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Stuffing down feelings: Bereavement, anxiety and emotional detachment in the life stories of people with eating disorders.

## Abstract

This study aimed to explore the life stories of people with eating disorders in order to better understand possible contributing factors to their development. It used a qualitative Life Story method, in order to reduce the tendency to focus on the negative in the lives of people with eating disorders. Sixteen people in contact with an eating disorders charity participated. Data were analysed using a thematic analysis. Despite the attempt to elicit both positive and negative information, most themes from the life stories were negative. Here, the focus is on the three most common themes reported, which are less often reported in previous research: 1. substantial bereavement and loss; 2. major issues with anxiety; 3. difficulties coping with emotions. A model is proposed whereby major losses and the resultant anxiety can lead to emotional deadening and “stuffing down feelings” with food, leading on to an eating disorder. This model implies that interventions need to consider psychological factors in an eating disorder, especially the use of it as a dysfunctional coping strategy, as well as the behavioural and physiological aspects of an eating disorder.

Keywords: Eating disorders, bereavement, anxiety, dysfunctional coping, detachment, Life story method, qualitative.

## Life stories of people with eating disorders

### What is known about this topic

- \* People with eating disorders have often experienced childhood abuse, trauma or maltreatment.
- \* Disordered eating usually develops in adolescence and tends to persist.
- \* There are many other possible influences on eating disorders.

### What this paper adds

- \* Bereavement and loss, anxiety, and difficulties managing emotions occurred in the life stories of almost all participants.
- \* An eating disorder may be a learned dysfunctional means of coping with emotion by 'stuffing down feelings'.
- \* The narrative of the eating disorder can sometimes mask other stressful and upsetting events.

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5863 words

Understanding the development of eating disorders is important because they are relatively common, severe, mental health problems with high morbidity and mortality, which can be difficult to treat, so prevention or early intervention would be preferable. Eating disorder prevalence is perhaps 5.1% amongst adults (National Institute for Health and Care Excellence, 2017) and people who have eating disorders (EDs) have high morbidity and mortality (e.g. Herzog, Nussbaum, & Marmor, 1996), as well as frequent comorbidity including depression and anxiety (Godart, Flament, Perdereau, & Jeammet, 2002; Hsu, Crisp, & Callendar, 1992; Hughes, 2012) and substance abuse (Jones, Cheshire, & Moorhouse, 1985). In the 21<sup>st</sup> Century, combined explanations are preferred (Abraham & Llewellyn-Jones, 2001) including the complex of factors to be reviewed below, rather than theories involving simple causation.

More longitudinal research on the development of ED is required (Ball & Lee, 1999) but it is rare because of the resources required, which would include a follow-up from childhood to early adulthood and a large sample size to include sufficient people who develop eating disorders. An alternative is the use of narrative methods, such as the life story method employed here, to obtain data about people's remembered history. While retrospective data is subject to biases of memory and narrative reconstruction, narrative methods can illuminate the interplay of factors in a person's life that may be pertinent to their eating disorder.

There is some quantitative longitudinal research on disordered eating, measured by questionnaire, but a high questionnaire score is not coterminous with ED diagnosis.

Predictors of disordered eating can be categorised as: (a) prior issues regarding weight

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and/or body image, including prior disordered eating, weight-related teasing and bullying;

(b) anxiety, perfectionism and low self-esteem, which also predict many other psychological

issues. For some people these may be related to prior weight issues, for others these may

be independent risk factors; (c) Poor relationships with parents, which additionally predict a

wide range of psychological issues. One longitudinal study explicitly looked at predictors of

EDs and found that childhood adversity in general, as well as parenting issues, were

predictive (Johnson, Cohen, Kasen, & Brook, 2002a).

Specific predictors of disordered eating measured by questionnaire in adolescence include

elevated disordered eating scores when younger (Evans et al., 2017) and body

dissatisfaction (Evans et al., 2017; Ferreiro, Seoane, & Senra, 2014). Bodily and eating

concerns tend to be stable across adolescence (Ferreiro, Seoane, & Senra, 2012, reflecting

the common finding in longitudinal research that past behaviour (usually measured by self-

report) is the best predictor of current behaviour (substance use predicts substance use,

offending predicts offending and so on; Hammersley, 2008, pp105-106). Other predictors of

disordered eating are: bullying (Copeland et al., 2015; Lee & Vaillancourt, 2018) including

weight-related teasing (Hunger & Tomiyama, 2018); perfectionism (Boone, Soenens, &

Luyten, 2014); anxiety (Hughes, 2012); depression (Haynos, Watts, Loth, Pearson, &

Neumark-Stzainer, 2016; Johnson, Cohen, Kotler, Kasen, & Brook, 2002a); poor relationship

with a parent (Cerniglia et al., 2017; Johnson, Cohen, Kasen, & Brook, 2002b); low self-

esteem (Haynos et al., 2016). Self-reported depression and anxiety are also often co-morbid

with eating issues in adolescence (Hughes, 2012), although the research evidence has been

of low quality due to methodological problems including small sample sizes, mixed or

unclear samples, undeclared sampling biases and diverse assessment methods (Godart et

al., 2002).

