WHAT ARE THE EXPERIENCES OF ADOLESCENTS DURING THE RECOVERY PROCESS FROM ANOREXIA NERVOSA AFTER RECEIVING INPATIENT TREATMENT? AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS STUDY.

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ABSTRACT

Background: Evidence suggests that eating disorders appear to be a significant issue in the United Kingdom. Report also suggests that people with eating disorders have a higher rate of mortality, with Anorexia Nervosa having the highest risk of mortality within eating disorders. Adolescents are most likely to be at risk suggesting closer attention should be given to this population. Despite the move towards outpatient services, inpatient treatment remains important to Anorexia Nervosa treatment for adolescents due to its life threatening features. Studies however indicate that a high number of patients who are discharged from inpatient treatment often relapse. Qualitative studies into the experiences of anorexic sufferers has shown that improvement during the recovery process may lead to new difficulties particularly in regards to managing their negative feelings without restricting their dietary intake. Most studies that have explored the experiences of people with Anorexia Nervosa tend to report more on their experience of treatment interventions. Furthermore, the limited research literature on recovery tends to focus more on adult experiences whilst little attention is given to the experience of adolescents.

Aim: This study aims to contribute towards the topic as it explores the experiences of adolescents during the recovery process from Anorexia Nervosa after receiving inpatient treatment.

Methodology: Semi-structured interviews were conducted with four adolescents who had been discharged into the community following inpatient treatment for Anorexia Nervosa.

Results: From the analysis, the following four super-ordinate themes emerged from the data: self & recovery; relational; the world against me: back in the world; and psychological recovery vs. physical recovery.

Conclusions: The findings highlight the impact of inpatient treatment on adolescents as well as the different roles played by parents, friends, and therapists in maintaining the course of recovery for adolescents with AN following their discharge from inpatient treatment. The findings also inform counselling psychologists as to how best to help adolescents manage the challenges they may face in the later stages of their recovery after discharge from inpatient treatment. Evaluation of the current study is followed by recommendations for future research.

REFLEXIVE STATEMENT

The reflexive process involves the researcher reflecting on how he or she may have impacted the research process (Yardley, 2000). It has been suggested that the researcher's beliefs and assumptions are likely to influence the method in which the data is gathered and analysed, and it is therefore of paramount importance that a researcher is clear about his or her owns assumptions and beliefs and be transparent about his or her own perspective (Elliot et al., 1999). In considering my process of research, I understand that my epistemological views may have influenced this process. I am not in agreement with the theoretical foundations of positivism that suggests that information derived from logical sensory experience is the exclusive source of all authoritative knowledge (Rohmann, 1999). I am more influenced by social constructive views that suggest the significance of context and culture in understanding what happens in society and the construction of knowledge (Burr, 2003). Upon reflection, I think this may be because of my own experience growing up in two different cultures. As a child, I lived in Nigeria West Africa, however I have spent most of my life in England, UK. I have noticed the stark contrast in culture and how that influences the perception of people. This has led me to believe that our environment and the context in which we live will have a huge impact on how we perceive the world. However, I have made a conscious endeavour to not let my personal epistemological position influence my review of the literature so that I can provide a balanced and comprehensive critique.

I am a twenty-eight year old black British man currently training to be a counselling psychologist. According to Breuer (2000), there are many reasons that a researcher may seek to investigate or explore a particular area and these may include: emotional and intellectual elements, personal curiosity in a specific population or roles that complement the style of the individual. I have never had an eating disorder (ED) of

any kind and so my main motivation for researching the topic of eating disorders (EDs), with the focus on anorexia nervosa (AN), stems from my experience working at an adolescent inpatient EDs unit as an assistant psychologist. Prior to working at this unit, I did not have any previous experience working with individuals with EDs which meant that my knowledge about EDs was fairly limited. However, through working with the young people, my knowledge about EDs increased and so did my curiosity about the complex nature of the illness.

At the EDs unit where I worked, part of my responsibility involved co-facilitating therapeutic groups. Often in these groups, the young people would discuss their personal struggles in coping with their particular type of ED and the ambivalence they often feel towards recovery. It was common for them to talk about not feeling understood by staff members and not being treated as unique individuals. This would often create an emotional response within me along with the thought of how I could do something to make their lives and plight more bearable. With most of the patients aged between 12 and 18 years, I could not help but ponder at what it must be like for them to go through such an ordeal at very young ages. It was also not uncommon to hear some individuals cry and express their distress whenever the time for their meals approached. Upon reflection, I think hearing these young people express their distress triggered memories of my childhood where I had sometimes felt helpless and not understood. Furthermore, a matter that equally drew my curiosity was the competitive nature of the illness, in which most patients were often trying to show that their illness was worse than everyone else's, implying that they needed more care. It always seemed like these patients experienced an internal struggle on a daily basis that could not just be simplified to a loss of body weight. I have often witnessed cases where patients at the later stages of their recovery would begin exhibiting compensatory behaviours (i.e.,

over-exercising) in an attempt to reaffirm their status of being 'unwell' and thus still in need of care. This is often a topic of discussion in therapy groups where the patients would describe their struggle in regards to dealing with the transition between being ill to being recovered.

Furthermore, I have felt frustrated at the structure of treatment that appears to focus more on weight gain than on the psychological aspects of recovery. I have also felt equally frustrated at the idea that recovery outcome is primarily measured through the medical model with less emphasis being given to psychological issues. There appears to be an emphasis on getting the patients to their target weight and discharging them as soon as possible despite any comorbid psychopathology that may still persist. My experience of service provision in the treatment of EDs is an issue that is reflected in the wider literature (e.g., Crow & Nyman, 2004).

Furthermore, my motivation for conducting this research can also be attributed to my desire to give a voice to children and adolescents. Upon reflection, I think this comes from my desire to make a difference and address the concerns of the young people with AN that I have worked with in the past. Giving voice to young people also happens to be in line with an international convention that emphasises children's rights (Unicef, 1989). Following this, listening to children's voices has become an important mantra for policy makers around the world. It has also been suggested that children's voices must be prominent when exploring what is happening in their lives (James, 2007). However despite such suggestions, children's voices are still being ignored and often suppressed in their everyday lives. As I intend on working with young people in my future practice, I would like this research to contribute to that endeavour and in so doing, influence the general practice of therapeutic treatment for AN.

My hope for this research is therefore to give a voice to adolescents struggling with EDs, particularly those with AN. I am also hoping that this research can highlight some of the limitations of their inpatient treatment but also shed light on possible areas for improvement. I am hoping to highlight the struggles and associated frustrations of adolescents with EDs during the inpatient treatment process as they themselves experience it and in addition, to also illuminate their experience of recovery following their discharge from treatment.

With this in mind, I acknowledge that these hopes may influence how I interpret the data collected from my participants. I may be biased towards interpreting the data in a way that might highlight the limitations of inpatient treatment more predominantly than the strengths. I also acknowledge that I may be making an assumption that all adolescents receiving impatient treatment may experience the process as a struggle or be frustrated by it. These assumptions may in turn influence how I collect and interpret my participant's data. I also acknowledge that because of my experience working with adolescents with EDs, I may be making an assumption that adolescents with EDs may give negative accounts of their experience of inpatient treatment. In addition, I acknowledge that I may be making an assumption that this client group will view the idea of discharge as a positive thing and would therefore welcome it. Once again, these assumptions may bias the way in which my data is interpreted. However, I also acknowledge that my perspective is a subject one and there are therefore other ways of viewing the subject matter under investigation and also other ways of interpreting the data. I have therefore made sufficient effort to maintain the dependability and validity of this study by following the principles proposed by Yardley (2000). I have endeavoured to discuss these principles further in Chapter 2.

1 INTRODUCTION AND CRITICAL LITERATURE REVIEW

1.1 Overview and background

This section aims to provide an understanding of what EDs are in an effort to highlight the significance and focus being given to AN. When the phrase 'eating disorders' (EDs) is used, it refers to a collection of disorders in which individuals have an excessive focus on their shape, weight and controlling their dietary intake, often with the aim of losing weight (Lask & Bryant-Waugh, 2000; Pettersen et al., 2013). The most recent Diagnostic and Statistical Manual of Mental Disorders [DSM-V] (American Psychiatric Association, 2013) provides diagnostic criteria for seven ED categories: Rumination disorder, Pica, Avoidant/Restrictive food intake disorder (ARFID), Bulimia Nervosa (BN), Binge-eating disorder (BED), Anorexia Nervosa (AN) and Other Specified Feeding or Eating Disorder (OSFED). It is beyond the scope of this study to discuss all the different categories in detail since this study aims to highlight the significance of AN.

The DSM-V defines AN with three essential features: restricting the intake of energy over a period of time; intense fear of gaining weight; and a distorted perception of body shape or weight (American Psychiatric Association, 2013). There are two different types of AN. There is restricting type which refers to sufferers who lose weight by exercising excessively and restricting their diet and there is binge eating/purging type which refers to sufferers who vomit repeatedly and binge eat (American Psychiatric Association, 2013). When compared with the other ED categories already mentioned, the onset of AN is most usually in adolescence (Steinhausen, 2002; Gowers & Bryant-Waugh, 2004). AN can therefore be seen as signalling the transition from being a child into being an adolescent. However, despite the marked significance of this

period, the majority of the research appears dominated by adult perspectives and experiences with relatively few focusing on young people with AN (Fichter & Quadflieg, 1995; Steiner & Lock, 1998).

The desire to be thin witnessed in AN may continue even when sufferers are severely underweight (Fairburn, 2008). Furthermore, individuals with AN can find it difficult to correctly describe how they are feeling both physically and emotionally (Fairburn & Harrison, 2003; Fairburn, 2008). In the cases of those who are able to identify their affective states, they can be defensive or vague when describing their feelings and can be easily influenced by those they regard to be significant (Fairburn & Harrison, 2003). The egosyntonic nature of AN that results in the loss of body weight being acceptable to the goal and ego of sufferers, has been suggested to be one of AN's most prominent feature (Rieger et al., 2001). This idea was originally proposed by Lasegue (1997), who suggested that the extreme weight loss witnessed in sufferers is not perceived by them to be a problem, but it is in fact a component that they value. This concept implies that sufferers may view their difficulties as accomplishments and consequently will oppose attempts at treatment (Westwood & Kendal, 2012). The views of sufferers in regards to treatment will be discussed in more depth later in this review.

Apart from the features already discussed, AN also shares several psychopathological symptoms with other mental difficulties. For example, sufferers often exhibit a rigid 'black and white' thinking style, low self-esteem, limited levels of interests in anything other than matters concerning weight and food, restricted social interactions, significant mood swings, irritability and difficulty sleeping. In addition, there is often very little interest in sexual activity and if it occurs, it is not usually enjoyed. Depressive symptoms are also very common as well as bipolar and anxiety disorders (Strober, 1991; Herzog et al. 1992). Individuals with AN can also exhibit

obsessive-compulsive features that may or may not be related to food (American Psychiatric Association, 2013).

1.2   Estimation of the prevalence, prognosis and incidence

It is important to have an understanding of the extent to which EDs are an issue, particularly in the UK. However, one must first acknowledge that the current epidemiological knowledge stems mainly from research derived from hospital and clinical records. This therefore suggests that true prevalence and incidence rates may be unreported since not all cases of EDs are referred for treatment (Rutter et al., 2011). Nevertheless, EDs seem to be a significant issue in the UK with research indicating that its prevalence is rising globally (Hay et al., 2008; Hoek, 2006; Zachrisson et al., 2008). AN has been suggested to occur in approximately 0.28% of the population (Fairburn & Brownell, 2002). It is most likely to be higher in adolescent girls in countries with high incomes such as the UK possibly as a result of economic and cultural factors (Favaro et al., 2003; Makino et al., 2004; Neumark-Sztainer & Hannan, 2000; Smink et al., 2012). The impact of society and culture on the development of AN will be discussed in more depth later in this review. Recently, Qian et al. (2013) showed that females had a higher ED lifetime prevalence than males which is consistent with previous research in the topic area. This seems to suggest that females may need more therapeutic input to manage the symptoms of EDs. There seems to be less of an occurrence of AN in males compared to females. Although the clinical symptoms are often similar, it has been suggested that the onset of the illness may be earlier in males in addition to having a worse prognosis (Carlat et al. 1997).

The term 'incidence' is used to describe the number of new cases recorded in a population within a given year. Research indicates that the incidence of EDs have increased over the last five decades however, this may be as a consequence of better

reporting on the issue (Wakeling, 1996). There also appears to be a cultural difference in incidence rates since AN is very uncommon among black people in the UK, USA and Africa (Anderson & Hay, 1985; Silber 1986; Dolan, 1991). Very few cases seem to be reported in places like China (Lee & Chiu, 1989) however there appears to be a higher incident rate in Japan (Suematsu et al. 1985). It would seem that AN particularly thrives in western societies or cultures that have been heavily influenced by western values such as Japan (Nasser,1988; Gordon, 1990). Evidence also suggests that outside western societies, the illness mostly affects those in the upper class of society. For example, more cases are recorded among the Caucasian population in South Africa (Ballot & Erskine, 1981) and among the upper class population in Chile (Pumarino & Vivanco, 1982). It is often assumed that the ample availability of food can be used to explain the higher incident rates in western societies since a disorder that involves diet restriction is less likely to occur in societies with a restricted supply of food (Gordon, 1990). However, the complex presentation of the illness makes it improbable that food availability is the sole determinant of AN incidence (Simpson, 2002). The suggested causes of AN will be discussed later in this review.

In regards to prognosis, it has been suggested that approximately 33.3% of ED sufferers continue to meet the requirements for diagnoses five years and longer after the course of treatment, nevertheless, significant improvement has been reported for half of patients over the same time period (Polivy & Herman, 2002). Report suggests that people with EDs have a higher rate of mortality, with AN having the highest risk of mortality (Arcelus et al., 2011). This emphasises the need for further research into the topic area that may add to our knowledge of EDs, which in turn may subsequently improve their prevention and the treatment offered.

1.3 Why focus on adolescents?

As previously mentioned, the onset of AN mostly occurs during adolescence. In many societies and cultures, adolescence is seen as a rather unique stage of development with influences on young people at this stage significantly impacting their fulfilment and their progression into adulthood (Garbarino, 1985). It is a stage where the boundaries are unclear which is one of the reasons why there is no definitive age range for adolescence. The age range for adolescence differs across society and cultures with some studies suggesting it begins at the age of 10 and extends to the age of 23 (UNICEF, 2011; Bezance & Holiday, 2013). There is a general consensus that during this time, young people experience significant behavioural, physical and psychological changes which have health care implications unique to this age group (Zarrett & Eccles, 2006). Eccles & Gootman (2002) also suggested that adolescents have to navigate shifts in relationship with parents, often from a position of dependency to a more mature status of independency. They also suggested that adolescents have to explore new roles, experience intimate relationships, develop their identity, plan for their future and acquire the range of skills and values needed to make a successful transition into adulthood. It is therefore unsurprisingly a challenging time for most young people even in the absence of AN. The experiences of young people with AN after receiving inpatient treatment during this challenging period of their lives has yet to receive any attention in the academic literature.

The impact of AN on adolescents can result in worse outcomes when compared to its impact during adulthood. For example, the physical consequences of AN vary by age. Adolescents are more likely to be at risk from the acute effects of malnutrition and dehydration and relatively small reductions in weight may have more severe medical consequences than in adults (American Psychiatric Association, 2006). In addition,

there has been a concern about the long-term consequences of prolonged under-nutrition in young people. Three significant areas of concern include growth retardation (Misra, 2008), osteoporosis (Munoz & Argente, 2002) and irreversible neurological damage (Katzman et al., 1997). These findings further contribute to the argument that more attention ought to be given to the topic of treatment and the recovery process for AN during adolescence. Furthermore, evidence suggests that treating AN from an early age can improve the chances of a positive outcome (Steinhausen, 2002). By addressing the issues that cause and maintain AN in young people from an early age, they may be less likely to be admitted for treatment during adulthood. Furthermore, they may also respond better to community based treatment.

As previously highlighted, people with AN have the highest risk of mortality. Research suggests that mortality by suicide represents a significant threat to adolescents with AN and is one of the most common cause of death in this population (Strober et al., 1997; Pompili et al., 2004). It has also been suggested that suicide rates were significantly higher in young people with AN when compared with the general population (Franko & Keel, 2006). This further adds to the argument that more attention should be paid to adolescents with AN in order to reduce the rates of suicide and improve the chances of recovery.

CRITICAL LITERATURE REVIEW

1.4   Literature search methodology

A systematic review of the literature was carried out in order to provide a summary of the most relevant literature relevant to the research question. The following sources were used to find relevant literature: PsychINFO, PsycARTICLES, PubMed, ScienceDirect, Ingenta Select, Wiley-Blackwell Interscience, The Cochrane Library, Academic Search Complete, WorldCat, Elsevier, ArticleFirst, Wiley Online Library and Google Scholar. These databases were searched from 1860 - 2017.

The keywords and phrases used in the search were anorexia, adolescents, children, recovery, eating disorders, treatment, and relapse. References used in the most relevant studies were also gathered and explored. The studies used met particular criteria that supported their inclusion. These are listed below:

Inclusion criteria

- Reported on EDs
- Reported on prevalence and incidents
- Reported on AN
- Reported on treatment and recovery
- Reported on children and adolescents

Criteria for exclusion

- Articles that were not in English

1.5   The pathogenesis of eating disorders

This section aims to provide an understanding of what causes eating disorders and the factors that may maintain them. Despite the breadth of literature on EDs, there has been no solitary cause identified (Fairburn & Harrison, 2003). However, the research shows that the pathogenesis is influenced by a variety of factors that seem to interplay within a developmental context (Fairburn & Harrison, 2003; Garner & Myerholtz, 1998). These factors include familial, biological, sociocultural, individual and precipitating incidents (Steiner et al., 1995; Stice, 2002; Jacobi et al., 2004).

1.5.1   Familial influences

Studies have yet to suggest that there is a typical type of family that makes the emergence of AN more likely (Palmer, 1990; Rastam & Gillberg, 1991). Nevertheless, research has shown that the families of sufferers can be dysfunctional in presentation (Steiger et al., 1995) although the extent to which such levels of dysfunctionality makes adolescents more vulnerable to the illness has yet to be explored. In a study conducted by Minuchin and colleagues (1978), families of adolescents with AN were described as rigid and entangled with an over-protective attitude towards their children. It was also suggested that the children were often involved in conflicts between the parents with little if any attempts at resolving such conflicts. Another suggestion was proposed by Stierlin & Weber (1987) who reported that an adolescent's quest for independence and autonomy is at conflict with the desire to maintain attention from his or her parents. The resulting conflict is expressed as diet restriction which forces the parents to give the adolescent attention and at the same time, the adolescent achieves autonomy through the control of their body weight and shape. Beyond the significance of family dynamics and pattern of interactions, there are other risk factors associated with the families of adolescents with AN. For example, there is a higher likelihood of weight and eating

problems in the family lineage, history of affective disorders, alcoholism as well as obsessive-compulsive disorders (Lilenfeld et al., 1998; Stein et al., 1999).

1.5.2   Biological influences

Research suggests that there are key biological changes that happen during and after the process of self starvation (Pirke & Platte, 1995). Normal body mechanisms that regulate the behaviour of eating become altered and a new set of biological rules are established. Although such understanding sheds light on how AN may be maintained biologically, it fails to illuminate how biology influences its aetiology. Nevertheless, it has been suggested that EDs are a result of an imbalance in the level of neurotransmitters of which serotonin is most notable (Carr, 2015). This therefore implies that EDs are a form of mood disorder that can be treated via the application of medication such as anti-depressants (Wilson et al., 2002). Family genetics have also been suggested to play a role in the development of AN. In their study, Holland et al. (1988) reported that an identical twin was more likely to develop AN if his or her twin had AN. However, there was less chance of AN developing in non-identical twin pairs given the same scenario. Although genetic predisposition seems significant in the development of AN, other literature suggests that it is a combination of environmental factors that influence the risk of such psychological difficulties (Fairburn et al., 1999). Studies also suggest that symptoms of depression and anxiety appear more frequently in the household of individuals who have AN than in the families of individuals who do not have AN (Lilenfeld et al., 1998; Rastam & Gillberg, 1991).

1.5.3   Sociocultural influences

There seems to be a prevailing rhetoric in western societies that emphasises the importance of weight and shape as a determinant of attractiveness. Such attitudes seem to have contributed to the increased risk of AN developing in young people within such

societies. The value placed on physical attractiveness consequently has an impact on adolescents who therefore strive for self-control in the attainment of the perceived demands of society. This strive for self-control is in itself a key feature of AN (Fairburn et al., 1999). The media also plays a role in perpetuating information about weight loss and weight ideals which only serve to increase negative attitudes towards weight gain (Shisslak et al., 1998). The glamorisation of dieting in the media has further contributed to the development of AN in young people (Huon & Strong, 1998). Adolescents who engage in activities such as ballet or modelling have been suggested to be more at risk of developing the illness (Smolak et al., 2000). It is however uncertain if such activities lead to an increased chance of a young person developing AN or whether young people with a predisposition for the illness are more likely to engage in such activities in the first place.

1.5.4   Individual influences & the issue of control

Other theories regarding the causes of AN have suggested that its psychopathology may be a result of an internal struggle for control between psychological and biological experiences (Crisp, 1995). This school of thought portrays an individualistic model in which the illness is a result of a self-deficit generated internally. Research has yet to highlight how this self-deficit reduces during the recovery process from AN. Similarly, psychodynamic theories have also attempted to explain the issue of control in AN. Such theories suggest that its aetiology lies in early developmental failures which leads to a strive for control (expressed as AN) later in adolescence (Surgenor et al., 2002). The issue of control appears to be a common theme in the literature concerning the causes of AN. Feminist theories also highlight this issue of control by suggesting that AN is borne out of the struggle faced by women to meet the prescribed gender standards of society that focuses on their appearance (Surgenor et al., 2002). Clearly, this issue of control is

pertinent to the topic of AN however research has yet to explore the experience of adolescents in recovery as to how they manage this issue without the restriction of their dietary intake.

It is beyond the sphere of this review to report all the available research on the causes of EDs. Since the focus of this review concerns the recovery process from AN after inpatient treatment, the sections to follow aims to provide the relevant background information to illuminate the topic area.

1.6   Treating Anorexia Nervosa

This section will discuss the main ways of treating AN as well as highlighting the studies that have looked at the views of sufferers in regards to their treatment. Managing an illness such as AN can be very challenging, lengthy as well as being physically and psychologically exhausting for both sufferers and their caregivers. Research shows that sufferers often do not engage well with therapeutic intervention (Strober et al., 1997). However, detecting AN early and initiating treatment can improve the outcome and limit the risk of a more serious condition developing later in life (Robin et al., 1998). There are several ways of treating AN however the main psychotherapeutic methods being used with young people appear to be family therapy, individual therapy and behaviour therapy (Lock et al., 2001; Fairburn et al., 2003). Furthermore, treatment often includes dietetic advice, appropriate exercise under supervision as well as psycho-education for sufferers and their families (Garner, 1997). AN treatment in the last few years seem to be transitioning from inpatient to outpatient services with greater importance being placed on family therapy (Robin et al., 1994; Eisler et al., 2000) This change in approach may be due to the increase in public awareness of the illness which has led to earlier presentations to treatment centres (Lock et al., 2001). In addition, the National Institute for Clinical Excellence (NICE, 2004)

have also suggested that outpatient treatment services should be used more than inpatient treatment services.

1.6.1 Inpatient treatment

Despite the move towards outpatient services, inpatient services remain important to AN treatment for adolescents. The necessary use of inpatient care can be attributed to the life threatening nature of AN. Inpatient treatment allows sufferers to be well looked after ensuring that they eat regularly and receive appropriate therapeutic and medical intervention. It may also help sufferers to realise the seriousness of their illness and perhaps make them more motivated to recover (Guarda et al., 2007).

Due to the limited research into the topic area, it has been difficult to determine the best type of treatment service for AN (Meads et al., 2001). Furthermore, clinicians have yet to agree on whether the outpatient approach is better than the inpatient approach. It has been argued that the reason for the lack of consensus regarding the best method of treatment is due to the problems associated with research into AN which includes; variable presentation of illness factors, comorbidity, the small sample sizes used in research and the lack of consideration for participant demographics when assessing treatment outcome (Bulik et al., 2007).

