Middlesex University and Metanoia Institute

‘Body of evidence’ - The experience of patients with anorexia nervosa regarding imagery related to food, weight and shape

Research Thesis

Suzi Doyle

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ABSTRACT

Aims: The primary aim of this study was to augment the body of largely quantitative empirical work informing psychological therapy with people diagnosed with eating disorders, in particular, anorexia nervosa, through a collaborative exploration of the lived experience of sufferers, focusing on imagery related to food, weight and shape. This involved the development of an understanding of the themes inherent in the experience of women with anorexia nervosa, based on their in-depth descriptions. **Design:** Interpretative Phenomenological Analysis (IPA) offers a framework for exploring the lived experience of people embedded within a context, and the meanings that people attach to their experience. This qualitative approach was considered suitable for this study, given its aim of engaging with rich descriptions of people's experiences. **Method:** Participants were ten women aged between 18 and 30, with a current diagnosis of anorexia nervosa, who volunteered for interview. In-depth, semi-structured interviews were conducted with the aim of learning about the participants' embodied experience and how they made sense of their experience. **Findings**: Analysis using IPA led to the emergence of three Master themes, each constituting a pair of constructs which represent polarities within a realm of experience, namely (1) fragmentation versus integration, (2) exposure versus protection and (3) isolation versus relatedness. Within each realm of experience, there was stronger support within the data for the first construct (namely, fragmentation, exposure and isolation) than for its polar opposite. Organisation of Master themes according to this interpretation allowed for the possibility that participants might potentially experience to a greater extent the opposite polarities of integration, security and relatedness. **Conclusion:** Psychological therapy for people diagnosed with anorexia nervosa can be enhanced by an understanding of the use of the body in constricting the self in order to feel safe. Imagery work may be integrated into therapy to support clients in developing the capacity for integrated, self-reflective and embodied engagement in their relating to self, others and the wider context.

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The body is the vehicle of being in the world, and having a body is, for a living creature, to be involved in a definite environment, to identify oneself with certain projects, and to be continually committed to them.

(Merleau-Ponty, 1962, p. 82)

1. Introduction

1.1. Prologue

This research constitutes an exploration of the experience of 10 young women with anorexia nervosa, with an intention to understand in particular - though not exclusively - the imagery related to food and their bodies that may permeate these women's experience. Through detailed descriptions faithful to the accounts of my participants, it is my aim to convey a sense of the embodied response to food and images of the body, the associated emotions and the meanings that are attached to the lived experience of one with anorexia nervosa.

1.2. Personal relevance

That I am not often asked why I chose to embark on a lengthy and detailed exploration of this particular pathology is interesting, considering that according to most standards, my own physique would be considered very slim – even 'skinny'. Perhaps their theories regarding my possible personal motivation to explore the unhealthy face of the drive for thinness cause others to hesitate at enquiring further. In actuality, my personal experience of relating to food and my body has at various times occupied a position at different points on the continuum between comfortable, fully-accepting security and anxious, pathological pre-occupation. If this is not necessarily a typical story for a Western, middle-class woman, it is certainly not unusual.

It was my good fortune that these issues lost potency during my training in psychological therapies. Despite wondering at times about what lay below the obvious explanations for my particular manifestation of the wounded self, my inclination was to close that unhappy chapter and embrace other, more fulfilling challenges. However, when searching for a research area with personal relevance, I was urged by some in the therapy field whom I trusted and respected, to make positive use of my experience. This idea grew in value as I entered the challenging role of mothering teenage daughters and was touched by the recognition of problematic relationships

with body and food in some of their friends. I undertook a training with the National Centre for Eating Disorders (NCFED) and, as a registered NCFED practitioner, I became more certain that through conducting a research study in this challenging area, I could make a contribution to the field that would be of value and of particular relevance to me personally.

1.3. Clinical considerations

Having chosen to re-engage with the topic of eating disorders from a researcher's perspective, I contacted several key practitioners in the field to seek guidance as to a focus that would be likely to lead to a meaningful contribution to the field. This quest led to a body of work by other psychologists who have used imagery to work with people suffering from social phobia. Characteristics shared by those with social phobia and people with anorexia nervosa raised the question of whether this approach might provide a means of assisting people with the eating disorder. A degree of comorbidity between anorexia nervosa and anxiety disorders lent further support to the rationale for exploring ways in which imagery work might be fruitful.

Given that the original impetus for my question arose within the context of a cognitive-behavioural conceptual framework, it is important to clarify my stance as integrative psychotherapist informed by humanistic philosophy. Engaging in dialogue with practitioners working within eating disorders research and treatment, in the context of a largely medical system, I was mindful of the creative tension between value bases. I have endeavoured to honour the potential inherent in the different models of understanding human psychology and the manifestation of eating disorders. Given the severe implications of the condition for the anorexia sufferer and for those close to her, it seems all the more important that we remain open to integrating effective interventions from different treatment models, as Garner and Garfinkel (1985) have observed. In the following paragraphs I will briefly elucidate the challenge presented by this chronic, debilitating and potentially fatal biopsychosocial condition.

For those affected by anorexia nervosa – sufferers, carers and practitioners working within the field of eating disorders – the threatening nature of the condition, together with the acknowledged inadequacy of current treatment options, is a highly emotive source of concern and distress. Of all psychopathologies, anorexia nervosa is one of the most difficult to treat (Vitousek, Watson & Wilson, 1998) and remains a particularly poorly understood condition (Schmidt & Treasure, 2006). The challenge is compounded by the relatively scant research base for the development of treatment interventions for anorexia nervosa (Kaplan, 2002). Prognosis statistics emphasize the importance of addressing this deficit: the mortality rate is higher than for any other psychiatric illness. Amongst surviving patients receiving treatment, fewer than half recover, one third improve, and one fifth remain chronically ill. (Steinhausen, 2002).

Detailed descriptions of the condition are available elsewhere, so I will simply highlight some relevant characteristics of people with anorexia nervosa (and in the interest of brevity, at times I will use the noun, 'the anorexic', without any depersonalisation implied). The typical anorexic profile is one of perfectionism and fear of making mistakes, together with an avoidant temperament, which involves a sensitivity to negative stimuli (Schmidt & Treasure, 2006). She (or he) is likely to display cognitive rigidity and constricted affect (American Psychiatric Association, 2004), with a superior detailed or local processing style and relatively reduced capacity for perceiving the gestalt (Schmidt & Treasure, 2006). For the person with anorexia nervosa, evidence suggests a greater likelihood of there being comorbid obsessive-compulsive traits (Halmi, Tozzi, Thornton, Crow, Fichter, Kaplan et al, 2005) and other anxiety traits (Swinbourne & Touyz, 2007). Elevated levels of insecure dismissive attachment, low reflective functioning and difficulties in emotional processing have also been found in women with anorexia nervosa (Ward, Ramsay, Turnbull, Steele, Steele & Treasure, 2001). It is widely considered that in anorexia nervosa concerns regarding weight and shape have an undue influence in the evaluation of the self. This view is consistent with diagnostic criteria (American Psychiatric Association, 2004) and typically supported by clinical experience of patients presenting with a morbid fear of fatness, pre-occupation with their bodies and a drive towards pathological weight loss (Bruch, 1973). Notably, however, Professors Schmidt and Treasure have questioned the

emphasis on weight and shape, proffering their view of the essence of the psychopathology as 'motivated eating restraint' (Schmidt and Treasure, 2006, p. 346).

Characteristic features include severe body image disturbances, difficulty identifying emotional and bodily states, a sense of ineffectiveness, eating-related rituals and in some cases, compensatory behaviour such as vomiting, misuse of laxatives or diuretics or excessive exercise (Bruch, 1985; Fairburn, 2008). These compensatory behaviours form the diagnostic criteria which distinguish the subtype of restricting anorexia nervosa from the subtype of binge-eating/purging anorexia nervosa (American Psychiatric Association, 2004). In half of all cases, neither psychological, behavioural, pharmaceutical, nutritional nor alternative treatments are effective (Herzog, Nussbaum & Marmor, 1996), evidently owing to the unassailability of anorectic cognitions.

The treatment process is lengthy and frequently hampered by resistance to change (Vitousek, Watson & Wilson, 1998). According to Mountford and Waller (2006), two main factors contribute to treatment resistance in the anorexic. Firstly, the ego-syntonic nature of the illness (the symptoms are valued by the sufferer) augments her ambivalence to treatment and undermines motivation to change. Secondly, rigidity of cognitive style (Garfinkel & Garner, 1982), which may be exacerbated by the effects of starvation, compromises her capacity to reflect on her thinking patterns and beliefs, ie. to mentalise. Difficulties in treating eating disorders in general, and anorexia nervosa in particular, may be attributed to ambivalence regarding change and firmly ingrained restrictive eating patterns, which undermine the affected individual's motivation to engage in treatment (Fairburn, Cooper & Shafran, 2003). It follows that there is a need for research designed to support the development of interventions for facilitating greater motivation for engagement in treatment, reflecting on self-process and communicating insights that are accessed in therapy.

1.4. Structure of this thesis

In this first chapter I have laid out the reasons behind my choice to explore the internal world of people with anorexia nervosa – encompassing the personal, the clinical and the conceptual or theoretical. My intention in the second chapter is to situate this work within the field and to articulate the contribution offered by this study to Counselling Psychology and Psychotherapy. In doing so, I include a review of literature relevant to this research, focusing on empirical studies and seminal works. My choice of research questions and methodology is explained and I describe how during the course of the study, the scope of my focus evolved in response to what emerged from my participants' accounts.

The third chapter comprises a description of the methodology employed in this study. Here I expand on the philosophical premises pertinent to my research question that informed my choice of research method, before detailing the steps involved in project planning, recruitment, interviewing and analysis. I will also describe my personal experience of the process of engaging with this research. In the fourth chapter, I present the findings of this study, outlining the themes that emerged from the process of my engagement with the interview data. There follows a fifth chapter which conveys my reflections on the process of conducting this research. This leads to the sixth and final chapter, comprising a discussion of my findings, with reference to the existing body of literature and to psychological theory.

2. The context of this research

With the aim of situating this research within the wider field, the following literature review presents a selection of relevant aspects of current and seminal theoretical perspectives on anorexia nervosa, incorporating both psychodynamic and cognitive-behavioural conceptualisations. There follows an appraisal of studies relevant to the experience of anorexia nervosa, leading to findings that raise questions regarding the involvement of imagery in the cognitive and emotional processes of anorexia sufferers. Subsequently, I introduce selected aspects of literature which I consider helpful in elucidating the application of imagery within therapy in general or which relate specifically to the use of imagery techniques in working with an eating disordered population. I will aim to show how the growing body of research into the role of imagery led to the development of the questions that underpin my rationale for undertaking this study.

2.1. Theoretical conceptualisations

Anorexia nervosa has a complex set of predisposing, precipitating and maintenance factors which theorists have endeavoured to elucidate by formulating various models for understanding this condition. In the following brief synopses, my aim is to convey a sense of some key contributions from the major theoretical approaches and their implications for treatment.

2.1.1. Psychodynamic theories

From a psychodynamic perspective, anorexia nervosa is conceptualised as multidetermined, including factors such as avoidance of the threat of sexual maturity, the possibility of a new identity, strategies for coping with counter-attacks on the self, the prospect of realising the true self, a defence mechanism for surviving parental conflict or management of annihilation anxieties.

In her seminal works, Hilde Bruch (1973, 1982) argued against traditional psychodynamic explanations attributing the ego deficits and sexual inhibition presenting in anorexia nervosa to unresolved oedipal conflicts. In Bruch's view, the condition has its origins in pre-oedipal experiences of an over-intrusive and controlling caregiver, specifically the mother, giving rise to the daughter's insecure attachment and development of a compliant false-self. This formulation holds that in adolescence, the young person's ego-vulnerability is actualised under growing pressure to demonstrate independence and embrace sexual maturity. After years of perceived parental culpability, there has more recently been diminishing regard for this explanation, which can be criticised on the grounds that the mother of an anorexic daughter (or son) is understandably more likely to display controlling behaviour when faced with her starving child. Aside from such questions concerning predisposing factors, Bruch (1982) has offered a valuable understanding of the perfectionism and self-denial encountered in anorexia nervosa as defences against underlying feelings of worthlessness or nothingness. "Every anorexic dreads that basically she is inadequate, low, mediocre, inferior and despised by others. All her efforts are directed towards hiding the fatal flaw of her fundamental inadequacy" (Bruch, 1982, p. 4).

Extending this formulation, Goodsitt (1997) and others within the self-psychology tradition have contended that people with anorexia nervosa are suffering from a disorder of the self, with anorexic symptoms serving to bolster the cohesion and stability of an extremely fragile sense of self. This empathic insight into the perception of self as inadequate has resonance with Arthur Crisp's developmental conceptualisation of anorexia nervosa as a 'flight from growth', arising from a failure to master and integrate aspects of psychobiological maturation, including adult role and sexuality (Crisp, 1995). He suggested that in response to her perceived inadequacy, the adolescent adapts by adopting a 'phobic avoidance stance' towards puberty, which imbues a sense of mastery and safety. His theory holds that this strategy for maintaining control over a changing internal self also requires the anorexic to exert control over her environment, thus involving manipulation of others in the family system. Whilst the typical emergence of anorexia nervosa in early adolescence would

appear consistent with these ideas, variations in the age of onset suggest the involvement of other factors.

The role of relationships in the etiology of anorexia nervosa continues to be upheld in current psychodynamic thinking, as Marilyn Lawrence of the Tavistock has maintained. She considers disturbances in relationships to underpin all eating disorders, specifically, "a difficulty in feeling open and receptive to the good things that relationships with others might have to offer." (Lawrence, 2008, p. 17). Her contention links with object relations theories regarding introjection or taking in to the mind of early caring figures (parents) as good and nurturing objects. In anorexia nervosa, Lawrence (2001) believes that there is a particular difficulty with dependency in relationship and a concomitant need to be self-sufficient, linked with a fear of being intruded upon. This formulation, which sits uneasily with Bruch's (1973) observations of over-involved mothers and anorexic daughters, is somewhat confusing in light of the vulnerable and dependent state that characterises many sufferers of anorexia nervosa.

In treatment, an important assumption is that a negative transference will develop, that the therapist will at some stage come to represent those frightening, oppressive figures in the mind of the anorexic. Accordingly, the therapeutic relationship is considered key to the playing out of the transference such that the patient ultimately is able to internalise a nurturing, good representation of the other. One implication for treatment, in Bruch's (1985) view, is that therapists' interpretations of the meaning of anorexic behaviour may constitute a re-enactment of the early empathic failures that resulted in the tenuous, incoherent self-structure, threat of disintegration and need for maintaining the sense of self through being grounded in the body. In her earlier work, Bruch (1973) has emphasized the importance of the patient's experience of being understood and respected for being able to discover her own capacities for feeling, thinking and deciding, given the likely original experience of ineffectiveness and discounting.

2.1.2. Cognitive-behavioural conceptualisations

Cognitive behavioural models are informed by a view of eating disorders as arising from and maintained by maladaptive thoughts and dysfunctional assumptions about food, weight and shape (Fairburn & Brownell, 2002). Christopher Fairburn and colleagues have presented a transdiagnostic view according to which all eating disorders share the same underlying core psychopathology, that being the over-evaluation of shape and weight and their control (Fairburn, Cooper & Shafran, 2003). This cognitive perspective holds that anorexia nervosa should not be distinguished from bulimia nervosa or Eating Disorder Not Otherwise Specified (EDNOS), and in support of his view, Fairburn (2008) has pointed to the tendency for patients to migrate from one eating disorder to another – a typical progression being the onset of anorexia nervosa in early adolescence evolving into to bulimia nervosa or EDNOS in later adolescence. It is interesting that having classified all eating disorders as sharing a common set of cognitive distortions, Fairburn's treatment model, Enhanced Cognitive Behaviour Therapy for Eating Disorders ("CBT-E"), involves the construction of a personalised formulation identifying the processes maintaining the individual's psychopathology. Thus the transdiagnostic model acknowledges and encompasses the specific (if not unique) factors underlying the individual patient's presentation. In further recognition of individual differences, CBT-E may address clinical perfectionism, low self-esteem and interpersonal difficulties, as well as mood intolerance.

As in other modalities, the therapeutic relationship is considered crucial for a positive outcome. In cognitive-behavioural work, it is the formation of a collaborative relationship - an alliance with the rational part of the client – that is held to be essential for facilitating engagement in treatment, to support the work of identifying and modifying irrational beliefs and behaviour patterns. Since the therapeutic alliance is commonly undermined by low motivation to change in eating-disordered clients, development of more effective approaches to supporting motivated engagement in the process of change is a focus of cognitive-behavioural thinking (Waller, 2012).

2.1.3. Integrative treatment perspectives

It is apparent that both psychodynamic and cognitive-behavioural views of treatment considerations hold to the importance of relationship in working with someone with anorexia nervosa. I agree with Lawrence (2008), amongst others, in the view that in the treatment of anorexic patients, there is value in both approaches and it is important to consider which type of treatment would be most helpful for an individual depending on severity, stage and relevant circumstances.

In recognition of the potential benefits of integrating approaches, Vitousek and Gray (2005) have proposed a combined model incorporating both psychodynamic and cognitive perspectives, with treatment adopting psychodynamic techniques to address false beliefs, nutritional concerns and difficulties with family. The importance of working with the context of the family system is strongly upheld in current treatment programmes, such as the Maudsley Model of outpatient care (Lock, Le Grange, Agras & Dare, 2001), a family-based treatment approach which aims to address the key factors believed to contribute to maintenance of anorexia nervosa. According to Schmidt & Treasure's (2006) maintenance model, the disorder is maintained not only by intrapersonal factors (perfectionism, cognitive rigidity and avoidance of intense negative emotions), but also by interpersonal factors (responses of close others conveying expressed emotion, both positive and negative). This cognitive understanding underpinned the development of their treatment approach, employing techniques of motivational enhancement therapy (Miller & Rollnick, 2002), structured writing tasks and cognitive analytic therapy (Ryle, 1995). Given the difficulties of engaging people with anorexia nervosa in a collaborative working relationship, it seems that a helpful direction would be to consider how much is understood about their subjective perspective regarding themselves, their bodies, and their relationship to others and their environment.

2.2. Perspective of people with anorexia nervosa

One of the most powerful first-person accounts of the experience of anorexia nervosa is Marya Hornbacher's (1999) seminal memoir describing her 14-year experience of bulimia and anorexia nervosa.

> "I was on a mission to be another sort of person, a person whose aspirations were ascetic rather than hedonistic, who would Make It, whose drive and ambition were focused and pure, whose body came second, always, to her mind and her 'art'. I had no patience for my body. I wanted it to go away, so that I could be a pure mind, a walking brain, admired and acclaimed for my incredible self-control.' (Hornbacher, 1999, p. 107).

Considering the motivations driving her self-deprivation, the issues of identity and self are evident, but what is also striking is Marya's alienation from her body, a feature of anorexia nervosa which has been addressed in both theoretical and empirical pieces.

Being simultaneously preoccupied with the body and alienated from bodily needs and experience, the person with anorexia nervosa is predisposed to specific forms of psychological distress. Farber, Jackson, Tabin & Bachar (2007) have identified the common simultaneous preoccupation with death and anxiety regarding annihilation in anorexia nervosa, bulimia nervosa and self-harming individuals. Paradoxically, these aspects of experience are accompanied by a striking and dangerous disregard for risk to the bodily self – a deficient signal anxiety or ability to detect danger. These authors attributed the apparent inconsistency to dissociative defences developed in childhood in response to psychic trauma. Through compartmentalising and separating psychological from somatic components of traumatic experience, dissociation interferes with the development of self-regulatory capacities and ego functions associated with signal anxiety. This allows preoccupation with death and annihilation anxieties to coexist with self-neglect or mutilation (Farber, Jackson, Tabin & Bachar, 2007).

This compartmentalisation of aspects of self-experience may manifest itself in other characteristics of anorexia nervosa: for instance, evidence suggests that people with eating disorders have difficulty with identification, verbal expression and regulation of forms of physical tension and emotional states (Bruch, 1973, Troop, Schmidt & Treasure, 1995). Relatedly, alexithymia – the inability to identify and express emotions and to distinguish physical sensations from emotional states – appears to be a characteristic of some eating disordered individuals (Schmidt, Jiwany & Treasure, 1993; Troop, Schmidt & Treasure, 1995).

Given that people with anorexia nervosa appear to have difficulties with connecting or associating - as well as communicating - aspects of self-experience, therapists may find it beneficial to work with alternative modes of exploring, expressing and working with emotions and cognitions. This brings us to two separate but related modes of access to and expression of experience: the symbolic use of the body as metaphor and the medium of imagery or mental representations. It seems to me that the former may sit more comfortably within the psychodynamic modality, whereas imagery has recently been a focus of research emerging from contexts with a largely cognitive behavioural perspective, which reinforces my sense of the potential for fruitful cross-fertilisation of ideas.

2.3. Symbolism and metaphor involving the body

A recent paper by Skårderud (2007a) conceptualises anorexia nervosa as a symbolic use of the body to articulate emotions through 'concretised metaphors'. These refer to the equivalence between bodily revelations and direct emotional, social or moral experience. Skårderud (2007a) based his study on the assumption that the body offers a vessel for implementation of metaphors representing aspects of psychic reality. To explore these body metaphors in anorexia nervosa, he interviewed ten female patients in treatment at his psychotherapeutic practice, supplementing interview data with recordings of therapy sessions. Arguably, the therapist's assumption of the role of interviewer was not optimal in enhancing the trustworthiness of his study. This concern aside, Skårderud's (2007a) study effectively elaborated on the symbolic role of

the body in its interaction with the world. The following concretised metaphors emerged:

- Emptiness/fullness – a metaphor for clarifying the mind in response to difficult emotions and cognitions
- Purity (small, discrete portions of food) – associations with certainty, simplicity and possibly, spirituality
- Spatiality (bodily size) – embodiment of low self-esteem and negative self-evaluation
- Heaviness/lightness – concretising emotions of sadness and worry, versus relief
- Solidity (hardness of bones) – embodying the experience of certainty
- Removal (of body tissue) – symbolising the possibility of a new identity and psychological self
- Control – use of the body as a tool for increased sense of control
- Vulnerability/protection – addressed through physical closing of the mouth and body
- Self-worth – expressed, measured and rewarded through the use of food

This paper was striking in its clarification of the connections between physical and psychological realities, resonating with the concept of embodiment, as eloquently articulated by Merleau-Ponty (1962). He upheld the holistic experience of the lived body, not simply a mechanical vessel responding to environmental stimuli, but an existential position of intentional embodied involvement with the world.

Where awareness and expression of self-experience is compromised, as in anorexia nervosa, the embodied involvement of the person with anorexia nervosa constitutes an avenue for exploring and perhaps communicating that which is otherwise inaccessible.

> "The essence of the metaphor is to understand and experience one phenomenon through another phenomenon." (Skårderud, 2007a, p. 164.)

An alternative avenue – which complements and at times overlaps with the use of metaphor - is mental imagery, a means of understanding and working with embodied phenomena, as the following sections will show.

2.4. The role of imagery

We can all consider imagery as a component of our mental experience, as we are frequently bombarded by images and perceptual stimuli that evoke ideas, memories and associations. To clarify the concept, the Collins English Dictionary defines an image as "A mental representation of something (especially a visual object) not by direct perception, but by memory or imagination" (Collins Dictionaries, 1995). Though the experience is indirectly instigated (as opposed to direct perception), mental images are sensory-perceptual representations involving activation of brain areas that overlap greatly with those activated during equivalent sensory perceptual events (Holmes & Mathews, 2010). They include phenomena such as memories and dreams in addition to automatically triggered or consciously generated images. Moreover, "imagery can involve multiple sensory modalities, including bodily sensations and feelings, and can represent complex actions and events that change over time" (Holmes & Mathews, 2010, p. 350).

Interest in the role of mental images in general is growing within research circles where the focus is on developing empirically-supported interventions for cognitive therapies. Professor Emily Holmes, Consultant Clinical Psychologist at the University of Oxford's Department of Psychiatry, has conducted extensive research with a focus on elucidating the role of mental imagery and interpretation bias in cognitive and emotional processes. Introducing the phrase, 'emotional amplifier', Holmes has shown that mental images are more emotionally powerful than verbal cognitions (Holmes & Mathews, 2005) and has suggested three ways in which images can evoke emotion:

- A direct influence of specific sensory signals (including those generated by images) on emotional systems in the brain

- A (possibly) less direct effect arising from the emotion-arousing interpretation of images as being similar to the perception of actual events due to overlapping activation patterns
- Through images, the arousal of memories for emotional events which can invoke corresponding feelings experienced in the past.

In these ways, the powerful effect of imagery can apply to both positive and negative emotions and can be invoked voluntarily or involuntarily (Holmes & Mathews, 2010). It is striking that whilst perceptual imagery is emotional, the converse also appears to be true, in that emotional memory is perceptual, or imagery-based in nature. This contention is based on a study by Arntz, de Groot and Kindt (2005), showing that emotion promotes stronger perceptual memory, possibly related to the powerful presence of perceptual memories in traumatic memory.

Although imagery itself is a normal phenomenon, its impact is evident across a range of psychological disorders (Holmes & Hackmann, 2004). A number of studies have examined the role of imagery in people with anxiety-related disorders and it appears that negative and distressing images are a feature of social phobia (Hackmann, Clark & McManus, 2000), agoraphobia (Day, Holmes & Hackmann, 2004), obsessive compulsive disorder (Speckens, Hackmann, Ehlers & Cuthbert, 2007) or specific phobias (Hunt & Fenton, 2007). Within eating disorders, it appears that imagery linked with memories of adverse life experiences is experienced by patients with bulimia (Somerville, Cooper & Hackmann, 2007), with themes of being humiliated, abused or abandoned (Hinrichsen, Morrison, Waller & Schmidt, 2007).

Endeavours to formulate the role of imagery in the dynamics of our thoughts, emotions and behaviours include the elaborated Intrusion theory of desire (Kavanagh, Andrade & May, 2005), which places mental imagery at the heart of the process by which people experience craving. "The theory holds that emotive imagery and associated sensations are especially important in craving because somatosensory links contribute a particular piquancy and motivational power to the experience." (Kavanagh, Andrade & May, 2005, p. 446)

The potential for imagery to facilitate healing and growth has been harnessed across models of understanding human psychology, as revealed in a selection of relevant literature. Within Buddhist practice, the use of imagery in the healing process has long been recognised as a means to developing compassion for self through repeated use of highly structured images (Dagsay Tulku Rinpoche, 2002). As a therapeutic means of exploring schemas that are likely to have originated in preverbal experience, imagery offers the potential to enable individuals to express and work through early interactions encoded in affective, visual or other sensory forms (Edwards, 1990). In the following section, some of the ways in which therapists work with imagery are described.

2.5. Therapeutic interventions utilising imagery

The recognition and application of imagery as a facilitating phenomenon within psychological therapy has a rich history. Rather than overviewing this history here, I refer the reader to a comprehensive account in an early chapter in Hall, Hall, Stradling and Young's (2006) accessible book on guided imagery. Notably, the earliest known example of imagery rescripting appears to have been Pierre Janet's (1919) use of 'imagery substitution' – often under hypnosis - to treat hysterical patients through substituting traumatic images with neutral or even positive ones. This technique, in which a negative or threatening image is transformed into a benign or positive one, is termed Imagery Rescripting "Type A" within contemporary cognitive-behavioural therapy (Holmes, Arntz & Smucker, 2007). These authors have coined the term to distinguish this intervention from "Type B", ie. interventions in which a positive image is constructed afresh to encapsulate positive meanings, enabling the patient to experience a more secure, confident sense of self.

Within psychotherapy, applications of guided imagery in various forms include Jung's active imagination for understanding unconscious processes (Watkins, 1976), Assagioli's (1965) guided fantasy in psychosynthesis, and the imagery psychodrama of

Perls and the gestalt therapists (Perls, 1969; Polster & Polster, 1974). This technique is also employed in cognitive-behaviour therapy, in the treatment of phobias through systematic desensitization, which involves the repeated invocation of images of feared objects (Wolpe, 1958). Within cognitive therapy, guided imagery offers a means of working with emotionally charged early memories, giving access to core intra- and interpersonal schemata (Edwards, 1990). It can be inferred from these references that as an intervention, imagery work is not modality-specific and may be incorporated with due ethical consideration and understanding. A useful resource is the guide to using imagery in therapeutic work by Hall, Hall, Stradling & Young (2006).

It seems that the potential for effective therapeutic work with imagery gives cause for exploring its role in the psychology of people with anorexia nervosa. With this aim, it is important to be informed by research that has a joint focus on imagery and anorexia nervosa.

2.6. Imagery and anorexia nervosa

The empirical literature includes a considerable body of experimental research offering a means of understanding the cognitive, emotional and physiological mechanisms involved in the processing of images – particularly related to food and bodies – for people with anorexia nervosa. Recent studies designed within a cognitive-behavioural conceptual framework have examined the physiological, attentional and emotional responses of people with eating disorders when exposed to visual or verbal food cues.

2.6.1. Investigating the impact of imagery in anorexia nervosa

Patients with anorexia nervosa, presented with a meal within experimental conditions, showed physiological arousal reactions (skin conductive levels) and emotional responses of anxiety, fear and disgust (Leonard, Perpina, Bond & Treasure, 1998). Evidently for these patients, the sensory and perceptual events that occurred in the

presence of food invoked significant physiological and emotional reactions. The greater attentional and emotional reaction to food appears to have neurobiological correlates - specifically, greater activation in the limbic areas of the brain (orbital frontal cortex, amygdala and insula). This was the finding of a study where eating disordered patients viewed food and aversive emotional images while brain activity was being recorded by functional magnetic resonance (Uher, Murphy, Brammer, Dalgleish, Phillips, Ng, Andrew, Williams, Campbell, & Treasure, 2004).

An approach to enhancing this understanding has been through monitoring the reactions of patients by tracking their eye movements to assess the degree of vigilance or avoidance in response to the images. Evidence from an eye-tracking study (Giel, Teufel, Friederich, Hautzinger, Enck & Zipfel, 2011) suggested that anorexic patients showed no attentional bias (either vigilance or avoidance) on exposure to food pictures, suggesting that initially they processed the images as healthy controls did. Subsequently, their eye movement indicated avoidance of the pictures, suggesting differential processing after the initial encoding and labelling of food. The authors concluded that the pattern of attention deployment was probably mediated by maladaptive cognitions, a contention that is interesting to consider in relation to the cognitive model of craving developed by Kavanagh, Andrade and May (2005). According to their elaborated intrusion theory, the generation of images plays a key role in the normal development of desire for food, but for people with anorexia nervosa, it appears that the appetitive process is disrupted.