Many people with EDs report childhood abuse and maltreatment (Molendijk, Hoek, Brewerton, & Elzinga, 2017), particularly sexual abuse (Dancyger, Narayan, & Fornari, 2017; Madowitz, Matheson, & Liang, 2015). The role of life events more generally as possible predictors of disordered eating has been less researched. Clinical studies find that negative or stressful life events often precede the development of an ED (Schmidt, Tiller, Blanchard, Andrews, & Treasure, 1997; Troop, 2016). Life stress is consistently found to be associated with the onset and development of disordered eating (Ball & Lee, 1999; Bennett & Cooper, 1999; Loth, van den Berg, Eisenberg, & Neumark-Sztainer, 2008) and childhood adversity is also a precursor (Johnson, Cohen, Kasen, & Brook et al., 2002b). One retrospective qualitative study using a family life cycle approach found that major life events including bereavements and major life transitions had often helped trigger an ED, particularly if the child had not received support during the life events (Berge, Loth, Hanson, Croll-Lampert, & Neumark-Sztainer, 2012). Another retrospective study found binge eating disorder was often triggered by traumatic events including bereavement, separation from a family member and accidents (Degortes et al., 2014).

Most studies are retrospective and conceptualised as studying the relationship between ED and some set of possible risk factors. Participants are asked about, or complete questionnaires about, their ED and their current and prior psychological condition. The implicit assumption is that bad things, such as an ED, are caused by prior bad experiences. Consequently, participants may be biased towards reporting prior bad experiences. Davies (1997) provides relevant examples of this type of bias in addiction research.

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Attempting to reduce such bias, the present study used the Life Story Method (McAdams, 2008a), which involves retrospective interviews that ask participants structured yet open-ended questions which facilitate reporting key life experiences. The method did not ask questions specifically about eating behaviours, allowing participants to place such issues in their lives however they felt was appropriate. This approach aimed to explore the life stories of people with eating disorders in order to better understand possible precipitating or contributing factors in the development of these disorders.

## METHOD

### Ethics

The research was approved by the procedures of the ethics committee of the Faculty of Health Sciences of the University of Hull, which accord with the Declaration of Helsinki. In conducting the research, there were three substantive ethical considerations.

Life story data are intimate and detailed, so the confidentiality of participants and all other people and entities was paramount. All names, geographical locations and other key details were anonymised. Quotations have not been attached to a participant number or name to further obscure identity.

Participants had or were recovering from EDs, so there was a duty of care. Most participants were already under the care of a local ED charity and had regular support from mental health professionals, support workers or their own support network. As interviews concluded, participants were asked to reflect on how they had found the experience and the researcher checked that participants felt alright and knew how to gain support if

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required. Interviews were conducted by health and social care practitioners (the first and third authors and another) who were competent to provide immediate emotional support if required.

Some risk of vicarious trauma existed for the researchers (Jenkins & Baird, 2002). There was research supervision by the first author, a clinical psychologist. Plus, for the second author who led on analysing the data, reflective journaling was used to allow the expression of any thoughts or feelings which had surfaced (whilst protecting the confidentiality of the data) during the interviewing and analysis stages of the research and ensuring that regular breaks were taken to reduce stress.

#### Participants

Service users were informed of the research project by the service's psychologist (1<sup>st</sup> author). Volunteer participants (n=16; 15 female and 1 male) were all current or former service users at a North of England based eating disorders charity, at various levels of recovery. All who volunteered were interviewed, without any purposive sampling strategy. The service is inclusive and allows self-referral, so while all participants described serious life-impacting issues with their eating, they did not necessarily have a specific diagnosis. The age range was from 19 to 58, 3 were students, 3 were in their 20s, 4 were in their 30s, 5 were in their 40s and 1 was in her 50s. All but two were university educated. Eight were or had been married or in a long-term partnership, while 4 had children.

Interview method:

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Dan McAdams' Life Story Interview (McAdams, 2008b) was used as adapted by Hammersley et. al., 2016) then adjusted to refer to eating disorders instead of drug injecting. This encourages systematic recall of key aspects of the person's life. The participant is asked to separate life into chapters or episodes of their choosing, then tell the story of each episode and identify the best and worst experience in each episode. Specific questions about life are also asked. The interview protocol is available in a supplementary file. Interviews occurred in a private room at the service and were audio recorded. Recordings were transcribed and erased after transcription. Transcripts ranged between 8,139 words and 21,464 words in length, with the modal length being 14,000-16,000 words.

Analysis:

Transcribed interviews were analysed using thematic analysis (Clarke & Braun, 2014), using the recommended phases: reading and rereading of transcripts with preliminary notes; initial coding of themes; organising themes and identifying superordinate and subordinate themes; reviewing data in light of draft themes; revising themes. The themes discussed here were the most common superordinate ones. Quotes used to support the themes have been edited to reduce repetition and irrelevant material (indicated by (...)), no attempt has been made to render regional accents.

Results:

All participants included having an eating disorder as a self-selected episode in their life stories. All participants also told stories that largely focussed on negative events and experiences, despite the life story method being neutral in how it asks about life. Consequently, as shown in Table 1, other than perfectionism and high achievement, the



themes found in the majority of the life story interviews were negative or problematised.

