretive about eating and eating certain food:
It was always very strange (...) very secretive, very naughty and erm (...) you always got the idea you had good foods and bad foods and erm the bad foods you'd have (...) when nobody else was looking. (Julia)

We all go and eat together (...) yeah (...) and we binge together erm (...) you know we also hide (...) like father will come out at night and eat for example. (Jo)

There is a strong sense of secrecy characterising both of these accounts. Although the nature of eating disorders is commonly secretive, it is interesting to note that the whole family seems to collaborate in such secrecy. The familial secrecy surrounding food seems characteristic of a family script, which is composed of the family's shared expectations of how family roles are to be performed in different contexts (Byng-Hall, 1999). It has been hypothesised that patterns of relating and functioning are transmitted down the generations in a family (Carter & McGoldrick, 1980). That would be in line with one of the participants' own understanding of the familial disordered eating, as we will now see.

Causal attributions for familial disordered eating

One of the participants, Julia, attributed her mother's disordered attitude to food and eating to her maternal grandmother's attitudes to food and appearance, i.e. intergenerational transmission:

You know grandma you know took all the fun out of food for mum and turned it (...) that she was never allowed biscuits (...) biscuits were evil and you get fat if you eat biscuits.

She also described how her mother had attempted to prevent her own attitudes about food and eating from affecting her daughter, but that she had failed to do so:

So I suppose she wanted (...) she didn't want to to put (...) to connect food with anything else [with appearance] she wanted it to be food (...) and not have so many other feelings and struggles mixed in with it link them erm (...) but it is so hard to get the balance right.
Julia's narrative seems to imply that her grandmother is really the one to blame for both her and her mother's eating disorders. Julia's grandmother is portrayed as passing on her own attitudes to food and appearance to Julia's mother more deliberately whilst Julia's mother tried to do 'the right thing' but could not get it quite right. By making sense of a family history of disordered eating in this manner, Julia seems to be protecting both her mother and her relationship with her mother. This could perhaps be an expression of an insecure family base where conflicts and the expression of anger (a functional part of family life) would undermine the security of the family base (Byng-Hall, 1999).

**Awareness of the mother's disordered eating**

All of the participants reported being aware of their mother's disordered eating but to differing extents. In addition, some of the participants described very different perceptions of their mother's disordered eating and the effect it had on them when they were growing up. Each of these perceptions will be discussed below.

**An exciting game**

One of the participants, Natasha, reported that as a child she was not aware that her mother's preoccupation with dieting was problematic. She described it as a seemingly positive activity that she wanted to be involved in:

> It [dieting] was exciting it was more like a game [ ] it was like this new game that I wanted to be involved in because my mum was doing it I wanted to do it and I didn't want to be excluded from that.

It seems that for Natasha, her mother's dieting was nothing to be concerned about: it was just another aspect of her mother's life that she wanted to be involved in. Perhaps dieting was one of her mother's activities that was somewhat easy for Natasha to get involved in because it occurred in the home and was therefore easy to join in with. Her narrative also seems to contain an element of fear of being excluded by her mother, and her joining in seems to have been a means to ensure that she would not be
excluded. This is further illustrated by Natasha’s account of how dieting created an exclusive bond between her and her mother:

And it [dieting] was something that me and mum did together it wasn’t something that you know my brothers were involved in or so on it was like this little kind of (...) you know this special kind of this kind of special dieting relationship I suppose.

It seems that by taking part in her mother’s dieting, which her brothers were not part of, Natasha believed she secured a unique position in her mother’s life. This position appears to have ensured proximity to her mother and may therefore have served to reduce her anxiety of being excluded from her mother. Separation anxiety is one of the features of Natasha’s account that seems suggestive of an insecure attachment between mother and daughter (Bowlby, 1973). For such individuals, ‘felt security’ is achieved by maintaining a high level of involvement with other people, in particular with their primary care giver (Howe, Brandon, Hinings & Schofield, 1999).

Knowing something is wrong

Two of the participants, however, reported that they were concerned with their mothers’ preoccupation with food and appearance, but that they did not know what this preoccupation was about. Julia, for example, reported that, when she (Julia) was young, her mother constantly expressed concerns about her (Julia’s mother’s) weight but that she did not understand why:

She would say that she was fat and I’d sit on her lap and tell her that she wasn’t (...) I’d say that she was cuddly and (...) I’d give her a big hug and that happened quite a lot that she would be very down about herself and her body [ ] you know she’d ask me and I’d assure her that she wasn’t [ ] I really didn’t understand how she could be so unhappy about it.

In this account, Julia seems to be expressing her confusion surrounding her mother’s discontent with her weight. She seems to have attempted to cope with her confusion by comforting her mother. In other words, Julia and her mother reversed roles in that
instance and Julia took on the caregiving role. Bowlby (1980) described the 
phenomenon of role inversion as ‘compulsive caregiving’, which can be activated 
when a child feels anxious about their caregiver’s distress. Indeed, instances of role-
reversal in parenting have been noted in the literature on the effects of parental eating 
disorders on offspring (Woodside & Shekter-Wolfson, 1990; Woodside, Shekter-
Wolfson, Branches & Lackström, 1993).

Jo’s awareness of her mother’s disordered eating as problematic seems to have 
stemmed from having her own needs neglected. In specific terms, as a child she was 
not fed on a regular basis:

I didn’t really know (...) that there (...) I knew there was a problem (...) because 
of this food business there was no food in the house and stuff like that (...) I’m 
sure the whole neighbourhood knew because I [laughs] (...) the whole school 
knew because I was never given food for lunch (...) so I mean everyone knew 
there was something (...) weird but not what it was.

This account seems to illustrate how Jo became aware of her mother’s disorder 
through her being different from other parents due to the absence of food in their 
home. There is some evidence to suggest that mothers with bulimia may restrict the 
amount or types of food in the house to control their own binges (Fahy & Treasure, 
1989; Franzen & Gerlinghoff, 1997; Stein & Fairburn, 1989). As a child, it seems that 
Jo was unable to ‘put a name’ on the problem. This may have been due to a lack of 
public awareness of bulimia at the time as bulimia, unlike anorexia, has come to 
medical attention only in recent years (Beumont, 2002). Jo further reported that the 
absence of food in the house also had an effect on how she felt about herself:

I think honestly the way I felt was that my mother didn’t love me enough (...) to 
give me a (...) nice lunch [ ] and I really felt (...) that you know (...) I’m not (...) 
worth it (...) yeah.

Jo’s account illustrates how she interpreted the absence of food as evidence that her 
mother did not love her enough. Furthermore, her mother’s lack of response to her
hunger seems to have had a negative impact on her self-concept in that she perceived herself as a person who was not worth the effort. Attachment theory holds that young children acquire internal working models of their own worth based on other people's availability and their ability and willingness to provide care and protection (Ainsworth, Blehar, Aters & Wall, 1978). As a child, Jo seems to have interpreted the absence of food as her mother being unwilling to provide her with food. Subsequently this seems to have affected the beliefs she held about herself as a person.

**Being fully aware**

Nearly half of the participants reported that they had been aware that their mothers' disordered eating was a problem and that they knew what the problem was. Chloe, for example, said:

> I've always known that she has problems with eating ever since we were children it was always an issue. (Chloe)

This account seems to indicate that Chloe's mother's bulimia was having a negative impact on the family, and that this was the main reason for Chloe being aware of the nature of the problem. Zoe, on the other hand, was able to put a name on her mother's difficulty by recognising her behaviour through a television show:

> I was probably eight or nine [ ] erm (...) I think I'd seen a show on somebody who had bulimia and I was wow (...) oh that was my mum.

It seems to have been a real revelation for Zoe to be able to put a name or label on her mother's behaviour. Individuals with medical or psychiatric conditions and their relatives can sometimes feel relief when they become able to label these conditions (Hillman, 1995). In addition, both Chloe and Zoe were subjected to maternal criticism of their weight and appearance, and this may have played a part in their gaining full awareness of their mothers' bulimia:
Erm (...) my mum always (...) when I was I think I was eight she took me to a dietician cos she said I was too fat (...) that she didn’t want a fat daughter. (Chloe)

Erm (...) when I started high school she was (...) just on my case about (...) everything from like (...) wearing designer clothes to (...) you know (...) working out and maybe you should be a size smaller (...) and (...) stuff like that. (Zoe)

These two accounts seem to illustrate how maternal preoccupation with food and weight can be extended to daughters. In Chloe’s case there seems to be an implicit threat of abandonment in that she felt that her mother would reject her if she did not lose weight. In both accounts, the mothers seem insensitive to the emotional needs of their children - for example, making them feel that they are not good enough and that they need to change. There is some evidence in the research literature that mothers with eating disorders are overconcerned about their children’s weight and may in some cases try to reduce their weight (Agras et al. 1999; Lacy & Smith, 1987; Smith & Hanson, 1972).

The family’s management of the mother’s disordered eating

The participants described two strategies that their families utilised in order to manage the mothers’ disordered eating. One strategy that some of the participants described was mocking, which seemed to be employed mainly by father figures.

Erm I remember that my stepfather used to kind of laugh about it really in a sense it was (...) you know [ ] me and my mum used to sit there with little salads and he’d be eating this radically different meal [ ] it was almost mocked really (...) not in a nasty way but (...) it didn’t seem to be of any kind of concern really there was no kind of awareness that maybe this wasn’t quite right. (Natasha)

[ ] my dad always used to make jokes about (...) that is she was upset she would gonna go and be sick (...) it was just a standard joke you know she was gonna be sick and she is gonna go up there [the toilet]. (Chloe)

There seems to be a difference in how mocking was employed in these two families. Natasha described it as stemming from a lack of awareness of the problematic nature
of the mother’s behaviour, whilst Chloe reported the mocking as being more deliberate. In Natasha’s family it does seem as if the mocking was a response to a behaviour that appeared confusing and was not understood. In Chloe’s family, on the other hand, it seemed to be more of a means of regaining some kind of control in order to cope with the mother’s behaviour.

Familial silence

The two participants who reported being aware of their mother’s bulimia as a child also described a familial culture of silence surrounding it. Zoe described her maternal grandparents being aware of her mother’s bulimia but said that it was something that they did not talk about within the family:

[ ] erm (...) my grandmother is completely (...) in a state about the fact that her daughter has an eating disorder (...) erm (...) and (...) I don’t remember her (...) or her [Zoe’s mother’s] father ever saying anything (...) about it (...) or [ ] I still don’t really (...) have the (...) I especially don’t speak to the family about it.

Despite Zoe’s grandparents being very upset about their daughter’s bulimia, they did not discuss their concerns openly. It is interesting to note that Zoe seems to have adopted the same strategy in that she does not speak to her friends or family about it. Chloe, on the other hand, reported that her mother’s bulimia was discussed within the family - mostly through jokes. She was, however, strongly discouraged from talking about it to anyone outside the immediate family. Chloe described how her mother attempted to prevent her from receiving treatment for her bulimia:

Then I tried to tell her [her mother] a couple of years ago that I have this problem [bulimia] (...) and (...) that I was getting treatment for it she told me that I could do it on my own and I wasn’t to see anybody else cos it was a family thing and had nothing to do with anybody else.

This account seems to suggest that Chloe’s mother felt threatened by Chloe receiving treatment. Her mother’s wish to ‘keep it in the family’ may be an extension of the
secrecy that individuals with bulimia commonly engage in to conceal their bulimic episodes (Beumont, 2002). By receiving treatment, Chloe seems to be deviating from the family script of not involving outsiders. The intention behind her mother’s negative feedback could possibly be to discourage any further such deviations. It has been suggested that relationships containing ‘pathology’ operate in a manner that discourages change, in order to maintain the stability of the relationship patterns (Jackson, 1957).

The mother as a role model

All of the participants had themselves developed eating disorders. One theme that emerged was their attributing their eating disorder to learning the relevant behaviours directly from their mothers. It has been noted in the literature that children of mothers with eating disorder show behaviours that are remarkably similar to their mother’s symptoms (Franzen & Gerlinghoff, 1997; Timimi & Robinson, 1996). The participants did, however, attribute somewhat different meanings to the expression of their mother’s symptoms. One of them, Natasha, reported that her mother was modelling dieting as a way of life:

Essentially I’d been I’d never done anything but diet (...) you know (...) all the way from kind of being this kind of age eight years old seven years old I had always dieted and it was like I didn’t know anything else it was very much a learned behaviour (...) I mean we [Natasha and her therapist] talked about how I had dieted with my mum since then and I felt that it was very much kind of a learned behaviour from what my mum was doing.

Natasha’s account illustrates that, for her, dieting was not something that she did to lose weight: it was a way of life. By joining in with her mother’s dieting behaviours from such a young age, it had become second nature to her. Julia, likewise, described how she internalised her mother’s attitudes toward food:

I was (...) you know I was worried that I would get into trouble for eating it [food] so there was that ‘generally food is bad’ (...) erm (...) and it (...) ‘it’s against you it doesn’t (...) all it does is (...) damage you and make you feel bad’ (...) erm (...)
so I don’t know that I’ve learned anything (...) directly but I’m sure I’ve picked up a lot (...) from just the way she felt about it [food] (...) and the way she felt about herself.

Julia seems to perceive that she adopted her mother’s behaviours and attitudes as a consequence of living in an environment in which a fear of food had been normalised. The belief that disordered attitudes toward food, weight and appearance were the norm is echoed by Zoe:

I don’t know somebody that (...) that could tell me that (...) she isn’t (...) normal (...) and that she has problems ‘don’t let her influence you’ like (...) if she has and that (...) she has that sort of perception of a lot of things and that (...) and that her example isn’t exactly the best to follow.

Zoe’s account seems to illustrate that her mother’s pursuit of the thin-ideal, in conjunction with her own lack of understanding of the nature of her mother’s disorder, promoted her internalisation of these goals. Whilst most of the participants reported that they internalised their mothers’ attitudes and behaviours, Chloe described her mother’s bulimic behaviours as being a means of coping with stressors. She reported that her mother modelled these behaviours to her, and that her grandmother had in turn modelled the same behaviours to her mother:

It sounds awful (...) it was the way we [her and her mother] were taught to (...) deal with things [ ] my mum just (...) dealt with her problems by eating and being sick [laughs] (...) so “oh that’s the way to do it” (...) her mother was bulimic as well so.

Despite Chloe’s assertion that her bulimic behaviour was learned from her mother, she seems reluctant to blame her mother for it. By pointing out that her maternal grandmother was bulimic as well, Chloe is protecting her mother from blame. In other words, Chloe’s mother did just what Chloe has done - learned it from her mother. Coping with stressors by adopting a specific behaviour related to disordered consumption is a phenomenon that has been found in the literature on adult children of alcoholics (e.g. Sher, Walitzer, Wood & Brent, 1991). Harter (2000) reviewed the
recent literature and concluded that adult children of alcoholics were more prone to use alcohol to cope with stressors and to expect beneficial effects from alcohol use.

All of these accounts of how the participants acquired their disordered attitudes and behaviours toward food and appearance from their mothers seem characteristic of the process of modelling. Bandura (1969), refers to modelling as a social influence process whereby observation of another performing a behaviour increases the likelihood of a person engaging in that behaviour. It is, however, rather unlikely that the process of modelling could solely cause an eating disorder, as most researchers on the aetiology of eating disorders agree that the pathways to symptom formation are multiple and interactive (e.g. Hoek, 1995; Vitiello & Lederhendler, 2000; Whitehouse & Harris, 1998). The participants acknowledged this and they attributed the adoption of disordered eating behaviours to a variety of additional factors.

_Causal attributions for adopting disordered eating behaviours_

Some of the participants attributed their development of anorexia to a process of identification with their mother. For them, their mothers’ dieting behaviours were just one aspect out of many that they identified with:

> I mean now I look back thinking it was abnormal but at the time I didn’t and it was generally this feeling of whatever my mum did I wanted to so I would (...) you know eat in the same way. (Natasha)

> There are all these things that because mum had said it (...) and because mum had said it (...) and because she believed it so much I believed it like the idea that not having (...) a dad hadn’t affected me (...) and (...) that (...) we don’t need breakfast because you’re (...) if you don’t have any and if you’re not hungry until lunch that’s a good thing and (...) really the idea of not being hungry until lunch I now know is a bad thing. (Julia)

Both Natasha and Julia, whose mothers suffered from anorexia, described idealising their mothers during childhood and not seeing their disordered eating as problematic. Their mothers’ disorders seemed to have been just another aspect of her that they
identified with. It is generally found that women with anorexia have idealised and
enmeshed relationships with their mothers (Hall, 1996b). It is interesting to note that
both Julia and Natasha describe such relationships with their anorexic mothers. In
explaining why they were identifying so strongly with their mothers, both of them
reported that the loss of their fathers had contributed to this. Natasha, for example,
described that it was a fear of losing her mother too after her parents’ divorce which
prompted her to copy her mother’s behaviours:

You know kind of inevitably I choose my mum’s side and so then it was almost
like in a sense that whatever my mum did I had to go along with it wholeheartedly
and (...) I think in a sense that’s why we became so close and I almost tried to (...) 
mask her behaviour in a way [ ] I wanted to do everything that my mum was doing 
erm (...) I guess that it would be quite probable that that was because I felt this
sense of loss because they’d split up and I was kind of frightened of it happening
again.

Natasha’s account gives a sense that her father’s departure gave her no choice but to
try to be just like her mother, otherwise she might lose her too. In other words,
Natasha feared that any difference between them may cause her mother to reject her
and ultimately leave her. Julia, on the other hand, reported that her father left before
she was born and she attributed the adoption of her mother’s behaviours to the absence
of external influences:

You know I would have learned everything from her felt everything from her erm
(...) without having (...) you know neither of us had (...) other relationships to get
in the way (...) we still saw it erm everybody but they didn’t live with us (...) so
we did everything together.

This account portrays Julia and her mother as being very enmeshed and Julia as
consequently assuming her mother’s behaviours. There is evidence from the literature
on children of alcoholics that suggests that a warm and nurturing relationship with one
parent can compensate for the potentially damaging effects of the dysfunctional parent
(Moser and Jacob, 1997). Although Julia seems to perceive her relationship with her
mother as close, her mother was suffering from anorexia, and perhaps the absence of
her father increased her susceptibility to being influenced by her mother’s disordered attitudes.

Zoe, however, postulates that although her mother showed her the behaviours, it was her own choice to adopt them:

I want (...) people to think that you know you make your own destiny (...) and (...) you can’t blame your parents for (...) a behaviour that you initiated (...) they might have shown you how to do it (...) but (...) it’s (...) you’re the one that (...) you know initiated the action.

Her account gives a strong sense of responsibility, of not wanting to place blame on anyone for her disorder. By doing this, she may regain a sense of control over her disorder which may serve to empower her; she was the one who initiated the behaviour and therefore she is the one who can stop it as well.

[I both enjoyed and loathed doing the analysis; this was both in terms of doing the actual analysis and in my commitment to my participants. The idea of IPA and its epistemological stance appeal to me, but I found it very difficult to strike a balance between interpreting the data and incorporating research and theory. After having completed an undergraduate degree in which every argument in every piece of course work had to be backed up with research and theory, I experienced difficulty with the transition to a doctoral course where you are expected to have opinions and original ideas. When I was doing the analysis, I often spent hours thinking about the interpretation of a particular quotation in a theme. I began experiencing doubts about myself and my own abilities and felt like I was not experienced enough in the diverse field of eating disorders to have my own opinions. It was very difficult for me to try to let go and trust my own interpretations. Furthermore, I believe that the end result was strongly influenced by the literature that I have read on offspring of parents with eating disorders, attachment theory and my therapeutic work at an eating disorders service. I also felt very strongly that I wanted to do ‘right’ by my participants. They volunteered time and effort to participate in the present study without getting any compensation. Furthermore, they all spoke very openly about experiences that have been important.
and sometimes painful for them to a complete stranger. This made it very difficult for me to select only four themes to focus on. There were so many themes in each transcript that seemed important but some of them were too different from the themes from the other participants' transcripts and at this instance had to be dropped. I suppose that is the nature of doing research, but this is the first time I have undertaken to do a piece of research on this scale that I feel strongly about. It has been an interesting experience.]

Overview

The aim of the present study was to explore reports of the mother-daughter relationship provided by adult daughters of mothers with anorexia or bulimia. This study has highlighted some of the difficulties that such offspring may face. It is, however, important to point out that no claims can be made about the generalisability of these findings. This sample cannot be seen to be representative of daughters of mothers with eating disorders, partly because very little is known about this population. The experiences of daughters of mothers with eating disorders from backgrounds different to the present sample might be quite different. Furthermore, the participants' age ranged from 19-39, with over half of the participants being in their early 20s. As there has been an immense increase in research and awareness of eating disorders over the last four decades, it is possible that the social context in which children of mothers with eating disorders are embedded today is different from that experienced by the participants in the present study. In addition, as the data set consisted of retrospective accounts, they may not be an accurate description of the events and experiences they describe. There is, however, evidence to suggest that claims concerning the general unreliability of retrospective reports and autobiographical memory may be exaggerated (Blane, 1996; Brewin, Andrews & Gotlib, 1993; Neisser, 1994; Ross & Conway, 1986; Rubin, Wetzler & Nebes, 1986; Wagenaar, 1986).

Owing to the difficulty in recruiting participants, there was an important intra-sample difference: nearly half of the participants were from the USA. Although both the UK
and the USA are Westernised societies, the participants’ accounts are likely to have been influenced by cultural factors specific to their country. Furthermore, the sample also consisted of daughters of mothers with either anorexia or bulimia, which are two distinct conditions. It is possible that offspring are affected in different ways depending on the whether the mother has anorexia or bulimia. In the present study, participants whose mothers suffered from the same disorder seemed at times to have had more similar experiences than those who did not. For example, the participants with bulimic mothers described their mothers as being more critical of their appearance, and reported being more aware of their mothers’ disorders. The participants with anorexic mothers, on the other hand, seemed generally less aware of their mothers’ disorders and described more idealised and enmeshed relationships. Although it is not possible to make any generalisation from a sample of five, a larger scale study may find more robust evidence of such differences.

There were, however, also a number of important similarities among the participants. Specifically, they had all developed eating disorders themselves, none of the mothers had received treatment from health services, and they all contacted the researcher and volunteered to take part in the present study. In other words, it seems that the participants shared some common factors which may have shaped these findings. Indeed, it does seem that the fact that the participants had an eating disorder particularly influenced the findings. Specifically, the findings relating to the relationship between maternal weight concerns and daughters’ eating pathology have been reported elsewhere (Levine, Smolak & Hayden, 1994; Levine, Smolak, Moodey, Schuman & Hessen, 1994; Pike & Rhodin, 1991). They have not, however, been reported for this population previously. Consequently, this study can claim originality on the basis of its exploration of adult daughters’ reported experiences of maternal eating disorders and the perceived impact of the disorder on the mother-daughter relationship. Although some concerns can be raised about the sample, the aim of the present study was to produce an initial, in-depth analysis of the accounts of a small number of participants in order to offer insights into some of these women’s experiences. It was the researcher’s hope that other researchers will explore the same issues but with groups that have not been represented here, with the aim of expanding
the existing evidence base in order to inform counselling psychology practice with this population.