There is a considerable body of empirical evidence suggesting the involvement of imagery in these disruptions (Steel, Kemps & Tiggemann, 2006; Tiggemann & Kemps, 2005). In experimental settings, psychologists have shown not only that imagery can intensify cravings, but that non-food-related images can be used to reduce cravings (Harvey, Kemps & Tiggemann, 2005). Carrying out visuospatial tasks reduces the vividness of food-related images and the intensity of cravings (Kemps, Tiggemann, & Christianson, 2008).

Whilst these quantitative studies inform the development of cognitive models, the question that might arise from within a counselling psychology framework concerns the nature of the associations underpinning these processes. There is cause to be curious about the way in which sensory-perceptual representations (i.e. imagery) associated with food might be experienced by people with anorexia nervosa. Before expanding on this idea further, the application of imagery techniques within treatment interventions for eating disorders, as currently evidenced in the literature, will be reviewed in the next section.

2.6.2. Treating eating disorders with imagery interventions

Therapeutic work involving imagery in eating disorders has increased in recent years (Mountford & Waller, 2006). Guided imagery to enhance self-soothing in a group of 50 patients with bulimia nervosa was evaluated in a study by Esplen, Gallup & Garfinkel (1999). Their intervention incorporated two types of imagery exercises- those designed to promote comfort and relaxation (meadow descriptions; creation of an 'inner sanctuary') and others to promote self-exploration or self-experience through metaphor (visualising oneself as a colour or use of a' theatre' to express interpersonal interactions). Significant improvements in eating disorder symptoms and ability for self-soothing over a six-week period evidenced the effectiveness of guided imagery within this population (though questions regarding the sustained effects of improved self-soothing capacities over time were not addressed and other therapeutic factors may have confounded the results).

In the context of an individual therapy setting, Ohanian (2002) incorporated imagery rescripting within a CBT framework to facilitate recovery from bulimia. The rationale for working with imagery is the recognition that more effective access to unhelpful schemas may be possible through affective, visual or kinaesthetic avenues than through linguistic interventions such as challenging core beliefs. The imagery rescripting involved asking the patient to imagine a significant traumatic event from

childhood, to describe it in the present and to articulate the beliefs about self, others and the world that emerged from the experience. Once the powerful affect associated with the memory was accessed, the therapist introduced the adult self of the patient into the event and supported the patient to express the adult perspective on the event. The aim was to challenge the oppressor, nurture the child and facilitate new, healthier beliefs about self, self-in-relationship and the world. Ohanian (2002) reported that whilst eight sessions of conventional CBT had reduced binge-purge symptoms by fifty percent, the single imagery rescripting session led to the cessation of almost all such behaviours. While this research points to the potential benefits of imagery-related interventions in therapeutic work with eating disordered clients, therapists need to be mindful of the importance of timing and the possible involvement of traumatization and dissociation, to ensure that interventions are used with sensitivity to the stage of readiness of the client.

In the interests of fostering a collaborative engagement with the work, an important goal in therapy with anorexic clients is to conceptualise the anorexia as separate from the person whilst continuing to develop the therapeutic relationship. To this end, Mountford and Waller (2006) have used imagery to facilitate the view of anorexic thinking as a separate part of the personality, in order to facilitate challenging of negative automatic thoughts and maladaptive core beliefs. The collaborative understanding of the anorexic mode – sometimes given a name such as 'anorexic minx' or 'gremlin', which fights for survival - has had some success in increasing patients' awareness of their pathology and allowing them to view themselves as separate from the ED. Using imagery to visualise the anorexic part as separate also offers a means of addressing body image distortion, through describing the differing body image perceptions of the patient and her anorexic mode and then exploring the discrepancies and motivations behind the distortions (Mountford & Waller, 2006).

In their exploratory study investigating the impact of various relaxation techniques on anxiety levels after meals, Shapiro, Pisetsky, Crenshaw, Spainhour, Hamer, Dymek-

Valentine & Bulik (2008) found that guided imagery, progressive muscle relaxation and self-directed relaxation significantly reduced post-prandial anxiety in women with anorexia nervosa . All three relaxation approaches reduced anxiety and increased relaxation more than the control condition, and participants reported enjoying their relaxation training. However, only the self-directed relaxation significantly reduced the intensity of thoughts about weight gain compared with the control condition. Arguably, this could be indicative of the importance of active involvement in the self-soothing process and facilitating the tailoring of interventions to meet the individual.

Building on these findings, Janet Treasure and colleagues designed an imagery-based intervention intended to offer people with anorexia nervosa a means of supporting themselves and alleviating anxiety prior to eating. This involved a short video which could be played on a mobile phone or iPod (hence termed a 'vodcast'), comprising both aural and visual imagery aimed at bolstering self-regulation (Treasure, Macare, Mentxaka & Harrison, 2011). Three versions of the vodcast were developed – An 'Energy controller', 'Mindful eating' and 'Motivational reflection'. The last version, which was most highly endorsed by participants, was used in a behavioural experiment in which they watched the video before being offered a smoothie drink. According to self-report and quantity of smoothie consumed, it appeared that the video facilitated more successful eating and alleviated anxiety, although individual differences in responses led the research team to conclude that "these results suggest the importance of tailoring the treatment and intervention to the individual" (Treasure, Macare, Mentxaka & Harrison, 2011, p. 520). This reinforces the case for giving a voice to those individuals with anorexia nervosa and creating a space for collaboratively developing a greater understanding of their perspectives.

2.6.3. Situating the issue of body image

Since much has been written about the issue of body image in eating disorders, this is a phrase that carries particular connotations. Therefore, a review of literature concerning imagery and anorexia nervosa would be deficient without attention to

body image in eating disordered populations. Body image disturbance (BID) refers to a range of reactions to a discrepancy between a person's perception of her weight, shape or appearance and an outsider's objective view. It is common for anorexic people to experience their bodies as big and fat despite being extremely thin. A meaningful contribution to the research on BID by Espeset, Nordbø, Gulliksen, Skårderud, Geller & Holte (2011) involved interviews with Norwegian women diagnosed with anorexia nervosa, focusing on their experience of body image in different contexts, across the day. Analysis using grounded theory yielded two constructs – subjective reality (estimation of own body size) and objective reality (objectively measured body size). Depending on whether individuals perceived their own bodies as fat or thin, from subjective or objective perspectives, their experience could be conceptually categorised as manifesting one of four psychological processes - integration, denial, dissociation or delusion. The authors interpreted these results as suggesting "that BID can be conceptualised as a dynamic failure to integrate the subjective experience of one's body appearance with a more objective appraisal" (Espeset, Nordbø, Gulliksen, Skårderud, Geller & Holte, 2011, p. 185) and they remarked on the fluctuating nature of the experience.

While it is important to be clear that my study is not specifically focused on body image, I have nevertheless been open to discovering how images of the body (pertaining to self and others) might manifest as a component of the experience of people with anorexia nervosa.

2.7. Research aims

How working with imagery might be used to enhance psychological therapy with people diagnosed with anorexia nervosa is a question that incited my curiosity. My search for research which focusses on imagery and anorexia nervosa has yielded virtually no studies exploring the phenomenon as experienced by this client group. In formulating my research aims, I was mindful of the challenge of maintaining the anorexic's engagement with treatment. As Mountford and Waller (2006) have observed, many therapists are familiar with the sense of 'hitting a brick wall' as the

person with anorexia nervosa struggles to articulate or even become aware of her restrictive thinking. This suggested to me that the process of engaging within therapy might be facilitated using an exploratory approach focusing on the imagery experienced by the person with anorexia nervosa. In their eloquent paper on enhancing motivation, Vitousek, Watson and Wilson (1998) have argued that clinicians working with these isolated individuals need to speak their language, using the client's own ideas, images and phrases. This observation reinforced my interest in exploring the contents of the imagined internal world, to gain a deeper shared understanding of the personal experience of this client population, with a view to enhancing growth and healing in therapy.

2.7.1. Questions originally addressed by this research

Therefore, the aim of this study was to explore mental imagery as perceived among a population of individuals with anorexia nervosa. This generated the following broad research questions:

- What is the nature of images or sensory impressions experienced by people with anorexia nervosa when they respond to sensations or thoughts related to food, weight and shape?
- What are the implications of the imagery for psychological therapy with individuals diagnosed with anorexia nervosa and other eating disorders?

2.7.2. Development of a broader focus

My initial interest in developing this project concerned imagery, and therefore my research question focused on this specifically. However, as the project progressed into the interviewing phase, it struck me that interwoven with the imagery there were other dimensions to the participants' experiences that I felt were critical to explore. This meant that the focus of my research became more inclusive of other aspects of the lived experience of anorexia nervosa apart from the conscious awareness of

imagery, developing in a way that I had not expected at the outset. I will provide further description of this shift when discussing my findings.

In expanding the area of enquiry, I also extended the questions which this study would aim to address, in the following manner:

- What are the experiences – including images or sensory impressions, thoughts and feelings - evoked for people with anorexia nervosa when they focus on issues of food, weight and shape?
- What are the implications of the understanding of this experience, including thoughts, feelings and imagery, for psychological therapy with individuals diagnosed with anorexia nervosa and other eating disorders?

2.7.3. Relating this research to my integrative framework

I believe that the aims of this study are aligned with my own principles for practice: I hold to the importance of respecting the subjective perspective of the person in a holistic sense. I see my research as integrating ideas from the major modalities, consistent with my integrative framework. I have drawn on cognitive-behavioural research and applications focusing on the role of imagery in formulating my questions. In the humanistic tradition, I adopt a relational, collaborative approach to exploring the potential role of imagery (fuelled by curiosity about the subjective experience of the individual with anorexia nervosa). In my analysis, I have interpreted what emerged from their accounts informed by psychodynamic concepts, particularly object relations theory.

It is important to acknowledge an area of tension. Reflecting on my choice to honour the voices of people with anorexia nervosa, I am aware that the values typically associated with this condition stand in stark contrast with the values that inform my approach to integrative psychotherapy. Traits such as rigidity, focus on detail and perfectionism, do not sit comfortably with my belief in the qualities of balance and

harmony, or flexibility and moderation. This reinforces my commitment to reflexivity throughout the process of recruiting participants, conducting interviews, analysis and writing up.

2.8. Contribution to integrative counselling psychology and psychotherapy

It is my intention that this research will enhance psychological therapy with people suffering from anorexia nervosa in the following ways:

If the findings of this exploration suggest that clients presenting with anorexia nervosa find imagery to be a relevant component of their experience (particularly related to food, weight and shape), then imagery work can be considered as a viable therapeutic intervention. This will enable psychological therapists to offer clients who are not easily able to identify and express their feelings, a means of accessing and working with the implicit in a non-threatening and creative medium.

A deeper understanding of the themes implicit in the experience of anorexia nervosa will enable practitioners to meet their clients more effectively in the intersubjective space. Through using imagery to augment the existing 'map' of the internal world of this vulnerable population, these insights will help to alleviate some of the difficulties posed by the reserved and unresponsive tendencies typically encountered in the therapy room.

2.9. An Interpretative Phenomenological Analysis (IPA) study

In designing this study, I aimed to address the following considerations:

- the importance of approaching the lived experience of the participants with a sense of openness and without preconceptions
- the need for the researcher to enter the life-world of the participants

- the acknowledgement that the analysis of the descriptions will aim to be both phenomenological (representing the participants' view of the world) and interpretative (implicating the researcher's own conceptions)

These ideas accord with the philosophical principles underpinning the phenomenological approach, which is particularly suitable for understanding personal experiences (Willig, 2001). My research aim of exploration of the personal experience of a typically private, withdrawn group of participants will be well-served by the principle of epoché that requires the researcher to set aside prior assumptions and theoretical explanations in the interest of returning to 'the things themselves' (Husserl, 1954, cited in Wertz, 2006). In my view, anorexia nervosa manifests as a particular manner of relating to the body, one that influences the relationship of the individual to the environment or context. This is consistent with phenomenology's recognition of 'the lived world', in which individuals engage in subjective ways of relating to their surroundings.

In accordance with these aims, I chose to conduct this study using Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2009) in order to explore the lived experience of my participants. As I shall explain further in the following section, IPA is an appropriate qualitative method of exploring, analysing and conveying the subjective experience of imagery and mental representations, embedded in the contextual world of the person with anorexia nervosa as she engages in her relationship with food, weight and shape.

3. Methodology

3.1. Philosophical stance

The philosophical basis for my choice of IPA as a methodology lies in the compatibility of my research question and my epistemological position with the three streams of phenomenology, hermeneutics and idiography, from whose theoretical principles IPA has emerged (Smith et al, 2009).

3.1.1. Phenomenology

My aim of exploring the lived experience of women with anorexia nervosa is consistent with the exploratory nature of the phenomenological approach, with its focus on experience and its perception, as Husserl (1927, cited in Smith at al, 2009) originally intended. Further development of his work by Heidegger (1962) emphasizing our embeddedness in the context of the world supports my stance of curiosity about the nature of the engagement with food, or use of food, in the world of anorexia. With similar acknowledgement of the contextual and situated nature of our being in the world, but an emphasis on its embodied subjective quality, Merleau-Ponty's (1962) perspective constitutes a reminder and a challenge: whilst aiming for an understanding of the role of the body as subject in shaping our knowledge of the world, I am aware that in anorexia nervosa the awareness of and relationship with the body has elements of conflict and dismissiveness. The challenge of reconciling these aims with the anticipated deficit in relatedness to the body is relevant to the hermeneutic component within IPA, as I intend to explain in what follows.

3.1.2. Hermeneutics

The endeavour to understand the meaning that people make of their experiences is consistent with the principles of hermeneutics which underpin the interpretative aspect of IPA. In a similar vein, my research aim is to develop an understanding of the

sense that women with anorexia nervosa make of their experience, which entails a willingness to offer a perspective on their accounts that goes beyond the explicit content. Aligning myself with writers on hermeneutics including Heidegger (1962) and Schleiermaker (1998), I recognise the interpretative role of the analyst, requiring my receptiveness to participants' accounts and implicating my own insights. The analysis therefore facilitates the emergence of meanings that may be hidden or disguised (possibly owing to the numbing of awareness anticipated in this study), through examining 'the thing itself' as Heidegger (1962) contended.

Acknowledging the fore-structures (assumptions and pre-conceptions) inherent in any interpretation, Heidegger (1962) articulated the role of bracketing by stating that the meaning-making of the analyst is coloured by previous experience. I accept that the impact of fore-structures is inevitable, but I also believe the analyst's awareness of this impact on the interpretation is essential to the credibility of the findings. As an IPA researcher endeavouring to understand how my participants make sense of their experiences, I therefore engage with the 'double hermeneutic' described by Smith et al (2009). The initial interpretation of pre-reflective experience is accomplished by the person, whose account is subsequently perceived through the researcher's interpretive frame. I acknowledge the subjective nature of this process, which has fortified Giorgi (2011) in his attack on IPA, including the accusation that such research is not replicable. It stands to reason that owing to the co-created nature of the exploration conducted within the collaboration between researcher and participant, the data that emerges will be unique to the embodied dialogical encounter (Finlay, 2009). This speaks to the importance of transparency in the communication between researcher and audience: a clear account of the research process from interview to final stages of analysis allowing for evaluation of the validity of the interpretations made.

3.1.3. Idiography

The idiographic quality of IPA places value on the individual account, with its associated meanings, in all their rich detail and subtlety, which elucidates "how particular experiential phenomena (and event, process or relationship) have been understood from the perspective of particular people, in a particular context" (Smith et al, 2009, p. 29); In similar vein, I hold to the principle of honouring the unique quality of the experiences described by each of the women with anorexia nervosa, by approaching their accounts with a receptiveness to the nuances inherent in each. This recognition of the divergence of individual experiences poses a challenge to the IPA researcher – ie, to look for convergence within the descriptions of people's experience, whilst acknowledging divergence between them. How I engaged with this paradox is described in a later sub-section on developing a hierarchy of themes and in the Discussion section.

3.2. A reflexive stance

In choosing to research eating disorders, I engaged with people who were likely to have experienced particular dynamics in their contact with psychological therapists, including counselling psychologists. The need for a reflexive stance – recognisably important in qualitative research – was consequently greater. Typically, young women with anorexia nervosa are accustomed to interventions aimed at corrective change, involving a degree of directiveness. In reflecting on the unconscious co-created dynamics between interviewer and interviewee, I was aware of the potential for parallel process to manifest – was I vulnerable to the urge to coerce towards confirming my preconceptions regarding imagery? It was important to maintain a balance between mining for information that was pertinent to my question and allowing an open space for interviewees to express their views and tell me what was foremost in their response to food and their bodies. I aimed to facilitate a collaborative encounter wherein each interviewee would feel supported and be

inspired to reflect deeply on their experience – in a sense, to feel that she was the 'expert', whose contribution was valuable and plausible.

In this aim, I was guided by Linda Finlay's approach:

> "If this more explicitly relational approach to phenomenological research is adopted, data is seen to emerge out of the researcher-co-researcher relationship, and is understood to be co-created in the embodied dialogical encounter. Researchers supportive of this way of working argue that what we can know about another arises from that intersubjective space between." (Finlay, 2009, p. 13).

My journey through this research piece spanned three years, as a consequence of the nature and extent of the work, together with the place it occupied amongst other commitments in my life. During this period, I experienced myself changing, growing overall in confidence and deepening my understanding of the research process. It was not always comfortable, unsurprisingly. For many months, there was a sense of chaos and insufficient control of the analytic process, and I gained little comfort from the assurances of experienced researchers that this was normal. Qualitative data analysis requires a tolerance of and willingness to engage with the apparently unmanageable, in my experience. Keeping a journal for recording research-related reflections served to contain these concerns together with rationale for my choices.

3.3. Recruitment of participants

To enhance the potential for my research to provide insights into particular experience for particular people, I employed purposive sampling to increase homogeneity of the participant group, using the following criteria:

- Since eating disorders typically affect young women aged between 15 and 25, the sample for this study would ideally be drawn from this population. However, ethical considerations led me to confine my sample to adults. I therefore recruited

women aged between 18 and 30 years (the upper age limit raised to take account of anticipated difficulties recruiting sufficient participants).

- Women who have a current diagnosis of anorexia nervosa would be eligible. In order to establish a current diagnosis, I intended to seek the professional opinion of the relevant practitioner treating each participant, after having obtained the client's consent. In the event, all participants indicated that they were either in treatment or seeking treatment, and I felt that to seek professional confirmation would undermine their autonomy and compromise the research alliance.
- With the aim of generating data relevant to women who have a reasonably entrenched experience of anorexia nervosa, I planned to recruit those who had been diagnosed more than six months previously. Anticipating that accessing this population was likely to prove challenging and that it might be necessary to widen the criteria to reach a sufficient number of potential participants, I decided to omit this exclusion criterion from the recruitment information sheet.

To generate a sample of 10 participants, I anticipated that I might need to approach 30 potential interviewees and aimed to do so via the following sources:

- The 'b-eat' website, where research can be posted with requests for participants. B-eat is a charity which provides helplines, online support and a network of self-help groups to help people in the UK (sufferers, carers and professionals) to beat eating disorders. B-eat's work is funded via a variety of sources, including community fundraising, donations, trusts and grants applications, professional services and government grants.
- The National Centre for Eating Disorders (NCFED) practitioner network, which has an online forum enabling messages to be sent to all members via email.
- The Institute of Psychiatry's Eating Disorders Research Unit's volunteer database.

Recruitment was a slow though steady process, with the pilot interview conducted in August 2009 and the final interview completed in March 2011. Ultimately, 8 of the 10 participants were women who volunteered after reading about my research on the b-eat website. It appeared, perhaps unsurprisingly, that NCFED practitioners were

reticent about involving their clients in this study. One NCFED practitioner contacted me offering to introduce a client, with whom I tried unsuccessfully to make contact. One participant was a patient in treatment with a colleague/therapist who specialised in working with eating disorders. I discovered that the Institute of Psychiatry's database would only be available to researchers who had applied for ethical approval through the NHS. However, a psychologist working within eating disorders research at Kings College introduced me to a participant who had indicated her willingness to assist in further studies. It was not necessary for me to reject any of the women who came forward for the study. However, one woman contacted me whilst an in-patient at an eating disorders treatment centre, wishing to be interviewed without informing her treatment team. After I made it clear that it was important to me to be transparent and open with her practitioner about my reason for visiting her, she apparently decided against participating as I received no reply. Another young woman aged seventeen expressed her interest and we agreed to delay her interview until after her eighteenth birthday. Despite feeling a degree of concern during the lengthy intervals between volunteers' coming forward, I was heartened by the marked sense of commitment amongst the women who wished to participate.

Table 1 conveys relevant information regarding participants, who all described their condition as anorexia nervosa, restricting subtype. Several had been hospitalised when at their lowest weight. Most women were working towards recovery from anorexia nervosa, which meant that they were well enough to engage within a research alliance, yet also impacted by their condition such that they could connect with the experience of anorexia nervosa. Some information was not provided, for instance, by participants who had not weighed themselves recently.

Table 1. Participant Characteristics

Participant No.	Age	Length of Illness	Body Mass Index
1	24	18 months	19.7
2	19	1 year	16.0
3	28	15 years	18.5
4	21		
5	26		19.4
6	25	13 years	
7	20	2 years	15
8	22	3 years	17.6
9	20	6 years	16.5
10	18	4 years	15.4

3.4. Ethical considerations

This study was conducted in accordance with the principles for research provided by the British Psychological Society (BPS, 2010). Approval to conduct this study was granted by Metanoia Institute and Middlesex University (Appendix 1). Given the vulnerable condition of participants, attention to measures for the purpose of addressing risk was of prime importance.

At the recruitment stage, prospective participants were sent an information sheet clearly describing the interview procedure. I ascertained that they were currently sufficiently supported, by treatment team and/or family. Prior to interviews, all participants gave written informed consent and were made aware that they could withdraw from the study at any point without having to provide a reason. The interview locations were arranged to provide a secure space for the work, as described in the later section on interviews.

On meeting, I offered participants an opportunity to ask questions to ensure that they felt reasonably comfortable about the process. I also asked their permission to audio-tape the conversation and assured them that all identifying details would be omitted from the transcripts. During the interviews, if I sensed that a participant was becoming upset, I reflected my awareness of her distress and asked whether she would like to take a break. This occurred on a few occasions and each time, the participant expressed her wish to continue. On interview completion, debriefing included an opportunity to describe the experience of the process and to ask further questions. I was mindful of not undermining participants' capacity to support themselves, whilst also making it clear that additional support was available if required.

It transpired that participants generally found the interview experience to be positive and appreciated the opportunity to speak of issues they considered important, demonstrated through their engagement and eagerness to provide me with helpful information. Where intense negative affect was aroused, this tended to be dissatisfaction or anger, expressed when describing treatment of the anorexia by eating disorder clinicians and, to a lesser extent, the role played by family members. When this happened, I listened and reflected my understanding of the experience, putting aside my research-oriented questions for a while. By the time the interview had drawn to a close, leading to debriefing, participants seemed to have moved into the here-and-now and their affective arousal had abated.

One interview which affected me particularly deeply involved the participant's disclosure that initially her food restricting had offered a potential avenue for feeling better about herself, but that after a few months it had become a means to end her life. At this point issues of ethics and duty of care superseded research aims and I was aware that the boundary between therapy and research was becoming blurred. I drew on my training and experience to respond to her disclosure with empathy, respect and acknowledgement of the importance of support to address the risk and ensure her safety. Endeavouring to establish the level of risk, I asked how long she had felt this

way, whether she had spoken to anyone about her intentions and what she would say to a friend who felt this way. When she indicated that she would not let her family down and that she was seeing her therapist later that day, I felt reasonably confident that the safety issue was in hand. My concerns were further ameliorated when she later asked whether I would be willing to speak about my research at her college, indicating future planning that was incompatible with a risk of suicide in the short-term. Being reasonably confident that this young woman's difficulties had not been exacerbated by the experience of taking part in my research, I followed the interview with the usual process of debriefing and ensuring that she was aware of the option to follow up the interview with further discussion if required.

For all participants, follow up included emails, expressing my thanks for their participation and, on completion of analysis, further emails with a summary of the themes that emerged from their interviews, together with my findings section. I made it clear that I would welcome their feedback. These measures were all designed to support the formation and maintenance of an ethical alliance between researcher and participant, and to convey my respect for the dignity and well-being of those involved (British Psychological Society, 2010).

3.5. Gathering data

3.5.1. Interview approach

In accordance with the principles of IPA, the semi-structured interview questions were open-ended and non-directive (Smith, 2004). My interview approach was guided by several considerations:

- To provide participants with a secure environment
- To discourage the view of researcher in a position of authority
- To facilitate a collaborative stance
- To set aside my own preconceptions and be open to discovery, to be surprised

- To hold my own specific questions lightly, for use to encourage participants to elaborate on their experience, where relevant.

With these specific aims in mind, but primarily considering my aim of learning about participants' embodied experience and how they made sense of their experience, I decided to ask a broad, open question initially:

> To start, I'd like to ask you a very general open question, and whatever seems relevant to you, whatever comes to mind, is of interest. I'd like to ask you when you think about food, or your weight, or your shape, or when you are faced with food, can you say a little about the sort of images or pictures that you might have in your mind?

Richness of IPA data is a measure of the extent to which the interviews are detailed, experience-near and reflective (Larkin, 2011). In order to elicit good interviews, yielding concrete descriptions of lived situations, I aimed to communicate my understanding of participants' descriptions and to deepen their contact with their experience. Therapeutic training and skills were helpful in this respect, though I was mindful of the important differences between interview and therapy session.

Depending on the content of participants' accounts, I intended to explore the following specific questions:

- Where images are part of the experience, what eating behaviours (e.g. restricting)/avoiding) tend to co-occur?
- How vivid and (if visual) visually clear are the images?
- What feelings are typically associated with imagery experience?
- What kinds of scenarios are they depicting/ what are the themes?
- If they seem evocative of earlier experiences, explore whether these images could be linked to memories.
- If they are associated with memories, explore ways in which the images might either be consistent with, or depart from the earlier experiences.

This written guide was not one I used slavishly, but rather, I held it in mind whilst following the themes that appeared in participants' accounts. This involved my clarifying, repeating and confirming what I heard, with the aim of approaching what Kvale (1996) has called 'communicative validity', or 'member checks' (Denzin & Lincoln, 2000). Where the sense of potential was stronger, diving deeper into the answers was a means of gleaning richer descriptions of experience, whilst preserving the validity of the data.

3.5.2. Pilot interview

I conducted a pilot interview to assist me in answering questions I held regarding the appropriate duration of interviews, the suitability of my questions and the appropriateness of using prompts (such as food cues) to facilitate deeper awareness of participants' experience.

During this initial interview lasting ninety minutes, the participant responded to my questions with vivid, detailed descriptions of her experience of imagery related to her body and food. This included admissions of painful self-denigrating thoughts and beliefs, which she delivered in a calm, matter-of-fact manner. She was keen to be helpful and showed no sign of distress, invoking in me a desire to protect her and offer something in return. I was therefore quietly pleased when she later commented that she had learnt something about herself during the interview.

Anticipating that participants might find it difficult to evoke memories of images they had experienced, taking into account the impact of starvation on concentration, I had considered introducing prompts (i.e. food) during the interview, to facilitate contacting of the 'lived experience' in the natural world. During the pilot interview I learned that this measure was unnecessary: When I asked the participant how she would expect to feel if I brought food into the interview setting, she seemed reticent, and clearly did not feel that the actual sight or smell of food was necessary to stimulate her

reflections. Although I had brought a bag of various items including sushi, fruit and chocolate, I decided that food prompts would potentially distract her from her account and would not be helpful in subsequent interviews.

In addition to providing answers regarding the format and style of the interviews, the pilot also yielded such valuable descriptions that I decided to include it in my research data corpus, as Interview 1.

3.5.3. Subsequent interviews

Nine further interviews were conducted face to face, generally in my practice. Several participants lived far from me and I arranged interview rooms closer to their homes. One interview with a participant who lives in Scotland, was conducted via telephone. Although the recording of this interview was unfortunately very unclear, the audible sections were valuable (and the participant was enthusiastic about being involved in the study); therefore, I included this interview in the body of the data. (I decided against asking the participant to repeat the interview, as it had clearly been quite demanding and somewhat distressing for her.)

All participants were offered payment of £8 as a gesture, to cover their travel expenses. Several participants chose not to accept the payment, stating that they were happy to be able to help with my research. I was deeply impacted by the wish of these women that their experiences might be used to enable others to recover from anorexia nervosa.

All interviews were recorded and transcribed verbatim, replacing participants' names with the letter, 'R', for respondent.

3.6. Process of analysis

In order to progress in my analysis from the essence of the experiences of my participants to a set of master themes, I followed the general guidelines for IPA as outlined in Smith et al (2009). This involved the following four phases for each interview, in preparation for the final overall consolidation phase:

3.6.1. Reading and re-reading the transcript

This facilitates active engaging with the data and trying to understand the dynamic flow of the whole interview.

3.6.2. Recording initial notes

These notes record exploratory comments, reflecting a close textual analysis that focuses on each line of the transcript. This analytic dialogue is developed using three types of comments:

- Descriptive comments, which capture the objects which structure the thoughts and experience of the participant.
- Linguistic comments, which highlight language use, such as pauses, particular pronouns, repetitions and metaphors.
- Conceptual comments which extends the analysis towards a more interpretative understanding of the transcript.

I find this approach more deeply engaging, creative and flexible than other potential usages of IPA. It facilitates exploration of underlying meanings and the emergence of an interpretative account of the transcript. The ultimate aim is to produce a comprehensive set of notes and comments on the data, which can be used in subsequent stages of the analysis.

3.6.3. Developing emergent themes

Using the initial notes and the original transcript, the aim is to produce concise phrases that are grounded in the participant's account whilst representing a more psychological conceptualisation of the data. This allows for identification of emergent themes (generally around 70 per interview – so staying close to the data).

3.6.4. Consolidating to form superordinate themes

This stage involves a greater degree of interpretation in the endeavour to identify connections, patterns and interrelationships using the emergent themes. This grouping yields around 8-10 superordinate themes per interview.

3.6.5. Across-case master theme formulation

After completing the above process for each transcript, the final phase of analysis comprises the cross-case development of master themes. This is a particularly creative phase, involving the identification of connections and relationships between superordinate themes across cases. The result is a set of master themes for all of the interviews.

The challenges inherent in the interpretative process – and my approach to dealing with them - will be outlined in the following sections.