Because space is limited, here the main focus will be on the three themes found in at least 15/16 participants: bereavement and loss; anxiety and depression; doing feelings. These are more novel as issues related to eating disorders, whereas the others in Table 1 have been repeatedly identified in previous research. This is not to suggest that the other themes are unimportant, indeed many of the stories told of complex lives with multiple challenges.

Before discussing the three themes, we will summarise two women's stories to illustrate how the themes reported here fit into diverse lives that also included the other themes commonly found in research on EDs, notably depression, trauma and maltreatment and perfectionism.

\*\*\*Table 1 about here.

The first example story includes maltreatment in childhood: One woman in her 20s told of growing up with an alcoholic, depressed, anxious and neglectful mother [maltreatment], being bullied at school for wearing glasses and for being clever [maltreatment], then becoming anorexic. She was close to her grandmother, but lost her when she was 14, which she did not deal with well [loss], for she felt she had not learned how to deal with feelings [doing feelings]. She told of her nephew being shaken as a baby and also of another event that was so bad that she was unwilling to talk about it. At her worst, depressed, she had attempted suicide [anxiety and depression]. However, she also felt that having anorexia nervosa had been the best thing in her life, because it had eventually led to therapy, personal growth and improvement. She married, before recovering, had two children and was currently studying for a Masters degree. She said 'she would like to say' that she was

fully recovered, distancing herself slightly from that possibility, although she mentioned that she tended to snack on chocolate as an illustration that her diet was not completely healthy.

Another woman did not tell of maltreatment as a child, but described being a fussy eater up to age 5. At this time she had her appendix removed and had to be deprived of food for three days [trauma?], which led to her eating 'everything and anything' for the next five years, becoming 'quite chubby', as she matter-of-factly put it, being put on a diet and taken to activities that were exercise-based. This led on to doing dance at a school that emphasised performing arts, although she had 'idolised' university since she was 12 [perfectionism/ high achievement]. All this led to her eating disorder. Additionally, she had kidney failure when she was 11 and again seriously at 19 [trauma]. She and her parents both restricted her diet until she was about 13. As academic pressure increased, she became more restrictive. By the time of A-levels she was fainting and developed physical problems due to her restricted diet. She had low self-esteem [anxiety and depression] and had been in an abusive relationship where the police were involved [maltreatment]. At University living away from home she continued to be a workaholic, to restrict, and re-engaged with sports which often led to her fainting and to extreme tiredness [perfectionism, anxiety?]. Due to having so many things on, she felt out of control and her eating disorder got worse because she could control 'my food and my size.' She was diagnosed with anxiety and depression and at time of interview was repeating a year, having failed an exam (the first time ever) due to fainting and relapsing to the eating disorder. Her best experience was getting good A-level results, but she described being extremely anxious beforehand [anxiety and depression]. She also described multiple bereavements in the family and that her parents had considered divorce more than once [bereavement and loss]. Losses included her brother dying of cancer when she was eight and the loss of many other relatives,

although she expressed pride in her ability to be fine about this despite people criticising her as 'cold' [doing feelings]. Her goal was to become a supreme court judge. She felt recovered at time of interview and felt that she had moderated her drive for perfectionism and high achievement.

### Bereavement and Loss

All participants reported bereavement, as well as other losses in their lives which severely impacted them. Some reported multiple bereavements. Six participants identified bereavements as their worst childhood memory. Some participants had experienced the death of a close family member before developing an ED.

*"My sister took her own life when she was fifteen...and then my mum died the first year of my degree."*

*"I can't tell you anything other than the death of my mum, that's been the worst thing that's happened to me hands down. Erm, you know, I wish I'd died instead of my mum to be honest. Yeah, then I have to live without her...Unfortunately I lost my dad in 2008, erm, which although me and my dad weren't half as close as my mum, it was still a major impact on my life to be suddenly alone with no parents"*

*"my mum died in intensive care and that were bad enough but then my dad got admitted to in... to intensive care where I worked before when he was ill, I mean he did survive that and then when on to die"*

Participants also described emotional suffering as a result of the loss or breakdown of a parental relationship. One participant described a series of events beginning with her husband being sent to prison for four years which resulted also in the loss of her home and her relationship with her parents.

*"We lost the house. (husband) went bankrupt, lost the house... I think if I hadn't had three children god knows what I would have done. But I thought I have got to provide with these three children...My parents wouldn't have anything to do with me, wouldn't help out because I wouldn't divorce (husband). So I was homeless"*

Another experienced an abrupt change from a previously very close relationship with her father which led to low self-esteem and depression in her teenage years and contemplation of suicide before she sought help as a young adult.

*"...when my dad stopped talking to me. Um, it wasn't like... it's not that he doesn't talk to me, but um, our relationship, kind of, really went downhill at some point. I think I was about thirteen, fourteen..... Um, we were really, really close when I was a kid, and it was just, like, perfect and then, as I kind of grew up, he just suddenly stopped... at first he would just, kind of, make fun out of me; just teasing me, and then it kind of just started to get a bit worse."*

One participant felt that her chronic bowel problems began when her Grandmother died and worsened when her parents moved abroad when she was 18 years old, leaving her to face her significant health problems without parental support.