It was apparent throughout the present study that all the participants perceived that their mothers’ eating disorders had had an impact on their relationship with their mother. They described a number of historical events that for them illustrated the influence of the maternal eating disorder on their relationship with their mother. Specifically those events included not being appropriately fed and receiving critical comments regarding their weight and appearance. It seems that some of those events impacted upon how the participants perceive themselves and on their own sense of worth. In other words, the relationship with their mother created beliefs about the loveableness, worthiness and acceptability of the self. Furthermore, this would be in line with attachment theory which holds that young individuals construct mental representations of the self and others based on the experienced interaction pattern with their principal attachment figure (Bowlby, 1969 / 1982, 1973, 1980). It is also important to bear in mind, however, that there is evidence to suggest that having an eating disorder distorts perceptions of relationships with family members (Vandereycken, 2002). In particular, as separation-individuation is a core issue for many sufferers of bulimia and anorexia, it has been suggested that it should be taken into account when analysing such individuals’ family perceptions (Vandereycken, 2002). As all the participants in the present study were suffering or had been suffering from eating disorders, this could have impacted on the findings.

Attachment theory was a valuable theory for informing the interpretations of some findings. During the analysis, however, it transpired to be a somewhat limited theory for the complex picture that emerged. For example, most of the participants introduced the construct of modelling, which may give an indication of the strength of this construct for them. Modelling seemed to be a means of understanding how the mother-daughter relationship contributed to the development of the participants’ eating disorders. Ideas from attachment theory did not seem sufficient in providing a plausible explanation for the construct of modelling, and other theories were therefore incorporated. Attachment theory could, however, be useful when exploring specific
aspects of the relationship between parents with eating disorders and their offspring. As attachment is only one aspect of development, however, it may be useful to incorporate family and systems theory in future research.

Although no generalisations can be made from the present study, it does add to the existing evidence base which suggests that parental eating disorders may have adverse effects on children. Stein et al. have made suggestions for interventions built on their research regarding infant development and maternal-infant interactions (1994; 1996; 2001; Stein & Woolley, 1996; Woolley, Wheatercroft & Stein, 1998). They urge clinicians to assess the quality of interaction between such parents and children if they suspect that the parental eating disorder is having an adverse effect on the young child. In addition, they suggest that it might be helpful to work with parents to lessen the attention and criticism that they may direct at their children’s weight and shape if older children are involved. The findings from the present study certainly support those suggestions. Additionally, these findings are also relevant for therapeutic professionals working with adult daughters of mothers with eating disorders as they offer insights into the emotional needs, and the range of psychological difficulties that daughters of mothers with eating disorders may face. In terms of future research, it may be useful to explore reports of the mother-daughter relationship provided by daughters who have not developed any disorder. Such information may help to shed more light on potentially protective effects. In conclusion, it is hoped that the present study has convinced researchers that the experiences of offspring of mothers with eating disorders is an area worthy of further study.
References


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Appendices

- Appendix A: Interview Schedule
- Appendix B: Background information form
- Appendix C: Time line used in the interview schedule
- Appendix D: Information sheet for participants.
- Appendix E: Consent form
- Appendix F: Ethical approval from University of Surrey’s Advisory Committee on Ethics
- Appendix G: European Eating Disorders Review’s notes for contributors
- Appendix H: Interview with participant J
Appendix A: The interview schedule used in the present study.

INTERVIEW SCHEDULE

Introduce research and explain about the tape recorder, gain consent and signature on the consent form.

Ask if there are any questions she wants to ask prior to the interview. Explain that there are some questions which may be difficult to respond to and tell the participant that they can tell me to go on to the next one if this is the case or indeed if they want to terminate the interview at any time.

Section I: Mother's eating disorder

I would like to start by asking you a few questions about events in your life which relate to your mother's eating disorder that you believe are significant. These might be significant either in terms of your mother's eating disorder and/or ways in which you believe this has affected you. This is a time line (show interviewee the time line [see appendix C]), and what I'd like to do together is to map onto it what you feel have been significant milestones in your life relating to your mother's eating disorder, starting when you first became aware of it and continuing to the present day.

(These questions will be asked during the mapping of the first milestone)

1. When did you first notice that your mother had problems with eating?
   Prompt: How old were you?
   How do you remember it so specifically (if appropriate)?

2. What form did these problems with your mother's eating take?
   Prompt: Was she bingeing, purging, fasting, using laxatives, exercising to excess etc.?
   How did you notice these problems?
   What makes you say that?
   Can you remember how you felt about this at the time?
3. What differences (if any) did you notice in your mother as her problems evolved?

Prompt: How was she different before?

How did you realise that she was changing?

What makes you say that?

(the following will be asked after all milestones have been mapped out)

4. Of these milestones, which would you say were the most significant in terms of the way in which these have affected you or in any way affected how you think or feel about yourself? (choose a maximum of three and use the following question and prompts for each of the three milestones)

5. Can you tell me about (the event)?

Prompt: Why do you think (the event) was particularly important to you / your mother?

What makes you say that?

How did you feel about (the event) at the time?

Why do you think that was?

Has the way you feel about it changed over time?

If yes, what do you think has led to the change?

How did other members in your family react?

Why do you think that was?

What happened after (the event)?

(if treatment has not been mentioned by the participant herself, the following will be asked)

6. Has your mother sought help for the treatment of her eating disorder?

(if no, go straight to question 12)

7. How would you describe the events leading to the time when your mother sought help?

Prompt: Do you think this (specify according to what the participant stated) was in any way related to your mother seeking help?

If yes, what makes you say that?
8. What kind of help did your mother seek/did she receive?

9. Did you notice any changes in your mother when she received help?  
*Prompt: If yes, what kind of changes?*  
How did that make you feel?  
Did this in any way affect your relationship with your mother?  
What makes you say that?  
What do you think led to that?  
How do you think other members in your family felt at the time?  
What makes you say that?  
Why do you think that was?

*(The following will only be asked if the participant herself has not covered it)*

10. Did your mother’s eating ever seem to get better and then relapse again? *(if no, go to question 12)*  
*Prompt: How did you feel when she relapsed?*  
Why do you think that was?  
What would you say contributed to her relapsing?  
What makes you say that?  
How do you think your mother felt about relapsing?  
What makes you say that?  
What happened then/after that?

11. How do you think other members of your family felt about your mother’s relapse?  
*Prompt: Was their reaction different/similar to yours?*  
Why do you think that was?

12. In your view, is your mother still suffering from an eating disorder?  
*(If yes go straight to the next section)*

13. How long did her eating disorder last for?
Prompt: What changed when things started to get better?
What were you feeling about her getting better at the time?
Has your initial reaction changed?
If yes, what do you think has led to these changes?
What makes you say that?

Section II: The mother-daughter relationship during childhood.

Now I would like to move on to focus in more detail on what things were like for you as a child. If I were to ask you to choose some words which describe your relationship with your mother in your childhood, what words would you choose?

1. Which of those words do you feel best describes your relationship with your mother in your childhood?
   (choose a maximum of four words)

2. Can you think of a situation in your childhood which your relationship with your mother was (first word)?
   Prompt: Can you tell me about that?
   How did that (the event) make you feel?
   Why do you think that was?
   How do you think your mother felt then?
   What makes you say that?
   What happened then/after that?
   Why do you think that happened?
   Why do you think your relationship with your mother was (first word)
   What might have brought that about?
   (repeat for the other key words)

3. How would you describe the relationships between your mother and each of the other family members?
Prompt: In what way are those relationships similar or different to your relationship with your mother?
What makes you say that?
Could you give me an example of this?
How did that make you feel?
Why do you think that was?
How do you think that made them (the family member) feel?
What makes you say that?

4. How did you feel about your mother's eating disorder as a child?
Prompts: Why do you think that was?
What makes you say that?
Did you act differently around her then?
Why do you think that was?

(the following question will only be asked if it has not already been covered by the participant)

5. When you were a child, was your mother ever admitted to hospital?
(If the response is no, go straight to question 10)
Prompt: How old were you at the time?
How long was she in hospital for?
Who was looking after you then?
How did you feel when she was admitted to hospital?
Why do you think you felt like that?

6. Did you know why your mother had been admitted to hospital?
(if no, go to question 9)
Prompt: Who told you?
How did you feel when you first learned about this?
Why do you think that was?
7. *(if appropriate)* Can you think of anything that would have helped you to feel better about her going into hospital?  
*Prompt: How would that have helped you?*  
*(go to question 10)*

8. Do you think you would have felt differently had you known why she was admitted to hospital?  
*Prompt: In what way do you think it would have made you feel differently?*  
What makes you say that?

9. How did people around you (for example, your father, siblings, grandparents etc.) react to your mother’s eating disorder at the time?  
*Prompt: Did anyone act differently around her?*  
Did anyone talk about it openly?  
If so, was that helpful/unhelpful?  
What was it about it that was helpful/unhelpful?  
What makes you say that?

10. When you were a child, did you share your feelings about your mother’s eating disorder with other family members? *[see below for follow-up questions]*  
With friends outside the family?*[see below]*  
With anyone else?*[see below]*  
*(if no, go straight to the next section)*  
*Prompt: Who was that person (s)?*  
Why did you choose to speak to that person (s)?  
How did you feel afterwards?  
Why do you think that was?

**Section III: The mother-daughter relationship at the present.**

Now I’d like to move on to consider the current relationship you have with your mother.
1. You described your childhood relationship with your mother as *(specify according to what the participant stated earlier)*. What words would you use to describe your current relationship?

*Prompt:* What makes you choose the same/different words?
In what way do you think your relationship is the same as/different from when you were a child?
What do you think has led to it remaining the same/changing?

2. Which of those words do you feel best describes your current relationship with your mother?
*(choose a maximum of four words)*

3. Can you think of a fairly recent situation in which your relationship with your mother was *(first word)*?

*Prompt:* Can you tell me about that?
How did that *(the event)* make you feel?
Why do you think that was?
How do you think your mother felt then?
What makes you say that?
What happened then/after that?
Why do you think that happened?
Why do you think your relationship with your mother is *(first word)*
What might have brought that about?
*(repeat for the other key words)*

4. How would you describe the relationships between your mother and each of the other family members?

*Prompt:* In what way are those relationships similar or different to your relationship with your mother?
What makes you say that?
Could you give me an example of this?
How did that make you feel?
Why do you think that was?
How do you think that made them (the family member) feel?
What makes you say that?

Section IV: Therapeutic Issues

As I mentioned before, I am doing this research as part of my doctoral course in Counselling Psychology. I would therefore like to look at some issues around counselling. When I talk about 'counselling' here, I mean situations where you have met with a health professional more than once on a one-to-one basis and where you talked about your mother, her eating disorder and its effects on you.

1. Have you ever received this sort of counselling?
   (if no, go straight to question 6)
   Prompt: Who provided this counselling?
   Was it your own decision to get counselling?
   How did you gain access to the service?
2. How often did you see him/her?
3. Before you began, what were you hoping that you would be able to achieve from counselling?
4. Did you find the way your relationship with your mother and her eating disorder was dealt with in counselling helpful/unhelpful?
   Prompt: In what way was it helpful/unhelpful?
   Why do you think that was?
5. Is there anything the (mental health professional) could have done to have made it (even more) helpful?
   Prompt: If yes, what do you think they could have done?
   How do you think that could have helped?
   If no, what makes you say that?
6. What would you feel about speaking to such a person about the relationship with your mother?

*Prompt:* What makes you say that?

**Section V: Closure of the interview**

1. Is there anything that you would like to tell me about your experiences which I have not asked you about during the interview?

2. Finally, may I ask how you felt taking part in this interview?

*Prompt:* Was there anything helpful or unhelpful about the questions I asked?

In what way was it helpful/unhelpful?

3. How do you feel now?
Appendix B: Background information form used in the present study.

BACKGROUND INFORMATION

To begin with, I would like to get some basic information about you and your family. This information will help me to see whether there are any background or familial similarities or commonalties amongst the participants.

The information that you give me here is entirely confidential and will not be used to identify you in any way. If you do not want to answer some of the questions, however, please do not feel that you have to.

1. How old are you?

2. What is your occupation?

3. What is your highest educational qualification?

4. What is your ethnic origin?

- White.................................
- Black-African.........................
- Black-Caribbean............... Pakistani........................
- Bangladeshi.................... Chinese........................
- Other.................................
  (Please specify)

5. What is your current marital status?
6. How many children do you have?
   (If none go to question 8)

7. How old are your children?

8. What is your parents' current marital status?

9. How old are your parents?

10. How old was your mother when she was diagnosed with an eating disorder?

11. What eating disorder was your mother diagnosed with (e.g. anorexia nervosa or bulimia nervosa)?

12. Do you have any brothers and sisters?

13. How old are your brothers and sisters?
Appendix C: The time line used in the present study

TIMELINE
Appendix D: Information sheet used in the present study.

Department of Psychology
PsychD in Psychotherapeutic & Counselling Psychology

Telephone: ***
E-mail: ***
Fax No: ***
Title of Project: Maternal eating disorders: Adult daughters’ reported experiences

Information Sheet

My name is Nadia Ahlenius and I am presently undertaking a doctoral course in Psychotherapeutic and Counselling Psychology at the University of Surrey. This is advanced professional training in the practice, research and academic aspects of Counselling Psychology, which is accredited by the British Psychological Society.

As part of this course, I am conducting a research project with adult daughters of mothers with Bulimia Nervosa; I hope to explore their experiences of their relationship with their mother. This study is being supervised by Dr Adrian Coyle (who can be contacted on ***), who is one of my Course Directors and Mrs Wendy Gairdner (she can be contacted on ***), who is a professional tutor on the course and a registered family therapist who works in St George’s Eating Disorders Service in South West London. This study has been approved by the University’s Advisory Committee on Ethics.

There are different types of eating disorder, for example Anorexia Nervosa or Bulimia Nervosa. People suffering from Anorexia Nervosa tend to limit or restrict the amount of food that they eat. They may also seek to control their weight and shape by exercising a lot. In contrast, people with Bulimia Nervosa tend to consume large amounts of food in a short period of time, and then engage in compensatory behaviour, such as self-induced vomiting or misuse of laxatives, in order to prevent weight gain. Despite the immense rise in the prevalence of eating disorders over the last four decades, there is relatively little
research on the experiences of the children of mothers with Bulimia Nervosa or Anorexia Nervosa. I hope that my project will shed light on these experiences and will help identify effective ways of supporting such families.

The study will require me to conduct interviews with adult daughters of mothers with Bulimia Nervosa. This interview will last between forty five and ninety minutes and will focus on your relationship with your mother during childhood, adolescence, and currently. The interview will be audio recorded and subsequently transcribed. Tapes will be kept in a locked drawer and will be erased as soon as they are transcribed. All information obtained in these interviews will remain confidential and, in the resulting research report, no participant will be identifiable to other people. You may listen to the taped interview first, before allowing the transcription procedure to continue. At any time if you feel that you no longer wish to participate in the study you may withdraw. Consequently, any material collected in relation to you will be removed from the study.

If you have any questions, require further information or would like to participate in this study, please contact me (see above). Thank you very much for your time and consideration.
Appendix E: The consent form used in the present study.

Department of Psychology
PsychD in Psychotherapeutic & Counselling Psychology

Telephone: ***
E-mail: ***
Fax No: ***
Title of Project: Maternal eating disorders: Adult daughters’ reported experiences

Consent Form

I the undersigned voluntarily agree to take part in the study: Maternal eating disorders: Adult daughters’ reported experiences. I have read and understood the Information Sheet provided. I have been given a full explanation by the investigator of the nature, purpose, location and likely duration of the study, and what I will be expected to do. I have been advised about any discomfort and possible ill-effects on my well-being which may result. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

I agree to comply with any instructions given to me during the study and to co-operate fully with the investigator. I shall inform her immediately if I suffer any deterioration of any kind in my well-being.

I understand that all documentation held on a volunteer is the strictest confidence and complies with the Data Protection Act (1998). I agree that I will not seek to restrict the use of the results of the study on the understanding that my confidentiality is preserved.

I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.
I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Name of volunteer: ............................................................................
(BLOCK CAPITALS)

Signed: ............................................................................

Date: ............................................................................

Name of witness: ............................................................................
(BLOCK CAPITALS)

Signed: ............................................................................

Date: ............................................................................

As the researcher, I formally undertake to conduct this interview in a sensitive manner and to ensure the confidentiality of the individual interviewed.

Name of researcher: ............................................................................
(BLOCK CAPITALS)

Signed: ............................................................................

Date: ............................................................................
Dear Ms Ahlenius

Adult daughters of mothers with bulimia nervosa: What are their reported experiences of the mother-daughter relationship in childhood and subsequently? (ACE/2002/01/Psych)

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol (and the subsequent information supplied) and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed. For your information, and future reference, these Guidelines can be downloaded from the Committee’s website at http://www.surrey.ac.uk/Surrey/ACE/.

This letter of approval relates only to the study specified in your research protocol (ACE/2002/01/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions, and if the study is terminated earlier than expected, with reasons.

Date of approval by the Advisory Committee on Ethics: 22 February 2002
Date of expiry of approval by the Advisory Committee on Ethics: 21 February 2007

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Advisory Committee on Ethics

cc: Chairman, ACE
Dr A Coyle, Supervisor, Dept of Psychology
Mrs W Gairdner, Supervisor, Dept of Psychology
Appendix G: European Eating Disorders Review’s notes for contributors

Instructions to Authors

Initial Manuscript Submission. Submit four copies of the manuscript (including copies of tables and illustrations) to Dr Robert Palmer, University of Leicester, Brandon Mental Health Unit, Leicester General Hospital, Gwendolen Road, Leicester, LE5 4PW, UK.

Authors must also supply:

- an electronic copy of the final version (see section below),
- a Copyright Transfer Agreement with original signature(s) - without this we are unable to accept the submission, and
- permission grants - if the manuscript contains extracts, including illustrations, from other copyright works (including material from on-line or intranet sources) it is the author's responsibility to obtain written permission from the owners of the publishing rights to reproduce such extracts using the Wiley Permission Request Form. Permission grants should be submitted with the manuscript.

Submission of a manuscript will be held to imply that it contains original unpublished work and is not being submitted for publication elsewhere at the same time. Submitted material will not be returned to the author, unless specifically requested.

Electronic submission. The electronic copy of the final, revised manuscript must be sent to the Editor together with the paper copy. Disks should be PC or Mac formatted; write on the disk the software package used, the name of the author and the name of the journal. We are able to use most word processing packages, but prefer Word or WordPerfect and TeX or one of its derivatives.

Illustrations must be submitted in electronic format where possible. Save each figure as a separate file, in TIFF or EPS format preferably, and include the source file. Write on the disk the software package used to create them; we favour dedicated illustration packages over tools such as Excel or Powerpoint.

Manuscript style. The language of the journal is English. All submissions including book reviews, must have a title, be printed on one side of the paper, be double-line spaced and have a margin of 3cm all round. Illustrations and tables must be printed on separate sheets, and not be incorporated into the text.

- The title page must list the full title, short title of up to 70 characters and names and affiliations of all authors. Give the full address, including e-mail, telephone and fax, of the author who is to check the proofs.
- Include the name(s) of any sponsor(s) of the research contained in the paper, along with grant number(s).
- Supply an abstract of up to 150 words for all articles [except book reviews]. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.
• Include up to five keywords that describe your paper for indexing purposes.

Reference style. The APA system of citing sources indicates the author’s last name and the date, in parentheses, within the text of the paper.

A. A typical citation of an entire work consists of the author’s name and the year of publication. Example: Charlotte and Emily Bronte were polar opposites, not only in their personalities but in their sources of inspiration for writing (Taylor, 1990). Use the last name only in both first and subsequent citations, except when there is more than one author with the same last name. In that case, use the last name and the first initial.

B. If the author is named in the text, only the year is cited. Example: According to Irene Taylor (1990), the personalities of Charlotte... 

C. If both the name of the author and the date are used in the text, parenthetical reference is not necessary. Example: In a 1989 article, Gould explains Darwin’s most successful...

D. Specific citations of pages or chapters follow the year. Example: Emily Bronte “expressed increasing hostility for the world of human relationships, whether sexual or social” (Taylor, 1988, p. 11).

E. When the reference is to a work by two authors, cite both names each time the reference appears. Example: Sexual-selection theory often has been used to explore patters of various insect matings (Alcock & Thornhill, 1983). Alcock and Thornhill (1983) also demonstrate...

F. When the reference is to a work by three to five authors, cite all the authors the first time the reference appears. In a subsequent reference, use the first author’s last name followed by et al. (meaning “and others”). Example: Patterns of byzantine intrigue have long plagued the internal politics of community college administration in Texas (Douglas et al., 1997) When the reference is to a work by six or more authors, use only the first author’s name followed by et al. in the first and all subsequent references. The only exceptions to this rule are when some confusion might result because of similar names or the same author being cited. In that case, cite enough authors so that the distinction is clear.

G. When the reference is to a work by a corporate author, use the name of the organization as the author. Example: Retired officers retain access to all of the university's educational and recreational facilities (Columbia University, 1987, p. 54).

H. Personal letters, telephone calls, and other material that cannot be retrieved are not listed in References but are cited in the text. Example: Jesse Moore (telephone conversation, April 17, 1989) confirmed that the ideas...

I. Parenthetical references may mention more than one work, particularly when ideas have been summarized after drawing from several sources. Multiple citations should be arranged as follows.

Examples:

- List two or more works by the same author in order of the date of publication: (Gould, 1987, 1989)

- Differentiate works by the same author and with the same publication date by adding an identifying letter to each date: (Bloom, 1987a, 1987b)

- List works by different authors in alphabetical order by last name, and use semicolons to separate the references: (Gould, 1989; Smith, 1983; Tutwiler, 1989).

All references must be complete and accurate. Online citations should include date of access. If necessary, cite unpublished or personal work in the text but do not include it in the reference list. References should be listed in the following style:

Journal Article

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production process. Prompt return of the corrected proofs, preferably within two
days of receipt, will minimise the risk of the paper being held over to a later issue.
25 complimentary offprints will be provided to the author who checked the
proofs, unless otherwise indicated. Book review authors will receive one free copy
of the journal issue in which their book review appears. Further offprints and
copies of the journal may be ordered. There is no page charge to authors.
Appendix H

TRANSCRIPT 3

(R=researcher, P=participant)

R1: First, here there is like a time line and what I would like you to do is to kind of put a cross on the time line erm...on like ages of events that you feel were really significant in you life relating to your mothers eating disorder.....so for example if you start like when you first became aware of that she had some problem with eating or any event that kind of sticks out in your mind that you think or.....you know that I really remember that time or something like that.

P1: Erm......we had a conversation when I was 14, so I’ll put that one on where she told me – it should probably go about there, erm......and this was just before I got really bad, in the winter 96 she erm......told me about her thinking it was, you know, feeling really guilty if she could get through a whole day without eating......erm, and there was me sitting there thinking you know I feel this, I think that but not being able to say it erm, and all, and I say there because I remember we were in our new house so it would have been a 6, that erm.....she would often talk about how she felt, that she was fat a lot, erm, but its always been I don’t know I suppose I didn’t really notice apart from, I didn’t notice when it was happening when she was at university, erm, or maybe I did but can’t remember, erm, cos it was, you know after I was born it was never that bad, so....I don’t know what else is this stuff know, erm.