Further insight could be gained from studies that use randomised control trials to compare the outcome in both inpatient and outpatient treatments. Despite the treatment approach adopted, the initial goal of AN treatment is to restore weight and establish a regular eating pattern. The literature on treatment outcomes seem to lack agreement on a recommended healthy weight criteria however most clinicians suggest that a target of 10% of recommended body weight would be appropriate (Steinhausen, 2002).

Nevertheless, it is generally agreed that an individual who is severely emaciated may need an admission to hospital to help manage the life threatening symptoms. Such admissions may occur with or without the individual's consent (Russell, 2001). Research suggests that individuals admitted under compulsion may achieve poorer outcomes in regards to treatment compared with those who are admitted with their consent (Appelbaum & Rumpf, 1998; Ramsay et al., 1999; Russell, 2001). However, this may simply be a reflection of the severity of the illness. Other studies have shown that there is a correlation between the seriousness of an illness and final outcome (Ramsay et al., 1999).

In their study, Gowers et al. (2000) argued that individuals in inpatient treatment still achieve poorer treatment outcomes when compared to their counterparts in outpatient treatment. Studies also indicate that a high number of patients who are discharged from inpatient treatment often relapse (Vandereycken, 2003). The reasons for this have yet to be fully explored within the literature. Furthermore, keeping sufferers of AN in inpatient treatment can add to their already present feelings of low self-worth (Gowers, 2000). Even though preserving the life of sufferers is important, it is also important to acknowledge that forcing sufferers into receiving treatment can be very stressful and also affect their motivation towards change (Guarda et al., 2007). In their study, Guarda and colleagues also suggested that individuals who voluntarily seek admission for treatment of AN may be doing so under coercion from friends, family or clinicians. The report showed that nearly half of the ED patients in their study who had initially denied needing inpatient treatment, changed their minds and supported their admission after two weeks of treatment. Another report has suggested that there is an increase in patient motivation towards treatment when patients accept and normalise the recovery process (Guarda, 2008). Research has shown that in such cases, the outcome of the treatment is

similar to those obtained in voluntary treatment cases (Newton et al., 1993; Watson et al., 2000).

Group therapy is also often used in inpatient treatment as it is considered to be helpful in challenging false beliefs, accepting the reality of the illness, providing positive examples and encouraging changes in behaviour, however, the extent to which it is effective has yet to be properly assessed (Guarda & Heinberg, 2003). Using medication to treat AN is also common however, the research data concerning their use has been largely disappointing (Attia & Schroeder, 2005). Future research should endeavour to gather qualitative data from sufferers of AN as to their experience of medication and whether they found it useful.

Therapy is often used as a means of increasing patient motivation and influencing their behaviour towards change (Feld et al., 2001). The patient's readiness to change has also been shown to predict the outcome of short term treatment (Geller, 2002). Research has yet to shed light on how long this readiness to change lasts for, particularly after the patient is no longer receiving inpatient treatment and is assumed to be in the later stage of their recovery. The complex nature of recovery will be discussed further later in this review.

1.6.1.1 Family therapy

Family therapy has been promoted as the treatment of choice in patients with AN (Minuchin et al., 1975; Wilson & Fairburn, 1998; Carr, 2000). The National Institute of Clinical Excellence also seems to support this view (NICE, 2004). The Maudsley's group evidence based, manualised programme for AN in young people describes three main stages of family treatment: engagement and re-feeding; negotiating a new pattern of family relationships; and addressing adolescents issues and therapy termination

(Lock et al., 2001). Although some authors have cautioned against using family therapy alone for a complex illness such as AN (Hall & Crisp, 1987; Vandereycken, 2003). Further critics of the use of family therapy have suggested that the research into such its effectiveness have used randomised control trials which fail to provide a comparison between family based interventions and other approaches to therapy (Gowers et al., 2007). In their study, Krautter & Lock (2004) reported that young people with AN perceived family based interventions to be unhelpful on its own unless when incorporated with individual therapy. Similarly, Paulson-Karlsson et al. (2006) suggested that individual focused sessions should be incorporated into family based therapy.

1.6.1.2   CBT-E

'Enhanced' Cognitive Behaviour Therapy (CBT-E) has been evidenced to be a very effective treatment for eating disorders (Fairburn et al., 2003; Cooper & Fairburn, 2011). Developed from standard cognitive behaviour therapy (CBT), it is specifically tailored to address the cognitive and behavioural processes that can be found at the root of most eating disorder difficulties. The cognitive behavioural therapeutic approach suggests that negative core beliefs and maladaptive thought processes lies at the foundation of most mental health difficulties. Cognitive behaviour therapy (CBT) therefore aims to help people recognize and challenge their unhelpful core beliefs and distorted thought processes in order to maximise coping efforts whilst reducing the experience of distress (Beck, 1991). Other studies seem to suggest that altering the thought process of individuals with AN is crucial to the prevention of relapse (Tierney, 2008).

1.7   Adolescent views of inpatient treatment

Adolescents are more likely to feel coerced when it comes to receiving treatment and they are also more willing to accept they needed treatment after two weeks of admission (Guarda et al., 2007). Previous research has also highlighted the views of adolescents with AN in regards to the treatment they have received. Such studies suggest that anorexic individuals prefer a treatment that is more holistic in approach with a consideration for their social and psychological needs, as opposed to just focusing on weight gain and other physical symptoms (Colton & Pistrang, 2004). Offord et al. (2006) explored the retrospective views of young people concerning their inpatient treatment of AN. The participants were all female with an age range of 16 to 23 years. Their results highlighted the importance of peer relationships, being treated as an individual, feeling powerless in regards to treatment and recovery, and the struggle of being an inpatient anorexic receiving treatment. Such findings shed valuable light on the advantages and disadvantages of AN treatment. However, the findings do not report on the subjective experiences of the adolescents in recovery after undergoing inpatient treatment. The transition from having regular eating routines and regular scheduled activities to having more autonomy over what they did with their time and what they ate has not been explored by the literature.

A review of the qualitative and quantitative literature examining young people's views towards their treatment of AN was conducted by Westwood & Kendall (2012). Eleven studies were included in their review and three main themes were identified. This included: the perception of AN as a way of taking control as well as it being a controller; the tension that existed between the sufferer's preferences for therapeutic intervention and treatments that focused on the physical symptoms of the illness; the importance of a therapeutic alliance in dealing with the sufferer's difficulties.

Therapeutic alliance is an important issue in treatment interventions for AN sufferers and yet, previous research suggests that it can be difficult to create such effective working relationships in specialised mental health settings (Thurston, 2003). The wide literature on EDs also seem to support this view, as the egosyntonic nature of AN does not allow sufferers to acknowledge the extent of their illness or realise that they may need clinical intervention (Westwood & Kendall, 2012). Such difficulty encountered in developing a therapeutic relationship can often lead to negative attitudes from nursing and care staff who may be of the view that sufferers of AN choose to remain the way they are and are simply seeking attention (Cameron, 1996; Ramjan, 2004; Tierney, 2008). Such attitudes may be further compounded when sufferers deny treatment efforts and at times, seek to disrupt it altogether (Fathallah, 2006). However, a more recent study by Woodrow et al. (2011) suggests that most care staff have a good understanding of the illness and are likely to be more sympathetic towards the behaviour of patients without necessarily developing negative attitudes.

Another important aspect of inpatient treatment is that AN sufferers will meet others like themselves and interact with one another. This peer interaction has been suggested to influence the development of therapeutic alliances between sufferers of AN and their therapeutic staff (Westwood & Kendall, 2012). Peers have been suggested to provide support and a sense of identity however, at the same time allowing for negative behaviours to be learnt and encouraging a competitive attitude among sufferers (Colton & Pistrang 2004). Tierney (2008) showed that sufferers of AN would often disclose to one another with the belief that they can only be understood by those going through a similar situation. This points out the significance and necessity of an empathic relationship between sufferers and their care staff. Ma (2008) suggests that a trusting therapeutic relationship can develop if care staff is able to communicate a desire to

understand their clients. Such views highlight the importance of empathy and support in developing positive perceptions of the treatment experience (Bell, 2003).

Research has also shown that therapeutic alliance may be influenced by the competency and perceived knowledge of staff members (Westwood & Kendall, 2012). Report suggests that anorexic patients found it unhelpful if care staff were perceived to be inexperienced because it did not make them feel safe (Tierney, 2008). There seems to be an intrapsychic contradiction between the sufferer's desire to lose weight and be free from control, and the desire for staff members who are more experienced and are more difficult to deceive (Westwood & Kendall, 2012). This highlights the fluctuations and ambivalence witnessed in anorexic patients in regards to their views on treatment. Research has yet to show how this ambivalence changes when sufferers get discharged and continue their recovery process without the strict control of inpatient treatment.

RECOVERY AND ANOREXIA NERVOSA

1.8   Recovery approaches in mental health

Recovery as a concept has been commonly discussed in the field of physical illness and disability (Wright, 1983; Bonney & Stickley, 2008) however within the field of mental health, it has historically received less attention in both research and practice (Spaniol, 1991). The field of psychiatry has historically focused on measuring the positive and negative symptoms of mental health as a way to determine recovery (Jacob, 2015). Models used in psychiatry tended to view recovery in mental health as similar to that seen in physical illness (Bonney & Stickley, 2008). The use of terminology such as 'relapse', 'remission' and 'recurrence' based on symptoms profiles over time further contribute to this view (Frank et al., 1991). This way of conceptualising recovery is often referred to as 'clinical recovery' and is solely based on the measurement of symptom profiles, global assessments of functioning, health outcomes and health service utilisation (Roberts & Wolfson, 2004; Slade, 2009). However, recovery in mental health is much more complex and involves more than recovery from the illness itself. People with mental illness often have to recover from the stigma associated with the illness as well as from the negative side effects of unemployment and a lack of limited opportunities for self-determination (Anthony, 1991).

More recently however, the meaning of the word 'recovery' has evolved in regards to what it means for people with mental illness (Andresen et al., 2003). It is now more commonly used to refer to the lived experience of individuals who are coming to terms with, and overcoming the challenges associated with having a mental illness (Shepherd et al., 2008). This is often also referred to as personal recovery. Anthony (1993) defined personal recovery as 'a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles...a way of living a satisfying, hopeful and

contributing life even with the limitations caused by illness'. Furthermore, it was also defined as a process of developing new meaning and purpose as an individual grows beyond the impact of the mental illness (Anthony, 1993). This definition argues against just treating or managing symptoms alone but taking into account what recovery means to each individual struggling with a mental illness.

It has been suggested that recovery principles should emphasis hope and a strong belief that it is possible for people with mental illness to regain a meaningful life, despite persistent symptoms (Jacob, 2015). Recovery is now often referred to as a process that provides a holistic view of people with mental illness, with an emphasis on the person and not just their symptoms (Ramon et al., 2007). It is also argued that such a recovery is possible and that it a journey rather than a destination (Bonney & Stickley, 2008). Recovery can therefore be a voyage of finding oneself and individual growth; experiences of mental illness can provide opportunities for reflection, change and the discovery of new skills, interests and values (Davidson, 2005).

1.9   Definitions of recovery in Anorexia Nervosa

This section aims to discuss what recovery is in relation to AN as well as the literature on the perspective of sufferers about recovery. The current research literature suggests a lack of agreement among researchers in regards to the definition of recovery in AN, with studies employing different criteria to investigate the subject matter (Couturier & Lock, 2006). Studies on treatment and outcome often describe the lack of AN symptoms as a sign of recovery. These symptoms are often those prescribed by the DSM-V (American Psychiatric Association, 2013). However, such criteria only takes into account the remission of physiological symptoms and the amount of weight gained but does not highlight the significance of ED cognitions and other psychological

difficulties that may still persist (Lowe et al., 2001). Research has yet to shed light on how young people manage these psychological difficulties during the later stages of their recovery after receiving formal treatment.

Recovery from AN continues to be a complicated subject and yet most of the literature on the topic adopt a medical model approach in defining it and measuring outcome (Dawson et al., 2014). In the medical model, recovery is viewed as an objective cure in which all symptoms are absent and there is a return to a standard level of functioning (Roberts & Wolfson, 2004). The medical model has also influenced the type of language used to describe EDs. For example, the majority of studies that were reviewed for this study tend to describe AN as an illness. This, ofcourse has implications for treatment and also recovery. It is possible that individuals who view their mental health challenges as an illness are more likely to seek an objective cure and so may struggle with the concept of recovery as a process. Whilst describing AN as an illness is consistent with the DSM-V's description of the phenomenon, it has been argued that using such language can be unhelpful for some people (British Psychological Society, 2000). Although, it must also be acknowledged that using terminology such as 'illness' to describe people with mental health challenges has been seen as an efficient diagnostic marker (Pennebaker et al., 2003). The constructionist paradigm argues that language is the base for all psychological phenomena since it makes reflexive thinking possible and thus, renders bodily experiences comprehensible to individuals (Neimeyer, 2002). The participants in this study often used the term 'ill' and 'illness' to describe their psychological state during their periods of distress during and after treatment. I have therefore endeavoured to reflect their experiences and use of language throughout this report in how I describe the subject matter.

In their study, Strober et al. (1997) defined partial recovery in AN based on the criteria proposed by Morgan & Russell (1975). It was proposed that a good outcome in the process of recovery for anorexic patients equates to having gained at least 85% of the average recommended weight in addition to having regular periods (Strober et al., 1997). However if this cannot be achieved due to inconsistency in maintaining the target weight or irregular menstruation, then this is said to be an average outcome. In cases where there is no occurrence of menstruation and very little weight gain, this is classed as a poor outcome (Strober et al., 1997). The criteria for good outcome needs to be sustained for a minimum of eight consecutive weeks in order for it to be valid (Strober et al., 1997). Individuals with zero AN symptoms maintained over a period of eight weeks are said to be in full recovery (Strober et al., 1997). According to Strober and his colleagues (1997), the criterion demanded that there had to be a complete cessation of weight loss, a change of attitude towards weight gain and shape, as well as the absence of compensatory behaviours. Pike (1998) suggested that this definition of recovery may be a reasonable point at which to begin defining recovery. However, it has been argued that such a definition might not account for a relapse in the future (Bardone-Cone et al., 2010). Also, it can be very difficult to determine if all aspects of the criteria has been met. For example, a change of attitude towards weight gain and shape might not occur till much later during the recovery process however research has yet to shed light on the experience of suffers in regards to this.

Taking into account the limitations of such stringent approaches to defining recovery, some studies have explored recovery from AN using qualitative methodologies that highlight the patient's experience of their recovery process (Dawson et al., 2014). Such studies have reported themes associated with recovery such as the importance of family, acceptance of one's self, motivation towards change, relationships

that are supportive, a determined attitude, being understood and the discovery of one's self (Federici & Kaplan, 2008). In contrast to the medical model, this approach is client driven and it portrays recovery as part of an individual journey, a result of empowerment leading to an improved quality of life (Anthony, 1993). This suggests that using a qualitative methodology to explore the complex process of recovery from AN may be the best approach for future research. Despite the qualitative research available on the subject of recovery, it is still uncertain as to what constitutes full recovery and thus, it is difficult to predict which individuals will make full recoveries and which individuals may struggle with the illness throughout their lifetime (Strober, 2004). It has been suggested that a more comprehensive approach that incorporates the importance of psychological symptoms as well as behavioural and physical symptoms, should be adopted when defining recovery, however, this approach has been rarely adopted in the academic literature (Bardone-Cone et al., 2010).

1.9.1   Recovery and the anorexic identity

Research has shown that any attempt to increase the food intake of AN sufferers with the aim of increasing their body weight could be perceived as an attack on their sense of self (Rieger et al., 2001). This has led to the suggestion that recovery may be viewed as a threat to the identity of the AN sufferer, which has been developed around their illness (Halse et al., 2005). Report has shown that AN patients with nasogastric tubes view it as a crucial part of their identity (Halse et al., 2005). Such evidence suggests an inherent uncertainty regarding the treatment of AN in which sufferers are prone to resist treatment efforts, inevitably resulting in poor treatment outcomes. It has thus been suggested that treatment efforts should aim to work with sufferers ideas of AN as opposed to working against them (Westwood & Kendal, 2012). Research has also shown that acceptability is a crucial aspect of successful treatments (Mays et al.,

2005). When AN patients are given control over their eating, this can aid and improve acceptability (Offord et al., 2006). It is argued that if sufferers are not given control, this may disrupt the recovery process as a result of negative feelings of resentment and punishment that may arise (Offord et al., 2006). The experience of such negative feelings have yet to be documented in the academic literature.

1.9.2   Patient perspectives on recovery

Qualitative studies that have explored the perspectives of patients who have recovered do not often provide clear definitions of recovery or provide a formal assessment of recovery (Nilsson & Hagglof, 2006; Patching & Lawler, 2009). In such studies, it is more common for participants to define themselves as recovered (Jenkins & Ogden, 2012). The problem with these self descriptions of recovery is that they might be biased and so may be unreliable. Other studies have also made use of patients with AN at different stages of their recovery process (e.g., Darcy et al., 2010; Garrett, 1997; Hardin, 2003; Jenkins & Ogden, 2012), however, the methodology used in these studies can prove problematic in regards to the extent to which the outcome of the studies can be trusted. It has been suggested that including participants who are not completely recovered is questionable, as their perception is likely to be influenced by the status of their illness (Keski-Rahkonen & Tozzi, 2005). Furthermore, it has been suggested that individuals with an ED often lack an insight into the fundamental cognitive features of their illness (Michel, 2002). Taking this into account may be important in future research.

Research has also shown that many individuals who have AN often go on to develop a prolonged course of the disorder, with a decreased chance of recovery the longer the duration of the illness (Strober, 2004). Dawson et al. (2014) investigated the recovery process. They used stringent, objective and comprehensive definition of

recovery that incorporated aspects of the medical as well as psychological model of recovery. The participants involved in the study had to have recovered for a minimum of five years and must have had AN for at least a period of seven years. The study was carried out in Australia and eight Australian women between the ages of 31 and 64 years old met the study's criteria for inclusion. The study followed a narrative inquiry design because the authors wanted to explore the participants' experiences over a particular period of time without depicting a fragmented account. Results of their study indicated that the recovery process of chronic AN is lengthy and multidimensional. The findings from their study suggests that recovering fully from chronic AN is possible and it also emphasises the importance of motivation, self-efficacy, hope and support from other people in attaining full recovery (Dawson et al., 2014). However, similar to the available literature on the recovery process from AN, their study did not shed light on the experiences of young people recovering from AN after receiving inpatient treatment.

1.10   Later stages of recovery after treatment

It can be argued that part of the aim of those going through the recovery process is to be able to function well in their communities and day to day life. However, the experience of individuals in the community going through the recovery process after they have been discharged from inpatient treatment, has not been researched. Studies that have utilised participant samples from the community tend to explore the patients' experiences of their treatment (e.g., de la Rie et al., 2006) as opposed to what life is like for them afterwards. Previous studies have also emphasised the importance of community based treatments in aiding the recovery process of psychological difficulties (e.g., Simmonds et al., 2001; Thornicroft et al., 1998) but yet they fail to report on the experience of the individuals involved.

I would like to argue that after the prolonged suffering experienced by individuals with AN, the later stages of their recovery after treatment may be experienced as more rewarding and positive because sufferers would already have had an experience of what it is like to make improvements. However, outcome focused research has shown that despite a reduction in the impact of anorexic symptoms, sufferers may still experience other mental health symptoms (Berkman et al., 2007).

Report suggests that anxiety is a common comorbid symptom associated with AN (Herpertz-Dahlmann et al., 1996). Individuals with AN are also likely to be anxious in social situations and have obsessive compulsive tendencies (Herpertz-Dahlmann et al., 1996). Social phobia affects 20% to 45% of AN sufferers whilst the range for obsessive compulsive symptoms is between 12% and 24% (Herpertz-Dahlmann et al., 1996). It has also been argued that approximately 45% of AN sufferers have depression (Santonastaso et al., 1991). Such studies suggest that comorbid psychopathology may impact the process of recovery during its later stages. However, the impact that these comorbid symptoms has on sufferers during their recovery has yet to be explored and neither has how they manage such symptoms after treatment.

Furthermore, qualitative studies into the experiences of anorexic sufferers has shown that improvement during the recovery process may lead to new difficulties particularly in regards to managing their negative feelings without restricting their dietary intake (Clinton & McKinley, 1986; Noordenbos, 1989; Noordenbos, 1992;). Thus, the assumption that there is a linear relationship between a reduction in anorexic symptoms and better psychological wellbeing may be questioned. Pettersen et al. (2013) explored how individuals with EDs experience the recovery process in its later stages. Their participants were thirteen female patients over the age of eighteen who had been suffering from EDs for a minimum of 3 years, and were in the later stages of their

recovery. Qualitative interviews were used to elicit the participants' account of their experiences. The analysis of their findings resulted in four main categories that included; the realisation of the negative consequence of having lived with an ED, the search for different coping strategies, the search for identity and normality, and the recognition and acceptance of losses (Pettersen et al., 2013). The report by Pettersen and colleagues suggest that those recovering from AN may require expert therapeutic help in accomplishing a functional resolve during the later stages of their recovery after treatment.

1.10.1 Psychosocial adjustment

Psychosocial adjustment may also impact recovery after discharge from formal treatment. The majority of studies have defined psychosocial adjustment as the integration of an illness into the life of the individual which also includes their identity, body image and self concept (Chan et al., 2009). Psychosocial adjustment has also been defined in terms of employment, academic achievement and marriage however, these have not been explored qualitatively (Pike, 1998). To date, the subject matter of psychosocial adjustment remains under-researched with the few studies that have explored it using quantitative methods that allow for large sample sizes (e.g., Striegel-Moore et al., 2003). Given the definition that has been described, difficulties with psychosocial adjustment has been reported to occur in approximately half of anorexic patients after treatment (Ratnasuriya et al., 1991). It has been suggested that although AN sufferers may experience improved relationships with members of their family on their way to recovery, they may still find it difficult to develop romantic relationships with members of the opposite sex (Windauer et al., 1993). This highlights the significance of further study into the general quality of life in the later stages of the recovery process after treatment.

1.11   Relevance to counselling psychology

At the core of counselling psychology is an emphasis on the respect for the individual, subjective experience of the client whilst in the pursuit of ground-breaking phenomenological methods for understanding the human experience (British Psychological Society, 2005). Moreover, counselling psychologists tend to focus primarily on the person as a whole rather than on the individual symptoms being presented. Employing a phenomenological approach that explores the individual needs and experiences of adolescents with AN, will allow counselling psychologists to be better informed as to how best to work with this client group. When young people with AN get discharged from inpatient treatment, most would still receive therapeutic help from counselling psychologists in the community (Herpetz-Dahlmann et al., 2001). Understanding how to establish a strong collaborative relationship with this very distinct client group would be advantageous to the work of counselling psychologists. Improvement in the therapeutic relationship will subsequently result in much better outcomes.

With the ever increasing involvement of counselling psychologists in the treatment of AN, gaining this knowledge will also be crucial in helping to prevent a relapse during the recovery process. Research findings can also inform counselling psychologists and other mental health professionals alike in their practice, as to how best to help young people manage the challenges they may face in the later stages of their recovery after discharge from inpatient treatment. Furthermore, based on the review of the current literature and the gaps identified in regards to the recovery process, this research will improve clinical expertise in the topic area whilst also identifying possibilities for new research.

1.12   **Conclusion & research question**

This review has highlighted a major gap in the literature that has failed to explore the experience of adolescents' recovery from AN after they have undergone inpatient treatment. The current study proposes an exploration of this sort with the question; 'What are the experiences of adolescents during the recovery process from AN after receiving inpatient treatment?'. The utilisation of a qualitative methodology will help to understand the experience of this unique population as well as comprehend a phenomenon that has not been fully explored. As evidenced by the literature reviewed, research into adolescent experiences of AN is fairly limited and so further exploration into this topic area will also contribute to the wider literature.

The literature suggests that a high number of AN sufferers relapse after discharge from inpatient treatment (Vandereycken, 2003). Having a better understanding of the experiences of these individuals will aid counselling psychologists and mental health professionals in their efforts to support these individuals. The importance of psychosocial adjustment after treatment has been highlighted by the literature however there has not been any research that has explored patients experience of this issue. The enquiry being proposed will shed light on this issue from a qualitative stance. Furthermore, the proposed research will shed light on the challenges young people face after they have been discharged from inpatient treatment and how they manage the ED cognitions and other psychological difficulties that may still persist. The specific qualitative method to answer the research question including a detailed breakdown of the recruitment strategy and data analysis procedure will be described in detail in the section to follow.