3.7. Managing data using Atlas.ti

I chose to manage the data generated during the analysis of interviews using a qualitative data analysis software product called Atlas.ti. It is important to emphasize that this was a means of storing, organizing and retrieving the products of my analysis and in no way replaced the process of engaging with and interpreting participants' accounts. There were no short cuts. The advantages of using Atlas.ti lay in the ease

with which I could verify decisions made during analysis, amend those decisions if necessary, create reports displaying the results of queries and provide an audit trail of my analysis.

In what follows I have identified terms used within Atlas.ti in italics.

3.7.1. Phase 1: Initial notes (quotes)

For each interview, this involved reading through and identifying pertinent sections of text (referred to within Atlas ti, as a *quote)*, which could vary in length between a few words and an entire paragraph. I felt it would be more true to the essence of my participants' accounts if I maintained the length of quotes to allow the context and connections between themes to be preserved. This meant that generally quotes contained two or more related sentences – some as long as a paragraph.

I recorded initial notes (my reflections) against each *quote*, storing these as *comments*, ready for the next phase. Initial notes were either descriptive summaries of the associated quote, linguistic comments on the choice of words or other devices, or conceptual interpretations of the literal content. Thus this phase involved both phenomenological description and analytical interpretation, oriented towards understanding the meaning of the particular experience for each participant.

Whilst writing initial notes, I was aware of the potential for moving away from participants' accounts towards my own interpretations. I aimed to maintain a balance between adhering rigidly to the text and losing the participants' essential experience. This tension has been acknowledged by Smith and colleagues: "At times this kind of exploratory comment may feel like stretching the interpretation pretty far. However, these provisional conceptual questions can really add depth and sophistication to the analytic process. As long as the interpretation is stimulated by, and tied to, the text, it is legitimate." (Smith et al, 2009, p. 89). As suggested by the above authors, I

documented these more interpretive reflections to ensure that I would review them again later in my analysis.

3.7.2. Phase 2: Emergent themes (*codes*)

The next step involved the identification of emergent themes associated with the initial notes, where I aimed to identify themes that had "enough particularity to be grounded and enough abstraction to be conceptual" (Smith et al, 2009, p. 92).

At times during this process, I experienced discomfort when it seemed I was losing the flow of the participants' accounts, as Smith et al have also noted: "the analyst may at first feel uncomfortable about seeming to fragment the participants' experiences through this reorganisation of data…. The original whole of the interview becomes a set of parts as you conduct your analysis, but these then come together in another new whole at the end of the analysis in the write-up" (Smith et al, 2009, p.91).

Emergent themes were stored as *codes* within Atlas ti. Each *quote* had one or more *codes* attached to it, depending on the richness and complexity of the *comments* attached to the *quote*. As with the first phase, I viewed the accounts through both phenomenological and hermeneutic lenses, producing some *codes* with descriptive qualities and others that were more conceptual, as shown in Table 2 below.

Table 2. Coding an Excerpt of a Transcript

Transcript Excerpt	**Emergent Themes (*codes*)**
I guess **when I was in-patient** and I can remember having meals put in front of me um … I remember it **looking like mountainfuls**. I remember, okay for instance I remember the first jacket potato I was ever given and it had cheese and beans with it and I remember looking at it and **thinking it was going to go on forever**	Severe stage experience Image of food mountains Feeling overwhelmed Ending versus endless processes Eating as ordeal

According to Smith et al (2009), when there are two or more participants in a study, it is important to analyse each account independently, aiming to honour the uniqueness of each account. So this would mean developing emergent themes for each interview as if it were the first and only account, without reference to themes identified for previous interviews. I decided to take a different approach - referring to themes already developed for the study as a whole - for the following reasons:

- I considered it more efficient and expedient to hold in mind the themes already identified, when analysing each account, particularly considering the relatively large number of cases.
- The iterative process could be facilitated by being able to view themes developed in other accounts - what emerged in a particular account might either reinforce previously identified themes, or might lead me to review and possibly modify them. Engaging with the part as well as the whole in the moment felt more natural and again, more efficient.
- The software package (Atlas.ti) supported this approach by providing a developing list of all 'codes' (themes) held across all interviews.

My decision accords with an earlier suggestion by Smith (2003) that 'You can either use the themes from the first case to help orient the subsequent analysis or put the table of themes for participant 1 aside and work on transcript 2 from scratch' (Smith, 2003, p. 173). As he has also contended, I aimed to be aware of the importance of noticing not only repeated patterns, but also new themes. As a result of my chosen approach, a *code* could be used a number of times within an interview and in addition, a *code* might have been used in other interviews - so *codes* were not unique to each interview. This was facilitated by referral to a list of *codes* held in Atlas ti, wherein it is possible to view all *codes* associated with a particular interview, or all *codes* across interviews, using a helpful filter function within Atlas ti.

3.7.3. Phase 3: Superordinate themes

When clustering emergent themes into superordinate themes for each interview, I drew on my understanding of intrapsychic processes as conceptualised within my integrative framework. In this creative process, I was guided by the principle of looking for commonality, highlighting convergence through being alert to similar clusterings of themes across different interviews. Measure of prevalence of themes is an important feature of IPA studies with more than 8 participants (Smith, 2011a). This information was collated and summarised with the reporting facilities of Atlas.ti.

In moving from emergent themes to more conceptual ideas, I was aware that participants' accounts of their experience at times remained at the relatively superficial level of the literal, leaving me concerned about whether our collaborative efforts had uncovered themes of sufficient depth and richness. This is unsurprising, considering relatively higher incidences of alexithymia evident in people with anorexia nervosa and the sense of distance from the body. I realised that I needed to look more closely at the essence of the experience underlying the superficial, with greater confidence, curiosity and willingness to hold ideas about the inherent meanings, albeit lightly. I was encouraged by Smith's article on the "gem in experiential qualitative psychology" (Smith, 2011b, p. 6), which struck me as an invitation to engage more confidently in the interpretative process. I endeavoured to continue 'diving for pearls' (Smith, 2011b, p. 6) as I moved between feeling that I was being too literal, and at times worrying that I had extrapolated too far from my participants' experiences in my interpretations.

Initially, I was wary of compromising the idiographic stance within IPA, by applying the same framework of superordinate themes to each interview. As I progressed through the third and fourth interviews, however, I realized that there was a core set of superordinate themes being repeated, with additional clusters of themes applicable to a few interviews or even a single interview. It began to seem possible to honour divergence of themes without losing sight of commonalities, or vice versa. Smith has

written of the challenge of balancing the "competing demands of individual nuance and collective experience" (Smith, 2011a, p. 21). In developing a set of criteria for assessing the quality of IPA studies, he suggested considering a theme as recurrent if it occurs in at least half the transcripts. I believe it was appropriate to adopt this approach – particularly considering the relatively high number of interviews in my study.

3.7.4. Phase 4: Master themes

Once I had developed superordinate themes for each of the interviews, I was able to gather common themes across interviews and organise them into Master themes. In developing an understanding of inherent meanings, I recognised the importance of traversing the 'hermeneutic circle' (Smith, 2011b), in an iterative process of relating part to whole and vice versa.

Once I had completed this final phase of the analysis, I used Atlas.ti to produce lists – for each Master theme – of all quotations provided by all participants that underpinned the Master theme. This was a valuable means of checking the validity of the findings, through verifying the relevance of the underlying emergent themes to the Master themes. I used these lists to produce a table for each Master theme, containing a relevant quotation from each of the interviews which contained emergent themes pertinent to the Master theme.

3.8. Evidence of rigour and trustworthiness

It has been my intent that rigour and trustworthiness appear as threads interwoven through the fabric of this research. The effectiveness of this endeavour can be judged by several criteria considered important in qualitative research (Yardley, 2000; Morrow, 2005), which I will now describe briefly.

Sensitivity to context can be evident in various aspects of qualitative research (Yardley, 2000). At early stages in the process, one way it is demonstrated is by the effective recruitment of participants who tend to be difficult to access. It is also essential for successful navigation through the interviews, which involves meeting participants where they can provide details of emotionally triggering experiences without becoming overwhelmed. I believe that the reader will find evidence of this aspect in the sections that follow, particularly in verbatim extracts from the interviews. Within IPA, an important aspect of this criterion is the demonstration of sensitivity to the data (Smith et al, 2009). The reader will be able to judge my research in this respect through evaluating the extent of care I have taken in collecting the data and in grounding my interpretations in participants' accounts. Employment of Atlas.ti for recording an audit trail of research activities, including tracking influences on my interpretation of accounts and emerging themes, has enabled me to preserve evidence of my empathic engagement with participants' stories. Thus perhaps paradoxically, a computerised system has supported a context-sensitive approach to the interpretative analysis process, whilst also providing evidence of dependability and ontological authenticity, both criteria for judging the trustworthiness of interpretivist qualitative research (Morrow, 2005).

In a number of ways, my engagement with the topic area of eating disorders has demonstrated my commitment to the topic area, a criterion within Yardley's (2000) framework for validating quality. Training as a practitioner at the NCFED has enabled me to work therapeutically in the field of eating disorders. Volunteering to provide telephone coaching to carers of people with eating disorders in series of a research projects conducted at Kings College constitutes another way in which I have maintained contact with the area outside of my own research. These activities have also increased my capacity to contextualise the interviews, supporting a deeper understanding of participants' meanings and greater ontological authenticity (Morrow, 2005). Through membership of an online community committed to supporting one another in the process of IPA analysis, I have continued to develop my understanding of the methodology and its philosophical stance.

Credibility of themes emerging from the interpretative analysis was addressed through ongoing dialogue and review of the findings, which also contributed towards transparency regarding the meanings I constructed from participants' accounts (Yardley, 2000). In addition to discussions with my supervisor and regular research discussion meetings with fellow researchers, I asked a peer researcher with specialist training and extensive clinical experience in eating disorder work to review my analysis of a single interview. This colleague followed the process from identification of emergent themes through development of superordinate themes and finally Master themes, paying close attention to the congruence between the interview content and the emergent themes, thus evaluating intrinsic coherence (Yardley, 2000). She found my interpretations of the interview content and clustering of emergent themes to be reasonable and could see how the superordinate themes fit well with the master themes. This affirmation of plausibility was important to me in light of my recognition that my own experiences and views had inevitably coloured my interpretations (Ballinger, 2006).

Density of evidence, one of the criteria for quality proposed by Smith (2011a), can be demonstrated by providing interview extracts from half the sample for each theme. This study has exceeded the requirement for evidence of sufficient sampling in that the superordinate themes are supported by quotations from at least half the participants, as illustrated in the Findings section and in Appendix 4.

Trustworthiness in qualitative research is further supported through the disclosure of reflexive measures to maintain awareness of the impact of researcher bias and assumptions. Following Heidegger's (1962) recognition that our prior assumptions will be embedded in the phenomenological investigative endeavour, I accepted the impact of my 'fore-understanding'. Honouring the principles of reflexivity and transparency (Morrow, 2005), I recorded my thoughts and feelings arising during the process of formulating my research question, interviewing, analysis and writing up. This included acknowledging potential areas of role conflict or tensions between ontological stances of people whose opinions I hold valuable (Ahern, 1999).

In terms of generalizability (Morrow, 2005), I acknowledge that the findings of this study are primarily applicable to the specialised patient group of young women with anorexia nervosa. Extrapolation of these findings to people with eating disorders or other broader groups is conceivable, as the reader may discern from reading the Discussion, though this consideration will not be addressed in the current study.

A common criterion employed in assessing the credibility of qualitative research is the method of triangulation (Ballinger, 2006). Within IPA, however, it is arguably less relevant to interrogate the data to establish convergence with alternate sources, because of the subjective nature of the interpretations. Reflecting on these considerations and the co-created nature of the interview process, I felt the appropriate course was to follow up each interview by sending the participant a summary of the themes emerging from her account. It took some time to reach a stage where I felt confident to share my interpretative analysis and therefore I informed participants that this phase was taking longer than anticipated to complete. Once I had completed the analysis and written up the findings, I contacted them to offer a copy of both the overall findings section and of the themes that had emerged from their own interviews. Several participants indicated their wish to be sent these materials. No one contested the emergent themes or their groupings, which may have been associated with the delay on my sending out my findings (or perhaps – from a more psychodynamic perspective – it may have been difficult for participants to take in, digest and share thoughts on what I had prepared). In further service of this aim, I also led a seminar at Metanoia Institute in which I presented the findings of this study to fellow students and the Head of Department. The audience's response to my presentation reinforced my belief in the impact and importance of this research as a contribution to the field of counselling psychology and psychotherapy (Yardley, 2000).

3.9. Initial assumptions of the researcher

Looking back to before I went into the field and began this research, I see my early assumptions as a collection of expectations based on early memories of encounters with 'successful dieters', snippets of literature and fantasies of what may be revealed

about the inner world of the anorexic based on my own experience. Some of these fore-structures are made visible here. Reflections on how they potentially influenced the findings of this study and how they were challenged by the data can be found in the Discussion.

I imagined that I might encounter a degree of pride and satisfaction – possibly a sense of superiority – in the women I would be interviewing. This assumption originated in my impressions gained as a young woman, when meeting others who had symptoms of anorexia. Their lives appeared orderly, meticulous and serene, unhampered by some of the messiness inherent in the business of consuming food or struggling to find clothing that would hang gracefully on the body. These memories led to my expectation (barely in awareness) that I might find similar qualities of neatness and purity in participants' descriptions and perhaps that this would lead naturally to orderly categorisation of data into themes.

In apparent contradiction with the aforementioned, I was also prepared to hear about traumatic experiences associated with the images. Flashbacks depicting painful memories might conceivably form part of the repertoire underpinning a willingness to starve. Furthermore, anecdotal evidence suggested that people with anorexia may experience frightening imaginary sensations such as a part of the body ballooning out, or the arteries clogging up with fat. I anticipated that I might learn of strategies employed to strengthen will-power and resist hunger urges, such as descriptions that connected particular foods with unflattering images of the body. Conversely, a desirable image of the body might be associated with food restriction and hunger. The underlying assumption was that participants consciously and deliberately would manipulate their experience through invoking images to reduce the appeal of food. This implied an element of choice inherent in the anorexic condition.

These fore-structures were likely to infiltrate the double hermeneutic, colouring my meaning-making during the eliciting and subsequent analysis of participants'

descriptions. Through this lens, I engaged in the interpretative process which led to the findings presented in the following chapter.

4. Findings

4.1. Summary of master themes

Analysis using Interpretative Phenomenological Analysis (IPA) led to the emergence of three Master themes, each constituting a pair of constructs which represent polarities within a realm of experience. These realms are fragmentation versus integration, exposure versus protection and isolation versus relatedness. It will become evident that in each realm of experience, the first construct (namely, fragmentation, exposure and isolation) is generally more strongly represented than its polar opposite. I decided to organise the themes in this way to be inclusive of the potential for participants to experience a greater degree of the opposite polarities of integration, security and relatedness.

4.2. Notes on characteristics of themes

The exploration of mental imagery experienced in anorexia nervosa has been my focus throughout this study, guiding my questions and informing my data analysis. It is my hope that the themes that I outline within this section will elucidate this area of enquiry. In addition to imagery, participants also spoke about other aspects of their experience which were meaningful to them and I felt it important to honour these contributions by including them in my analysis. In some accounts, imagery did not feature as strongly as beliefs and associated emotional and behavioural responses to food and the body. In the spirit of exploratory enquiry that is consistent with my understanding of IPA, I have chosen to represent these aspects alongside imagery-related themes. The divisions between imagery, memories, thoughts and beliefs are sometimes blurred. I could have made the divisions clear, categorising and separating these psychological components, but this, I believe, would have compromised the rich and informative quality of the themes that emerged.

4.3. Constitution of master themes

Although I have begun by describing the Master themes, the analysis effectively proceeded in a bottom-up fashion, beginning with the identification of emergent themes. (See Appendix 2 for an extract of an interview with initial notes and emergent themes). The initial phase of analysis yielded 451 emergent themes across 10 interviews. The number of themes identified for each interview averaged around 70. It is notable that owing to a degree of commonality (convergence) a considerable number of themes were shared across interviews. The table of emergent themes appears in Appendix 3.

After reflecting on the emergent themes for each interview, I developed a set of 20 superordinate themes – generally around 8 per interview (again, with a notable degree of convergence across interviews). In the following sections, I will introduce the Master themes briefly and include a table displaying their component Superordinate themes, together with the interviews in which the themes appeared, before describing these constituent parts more fully and providing illustrative quotations from the participants' accounts. All names have been changed to protect confidentiality. Each table also appears in expanded form in Appendix 4, including representative quotations.

4.4. Fragmentation versus integration (first master theme)

This realm of experience encompasses themes related to the degree of wholeness and connection experienced within the self, and the external dynamics impacting on this experience. At the polarity of fragmentation there is an implied awareness of the threat posed by external, uncontrollable phenomena – the unknown, unquantifiable, unpredictable or unreliable. Fragmentation within the self manifests in a disconnection between aspects of self-experience. At the opposite polarity, the experience of integration is described in terms of reflections which acknowledge the self as a whole, body and mind as one, and which organise experience systematically.

This polarity is notably less well-represented than its opposite, fragmentation, where powerful imagery features more prominently.

Table 3. Components of Fragmentation versus Integration

Superordinate Theme	**Interviews containing this theme**									
Threat of uncontrollable phenomena (uncertainty or chaos)	1	2	3	4	5	6	7	8	9	10
Control, rules and restrictions	1	2	3	4	5		7	8	9	10
Food as threat	1	2	3	4		6	7	8	9	
Disconnection within the self	1	2	3	4	5	6	7	8	9	
Subjugating body	1	2	3	4	5		7	8	9	
The reflective self	1			4	5		7	8	9	
Relating imagery to previous experience	1	2	3	4	5			8	9	

4.4.1. Threat of uncontrollable phenomena (uncertainty or chaos)

The discomfort or fear experienced in response to uncertainty, chaos or uncontrollable events is often expressed implicitly in descriptions of stress-inducing situations involving food or the body. Participants seem to be acknowledging that their anxiety in the face of the unknown or unmanageable is conceivably greater than would normally be expected. Their responses to these phenomena suggest difficulties in regulating their felt response to the unknown or unquantifiable. For instance, when the calorie content of food is unknown, or when trustworthiness of weight or calorie-related information is questionable, heightened anxiety results. Layla fears bowls of leftover food whose unquantifiable contents she would experience as a foreign object infiltrating her body:

Layla: Yeah, it's definitely uncertainty and I think one of the things with the bowl food as well is that because it's not a portion and you don't know what's in it, you don't know how many calories are in it so it's not even so much that I would eat it, it's that I would eat it and I wouldn't know what I'd eaten which is a massive, that's really horrible because then, then you'd have to think about and you don't know and that's not even guilt, it's worse than guilt because it's like having an unknown thing inside you, that's, yeah. I suppose that's what's really horrible about the bowl food.

Layla does not name the feeling worse than guilt, but she alludes to something 'massive' and 'horrible', reflecting the unpredictable impact on her body. The discomfort of not knowing is a 'very gnawing' feeling that she feels powerless to moderate. Layla also intimates that she might eat the leftovers against her better judgement, this betrayal of her principles providing evidence that the body and its desires are untrustworthy, liable to expose her to indeterminate risks. She therefore sees it as very important to eat in a methodical, logical way, rather than in a feeling way, avoiding uncertainty through engaging 'mind over matter'.

The perception of the body expanding uncontrollably is an anxiety-provoking experience described by several participants. The sense of an insidious substance within the body can be accompanied by powerful imagery that compounds the threatening nature of this experience:

Kelly: It's like a total red ball of fire inside my stomach. I just feel it rolls around and lets off, like it's just firing up inside me. It's horrible.

Lisa: If I'd eaten like maybe a gram extra of fat than I planned to that day, then I would literally, I wouldn't see, like okay I wouldn't see like I had fat at the top of my leg, but I'd feel, well I'd see it in my mind like going into my body and like just spreading around and like - so it's like under the skin.

For Lisa, the feeling and mental image of the fat spreading beneath her skin is possibly as real to her as literally seeing her legs fattening. Relatedly, Leigh described the panic she feels on being weighed, when she sees and feels her body expanding uncontrollably, in a reaction that is arguably disproportionate to the increase in her weight:

Leigh: You can feel small, and then you get on the weighing scales. You see the numbers increase and then all of a sudden your leg size increases, your face increases literally at the same time as you've just seen the number increase. So I can be sitting here normal weight, go on the scale, put on let's say point five from the week before. Honestly your whole world, your - that whole picture image of you can sit there and you can feel your face and cheeks puffing up, your legs growing. You're no longer fitting into your clothes. Even though you're just sitting there at the same time. It's just that mental image just grows. And then that's when you really believe and that mental image grows.

Powerless to halt the relentless expansion of her face and limbs, she feels the impact throughout her body. A small increase in the number on the scales has a dramatic effect on her sense of self in the world and, like other participants, she equates being big with having lost control. In other instances, the body itself may be the instigator of chaos, as might occur if she experiences a breakdown of control over the desire for food and succumbs to unrestrained eating:

Leigh: You know like those pictures of like where you see people just stuffing your - their mouths with food type thing, you just get that vast like stuffing things in your mouth type thing and it's because you're going - of course because you're scared of it you're going it, you've obviously enjoyed it, so you're scared of enjoying it and then going back for more and more and more and then the image growing and growing.

In an apparent slip of the tongue, Leigh initially referred to her own mouth being stuffed with food, before correcting herself, as if trying to distance herself from

involvement in the chaotic image. She later illustrated this experience using the character of Mr Messy, from the Mr Men children's book series by Roger Hargreaves (1998), as a metaphor for her feeling of being messy and unboundaried, explaining 'You're not in line anymore'. For the anorexic, the prospect of losing control around food engenders a sense of being unsafe, caught up in an unpredictable turmoil that may never end. She is also aware, on some level, of the possibility that this threat may be realised, when she begins to eat normally and experiences powerful cravings.

Images and feelings regarding the uncontrollable are generally focused on the body and food. However, these fears do not relate exclusively to chaotic physical changes or eating, as Ella appeared to be saying:

Ella: I've said things that I hadn't realised - like the chaos and the controlling of your image with you know seeing specific parts of the body. I hadn't thought about that before um as a way of controlling the chaos.

4.4.2. Control, rules and restrictions

This theme is strongly supported with accounts of anorexic modes of thinking and behaviour, with rich descriptions of different visual images and other sensory impressions. Paradoxically, although the anorexic might feel in control, her sense of autonomy is undermined. Because the locus of control is with anorexia, she feels restricted and rule-bound. Inasmuch as anorexia controls the person, the anorexic aims to control her world - 'It seems to be like needing to control something always'. This means defying others and resisting situations involving spontaneity or freedom, as if conveying to them her constricted experience.

For some participants, injunctions are experienced as if spoken by an internal voice, commonly uttering a simple, abrupt 'No' in response to food. Although the anorexic voice is not experienced by all, those who perceive a controlling influence might describe a strict, 'taskmaster type voice' issuing commands regarding exercise or diet.

For some, it is their own voice, for others, a male voice. (The anorexic voice is described further in the theme, relationship with anorexia.)

Participants described their food-related rules and restrictions with precision and detail, reflecting their obsessive rumination to ensure accurate accounting of their energy intake and expenditure. This is evident in accounts of calculations that are checked and re-checked, to ensure that the calories contained for a meal or for the day are within self-imposed (or rather, anorexia-imposed) limits. Imagery depicting numbers features strongly: her weight on the weighing scales, the calories in her food 'flashing up'. She might not even see the food, but rather, its calorific value, a stark image in black and white, similar to content specifications on food packaging. Thus sensory experience is minimal. The smell of food, which she cannot ban from her experience, is an unwelcome intrusion.

Mia: it's a bit like um when I saw the film *The Matrix* and it was black and it had like the numbers I think and they're like green. And it's a bit like that in my head just with the sheer amount of numbers and they're sort of all kind of processing and um it's kind of all being I think weighed up in my mind I think.

Whilst grappling with lengthy numerical deliberations, participants try to ensure that eating is a systematic, logical and rational process. Thus a common rule is not to eat when hungry, since actions driven by physical desire are unrestrained – therefore, drink a coffee before the meal and stay in control, because 'I like to eat in a logical way rather than a feeling way'. Enhancing the sense of control, rituals for eating include cutting up food in a particular way, usually into very small pieces (though one participant cut large chunks at sharp angles to ensure it would hurt her as she swallowed pieces whole, since 'if I have to have it, it has to hurt').

Layla: Yeah I have to imagine how I would eat it I think and generally it's better if I can imagine eating it in a specific way or like slowly or, things like, I guess I like it if there's a special way to eat it things like porridge if you make it really, with a lot of water and you do it in the microwave you get like a bit of froth on top and

things like, I always know you have to like scoop that bit off and there's like a little bit of a ritual to eating it so it takes longer and it, I suppose it's sort of less involved with like taste and eating and more. It's like a different, I don't know, it's like an odd thing to do with it and also things like if it's hot that's good because then you have to blow on it before, you couldn't just like you eat it you have to blow on each bit…

Layla spoke of porridge as a safe food, contrasting it with unsafe or 'fear' foods. Food is unsafe if the anorexic believes she does not deserve it or that she may be unable to stop eating it, particularly if she has denied herself this food for a lengthy period of time.

Ella: I wish I was someone who could have Chinese, but I know that I'm not allowed, which is a shame. But good, I'm glad I'm not allowed because otherwise I could lose control. Very confusing and conflicting.

The strict quality of the anorexic's rules is illustrated in one participant's metaphor suggesting that eating a meal is like climbing a wall, a challenge requiring a methodical approach – putting a foot wrong could result in a brick falling out, just as eating the 'wrong' food could cause damage or increase the risk of disaster. For some, however, knowing the rules allows the possibility of negotiating with anorexia –going for a long walk might earn her permission to eat a meal.

Acknowledging the control her anorexia yields over her, Leigh envisages the image of a rule book, with a page for each new day, listing rules which must be ticked off as she obediently follows instructions. When she fails to comply, the rules for the following day are adjusted to compensate, stipulating additional exercise or restricting.

Leigh: I think image for control I probably see like your rule book type thing, a book with rules on it. So like ticking the rules. Have I done this? Have I done that? So in my head it's that little rule book that I have to tick off that I've done this, I've done that. Right now it's have you gone for your walk? Have you done this?

Have you done that? Or before it would be you must – in-patient for example the walks were taken away from you. But it's at this time you must walk up and down in your room, when at meal time you must eat in a specific way. It's just following the images, this rule book with loads of small little rules written down and you must tick them off as you go along.

4.4.3. Food as threat

Participants expressed their perception of food as threatening in various ways, at different stages within the process of engaging with food. As she considers the prospect of consuming food, the anorexic experiences a rising sense of dread. Fuelled not only by anxious calculations of calories and fat content, her perception of threat intensifies with her aversive visceral response.

Ella: I'll sit there almost feeling sorry for myself because I know that there's absolutely no chance I would touch the food, let alone eat it. I wouldn't be able to. If I put the fork into my mouth it wouldn't happen, I think my hand would stop and I'd look at it and it'd just be like grease and …. lumps of things that just shouldn't - it's unclean, it's dirty. So it looks unclean.

Compounding the visually invoked discomfort, the smell of food is an unwelcome intrusion which cannot easily be barred from experience. Other instances of the overwhelming impact on the senses include the metaphor of a mountain, requiring endless effort to overcome, when contemplating a plate of food. One participant envisages a red flag ' like a warning in my head', experienced before she eats. The colour red features in other accounts too. A particularly powerful example is the impression that meat is 'covered in blood, even though it's not'.

During the process of eating, awareness of the taste and texture food is heightened at times, absent at others. When intensely aware of food, the overwhelming sensory experience requires her to focus on eating, excluding all distractions as she struggles to

combat her disgust and guilt. For some, paradoxically, it is safer and less guilt-inducing to eat food that appeals less, whereas food that would have been enjoyed pre-anorexia invokes shame and feelings of being soiled – 'If I smell it and it's horrible, it's fine. If I taste it and it's disgusting, it's brilliant'. In contrast with intense awareness, it is sometimes possible to get through the ordeal in a numbed state, dissociated from the experience.

Compounding the threatening experience is the fear of how she will feel after eating (the theme, Punishment and recriminations, expounds this concern). The image of food inside her stomach invokes discomfort and revulsion, particularly when as in-patient her digestive system, unaccustomed to the high-calorie diet, struggles with bloating and constipation.

Mia: I find when I've eaten in the first kind of half an hour-hour or so after I've eaten I'm still anxious because I think, it's almost a bit like a switch, like when it's coming up to eating it's like woah, red! Right, eating, like try and get through that, and then gradually it will just kind of fade. So I guess in a way it's a little bit like a sort of screening I guess, but yeah it's always the fear of how I'll feel afterwards. And I think afterwards it still takes me a little while to figure out exactly how I do feel about it I think. And I think that's when sometimes the numbers [of calories] and things can come back because it's then, so how do I feel about that? Right well, it fitted in with those numbers and then it's kind of like, a bit like a puzzle when I'm done. It's kind of piecing together, right okay so we did those numbers and you know so is that okay and then if it's okay it's kind of like red screen comes down, like that was okay, I think.

4.4.4. Disconnection within the self

Participants alluded to disconnection between aspects of self-experience through their descriptions of images, attitudes and physical sensations. Imagery is suggestive of the body experienced as a separate object, disowned, rejected or simply excluded from

awareness. When awareness is low, feelings are numb, whereas fear or a sense of impending fragmentation arises when the body does not conform to the desired standard.

Leigh: I think when I feel weight gain I feel out of control, that messy, like you know that Mr. Men scribbly guy? You just feel like that. That infant little scribbly guy.

Leigh uses the metaphor of Mr Messy to represent the sense of being uncontained, as if exceeding the boundaries of the space she ought to occupy, when she gains weight. Her reference to 'that infant' emphasizes the random, unmanageable nature of her embodied experience.

Another participant described her urge to cut off parts of her body which she experienced as having been stuck on to her frame. The sense of foreign objects attached to or within the body is a striking metaphor for alienated aspects of the self.

Layla: I feel like soft bits on my body are bits that should be like removed, rather than, it's not, losing weight was actually kind of unsatisfactory because all that happens is you just get a bit like reduced but you're still kind of the same shape, but what I would rather have done was just like cut bits off that, like interfere with the shape.

Disconnection also manifests in non-imagery-related experience where women are not aware of their bodily signals or interpret them in specific ways: hunger can represent a positive feeling of losing weight or may be absent from awareness. It may be a threatening sensation which conveys a message that the body cannot be trusted, for to eat when hungry carries a risk of being unable to stop. One woman described the danger of 'unrestrained eating', which she avoided by eating only when not experiencing hunger. As if compliant with this injunction, the body no longer communicated hunger signals, though dizziness or stomach pains replaced hunger in communicating the body's need for food.

