The Couples' Story: A narrative analysis of couples' presentations of the experience of living with an eating disorder.

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CONTENTS

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Huge thanks to my parents, for your ever-continuing love, help and support of me to follow my passions in life.

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2 DECLARATION

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3 PREFACE

Here I aim to introduce each piece of work within this portfolio, to discuss the reasons behind each piece, and the ideas that link the pieces together.

I have written all the pieces of work at various stages of my doctorate training so they both reflect and have impacted upon my development as a professional; clinically and academically. They reflect different aspects of my professional working and ideas, from across my clinical experience, professional interest and methodological preferences. These are based on my professional and personal philosophies and views on human nature and people.

My portfolio begins with my research thesis – The Couple's Story. This is a narrative analysis of the presentations of the experience of living together while one member of a couple has an eating disorder. Content and performative aspects of the narrators' accounts presented together as couples to me as a researcher are explored. A single person's narrative of a previous relationship with this experience is used as a comparison.

While I believe experience is individual, it is a relational aspect of life and therefore this research looks at how the narrators present themselves, using language, in relation to each other and the relationship in the context of living with an eating disorder. This is in line with the assumptions I hold within a narrative analysis framework, as is discussed in the following paragraphs.

The use of narrative analysis is based on my beliefs about how we organise our experiences and the need for an understanding of the couples' experiences in the way they view them; I believe this to be integral to counselling psychology. As therapy and counselling are based on talking, I feel strongly that there is much to be learned from close attention to language and its uses, both within research academically, and clinically - within counselling psychology and other psychological therapeutic settings. A qualitative approach was thus chosen over a quantitative approach in order to explore language in depth.

The research topic came about by a fusion of my areas of interest - eating disorders and relationships. Eating disorders have a personal as well as professional interest for me, having personally experienced living with an eating disorder, and knowing people close to me who have had the experience, along with my professional experiences clinically. Understanding people's experiences of this has lead me to want to know more about what is available for adults with eating disorders, and how their lives are affected by them. I am also inspired by stories of people managing their eating disorders, or coming to a position where they feel they have recovered. I think it is incredible the strength that people can have, and if I can help to increase understanding in this area, to help improve some peoples' lives, in even a small way, it will be a successful outcome.

I feel strongly about the need to focus on the area of adult eating disorders related to intimacy and relationships. While there is an ever-increasing volume of literature on adult eating

disorders, there is less on this specific area. Such relationships are often overlooked in favour of parental and familial relationships, as most eating disorders begin in adolescence when the family plays a crucial role in the potential maintenance or recovery of an eating disorder. However this growing body of literature on adult eating disorders suggests that relationships that are central to adult life could be as central as these familial and parental roles with earlier eating disorders.

Humans are relational creatures and thus the way that relationships form, continue or dissolve are everyday occurrences, but are complex. From a counselling psychology perspective, couples present often for therapy to help with their relationship difficulties, and individuals and couples present with individual difficulties they are trying to help each other with. Looking at ourselves within adult relationships can help us understand our development, and ourselves. My aim is to explore this within my thesis, with a focus on eating disorders partly as a vehicle for this but also for the reasons set out above. I acknowledge the limitations in terms of the influence this information may have in what is a large world of psychology and therapy, but nevertheless believe that even small amounts of new information can stimulate thought and conversation around familiar areas of work. This is akin to the nature of counselling psychology – to keep an open mind and generate ideas and understanding of peoples' experiences.

Following from my thesis is a client study, focusing on existential issues of being understood - especially in relation to language, and Aspergers' Syndrome. I have included this client study as again it reflects my interest in how people understand themselves and their worlds, the meanings they give to their experiences and how they understand their experiences. The client study is a product of my time spent working in a specialist service for adults with autism, where I have up until now gained most of my clinical experience. This work taught me much about client idiosyncrasies, and how it is of utmost importance to work with the client, being aware of their strengths and difficulties. As a trainee, it was easy to think that to get things 'right' with a client I had to follow the textbooks word for word. However, the writing of this client study was valuable in helping me reflect that this is neither always possible nor helpful for the client. This is demonstrated within the client study and has informed my practice in what I feel to be an invaluable way. I aim with this client study to convey my person-centred framework for working with clients, which forms the basis for all the work I do, and guides my interests and studies.

For me, understanding each person for who they are and how they understand and experience the world is the most crucial aspect of my work, and in writing this client study I was enabled to delve even deeper into this understanding. It seems almost a luxury to have the time to explore in this much depth the work with one client, but I hope to take the learning with me, and delve as deep as possible into the world of each client I work with in order to understand how best to help them achieve their goals. This client study also demonstrates the significance of language, and how for some people it can be something that helps them immeasurably, while at the same time is detrimental for their well being. Again this is linked to people's understanding of

themselves and their worlds, and what they understand the meaning to be of the language they use.

Finally, I present a review of my research as a publishable paper. As I am researching an area I feel is of importance to applied psychology, and the broader fields of eating disorders and relationships, it is important to aim for the research to reach as many people as possible within these fields. Therefore I felt it important to write an article for publication that covers the main aims, findings and discussions from the research. I intend to submit the article to the *European Eating Disorders Review*. This is with the aim of reaching many professionals working within the eating disorders field, to stimulate further thought and research into this area.

The main link present throughout my portfolio is the underlying philosophy of a person-centred approach and the importance of language in understanding people and how they organise their experience.

I approach my work with clients from a person-centred perspective, that is, from the point of view that each person is an individual, with their own values beliefs and experiences that they use to make sense and meaning of their lives. This, coupled with my views on how much of this is created in relationships, has a strong influence in how I have conducted this research. I believe it is important to understand idiosyncratic experiences – this is after all what we work with within therapy – and to try to understand any similarities across peoples' experiences that can potentially help other people experiencing similar situations.

This may sound contradictory but it is intended to illustrate my belief that while meaning is co-created, we all can only live in our own mind and therefore we use what has been co-created to help us know in ourselves what we think and feel. By examining couples' experiences within this research, I am attempting to demonstrate the co-creation of meaning using the individual members' experiences and understanding.

I acknowledge explicitly throughout this research that my own opinions, experiences and understandings will have an impact on discoveries I make within the analysis; this is an integral part of a narrative approach and incorporates my role in the relational meaning making of others' experiences.

I feel that the different elements of my thesis all demonstrate the significance of language in understanding individual experiences and how each person understands them, and want them to be understood by others. The nuances of language help us to see these aspects, if we know what to look for. I have certainly found that conducting this research and compiling this portfolio has heightened my awareness of the subtleties that language can give away, and is a valuable resource for working with clients.

I believe this portfolio demonstrates the necessity within counselling psychology to be flexible, to work in different ways, as each client is different, and each service has different specific requirements that counselling psychologists need to be able to have an awareness of and be able to adapt to. This reflects the many and varied aspects of work for counselling

psychologists, as each client who enters our therapy room is unique with their own story to tell. It is our duty to use skills and techniques we feel will best help us understand their story and achieve their aims for change.

4 ABSTRACT

Aims – To gain insight into the functioning and dynamics of couples living with an eating disorder by exploring their experiences.

Methodology- Narrative analysis is used, focusing on the content and performative elements of the stories of three couples and one single man, regarding being in a relationship and living with an eating disorder.

Findings – Content and performative elements of the narrators' stories are explored in relation to what they suggest about the experience of living with an eating disorder in a relationship.

Discussion –The main findings from the analysis regarding what the narrators tell and how they tell it, what these content and performative elements and what they might imply for counselling psychology are discussed in relation to recovery from eating disorders and relationships functioning, Strengths and limitations of the research along with suggestions for further research are explored.

5 INTRODUCTION

5.1 Overview

This chapter will examine the breadth of literature dedicated to discussing eating disorders, relationships and relational aspects of eating disorders. Such a breadth of information on these topics, but with limited depth of focus on the combination of adult intimate relationships and eating disorders, leads me to think that exploring adult intimate relationships is an important area for research. While I acknowledge eating disorders affect both men and women, I refer throughout this research to women and anorexia, as within the sample of participants for this research the eating disorder sufferers are the women in the relationships, with the eating disorder being anorexia.

The intention of this research is to illuminate couple dynamics relating to eating disorder experiences among couples, to provide further insight for work in this area. This is focused particularly in the field of counselling psychology where adults present for therapy or treatment of eating disorder issues and marital issues.

An exploration of theories relating to the onset, manifestation, maintenance and ceasing of eating disorders, and the relevance of this for counselling psychology begins the chapter. This is followed by a literature review regarding theories of intimate relationships together with the relevance of this area for counselling psychology understanding and practice.

Finally an exploration of literature pertaining to a link in the areas of eating disorders and relationships follows, and conclusions are drawn about gaps in the literature. These relate to couple identity presentation and narrators' joint presentation of the experience of living together as a couple with an eating disorder, which leads into the current study.

5.2 Eating disorders - Anorexia

Anorexia has the highest mortality rate of all psychiatric illnesses (Martin, 2007). Adults with anorexia are often in relationships, and report that their partners are an essential part of their recovery process (Tozzi et al., 2003; Bulik, Baucom Kirby & Pisetsky, 2011). Furthermore, anorexia is associated with considerable and prolonged caregiver stress (Bulik, Baucom & Kirby, 2012). For these reasons I believe anorexia and relationships is an invaluable area to work on and attempt to increase understanding of, and therefore will be focusing on anorexia nervosa throughout this thesis. This is with the acknowledgment of the presence of eating disorders not expanded on here such as bulimia nervosa, binge eating disorder and eating disorder not otherwise specified.

Anorexia Nervosa was first described by Charles Lasègue in France in 1873, and Sir William Gull in the UK in 1874 (Carr & McNulty, 2006). Carr and McNulty state that there has been an increase in eating disorders since the 1960s.

Eating disorders consist of distinctive clinical features of behaviour, cognition, emotion, social adjustment and physical health (Carr & McNulty, 2006), the DSM-IV criteria can be seen in Appendix 1 with further descriptions summarised here. With anorexia, restrictive eating is present, and individuals often and ultimately present as thin or emaciated and in most cases of eating disorders there is present a distorted perception of body image (Carr & McNulty, 2006); usually with the individual believing their body or parts of it are bigger than they physically are. Individuals with eating disorders often have low self-esteem and self-efficacy, and, particularly with anorexia, perceive taking control of their bodies as something they are able to do, and do well and often compounded with perfectionist tendencies (Wilson & Agras, 2001; Collier & Treasure, 2004; Steiger et al., 2004).

Depressed and irritable moods are often present with eating disorder individuals, often linked to failure to achieve a level perceived to be expected. Withdrawal from social relationships is also common, along with impaired performance at school, university or work, due to eating problems. Physical health effects can be serious, and can result in death if the eating disorder continues for any length of time, particularly with vomiting as there is a risk of electrolyte imbalance potentially leading to a fatal arrhythmia (Carr & McNulty 2006).

There is a high correlation between eating disorders and mortality, as Herzog et al. (2000) reported in relation to anorexia. An increased mortality rate amongst individuals with anorexia and bulimia, as written by Crow, Praus and Thuras (1999), is due to physical complications resulting from the eating disorders and suicide (Belangee, 2007; Zerbe, 1995). There are also many long-term physical, psychological and interpersonal issues related to eating disorders (Gordon, 2000; Pipher, 1995).

Anorexia is most common in young female adolescents and young women (Hoeck & Van Hoeken, 2003; Masjun et al., 2003; Palmer, 2000; Van Hoeken et al., 2003). Carr and McNulty (2006) state that the prevalence of anorexia among female adolescents is 0.3%, and there has been an increase in the US and UK of eating disorders since the 1960s. Recent suggestions are that the prevalence of experiencing an eating disorder at some point in one's life is 5%, with causal factors such as genetic (Eley, Collier & McGuffin, 2002) cultural, social and interpersonal elements being attributed to the underpinning of eating disorders (Treasure, Claudino & Zucker, 2010)

It is the aim within this research to expand on the current knowledge with information from couples and with more of a focus on adult relationships. The use of a more subjective analysis method is intended to inform of possibilities and experiences that may exist when a couple is living with an eating disorder. This understanding of subjective experience is a major part of counselling psychology.

5.2.1 Development of eating disorders in particular anorexia

There are cautions against trying to pin down one explanation for eating disorders, as it is often a complex combination of reasons (Zerbe, 1993). Here I explore some of these reasons that are believed to contribute.

Genetic predisposition has been suggested to contribute moderately to the aetiology of eating disorders (Eley, Collier & McGuffin, 2002), especially to temperamental disposition, which underpins personality traits associated with eating disorders - such as depression, perfectionism and harm avoidance. Some individuals with such a biological base may be in environmental situations that contribute to the development of eating disorders (Collier & Treasure, 2004).

With regard to personality traits, perfectionism is often associated as a risk factor for anorexia and bulimia (Bastiani, Rao, Weltzin & Kaye, 1995; Srinivasagam et al., 1995; Fairburn et al., 1998; Kaye et al., 1998; Fairburn, Cooper, Doll & Welch, 1999; Lilenfield et al., 1999; Tyrka, Waldron, Graber & Brooks-Gunn, 1999; Halmi et al., 2000; Pratt, Telch, Labouvie).

Perfectionism has been shown to continue to exist in individuals following recovery from anorexia, and is found in relatives of individuals with eating disorders (Woodside et al., 2003; Lilenfield et al., 2000). Self-oriented perfectionism - critical self-scrutiny, unrealistic self-imposed standards, and requiring perfection of oneself (Flett and Hewitt, 1991) – is more specific to eating disorders than other psychiatric disorders such as anxiety and depression, which tend to have a higher rate of socially-prescribed perfectionism (Castro-Fornieles et al., 2007). Anorexic individuals tend to see their perfectionism as self-imposed rather than imposed by others, and are more concerned over mistakes than people with other psychiatric disorders (Bastiani et al., 2005; Bulik et al., 2003).

Looking from a psychodynamic perspective at females with anorexia, parental influence is considered to have a strong effect through over-involvement. This is understood as a daughter trying to assert her independence from her mother, showing she does not need her to nurture her any more (Zerbe, 1993). These ideas are linked to Bowlby's theories of attachment (1969, 1973).