R2: If there is anything that happened lately as well it doesn’t have to be during childhood it could be...

P2: Erm, see......we’re not talking that much at the moment which a lot of people think is really strange and really said who what’s your mum what’s your mum and dad doing about it and I said well nothing cos they don’t know, well they know but I don’t, I don’t tell them. Erm...
R3: Why do you think that is?

P3: Because I'm... I don't know I'm just to scared to, it took me about 4 months to tell them in the first place when I told mum at the end of August last year, erm and X had been saying look if you don't tell them I'm going to so I did do it in the end but since then we haven't really talked about it, they've gone for the complete acceptance of what I'm doing so they don't pressure me to do anything which in a way is really good but at the same time, I need......I need boundaries cos when I was growing up as well they, they've both been brought up very strictly, so they didn't want to do that with me so I was, you know I did everything with them I didn't, my world wasn't really separate from theirs so when I would get into trouble for things I often didn't understand because......you know if I was allowed to do all these things why wasn't I allowed to do that so in a way I want them to come in and say 'no your not doing this, I'm stopping you dong this' and come and kind of rescue me, but I can't, it's why -- I want them to notice I can't tell them, erm......and lots of people have wanted to tell them for me but I've said well, cos X wants to tell my mum and I've said well but no because then she'd have the knowledge that I couldn't tell her myself which I'm worried about, so its erm its easy to think of things related to mine but not so much to mums, erm...

R4: Yeah, that fine if you can only think of 2 at the moment that's fine.

P4: I'm sure... I might come up with some others later...

R5: So erm, I'll go back to that in a minute I'd just like to ask a little bit about your mums eating disorder, what form did that take did she, you know, diet or abuse laxatives or exercise.

P5: I... I don't think she ever did laxatives and she never did exercise -- me and her don't have the erm [draws breath and chuckles slightly] will power to do exercise it always seems so bloody boring, erm, she did go swimming a lot, its
erm, I don’t think she used laxatives, I did for a while but didn’t anymore don’t any more and will never do again, she... I think she was making herself sick but I don’t know, for certain, I know when she was a teenager it was not eating at all which is what I do rather than just, you know cut down to certain things we’d just cut out completely, erm...... and go, I don’t know how long she went in one go but I went about 25 days without eating anything, erm, so, but I know when she was doing her degree it was bulimia, so she must have been making herself sick cos... she did diet a lot, she dieted for the wedding and that worked, she went on X diets, then she found the carbohydrates addicts diet, that now that I see a dietician I know that that’s actually a really bad idea, but it worked when she first did, when she first did it for the wedding and she was erm... I think she said she got down to about 8½ stone she’s only 5’ so she’s not very tall so she was really happy with that, erm, I know she’s unhappy know cos she’s just had a baby and I do keep telling her, you know you’ve just had a baby and Z keeps saying ‘have you got another baby in there’ cos she’s breastfeeding so she hasn’t lost it all yet and she’s, she says she’s not taking that too badly, and, of course he doesn’t understand, but, I’m sure it does get her somewhere, erm, even though my dads always telling her how gorgeous she is, but she still doesn’t quite believe it, she’s er......not very good now with listening to what her body wants at all, she will go a lot of the day without eating anything and then eat more in the evening erm... really shes just a bit erating, not being strongly one way or the other anymore, she’s trying not to – she’s doing really well – she’s trying to stop herself feeling guilty for doing things and eating things and erm, it was easier while she was pregnant cos it was like well I’m pregnant so I’ve got to eat what my body says I want, when I want it, and if that means chips at 11 O’clock in the morning then that what I’ll have.

R6: And I guess when its for the baby as well its easier because you know your doing it for someone else, and maybe not for yourself so much.

P6: Yeah, and she learnt some things when she was pregnant with me or when she was breastfeeding me like not to eat a whole packet of fig roles because erm
it went straight through me and straight through her – no, the other way around, so I now have a passion for fig roles I don’t know if that’s where that started but erm, its, its something we don’t, I mean I know, I know it was always there, and I suppose I should really have been able to notice things, I mean we were always, mum was always cooking three meals, one for dad, erm, one for her and one for me. Sometimes I’d, cos she was vegetarian, dad wasn’t, dad is a northern man, he won’t eat anything but meat and two veg, he won’t eat pasta or anything which is very very difficult if your vegetarian because dad won’t touch anything vegetarian so she always ended up cooking more.......erm, and she would always have a small plate and dad would always have big one, so I knew that she would eat less at meals and neither me or her did breakfast, dads always objected to that saying that breakfast is really important and we’ve just never had it, mum used to say that if she ate breakfast she was hungry again by half past 10, if she didn’t she wasn’t hungry till lunch, so she would not have breakfast because it meant that she didn’t eat as much in general.

R7: And how come you didn’t have breakfast?

P7: Erm, I think just because mum didn’t, so when it was, when we moved out of, I was living with my grandma till, me and mum at grandmas till I was just over a year old, and then when mum went back to school we moved into a flat in X erm, which was just 5 minutes away from grandmas but, erm, so because she didn’t I didn’t, I used to have, we often had you know bacon sandwiches on a Sunday morning, but that was always lunch time anyway......Sundays were always different, and I’d have breakfast at my grandmas, again on a Sunday morning, it was always a mackerel... erm, but erm, I just never did cos she never did, so, but erm, she would always send me to school with a piece of fruit erm, so even if she didn’t eat breakfast for a time she was trying to get me to eat it because, I was a child and she saw that it was important for me to do it, erm, so, that’s always, that’s one out of three meals gone, and then I don’t know she is with lunch, I know I completely cut out lunch until a few months ago, erm, and its really weird to erm, when I was trying to work out what I’d have for lunch
thinking well, what do people actually eat for lunch......cos I stopped eating lunch when I was 12, and I hadn’t done it since and its really weird, erm, sorry I’m talking about me instead of mum, erm...

R8: So how come she... you said she was cooking three different meals, how come she was cooking a different one for you?

P8: Erm, sometimes it was 3, I would either had what dad had or what mum had, erm but some days, there would like, I can’t stand macaroni cheese, and often when I was, when I was 14.....and I was being vegetarian as well, mum had, I don’t know if she was still ill or not, erm, I was cooking my own diner, so mum was doing dads and hers, now she sometimes cooks three.....one for Z who won’t eat anything but meat and sausages [chuckles] erm and one for me and her, and one for dad, erm, but we very rarely ate round a table, we never ate the same thing, erm, and when, we didn’t always eat at the same time, we were often sitting on the sofa with it on our laps, and a lot of people say you know you should have meals together at a table, but, we did sometimes like the four times a year that mum got round to doing a roast we’d have it round the table but with dad working and mum teaching she wouldn’t get in till 5 and then shed have to plan lessons all night and do marking that we were just never together long enough to have dinner together erm, so we were used to just kind of doing it differently...... I mean I always went through phases, I had a vegetarian lasagne phase, and a jacket potato phase and erm, things, that I would often have at a completely different time from mum and dad so it was always very...... mum would always try to put no pressure on food at all, but like with the erm being strict it was a bit far the other way, so it was too relaxed, but...

R9: Do you think that had something to do with her own experience of having had an eating disorder that she didn’t want to force you...?

P9: Yeah, yeah, because her mum had said you must eat everything on the plate, always, and is, I’m a lot like my grandma she’s very controlling erm, but I’ve
recognised it in myself and can work on it, erm, so yeah, she was always watched and she didn’t want to do that with me, I mean I spent most of my teenage leaving at home eating in my room, erm, which now that I look at it......I think that that’s actually quite weird, that I’d come in I’d sort my stuff in the microwave, and the microwave although it was in the kitchen its not like next to the cooker so I would be in my own little world thing and I’d put it on a plate and I’d disappear upstairs, and erm, they were never questioned it and when I used to deliberately, they they didn’t bother me if it looked like I wasn’t eating that much although then I would oft... I would always have a proper meal but put it in the bin, they’d wouldn’t, they never questioned anything, with me, because of the experience because of the experience they’d both had and then when I was 13 my cousin whose my dads niece, whose not technically my cousin but......erm, she, everyone was told that she was anorexic and dads reaction was, oh just make her eat, and that was when mum and dad started talking and mum said no you can’t do that, that, you know that doesn’t work at all, erm......so I was, cos even then it was going on with me and I was really worried that you know if that was how dad was going to react to it, then, it was going to make me even less likely to tell them because all he was going to do is sit me down and force food down me, but erm, he’s brilliant now......W even stood up against his mum against me, when she erm exploded all over me, which was really really good because he’s always backed his mum over me and my mum, but he backed me which was really nice.

R10: Yeah, it sounds like it was a really positive experience.

P10: Yeah it was, it was brilliant, erm and he does understand so much now, which is good, but erm....... sorry I keep loosing my point......

R11: I thought it was interesting what you said when you said you were worried that you would be told to sit down and you know eat your food because that was so different from how...they normally were with your food and......
P11: Yeah

R12: And I guess that must have been like a real contrast thinking that he would do that and on the other they seem so relaxed about everything else.

P12: Yeah, erm, I mean I did generally have, I was always very secretive with my eating and and me and my whole family have, they, we don't all have eating disorders but we've all got disordered eating one way or another.

R13: Even your dad?

P13: Erm my dad because he's so fussy - yes. Erm, because he won't eat... he won't eat pasta he won't eat eggs and if you're a vegetarian you live off pasta and eggs and he just won't do it......erm, so not so much my dad, but my grandma his mum is an amazing cook and her, all functions at her house are centred around her cooking and all this food, erm, which makes them very very difficult for me, mum and my cousin, especially as grandma is this person that you will never be good enough for her, umm, me and my mum often think that well we don't want to be like her so why does it matter, but it does and its um, its, its not nice the way it does matter so much, erm but my grandma, my mums mum, has a big meal at lunchtime......erm, which isn't very good because whenever we go out for lunch which grandma does a lot nobody else is that hungry at lunchtime because we all have it at dinnertime and then my granddad doesn't eat during the day, erm, but then keeps snacking in the evening which is what me and mum do, erm, and I used to get up really early on a Saturday and Sunday morning and raid the cool box for the little bars of chocolate and sit and watch the test card till cartoons came on.......and I used to sit under the table with a jar of peanut butter or chocolate spread and a spoon and eat it out of the jar, and I don't know why I was hiding under the table, I suppose I thought I'd get into trouble if they caught me...

R14: And did they ever?
P14: Erm, I think they must have done but I didn’t get into that much trouble or I would have remembered it more clearly, but, we would, whenever dad was away over the summer which was a lot, cos he had to erm, he was the regional manager for X, and he used to have to go when all the branch managers got to go on holiday abroad for a week in the summer he had to go to their offices and cover for them, so he got ten days holiday in the winter, so he was nearly always away for my birthday, erm, me and mum would have very strange things, like we would have strawberries and cream for breakfast because we could, and erm we had mango one morning as well, so it was all, it was always very strange very secretive, very naughty, and erm, you always got the idea you had good foods and bad foods, and erm, the bad foods you’d have.... When nobody else was looking, well or now its ok if we both do it, you know, we both love ice cream, and its, its, criminal when the X [supermarket] does buy one get one free on Haägen Das, because you can’t not buy it, but, of course as soon as you do you end up eating the whole pot because its so nice, but we both feel better if we’re both doing it.

R15: If you do it together.

P15: Erm, same as my dad he’s a good one late at night to put a biscuit tin in the middle of the table and sit and talk and drink and eat biscuits and so long as, generally with me and mum if somebody else is doing it too it must be okay, so... but you still then get the guilt afterwards which we, I mean we should talk about it more that we erm, we still don’t yet, so but then there are some things that I’m not sure I’d want to know because, or I’m not sure I want her to know, and I don’t know if I want to see if she does the things that I do, because then we’ll know too much of each other, she’ll know too much of me, I don’t, I don’t want he image of my mum making herself sick the way I have it with me, which is a bit strange, erm...
R16: It sounds almost as if there’s a struggle that part of you really wants to talk to your mum and relate to her but the other part is scared of what you might find out if you actually take the step to talk to her about it.

P16: Yeah, and what, you know if I ask for help I don’t have to take it, if I don’t, you know I can’t ask for it and they say well actually no I don’t want it. Its like I’ve always been saying I want somebody who can just look at me and say I now what you mean, I know how that feels and erm, we’ve worked out that person is problem going to be my mum, erm but, its umm, it’s a huge step for me to actually say anything to her which is why I need her to say something to me but shes probably feeling exactly the same and thinking that she doesn’t want to crowd me, she doesn’t want to push me away, by questioning me, erm, which can make it very difficult because we had this chat a while ago and she said, that it might seem like she doesn’t care, but she does, its just that she doesn’t know what to do so she’s going for, letting me do what I can cope with and not expecting anything.

R17: It sounds almost like because of the way she was bought up, and it sounds like she’s terrified of doing the same thing to you...

P17: Yeah... so it’s a complete opposite.

R18: So she’d rather not do anything to just kind of give you the space and you know kind of freedom to do what you need to...

P18: Yeah... which is exatley erm, what she planned to, because my granddad, his mother forced him to eat vegetables and now he won’t, he can cope with a few peas just about, but he refuses to et any vegetables, and mum, and you know grandma you know took all the fun out of food for mum and turned it, that she was never allowed biscuits, buiscuits were evil, and you’d get fat if you eat biscuits, so, for, her it was a symbol of control and for mum as well, so I suppose she wanted, she didn’t want, to, to put, to connect food with anything
else, she wanted it to be food, and not have so many other feelings and struggles mixed in with it link them, erm, but its so hard to get the balance right...

R19: Yeah it is isn’t it, it sounds like your whole family have had quite a thing about food...

P19: Yeah.

R20: …that there like, its been so many feelings associated with food and that has been quite a difficult thing like, like sort of through generations really.

P20: Yeah, and my uncle who died he was probably anorexic me and my grandma think, he was 6st before he had his legs taken off and he was 5’10” so, and he’d done all, things like stopping having milk and sugar in his coffee and grandma found loads of recipes and stuff lying around and he’d always been like that he was one these, and I, I don’t know if you know if you know I keep meaning to find out if there are any connections between early feeding problems and later eating?

R21: A lot of research going on about that...

P21: Because, I really want to know about that cos I had problems and so did V, when V was born health visitors and doctors were god and you, you know and you did everything they said and because he was crying a lot and the doctors told my grandmother she was overfeeding him, so she had to cut down what what she was feeding him and, it didn’t work so erm...its, its all there, erm... so, and also my mum idolized V, and there, there are the 2 sorts of body shapes in our family, there was V and my grandma and my great granddad who were very tall and thin – my grandmas not very tall but she was thin, and then there’s my mum and my great grandma who are short and not, they call themselves the Shetland ponies apparently, and erm.. mum you know she jokes about it and she makes it seem like she doesn’t care but she does, erm...a lot, and when we went on
holiday in X in the summer, erm, I was trying to persuade grandma to come swimming because she always used to come swimming with us and she said no no I can’t swim cos I’m too fat, so, everybody feels awful about their body, except U whose my great grandma she doesn’t really seem to, but then erm...this is the woman who buys 8lbs of sugar everytime she goes shopping I’m sure she’s convinced were still rationing and that one day the shops aren’t going to have any sugar left and she’ll be left stranded.

**R22:** Ermm, you set a little cross here, what was that event or do remember anything in particular?

**P22:** That would have been me sitting on mums lap in erm, in our new house in X she when she would te, say that she was fat and I’d sit on her lap and tell her that she wasn’t, I’d say that she was cuddly, and I’d give her a big hug and that happened quite a lot that she would be very down about herself and her body and dad had been telling her, and you know she’d ask me and I’d assure her that she wasn’t, erm, and you know I, It would be frightening to know what, how she would feel if my dad hadn’t had been the way he was and always telling her how beautiful she was erm, yeah cos I’m sure it must help...

**R23:** Yeah.

**P23:** Even if it doesn’t completely, I know for me it all adds to it and one day you’ll believe and one day you’ll believe, kind of builds, if it builds up enough you’ll think yeah.

**R24:** So, what, what were you feeling at the time when you were sitting there on your mums lap and she was saying that she was fat, how did you feel when she said that?

**P24:** I didn’t really understand......because I didn’t see her as fat at all, I just saw her as my mum who was just my world, cos until dad came along and dad
didn’t move in with us until I was 3 or 4...it was just me and mum and we were this single unit, erm, I, I didn’t understand how she could be......so unhappy about it, and, I just wanted to make it better I suppose and that always seemed to be the right answer, cos I’d always, I’d always sit and hug her for a while erm....and I seem to remember it was generally in the evenings that she’d feel worse, erm...

R25: Why do you think that was?

P25: Probably because she wasn’t eating much all day and then she’d eat too much in the evening so...

R26: Its almost like she failed in, you know, she’d been good all day and then she kind of failed in the evening.

P26: Yeah, and then you mess it up, and then if you’ve messed it up to a point you think well I’ve done it so I may as well carry on, you know at least if I eat it now I can’t eat it tomorrow, erm..... So, its erm,...its very hard for her to take pleasure in eating and then hold on to it afterwards, erm...

R27: Because you mentioned before that both you and your mum feel guilty if you have that tub of Haagen Dazs.

P27: Er yeah, particularly if [chuckles] you eat the whole tub, erm...there’s something about ice cream, I keep telling myself you know its just cold milk, there’s nothing, nothing dangerous about it, erm.....I mean I don’t, I think she has as well but we don’t know how, what you eat effects what you weigh, so you think that if you have a couple of extra biscuits you’ll of put on 3lbs, which logically can’t happen, but erm...

R28: That’s just how it feels
P28: Yeah cos you just don’t know what……what it’s doing to you and.........I think that’s where well there is where basically once it’s there you can’t.........you have no control of what it’s doing to you........and.......and.......you don’t know what it’s going to do which scares you even more and the only thing you can think of to stop it doing it is to get rid of it again......which.......is possibly more damaging than just not eating it in the first place......but......being sick can often seem like..............for so many reasons it could seem like the perfect.........thing the perfect escape.........first of all you get to eat all these things that you really, really like..............and then do you have a tissue?

R29: Yeah sure, I’ll get it

P29: Um.........yeah you get to eat all these things that you really like and not have to worry about it because you can always be sick...................and then um..............if after you’ve eaten you feel..............and this is why I find it hard to stop being sick because to me.......I eat, I feel terrible...................and if I get to be sick........... I don’t feel terrible anymore.......so it seems so.......logical yeah if I do this I feel bad if I do this it stops me feeling bad.......it’s hard to........get out of it and as much as you try and...............um........not do it and not feel bad about eating things it’s..................just far too strong........to........not do it and it’s worse when.............like the position I’m in now........when you fully believe that’s there’s nothing wrong with what you’re doing.......it’s much easier to say it........to deny anything but as soon as you can see what’s wrong with it.............and you kind of watching yourself doing it and thinking “this is wrong, this is wrong, this is really, really bad” but you can’t........do anything about it I think it’s worse than..............than believing it fully......

R30: It sounds like you’re really trapped then........because you feel that it’s bad but you still can’t stop yourself from doing it........and I guess as well being sick must be like the perfect compromise because it’s all these foods that you
want to eat and then you know that you feel bad and you know you get better if you get rid of it.................

P30: Yeah........and it’s so.........hard to stop...me and my mum had this chat the other night that a few weeks ago when I was down before I was after a biscuit just a particular kind of biscuit but........I deliberately didn’t bring it with me cos I thought if I bring it with me I’ll eat them and if I don’t I can’t........and........but because........we didn’t have this particular biscuit........I was going through everything else in the house........not literally but....trying to find you know....trying to see if anything else would do..........and of course I ended up eating up more than if I’d just........gone and got what I wanted in the first place........um........and she said that it says that in.........because she buys or has bought a lot of books like I have........um........and I don’t mind me do it because we read them and it always makes us feel terrible........and makes us feel that we’re not good enough and all these people in the books are doing so much better than us....

R31: What kind of books are those?

P31: Um.....well there are some....we used to read a lot of novels about it.....if you can call it novels

R32: About eating disorders?

P32: Yeah.....um......I read X [title of a book] when I was 11........um.............and I was always worried that people will think that I just started doing it because I read it in a book......which I get really worried that everybody cos.......I worry that people won’t believe me.....because I always thought that I’m not.......you know I’m not actually thin enough to show that.........that.....um there is anything wrong.........and.....I’ve had a few.......incidents where people haven’t believed me you know..........accused me of lying about things.............so........but......I buy them.......and you
buy them to feel...........I don't know if you think it will help...........and then........in a way it does but the ones that are..... kind of textbook........statistics ones.........far removed for it to actually have an effect cos I was saying that I know.....I know all these dangers and I could list them all but......they don't apply to me.........um......you know other people will die.....other people will tear holes in themselves......but that's not actually gonna happen to me.......um......and then it's the other ones that......are more personal stories........and instead of focusing on how they got better from it you focus on how bad they were in the first place and......how they managed to do all these things that you never could um.......but that means that you're not real...........

R33: I think that actually is very common experience cos I've heard lots of other people........read studies about it as well........that often these books and articles in magazines are more harmful than helpful cos.......girls or boys with eating disorders read them and thing that the other people are doing it much better and they get tips from it or “that was a good way, I want to try that instead” or.............

P33: Well that's nice to know...............that um.....cos I had this big thing about not feeling real.......um......which and it really annoys me when everybody says “oh it’s obvious what’s wrong with you, it all comes down to the fact that you didn’t have a father”.......and I'm like “no” I refuse to believe that.......because

R34: Well it sounds like you had a really good father

P34: I did! I had an amazing one.....I mean.....for the first three years yeah I didn’t but I had.....my grandma and my granddad and I had my mum all to myself...........um........so.....I mean the person I see in X [city where she lives] he’s.......when I say “you’re not gonna say that it’s all down to my mum being a single mum” he says “no, no, no it’s much more to do with your
relationship with your mum”.......and I was like “yes, at last, somebody has
chosen the right parent to focus on”.......so cos it really annoys me because it’s
like they can’t see anything else and I.......and it wasn’t like I had one....and he
walked out dramatically........it was they split up and then mum found out she
was pregnant........so he was never there in the first place........so it’s like I had
an absence........but I didn’t notice it was an absence and then I had my dad
come along.......um........so.................................so......I don’t
know......sorry I do that a lot I lose.......what I’m trying to say

R35: Don’t worry about it.......okay so we can.......what about erm.......you said
that you had a conversation with your mum....

P35: Yeah that was the conversation on the.......on the ground in the X [a
place] in ’96........um A [a friend] had come with me for the first week.......and
then gone home cos my grandparents used to do caravan holidays on
campsites.......and my parents did cottage holidays in the hills which was much
more exciting.......but.......interestingly when we were in X [another
place]...........when I was 12 no 10..........I met the anorexic twins.......they
were staying in a caravan opposite ours on the campsite and my grandma told
me that they had cancer or diabetes or something..........and I didn’t know any
different cos I was only 10.......so I just thought that was interesting.......um.......they were really nice people they smelled a bit funny
but anyway.......they were nice [laughs].......I remember offering them a sweet or
something and not having one........um...........yes so I wasn’t eating at this
point and that was when I started cutting myself that summer....which didn’t last
very long cos I don’t like pain......