Lisa: your hunger kind of goes to be honest and it replaced, for me what replaced it was like actual, I'd get like tummy pains. I'd get really like really vicious pain that I would like have to curl up, and that's what I'd get. I guess maybe that was my body saying it was hungry, I don't know.

In describing the broken connections or incoherent messages between body and mind, or between thoughts and feelings, participants seemed to formulate a metaphor of the brain as a piece of technology, rather than an embodied part of the self:

Keira: I generally don't know what I'm feeling or what I feel about some things because I've spent so long just like blocking that connection in my brain, or blocking that path so that I don't think about my feelings. So then when people ask me to, it's quite hard to… just because I'm used to blocking that thought process.

There is a sense of fragmentation in this quote, and the idea of pathways within her brain which are now obstructed is suggestive of space within which the fragments of her experience are held.

4.4.5. Subjugating body

A theme related to that of disconnection is the sense of being able to rise above the needs of the body, as if physical signals are spurious and unworthy of attention. There may be a neutral disregard for bodily needs or an apparently intentional attack on the body, masochistic in nature. Below, Clara admits to manipulating her body through creating a sensation of satiety, as if her anorexia has powers superior to her unwitting body, which can be fooled into feeling full, through a punitive, underhand strategy:

Clara: I will subconsciously save up all my calories until, mostly until one part of the day. And it must be so that um there is the potential for me to feel unpleasantly full so that there is a possibility that I might not eat some of that food that I was supposed to eat. It's so devious.

The devious 'it' appears to be her own subconscious mind, and she seems to experience herself as divided, with a propensity to give greater authority to her head, whilst recognising the subjugation of her body's needs. The occasional realisation of the impact of bodily neglect instigates feelings of fascination, disbelief or alarm:

Layla: I actually remember that quite distinctly, like the image of it being less than seven stone was quite shocking actually because I was like, there was just no way I was getting, that I was that light…But it was also in a kind of sick way a little bit exciting because it was like, "Wow, that's way lower than I thought I'd ever get." and it's like kind of forbidden, it's like, "Ooh, look…", it's like un-chartered territory that side of the seven [stone].

Recalling the image of the dial on her weighing scales, Layla describes feeling worried about her unintended new low weight, as if an unspoken agreement with herself has been violated. Her reference to 'unchartered territory' suggests a sense of pioneering achievement, where the risk to body is acknowledged, but discounted. The minimising of concern for the lived body is also expressed in Ella's jocular image of her stomach contents when she and other in-patients experience constipation after days of re-feeding:

Ella: I just remember this mental image um and laughing about it because I was doing a rap about it, like taking the micky. Um it was imagining what my tummy looks like and because nothing's coming back out, I've got Weetabix-milk-Weetabix-milk-toast-weetabix-weetabix and then beans-jacket potato-beans-pasta-beans-pasta-salad-salad-salad um like toast-toast-toast-butter-butter-butter-butter.

Her humour appears in stark contrast with the distress she described at other points in the interview. This banal means of lightening the mood for herself and fellow patients involves holding up her physical and emotional pain for amusement, incrementing the sense of apparent careless dismissal of her body.

4.4.6. The reflective self

This theme comprises a relatively small number of subtle suggestions that participants were contemplative regarding their relationship with food or their bodies and open to considering different ways of being. A number of these statements conveyed criticism of their own values, beliefs and patterned responses to challenging situations. Although it is possible to view these utterances as self-attacking, there is also a plausible alternative interpretation which allows for the possibility of movement towards a different stance in relation to their world.

For example, in response to my interest in better understanding her uncomfortable physical sensations of hunger, fullness and nausea, Keira expressed her surprise and confusion:

Keira: Yeah…you're now making me think that there's a possibility that comfortable feelings exist, and that concept just is brand new because I don't understand that at all. That's never even crossed my mind.

My question appeared to have stimulated a discovery for Keira. Although the revelation that her feelings might also be comfortable seems positive, she does not appear hopeful that this experience might be available to her. This reflective appraisal of her emotional repertoire has a similar quality to other statements in which participants compared their experience to that of others. One participant frequently maintained that other (non-anorexic) people would have reactions different to hers, particularly regarding food or sensations in the body – 'Hunger becomes not like normal people would, non-eating disorder people would experience hunger. It becomes ... a good feeling'.

In contrast with Keira's relatively neutral reflection, there were new insights that participants experienced as positive, such as Ella's realisation that her strategy for coping with chaos is to focus on a specific detail:

Ella: The way I'd cope with the chaos is by trying to narrow it down to the smallest situation. And I guess I narrow down visually, so visually I'd look at myself at one aspect instead of the whole thing, which of course makes that one aspect seem bigger. Do you know I've never said this before, this is really strange and really, really helpful to me. [Slight laugh] Thanks.

Her enhanced self-knowledge allowed Ella to understand how come she experiences parts of her tiny body as disproportionately larger or more prominent than would normally be perceived. She seemed to feel excitement and her slight laugh suggested anxiety – as would be expected on discovering that her visual self-perception may be influenced by her tendency to focus on detail.

For the anorexic, increasing awareness of the impact of anorexia is uncomfortable: it can include the realisation that she faces long-term health risks, such as osteoporosis; she might catch a glimpse of her reflection in a mirror and be shocked by the reflection of 'this manic lady doing her exercises'. Though uncomfortable, these contemplations can prompt curiosity regarding recovery:

Mia: I think it felt still very kind of grey and still quite misty, but I felt like it was um ... something I wanted to find out. So it was kind of this mist but I really wanted to kind of get through it and figure out what was there so that um I don't have this need for the cloak I think because I was very aware that you know clearly this is a negative you know kind of health thing.

Though tentative, Mia seems drawn to explore the unfamiliar realm of being, independent of the protection that her anorexia provides. She understands the cost of remaining under her 'dark cloak' and feels willing to navigate through the mist-like unfamiliarity. The imagery she has employed conveys her apprehension and tentative confidence in herself.

4.4.7. Relating imagery to previous experience

This theme relates to the process of making connections between the experience of imagery in the present and memories of what was experienced in the past. There was considerable variation in the qualities of the imagery described, reflecting different ways in which people retained fragments of their previous experience. For some, visual images were as realistic as a photograph or movie and could be traced to specific events. Referring to two separate images, Keira affirmed that her imagery had its origins in actual experience:

Keira: One image is like of me like…and this is from the situation where I was really having to force myself to eat, as I didn't even want to put food in my mouth. So like I remember that exact situation.. and there's an image attached to that situation and the image of me standing in front of the mirror is like from a specific time, it's not just something I've made up, it's like an image I've sort of seen or from an event.

The salience of the experience in the past is evident in Keira's description of the effort involved in forcing herself to eat. The image appears to be associated with intense feelings and a clear memory of the event. This accords with participants' accounts of how the imagery entering conscious awareness in the present seemed to vary according to their emotional state, such as how anxious they felt.

It seemed important for Keira that she emphasize the accuracy of the images of herself as depictions of a previous experience. Later, she was interested to notice a discrepancy between the image and her appearance – namely, that in her image she could not see the scars that she now has on her body.

Keira: you know I said the image is from a particular sort of situation or day or time? This particular image, it - maybe that at that time I didn't have these marks and

now I do, but I've not edited the photo, or edited the image… it might be that. It actually could well be.

By considering her image as a photograph that remained static in time, despite changes occurring, Keira made sense of the discrepancy between her imagery and actual experience in the present. Other participants described factors impacting on the 'accuracy' of images, which sometimes contained fragments of previous experience. The anorexic voice might be a man's voice, which although different from an abusive stepfather, nevertheless reminded her of aspects of his personality. One participant held in mind an image of herself at a younger age, where her face was transposed on the fatter body of her younger sister.

Leigh: I picture someone in my family who's quite big. So you just picture them. And then you think, that could be you. So because I think, you just associate with a fat person that you can picture them in that situation, going back for more and more and more. So then you picture your face on their shape…. Because then it's a real like, it feels even more real because you're like, look, that is a real body you can go back to, you can become like that and if you go back for more and more and more. If you start then that's you in the end.

Leigh understood how her creative manipulation of two images yielded a visual image that provided a powerful deterrent when she had access to food. It seemed important to her that the image was credible – a 'real body'- representing a real potential threat. Whilst there were other instances of manipulation of what has been seen, such as imagining cooked meat as blood-soaked, imagery was not an aspect of experience for all participants. Instead, flashbacks or a felt response to the actual appearance of food were salient:

Layla: I don't imagine things that I don't - it's not my imagination, I don't think of something and see something there, but if I just see the food there, it's like actually seeing the food, the image of the food, that would like panic me.

Rather than an aspect of her imaginal world, it is the concrete perception of food that invokes Layla's fearful response. For her, the experience is literal, grounded in the present. This is an example of how for some participants, imagery is not a notable component of experience.

4.5. Exposure versus protection (second master theme)

The experience of exposure features feelings of shame and painful self-berating for perceived failures, particularly relating to the body and food-related behaviour. Punishment or recriminations both exacerbate the shame experience and also seem to serve the purpose of guarding against the threat of being seen or of taking up too much space. Avoidance of exposure, shame and self-criticism facilitates the opposite experience of protection, comfort and security. The self can thus be contained and made to feel safe – sometimes hidden. Imagery associated with both polarities is vivid and presents a barrier to change (ie seeming to make changes in anorectic patterns more difficult).

Table 4. Components of Exposure versus Protection

Superordinate Theme	Interviews containing this theme									
Body as Threat	1	2	3	4	5		7			
Exposure and Shame	1	2	3	4	5	6	7	8	9	
Punishment and Recriminations	1	2	3	4	5	6	7	8	9	10
Security and Safety	1	2		4	5				9	

4.5.1. Body as threat

The body represents a threat that the anorexic experiences not only in relation to her own body, but also to other bodies – particularly those that appear fat. Believing that the body cannot be trusted, she views it with wariness and suspicion. Reminders of

the potential for the body to sabotage the person are found in images of overweight people and their behaviour around food. Some participants described images of people over-eating, undignified and 'sweating constantly, the smell, lack of hygiene and all that'. These unpleasant sensory impressions increase their embodied response of disgust and aversion, confirming the association, 'food equals fat which equals dirty'. From some accounts there emerged meanings associated with fatness: uncontrolled eating habits could be assumed, together with feelings of shame and powerlessness, particularly given the mixture of pity and contempt that fat people are seen to invoke.

Joss: Images probably like looking at those pictures of those like super obese people that you see, like the ones that get broke out [of] their houses.

Fearful of her body's potential to undermine her perceived self-worth, Joss contemplates the unlikely possibility of becoming so obese that she cannot move from her home. This can be interpreted as suggestive of the body (or indeed the self) ending up helplessly compressed or trapped within a constricted space. An associated experience – albeit on a smaller scale – could arguably be the discomfort of feeling her clothing becoming tighter as she gains weight in recovery – 'I'd do anything in the world to crawl out of my skin'.

The sensation of her body growing as the food goes in, voluntarily or through force-feeding, elicits intense feelings of panic and self-loathing. Images of the body may depict it as appearing larger than in reality and for some this may involve imagining her own head superimposed onto a body of a larger person. The threat of there being 'too much' of her intensifies the urge to manipulate her body, reflected in graphic fantasies of cutting off the offending parts:

Clara: I do sometimes think of wanting to cut off everything, you know, cut off all the fat. It's very violent but it just feels so unbearable. It feels like that.

In describing her powerful urges to attack her body and mould it into a different shape, Clara talks of cutting off all the fat, just as one would remove fat from a portion of meat. Connections between characteristics of food and bodies also appear in Layla's description of imagery, where she conveys her beliefs about the tactile and visual qualities of bread and the type of body that would result from eating it.

Layla: …white bread that doesn't come ready sliced that goes like big, doughy…doughy thing, doughy people I guess. Yeah, I think that food is generally associated with a certain, probably incredibly judgemental image of what people who eat that food will look like.

The message from Layla's image seems to be that her body – like others - has the potential to be big and doughy, if she lowers her guard. The image of a fat body commonly enters awareness at times of eating or when thoughts turn to food, with heightened emotions of fear and disgust, which seem by association to engender a similar response to the food. This experience has the quality of a flashback, triggered instantly in threatening eating situations, as below where Keira describes an image of herself standing naked in front of a mirror, looking fat:

Keira: Well, it's just like I don't think I even have to really consciously think about it, I think that it just gets put into my brain and then on autopilot like if I'm trying to eat something that's hard to eat, something like with more fat or that I'm not comfortable with, the image will just come up to stop me eating and I won't think about it, it'll just happen so I'll instantly think "Oh yeah you're fat don't eat it." and that will be that, I won't think any more about it.

The image of her body appearing fat seems to appear automatically, with a powerful message to which she responds without question. The feelings that Keira has not mentioned in her matter-of-fact description will be explored in the following section.

4.5.2. Exposure and shame

Participants conveyed their sense of exposure by describing how they believed others might be observing them critically. They alluded to their shame by describing how they viewed themselves, with denigrating self-talk, as if uttered by a harsh inner critic – '"You mustn't do this, you can't eat this. Look, you're becoming so fat, you're letting yourself go, you shouldn't do this". The experience of exposure is inherent in one anorexic's image of herself staring at her own image in the mirror. Her focus on specific areas, which appear disproportionate, intensifies the impression of her body as warped or expanding:

Keira: It's just me standing in front of the mirror and just the fat bits are just sort of zoomed in and highlighted.

Keira's reference to how her 'fat bits' are emphasized through technological means suggests a clinical, depersonalised process, as if someone or something has projected her image onto a screen for examination. There were other instances of images manipulated as if via digital technology: One participant feels fear and disgust when she imagines her own face on the body of her (significantly larger) sister, repeatedly returning to fill her plate with food. This image of an expanding body will eventually become realised, as in recovery she begins to gain weight, an experience perceived as so degrading that she may avoid her reflection in the mirror.

For another participant, observing her image in the mirror leaves her convinced that there is 'too much' of her, as if ashamed of her own physicality and the space she occupies. To defend against the shame, she experiences destructive impulses to reduce her excessive presence, whilst others express their wish to disappear or hide. Ironically, these efforts to reduce painful exposure may exacerbate the very experience the anorexic aims to avoid, as she becomes painfully aware of invoking negative responses from people shocked at her emaciated appearance.

Ella: And then after a meal when I had that feeling of hugeness I'd take my scarves and I'd wrap them round me like blankets and huggle into them in my own bubble I guess, so that no-one else can see and so that I can't see it. And so that everything I feel is covered and so that I can't visualise it and I can hide from the image of myself and hide from what I don't want to see, this warped, expanding body.

4.5.3. Punishment and recriminations

Participants experienced self-inflicted recriminations and punishment after the breaking of personal rules and the anticipation of these unpleasant consequences strengthened their fearful aversion to food. Describing the image of a rule book to illustrate this process, one participant explained that the rules she had 'broken' appeared in red print on the page, effectively dictating that compensatory efforts would be necessary on day following her 'disobedience'. For several participants, the colour red featured in imagery, including a red screen, warning of the danger of making a mistake as mealtime approached. Imagining the regret she would suffer as a consequence led to lengthy deliberation prior to eating, as a safety strategy to avoid exceeding calorie limits or other boundaries. Violations of anorexic rules incur penalties involving the experience of worthlessness and horror at the irreversibility of the consequences.

Mia: I think if I feel that if it was the wrong choice on some level that's when the kind of blackness and stuff can kind of sort of creep in I think. And yeah, I get a sense of perhaps this kind, this box you know sort of, yeah it kind of I suppose closing in because it's like oh you know you've done the wrong thing and you know that was bad and you can't undo that now, I think.

Given the potential threatening consequences, one woman had concluded that it was easier not to eat at all. Some were afraid that if they enjoyed the taste or texture of food, they ran the risk of losing self-control and betraying themselves. Moreover,

enjoyment of food was a privilege they did not feel they deserved. To alleviate guilt and self-recriminations, one strategy was to avoid the sensory experience of eating, by placing food at the back of the mouth and swallowing it whole:

Ella: There's still guilt because you get the feeling of full afterwards, but there's no guilt because you're not eating. Or I didn't feel any guilt because I wasn't eating it. I'd gone for swallowing it not tasting it and it's the least dirty way of having what they wanted me to have. At least it wasn't real food.

Ella felt dirty when she consumed palatable food and her denial of physical pleasure touched on a sense of spiritual purity. By avoiding the experience of eating, she could pretend it was not 'real food' nourishing her. The punishing guilt after eating was persistent, even during treatment, where participants believed they ought to resist coercive encouragement to eat. In some cases, force-feeding – where the choice to eat was not their own – afforded some respite from guilt. However, complex reasoning often meant that self-criticism could not be avoided and the sense of failure was strong. One participant described an image of her guilt as a genie which escaped from a bottle:

Kelly: The guilt one I suppose if I'm thinking about it right now is like .. oh, if you can imagine a genie in a bottle….But the genie coming out the bottle like instantly and it being like grey, grey-black colour, but being really kind of garish looking, like a ghost sort of thing. And it would just, it would sort of be a bit jelly-like and fluid like in its movements.

The image of inner contents oozing out of the self suggests the existence of an alien presence within the body, under pressure, threatening to burst out and inflict damage. This panic-inducing prospect seems more credible given that at extremely low weight the stomach becomes bloated after eating – thus embodied experience augments the sense of punishment.

The inner self-berating evokes an image of a highly critical authority figure, who takes pleasure in inflicting psychological pain on the passive recipient of its vicious tirade. This persona - generally acknowledged as the anorexic voice – is discussed in the theme, Relationship with Anorexia. Its language is violent and extreme, including expletives that seem incongruous with the generally polite and genteel manners of anorexic women.

Some women would occasionally block the self-recriminations from awareness, allowing themselves a temporary reprieve. During this brief defiant phase of disregarding the rules, it might seem that anorexia's influence was in decline. For one participant, it seemed that the door to the room where anorexia resided in her head had been slammed shut in a sulky retreat. 'So like when you disobey it that slam of door, it shuts up, type thing. So it's like slamming of the door and then quietness and you can focus, it's your own thoughts again'. However, in due course the door would open and the inner tirade would resume with increased severity. Disproportionate with the digression, the harsh consequences might include extreme exercise to work off many times the calories consumed in a few extra grams of fat.

Ella: I'll just have to be punished in some way. And I'm always scared because I don't know what that punishment is going to be, whether it's I have to not speak for a day, or um, or I have to swallow that food so that it hurts so much that I've got pain in my throat, or if it's going to be um … like having to really over-exercise until it hurts or just the voice screaming at me and screaming at me and screaming at me and screaming at me. And I know that I'll feel a bloating in my stomach afterwards, so the voice can really pick on to that and fool me into thinking that I'm enormous, really fat.

4.5.4. Security and safety (the illusion)

Allusions to the experience of security and safety emerged in references to feeling protected, comforted or in control when adhering to anorexic modes of being.

Participants valued the predictable and reliable qualities of their condition, contrasting it with the sense of threat perceived in the world without anorexia, and their own fallibility.

Mia: I don't know if that's perhaps why the eating disorder partly is a kind of safe thing because I'm so disorganised the rest of the time that the disorder was being kind of ordered, structured, strategic as something perhaps I like, I suppose... I guess it's, yeah it's you know, predictable I suppose.

Further support for this theme emerged indirectly, in the behavioural measures participants employed to create the illusion of security. An example is the strategy of setting limits on calorie intake. It feels safer to consume less than the limit, in case of error in calculations or misinformation regarding the calorific content of foods. Relatedly, the number of calories in a food product is rounded up, to guard against exceeding the limit. Questioning the trustworthiness of information is common practice, and anorexia offers ways to remain safe and secure in an uncertain, misleading world.

Leigh: by weighing you're not eating, you're not deceiving yourself, you know you've eaten what you said you've eaten. You don't trust packaging. If anything comes in a package you still weigh the package. So you just know everything's for real, you're not conning yourself. You're allowed to say you've eaten more, but you haven't eaten um no, yeah, you're allowed to say the number's more, but you can't say you've eaten 1500 whereas the package would have been like 10 grams heavier and you've eaten 1550, you know you've done what you said, you're not lying to yourself. You followed the rules. So I think numbers just make me follow the rules.

Leigh's efforts to ensure she does not 'con' herself and remains safely within her limits convey the intensity of her need to feel secure. By weighing food owing to her mistrust of the information on the package, she reassures herself of her own trustworthiness. Information may be misleading, but she can rely on herself for the

meticulous attention to detail that her standards stipulate. These suspicion-laden beliefs are likely to underlie the anorexic's insistence on preparing her own meals.

Pursuit of the experience of safety is also inherent in participants' accounts of limit-setting processes regarding their weight. A common safety strategy is to set a target weight which is then undercut, by reaching an even lower weight. This provides a sense of security in that weight can be gained without exceeding the target. In time, the lower weight becomes the new target and no longer offers insurance against failure, as intimated by Clara's persuasive anorexic voice:

Clara: But it says it in such a way that you believe it. Yeah I believe it. And when I got to 7 stone 7, it would say, "You'll just feel so much better if you were hooked under 7 stone. If you were at 6 stone 12 that would be a security for you". And then by that case of course my thinking is all gone.

The sense of safety is aptly represented in one participant's image of anorexia as a cloak, offering protection against a threatening world. This image seemed related to childhood memories of dressing up in princess costumes, playful make-believe in a safe and comforting world. Below, Mia explains how when she feels that she has failed in some way, and punishment and recriminations are threatening, she can rely on the cloak to relieve her anxiety and offer a place to hide.

Mia: the disorder I almost see a little bit like a sort of cloak and I think it's kind of I see kind of the recovery and I see eating as part of that as a kind of taking away the, this kind of cloak which is - and I kind of see it as a kind of a dark cloak I think because it's, although I know that the disorder is a kind of unhappy place and it's um - yeah I think dark and sort of lonely, but it's in a way a cloak still is some kind of protection.

The cost of the security and safety is a narrowing of experience, as if in a box – Mia also used the metaphor of her disorder as a box that is 'kind of small and enclosed, because that's also how I … can be if I sort of feel that I've done something wrong'. The

seclusion is uncomfortable, yet protective, whilst the world without anorexia appears dangerous, unpredictable and untrustworthy. Frequently, participants described their anorexia as something reliable, consistent and predictable. Occasionally, however, they also alluded to the falsity of this illusion:

Mia: It's not really protection, like it's not anything that's really secure or strong but it's still something that might give me that sense of that, like a bit like when a child might I don't know put a blanket over their head, something like that I suppose. It's sort of false sense of security perhaps?

By expressing her awareness of the incongruence between her experience and probable reality, Mia acknowledges that the illusion of safety is untrustworthy, like a child's imaginary play, or infantile efforts to self-soothe. This conveys ambivalence inherent in the anorexic beliefs and behaviours. Clara uses a metaphor of a path, with forks in the road, to explain how she follows a direction where she feels positive, pure and in control:

Clara: So um, if you feel empty you feel a bit purer maybe. Um, the dizziness even is good. Translated as good, in control, you know, I'm on the right path (laughs). Really on the wrong path, but um ... So it's not hunger, it's not for me interpreted in an unpleasant way. It's, it's a feeling, of control really.

Clara's laughter and her aside about the 'wrong path' allude to her sense that all is not as benign as it seems along the path of anorexia. Later, she expresses a more sinister perception of what lies behind the illusion of security:

Clara: …really it wants to kill you and it would do it, um, you know with a mask on and a smile and, and um convincing you that what you're doing is the right path, you know.

Recognising the risk, yet seduced by the promises, the anorexic seems drawn to pursue the illusion of security and protection, guided by her conviction, 'Better the

devil you know'. This leads in to the final master theme concerning the part that relationships play in the experience of anorexia.

4.6. Isolation versus relatedness (third master theme)

This realm of experience incorporates the nature and extent of relating to the self, to anorexia as an aspect of the self and to others. At the polarity of isolation, disconnection from others typifies experience. There is a tendency to feel attached to anorexia as an aspect of the self and as a representation of another presence. Others are perceived as intrusive, unreliable or potentially threatening, which restricts interpersonal relating. Towards the polarity of relatedness, there is more openness to including others in the relational experience. This includes acknowledging their role in confronting anorexia. The nature of relationship with self (including identity) spans across polarities, from self in isolation to self in context with others. Relationship with body is notable by its absence, as attitude towards body is generally dismissive or attacking (see theme of Subjugating Body, previously) Imagery within this realm is more subtle and implicit than within the preceding Master themes.

Table 5. Components of Isolation versus Relatedness

Superordinate Theme	Interviews containing this theme									
Relationship with self		2	3	4	5		7		9	
Relationship with anorexia	1	2	3	4	5				9	
Relationship with others	1	2	3	4	5	6	7	8	9	10
Confronting anorexia	1	2		4	5		7	8	9	

4.6.1. Relationship with self

Arguably, significant aspects of this theme are encapsulated within other themes, many of which inform an understanding of the anorexic's relationship with herself.

However, a sufficient number of emergent themes which were not subsumed into other superordinate themes warranted the inclusion of a description of relationship with self in its own right.

Both implicitly, through hesitant, faltering linguistic style and imagery, and explicitly, participants conveyed a fragile sense of self. Implicitly, this is illustrated in Leigh's use of Mr Messy as a metaphor for the experience of self as disorganised and incoherent - exceeding the 'lines', or boundaries between self and context. More explicitly, a tenuous self-concept is acknowledged in reference to the eating disorder:

Joss: I can't really tell where it begins and I start or it ends and I begin or even if, even if that actually occurs.

For some participants, this difficulty defining what is internal (self) versus external (context or other) manifests more concretely in embodied form, such as envisaging a foreign thing inside the stomach:

Kelly: Yeah, jelly-like stuff, yeah. Sort of like, you know if you kind of imagine like you see it in cartoons but as something explodes it spreads and it's gonna ooze like it's almost got a life of its own.

The substance that occupies Kelly's insides is uncontrollable and consistent with an experience of being 'too much', reported by some participants. Uncertain of her identity without the disorder, she feels compelled to maintain her attachment to anorexia, a 'known quantity', in Mia's words.

Mia: I think I don't ever feel I can really quite trust myself um and I certainly never ever feel I can trust a gut instinct. I don't do anything really instinctively, I think.

Avoiding the risk of testing her capacity to make her own choices, she cedes power to anorexia or to others. As her dependency and lack of self-determination increase, so her confidence and belief in herself erodes further. In the more severe stage of illness,

her sense of self is fused with anorexia, such that during recovery it can feel that she is losing her identity. Letting go of her anorexic achievements represents a painful loss, particularly as any positive self-regard has been conditional on her maintaining strict standards of self-deprivation and thinness.

Joss: Because when I'm not anorexic I feel like a failure, a big fat failure.

The painful self-denigration she suffers is often coupled with a sense of being 'too much', as though she is not entitled to her existence. This is consistent with the vicious, self-attacking inner dialogue, destructive drive and objectifying of her embodied self.

Ella: Well it's my own voice I guess, but it um it's my own conscience screaming at myself but it's really aggressive and it's, don't you dare touch that, don't you dare touch that, and a lot of - I hate it. It's really embarrassing because there's a lot of swear words involved and I don't know who you are. It's really horrible.

Although Ella appeared to recognise her inner aggressor as herself, she accidentally referred to the owner of the verbally abusive voice as 'you', implying that it may be someone else. This unwitting communication may point to her sense of disconnection within the self, a theme described earlier. She later described an internal dialogue, which contrasted strongly with the hostility conveyed above, where she endeavoured to defend and comfort herself:

Ella: In fact one of the coping mechanisms I figured out when I was in hospital is the way to deal with an after a meal feeling bloatedness after a meal, just say sit there in a mantra, shut my eyes, it's not going to last forever, it's going to go away soon, it's not going to last forever, it's going to go away soon. To try and remind myself that I won't get fat from that meal, it is just bloated because my body's not used to taking in that quantity and it hurts and I feel so fat and so, so dirty and huge and rounded and curved ….

Strikingly, her efforts to self-soothe gradually seemed to give way to self-denigration, as if she was unable to sustain her reassuring thoughts, evidencing the struggle between compassionate and antagonistic aspects of the self.

The ambivalent relationship with the self can also be inferred from the adoption of anorexia as an alternative identity, shown in Mia's description where she used a metaphor of play-acting and fantasy of being someone special:

Mia: Yeah, just escaping it for a bit and yeah perhaps I guess as well being somebody different, because I think that's the thing with the disorder it does impact on the way you behave and the way you are as a person in the same way that if you're playing dress-up you know you might try and act like a princess or something you know rather than being yourself I suppose, yeah.

4.6.2. Relationship with anorexia

While some participants made little or no reference to anorexia as a separate entity, others described their experience of relating to their eating disorder, using sensory impressions, primarily aural. Descriptions suggested that at different stages of the illness, there were shifts in the way that anorexia was experienced. During the most severe stage, prior to or commencing treatment, they were more likely to experience fusion of the self with anorexia. As they progressed through treatment, awareness of anorexia as a separate entity developed, with it the experience of a dialogue between self and anorexia. In contrast, during recovery anorexia is a more intermittent presence, likened by one participant to a ghost that comes and goes.

Amongst those who reported an inner dialogue, some recognised the commentary regarding food and the body as their own voice, sounding bossy or pushy. For others, anorexia had a man's voice, demanding her attention, like a taskmaster or dictator issuing orders regarding exercise and what to eat.

Cara: it's just very sharp and very quick and very extreme and always knows um .. always can answer back something else. So if you say anything to it, it's already there on the, with - with something which would supposedly demolish your argument you know.

The powerful authority figure exercises strict control, though paradoxically it also removes the need to make choices or decisions, thus offering her a freedom from responsibility. Like an overbearing parent who is easily displeased and provides protection and reassurance in return for her loyalty and obedience, anorexia offers her a relationship where she often falls short of the conditions of love.

Leigh: So it's like in your head there's little compartments of doors, so for instance like coming down a corridor it can be open door the anorexia's talking to you. But sometimes the door shuts so then it's doing its own thing in your own little head and lets you get on with stuff… so you can experience life and have life and then when it starts to feel threatened, oh look she's getting on with her life, oh she's put on weight, it comes back. And then that's why as soon as you see the number increase on the scale that's when all the, that's why you see yourself grow because the anorexia has opened that door again, so it's talking to you.

The temporary respite, when anorexia withdraws to allow her relative autonomy, ends once awareness of her potential recovery dawns. When she fails, the anorexic presence is experienced more intensely, as if disapproving and contemptuous of her weakness.