2   METHODOLOGY

The reason for my choice of methodology will be explained in the section to follow. In addition, I will describe how my participants were recruited, how my data was collected and analysed, and how I have endeavoured to maintain a reliable and ethical research process throughout this study.

2.1   Qualitative or quantitative?

Before deciding on the research paradigm to follow, it was important to consider what each had to offer, particular in relation to the research question under investigation. Quantitative research follows a paradigm that is rooted in positivism. This follows the view that scientific research is determined by empiricism; a suggestion that there is an absolute truth that can be found. This is an ontological position that proposes an objective form of reality irrespective of human subjectivity. Furthermore, the epistemology of this paradigm dictates that the researcher and object being researched are independent of one another. The idea is that neither of these entities will influence each other during the process of investigation (Guba & Lincoln, 1994). The primary objective of this being to observe and provide analysis on the relationship between variables (Denzin & Lincoln, 1994). There is often an emphasis on rigid structured protocols as well as large sample sizes.

On the other hand, the qualitative approach to research is rooted in both constructivism and interpretivism (Altheide & Johnson, 1994; Guba & Lincoln, 1994). From an ontological perspective, this suggests that there can be more than one truth depending on who is constructing the reality (Berger & Luckmann, 1966). It has been argued that one cannot access reality without the engagement of the mind since we have no other means of affirming what is true (Smith, 1983). Within the context of research, this

concept suggests that the researcher and the topic under investigation are connected through the process of mutual interaction between them (Guba & Lincoln, 1994). The reality that is created exists as a result of the research process and therefore becomes non-existent upon the cessation of the focus initially placed on it (Smith, 1983). Understanding process is a significant aspect of qualitative research. Unlike the quantitative approach, participant samples are not required to be large in number. Small participant samples are often used to generate important qualitative data that may not be accessible through quantitative methods.

The majority of research into the process of recovery have been conducted largely from the view point of quantitative outcome studies which have predominantly focused on recovery probability and chances of relapse (Dawson et al., 2014). Nevertheless, using qualitative methodologies to explore patient experiences of AN has increased. Despite the increase in such studies, the number of qualitative studies available still pales in comparison to the vast amount of quantitative studies. Taking this into account as well as considering how best the research question can be addressed, a qualitative methodology will be adopted. Using qualitative methods to explore new phenomena has been commonly used in the past (Lincoln & Guba, 1985). Beckstead and Morrow (2004) noted that the use of a qualitative research method will allow for a clearer picture of the complexity and meaningfulness of human behaviour and experience by allowing more openness to findings and accessing a more holistic description of participants' realities.

2.2   Interpretative phenomenological analysis

Interpretative phenomenological analysis (IPA; Smith, 1996) is the qualitative method that was used to analyse the data acquired from the participants. IPA is focused on the exploration of the lived experience of individuals and therefore has its roots in phenomenology.

The philosophy behind phenomenology means that it allows for a thorough exploration of people's perception of a phenomena and the appraisal they give to such phenomena (Finlay & Ballinger, 2006). According to Husserl who was the initiator of the phenomenological movement, phenomenology concerns the careful examination of human experiences (Kockelmans, 1994). IPA therefore, has a focus on how people experience the world within their specific cultural, historical and social contexts (Willig, 2001). The use of IPA allows the researcher to establish connections of the most dominant themes across and within participants' accounts (Smith et al., 1999). Such an approach is an idiographic one in that it allows the researcher to talk about particular individuals under investigation as well as the group as a whole, thus allowing for a different way of establishing generalisations (Smith et al., 2009). Furthermore, the use of IPA allows for the unexpected to emerge which is believed to be a central feature of IPA (Smith et al., 1999).

Before deciding on IPA, other qualitative methods were considered. Discourse Analysis (DA) was considered however, as it pays more attention to the use of language in the construction of social realities and its scepticism about the accessibility of cognitions (Smith et al., 1997), it was deemed inappropriate for the proposed study. On the other hand, the process of IPA allows for an engagement with the participants' data that highlights the meaning in their thought process (Smith et al., 2009). Grounded Theory was also considered however, as this draws on convergences within a bigger

population in order to support broader explanations of concepts, it may be considered to be more sociological in approach (Willig, 2001). In contrast, IPA lends itself more to a psychological framework in its concern for providing more information on the experiences of the individuals being explored and gives less significance to large populations (Smith et al., 2009).

2.3   Participants

IPA emphasises an idiographic approach which means that it focuses more on the richness of participant data as opposed to gathering as much data as possible (Smith et al., 2009). Therefore, using a small population size is considered appropriate (Smith & Osborn, 2003). Based on this, I decided to have a sample size of four participants. The sample was selected on purpose as opposed to being an opportunity sample. Participant homogeneity is considered to be important when using IPA since the method of exploration focuses on specific individuals and the experiences they have in common (Smith et al., 2009).

2.3.1   Inclusion and exclusion criteria

- It was a requirement for the participants to have been diagnosed with AN, received formal treatment and been subsequently discharged.

- Participants had to be adolescents aged between 12 and 19 years old. As previously mentioned, there is no definitive age range for adolescence however it is assumed that it lies between childhood and adulthood; which will vary based on society and culture (Garbarino, 1985). Some studies have suggested that this age group begins at the age of 10 and extends to the age of 23 (UNICEF, 2011; Bezance & Holiday, 2013), however, the majority of research into adolescent eating disorders have focused on participants between the ages

of 11 and 18 years. With all these considered, the age range of 12 to 19 years seemed reasonable.

- All participants were also required to be able to speak and understand the English language. This is to ensure that the meaning behind the participant's stories is not lost in translation. Nevertheless, there was no reason to exclude anyone from the research process since everyone who agreed to take part in the study were native speakers of English.

- Participants who were contacted had been discharged from inpatient treatment for at least six months. The rationale behind this was that they would have had sufficient time to experience life after inpatient treatment.

- Individuals who met eligibility criteria but due to their age could not consent to participating in the study, will not be allowed to take part. This was not an issue during the recruitment process since all those who volunteered to take part were able to provide consent. Furthermore, informed consent was obtained from the parents or guardians of participants under the age of 18.

2.4 Recruitment

The participant sample was recruited from the community via a private hospital in the UK. This hospital is not run by the NHS and so there was no need to go through NHS channels for recruitment purposes. This hospital provides a specialist eating disorder service that includes inpatient treatment and care for adolescents suffering from severe eating disorders. Patients are referred to the service from all over the UK resulting in a fairly diverse patient population. When patients meet their required weight targets and are able to eat without much support, they are subsequently discharged from the service. It is these patients who have been discharged into the community that were contacted and asked to participate in the study.

As of the time of the recruitment process, I was working as an assistant psychologist at this hospital. This gave me an advantage in that I was familiar with the staff, patients and setting. Having already obtained ethical clearance from my university, I was able to seek approval for my research at the hospital. My research proposal was sent to the hospital management team, clinical team, research lead and medical director. I was also able to discuss my research in person with the medical director and members of the clinical team in order to further clarify my intentions.

Response was not swift however my research was eventually approved. The next stage of the recruitment process involved accessing the database of discharged patients who had been diagnosed with AN and sending them letters which included the information sheet and consent forms about my research. I was conscious of not making potential participants feel obliged to take part in the study and so it was stressed in my correspondence with them that their participation was entirely voluntary and they could decided not to take part without giving a reason. My familiarity to the service also meant that some participants may have felt more comfortable responding to a research participation request from a familiar member of staff as opposed to a random stranger.

Response to my research invites was slow. This might have been due to several factors. It is possible that some of the ex-patients had relapsed and were on admission elsewhere. It is also possible that the address to which the information sheets and consent forms were sent could be wrong as these are not updated after patient discharge. Furthermore, some ex-patients might have had a negative experience of treatment and might not be willing to participate in research associated with the hospital. I was also contacted by ex-patients who expressed that they would have taken part however, they were struggling with other difficulties and might be triggered by the interview process.

Nevertheless, an opportunity to contact more participants came to be. The hospital organises a yearly fete where ex-patients are invited to come and have fun as well as raise money for charity. Since the clinical team were already aware of my research, I gave them copies of the research information sheet and asked that they give it to those who meet the criteria for the study. This proved to be very effective as potential participants were able to discuss the research in person with members of the clinical team of which they were familiar. I was careful not to contact participants directly in order not to influence their decisions or make them feel obliged to participate in order to please me.

2.4.1   Why utilise four participants?

Despite the fact that a total of thirty letters were sent out to potential participants during the recruitment stage, only six people responded and agreed to take part in the study. Of the six people who responded, two of them dropped out. As I had initially intended on recruiting six participants, I considered approaching another Eating Disorder Service in order to have access to their discharge patient database however, given the time restrictions of the doctoral programme, the length of time it would take to re-apply for ethical approval at the new service and at the university as well as the length of time it might take participants to respond, I decided not to pursue that option. Furthermore, working with such time restrictions for recruitment purposes would have left me with less time to properly analyse the data. I was therefore left with four participants and so decided (with my supervisor) to continue with the research process without trying to recruit anymore participants given the low response rate.

There seems to be a general trend towards the utilisation of smaller sample sizes in research (Smith, 2004; Smith et al., 2009; Reid et al., 2005). IPA is particularly concerned with the lived experiences of people and can therefore benefit from greater

focus being given to a fewer number of participants (Smith et al., 2009). It has also been suggested that for most student projects, a sample size of three participants is more than sufficient (Smith et al., 2009). It has been argued that qualitative research advances knowledge through its use of detailed and small scale studies (Touroni & Coyle, 2002). It has also been suggested that such studies provide a deeper and more specific knowledge that may not be available in larger scale studies (Turner et al., 2002). Therefore, this suggests that having many participants will not determine the quality and authenticity of the research but rather it is the quality of the content provided by the participants that is more important. The principles and philosophy of IPA are better adhered to with a small sample size than with a large sample size.

However despite this, there are some limitations to having only four participants. For example, the four participants who agreed to take part in the study were participants who were (by their own assessment) already doing well on their journey of recovery. As previously mentioned, there were some ex-patients who got in touch with me to say that they could not take part because they were struggling with other difficulties following their discharge from inpatient treatment. It is therefore possible that if these participants had taken part in this study, it might have affected the final results. It is possible that they may provide a more negative account of life after their discharge from inpatient treatment which might result in a different interpretation of the data and subsequently, different themes.

Furthermore, the accounts of the four adolescents who agreed to take part in the study may not be representative of all adolescents who have experienced inpatient treatment for AN particularly in other hospital settings and other parts of the world. It is possible that utilising more participants who had experienced other hospital settings as well as those who live in other parts of the world might yield different results about the

experiences of this population following discharge from inpatient treatment. The four participants who took part in this study were all based in the UK and so their experience of life after discharge from inpatient treatment would also be a reflection of the society and culture in which they live. The experiences of adolescents from a different society and culture might therefore have offered more insight into the lived experiences of adolescents with AN following their discharge from inpatient treatment.

2.4.2   The Sample

The participants were four women aged between 17 and 19 years old. The ethnic origin of the participants was varied but all were English speakers and all lived in the UK. Table 1 below describes the participants' characteristics. Please note that all names referred to in this study are pseudonyms.

Table 1

Participant characteristics

Participant Pseudonym	Age	Onset of the Disorder	Length of inpatient admission	Length of time since discharge from impatient admission
Paris	16 years old	June 2013	7 months	9 months
Albany	17 years old	May 2012	6 months	1 year 9 months
Milan	15 years old	September 2013	1 year 3 months	1 year 3 months
India	17 years old	August 2007	3 months	6 months

2.5   Data collection

The qualitative data for this study was obtained through semi-structured interviews. This is the most commonly used approach to gather data for IPA studies. This method of interviewing is flexible and takes into account the context in which the interview is taking place making it seem like a natural discussion (Smith & Eatough, 2006). It is also easier to manage semi-structured interviews due to the natural rapport that develops throughout the interview process, primarily because participants value the opportunity to talk freely and be listened to (Reid et al., 2005).

An interview schedule (see Appendix 8) was used to help guide the interview. It allowed for the setting of a loose agenda, the anticipation of potentially sensitive issues and the framing of questions in suitably open forms. I was also able to give participants a copy of the interview schedule an hour before the interview began. This was to help put them at ease in preparation for the interview process and also to give them an opportunity to highlight any questions that may be particularly distressing for them to answer.

The interviews were in part led by the concerns of the participants and I followed up on the matters that arose even if they were not on the interview schedule. This idea has been supported by Smith et al. (2009) who suggest that participants being interviewed know more about the topic being explored and therefore, they should have more control on how the interview goes. I made sure to use open ended questions during the interviews and participants were encouraged to talk for as long as they want with minimal verbal input from me. I was particularly conscious of not making any assumptions about the participants' experiences when phrasing particular questions so as to not lead them towards particular answers. It has been suggested that an interview

schedule should contain between six to ten open questions along with possible prompts (Smith et al., 2009). My interview schedule originally contained eight questions and included several prompts in relation to those questions however after my first interview, I included an extra question and more prompts. This highlights the dynamic and flexible process of IPA as a methodology and how it focuses on the experience of participants to emerge.

The interviews all took place on the hospital premises as it was a comfortable, familiar and safe setting for the participants. The interviews were audio recorded and subsequently stored securely. At the end of the interviews, a debrief was provided for the participants which gave them a chance to ask questions if they had any.

2.6   Data synthesis, analysis and interpretation

IPA requires a verbatim and semantic record of the interview which means the production of a detailed transcript. The transcript was read many times before a free text analysis took place (Smith et al., 1999). This involved making unfocused notes that reflected my initial observations and thoughts. The margin on the left hand side of the transcript contained these notes including; questions, associations, comments on language use, summary statements and descriptive labels. The right hand margin of the transcript contained the themes that characterized each section of the participant's account. The next stage of the analytical process involved making a list of all the themes before grouping themes that shared similar meanings and references. I then clustered themes that were related under appropriate super-ordinate conceptual headings. The sub-themes and super-ordinate themes were those I felt reflected the most notable meanings in the participant's account. However, themes that were not well represented within the transcript were excluded. Throughout the analytical process, I kept going back to the transcript to make sure that the themes remained representative of the

narrative. This organised structure was used to aid and establish the concluding written analysis.

Even though IPA aims to explore participants' experiences from their perspective (Smith & Osborn, 2003), it however recognises that such an exploration must necessarily involve the researcher's world view as well as the nature of the interaction between the participant and the researcher (Smith et al., 1999). IPA recognises that interpretations will depend on how well the participants describe their ideas and experiences (Baillie et al., 2000). As a consequence, the phenomenological analysis that I have produced is also based on my interpretation of the participant's experiences. In acknowledgement of this, IPA demands reflexivity from me as the researcher since my views have inevitably illuminated the analysis (Willig, 2001).

2.7   Ethical considerations

It was clearly stipulated in the participant information sheets that parental consent will be sought if they were under 18 years of age. For participants who are over the age of 18, parental consent was not needed. Before commencing the interviews, I offered the parents of those under the age of 18 an opportunity to meet with me if they had any concerns or wished to gain a better understanding of what my study was about. Furthermore, on meeting with the participants, I ensured that they fully understood what their participation involved and then the consent form was given to them to read and sign (please refer to Appendix 4 for a copy of the consent form). A photocopy of the signed consent form was also made so that the participants had their own copy. I informed the participants that they could withdraw their participation from the study up to three weeks after taking part in the interview. They were also made aware that they would not need to give any reason if indeed they wished to withdrew their participation.

2.7.1   Confidentiality issues

The issue of confidentiality was also discussed in detail with the participants. I informed them that I will include quotes from the interview transcript in my final thesis write up however, such quotes could not be traced back to them in any way. This means that all places and names mentioned will not be included in the final report. I also informed the participants that my project supervisor will also be able to see the anonymised transcripts. I made sure to explain that the only case in which confidentiality might be broken is if I thought that they may be in danger or risk of getting harmed. I explained that if I thought any of them was at risk, I will inform appropriate services. Fortunately, there was no need for such action throughout the interview process.

2.7.2   Distress Protocol

It was possible that some participants may experience distress as a result of taking part in the study. To address this issue, I made sure that the participants were fully aware of what their participation involved. During the interview process, I informed the participants that they can take time out at any given moment and if they did not want to answer any of the questions, they would not be forced to. My experience working with this unique population coupled with my counselling psychology training meant that I was able to carry out the interview in a very sensitive manner. I debriefed the participants at the end of the interviews and also checked how they felt about being interviewed and if they had any concerns. I also provided the participants with a debrief sheet which included the details of organisations they could contact for support if they needed it (please see Appendix 7 for a copy of the debrief sheet).

2.8   Validity and reliability

Validity and reliability are important aspects of all research, particularly within the context of qualitative research where there is a greater degree of human subjectivity involved when compared to quantitative research. Validity refers to the truthfulness and accuracy of findings (LeCompte & Goetz, 1982) whilst reliability refers to the consistency and repeatability of the results (LoBiondo-Wood & Haber, 2014). Due to the interpretative nature of qualitative research, applying the quantitative concept of validity can prove problematic (Banister et al., 1994). The concept of 'validity' within a quantitative research context often corresponds to how things appear in the world however within a qualitative context, it is used to describe interpretation or description that has been concluded and agreed upon (Smith & Heshusius, 1986). It has been argued that the validity of qualitative research should be assessed in terms of how applicable the themes are to similar situations (Holt & Slade, 2003). Furthermore, it has been suggested that the term 'dependability' should be used instead of reliability for qualitative research (Lincoln & Guba, 1985; Koch, 2006). Most IPA studies do not seek to achieve a representative sample in terms of either population or probability. Rather, conclusions drawn are specific to the particular group under investigation therefore generalisations are approached with caution (Flowers et al., 1997). It is also argued that the idiographic approach employed by a methodology such as IPA enables the observation of patterns across case studies whilst still acknowledging the particularities of the individual lives from which those patterns have emerged (Smith, 1999).

Smith et al. (2009) suggest that the four broad principles proposed by Yardley (2000) for assessing the dependability and validity in research are more than sufficient.

Therefore, this study drew on the work of Yardley (2000) in order to meet the goals and ideals of qualitative research.

2.8.1 Sensitivity to context

The first of these principles is sensitivity to context. This refers to the sensitivity shown to socio-cultural factors, the participant's data, as well as the awareness given to existing literature (Smith et al., 2009). I have made every effort to abide by these principles throughout the research process. For example, during the recruitment process, a conscious decision was made not to call participants directly over the phone but to send them letters instead. This was to reduce the chances of them feeling like they had to take part and ensure that their participation was entirely voluntary. In addition, I made sure that during the interview process, I tried to show empathy in regards to the participants experiences by allowing them to describe their feelings and thoughts whilst acknowledging them. I have also demonstrated sensitivity to context by engaging in reflexivity throughout the process. I have considered my motivations for conducting the research, acknowledging the individual characteristics of my participants and considered the manner in which I gathered my data. I have also attempted to demonstrate sensitivity to the data through conducting and describing an in-depth analysis and supporting my arguments with verbatim extracts. I have also endeavoured to refer to appropriate, relevant and up-to-date research concerning the topic area in my introduction. I have also referred to such research in the discussion of my findings.

2.8.2 Commitment and Rigour

The second principle described by Yardley (2000) is commitment and rigour. Firstly, commitment refers to the seriousness and attentiveness given to the participant data as

well as the level of engagement with the topic under investigation as a whole. I have endeavoured to achieve this by taking care over the analysis and making sure that the process is not rushed. An example of my analysis can be seen in Appendix 9 as evidence of my attentiveness to detail concerning the participant's accounts. Smith et al. (2009) also suggest that commitment can be demonstrated through the development of skills needed to conduct an IPA research. I have strived to meet this requirement by attending lectures and workshops on this method as part of my doctoral training.

Rigour refers to the thoroughness of the study in terms of the appropriateness of the sample chosen and the process of analysis. I have endeavoured to achieve this by discussing my study with peers and my supervisor. Reviewing with peers has been suggested to stimulate consideration and exploration of additional perspectives at various stages of data collection and analysis (Hammersley, 1992; Robson, 1993). Furthermore, I have presented my research to peers and other academics as a means to test the rigorousness of my study. At each stage of my study, my supervisor who is an IPA specialist, helped to provide constructive criticism on the process. Holloway & Wheeler (1996) suggest that supervisors play a key role in ensuring rigour in the study of research students.

2.8.3   *Transparency and Coherence*

According to Smith et al. (2009), transparency refers to how clearly the process of research has been described in the write up. I have tried to achieve this by giving a detailed outline of my recruitment and interview process. I have also aimed to enhance the transparency of my analysis by including an audit trail in my appendices. Coherence refers to the level of consistency between the underlying theoretical

assumptions of the approach being utilised and the actual research that was carried out (Smith et al., 2009). I have attempted to meet this criteria in my discussion section. Furthermore as suggested by Yardley (2000), I have endeavoured to maintain a reflexive journal throughout my research process. A summary of this can be seen in my reflective statement below.

2.8.4   Impact and Importance

The final principle suggested by Yardley (2000) is that a piece of research should inform the reader about something interesting and useful. I have attempted to meet this requirement by including a consideration of the clinical relevance of this study in the Discussion section.

3   ANALYSIS

3.1   Overview

This chapter outlines the results from the interpretative phenomenological analysis of four adolescents during the recovery process from anorexia nervosa after receiving inpatient treatment. Four super-ordinate themes emerged from the data; self & recovery, relational, the world against me: back in the world and psychological recovery vs. physical recovery (Table 2). This also included eleven sub-ordinate themes; cognitive change, acknowledgement of illness, becoming more confident, acceptance of self (clustered into Self & Recovery), parents, friendships, therapy (clustered into Relational), school as a stressor, conflicting emotions (clustered into The world against me: Back in the world), managing weight gain, recovery is trusting oneself (clustered into Psychological recovery vs. Physical recovery).

This chapter aims to explore the super-ordinate themes and sub-themes. Verbatim extracts will be used to illustrate each theme in order to aid understanding and maintain sensitivity to the context (Smith et al, 2009). It is recognised that the themes were selected for their relevance to the research question and to counselling psychology and may not reflect all nuance of experiences.

Table 2

Super-ordinate Themes and Sub-themes

Super-ordinate theme	Sub-theme	Key quotes
Self & Recovery	Cognitive change	Kind of realising that everything I had thought before wasn't really how it was. I was kind of stuck in a weird mindset but after the treatment it's like I saw things differently and think differently. (Paris, 256 - 258)
	Acknowledgement of illness	It'd only being like five or six months since I'd become quite unwell so it was a change in environment...several months earlier I would have considered myself quite normal so it was just such a quick change. It was like being in hospital helped me realise that I was actually ill and really needed help. (Milan, 99 - 103)
	Becoming more confident	Because you kind of get a little more confident about things, being around different people and I just feel like no matter what happens in my life now I can handle it. (Paris, 75 - 77)
	Acceptance of self	...like before I was just convincing myself everything was okay and down underneath that, I wasn't okay and I didn't try and convince myself I was happy anymore at the end so I was just showing the truth. This is who I am and I just needed to accept that. (India, 436 - 439)
Relational	Parents	My parents would erm sit with me and tell me that "I would have to do this, it not my choice to eat, I need to keep going, I don't want to end up having to go back to hospital, my family needs me" you know that sort of thing and erm like errm their support was like amazing. (Albany, 356 - 360)

Table 2 (Continued)

Super-ordinate theme	Sub-theme	Key quotes
	Friendships	...but I found it difficult hearing people talk about food or things like that. And then once I was in a dance theory class, and I got really upset and my friend took me out of the class and sat down with me and made me feel better...she just kind of comforted me and like said like everything she was saying was normal. (Paris, 205 - 210)
	Therapy	I got another therapist in CAMHS and she was really helpful... it was quite nice so I could talk about the new challenges I was facing back home... (Milan, 203 - 206)
The world against me: Back in the world	School as a stressor	And then going back to school was impossible like in my first French lesson my teacher asked me where I've been in front of the whole class and I was there like 'I've been poorly' errmm yeah so that was kind of bad. (India, 452 - 455)
	Conflicting emotions	...so I was extremely excited to be discharged but I was also very nervous and had a lot of thoughts creeping in and it was kind of immediately or the minute you're discharged...(Albany, 223 - 225)

Table 2 (Continued)

Super-ordinate theme	Sub-theme	Key quotes
Psychological recovery Vs. Physical recovery	Managing weight gain	Okay so on the whole the weight gain was extremely hard to deal with as you literally feel yourself like doubling every meal and it was really difficult to go through even when you are at a healthy weight you can see when you look in the mirror you are changing in size even though in reality you're not...(Albany, 387 - 392)
	Recovery is trusting oneself	I didn't have much faith in myself.. it was probably, I sort of expected that they were expecting me to kick off or struggle, I guess them saying that I can class myself as sort of recovered... kind of made me think I can do this but yeah it kind of took them to say that to me for me to believe it. (Milan, 144 - 148)

3.2   Self & Recovery

This super-ordinate theme aims to capture the participant's experience of change within themselves during their process of recovery. It was clear from the participant's account that the process of recovery following discharge from inpatient treatment involved a change in the way that they perceived themselves and their difficulties. They all expressed noticing a difference in themselves during and after discharge from inpatient treatment when compared with how they perceived and felt about themselves before their admission to hospital. Their accounts all seemed to acknowledge that the resulting change was a positive one that has benefited their lives.