R36: Was this ’96?

P36: Yeah it was summer ’96 winter ’96 was when it all went horribly, horribly
wrong.......um.......and then in February....in 97 that was when....my art
teacher and my mum’s ex-friend.......locked me in her classroom forced me to

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tell my mum what was going on.................which I was furious about..........and.........and then [laughs] this bloody woman! She then.......had a go at me because my counselling session.......clashed with her art lesson...and I thought “hang on you’re the one who started who started all this off if you hadn’t said anything I wouldn’t be missing your lesson” so.........you know “shut up!”.......but anyway she was funny but this was mum talking to me on the......grass....... 

R37: So this was before all of this happened?

P37: Yeah...this was in August ’96 and that was beforehand and it was when I was........just starting again.....it never been too bad up until then I just didn’t eat till tea time or till I got back from school....um..........but then I would still have dinner..........but I um winter ’96 I stopped doing everything so she was talking to me and telling me how she used to feel when she was.........um........about 13 and how she.........actually that would have been about........here [points at the timeline]........um...............um she told me how.....after she had........flu...see I never had that experience a lot of people are ill.......and lose weight and then like it.........um.......and she said that she loved being................six thirteen..........and I was thinking “yeah that’s how I feel” um.....and then she said that she thought it was wonderful and she got through a whole day without eating.....and I was sitting there thinking “that’s exactly how I feel” I do that but I can’t say it

R38: So um.......at this point before this point where you aware that your mum had had these problems or was this the first that you sort of knew of it or?

P38: I think I knew it was there.........

R39: But it was more explicit this time?
P39: Yeah.....I mean it wasn’t it wasn’t a huge surprise so I must have known.........something maybe I picked up on her going to the EDA when she was at university without me really noticing.........um......cos I suppose she wasn’t there much anyway so................another hour of wait wouldn’t have made much difference........so......I think it was like...............my dad not being my dad I’d always known though....................I was never............actually told because I always just knew........um........so......I suppose I must have just picked things up..............um.......and with everything and.....the way she obviously felt about her body throughout my life..........I suppose it was and I’m sure I knew about her when she was a teenager......but I don’t know when she would have told me.......it might have been then when she told me but I can’t.......remember exactly

R40: So what was it like for you sitting there and hearing her telling you this and you feeling “oh my God this is exactly how I feel” what was that like?

P40: I was just wanted to tell her........I just really wanted to say “that’s exactly how... I feel about this” and I just wanted to tell her everything

R41: And do you think she told you just so.........because she had noticed that something was wrong

P41: She didn’t know............she always knew.........um........but she didn’t know what to say......to me.....she didn’t want to...............you know make me.............react to it straight away......cos you know if she’d come and confronted me about it I was more likely to......withdraw and then she wouldn’t stand a chance..............so.............um........she when I was forced to tell her...........in February she knew she’d always known......she knew in middle school......when I......I didn’t go into lunch and I had an agreement with the...dinner lady...........one of them that was really nice that you have first your second dinners and the people who ate second could then go to the library over first dinner.......but I’d worked out with them that I could go in all lunch time
and one of the dinner ladies checked me out...a the library so I had to go and eat and then the librarian...slash teacher person said...that um...you know I said that I'm allowed in there and she said "why aren't you having dinner" and I said "well cos I don't feel like it" and she said "does your mum know that you're not having dinner?" and I said "yes" and she kind of looked at me and I said "yes she does" and I was so scared that she was gonna tell mum...that I...ran home which was literally...across the alley way you know you could see into the school yard from my bedroom...well...the bedrooms around in the house....but and I went home and I told her and I said um...I didn't go into dinner today...and she said "why not?" and I said "cos I wasn't hungry" and I said "I'm often not hungry".........and...that was it I didn't say I often don't go into lunch I just said I often wasn't hungry.......and she said "well just keep the money until tomorrow"........so................she knew then what was going on I suppose because I soon as I got home from school I'd............go in the cooler box and have some crisps.........or something and she never went snooping around because grandma had been snooping around

[end of tape]

that I could that I would never read it and I could often leave my diary on the table and know......that they wouldn't touch it because mum had been violated like that and she....knew how important it was for her.........and.....was determined not to have done that....for me I mean some of the things that I was doing in my room it must have taken........a hell of a lot to...not.......go and look and I was thinking.....you know what would I do with.......my children cos I'm determined to have sorted myself out before I have children so that they have less chance of learning anything from me.........and I thought what would I do if......I could see it going on I would need to go and look I would need to.......look in their bin see what they've got under their bed and stuff.......but my dad did find my laxatives......which wasn't good at all........um........they were moving my bed and I been.....they were putting
a new fire in my bedroom and they said they had to move my bed and I thought I cleared it all out......there were just the empty boxes cos I’d put all the I used to put them in a big jar.......um....this was after stealing them in the first place um......and they found them.......and mum.....had a chat with me after I got back from school one day and said...............you know in a way she said “you may as well just...flush them down the toilet cos they don’t do anything but that anyway”........and everybody says that laxatives don’t make you lose weight but they actually do........you know if you weight yourself and then you take laxatives and then you weigh yourself again you do actually lose weight so I often do wondered about that but I know it’s not real weight but um.......I only did it once or twice and I took loads and I ended up.......in agony on the bathroom floor.....um.....and decided I wasn’t going to do it again........so......even now I don’t do it.....but then I’ve said that about being sick I said no after I threw up blood in ’99 that I was never gonna do it again........um......and that lasted a while and then it started again so it’s.....but I still maintained that.......laxatives isn’t a thing that I’m gonna get back to cos it was just.............how on earth anybody could do it I don’t know because it’s awful.......but um.......so she knew about it then.....and didn’t......didn’t pressure me...............into anything and it must...........it must be even worse for her knowing......what she’s like.......I suppose she can see more than other mums could...see........um.......and would feel worse because................she can see more

R42: You mentioned before you said that when you have children you don’t want them to learn anything from you and do you feel like it sounded almost like you feel that you have learned something from your mum?

P42: I think I must have done I must have........felt that.......the atmosphere that was around food that it wasn’t fun it wasn’t........it.....it was a necessity that..........we hated.......um.......and it was always stressful.....or.....it was.......too much fun but then stressful later........um...........so I’m sure I must have picked...........things up from lots of people.......um..........I
mean I must have picked up being........secretive about it from somewhere........I don’t know where maybe....mum...I imagine mum was doing it as well..........um..........but I was....you know I was worried that I would get into trouble for eating it so there was that generally food is bad.............um.......and it......it’s against you it doesn’t................all it does is.......is damage you and make you feel bad........um.....so I don’t know that I’ve learned anything........directly but I’m sure that I’ve picked up a lot.......from just the way she felt about it........and the way she felt about herself.......that I wouldn’t have had...........I wouldn’t have had confidence in myself coming from her....cos she didn’t have confidence in herself........um........and........because the um......those three years it was just me and her um........you know I would have learned everything from her felt everything from her........um.......without having..............you know neither of us had........other relationships to get in the way..........um........and we still saw it um everybody but they didn’t live with us........so...we did........everything together I never had any baby sitters except my grandma when mum went to school..........but um.....cos they wouldn’t let her take she the school was at the top of the road and it was just stupid when she was doing it you still had to do PE in the sixth form which we always have hated PE....we hate netball players.......so........sorry if you’re a netball player they’re evil [laughs] they’re nasty people........um.......and she used to have to go in in the afternoon even if she wasn’t in lessons.......which meant taking me to my grandma’s.....then going.....to school which was in the opposite direction........saying “yes I’m here” and then going back picking me up and going home again........um..........so...it was difficult

R43: So has your mum ever........been in hospital?

P43: Yeah

R44: Has she ever....to your knowledge had any treatment for her eating disorder I know you mentioned she’s been to the EDA but
P44: Um I think that’s about it because when she was living in........X [a town] when she was younger she had the same doctor that I had........I had hernia when I was five..........and he said if I would get on with it it will go but anyway it’s not hernia only boys get hernias........I remember we moved to X [another town] we changed doctors and.....he was like why hasn’t this been dealt with........so this particular doctor was........completely useless........so it’s unlikely that anything........would have actually had happened she’s had counselling..........and she’s seen the EDA.........but apart from that no

R45: And when...and when she had counselling and when she went to the EDA did you notice anything different about her or did anything change or?

P45: Um................not really things have changed........recently in the last few years.....

R46: And what do you think has caused those changes?

P46: Z [her younger brother] being born........was a big one because she was........she started off being a teacher cos that what she always wanted to do........um........and she did that for six years........before realising that she didn’t want to do it anymore........she didn’t like other people’s children.........and she didn’t like taking me to school cos she didn’t like other children’s parents........so............she um........she gave up teaching........teaching just........brings hell for her regularly she’d come home........and sit in the bathroom in tears because of what........some people at school it the head........the head of this one school just hated her........and..........was regularly you know just trashing her........um........because she didn’t have a silent working........atmosphere........um and they actually worked........it was one of those people who thinks you can only get results if they are being perfectly silent and write everything down how the hell are you suppose to teach French........if
you’re not allowed to speak? So........it was one of those she was a good teacher and he didn’t like it........so she gave up that........and then she had Z.......eventually and..........realised that that’s what she wanted to do.......and now she’s just.......bringing up.......children I mean it’s taken her.........till she was 30 to realise that’s what she wanted........but......that is what she wants she’s going to teach them at home as well.......um.........cos she doesn’t want them to have to go through what we all went through at school which was just a..........nightmare...I mean my mum we all got glasses my dad hasn’t and having glasses is a bad one.......um.......we were both you know new girls my mum moved to X [a town] when she was two and if you haven’t lived.......in that area forever........you’ll never be accepted which isn’t........good um.......Z is ginger which won’t help........I mean it’s awful you get bullied for it.......but they don’t need.......they don’t need......some things I got bullied for are ridiculous like the way I walk.......apparently is........strange and I don’t have a X [a place] accent which they don’t like so............. I mean I’m only worried............and what most people are worried about is the social aspect...but she’s hoping to get together and form a small school...with some other people......so they can have each other as........as............you know social contact and stuff so I think......it all will work but that’s..........while she was pregnant with Z she had to listen to her body.......and she had to trust it........um......and she never had a need to before so she..............you know she’s never had a reason to trust to try and..........sort it out a bit but um........when she was.......pregnant and cos she breastfed Z until he was nearly 2........and so all that time......she was having to eat properly and eat what her body told her to because she needed the strength.......for........feeding and for carry him and stuff.......and then she did the same with R [her younger sister] as well.......but erm and she’s doing and she does it with Z but Z doesn’t have set.......eating times.........she’s trying to do this instinctive eating where he says “I’m hungry can I have something to eat” she’ll give it to him where my grandma would say “no it’s not tea time yet” which.........mum’s trying to show Z that when he’s hungry.......he should be able to eat he shouldn’t have to wait for what he would see as no apparent reason........erm.......so having.......having Z and R has really
helped her...eating her listening...to what she needs and not feeling as bad about it because...she can’t afford...not to do it because she’s got...two children and responsibility and...she needs to show them...what you should do...rather than what...she did with...me which wasn’t her fault...cos she...I...you know if ever she got anything wrong...I think so yes but she was only 17.......

R47: It’s very young, it’s very young age to have a child

P47: Yeah I mean I couldn’t do it now...so...erm...that’s always.........my reason for anything.........she may not have done quite right.......but erm she always tried to....it wasn’t that she ever actively did anything wrong.........and with.......with the boundaries and being so relaxed.......she was trying to do the right thing.......and in general she did it was just a little.......I just need...needed some boundaries.......I needed to not be allowed to do some things and know why.........

R48: I would like to stay and focus on things a little bit when you were a child...if that’s alright and if I ask you to think about let’s say three words or something that would describe your relationship with your mum when you were little, what words would you chose?

P48: Erm.................erm...it was......it was very strong............and........

R49: If you can just think of two words that’s fine as well

P49: ........it was kind of a dependency on each other that we were everything to each other.........erm..........
R50: So erm...if I would ask you to describe...a situation in your childhood that you can remember when your relationship was strong or something that just kind of reflects that word...can you think of a situation or an event or?

P50: Erm........................................I suppose the way I would be able to............go away for a while...........and not...........or she'd be able to go away for a while..........and I wouldn't think she'd left me........I would know that she always come back.......and that was........that was good

R51: So you were sure that she wouldn't leave or sure that she would come back

P51: And when she did come back she'd........erm...she'd....erm compensate in attention and affection for all the time she had been away......and it was just when she was at university........erm when she went back or more when......when she went back to school cos I was only just over a year old when she went back to school erm...............so..............yeah I never felt ......never felt that she wouldn't come back erm......

R52: And what about the other one you said dependent on each other, can you think of an event or situation when that was?

P52: Living in X before I went to school my granddad was a bus driver.......we used to spend a lot of time.......sitting at the top on the front seat......driving around on my granddad's bus ......for.......no apparent reason other than just being together and................erm....it reminds me of a song......or rather it's a song reminds me of it and just............all the time we were living in X before my mum's......friend moved in......E [name of friend] before she met her we were just.......we used to do everything together.....you know I didn’t have things she didn’t have apart from school.......there was nothing that she did.......without me.....and.......there’s nothing that I did without her............so........we were everything to each other for.......three years at least
R53: It sounds like you were really....really close........and in what way do you think........erm......the relationship between I know R is only four months but Z is four years old in what way do you think his relationship is similar or different to........yours when you were his age or?

P53: Erm........he’s......he’s just as independent as I am.....cos that’s very strange although me and my mum were so close..........I was.....very independent......and always wanted to be......and he is as well erm........he’s..............he’s got the advantage that mum is much more relaxed she knows........see with me she didn’t.....she had grandma.......standing over her all the time telling her what......to do and she wanted me.......in bed with her cos both Z and R are in bed not Z anymore they were both in bed with them erm........and grandma insisted on me being in a cot........erm mum used to ‘accidentally’ when she fed me in the middle of the night forget to put me back and fall asleep with me in bed with her.......and kind of rebel a little so she’s much........more in charge now.......she knows she can have exactly what she feels is right..........and......he’s..............he’s closer to dad I think.............erm maybe that’s a difference.......that he’s always had two parents up until now I’ve only ever had.......one properly I mean the other one was there but he didn’t live with us so........he’s..................I don’t know it’s hard to......I can always think of loads when I’m looking at him [laughs] erm........

R54: It’s alright if you think of something you can

P54: He’s got the same thing with me that he........seems to prefer....adults and older children than.......children his own age and younger than him he’s very bossy like me.......he likes to either be doing it on his own.......or in charge........erm and because I never had any.......siblings or.......other children that I really......played with until I went to school I’d.......at school I often spent more time with the older children who were.......seemingly much more intelligent
that my my age so he’s he’s better functioning with adults than children which could be tricky for him if they’re too old.

R55: I might already have asked you this question so erm let me know if you feel that you’ve answered it already but how did you feel about your mum’s eating disorder when you were a child I know you said you weren’t really aware of it but it was kind of there in the background I know when you mentioned when you were 12 or 13 when you spoke to her you kind of felt relieved that she kind of felt the same as you did is there anything else that you can think of?

P55: Erm not really I was just aware of the conflict between different people in the family and food like the way grandma was and the way mum was and erm I think with me when I was first put on formula by grandma because mum only fed me for 2 ½ months and if it wasn’t for her mum would have fed me for a lot longer so I suppose all I really knew was that food in my house was different...from other people’s other people had meals together and would have breakfast erm.

R56: And how did you feel about that being different knowing that food was different from other homes?

P56: I was happier because it just seemed so much more relaxed it seemed less forced than all sitting there around table when you haven’t necessarily got anything to say and also if you’re not all hungry at the same time it mum didn’t like us having to wait for dinner if we were hungry unless she was cooking it and we wanted a bag of crisps five minutes before it’s ready you know that kind of thing but the whole idea of people sitting around the table was very frightening maybe because the only house it happened in was grandma X
And when you were a child.....did you ever share your feelings about your mum’s eating disorder with anybody else with anyone in the family or anyone outside or?

P57: Erm........no....not until..........I was a teenager......and then.......A [her friend] and my mum have talked quite a lot see A probably knows more about it than I do.......erm......cos A went through a period of fancying my uncle.......erm.......she came out of it luckily so she was talking to mum a lot cos when mum had to come down to X [a hospital].......erm they’d.......A would go with her and they’d go and see S [the uncle] A so she could see him and mum so she could have protection from seeing him.......cos he’s the kind of big brother that used to play football with her by standing her against the door and kick the football at her......not very nice......big brother.......erm.......so no I never really..........apart from talking to A more recently......I never really said anything........to........anyone about it I suppose it just never came up people were much more interested in the fact that my dad wasn’t my real dad and why my parents weren’t married.......so....erm....

R58: So what was is like for you to speak to A about it?

P58: Erm..........it...........it was good to say it because even if you write it.......or just think it it’s not always.......it doesn’t always seem completely real.......and it can....become more organised if you actually.......you know even if you just say exactly what you’ve written.......just having said it makes it.......feel different..........erm...............so.......and...and she’s very good at.......erm I’ll sit and babble and then she’ll repeat it in English.......for
me.....which is wonderful.....I mean I often sit there and...and tell her what you
know if I’d seen something or thought something she’ll sit there and make notes
and then we put it into an understandable.......order

R59: It sounds like you’re very close you and A

P59: Yeah I’ve known her the only person that I’ve know longer than her is T
[another friend]....erm T was the first person to be nice to me at my new school
in X.........which was really sweet he came and asked me what was wrong and
I said that....erm everyone was being horrible and he took my hand and he said
“I won’t be horrible” and he took across the playground and was nice and
sweet.....we didn’t we weren’t always together but....we....erm we became
friends again in high school.......so but A I’ve known.......since we were
13...so only a year after....it all started with me.......so......yeah and I’ve been
talking to her..........every day since September........trying to....sort things out
me and her are getting much more done than me and my psychiatrist but that he
just has this amazing ability to seem to understand nothing.......at all and it’s
really quite [giggles]........tiring at times......but erm.......A is A is
wonderful........like that

R60: So erm.......when you were little how did people around you.....react to
your mother’s eating disorder.....do you remember anything like.......?

P60: Grandma X was always........very erm........she objected to mum being
a vegetarian........she....because it wouldn’t it would mean that mum would do the
cooking....I mean she still ate chicken so grandma would have to cook
something else for mum and she’d..........often.....you know ask her loads of
questions about it.......and.....generally put loads of pressure on her
which........she.....does in general........erm........my other grandma my mum’s
mum she also had a go at mum for being vegetarian.....a couple of year later she
turned vegetarian........same happened with having the ears pierced when she
had her ears pierced she had a go at her and a few years later she got hers done
too...now she's got more ear rings than me and mum put together..............so...she can be a bit like that........erm a lot of people I mean my dad........never liked the fact that we didn't do breakfast he was always...saying that breakfast is the most important meal of the day bla bla bla........erm.......and I never understood it cos there are all these things that because mum had said it........and because she believed it so much I believed it like the idea that not having........a dad hadn't affected me...............and........that........we don't need breakfast because if you're........if you don't have any and if you're not hungry until lunch that's good and.......really the idea of not being hungry until lunch I now know is a bad thing........but erm........I believed because she believed it........erm........so........and I know at university it was her and her friend who both spotted it in each other........and said right come on........let's sort this out........erm

R61: So it sounds like she had some people around her that were supportive like the friend and then she had other people around her who weren't so understanding and supportive........and it sounds like your dad was quite worried about her........but still being supportive and not trying to force her.............

P61: Yeah......he was.......he was good he wasn't I mean I imagine if she wasn't eating at all he would have been saying "eat, eat, eat" but erm........he just kept saying how........he just really liked to bang on about breakfast really........and I never........understood why........I'm the only one of my friends who doesn't do breakfast everybody........A especially has huge breakfasts........it's the first thing she does before she.......the first thing she goes to the loo and she gets breakfast and I need a fag and a cup of tea first and then I do breakfast these days but........erm..............it's now that I've realised that not having breakfast is.......isn't the norm.......it's.......quite strange actually........everybody else does it........so.......
R62: So now...I just like to move on and focus a little bit about what the relationship with your mum is like now.........so you said that when you were a child that your relationship was very strong.......and that you were quite dependent on each other.......and what words would you chose now to describe your relationship.....? Would you use the same ones or different ones?

P62: It's still very strong..........there's this.........I had to do, do you know about the social act?

R63: No.

P63: Well K who is my guy at the hospital he got me to..........draw and I hate art therapy cos I can't draw I really but I did it and this wasn’t quite as vicious cos it was a diagram and I had to draw myself and.........people around me I did it a few years ago with stones on a table where I picked stones to represent people and positioning them around myself and one of the connections that I had there is........that I called a natural bond.........and an emotional bond...........and..........the emotional bond I have with like my friends and the natural bond I have with my grandma and my mum..........erm and we got that........cos we don't........we don't talk about it........now because we're both........scared to........erm......she's scared she'll say the wrong thing and drive me away and I'm scared she'll be angry or disappointed................erm...............so really.........we just need to make that connection again........and..........and it will all......it will.......it will be the best thing we do when we do it........

R64: So it's almost like that has come between you......because it's like you both kind of want it so much but you're both kind of scared of it so it's almost like it's come between you a bit..........because it's something that you want to talk about but you don't really so....
P64: And I suppose it’s too close........as well you know if I had a different problem........it would probably be much easier but........I’m sure we see too much of ourselves in each other........erm........I know with me I’m........there are things that I don’t I don’t like telling people my secrets I mean when I first got together with F [her boyfriend] I said you know if I if you ever see me........eating lots of chewing gum it means that I’m not eating........and I wish I hadn’t told him that cos when I started eating loads of chewing gum he knew........erm........and I would feel kind of........exposed........and........empty if I tell people everything I do........and........

R65: So it’s almost like you don’t have any protection anymore and you get really vulnerable........

P65: Yeah so in a lot of ways it would be really good cos mum can give me that reflection that I need........but at the same time it scares me because........erm........erm........I’m worried about knowing things about her that are too similar to........to me and how that would feel for both of us........so........it we really do we always want to talk to each other and we do sometimes but just neither of us........can do it yet........I mean I’m sure if one of us does do it it’ll be fine........I mean it happened when I told them in the first place in August when F persuaded me to........and........I told my grandma first but that’s because my grandma asked me a direct question and I can’t lie to her erm........I could but I can’t see the point in lying these days.............cos it’s not gonna achieve anything........erm........and then when I went down in September I went down........well I went down on September the 11th well the 12th I ......it was the most relaxed visit I had because......they just said “no pressure at all you can eat and not eat exactly what you want, don’t think you have to do this for us, don’t think we’ll be angry, or disappointed if you don’t do it” and it did make it a lot easier because coming down all the way so stressful from being........cos I have no friends in C [the town where she lives] I don’t know anybody apart from the people at the hospital so I spend my time doing cross stitch and listening to Radio 4.............erm........so it’s very easy for me not
to eat because it's nobody to pull me up on it......but down here I can't not eat because there're situations where you have to eat.......erm.....so it was always very, very frightening coming down because I had to go back and live with my parents which I hadn't done for a long time.....I mean now it's not so bad cos I can stay at the old house........erm.....though I quite liked staying with them so it did.........it took so much for me to actually build up and say it......but erm.......