Leigh: I think for me it's, it might go and then it'll come and kick me. Like so it'll be a louder voice the next time it comes. So if that makes sense? So like in the same day, it'll say fine you've won. So it's more like a stubborny voice and it's like, pah fine, you want to do it that way. So then next time it's like fine you've done that but so it's like fine you did that so your next meal is going to be rubbish. You're not going to enjoy it or you're going to have to hide this.

This painful state can be alleviated through reconciling herself with her oppressor, who despite all manner of criticism and abuse, is always there for her. Others may let her down, but anorexia is reliable and predictable – thus the powerful attachment is maintained.

Mia: Yeah I think the black, yeah the black comes in and then there's this kind of cloak. Okay so we'll sort of do that you know and then starting to sort of do that and then that is sometimes when it can then go back to the numbers [of calories] because you know there's the kind of the disorder seems more attractive at that time, especially if I've made the wrong decision.

4.6.3. Relationship with others

This superordinate theme emerged alongside other themes which more directly related to the experience of imagery. Possibly because the research questions – and therefore, the interview questions, were focused on participants' weight, shape and food-related imagery, there was modest support for this theme from the data. However, participants indicated with their references to other people, that this facet of their experience was sufficiently significant for them, to warrant its inclusion in these findings.

Disconnection from others was a feature of participants' experience and this was consistent with their enmeshment in the relationship with anorexia. Their expectation was that others would not understand their perspective, and they found some evidence to support this belief, in certain reactions from family and friends. A few participants acknowledged the possibility that they might have perceived more intense animosity or critical judgment than was actually being expressed by others. For Lisa, it later became clear that the uncomfortable experience of receiving unwanted attention was due to reactions which she had misinterpreted.

Lisa: I'd become very, very conscious of everyone around me and what they were thinking, so because I was small and people used to look at me a lot in the street and I thought they were looking at me because I was really fat, but it was the opposite.

Thus Lisa retrospectively understood that her fantasy that others shared her opinion of herself as 'really fat', was far from reality. Though she could not ascertain the reasons for their reactions, she intensified her efforts to read their thoughts. This struggle, where her subjective experience differed markedly from that of others, contributed to the sense of disconnection. Mia described this as like being enclosed within a box, which she had built up around her, a place of solitude, impregnable from the outside and not conducive to communicating her perspective.

Mia: I feel it's this box because it's somewhere that other people can't really understand and I probably can't, er get through to explaining how it is.

Sensing that her condition alienates her from others, the anorexic withdraws further and becomes more reliant on her illness, a form of presence that is reliably and predictably available.

Leigh: When it's open, you can just zone out - you're in your anorexic life, you're in your own little world because you've got your companion, you don't need anyone else. You've got someone there with you. But when it's shut you face the world.

In facing the world, the anorexic seems to anticipate that she will generally be disappointed or misled by people; she is therefore vigilant for signs of inauthenticity. Memories of painful experiences underpin this expectation and enter her awareness, often triggered in conjunction with inner conflict between the choice to eat or not. One participant clearly recalled the instant she realised that she could say 'no' when her mother offered her the bread basket. Recalling her mother's conflicted relationship with food, and how this had affected their relationship, she found a means

of distancing herself from the fray, through simply denying her own bodily needs. When describing their attitudes to their own weight, participants occasionally referred to relatives with overweight problem. Sometimes the motives of others appear questionable, as Leigh explained, referring to her family members' response to a photograph of her pre-anorexia, where she believed she was overweight.

Leigh: Yeah, because everyone's saying you weren't fat, you weren't fat when you were younger, you just think… I looked fat in that picture, so you guys are no good judgement - you're going to make me fatter.

Alongside her doubts about the trustworthiness of carers or clinicians, the anorexic often experiences pressure to cooperate, once treatment has begun. The loss of her autonomy can sometimes offer some relief, as she is forced to relinquish responsibility for defying her anorexic voice. However, it is also frequently an unwelcome intrusion, the most extreme example being what one participant described as the 'living nightmare' of tube-feeding. Notwithstanding negative associations sometimes inherent in relationships with others, it also emerged that participants cared deeply about the impact of their condition on those close to them, as will be explored further in the following theme, combatting anorexia.

Ella: I don't want to upset my mum. I know that it's horrific to see someone you love being a skeleton and starving themselves and I don't want to have to put anyone through that. I just wish that they could understand that I don't mean to do it to them, I do it because I have to.

4.6.4. Confronting anorexia

Those participants who considered the possibility of living without anorexia conveyed wishes, goals and values that would motivate them to make a stand against their current way of being. A potential healthy relationship with her partner, hope of harmony with close family members, desire to compete in athletics or other sport, a

promising singing career – these aspirations facilitated consideration of the cost incurred and enhanced motivation to fight for health.

Leigh: I think for me relationships working is more, it's like the most important thing. If the relationship doesn't work, or if I've made someone angry for instance, I feel worse about myself. So that image of a perfect family, not a perfect family but perfect relationship, that made me want to eat, oh if I do that, I can do that.

Weighing up the possibilities and reflecting on an attainable goal, Leigh described how the instillation of hope influences her capacity to eat, as if she might give herself permission to defy anorexia, when armed with the positive familial image. Opposing her established behaviour patterns instigates conflict in which she battles against an aspect of herself, therefore, her equal in intellect and creativity. As described earlier in the theme, punishment and recriminations, the repercussions for combatting anorexia are commonly uncomfortable and distressing, as Clara experienced when she defied the anorexic voice:

Clara: I'm not going to listen to you anymore and I'm going to do my singing and you can just you know get lost. And then it actually responds with a feeling of real fatness, that's its response. It just, it kind of even had a - just a knowing grin. I'm not accepting, but feel this, you know.

The experience of a malicious presence, strengthening its hold on her through the dreadful sensation of fatness, points to the importance of support in resisting the powerful pull to maintain existing patterns. Some participants spoke of their wish to receive guidance, someone to stand with them in the conflict. For one participant, telling someone she was going to eat made it easier for her to do so, as this commitment armed her with an excuse to defy her rules. Negotiating a compromise between anorexia and healthy strivings was another strategy emerging from descriptions, illustrated in Mia's recounting of her inner dialogue:

Mia: Since I've been in treatment I have kind of like a calorie target for the day and then um, so there's kind of that. So right this meal should have this amount, but then the kind of disorder would be that, well no I think this would be a better kind of thing and then it's - yeah I guess it's some kind of weighing up between that - nearly always it's something in between. Can that kind of satisfy both what I should be doing and what the disorder wants, so it's yeah lots of kind of like a jumble of numbers I guess.

She seems to feel required to mediate between two opposing forces, on one side a calorie target she 'should' achieve, versus her restrictive anorexic limits. As she navigates a middle path, without reference to her own wishes or needs, she is aware of images of jumbled-up numbers, demanding rigorous mental calculation and comparison. Thus the experience of confronting anorexia seems coloured by imagery that impedes rather than enhances recovery.

The prospect of invoking positive imagery seemed of interest, though more difficult to access than the guilt- and anxiety-inducing images generally in awareness. Keira had not considered the possibility of images that would facilitate recovery and whilst expressing openness to the novel idea, she also acknowledged that her motivation might be an issue.

Keira: I'd need to know basically what positive is and what like positive images are, so that I'd recognise them and then could like make an effort to sort of keep them, and I'd probably actually want, I'd need to want to keep them.

As her fellow participants had suggested, a helpful starting point might be a believable image of her potential future self. This accomplishment would involve a different identity and role in her experience of self, others and context. She would need the ability to meet the unknown and trust in her capacity to tolerate the inevitable discomfort without resorting to previous methods. The curiosity and apprehension experienced in response to this prospect is evident in Mia's description of recovery, rich in imagery and suggestive of a courageous journey of discovery.

Mia: I suppose it's almost I wanted to not feel that I have to use anything, I guess. Maybe just kind of coming through this mist, seeing things, acknowledging sort of you know sort of different colours, different shapes, and being, not feeling I have to hide away from anything, that I can actively sort of confront them um so that I don't feel that I do have to kind of hide away, or use something else to guide me.

5. Reflections on the research process

5.1. Consideration of culture

I have reflected on the potential criticism of this study as being rooted in a largely Western conceptualisation of what constitutes a healthy relationship with food and the body. Since my interview schedule and style was open, exploratory and participant-led, I feel reasonably confident that my research was inclusive and allowed for the emergence of cross-cultural values and norms. Nevertheless, it is important to acknowledge that of the ten participants, all but two were white British women. The remaining two were British women of Asian heritage, one of whom found it extremely difficult to speak to me, appearing overwhelmed by shyness and anxiety. I was moved by how despite her timidity, she had found the courage to volunteer for the interview. She apologised at various points during the interview for the absence of imagery within her experience. I assured her that it was of great interest to me that imagery did not feature in her internal world and that I was keen to include descriptions that suggested alternative experiences. It was an important aspect of the trustworthiness of my research that I did not simply include accounts that would support any assumptions I might hold, but rather allowed for the emergence of data that might offer contradicting or unforeseen evidence.

5.2. Therapist as researcher

During the interview process I was aware of the invitation to enter a therapeutic mode of relating to the participants. My therapeutic training was generally helpful in facilitating phenomenological enquiry through the use of reflections, empathic attunement and participant-centred exploration. At times this stance seemed about to cross the boundary into therapy. My sense of ethical responsibility and the participants' vulnerability increased the pull towards therapeutic engagement.

A powerful example occurred towards the end of my sixth interview, when the participant experienced a strong sense of being unsuitable for the interview, viewing herself as obese. She described her sense of being under attack by a scornful, deriding anorexic self-object, and believed that I was of a similar opinion about her being obese and presumptuous for having volunteered. I responded to this transference-related phenomenon by acknowledging her experience and then asking her how she might view the situation differently (within the framework of motivational interviewing, these interventions could be considered an affirmation followed by an open question).

Finlay and Evans (2009, p. 99) have described the 'blurry lines' within the dialogical encounters during research that do not always clearly distinguish these from therapeutic processes. It was important to me to hold in mind the aim of my research – my focus – to facilitate deep exploration of the responses that pertain to the question of imagery. In addition, I aimed to be aware of the times when I might slip into therapeutic practice, influenced by the sense that the participant could potentially benefit from the encounter. At these I found it helpful to remind myself that the process of coming into deep relational contact with another person – researcher or otherwise - can itself be beneficial. Relatedly, Birch and Miller (2000) have explored the concept of the interview as a therapeutic opportunity in which participants are able to construct narratives of experiences.

5.3. Participant experience of interviews

After the interviews, when I asked how the process had impacted them, participants tended to say that they had learned something about themselves. This suggested that participating in the research constituted an intervention for some.

Keira: I didn't really think about it like because I don't think a lot of these things are conscious but can tell you when you look at it. Like because I would never have said that that's what happens but when you sit and actually think about it, it makes you think and you can bring to the fore really what's under the surface.

My attending to the welfare and safety of participants was particularly important, considering their vulnerability. I was aware of feeling responsible and protective towards them, yet mindful of the importance of not patronising or infantilising. My endeavouring to maintain this balance was demonstrated towards the end of the sixth interview, conducted via telephone, when the participant described how she was feeling something awful (a knottedness in her stomach, as if a red ball of fire was rolling around, emitting flames.) The following transcript illustrates how I conveyed my trust in her ability to take care of herself.

R: You see that's the thing. This can happen at any time. It's a horrible thing, it sort of takes me by surprise. It just appears. And I don't know what to do about it when it does. Um, it can be - like right now I feel it.

I: You're feeling it at the moment.

R: Yeah. And I think sometimes it comes from me like drawing attention to how you physically feel by talking about things or by actual physical circumstances, like room just being hot and that can start it. Then I get agitated and it doesn't really make much sense and then I get annoyed that I'm feeling like that and then it becomes worse and-

I: Well, it's helpful that you're telling me that that's how you're feeling at the moment, um and I'm wondering whether it might be a good time for you to um tell how you best deal with it, what you find most helpful when that feeling comes.

R: … I generally go for a walk or exercise, something like that.

I: Hmm. Okay. Are you feeling now like you might like to go for a walk?

R: I'm going to do some yoga once I've spoken to you.

I: Okay.

R: That can be helpful.

I: Okay, because um obviously the most important thing is that um we take care of you.

R: Yeah, it's okay, don't worry.

I: Hmm. It sounds like you're used to saying to people don't worry.

R: Yeah.

I: Mmm. Well I'd like to ask you to be very honest with me now as to whether you'd like to um bring our interview to a close. Um, you've been describing some powerful images, um and obviously the latest one um is, is very much present for you.

R: No, I'm happy to go on, it's just if you've got more questions I'd rather do it all.

5.4. Suggestions of parallel process

During writing up, I became aware of the parallel between some of the themes emerging form my analysis, and my own experience. Initially I viewed this parallel process as offering the potential for deeper empathic engagement with the accounts of participants' experience, but soon thereafter I also appreciated the importance of preserving the validity of my interpretations, of not colouring them with aspects of my own process. As an example, in relation to my research, I experienced intense anxiety, involving a fear of failing to achieve the necessary level of performance, with the threat of recriminations. At the same time, I was aware of a paradoxical sense of comfort in the certainty that my research project would always be there, a refuge from stresses found in the external world. I became aware that my own perfectionism and attention to detail were impacting considerably on my sense of well-being. I felt wretchedly inadequate at times, and had to force myself to persevere with writing, struggling to ignore the negative voice within.

5.5. Enactment at psychology conference

After arranging to present a poster at the BPS Division of Counselling Psychology annual conference in July, 2011, I expended considerable energy creating a poster that I felt depicted my research professionally and honoured the contributions of the participants. My efforts included purchasing a software product called 'poster genius' to increase my confidence in my poster (more accurately, to allay my anxiety!) and eliciting the help of a talented young photographer to provide images for illustrating the emerging themes.

After the poster was printed, I anguished over the size of my poster. Despite my perfectionist tendencies, in my anxiety I had misunderstood the dimensions stipulated in the guidelines and produced a poster that would only just fit within the boundaries of the poster board. The discomfort and shame that I experienced while travelling to the conference with my oversized poster roll struck me as a painful and potent manifestation of the experience described by many of my participants – the sense of being too large, constrained within a tight space, wanting to be smaller or even to disappear. My poster, it seemed, had become through my over-achieving, a metaphor for the experience I was aiming to explore.

6. Discussion

In this section, I will present my response to the findings of this study by relating them to the theoretical concepts raised in the introduction, as well as other theory that I consider relevant. The implications of these findings for psychological therapy with people with anorexia nervosa will also be considered, together with the impact of this research for professionals in the field. I will reflect on what may be missing or now apparent as a potential future direction. In this way, I hope to address the intrinsic research-related questions of "what?", "so what?" and finally, "now what?"

6.1. An inclusive approach

My initial aim had been to explore the experience of imagery as described by women with anorexia nervosa. During the course of this study, it became clear that whilst some participants were aware of visual images and auditory or olfactory impressions, others had little such awareness, and were more readily able to access experiences relating to their habits, beliefs and felt responses. This may be associated with the powerful impact that imagery has on emotion (Holmes & Mathews, 2010), which perhaps might explain emotional imagery avoidance achieved through engaging in excessive rumination: thinking about possible distressing outcomes can be a means of blocking out the images which are likely to be more powerful than thoughts. For some of the participants whose descriptions focused on their fears, preferences and beliefs, a growing awareness of imagery was stimulated in the process of my following their phenomenological accounts and they were then able to describe their images. I chose to include all facets of their experience, in order to honour their contributions and to provide a more complete account of the experience of anorexia nervosa within which imagery-specific descriptions could be contextualised. Given the tendency for people with anorexia nervosa to keep eating behaviours, bodily sensations, and underlying emotions separate from each other (Zerbe, 1993), it is important to challenge this fragmented, dissociative stance. Moreover, I believe that in broadening my focus rather than merely looking for data that supported my expectations, I have

strengthened the trustworthiness of my findings. "If essential – or even merely general – structures do emerge as a result of our studies, the fact that the existence of these has not been presupposed in the methodology of the research means that they gain enormous credibility." (Ashworth, 2003, p. 147).

Imagery is one aspect of the process by which we make sense of what we perceive, and this interaction between perception, association and representations (the Freudian term for imagery) has been of interest within psychoanalytic thinking, as Rizzuto (2001) has discussed. Further elucidating the role of imagery in our embodied interaction with the environment, Kosslyn and Sussman (1995) have shown how pre-existing imagery "is used to complete fragmented perceptual inputs, to match shape during object recognition, to prime the perceptual system when one expects to see a specific object, and to prime the perceptual system to encode the results of specific movements.… Imagery acts as a bridge not only between perception and memory but also between perception and motor control." (p. 1035) In light of these conceptions, one can more easily appreciate the utility of exploring not only imagery, but also the other components of embodied experience that are involved in our interaction with the world. One result of the inclusive approach I have taken is that this study has yielded a series of rich accounts that support the body of evidence pointing to the strong association between emotion/cognition and imagery (Holmes & Mathews, 2005).

6.2. Implications of researcher assumptions

As acknowledged towards the end of the Methodology Chapter, I commenced this project with an awareness of my pre-conceptions regarding the characteristics and experience of the participants. This sub-section is included with the aim of providing some transparency regarding the role of these fore-structures and how they might have been changed during the course of the study.

6.2.1. Influence of fore-structures on interpretative process

I have reflected on how my optimistic expectation that the data would lend itself to organisation into orderly categories might have influenced my thinking in the process of analysis. In the early stages of identifying emergent themes for each transcript, I was aware of a growing realisation that what was emerging seemed messier and more chaotic than anticipated. Despite this discomfort – perhaps because I was aware of my propensity for systematic order and was determined to ensure it would not compromise the integrity of my analysis – I maintained a rigorous faithfulness to the meanings I perceived in participants' accounts.

It is my belief that my fore-understanding concerning the possibility of volition in the experience of anorexia influenced the structuring of superordinate themes into master themes which contained opposing constructs. This meaning making which allows for the potential for movement towards a more positive, life-enhancing experience (from fragmentation to integration, for instance), rests partially on an assumption of some element of free will for the person involved.

6.2.2. Challenges to researcher pre-conceptions

Instead of the self-satisfied serenity anticipated, I encountered images of chaos and overwhelming forces beyond control. The powerlessness participants felt under the tyranny of anorexia was a striking repudiation of any preconceived impression of the ego-syntonic characteristics of the illness, such as a pure and simple focus. This realisation of how helpless participants felt faced with the overwhelming hold of anorexia on their thoughts, feelings and behaviour was a surprise in the data.

As opposed to my pre-conceptions of strategies for manipulating the experience of food, there was scant indication of choice to remain ill as opposed to fighting the condition. To demonstrate this, I shall describe a rather extreme analogy which struck me as I made initial notes for interview number seven. It seemed that the guilt arising from eating forbidden food was as intense as if the speaker had been raped and felt

that she might have prevented the violation. The sense that she had a choice not to eat - and yet had gone ahead and eaten the food - invoked self-judgement equivalent to the intense guilt that might be experienced if she had complied with a rapist's wishes. This metaphor was a stark illustration of the challenge the anorexic must face in order to combat her fundamental belief that she is flawed, unworthy and not entitled to nourishment.

6.3. Finding convergence in implicit themes

As expounded in the previous section, there was considerable variation in the content of the images described, which was reflected in the divergence of the underlying emergent themes. When I took a conceptual view, interpreting the underlying meaning of these images, I found a greater degree of commonality and therefore convergence within the data. This underlines the importance of taking into account individual differences in the explicit content of the images that enter awareness, whilst understanding the common themes implicit in the meanings attached to the images. In effect, this involved adopting the 'hermeneutics of suspicion' (Ricoeur, 1974). I sense a similarity in the position adopted by Skårderud (2007a) in his exploration of concretised metaphors. He has identified ways in which various physical and sensorimotor experiences are the embodied forms in which emotions and meanings manifest themselves for a person with anorexia nervosa. "When psychic reality is poorly integrated, the body may take on an excessively central role for the continuity of the sense of self, literally being a **body of evidence**. Not being able to experience the self from within, the patients are forced to experience the self from without." (Skårderud, 2007c, p. 324). In the following sections, I will indicate parallels between superordinate themes within my findings and the concretised metaphors described by Skårderud (2007a), which he believes to be indicative of impaired reflective functioning in anorexia nervosa.

6.4. Broad implications of the findings

The aim of this study has been to describe the experience of imagery in anorexia nervosa, as opposed to development of a model. However, the findings of this descriptive research may potentially inform a model of the experiential components of anorexia nervosa. These findings provide insight into the ways in which young women with anorexia nervosa relate to themselves, their bodies, their food and to others. This research illustrates the diverse ways in which imagery plays a role in these experiences and the rich meanings that can be uncovered through exploring imagery. The depth of implicit meanings attached to the images described speaks of the importance of following this potential avenue of understanding when working with this vulnerable population, not simply as a route to replacing maladaptive images with more helpful ones, but as a collaborative venture leading to insight and understanding that offers the opportunity for change.

6.5. Reflecting on fragmentation versus integration

The first of three master themes, fragmentation versus integration, is a product of seven superordinate themes which relate to the extent to which women suffering from anorexia nervosa experience a sense of self that is fragile and disconnected, versus cohesive and integrated. These seven themes show that participants feel vulnerable to threats originating from both external and internal sources, suggestive of an incohesive, fragile self. This is consistent with Bruch's (1973) description of the tenuous anorexic self-structure and the self-psychological view of the person with an eating disorder as suffering from a fragile and incohesive sense of self (Miller, 1991).

6.5.1. Disconnection and chaos (external)

From external sources, uncertainty and chaos pose a threat to self-cohesion. With a tenuous sense of self, that which cannot be controlled or anticipated must be guarded against. For people with anorexia nervosa, difficulty tolerating uncertainty has not

been directly explored until the recent study by Sternheim, Konstantellou, Startup & Schmidt (2011). This IPA study found that women with anorexia nervosa experienced discomfort in response to uncertainty in situations including but not limited to, food, eating, weight gain and recovery. Compared with the non-eating disordered population, people with eating disorders are more likely to suffer from anxiety disorders (Swinbourne & Touyz, 2007) and those with anorexia nervosa show a marked preference for order and precision (Srinivasagam, Kaye, Plotnicov, Greeno, Weltzin, & Rao, 1995). It is conceivable that the discomfort arising within uncertain situations reported by participants is an aspect of the psychological processes involved in the anxious and obsessional traits that tend to accompany eating disorders.

6.5.2. Disconnection within the self

Alongside the threat of chaos and uncertainty (disconnection experienced externally), women with anorexia nervosa described experiences indicative of disconnection within the self. This can be conceptualised as the intrapsychic consequence of or defence against the external threat of uncontrollable and therefore is part of the master theme of fragmentation. In his seminal work, The Divided Self, R.D. Laing (1969) has described how the experience of ontological insecurity underpins the defence of fragmentation. The ontologically insecure person may survive by splitting the self, divorcing body from mind to yield an unembodied self. "Instead of being the core of his true self, the body is felt as the core of a *false self*, which a detached, disembodied, 'inner', 'true' self looks on at with tenderness, amusement or hatred as the case may be." (Laing, 1969, p. 69). In eating disorders, this severing of mind from body manifests as a sadomasochistic relationship involving poor self-care and bodily self-neglect (Zerbe, 1993), with the body viewed as a persecutory object. The theme of body as threat that emerged in this study through the exploration of imagery reflects participants' implicit awareness of this relationship, which Zerbe (1993) has conceptualised as a psychosomatic condition.

In referring to disconnection, I suggest a potential link with the work of Nijenhuis and van der Hart (2011), who propose an understanding of dissociation as an insufficiently

integrated personality, manifesting in two or more parts of the personality which lack integration. This structural dissociation of the personality (Van der Hart, Nijenhuis & Steele, 2006) is considered to occur within the context of trauma, either acute or chronic. It is important to acknowledge that the role of trauma has not been addressed in this study. Nevertheless, I have felt it appropriate to include these concepts in discussing the findings of this study for two reasons. Firstly, when discussing the theme of fragmentation, it is helpful – necessary, arguably – to provide clarification of the meaning of dissociation. Secondly, it is conceivable that there may be certain parallels between the fragments of the phenomenology of anorexia nervosa and the dissociative parts of the personality, as I now intend to explain. The unintegrated aspects of the experience of anorexia nervosa incorporate psychological (thoughts, feelings, images) and behavioural components, with particular roles to play. Correspondingly, each of the unintegrated subsystems in the structural dissociation of the personality has an "organized set of manifest and latent mental and behavioural actions" (Nijenhuis & Van der Hart, 2011, p. 419). In a similar vein to the disconnected anorexic components, the dissociative subsystems are functional, fulfilling particular roles to protect the individual from further threat.

There are other characteristics of the dissociated unintegrated parts that are not necessarily evident in the phenomenological accounts of the participants of this study. (This is understandable, considering that dissociative aspects of experience were not a focus of this exploration.) For instance, within structural dissociation of the personality, the dissociated parts are experienced with a rudimentary sense of first-person or subjective perspective (Nijenhuis & Van der Hart, 2011), whereas, according to the interviews, many of the disconnected parts of the anorexic experience do not appear to feature in conscious awareness (the anorexic voice, which is consciously perceived by some, is a notable exception). In identifying the links between the theme of disconnection and structural dissociation, I do not therefore imply equivalence. There is reason to believe, however, that a subset of eating-disordered individuals suffers from post-traumatic stress (Brady, Killeen, Brewerton & Lucerini, 2000) and that for some, dissociative symptoms are comparable in severity to those found in dissociative disorders (Vanderlinden, Vandereycken, Van Dyck & Vertommen, 1993).

Thus the recent work on dissociative disorders offers a means of understanding how intrapsychic division and a stance of disembodiment function in certain anorexic patients and how they may be worked with in therapy (Van der Hart et al, 2006).

6.5.3. Concrete functioning as adaptation

For the person with anorexia nervosa, it appears that the body is not only a disconnected part, but that it is also **used** to bolster the fragile, incohesive sense of self. In Skårderud's (2007b) view, the body is the vehicle for concretised metaphors, which serve as restitutional efforts in response to a threat of inner fragmentation, with the aim of maintaining a cohesive mental configuration (Campbell and Enckell, 2002). Thus the body is recruited to conceptualise and express that which cannot be symbolised, allowing "the encapsulation of structures of experience by concrete, sensorimotor symbols" (Atwood & Stolorow, 1984, p. 85). This leads to the view that concretisation in anorexia nervosa is indicative of impaired reflective function, suggesting "the body speaks when there is a lack of a good-enough verbal language to identify and express emotions". (Skårderud, 2007b, p. 248). For instance, faced with the threat of uncertainty, one strategy is to reduce complexity in the concrete realm of food and the body, thus eating only pure foods, separated on the plate. Skårderud (2007a) termed this concretised metaphor, 'Purity', linking this minimalist theme with asceticism and spirituality, qualities that are important to some people with anorexia nervosa (Hornbacher, 1999), though these did not emerge as themes in this research.

6.5.4. Control as defensive solution

A related theme that was strongly supported is that of control, with its associated mechanisms of rules and restrictions. The role of control in the psychology of anorexia nervosa has been extensively discussed (Surgenor, Horn, Plumridge & Hudson, 2002) and the construct features strongly in the major theoretical accounts of the disorder (Bruch, 1973; Orbach, 1986; Crisp, 1995). Bruch (1973) defined anorexia nervosa as a struggle for control as a defence against a sense of ineffectiveness, through denial of food which increases perceived autonomy, self-efficacy and independent identity.

According to feminist writers (eg Orbach, 1986), women with anorexia nervosa use control and denial of food as a solution in response to the control that the world exerts through externally imposed gender-specific expectations and inner conflict regarding their own desires in relation to prescriptions of femininity. Crisp (1995) maintained that anorexia nervosa develops as an adaptive response to adolescent fears regarding the challenge of mastering psychobiological maturation. An internally sited 'sense of control' of the self is achieved through control of the body, the person's environment and therefore of others.

Strikingly, participants' descriptions of the experience of control and associated rules and restrictions resonate strongly with both psychodynamic and feminist accounts. For instance, "like other theorists, Bruch notes that this personal attempt to win symbolic control quickly overpowers people with anorexia nervosa who find themselves engaged in bizarre and abnormal rituals and ruminations" (Surgenor, Horn, Plumridge & Hudson, 2002, p. 90). In the feminist view, the control achieved through denial of food evolves into loss of control for the individual, as anorexia nervosa itself assumes dominant position (Orbach, 1978). Paradoxically, the adaptive means of defending the self against the threat of loss of control evolves into an object which ultimately controls the person, who continues to fear the potential for chaos in herself or her environment. This painful irony is vividly portrayed in the image of the rule book that one woman devised to provide order and certainty, only to find herself dominated by a restrictive, punitive regime, with tasks to be ticked off and limits to be obeyed.

The theme of control identified in this study is mirrored in Skårderud's (2007a) findings, where control emerged as a concretised metaphor in that his anorexic patients reported a clear connection between their eating behaviour and the need for psychological control. He cited Fonagy, Gergely, Jurist and Target (2002) on mentalisation, the capacity which provides the ability to distinguish inner from outer reality and interpersonal mental and emotional processes from interpersonal communications. When mentalising capacities are compromised, psychic equivalence is experienced and in anorexia nervosa, this manifests as use of the body to maintain

continuity of the sense of self. The theme of 'Subjugating Body' is illustrative of the use and abuse of the body: participants have gained psychological relief through manipulating an object of the self, in a stance that can appear as disdainful disembodiment. The release from burdensome emotions through the concrete experience of losing weight is echoed in Skårderud's (2007a) concretised metaphor of Heaviness/lightness. It also invokes associations with Ogden's (1989) autistic-contiguous position, a means of organising the internal world using sensory-dominated experience, particularly body-surfaces, to maintain a sense of boundary between inside and outside.

6.5.5. Contemplating the alternatives

Some participants' accounts contained a glimpse of the potential for change, represented in the findings within the polarity of integration. This structure emerged from my sense that some participants were open to experiencing themselves as integrated and willing to engage with the challenge of embodied involvement in the world. The theme of the reflective self suggests the beginnings of being open to change, strengthened by awareness of the implications of living with anorexia nervosa and thoughts about alternative potential ways of being. Within the framework of the transtheoretical model of change (Prochaska & DiClemente, 2003), this awareness constitutes some indication that the individual may be within the contemplation stage. This has implications for therapeutic approach, as clients in contemplation are more open to consciousness-raising interventions. It is conceivable that use of imagery as a focus in therapy can elicit the articulation of aspects of experience that provide a mirror for self-reflection, allowing the individual to reach a state of readiness to move within the process of change. A person within the contemplation stage is also more likely to re-evaluate their values, problems and themselves affectively and cognitively (Prochaska, DiClemente & Norcross, 1992). Given that people with anorexia nervosa typically show disregard or minimal concern for their compromised physical and psychological states, it is encouraging to consider that this study showed how people with anorexia nervosa, when supported to think about their experience of imagery, responded with accounts of affective and cognitive aspects as well. An interesting

possibility is that the reflective self, whilst emerging as a theme within descriptions of anorexics' experiences, might in part be a function of my focus on mental imagery within the interviews. This suggests that the reflections and questions used within interviews constituted an intervention for participants, and lends weight to the validity of considering the use of imagery in therapy, given its impact on increasing understanding of mental states.