*"Erm, my parents moved abroad when I was eighteen. Erm, and they'd talked about it since I was about fifteen, sixteen so I always knew that it was on the cards. When my parents moved abroad, erm, after that was when my illness got worse really... Erm, I ended up having surgery things and my parents never came back...I was completely on my own when I had surgery"*

Participants also reported experiencing unresolved bereavements that they felt they had not dealt with or ever gotten over. Unresolved bereavement can have persistent adverse effects, where the initial pain of the loss remains intense for many years and sorrow and rumination underpin a lack of acceptance of the loss (Shear, 2015).

*"My brother died...I was eighteen. Well I didn't deal with my grief really from my brother dying 'cos that was... He died at Christmas and I went (to work abroad) in the February. And I'm realising now, although I'm just a bit of an emotional wreck anyway in general, but for me to even think about him to make me cry so much, I should be over that immediate stab of grief by now. And I think I should be but because I think I just...I shut the door to it for such a long time"*

*"And it was me mum and me mum was never ill and she always used to say to me, oh you'll be alright when you was ill and that was a bit of, like that, you know. Never had... never realised and all of a sudden, you know, my rock was gone and I always said, like I say that*

*my life ended when my mum died. That's very sad to say and I know it is because potentially I could have another thirty or forty years of my life and am I still gonna spend the rest of my life saying that. But I think I am because I'll never get over it."*

Some participants who had experienced multiple bereavements described a detached method of coping, see also the 'Doing feelings' theme to follow:

*"So it's natural for relatives to die off. Like we all get old. And it's just a really common thing.... I have been accused of being cold when it comes to death because I don't, it doesn't last long. You know, obviously from finding out they are dead and then the funeral, its, you know I am a bit upset but like the day of the funeral it's usually the most emotional, but after that, I am just like you know I have had my time, I don't need any more. It's a week tops of affecting me and then I just carry on as if it never happened"*

*"It's not a case of they've died, your upset...You're upset because you're selfish. So I, I kind of turn round and I go, if somebody's died, I go, "Hey, ho."*

Many participants experienced significant loss in their lives other than through death, such as divorce, the loss of a relationship, health, career, freedom, fertility and loss of own identity and felt that the losses played a significant part in their life story.

*"And everything I owned has been in boxes for the last twelve years. In storage in a garage, I'd lost my identity. I didn't know who I was. (...) You know, I used to be life and soul of a party"*

*"Mum and dad getting divorced... which meant selling the house, (Sister) said because we were strong enough that one would go with one parent and one would go with the other, so neither one are on their own. (Sister) said you have to go with mum because I think she felt if I didn't we would just grow apart. Whereas I did everything with my dad."*

So, all participants remembered substantial bereavement and loss in their younger lives. However, in general stories did not attribute participants' eating disorders to these or other adverse life events. Only five participants mentioned that the difficulties they recounted had contributed to their general psychological problems, of whom only two specifically mentioned their eating disorder.

Anxiety

There was a level of anxiety which affected thoughts and behaviours present in the life stories of all participants, both in the present day and in childhood. Common anxieties included catastrophic worries and avoidance of everyday activities. One woman described being anxious and fearful as a child due to being beaten by her parents for causing any mess or wasting food.

*“And there was a lot of unpredictability; we never knew when she was going to blow, and when she did blow she just wrecked the house if she didn’t get her own way...She would just wreck the house. Probably the unpredictability, I was just on edge as a child all the time”*

She then described her lifelong anxiety which she feels increases in severity as she gets older and leads her to try and control her life as a safety behaviour.

*“I just worry about everything, like the kids from London and all these attacks I am thinking oh god, ..the children get. And just let go thinking just let life happen, but I need to control. I think that’s when I figure out the control, and I think that’s what I would like to do not control.”*

Another woman developed anxiety after her father became emotionally distant from her and started to cruelly mock her in front of others.

*“I only really struggled with anxiety, and that was something I definitely did want to get better from because it was just, like, pretty much ruining my life.”*

For her, this led to avoidance of new experiences and a preference for being at home in a safe place.

*“But certainly, was frightened of going on a plane, not because of it crashing and stuff, just ‘cause it was all like alien to me and I don’t like pushing myself to do new experiences. I’d rather stay at home, do you know what I mean, because it’s easier.”*

Another man was diagnosed with anxiety and depression, which he had not recognised, presumably not fully realising that people with anxiety and depression are not unhappy continuously.

*“I was diagnosed with severe anxiety erm disorder which is linked to my panic attacks and fainting and then I also got diagnosed with depression as well, which I thought was really unusual because I am a really happy jolly person”*

After he had relocated, he was unable to pin-point the cause for his physical symptoms until they developed into a panic attack and emotional breakdown.

*“I was starting to feel ill but I didn’t know what was wrong. I just thought it was the excitement of moving and relocating and whatever, I wasn’t sleeping. And that’s when the bingeing started because I couldn’t use the kitchen. I was ordering take-aways and living off pies, pasties Anyway I got made redundant, erm, from that and I got, I managed to get a job back with my old company, but I had to relocate. Woke up one morning and I couldn’t move, I couldn’t get out of bed. I was breathless, erm, I managed to get up, get myself to work and I couldn’t get out of the car. So I just sat in the car and I just broke down”*

Other participants described a fear of anxiety itself that worsened things; worry that severe anxiety will return to ruin future life events.