3.2.1 Change in cognition

It was clear throughout the data that the participants experienced a change in their cognition as a result of being admitted to hospital for inpatient treatment. For example, Paris states:

> *Ermm well I supposed it kinda changes you as a person, you think*
>
> *differently about things.. (Paris, 72 - 73)*

Here, Paris seems to highlight that there has been a change in who she is as a result of her experience. Her description seems to imply that her perception of the world has changed. The use of the word 'change' is in itself significant because it suggests that there has been a transformation in regards to her sense of self that was so obvious to her that she had to acknowledge it.

Paris further emphasised her experience of a changed self later in the interview. She states:

> *Kind of realising that everything I had thought before wasn't really*
>
> *how it was. I was kind of stuck in a weird mindset but after the*
>
> *treatment it's like I saw things differently and think differently.*
>
> *(Paris, 256 - 258)*

Here, Paris seems to imply that the reality she experienced before inpatient treatment was a false one which at the time was not apparent to her. Her description seems to paint a more vivid picture of her experience. She uses the word 'stuck' which seems to imply a state of fixation that she was unable to free herself from. It also seems to suggest that she might have felt trapped and unable to progress in her recovery. Such language implies that help was needed in order to become free from that state of

stuckness. There was also a vivid description of her mental state in her use of the word 'weird'. This language often used to describe experiences that are uncanny or even supernatural in nature seems to indicate the level of abnormality of Paris' mental state.

Similarly, Albany's account also describes a change in her thinking. She states:

> *Okay at the time I was not very grateful for the treatment because I was completely against it, but with time, and looking back at it now, I am very grateful for it and errm I can see that I received really good treatment and I wouldn't be where I am in my recovery now if it weren't for my hospital admission so it really did save my life and really put me on the road to a proper recovery. (Albany, 49 - 54)*

Her account seems to convey a retrospective sense of gratitude about the treatment she received. This gratitude she describes suggests a deep appreciation for the help she received during her treatment. She also seems to suggest that time played a significant part in the resulting change that she experienced. It is implied that during treatment, she could not see the benefit of going through such an experience. However after discharge from inpatient treatment, she was able to see the benefit of the treatment which in turn led to her feeling grateful for it. Albany tries to convey the level of gratefulness she now feels by stating that the treatment saved her life. This description implies that the treatment was powerful and perhaps even heroic. She also seems to imply a change of direction to her life trajectory as a result of the treatment. Her use of the word 'road' seems to indicate that she is on a journey. Using this word also seems to suggest that she was on a different journey before her admission but now she is on a more helpful journey, hence her gratitude.

India's account further echoes the change in thinking experienced by Paris and Albany. She states:

> *Like I was just, well I was like delusional when I... I guess that that has changed...like I was delusional I thought everything was amazing like before I came and got the shock but like I was just miserable (India, 430 - 432)*

Her use of the word 'delusional' seems to imply that she held idiosyncratic beliefs that were contradicted by reality or rational argument. It seems to suggest a state of mind that could not be reasoned with. She also seems to imply that her state of mind prior to treatment not only affected her perception of the world but also how she felt within herself. She appears to indicate that she was in a deep state of sadness that she was not aware of as a consequence of her distorted state of mind. Her use of the word 'shock' seems to suggest a sudden and unexpected transition to her state of mind which subsequently led to a change and acknowledgment of her true affective state after treatment.

3.2.2   Acknowledgement of illness

There was much evidence throughout the data of the participants acknowledging their illness as a result of undergoing inpatient treatment. For example, Milan states:

> *It'd only being like five or six months since I'd become quite unwell so it was a change in environment...several months earlier I would have considered myself quite normal so it was just such a quick change. It was like being in hospital helped me realise that I was actually ill and really needed help. (Milan, 99 - 103)*

Here, Milan's account seems to highlight the impact of being admitted to hospital. It appears as though the change in environment she experienced influenced her to re-evaluate her sense of normality. It is suggested that she considered her ill state prior to admission to be the norm, therefore also implying that she did not consider it to be a problem. However, it seems as though she experienced a different type of normality during admission that made her to question her own understanding of a typical healthy state of being. It is also implied that this process led to an acknowledgement of her own ill state. Subsequently, it seems that her acknowledgement of her ill state also led to an acknowledgment that she needed treatment to help her achieve a healthier state of being.

Similarly, Albany also describes the process of acknowledging her illness. She states:

> *Errrrmm yeah, at the time I was very immersed in my disorder and I*
>
> *was very unaware of a life outside of anorexia and it was consuming*
>
> *my entire life and I didn't think ...I thought this was going to be my*
>
> *life really . It took me a while to realise that I had an illness and that*
>
> *my life didn't have to be that way. (Albany, 6 - 10)*

Here, Albany highlights a distinction between a pre-treatment and post-treatment experience. She uses the word 'immerse' to suggest that the illness was like a liquid that she was unable to get out of. Her account seems to convey an image of desperation and hopelessness in regards to her experience of life with anorexia nervosa. In her use of the word 'consumed', she seems to highlight a state in which she had been completely taken over by the illness. This seems to suggest that she was not able to think about a life outside of her illness. Furthermore, her account also seems to imply that she was unable to acknowledge her illness as a problem because she could not see anything other than her illness and so could not differentiate between her ill state and an alternative state of

being. Her use of the word 'time' in her description suggests that the acknowledgement of her illness was not instant but rather a change that occurred gradually.

Paris' account highlights how she acknowledged that there were some behaviours that she was engaged in that were actually part of her illness. She states:

> *Like all the habits were kind of for a reason, so when you realise what the reason is, you're like oh why should I do that then? There comes a point when you just realise that those habits are part of the illness and that wasn't something I wanted. (Paris, 182 - 185)*

Her use of the word habit seems to suggest that the behaviours she was engaged in prior to treatment had become regular practice and were therefore difficult to give up. This also suggests that there was a time when she thought that these behaviours were not problematic and she engaged in them long enough for them to become a habit. Her account seems to highlight a moment of change that led to a decision to cease her unhelpful behaviours. She also seems to imply a greater autonomy in being able to make the decision to change and stop her unhelpful habits.

3.2.3   *Becoming more confident*

Throughout the data, there was much evidence of the participants becoming more confident after their inpatient treatment experience. For example, Paris states:

> *Because you kind of get a little more confident about things, being around different people and I just feel like no matter what happens in my life now I can handle it. (Paris, 75 - 77)*

Here, Paris seems to highlight an increase in confidence as a result of being around different people during her inpatient admission. It is implied that her various

interactions with both peers and staff during her inpatient admission helped her to develop a more assertive and assured sense of self. Her account also seems to suggest that she feels more self assured in facing any life stressor that she may come across. Her description also seems to infer that she is more able to rely on her own resources rather than those of others.

Similarly, Milan also describes becoming a more confident version of herself as a result of her inpatient treatment. She states:

> *It's definitely worth it cause I always used to say I wanted to be how*
> *I was but like I'm sort of a new version of myself and it's a better*
> *more sort of confident version. (Milan, 293 - 295)*

Milan highlights her inpatient treatment experience as worthwhile even though she recognises that there was a time that she did not want to change and would have preferred to maintain her anorexic identity. Her use of the word 'new' in this account suggests that the change in self she has experienced is a positive and more improved version of who she used to be. Furthermore, it is thus implied that the confidence she feels is evidence for this new version of herself.

Albany's account also highlights an increase in confidence particularly when she compares herself post discharge to how she felt before her admission. She states:

> *I'm definitely a lot more confident, quite a few people have said this*
> *to me ermm, I'm much more confident than when I was restricting*
> *because I just lost so much of myself during restriction and err I'm*
> *more myself than I have been in quite a few years which is always a*
> *really nice experience... (Albany, 526 - 529)*

Albany's account draws attention to external evidence in the form of people's comments as evidence for the change in her confidence level. Her reference to this external evidence implies that the confidence she feels is not just a personal subjective experience but one that has been objectively observed by others. This also implies that her confidence has resulted in a change in outward behaviour that was distinctly different to how she used to be before her inpatient treatment. Her account also highlights a loss of self that occurred as a consequence of her diet restriction. There is a suggestion that since she no longer restricts her diet, she has gained herself back. Furthermore, she seems to be implying that the process of gaining herself back is synonymous with the process of gaining back her confidence.

3.2.4 Acceptance of self

Much evidence of the participants' acceptance of self after receiving inpatient treatment pervaded the data throughout. For example, India states:

> *...like before I was just convincing myself everything was okay and down underneath that, I wasn't okay and I didn't try and convince myself I was happy anymore at the end so I was just showing the truth. This is who I am and I just needed to accept that. (India, 436 - 439)*

India's account seems to highlight a state of denial before her admission to hospital. There is a suggestion that although she was aware that she was not well, she was reluctant to accept this truth. Her use of the word 'convince' suggests that she actively tried to persuade herself to believe that she was happy when this not true. Her description of acceptance in this account seems to convey her willingness to tolerate the difficult reality of her ill state which it seems, she had been denying for so long.

Similarly, Albany's account highlights how she has come to accept some of her difficulties as a part of who she is. She states:

> *I still have my fear foods and I'm still scared of food in some sense but I'm comfortable with a lot more foods now than I was 2 years ago. I just think that this illness is a part of me now, I can't really change that. I'm probably not gonna get rid of some of my thoughts but I can't let that stop me from living my life and doing what I need to do. (Albany, 409 - 414)*

Albany's account seems to highlight the fact that there has been an improvement in her attitude towards food when compared with how she used to be. Her account also seems to suggest that by accepting the fact that she is unwell, she is better able to tolerate the difficulty that may come with the recovery process. Furthermore, there seems to be a sense of determination that is being conveyed in regards to maintaining her recovery.

Milan's account appears to describe the recovery process as the acceptance of a struggling self. She states:

> *...everyone is going to struggle..it's just human nature so I think recovery is accepting that that's just going to be the case and learning to work with it and coping in the bad times and not going off the rails and panicking when things are not going your way. (Milan, 174 - 177)*

Milan's account appears to suggest that in order to continue her recovery process, she has had to come to terms with the knowledge that the process may not be an easy one. Her account also seems to highlight a sense of resilience which suggests that her

capacity to recover quickly from difficulties has improved. Similarly to Albany's account, there is a shared sense of determination in being able to overcome future challenges.

3.3 Relational

There was much evidence throughout the data of the participant's experience of key relationships and interactions with significant others and how it was vital to their recovery process. All the participants described the importance of feeling cared for and being assisted along their recovery by family and friends. They all described how the connections they had with people within their social context helped to compensate for the support they no longer received from the hospital after their discharge.

3.3.1 Parents

Throughout the data, there was much evidence of how the participants' parents helped them in various ways after discharge from inpatient treatment. However, of particular focus was the role of parents in helping to maintain structure to their meal plans after discharge. For example, Paris describes how her parents helped her to maintain structure to her meals. She states:

> *I would say my parents. Ermm but that was more with meals and*
>
> *stuff. It wasn't really...like anything else....they kind of set boundaries*
>
> *and things, they like dish out certain portions that I knew were ok.*
>
> *(Paris, 213 - 217)*

Paris highlighted the fact that her parents helped to set boundaries for her. Her use of the word 'boundaries' suggests that there was an imposed limit to what she could do and not do, particularly in regards to her eating behaviour. However, Paris does not seem to suggest that these boundaries were restricting but rather were helpful in helping her

manage her life after being discharged from hospital treatment. She also highlighted the fact that her parents kept a close eye on what she ate because they helped her to portion her food. She further adds that her parents gave her portions that she knew was okay. This suggests that although her parents helped to set the boundaries, these boundaries were boundaries that she was comfortable with and not boundaries that were imposed on her. This also seems to indicate a collaborative working relationship between her and her parents.

Paris further highlights the role of her parents in her recovery. She states:

> *Obviously being here, you do have support but when you're at home you know it's kind of your parents support if that makes sense. Cause obviously here, the support is from the staff and it's always different people so you're not always familiar with who you're talking to and also with the friends here, you have them for a while but if they leave before you, it's kind like...yea... but the support from home is more permanent. (Paris, 303 - 308)*

Here, she seems to be highlighting the difference between the support she received from hospital staff and the support she receives at home from her parents. She seems to be suggesting that the stability of parental support received at home is better than the constantly changing support she received whilst on admission in hospital. Furthermore, she seems to be suggesting that the role of parents is not just limited to the support they provide but also includes the stability of ongoing support. Paris seems to be highlighting that unlike her friends and support worker who leave, her parents will not leave and that in itself serves a positive purpose towards her recovery.

Milan also describes how her mum helps her to maintain the structure of her meals. She states:

> *When I first started going back to school I was part time until sort of*
> *September last year so I was part time for quite a few months but*
> *mum used to come in and do snacks with me and lunch with me*
> *eerrm in like a separate room away from my friends which was really*
> *helpful... (Milan, 252 - 255)*

Similarly to Paris, Milan's account illustrates the significant role of her mother in helping her to maintain the structure of her meals upon her return to school. She seems to be implying that going back to school presented a challenge to maintaining her meal plans. However, she seems to suggest that her mum was dedicated to helping her with her recovery hence the reason for her coming to her school to have snack with her. Milan also highlights the fact that her meals would take place in a separate room away from her friends. This also seems to suggest that her friends may not have been particularly helpful with helping her to maintain structure post discharge.

Albany's account also highlights the support she receives from her parents. She states:

> *My parents would erm sit with me and tell me that "I would have to*
> *do this, it not my choice to eat, I need to keep going, I don't want to*
> *end up having to go back to hospital, my family needs me" you know*
> *that sort of thing and erm like errm their support was like amazing.*
> *(Albany, 356 - 360)*

Her account seems to highlight her ambivalence in keeping up with her meal plan after discharge from inpatient treatment. She seems to be suggesting a rather forceful

approach by her parents in supporting her to eat. There appears to be a threat element to the nature of the support. Perhaps quite surprisingly, her verdict on that type of support is that it is 'amazing'. This further suggests that she is happy with the nature of the support and does not wish to change it. Her account supports the account by Paris that also suggests the importance of strict boundaries within the nature of the support.

3.3.2   Friendships

There was much evidence throughout the data of how friends were important in helping the participants along their journey of recovery. For example, Paris states:

> *...but I found it difficult hearing people talk about food or things like*
>
> *that. And then once I was in a dance theory class, and I got really*
>
> *upset and my friend took me out of the class and sat down with me*
>
> *and made me feel better...she just kind of comforted me and like said*
>
> *like everything she was saying was normal. (Paris, 205 - 210)*

Here, Paris seems to be highlighting how her friend provided support during a difficult moment. It seems that in this situation, her friend provided support by showing that she cares and is concerned about how she was feeling. Her description suggests that her need for support was not so obvious because she was in class with many other people. However, it is suggested that the need for support was noticed by her friend who took appropriate action to soothe her.

Milan also describes how her friends were very helpful in helping her maintain her recovery after discharge. She states:

> *a couple of time I didn't manage very well and it got to the point*
>
> *were I was nearly going to be sent back to general hospital um but I*

sort of began to talk more to my friends and I kind of found my

friends sort of understood a little bit more than I thought they did i

realised I hadn't didn't given them enough credit cause even though

not many of them were coming to visit me when I was there, they had

sort of read up on what was wrong with me which was really really

touching. (Milan, Line 191 - 197)

Here, Milan's account appears to suggest that by simply talking to her friends, she was able to avoid another hospital admission. It is implied that the communication that occurred between her and her friends led to better insight for her. It seems that by her friends showing that they care and that they understood what she was going through, she was able to maintain her recovery and avoid another hospital admission.

Albany also described how her friends provided her with support. She states:

Yeah my friends from home, they were supportive but they didn't

really understand a lot about the disorder so they kind of shut me out

a little bit and so I was a bit on the outside... a bit of an outcast

errrm but my friends from hospital were always really supportive

whenever I needed anyone , they were there for me and they knew

exactly what to say as well so their support was kind of.. it was like

gold coin to me like I could have swapped anything for it, like it was

just amazing. (Albany, Line 367 - 373)

In her account, Albany made a distinction between her friends from home and the friends she made during her hospital admission. She highlighted the fact that her friends from home were supportive however they did not really understand her condition. It is implied that her friends not understanding made her feel like an outcast. This suggests

that she may have felt rejected and unwanted by her friends from home. In a stark contrast, she compares the support from her friends from hospital to a 'gold coin'. This comparison suggests that she places a very high value on the support offered by her friends from hospital. From this account, it seems that the main difference between the two friendship groups is the level of understanding each group has about the illness. It can perhaps be implied that friendship support is helpful when friends really understand.

3.3.3 Therapy

It was clear throughout the data that the participants all found therapy useful and considered it to be important to their recovery. For example, Milan states:

> *I got another therapist in CAMHS and she was really helpful... it was*
>
> *quite nice so I could talk about the new challenges I was facing back*
>
> *home... (Milan, 203 - 206)*

Here, Milan seems to suggest that being able to express her difficulties and experiences verbally is important to her recovery process. Furthermore, there is a suggestion here that the challenges being faced in the community is different to the challenges faced while in hospital receiving treatment.

Milan further illustrates the role of therapy in her recovery. She states:

> *... I was so alone in my thoughts like I could talk about them to my*
>
> *therapist or friends or cousins and stuff it was just not keeping it all*
>
> *to myself in a way otherwise I'd keep thinking and so I could get*
>
> *somebody else perspective to it... it was just nice to just sort of snap*
>
> *me out of what I was thinking. (Milan, Line 217 - 222)*

Here, Milan's use of the word 'alone' conveys an image of isolation and helplessness in regards to her thoughts. However, her description suggests that being able to talk to her therapist about these thoughts that she feels so alone with helped her to feel less alone. She highlights the fact that this stops her from keeping all her thoughts to herself. Keeping her thoughts to herself is therefore suggested to be an unhelpful thing to do. Being able to get an alternative perspective on her thoughts is suggested to be helpful. She also highlights being snapped out of her thoughts. The use of the word 'snap' suggests a sudden break from her usual pattern of unhelpful thoughts, which might be difficult and perhaps even painful, but is ultimately helpful and necessary for her recovery.

Albany's account also describes how therapy was helpful for her recovery. She states:

> *..I feel like talking therapy was a way for me to get my emotions off*
>
> *my chest and kind of vent and it was important for me to have that*
>
> *space, that platform for me to talk about how I was feeling otherwise*
>
> *it would have come out in more negative behaviour such as you know*
>
> *self-harm or other dangerous behaviours and potentially like me*
>
> *holding onto my restrictive behaviours more... (Albany, 89 - 94)*

Albany's description of getting her 'emotions off' her chest suggests the idea that her emotions were weighing her down and causing her distress. Her use of the word 'vent' implies that her emotions are like gas that has become pressurised due to being confined within a small space. This also suggests that keeping her emotions in can therefore be dangerous to her wellbeing if it was not expressed. She further adds that if she did not let out her emotions, it might have been let out in more unhelpful ways. This seems to suggest that her emotions are supposed to be expressed and if she had not done so in a

controlled way through the help of therapy, it might have been expressed in less controlled and more destructive ways.

3.4   The world against me: Back in the world

Throughout the data, there was much evidence from the participants about their experience of being back in the world and the associated challenges that accompanied it, following discharge from inpatient treatment. This super-ordinate theme aims to capture how the participants managed the different stressors they faced upon returning to their communities as well as how they coped with conflicting emotions. There was a sense that the world was not as welcoming and comforting as they expected. This also required a re-adjustment to life following their experience in hospital. The participants had to cope with going back into a world in which they first experienced their illness but now they have to try and navigate this world during their process of recovery.

3.4.1   School as a stressor

Much evidence of the participant's experience of school as a stressor pervaded the data throughout. For example, Albany states:

> *...I was discharged into my final year of school so into the run up to my GCSE's I didn't really have a lot of time to kind of recover from being in hospital...before I knew it I was back full time revising for my GCSE's and that's where things started to take their toll again in me mentally and I started to restrict again and exercise more and my anxiety got worse and I became more rigid...but I managed to pick myself up after that because they were telling me that if I lost any more weight I would end up back in hospital so I turned things*

> *around at home and errm gained the weight back. (Albany, 309 -*
>
> *321)*

Here, Albany highlights how going back to school and studying for her exams affected her mental health. Her account also seems to suggest a suddenness in regards to the transition back to school. She highlights engaging in unhelpful behaviours upon her return back to school. It is implied that these behaviours were a way of coping with the stress of having to do her exams. It is also implied that these behaviours were not present at the point of discharge from inpatient treatment but returned only after she encountered stress in the form of her exams. Her use of the word 'rigid' suggests a stuckness and inflexibility that she experienced in regards to her unhelpful behaviours. There is also a suggestion that she had to make a personal decision to stop her unhelpful behaviours and continue her recovery process. The idea of picking herself back up seems to suggest that she was at a low point that she did not wish to be and this was something that she recognised hence, her choice to pick herself up. She also describes 'turning things around' to further illustrate the conscious decision needed to continue along the path of recovery.

Milan's account also describes her experience of school as a stressor. She states:

> *...it was sort of like people at my school knew what had happened*
>
> *cause one of my friends had told them so there was a bit of stigma*
>
> *and people sort of they didn't act towards me as they did before*
>
> *which was kinda stressful. I was unwell and that made me think what*
>
> *have I done wrong? What's changed about me? (Milan, 164 - 168)*

Milan's account highlights her experience of going back to school and then finding out that the people at her school were aware that she had been receiving inpatient treatment

for anorexia nervosa. Her acknowledgement of people finding out about her inpatient treatment suggests that she would have rather preferred if this information was kept private. She did not have control over who found out about this information and it would seem that this lack of control over who knew this information also contributed to her experience of stress. She highlighted the fact that people at school did not treat her the same way that they treated her before she was admitted to hospital. Her description suggests that she felt different in comparison to her peers at school which further contributed to her stress levels. She also used the word 'stigma' which implies a perceived sense of disgrace and shame that she felt in relation to her treatment when she returned to school. She also appears to question what it was that she had done wrong because she could not understand why she has to be treated differently.

India's account about school as a stressor also echoes the account by Albany and Milan. She states:

> *And then going back to school was impossible like in my first French lesson my teacher asked me where I've been in front of the whole class and I was there like 'I've been poorly' errmm yeah so that was kind of bad. (India, 452 - 455)*

India's use of the word 'impossible' in this account seems to suggest that she found her return to school very hard to cope with. Her account also seems to suggest that she felt different to her peers by being made to say where she had been in front of the whole class. She seems to be highlighting the awkwardness that came with the transition back to school which she seemed to find unpleasant.

India further illustrates her experience of school as a stressor. She states:

...so yeah coming back to school with 1500 people was just hard…

yeah and my school was so pressurising so they were like ' have you

caught up with your work yet' and I was like no I can't really do that

like and it was just too much for me at the time... (India, 478 - 481)

Here, India seems to further highlight the fact that coming back to school and facing so many people was particularly challenging. She uses the word 'pressurising' when describing her experience which suggests that she had a feeling of stressful urgency caused by the necessity to achieve academically, particularly within a limited time frame. Her account also seems to convey a lack of sympathy from her school in regards to her mental health. There seems to be a suggestion that her school were more concerned about her academic performance than her wellbeing which it seems was too much for India to bear.