It is cautiously suggested that exploring imagery could provide a means of enhancing the development of reflective functioning in people with anorexia nervosa, who are believed to feature compromised mentalisation (Skårderud, 2007b). There are a number of ways in which images and sensory impressions can stimulate consciousness of internal self-states, supporting a mentalising stance as described in Bateman and Fonagy's (2005) framework. The application of this stance to working with anorexia nervosa, as Skårderud (2007c) has proposed, includes bridging the gap between primary affective experience or behaviour, and its symbolic representation, which suggests a role for the phenomenological exploration of imagery as employed in this study.

6.6. Reflecting on exposure versus protection

The second master theme, comprising four superordinate themes, provides insight into the anorexic experience of exposure to perceived threat from both internal (intrapsychic) components and from external (interpersonal) sources, and the illusion of security and protection provided by the disorder. The strength of the hold exerted by anorexia on the afflicted individual can be understood as being related to the perceived benefits, which are perceived to outweigh the costs, as are illustrated in the theme of exposure versus protection. The powerful reinforcers that undermine motivation to engage in the process of change have been recognised clinically and sufferers have been supported to articulate the advantages ('pro-codes') and disadvantages ('anti-codes') of being anorexic, using letter writing, as described in a study by Serpell, Treasure, Teasdale & Sullivan (1999). The sense of security and safety, a powerful reinforcer that the disorder offers to some sufferers, is akin to the

pro-code of anorexia as 'Guardian' (Serpell et al, 1999). In this research, the theme of security and safety described by 5 participants, was not as strongly supported as other themes and those who mentioned it appeared to recognise the illusory quality of this experience. This theme illustrates the potential application of imagery work in stimulating exploration of the functions and meanings of concrete symptoms of anorexia nervosa (Skårderud, 2007c), allowing recognition of ambivalence and resistance to change.

6.6.1. Shame and awareness of the objective self

The body plays a focal role in being both the source of discomfort and the focus for remedial strategies, as the person with anorexia nervosa engages with psychological challenges in a concrete manner. Shame is a key organising emotion, both as a factor contributing to anorexic behaviour and as a consequence, forming a perpetuating shame-shame cycle (Skårderud, 2007d). For some anorexics, the achievement of thinness facilitates a shame-pride cycle, though this experience did not emerge in the findings of this study, possibly reflecting the stage of illness of most participants: since most were in recovery, the women had generally let go of their ego-syntonic symptoms and, therefore, their potential source of anorexic pride. Since silence is often the refuge of the shamed person, shame can sabotage the therapeutic dialogue (Skårderud, 2007d). This understanding has value for therapists faced with the frustrating or perplexing task of engaging with an apparently unresponsive anorexic client.

For several participants, the experience of exposure was related to the image of self in the mirror, which is rich in symbolic meanings. It has associations with use of the body as mirroring object, a concrete affirmation of the person's existence which is felt and expressed using the body. Gillian Straker (2006) interpreted self-harming as a means of fulfilling the function of auto-mirroring, an attempt to put what is inside, outside, to facilitate self-soothing and affect regulation. In the same way, when the capacity for mentalization is impaired, the body is put to work to represent the abstract in a

concrete form. Anorexia nervosa can be understood as one manifestation of such difficulty in symbolic representation, or metaphor, an idea articulated by Skårderud (2007a).

Further work on mentalization and the body indicates the relevance of reflexive self-functioning to the anorexic's experience of exposure. Aron (1998) has described the mental capacity to move back and forth from the sense of self-as-subject to self-as-object, which conceptualises self-reflexive functioning. He understands self-as subject is the "integrated experience of agency, continuity, distinctness and reflection constituting the self that initiates, organises and interprets experience and (b) the self-as-object, the 'me', the self as observed by a subject, which forms the basis of the self-concept" (Aron, 1998, p. 6). Holding the dynamic tension between these two perspectives on the self produces psychological conflict, and in psychopathology, the individual is particularly unsuccessful in integrating objective and subjective self-awareness. When there is a predominant experience of self-as-object to the exclusion of the other, a strategy of augmenting the deficient sense of self may involve attacking the body (Auerbach and Blatt, 1996). These ideas are relevant to the anorexic experience of shame and exposure elucidated in this research in two ways. Firstly, it is possible to view the shame of the person with anorexia nervosa, vividly depicted in the image of self in the mirror, as a manifestation of a predominantly objective self-awareness. Secondly, the anorexic's attacks on the body can be conceived of as constituting attempts to establish some sense of existence, given the weakly integrated sense of self as embodied subject.

6.6.2. Protection from intolerable affect

Another component of the experience of exposure, the perception of the body as a threat, is a theme that shares features with the concretised metaphor which Skårderud (2007a) has identified as emptiness/fullness, a sense of needing to empty the body in order to avoid being overwhelmed by emotions. Both participants in this study and in Skårderud's (2007a) study described a feeling of being 'too much', which can be interpreted as a metaphor for being overwhelmed by difficult emotions and

cognitions. This is akin to dysregulation of affect and it appears that some form of regulation of intolerable affect may be achieved via concrete means, through the medium of the body. Thus participants' accounts resonate with evidence suggesting the importance of avoidance of emotions for people with anorexia nervosa (Serpell, Teasdale, Troop & Treasure, 2004), who value the capacity to stifle emotions (Gale, Holliday, Troop, Serpell & Treasure, 2006).

In further concurrence with the abovementioned questionnaire-based studies, this qualitative exploration elucidated the anorexic's notion that her illness offers a sense of security and safety, a protective shield behind which to shelter not only from exposure to others, but also from the vicious attacks of a harsh inner critic. While this illusion of security prevails, it is unsurprising that the person with anorexia nervosa clings to her defensive strategy and fiercely resists attempts to dismantle it, evoking the mantra, 'better the devil you know'.

6.5.3. When protection involves punishment

The experience of punishment and recriminations described by participants is particularly striking in light of clinical evidence of altered sensitivity to punishment observed in people with eating disorders. Empirical evidence supporting this observation has been presented in a review of self-report data regarding atypical sensitivity to reward and punishment by Harrison, O'Brien, Lopez & Treasure (2010). A subsequent questionnaire-based study comparing reward and punishment sensitivity in anorexia nervosa and healthy controls found that women with anorexia nervosa displayed increased sensitivity to both punishment and reward (Jappe, Frank, Shott, Rollin, Pryor, Hagman, Yang and Davis, 2011). As these authors suggested, it is possible to understand their participants' heightened sensitivity as reflecting the involvement of an oversensitive motivational system. It certainly emphasizes that for the person with anorexia nervosa, the pain of any punishment inflicted by a disapproving inner critic would be all the more intense. As Jappe et al (2011) have pointed out, this sensitivity has implications for treatment regimes that involve a system of reward and punishment, since sufferers may already be overwhelmed by

their own internal punishing dynamics and therefore less able to discern or respond to benefits or drawbacks imposed externally.

Given the intensity of the experience of punishment, it is understandable that a means of avoiding threat is a feature of anorexia nervosa. This is provided by the same entity, that paradoxically enables the sufferer to feel secure and protected, whilst threatening painful consequences as a result of any defiance of anorexic rules. This powerful self-object which assumes the role of both critical parent and nurturing parent is vividly conveyed in the image of a dark cloak beneath which to hide from the world. This theme has implications for therapy in pointing to the importance of working with shame and developing healthy strategies for increasing the anorexic's sense of security.

6.7. Reflecting on isolation versus relatedness

The third master theme gathers up superordinate themes that describe the experience of relationships, both intra- and interpersonal, for the participants. Whilst making no causal associations between relational developmental history and the onset or maintenance of anorexia nervosa, this research offers insights into the experiential world of the anorexic which link to existing theory, clinical observation and research.

6.7.1. Isolation and dissociation

Harrison, Tchanturia, Naumann & Treasure (2012) used various measures to assess social emotional functioning in people with eating disorders. Their finding that EDs scored highly on the social emotional difficulties profile can be understood as the visible product of the inter- and intrapersonal experience described by participants in this study. The sense of being distanced from others, alone locked in relationship with a powerful inner parental figure that offers conditional love, resonates with McKnight's powerful personal account, summing up anorexia nervosa in one word - isolation (McKnight & Broughton, 2010). The alienation of the anorexic from concerned carers, therapists, relatives and friends can be understood as the external

reflection of a split in the person's inner object world (Zerbe, 1993). The meanings uncovered through interpreting participants' accounts pointed to their implicit recognition of this split, wherein one part of the self strives towards safety and self-care, whilst another punishing part shows disdain for the body and emotional state of the individual.

If we consider these parts of the person within the framework of structural dissociation of the personality (Van der Hart, Nijenhuis & Steele, 2006), there is resonance with the concepts of the unintegrated parts described within the model. Briefly, the person with a trauma-related dissociative process will have an apparently normal part (ANP) that operates with the outside world, as well as one or more emotional parts (EPs), which contain the responses associated with the trauma. It is possible that for some anorexics, there is an EP that holds the shamed, traumatised, hurt internal part of the personality, together with an EP that holds the necessary internal control in order to protect the injured part from showing itself to the world and being further shamed. The way that participants have described their anorexia as having a personality or a voice of its own can be seen as equivalent to the EP that exerts internal control and protection (Maria Gilbert, 2012, informal written communication). This is resonant with the imagery work which Mountford and Waller (2006) have used with promising results to elucidate the anorexic mode.

6.7.2. Anorexia nervosa as identity

More explicit acknowledgements regarding relationship with self that emerged within the findings point to the role of anorexia as identity, which accords with the results of other qualitative research, as reviewed by Espindola & Blay (2009). These authors found a consensus of evidence that anorexia can constitute a lifestyle, serving to structure the lives of the sufferers and to offer a strategy for dealing with challenges. In a similar vein, the possibility of reconstructing a new identity through taking something negative away (implemented through the removal of body tissue) was one of the concretised metaphors identified in Skårderud's (2007a) study. Such functions, which have resonance with the theme of control, are components of the disorder that

require working through in therapy, as moving towards recovery constitutes a loss of identity and letting go of a familiar, albeit painful, way of relating to the self. The strength of this attachment can be conveyed through understanding that the reliable, predictable quality of anorexia nervosa gives it the status of transitional object (Winnicott, 1971).

6.7.3. An attachment perspective

Thus, dismissal of being-in-relationship leaves a void which is filled by the relationship with anorexia, which constitutes a means of achieving the experience of intersubjectivity, albeit a flawed one. Attachment theory is relevant to the sense of separation from others and has been applied to the understanding of eating disorders in a number of studies (see Zachrisson & Skårderud, 2010, for a review). There is a general view that restricting behaviour is associated with a dismissing attachment pattern and that people with eating disorders tend to display an insecure attachment style. This is consistent with the conclusions of Ward, Ramsay, Turnbull, Steele, Steele and Treasure (2001), who found that both daughters with anorexia nervosa and their mothers displayed an insecure avoidant attachment pattern. Although the design of this study does not support comparison with empirical work focusing specifically on attachment style, its findings offer moderate support to these ideas. It also offers a more experience-near understanding of the anorexic's withdrawal from relationship and ambivalence towards contact with others. The image of the self as being enclosed in a box, safe and protected from the unpredictable external world and others who may be unreliable or inconsistent (Sternheim, Konstantellou, Startup & Schmidt, 2011), conveys the dilemma that undermines the anorexic's motivation to engage with therapists and carers in the process of recovery. Thus efforts to form a collaborative alliance against anorexia are viewed with suspicion even whilst the highly visible quality of the disorder creates a shared attentional focus, with the impact of an intentional communication.

6.7.4. Projection of internal splitting

Where the condition of the sufferer becomes so severe that inpatient care is necessary, the patient will typically spend a protracted period on an eating disorders ward receiving treatment by a multidisciplinary team. Within this context, there is scope for projection of powerful feelings and aspects of her inner world onto members of staff and other patients. These transferential and counter-transferential dynamics involve strong invitations for others to enact or recreate situations which reflect the patient's earlier experiences, relationships or split-off aspects of the self (Marsden, 2001; Gairdner, 2002). The insights into the world of anorexia nervosa that this study has uncovered give further cause for consideration of the ways in which others on the ward might be propelled into relationships with the patient. Marsden (2001) has stressed the importance of team meetings for reflection on these dynamics in order to create a 'map' of the patient's internal objects, allowing staff to provide better containment. Within therapy, the psychotherapist may be informed by this 'map' in order to support the patient more effectively to re-integrate parts of herself that may be split-off. The understanding of the experience of self-fragmentation that has emerged from this study reinforces the sense of the importance of this task for psychological therapy with the person suffering from anorexia nervosa. Given the internal compartmentalisation and disconnection that serve as a defence against the threat of uncontrollable phenomena, chaos and uncertainty, it is hardly surprising that multidisciplinary teams experience divisive and conflictual dynamics akin to The Ailment described by Tom Main (1957).

6.8. Implications for psychological therapy

The reader will have noticed how at various points through the course of discussing the master themes, I have suggested ways in which the findings of this study are relevant to the practice of psychological therapy with anorexic clients. In what follows I will propose further implications of the findings, based on the extent to which imagery reflected and encapsulated the experience of the majority of participants.

6.8.1. Body as vehicle for symbolic expression

The superordinate themes emerging from my analysis show a notable degree of consistency with the concretised metaphors described by Skårderud (2007a). It seems that whilst addressing the aim of exploring imagery, this study has contributed further evidence elucidating the ways in which emotions and meanings are concretised in bodily expression and experiences. This insight offers an avenue for accessing that which cannot easily be expressed in words, for patients and therapists in general, and particularly valuable for those affected by anorexia nervosa, where feelings cannot easily be articulated and communication with others can be threatening.

> "This inevitable processing of information through the mediation of affectively valued bodily perceptions gives the metaphorical function—the human capacity to organize experience and life in metaphoric ways—the ability to create linguistic metaphors that can capture and express otherwise inexpressible psychic experiences" (Rizzuto, 2001, p. 535).

6.8.2. Role of compromised mentalization

There is potential value in drawing on the resonance between Skårderud's (2007b) formulation and the findings I have presented. Informed by a phenomenologically-based understanding of reduced symbolic capacity in anorexic clients, psychological therapists may be better equipped to extrapolate the difficulties with mentalization to limitations and challenges for psychotherapy and treatment of the disorder. In this respect, Skårderud (2007b) has outlined a number of important considerations: firstly, the anorexic patient does not perceive the symbolic communication utilising the body as metaphoric, but rather as concrete reality. This is related to aspects of impaired mentalization which are extensively described in the work of Fonagy and his colleagues (Fonagy, 2006; Fonagy, Gergely, Jurist & Target, 2002) and which were evident in the interviews in this study. There was a sense of participants' viewing the external world as equivalent to their internal states, indicative of psychic equivalence, where mind

and outside world are isomorphic (Fonagy & Bateman, 2008). For instance, the themes of Body as Threat and Food as Threat seem to suggest the concretisation of a perspective of the world as untrustworthy, where there is no 'as if' quality to a person's experience and the body is experienced as too real, or too much. Conversely, there were also indications of participants' experiencing a later developmental perspective wherein the person's internal state is dissociated from the external world. This pretend mode manifests as a decoupling of affect from thoughts and actions (Fonagy & Bateman, 2008), as was apparent in the theme of Disconnection within the Self.

In normal development a child integrates the two modes of psychic equivalence (world too real) and pretend mode (unreal world) to arrive at a reflective mode of functioning. This is the capacity to mentalise, wherein thoughts and feelings are experienced as subjective representations. Where prementalistic representations of internal states are found, it is important for therapists to understand these mechanisms and there are strong indications that this is relevant in the treatment of anorexia nervosa.

6.8.3. Understanding the valued function of symptoms

As observed clinically and evident in participants' accounts, the phenomena of anorexia nervosa – the symptomatic behaviours - are experienced as positive, even solutions, offering certainty, security and protection. These perceived benefits of the disorder have implications for certain therapeutic aims considered important when working with anorexia nervosa. For instance, the new Maudsley method (Treasure, Smith & Crane, 2007) refers to the tendency for people with anorexia nervosa to have difficulty taking a 'bigger picture' perspective. Considering the threat of fragmentation inherent in the anorexic experience, it is possible to understand how therapeutic efforts to increase the capacity for seeing the 'bigger picture' may easily flounder. The propensity to focus on detail offers a means of avoiding the threat of that which is

uncontrollable and attachment to this defence is likely to hamper these therapeutic endeavours.

With the aim of at rehabilitating the person's mentalising capacity (Skårderud, 2007c), therapy with the anorexic client needs to embrace the challenge of minding (mentalising) the functions of anorexic behaviour and thinking. This means that rather than focusing on what is symbolised, developing an understanding of how symbols are used (in terms of function rather than meaning) can enhance the capacity for symbolising and provide an alternative to concretised functioning. Applying this principle to working with imagery, it follows that a collaborative exploration of the way in which images implicitly represent underlying dynamics at play in the world of the anorexic is likely to be more helpful than examining the explicit content of the images. Rather than a literal, face-value perspective on what is being expressed, therapists aiming to developing the function of 'minding' oneself and others will engage the anorexic client in dialogue that seeks to discover the underlying function of thoughts, images, feelings and behaviours.

6.8.4. Impact on therapeutic alliance

A further potential undermining influence concerns the therapist's inability to understand the impact that deficits in the mentalisation capacity of the anorexic may have on the therapeutic relationship: the concrete functioning style can manifest in a paucity of verbal collaboration, potentially inciting the therapist's frustration and ill-considered interventions. Albeit challenging, a more promising approach would involve maintaining a balance to ensure that the patient experiences the therapist as able to maintain the dialogue, even when the patient may often be silent (possibly shame-based), whilst not invading or threatening the patient with overwhelming activity in therapy (Skårderud, 2007c). Regulating the intensity and activity within the therapeutic encounter is an important on-going task, which supports the alliance and the development of more effective regulatory capacity in the client.

Informed by the findings of this study, therapists may draw on their enhanced insight into the themes at play in the experience of the anorexic in order to open up the possibility of engaging in meaningful dialogue. In this way, the therapist is able to be experienced by the anorexic as situated in a position of knowing, with a stance of not-knowing – i.e. curiosity and openness to learn about the way in which the known themes are experienced by this particular person with anorexia nervosa.

The therapist's empathic awareness of the anorexic's immersion in the concrete can enhance the quality of the dialogue: rather than offering interpretations that the anorexic client, being immersed in the concrete (presymbolic) world, is unable to digest, it is more helpful for the therapist to enter the realm of the concrete. Though attending to the anorexic client's preoccupations, one aspect being concretized structures (including perceptual imagery), the therapist can offer attunement, validation of experience and the potential for experiencing a more cohesive, integrated sense of self. This is akin to the object relations conceptualisation of the use of self-object and gradual internalisations of self-object functions that contribute towards the development of self (Kohut, 1971).

6.9. Contribution of this study

In many respects, this research simply offers support for a range of existing theories regarding the defensive functions served by eating disorders in general, and anorexia nervosa in particular, together with the self-structures that underpin the presentation and the important role played by relationships. There is arguably value in reinforcing, integrating and building upon existing theory, as well as applying this understanding to practice. This alone would – I believe – be a worthwhile contribution to the field.

However, there are aspects of value emergent from this research that go further than supporting theory, which I feel are important to acknowledge. One such aspect is largely due to the choice of IPA, and the concomitant spirit of collaboration and honouring of the participants' experiences as described in their own words. The advantage this offers is the possibility of bringing the understanding of the

precipitating and maintaining factors into the therapy room with the anorexic client, in a manner that is accessible, sufficiently 'concrete' and that can be worked with in the intersubjective space. I will go so far as to suggest that the themes that were present within participants' accounts could also be found within the stories told by clients, often implicitly, though sometimes explicitly. Some clients will convey the themes using imagery, particularly if this means of phenomenological expression is facilitated in the therapeutic dialogue. The contribution of this research has relevance to a variety of people involved in the battle against anorexia nervosa and I shall mention a few.

For clients who typically struggle to connect with their felt sense of self, experiencing isolation, fear and shame, this research has highlighted an effective means of gaining awareness of the body through the medium of exploring concrete thoughts, behaviour and images. Through using 'their own language' anorexic clients may find it easier and less threatening to begin to connect with aspects of themselves that they have disowned. They may feel more accurately understood by their therapists, who can be better equipped to set aside judgment, frustration and impatience and more effectively able to meet them in the realm of the concrete.

Conversely, from the perspective of psychological therapists working in the field of eating disorders, drawing on this research offers the potential for enhancing the therapeutic relationship. Empathic engagement with typically avoidant clients may be facilitated through deeper insight into the experience of anorexia nervosa. It is important for therapists to be mindful of the manifestation of anorexia as a powerful, manipulative and punishing internal object. By maintaining an awareness of the possibility within the transference of identifying with this oppressive self-object, therapists will be less likely to stumble into unhelpful or abusive re-enactments (or where such phenomena arise, they will be more readily able to perceive them).

In addition to the abovementioned considerations for therapy, supervisors will gain from this research an appreciation of the dynamics that may be played out in parallel process in their supervision of therapists working with anorexic clients. Informed by

insights into the impaired mentalising capacity and concrete modes of relating to self and others by anorexic clients, supervisors will be better able to recognise the signs in those of their supervisees who may find elements of their own mentalising capacities compromised by virtue of (over)-identification with their clients.

Professional training in the field of eating disorders varies in the depth and focus of interventions taught, depending on the theoretical conceptualisation or modality underpinning the course. Trainers of most orientations in the field of eating disorders may draw on this research to convey to their students the effectiveness of imagery exploration as a medium for supporting the development of a collaborative interpersonal engagement and a greater intrapersonal awareness. Given the underlying fragility of the eating-disordered person's self-structure and the adherence to concrete forms of relating to self and the world, it would be responsible for trainers to include guidance regarding the sensitive pacing of behavioural interventions, particularly considering the role of shame and exposure in the phenomenology of anorexia nervosa.

In my own practice as a psychological therapist, I have integrated what I have learned from this research into my understanding of the challenge of working with anorexic clients. This, I believe, strengthens my patience, compassion and attunement, so necessary for the interplay between frequently opposing subjectivities. I draw on my findings in order to recognise more readily that what may appear as 'resistance' can also be respected as an achievement involving dissociative processes adapted to serve functions of self-preservation valuable to the person with anorexia nervosa. When I begin to sense my exasperation and sense of failure in the face of perceived low motivation to engage in the therapeutic alliance, understanding the meaning underlying the anorexic client's presentation fortifies my own self-regulatory capacity and supports me in the maintenance of openness, authenticity and stability. These qualities are essential components in the process of developing the client's own gradual and incremental awareness, tolerance and regulation of threatening and disowned affect.

6.10. Limitations and considerations for future research

Looking back, I can see various choices made during this research project, which have given rise to certain challenges, notably during the recruitment, interviewing and analysis phases. Interestingly, though at the time I may have wished I had taken a different approach, it now seems to me that the process of dealing with each challenge has in some way enriched the study, in some cases helping to identify areas for further enquiry.

I do admit that notwithstanding my rationale for expanding the area of enquiry by adopting an inclusive approach towards the contents of the interviews in this study, the large number of themes that resulted has limited the depth of discussion on individual points. A deeper understanding of themes such as shame and the felt need for security and protection in the phenomenology of anorexia nervosa would be potentially fruitful focus of further studies aiming to inform therapeutic work with anorexic clients.

Relatedly, the open question I used to elicit descriptions allowed for a wide exploration of participants' experience. This yielded interview data that was not all specifically pertinent to imagery. A more focused study might employ a structured interview such as those used in previous clinical mental imagery studies (Day, Holmes, & Hackmann, 2004; Hackmann, Clark, & McManus, 2000; Holmes, Grey & Young, 2005). In these interviews, the term ''mental imagery'' was explained using examples and feedback elicited to confirm comprehension. Participants were asked whether they had experienced any images or verbal thoughts for each of nine topics and to describe examples to check comprehension. It may well be appropriate to use a method other than IPA for this more structured, directive approach.

The exploratory, participant-led approach and subsequent interpretative analysis of the phenomenology of anorexia nervosa has yielded one of the most important contributions of this research. This, I believe, has been the highlighting of the need to

address the dissociative processes in the anorexic self-structure. Questions that arise from this insight concern the ways in which awareness of the body self can be increased, in order to begin to dissolve the dissociative processes and lead to a more integrated sense of self. The possibility of using sensori-motor work together with imagery, to move from a position of dissociation from the body to embodiment, incorporating the experience of the lived body (Merleau-Ponty, 1962), is a potentially fruitful area for future exploration. Such work should be designed to take into account the phenomena of psychic equivalence and pretend mode (Fonagy & Bateman, 2008), for it seems conceivable that these ways of perceiving the world might present challenges when exploring experience through imagery. If the external world is too real, images may be viewed as isomorphic with the external world; alternatively, if there is an unreal quality to the world, the impact of images is likely to be diluted.

7. Conclusion

The images and sensory representations described by women with anorexia nervosa come laden with meanings, embodied messages and memories. The themes that emerged from interpretation using IPA have the following broad implications for treatment – the person with anorexia nervosa will need support in working with a fragile self-structure, a masochistic inner critic and self-compromising object relations. That people with anorexia nervosa describe their experience of fragmentation, exposure, protection and relatedness is consistent with theories about the self-structure underlying the condition, but also significant in that this awareness - implicit in their images, feelings, thoughts and behaviour – can potentially be acknowledged and worked with in therapy. Imagery work can play a part in providing a means of accessing and articulating emotions and thoughts, and making connections between behaviours and the functions they serve. The form that this work takes can be drawn from a range of interventions from the collaborative exploration of images used in this study, through graphical depictions of lived experience, to guided imagery scripts. Imagery work is thus an option to be mindfully integrated into treatment, with due consideration of the state of readiness and capacities of the individual client. It is my hope that this research will enhance our capacity to support the person with anorexia nervosa in the tasks of learning that feelings can be experienced and expressed in ways other than bodily pain and in developing healthier internal object relationships to achieve freedom from a punitive inner oppressor.

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My husband Gavin and my daughters Katharine and Louisa,

for their patience, support and good humour

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APPENDIX 1: Ethical approval letter

METANOIA INSTITUTE

13 North Common Road
Ealing, London W5 2QB
Telephone: 020 8579 2505
Facsimile: 020 8832 3070
www.metanoia.ac.uk

Susan Doyle
26 Paultons Square
London
SW3 5AP

26th June 2009

Dear Susan,

RE: **The experience of patients with anorexia nervosa regarding imagery related to food, weight and shape**

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please discuss these with your research supervisor in the first instance, and inform me as Chair of the Research Ethics Committee.

Yours sincerely,

Dr Patricia Moran
Research Co-ordinator
Chair of Metanoia Research Ethics Committee

Registered in England at the above address No. 2918520

Registered Charity No. 1050175

APPENDIX 2: Interview transcript excerpt

Emergent Themes (Codes)	**Transcript Extract** (Quotes highlighted in alternating colours)	**Initial notes**
Hunger a forbidden sensation Hunger out of awareness Voice of anorexia Hunger a forbidden sensation Fear of unrestrained eating Filled up with fear Hunger out of awareness Eating as ordeal Image of body expanding Fullness a feeling of fatness Image of body expanding	**R:** Right now I do feel hungry but if I take myself back to the worst time I was, I mean I think that anorexic voice is so strong that it almost - it overrides the hungry rule. It like, you're not allowed to be hungry, you're not allowed to feel that emotion. It blocks it out because if you're hun-, yeah for me hunger meant out of control and if you listened to it you won't know when to stop, you shouldn't eat when you're hungry because it's never ending. **When there's so much fear in you that it fills up hunger for you**. I think that when you're at your worst that image of just that you're going to grow, because literally it is immediate growth that you see, that eating is just not on, it's not bearable. That feeling of fullness means fatness even though now I know that to get digested it takes time, this and that, but then it's '**eat - grow'**, there's no such thing as digestion. The food goes in, you grow.	The anorexic voice - rather than images - blocks out the sensation of hunger. Her belief is that if she begins to eat she will lose control. Her sense is that hunger cannot be satisfied - she cannot trust her body - so its needs are denied. Fear supplants hunger - image of fear filling her up as if it was food. Resonates with sense of constriction. Visual image of immediate growth as a consequence of eating. 'Not bearable' suggests the heaviness of the burden presented by food. Feeling full is perceived as feeling fat. So her sensory impression here is the tactile experience of fatness.
	I: So there's this threat of instant growth.	
Experience during eating Image of body expanding Making my own decisions	**R:** Yes, like even if you have a full plate, if you finish your plate you've grown. If you manage to leave one piece of food on your plate the growth is not as bad, you've done something, you've at least given some control to show that you didn't finish it off. Like for instance, in-patient - the plate was always full. You always want	She describes a strategy for increasing her sense of agency - her capacity to regulate the discomfort of feeling full and therefore fat. Not imagery-related. However this should be coded as it provides insight

Divisive influence of anorexia Locus of control	to leave that one crumb or flick that one pea on the plate to say you didn't finish. You had the control, you didn't finish it all. So it's just the control as well I suppose.	into alternatives to using imagery and the issue of control is later shown to be related to imagery (the rule book).
	I: Mmm. I wonder if there are any images around that would relate to that issue of control for you.	
	R: Image, control? I just think image what is. Sorry that's a hard one.	
	I: That's okay.	
Complying with anorexia rules Image of rule book	**R:** …. I think image for control I probably see like your rule book type thing, a book with rules on it. So like ticking the rules. Have I done this? Have I done that? So in my head it's that little rule book that I have to tick off that I've done this, I've done that. Right now it's have you gone for your walk? Have you done this? Have you done that? Or before it would be you must - in patient for example the walks were taken away from you. But it's at this time you must walk up and down in your room, when at meal time you must eat in a specific way. It's just following the images, this rule book with loads of small little rules written down and you must tick them off as you go along.	The image of a rule book depicts control. A list of rules that she must obey.
	I: Okay, what's the book - can you say a bit more about what it looks like?	
Image of rule book	**R:** I think it's black - black with small writing, so like it's a big book filled with rules, so - fat book.	Book of rules is an image relating to authority and control or order.
	I: So would you say that's something that you, you imagine you're ticking off these rules?	