*“But at the moment because I’m sort of suffering with like anxiety and stuff at the minute, I am frightened that when I get these feelings and these tightenings in my chest and I start to panic, I am scared that it’ll...that it’s going to set me back.”*

*“And it spoils things. It’s like the wedding again just because it is quite important at the moment but like, I don’t want to ruin that day because I can’t cope with being me and I do blame, I blame myself for it but I am like, why don’t other people feel this. Why is everyone else seems to be fine having like coffee and cake and like, you know when it’s like a bit warmer and people are putting on skirts and stuff, not like really short but just a skirt and I think like, why can’t I do that?”*

This woman developed anxiety as a child which she attributed to her mother’s anxiety about her father’s wellbeing, which she also felt to be her worst childhood memory.

*“The worst things I remember and what was giving me most of the anxiety at that time, was we were always waiting for my dad to come back from work. Because, er, we didn’t have mobile phones.....in the early nineties, I think. It was like we had to, because he was driving sometimes long distances, my mum was always worried that he’s not going to come back*

*home. That something's going to happen. And er, and I remember just waiting, you know, sometimes eight, nine, ten o'clock, he was coming late from work, just sitting on the windowsill, looking at him, whether he's coming or not, and my mum was very worried and very scared. Where is he, what is he doing? Maybe he had some accident, you know, all of some sort of scenarios. So I remember this wasn't very good because I was worrying that something may be wrong, going to happen."*

In short, all participants experienced significant anxiety and some related this to recurrent anxiety provoking events from childhood.

#### Doing feelings

Many participants told of difficulties expressing or describing emotions. Sometimes they were quite explicit about this, at other points in the stories it came through as contradictory statements, uncertainty about their own behaviours and motivations and in difficulty explaining their beliefs. Some participants felt unable to cope with life challenges and used restrictive behaviours instead as something that they could control.

One woman described her adolescent years as *"trying to stay thin and block emotions out"*. Others said similar things.

*"Um, I'm not very good at showing my emotions, so I bottle a lot of it up, um, so on the outside I'm okay uh but on the inside um I felt quite poorly, quite sick – you know, I couldn't eat, sleep. And it...I think people who can express their emotions quite well always seem to do better than the people that can't"*

*"Erm, and I found, as a child, I used to, erm, because I couldn't communicate as such, I, I used to, I guess I, I found peace in food. I used to hide food under my bed."*

Some participants felt that they coped successfully with emotional events by detached or avoidant coping. However, in trauma treatment research detachment is considered a symptom of traumatisation, not a coping method (REF).

*"I have had grandparents, aunts and uncles. You know just, we have quite a lot of deaths in the family and I cope a lot better than people expect me to cope"*



*“So I, I kind of turn round and I go, if somebody’s died, I go, “Hey, ho.”...It happens. So, you know, at least they’ve got a family network who can go and support them....I’ve never I suppose in all the years, I’ve, I’ve I, I’ve seen death and dealt with it, I’ve never, I’ve given the support but I’ve never been offered it back. So my outlook on death is, it happens.”*

Participants described their responses to upsetting life events and how the ED is used to avoid emotional pain.

*“that’s the thing in our family, don’t say anything, you know, which comes in with the food. Don’t say anything so you stuff it down, you know. Don’t, like don’t upset your mam, stuff it down. Don’t upset your son, stuff it down, you see.”*

*“Erm, another reason I binge eat is ‘cause of the, I see me as, as ugly and I think if I met myself this way then I know,...People won’t ev- even give me a glance.”*

Another participant gave a factual account of some very challenging life events including life threatening health problems, coping with miscarriage and divorce, but when asked how these events had made her feel, there was a lack of emotional content in her reply. Other participants use caring for others as a method of avoiding their own emotions;

*“One of them died an hour before my brother did. And then they lost his son. And you know when you just think god that must be really hard for him, and I remember thinking that at the time. I wasn’t really thinking oh my god my brother’s died, I was just thinking oh poor dad has just lost three members of his family just like that. And my mum’s lost a child, how can anyone, how can anyone know how that feels you know [Sniffles] and I just remember thinking god how awful ...for them.”*

*“I just tried to be strong for everyone else. .... And, um, I remember when I was telling my counsellor about it, when I, when I went back to college, he was just like, “You just thought about everyone else but you never thought that you were hurting as well,” and I was, like, it’s, kind of, true; I just didn’t.”*

Additionally, some stories initially narrated an account of developing an ED in childhood and adolescence, then, when asked more direct questions such as ‘What was your worst childhood experience’, told about major and traumatic life difficulties that had also occurred. It was as if the story of the ED had come to block and replace the other upsetting

narratives. Participants told of using ED behaviours as something that they could control when things were difficult. It also seemed that having an ED was a way of detaching from other problems. While focussing on restraint, they needed to think less about emotional events such as bereavements.

## Discussion

This study found that people with EDs remembered substantial bereavement, sometimes multiple bereavements. All participants told of substantial challenging losses that had affected them badly, being, for example, the worst thing that they could remember from childhood. Findings using the life story method confirm that the precursors of EDs and disordered eating often include major stressful life events (Bennett & Cooper, 1999; Ball & Lee, 1999). Thinking about severity rather than causality, the events reported by most participants potentially constitute severe trauma (Cohen et al., 2012) because they were often repeated, involved family members and had major consequences, although participants' stories did not generally mention Cohen et al's (2012) final criterion of internalising responsibility for the events. It appears that it is possible for people with eating disorders to be traumatised even if they have not specifically experienced maltreatment, although some reported both.