3.4.2   Conflicting emotions

There was much evidence throughout the data of the participants' experience of emotions after discharge from inpatient treatment. For example, Paris states:

I was really scared and I got really upset cause I was really

nervous...Just like going back to where I was before, being in the

same environment all the time where things got bad, so I was kinda

nervous...I kinda tried not to think about it. I found it hard at first but

I stuck to it and eventually I got used to it again. (Paris, 223 - 227)

Here, Paris highlights feeling scared and anxious at the point of discharge from inpatient treatment. She appears to be conveying a real sense of trepidation about leaving hospital. Her expression of fear and anxiety suggests that there is a threat that she may be anticipating. It is also implied that the threat that she may be perceiving is a

threat to her wellbeing and recovery. Her account suggests that the fear and anxiety she feels is about going back to where her difficulties began. There appears to be a suggestion that she is worried that by going back, her difficulties may therefore return. However, she seems to suggest that by not thinking *'about it'*, she is able to reduce the fear and anxiety she was experiencing.

Similarly, Albany's account also highlights the conflicting emotions she experienced after discharge from inpatient treatment. She states:

> *...so I was extremely excited to be discharged but I was also very nervous and had a lot of thoughts creeping in and it was kind of immediately or the minute you're discharged...(Albany, 223 - 225)*

Here, Albany's account highlights the stark contrast between the emotions she felt at the point of discharge. It is suggested that the thoughts associated with her emotions caught her by surprise. Her use of the word '*creeping*' seems to portray an image of an intruder or an unwanted entity. This suggests that the thoughts she experienced were not very helpful which led to the anxiety she felt despite the excitement she was also feeling.

Milan's account also describes her experience of emotions after discharge from inpatient treatment. She states:

> *...I wanted to be comfortable in myself and happy again and I sort of started to realise I'd never really felt like this angry and this low since before I became unwell and so every time I got angry or sad, I'd sort of blame it on my eating disorder kind of thing and it would in a way kind of spur me on so when I got angry or low, I would be like 'this is your fault' and I would push myself a little further just*

gently kind of thing…yeah. I wanted to get rid of it because I wanted

to be happy again. (Milan, 272 - 278)

Here, Milan also highlights a range of seemingly conflicting emotions. Her account seems to highlight her desire to be happy however in her attempt to achieve happiness, she also seems to be experiencing anger and sadness which in turn seem to motivate her towards maintaining her recovery. It seems as though it was her quest for happiness that led to the realisation that she was also feeling angry and sad. She seems to suggest that the reason for her anger and sadness was due to her eating disorder. Her account seems to humanise her eating disorder through her use of the word 'blame'. This seems to suggest that it is her eating disorder that is at fault in regards to the sadness and anger that she feels. This further implies that she is drawing a distinction between herself and her eating disorder. She seems to further humanise the eating disorder when she states, *'this is your fault'* almost as though to highlight the object to which her anger is being focused. There also seems to be a suggestion that her eating disorder is a physical object that she can *'get rid of'* which in turn seems to convey an image that she is in control and not her eating disorder.

3.5   Psychological recovery Vs. Physical recovery

Much evidence existed throughout the data of the participants experience in managing the psychological and physical aspects of their recovery process after discharge from inpatient treatment. This super-ordinate theme aims to capture the participants' experience of weight gain post discharge and how they managed the associated challenges. In addition, this super-ordinate theme also aims to describe the more intricate psychological process of trusting oneself in relation to maintaining the recovery process post discharge.

3.5.1   Managing weight gain

There was much evidence throughout the data of the participant's struggle with managing weight gain after discharge from inpatient treatment. For example, Albany states:

> *Okay so on the whole the weight gain was extremely hard to deal with as you literally feel yourself like doubling every meal and it was really difficult to go through even when you are at a healthy weight you can see when you look in the mirror you are changing in size even though in reality you're not...(Albany, 387 - 392)*

Here, Albany's account seems to highlight a false perception of her body in relation to weight gain. She seems to suggest that there is a difference between what she perceives to be true and what is actually factual. She also seems to suggest that her perception of her body is grossly exaggerated when compared to what it is in reality. Her account also seems to suggest that this false perception persists even when she is at a 'healthy weight' thus implying that the difficulty with weight gain is not strictly biological but perhaps more psychological in nature.

India's account also highlights the difficulty in maintaining weight gain after discharge from inpatient treatment. She states:

> *...I didn't know what I was going to do either with the whole like food thing.. I didn't think I was ready to gain any weight after my discharge or whether I even wanted recovery or I was just going to give up and yeah I just was like…I had so many decisions to make and yeah .. I just don't think I was ready mentally. (India, 342 - 347)*

India's account here seems to suggest a strong ambivalence towards weight gain after discharge. She seems to be experiencing a state of uncertainty in regards to her willingness to continue eating and putting on weight. Her account also seems to imply that weight gain and recovery is a choice that must be consciously made. Similarly to Albany's account, there is a suggestion that her weight gain is inescapably linked to a psychological state of readiness.

The link between the psychological state of recovery and the physical state of recovery is further emphasised by India when she states:

> *I don't think you can fully recover… I think once you've got it you've just got it for the rest of your life… I think people can get to a point where they can just manage themselves and they can basically eat with an okay mentality and I just don't think full recovery is possible and yeah I just can't imagine full recovery. (India, 394 - 398)*

Here, India appears to be suggesting that the physical aspect of recovery is perhaps less challenging and therefore more achievable than the psychological aspect of recovery. Her description appears to suggest that there is a difference between an *'okay mentality'* and *'full recovery'*. It is thus implied that an *'okay mentality'* is sufficient for weight gain, this weight gain does not however suggest that full recovery has taken place.

Paris' account also seems to support the view described by India. Paris states:

> *I wouldn't say I was in recovery after discharge but obviously physically I had gained the weight and it did get a little bit more difficult cause there was a big change, but I felt like after that, after*

> *like 6 months or so, things gradually got a lot better. (Paris, 260 -*
>
> *263)*

In her account, Paris also seems to highlight the weight gain that had occurred during her inpatient treatment. Similar to India's account, she seems to suggest that the weight gain that had occurred during her inpatient treatment was not synonymous with her definition of recovery. She also seems to indicate that the process of maintaining her weight after discharge was challenging. Her account seems to suggest that the process of weight gain during inpatient treatment is less challenging than the process of managing weight gain in the community.

3.5.2   *Recovery is trusting oneself*

There was much evidence throughout the data of the participants' experience of recovery as a process of trusting oneself. For example, Milan states:

> *I didn't have much faith in myself.. it was probably, I sort of expected*
>
> *that they were expecting me to kick off or struggle, I guess them*
>
> *saying that I can class myself as sort of recovered... kind of made me*
>
> *think I can do this but yeah it kind of took them to say that to me for*
>
> *me to believe it. (Milan, 144 - 148)*

Here, Milan seems to be highlighting the lack of trust she had in herself after she was discharged from inpatient treatment. She also seems to be suggesting that it was the belief of others that helped her to believe in her own recovery. She uses the word '*faith*' in her description which appears to convey a great lack of trust and confidence in her own ability to continue her recovery. Her account also seems to suggest that she is unsure of what recovery is and could not be sure if she had achieved it. It is implied that there was a need for external confirmation from other sources as to whether or not she

was recovered. Furthermore, her account seems to suggest that it was important that she trusted herself to recover because this appeared to act as a form of motivation.

Paris' account also seems to support Milan's experience of trust during the process of recovery. Paris states:

> *Ermm just kind of that I was trusted if that makes sense. They just trusted me to continue making progress. It took me a while before I could trust myself though. (Paris, 268 - 270)*

In her account, Paris also seems to suggest that the process of trusting herself to maintain her recovery was preceded by the trust that others had in her. There also seems to be a suggestion that little evidence was involved in order for her to be trusted. Similar to Milan's account, it is implied that there was a degree of faith needed in order to overcome the uncertainty that seems apparent during the recovery process.

Albany's account also highlights the importance of trusting oneself as part of the recovery process. She states:

> *I feel that the recovery process isn't just about gaining weight it's about learning to live life again and trusting yourself more, trusting that you won't restrict again or harm yourself, trusting your body with food and learning to enjoy food and errm learning to just live and not exist so that for me is recovery. (Albany, 246 - 250)*

Here, Albany seems to be suggesting that the process of trusting oneself also involves a period of learning. There is a suggestion that her illness has made her forget how to live life and so the process of recovery from the illness must also involve a period of reacquiring the knowledge that she has lost. Her account also seems to suggest that the

process of trust involves a collaborative working relationship with her own self. She also seems to convey an image of hope that her life can be better if she is able to develop the trust in herself.

4   DISCUSSION

4.1   Overview

This study aimed to explore the experiences of adolescents during the recovery process from anorexia nervosa after receiving inpatient treatment. Qualitative data from four participants was analyzed using an interpretative phenomenological approach, which resulted in four super-ordinate themes; self & recovery, relational, the world against me: back in the world and psychological recovery vs. physical recovery. Few qualitative studies have examined the experiences of adolescents with AN during the process of recovery particularly after discharge from inpatient treatment. The current study was anticipated to expand on the limited existing knowledge base in this area. This chapter will explore the findings in relation to previously reviewed literature whilst also highlighting any novel aspects which make an original contribution to the knowledge base in this field.

The main research question was:

What are the experiences of adolescents during the recovery process from AN after receiving inpatient treatment?

The following areas were considered in relation to this question:

- How do adolescents with AN experience the recovery process after receiving inpatient treatment?

- What are the challenges faced by adolescents with AN during their recovery process after inpatient treatment?

- What are the experiences of adolescents with AN of their inpatient treatment process?

This chapter will discuss these questions in more detail in relation to the findings. This chapter will also introduce further literature that will be considered in light of the findings. Furthermore, the implications of the findings for clinical practice will be discussed. Finally, this chapter will also examine the limitations of the current research, suggest directions for further research and reflexive considerations will be provided.

4.2 Self & Recovery

4.2.1 Cognitive change

All the participants in this study highlighted a change to their cognition as a result of their inpatient treatment experience. Of interest is how they all seem to describe a change in their perception and attitude towards treatment and equally recovery. Their account seemed to portray a state of distorted cognition before treatment with one of the participants even using the word 'delusional' to describe her experience. Although this state of distorted cognition in relation to AN has not been previously documented in the literature, it appears similar to the experience of individuals with psychosis.

The relationship between psychosis and delusions has been very well established in the literature (Menon et al., 2007). It has been suggested that people who suffer from delusional beliefs often jump to conclusions and have poor belief flexibility (Garety & Freeman, 2013). In other words, they tend to struggle with the metacognitive process of thinking about their own delusional beliefs, changing them in the light of reflection and evidence and considering new alternatives. The participants in this study highlighted a state of stuckness and rigidity in thinking prior to treatment. They acknowledged holding beliefs that were untrue and were contradicted by reality and rational argument.

They also highlighted being unaware of their true affective state because of their distorted state of mind.

Previous research has suggested that neurocognitive deficits can worsen the experience of delusional beliefs (Joyce & Huddy, 2004). Perhaps it could be said that the participants in this study were experiencing deficits to their cognitive functioning prior to treatment which subsequently impacted their perception of the world around them. Previous studies have highlighted the link between cognitive functioning and eating disorder pathology (Green et al., 1995; Lena et al., 2004). It has been suggested that extreme weight loss can severely impact cognitive functioning (Green & Rogers, 1995; Neumarker et al., 2000). It is perhaps therefore unsurprising that the re-feeding program of an inpatient treatment program will lead to a change in cognitive functioning. Although the re-feeding process can be initially difficult and AN sufferers can be resistant to the process, it appears necessary in order for cognitive change to take place.

 Improvement in cognitive functioning as a result of weight gain during treatment has also been supported in literature (e.g., Lauer et al., 1999; Moser et al., 2003). In their study, Moser et al. (2003) conducted an investigation to determine whether neuropsychological dysfunction associated with AN resolves with inpatient treatment. Their results showed that neuropsychological functioning improved across the course of treatment. However, it has also been found that depression negatively affects cognitive functioning in various areas so it can be argued that improvement in cognitive function is not a result of weight gain alone but also because of an improvement in mood (McDermott & Ebmeier, 2009). The relationship between eating disorder behaviour and affect regulation has been very well documented in literature (e.g., Bydlowski et al., 2005; Harrison et al., 2009; Espeset et al., 2012). Nevertheless, the effect of low body

mass index (BMI) on cognitive function over the course of a life time still remains unclear in the literature (Giel et al., 2012; Weider et al., 2015).

4.2.2   Acknowledgement of illness

All the participants in this study highlighted a process of acknowledging their illness as a result of their inpatient treatment experience. Their account suggested that they had been in denial about their illness prior to treatment however the process of being admitted to hospital led to clearer insight into their ill state. As highlighted in my literature review, people with AN very often deny their illness and symptoms (Lasegue, 1997). Although impaired insight is considered in the literature to be a common feature of eating disorders (Fairburn, 2008; Dawson et al., 2014), the process of gaining insight has not been fully explored. However, the concept of insight has been highlighted in the literature on psychosis. Lack of insight is a core feature of schizophrenia, which has been linked to poor treatment compliance (Kemp & David, 1997), severity of psychopathology (Mintz et al. 2003) and poor global functioning (Pyne et al. 2001). This can be said to be similar to the experiences of the participants in this study who described being immersed in their illness prior to admission and were therefore initially reluctant to receive treatment. Although the mechanisms underlying insight impairment are still unclear, good insight has been found to be at least partially dependent on intact neurocognitive functioning in psychosis (Aleman et al. 2006).

As previously mentioned, evidence suggests that neurocognitive functioning can be improved as a result of weight gain (Moser et al., 2003). It can perhaps be reasoned that as the participants in this study experienced an increase in weight as a consequence of re-feeding during treatment, they became more able to process and acknowledge their ill state. The participants in this study highlighted that the acknowledgement of their illness was crucial to their recovery process. This supports previous evidence that

suggests that higher levels of insight in AN were associated with better long-term outcome measures (Greenfeld et al., 1991).

4.2.3   Becoming more confident

It was observed that the participants described becoming more confident after their inpatient treatment experience. Their accounts seemed to highlight a process of developing a more assured sense of self. They also seemed to suggest a changed self that was more confident about facing any subsequent challenges that may come their way. Such improvement in confidence appears to mirror the features of high self-esteem. Self-esteem is a positive global appraisal of one's self-worth that tends to lead to improved confidence in one's own abilities and self-acceptance (Rosenberg, 1965). A large body of research has found that high self-esteem protects against eating disorder pathology whereas low self-esteem is a risk factor for later disturbances in eating and body image (e.g., Fairburn et al., 1999; Gilbert & Meyer, 2005; Granillo et al., 2005).

In their study, Karpowicz et al. (2009) reported that self-esteem significantly improved in line with eating psychopathology. Similarly, Collin et al. (2016) examined multi-dimensional self-esteem and magnitude of change in eating psychopathology among adults participating in a specialist inpatient treatment programme for AN. They also found that self-esteem improved with eating psychopathology and weight over the course of treatment. It was suggested that the improvement in self-esteem may be due to the treatment programme which encompassed skills such as self-awareness, social skills and anxiety management. It is also likely that the participants in this study experienced an improvement in their confidence and overall self-esteem as a result of the treatment programme and environment. The treatment programme at the hospital where the participants received their treatment was cognitive behavioural in orientation. Literature suggests that cognitive behavioural treatment is highly effective for improving low self-

esteem (Fennell, 1997). However, it should be noted that some studies have found conflicting results in regards to self-esteem improving in line with eating disorder psychopathology. Mehl et al. (2012) reported that weight gain after treatment did not lead to improved self-esteem for their participants. The conflict within the literature concerning this issue suggests that it may warrant more exploration.

4.2.4   Acceptance of self

All the participants highlighted self-acceptance as a result of their inpatient treatment. They described coming to terms with their difficulties and accepting that they may continue to struggle with weight and shape however they were determined to not let it affect their recovery process. Previous literature has highlighted self-acceptance has a significant phase of the recovery process from AN (e.g., Redenbach & Lawler, 2003; Keski-Rahkonen & Tozzi, 2005; Federici & Kaplan, 2008; Espindola & Blay, 2009). In their study, Espindola & Blay (2009) suggested that self-acceptance is when patients with AN start to change the dysfunctional view they have of themselves and begin to function in a more integrated manner. The topic of the self has also been gaining traction within the research and clinical literature (e.g., Kinderman et al., 2006). Jones (2004) argues that the self is conceptualized as a mental schema that organizes a specific kind of information: people's beliefs about themselves, their interpretations of past experiences, and expectations about their worth in the future.

Acceptance involves a person's assent to the reality of a situation, recognizing a process or condition without attempting to change or protest it (Keski-Rahkonen & Tozzi, 2005). In their study, Williams et al. (2016) suggested that recovering from AN meant accepting the fear of the unknown and discovering the 'real self' by separating the self from the eating disorder. The participants in this study had to come to terms with the fact that although they may prefer to be thinner or have a different shape, the inability to

conform with this ideal is not a catastrophe nor is it necessary for a happy and fulfilling life. This supports previous literature on acceptance and change that advocates acceptance as a crucial part of psychological treatment for AN (Wilson, 1996). It is perhaps unrealistic to think that sufferers of AN, some of whom loather their bodies will radically start to love their bodies. It has been suggested that sufferers (most of whom are women) may well remain dissatisfied with how they look, after all such discontent is normative for young women in western societies (Rodin et al., 1984). Cash (1995) suggests that the way to resolve the profound dissatisfaction with one's own body often witnessed in AN is to make peace with one's body. This however entails compromise, accepting less than what would be ideal.

4.3   Relational

4.3.1   Parents

The account of the participants in this study highlighted the significant role of parents in providing social support after discharge from inpatient treatment. The importance of social support in the literature on recovery from EDs has been well documented (e.g., Woods, 2004; Cockell et al., 2004; De la Rie et al., 2007). Social support refers to the perception and actuality that one is cared for and has assistance available from other people (Wills, 1991). In a study on coping strategies and recovery, Bloks et al. (2004) found that recovery in ED patients is associated with seeking social support. Furthermore, De La Rie et al. (2007) argued that the quality of ED patients' social relationships is positively correlated with enhanced quality of life. The participants in this study all highlighted the importance of the social support they received from their parents after their discharge from inpatient treatment. Of interest is how the participants described how their parents helped to maintain structure and strict boundaries to their eating routine which they found advantageous to their recovery.

Previous research has highlighted the key role of parents in helping their children take control of their eating (Ma, 2008). Whilst in inpatient treatment, the participants in this study experienced strict rules and boundaries in regards to eating which helped them to gain weight and return to a healthier BMI. It can be reasoned that once discharged from inpatient treatment, these strict rules and boundaries are no longer enforced by the hospital and participants are free to return to unhelpful behaviours. However, it seems that the parents of the participants in this study took on the role of enforcing these rules and boundaries which helped the participants to maintain structure to their eating routine and subsequently continue their recovery. This appears consistent with previous literature that advocates the effectiveness of family based interventions in the treatment of AN (Wilson & Fairburn, 1998; Loeb & le Grange, 2009). Furthermore, it supports the notion that the family is not to be blamed when considering the causes of an individual's ED (Lock et al., 2001). Rather, parents and the family unit can be utilised as resources to create positive changes in the treatment of EDs (Loeb & le Grange, 2009).

4.3.2   Friendships

The role of friendships, during the recovery process after discharge from hospital, was highlighted by the participants in this study. This supports previous literature, which suggests that supportive friendship relationships are important to recovery (Tozzi et al., 2003; Espindola & Blay, 2009). The participants in this study described the importance of feeling cared for and understood by their friends and how this motivated them to continue their recovery. This is also consistent with previous findings that suggests that people will heal faster in an environment where they feel cared for (Duffy, 2013). Furthermore, it is proposed that people who feel cared for are more likely to engage in health promoting activities such as following treatment plans and maintaining healthy life choices (Duffy, 2013).

Davidson et al. (2017) explored behaviours that stimulate the emotion of feeling cared for during hospitalization among a sample of stroke patients. They found that caring touch and warm friendly actions were important to help generate the emotion of feeling cared for. They suggested that deploying care in this way helps patients to gain trust and reassurance thereby emphasising the importance of connecting to ill patients during the recovery process. The participants in this study also emphasised the importance of connectedness particularly in relation to their friendship group from hospital. There was a distinction made between the type of support received from friends with an understanding of AN and friends who did not understand the illness. Their descriptions suggested that the support from friends who have a better understanding of their struggle was more valuable than the support they may have received from friends who knew little about their experience. This supports the study by Offord et al. (2006) which found that adolescents in inpatient treatment described a strong sense of community within their general adolescent unit and stressed the importance of friendships with other patients, partly because they offered a sense of genuine acceptance. Similar to the participants in this study, friendships appear to offer sufferers of AN the opportunity to identify with others and learn positive ways of coping.

4.3.3   Therapy

The participants highlighted therapy as a particularly useful avenue by which they could express their thoughts and emotions. The value of talking about their struggles and experiences was highlighted as being very helpful in helping them to not feel so alone. This supports previous research into AN that suggests that therapy is a helpful tool for recovery (Tozzi et al., 2003). Previous research has also highlighted the importance of therapy in helping to facilitate the expression of emotions (Burum & Goldfried, 2007).

Furthermore, the importance of talking about emotional experiences has been highlighted in previous literature (Rimé, 2007).

Therapy was described by one of the participants in this study has a tool that helped her to 'snap' out of her thoughts. There was a suggestion that therapy helped her to challenge unhelpful thoughts and perhaps develop more helpful thoughts that were more consistent with her recovery. This supports evidence into the effectiveness of therapeutic models such as Cognitive Behavioural Therapy (CBT) that aims to help people recognize and challenge their unhelpful core beliefs and distorted thought processes in order to maximise coping efforts whilst reducing the experience of distress (Beck, 1991). It has been argued that EDs are essentially cognitive disorders as they have as their distinctive core feature an over-evaluation of shape and weight and their control, which results in those with these disorders judging their self-worth largely or exclusively in these terms, such as in the case of AN (Cooper & Shafran, 2008). The account of the participants in this study gives further credence to this claim and emphasises the important role of CBT-E during the treatment and recovery process from AN.

4.4 The world against me: Back in the world

4.4.1 School as a stressor

The participants' account about being back in the world in addition to its associated challenges gave particular attention to their experience of school as a stressor. Whilst stress is a common experience among adolescents (Chandra & Batada, 2006), previous literature has identified school related stress has a unique phenomenon that can negatively affect the psychological well-being of adolescents (Kenny et al., 2002; Kaplan et al., 2005). School related stress can be caused by dysfunctional interactions

with peers and repetitive judgments that can be particularly distressing during adolescence. For adolescents, the school environment is valued as the most significant, and therefore sources of stress within this context may be especially evocative and disruptive (Teicher et al., 2010). This is consistent with the participants' account that highlights the impact of going back to school and trying to catch up with academic work and meet school expectations after discharge from inpatient treatment.

School and performance oriented contexts such as written class exercises or homework has been shown to contribute to stress in adolescents (Lohaus et al., 1997). It has also been shown that children and adolescents often struggle to cope with school stress which in turn contributes to a wide range of health and social problems (Bandel-Hoekstra, et al., 2000). Furthermore, stress has been widely studied in EDs and has been shown to be associated with AN symptomatology (Rojo et al., 2006). It is clear from the account of the participants in this study that returning to school after discharge from inpatient treatment contributed significantly to their levels of stress which in turn was unhelpful to their recovery. Their account suggested that they struggled to cope with the stress initially however it was their personal determination to recover that helped them manage the stress from school. This is consistent with Self-Determination Theory (SDT) (Deci & Ryan, 2000) that suggests that intrinsically driven motivation is crucial for achieving sustainable change in EDs (Vansteenkiste et al., 2005; Halvorsen & Heyerdahl, 2007).