The development of eating disorders is often seen as a reaction to psycho-sexual maturity, linked to the stressors involved with sexual maturity, and fears of separation and individuation (Woodside et al., 1993; Crisp et al., 1977; Crisp, 1980). This is especially the case with anorexia, (Beaumont et al., 1981). Other results such as those of Hsu, Crisp and Hardy (1979) and Heavey et al. (1989) found that anorexic individuals avoided sex, thus demonstrating a discrepancy among findings, although the common theme is that there are sexual issues strongly related to eating disorders.

Cultural and social influences can exacerbate the effect of these issues with some people, and if an individual has not had sufficient psychological nurturing during early development there is a likelihood their self-esteem will be less robust than it could be, adding to the development of

eating disorders. There is also the suggestion that eating disorders can be a result of the complex struggle of adolescent daughters to become autonomous yet still being mothered, (Zerbe, 1993). Some authors suggest that daughters unconsciously feel the resentment their mothers in turn feel for the sacrifices made to care for them. The daughter then feels as though she ought to be living up to her mothers' expectations, and with this potentially being overwhelming, food is the direction in which some will turn (Chernin, 1986).

The media is another area that has been suggested as playing a part in the development of eating disorders, particularly among women (Smith, 2000; Strong, 2001; and Fister & Smith, 2004). It is easy to understand why, as media is a large part of current life, and there are many images of flawless-faced and impossibly thin women and models on billboards, in the pages of magazines, in television adverts and in films, with products seemingly promising women will look that way if they buy and use that product. Also supporting this suggestion of mass media influence being a variable risk factor for eating disorders is young women's self-reports of being influenced by film and television celebrities and the endorsement of fashion magazine models (Levine and Murmen, 2009). This is further evidenced by a significantly greater dissatisfaction with body image of girls who watch more than eight hours of television a week compared to those with less television viewing (Thompson & Heidberg, 1999; Garner, 1997; Gonzalez-Lavin & Smolak, 1995). It appears that there is a tendency among females to internalise the messages from the media regarding what is attractive. As these images are often highly processed and altered - and therefore unobtainable - it can lead to the development of negative body image or disordered eating behaviour (Thompson & Heidberg, 1999).

A history of sexual or physical abuse has also been found to be associated with a high number of individuals with eating disorders (Woodside, Shekter-Wolfson, Brandes and Lackstrom, 1993). Behaviours such as binging, purging and self-starvation can occur as expressions of defence mechanisms such as denial, dissociation and self-hypnosis in reaction to prolonged trauma (Zerbe, 1993).

In a similar vein, affect, cognition and behaviour effects are found to be very similar in women with eating disorders as with women who have been victimised (Root, Fallon & Freidrick, 1986; Root & Fallon, 1988). There is suggestion that following abuse, women are likely to have low self-esteem and high self-consciousness about their body (Beckamn & Burns, 1991; Waller, 1991). Therefore eating disorders can emerge as a way to 'de-sexualise' one's body (Crisp, 1980; Sloan & Leichner, 1986; Goldfarb, 1987; Hall, 1989; Hall et al., 1989; Waller, 1991). There are findings to suggest that the rate of incest among eating disordered females is alarmingly high (Hall et al., 1989; Beckman & Burns, 1990; Woodside et al., 1993).

Life stresses have been suggested as another factor contributing to the development of eating disorders, as a way of coping with them (Carr and McNulty, 2006). This is important in looking at adult relationships, as there are many life stresses such as marriage, pregnancy and birth – eating disorder symptoms at conception have been reported to worsen during pregnancy in

some individuals (Stewart et al., 1987) - house buying and moving, job changes and so on, that could contribute to both onset and course of an eating disorder.

This summary of literature and theories on eating disorders in particular anorexia leaves a question of how much the interpersonal aspect has been explored in research, in particular with adult romantic relationships.

5.2.2 Relevance for counselling psychology

Within the field of counselling psychology, and more broadly counselling, psychotherapy and psychology, there are many organisations, treatment centres and academic and research journals based solely on working with individuals with eating disorders. This suggests it is important to have a good and up to date understanding of the area of eating disorders. An understanding of the effects an individual's environment, social network and support can have on the eating disorder, and vice versa, is essential. This is especially the case as within counselling psychology there is awareness of how important an understanding of an individual's world is to understand the context of their difficulties. With more understanding can potentially come even more effective treatment and support for individuals and those who may be caring for them. There is the potential that findings from this research could be used to inform couples' therapists working with eating disorders. To this end the information regarding how individuals in a couple position themselves in relation to each other and the eating disorder could provide insight.

5.3 Relationships

5.3.1 Background of relationships

I will be referring to intimate relationships throughout this research as relationships, intimate relationships, or marriages. These terms relate to adult one-to-one and heterosexual relationships as this is representative of the narrators who came forward to be involved in this research.

As far back as the twelfth century marriage was arranged politically between noble persons, and if they liked each other this was considered a bonus (Duck, 1992). Indeed, in some cultures presently there are still arranged marriages, mainly for religious and traditional reasons but in the West love is a prevalent and oft-cited reason for getting married (Acitelli, Duck & West, 2000).Therefore an understanding of love and the fact that it can be experienced through different mediums within marriage (through labels, physiological arousal, behaviour towards each other, and non-verbal communication) is essential in this exploration of couples' experiences of their relationship, where there is the presence of an eating disorder. This calls for an understanding of some of the theories about love and marriage.

There have over time been many attempts to categorise or label love, such as the six types of love found by Marston, Hecht and Roberts (1987): *collaborative love* - supportiveness, *active*

love – joint activities and erratic rhythms such as changes to the pace of daily routines, *intuitive love* –ability to non-verbally communicate feelings to each other, *committed love* – togetherness, *traditional romantic lov*e – future commitment to each other and the relationship and feeling good within the relationship, and *expressive love* – telling the other person about one's feelings.

Other labelling of love includes Lee's (1973) proposed six types of love: *Eros* (romantic love) – focusing on beauty and physical attractiveness consisting of a sensual love that is expected to be returned by the partner; *Ludus* (game playing love) – love is seen as flirty and fun, not to be taken seriously. *Storge* (friendship love) – based on caring about the partner or each other rather than passion; *Pragma* (logical love) – based on practicality and the appropriateness of a partner for future plans, and is relatively unromantic; *Mania* (possessive, dependent love) – uncertainty, anxiety, obsessiveness and possessiveness, with partners fearing they may be thrown aside at any moment; and *Agape* (all-giving, selfless love) – compassion and unconditional love are paramount here, with men being more likely to have attitudes akin to Eros and Ludos, and women to Pragma, Storge or Mania (Hendrick, Hendrick, Foote & Slapion-Foote, 1984).

Recognising these types of love within the stories that couples tell me for this research will add to understanding of the relational aspects of their experience with an eating disorder. This is especially relevant to the suggestion that individuals who love in a Mania sense are more likely to resort to some kind of illness in order to retain their partner (Lee, 1973), and so could have links to the presence of an eating disorder within relationships.

However, in line with the ethos of counselling psychology, I am exploring narrators' experiences, rather than my opinion of how well their relationship appears to fit such labels, and am therefore interested in Duck's (1992) ideas that there are different ways of experiencing love, rather than there being differing types of love.

This could be understood from a narrative perspective, as Billig (1996) suggests we express our attitudes in certain ways depending on who we are addressing, and so it could be that the way we describe our experience of love is context dependent, and equally as dependent on how we have learned to talk about it. This poses an interesting idea for this research, looking at how a couple together may be expressing their joint experience and understanding of love within a specific context.

Within the narratives presented by the participants of this research of their experience as a couple living with an eating disorder, it is thought that the functions served by the relationship will come to light, to enable further understanding of such issues. Some such functions have been suggested by Howitt et al., (1989) as *security* - knowing that we have someone we can turn to and so make us more confident about exploring new situations, and helps us remember that people care for us; *self- worth* - it becomes easier to accept ourselves knowing that someone loves us no matter what; *expressing feelings* - having someone with whom we can discuss how we feel makes us feel comforted; *social comparison* - we can compare our

situation with those who care about us to make decision making processes easier; *advice elicitation* - those who are close to us can provide advice and practical help, as well as inspiration; and *well-being* - being with people we care about and who care about us can increase our sense of well-being, and having a good time can help us feel better or distract us from difficulties. Remaining open to the potential presence of these functions within the narratives is important in this research, along with looking for how couples talk of these functions.

5.3.2 Attraction and togetherness

It is interesting within the context of this research to think about what brings people together and what maintains this togetherness as a couple.

Individuals in couples relate to each other in different ways at different times. Berne (1964) describes three ego states in his transactional analysis description of relationships:

- *parent* - individuals taking on the parental, authoritative role in the relationship;
- *adult* - individuals taking on an objective position, forming judgements not unduly based on prejudices; and
- *child* - individual relating as a child might.

Berne's suggestion is that couples engage in roles that are complementary when they are operating what he terms 'complementary transaction', such as one taking on the adult role when the other is in child mode and requiring comfort. This leads me to want to explore ‘games’ that maybe being played within couples – where there are hidden elements to what is being said -, and to see how this interaction both affects and is affected by eating disorder behaviour.

Berne’s theory recognises the active role people play in the roles they assume (Howit et al., 1989) – fitting in with the person centred philosophy, and this active role overlaps into the narrative element in terms of what they tell and to whom. I am interested to see if what Berne terms 'crossed transactions' are present for the couples, where the role being taken on by one partner is not what the other is in need of, which can lead to difficulties within the relationship.

Berne’s theory gives understanding of the two-way process within relationships, i.e. what people put in and what they take out, and how these can work together, and is a main part of whether or not people stay in a relationship. The success of that relationship can depend on what individuals feel they need from a relationship and what they are getting from it - which can change over time - and what is reinforcing their desire to be in the relationship or with that particular partner.

The idea of reinforcement was explored in terms of relationships by Byrne (1972) and Clore and Byrne (1974), with the 'reinforcement-affect' model; based on Festinger's (1954) theories about social comparison processes. Underlying this is the theory of our need to compare ourselves with others, in order to create socially compatible impressions of ourselves, i.e. how

we think others want us to be and how we portray this in order to ‘fit in’ where we want to. Therefore we are attracted to others who reinforce who we are and validate us for who we are, linking with Newcomb's (1961) ideas about 'interpersonal balance theory'.

Newcomb states we are attracted to others who share similar opinions to us, or shift our thinking to be more in line with those around us. In terms of relationships with eating disorders this idea could suggest individuals with eating disorders are attracted to people who reinforce the idea that their behaviours are valid and socially compatible. As psychological survival is an important aspect within this theory it will be interesting to explore if there are demonstrations of the women wanting their partners to validate them as they are or help them create a more ‘socially acceptable’ version of themselves.

An alternative theory about relationships is the interdependence theory, described by Howitt et al. (1989) which suggests partners gain something from each other - 'rewards'. The idea is that the more an individual gains from their partner, the more attracted they are to them, although this does suggest an element of dependence. This could be viewed as a behaviourist theory; however this can be countered by the active role individuals are viewed as taking in reviewing their relationship progress at different stages, with each one determining the subsequent stage. As Thibaut & Kelly, (1959) suggest, this ensures they are maximising their outcomes at each stage.

I am lead therefore to wondering about the gains received within a relationship with an eating disorder present, due to the large presence of the eating disorder. What is each partner gaining from each other and how does this impact on the eating disorder? How does the extent of the eating disorder impact on these gains or needs from each other? I aim to explore some of these within the analysis.

It would therefore be of value, I believe, to explore if the reinforcement-affect model (Byrne, 1972 and Clore & Byrne, 1974) or the interdependence theory (Howitt et al., 1989) appears in the narratives of the individuals within this research.

5.3.3 Maintenance of relationships and relationship satisfaction

As social chameleons, we express ourselves differently in different contexts, dependent on to whom we are talking, and others' expectations and understandings of our relationships can shape our own expectations of relationships and partners (Duck, 1991). This can lead to marital distress, depression and illness if we are not able to live up to these expectations and socially constructed ideas of how our relationship should be. This can also lead to demands being placed on us to provide help, comfort and resources to others (Schwarzer & Leppin, 1991).

There is then a question in terms of when illness or difficulty occurs for a member of a couple, and what the other partner feels obliged to do for their partner, due to their own assumptions of what one should do and what the expectations are from their partner and others around them. Friendship and kin oblige us to be available to others when they are in times of difficulty, such

as illness and stress (Wiseman, 1986). The pressure that one partner feels under to help the other partner, and how much help they give as a result, could be an interesting area to explore in my research, especially in relation to an eating disorder. Reasons for helping may be because they want to, because they care about that person or because of socially constructed ideas about what they should be doing in those circumstances.

Continuing with the idea of social constructionism it is interesting to observe how these expectations, demands or wants are explained by couples within this context. There is the possibility that some of these may be implicit and therefore not recognised or acted upon, or that not everyone is able to produce the resources that may be necessary to help another when it is needed (Burleson, 1990), and that this could lead to that person feeling inadequate because they have been unable to do so (Barbee, 1990).

Care-giver burnout – when a person is trying so hard to provide what another needs, what they think another needs, or what they want to provide, causing the care-giver to run out of energy in doing so (Miller, Stiff & Ellis, 1988) – could occur in a relationship where an eating disorder is present. I am intrigued to explore the potential of this within my research and if there is an impact of social expectation involved.

There are suggestions that discrepancies of interpretation are an inevitable part of everyday life (Duck, 1992; McCarthy, 1983), that partners will not always agree on how they interpret situations, or maybe even their relationship as a whole. It is likely then that partners will probably see different events in their relationship as crucial, which leads to assumptions that it is inevitable that partners will not agree on everything about the relationship's nature or course. There could also be discrepancies in how partners explain events and situations to others, due to similar reasons of interpretation, and I hope to observe if this occurs within the context of my research.

It is rare that people discuss their views on their relationships openly or explicitly with their partner unless they think there is something wrong (Baxter & Wilmott, 1984), which could lead to skewed assumptions. Socially constructed ideas of how relationships ought to function may play a part in this, and there is a potential for depression anxiety or low self-worth to be present in such situations (Cramer, 1985, 1988) and I will be interested to see if any of this is presented within the narratives.