One cannot infer cause and effect in a retrospective narrative study, but all participants also told of struggling with anxiety, and having difficulties with emotions. This is concordant with participants reacting to repeated trauma by learning that bad things can happen and becoming anxious and also detaching emotionally (Cohen et al, 2012). Some participants came from families that reportedly did not 'do' emotions. Berge, et al., (2012) found that transitions, including bereavements and maltreatment, without emotional support from the family could precipitate eating disorders. Participants' stories did not tell of the impact of bereavement and other trauma on their parents, which may have affected the entire family's handling of emotions and also have reduced the support provided. These events may have been formative in the development of an eating disorder, but they also led to anxiety and avoidance coping. Avoidance coping tends to impair academic performance (Boyras, Zhu & Waits, 2019), so perhaps eating disorders can serve the function of detachment without avoidance. This enables the person to continue to engage and perform adequately in stressful situations, such as in education, while using their ED behaviours as

something to control (Williams & Reid, 2010), with the added benefit that this control prevents the typical weight gain associated with stress (Wardle et al., 2011).

Weaknesses of this study were that it involved a modest number of participants, mostly women, and was retrospective. However, the methodology structures the life story in a balanced way, rather than focussing on negative antecedents of current problems.

Nonetheless, the stories that were told and the themes in them were negative and told of serious life challenges that predated the eating disorder.

Recovery from an eating disorder does not necessarily entail being symptom free (Slof-Op't Landt, Dingemans, Torre Y Rivas & Furth, 2019). The present data suggest that often this may be due in part to the person still not having dealt with whatever serious adversities they had experienced prior to developing an eating disorder. An eating disorder, like other mental health problems, can be both a consequence and symptom of life adversities. To fully recover, people may need to learn to identify, accept and deal with emotions and thoughts, including about bad things that they had done in the course of their problems. Moreover, with serious trauma 'recovery' may be a misnomer because trauma is not a 'condition' or a 'disease', so moving on from trauma does not return to some normal pre-disease state. Instead, knitting oneself into society (Cyrulnik, 2009), may require learning alternative ways of coping with negative memories and feelings other than 'stuffing them down' and learning psychosocial skills that may have been previously impaired or absent, such as trust, doing feelings and remaining engaged even when life becomes negative. From these data, and previous research on people who have injected drugs (Hammersley et al., 2016) it appears that multiple unexpected bereavements can traumatise people and contribute to serious mental health problems.

Psychological treatment for eating disorders currently tends to focus on changing present dysfunctional behaviours and thoughts. There appears to be a need also to address more longstanding issues from the past, especially bereavements, anxiety and abuse, and to learn more functional strategies for coping with feelings. Indeed, schema therapy for eating disorders is beginning to be used for this purpose (Pugh, 2015; Simpson & Smith, 2019).

Figure 1. summarises the relationships between prior difficulties and an eating disorder. Focusing on weight gain and a balanced diet will not address whatever trauma issues

remain from the past, nor will it help people to express emotion or manage anxiety more effectively. Because these different issues are interdependent, it will often be difficult to treat them separately, which is where more systemic interventions such as schema therapy may have potential.

In conclusion, this study adds to the evidence that suggests that interventions for eating disorders need to consider how the past is continuing to affect the client's current psychological condition, as well as implementing changes in dysfunctional patterns of eating and restraint activity.

## References

- Abraham, S, and Llewellyn-Jones, D. (2001) *Eating Disorders: The Facts*. Oxford: Oxford University Press.
- Ball, K., & Lee, C. (1999). Relationships between psychological stress, coping and disordered eating: A review. *Psychology & Health, 14*(6), 1007-1035.
- Bennett, D., & Cooper, C. (1999). Eating disturbance as a manifestation of the stress process: A review of the literature. *Stress Medicine, 15*(3), 167-182.  
doi:10.1002(SICI)1099-1700(199907)15:3<167:AID-SMI812>3.0.CO;2-7
- Berge, J. M., Loth, K., Hanson, C., Croll-Lampert, J., & Neumark-Sztainer, D. (2012). Family life cycle transitions and the onset of eating disorders: A retrospective grounded theory approach. *Journal of Clinical Nursing, 21*(9-10), 1355-1363. doi:10.1111/j.1365-2702.2011.03762.x
- Boone, L., Soenens, B., & Luyten, P. (2014). When or why does perfectionism translate into eating disorder pathology? A longitudinal examination of the moderating and mediating role of body dissatisfaction. *Journal of Abnormal Psychology, 123*(2), 412-418.  
doi:10.1037/a0036254
- Boyratz, G., Zhu, Y. & Waits, J.B. (2019) Avoidance coping and academic locus of control as mediators of the relationship between posttraumatic stress and academic achievement among first-year college students, *Anxiety, Stress & Coping, 32*:5, 545-558, DOI: 10.1080/10615806.2019.1638681

Life stories of people with eating disorders

Brinkman, S. & Kvale, S. (2014) *InterViews: Learning the craft of qualitative research interviewing*. 3rd Edition. London: Sage.