R66: It sounds like the things that you were scared of like your mum being disappointed or angry with you it sounds like they sort of took up those things and said “look we won’t be angry or disappointed with you” which in sense must have been a relief but it sounds like

P66: Yeah but then it comes back.....it works for a while but then I start asking it again.......erm......really they need to kind of say it every time.....to keep it going

R67: Yeah it sounds like you want that reassurance all the time

P67: I need it when I’m doing anything I need somebody to say “yes you can do this” you know......you are chopping that onion okay yes you do put the stalk in now..........is......I'm not a terrible good cook but I'm learning.......erm......no but I do I need somebody I can do it's like looking at myself.......when I first look at myself.......every now and then I can see what other people see.........but then as I go through the day the further I go away from that image I had in the morning.......the more I doubt it and.......it's a bit like that with other things while they say it I can believe it but.............as it goes on I doubt it again and I end up............not believing it and then I end up doubting that they actually said it and meant it and.......and that it was actually true.......in the first place
R68: And I guess you spending so much time on your own as well... you don’t have anyone to sort of reinforce that all the time you only have yourself and your own thoughts and........

P68: A does A is brilliant she’s.......always telling me erm.......do believe it you know I can now tell her.......when....I do something that she won’t like.......I was always worried to and I said........that....I was worried to cos the way she’d react because she’d be angry.......and......I now know that she’s not at all.......so but that’s taken six months of her.......telling me every day that there.....aren’t any barriers with her

R69: But you’re there now which is...........it took six months but you’re there

P69: It took six months yeah .....and I do still have days where...like if I go....I used to go completely without eating anything....and then I had I stopped doing that at the end of May last year when F [her boyfriend] said “right you have to eat a piece of toast everyday whether you like it or not”.......erm....which was not very nice but I did it....but then I.....didn’t eat anything at all on Easter Sunday....which was...quite frightening actually and I.....originally I lied to her......and I’d....I’d sat and thought about it in beforehand and thought I can’t tell her cos she’ll be really, really angry because you know I.......I’ve done so well and now I’ve come back to it.......and.......I thought well I try and lie but she probably won’t believe me anyway..........and I did lie to her and......then later on in the conversation I told her that I lied to her......and........she.......she said all she...all she ever felt in situations like that were......worry.......and love.......and not anger.......or anything so it’s.......it’s getting there and I’m sure if my parents say I’d believe it........from them as well but I’m just so worried because it’s so close and.......and such an emotional thing that even if they say they wouldn’t be disappointed there’s just that moment of feeling you can’t control which.....is what I’m worried about.......so I have this thing that I need to control........everybody’s thoughts about me....and everything my dad said when he took me out for a driving
lesson at the weekend he said.............you know “do you know how many
times you’ve said sorry so far to me this morning? And stop doing it, please!”

R70: So you said that your relationship with your mum is still strong, would you
use any other words to describe it?

P70: Erm.........................it.....it needs improvement........not just that
it’s there....we just need to get it going again erm...........

R71: And why do you think that it needs improving?

P71: .................because we need to start talking again........erm.....because I’m
sure...........that she’s gonna be one of the.......probably the most important
thing in helping me get through it........and.....in turn helping herself......I
imagine erm.......so.....as much as I think oh but I’m living with F [boyfriend]
he’s the one who’s got to love me and help me.....it’s erm it’s still gonna be
mum who’s gonna do a lot of it

R72: It sounds like because she’s been through it herself it sounds like it’s really
important for you to have to be able to talk to her and have that understanding
with someone and that connection I guess.......What I would like to do now
is.....I’m sure I’ve mentioned this to you I hope I have that I’m doing this
research as part of my doctorate in psychotherapeutic and counselling
psychology so I’m interested in sort of counselling issues as well and when I talk
about ‘counselling’ here I talk about a person that you’ve met on a one-to-one
basis more than once. And you’ve mentioned before your psychiatrist so I
assume that you are seeing someone

P72: I saw a counsellor for just under two years........erm when I was living at
X at the end of ’98 I saw.......beginning of ’99 I saw another psychiatrist
who.........runs X house in X [a town] and I saw her........and this tells you
how much money they’ve got I saw her once every three months..........and
that was it....that was my therapy......erm....and she put me on X [antidepressant medication] which I had a really bad reaction to......and.........erm but then I moved to X [another town] and.....I saw my doctor......it's amazing....down here you phone your doctor...for an appointment and they give you one in like three weeks time......in X they apologise for the first one they've got being tomorrow afternoon.....and.....I joke that X erm Scotland and England must get the same NHS budget......but because they're so much less of Scotland they end up having more money per......place......up there I saw my doctor first off in because it started when my uncle died it started two days after the funeral that I stopped eating again......erm and I'd gone like 18 months.....ever since I met F [boyfriend]...erm....I was doing really well but when my uncle died and........my granddad dying kind of came up and hit me at the same time.........erm.......and I didn't understand why.....I was....so unhappy you know.....I was talking to some woman from X [a hospital] and I was like but it was six weeks ago I should be over it by now......and she said “no, no dear it can take years” ........and I thought “well I see your point but that really wasn’t a very good way of putting it” but yeah....I expect myself to be able to do things too quickly.......and....I didn’t expect moving to X to be anything major erm.......so anyway I saw this doctor knowing.......knowing that it was happening cos I could see it happening this time and I didn’t like it at all and she referred me to the eating disorders people but because that was gonna be six months she also referred me to......the general psychiatrist who I saw......I saw her the middle of......I saw her once a month I saw her in June, July and then August and then after my mum had gone home in August.........and I'd.....cos she came up to visit for a week and I had stopped eating again like I do........and......F had phoned her........phoned G [the psychiatrist] erm....and got her to see me again and then I saw her every week until at the end of August.....she told me that I had been moved up the waiting list.......of....the eating disorders people........from number 24 to number 1 how the hell they managed that but I did.....and then I started seeing them........in the middle of September..........originally I was seeing K once a fortnight he's the
psychiatrist and L who’s my dietician once a week..........erm.....but since January I’ve been seeing K once a week....and L once a week

R73: And........during this therapy that you’ve had with K or anyone have you ever talked about.......your mum’s eating disorder? Or how that has affected you or?

P73: Erm........... we’ve talked about the general eating habit of my family and.......a lot of the emotions connected to food in my childhood but never..........actively about mum’s but that’s possibly because I don’t know many actual details.....of it....but he knows that it’s there and that it’s important

R74: And do you think it would be helpful for you to talk about it?

P74:Erm..........I think it would be more helpful for her to talk about it ......

R75: For your mum?

P75: Yeah for.......herself........erm..........I think yeah because I think it would help me it could help me to understand where some of my things have come from that they might not......that some things that haven’t obviously come out of books........erm......or aren’t typical.......that I have that it might turn out that there’re.........similar to.......mum than other people.....so yeah it could I think it could really help and understanding why, why it happened in the first place........cos.......it can’t just have turned up when I was 12 it must have been there longer......for it to.......have lasted so long

R76: It sounds like you really would like to have an understanding of it and how it all fits together and everything to come and get a more of a rounded view

P76:Yeah cos I feel that’s the only way that I’m gonna be able to change it.......cos I know.......there’re doing cognitive.......we got this conflict that he
wants me to change my behaviour......so that I can stabilise it so that we can understand why but I feel that I need to understand why before I can change it......and it’s difficult cos he says “well but you’re not strong enough to understand it yet, you got to get it stable first and then we’ll talk about it” but I can’t do that until I understand it it’s very difficult for him saying....this......belief is wrong replace it with that one......and when something’s been there for like 7 years even though you know it’s wrong you can’t just start believing something else

R77: It sounds like you really want to understand why the belief is there in the first place kind of thing and you want to change it once you’ve understood why it’s there.....

P77: Yeah that’s exactly it but erm cognitive doesn’t seem to allow for that......but then he does psychodynamic as well.......but that’s gonna be later........

R78: So he wants to do the CBT first and then go on and do the psychodynamic stuff

P78: Yeah he, he is not a cognitive therapist.....I can tell that’s not his.....he’s having to do it he would much rather........do psychodynamic which is really encouraging but.......it’s I can’t stand it, it seems to be what you do when......you dealing with eating disorders you have to do cognitive and I suppose a lot of people aren’t as self aware as I am....erm......so.......for a lot of people it must work although they wouldn’t do it but it is good and I’m learning that I am in control of this therapy I’m still.......I’m still worried and I saw him last week....and he’d asked me to do something and I......was worried that because I didn’t feel ready to do it....that I actually didn’t have a right to.......say that I wasn’t ready to so something.....but he said......and this has happened a couple of times where I’ve been worried about him thought he be
angry or disappointed and he’s not been at all……so I am getting there with him now but and if I don’t feel comfortable with it we’ll do something different

R79: It sounds like you’re getting there with a few people, with him and with A cos it seems to be the things you’re worrying about people being angry and disappointed with you and you’re slowly learning that……you know that that may not always be the case and…..you know it may be more in your head than actually what people think and it’s good to kind of test it out a bit and notice that hey they weren’t angry and disappointed

P79: And it would be good to know where that came from……possibly grandma [on stepdad’s side] but then there’s the suggestion which comes from A bless her she is still stuck on the dad thing unfortunately she used to believe that I was conscious of it when I was like 6 months old and she now knows that it’s not possible……but I seem to put all my bad feelings onto my grandma……and……some people suggest that maybe it’s because they actually belong to my dad but I’m not ready to think about them in terms of my dad so……I……transfer them to grandma which is easy……cos she’s the person who’s made me believe I’ve never been good enough……for her……not being real cos I’m not her real grand daughter

R80: Well the other thing that I mean I don’t know but because you’ve never had any proper boundaries maybe you don’t know where the line is……where people get angry and disappointed with you because you never really had that……so it might be difficult for you to know realistically when people would get angry and disappointed

P80: Yeah and sometimes it didn’t……..make certainly one of the biggest row me and my dad ever had when I just looked him squarely in the eyes and swore at him he knew he never hit me actually but I told him Z when he was only a few weeks old and he didn’t and I interpreted that as oh he was gonna hit me but I was holding his son……so he wouldn’t but when in actual fact it was because I
had borrowed some batteries the whole...argument and me moving out for a fortnight was because I'd...first of all borrowed these batteries...

[end of tape]

erm.........yeah I didn't understand how.........you know for ages.......they've been trying to persuade me not to lie and then I do lie and I get into even more trouble............or I do not lie rather........and........getting into more trouble about it so........I mean I know it seems that with mum and dad..........my world and their world..........were the same thing but at grandma X.......it was the adult's world and the children's world..........and.......they were very definitely separate and I associated one scenario with love and one with rejection so........erm........it's..........it has been really........tricky.......trying to...........work out how people will react to things and where I'm supposed to be...........

R81: But it sounds like you really work on a lot of things and that you're doing really well I mean you're thinking about it all the time and you're just not pushing it to the back of your mind....and trying to ignore it and that's good............so okay.......erm I was just wondering now if there's anything that I haven't asked you that you would like to tell me about.....before we sort of start to wind down...........

P81: Erm..............................................I don't think so

R82: And may I ask you how you felt about taking part in this interview?

P82:Erm.......I nearly cancelled.........last week on Sunday cos I was really worried about it but that's cos Sunday was a bad day........and I thought I can't now I only got until Tuesday to make a decision so I have been........kind of backwards and forwards.......thinking "yeah this is gonna be really good, it's either gonna be really good and really helpful or it's gonna be....not too difficult
and you know neither one way or the other or it's gonna be really hard”
erm........it hasn't been really hard.....I was nervous today as well.......but
erm.............no it was fine I was a bit worried......at times but on the
whole......I felt it would be really helpful and........a really positive thing to
do..........

R83: And how did you find it hard or?

P83: Very good.......I was still a bit worried that there would be bits that I
wasn’t erm......happy about but.......the only thing that’s bothered me is being
not always seem to have a good answer for things........

R84: Well I guess that ties in with your whole way of being like wanting to do
the right thing and give the right answer and you know........

P84: Yeah being a perfectionist and stuff.......so.......it’s been good

R85: And how are you feeling now?

P85: Erm..........okay.......in need of another cup of tea and a cigarette but
[giggles] but no yeah.......alright I’m more relaxed now then when I
started.....actually so.......it’s been good I’ve tore some tissues but........
Abstract

There is an accumulating body of evidence to suggest that a parental eating disorder can have a negative impact on a child’s development. Clinicians in eating disorders services would be in a good position to consider the impact of a disorder on the children and to refer children who have difficulties for appropriate help. The aim of the present study was to ascertain which specific factors were the best predictors of mental health professionals’ decisions to respond to information about possible effects of clients’ eating disorders on their children. A questionnaire was sent to 226 mental health professionals in eating disorders services, and 79 (37%) completed questionnaires were returned. The results of the present study indicate that the main difference between referrers and non-referrers was that referrers seemed to have a higher estimation of the probability of risk to these children. Implications for practice and directions for future research are discussed.

Keywords: decision-making, mothers with eating disorders
Introduction

There is increasing evidence that children of parents with psychological disturbance are at risk of developing problems themselves (Garmezy & Masten, 1994; Richman et al., 1982; Rutter, 1989; Rutter & Quinton, 1984). Although eating disorders have been the subject of considerable research, it is only in recent years that the possible effects of parental eating disorders on offspring have been explored. Patel, Wheatcroft, Park and Stein (2002) conducted a review of the existing literature, and put forward five broad mechanisms by which a parental eating disorder can affect offspring. Firstly, results of studies of genetic factors in eating disorders seem to indicate that there is a genetic susceptibility to the development of eating disorders (Strober, 1992, 1995; Treasure & Holland, 1990). Secondly, there is evidence to suggest that parental eating psychopathology can have a direct effect on offspring. For example, the parent’s morbid fear of getting fat can in some cases extend to their children, which may cause them to underfeed their children and also lead to conflict during mealtimes (Agras, Hammer & McNicholas 1999; Hodes, Timimi & Robinson, 1997; Lacy and Smith, 1987; Russell, Treasure & Eisler, 1998; Scourfield, 1995; Smith & Hanson, 1972; Stein, Woolley, Cooper & Fairburn, 1994; Stein, Murray, Cooper & Fairburn, 1996; Stein, Woolley & McPherson, 1999). Thirdly, the parent’s preoccupation with food, body shape and weight may interfere with their general parenting functions, particularly with their ability to respond to and understand the child’s needs (Evans & le Grange, 1995; Hodes et al., 1997). Fourthly, because of their disturbed eating behaviours and attitudes toward food, such parents may act as poor role models for their children. Finally, eating disorders are often associated with interpersonal difficulties, including high rates of divorce and separation, which may contribute to additional adverse effects on the children (Hodes et al., 1997; Woodside & Shekter-Wolfson, 1990).

As there is an accumulating body of evidence to suggest that a parental eating disorder can have a negative impact on a child’s development, early intervention may be important in order to interrupt the intergenerational transmission of difficulties (Hodes, 2000; Patel et al., 2002). In recent years a small number of studies have offered suggestions on the management of children with varied problems whose
mothers have eating disorders (Griffiths et al., 1995; Hodes, 2000; Russell et al., 1998; Woolley, Wheatcroft & Stein, 1998). These studies have strongly advised mental health services to see all the children of mothers with eating disorders who present to them, in order to identify any potential risks as early as possible. Furthermore, it has been argued that it is particularly important that therapists\(^1\) are aware of the risks to these children. Specifically, the therapist is in a unique position to manage the children’s and mothers’ difficulties through education and by influencing parental attitudes through various therapeutic techniques (Hodes, 2000; Russell et al., 1998).

Adult psychiatrist teams in general psychiatry have, however, traditionally been more concerned with a client’s family of origin than the family of procreation (Oates, 1997). Indeed, Berg and Hodes (1997) found that although there seems to be an overall interest in the field, adult psychiatrists had little information regarding the children whose mothers they treated for eating disorders. In recent years there has been a rapid growth of specialist eating disorders clinics in the UK, and mental health professionals in such clinics would be in a good position to consider the impact of a disorder on the children, and to refer children who have difficulties for appropriate help (Hodes, 2000). Little is known, however, about the extent to which the children of female clients in specialist eating disorder services are considered in the assessment and treatment process. There is also evidence to suggest that there is a difference in clinical judgement\(^2\) between professional disciplines in multidisciplinary teams, and that the judgement varies more with severe problems (Bailey, Buyusse, Simeonsson, Smith & Keyes, 1995; Laderman, Stein & Papanastassiou, 1999). This difference may have developed from a basic difference in the theoretical underpinnings of each discipline and a different focus in training (Laderman et al., 1999). In light of the potential risks to these children and the important contribution that mental health professionals in eating disorders services can make in terms of identifying risks and managing the children’s difficulties, it would be valuable to gain an understanding of

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1 Here the term ‘therapist’ refers to any mental health professional who is in therapy (i.e. psychotherapeutic interventions designed to enhance the psychological functioning, effectiveness and well being of an individual) with a client.

2 The terms ‘clinical decision-making’ and ‘clinical judgements’ will be used more or less interchangeably in this report.
the specific factors that influence their clinical decision-making regarding these children.

Weinman’s (1987) model of clinical decision-making

Variability in clinical decision-making has traditionally been understood in terms of differing levels of knowledge and expertise (Ogden, 2000). It is, however, likely that the clinical decision-making process is more complex than previously thought. Weinman (1987) has put forward a model of clinical decision-making which provides a comprehensive explanation for variability in health professionals’ behaviour (see Figure 1 below). In this model, clinical decisions are conceptualised as a form of problem-solving and involve the development of hypotheses early in the assessment process. According to Weinman (1987), the process of forming a decision involves four stages, viz. accessing information about the patient’s symptoms, developing hypotheses, searching for attributes and making a management decision. Once a hypothesis is formed, clinicians have a tendency to search for confirmatory evidence (MacWhinney, 1973). Therefore, the development of the original hypothesis (i.e. the second stage of the model) is the most important stage in terms of leading to variability in health professionals’ behaviour.

Figure 1: Clinical decision-making as a form of problems solving. From Weinman (p. 201, 1987)

Weinman (1987) proposes that six factors may influence the generation of the original hypothesis. Firstly, the health professional’s pre-existing notions about the nature (i.e. cause) of clinical problems will exert an important influence on what information is sought. Secondly, the health professional’s estimate of the probability of the
hypothesis and disease: the health professionals will have pre-existing beliefs about the prevalence and incidence of any given health problem and these will influence the process of developing a hypothesis. Thirdly, the health professional’s beliefs about the seriousness and treatability of the disease: for example, health professionals vary in their perception of the seriousness of diabetes and this influences their recommendations for treatment (Marteau & Baum, 1984). Fourthly, the health professional’s personal knowledge of the patient will influence the development of a hypothesis. Hennessey and Shen (1986), for example, found that clinical judgements by mental health professionals varied with the amount of information they had about their clients, although different disciplines judged different types of information to be ‘clinically relevant’. Fifthly, the health professional’s stereotypes are believed to play a central role in the development of a hypothesis. Gordon, Perez and Joiner (2002), for example, found that the race of an adolescent girl had a significant impact on the detection of disturbed eating patterns. Finally, the profile characteristics of the health professional, such as previous experience: for example, Berg and Hodes (1997) found that a previous placement in child and adolescent psychiatry was associated with greater awareness of possible problems for children of mothers with eating disorders.

Research aims

The aim of the present study is to examine the factors influencing the clinical decision-making process by mental health professionals in specialist eating disorders clinics concerning the children of their female clients. Since this has not been examined before, this is an exploratory study. The present study will be informed by - but will not seek to test - Weinman’s (1987) theory of clinical decision-making. As the National Service Framework (Department of Health, 2001) states that the welfare and safety of children living with a parent with a mental health problem should be considered in the initial assessment process, this study will focus on the clinical decision-making process during the assessment. Specifically, the main aim is to ascertain which specific factors in this model are the best predictors of mental health professionals’ decisions to respond to information obtained during assessment about possible effects of the client’s disorder on their children. Although Weinman (1987) does not hypothesise which factors in this model are the best predictors of clinical
decision-making, the following hypotheses can be developed on the basis of previous relevant research cited earlier in this paper (e.g. Bailey et al., 1995; Berg & Hodes, 1997; Hennessey & Shen, 1986; Laderman et al., 1999).

1. Due to a different focus in training, there will be a significant difference in the number of children referred by differing professional disciplines.
2. Due to a different focus in training, the different professional disciplines will differ significantly in the amount of information they have gathered during assessments about possible effects of the maternal eating disorder on the child.
3. Professionals with previous experience in child and adolescent services will have significantly higher estimates of the probability that children of mothers with eating disorders will have difficulties as a result of their mothers' disorders than professionals without such experience.

[My interest in this particular topic was sparked by the qualitative research project I carried out last year. The aim of that study was to explore reports of the mother-daughter relationship during childhood, adolescence and adult life, provided by adult female offspring of mothers with anorexia nervosa or bulimia nervosa, and their perception of the possible effects of the maternal eating disorder on this relationship. All the participants in that study had also developed eating disorders. During the interviews the participants expressed a wish that the mental health professionals involved in their mothers' care would have provided them with some form of psycho-education in terms of 'normal' attitudes to food, body weight and shape. Some described feeling bewildered by their mothers' behaviours and attitudes, and not realising that something was 'wrong' until they reached adulthood. I could strongly identify with the participants' stories as my own childhood experience of having a parent with mental health problems was very similar in terms of not understanding what was wrong and not receiving support from the relevant services. Although the participants in my study were adults and their accounts were retrospective, it made me wonder about the extent to which children of mothers with eating disorders are currently considered by mental health professionals in specialist eating disorders services. Perhaps my participants' and my own similar experience were a coincidence? If not, have times changed and is more importance placed on the children's experience]
of a maternal eating disorder? A review of the literature did not answer my questions and revealed that very little research had been carried out in this area. The experience of carrying out my research project last year, my childhood experience and the fact this area appeared under-researched jointly contributed to my decision to carry out this project.