5.3.4 Communication within relationships

Conversation in everyday life is an important tool for developing and sustaining relationships (Duck, 1992) suggesting that talking openly allows room for discussing thoughts and feelings about the relationship. This enables individuals to clarify interpretations of situations, behaviour and actions, and to be more certain about what partners expect from each other. Individual assumptions of how a relationship ought to function may have an impact on the occurrence of such conversations.

Conflict is an inevitable part of couple relationships, manifesting itself as disagreements, incompatibilities and differences in viewpoints (Eğeci & Gençöz, 2006). Evidence shows that as conflict increases it can become a negative and destructive part of relationships, with unresolved conflicts being associated with the instability of a relationship (Cahn, 1992; Berndt & Keefe, 1992).

There is another view, that conflict can be positive and lead to personal and relational growth (Schaeffer & Rollins, 2001), with an argument that couples could feel closer if they feel they are able to resolve a conflict between them and therefore achieve mutual understanding (Rands, Levinger & Mellinger, 1981).

Rather than the presence or not of conflict being indicative of relationships success, it is suggested that how conflict is handled reflects relationship functioning (Shantz & Hartup, 1992). Importance is placed on individuals' appraisals of their problem solving skills and resources, with an individual's opinion of their skills in managing conflict playing an important role in how they respond to conflict, and therefore the efficacy of those responses in managing the conflict and overall relationship satisfaction (Heppner and Lee, 2002).

Inadequate communication skills - such as when mutual communication cannot be achieved, due to alterations that occur to the message during the process of the information transferring from one individual to the other - lead to poor conflict resolution within relationships (Harary & Bell, 1981; Bradbury & Karney, 1993).

As these communication problems continue, the couples' ability to resolve conflicts decreases, leading to a decrease in relationship satisfaction (Bradbury, Cohan & Karney, 1998; Gottman, 1994; Keicolt-Glaser & Newton, 2001), presenting the argument that communication skills are a crucial factor for relationship satisfaction. Individuals' perceptions of their communication within their relationship has been taken into account by Eğeci & Gençöz (2006), who demonstrate that confidence in problem solving skills are significantly associated with relationship satisfaction. The authors also found communication skills to be an important associate of the relationship satisfaction, with increased level of negative communication impairing couples' abilities to handle conflicts, in turn affecting the relationship satisfaction.

Attachment schemas are also suggested to be of importance in conflict situations, as this is where they tend to be activated (Kobak & Duelmer, 1994), due to the beliefs individuals hold about themselves and their abilities in such situations. This suggests that having a secure attachment style is important for relationship satisfaction. A suggestion for further work focusing on both partners, and with non-student adult couples rather than a limited student population would be useful to generate further understanding of the interactional pattern of conflicts is presented (Kobak & Duelmer, 1994), providing support for the research I am carrying out here.

A pattern of demand/withdraw has been suggested as being the most important marital interaction (Bradbury, Fincham & Beach, 2000), where typically the wife demands change and emotional closeness, and the husband avoids or disengages from this process. The husband's

level of withdrawal is positively correlated with the wife's level of demand (Heavey, Christensen & Malamuth, 1995; Klinetob & Smith 1996).

This is linked to work by authors such as Belsky & Kelly (1994) suggesting such a pattern is negatively related to marital satisfaction at early middle and late stages of relationships. This could suggest that the more a husband withdraws or disengages from a wife's demands for change or emotional closeness, the more the wife demands, and the more elaborate her behaviours are in demanding this from her husband. This could be linked to behaviours such as those related to eating disorders, if an individual is sensitive to eating disorder behaviour, this could become her way of demanding the closeness she requires from her husband.

5.3.5 Individual and couple identities

Dym & Glenn (1993) discuss their theory of the three-phase cycle that couples go through, and do this in the context of these phases being made up of, and influenced by, the individual and couple narratives and identity that are brought into the relationship. These three stages are:

- *Expansion* – when both individuals are enthusiastic, becoming more focused on the 'self' than they have been before, being the best they can be for themselves and their partner. Linked to this, individuals like everything about themselves and their partner.
- *Contraction* – issues that are not satisfactory within the relationship for one or both people come to the fore, resulting in disagreements, arguments and withdrawing behaviour. This leads to a possible result of each individual's behaviour exacerbating that of the other, possibly leading them to behaving in a way opposite to how they want.
- *Resolution* – where things work out, either by the couple reaching a compromise, or agreement, finding a way to work together and, resultantly, feeling close again.

Dym & Glenn believe all couples go through these cycles, and they can be mini cycles, as short as a few hours, but others can last for years in one phase. They believe that couples find a 'home base', in one of the three stages of the cycle. The relationship remains in this stage for most of the time; the couple tend to start and end their cycles from that stage.

It is suggested that most couples begin in expansion, eventually working through the cycle before finding their home base. It is usually when couples find they cannot get out of the contraction stage that they break up. This idea unifies the couple, almost like a team working together, but with individual elements.

The disagreements that can arise could be as a result of narratives the individuals have about their life, relationships, and their role within a relationship, for example. These individual narratives can then affect how they feel about the relationship and their role within it, and are weaved into the couple and its identity - from this decisions are made as to whether or not an individual is willing to make changes to themselves for the health of the relationship and the

couple. During expansion, individuals will set out what they want from the relationship, although this may be subtle and not necessarily conscious. External issues such as illness are seen as crises that may throw the couple into disarray, and could move the couple into a different phase.

This is thought provoking in terms of this research, as eating disorders could be seen as crises, and I am curious to explore this further with my data. However it is not made clear how the conclusions were drawn, although it gives a useful form to potential patterns of relating.

Van den Broucke et al. (1995a) have proposed a model of marital intimacy, based on existing social psychological views regarding intimacy. They suggest components of marital intimacy as distinguished in three levels:

- *Dyadic level* – intimacy refers here to the affective, cognitive and behavioural interdependence between partners, as reflected in their emotional closeness, validation of each other's' ideas and consensus – implicit or explicit – of rules which guide their interactions;
- *Individual level* – authenticity, the ability to 'be oneself' and openness, the readiness to share ideas and feelings with the partner;
- *Social group or network level* – an aspect of dyadic identity or exclusiveness that is related to long-term commitment. This is revealed by private expressions, and use of 'we' or 'us'.

This third level of social groups or networks is of particular interest to me exploring within this research how this dyadic identity is presented. Particularly as the authors suggest it could provide useful in studying intimacy in marital relationships with eating disorders, reflecting as it does other models of marital intimacy such as L'Abate (1986).

5.3.6 Attachment

Attachment refers to a lifelong, organic behavioural system that accounts for bonding, security, affect and behaviour in emotionally important relationships (Bowlby, 1988, Mikulincer & Shaver 2003, 2007). According to Bowlby (1979) the *"formation of a bond is described as falling in love, maintaining a bond as loving someone"*, and *"no form of behaviour is accompanied by stronger feeling than is attachment behaviour"* (Bowlby 1969, p. 209).

In love relationships, partners share care-giving and attachment bonds which manifest as goal-corrected partnerships, whereby partners coordinate and adjust behaviour to achieve motivational goals (Bowlby, 1969, 1988; Kunce & Shaver, 1994). When one partner exhibits attachment cues, the other partner is motivated to provide care-giving functions, accompanied by strong emotion, which constitute accessibility to the partner, and culminate in the partner's felt security.

Adult attachment provides a template-like schema or working model that is usually linked to childhood history, with secure attachment being associated with more effective relational

behaviour, such as communication (Mikulincer et al. 2002; Mikulincer & Shaver, 2007), conflict resolution and relationship satisfaction (Feeney, 1999; Cocoran & Malilinckrodt, 2000; Shi, 2003). As understanding of attachment is so crucial to understanding relationships, it is an area of literature that is essential to be considered throughout this research process.

5.3.7 Effects of attachment on adult relationships

Individual differences as to anxious or avoidant attachment can be an indication as to how much a person may worry about the availability of their partner, or that they may be unresponsive in times of need. An individual's position on the avoidant dimension indicates the extent to which they will distrust their partner's good will, leading to them attempting to maintain behavioural independence and emotional distance from their partner (Brennan, Clark & Shaver, 1998; Collins & Read, 1990; Feeney & Noller, 1990; Simpson 1990).

Avoidant attachment is also associated with intimacy aversion, (Doi & Thelen, 1993), distancing relationship partners from the 'core self' (Rowe & Carnely, 2005). Such individuals express discomfort when another moves into their personal space (Kaitz, Bar-Hain, Lehrer & Grossman, 2004). These findings suggest that difficulties could be encountered in the establishment and maintenance of relationships.

Attachment anxious individuals are ambivalent in their relational tendencies, they wish to be close to their partner, but at the same time are anxious of rejection. These individuals also have strong motivational ambivalence regarding closeness, which was found to be intensified in relational contexts that encouraged either approach or avoid tendencies towards their partner (Mikulincer, Shaver, Ein-DOr & Bar-On, 2010). Mikulincer & Shaver (2003) also suggest that individuals who are avoidantly attached manage attachment affect by defensively suppressing the attachment system, whereas those who are anxiously attached have a continuously active attachment system and almost constantly monitor and seek their partner's accessibility. If one partner is frequently rejecting, unresponsive or unavailable in times of need, this leads to attachment security being undermined, creating doubts of their availability for the other partner, and of the other partner's own lovability and value (Main, 1990).

5.3.8 Mental health issues within relationships

Management of mental health issues within relationships is fascinating, as relationships are complex to begin with - a reason for exploring couples' experiences of their relationship with an eating disorder present.

Research in this area generally suggests mental health issues and relationships can affect each other in many ways, such as high marital quality (self-reported) being significantly associated with lower stress and lower depression. High marital quality groups exhibit lower blood pressure than single or low marital quality comparison groups (Holt-Lunstad, Birmingham & Jones, 2008).

Depression and perceived marital quality was also explored, over 14 years, finding a strong bi-directional correlation between the two, suggesting that poor quality relationships can lead to or maintain depression, and that being depressed can lead to or maintain poor quality relationships. I wonder, then, if such an association is present with eating disorders, due to the links between depression and eating disorders (Woodside, Shekter-Wolfson, Brandes & Lackstrom, 1993).

I have discussed here that poor quality and good quality relationships have affects on mental health and vice versa, but what constitutes a good quality relationship? This may be something that is too subjective to have a general answer to, but there is some research that suggests aspects of relating which, if present, could have a positive effect on the experience of the relationship. For example, Cramer (1987) found a significant relationship between female self-esteem and relational qualities of empathy, congruence and unconditional positive regard with their closest friend. As these qualities are what Rogers (1957) posits as facilitative for close relationships, it suggests they are conducive to a positive relationship. Although Cramer's research was looking at friendships, it gives an insight into potential qualities that are helpful in relationships, and social support affecting individual mental health.

I am interested to understand if these aspects are also part of good quality marital relationships, as suggested by Larned (2007) who found that expressed and perceived empathy were directly associated with marital satisfaction. This leads to questions of how these effects may affect or be affected by mental health issues, especially in relationships, as there appears to be an entwining of relational aspects, mental health issues and relationship satisfaction.

5.3.9 Relevance of marital issues for counselling psychology

Psychotherapy has been applied to work with couples for many decades (Gurman & Jacobson, 1986) with new ideas constantly being evolved. As humans we are social and relational creatures; our issues, difficulties and recoveries are based within this context. It is therefore an important field for counselling psychology, either in relation to working directly with couples in marital or couple therapy, or simply to understanding the wider context of an individual's life when they are presenting for therapy.

5.4 Relationships and eating disorders

There is a void of research looking at eating disorders and marital relationships, which Kenyon (2007) comments on. As a result, Kenyon uses grounded theory looking at eating disorders within marital relationships, to find these main themes of role dynamics: *couples' approach to the eating disorder; support; trust; acceptance; communication; intimacy,* and *security*, with emotional accessibility being revealed as a main factor influencing the course and maintenance of the eating disorder.

While I believe this is valuable information regarding couples living with an eating disorder, I feel there is value in also exploring the way narrators present their experience of living with an eating disorder as a couple by looking in depth at the language used in order to get another perspective on this area. In this way I aim to add something to this void that Kenyon describes, especially in a way that is focused within counselling psychology.

There is a suggestion that the number of women presenting with eating disorders at later ages is increasing, meaning that they are usually of an age where they are more likely to be married or in long term relationships (Dally, 1984; Garfinkel & Garner, 1982; Heavey et al., 1989; Hedblom, Hubbard & Anderson 1982). The average age of presentation is 40, in a range from 22 to 60 years of age (Woodside, Shekter-Wolfon, Brandes & Lackstrom, 1993; Van den Broucke & Vandereycken, 1989c); presenting support for researching adult eating disorders within relationships.

Likewise Bulik et al.'s research (2012) supports the necessity of researching experiences of living as a couple with an eating disorder. Such research is based within the field of cognitive behavioural therapy, and is aimed at therapists and practitioners generally who work within the field of eating disorders. An implication of this not being based within the field of counselling psychology is that there is more of a call for systemic thinking and practice within the general field of therapy and mental health, which are major areas of work for counselling psychologists.

It is interesting that Heavey et al., (1989) and Van den Brouke, Vandereycken and Norré, (1989b) found married and older women presenting for treatment for anorexia tended to be ill for longer than younger, single women although symptomology was consistent across the two groups. Van den Broucke et al. (1989b) mention Crisp (1977) as suggesting that marriage is a factor affecting poor outcomes in eating disorders and query as to what contribution the marital relationship has to the course of the eating disorder.

While these findings offer support to the link between interpersonal issues and eating disorders, specifically in terms of marital and long-term relationships, there is no focus on positive aspects. I feel this would be a beneficial contribution to this area of knowledge, especially to inform people who are already experiencing high levels of distress.

Interestingly, Van den Broucke and Vandereycken (1989 a, b) looked at late onset (early 20s) anorexia, concluding that marital relationships contributed to it, but that the couples denied this, instead attributing it wholly to body image issues and body dissatisfaction. This leads to the

debate regarding who knows best – indeed does anyone have the 'right' answer? – in terms of knowing what is helpful or not – the professional who understands theories around a difficulty or the individuals experiencing it? This is within counselling psychology an aspect of therapeutic work that is always challenging yet important.