Cerniglia, L., Cimino, S., Tafa, M., Marzilli, E., Ballarotto, G., & Bracaglia, F. (2017). Family profiles in eating disorders: Family functioning and psychopathology. *Psychology Research and Behavior Management*, 10, 305-312. doi:10.2147PRBM.S145463

Clarke, V. and Braun, V. (2014) Thematic Analysis. In Teo, T. (Eds) *Encyclopedia of Critical Psychology*. Springer: New York.

Cohen, J.A., Mannarino, A.P., & Deblinger, E. (Eds.). (2012). *Trauma-focused CBT for children and adolescents: Treatment applications*. New York: Guilford Press.

Copeland, W. E., Bulik, C. M., Zucker, N., Wolke, D., Lereya, S. T., & Costello, E. J. (2015). Does childhood bullying predict eating disorder symptoms? A prospective, longitudinal analysis. *International Journal of Eating Disorders*, 48(8), 1141-1149. doi:10.1002/eat.22459

Cyrułnik, B. (2009). *Resilience*. London: Penguin.

Dancyger, I., Narayan, G. A., & Fornari, V. (2017). Eating disorders and abuse. *Adolescent Psychiatry*, 7(4), 236-252. doi:10.21742210676608666180112123154

Davies, J. B. (1997). *The myth of addiction*. London: Psychology Press.

Degortes, D., Santonastaso, P., Zanetti, T., Tenconi, E., Veronese, A., & Favaro, A. (2014). Stressful life events and binge eating disorder. *European Eating Disorders Review*, 22(5), 378-382. doi:10.1002/erv.2308

Evans, E. H., Adamson, A. J., Basterfield, L., Le Couteur, A., Reilly, J. K., Reilly, J. J., &

Parkinson, K. N. (2017). Risk factors for eating disorder symptoms at 12 years of age: A 6-year longitudinal cohort study. *Appetite, 108*, 12-20. doi:10.1016/j.appet.2016.09.005

Ferreiro, F., Seoane, G., & Senra, C. (2012). Gender-related risk and protective factors for depressive symptoms and disordered eating in adolescence: A 4-year longitudinal study. *Journal of Youth and Adolescence, 41*(5), 607-622. doi:10.1007/s10964-011-9718-7

Ferreiro, F., Seoane, G., & Senra, C. (2014). Toward understanding the role of body dissatisfaction in the gender differences in depressive symptoms and disordered eating: A longitudinal study during adolescence. *Journal of Adolescence, 37*(1), 73-84. doi:10.1016/j.adolescence.2013.10.013

Godart, N., Flament, M., Perdereau, F., & Jeammet, P. (2002). Comorbidity between eating disorders and anxiety disorders: A review. *International Journal of Eating Disorders, 32*(3), 253-270. doi:10.1002/eat.10096

Hammersley, R. (2008). *Drugs and Crime: Theories and Practices*. London: Polity.

Hammersley, R., Dalgarno, P., McCollum, S., Reid, M., Strike, Y., Smith, A., Wallace, J., Smart, A., Jack, M. & Liddell, D. (2016). Trauma in the childhood stories of people who have injected drugs. *Addiction Research and Theory, 24*, 131-151  
<http://dx.doi.org/10.3109/16066359.2015.1093120>.

Life stories of people with eating disorders

Haynos, A. F., Watts, A. W., Loth, K. A., Pearson, C. M., & Neumark-Stzainer, D. (2016).

Factors predicting an escalation of restrictive eating during adolescence. *Journal of Adolescent Health, 59*(4), 391-396. doi:10.1016/j.jadohealth.2016.03.011

Herzog, D., Nussbaum, K., & Marmor, A. (1996). Comorbidity and outcome in eating

disorders. *Psychiatric Clinics of North America, 19*(4), 843. doi:10.1016/S0193-953X(05)70385-3

Hsu, L., Crisp, A., & Callender, J. (1992). Recovery in anorexia-nervosa - the patients

perspective. *International Journal of Eating Disorders, 11*(4), 341-350.

doi:10.1002/1098-108X(199205)11:4<341::AID-EAT2260110408>3.0.CO;2-G

Hughes, E. K. (2012). Comorbid depression and anxiety in childhood and adolescent

anorexia nervosa: Prevalence and implications for outcome. *Clinical Psychologist, 16*(1, SI), 15-24. doi:10.1111/j.1742-9552.2011.00034.x

Hunger, J. M., & Tomiyama, A. J. (2018). Weight labeling and disordered eating among

adolescent girls: Longitudinal evidence from the national heart, lung, and blood institute growth and health study. *Journal of Adolescent Health, 63*(3), 360-362.

doi:10.1016/j.jadohealth.2017.12.016

Jenkins, S., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A

validation study. *Journal of Traumatic Stress, 15*(5), 423-432.

doi:10.1023A:1020193526843



Life stories of people with eating disorders

Johnson, J., Cohen, P., Kasen, S., & Brook, J. (2002a). Childhood adversities associated with risk for eating disorders or weight problems during adolescence or early adulthood.