4.4.2 Conflicting emotions

The participants all emphasized their experience of emotions and the conflict they felt in regards to them. For example, they described how they were happy about discharge but at the same time also felt anxious and frightened. In another case, one of the participants experienced anger and sadness in her efforts to try and be happy. This phenomenon has

not been previously highlighted in the literature on EDs. However, the idea of conflicting emotions has been identified in previous literature (e.g., Zautra et al., 1997). Theories on emotions have traditionally viewed positive and negative emotions (e.g., happiness and sadness) as two mutually exclusive ends of a continuum and therefore uncommon as co-occurring experiences (e.g. Russell, 1979; Russell & Carroll, 1999). A more recent body of work has challenged this traditional view, suggesting that simultaneous experience of positive and negative emotions is a normal consequence of intrapsychic conflict (Hong & Lee, 2010; Du et al., 2014). Intrapsychic conflict is a nuclear concept in psychoanalytic theory that describes an emotional clash of opposing impulses within oneself (San Martino & Newman, 1975). The concept of internal conflict has long been suggested to be a root cause of eating disorders in previous literature (Striegel-Moore, 1993; Friedman et al., 1997).

It can perhaps be reasoned that the conflict experienced by the participants in this study may have been present prior to their recovery process. However this has gone largely un-noticed by them since they had used their eating disorder behaviour to manage their emotions. This supports previous evidence that suggests that patients with AN have problems identifying and regulating their emotions (Parling et al., 2010). Furthermore, Schmidt & Treasure (2006) proposed a maintenance model of AN that emphasizes the role of anorexic symptoms in facilitating avoidance of negative affect. They suggest that the exclusive mental focus on food and eating is associated with emotions becoming less salient and the patients describing themselves as emotionally 'numb'. It can therefore be reasoned that as the participants start to eat more regularly and reduce unhelpful behaviours, they were able to notice their emotions more as well as the conflict within themselves.

4.5   Psychological recovery vs. Physical recovery

4.5.1   Managing weight gain

All the participants described their experience of weight gain as difficult after discharge from inpatient treatment, which is consistent with previous research in the topic area (e.g., Colton & Pistrang, 2004; Tierney, 2008). As previously highlighted in my literature review, the loss of body weight is perceived by anorexics as being acceptable and it is in fact a component that they value (Rieger et al., 2001). The account of the participants in this study suggested that weight gain continues to be a challenge even after they have reached their recommended healthy body weight at the time of discharge. Their descriptions suggested that they struggled to come to terms with the physical increase in the size of their body and there was an ongoing fear of continuous uncontrolled weight gain.

Such reasoning when it comes to food intake is seen as catastrophic and it is a common feature of AN and has been supported in previous literature (e.g., American Psychiatric Association, 2013; Pettersen et al., 2013). Previous literature has tried to suggest the reason for the continued fear of weight gain in patients recovering from AN. It has been suggested that the pathological eating habits in AN could in some way be related to the fear of gaining weight (Foerde et al., 2015). A recent study (Kissileff et al., 2016) investigated the expected anxiety related to the maximum tolerated portion size in AN patients and control participants and reported that the expected anxiety response was greater for patients with AN compared to healthy control participants. This supports the findings from this study as the participants in this study also highlighted the anxiety they experienced when thinking about food and eating.

A more recent study by Milos et al. (2017) investigated the subjective estimation of weight gain in patients with AN when being confronted with food cues both in a general (a condition without specific additional instruction) and in an intent-to-eat condition (in which they were instructed to imagine that they would eat the snack themselves). Compared to healthy women, patients with AN estimated a higher weight gain only in the intent-to eat condition but not in the general condition. In the patient group, mean estimations of weight gain were associated with the "drive for thinness". Their study suggested that cognitive abnormalities were related to the effects of food intake on the weight gain in AN, and that these cognitive anomalies could be related to the fear of gaining weight. This appears consistent with the earlier findings of this study that highlights the cognitive difficulties experienced by sufferers. However has previously discussed, the participants in this study experienced cognitive change which literature suggests is linked to an increase in weight gain. It can perhaps be reasoned that the difficulty with weight gain experienced by the participants after discharge from inpatient treatment is fuelled by the anorexic drive for thinness which still persists even after treatment.

4.5.2   Recovery is trusting oneself

The participants all highlighted how recovery involves a process of trusting oneself. Their descriptions appeared to suggest a process of trust that involves a collaborative working relationship with the part of themselves that wants to recover. This concept has yet to be explored in the literature however the relationship between the self and AN has been identified (e.g., Bruch, 1978). As highlighted in my literature review, AN has been considered to play an egosyntonic and functional role because the resultant feelings of control and the thin body agree with the goals of the self (Vitousek et al., 1998). However, the participants description of trusting themselves to recover suggests that the

goal and ideal of the self may have changed perhaps as a consequence of their inpatient treatment experience. Furthermore, it may also be possible that whilst the anorexic self still remains, the self that wants to recover is being given more of a voice.

In their study, Williams & Reid (2012) explored the experiences and meanings of AN from the perspective of those who use pro-recovery websites for EDs. They found that the participants experienced an 'anorexic voice' with both demonic and friendly qualities. Applying dialogical theory (Hermans, 2002), they suggested that the anorexic voice is a self critical position which disagrees with and attempts to dominate the more rational self. It was suggested that in order to move on from AN, the individual needs to address his/her anorexic voice and develop a new dominant position that accepts and values his/her sense of self. It could be said that the participants in this study were able to develop a more dominant sense of self that was more in accordance with their recovery goals. Subsequently, they were able to learn to trust this part of themselves perhaps because through their inpatient admission, the anorexic voice has been seen as unpleasant, critical, and most importantly, harmful to the self.

4.6   Implications for clinical practice and counselling psychology

This section will focus on the implications of this study on clinical practice and contributions to the field of counselling psychology will be emphasised.

It was hoped that this study would contribute to the field of counselling psychology by informing counselling psychologists and other mental health professionals alike in their practice, as to how best to help young people manage the challenges they may face in the later stages of their recovery after discharge from inpatient treatment. As could be seen in the analysis chapter, the accounts of the participants showed that the process of recovery following discharge from inpatient treatment involved a change within

themselves. The changes identified includes cognitive change, acknowledgement of their illness, improvement in confidence and an acceptance of self. These new findings may have practical implications for how counselling psychologists work with adolescents with AN. It may be helpful for therapeutic interventions to include psycho-education on the impact of a re-feeding program on cognitive functioning. Adolescents with AN may benefit from such knowledge particularly because the re-feeding process can be difficult and a better understanding of why they are undergoing such an ordeal may make them less resistant to the treatment process. Furthermore, counselling psychologists can also help adolescents with AN by helping them to accept themselves and coming to terms with the reality of their illness.

However, it must be acknowledged that the most significant finding from this study is the super-ordinate theme 'Relational'. This theme highlights the different roles played by parents, friends, and therapists in maintaining the course of recovery for adolescents with AN following their discharge from inpatient treatment. This is a crucial finding that has not yet been documented in the current academic literature. These three different types of relationships fulfil crucially different functions but altogether, they helped the participants in this study to: maintain their meal plans and healthy eating routines; feel cared for and a genuine sense of acceptance; and to express and manage their distressing thoughts and feelings in the absence of unhelpful eating behaviours. I would like to argue that these three principles are crucial for a successful recovery process following discharge from inpatient treatment. With this in mind, it would therefore be helpful for ED hospitals to plan accordingly with adolescents and their families by putting strategies in place to ensure that these three principles are catered for.

For example, it may be helpful for counselling psychologists to work more collaboratively with parents of adolescents with AN so they can better understand how to provide their children with more support during their recovery process, particularly after discharge from inpatient treatment. This support can include skills workshop that are facilitated by psychologists. Such workshops can provide more psycho-education on AN and in particular, how to help adolescents maintain a healthy eating pattern following discharge from treatment. Furthermore, this can include what to do at meal times to encourage healthy eating behaviours. Examples of this could be; to eat together during meal times; making sure that meal portions are balanced; and offering appropriate verbal encouragement. This idea of helping parents in this way is very much consistent with NICE (2004) guidelines that recommend that services for eating disorders should consider the needs of families.

The participants in this study highlighted how their parents helped to maintain structure and strict boundaries to their eating routine which they found advantageous to their recovery. Literature suggests that caring for a daughter with AN is a complex and demanding role (Honey & Halse, 2005, 2006) and one that can cause parents to experience high levels of stress, distress and burden (Treasure et al., 2001). The few studies to examine the perceptions of parents of children with anorexia suggest that clinicians can have a substantial impact on their experiences and coping abilities. Moreover, parents report that their need for professional support is often not met (de la Rie et al., 2005; Haigh & Treasure, 2003). Parents' specific complaints have included difficulty accessing appropriate services, inadequate post-hospitalization follow up, lack of information and consultation, lack of understanding and compassion, and negative assumptions being made about both children and their parents (Gilbert et al., 2000; Haigh & Treasure, 2003; Highet et al., 2005). However, this study has emphasised the

vital role of parents in the recovery process for adolescents with AN. It is therefore important that counselling psychologists devote particular attention to reassuring parents that they are not blamed, that their current distress and turmoil are to be expected, and that, as primary carers, they are an important resource for their child and his or her recovery.

Nevertheless, it must also be acknowledged that not all adolescents who receive treatment for AN have parents who are together in a caring relationship or are supportive to their child who is unwell. Some adolescents often have to return to dysfunctional family environments which have the potential to exacerbate and maintain their difficulties (LeGrange, 2005). Research also suggests that exposure to high levels of interparental conflict can place young people at an increased risk of developing mental health challenges (Grych & Fincham, 2001; Dunn & Davies, 2001). In such cases, adolescents who have been discharged following inpatient treatment may therefore struggle to maintain their recovery. They may also be more prone to relapse since they would lack the vital support needed to help them maintain their healthy eating patterns. It is therefore important that ED hospitals take this into account when planning discharges for adolescents recovering from AN. It is therefore advisable that in such cases, additional support is provided for adolescents to help them fill the gap that has been left by their absent or unsupportive parent. This support could be in the form of support workers who will meet with adolescents in their homes and help them with meal times.

As previously mentioned, friendships are very important to the recovery process of adolescents with AN. Whilst some adolescents may already have established friendship groups, others may need support in fostering new friendships. ED hospitals can make effort to provide adolescents being discharged with a list of relevant support groups in

their communities. This can be a great way to make new friend and meet with others who have similar mental health challenges. Furthermore, suggestions of community activities and or volunteering opportunities that the particular adolescent may be interested in can be made, as this can also help to foster new relationships. I may also be helpful for hospitals to provide a support worker that regularly meets with adolescents following their discharge in order to help facilitate the transition from hospital back to their communities. This support worker can help to create the feeling of connectedness and a sense of 'being cared for' which the participants in this study highlighted as a significant part of why friendships were so significant.

The significant role of therapy also needs to be discussed with adolescents and their parents. ED hospitals should make plans for adolescents to continue therapy with psychologists following their discharge from treatment. If it is not possible for adolescents to access therapy through the hospital, then links should be made with psychologists within the community who will be able to support and work with adolescents during their process of their recovery.

Furthermore, the findings highlight the difficulty adolescents face when trying to adjust to their social life after discharge from inpatient treatment. Of particular note is how they highlighted school as a stressor. It may therefore be helpful for adolescents to receive more specialised support upon their return to school after discharge from inpatient treatment. It may also be helpful for clinicians to liaise better with schools as to the medical needs of adolescents recovering from AN. Psycho-education on managing AN could also be provided to teachers so that they can be more aware of the challenges faced by adolescents struggling with AN. The participants in this study highlighted how they felt overwhelmed by the workload from school and it seemed that little regard was given to the fact that they were still recovering from an illness. It would

therefore be helpful if schools can monitor the workload of students who have just been discharged from inpatient treatment so that they are not overwhelmed and stressed which in turn can negatively affect their recovery.

4.7   Evaluation of the Current Study and Suggestions for Further Research

The following section will evaluate the current study by considering both strengths and limitations. In light of this discussion, suggestions for future research will be presented.

The findings met the initial aims of the research by using a qualitative approach of IPA, which was appropriate to the research aims. It has provided an in-depth and rigorous exploration of the experiences of adolescents with AN during their recovery process after discharge from inpatient treatment. In line with IPA principles, the research is idiographic in nature and does not intend to make sweeping statements in relation to all adolescents recovering from AN. However, it aims to make sense of individuals' experiences and contribute these to a developing knowledge base (Smith et al., 2009). Whilst other adolescents with AN may have had similar experiences, the results of this study should be considered within the context of the four adolescents interviewed for this research. The small sample size may be deemed by some as a weakness; however, this ensured the level of depth required to make sense of each individual's experience. The homogenous sample of all the adolescents who had been diagnosed with AN and had received inpatient treatment before being discharged offered an advantage when searching for meaning across the sample. However, it must be acknowledged that all the participants were female which is a reflection on the fact that the majority of people diagnosed with AN tend to be female. It is possible that male experiences of recovery following discharge from inpatient treatment for AN may be different and could therefore be an interesting area for further study.

This research attempted to offer transparency throughout to ensure clarity of the process. However, it should be taken into account that the interpretative themes have been derived from the researcher's perspective and others might have found themes which they thought more pertinent. During the interview process the researcher was mindful of avoiding leading questions; however, the interview schedule will inevitably have had an effect on the themes interpreted in the analysis. It should be acknowledged that the participants who took part in this study described themselves as being in recovery and were therefore doing well following their discharge from inpatient treatment. Perhaps they were therefore more motivated to speak about their experiences than other adolescents with AN who were perhaps not doing so well. It is acknowledged that participants' motivation to take part in this research could have a potential impact on the findings of this study and a differently phrased research question would perhaps have attracted different participants. All participants were given the opportunity to offer any further comments they felt relevant at the end of the interviews to enable material to emerge that was not elicited by the interview schedule. Furthermore, the definition of recovery was not objectively measured in this study. This was because the study's aim was interested in the experiences of participants which therefore includes their subjective experience of recovery. This study might have benefited from using an objective measure such as the Eating Disorder Examination Questionnaire [EDEQ] (Fairburn & Beglin, 1994) to assess the participants' level of recovery.

Moreover, taking into consideration the participants' accounts on the impact of school stress on their recovery, future research could investigate the experience of school stress for adolescents during the recovery process from AN. In addition, given the unique accounts of how parents played a vital role during the recovery process particularly in relation to maintaining the structure to meal times, future research could investigate the

effectiveness of parental support on recovery perhaps by comparing a sample of adolescents who did not receive adequate parental support with a sample that received more parental support.

5   REFLEXIVE STATEMENT PART TWO

The first part of the reflexive statement was concerned with my pre-results reflections, whilst, this section will include my reflections on the analysis and findings of this study.

When I first began the research process, I was a first year trainee counselling psychologist with relatively little experience in the field of eating disorders. However, for my second and final year placement, I worked at a specialist adult eating disorders service which significantly added to my knowledge base in the topic area. I simultaneously found the research process useful in my work as it helped me to better understand the individuals who presented to the service for treatment. Although at times, I found it challenging trying to manage the balance between being a researcher and a practitioner at the same time. I found that working as a practitioner often involved working towards specific treatment outcome accompanied by the expectations of both the service users and the service in which I work. However the nature of being a researcher meant working with the unknown and often not being sure of what the outcome will be. I was particularly surprised by how emotional the process of research was and how uncomfortable and anxiety provoking it was to work with such level of uncertainty.

This uncertainty concerns not being sure at times if the results of this study would be considered valid or useful. In addition, it is also about not being sure if my efforts throughout the process of this doctoral training will be rewarded at the end with the qualification that allows me to practice as a counselling psychologist. Furthermore, my anxiety and uncertainty was also about whether or not I could make the transition from being a student researcher to a fully qualified research practitioner. Upon reflection, I wonder if the anxiety and uncertainty I experienced mirrored my participants'

experience of anxiety and uncertainty along their journey of recovery. This mirroring or countertransference (as it is sometimes known in the psychodynamic literature) refers to the unconscious redirection of feelings from one person to another (Goin, 2005). I wonder if the anxiety my participants experienced about whether they could recover or even maintain their recovery after discharge from inpatient treatment is similar to my experience of the anxiety and uncertainties I previously mentioned.

In order to manage this anxiety, I made good use of supervision to both reflect on and help make sense of my anxiety. Although, discussing my uncertainties with my supervisor did not of course remove the anxiety, it however allowed for an avenue by which I could process my thoughts and feelings about the research process. I also discussed some of my anxiety and uncertainties with peers who were also engaged in their own research. I found that by sharing our uncertainties with one another, it helped me to feel like I was not alone on this journey that often does feel like a lonely process. Nevertheless, I feel I have grown through this process of uncertainty and I think as a counselling psychologist, one must learn to be comfortable with the unknown and maintain a state of continuous curiosity in our work with clients.

I acknowledge that my work at the adult eating disorder service in the last two years would have in some way influenced my analysis and subsequently the results of my study. Consequently as a researcher, it was important that I was able to bracket off my own feelings and experiences whilst immersing myself in the participants data. This at times proved a challenge due to my prior experience working with adolescents with AN. However, I used my academic supervision sessions to reflect on these challenges and obtain an alternative perspective which in turn helped me to maintain a clearer focus on my research objectives.

As was hopefully evident in the analysis chapter, the participants indicated school as a stressor and they described how this was unhelpful to their recovery process. They also highlighted feeling conflicted in their emotions especially in relation to their experience of treatment. These themes resonated with me in particular because I have found the process of research and training to be quite stressful which in turn has led to me feeling conflicted in my emotions. There are times when I have felt happy to have had the opportunity to engage with the training and conduct research into an area that is relatively under developed in the field of EDs. Nonetheless, at other times, I have felt sad, anxious and even angry at the intellectual pain that this process has caused. I remember that in initial training interviews, we were warned that training will be stressful however what we were not told was that in order to complete this process of research, training and practice, one must also learn to trust oneself.

The idea of trusting oneself was also described by the participants in this study. The participants spoke about recovery as a journey through the unknown in which there are many challenges and success if at all, is not assured. This appears synonymous with my experience throughout this research process and as I conducted the analysis, I felt better able to connect with the experience of my participants through this theme. I have come to realise that trusting oneself involves a certain amount of faith despite experiencing a constant feeling of anxiety. This anxiety relates to sometimes feeling unsure about the results of my study especially when I consider the subjective nature of conducting qualitative research. At times, I have often tried to seek re-assurance from my supervisors and academic colleagues in an attempt to reduce my anxiety however this has only served to perpetuate my anxiety further. I wondered if this was similar to the experience of individuals with AN who often seek assurance by constantly weighing themselves, body checking and counting calories. These behaviours only perpetuate

their eating difficulties further and would therefore make recovery difficult. The way forward it seems, is not to try to avoid the discomfort of anxiety but to work within it and perhaps even embrace it. In the past, my personal preference has been to avoid anxiety and work within a framework that provided me with more certainty however, this is not in line with the epistemological framework of IPA (Smith et al., 2009). I have therefore engaged in a continuous process of self reflection throughout this process that has helped me to manage my craving for certainty. I also feel that through this, I have developed my ability to trust my own judgments both as a research and as a practicing clinician.

Examining the themes of this study as a whole, they seem to describe a transition process for the participants. The process of being admitted to hospital followed by the process of treatment, then the process of discharge from hospital and then the process of recovery. Adolescence in itself represents a period of transition into adulthood for the participants. This idea of transition also resonates with me in regards to my personal journey throughout my doctoral training, more so now as I come to the end of this particular research process. Whilst for my participants, the transition from adolescence into adulthood represents a process of maturity, it could be said that this research process has matured me as a researcher and improved my confidence in overcoming new challenges.

When I consider how this research as impacted me personally, I must acknowledge that I now feel more sympathy with people who have EDs than I did at the start of this research process. I feel as though I have a better understanding of their plight and struggles. When I first started this research process, my motivation was to give a voice to young people with AN. I feel I have been able to do this which for me gives me a sense of achievement. Personally, I have a sense that I have not only added to the

literature on the subject matter but that I have been able to help young people recovering from AN to feel better understood. I must therefore admit that with this sense of achievement also comes a feeling of pride at being able to contribute to a field that has grown ever closer to my heart.

From a professional standpoint, I feel that this process has given me the opportunity to contribute to the wider literature on this subject matter. I also feel like it has given me more of an insight into the feelings and thought processes of individuals who are struggling with AN. I therefore feel more confident in working with this client group as well as individuals who present with other complex psychological difficulties.

Working with IPA during this research process has also contributed to the anxiety I experienced throughout. In my strive and effort to give a voice to adolescents with AN, I was aware that my analysis will be influenced by the limits of my language and conceptualisations. This has added to my anxiety because I am aware that my perspective is only one of many and therefore the language I use to describe my themes may not be used by others, and could therefore result in a completely different interpretation of the participants' data. However, I was able to navigate this by using supervision to reflect on my use of language and therefore consider other ways by which the participants' data could be conceptualised as themes.

The use of IPA in this study has allowed the quality and texture of individual experiences to be captured. This method of analysis should be regarded as complimenting rather than replacing existing quantitative and quasi-experimental research as it has been able to develop the existing knowledge on AN and the recovery process, relatively unhampered by a priori assumptions. The use of semi structured interview has provided me with a method of data collection which has allowed for an

interaction with the participants in a manner that is appropriate to the subject matter. It must however be noted that interviews are subject to self-report bias and it is therefore important to acknowledge that aspects of my identity may have nonetheless influenced the participants' responses.

Despite the advantages of using IPA, I must also acknowledge a challenging aspect of the process. The process of conducting the semi-structured interviews, recording the interviews before then transcribing and analysing them is very long and therefore requires a great deal of patience. It is relatively easy for one to lose focus or become discouraged by the drawn out process. This can therefore affect how one interprets the data at the start of the process versus how one interprets it nearer the end. Apart from the use of supervision, another way I tried to navigate this issue was to make sure I did not leave too much of a time gap between the analysis of the participants' transcripts. This allowed me to maintain my focus and remain true to the principles of IPA. A major learning point for me during this process is that research can be a long and challenging process that requires a lot of time and patience. I also wonder if this mirrors the experience of treating EDs which in itself can also be a long and challenging process that also requires time and patience.

Overall, I have benefited from conducting this research and I maintain a strong interest in working with individuals with EDs. I also believe the research has contributed to the current research body and generated new questions for future research.

6   CONCLUSION

The aim of this research was to explore the experiences of adolescents during the recovery process from AN after receiving inpatient treatment. As evidenced by the literature reviewed, research into adolescent experiences of AN was fairly limited and so further exploration into this topic area aimed to contribute to the wider literature. As a result, this study used a qualitative method of analysis, specifically IPA, to provide a new understanding of the experience of adolescents' recovery from AN after they have undergone inpatient treatment. From the analysis, four super-ordinate themes emerged from the data; self & recovery, relational, the world against me: back in the world and psychological recovery vs. physical recovery. The findings of this research sheds light on the impact of inpatient treatment on adolescents with AN. The findings suggest that adolescents with AN experience a change in their cognition and develop an acknowledgement of their illness as a result of their admission to hospital. The findings also suggest that adolescents with AN become more confident and are better able to accept themselves as a result of their admission. Furthermore, the findings suggest that whilst the process of recovery can be challenging, parents have an important role to play in helping adolescents maintain structure to their meals. Friendships were also highlighted as important as they help to foster ongoing support. The findings also suggest that therapy was a useful avenue by which the participants could express their thoughts and emotions. Finally, the findings also highlight a distinction between the psychological and physical aspects of recovery from AN. The findings suggest that the participants found the process of ongoing weight gain difficult after discharge from inpatient treatment however, the process of trusting oneself to maintain recovery was highlighted as being crucial to long term recovery.

The findings have informed the field of counselling psychology by informing counselling psychologists as to how best to help young people manage the challenges they may face in the later stages of their recovery after discharge from inpatient treatment. The clinical implications for counselling psychologists and other mental health professionals have been outlined. Limitations identified include the small sample size which may be deemed by some as a weakness; however, this ensured the level of depth required to make sense of each individual's experience. It was also acknowledged that all the participants were female which is a reflection on the fact that the majority of people diagnosed with AN tend to be female. It was suggested that male experiences of recovery following discharge from inpatient treatment for AN may be different and could therefore be an interesting area for further study.

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8 APPENDIX 1 – ETHICAL APPROVAL

London Metropolitan University,
School of Psychology,
Research Ethics Review Panel

I can confirm that the following project has received ethical approval by one anonymous Reviewer, the Head of School of Psychology and the Dean of the FLSC to proceed with the following research study (Professional doctorate):

Title: What are the experiences of adolescents during the recovery process from anorexia nervosa after receiving inpatient treatment? An Interpretative Phenomenological Analysis Study Revised proposal dated 4th January, 2016

Student: **Ms Oluwapelumi Olawale**

Supervisor: Dr. Angela Loulopoulou

Ethical clearance to proceed has been granted providing that the study follows the most recent Ethical guidelines to dated used by the School of Psychology and British Psychological Society, and follows the above proposal in detail.