Possible precipitating factors for eating disorders include marital problems, separating from parents, and difficulties with child rearing (Van den Brouke, Vandereycken & Norré, 1997). It is interesting that marital problems are highlighted as a potential trigger, as the causal relationship between marital problems and eating disorders is not specified here. Suggestions have been made previously - for example Woodside et al. (1993) suggest that eating symptoms serve to occlude other problems within marriages, and Foster (1986) suggests that when a woman is suffering with anorexia the eating symptoms serve as a distraction for other marital issues, and a prominent interactional style of conflict avoidance is evident.

There are understandable reasons why women with eating disorders may have difficulty with interpersonal relationships (Fowler et al., 2002; Hartmann, Zeeck & Barrett, 2010) such as exhibiting a non-assertive, submissive personality style, and difficulties with social inhibition and non-affiliation.

The literature detailed in the section above regarding eating disorder development leads me to understand the possibility of individuals experiencing powerlessness in relationships, susceptibility to further victimisation, low self-esteem, guilt, anxiety, hostility, self-destructive behaviour, body image disturbance, difficulty trusting, sexual maladjustment and a sense of isolation; especially so if attachment issues are present as this can lead to a reluctance to form close relationships (Schecter et al., 1987; Hall et al., 1989). Along with perceived pressures from media and social and cultural influences it can be understood that individuals perhaps with already low self esteem can believe that they need to conform to these 'ideals' in order to keep their partner and maintain their relationship,

It is also worth considering the impact some of the personality traits mentioned previously, such as perfectionism and needing to assert independence, could have on a relationship. If such traits are of high importance for the individual to assert it could mean that these become overwhelming within the relationship, resulting in them being difficult for a partner to cope with - potentially putting a strain on the relationship.

Life stresses such as marriage, pregnancy, moving house – all of which occur within adult relationships - especially if coupled with an absence of social support, and an internalised ideal of a thin body image, potentially predispose people to eating disorders (Stice, 2002; Serpell & Troop, 2003). This could be further supported by the ideas put forward by Belsky & Kelly (1994) that marital satisfaction is negatively correlated with a pattern of demand/withdrawal within relationships (Bradbury, Fincham & Beach, 2000), and this has been understood to correlate positively with eating disorder symptoms. Therefore it could be viewed that eating disorder symptoms are a way of engaging such a pattern.

More specifically within the relationship, Barrett and Schwartz (1987) label a complementary dynamic of *over-responsible/under-responsible*, described as becoming a functional way of mediating power and control within the marriage, as neither partner is required to take responsibility for themselves or the relationship. However, other researchers have found no evidence of mutual dependency with eating disorder marriages, finding instead that marriages were reported to grow stronger and more positive as a result of eating disorders (Levine, 1988).

As this is an area of discrepancy it suggests the importance of exploring it further with couples to understand their opinions of the strength of and dynamics within their marriage. It is possible that this dynamic reflects what Levine refers to as *'satisfying dependency'*, a result of - rather than a cause of - relationship power imbalance, and therefore a benefit in the relationship.

This is further supported by Van den Broucke and Vandereycken (1989a, b), who found a hierarchical pattern of relating, describing it as a *'satisfactory and cooperative'* pattern, rather than one that causes frustration for the spouse. They suggest that this interdependence, of care-taking husband and dependent wife, may be mutually satisfactory and that marriages with anorexia may be more likely to develop a pattern of stable distance, with difficulties in communication. They propose that bulimic marriages have more power imbalances.

5.4.1 Social support

Social support is a term I use here to refer to the network around an individual. This could be family, friends, partners, colleagues or classmates.

Social support is a complex area for individuals with eating disorders, and their friends and family, demonstrated by findings that friends and family often do not know how to help their loved one, seemingly being ones that the individual finds unhelpful (Grisset & Norvell, 1992). Individuals with eating disorders can become dissatisfied with the level of social support they receive related to their eating disorder (Tiller, Sloane, Schmidt, Troop & Treasure, 1997; Rorty, Yager, Buckwater & Rossotto, 1999).

While these findings highlight the presence of this dissatisfaction, they do not explain the reason for it. Interesting to ask would be such questions as - is it due to friends and family being ignorant about the eating disorder, having a dislike of the eating disorder, having a fear of upsetting their loved one, or being worried about making the eating disorder worse?

Further to this, family and friends of individuals with eating disorders often feel it is their role or responsibility to fix the situation or make things better for the individual, perceiving it a failure on their part if unsuccessful (Troop, Holbrey & Treasure, 1998). This can lead to distress for the partner, which has been shown to be significant - with experiences being similar to that of individuals caring for someone with psychoses, yet levels of distress were reported as higher with the eating disorder family members than psychoses family members (Treasure et al., 2001). With partners being one of the most frequent providers of support for individuals with

eating disorders (Quiles & Terrol, 2009) it highlights the importance of their role. It is also necessary therefore to have an understanding of the distress experienced by the partners along with what is helpful or not for the individual (Whitney, Haigh, Weinman & Treasure, 2007).

There is, however, little information about what kind of support such partners are providing, how it is received, how both members of the couple deal with the need for support, and the subsequent effects on the relationship. I am therefore keen to explore this dynamic in an attempt to demonstrate a more holistic perspective of both partners and the relationship. I observe here the potential for more open communication between family members in these situations, to understand what each other is trying to achieve and what would be most helpful. However, with knowledge of eating disorder behaviour, and as mentioned previously, such individuals may not want help, think they don't need it, or not know what kind of help they do want or need. Troop et al. (1998) suggest further exploration of these issues, therefore it will be interesting to explore if they are presented in the content or performative elements of the narratives in this research.

5.4.2 Weight issues within relationships

Findings of research looking at weight stigma in relationships suggest that heavier women have lower quality relationships and which these women predicted to be more likely to end than lighter women (Latner, 2009). The heavier women were found to partner with less desirable men and assumed their partners would rate them as less warm and trustworthy. This is somewhat supported by their partners, who describe them as being less attractive than their ideal partner.

Further to this, eating, weight and shape (EWS) issues within relationships are thought to play a role in affecting relationships (Morrisson, Doss & Perez, 2009). They suggest partners' assumptions and attitude towards weight can have an effect on how individuals feel about themselves and their attractiveness. This can lead to reduced confidence, and ensuing issues within the relationship, as body image can have an effect on self-image through cognitive, emotional and behavioural means. This can lead to such psychological disturbances as social isolation, anxiety, and low self-esteem (Hutchinson, 1994; Kearney-Cooke, 1989; Rosen, 1990).

It would be intriguing to explore this from a qualitative perspective, to gain insight into the discourses around these issues. Applying this idea to eating disorders could give support to notions that both partners and relationships have a part to play in maintaining, beginning, ending or recovering from an eating disorder.

This idea is reinforced by body image issues having been shown by Van den Broucke & Vandereycken (1989b) to be of significant relevance to satisfaction levels within relationships, with both partners' attitudes, values and beliefs towards body image being found to be a potentially significant factor in the development of an eating disorder. They found physical

attractiveness was an important factor for both partners, and an important factor of mate selection with some eating disorder couples.

Exploring these issues with individuals affected by them is warranted in order to gain a perspective of how the individuals actually experience them, rather than simply knowing the issues are present. This is in line with counselling psychology practice of focusing on individual experience.

There is the possibility of more underlying issues with separation individuation and other attachment dynamics as discussed in the attachment section that could contribute to this. All of these issues, however, have an effect on the intimacy within relationships, as found by Van den Broucke and Vandereycken (1989a, b).

Within their findings is the suggestion that eating disorder couples avoid intimacy, yet maintain a connection using the eating disorder as a common enemy which acts as a way to prevent the development of a genuinely intimate relationship. Engaging with each other is then, instead, experienced as a more superficial pattern of communication, and often within this the spouse is more open than the eating disorder individual in expressing dissatisfaction with the relationship.

Certain communication skills are found to be lacking with eating disorder couples, as they use less meta-communication and neutral problem description compared to non-distressed couples (Van den Broucke, Vandereycken & Norré, 1997). The authors suggest that such couples do avoid a critical, justifying and disagreeable communication style that is demonstrated by couples who report more marital distress. They suggest that communication difficulties such as these and eating disorder behaviour are involved in a circular existence, rather than there being a causal relationship present.

5.4.3 Partners and husbands

Husbands of women with eating disorders have been described as having poorly defined sense of self-identity. This leads the husband to take on an identity through caring for his sick wife, thus remaining invested in her eating disorder, as it helps support his 'false self'. As a result, unresolved conflicts surrounding individual or couple identity will potentially need to be faced if the wife's eating disorder symptoms get worse or there are any health crises (Foster, 1986).

Similar to this is the idea that both members of the couple have difficulties clearly defining themselves, taking on inter-dependable marriage roles, which allow both partners to avoid their own neurotic issues. Instead, they take turns with their 'illnesses' and return to care-taking mode when the other becomes overwhelmed with their symptoms (Barrett & Schwartz 1987). This is echoed by Woodside et al. (1993) suggesting that husbands of eating disordered women tend to either have severe psychological problems of their own, or are described as 'near saints'.

Husbands of anorexic women have been described as having a need to have a 'sick' wife, in order to, through his ability to tolerate or care for her, uphold his own self-esteem, believing that this stabilises the relationship temporarily, as the wife also needs this. If and when the wife pursues recovery, the husband is pushed to look for himself at ways of promoting his self-esteem (Barrett & Schwartz, 1987). This idea is further supported by the identification of higher levels of neurotic and psychiatric symptoms among husbands of women with eating disorders than a control group, with these men being described as caring and supportive by their wives. However, it appears that these attributes protect the mutual dependency the couple had developed in a superficial relationship (Van den Broucke & Vandereycken 1989a,b), and would provide an interesting angle to explore within this research to see if any of these such issues are present.

These ideas further support the need for a qualitative approach to this topic, as there are so many variables and possibilities to how this dynamic may play out, and so many factors that could have an impact on it that it would not be possible to explore this with a quantitative approach.

5.4.4 Attachment, eating disorders and relationships

Marriages that involve eating disorders are likely to be influenced by attachment issues from childhood, particularly those issues and conflicts that are unresolved (Root et al., 1986). Relationship stresses potentially re-provoke these unresolved conflicts and/or earlier difficulties with eating (Woodside et al., 1993; Levine, 1988; Heavey et al., 1989; Dally, 1984; Anderson, 1985; Van den Broucke & Vandereycken, 1989a, b).

Some couples establish their marriage in order to protect themselves from their own neurotic needs (Crisp, 1977). When the idealisation they have created is under threat by the emergence or worsening of eating disorder symptoms, the partner/husband becomes distressed, with a consistent pattern of the partner having to accommodate the woman's 'illness' (Dally, 1984).

It could be that these patterns of relating have been learnt from the partners' parents, as there have been similarities found between generations' marriages (Woodside et al., 1993), and replications of father-daughter relationships with the husband reflecting underlying anxious attachment.

Engagement and distancing appear in some relationships where an eating disorder is present, as basic drivers of relational change and maintenance (Newton, Brown, Boblin & Ciliska, 2005). In such instances, the eating disorder is used as a way of gaining attention, and also as self-preservation through distancing to avoid emotional risks. This leaves the couple experiencing an entwined relationship between engagement, distancing and the eating disorder.

5.4.5 Relevance to research

As is evident from the above summaries, attachment, and patterns of relating from childhood have been shown to be independently important in understanding adult relationships and

eating disorders. Therefore, it is of little surprise that their effects have been explored within relationships where eating disorders exist. In terms of this research, understanding of attachment issues in these areas adds to understanding within the analysis of couple functioning where an eating disorder is present.

5.5 Relationship and eating disorder interventions.

5.5.1 Eating disorder interventions

There is a recognition for the need to include partners in treatment for eating disorders in a way that is more suitable for adults than family approaches such as the Maudsley method (Lock et al., 2001), due to the perceived inappropriateness of partners taking control of re-nourishment of an individual (Bulik, Baucom & Kirby, 2012). Bulik et al. are therefore developing a cognitive behavioural programme for couples; based on standard cognitive behavioural couples' therapy but integrating specific aspects for anorexia.

While Bulik et al.'s research and programme development is still in the early stages, it is encouraging that there is an emergence of such a programme, lending support to the importance of this area of work and for research to increase knowledge and ideas within this area.

Gilbert (2000) suggests that it can be helpful to bring family members, friends or partners into therapy if they are aware of and involved with the symptoms and behaviour of the eating disorder. Gilbert cautions that this ought to be at the relevant stage in individual therapy, when the individual is ready to allow their partner to help. This help would consist of focusing on agreement about ways to communicate about the eating disorder and behaviours, with an understanding of what would be most helpful for the individual, whilst being mindful of effects on the relationship.

Likewise Atkins and Warner (2000) recognize the potential helpfulness of involving partners, suggesting they are often willing to help but are frustrated that efforts have not proved successful; there can be some who do not recognise their role in maintaining the behaviours. The authors suggest the most important initial aspect of therapy is to focus on the strengths of the relationship and exceptions to the problem. Following this, identifying and preparing the couple for how to deal with the potential different dynamics that may occur as the individual reduces or increases the eating disorder behaviours, and potentially becomes more assertive or self-assured.

5.5.2 Relationship interventions

There are relationship interventions that recognise eating disorders and present ways they approach them.

A behavioural-systems approach to the situation of one individual experiencing a psychiatric difficulty is to reframe: placing the problem as within the relationship rather than the individual. This then allows for work on the relationship in order to understand unhelpful ways of relating

to the problem that may have been maintaining it, and work on altering those patterns (Crowe & Ridley, 1990).

Stanton (2002; 2005) presents behavioural couples' therapy (BCT) as an approach for working with couples when there is an addiction present; this is relevant as eating disorders are often viewed as an addiction. Stanton describes working on understanding and adapting unhelpful patterns of reacting to the addictive behaviour, and using motivational interviewing (Di Clemente & Velasquez, 2002), to determine what stage of change the individual is at, therefore what patterns of reacting would be more helpful.