Complying with anorexia rules Recriminations and regret Repercussions for perceived failures Retaliation after reprieve	**R:** Yeah, so you do this and this. And every day you have to start afresh. And if you're bad one day the rules become bigger the next day. You have do one other thing extra or carry over what you've done wrong the day after, or if you're trying to do something right and you go wrong, then it goes on the next day. You can't go above like, for example food limit. If you've eaten let's say breakfast, lunch, dinner, the next day you can't include a snack you can only have breakfast, lunch, dinner because you didn't do it yesterday. You still feel - you've woken up, you don't feel like you've changed therefore if you eat any more you're obviously going to get fatter, so the rule book dictates what you're allowed to do in a day, so it's yeah, you have to check it every day.	Repercussions of not complying with the rules in the rule book are penances involving more severe restrictions, or forfeits, the following day. This illustrates the close monitoring of her performance in relation to the rules of anorexia.
Complying with anorexia rules Repercussions for perceived failures		An example of a rule - she demonstrates the systematic nature of her self-imposed rules.
Image of rule book		Rule book dictates her behaviour. She checks regularly - so as a routine and a set of guidelines, it serves to regulate her.
	I: So there's this book that's in a sense dictating what you, what you do?	
	R: Yeah.	
	I: And it sounds like it keeps a record from day to day?	
Image of rule book Repercussions for perceived failures	**R:** Yeah. So it's not just a new page rule book, it's the rules are dictated the day before, from your behaviours from the day before, the week before.	There is a continuity to the rules - dependency on her performance from previous days or week. This implies an element of punishment - what about reward?
	I: And how, how - can you say anything more about what the book was like?	
Image of rule book	**R:** I do think it's something quite sturdy so you know like those diaries you get like with the leathery, not leather but they're	The description of the book as sturdy, proper and with neat clean writing conveys

Image of rule book Repercussions for perceived failures Satisfaction in perfect performance	proper sturdy ones with the gold rim on the edge. So it's a big, proper thing you can't lose. The pages are all nice and clean like, the writing in order as well. So it's very neat but there's no - there's not allowed to be any messy so if you've got scribbles in it, the next day it has to be perfect. So like there's crosses when you don't obey. The next day you have to work harder. So it has to be clean. So I think it's a very tidy perfect straight-line notebook. The ticks are all in a line in little boxes.	the safety and reliability of the rule book. Again, she refers to the implications of failing to reach the standards specified in her rule book. She has to work harder to avoid messy crosses in her rule book. She seems proud of the book - perhaps suggesting the reward being a sense of achievement when she has been awarded ticks in a line in little boxes.
	I: Who's writing is in the book?	
Image of rule book	**R:** My own writing, so it's small writing kind of thing.	Her own writing is in the rule book - suggesting she identifies with the rules and they are self-imposed.
	I: So it's something that you might have written for yourself, these rules?	
Complying with anorexia rules Image of red suggesting threat Image of rule book Repercussions for perceived failures	**R:** Yeah. And then like when a rule, if it hasn't been obeyed it will probably be red writing to make sure you must obey. So you must obey this rule and you didn't do it. So red when you've been naughty and if you haven't obeyed it for quite some time it becomes more predominant. So it would be red bigger writing, capital letters. Whereas all the other ones are just normal writing. Each line's a line. And like yeah no scribble, like just close, neat, perfect type thing.	The book contains a warning system with increasing levels of severity to ensure she obeys the rules.
	I: It sounds like a really impressive book.	
Image of rule book	**R:** Yeah it's short and sweet, but fat. So it's a big one.	

	I: Yeah. So it's a fat book too?	
	R: Yeah. It keeps your record.	
	I: Aha. And um, okay, so it's your writing in the book and it's very neat. But sometimes you said that the writing might be messy?	
Complying with anorexia rules Image of dirt and messiness Image of rule book Repercussions for perceived failures	**R:** Like yeah, if it's no like - if you don't obey, you've crossed it out so you haven't done this. And so it's messy there. So because I don't like mess, um - oh yeah that's another image I see with me, I become messy.	She describes how writing in the book becomes messy - when she has failed to complete a required item on her list. She doesn't like mess - disorder, chaos - and sees herself as messy sometimes.
	I: Can you say some more about that?	
Disgust Image of dirt and messiness Image of people stuffing mouths Images of very fat people Meanings associated with fatness Smell of poor hygiene	**R:** It's like I think fat equals messy. And I don't like messy or dirt. So therefore when you're not eating you're clean, you're tidy, you're - yeah you're clean. But when you're fat, you're messy, you just see those images like you know on the train when you can see people eating and they're quite obese, they're just sweating constantly, the smell, lack of hygiene and all that. So you just associate it with bad smells, dirty looks, so yeah so fat equals dirty in my eyes. And food equals fat which equals dirty.	Connecting food with fat and being dirty or messy is a powerful association that invokes disgust. And if food is associated with disgust this is likely to increase the propensity to avoid food. This conveys the ambivalent attachment to food as an object of great interest but also a threat.
	I: Okay. So I can see that strong association. And you mentioned that, yeah that it might be smells and smells are also interesting to me in terms of other sensory impressions. Perhaps you could say some more about different smells and how they would affect you when you were ill.	
	R: When I was at my worst I think oily	

Image of body expanding Image of dirt and messiness Invasive smell of food (uncontrollable) Shapes rounded or circular	smells, you also felt like you're fatter. So oily smells, even though if you're not eating it, just being around the like the frying of food, you just feel it like going in you. So once again because you feel dirty in yourself, you feel fatter again. Even though you haven't eaten it, but just the oil's clogging up, you can just see your face roundening or - so yeah, so it's just even being in that atmosphere. Whereas I think there are pleasant smells like going by a bakery, then you smell that and you think, oh I want that, and then it's like, yeah and then you're going to keep on eating it and then you're going to be fat. So I think you associate fresh bakery smells with indulgence and so therefore indulgence of course isn't allowed in my rule book, so then you go back to the fat feeling again. So if it's not allowed in the rule book, anything that's not in the rule book and you go against it equals fat - not so good.	The smell of food frying is threatening in itself - she can't control the invasion of the oily smells. She feels as though she becomes a passive recipient of the calories. Here she describes her initial response to the inviting smell of the bakery - initially a pleasant association - which is interrupted by the admonition that she will lose control. The rule book uses the ultimate threat that she will become fat if she disobeys.
Complying with anorexia rules Fear of feeling big Fear of unrestrained eating Image of rule book Smell of food Threat of fat self		
	I: So that rule book might appear to you in some way or you'd have a sense of it?	
Complying with anorexia rules Image of rule book Recriminations and regret	**R:** Yeah I think the rule book is like, I think it's like in the brain type thing. So it's just, it's always there. So even if you're not flipping over the pages and seeing ooh is this in there, you know what, it's like you know your do's and don'ts. So by having that you've disobeyed it so then you're fat. I don't think there is a middle ground between being thin or fat, you're just either fat or normal. You don't, yeah you're not allowed the middle way of-… You're gonna just gradually gain weight. As soon as, like for instance weighing scales for instance. You can feel small, and	She views the rule book as a metaphor for her internal process. So she might not actually experience herself flipping through the pages, but she is aware of the do's and don'ts and her own rules for self-regulation.

Image of body expanding Myself looking fat Number on the scales The constricted self Weighing and checking	then you get on the weighing scales. You see the numbers increase and then all of a sudden your leg size increases, your face increases literally at the same time as you've just seen the number increase. So I can be sitting here normal weight, go on the scale, put on Ite's say point five from the week before. Honestly your whole world, your - that whole picture image of you can sit there and you can feel your face and cheeks puffing up, your legs growing. You're no longer fitting into your clothes. Even though you're just sitting there at the same time. It's just that mental image just grows. And then that's when you really believe and that mental image grows.	Powerful image of herself expanding in a vastly exaggerated manner disproportionately to her actual weight gain. A small increase is experienced as initiating an uncontrollable process of relentless growth. This is a visual and tactile sensory impression, including the image of fat self and the sensation of constricted body straining against her clothing.
	I: So that might be nothing to do with what you're actually seeing, that you've got a mental image that's fat.	
Image of body expanding Myself looking fat Negative messages about myself Weighing and checking	**R:** Yeah. So - oh no but like yeah, so because of your mental image. Because you're just sitting there when you look at your legs you're like, yeah they have grown haven't they? I'm too dumb I didn't see that. Sorry I might have deviated but I just thought -	She trusts her image of her legs having grown more than her actual perception in the moment. She then berates herself as dumb for not having noticed the increased size of her legs.
	I: No, no, I'm just taking it in. Don't worry, it's, it's all very relevant. So, so that's interesting. You have this image just when you get on the scale and you've put on some weight, even half a kilo you'd have an image of yourself as, as having grown. And you say it's not, it's not a gradual growth -	
Image of body expanding	**R:** Yeah, it's immediate growth. It's not even like you wait till you go home and think have I actually put on that much	Feeling immediate growth when the scales indicate a half-kilo increase conveys the

Myself looking fat Number on the scales Weighing and checking	weight. You know the half a kilo is insignificant in a sense. But you can see in every single place it has grown, it's this much bigger or that much bigger and yeah, then … yeah so.	strength of the association. Perhaps this is an early warning system , or strategy for pre-empting any significant weight gain, by instantly being on the alert.
	I: And what I'm wondering about is what you feel like, when you have this image of yourself.	
Feeling clean and untainted Image of dirt and messiness	**R:** I would mostly say you feel dir- as I said dirty is a very strong - you feel like you need to be cleansed. Like if you've put on the weight, you can just feel yourself like dirty, sweaty, icky person and you just need to be clean and, and like the world's gone messy as well. So you're dirty and everything around you is messy and you must get order back. So I think when I feel weight gain I feel out of control, that messy, like you know that Mr. Men scribbly guy? You just feel like that. That infant little scribbly guy.	Feeling she has put on weight leads to a perception of the self as dirty, icky and sweaty - and accompanies the strong wish to be cleansed. So from weight she extrapolates to other undesirable traits. This includes a sense of the world around her being messy and disordered. Feeling like Mr Men scribbly character underlines the chaotic sense of self when she gains weight. Mr Messy is a pink scribble - no substance, shapeless, rounded (compared with the straight lines in her rule book).
Feeling out of control Image of dirt and messiness The incohesive self The unregulated self		
	I: Yeah, I know.	
The incohesive self The unregulated self	**R:** Yeah him. So you just feel like that. You feel like oh you're not in line any more, you've just grown out of all the lines and -	Feeling as though she has grown out of all the lines is akin to spilling over, breaking her boundaries and being uncontained - with the accompanying threat of unpredictability and uncertainty.
	I: Yeah it does sound a bit out of control.	
Feeling out of control Image of dirt and messiness	**R:** Yeah, so I think that's the best picture image I can give you, the scribbly guy, Mr Scribble. You feel actually like that.	Feeling as though she has grown out of all the lines is akin to spilling over, breaking her boundaries and being uncontained - with the accompanying threat of unpredictability and

The incohesive self		uncertainty.
	I: Okay. And I wonder if that um, you might take a little while to think this through. I'm wondering whether this image er has any, has any association for you with any memory, whether there's any memory of yourself actually growing bigger.	
Distortion of body image Focusing on specific areas of 'fat' Image different from reality Image of two photos blended Memory of plump sister Myself looking fat Rejecting the body Shapes rounded or circular	**R:** I think for me, I can only say that there's only ever been one picture - like right now if I go and look at the pictures from when I was younger, I'd say wow, I'm so fat compared to that. But when I was like just I think developing the anorexia type thing there was one photo when I was on holiday in Spain where I did have my rounded face. Even though everyone said I was small, but to me that face was round. Then - and my sister was quite chubby when she was younger, and she was very rounded. So I just disregard my body on that photo, look at that round face and put it on her body. So that's, I blend the two photos in my head. So I just see that picture whenever I think oh I'm fat, I blended that photo of that rounded face I see in my photo with that rounded picture of my sister.	She created an image that blends her rounded face with her sister's chubby body. Again, rounded images are undesirable. 'I just disregard my body' is a strking phrase, as this is a common phenomenon in anorexia.
	I: Oh so you've combined the two?	
Image different from reality Image of two photos blended Memory of plump sister Rejecting the body Threat of fat self	**R:** Yeah, so it's a combined picture. And I think that's the one I always see when I think, because my cousins also are quite fat, but I don't - I think I can't relate that to myself because they're also tall, this and that, but my sister's my height so it's quite easy to move my head onto her	She describes the rationale for using her sister's body in her hybrid image. Her sister's body is sufficiently similar to enable her to create a believable image - she can imagine her own body growing to similar

	body. So yeah -	proportions.
	I: Aha. So it seems like a realistic possibility?	
Image different from reality Image of two photos blended	**R:** Yeah I think and it becomes like real and. Yeah, that's the picture. (giggles) So it's not a single picture, it's a blended one.	

APPENDIX 3: Emergent themes showing density by interview

Codes	Interviews										
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**
A million percent conscious	0	0	3	0	1	0	0	0	0	0	4
Absence of hunger	0	0	1	0	0	0	0	0	0	0	1
Absence of separate anorexic persona	3	1	0	0	0	0	1	1	0	0	6
Ambivalence towards recovery	0	0	0	11	0	0	0	0	0	0	11
Anorexia as a dark cloak	0	0	0	16	0	0	0	0	0	0	16
Anorexia as controlling other	0	1	10	0	0	0	1	1	0	3	16
Anorexia as cruel punisher	0	0	0	0	0	0	4	6	0	2	12
Anorexia as devious	0	0	0	0	0	0	5	0	0	0	5
Anorexia as identity	4	0	0	4	0	0	0	2	0	0	10
Anorexia as intermittent ghostly presence	0	0	0	0	1	0	0	0	0	0	1
Anorexia as long-term risk	0	0	0	6	0	0	2	0	0	0	8
Anorexia as powerful authority figure	0	0	0	9	7	0	10	3	0	0	29
Anorexia as reliable companion	0	0	3	6	3	0	1	0	0	0	13
Anxiety over decision-making	0	0	0	6	0	0	0	0	0	0	6
Apathy regarding eating	0	0	0	0	0	0	0	0	0	2	2
Appealing to God	3	0	0	0	0	0	3	0	0	0	6
Assuming the worst	0	0	2	0	0	0	0	0	0	0	2
Avoiding my own image	2	0	0	2	0	0	0	1	0	0	5
Awful sight of my body	3	0	0	0	0	0	0	1	0	0	4
Being lured down a path	0	0	0	0	0	0	9	0	0	0	9

Black and white, stark images	0	0	0	2	0	0	0	0	0	0	2
Body as object	0	1	2	2	0	0	6	2	0	4	17
Body part experienced as foreign	0	1	0	0	0	1	0	0	0	0	2
Brain as mechanical object	0	0	7	2	0	0	0	0	0	0	9
Calculating calorie content	0	0	5	5	5	0	0	0	0	0	15
Calculating fat content	0	0	1	0	2	0	0	0	0	1	4
Challenging her anorexic self	0	0	0	0	0	0	4	0	0	0	4
Chaos and uncertainty	0	0	0	0	0	0	0	2	0	0	2
Choosing anorexia over life goal	0	0	0	0	0	0	1	0	0	0	1
Colours associated with letters	0	1	0	0	0	0	0	0	0	0	1
Colours associated with numbers	0	5	0	0	0	0	0	0	0	0	5
Colours to guide and reinforce choices	0	0	0	0	0	0	0	0	0	0	0
Comfort and protection	0	0	0	5	1	0	0	0	0	0	6
Comfort in certainty and control	0	5	0	0	2	0	1	1	0	0	9
Comfortable feelings a new concept	0	0	2	0	0	0	0	0	0	0	2
Comparing my experience to others	0	1	5	0	1	1	4	0	0	0	12
Complexity of real situations	0	2	0	0	0	0	0	0	0	0	2
Complying with anorexia rules	0	2	0	0	13	0	0	0	0	0	15
Conflict-avoiding strategies	0	0	0	0	0	0	0	7	0	0	7
Conflict and combat-related imagery	0	0	0	1	2	0	0	2	0	0	5
Conflict between anorexia	0	1	0	4	1	0	9	8	0	3	26

and healthy striving											
Contempt	1	0	0	0	2	0	0	0	0	0	3
Critical view of her own process	0	0	1	0	3	0	4	7	0	2	17
Cutting off my fat bits	0	4	0	0	0	0	4	0	0	0	8
Denigrating self-talk	6	0	0	0	0	0	0	0	0	0	6
Destructive drive	0	0	0	0	0	0	7	2	0	0	9
Detached from my experience	0	0	4	5	0	0	3	0	0	1	13
Dialogue with anorexia	0	4	5	3	6	0	2	0	0	0	20
Difficulty shifting focus from food-related thoughts	0	0	0	3	1	0	0	0	0	0	4
Directives versus autonomous choices	0	0	0	0	3	0	0	0	0	0	3
Disconnection from uncomfortable feelings	0	0	1	0	0	0	0	0	0	1	2
Disgust	3	0	0	0	1	1	0	6	0	0	11
Dissatisfaction with body image	0	0	8	0	1	0	0	0	0	0	9
Dissatisfaction with my soft bits	0	6	0	0	0	0	0	0	0	0	6
Distinctive colours conveying vitality	0	3	0	0	0	0	0	0	0	0	3
Distortion of body image	0	0	2	0	2	1	0	0	0	0	5
Distracting myself from hunger	0	2	0	0	0	0	0	0	0	0	2
Divisive influence of anorexia	0	0	0	0	5	0	0	0	0	0	5
Dizziness as a hunger signal	0	1	0	0	0	0	1	0	0	1	3
Drinking to assuage hunger	0	4	0	0	0	0	0	0	0	0	4
Easier not to bother eating	0	0	4	0	0	0	0	0	0	1	5
Eating as a logical, rational process	0	4	0	0	0	0	0	0	0	0	4

Eating as betrayal of self	0	0	0	0	0	0	0	4	0	0	4
Eating as ordeal	4	0	0	0	1	0	0	1	0	0	6
Eating very slowly	0	0	0	0	0	0	0	7	0	0	7
Eating without difficulty	0	0	2	0	1	0	0	0	0	0	3
Emptiness a positive feeling	0	0	0	0	3	0	2	0	0	0	5
Enclosed within	2	0	0	0	0	0	0	1	0	0	3
Ending versus endless processes	0	0	0	0	1	0	0	3	0	0	4
Escape from reality	0	0	0	3	1	0	0	0	0	0	4
Escape from unbearable feelings	0	0	0	0	0	0	3	0	0	0	3
Experience after eating	0	0	0	8	1	7	0	3	0	1	20
Experience before eating	0	0	0	10	1	0	0	0	0	1	12
Experience during eatiing	0	0	0	13	2	0	0	2	0	0	17
Experience of 'no' in my head	0	0	0	0	0	0	0	4	0	0	4
Experience of being 'too much'	0	0	0	0	0	0	14	4	0	0	18
Experience of being in a box	0	0	0	5	0	0	0	0	0	0	5
Experience of being laughed at	0	0	0	0	0	0	1	0	0	0	1
Experience of being stuck in my head	0	0	0	0	0	0	0	0	0	1	1
Experience of body expanding	0	0	0	0	0	0	0	0	0	2	2
Experience of climbing a wall	0	0	0	6	0	0	0	0	0	0	6
Experience of compartmentalised mind	0	0	0	0	5	0	0	0	0	2	7
Experience of constipation	0	0	0	0	0	0	0	4	0	0	4
Experience of difficulty swallowing	0	0	0	0	0	0	0	0	0	3	3

Experience of disapproval	0	0	0	0	0	0	0	0	0	1	1
Experience of failure	0	0	0	1	0	0	0	0	0	0	1
Experience of kissing when eating	0	0	0	0	0	0	1	0	0	0	1
Experience of pain self-inflicted	0	0	0	0	0	0	0	3	0	0	3
Experience of release/relief	0	0	0	0	0	7	0	0	0	0	7
Experience of sniffing cocaine	0	0	0	0	0	0	0	1	0	0	1
Experiencing red ball of flames inside	0	0	0	0	0	10	0	0	0	0	10
Expressing feelings non-verbally	4	0	0	0	0	0	0	0	0	0	4
Extreme polarities of experience	0	0	1	0	0	0	0	0	0	0	1
Face absent from image	0	0	2	0	0	0	0	0	0	0	2
False sense of security	0	0	0	1	0	0	1	0	0	0	2
Fantasies re opinions of others	2	0	0	0	1	0	1	2	0	3	9
Fat people clothes	2	0	0	0	0	0	0	0	0	0	2
Fear and fascination at low weight	0	3	0	0	0	0	0	0	0	0	3
Fear of body's revenge	0	1	0	0	0	0	0	0	0	0	1
Fear of feeling big	0	0	0	2	3	0	0	0	0	1	6
Fear of feeling full	0	0	0	0	0	0	3	0	0	0	3
Fear of future punitive self	0	4	0	11	1	0	0	4	0	0	20
Fear of unrestrained eating	0	7	0	1	5	0	0	3	1	0	17
Feeling a failure	2	0	0	0	1	0	0	0	0	0	3
Feeling annoyed	0	0	1	0	0	1	0	0	0	1	3
Feeling anxious	0	0	0	0	0	1	0	0	1	0	2
Feeling bones protruding	0	0	0	0	2	0	0	0	0	0	2

Feeling clean and untainted	2	0	0	0	1	0	2	0	0	0	5
Feeling confused	1	0	0	0	0	0	2	3	1	0	7
Feeling depressed	0	0	0	0	0	1	0	0	0	0	1
Feeling dirty	0	0	0	0	0	0	0	2	0	0	2
Feeling disgust	0	0	12	0	0	0	1	1	0	1	15
Feeling drawn to explore/discover	0	0	0	13	0	0	0	0	0	0	13
Feeling embarrassed	0	0	0	0	0	0	0	0	0	1	1
Feeling exposed	0	0	0	0	0	0	0	2	0	2	4
Feeling frustrated	0	0	0	0	0	0	0	2	0	0	2
Feeling guilty	0	1	0	1	1	8	0	15	3	0	29
Feeling hideous	1	0	0	0	1	0	0	2	0	0	4
Feeling hopeful	0	0	0	2	0	0	0	0	0	0	2
Feeling in control	0	0	0	0	0	0	3	2	0	0	5
Feeling messy (untidy)	0	0	0	0	1	0	0	0	0	0	1
Feeling nauseous	0	0	0	0	0	0	0	0	0	2	2
Feeling not too full	0	0	0	0	0	1	0	0	0	0	1
Feeling nothing is wrong with me	0	0	0	0	0	0	0	0	0	1	1
Feeling of fatness	0	0	1	0	5	0	5	4	1	1	17
Feeling out of control	0	0	0	0	2	3	0	3	0	1	9
Feeling overwhelmed	0	0	0	0	0	5	2	9	0	0	16
Feeling panic	0	0	0	0	0	4	0	1	0	2	7
Feeling safe and protected	0	0	0	7	0	0	1	0	0	0	8
Feeling shocked at realisation	0	0	0	3	0	0	0	1	0	1	5
Feeling sorry for myself	0	0	0	0	0	0	0	1	0	0	1
Feeling unable to eat as primary experience	0	0	0	0	0	0	0	0	0	4	4
Feeling watched	0	0	0	0	0	0	0	0	0	3	3

Feelings blocked off	0	0	15	0	1	0	1	0	0	2	19
Feelings difficult to identify	0	0	4	0	0	0	0	0	0	0	4
Filled up with fear	0	0	0	0	1	1	0	0	0	0	2
Focus on short-term relief	0	0	0	7	0	0	0	0	0	0	7
Focusing on specific areas of 'fat'	0	0	5	0	6	0	4	5	0	5	25
Food as an intrusion	0	0	0	0	0	0	2	0	0	0	2
Food as an over-complication	3	0	0	0	1	0	0	0	0	0	4
Foods I find hard to eat	0	0	5	0	0	0	0	1	0	0	6
Forbidden to enjoy food	0	0	0	0	0	0	1	14	0	0	15
Forcing myself to eat (conflict)	0	0	5	0	0	0	4	3	0	0	12
Foreign thing inside of you	0	4	0	0	0	3	0	0	0	0	7
Freedom from complexity	5	0	0	0	1	0	0	0	0	0	6
Frustration with perceived failures	2	0	0	0	0	0	0	0	0	0	2
Fullness a feeling of fatness	0	0	0	0	4	0	0	2	0	0	6
Fuzzy vision as a hunger signal	0	1	0	0	0	0	0	0	0	0	1
Good weight numbers	0	2	0	0	0	0	0	0	0	0	2
Hearing chattering conflictual conversations	0	0	0	1	0	0	0	0	0	0	1
Heightened awareness of food	0	0	8	0	0	0	0	0	0	0	8
Helping me decide whether to eat	0	0	7	0	0	0	0	0	0	0	7
Helpless to defy anorexia	0	0	0	0	0	0	0	3	0	0	3
Here and now experience versus imagery	0	0	1	0	0	0	0	0	0	0	1
Hunger a feeling of losing weight	0	1	0	0	0	0	0	0	0	0	1
Hunger a forbidden	0	0	0	0	2	0	0	0	0	0	2

sensation											
Hunger a positive feeling	0	0	0	0	0	0	4	0	0	0	4
Hunger awakened after eating	0	2	0	0	0	0	0	0	0	0	2
Hunger just having to be endured	0	1	0	0	0	0	0	0	0	0	1
Hunger out of awareness	0	0	0	0	3	0	0	0	0	4	7
Illusion of being bigger than reality	0	0	0	0	0	0	0	0	0	5	5
Image as unchanging, constant	0	0	1	0	0	0	0	0	0	0	1
Image associated with a situation	0	0	9	0	1	1	0	0	0	3	14
Image different from reality	0	0	3	0	3	0	0	0	0	2	8
Image flashing up	0	0	5	0	0	0	0	0	0	0	5
Image of 'bad' food	0	9	0	0	0	0	0	2	0	0	11
Image of blood-soaked food	0	0	0	0	0	0	0	0	0	2	2
Image of body as disproportionate	0	0	0	0	4	0	1	3	0	0	8
Image of body expanding	0	0	0	0	21	0	0	3	0	5	29
Image of bones	0	0	0	0	3	0	0	2	0	0	5
Image of cotton bud or candy floss	0	0	0	0	0	0	0	2	0	0	2
Image of dirt and messiness	0	0	0	0	9	2	0	0	0	0	11
Image of fat spreading through body	0	0	0	0	0	0	0	0	0	3	3
Image of food as dirty	0	0	0	0	0	0	0	2	0	0	2
Image of food growing	0	0	0	0	0	0	0	1	0	0	1
Image of food label on a bag of apples	0	0	4	0	0	0	0	0	0	0	4
Image of food mountains	0	0	0	0	0	7	0	6	0	0	13

Image of genie in a bottle	0	0	0	0	0	4	0	0	0	0	4
Image of greedy self	0	0	0	0	4	0	0	0	0	0	4
Image of healthy 'good' food	0	9	0	0	1	0	0	0	0	0	10
Image of jelly oozing	0	0	0	0	0	5	0	0	0	0	5
Image of lean body	0	1	0	0	0	0	0	0	0	0	1
Image of myself as observed from outside	0	0	7	0	1	0	0	0	0	0	8
Image of myself threatening	0	0	0	0	0	0	0	3	0	0	3
Image of people stuffing mouths	0	0	0	0	3	0	0	0	0	0	3
Image of red suggesting threat	0	0	0	13	1	1	0	0	0	0	15
Image of rule book	0	0	0	0	14	0	0	0	0	0	14
Image of self as evil	0	0	0	0	3	0	0	0	0	0	3
Image of self running away	0	0	0	0	0	5	0	0	0	0	5
Image of stomach contents	0	0	0	0	0	0	0	6	0	0	6
Image of two photos blended	0	0	0	0	3	0	0	0	0	0	3
Image of vagueness and uncertainty	0	0	0	5	0	0	0	2	0	0	7
Image that facilitates healthy eating	0	0	0	0	3	0	1	1	0	3	8
Images larger than life	0	0	1	0	0	0	1	0	0	0	2
Images of very fat people	8	2	0	0	3	0	0	0	0	0	13
Imagining a calm experience	0	0	0	0	0	1	0	0	0	0	1
Imagining balloon bursting	0	0	0	0	0	8	0	0	0	0	8
Imagining future regret	0	4	2	0	0	0	0	0	0	0	6
Imagining myself in pain	0	0	0	0	0	0	0	0	0	1	1
Imagining special ways to eat	0	2	0	0	0	0	0	0	0	0	2

Importance of controlling my experience	0	0	3	0	1	0	0	1	0	0	5
Importance of systematic food selection criteria	0	3	0	0	4	0	0	0	0	0	7
Importance of weighing up choices	0	0	0	6	0	0	0	0	0	0	6
Influence of mood on imagery experience	0	0	0	0	3	0	0	0	0	0	3
Influence of perspective on images	0	0	2	0	0	0	3	0	0	0	5
Influence of relationship	4	1	0	0	4	0	3	3	1	5	21
Invasive smell of food (uncontrollable)	0	0	4	0	1	1	0	1	0	2	9
Irreversible quality of meal	0	0	0	2	0	1	0	0	0	0	3
Isolation	0	0	0	3	4	1	0	1	0	3	12
Joking about bad situation	0	0	0	0	0	0	0	3	0	0	3
Judging myself more harshly	2	0	0	0	0	0	0	0	0	0	2
Lack of communication	3	0	0	0	0	0	0	0	0	0	3
Lack of self-determination	10	0	0	2	3	0	0	0	0	0	15
Laughing at temptation	0	0	0	0	0	0	0	1	0	0	1
Locus of control	0	0	0	0	2	0	4	0	0	0	6
Longing to escape	2	0	0	0	0	0	0	0	0	0	2
Looking at me scornfully	0	0	0	0	0	0	3	0	0	0	3
Loss of anorexic achievements	6	0	0	0	3	0	1	0	1	0	11
Loss of previous self	0	0	0	0	0	0	0	0	0	2	2
Loss of taste sensation	0	0	0	0	0	0	0	2	0	0	2
Low affective response to images	0	2	0	0	0	0	0	0	0	0	2
Making my own decisions	2	0	0	0	1	0	0	0	0	0	3
Manipulating/combining images	0	0	0	0	2	0	1	0	0	0	3