*American Journal of Psychiatry*, 159(3), 394-400. doi:10.1176/appi.ajp.159.3.394

Johnson, J., Cohen, P., Kasen, S., & Brook, J. (2002b). Childhood adversities associated with risk for eating disorders or weight problems during adolescence or early adulthood.

*American Journal of Psychiatry*, 159(3), 394-400. doi:10.1176/appi.ajp.159.3.394

Johnson, J., Cohen, P., Kotler, L., Kasen, S., & Brook, J. (2002). Psychiatric disorders associated with risk for the development of eating disorders during adolescence and early adulthood. *Journal of Consulting and Clinical Psychology*, 70(5), 1119-1128.

doi:10.1037/0022-006X.70.5.1119

Jones, D., Cheshire, N., & Moorhouse, H. (1985). Anorexia-nervosa, bulimia and alcoholism - association of eating disorder and alcohol. *Journal of Psychiatric Research*, 19(2-3), 377-380.

Lee, K. S., & Vaillancourt, T. (2018). Longitudinal associations among bullying by peers, disordered eating behavior, and symptoms of depression during adolescence. *Jama Psychiatry*, 75(6), 605-612. doi:10.1001/jamapsychiatry.2018.0284

doi:10.1001/jamapsychiatry.2018.0284

Loth, K., van den Berg, P., Eisenberg, M. E., & Neumark-Sztainer, D. (2008). Stressful life events and disordered eating behaviors: Findings from project EAT. *Journal of Adolescent Health*, 43(5), 514-516. doi:10.1016/j.jadohealth.2008.03.007

doi:10.1016/j.jadohealth.2008.03.007

Life stories of people with eating disorders

Madowitz, J., Matheson, B. E., & Liang, J. (2015). The relationship between eating disorders and sexual trauma. *Eating and Weight Disorders-Studies on Anorexia Bulimia and Obesity*, 20(3), 281-293. doi:10.1007/s40519-015-0195-y

McAdams, D. P. (2008a). Personal narratives and the life story. In O. John P., R. W. Robins & L. A. Pervin (Eds.), *Handbook of personality: Theory and research* (3rd ed., pp. 242-262). New York: Guilford Press.

McAdams, D. P. (2008b). *The Life Story Interview*.

<https://www.sesp.northwestern.edu/foley/instruments/interview/>, accessed 24/1/2019

Molendijk, M. L., Hoek, H. W., Brewerton, T. D., & Elzinga, B. M. (2017). Childhood maltreatment and eating disorder pathology: A systematic review and dose-response meta-analysis. *Psychological Medicine*, 47(8), 1402-1416. doi:10.1017/S0033291716003561

National Institute for Health and Care Excellence. (2017). Putting NICE guidance into practice. resource impact report: Eating disorders: Recognition and treatment. *NG69*

Pugh, M. (2015). A narrative review of schemas and schema therapy outcomes in the eating disorders. *Clinical Psychology Review*, 39, 30-41. doi:10.1016/j.cpr.2015.04.003

Schmidt, U., Tiller, J., Blanchard, M., Andrews, B., & Treasure, J. (1997). Is there a specific trauma precipitating anorexia nervosa? *Psychological Medicine*, 27(3), 523-530. doi:10.1017/S0033291796004369

Life stories of people with eating disorders

Simpson, S., & Smith, E. (Eds.). (2019). *Schema therapy for eating disorders: Theory and practice for individual and group settings*. London: Routledge.

Slof-Op 't Landt, MCT, Dingemans, AE, Torre Y Rivas, J, Furth, EF. (2019). Self-assessment of eating disorder recovery: Absence of eating disorder psychopathology is not essential. *International Journal of Eating Disorders*. 52: 956–961.  
<https://doi.org/10.1002/eat.23091>

Troop, N.A. (2013) Helplessness, mastery and the development of eating disorders: Exploring the links between vulnerability and precipitating factors. *Eating and Weight Disorders*. 17 (4), e274-e281.

Troop, N. A. (2016). Social rank, rank-related life events and eating pathology. *European Eating Disorders Review*, 24(1), 75-77. doi:10.1002/erv.2386

Wardle, J., Chida, Y., Gibson, E. L., Whitaker, K. L., & Steptoe, A. (2011). Stress and adiposity: A meta-analysis of longitudinal studies. *Obesity*, 19(4), 771-778.  
doi:10.1038/oby.2010.241

Williams, S. & Reid, M. (2010). Understanding the experience of ambivalence in anorexia nervosa: the maintainer's perspective. *Psychology and Health*, 25, 551-567.

Table 1: Summary of themes in life stories of participants with eating disorders

Life Experience	Frequency
Bereavement and loss	16/16
Anxiety	16/16
Doing feelings: Difficulties expressing emotions and being emotionally resilient	15/16
Depression and suicidal ideation/attempts	14/16
Stability and attachment issues	14/16
Pre-occupied with control	14/16
Social isolation and exclusion	14/16
Low self-esteem	13/16
Victim of physical, sexual and/or emotional abuse	12/16
Victims of bullying	12/16
High achieving/Academic	11/16
Problematic parental relationship	10/16
Food anxiety	9/16
Guilt and shame	9/16

Figure 1: Relationships between prior life difficulties and an eating disorder.