Interpersonal therapy (IPT) for bulimia focuses on the interpersonal context within which the eating disorder developed, and in which it is maintained (Fairburn, 1994). Further to this is examining the effectiveness of interpersonal interaction for the individual, and exploration of the interpersonal context of bulimic episodes. Within this therapy the eating disorder itself is not addressed directly, the focus is interpersonal skills and the effectiveness of this with the aim of improving this.

Root, Fallon & Freidrich (1986) acknowledge that individual therapy with a bulimic individual would mean denying the system of which they are a part. They discuss couples therapy within this context, incorporating different styles of therapy but focusing on techniques such as rebalancing – noticing and challenging when there is a potentially unhelpful labeling or understanding of the situation or the eating disorder. Other techniques include boundary delineation – helpful when there are poor boundaries or too much dependence, and has the effect of helping contain and rebalance difficulties and the relationship.

These examples demonstrate that the entwining of relationships and eating disorders is a relevant area within which to conduct research, particularly if this is from a new angle that can potentially provide new insight and ideas.

5.6 Why conduct research in this area?

Noordenbos & Suebring (2006) involved ex-clients of eating disorders and therapists to discover which elements of recovery were important to them and are actually realised, from a list of 52 criteria. They found that ex-clients and therapists agreed on many of the items. They also found that the criterion of 'having an intimate relationship' was not important to participants. This implies that the gaining of an intimate relationship is not an important signifier of recovery. However, it does not explore current intimate relationships of individuals and does not allow for explanation of answers, relying only on a self-report checklist.

Conversely, Pettersen and Rosenvinge (2002) also conducted a study looking at improvement and recovery from eating disorders, from the individuals' perspective finding that interpersonal relationships were one of the important recovery factors. This was not necessarily with symptom absence, suggesting how important a relationship can be regarding how an individual feels. Details that participants suggested as important in this area included: their partner being

the first to know about their problems, the first to encourage them to seek professional help, the main source of trust, acceptance, and practical and emotional support. This contribution is vital for an increase in their self-esteem.

It is also reported here that for those without children the thought of having children one day was an important motivator to recover – a situation that someone with a partner could be strongly affected by, depending on previous discussions and plans made with their partner. Pettersen and Rosenvinge highlight the difficulty with clinical opinion about recovery, suggesting that it tends to be skewed towards treatment, and discounts other factors that may be outside of that treatment. This may result in an underscoring of patient resources.

I am therefore lead to considering the aspects within a relationship that may be of benefit to the patient, that are 'given' to them or that they find within it. Formal measures of recovery may conceal other problems as many of them are very narrow, so when recovery is defined by clinicians and researchers, important aspects may be overlooked. An example of this may be focusing primarily on the physical, cognitive or emotional aspects rather than a mixture of the three. A patient's perspective may reveal important recovery factors not derived from theory – supporting my proposed plan of talking to individuals/clients and their partners, which may uncover yet more factors that are constructed within and between a couple.

Pettersen and Rosenvinge's research also shows that clients found therapy most effective when the therapist respected them as an individual, and helped them look at the issues underlying the eating disorder rather than just the symptoms. This could relate to their relationships with their partner and so it would be interesting to see if anything similar emerges from my research.

Belangee (2007) reports that much of the research looking at couples and eating disorders is focused on the question of maintenance and development of an eating disorder being affected by being in a relationship, and that research looking at eating disorders from an individual psychology perspective are mainly from a quantitative angle. Belangee goes on to suggest that there is not enough research looking at the effect on eating disorders to understand the full impact that may occur.

For these reasons, and the significant amount of literature read on the topic of eating disorders and relationships for this research, it is clear that there are effects between relating and eating disorders, with a large amount of the literature focusing on attachment, issues of conflict resolution and independence beginning and developing in the family of origin, and with this continuing into adult relationships. However, despite the high volume of work in this area, there is little qualitative exploration of the experience of living as a couple when one has an eating disorder, or how couples present this experience and therefore themselves and their identity as a couple, to people outside of their relationship – specifically to someone within the field of counselling psychology.

As there is beginning to be an acknowledgment of relationships and eating disorders affecting each other, and treatment developing, it demonstrates that it is becoming recognised as an area of need. Therefore research focusing within this field that can add to understanding and knowledge is important and worthwhile: my research can contribute to this – albeit in a relatively small way – in order to stimulate awareness, ideas and thoughts.

6 METHODOLOGY

6.1 Research Design

A deeper understanding of the experiences of living with an eating disorder will be gained by exploring the co-construction of reality and experience between and within couples, and between the narrators and myself - the interviewer. This will be done through the analysis of narrative and language use and adopting a social constructionist epistemology informed by a critical realist perspective, a standpoint that marries epistemological relativism and ontological realism. This study is based on the premise that people organise and construct their experiences in story form, bearing in mind the context in which they tell their stories. This study is also based on the assumption that these constructions impact on, and portray, individual identity and, in the specific case of this study, couple identity, functioning and dynamics. This chapter will explore the assumptions, philosophy and nature of narrative analysis, my epistemological standpoint, and outline the steps involved in the analytic procedure. The implications of these findings for practice within counselling psychology are also discussed.

6.2 Narrative Psychology

6.2.1 Main assumptions of narrative psychology

Narrative psychology assumes that human experience and behaviour are meaningful, and there is a need to explore 'meaning systems' and the structures of meaning that make up our minds and worlds (Polkinghorne, 1988). Narrative psychology takes the belief that we as humans are essentially interpretive creatures, reflecting on what is happening around us, and that we do this with the use of language – by writing and talking we are in a constant process of creating and defining ourselves (Gergen, 2009). This process is dynamic and relational (Bruner, 1991; Elliott, 2005), illustrated by Androutsopoulou's description: *'a continuous construction of self-narrative, aiming to secure a sense of historical continuity, directionality and coherence'* (2001:282). An extension of this idea is provided by Gergen (1989) with the notion of a '*warranting voice*'; each of us wanting to have our version of events heard, presenting constructions of ourselves that give us validity and legitimacy, implying our ability to use and manipulate discourse to do so.

Narrative psychology also assumes that imposing structure on experience is a natural human quality and that storytelling is a way of doing so (Sarbin, 1986). This has been demonstrated by studies where people attribute story like qualities and structure to the seemingly abstract and meaningless, such as reporting a film of geometric shapes in story form, casting the shapes as actors engaged in some endeavour (Heider & Simmel, 1944; Michotte, 1963).

There is a suggestion within narrative psychology that memory is a collective rather than individual act, generating 'what happened' in conversation (Gergen, 2009). Therefore no matter

how personal memories may feel or appear to be, they exist through their relation with what has been shared with others previously. This includes language, events and all that constitute the society within which one is a part, and contribute to the maintenance of one or other kind of social order (Shotter, 1990).

There have been contradictions within the development of narrative inquiry, such as the maintenance of a humanistic conception of a singular, unified subject, and that narrative must always be multiple, socially constructed, re-interpreted and re- interpretable. Andrews, Squire and Tamboukou (2008) state that whilst these contradictions do not go unnoticed within the field of narrative inquiry, most researchers try to work across the contradictions, rather than trying to resolve conflicting positions that are historically and disciplinarily distinct. The social constructionism perspective, with which I mostly agree, assumes that one will say certain things, and omit others, to tell a story in a certain way, depending on the audience. Also, the interpretation will differ depending on who is doing the interpreting, and in what context it is being told and interpreted.

6.3 Narrative analysis

The idea of narrative can be traced back to Aristotle's Poetics (Bruner 2002; Chatman, 1978; Leitch, 1986 and Martin, 1986), with the origins of the word 'narrative' traceable to the Latin '*gnarus*', meaning 'knowing'; and 'story' from the Greek and Latin '*historia*', meaning knowing by inquiry, as well as accounts of events (Holoway & Freshwater, 2007). It is also thought to be derived from the Indo-European root 'gna', meaning both 'to know' and 'to tell' (Hincman & Hinchman, 1997). Both possibilities highlight the knowing and telling of a story, and lead to the assumption that such practices are well embedded in human nature.

According to Squire, Andrews & Tamboukou (2008), the antecedents of contemporary narrative social research came from a rise of humanistic approaches within the field: Russian structuralist, followed by French post-structuralist, post-modern, psychoanalytic and deconstructionist approaches to narrative within the humanities. This had effects on English speaking worlds from the 1970s, when work began to be focused on story structure and content, and also narrative fluidity and contradiction. There was a focus on conscious and unconscious meanings, within which narratives became possible. Contemporary narrative analysis can be seen as developing from the 1980s, with authors such as Sarbin (1986) and McAdams (1988) as influential, and Tomkins (1979), McAdams (1985) and Hermans, Kempen & Van Loon (1992) beginning to describe new narrative theories of personality.

6.3.1 Discursive psychology and narrative analysis

Discursive psychology (Potter & Wetherell, 1987; Edwards & Potter, 1992; Harré, 1995) has been generated from the ideas of ethnomethodology and conversation analysis, which focus on the role of everyday language and social interaction (Willig 2001). This is the most popular area of social constructionism, with the focus on social interaction and language as a form of social action. Potter (1996a) suggests that it is not trying to answer what factuality is, but how people go about their constructions and how others react to those constructions. The interest is in looking at how people use language in their everyday actions, and what implications there are from this. Potter goes on to suggest that memory, emotion and other psychological phenomena become things we 'do', suggesting that we produce and perform these things rather than 'have' them.

Throughout Piaget's work on child development (1896-1980) and Mead's (1863 – 1931) the emphasis was on the importance of language in children developing a sense of self and others. The use of 'I' and 'me' was noted as ways of distinguishing self from others. This suggests that from early on in life, humans use language to make sense of the world around them, including themselves and the events that they are in. However, it does raise a question of whether thought or language develops first; Piaget's (1950) theory suggests that thought develops before language. However this does not fit with the social constructionism belief that meanings are created with language, suggesting that language would be required before thought could be produced. This demonstrates a distancing from traditional approaches to psychology.

Parker describes discourse as *'a system of statements which constructs an object'* (1992:5), and Burr (1995) suggests that there are always multiple discourses to describe everything, and as a backdrop to what we say, suggesting that *'life as text'* could be the metaphor underlying the discourse approach. Wetherell & Potter (1988) showed that attitudes expressed are usually inconsistent, when they found that the same person during the same research interview expressed opposing attitudes, and therefore stress the importance of exploring what people are trying to do with their language rather than the content, to understand what purpose their accounts are achieving. Foucault (1972) viewed discourses as creating the objects they are from, holding an extreme view that without language there is nothing.

6.3.2 Limitations of Narrative Analysis

There are possible limitations to using narrative analysis, such as how information gets re-interpreted at many stages, by the researcher, and by each reader (Squire, Andrews & Tamboukou 2008). This could be said to limit the validity of what is found, yet I would suggest that from a narrative perspective, this is reflecting what occurs naturally with spoken and written word. There is also the fact that as the researcher I am creating the context where the interview takes place, which could again be seen to be reducing validity, although as has been argued previously in this chapter, this is what occurs all the time. As this research is aiming to inform work and services within counselling psychology, there is an argument that the context is not

too far removed from how it might be for someone in therapy or treatment. Linde (1993) also argues that as life stories can occur naturally in any context, this would include research interviews, suggesting narratives within interviews are robust.

There is a question of whether or not human life really is narratively configured and if within narrative analysis we are overplaying the significance of storied form. Crossley (2000) answers this by suggesting that we are *partially* determining the stories of our lives by doing so - she quotes Carr (cited in Wood 1991) saying *'each of us must count himself among his own audience since in explaining ourselves to others we are often trying to convince ourselves as well'* (165). The word partially is emphasised here, as our stories are based in our history and experience – which inevitably involves others - and we are not in complete control of how our story develops. This is especially the case when looking at this from the perspective I am within this research – with the idea that our meaning is co-created inter-relationally, then with this meaning we make our own decisions and use this meaning to inform us in our individual endeavours. In this way there can be a marriage of the ideas of a social constructionist approach yet a person-centred philosophy.

While it is important to bear in mind what Crossley cautions against - assuming that narrative configuration is a universal characteristic - it is also relevant to be aware that there are a number of researchers and authors mentioned throughout this chapter who have found it to be a way people organise their experience. There is a hole within social constructionist theory in relation to the 'self', the humanistic concept. There is an argument that this cannot be reconciled with social constructionism (Burr, 2003), yet it has not been replaced in another way. Burr recommends that the self be reclaimed for social constructionist psychologists, without compromising theoretical assumptions. For me this entails an understanding that while our experiences occur with other people and therefore meaning is co-created inter-relationally, there is always a strong element of individual agency in terms of decisions we make and how we ultimately understand our experiences.

These experiences are, I believe, heavily influenced by the world around us in terms of cultural context, media influence, friends, family and other people related to our experiences. Ultimately the way we choose to understand our experiences and the decisions we make related to this is an individual endeavour. In terms of this research, I believe that the experiences the individual narrators present are heavily influenced by their partner and may well have been discussed in depth as a couple but they are ultimately individual experiences. The way the narrators present their stories together will demonstrate how much they are attempting to come together to tell their story, and how much they want to be seen as a couple or as individuals.

6.4 Rationale for a qualitative approach.

The review of the literature in the previous chapter demonstrates clearly that there is a narrow breadth of research in the area of adults and eating disorders, especially concerning couples affected by eating disorders. I note that further lacking are qualitative accounts or

understandings of such experiences. As qualitative research is in unison with counselling psychology values (McLoed, 2003), with which I have a definite affinity, I have a strong pull towards using a qualitative approach. My aims for the research are to explore individual and couple experience and how they portray their identity, in alliance with the process of therapy, and to explore clients' lives as they experience it - and help them understand it for themselves. I therefore deem quantitative approaches to be inappropriate to fulfil the research aims, as they would not deliver the depth of information regarding individual and couple experience required, and would give less insight into couple functioning and dynamic.

The significance of language in the creation and understanding of self and identity highlights the appropriateness of choosing qualitative over quantitative as a method of research enquiry, when looking at the identity that couples' present together. Qualitative methods, especially narrative, provide a natural way of understanding temporal dimensions of human psychology, something that according to Crossley (2000) is necessary for understanding the connection between time and identity. This is due to the way in which humans make meaningful sense of, and interpret experience in, relation to time and sequence.