**Method**

**Participants**

As the aim was to represent the diversity of mental health professionals who conduct psychological assessments of clients in specialist eating disorders services, a broad range of multidisciplinary professionals was approached for inclusion in the present study. The participants did not need to meet any criteria other than being clinical staff who conduct psychological assessments at an eating disorders service. Accordingly, a list of all the National Health Service (NHS) services treating adults with eating disorders in the UK was obtained from the Eating Disorders Association (EDA). This list did not include telephone numbers of the services. Telephone numbers were obtained through the internet and directory enquiries for 35 of the 51 services believed to be adult specialist eating disorders services. Initial telephone calls were made to listed services in order to obtain names of managers. Subsequently, the managers of the 35 listed specialist eating disorders services and the 16 unlisted services were contacted through a letter (see Appendix A) asking for permission to send questionnaires to the relevant members of their staff. It should be noted that as the list provided by the EDA was rather dated, it is possible that some of the 16 unlisted services had been discontinued or changed their addresses. Follow-up telephone calls were made to the managers of listed services who did not respond within two weeks, during which permission was obtained. 31 specialist eating disorders services agreed to participate. A total of 226 postal questionnaires were distributed: 108 were sent to named individuals and 118 were sent to managers for distribution to relevant members of staff. Follow-up letters were sent out to all potential participants two weeks after the deadline stated on the questionnaire.
Instruments

In order to permit the surveying of many professionals' current practices, perspectives and experiences, a postal questionnaire (see Appendix B) was used. As there is evidence to suggest that the mother's psychiatric diagnosis and prognosis form the basis for mental health professionals' recommendations about a child's future (Grünbaum & Gammeltoft, 1993; Reder, 1996), most of the questionnaire items were developed from an eating disorders perspective. As it is only in recent years that the possible effects of parental eating disorders on offspring have begun to be explored, there are as yet no available data or estimates of how many women with anorexia or bulimia care for children under 16. In addition, there is a significant overlap in core psychopathology between anorexia and bulimia: occasionally some individuals change from one disorder to the other and there is frequent comorbidity of both anorexia and bulimia (Hodes, 2000). For these reasons it was decided that the questionnaire would consider the two disorders together, despite them being regarded as distinct disorders in official psychodiagnostic classification systems (for example, American Psychiatric Association, 2000).

A preliminary sample of questionnaire items was developed for four of the six factors contributing to variability in clinical decision-making in Weinman's (1987) model. Accordingly, the items corresponded to four scales: the health professional's own beliefs about the nature of eating disorders, the health professional's estimate of the probability that children of mothers with eating disorders would have difficulties as a result of their mothers' disorder, the seriousness and treatability of eating disorders, and the health professional's stereotypes of mothers and of individuals with eating disorders. The remaining two factors contributing to variability in clinical decision-making in Weinman's (1987) model (i.e., personal knowledge of the client and the profile characteristics of the health professional) were presented as multiple response items and included in the demographics section.

There is a number of different theories prevalent in the academic literature regarding the cause of eating disorders. A review of this literature suggested that socio-cultural, genetic, systems, psychodynamic and cognitive theories prevail. Subsequently,
subscales with items reflecting the above theories were included on the ‘health professional’s own beliefs about the nature of eating disorders’ scale. Moreover, a review of the literature on the treatability of eating disorders suggested that the stage of the evolution of the disorder was an important aspect of its treatability (e.g. Fairburn, 1995). Thus, subscales with items reflecting primary and secondary prevention, in addition to the treatability of eating disorders were included in the ‘seriousness and treatability of eating disorders’ scale. On the ‘clinician’s stereotypes of the patient’ scale, two subscales with items relating to stereotypes of mothers and of individuals with eating disorders were included. This was done because stereotypes are widely shared generalisations about members of a social group (e.g. Leyens, Yzerbyt & Schadron, 1994) and as the incidence of eating disorders is relatively low, the incidence of mothers with eating disorders is even lower, so the assumption was made that a stereotype of mothers with eating disorders has not been constructed. All the items were developed by drawing on previous research findings (e.g., Berg & Hodes, 1997; Furnham & Hume-Wright, 1992; Goldbloom & Sidney, 1995; Gordon et al., 2002; Mitchell, 1995; Olmsted & Kaplan, 1995) and themes were identified from extensive reviews of the literature on the effects of maternal eating disorders on offspring (Ahlenius, 2001; Patel et al., 2002). In addition, the development of the questionnaire was facilitated by consulting a key informant with extensive experience of working with clients with eating disorders. Two psychologists with extensive experience of questionnaire design offered feedback on the wording of all the items.

An initial version of the questionnaire was developed which consisted of 43 items. Every item on the scale, the instructions and the layout were piloted at the researcher’s clinical placement, which was in a multi-disciplinary setting where clients with eating disorders were assessed but not treated. 25 questionnaires were administered to clinical and counselling psychologists, clinical nurse specialists (CPN) and social workers. 15 completed questionnaires were returned and offered feedback on both its content and layout. Three items were considered vague and open to multiple interpretations by the participants and these items were slightly rephrased. The final version of the questionnaire consisted of 43 items which were presented to the respondents in a Likert format with a 7-point scale ranging from strongly agree to strongly disagree. Demographic questions were included at the end (de Vaus, 1996).
Procedure

All the participants received a covering letter explaining the purpose of the study (see Appendix C), a questionnaire with specific instructions about taking part, and a pre-paid addressed envelope for returning the questionnaire.

Data Analysis

In order to test whether the factorial composition of the questionnaire was as hypothesised, exploratory factor analyses were carried out. Internal consistency tests, Cronbach’s alpha (Cronbach, 1951), were carried out on the resulting scales. Furthermore, chi-square tests were carried out to explore hypothesis 1, a Kruskal-Wallis test was used to test hypothesis 2, whilst an independent samples t-test was carried out to explore hypothesis 3. Finally, independent samples t-tests were carried out in order to identify candidate predictor variables which might be used to build a logistic regression model.

[ I am not naturally a quantitative researcher and I found the experience of designing a questionnaire very difficult indeed. The idea of generating items appeared daunting to me and the actual experience of doing it was just as difficult as I had imagined. Although the generation of items was assisted by a key informant and I was given feedback on the wording by my supervisors, I believe that my difficulties with this task in combination with the time pressure contributed to the items being less useful than they could have been. Although I did pilot the questionnaire and changed some of the items according to the feedback, I believe, with the benefit of hindsight, that designing a questionnaire without much previous research to draw on was too ambitious given the time constraints. I believe that in order for the questionnaire to have been a more useful tool for the purpose of this project, further careful pilot work would have been needed. Designing an interview schedule last year was a very different experience indeed as the questions in the interview schedule were meant to open up avenues for further exploration, as opposed to having participants just agree/disagree with a statement. I found that exercise more inspiring, as it gave room for unexpected issues to arise from the interviews whilst a questionnaire can only... ]
answer the question that was posed in the first place. Moreover, I also found that conducting qualitative research was more congruent with my experience of being a trainee counselling psychologist and perhaps that is the reason that I enjoyed carrying out the qualitative research project so much more. Specifically, exploration is an aspect of the therapeutic work that I particularly enjoy, and exploration was an important aspect of my qualitative research. Although I believe that designing a questionnaire and carrying out a quantitative research project has been a useful experience, it was an experience I did not particularly enjoy.

Results

Sample characteristics

Of the 83 participants, 81 answered questions regarding demographic information. Sixty-nine participants (85.2%) were female and 12 (14.8%) were male. Regarding the participants’ age, 3 (3.7%) were aged 18-25 years, 27 (33.3%) were aged 26-35 years, 26 (32.1%) were aged 36-46 years, 21 (25.9%) were aged 46-55 years, 3 (3.7%) were aged 56-65 years and 1 (1.2%) was aged 66+ years. Seventy-nine (97.5%) of the participants described themselves as white and 1 (1.2%) as Chinese and 1 (1.2%) as Indian.

There were 26 (32.1%) clinical psychologists, 18 (22.2%) clinical nurse specialists (CPNs), 13 therapists (16.1%), 8 psychiatrists (9.9%), 6 (7.4%) counselling psychologists, 3 (3.7%) social workers and 7 (8.6%) others (including mental health workers and dieticians). The participants’ years of practice ranged from 2-46 with a mean of 13.9 (standard deviation [SD] 9.2). Regarding their preferred mode of working with clients, 32 (39.5%) were integrative, 24 (29.6%) were cognitive-behavioural, 9 (11.1%) were psychodynamic, 5 (6.2%) were systemic, 3 (3.7%) were interpersonal, 1 (1.2%) was existential, 1 (1.2%) was humanistic and 6 (7.4%) ticked the ‘other’ category. Some of the ‘other’ orientations that were specified were cognitive-analytic therapy and psycho-educational.
Over the past 12 months the participants estimated that they had assessed 697 female clients with eating disorders who had children. On an individual basis, the number ranged from 0-50 with a mean of 8.6 (SD 10.8). Sixty-nine participants (85.2%) had over the past 12 months assessed 1 or more women with eating disorders who had children and 12 participants (14.8%) had not assessed any. Fifty-three (76.8%) professionals knew of clients’ children who were experiencing difficulties, 11 (15.9%) knew that the children were not experiencing difficulties and 5 (7.3%) did not know if the children were experiencing any difficulties. Finally, 29 (36.7%) had referred clients’ children for help and 50 (63.3%) had not. Table 1 summarises the replies concerning the specific problems of the children known to the participants. Emotional problems were the most commonly reported difficulty (65.3%), followed by behavioural (61.0%), eating habits (47.8%) and weight gain and growth (27.5%). Two participants (2.9%) reported that the children of their female clients had other difficulties, which included abuse and difficulties with maintaining boundaries.

<table>
<thead>
<tr>
<th>Responses</th>
<th>Behavioural</th>
<th>Emotional</th>
<th>Eating Habits</th>
<th>Weight gain &amp; growth</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>42 (61.0%)</td>
<td>45 (65.3%)</td>
<td>33 (47.8%)</td>
<td>19 (27.5%)</td>
<td>2 (2.9%)</td>
</tr>
<tr>
<td>No</td>
<td>11 (15.9%)</td>
<td>11 (15.9%)</td>
<td>14 (20.3%)</td>
<td>20 (29.0%)</td>
<td>13 (18.8%)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>16 (23.1%)</td>
<td>13 (18.8%)</td>
<td>22 (31.9%)</td>
<td>30 (43.5%)</td>
<td>54 (78.3%)</td>
</tr>
</tbody>
</table>

Factor Analyses

As the questionnaire had been designed specifically for the present study, it was imperative to test whether the factorial composition of the questionnaire was as hypothesised. Three exploratory factor analyses were carried out. The 15 items that had been designed to measure the clinicians’ beliefs about eating disorders were analysed first. However, two items were excluded from the factor analysis as their distribution was skewed and had an unacceptably small standard deviation (<1.3 [Howard, 1997]), and as a result only 13 items were included. The 12 items that had been designed to measure items on the ‘seriousness and treatability of eating disorders’ scale were included in the second analysis. The remaining 10 items relating to clinicians’ stereotypes of the client mothers were included in the third analysis. As interpretability is considered to be the most important aspect of a ‘good’ factor
analysis (Hammond, 2000a; Tabachnick & Fidell, 2001), trial rotations were performed, each time specifying a different number of factors until the interpretability of the factors was satisfactory. As a result, 12 items were excluded from the final version as they compounded the interpretability of some factors and so compromised the construct validity of the factors. It is generally recommended to have a participants-to-variables ratio of between 2:1 and 10:1 (Gorsuch, 1983). The number of participants was therefore adequate for a factor analysis as the participants-to-variables ratio was 2.4:1. Principal component analysis (PCA) has been recommended as a first step in exploratory factor analysis (Ferguson & Cox, 1993). Therefore, exploratory factor analysis was performed using PCA in SPSS (v. 11.5). Oblique rotation was used as it was assumed that the constructs were related to each other.

*Factor analysis of the 'clinician's own beliefs about the nature of eating disorders' items*

In the first factor analysis of 'The clinician’s own beliefs about the nature of eating disorders' 13 items were entered. Trial rotations were performed, varying the number of components selected. Analysis initially indicated that 6 factors accounted for 66.9% of the variance (eigenvalues greater than 1). Items relating to psychodynamic beliefs about the nature of eating disorders and the items relating to cognitive therapy beliefs were combined in the factor analysis and loaded on two separate factors. Those items were considered not to have construct validity and as interpretability is an important criterion for selecting the number of factors, these items were deleted from the analysis (Hammond, 2000a). Therefore, the most meaningful solution in terms of the theory underpinning the scale consisted of three factors. An oblique rotation was performed and produced the rotated matrix in four iterations. Factor 1 accounted for 30.5% of the variance, factor 2 accounted for 23.1% of the variance, and factor 3 accounted for 21.2% of the variance. Factor loadings in the three-factor solution is presented in Table 2 below.
Table 2: Factor loadings in the three-factor solution using oblique rotation.

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Eating disorders result from conflicting messages of the media to eat but to be slim at the same time.</td>
<td>.789</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Eating disorders are result of Western ideals of physical thinness</td>
<td>.722</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. People who suffer from eating disorders are individuals who are affected negatively by society’s emphasis on health and fitness</td>
<td>.671</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Eating disorders are more common in families where there are difficulties in managing conflict.</td>
<td></td>
<td>.915</td>
<td></td>
</tr>
<tr>
<td>5. Eating disorders occur more often in families where the channels of communication are confusing.</td>
<td></td>
<td>.915</td>
<td></td>
</tr>
<tr>
<td>6. Genetic factors play an important role in the development of eating disorders</td>
<td></td>
<td>.867</td>
<td></td>
</tr>
<tr>
<td>7. The environment in which a child is raised plays a greater role than genetic factors in the development of eating disorders</td>
<td></td>
<td></td>
<td>-.863</td>
</tr>
</tbody>
</table>

Factor 1 included items 1, 2 and 3 which were considered to be related to beliefs that Western culture contributes to the development of eating disorders. Thus the resulting subscale was entitled ‘socio-cultural’. Factor 2 included items 4 and 5 which were considered to be related to beliefs that dysfunctional family interactions contribute to the development of eating disorders. The resulting subscale was entitled ‘dysfunctional family interactions’. Factor 3 included items 7 and 8 which were considered to be related to beliefs that there is a genetic susceptibility to the development of eating disorders, and the resulting subscale was entitled ‘genetic predisposition’. Although it is not generally recommended to have a factor consisting of only two items, it is acceptable if the factor loading exceeds 0.7 (Tabachnik & Fidell, 2001). The factor loadings on the ‘genetic predisposition’ factor and the ‘dysfunctional family interactions’ factor were considerably above 0.7 and were therefore considered reliable.

*Factor analysis of the 'seriousness and treatability of eating disorders' items*

A second exploratory factor analysis was carried out on the items relating to the ‘seriousness and treatability of eating disorders’ scale. Analyses initially indicated that 5 factors accounted for 56.9% of the variance (eigenvalues greater than 1). Trial rotations were then performed, varying the number of components selected. It had been hypothesised that items relating to ‘seriousness of eating disorders’ would
emerge as a separate factor. These items loaded on different factors, which compounded the interpretability of the factors and were subsequently excluded from the analysis. Therefore, the most meaningful solution in terms of the theory underpinning the scale consisted of two factors. An oblique rotation was performed and produced the rotated matrix in three iterations. Factor 1 accounted for 25.9% of the variance and Factor 2 accounted for 18.6% of the variance. Factor loadings in the two-factor solution are presented in Table 3 below.

Table 3: Factor loadings in the two-factor solution using oblique rotation.

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor 1</th>
<th>Factor 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Psychoeducational groups for family members of sufferers of eating disorders</td>
<td>.711</td>
<td></td>
</tr>
<tr>
<td>are a good strategy for preventing other members of the family from developing similar problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. It is important to give mothers with eating disorders nutritional counselling regarding their children’s dietary needs in order to prevent the children from developing similar problems</td>
<td>.724</td>
<td></td>
</tr>
<tr>
<td>3. Educating the mother about how her eating disorder could affect the children would not make any difference as to whether the children would develop similar problems</td>
<td>-.651</td>
<td></td>
</tr>
<tr>
<td>4. All children of mothers with eating disorders should be screened for signs of disordered eating because if they have similar problems the duration of the disorder could be shortened</td>
<td>.476</td>
<td></td>
</tr>
<tr>
<td>5. Improving access to self-help materials would shorten the interval between the onset of an eating disorder and the seeking of help.</td>
<td>.572</td>
<td></td>
</tr>
<tr>
<td>6. The best way to shorten the duration of eating disorders is to increase general awareness of the nature and signs of eating disorders so that sufferers and others can quickly recognise when there is a problem</td>
<td>.536</td>
<td></td>
</tr>
<tr>
<td>7. Most clients with eating disorders are extremely resistant to therapeutic intervention</td>
<td></td>
<td>.740</td>
</tr>
<tr>
<td>8. The drop-out rate in therapy with clients with eating disorders is much higher than in other client groups.</td>
<td></td>
<td>.709</td>
</tr>
<tr>
<td>9. Clients with eating disorders are easy to engage in therapy.</td>
<td></td>
<td>-.764</td>
</tr>
</tbody>
</table>

Factor 1 included items 1, 2, 3, 4, 5, and 6 which were considered to be related to preventative intervention for eating disorders, and the resulting sub-scale was entitled ‘preventative intervention’. Factor 2 included items 7, 8, and 9 which were considered to be related to the treatability of eating disorders. Thus the resulting scale was entitled ‘treatability of eating disorders’.

Factor analysis of the ‘clinician’s stereotype of the patient’ items

A third exploratory factor analysis was carried out on the items relating to the ‘clinician’s stereotype of patient’ scale. Trial rotations were performed, varying the number of components selected. Analyses initially indicated that four factors
accounted for 62.9% of the variance (eigenvalues greater than 1). Four items (two relating to each stereotype) were combined in the factor analysis and loaded on two separate factors, which compounded the interpretability of the factors and were subsequently excluded from the analysis. An oblique rotation was then performed and produced the rotated matrix in three iterations. A two-factor solution emerged in which Factor 1 accounted for 28.4% of the variance and Factor 2 accounted for 23.7% of the variance. Factor loadings in the two-factor solution are presented in Table 4 below.

Table 4: Factor loadings in the two-factor solution using oblique rotation.

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor 1</th>
<th>Factor 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mothers do not spend as much time with their children as fathers do</td>
<td>-.575</td>
<td></td>
</tr>
<tr>
<td>2. Mothers generally cook the majority of their family’s meals</td>
<td>.851</td>
<td></td>
</tr>
<tr>
<td>3. In general, mothers run the family home</td>
<td>.802</td>
<td></td>
</tr>
<tr>
<td>4. Individuals with eating disorders are often so obsessed with their self-image that they find it difficult to concentrate on anything else</td>
<td>.828</td>
<td></td>
</tr>
<tr>
<td>5. In general, people with eating disorders do not have a problem with keeping food in the house</td>
<td>-.540</td>
<td></td>
</tr>
<tr>
<td>6. People with eating disorders only eat when everyone else is out of the house</td>
<td>.615</td>
<td></td>
</tr>
</tbody>
</table>

Factor 1 included items 1, 2 and 3 which were considered to be related to stereotypes of mothers, so the resulting scale was entitled ‘stereotypes of mothers’. Factor 2 included items 4, 5, and 6 which were considered to be related to stereotypes of individuals with eating disorders. Thus, the resulting scale was entitled ‘eating disorders stereotypes’.

Reliability of scales

The subscales resulting from the factor analyses and the ‘estimate of probability that children of mothers with eating disorders have difficulties’ scale were subjected to reliability analyses. The majority of the scales were sufficiently reliable, being higher than the normally accepted Cronbach’s alpha threshold of 0.6. The reliability of the ‘treatability of eating disorders’ subscale was just below 0.6 and it was retained in the analysis as it was deemed theoretically important, and as it was very close to the threshold. The ‘eating disorders stereotypes’ subscale was, however, excluded from subsequent analyses as that scale was not sufficiently reliable (Cronbach’s alpha = 0.42). See Table 5 below for reliability analyses and descriptive statistics.
### Table 5: Cronbach’s alpha, mean and standard deviation of each of the subscales of the measure.

<table>
<thead>
<tr>
<th>Subscales</th>
<th>Cronbach’s alpha</th>
<th>Mean (SD)</th>
<th>Possible min / max</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Socio-cultural</td>
<td>.69</td>
<td>12.6 (3.2)</td>
<td>3-21</td>
</tr>
<tr>
<td>2. Genetic Predisposition</td>
<td>.71</td>
<td>7.53 (2.3)</td>
<td>2-14</td>
</tr>
<tr>
<td>3. Dysfunctional family interactions</td>
<td>.79</td>
<td>10.1 (2.0)</td>
<td>2-14</td>
</tr>
<tr>
<td>4. Estimate of Probability that children of mother’s with eating disorders have difficulties</td>
<td>.60</td>
<td>11.8 (3.1)</td>
<td>3-21</td>
</tr>
<tr>
<td>5. Preventative Intervention</td>
<td>.65</td>
<td>19.7 (4.4)</td>
<td>6-42</td>
</tr>
<tr>
<td>6. Treatability of eating disorders</td>
<td>.58</td>
<td>9.4 (3.1)</td>
<td>2-14</td>
</tr>
<tr>
<td>7. Stereotypes of Mothers</td>
<td>.61</td>
<td>16.8 (2.1)</td>
<td>3-21</td>
</tr>
<tr>
<td>8. Eating disorders stereotypes</td>
<td>.42</td>
<td>12.8 (3.1)</td>
<td>3-21</td>
</tr>
</tbody>
</table>

**Relationship between number of children referred and professional discipline**

In order to test the first hypothesis, that there will be a significant difference between the number of children referred by differing professional disciplines, a chi-square test was carried out. As the sample sizes in the differing professional disciplines varied greatly, which can lead to small expected frequencies, the groups were redefined and collapsed into new groups: psychologists (clinical and counselling psychologists), participants with medical training (psychiatrists and CPNs), therapists and others (social workers, mental health workers and dieticians). A significant difference was found ($X^2 (3) = 8.48, p = < 0.05$); however, 2 cells (25%) had expected differences of 5 or less. It was therefore decided to exclude the ‘others’ group from the analysis, as this group was rather heterogeneous. A second chi-square test was then carried out including only the psychologists, medics and therapists. This test did not, however, yield a significant difference ($X^2 (2) = 4.68, p>0.05$).

**Relationship between professional discipline and amount of information gathered**

The second hypothesis stated that due to a different focus in training, the different professional disciplines will differ significantly in the amount of information they have gathered during assessments about possible effects of the maternal eating disorder on the child. A scale that summarised the replies concerning the specific problems of the children known to the participants was created. The specific problems

---

4 Maximum score indicates strong belief.
were: behavioural, emotional, eating habits, weight gain and growth and other. This scale was scored by assigning a score of 1 for each 'yes' or 'no' (where 1 indicated that the participant knew whether or not their clients' children were having difficulties in that area) and 0 for 'don't know' (where 0 indicated that the participant did not know whether their clients' children had difficulties in that area). The maximum score was 5. The professional groups were again redefined as psychologists, professionals with medical training, therapists and others. The data were significantly negatively skewed and data transformations were carried out (specifically, reflect and square root transformations). However, the distribution was still skewed and non-parametric tests were therefore indicated. A Kruskal-Wallis test was carried out. However, no significant difference was found in the amount of knowledge between the differing professional disciplines ($H(3) = 4.02, p > 0.05$).

*Relationship between experience of child and adolescent mental health and number of referrals*

The third hypothesis stated that mental health professionals who had previous experience of child and adolescent mental health would have referred more children of their clients than those without such experience. An independent samples t-test was carried out but did not yield a significant difference ($t(74) = 1.14, p>0.05$).