The researcher and her supervisor are responsible for conducting the research and should inform the Ethics panel if there are any substantive changes to the project that could affect its ethical dimensions, and re-submit the proposal if it is deemed necessary.

Signed: _Lange-Küttner_   Date: 11 January 2016

Prof Dr Chris Lange-Küttner
(Chair - School of Psychology Research Ethics Review Panel)

Email c.langekuettner@londonmet.ac.uk

9   APPENDIX 2 - PARTICIPANT INFORMATION SHEET

Please read carefully.

You have been invited to take part in a psychological research study as part of a doctoral project that aims to explore the experiences of adolescents during the recovery process from anorexia nervosa after they have received inpatient treatment.

Who is conducting this study?
My name is Pelumi Olawale and I am a trainee counselling psychologist. This study is being conducted as part of the requirements of my doctorate in counselling psychology. My supervisor is Dr Angela Ioanna Loulopoulou (Principal lecturer and chartered counselling psychologist at London Metropolitan University).

Main objective
The main objective of the study is to add to the research knowledge on anorexia and understand from a qualitative perspective, young people's experiences during the recovery process from anorexia nervosa after they have been on admission and received inpatient treatment.

What your participation involves
As a participant in this study, you will be interviewed by the researcher in regards to your experience of anorexia and your recovery process after inpatient treatment. You will be required to discuss and talk about your understanding of your difficulties; your experience of treatment and your experience of your recovery process so far. You will only be required to talk about the experiences you wish to disclose. The research is only interested in your experience of the recovery process from anorexia nervosa since you have been discharged from inpatient treatment.

If you are happy to partake in the study, you can contact me using the details provided below. If you wish to ask me any more questions about the study, I encourage you to do so and I will be delighted to answer them. If at this point you still want to think about it, you may do so if you wish. Also, if you would prefer us to meet to have a discussion about the study in person, we can schedule a time and place that will be convenient. The interview will take approximately one hour to one and a half hours and will be audio recorded. At the end of the interview, you will be given further opportunity to ask me any questions or highlight any concerns you may have.

Do I have to take part?
No. This research is entirely voluntary and you may stop your participation at any point during the interview without explanation. If you do this, any responses you have given will not be transcribed and so will be destroyed through permanent deletion from the electronic recording device. If you are under the age of 18, your parent or legal guardian will need to sign a consent form in order for you to take part in the study. Requests for data withdrawal made within three weeks of the

interview will not be included in any publication or report and will be destroyed. Requests made after three weeks may be included in the written report but will not be included in any further publications or reports and will be destroyed.

What will happen to my interview data?
The interview data that you provide will be transcribed so that it can be examined in detail. This is so that I can uncover the common themes that are important in understanding your experiences. Both the recordings and the typed out transcripts will be made anonymous and kept in a locked storage facility. Please note that anonymised sections of the information collected from the interview will be looked at by my supervisor.

You will also be given the option to have the research summary sent to you after the completion of the study.

Are there any potential risks or disadvantages of participating in the study?
The questions you may be asked could be potentially upsetting however, there will be protocols in place to make sure that there is a reduced risk of distress. If at any point during the interview you do not wish to answer a particular question, you will not be obliged to and can therefore skip it. If you become distressed in any way, you will have the option to take a break or stop the interview altogether. After the interview, you will have the opportunity to discuss any of the topics that was raised. I will be able to provide suggestions of whom you can go to for further help and support and will provide you with a sheet containing this information.

What are the potential benefits of taking part?
The results of this study will develop our current understanding of anorexia nervosa in young people, the recovery process and should therefore improve treatment in the future. Nevertheless, I cannot guarantee that this study may be of benefit to you however you may appreciate the chance to talk about your experiences.

Will my answers be kept confidential?
No. However, nowhere within the study will any of your personal details appear and neither will the data you provide be traced back to you. As part of the doctoral programme, I will write up a report of the research. Full anonymity will be provided as all place and people names will be replaced with pseudonyms. In addition, all descriptions of events will be unidentifiable.

What if I want further information on the research?
If you have any comments or require further information regarding the study, please do not hesitate to contact the researcher via email at olo1159@my.londonmet.ac.uk.

What if I want further help and assistance after my participation?
If you require further help and assistance, appropriate advice will be offered and you will be signposted to relevant services.

What if I have complaints regarding the study?

If you have any complaints regarding the study, please contact the project supervisor: Dr Angela Ioanna Loulopoulou: a.loulopoulou@londonmet.ac.uk

10   APPENDIX 3 - PARENT INFORMATION SHEET

Please read carefully.

Your child has been invited to take part in a psychological research study as part of a doctoral project that aims to explore the experiences of adolescents during the recovery process from anorexia nervosa after they have received inpatient treatment.

Who is conducting this study?
My name is Pelumi Olawale and I am a trainee counselling psychologist. This study is being conducted as part of the requirements of my doctorate in counselling psychology. My supervisor is Dr Angela Ioanna Loulopoulou (Principal lecturer and chartered counselling psychologist at London Metropolitan University).

Main objective
The main objective of the study is to add to the research knowledge on anorexia and understand from a qualitative perspective, young people's experiences during the recovery process from anorexia nervosa after they have received inpatient treatment.

What my child's participation involves
As a participant in this study, your child will be interviewed by the researcher in regards to his/her experience of anorexia and their recovery process so far. Your child will be required to discuss and talk about their understanding of their difficulties; their experience of treatment and their experience of their recovery process so far. He/she will only be required to talk about the experiences they wish to disclose. The research is only interested in their experience of the recovery process from anorexia nervosa since they have been discharged from inpatient treatment.

If your child decides that he/she would like to take part in the study, they can contact me using the details below. The interview will take approximately one hour to one and a half hours and will be audio recorded. After the interview your child will have an opportunity to ask any questions and raise any concerns they may have.

Does my child have to take part?
No. This research is entirely voluntary and your child may stop his/her participation at any point during the interview without explanation. If your child does this, any responses he/she has given will not be transcribed and so will be destroyed through permanent deletion from the electronic recording device. If your child is under the age of 18, you will need to sign a consent form if he/she agrees to take part in the study. Requests for data withdrawal made within three weeks of the interview will not be included in any publication or report and will be destroyed. Requests made after three weeks may be included in the written report but will not be included in any further publications or reports and will be destroyed.

What will happen to my child's interview data?

The interview data that your child provides will be transcribed so that it can be examined in detail. This is so that I can uncover the common themes that are important in understanding your child's experiences. Both the recordings and the typed out transcripts will be made anonymous and kept in a locked storage facility. Please note that anonymised sections of the information collected from the interview will be looked at by my supervisor.

Your child will be asked if he/she would like a summary of the research findings when the study is complete.

Are there any potential risks or disadvantages of my child participating in the study?

The questions your child may be asked could be potentially upsetting however, there will be protocols in place to make sure that there is a reduced risk of distress to your child. If at any point during the interview your child does not want to answer a particular question, he/she will not be obliged to and can therefore skip it. If your child becomes distressed in any way, he/she will have the option to take a break or stop the interview altogether. After the interview, your child will have the opportunity to discuss any of the topics that was raised. I will be able to provide suggestions of whom your child can go to for further help and support and will provide him/her with a sheet containing this information.

What are the potential benefits of my child taking part?

The results of this study will develop our current understanding of anorexia nervosa in young people, the recovery process and should therefore improve treatment in the future. Nevertheless, I cannot guarantee that this study may be of benefit to your child however your child may appreciate the chance to talk about his/her experiences.

Will my child's answers be kept confidential?

No. However, nowhere within the study will any of your child's personal details appear and neither will the data your child provides be traced back to him/her. As part of the doctoral programme, I will write up a report of the research. Full anonymity will be provided as all place and people names will be replaced with pseudonyms. In addition, all descriptions of events will be unidentifiable.

What if I or my child want further information on the research?

If you or your child have any comments or require further information regarding the study, please do not hesitate to contact the researcher via email at olo1159@my.londonmet.ac.uk.

What if my child wants further help and assistance after his/her participation?

If your child requires further help and assistance, he/she will be offered appropriate advice and signposted to relevant services.

What if my child has complaints regarding the study?

If your child has any complaints regarding the study, he/she can contact the project supervisor: Dr Angela Ioanna Loulopoulou: a.loulopoulou@londonmet.ac.uk

11   APPENDIX 4 - PARTICIPANT CONSENT FORM

As an informed participant of this study:

1) I understand that I am taking part in a research process.   ☐

2) I understand that my participation is voluntary and I may cease to take part in this interview at any time, without giving a reason.   ☐

3) I understand that I may ask for my interview data to be withdrawn within 3 weeks of the interview date.   ☐

4) I am aware of what my participation involves.   ☐

5) I understand that there are no risks involved in the participation of this study.   ☐

6) I understand that my name will never be connected to my responses.   ☐

7) I understand that information that would make it possible to identify me or any other participant will not be included in any sort of report.   ☐

8) I understand that the transcript data will be accessible only to the researchers conducting the study.   ☐

9) I confirm that I am / I am not (delete as appropriate) 18 years of age and above.   ☐

   9a) If below 18 years of age, even if you give consent, your parent / legal guardian will need to provide consent that they will be happy for you to take part in the study.   ☐

9b) If 9a is relevant, I consent to my records being accessed for
the purpose of the researcher finding my parent's / legal guardians
contact details to request consent.

10)   I hereby consent to the audio recording and transcription of the
interview, and the use of direct quotes in the write-up of the study
(which I understand will be anonymised).

At this time you may ask any questions you may have regarding this study.

I have read and understood the above, and give consent to participate:

Participant's Signature:_____

Date:_____

Unique Identifier:

Participant email :

12 APPENDIX 5 - PARENT / LEGAL GUARDIAN CONSENT FORM

As an informed parent / legal guardian:

1) I understand that my child will be taking part in a research process. ☐

2) I understand that my child's participation is voluntary and my child may cease to take part in the interview at any time, without giving a reason. ☐

3) I am aware of what my child's participation involves. ☐

4) I understand that there are no risks involved in the participation of this study for my child. ☐

5) I understand that my child's name will never be connected to his/her responses. ☐

6) I understand that information that would make it possible to identify my child or any other participant will not be included in any sort of report. ☐

7) I understand that the transcript data will be accessible only to the researchers conducting the study. ☐

I have read and understood the above and the information sheet provided, and give consent for :

_____ (Child's name) to participate in the study.

Parent's / legal guardian's signature:_____

Date:_____

13   APPENDIX 6 - DISTRESS PROTOCOL

Protocol to follow if participants become distressed during participation :

This protocol has been devised to deal with the possibility that some participants may become distressed and/or agitated during their involvement in the study. This protocol will serve to make sure that any distress can be well managed and subsequently reduced.

Distress
- A participant indicates they are experiencing a high level of stress or emotional distress.
- A participant exhibit behaviours suggestive that the discussion/interview is too stressful such as uncontrolled crying, tearfulness, voice becomes choked with emotion/ difficulty speaking, shaking or restlessness.

Stage 1 response
- Stop the discussion/interview.
- The researcher will offer immediate support.
- Offer the participant time to pause and compose him/herself.
- Assess mental status:
  - Tell me what thoughts you are having?
  - Tell me what you are feeling right now?
  - Do you feel you are able to go on about your day?
  - Do you feel safe?
- Ask participant if they are happy to continue or would like to stop.

Review
- If participant feels able to carry on; resume interview/discussion.
- If participant is unable to carry on, go to stage 2.

Stage 2 response
- Remove participant from discussion and accompany to a quiet area or discontinue interview.
- Offer, with participant consent, for the researcher to contact sources of support.

Follow up
- Follow participant up with a courtesy call (if participant consents)
- Encourage the participant to call either if he/she experiences increased distress in the hours/days following the interview.

14 APPENDIX 7 - DEBRIEFING FORM

Research title: **What are the experiences of adolescents during the recovery process from anorexia nervosa after receiving inpatient treatment? An interpretative phenomenological analysis study.**

Thank you again for giving up your time to participate in this research. Your responses will be transcribed along with the responses of other individuals also participating in the research and will be kept anonymous. The transcribed data will then be analysed individually in order to highlight common themes that arise between participants. If you would like to know the findings of the overall research, please contact the researcher who will be able to send you a summary of the research findings.

This research aims to provide a better understanding of young people's experiences during the recovery process from anorexia nervosa after they have received inpatient treatment, in order to inform counselling psychologists and other mental health professionals alike in their practice, as to how best to work with young people recovering from Anorexia Nervosa. Please remember that you can withdraw your data within three weeks from the interview date. Requests made after three weeks may be included in the written report but will not be included in any further publications or reports and will be destroyed.

I would now like to offer some time for you to bring up any concerns which may have arisen for you during the interview process.

Is there anything in particular that you would like to talk about that came up from this
interview?

Do you feel that you have any further comments or questions before we end for today?

If you do think of anything later, I will be available by e-mail (olo1159@my.londonmet.ac.uk.) to answer any questions that you may have about this research.

If you felt that any difficult issues came up for you during the interview, you can contact the organisations listed below for support in case the research process caused any emotional distress:

- ***beat*** (tel. 0845 634 7650; www.b-eat.co.uk) *beat* (the working name of the Eating Disorders Association) is the leading UK charity for people with eating disorders and their families, providing information, help and support. Their helpline staff have received a comprehensive training programme, and are there to listen. They will offer information about treatment and other sources of help available, encouraging callers to make their own decisions about a way forward.

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

Thank you again for taking part.

15   APPENDIX 8 - INTERVIEW SCHEDULE

1) Can you please tell me a little about yourself and your difficulties?
   a. What led to your admission to hospital?
2) Can you please tell me about the treatment you received while on admission?
   a. What was the most helpful aspect of your treatment experience? Please give examples.
   b. What was the least helpful aspect of your treatment experience? Please give examples.
   c. Was there a turning point in your treatment where things got better or worse?
3) What was it like when you were first admitted to the hospital for treatment?
4) How would you describe your experience of inpatient treatment?
   a. If you could change any aspect of the treatment you received, what would it be?
5) What enabled you to be discharged from inpatient treatment?
6) How did you feel about being discharged from inpatient treatment?
   a. Did you have any concerns? If so what were they?
7) What is your understanding of recovery?
   a. Would you say you were in recovery when you got discharged from inpatient treatment?
8) Have you experienced any challenges to your recovery process since you've being discharged from inpatient treatment?
   a. What factors may be hindering your recovery process since your discharge?
   b. What factors are enabling your recovery process since your discharge?
9) What do you think may help your ongoing recovery process in the community?
10) Reflecting back on the things we have discussed, is there anything else you would like to add?

Thank you for your time.

16   APPENDIX 9 - SAMPLE OF ANNOTATED TRANSCRIPT

124	good and ermm just as i sort of started to build up time a bit more and
125	started to be a bit more independent when i'm outside, not have staff with
126	me when i'm outside and stuff, that's probably when it started becoming a
127	possibility when i started going out overnight locally, yeah.... people
128	trusting you a little but more kind of and then you trust yourself yeah...
129	I: Were you confident you could trust yourself?
130	p2: not always not 100 per cent. i was still inpatient and at least a few night a
131	week i would be back on the ward and be surrounded by all the people
132	struggling even though they were trying and my thoughts could never really
133	disappear until i was completely home and cut off from it. So yeah they
134	were still there.. so i was still sort of weary that there were still thoughts
135	and possibilities coming into my head.
136	i: So not just for you to trust yourself, but for the professional to trust you as
137	well?...
138	p2: yeah...it gave me a bit of confidence in myself that the professionals thought
139	you could do it..yeahh..
140	i: before the professionals came and said this was going to be happening, as in
141	you were going to be going on leaves did you think to yourself, im okay i
142	think i can manage now? or was it after the professionals had said
143	something that you started to take that on board.
144	p2: it was probably after. cause i didn't have much faith in myself...it was
145	probably , i sort of expected that they were expecting me to kick off or
146	struggle, i guess them saying that i can class myself as sort of recovered...
147	kind of made me think i can do this but yeah it kind of took them to say that
148	to me for me to believe it.
149	i: How did you feel about being discharged? the process of you being discharged
150	involved you going out on leaves and you developing your confidence but
151	when it got to the time of you being discharged, how did you feel about
152	that?
153	P2: i guess i was sort of scared...i was really scared because id been out for a
154	while and id gotten used to it and i gotten used to having people at the end

Comment [PO44]: Parents were important for adjustment

Comment [PO45]: Being trusted to be alone.

Comment [PO46]: Being independent is important for recovery.

Comment [PO47]: Trust is important.

Comment [PO48]: Could not always trust self initially.

Comment [PO49]: Being away from inpatient unit helped cognitive change. / Struggle to get rid of unhelpful thoughts whilst still in teatment.

Comment [PO50]: Inpatient treatment re-enforces eating disorder cognitions

Comment [PO51]: Trust from clinicians inspired confidence.

Comment [PO52]: Was not confident in ability to maintain recovery initially. / Uncertainty.

Comment [PO53]: Taking responsibility for own recovery.

Comment [PO54]: Scared about discharge.

5

155   of the phone and i could call them but it wouldn't be quite the same, i

156   wouldn't be an outpatient i would be an ex patient and i felt like i couldn't

157   really call them up all the time because they had other people to focus on

158   as well...so it was quite scary... i wasn't on my own but it did feel a bit like it

159   cause i was used to having staff around me all the time and just people to

160   talk to..you just put your hand up or something and it was different being at

161   home because hardly anyone really understood it so... it was quite scary.

162 i: you said people didn't really understand..did you have any particular concerns

163   about them not understanding about yourself and how you'd manage?

164 p2: yeah..it was sort of like people at my school knew what had happened cause

165   one of my friends had told them so there was a bit of stigma and people

166   sort of they didnt act towards me as they did before which was kinda

167   stressful. I was unwell and that made me think what have i done wrong?

168   whats changed about me? i was trying to be who i was eeerrrmmm but i

169   was never going to be exactly who I was because i had gone through a

170   whole new experience and its changed me a lot for the better i think.

171 I : What is your understanding of recovery?

172 p2: errrm i think its just sort of being independent again and trusting yourself

173   completely and accepting yourself cause not everyone seems to be happy

174   all the time and everyone is going to struggle..it's just human nature so i

175   think recovery is accepting that thats just going to be the case and learning

176   to work with it and coping in the bad times and not going off the rails and

177   panicking when things are not going your way..yeah..

178 I: At the time of discharge, would you say you were in recovery based on your

179   understanding know of what recovery is?

180 p2: No, i probably wasn't...cause i was thinking to myself when i get home im

181   going to lose weight...im gonna kill myself or something cause ill be able to

182   and that kind of sort of happened when i got home. It took me a few good

183   months for me to sort of change who i was cause for me, being back home i

184   wasn't ... i wanted to be like my friends but i couldnt.. i wanted to be sort of

185   normal and like trusted , just to be able to go outside when i wanted to

186   without having to be watched or anything and i think i didn't think i could

6

Comment [PO55]: Support from staff was important.

Comment [PO56]: She's emphasising the importance of support / was worried she would lose her support./ Support is important, WORRIED ABOUT LOSING SUPPORT

Comment [PO57]: Being alone was unhelpful

Comment [PO58]: People at home did not really understand. / It is important that people understand difficulty.

Comment [PO59]: Fear

Comment [PO60]: Adjustment to school life was difficult.

Comment [PO61]: Acknowledged personality change.

Comment [PO62]: Change of person / Cognitive change

Comment [PO63]: Experience of inpatient treatment changes you.

Comment [PO64]: Recovery is independence / Trust is important / Trusting yourself/ Acceptance of self

Comment [PO65]: Recovery is acceptance/ Acknowledgement that struggle may persist long-term.

Comment [PO66]: Was not in recovery after discharge.

Comment [PO67]: Cognition still disordered.

Comment [PO68]: Time needed for change / Change was gradual.

Comment [PO69]: Extrinsic motivation to be like friends / Adjustment difficulties

Comment [PO70]: Desire to be normal and be trusted.

17 APPENDIX 10 - SAMPLE PAGES OF THREE-COLUMN ANALYSIS

Emergent themes	Transcript 2 - Milan	Exploratory comments
Trust	I: Were you confident you could trust yourself? p2: not always not 100 per cent. i was still inpatient and at least a few night a week i would be back on the ward and be	Could not always trust self initially.
Cognitive change	surrounded by all the people struggling even though they were trying and my thoughts could never really disappear until i was completely home and cut off from it. So yeah they were still there.. so i was still sort	Being away from inpatient unit helped cognitive change. / Struggle to get rid of unhelpful thoughts whilst still in treatment.
Inpatient treatment and cognitive change	of weary that there were still thoughts and possibilities coming into my head. i: So not just for you to trust yourself, but for the professional to trust you as well?... p2: yeah...it gave me a bit of confidence in myself that the professionals thought you could do it..yeahh.. i: before the professionals came and said this was going to be happening, as in you were going to be going on leaves did you think to yourself, im okay i think i can manage now? or was it after the professionals had said something that you started to take that on board.	Inpatient treatment re-enforces eating disorder cognitions Trust from clinicians inspired confidence. Was not confident in ability to maintain recovery initially. / Uncertainty. Taking responsibility for own recovery.
Emotions	p2: it was probably after. cause i didn't have much faith in myself...it was probably , i sort of expected that they were expecting me to kick off or struggle, i guess them saying that i	Scared about discharge.
Conflicted Emotions	can class myself as sort of recovered... kind of made me think i can do this but yeah it kind of took them to say that to me for me to believe it. i: How did you feel about being discharged? the process of you being discharged involved you going out on leaves and you developing your confidence but when it got to the time of you being discharged, how did you feel about that?	Support from staff was important. She's emphasising the importance of support / was worried she would lose her support./ Support is important, WORRIED ABOUT LOSING SUPPORT
	P2: i guess i was sort of scared...i was really scared because id been out for a while and id gotten used to it and i gotten used to having people at the end of the phone and i could call them but it wouldn't be quite the same, i wouldn't be an outpatient i would be an ex patient and i felt like i couldn't really call them up all the time because they had other people to focus on as well...so it was quite scary... i wasn't on my own but it did	Being alone was unhelpful. People at home did not really understand. / It is important that people understand difficulty. Fear
Social adjustment / School Stress	feel a bit like it cause i was used to having staff around me all the time and just people	Adjustment to school life was difficult.

Cognitive change	to talk to..you just put your hand up or something and it was different being at home because hardly anyone really understood it so... it was quite scary. i: you said people didn't really understand..did you have any particular concerns about them not understanding about yourself and how you'd manage?	Acknowledged personality change. Change of person / Cognitive change Experience of inpatient treatment changes you.
Acceptance of self	p2: yeah..it was sort of like people at my school knew what had happened cause one of my friends had told them so there was a bit of stigma and people sort of they didnt act towards me as they did before which was kinda stressful. I was unwell and that made me think what have i done wrong? whats changed about me? i was trying to be who i was eeerrrmmm but i was never going to be exactly who I was because i had gone through a whole new experience and its changed me a lot for the better i think. I : What is your understanding of recovery? p2: errrm i think its just sort of being independent again and trusting yourself completely and accepting yourself cause not	Recovery is independence / Trust is important / Trusting yourself/ Acceptance of self Recovery is acceptance/ Acknowledgement that struggle may persist long-term. Was not in recovery after discharge.
Change of cognition	everyone seems to be happy all the time and everyone is going to struggle..it's just human nature so i think recovery is accepting that thats just going to be the case and learning to work with it and coping in the bad times and not going off the rails and panicking when things are not going your way..yeah.. I: At the time of discharge, would you say you were in recovery based on your understanding know of what recovery is? p2: No, i probably wasn't...cause i was thinking to myself when i get home im going to lose weight...im gonna kill myself or something cause ill be able to and that kind of sort of happened when i got home. It took me a few good months for me to sort of change who i was cause for me, being back home i wasn't ... i wanted to be like my friends but i couldnt.. i wanted to be sort of normal and like trusted , just to be able to go outside when i wanted to without having to be watched or anything and i think i didn't think i could	Cognition still disordered. Time needed for change / Change was gradual Extrinsic motivation to be like friends / Adjustment difficulties Desire to be normal and be trusted.