6.4.1 Rationale for using narrative analysis

As I consider that stories are a significant way of expressing and building personal identity and a sense of agency, narrative analysis is an obvious choice for my research (Bruner, 1990; Squire, 2008), and eclipses other methods that, whilst they are important and valuable in the right context, are not suitable for my research. For example, interpretative phenomenological analysis (Smith, Flowers & Larkin, 2009) explores experience, and while this is at the forefront of counselling psychology, I deem it to be missing the way people organise this experience. I feel that it is of much value within counselling psychology to look at the way – subtle or obvious – that people organise and tell others about their experience. As I am exploring, rather than trying to find a new theory or framework, I feel that grounded theory (Glaser & Strauss, 1967, 1999) would also not provide an appropriate method of analysis.

McAdams' (1985) life story model presents a good argument for using the narrative approach to analysis, which takes off from the grounding of Erikson's (1963) developmental concept of ego identity. Erikson's fifth proposed developmental stage - late adolescence and young adulthood – is where people first come face to face with the problem of identity versus role confusion and explore ideological and occupational options available in their society. Within this exploration is experimentation with a range of social roles, as individuals hope to find the roles that they wish to pursue and use to create a solid life plan. This means identity is an integrative configuration of self-in-the-world.

Narrative analysis allows for a holistic approach to discourse, preserving the context, and may reveal information that other methods do not (Smith, 2000; Bruner, 1986; Polkinghorne, 1988; Veroff, Sutherland, Chadiha & Ortega, 1993). This means that the stories narrators tell me are told in the way they choose, reflecting how they want to be seen and understood by others.

How narrators want to be seen and understood is more valuable to this research than trying to find out answers to specific questions, fulfils the research aims more satisfactorily, and mirrors the process of therapy whereby clients relay their experience in their own way. As therapists are constantly trying to understand individuals' experiences, Crossley's (2000) argument that the narrative approach is grounded in this attempt further validates the use of narrative inquiry in the field of counselling psychology.

If *'lives are told in being lived and lived in being told'* (Carr, 1986:61), it means that actions of life can be seen as being a process of telling ourselves stories, acting them out or living through them, and listening to those stories. This implies that everyday reality is permeated with narrative, which would suggest it is an especially appropriate method of analysis. Indeed this is echoed by Oliver Sacks (1985), who states that:

"*.....to restore the human subject at the centre – the suffering, afflicted, fighting, human subject – we must deepen a case history to a narrative or tale: only then do we have a 'who' as well as a 'what', a real person, a patient, in relation to the disease, in relation to the physical*" (pg x).

This to me echoes the essence of counselling psychology: that it is a person or people we are working with, they are affected by something and the work is in understanding how *they* are affected by *it*, and how thus to help them.

The experience of mental illness has been described by Polkinghorne (1988:179) as similar to suffering from an *'incoherent story'*, or an *'inadequate narrative account of oneself'* by Howard (1991) or a *'life story gone awry'* by Showalter (1997:11). There is a field of psychotherapy focusing on reconstructing one's life story – narrative therapy (White & Epston, 1990). There is, then, value in looking at the stories of people who have experienced mental health difficulties, and of those who live with them at the time, to understand both how they story their lives in these times, and how they do this as a couple. Reissman (1993) states that other approaches to qualitative analysis tend to break up what is said by participants into 'bits' rather than look at it as a whole, as a story, and therefore eliminate the structural and sequential features that characterise narrative accounts, which for this research is felt to be highly important.

Narratives are a *'basic and universal mode of human expression'* according to Smith (2000:327), and Labov and Waletzky describe them to be *'the oral versions of personal experience'* (1967:12). Holloway & Freshwater (2007) discuss narrative as attempting to close the gap between knower (the researcher) and known (the narrator's story). This is extremely applicable to counselling psychology, in order to learn more of the experiences of people in certain situations, to help inform work within this field. As Hardy suggests: *'We dream in narrative, daydream in narrative, remember, anticipate, hope, despair, believe, doubt, plan, revise, criticise, construct, gossip, learn, hate and love in narrative'* (1968: p.5), and Gergen (2009) suggests that the same can be said for the way others respond to us.

Narrative, therefore, through its emphasis on self-construction through language and social construction, as it is how we communicate and make sense of our experiences naturally, is the

closest we can come to experience itself. When one is interested in experience then, it is better (in order to help the understanding of how couples co-create their reality) to allow the experience to be expressed as naturally as possible, rather than using techniques and strategies that may obscure the experience (Clandinin & Connelly, 2000). This was felt to be of utmost importance for this research, set in the field of counselling psychology where individual experience is given high importance - therefore the interest lies in the participants' stories, and how they present them, rather than trying to elicit specific information from those stories.

6.5 Epistemology

In this section I will explore and describe my orientation to a social constructionist epistemological stance, informed by a critical realist perspective. I explain the main ideas and issues around this perspective. I intend to illustrate how these have contributed to my choice of methodology and analysis.

6.5.1 My standpoint

My standpoint is that what people say is influenced by the context of who they are telling, what the purpose is of telling that person or those people, and what they hope to accomplish by telling, but recognising that people do have the capability to make decisions and choices regarding these discourses. While this study is interested in how couples tell of their experience of living with an eating disorder and how they present their reality as a couple and as individuals in doing so, there is also interest in what that experience is, and how they make sense of it as a couple. This is an attitude stated by Arksey and Knight, when they say *'qualitative interviewing is a way of uncovering and exploring the meanings that underpin peoples' lives'* (1999:32).

Potter & Wetherell (1987) claim that the aim of social constructionist approaches is to shift the focus from what the self-entity is, to how it is constructed, talked about and theorised in discourse. They argue that the more traditional approaches to psychology have a problematic view of the self - with what they refer to as 'realist' assumptions, seeing the self as an entity that can be described as any material object.

I am therefore basing my assumptions of how narrators are telling me their stories, and the content that they choose to convey within those stories, on ideas of social constructionism, an epistemology based on a critical realist perspective.

A critical-realism stance is a way to take a middle ground, combining epistemological relativism and ontological realism. This takes into account the role of language and discourse in socially creating our experience and reality, while allowing for acknowledgment of the limit the material world places on these constructions. This allows for consideration of the influences on the narrative being produced, such as the discourses available, and the social, political and psychological implications of presenting a certain narrative. Within this research, it allows for the acknowledgment of discourse providing the story of couples' experiences, and insight into

how they want to be perceived by taking into account the context and influences on what they say, whilst valuing the individuals as being able to make the choice of what to say and how to say it. As valuing of the individual and their experience is so important in counselling psychology, and a value I adhere to strongly, this is very relevant for research in this field. Outhwaite (1987) suggests that the social sciences require *'a plurality of methodological approaches'*, and that this is best achieved by a *'realist philosophy of science and a qualified or critical naturalism'* – this idea has much room for further development.

The following section of this chapter formalises my standpoint, based on the theories of social constructionism, critical realism and the relativist/realist debate.

6.5.2 Social constructionism

Gergen (2009) presents answers to some arguments in favour of using empirical rather than qualitative research. The first of Gergen's arguments for the use of empirical research is that phenomena need to be recorded as accurately as possible. However, this first of all assumes the existence of the phenomena, and Gergen argues that constructionist researchers are giving voice to cultural traditions of which the phenomena are a part, saying that mental illness, crime and so on are not innately 'there', more they are cultural constructions, embedded so deeply in history that they are taken to be there.

Another aspect is that an aim of empirical research is to remove personal bias, reflecting the world as it is. However, the constructionist view is that whatever researchers do, values of the traditions within which they live will be reflected. This is because the focus of research is drawn from the social traditions of the culture within which the researcher exists, with their own views being influenced by that social and cultural environment. It also assumes that numerical data is more accurate than language – which I feel cannot give an accurate representation of the experience under study here – and it can more easily predict and control the data. However, I think that this implies that nature remains persistent and relatively stable over time.

In line with many other constructionists I feel this view of being able to predict and control data in this way puts the researcher in a superior position of being able to do this with their participants, rather than being alongside them trying to understand, which is an essential component of counselling psychology.

My feeling is that with empirical research some individual elements are lost that from other standpoints are considered essential – such as narrative. As the focus of this research is the individuals and how they present their subjective experience, I feel it necessary to use a method that will capture that to the fullest, an idea summarised by Reissman: 'Science cannot be spoken in a singular universal voice' (2000:23). Harré (2004) argues that qualitative research is scientific because it involves reflexivity, meaning and specificity, calling this second-level reflection and maintaining that this contributes to the scientific character of research.

Discrepancies in how people present their experience of shared events and situations could be due to different interpretations of events within the relationship, or reasons for that event. How an individual explains an event may also depend on whom they are telling, and how they want to be seen – this in turn may be driven by socially constructed ideas. As well as socially constructed ideas, interpretation can depend on expectations of what the other partner's interpretations may be, due to their own socially constructed ideas. This reinforces the need to understand couple functioning, identity and dynamic from a socially constructed perspective, as is the case with my research.

Looking specifically within the field of discourse analysis as a whole, it can be seen that such methods aim to go further than others towards providing explanations by going beyond the lived experience of people, as explored by phenomenological methods (Willig 1999b). This has potential implications for the practice of counselling psychology, as it helps to understand how people construct their reality, as well as what reality is for them and how they understand it and want it to be understood by others.

6.5.3 Social constructionism development and the role of language

Social constructionism insists that we take a critical stance against ways, taken for granted, in which we understand the world and ourselves (Burr 2003), such as humanistic, psychodynamic and experimental or behavioural within psychology, and essentialism more broadly, and challenge the assumptions in these (Crossley 2000). Social constructionism draws influence from a number of disciplines including philosophy, sociology and linguistics, and is therefore multi-disciplinary in nature (Burr 1995). It takes the view that ideas of the social world are a product of social processes and therefore people and the world can have a predetermined nature, it is a dynamic and evolving process. Burr also argues that there is no single definition of social constructionism that would satisfy everyone who writes as a social constructionist, but posits Gergen's (1985) main criteria as a basis for understanding what social constructionism is:

A critical stance towards taken-for-granted knowledge - i.e. to be critical of what we assume to be true of the world. This would be in opposition to positivism and empiricism - the assumption that the world can be revealed by observation, i.e. just by seeing things we can know what it is and what it means.

Historic and cultural specificity - the ways that we understand the world, the categories and concepts we use, are historically and culturally specific - i.e. what we understand and how we perceive it is dependent on where we are in the world, where we have been, or where we may be going. This also means that perceptions are temporary, i.e. they are based on our understandings and the culture at a particular time, and this can shift over time to create different opinions and perceptions.

Knowledge is sustained by social processes - the social constructionist idea is that knowledge is created between people, through daily interactions in the course of social life, so that our

versions of knowledge get fabricated. Therefore, language is of great interest to social constructionists. It can also be said from this perspective that truth is a product of the social processes and interactions between people, rather than of objective observation of the world.

Knowledge and social action go together - this is the idea that depending on what knowledge is created between people, different action towards that knowledge is taken. Therefore opinions are created depending on the culture, time, and context, affecting how people react to situations, events and happenings. Burr continues the description of this by saying that descriptions or constructions of the world sustain some patterns of behaviour and exclude others, depending on what knowledge is socially created.

This could be a relevant thought to consider throughout the analysis of the interviews for this research, as it may depend on what the knowledge is regarding relationships and eating disorders that leads people to behave, act and react the way they do to issues around these areas. It will be interesting to be aware of these elements when analysing the interview content. How it is conveyed in the interviews - i.e. how the individuals want to be seen, and how much this is influenced by what the socially created knowledge is around their issues – is of relevance in understanding to what level Burr's ideas hold true in this research.

The argument that there is no single definition of social constructionism is within itself suggestive of the nature of social constructionism, that there can be no single defined truth or fact as these are constructed socially, and are malleable. Gergen (2009) extends this argument with suggestions that the constructionist dialogue is an invitation to a way of understanding, and that constructionist ideas enter our ways of talking and influence our actions. Gergen highlights what he believes to be the most important constructionist message: *'the moment we begin to speak together, we have the potential to create new ways of being'* (2009:29).

Social constructionism is mainly concerned with understanding and explaining the influences on, and the processes by which people describe and explain themselves and their experiences within the world they live (Daymon & Holloway, 2002), and focuses on relationships and interaction.

Social constructionism views personality as socially constructed (Burr 1995), with the idea that we act and behave differently with different people and in different contexts. Memory allows us to look back at behaviours and experiences and to find patterns and memories that 'hang together' in some coherent sense in a narrative framework - the story of our lives (Burr, 1995). Therefore in this study I am exploring how couples construct their personality and life stories as they present them to me, as researcher and someone within the field of counselling psychology. This being psychological research, thoughts are of interest, which again emphasises the appropriateness of a narrative approach, as thought and language are viewed as inseparable (Burr, 1995).

Important things that happen in life occur in relational encounters between people, in their dialogic exchanges (Shotter, 1997). This is a spontaneous and practical interaction, and

conversational activities are foundational, providing *'the living basis for everything we do'* (Shotter 1997: 9). Shotter believes that focusing on this interactional aspect of conversation and language can provide understanding of the more personal aspects of individuals, their thoughts, feelings and experience, and the sense individuals try to make of their own lives, which gives an argument for using a method of analysis within this research that looks at these aspects, such as narrative.

There is a view that reality is constructed between people within a constructionist-interpretive stance, and the presence of the relationship between the 'knower' (participant) and 'would-be knower' (researcher), with the researcher's role being to facilitate the participants' construction and expression of their lived experience (Ponterotto, 2005). Reality is viewed as being constructed between people within a constructionist-interpretive stance. Similar to the context of therapy, there is a relationship present between the 'knower' (client/participant) and 'would-be knower' (therapist/researcher), with the therapist/researcher's role being to facilitate the participants' construction and expression of their lived experience (Ponterotto, 2005). Ponterotto also discusses axiology, relating to the necessity of the researcher to acknowledge their own values and experiences, and that these ought to be described within the research, bracketed off but not eliminated. This is based on the assumption that the participants' experiences and knowledge are the objects of interest, but that it is impossible to assume that the researcher's own views and values are not present or involved, therefore throughout this research this is my aim.