*Predicting referral of clients' children by using factors from Weinman's (1987) model of clinical decision-making*

In order to identify candidate predictor variables, which could be used to build a logistic regression model, a number of t-tests were carried out to ascertain on which scales and subscales there were significant differences between referrers and non-referrers. In the event, only a single variable yielded a significant bivariate result between referrers and non-referrers, making the building of a satisfactory multi-predictor logistic regression model unlikely. Referrers scored significantly higher on the 'estimate of probability that children of mothers with eating disorders would have difficulties as a result of their mothers' disorders' scale than did non-referrers ($t(70.56) = 2.70, p<0.05$).
Before analysing the data I had been very concerned about what the results would convey. I was aware that my lack of questionnaire design experience, and the fact I probably would have needed to undertake further pilot work, had the potential to cause difficulties with the statistical analyses. My concerns were not so much about not finding what was expected, but about getting data that could not be used to complete all the analyses that I had planned to do. In addition, my experience of undertaking a placement in an eating disorders service last year highlighted to me just how many research projects you get bombarded with as a clinician, and how difficult it is to find the time to complete them. I was therefore also concerned about not getting enough participants and was rather pleased with a response rate of 37%. As I started to carry out the data analysis, I became more and more disheartened as numerous difficulties with the questionnaire emerged during the factor analysis, and the majority of the statistical tests did not yield any significant differences. When I had completed all the statistical analyses and had the results, I felt very discouraged and disappointed. Those feelings were more about this topic being very close to my heart, and my wanting to make a useful contribution to this field rather than being disappointed with the result of the statistical tests per se. As I was writing the report up, however, those feelings subsided somewhat as I realised that the demographic information was quite useful, particularly as it emerged that the majority of the clinicians had assessed one or more mothers with eating disorders, and that they did seem to be aware of the potential risks to the these children. About 20 participants returned the reply slip indicating that they wanted a copy of this report, and it is my hope that, although the results from the present study were not ‘groundbreaking’, they may still find the demographic information of some use to them.

Discussion

The aim of this study was to ascertain which specific factors in Weinman’s (1987) model of clinical decision-making were the best predictors of mental health professionals’ decisions to respond to information obtained during the assessment about possible effects of clients’ eating disorder on their children. Furthermore, the relationship between likelihood to refer and professional disciplines was investigated.
Response rates

The overall response rate was 37%. A low response rate is to be expected, however, in a postal survey (Fife-Schaw, 2000). Moreover, it is also usual to get a lower response rate when the topic is especially sensitive (Fife-Schaw, 2000) and some mental health professionals may have declined to take part as they perceived the present study to be questioning their professional practice. It should also be noted that mental health professionals in eating disorders services are often subjected to many requests to participate in research which may also have had an impact on the response rate. Overall there was a gender imbalance with 85.2% of the sample being female. As 81% of the sample were either psychologists, therapists, CPNs or social workers, the gender imbalance may be a reflection of the wider trend in these professions in which there is a greater prevalence of female applicants (Universities & Colleges Admission Service [UCAS], 2003). Females also tend to be more co-operative than men in terms of completing surveys (Fife-Schaw, 2000) which may also have contributed to the gender imbalance.

Knowledge of mental health professionals

A total of 697 females with eating disorders who had children had been assessed over the past 12 months. Sixty-nine participants (85.2%) had assessed 1 or more clients who had children and 12 (14.8%) had not assessed any. This is in stark contrast to Berg and Hodes’ (1997) findings in which only 25% of adult psychiatrists in general psychiatry has assessed female clients with eating disorders who had children over the past 12 months. These findings may not be so surprising, however, as the participants in the present study worked in eating disorders services, and are therefore likely to come across a higher proportion of mothers with eating disorders than psychiatrists in general psychiatry.

The findings of the present study seem to indicate that the majority of mental health professionals in eating disorders services have contact with female clients who have children. Although it was not ascertained how many children these women had between them or how many of these children had difficulties, 53 participants (76.8%)
knew of children who were experiencing difficulties, 11 (15.9%) knew of children who were not experiencing difficulties and 5 (7.3%) did not know if the children were experiencing any difficulties. In Berg and Hodes' (1997) study, 43% of the participants did not know if the children had difficulties. These findings seem to indicate that mental health professionals in eating disorders services are aware of the risks to the children of their clients and that the majority include questions about the children in their assessments. Indeed, 29 (36.7%) had referred female clients' children for help and 50 (63.3%) had not. It should be pointed out, however, that although the majority of eating disorders services in the UK were invited to participate in the present study, the response rate was only 37%. This could have led to sampling bias in that the mental health professionals who were more interested in the topic were more likely to complete the questionnaire. It is also possible that if they were more interested in the topic, they may have actively sought information and thus may be more aware of the risks to the children of their clients than their colleagues.

The factorial composition of the questionnaire

Three exploratory factor analyses were carried out on the scales of the newly developed questionnaire in order to test whether the factorial composition of the questionnaire was as hypothesised. In the first scale "the clinician's own beliefs about the nature of eating disorders", three underlying dimensions emerged: genetic predisposition, socio-cultural and dysfunctional family interactions. It had, however, been hypothesised that another two underlying dimensions relating to psychodynamic and cognitive theories of the aetiology of eating disorders would emerge. There may be a number of reasons as to why these dimensions did not emerge from the factor analysis. A possible explanation for the unexpected result of this factor analysis could be wording problems with the items of the psychodynamic and cognitive scales. During post hoc examination of the items of those scales, it emerged that some items related to the cause of eating disorders, some to the functions of eating disorders whilst others related to characteristics of individuals with eating disorders. As a result, the items on those scales may have been measuring different issues, which could explain the present findings. Sampling error may also have contributed to the unexpected result of this factor analysis. Although the ratio of 2.4:1 participants-to-
variables was adequate for carrying out a factor analysis, it only just met the minimum recommendations for the ratio of participants-to-variables. In order to reduce the risk of sampling error as much as possible, a ratio of at least 4:1 participants-to-variables has been recommended (Hammond, 2000b).

The number of factors emerging from the second and third factor analyses was essentially as expected. Two separate factors emerged from the second factor analysis, although the underlying structure of the ‘seriousness and treatability of eating disorders’ scale had been hypothesised to be four factors. Primary and secondary prevention emerged as one factor and the treatability of eating disorders as another. Owing to difficulties with construct validity of the ‘seriousness of eating disorders’ sub-scale, it had to be excluded from the analysis. It seems likely that although it is conventional in the literature to classify preventative interventions according to the stage in the evolution of the disorder at which they are directed (Fairburn, 1995), it may not have much relevance in clinical practice. Specifically, preventative programs have yet to be implemented on a larger scale in the UK as there is an absence of research findings that suggest that preventative interventions work (Fairburn, 1995). This may be one explanation as to why items relating to primary and secondary prevention loaded on the same factor.

In the third factor analysis, two factors emerged. One related to items designed for the ‘stereotypes of mothers’ sub-scale, and the other related to items on the ‘eating disorders stereotype’ sub-scale. However, the internal reliability of the ‘eating disorders stereotype’ was unacceptable and it was excluded from further analyses. The decision to consider anorexia and bulimia together in the questionnaire could possibly account for these findings. The participants in the present study come across a much larger proportion of individuals with eating disorders than the general population. Stereotypes can change their configuration, in response to disconfirming instances, by the formation of subcategories (Weber & Crocker, 1983). In other words, as the participants in the present study encounter individuals with eating disorders on a daily basis, their stereotypes of such individuals may have changed their configuration to form subcategories, i.e. stereotypes of individuals with anorexia and stereotypes of
individuals with bulimia. It may therefore have been difficult for the participants to relate to stereotypical statements that considered anorexia and bulimia together.

**Relationship between number of referrals and professional discipline**

Hypothesis 1 stated that due to a different focus in training, there will be a significant difference in the number of children referred by differing professional disciplines. Due to the small number of participants in certain professional groups, the groups were redefined to ‘psychologists’, ‘professionals with medical training’ and ‘therapists’. The ‘other’ group was excluded from the analysis as it was a very heterogeneous group of professionals. A chi-square test was carried out but it did not yield a significant difference. Therefore, the present study does not support previous findings where significant differences in clinical judgement between professional disciplines in multi-disciplinary teams have been found (Bailey *et al.*, 1995; Laderman *et al.*, 1999). It is, however, possible that, in collapsing the professional disciplines into new groups, any potential differences were masked. For this reason, it is difficult to draw any firm conclusions based on this finding.

**Relationship between amount of information gathered and professional discipline**

Hypothesis 2 stated that due to a different focus in training, the different professional disciplines will differ significantly in the amount of information they have gathered during assessments about possible effects of the maternal eating disorder on the child. A Kruskal-Wallis test was carried out but yielded no significant differences. This is not in line with previous research, which has found that the kind of information gathered during an assessment varied between differing professional disciplines (Hennessey & Shen, 1986). Again, as the groups of the differing professional disciplines had to be redefined because of the small number of participants in some of the disciplines before carrying out the Kruskal-Wallis test, it is possible that any differences went undetected. The descriptive data, however, indicate that the majority of the participants did in fact include questions about the clients’ children in the assessments which suggests that there were no real differences between the differing professional disciplines.
Relationship between previous experience of child and adolescent services and referral

Hypothesis 3 stated that professionals with previous experience in child and adolescent services will score significantly higher on the "the health professional’s estimate of the probability that children of mothers with eating disorders would have difficulties as a result of their mothers’ disorders" scale than professionals without such experience. An independent samples t-test was carried out but did not yield a significant difference. This is in contrast to previous research findings which indicated that a previous placement in child and adolescent psychiatry was associated with greater awareness of possible problems for children of mothers with eating disorders (Berg & Hodes, 1997). As the majority of this sample seemed to be very aware of the risks to these children, it is possible that further training regarding the risks had been provided by the services. On the other hand, these results could also have been due to sampling bias. For example, the professionals who took part in the present study may have felt better prepared to complete the questionnaire because they had more knowledge of the topic than the professionals who did not take part.

Predicting referral of clients' children by using factors from Weinman's (1987) model of clinical decision-making

As only one t-test yielded a significant difference between referrers and non-referrers, it was unlikely that a satisfactory multi-predictor logistic regression model could be built. Although that result was disappointing, it was interesting that referrers scored significantly higher on the ‘estimate that children of mothers with eating disorders would have difficulties as a result of their mothers’ disorder’ scale than did non-referrers. This result indicates that referrers estimated the probability of risk to these children as higher than the non-referrers. As none of the other variables yielded significant results, it is difficult to speculate about the reasons for the referrers scoring more highly on this scale and how significant this finding is. There may be a number of reasons as to why only a single scale yielded a significant difference between referrers and non-referrers. Although the hypothetico-deductive model of decision-
making has been applied to many different forms of problem-solving (Ogden, 2000), Weinman's model of clinical decision-making has not been tested before. The results could therefore be due to a flaw in the model. Furthermore, some authors have argued that the current theoretical frameworks for decision-making cannot account for the complex, diverse and dynamic process of decision-making and that new and improved frameworks and research methodology are needed (Chase, Crow & Lamond, 1996; Ingham, Woodcock, & Stenner, 1992).

Implications for training and practice

The results from the present study indicate that mental health professionals in eating disorders services have frequent contact with mothers with eating disorders. Although the majority of the participants considered the children in the assessment process, there were variations in the extent to which they were considered. For example, the research to date indicates that children of mothers with eating disorders may be at risk of growth faltering (Patel et al., 2002), yet 43.5% of the participants did not know if the children had any difficulties with weight gain and growth. In addition, participants who had referred children of mothers with eating disorders for help estimated the probability of risk to these children as higher than the non-referrers. Both of these findings seem to suggest that further training regarding the risks to these children may be needed. Additionally, the importance of further training becomes even more pertinent when considering the significant contribution that therapists can make in terms of managing the mothers' and the children's difficulties. If they are aware of the potential risks, therapists could help to identify and address specific difficulties, such as disputes during mealtimes, in therapy.

Future research

In order to further investigate the factors that contribute to the clinical decision-making of mental health professionals in eating disorders services regarding the children of their clients, future research might consider developing further the instrument used in the present study. By developing two instruments, one relevant to anorexia and one relevant to bulimia, some of the difficulties encountered in the
present study may be avoided. Due to time constraints, extensive revisions and refinements of the questionnaire employed in the present study were not feasible. In-depth interviews with mental health professionals in eating disorders services could be undertaken in order to generate items that were more relevant to their context, which could help to bring the questionnaire(s) to maturity. Surveys have often been criticised on the grounds that the questions asked are too abstract and, as a result, people tend to answer 'it depends' (e.g. de Vaus, 1996). Therefore, future research may consider using vignettes. A vignette is a short description of a situation or person, which contains information that is considered to be important in the decision-making process or judgement-making of the participants. Thus, a vignette provides the same context for all participants. The use of vignettes and revised versions of the questionnaire may help to clarify some of the questions raised by the present findings, such as the relevance of referrers' higher scores on the 'estimate that children of mother's with eating disorders would have difficulties as a result of their mothers' disorder' scale.

Conclusion

The aim of the present study was to ascertain which specific factors in Weinman's (1987) model of clinical decision-making were the best predictors of mental health professionals' decisions to respond to information obtained during the assessment about possible effects of clients' eating disorders on their children. The results of the present study indicate that mental health professionals in eating disorders services frequently have contact with mothers with eating disorders, and are largely aware of the risks to these children. The main difference between referrers and non-referrers was that referrers seemed to estimate the probability of risk to these children as higher than the non-referrers. It is hoped that, despite the disappointing results in terms of building a multi-predictor logistic regression model, the findings from the present study will spark an interest into this under-researched area.
References


Appendices

- Appendix A: Introductory letter sent to the managers of the eating disorders services.
- Appendix B: Questionnaire.
- Appendix C: Covering letter.
- Appendix D: Questionnaire items within each of the four scales of the questionnaire.
- Appendix E1 SPSS output of the factor analyses
  E2: SPSS output of the chi-square tests used to test Hypothesis 1.
  E3: SPSS output of the Kruskal-Wallis test used to test Hypothesis 2.
  E4: SPSS output of the independent samples t-test used to test Hypothesis 3.
  E5: SPSS output of the independent samples t-test used to identify candidate predictor variables.
- Appendix F: Ethical Approval from University of Surrey’s Advisory Committee on Ethics.
- Appendix G: European Eating Disorders Review’s notes for contributors.
Appendix A: Introductory letter sent to the managers of the eating disorders services.

Department of Psychology

PsychD in Psychotherapeutic & Counselling Psychology

Telephone: ***
E-mail: ***
Fax No: ***

Title of Project: Children of mothers with eating disorders: Clinicians’ clinical decision-making.

Dear [Name of manager],

My name is Nadia Ahlenius and I am presently undertaking a doctoral course in Psychotherapeutic and Counselling Psychology at the University of Surrey. This is an advanced professional training in the practice, research and academic aspects of Counselling Psychology, which is accredited by the British Psychological Society.

As part of this course I am conducting a survey, which looks at mental health professionals in specialist eating disorders services current practice regarding their female clients’ children. This study is being supervised by Dr Adrian Coyle (who can be contacted on ***), who is the course Research Tutor and Mrs Wendy Gairdner (she can be contacted on ***), who is a professional tutor on the course and a registered family therapist and works in St George’s Eating Disorders Service in South West London. This project has been approved by the University’s Advisory Committee on Ethics.

Although eating disorders have been the subject of considerable research, it is only in recent years that the possible effects of parental eating disorders on offspring have been explored. As you know, mental health professionals who work in specialist eating disorders services frequently have contact with women with eating disorders who have children. These professionals are therefore in a good position to consider the impact of the disorder on the family. Despite this, research to date has failed to
consider the understandings, opinions and practice of mental health professionals in such services. Hence, the aim of the present study is to address this shortcoming and explore your views and current practice concerning the children of your female clients.

The study will require the distribution of postal questionnaires to mental health professionals who conduct psychological assessments of clients in specialist eating disorders services. Questionnaires should take no longer than 20 minutes to complete. Although the questionnaires will be sent to named individuals, neither the names of these individuals nor respondent numbers will appear on their questionnaire, thereby enabling anonymous return. Hence, the data cannot be traced to particular individuals or services. In addition, all data collected will be held and processed in confidence and in accordance with the Data Protection Act (1998).

I am writing to ask if you would consider assisting me by providing me with the names of members of your staff who conduct initial assessments, in order that I might send them a questionnaire. Names could be sent to the address above or via e-mail. I understand that you may well, of course, be rightly protective of your staff and I am happy to meet with you to discuss this further. I hope to disseminate my findings to other professionals in the eating disorders field by writing a paper for a relevant academic/practice journal. In this way, your contribution to the study may ultimately help to inform practice on this issue. Thank you very much for considering this proposal. If you have any questions or would like any further information, please do not hesitate to contact me. I look forward hearing from you in the near future.

Yours sincerely,

Nadia Ahlenius
Counselling Psychologist in Training
Appendix B: The questionnaire used in the present study.

**QUESTIONNAIRE**

**Instructions:** There are 43 statements on the following pages relating to your views of and current practice concerning your female clients and their children. Please tick the box beside each statement that reflects or is most like your opinion of the subject. There are no right or wrong answers, I am only interested in your views. Although I appreciate that questions about your practice may be a rather sensitive subject, I would be grateful if you could be as honest as possible in your responses. You do not need to think too hard about each statement, the first answer which comes to mind is usually the best. At the end you will be asked to provide a little bit of background experience about yourself and your professional experience. This information will help me to see whether there are any background or professional similarities or commonalities amongst the participants. If you wish to decline answering particular questions, please feel free to do so.
1. Eating disorders are a result of Western ideals of physical thinness.

2. It is likely that mothers with eating disorders will underfeed their children.

3. All children of mothers with eating disorders should be screened for signs of disordered eating because if they have similar problems the duration of the disorder could be shortened.

4. Mothers do not spend as much time with their children as fathers do.

5. Children of mothers with eating disorders are more likely to experience psychological difficulties than other children.

6. Individuals with eating disorders are often so obsessed with their self-image that they find it difficult to concentrate on anything else.

7. Eating disorders are due to a distortion in how they see their bodies.

8. Psychoeducational groups for family members of sufferers of eating disorders are a good strategy for preventing other members of the family from developing similar problems.

9. Because individuals with eating disorders usually try to keep their disorder secret, it is unlikely that the children of such mothers would copy their behaviour.

10. People who develop eating disorders are usually from underprivileged social classes.
11. Most clients with eating disorders are extremely resistant to therapeutic intervention.

12. The drop-out rate in therapy with clients with eating disorders is much higher than in other client groups.

13. Eating disorders are more common in families where there are difficulties in managing conflict.

14. Sufferers with eating disorders can cause irreversible harm to their bodies.

15. People with eating disorders are no more likely to die of their condition than individuals with other psychiatric conditions.

16. Eating disorders can often be a way to cope with overwhelming emotions, such as rage, fear and envy.

17. The environment in which a child is raised plays a greater role than genetic factors in the development of eating disorders.

18. Fathers are usually more involved with the children’s social obligations than mothers.

19. Fathers usually play with the children more often than mothers.

20. It is important to give mothers with eating disorders nutritional counselling regarding their children’s dietary needs in order to prevent the children from developing similar problems.

21. In general, individuals with eating disorders do not have a problem with keeping food in the house.
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<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Slightly Disagree</th>
<th>Neither agree nor disagree</th>
<th>Slightly Agree</th>
<th>Agree</th>
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<tr>
<td>22. Eating disorders occur more often in families where the channels of communication are confusing.</td>
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<td>23. Educating the mother about how her eating disorder could affect the children would not make any difference as to whether the children would develop similar problems</td>
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<td>24. People with eating disorders are just as confident as other people.</td>
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<td>25. Eating disorders result from conflicting messages of the media to eat but to be slim at the same time.</td>
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<td>26. Eating disorders reflect a child's refusal to accept a mother's love by refusing or vomiting food that she has prepared.</td>
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<td>27. Mothers with eating disorders often find it difficult to prepare their children's meals.</td>
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<td>28. People who have eating disorders believe that their personal worth is dependent on their weight.</td>
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<td>29. Improving access to self-help materials would shorten the interval between the onset of an eating disorder and the seeking of help.</td>
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<td>30. Eating disorders are not more common among the biological relatives of people with eating disorders than in the general population.</td>
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<td>31. People are less likely to develop an eating disorder if they have seen a family member suffer from it.</td>
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<td>32. People who develop eating disorders often have problems in separating from their mothers.</td>
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<td>Neither agree nor disagree</td>
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<td>33. Genetic factors play an important role in the development of eating disorders.</td>
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<td>34. Eating disorders are often associated with significant medical complications.</td>
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<td>35. People who develop eating disorders think that to be thin will bring them happiness.</td>
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<td>36. People who suffer from eating disorders only eat when everyone else is out of the house.</td>
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<td>37. Mothers generally cook the majority of their family’s meals.</td>
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<td>38. In general, mothers run the family home.</td>
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<td>39. The best way to shorten the duration of eating disorders is to increase general awareness of the nature and early signs of eating disorders so that sufferers and others can quickly recognise when there is a problem.</td>
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<td>40. The intergenerational boundaries are often blurred in the families of individuals with eating disorder.</td>
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<td>41. Children of mothers with eating disorders are no more likely to develop eating disorders than children of non-eating disordered mothers.</td>
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<td>42. People who suffer from eating disorders are individuals who are affected negatively by society’s emphasis on health and fitness.</td>
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<td>43. Clients with eating disorders are easy to engage in therapy.</td>
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Finally, could you please provide some information about yourself. This information will not be used to identify you, and any personal details will remain strictly confidential.

1. Are you? Male □ female □

2. To which age group do you belong?

   18-25 years □  46-55 years □
   26-35 years □  56-65 years □
   36-45 years □  66 years +  □

3. Which of the following ethnic groups would you say you belong to?

   (a) White British □ Irish □ Any other White background □ (please write in below)
   (b) Mixed White and Black Caribbean □ White and Black African □ White and Asian □
   Any other mixed background □ (please write in below)
   (c) Asian or Asian British Indian □ Pakistani □ Bangladeshi □
   Any other Asian background □ (please write in below)
   (d) Black or Black British Caribbean □ African □
   Any other Black background □ (please write in below)
   (e) Chinese or Other ethnic group Chinese □
   Any other □ (please write in below)
4. What is your highest educational qualification?

- GCSE(s) / O-level(s) □  Degree (BSc, BA etc.) □
- A-level(s) □  Higher Degree (MSc, MA etc.) □
- Diploma (HND, SRN, etc.) □  Doctorate (PhD / PsychD etc.) □
- Other Qualification □

(Please specify): ..........................................

5. What, if any, post-qualification training have you undertaken?

(Please specify): ..........................................................................................................

6. What is your profession (e.g. clinical / counselling psychologist, clinical psychiatric nurse, psychiatrists, psychotherapist, registrar, etc.) and status (e.g. student/trainee, consultant, etc.)?

(Please specify) ..........................................................................................................

7. How many years have you been practising (including training years)?

(Please specify) ..........................................................................................................