18   APPENDIX 11 – MASTER TABLE OF THEMES

Super-ordinate theme	Sub-theme	Key quotes and line numbers
Self & Recovery	Cognitive change	Kind of realising that everything I had thought before wasn't really how it was. I was kind of stuck in a weird mindset but after the treatment it's like I saw things differently and think differently. (Paris, 256 - 258)
		Ermm well I supposed it kinda changes you as a person, you think differently about things.. (Paris, 72 - 73)
		Okay at the time I was not very grateful for the treatment because I was completely against it, but with time, and looking back at it now, I am very grateful for it and errm I can see that I received really good treatment and I wouldn't be where I am in my recovery now if it weren't for my hospital admission so it really did save my life and really put me on the road to a proper recovery. (Albany, 49 - 54)
		Like I was just, well I was like delusional when I… I guess that that has changed…like I was delusional I thought everything was amazing like before I came and got the shock but like I was just miserable (India, 430 - 432)
		My thoughts could never really disappear until i was completely home and cut off from it. (Milan. 132 - 133)
	Acknowledgement of illness	It'd only being like five or six months since I'd become quite unwell so it was a change in environment...several months earlier I would have considered myself quite normal so it was just such a quick change. It was like being in hospital helped me realise that I was actually ill and really needed help. (Milan, 99 - 103)
		Errrrmm yeah, at the time I was very immersed in my disorder and I was very unaware of a life outside of anorexia and it was consuming my entire life and I didn't think …I thought this was going to be my life really . It took me a while to realise that I had an illness and that my life didn't have to be that way. (Albany, 6 - 10)
		Like all the habits were kind of for a reason, so when you realise what the reason is, you're like oh why should I do that then? There comes a point when you just realise that those habits are part of the illness and that wasn't something I wanted. (Paris, 182 - 185)
		Well at the time I thought I was doing amazing and was on the top of life, which kind of isn't really what was happening at the time but I was just delusional to everything around me (India, 23 - 25).
	Becoming more confident	Because you kind of get a little more confident about things, being around different people and I just feel like no matter what happens in my life now I can handle it. (Paris, 75 - 77)
		It's definitely worth it cause I always used to say I wanted to be how I was but like I'm sort of a new version of myself and it's a better more sort of confident version. (Milan, 293 - 295)
		I'm definitely a lot more confident, quite a few people have said this to me ermm, I'm much more confident than when I was restricting because I just lost so much of myself during restriction and err I'm more myself than I have been in quite a few years which is always a really nice experience... (Albany, 526 - 529)
	Acceptance of self	...like before I was just convincing myself everything was okay and down underneath that, I wasn't okay and I didn't try and convince myself I was happy anymore at the end so I was just showing the truth. This is who I am and I just needed to accept that. (India, 436 - 439)
		I still have my fear foods and I'm still scared of food in some sense but I'm comfortable with a lot more foods now than I was 2 years ago. I just think that this illness is a part of me now, I can't really change that. I'm probably not gonna get rid of some of my thoughts but I can't let that stop me from living my life and doing what I need to do. (Albany, 409 - 414)
		...everyone is going to struggle..it's just human nature so I think recovery is accepting that that's just going to be the case and learning to work with it and coping in the bad times and not going off the rails and panicking when things are not going your way. (Milan, 174 - 177)
Relational	Parents	My parents would erm sit with me and tell me that "I would have to do this, it not my choice to eat, I need to keep going, I don't want to end up having to go back to hospital, my family needs me" you know that sort of thing and erm like errm their support was like amazing. (Albany, 356 - 360)

		I would say my parents. Ermm but that was more with meals and stuff. It wasn't really...like anything else....they kind of set boundaries and things, they like dish out certain portions that I knew were ok. (Paris, 213 - 217)
		When I first started going back to school I was part time until sort of September last year so I was part time for quite a few months but mum used to come in and do snacks with me and lunch with me eerrm in like a separate room away from my friends which was really helpful... (Milan, 252 - 255)
		Obviously being here, you do have support but when you're at home you know it's kind of your parents support if that makes sense. Cause obviously here, the support is from the staff and it's always different people so you're not always familiar with who you're talking to and also with the friends here, you have them for a while but if they leave before you, it's kind like...yea... but the support from home is more permanent. (Paris, 303 - 308)
	Friendships	...but I found it difficult hearing people talk about food or things like that. And then once I was in a dance theory class, and I got really upset and my friend took me out of the class and sat down with me and made me feel better...she just kind of comforted me and like said like everything she was saying was normal. (Paris, 205 - 210)
		a couple of time I didn't manage very well and it got to the point were I was nearly going to be sent back to general hospital um but I sort of began to talk more to my friends and I kind of found my friends sort of understood a little bit more than I thought they did i realised I hadn't didn't given them enough credit cause even though not many of them were coming to visit me when I was there, they had sort of read up on what was wrong with me which was really really touching. (Milan, Line 191 - 197)
		Yeah my friends from home, they were supportive but they didn't really understand a lot about the disorder so they kind of shut me out a little bit and so I was a bit on the outside... a bit of an outcast errrm but my friends from hospital were always really supportive whenever I needed anyone , they were there for me and they knew exactly what to say as well so their support was kind of.. it was like gold coin to me like I could have swapped anything for it, like it was just amazing. (Albany, Line 367 - 373)
	Therapy	I got another therapist in CAMHS and she was really helpful... it was quite nice so I could talk about the new challenges I was facing back home... (Milan, 203 - 206)
		... I was so alone in my thoughts like I could talk about them to my therapist or friends or cousins and stuff it was just not keeping it all to myself in a way otherwise I'd keep thinking and so I could get somebody else perspective to it... it was just nice to just sort of snap me out of what I was thinking. (Milan, Line 217 - 222)
		..I feel like talking therapy was a way for me to get my emotions off my chest and kind of vent and it was important for me to have that space, that platform for me to talk about how I was feeling otherwise it would have come out in more negative behaviour such as you know self-harm or other dangerous behaviours and potentially like me holding onto my restrictive behaviours more... (Albany, 89 - 94)
The world against me: Back in the world	School as a stressor	And then going back to school was impossible like in my first French lesson my teacher asked me where I've been in front of the whole class and I was there like 'I've been poorly' errmm yeah so that was kind of bad. (India, 452 - 455)
		...it was sort of like people at my school knew what had happened cause one of my friends had told them so there was a bit of stigma and people sort of they didn't act towards me as they did before which was kinda stressful. I was unwell and that made me think what have I done wrong? What's changed about me? (Milan, 164 - 168)
		...so yeah coming back to school with 1500 people was just hard… yeah and my school was so pressurising so they were like ' have you caught up with your work yet' and I was like no I can't really do that like and it was just too much for me at the time... (India, 478 - 481)
		...I was discharged into my final year of school so into the run up to my GCSE's I didn't really have a lot of time to kind of recover from being in hospital...before I knew it I was back full time revising for my GCSE's and that's where things started to take their toll again in me mentally and I started to restrict again and exercise more and my anxiety got worse and I became more rigid...but I managed to pick myself up after that because they were telling me that if I lost any more weight I would end up back in hospital so I turned things around at home and errm gained the weight back. (Albany, 309 - 321)
	Conflicting emotions	...so I was extremely excited to be discharged but I was also very nervous and had a lot of thoughts creeping in and it was kind of immediately or the minute you're discharged...(Albany, 223 - 225)
		I was really scared and I got really upset cause I was really nervous...Just like going back to where I was before, being in the same environment all the time where things got bad, so I was kinda nervous...I kinda tried not to think about it. I found it hard at first but I stuck to it and eventually I got used to it again. (Paris, 223 - 227)
		...I wanted to be comfortable in myself and happy again and I sort of started to realise I'd never really felt like this angry and this low since before I became unwell and so every time I got angry or sad, I'd sort of blame it on my eating disorder kind of thing and it would in a way kind of spur me on so when I got angry or low, I would be like 'this is your fault' and I would push myself a little further just gently kind of thing…yeah. I wanted to get rid of it because I wanted to be happy again. (Milan, 272 - 278)

Psychological recovery Vs. Physical recovery	Managing weight gain	Okay so on the whole the weight gain was extremely hard to deal with as you literally feel yourself like doubling every meal and it was really difficult to go through even when you are at a healthy weight you can see when you look in the mirror you are changing in size even though in reality you're not...(Albany, 387 - 392)
		I don't think you can fully recover… I think once you've got it you've just got it for the rest of your life… I think people can get to a point where they can just manage themselves and they can basically eat with an okay mentality and I just don't think full recovery is possible and yeah I just can't imagine full recovery. (India, 394 - 398)
		I wouldn't say I was in recovery after discharge but obviously physically I had gained the weight and it did get a little bit more difficult cause there was a big change, but I felt like after that, after like 6 months or so, things gradually got a lot better. (Paris, 260 - 263)
		...I didn't know what I was going to do either with the whole like food thing.. I didn't think I was ready to gain any weight after my discharge or whether I even wanted recovery or I was just going to give up and yeah I just was like…I had so many decisions to make and yeah .. I just don't think I was ready mentally. (India, 342 - 347)
	Recovery is trusting oneself	I didn't have much faith in myself.. it was probably, I sort of expected that they were expecting me to kick off or struggle, I guess them saying that I can class myself as sort of recovered... kind of made me think I can do this but yeah it kind of took them to say that to me for me to believe it. (Milan, 144 - 148)
		Ermm just kind of that I was trusted if that makes sense. They just trusted me to continue making progress. It took me a while before I could trust myself though. (Paris, 268 - 270)
		I feel that the recovery process isn't just about gaining weight it's about learning to live life again and trusting yourself more, trusting that you won't restrict again or harm yourself, trusting your body with food and learning to enjoy food and errm learning to just live and not exist so that for me is recovery. (Albany, 246 - 250)

19   APPENDIX 12 - SAMPLE PAGES OF PARTICIPANT TRANSCRIPT (MILAN)

1   **Milan**

2   I: Can you please tell me a little about yourself and your difficulties.

3   P2: OK, well I live in XXXX and I've always been quite confident with myself and
4   when i became.. when i went up to high school , it was new schooling
5   system, it was the first year on the island going straight from primary school
6   to secondary school... that was quite hard. And then in 2013, I started
7   getting so anxious and sort of low and then I started developing anorexia
8   nervosa.

9   I:In terms of the process of you going to hospital, can you say a bit about that in
10   terms of what happened, in terms of you actually having to go to hospital.

11   P2: So it came on quite quickly. I went skiing over new year 2014..well 2013 to
12   2014 and obviously i wasn't eating very much and it was becoming quite
13   obsessive and all the exercising i was doing, i was still doing more on top of
14   a day's worth of skiing and it just...I became really unwell over that
15   trip..cause it was cold as well, i lost a lot of weight in just a week. It was
16   quite intense. And then I think a couple of days after, after i came back, i
17   think it was like two days or something, my mum found me in my bed and i
18   was really pale, i think something was going on with my kidneys or liver or
19   something, and my mum wasn't sure if i was even going to make it but yea
20   she took me down to the children's general hospital like straight away and
21   they sort of...my mum had been liaising with them saying i think something
22   might be wrong with me cause she can just tell and it came on quite quickly
23   so it was quite noticeable...yea ..so they were kind of expecting me to come
24   but not as severely as i was.

25   I: And that was what led to your admission to hospital?

26   P2: Yea.

27   I: Ok. So can you say a bit about your experience of treatment in general, when
28   you think about that time, what are your memories about that time?

29   P2: Yea..obviously, it was a really difficult time to be away from home and i was
30   only 14 so it was strange as i'd never been away from home but it was
31   good, it was just a completely new environment for me and i wasn't exactly

1

32   sure how to adapt to it or interact with anyone because i don't really go out
33   of my comfort zone very much, i never really have them, it was quite hard
34   having to be with all these whole new people that i've never known before,
35   that was quite hard but the staff were really nice, they understood it and
36   the other patients were very accepting, they were very accepting cause
37   they completely understood my circumstances and how i was feeling so
38   yea.

39   I: So thinking back towards that time, what would you say was the most helpful
40   aspect of your treatment?

41   P2: (Smiles) It was probably my individual therapy yea with my own
42   psychologist, that was..that was definitely a really helpful part of my
43   treatment..yea definitely.

44   I: How come? Can you say a little bit more about that?

45   P2: I dunno, i really clicked with my therapist, we just got on really well and i felt
46   comfortable with her. It took a while to build up a relationship but it was
47   just really nice to have a consistent sort of weekly therapy appointment,
48   the fact that she was also around the hospital meant that you could just go
49   up to her and like if you needed something you could talk to her for a few
50   minutes just to say...whatever was troubling you. That was really helpful.

51   I: And in terms of the least helpful aspect of that time, what would you say that
52   was for you?

53   P2: Ermm (laughs) probably..it was probably something to do with the
54   competitiveness of the illness that being with the other patients so it was
55   getting quite intense and you copy habits off other people and it ..they
56   were helping you with it but new habits were being introduced to you that
57   you kind of copy cause you have to be the best at that or which often made
58   you the worst in other ways so yea.

59   I: So it was almost like a contradiction where you were trying to get better but at
60   the same time you were also trying to be better at something else that
61   really wasn't helpful for you.

62   P2: Yea definitely.

63   I: Ok. And how would you say you managed that contradiction at the time?

64   P2: I...I didn't manage it very well cause i moved units eventually cause i picked
65   up lots of unhelpful habits but i sort of separated myself from people a lot
66   and i was on my own a lot of the time even though people come up and talk
67   to me, I just didn't like to be around people cause like it wasn't helping me
68   and i just didn't like how it made me feel.

69   I: In terms of the overall treatment, was there a turning point for you, was there
70   a point where you thought things clicked for you and things changed, did
71   that happen at all?

72   P2: Yea probably cause I got moved to the ICU unit and i think it was just sort of
73   being with the variety of mental illness that it wasn't just eating disorders
74   and anorexia, it wasn't as competitive and i just sort of saw all the different
75   people struggling and how they wanted to get better even if they weren't
76   able to think for themselves that kind of thing, they didn't want to be there
77   and they weren't being competitive and people were trying there and I
78   think that definitely helped me cause on the eating disorders unit everyone
79   was trying to be the worst they could possibly be whereas on the ICU no
80   matter how old they were, there was a little bit of hope in way i guess...yea.

81   I: So being in a different environment where you perceived that people were
82   trying to get help with behaviours... (P2 interrupts)

83   P2: ..even though it was really hard for them.

84   I: Yea. Ok. So can you say a little bit about how that affected your behaviour
85   after that? Did you find that you were able to manage your own difficulties
86   better because of that?

87   P2: Yea I think so like...uh it was different cause on the eating disorder unit
88   there'd be like pacing and slow racing and just..it wasn't there on the ICU,
89   there wasn't people slow racing cause there was only maybe two or three
90   of us at any one time with an eating disorder and we were separated like
91   sitting apart so you couldn't really see each other and i think it just sort of
92   made you think more about yourself rather than repeating with everyone

3

20   APPENDIX 13 - SAMPLE PAGES OF PARTICIPANT TRANSCRIPT (ALBANY)

33   hospital because I thought they had no right errm I thought this is my life

34   you know I can live it how I want and eerrm that they were destroying my

35   desire to look what I thought would be normal and what I thought was

36   attractive but errmm I didn't know I looked haunted instead and dead and

37   so I was definitely very confused and I didn't understand why I was being

38   admitted to hospital like I didn't understand anything about sections I

39   didn't understand anything about just why I was being admitted... I thought

40   I didn't have an eating disorder.

41   I: Okay yeah so quite a range of emotions... it seemed like it was quite a

42   confusing time

43   P3: yeah definitely

44   I: Okay so now moving on to the next question...if you could just say a bit about

45   your treatment so the treatment you received in general, when you think

46   back to that time sort of you know...what do you think about the treatment

47   and what were the things that maybe stood out to you errm in terms of

48   your experience with that?

49   P3: Okay at the time I was not very grateful for the treatment because i was

50   completely against it, but with time, and looking back at it now, I am very

51   grateful for it and errm I can see that I received really good treatment and I

52   wouldn't be where I am in my recovery now if it weren't for my hospital

53   admission so it really did save my life and really put me on the road to a

54   proper recovery.

55   I: you seem to have taken away a lot of positives from your time in hospital,

56   what would you say was the most helpful aspect of your treatment

57   experiences and if you give specific examples as well.

58   P3: I think the fact that if I didn't choose to eat the food then I would have been

59   chuffed so that idea to me terrified me and errrm so the way they actually

60   got me physically to eat really helped me in like stomaching and keeping

61   solid food down as opposed to having a liquid replacement was a really

62   beneficial aspect of my treatment. It really helped to keep me on track and I

63   feel like if there wasn't the liquid replacement as a punishment so to say,

2

64   errm then I would have strait up refused to eat and I wouldn't have done it

65   and I wouldn't have made any progress whatsoever.

66   I: Okay so what you are saying is that the fact that there were these sort of

67   perhaps rigid , strict rules that helped you to..

68   P3: yeah definitely

69   I: Okay errm and so can you talk about maybe the least helpful aspect of your

70   treatment, you know if there are any in terms of your experience..

71   P3: Errm I think it wasn't unhelpful but I just think I wasn't in the mind for it..i

72   wasn't in the right place mentally to receive therapies such as CBT and DBT.

73   I don't really remember a lot about the treatment that I received.. I

74   remember, sitting in a group with errm therapists and we were discussing

75   emotions and stuff like that but I don't really remember taking a lot from it

76   because I was still struggling a lot mentally and I was still very malnourished

77   and errmm so I couldn't really take a lot from the therapy whereas now I

78   receive DBT treatment and errm that's helped me a lot more and im able to

79   take a lot more from it because I'm in a better place physically and

80   mentally as well.

81   I: okay so you felt that because at the time you were struggling it was hard for

82   you to connect with your emotions and what therapy had to offer at that

83   time...

84   P3: yeah.. oh sorry I haven't said that I thought talking therapy was beneficial

85   because it was nice to get stuff of my chest.

86   I: Okay can you say a bit more about that.. talking therapy in terms of.. I mean

87   can you say a bit more about how that was different from the type of

88   therapy you received while on treatment?

89   P3: Yeah eerrmm I feel like talking therapy was a way for me to get my emotions

90   off my chest and kind of vent and it was important for me to have that

91   space, that platform for me to talk about how I was feeling otherwise it

92   would have come out in more negative behaviour such as you know self-

93   harm or other dangerous behaviours and potentially like me *holding* onto

94   my restrictive behaviours more so I feel like if I had got home leave and I

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95   hadn't have had talking therapy I would have restricted a lot more and I

96   would have probably engaged in more dangerous behaviours and it would

97   have prolonged my recovery so I feel talking therapy was an extremely

98   beneficial part of my treatment as well.

99   I: Okay that's good to know, errm and again so thinking about your time in

100   hospital and receiving treatment input from doctors and other members of

101   the team, where would you say was a turning point where maybe things

102   started to either get better or was there a point where things didn't get

103   better and maybe got worse you know were there certain key points key

104   moments for you during that time?

105   P3: Errm there was definitely a point where things started to get better and that

106   was when I was pushed to go into the downstairs dining room because I

107   was just quite stuck in the upstairs dining room and I wasn't making any

108   progress, i was still having to be supported and all my close friends from the

109   unit were in the downstairs dining room and I felt quite let out and

110   errmmm I was still being tormented by own head and forced to…I thought

111   that if I went downstairs then everyone would have thought that I was okay

112   and it had gotten to a point where i thought I didn't want to be stuck in the

113   upstairs dining room anymore I wanted to go home and so I made the

114   decision to do the tick chart and that's when things really picked up… quite

115   quickly I errm got my meals in and my snacks in and my meals out and my

116   snacks out and then before I knew it was home again like I think within like

117   2 maybe 3 weeks I was back home after having gone downstairs and errm it

118   really started to improve and before I knew it I'd had a discharge date so

119   things rapidly picked up. There was a time where things were errm.. I did

120   have a bit of a negative turning point and that was when I was still in the

121   upstairs dining room so this was before I went downstairs and erm I was

122   having a lot of epsiodes where I was trying to self harm a lot and errm it

123   was very difficult and errm I was on levels quite constantly and I was not

124   allowed bathroom privacy so that was quite a hard time for me.

125   I: during that time how did you manage things.. for you it sounded like quite a

126   difficult time so how did you keep going how did you keep yourself going in

127   the treatment?

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21 APPENDIX 14 - SAMPLE PAGES OF PARTICIPANT TRANSCRIPT (PARIS)

215   I: So when you said with the meals, how did they help you with the meals?

216   P1: Well they kind of set boundaries and things, they like dish out certain
217   portions that i knew were ok...yea.

218   I: How did you feel about being discharged from inpatient treatment? What was
219   that like for you?

220   P1: I was really scared and I got really upset cause I was really nervous.

221   I: Interesting cause you were scared when you were going and now scared when
222   you are leaving. How did you manage that? What were you scared about?

223   P1: Just like going back to where I was before, being in the same environment all
224   the time where things got bad, so I was kinda nervous.

225   I: How did you manage your anxiety at this time?

226   P1: Well...I kinda tried not to think about it. I found it hard at first but i stuck to it
227   and eventually i got used to it again.

228   I: Ok. Were your friends and family aware that you were feeling that way?

229   P1: Ermm..yea they knew that I was a bit worried about coming back but i
230   dunno. At the time, obviously i wasn't as close to them as i was before
231   cause i hadn't seen them in ages but when i was back at school, they were
232   happy i was back.

233   I: When you left inpatient admission, did you go back to school straight away?

234   P1: Yea I went to school a couple of days while I was here.

235   I: And what was it like going back to school?

236   P1: Well it was ok, I had a really good day going back but like every second, oh
237   look she's back (laughs). No one had known where I'd went, not a lot of
238   people knew.

239   I: What was it like having to manage that transition cause you were going from
240   here and then back to school full time life really and people were asking
241   questions.

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242   P1: Well it was really weird seeing different behaviours but I really like the first
243   day back and it wasn't really much of a problem for me.

244   I: And when people ask you where you'd been? was that something you talked
245   about?

246   P1: Well it depends, it was someone i wasn't really friends with then i would say
247   don't worry but if it was someone i kinda knew then i would say.

248   I: So yea you've talked about your concerns, were there any personal concerns
249   for yourself? Anything that you were more scared of or worried about than
250   anything else?

251   P1: Not really no.

252   I: What is your understanding of recovery?

253   P1: Ermm....(pause) I'm not too sure but with me it just kind of happened like
254   eventually over time.

255   I: What is the recovery that has happened for you?

256   P1: Kind of realising that everything i had thought before wasn't really how it
257   was. I was kind of stuck in a weird mindset but after the treatment it's like I
258   saw things differently and think differently.

259   I: Would you say that at the time of your discharge, you were in recovery?

260   P1: Ermmm... I wouldn't say i was in recovery after discharge but obviously
261   physically I had gained the weight and it did get a little bit more difficult
262   cause there was a big change, but i felt like after that, after like 6 months or
263   so, things gradually got a lot better.

264   I: So you wouldn't say you were in recovery at the time of your discharge?

265   P1: No. I don't think I was in recovery at the time of my discharge.

266   I: That's interesting that you were still discharged. Thinking about that, what are
267   your thoughts about that?

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268   P1: Ermm just kind of that I was trusted if that makes sense. They just trusted
269   me to continue making progress. It took me a while before I could trust
270   myself though.

271   I: trusted. so could we say your discharge was partly based on trust?

272   P1: Yea

273   I: Ok. Have you experienced any challenges to your recovery process since
274   you've been discharged from inpatient treatment?

275   P1: Ermm nothing big just obviously like little triggers and things like that,
276   nothing huge. Just like things that people would say. So like them kind of
277   saying things like 'I'm so unhappy about my body' and I'm kind of sat there
278   a bit awkward and not being able to say anything. You don't get that while
279   you're in hospital cause everyone is careful about what they say around
280   you.

281   I: How do you manage that?

282   P1: I just try to contradict what they are saying. That's it really, not much else I
283   can do.

284   I: In terms of your thoughts, are those sometime challenging?

285   P1: not really, not anymore.

286   I: when did that start to change for you?

287   P1: Ermm that wasn't really a point, it was all really just gradual.

288   I: And it wasn't something that happened at the point of discharge?

289   P1: No, it was after.

290   I: Is there anything that's hindering or affecting your ongoing recovery?

291   P1: No.

292   I: We've talked about friends and family, what else would you say is enabling
293   your recovery right now?

294   P1: Ermm kind of motivation almost, just kinda carrying on what i'm doing.

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