Constructionists are interested in the *'how'* (Gubrium & Holstein, 1997), with research focusing on the identification of meaning making practices, and understanding the ways people participate in the construction of their lives. From this, there is the notion that an interest in narrative would stem, for constructionists, from the fact that it is a social accomplishment, that it needs the collaboration of an audience. In the case of this research the initial audience is myself and subsequent audiences are those who read this research. Each audience will create their own meaning from what is presented within the research, partially influenced by their own narratives that result from their own experiences and cultures. This necessitates acknowledgment that there will be different understandings of the research and the meaning of it may change, dependent on the audience.

6.5.4 The relativist-realist debate

Gergen (1999) suggests that the social constructionist philosophy which underpins narrative analysis may have limitations, proposing that there can be no way of saying that the world exists outside of our constructions. Burr (1995) talks of the self-referential nature of discourse, suggesting there is no way of emerging into the real world if each discourse is influenced by a previous or potential discourse, meaning they cannot be said to be true or false. This suggests that there can never be a single reality, because if language is forming our reality, and there are multiple discourses for everything, then a single reality can never exist, and any perceived reality may change instantaneously. This indicates a relativism/realism debate, with the view

that an extreme relativist stance sabotages any possibility for the integration of constructionism with other forms of knowledge, as suggested by Bhaskar (1989) and Erwin (1997).

In order for research to ensure that it is looking at not only the description of constructions, a standpoint of critical-realism is required. This enables a view of why constructions are as they are, along with related dynamics – mainly regarding subjectivities and potentialities of discourse – whilst ensuring that the context (social, political, material) is taken into consideration. This emanates from the work of Bhaskar (1975), who elliptically constructed the phrases 'transcendental realism' with 'critical naturalism'. Bhaskar (1998) argues that an adequate philosophy of science must have the capacity to sustain and reconcile the social character of science and an independence from the science of objects of scientific thought. Within this process is a distancing from empiricism, revealing the agency of participants, which for this research is an important aspect.

6.5.5 Critical realism and implications for research

Discursive analytic approaches take a relativist standpoint and, being anti-realist, view truth as problematic, in suggestion that there cannot be objective fact within constructionism. This is echoed by many proponents of narrative analysis, such as Gergen (1985), Sarbin (1986), Polkinghorne (1988), Reissman (1993), and Mishler (1995) who reject the objective, realist and positivist-empiricist attitudes. This could be viewed as problematic, as it does not take into consideration the 'self', or subjectivity, therefore excluding reasons why people choose certain constructions over others. Burr (1995) discusses ideology in relation this, as knowledge in the service of power, that ideas are not ideological, they can be true or false, but they can be ideological in how they are used. This can be understood as ideology of lived experience, going beyond what people think. With ideology being dilemmatic, meaning that thought, its content and processes are provided by wider socially shared concepts, it implicates the person as an active thinker, capable of making decisions and choices, with discourses as systems of meaning and also as ways of representing ourselves and our social world. These discourses can be deployed ideologically with an aim of power or control, while acknowledging that people still have the ability to make choices in terms of the discourses they choose to employ.

6.6 Conducting the narrative analysis

6.6.1 Pilot study

Pilot interviews were conducted with couples known to me, allowing me to practice the interview technique, as I was aware it would be different to the process of therapy, although therapeutic skills would be extremely useful.

These interviews involved asking the narrators to tell me their story about something they had experienced together, such as recently moving away from their home town. As I was new to engaging with couples in this way, it allowed me to become more familiar with this process, and also to gain feedback from the couples as to how they found the experience. From this, I

learned that it was not necessary to ask many questions throughout the interview. I had been concerned that couples would run out of things to say without enough questions, yet did not want to ask many questions in order not to disrupt the narrators' stories. I also found that the more relaxed and informal I was during the process, the more comfortable the couples felt, and that this aided them in telling their story.

Conducting these pilot interviews helped me to go into the main research interviews feeling more comfortable and confident, and thus hopefully allowing the interviewees to also feel more comfortable and willing to share their story, and feel positive about the experience of doing so.

6.6.2 Recruitment

Previous research into the area of relationships and eating disorders has mainly looked at numbers, or information of the partner's experience, therefore this research is focusing on the couple together and understanding their experience. There has also been a bias in research towards adolescents, which is a reason for this research focusing on adults over the age of eighteen years.

An idiographic form of enquiry was adopted, in order to understand the experience of living with an eating disorder from the perspective of individuals within a couple (together), as opposed to understanding the numbers of people in this situation. It was felt that from a counselling psychology perspective this was more appropriate to the field, which is focused on understanding individual experience in order to help individuals with difficulties, and it is a field which places high value on the individual, rather than generalisations across populations.

Due to my research aim of exploring a specific experience among a specific group of people, participants were sought through purposive sampling, which is recruiting for participants meeting certain criteria (detailed below). Adverts were placed on websites of eating disorder organisations (an example can be viewed in Appendix 2), online forums relating to eating disorders or relationships, fitness websites, health food shops, gyms, local newspapers (this advert can be viewed in Appendix 3). I felt that these were possible places where people appropriate for the research may frequent and therefore see the adverts. The adverts directed interested people to a website designed by myself (a copy can be viewed in Appendix 4), where there was more information about the research, and two questionnaires.

The website questionnaires served as a basic screening tool to ascertain if interested individuals met the recruitment criteria, and were produced under the guidance of a practitioner specialising in eating disorders. I initially planned to use more formal assessments as screening tools, deciding ultimately that individuals' experience of disordered eating or eating difficulties is more important than if they had a confirmed diagnosis. One questionnaire was for individuals who had had or were having eating difficulties, and the other was for partners of such individuals. They asked questions relating to the nature of their difficulties, and if they lived with their partner. The answers also gave me some information about couples living with

such an experience in that they gave a few details relating to their eating difficulties and indeed some people wrote a brief story in this initial contact.

There were difficulties with advertising for participants, particularly with online eating disorder communities. There were numerous forums that responded to the request by removing it, or replying with many questions about the research, with no further response following my replies. It seems that the owners or managers of these forums and communities are very protective of their users, and it was very difficult to penetrate this. Therefore access to what were potentially strong areas for reaching participants was restricted.

People who had responded with interest in being involved either by direct email contact or via the website were contacted by email. Any questions they had were answered, an information sheet (Appendix 5) was sent to them as an email attachment, and arrangements for meeting for the interview were made. Following the interviews participants were also given a debriefing sheet (Appendix 6) either in person at the end of the interview, or shortly afterwards as an email attachment. I stated I was happy for them to contact me following the interview if they had any further questions concerns, or wished to withdraw. I did not hear from any of the couples following the interviews, although they all expressed an interest in receiving a summary of the findings upon completion of the study.

6.6.2.1 Inclusion criteria

Satisfaction by participants of the following criteria was necessary for inclusion in the research:

- Adults (over 18)
- A couple at the time of the research as well as during the presence of the eating disorder.
- Living together during the presence of an eating disorder or eating difficulties with at least one of the individuals
- Individuals who had experienced an eating disorder were required to have a minimum Body Mass Index (BMI) of 15. This was advised by eating disorder specialists as a weight under which cognitive functioning can be impaired, thus rendering judgments that the individuals make about participating, and the data they may provide, unreliable.
- If they had been in treatment for the eating disorder or couple issues, treatment was required to have been terminated at least six months prior to the interview, in order to avoid contaminating the process.

Interviews were conducted in quiet, private places and at times that were convenient to the participants and myself, although weighted more towards the convenience of the participants. It was felt this would be more appropriate, as they were giving their time voluntarily to help the research. The interviews were held in a room at a local (to the participants) library, a closed café in a hotel (where the participants were staying, which coincidentally was close to my location that day), in the participants' home and in a tutorial room at the university.

Narrators were reminded of the purpose of the study at the outset, and I checked with them that they were still happy to be involved and for their data to be used within the research. A consent form was signed by all narrators, and by me. Any questions that participants had were answered as honestly and fully as possible. Following the interview, the participants were thanked, and it was ensured that they felt comfortable with what they had spoken about, and were still happy for this to be included in the research. It was ensured that they felt ready to leave before doing so, and a brief discussion about the hopes from all three people about the research occurred before leaving. Participants seemed interested and keen that the research could help illuminate the area that they also felt is important, and therefore be able to help others.

6.6.2.2 Sample Size

Initially I felt I ought to recruit 6-8 couples, as many qualitative researchers suggest this number as being appropriate. However upon reflection I realised that this would in fact equate to 16 participants, and therefore aimed to recruit 3-4 couples. The resulting sample was 3 couples and one individual, therefore 7 individual narrators. As I am viewing the couples as a unit of analysis together, in all there are 10 units of analysis

As the aim of discourse analysis studies is not to generalise much further than the sample, it is at the researcher's discretion that an endpoint is reached when they feel they have sufficient data to justify the points they are trying to make or validate (Wood & Kroger, 2000). I felt that during the analysis the data I was uncovering was sufficiently rich to be satisfied with 3 couples being involved and therefore did not continue recruiting for a fourth couple. I was also approached by a man who had been in a relationship previously with a woman who had an eating disorder. This therefore gave me the ability to compare the narratives from the couples and an individual.

6.6.3 Use of interviews

I interviewed the narrators by asking them to tell me their story. This was with as little interruption from myself as possible, following recommendations from Thompson (1978), Mishcler (1986), and Holloway and Freshwater (2007), of minimising questions and focusing rather on the flow of talk from participants. This results in a more productive interview, when the researcher suppresses their own desire to speak, as there is a danger if the researcher interrupts too often the flow of participants' story may be lost. This is also corroborated by Kvale (1996) who describes an interview like this as a journey the researcher and participants travel on together, the participants telling of their 'lived world'. Similarly, Bauer (2000) advises interviewers not to pre-structure the talk within interviews, so that they have minimum control, which allows for the interviewees to be stimulated and encouraged to tell their stories how they want to.

I conducted the interviews for this study by asking participants for their stories of their experiences of living together with an eating disorder. The participants were aware that I was researching such experience, due to the nature of my recruitment advertising. The interviews were tape recorded which, as Crossley (2000) points out, contains the raw data and allows a much fuller record than would taking notes during the interview, which may also hinder the researcher's ability to listen and engage with the story. There are debates about the degree of detail into which to go with transcription - whether to include pauses, intonation, overlaps and so on. Some authors such as Hutchby and Wooffitt (1998) place great emphasis on timing and intonation, whereas others such as Potter and Wetherell (1987) suggest that such details may negatively affect the readability of the transcript, and may not be necessary for answering the research question. As the focus of this research is on the performative elements of how narrators tell their story as well as the content, details such as pauses, intonation, overlaps, etc. are of high importance to understand the nuances of how they interact to co-create their story with each other and me. The transcription process is elaborated on below Appendix 7.

6.7 Methodological reflexivity

When I began formulating ideas of my research and the analytic procedure, deciding on narrative analysis as I felt I wanted to explore how people told their stories as well as what their stories were, it was during my preparatory reading that I discovered some of my undergraduate lecturers are well known in the field of discourse analysis. While this had not been clear to me in these initial stages, it appears it had an influence on the development of my view of how reality is created and the importance I place on understanding how this is interpersonally co-created.

I found the reactions from some communities difficult initially, mainly online forums, as their protectiveness felt like a personal attack on myself. It took some time to understand that they were reacting to what may have felt like an intrusion, or to the idea of the research rather than to myself as an individual. It also made me realise that while I was aiming to increase understanding of the area in which they are in, some individuals or communities are not open to such development.

I attended a support group to raise awareness of my research and potentially recruit participants, and found myself feeling obliged to disclose my background with eating disorders to ensure that the other group members saw me as 'one of them' on a personal level, so they could see I was approaching this area of research from 'their side', with the ability to use my professional position to help people like themselves. Perhaps this is also a reflection on the nature of the group, in terms of myself feeling comfortable to engage in this way.

I feel that my position as a trainee counselling psychologist and the training behind me up to the point of my research helped to facilitate an empathic environment where people felt comfortable and not judged when telling their story.

6.8 Analytic Procedure

6.8.1 Transcriptions

Transcriptions of the recordings were made verbatim, and annotated using the Jefferson System, as detailed in Appendix 7. As Hutchby and Wooffitt (1998) describe, the recordings are the actual data rather than the transcripts. Holloway & Freshwater (2007) also suggest that the data ought to be analysed in its original form, in order that it can reveal and shape itself in a more true way, as well as revealing the participants and their voices more. It also allows for the researcher's thoughts and feelings to come through more freely. However, I felt it important to transcribe the recordings, especially in the level of detail laid out in the Jefferson System, in order to allow more detailed analysis due to exploring how the two narrators within a couple present their experiences together. I also transcribed the single narrator's interview in the same way to allow for a more in depth comparison. The transcription with annotation allows for clearer visibility of patterns of nuances: small details of overlaps, word lengthening or emphases, and other linguistic distinctions that may be missed even with careful listening, as subtle patterns can be easier to see than hear. However I ensured that I listened to the recordings numerous times before beginning to transcribe, and several more times following transcription, in order to help the transcription feel more alive, and pick out anything else I may have missed. As the transcripts are detailed accounts of narrators' experiences, and thus contain much sensitive and personal material, to protect confidentiality I have not included them in the appendices, although quotes and segments are used to illustrate points made in the analysis.

Ollerenshaw and Cresswell (2002) comment that there is no consensus about the nature of narrative research. This could lead to the assumption that this method is not particularly valid because there is no definitive way to go about it; therefore each researcher is likely to go about it in a slightly different manner. It could also be argued that if there is no definitive process it is not a robust method. However, it is within the social constructionism field, meaning that it is acknowledged that people create meanings between themselves. Understanding the meaning of what a person has said to a researcher is a further act of this, and it highlights the importance of remembering this throughout. One should also be aware that any researcher is likely to conclude different findings to another researcher, or possibly the same researcher at a different time. This is particularly relevant for counselling psychology, as within the therapy room each therapist may draw slightly different conclusions to another therapist, which may also differ from how they understand it again at a different time.