Meanings associated with fatness	0	0	0	0	4	0	1	0	0	0	5
Memories - flashbacks	0	0	0	0	0	0	0	0	0	2	2
Memories of distressing experiences.	0	0	0	0	0	0	0	0	0	2	2
Memories possibly blocked	0	0	0	0	0	0	1	0	0	0	1
Memory of carefree childhood	0	0	0	2	0	0	0	0	0	0	2
Memory of controlling stepfather	0	0	0	0	0	0	10	0	0	0	10
Memory of discovering 'no'	0	0	0	0	0	0	0	1	0	0	1
Memory of father overweight	4	0	0	0	0	0	0	0	0	0	4
Memory of mother's conflict with food	0	0	0	0	0	0	0	1	0	0	1
Memory of mother's criticism	2	0	0	0	0	0	0	1	0	0	3
Memory of plump sister	0	0	0	0	2	0	0	0	0	0	2
Memory of sexually intrusive relationships	0	0	0	0	0	0	1	0	0	0	1
Metaphor of body as food	0	6	0	0	0	0	0	0	0	0	6
Minimising risk	0	0	3	0	1	0	0	0	0	0	4
Myself looking fat	0	3	13	0	14	0	1	2	0	1	34
Myself looking in the mirror	0	0	18	1	0	0	7	1	0	4	31
Nauseated by myself	1	0	0	0	0	0	0	0	0	0	1
Need for accuracy	0	0	1	0	1	0	0	0	0	0	2
Need for strategy and tactics	0	0	0	10	0	0	1	0	0	0	11
Needing guidance/education	0	0	2	0	0	0	1	0	0	0	3
Negative images primarily experienced	0	0	2	0	0	0	1	0	0	0	3
Negative messages about	0	0	6	0	4	0	6	5	0	1	22

myself											
No associated memory	0	0	1	0	0	1	0	0	1	0	3
No imagery experienced	0	0	3	0	0	1	0	0	0	7	11
Not deserving food	0	0	0	0	2	0	1	0	1	0	4
Not entitled to exist	0	0	0	0	0	0	2	2	0	0	4
Number of calories appearing	0	0	11	5	3	0	0	0	0	0	19
Number of calories as a limit	0	6	0	2	0	0	6	0	0	0	14
Number on the scales	3	5	4	0	3	1	0	1	0	1	18
Overestimating calorie content	0	2	6	0	1	0	3	0	0	0	12
Panic at unexplained weight gain	0	2	0	0	0	0	0	0	0	0	2
Perceiving self as unwell	0	0	0	0	0	0	3	2	0	2	7
Physical experience mirroring mental	0	0	0	0	0	0	0	1	0	0	1
Pleasure of feeling my clothes too large	2	0	0	0	0	0	0	0	0	0	2
Positive images difficult to imagine	0	0	6	0	0	0	1	0	0	0	7
Possibility of manipulating the body	0	2	0	0	0	0	5	0	0	0	7
Pre-anorexia experience as etiology	0	8	0	0	0	0	2	1	0	0	11
Precautions against self-delusion	0	0	0	0	2	0	0	0	0	0	2
Pride in superiority	3	0	0	0	0	0	0	0	0	0	3
Questioning trustworthiness of an image	0	0	2	0	3	0	0	0	1	1	7
Questioning trustworthiness of information	0	0	2	0	4	0	2	1	0	1	10

Reaching a limit of tolerance	0	0	0	0	0	3	0	0	0	0	3
Recognising futility of strategies	0	0	0	0	0	0	2	0	0	0	2
Recovery appearing misty and grey	0	0	0	9	0	0	0	0	0	0	9
Recovery experience of confusion	1	0	0	0	0	0	1	0	0	0	2
Recovery stage experience - negotiating with AN	0	0	0	0	3	0	0	0	0	0	3
Recovery stage experience - separating from AN	0	0	0	0	2	0	1	0	0	0	3
Recriminations and regret	0	0	0	12	3	2	1	7	1	0	26
Rejecting the body	8	5	2	0	2	0	0	0	0	2	19
Reminder to restrict	0	0	12	0	0	0	0	0	0	0	12
Repercussions for perceived failures	0	0	0	0	6	3	1	2	0	2	14
Retaliation after reprieve	0	0	0	0	8	0	4	0	0	0	12
Risk of disappointment	0	0	0	1	0	0	0	0	0	0	1
Rituals for engaging with food	1	1	0	0	0	0	0	4	0	0	6
Rumination regarding food	0	0	0	3	0	0	0	0	0	0	3
Safe versus unsafe foods	0	3	6	4	3	0	3	7	1	1	28
Salience of memories	0	0	2	0	0	0	0	0	0	0	2
Satisfaction in perfect performance	0	0	0	0	2	0	0	0	0	0	2
Scars on my body	4	0	3	0	0	0	0	0	0	0	7
Self-blame for impact of anorexia	0	0	0	0	2	0	0	1	0	0	3
Self-criticial of values	4	1	0	0	0	0	0	0	0	0	5
Self-doubt	0	0	0	3	2	0	0	0	0	0	5
Severe stage anorexia experience	0	5	1	0	6	0	1	2	0	4	19

Severe stage experience - fusion of self with AN	0	0	0	0	4	0	0	2	0	0	6
Shame		2	0	3	0	1	0	1	6	0	1
Shapes rounded or circular	0	0	0	1	8	0	0	2	0	0	11
Shapes warped or distorted	0	0	0	0	0	0	0	3	0	0	3
Smell of food	0	0	0	0	1	0	0	6	0	0	7
Smell of poor hygiene	0	0	0	0	1	0	0	0	0	0	1
Smell relevant or not	0	0	0	0	0	0	1	0	0	0	1
Soothing myself	0	0	0	0	0	0	0	2	0	0	2
Sound of door slamming	0	0	0	0	2	0	0	0	0	0	2
Sound of screaming in my head	0	0	0	0	0	0	0	6	0	0	6
Starvation not a difficult process	2	0	0	0	0	0	0	0	0	0	2
Strict quality of anorexic rules	0	1	2	4	2	0	6	3	0	4	22
Struggle for autonomy	0	0	0	2	0	0	0	0	0	0	2
Subtle quality of imagery	0	0	1	0	0	0	0	0	0	0	1
Support against anorexia	0	4	0	1	7	0	13	4	0	4	33
Swallowing food whole	0	0	0	0	0	0	0	4	0	0	4
Taken over by anorexic personality	0	0	0	0	9	0	0	3	0	0	12
Taste of food	0	0	1	0	1	0	0	12	0	0	14
Temporary reprieve from anorexia	0	0	0	0	12	0	2	0	0	0	14
Texture of food	0	0	1	0	0	0	0	3	0	0	4
The awful sensation of food in my mouth	0	0	9	0	0	0	0	1	0	1	11
The comfort of not eating	0	0	2	0	0	0	2	0	0	0	4
The constricted self	5	0	0	4	1	2	0	1	0	1	14
The devil you know	0	0	0	4	1	0	0	0	0	0	5

The incohesive self	3	2	0	0	4	1	0	1	0	0	11
The invaded body	7	0	0	0	1	0	0	5	0	0	13
The unregulated self	0	0	0	0	8	3	0	0	0	0	11
Thoughts blocked off	0	0	6	0	3	0	1	0	0	0	10
Threat of fat self	8	0	0	0	11	0	1	0	0	3	23
Threatened by unspecified quantities	0	9	0	1	0	0	0	0	0	0	10
Tummy feeling knotted	0	0	0	0	0	2	0	0	0	0	2
Tummy like a balloon	0	0	0	0	0	11	0	1	0	0	12
Tummy pains vicious	0	0	0	0	0	0	0	0	0	2	2
Uncertainty of world without anorexia	0	0	3	12	3	0	0	0	0	0	18
Undercutting her calorie allowance	0	0	0	0	0	0	5	0	0	0	5
Unreliability of others	0	0	0	0	2	0	0	0	0	0	2
Vehicle for unexpressed emotions	0	0	0	0	3	0	0	0	0	0	3
Violation of ethical values	2	0	0	0	0	0	0	0	0	0	2
Visceral response	2	0	0	0	0	0	0	0	0	0	2
Vividness of Images	0	0	4	2	1	0	2	0	0	0	9
Voice of anorexia	0	0	0	6	13	0	24	8	0	2	53
Waking nightmare of force-feeding	1	0	0	0	0	0	0	0	0	0	1
Weighing and checking	0	0	3	0	3	2	0	0	0	2	10
Weighing up cost versus pleasure	0	3	0	0	1	0	0	0	0	0	4
Wishing to disappear or hide	1	0	0	0	0	0	0	3	0	0	4
Totals	**168**	**185**	**330**	**321**	**428**	**137**	**302**	**351**	**20**	**165**	**2407**

APPENDIX 4: Superordinate themes with illustrative quotations

1. Experience of Fragmentation Versus Integration

Superordinate Theme	Int.	Quotations within Interviews
Threat of uncontrollable phenomena (uncertainty or chaos)	1	if you're going to eat you sort of have a decision whether you actually physically eat, but if it's just smelling food it's just put on you because you can't control what's in the air, so I really don't like that at all. It just invades your senses.
	2	It would be unpleasant, it would be very gnawing. It's like, I've had that before when for whatever reason I've been uncertain about what was in something and it's just like this relentless thought because it's not closed, it's not a closed situation
	3	It just feels a mess now. A big one.
	4	You feel you're growing because the food's fatty, but also because you're going to go back for more so you're just going to get bigger and bigger and bigger because you won't know when to stop.
	5	The feelings of being far too much, um, were very strong then in that period and had I forced myself to eat that, they would have been almost unbearably strong and then they would have had an emotional impact.
	6	And then it sort of connects to like feeling really depressed as well and kind of out of control like it's a big mish-mash of yeuk.
	7	And all I see is two whales there and my stomach it suddenly feels like instead of just being a bit bloated, I can feel rolls of fat heaping…
	8	…it literally just feels like they're expanding. You

		feel like something like blowing up a balloon. It feels like that but around my legs, just getting bigger and bigger. And that's just the feeling that I had.
	9	…it kind of feels like when eating is like kind of climbing up a wall I guess. What you need to do is to kind of get where you want to be but it's something that's sort of difficult to do I think, um and you don't know exactly if it's sort of well I guess what's on the other side.
	10	Like it feels like I shouldn't have to have it but if I do it'll get me into like - when I do have it, that I couldn't resist…
Control, rules and restrictions	1	I think it's the eating disorder just trying to sort of really focus me and that's all it takes, it will just flash up and that's enough , I don't need to stop and think about it. Having just like been made aware of the number and then that's it, you know then.
	2	I don't generally feel hungry before a meal but if I do I would drink something or have coffee or something so that I be, I would know that I was not eating to kind of like give into a desire but more just because…I like to eat in a like logical way rather than a feeling way so I eat because I've decided to eat -- not because I'm hungry.
	3	I have ritualised ways and thoughts and things that I must do, but not necessarily like a voice in my head. It feels […] more serious than that at times.
	4	I think for me it was following the rules, keeping within the rule and like limit and you're being healthy so, you're being healthy you can't be fat. And because most foods were fruit that had low calories and low fat, you followed every- like there's no way you can become fat you're

		doing everything right
	5	I think that um for example if on an occasion where I would eat something out with my allowance it would be you know much more intense um imagery than if it was within my safe allowance.
	7	When I'm eating in an anorexic way, my own way **with my choice of foods I do take a lot of time to make everything** exact, precise. And when I'm making salads it's incredibly precise. I cut everything up in a very certain way.
	8	I had a real craving for parma ham, you know it's really salty. And I walked past it and I was like, oh god. I don't know though because like it's, I was thinking this is like, this is out of my rule, my rule boundary, no I don't eat ham, like I can't do that.
	9	I think often in terms of the kind of calorie and things of food, so it's very kind of numerical when I think about it in my head. I almost don't think about the food in terms of um how it looks or anything like that I think it's all kind of numbers.
	10	I don't have any images of safe food but anything that's sort of a proper meal or has more calories is- that I couldn't associate with.
Food as threat	1	It's just like a really, really over aware feeling of food in your mouth and stuff. I could guess normal people don't really think about it, they just probably eat it and swallow it and just carry on but it's quite sort of, horrible when you're really, really aware, over aware.
	2	She always leaves chilli in bowls and rice and I don't like that because they just look, it's not a meal and it's not, it's just like weird unspecified kind of food and that, it makes me, that's what I

		imagine when I imagine like bad eating and that kind of strange semi-meal which you can keep in the fridge. Yeah, that, I find those kind of upsetting.
	3	I mean the response [to food] was very, very physical really. It could make me squirm in, whether I was sat or standing physically it would send like a shiver up my spine.
	4	… those images like you know on the train when you can see people eating and they're quite obese, they're just sweating constantly, the smell, lack of hygiene and all that. So you just associate it with bad smells, dirty looks, so yeah so fat equals dirty in my eyes. And food equals fat which equals dirty.
	6	And there'd be steam coming off it and like you'd get a sort of smell and it'd be really hot and sort of stuffy and kind of disgusting type. And I have to eat it.
	7	So when you're given like that jacket potato and not only is it a scary food but it's, it's huge and, and it's huge and it's scary. It just looks like this forever going mountain.
	8	I try and like when I swallow food, honest to god it feels like, it feels like it's going down so, so, so slowly. Like whatever I eat, and it feels like it's like a rock in there. And it's like so hard to swallow. I can feel it going all the way down there…
	9	I guess a red kind of … I think it is almost like a flag, like a warning in my head, oh gosh I'm going to have to eat something and like it might be a food that's not gonna be okay um and, yeah I um … I think yeah it is kind of … yeah I think red (66)

Disconnection within the self	1	But then when I do actually go through with it and eat it, it's just blank, I don't think about anything I don't think, it's just…I don't know, my brain just shuts down.
	2	…there's a bit which is clearly not attached to muscle it's just like a blob of fat and it looks so clearly separate from what I think is like a proper body underneath.
	3	…with that fat I feel is hanging off me I just feel so disgusting.
	4	So it's like in your head there's little compartments of doors, so for instance like coming down a corridor it can be open door the anorexia's talking to you. But sometimes the door shuts so then it's doing its own thing in your own little head and lets you get on with stuff.
	5	If you feel empty you feel a bit purer maybe. Um, the dizziness even is good. Translated as good, in control, you know, I'm on the right path (laughing).
	6	[My stomach] just like really round and protruded but like out of place. Like not meant to be there sort of thing.
	7	I'll see my thighs and I'll go into that bubble world feeling because I'll only look at them instead of the whole body as a picture, and they'll be quite big.
	8	…something like from the past I've been thinking about a lot and I'm really stuck in my own head. And then it's almost like it numbs all the hunger and you don't feel it.
	9	… it sometimes just feels like oh it's all in my head, and because I'm very detached I think from my body and its kind of needs and things,

		it's almost sort of forgot – 'oh yes that, you know'.
Subjugating body	1	you don't even get hungry because your body sort of realises it's not going to get food so it stops asking
	2	I like to eat in a like logical way rather than a feeling way so I eat because I've decided to eat -- not because I'm hungry
	3	I just almost wanted everything to be as .. blank as possible and a lot of it was almost a challenge to myself really how much I would kick the shit out of my body really to lose weight and think like that. But I did, I enjoyed it very much.
	4	…because there were no cushions so you can feel the bones were actually there. So the physical feeling as well as just the seeing because as I said you can't always trust the image.
	5	I do sometimes think of wanting to cut off everything, you know, cut off all the fat. It's very violent but it just feels so unbearable. It feels like that.
	7	it's drawing a focus .. to one thing that's imperfect .. um … and there's a need to take control of it and prove that you can make it what you want it to be, which is less, always less.
	8	I'd almost imagine it going into my body and then whatever area I was feeling self conscious about it would just stick right on there. And then I'd have to go to the gym and I'd have to work it off and I'd have to work so hard until I felt like that particular bit of fat in my body had been worked off.
	9	I was diagnosed with osteoporosis, which was

		quite a big sort of shock because I think I'd forgotten, oh gosh like there really are long term consequences
The reflective self	1	Yeah…you're now making me think that there's a possibility that comfortable feelings exist, and that concept just is brand new because I don't understand that at all. That's never even crossed my mind
	4	I can now dissociate myself from the anorexic thoughts so I can give a clear picture of what I'm thinking anorexically and what I know is real as well
	5	Sometimes I will catch a glimpse of myself um and think .. that person isn't overweight actually. You know she doesn't actually look very well, you know.
	7	I'm aware that I'm ugly to guys and I look like a pre-pubescent boy. Um, I'm aware it's unattractive, I don't like it, I hate it, actually I hate it, I think it's disgusting. I'd do anything to be beautiful and feminine, but at the same time when I get that big feeling I can't cope with it, so it has to be less.
	8	And that was something that made me go, woah I remembered what I used to be like and how I was now and I was like, this is just not good…
	9	It [Recovery] does still feel yeah like this kind of grey mist but very much something I was sort of walking through and trying to find what was underneath so that I've got things that I can use um so that I'm not drawn back to, back to the cloak I think.
Relating imagery to previous experience	1	It's just basically not an image I've made up, like for the one in front of the mirror it's an image I've seen, it was an exact day I saw myself in the mirror and that's the image, and the image of

	me like eating is from an exact day when I was having to force myself to eat. So basically what I'm trying to say is they're not made up images, I know the exact day that that image is from.
2	It's because when I was, because I got fat and when I was bigger I remember thinking I looked really like doughy. Like particularly here, my chest was like…like I put on this dress and I was like, "I look like dough." it was really…Yeah, it's that like soft, it's like a tactile, yeah. It's something to do with soft things.
3	My dad was overweight, very overweight but probably not obese. And since I was a child I have been petrified of ending up like him.
4	Sometimes you do see like, when you eat, if you, you just see an image of yourself about 10 kilos heavier let's say. So a bigger version of yourself. That depends on your mood as well if it's something you're comfortable, not comfortable.
5	I think it, it is something else you're seeing because it varies what you see you know. So you can look in one time and see something completely different from another time.
8	So if I see something like tomatoes or even like apples then I guess I immediately go, and I have visions like white like acid basically and I see myself in pain. So I avoid it. So I guess that's a kind of imagery as well.
9	I do remember when um when me and my sister were younger, I do remember we had a dressing up box and I do remember being very into the cloaks and that because I think we were into dressing up as princesses or something like that and I do remember my mum used to buy a lot of like these big pieces of fabrics and I do

		remember kind of running around the house with these kinds of cloaks on and I think I actually had a, I think it was a Snow White dress actually that someone had made me and that had I think like a cloak and I liked the dressing up and things. So I suppose if I think about it, yeah the cloak sort of perhaps goes back to that and I guess I think of childhood as quite a safe time and you know obviously it's a playful time.

2. Experience of Exposure versus Protection

Superordinate Theme	Int	Quotations within Interviews
Body as Threat	1	I've made that connection and got that image of me in front of the mirror looking fat and decided that I don't want to look like that and I'll look even fatter so don't eat it.
	2	You don't eat the fat though on the meat though, you just like want the meat bit, it's that same image of like there being like an extra, like a gross bit you want to get rid of…
	3	Images probably like looking at those pictures of those like super obese people that you see, like the ones that get broke out their houses. Like those kind of images in my head. Or sometimes just very, very large people and um ……
	4	I picture someone in my family who's quite big. So you just picture them. And then you think that could be you. So because I think, you just associate with a fat person that you can picture them in that situation going back for more and more and more.
	5	I think it's a kind of self hatred which is, is then directed at the, the body. So something in a

		sense. So it's just a feeling of, of being really big.
	7	I look down at my thighs and they just, they just, it's like warped, like when you look through a magnifying glass or a bubble I guess is the right thing to use. You look through a bubble or a vase and it's bigger when you look through that way. It's like that and everything looks bigger, and it's like wooaah.
Exposure and Shame	1	I've made that connection and got that image of me in front of the mirror looking fat and decided that I don't want to look like that and I'll look even fatter so don't eat it.
	2	I put on this dress and I was like, "I look like dough." it was really…Yeah, it's that like soft, it's like a tactile, yeah. It's something to do with soft things.
	3	I feel quite often literally I suppose like … I'd do anything in the world to crawl out of my skin. I don't know if this is answering your question properly, but I can't stand to be in my body as it is sort of that much kind of thing.
	4	So the image is, you'll see an image of yourself going back for more. So you just see it like, er, not a hungry but yeah you feel like you also have a greedy image of yourself.
	5	I can't be objective when I do look in the mirror now, I do see that I have to remove fat from certain places. [] I think that people will look at me and think, God look how fat her stomach is, or her bum you know.
	6	Thinking about my tummy, it felt like a balloon. That's the image I had about it.
	7	I'm disgusted by it and how unattractive it is and how, and I'm embarrassed and I'm ashamed it and I want to cover up from other people

		because I'm so embarrassed by being so little and I'm so scared of people's comments and I'm scared about people seeing it.
	8	I'd become very very conscious of everyone around me and what they were thinking, so because I was small and people used to look at me a lot in the street and I thought they were looking at me because I was really fat, but it was the opposite.
	9	I'm almost worried about looking and thinking about my shape in case I don't like what I see because I feel that would be very difficult to see and that would be like a concrete thing and then that would be something I'd feel I have to do something about.
Punishment and recriminations	1	It was such a hard process to try and make yourself eat and all those horrible feelings of putting the food in your mouth and then worrying about it afterwards, instead of going through all those things just don't eat, then you don't have that.
	2	I would just feel really guilty about it, so I worry that I'll eat something and then regret it and be upset about having eaten it because that's kind of the worst feeling…
	3	I know it's oh but maybe that's how I have to be. If I need to lose weight then I need to not have any of these things in my diet and blah blah blah because I'm such a fat cunting freak, I'm sorry to use that word, sorry.
	4	So you can experience life and have life and then when it starts to feel threatened, oh look she's getting on with her life, oh she's put on weight, it comes back. And then that's why as soon as you see the number increase on the scale that's when all the, that's why you see yourself grow

		because the anorexia has opened that door again, so it's talking to you.
	5	It goes wild in using very extreme language. Um .. and it doesn't even need to use the extreme language because it's such a powerful um image that it just needs to be more visible and say something and it just feels massive and crushing you know.
	6	Just being able to kind of release the feeling of being so full and that you're kind of stretched so much. Kind of instant regret of what I've done like.
	7	I guess it's a mental overwhelming which projects to being physical and you project the mental overwhelmingness into being physical, so when I can't cope with the fact that my head's screaming at me saying how disgusting I am for having eaten and saying how fat I am, um it's almost inflicted onto my body into the literal feeling of being full and my stomach hurting and feeling like it's going to explode.
	8	I'd almost imagine it going into my body and then whatever area I was feeling self conscious about it would just stick right on there. And then I'd have to go to the gym and I'd have to work it off and I'd have to work so hard until I felt like that particular bit of fat in my body had been worked off.
	9	There's always a fear of how I'll feel after I've had the food so I think just before I eat there's a kind of .. yeah I think a sort of definitely a kind of almost red flag I think kind of comes to mind I think in terms of you know is this the right thing to do.
	10	I tell myself I shouldn't have eaten it. It wasn't worth it.

Security and Safety	1	I think that it's like a comfort, because it is always there, it's like if everything else in the world might not always be there but you can always not eat.
	2	but if food is say like a salad where all the different parts are kind of visible and more tangible that's kind of obviously better because there's more, I guess more control over it, you know what's there so that's like a bit more comforting.
	4	No matter how much you hate the person [anorexia], it's still the one and only person you have. But when it's open [door to anorexia], closed I mean it's just you on your own facing that big wide world. You have to find another friend, you have to find, you have to get on with life. But when it's open, you're just like you and your anorexia type thing and zoned out from the world.
	5	The emptiness becomes a kind of safe, in control feeling. On target you know.
	9	I'm aware that the disorder is not something that makes me happy but I think it's something that makes me feel kind of safe and protected and there's always I think the worry about what the alternative is like.

3. Experience of Isolation versus Relatedness

Superordinate Theme	**Int**	**Quotations within Interviews**
Relationship with Self	2	there's a thing covering the structure of the proper anatomy of your body and, well, my body, and you could kind of remove it but obviously that's not what happens because you lose muscle as well so obviously it just gets reduced, it doesn't, there's no way to just like

		skim off the top and like, which is annoying.
	3	It feels a lot like identity theft really, I don't … without actually fitting into the anorexic range and meeting all the criteria I don't feel like me. I don't even feel human really.
	4	The round shape, you're ugly, you're… like, yeah you're uglier, you're fatter. It's everything, you just - the image of yourself completely, like turns to dust and some other horrible, the horrible version who you become - in a sense you picture yourself not uglier but eviler, if that makes sense.
	5	…it's a feeling, it is a sensation of being too much. And whether that's too much me, too much alive, too much .. you know it's too much something. It's not to do with weight and looks and fat, it's not.
	7	I'll never be thin enough because I'd always look down and there'll be something and it'll never be good enough until there's nothing, which is confusing.
	9	I'm trying to make a kind of actively to really try and explore kind of who I am, what I like independently of the disorder so that you know hopefully when the cloak's gone, well that's okay because I know who I am and I've got that anyway. Because I think the disorder makes you forget everything but you know you have the disorder I suppose.
Relationship with anorexia	1	Well its just my own voice but it I suppose just talks quite negatively and things like that… and most of the time it just says like don't do stuff and don't have that or…just says horrible things basically
	2	… I don't imagine it to have a character and I don't imagine it to be a very human…a human

		thing, it's *(pause)* it's more like a restriction it's not, I don't it personified, I don't imagine, I don't know, people kind of…I think some people do see it as like a, a person with a voice but I really, I would have difficulty pinning down an image. I don't really see it as a person, a personified voice, I…it's more like something of yourself, which…like a bad part, a restrictive part but not like a…yeah, not like a person, I don't have an image really.
	3	I know there's a lot of stuff done around you know picturing your anorexia as something outside of you and all that kind of stuff and I've never been able to do that. I can't - I don't have a picture in my head of what it looks like. It doesn't look like anything. It, it's something in me.
	4	I think the voice I now see it as like a little like ghost type thing, like it comes and goes through me. But before it just… and then when you're at your worst it's just you, so you just see it as you and you can't differentiate, you just think, it makes you feel worse about yourself.
	5	Really, it wants to kill you and it would do it, um, you know with a mask on and a smile and, and um convincing you that what you're doing is the right path you know…
	9	I feel that it dominates you so much that you sort of forget most of who you are I think as a person because you're so used to always thinking about things in terms of the disorder. What you like, what's okay for the disorder and things.
Disconnection from others		
	4	Oh my gosh, look at me, I'm becoming a horrible

		person and you just, you already are really quite low and it just brings it lower and you feel worthless because you're like, look I'm not going to have any friends. If I carry on like this everyone's going to hate me more. So this just sort of brings you more down than anything.
	5	I often speak about it, you know the voice this, the voice that. They probably think I'm nuts (laughs). It's a very strong thing.
	6	Just being out of control. Um … and a bit alone.
	7	I'm aware that I'm under weight, I'm aware that bones are sticking out places they shouldn't. I'm aware that I'm ugly to guys and I look like a pre-pubescent boy. Um, I'm aware it's unattractive, I don't like it, I hate it, actually I hate it, I think it's disgusting.
	8	I get more conscious about what other people think of me than, so maybe you could say that I kind of see them talking about me behind my back, but I don't know whether I see that or whether that's something that I just think.
	9	I'm very aware of it kind of being dark and sort of lonely because it does cut you off from other people and other people that don't have the disorder can't really understand it. But at the same time it's something that - I suppose I think of it as a cloak.
Role of others	1	Right now I find it a hard concept to understand that someone has a memory or an image from their own perspective, like from they're own view, because the only things I know is what I see and what I think and that seems to always be like from like a fly-on-the-wall view.
	2	I think what I really wanted was like nutritional help, like someone to actually tell me how to do a diet by not starving myself would have been

		quite helpful.
	3	… I suppose again images of sort of really fat people in my head or …. or thoughts about what other people would say or, or think of me or, what I think of myself kind of thing.
	4	When I was at my worst, everyone was so upset. I couldn't be around people, I didn't have fun with my sister, I thought people were glaring at me…
	5	I'm listening to this thing in my head which is saying, no, no, don't do this, don't do this, which is directly sabotaging my tuition so much that my teacher is saying, look go and get help, sort it out, I'm not going to teach you again you know. This is her making a point, she's a very nice person.
	7	When I was younger, if I wanted to have something else or have seconds or something, oh can I have some more rice or something, she'd say, do you really need that? And do a sort of blowfish face as if to say, warning, careful. And I'd feel bad but I'd sort of say, I don't care I'd have it anyway. But then I started hiding food from her because when I did want something, I felt bad, but I didn't want to show her that I was eating it, so I'd hide it and I started eating sort of frozen foods so that she wouldn't notice they'd gone.
	8	I was worried about how I'd be perceived because like I don't know exactly who in the family knows I've got anorexia and stuff but I know quite a few of them do. And I just feel like I'm being watched and I hate that feeling.
	10	I don't want to let, make my family [upset], or let anyone down. I don't want to ….. like I don't feel like it now, so I don't want to let myself

		down I guess.
Combatting anorexia	1	If I haven't thought of me looking fat in front of the mirror or what the scales say then I would have just carried on eating, but that's the situation where I'm completely blank and there's no connection with anything. They're the only times where I sort of, successfully eat.
	2	Yeah, there's very much like two sides to it, there's the part that says you should always eat less and the part which says well, no because that's a bad idea and you're not supposed to be doing that anymore and that there's no need to do that and you should try and be healthy and let the kind of, let the like healthy part, the logical part and the ill part I suppose…but what is a problem is they don't agree so like often
	4	If I eat the food I can get on with my sister. And then I think that sometimes that confuses the anorexia so there's not that rule book, oh you're going to become fat. You just think, oh I must eat this, make her happy, and then I can be happy with her.
	5	I can see how devious it is. And yet I get seduced by it and allow myself to be seduced by it, probably because I haven't received the, the guidance you know the somebody that can help me fight it more efficiently maybe.
	7	I'll look down and my vision's almost blurred because I'm so angry at myself for having had it and so paranoid and disgusted and so conflicted between my own voice in my head and the anorexic voice in my head and it's like I'm looking from one side of my brain to the other but inwardly trying to argue between the devil and the angel. And so my eyes are literally almost doing that which makes my vision do that which makes me see everything in a

		frustrated blur
	8	I guess when I eat well actually what I'm doing is I'm kind of - because the music's like, it is literally the most important thing to me. So when I don't actually and fuelling myself well, then I do kind of see myself in the future singing on stage and being successful. So yeah, that's, I guess that's imagery as well.
	9	The disorder is not a good thing long term, you need to be able to find a way to be okay without it and I think it does still feel yeah like this kind of grey mist but very much something I was sort of walking through and trying to find what was underneath so that I've got things that I can use um so that I'm not drawn back to, back to the cloak I think.