8. What is your preferred theoretical orientation / mode of practice?

- Cognitive-behavioural □  Interpersonal □
- Existential-phenomenological □  Psychoanalytic / psychodynamic □
- Humanistic □  Schema □
- Integrative □  Systemic □
- Other □

(Please specify): .................................................................

9. Did you undertake a child and adolescent placement during your training?

Yes □  No □

(If no, please go straight to question 11)
10. If yes, how long did you stay at that placement for?

(Please state length) ......................

11. How many female clients with eating disorders who have children (their own birth children and also any partners’ children for whom they are a primary caregiver) have you assessed over the past 12 months?

(Please state number) ......................

(If zero, please go straight to question 15)

12. If more than zero, do you know if any of the children of these clients are experiencing difficulties?

Yes □  No □  Don’t know □

(If no, please go straight to question 14)

(If don’t know, please go straight to question 15)

13. If yes, in which if these areas do they have difficulties?

- Behavioural  Yes □  No □  Don’t know □
- Emotional  Yes □  No □  Don’t know □
- Eating habits  Yes □  No □  Don’t know □
- Weight gain and growth  Yes □  No □  Don’t know □
- Other  Yes □  No □  Don’t know □

(Please state) .................................................................

14. Where did you get this information from?

- Own assessment  Yes □  No □
- Relatives of the client  Yes □  No □
- GP  Yes □  No □
Social worker  Yes □  No □
Other  Yes □  No □

(Please state) .............................................

15. Have you ever referred any of your clients' children whom you suspected were having difficulties for appropriate help?

Yes □  No □

16. If yes, how many such children have you referred?

(Please state number) .............................................

Please could you return the questionnaire in the envelope provided by:
30th of April, 2003, at the latest.

Thank you for taking part in this survey.
Appendix C: Covering letter

Department of Psychology
PsychD in Psychotherapeutic & Counselling Psychology

Telephone: ***
E-mail: ***
Fax No: ***
Title of Project: Children of mothers with eating disorders: Clinicians' clinical decision-making.

Dear [name of potential participant]

My name is Nadia Ahlenius and I am presently undertaking a doctoral course in Psychotherapeutic and Counselling Psychology at the University of Surrey. This is an advanced professional training in the practice, research and academic aspects of Counselling Psychology, which is accredited by the British Psychological Society.

As part of this course I am conducting a survey, which looks at mental health professionals in specialist eating disorders services current practice regarding their female clients' children. This study is being supervised by Dr Adrian Coyle (he can be contacted on ***) who is the course Research Tutor and Mrs Wendy Gairdner (she can be contacted ***) who is a professional tutor on the course and a registered family therapist and works in St George's Eating Disorders Service in South West London. This project has been approved by the University's Advisory Committee on Ethics.

Although eating disorders have been the subject of considerable research, it is only in recent years that the possible effects of parental eating disorders on offspring have been explored. As you know, mental health professionals who work in specialist eating disorders services frequently have contact with women with eating disorders who have children. These professionals are therefore in a good position to consider the impact of the disorder on the family. Despite this, research to date has failed to consider the understandings, opinions and practice of mental health professionals in such services. Hence, the aim of the present study is to address this shortcoming and explore your views and current practice concerning the children of
your female clients. Whilst I know how valuable your time is, I would be very grateful if you could take a few minutes to fill out the enclosed questionnaire.

The questionnaire will take approximately 20 minutes to complete and it is entirely anonymous. The information that you provide will not and cannot be used to identify you. In addition, all data collected will be held and processed in confidence and in accordance with the Data Protection Act (1998). If you do want to answer some questions, however, please do not feel that you have to.

If you decide to participate in the present study, please return the completed questionnaire in the pre-paid envelope provided. If you wish to receive a copy of the final report of this study, please fill out the reply slip below and return it separately from the questionnaire. I will then send you a copy of the final report in August. I also hope to disseminate my findings to other professionals in the eating disorders field by writing a paper for a relevant academic / practice journal. In this way, your contribution to the study may ultimately help to inform practice on this issue.

If you have any questions about the study, please do not hesitate to contact me or any of my supervisors on the above numbers. Thank you very much for your time and consideration.

Yours sincerely,

Nadia Ahlenius

Counselling Psychologist in Training
Please send me a copy of "Children of mothers with eating disorders: Clinicians' clinical decision-making".

Name: .........................................................

Address: .........................................................

.................................................................

Post Code: .................
Appendix D: Questionnaire items within each of the four scales of the questionnaire.

- The clinician’s own beliefs about the nature of (i.e. cause) of eating disorders

Genetic perspectives
1. Genetic factors play an important role in the development of eating disorders.
2. Eating disorders are not more common among the biological relatives of people with eating disorders than in the general population (negative).
3. The environment in which a child is raised plays a greater role than genetic factors in the development of eating disorders (negative).

Cultural influences
4. Eating disorders result from conflicting messages of the media to eat but to be slim at the same time.
5. Eating disorders are a result of Western ideals of physical thinness.
6. People who sufferer from eating disorders are individuals who are affected negatively by society’s emphasis on health and fitness.

Systems theory
7. Eating disorders are more common in families where there are difficulties in managing conflict.
8. Eating disorders occur more often in families where the channels of communication are confusing.
9. The intergenerational boundaries are often blurred in the families of individuals with eating disorder.

Cognitive theory
10. People who have eating disorders believe that their personal worth is dependent on their weight.
11. Eating disorders are due to a distortion in how they see their bodies.
12. People who develop eating disorders think that to be thin will bring them happiness.
Psychodynamic theory

13. People who develop eating disorders often have problems in separating from their mothers.
14. Eating disorders reflect a child’s refusal to accept a mother’s love by refusing or vomiting food that she has prepared.
15. Eating disorders can often be a way to cope with overwhelming emotions, such as rage, fear and envy.

• The clinician’s estimate of the probability of children of mother’s with eating disorders have difficulties as a result of the mother’s disorder

16. Children of mothers with eating disorders are more likely to experience psychological difficulties than other children.
17. Because individuals with eating disorders usually try to keep their disorder secret, it is unlikely that the children of such mothers would copy their behaviour (negative).
18. It is likely that mothers with eating disorders will underfeed their children.
19. Children of mothers with eating disorders are no more likely to develop eating disorders than children of non-eating disordered mothers (negative).
20. Mothers with eating disorders often find it difficult to prepare their children’s meals.
21. People are less likely to develop an eating disorder if they have seen a family member suffer from it (negative).

• The seriousness and treatability of eating disorders

Seriousness

22. People with eating disorders are no more likely to die of their condition than individuals with other psychiatric conditions (negative).
23. Eating disorders are often associated with significant medical complications.
24. Sufferers with eating disorders can cause irreversible harm to their bodies.

Treatability

Primary prevention

25. It is important to give mothers with eating disorders nutritional counselling regarding their children’s dietary needs in order to prevent the children from developing similar problems.
26. Psychoeducational groups for family members of sufferers of eating disorders are a good strategy for preventing other members of the family from developing similar problems.

27. Educating the mother about how her eating disorder could affect the children would not make any difference as to whether the children would develop similar problems (negative).

Secondary prevention

28. The best way to shorten the duration of eating disorders is to increase general awareness of the nature and early signs of eating disorders so that sufferers and others can quickly recognise when there is a problem.

29. Improving access to self-help materials would shorten the interval between the onset of an eating disorder and the obtaining of help.

30. All children of mothers with eating disorders should be screened for signs of disordered eating because if they have similar problems the duration of the disorder could be shortened.

Treatment

31. Most clients with eating disorders are extremely resistant to therapeutic intervention.

32. The drop-out rate in therapy with clients with eating disorders is much higher than in other client groups.

33. Clients with eating disorders are easy to engage in therapy (negative).

- The clinicians stereotype of the patient

Mothers:

34. In general, mothers run the family home.

35. Fathers usually play with the children more often than mothers (negative).

36. Mothers do not spend as much time with their children as fathers do (negative).

37. Fathers are usually more involved with the children's social obligations than mothers (negative).

38. Mothers generally cook the majority of their family's meals.

People with eating disorders:

39. People with eating disorders are just as confident as other people (negative).
40. People who develop eating disorders are usually from under-privileged social classes (negative).

41. People who suffer from eating disorders only eat when everyone else is out of the house.

42. In general, people with eating disorders do not have a problem with keeping food in the house (negative).

43. Individuals with eating disorders are often so obsessed with their self-image that they find it difficult to concentrate on anything else.
### Appendix E1: SPSS output of the factor analyses

#### Pattern Matrix

<table>
<thead>
<tr>
<th>Component</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>cultural influence1</td>
<td>.746</td>
<td></td>
<td></td>
</tr>
<tr>
<td>cultural influences2</td>
<td>.832</td>
<td></td>
<td></td>
</tr>
<tr>
<td>cultural influences3</td>
<td>.783</td>
<td></td>
<td></td>
</tr>
<tr>
<td>systems theory1</td>
<td></td>
<td>.925</td>
<td></td>
</tr>
<tr>
<td>systems theory2</td>
<td></td>
<td>.921</td>
<td></td>
</tr>
<tr>
<td>genetic perspectives1</td>
<td></td>
<td></td>
<td>.878</td>
</tr>
<tr>
<td>genetic perspectives3</td>
<td></td>
<td></td>
<td>-.867</td>
</tr>
</tbody>
</table>

Extraction Method: Principal Component Analysis.  
Rotation Method: Oblimin with Kaiser Normalization.  
*a. Rotation converged in 4 iterations.*

#### Pattern Matrix

<table>
<thead>
<tr>
<th>Component</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>primary prevention1</td>
<td>.711</td>
<td></td>
</tr>
<tr>
<td>primary prevention2</td>
<td>.724</td>
<td></td>
</tr>
<tr>
<td>primary prevention3</td>
<td>-.651</td>
<td></td>
</tr>
<tr>
<td>secondary prevention1</td>
<td>.476</td>
<td></td>
</tr>
<tr>
<td>secondary prevention2</td>
<td>.572</td>
<td></td>
</tr>
<tr>
<td>secondary prevention3</td>
<td>.536</td>
<td></td>
</tr>
<tr>
<td>treatment1</td>
<td></td>
<td>.740</td>
</tr>
<tr>
<td>treatment2</td>
<td></td>
<td>.709</td>
</tr>
<tr>
<td>treatment3</td>
<td></td>
<td>-.764</td>
</tr>
</tbody>
</table>

Extraction Method: Principal Component Analysis.  
Rotation Method: Oblimin with Kaiser Normalization.  
*a. Rotation converged in 3 iterations.*

#### Pattern Matrix

<table>
<thead>
<tr>
<th>Component</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>gender stereotype1</td>
<td>-.575</td>
<td></td>
</tr>
<tr>
<td>gender stereotype4</td>
<td>.851</td>
<td></td>
</tr>
<tr>
<td>gender stereotype5</td>
<td>.802</td>
<td></td>
</tr>
<tr>
<td>ed stereotype1</td>
<td></td>
<td>.828</td>
</tr>
<tr>
<td>ed stereotype3</td>
<td></td>
<td>-.540</td>
</tr>
<tr>
<td>ed stereotype5</td>
<td></td>
<td>.615</td>
</tr>
</tbody>
</table>

Extraction Method: Principal Component Analysis.  
Rotation Method: Oblimin with Kaiser Normalization.  
*a. Rotation converged in 3 iterations.*
**Appendix E2**: SPSS output of the chi-square tests used to test Hypothesis 1.

### Case Processing Summary

<table>
<thead>
<tr>
<th>cases</th>
<th>Valid</th>
<th>Missing</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>Percent</td>
<td>N</td>
<td>Percent</td>
</tr>
<tr>
<td>referred for help * professions recoded2</td>
<td>78</td>
<td>94.0%</td>
<td>5</td>
</tr>
</tbody>
</table>

### referred for help * professions recoded2 Crosstabulation

<table>
<thead>
<tr>
<th>professions recoded2</th>
<th>psychologists</th>
<th>medical</th>
<th>other</th>
<th>therapists</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>referred yes</td>
<td>8</td>
<td>13</td>
<td>1</td>
<td>7</td>
<td>29</td>
</tr>
<tr>
<td>for help no</td>
<td>22</td>
<td>12</td>
<td>9</td>
<td>6</td>
<td>49</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>25</td>
<td>10</td>
<td>13</td>
<td>78</td>
</tr>
</tbody>
</table>

### Chi-Square Tests

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>8.480²</td>
<td>3</td>
<td>.037</td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>9.086</td>
<td>3</td>
<td>.028</td>
</tr>
<tr>
<td>Linear-by-Linear Association</td>
<td>1.050</td>
<td>1</td>
<td>.305</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>78</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* 2 cells (25.0%) have expected count less than 5. The minimum expected count is 3.72.
## Case Processing Summary

<table>
<thead>
<tr>
<th>Cases</th>
<th>Valid</th>
<th>Missing</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Percent</td>
<td>N</td>
</tr>
<tr>
<td>referred for help *</td>
<td>68</td>
<td>97.1%</td>
<td>2</td>
</tr>
<tr>
<td>professions recoded2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### referred for help * professions recoded2 Crosstabulation

<table>
<thead>
<tr>
<th>Count</th>
<th>psychologists</th>
<th>medical</th>
<th>therapists</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>referred yes</td>
<td>8</td>
<td>13</td>
<td>7</td>
<td>28</td>
</tr>
<tr>
<td>for help no</td>
<td>22</td>
<td>12</td>
<td>6</td>
<td>40</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>25</td>
<td>13</td>
<td>68</td>
</tr>
</tbody>
</table>

### Chi-Square Tests

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>4.678a</td>
<td>2</td>
<td>.096</td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>4.782</td>
<td>2</td>
<td>.092</td>
</tr>
<tr>
<td>Linear-by-Linear Association</td>
<td>2.909</td>
<td>1</td>
<td>.088</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>68</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 5.35.
Appendix E3: SPSS output of the Kruskal-Wallis test used to test Hypothesis 2.

Descriptive Statistics

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>total knowledge reflected</td>
<td>76</td>
<td>4.5921</td>
<td>3.98389</td>
<td>1.00</td>
<td>13.00</td>
</tr>
<tr>
<td>professions recoded2</td>
<td>76</td>
<td>2.0789</td>
<td>1.10469</td>
<td>1.00</td>
<td>4.00</td>
</tr>
</tbody>
</table>

Ranks

<table>
<thead>
<tr>
<th>professions recoded2</th>
<th>N</th>
<th>Mean Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>total knowledge reflected</td>
<td>30</td>
<td>30.80</td>
</tr>
<tr>
<td>psychologists</td>
<td>23</td>
<td>30.09</td>
</tr>
<tr>
<td>medical</td>
<td>10</td>
<td>40.00</td>
</tr>
<tr>
<td>other</td>
<td>63</td>
<td></td>
</tr>
</tbody>
</table>

Test Statistics\(^a,b\)

<table>
<thead>
<tr>
<th></th>
<th>total knowledge of difficulties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi-Square</td>
<td>4.021</td>
</tr>
<tr>
<td>df</td>
<td>3</td>
</tr>
<tr>
<td>Asymp. Sig.</td>
<td>.259</td>
</tr>
</tbody>
</table>

\(^a\) Kruskal Wallis Test

\(^b\) Grouping Variable: professions recoded2
Appendix E4: SPSS output of the independent samples t-test used to test Hypothesis 3.

### Group Statistics

<table>
<thead>
<tr>
<th>child &amp; adolescent placement</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>47</td>
<td>12.0851</td>
<td>3.00601</td>
<td>.43847</td>
</tr>
<tr>
<td>no</td>
<td>29</td>
<td>11.2414</td>
<td>3.33440</td>
<td>.61918</td>
</tr>
</tbody>
</table>

### Independent Samples Test

<table>
<thead>
<tr>
<th>Estimate of probability2</th>
<th>F</th>
<th>Sig.</th>
<th>t</th>
<th>df</th>
<th>Sig (2-tailed)</th>
<th>Mean Difference</th>
<th>Std. Error Difference</th>
<th>95% Confidence Interval of the Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equal variances assumed</td>
<td>.299</td>
<td>.566</td>
<td>1.140</td>
<td>74</td>
<td>.258</td>
<td>.8437</td>
<td>.74012</td>
<td>-63099 - 2.31845</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>1.112</td>
<td>54.744</td>
<td>.271</td>
<td></td>
<td>.8437</td>
<td>.75871</td>
<td>-.67693 - 2.36438</td>
<td></td>
</tr>
</tbody>
</table>
Appendix E5: SPSS output of the single independent samples t-test that yielded a significant difference (during the attempt to identify candidate predictor variables).

### Group Statistics

<table>
<thead>
<tr>
<th>referred for help</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>26</td>
<td>12.8462</td>
<td>2.42804</td>
<td>.47618</td>
</tr>
<tr>
<td>no</td>
<td>45</td>
<td>11.1556</td>
<td>3.38416</td>
<td>.50448</td>
</tr>
</tbody>
</table>

### Independent Samples Test

<table>
<thead>
<tr>
<th>Levene's Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
<th>95% Confidence Interval of the Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimate of probability2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>F = 4.691, p = .034</td>
<td>t = 2.234, df = 69, p = .029</td>
</tr>
<tr>
<td></td>
<td>Mean Difference = 1.6906</td>
<td>Std. Error Difference = .75683</td>
</tr>
<tr>
<td></td>
<td>Lower = .69372, Upper = 3.07580</td>
<td></td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>F = 2.437, df = 66.634, p = .018</td>
<td>t = 1.6906, Std. Error Difference = .69372, Lower = .30540, Upper = 3.07580</td>
</tr>
</tbody>
</table>
25 February 2003

Ms Nadia Ahlenius  
PsychD Student  
Department of Psychology  
University of Surrey

Dear Ms Ahlenius,

Clinical decision-making by mental health professionals in eating disorders services regarding the children of their female clients (ACE/2003/09/Psych)

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed. For your information, and future reference, these Guidelines can be downloaded from the Committee's website at http://www.surrey.ac.uk/Surrey/ACE/.

This letter of approval relates only to the study specified in your research protocol (ACE/2003/09/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions, and if the study is terminated earlier than expected, with reasons.

Date of approval by the Advisory Committee on Ethics: 25 February 2003
Date of expiry of approval by the Advisory Committee on Ethics: 24 February 2008

Please inform me when the research has been completed.

Yours sincerely,

Catherine Ashbee (Mrs)
Secretary, University Advisory Committee on Ethics

cc: Chairman, ACE  
Dr Adrian Coyle, Supervisor, Dept of Psychology  
Mrs W Gairdner, Supervisor, Dept of Psychology
Appendix G: European Eating Disorders Review's notes for contributors

Instructions to Authors

Initial Manuscript Submission. Submit four copies of the manuscript (including copies of tables and illustrations) to Dr Robert Palmer, University of Leicester, Brandon Mental Health Unit, Leicester General Hospital, Gwendolen Road, Leicester, LE5 4PW, UK. Authors must also supply:

- an electronic copy of the final version (see section below),
- a Copyright Transfer Agreement with original signature(s) - without this we are unable to accept the submission, and
- permission grants - if the manuscript contains extracts, including illustrations, from other copyright works (including material from on-line or intranet sources) it is the author's responsibility to obtain written permission from the owners of the publishing rights to reproduce such extracts using the Wiley Permission Request Form. Permission grants should be submitted with the manuscript.

Submission of a manuscript will be held to imply that it contains original unpublished work and is not being submitted for publication elsewhere at the same time. Submitted material will not be returned to the author, unless specifically requested.

Electronic submission. The electronic copy of the final, revised manuscript must be sent to the Editor together with the paper copy. Disks should be PC or Mac formatted; write on the disk the software package used, the name of the author and the name of the journal. We are able to use most word processing packages, but prefer Word or WordPerfect and TeX or one of its derivatives.

Illustrations must be submitted in electronic format where possible. Save each figure as a separate file, in TIFF or EPS format preferably, and include the source file. Write on the disk the software package used to create them; we favour dedicated illustration packages over tools such as Excel or Powerpoint.

Manuscript style. The language of the journal is English. All submissions including book reviews, must have a title, be printed on one side of the paper, be double-line spaced and have a margin of 3cm all round. Illustrations and tables must be printed on separate sheets, and not be incorporated into the text.

- The title page must list the full title, short title of up to 70 characters and names and affiliations of all authors. Give the full address, including e-mail, telephone and fax, of the author who is to check the proofs.
- Include the name(s) of any sponsor(s) of the research contained in the paper, along with grant number(s).
- Supply an abstract of up to 150 words for all articles [except book reviews]. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.
- Include up to five keywords that describe your paper for indexing purposes.

Reference style. The APA system of citing sources indicates the author's last name and the date, in parentheses, within the text of the paper.

A. A typical citation of an entire work consists of the author's name and the year of publication.
Example: Charlotte and Emily Bronte were polar opposites, not only in their personalities but in their sources of inspiration for writing (Taylor, 1990). Use the last name only in both first and subsequent citations, except when there is more than one author with the same last name. In that case, use the last name and the first initial.

B. If the author is named in the text, only the year is cited.
Example: According to Irene Taylor (1990), the personalities of Charlotte...

C. If both the name of the author and the date are used in the text, parenthetical reference is not necessary.
Example: In a 1989 article, Gould explains Darwin's most successful...

D. Specific citations of pages or chapters follow the year.
Example: Emily Bronte "expressed increasing hostility for the world of human relationships, whether sexual or social" (Taylor, 1988, p. 11).

E. When the reference is to a work by two authors, cite both names each time the reference appears.
Example: Sexual-selection theory often has been used to explore patterns of various insect matings (Alcock & Thornhill, 1983). Alcock and Thornhill (1983) also demonstrated...

F. When the reference is to a work by three to five authors, cite all the authors the first time the reference appears. In a subsequent reference, use the first author's last name followed by *et al.* (meaning "and others").
Example: Patterns of byzantine intrigue have long plagued the internal politics of community college administration in Texas (Douglas *et al.*, 1997). When the reference is to a work by six or more authors, use only the first author's name followed by *et al.* in the first and all subsequent references. The only exceptions to this rule are when some confusion might result because of similar names or the same author being cited. In that case, cite enough authors so that the distinction is clear.

G. When the reference is to a work by a corporate author, use the name of the organization as the author.
Example: Retired officers retain access to all of the university's educational and recreational facilities (Columbia University, 1987, p. 54).

H. Personal letters, telephone calls, and other material that cannot be retrieved are not listed in References but are cited in the text.
Example: Jesse Moore (telephone conversation, April 17, 1989) confirmed that the ideas...

I. Parenthetical references may mention more than one work, particularly when ideas have been summarized after drawing from several sources. Multiple citations should be arranged as follows.

Examples:

- List two or more works by the same author in order of the date of publication: (Gould, 1987, 1989)

- Differentiate works by the same author and with the same publication date by adding an identifying letter to each date: (Bloom, 1987a, 1987b)

- List works by different authors in alphabetical order by last name, and use semicolons to separate the references: (Gould, 1989; Smith, 1983; Tutwiler, 1989).

All references must be complete and accurate. Online citations should include date of access. If necessary, cite unpublished or personal work in the text but do not include it in the reference list. References should be listed in the following style:

**Journal Article**

**Book**

**Book with More than One Author**
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