It was felt that two of Reissman's (2006) main approaches to narrative analysis – thematic and performative – would be appropriate to follow through the analysis of this research due to my aim to discover information about the narrators' experiences and how they produce this together to an audience. I anticipate that the exploration of how couples co-create their reality will give insight into couple functioning and the relational aspect of creating one's identity and

describing experience, as well as understanding more about the actual experience of couples living with eating difficulties. Linked to the analysis of performative elements of the narratives, I find Goffman's (1961; 1981) dramaturgical metaphors useful in exploring how narrators present their experiences. This involves looking for characters, scenes, roles and positioning, and will use these throughout this research to explore the importance placed by narrators on these aspects of their stories.

I am interested in the experience described by the narrators and indeed how these experiences are portrayed and presented by the narrators, in order to help inform services working with individuals and couples in similar situations. I am mindful that due to a small sample size and a focus on individual experience information from this research is difficult to generalise as such. Rather the aim is to use the information as stimulation for ideas and awareness. Such information was explored by looking at details of what the narrators said happened, and how they found these experiences – how they felt about them, what it meant for them and other significant characters involved in the narrative. Who these other significant characters are is also an important element to understand - who the main characters are making up this experience for and what role they are playing. This links to the performative element, which I explore by looking at how the narrators, individually and together (the couples), portray different characters in their story – the roles they have, the importance placed on these roles, and the effects of these roles. Within this is the positioning of the characters, including the narrators themselves.

The main questions involved with the analysis are:

- In what kind of story do the narrators place themselves?
- What is the effect of these characters on the other characters?
- How do the narrators position themselves in relation to other characters?
- How do the narrators position themselves in relation to themselves, to make identity claims? (i.e. how do they talk about themselves)
- How do the narrators position themselves in relation to the audience?
- What characters are cast, and what is their role?

(Bamberg, 1997b).

Using these questions as a guide is helpful to organise the analysis, although deciding on segments of interview to analyse, and deciding the beginnings and endings of these is as Reissman (2000) suggests; a *'complex interpretive task'*. Finding these segments is aided by answering the above questions and noting where what appear to me to be significant 'scenes' occur. Acknowledgment of the element of my own interpretation is necessary here, as I am looking at what the narrators have told me, and I am making decisions on what is significant based on my knowledge, experience and desire to find answers to my research aims. This may of course differ from what the narrators feel is significant, and also from what any other analyst or reader may feel is significant. As stated previously, this mirrors what happens within the therapy room as a therapist is interpreting what they deem significant or notable from what a

client is telling to them; which both in turn mirror what we all do on a daily basis interactionally with others.

The transcriptions are analysed in stages, beginning with listening several times to the recording, listening freely to allow any formative ideas to develop. This is followed by transcribing the couple interviews, using the Jefferson System, as detailed in Jefferson (2004) (see Appendix 7). It is important for fulfilling the research aims to work with such detailed transcription so that by looking at the interactional elements of the talk from the narrators, I can observe and analyse the more subtle nuances of conversation and storytelling that would be missed with less detailed transcription.

I made a conscious decision from the outset of my research that I would not be returning to the narrators nor using a peer for cross-checking my interpretation of the data. This is in line with ideas of Andrews (2008) that researchers will view their data differently over time, and that each person will view things differently from another. Also in line with the strong idea within narrative that there is no single defined 'truth' (Gergen, 2009), rather that it is a product of social processes and interactions between people (Gergen, 1985). With this in mind my view is that if a researcher were to cross check interpretations, this ought to be an ongoing process with a new set of results each time. I believe that this can indeed be a valuable way of researching, or of re-visiting data with an understanding of how we will be looking differently at data and narrators may too have changed their ideas about their story. Revisiting and cross checking then can be a valuable way of understanding data over time, or of understanding how interpretations of experiences change over time and in different contexts, but is not relevant for the aims of this research.

6.9 Improving the quality of the research

As this research is from a constructionist perspective, and particularly due to the focus being on couples and their co-created story, there is no claim to be aiming to discover the 'truth' or to discover facts, which would be deemed positivist. Rather, my view is that there is no single definitive reality; it is constantly being co-created between people. The aim of the research is to begin to explore insights into the experience of a specific group of people, to help understanding. I also feel that due to the nature of counselling psychology it is more beneficial to begin to develop ideas about how people may experience certain phenomena rather than to assume that there is a certain way that phenomena may be experienced. Each client is an individual and while similarities may exist, each experience will be different. It is also the case that with a small sample size the ability to generalise any findings is limited, however the aim is to create thinking and awareness of an area that is not given much research weighting to inform and hopefully improve services.

The literal truth of an account is not relevant in most cases, as Spence (1982) suggests, contrasting historical truth - *'what really happened'* - with narrative truth - *'the criterion we use to decide when a certain experience has been captured to our satisfaction'* (1982 p. 31).

Therefore narratives used are a reflection of the truth as the narrator sees is, or how they want the truth to be seen. It begs the question of the relevance of what the literal truth is, if there is even a literal truth. It could be said that everyone will experience events and situations differently, and therefore can there be a literal truth if no two people can experience something the same?

Choosing depth over breadth is an important aspect of research (McAdams & Zeldow, 1993), in order to increase construct validity. Along with this is the importance of being aware that while narrative analysis can tell us something about a person and their personality, due to identity being entwined in narrative, it does not tell us everything about them. Therefore with my research the focus is on a small number of participants, looking in detail at the data produced, and paying interest to how the couples present themselves and their experience so attempting to understand the identity they show, but also bearing in mind that this is not definitive.

6.10 Ethical considerations

Ethical considerations are paramount in any research that involves individuals, especially qualitative research as this characteristically involves participants divulging personal and often sensitive information. This was very much the case for this research, with narrators being asked to discuss a particularly sensitive time and experience in their life. It was also paramount to be ethically sound with this research as couples were telling their story together, and so there were additional concerns of issues raised that may be new or from a perspective not previously recognised by the other partner.

Participants were initially guided to the research website (Appendix 4), where there was detailed information about what the research was looking at, the reasons for this and what was involved. There was an opportunity through the website for interested people to ask further questions, and anyone who stated they wished to be involved was sent an information sheet (Appendix 5) with details of the process of the research, contact details of myself and of my research supervisor. This ensured that participants were fully informed about the nature and process of my research, and how their data would be used. Participants were informed that they could withdraw at any point and all data was stored securely and anonymously.

It was emphasised to participants that this was a research project, and whilst the interviews aimed to be therapeutic in the sense of the researcher employing counselling psychology skills to encourage a warm and non-judgmental environment with participants potentially benefitting, we were not entering into a therapy contract and there would not be any further similar meetings that could be considered an ongoing therapy. Contact details of relevant eating disorder organisations and relationship organisations were provided where participants felt they required further support, and they were debriefed at the end of the interview to ensure they were ready to go back into their day. Ethical approval was granted from City University in order to protect the rights of participants (Appendix 8).

All the narrators expressed an interest in receiving a summary of the findings of the study, and as this was to be some time after the interviews, I felt it important to check with them on completion that they would still like to receive it. This was to ensure that they did not receive information that could affect them in any way if they were not fully aware of what they were receiving, and to ensure they were prepared to receive the information. I also emphasised that the results would be based on my subjective analysis and interpretation, and that if they had any questions they were welcome to ask me.

7 ANALYSIS

7.1 Introduction

I begin this chapter with a brief introduction to the narrators involved in this research. The characters are presented, followed by within and between couple summaries. The dominant interpersonal-performative elements are explored. Exemplary narratives are included for illustration.

I am mindful that by making observations and presenting understandings of the narrators' meaning making, I am of course making my own meaning, contextualised by my experience, knowledge and environment. My aim is to make this process transparent throughout.

7.2 Narrators and Characters

I will present the narrators in the order in which the interviews were conducted. The characters I present are a product of the meaning making process co-created between the narrators and their story and my interpretations of these narratives. Characters are presented in the order I understand their role within the stories to be positioned, with the most prominent first. I contextualise the characters using factual information from the narrators.

Note that pseudonyms are used to protect participant confidentiality.

7.2.1 Simon (Narrator)

Simon is a man in his late 20s, presenting his story of a previous relationship of two years duration (ending around a year prior to our interview), with Jane who had an eating disorder. Simon and Jane met at work, where they developed a friendship first. It was '*common knowledge'* (line 6) at work that Jane had difficulty with food, so he was aware of this before they developed their relationship. Simon "*for some reason found that endearing..." (line 9)* Despite this, they did not broach the subject of Jane's eating problems in the initial stages of the relationship; demonstrated with *Extract 1*:

Extract 1

> *"In the early stages we avoided it I think – the age old saying of elephant in the room we were kind of too busy having fun as well as just enjoying each others' company, showering each other with affection and gifts and fun nights out...it was all a bit of a side issue and something to deal with later..." (lines 210-212)*

Simon talks about their relationship as being quite tumultuous, in that they would get on really well and "*bring out the best in each other*" (line 318), yet also having frequent and intense arguments. Jane did not receive any formal diagnosis for her eating difficulties, but it appears her main behaviour was self-induced vomiting.

Simon does not present many characters. This seems to reflect the isolative nature of the relationship and difficulties around the eating behaviours that he describes. I will now present these and explore how they are positioned.

7.2.1.1 Characters

Simon – describes himself as initially intrigued by Jane, wanting to help her and finding her endearing because she is a "*troubled soul*" (line 9). Simon positions himself as attempting to "*fix her*" (line 419), seemingly keen to point out this is from more of an affectionate than arrogant perspective – perhaps to present himself a more socially acceptable manner. Simon seems disappointed he was not able to do this and speaks of regret at having not pushed harder for Jane to accept help. However Simon acknowledges that this is likely to be due to his energy having run out for this, that he felt almost that there was no point. Perhaps this is to help himself feel better about how the course of their relationship and the eating difficulties for Jane played out.

Simon presents as dissatisfied with the lack of emotional intimacy and closeness he gained from Jane. *Extract 2* demonstrates how this ultimately led to the ending of the relationship, along with burnout which Simon seemed to have reached but did not necessarily notice until after the relationship had ended:

Extract 2

> *"... she was kind of super generous with her love she was very affectionate she loved cuddles she loved closeness she loved sex that was a big thing for her, but after a while I think all of that became a little bit shallow, and because I didn't believe it I stopped believing it was real it was like her grabbing hold of someone when I wanted intimacy I wanted to feel someone close to me rather than to cling onto me you know I wanted to share my experiences my life and everything but it didn't feel like a sharing..." (lines 475-483)*
>
> *"I did say to the guys [after he and Jane had broken up] "I feel like I've just woken up like I've been in some kind of – I just didn't feel present at all for the last year or two it was so all consuming"..." (lines 340-342)*

Simon seems to have enjoyed being the only person to see the gentle sweet side of Jane, as though he was privileged.

Simon positions himself as lonely, unable to talk to anyone about Jane's difficulties. This is emphasised with the lack of supporting characters within Simon's story, and contributes to Simon being burnt out by the end of the relationship.

Jane – Presented as having a hard exterior yet having a sweet, gentle and loving side that only Simon gets to see. Perhaps this for both Jane and Simon was a barrier to recovery – that Simon enjoyed this privilege and perhaps for Jane it was something special to only 'give' to one person.

Jane is presented as difficult to get along with, being angry, defensive and withdrawing into disordered eating behaviour if Simon did not react to her in the way she wanted him to. Simon

emphasises Jane's lying perhaps to demonstrate further the difficulty he had in reaching and helping her.

Simon presents Jane as being almost too affectionate towards the end of their relationship, desperate for closeness, as illustrated with *Extract 2* above.

Jane is presented as being possessive of her eating difficulties; referring to them as *"her thing"* (lines 260, 523 and 525). This is presented as an obstacle to the relationship developing.

I understand Jane to have been ambivalent about her eating behaviours. *Extract 3* below illustrates her conflicting behaviours of wanting to be secretive but wanting Simon to know - positioned as a difficulty for Simon to know how to help her.

Extract 3

> *"...she's living a lie, she doesn't want anyone to know, although she would leave signs which I'd noticed before, and that might be a calling for help at times. Erm I used to – this is quite disgusting I suppose on the face of it but you could sometimes smell that she had made herself sick in the toilet. She used to spray deodorant or air freshener and I always used to think that when she stopped spraying it she wanted help because she knew I would know..." (lines 133-139).*

Perhaps this was something that Jane was proud of in some sense. The ability to control her weight as and do this completely alone without the help of anyone else perhaps felt like an achievement for her.

Eating behaviours - a character obvious to other people from early on, and being part of what endeared him towards Jane initially. Eating Behaviours are presented as Jane's possession and therefore responsibility. I understand them to be Jane's defensive shield to prevent people getting close to her, and to communicate she was struggling. Simon perhaps presents them in such a way to further reinforce how difficult it was for him to reach Jane with regard to her difficulties, justifying his inability to help her.

Other Behaviours - described as: lying, becoming emotional, withdrawing, crying, becoming angry and being defensive, being tied in with Eating Behaviours, and equally as present. Other Behaviours are presented as the ultimate barrier to preventing Simon getting as close as he would have liked with Jane, again perhaps as further reinforcement of what he was 'up against', to improve his self-image.

7.2.2 Character summary

I understand Simon's story to be an unsuccessful rescue story – with Simon the very willing hero who is ultimately defeated due to the victim's reluctance to be rescued. It seems that he reached a realisation that there is only so much someone can do for another who does not want or is unable to accept that help.

I feel that Simon is trying to demonstrate extensive knowledge about eating disorders, showing that he ought to have been capable, in a way to demonstrate just how difficult it was to help Jane. Simon's story reflects his own struggle with his self-concept – he sees himself as a hero but is not able to fulfil this role, and so ultimately walks away from it. There is a lot of hope initially from Simon, in terms of him being able to help Jane, her getting better and them having a successful relationship. However at the end of the story this is more of a weary acceptance that he was unable to achieve these hopes.

The lack of a large cast within Simon's story reflects his reported loneliness and isolation in his attempts to help Jane. Along with this is Jane's defensive possessiveness of the eating difficulties which made it very hard for anyone to get close to her, leaving Simon alone within the relationship as well as outside of it. Simon's presenting of Jane's possessiveness leads me to understand that she wanted to keep it to herself, that it was almost something special for her. This presents a huge obstacle to recovery for her, and to a functioning relationship.

7.2.3 Sally and David

Sally and David, in their late twenties and early thirties respectively, have been together for three years, and married a few months prior to the interview. Sally developed anorexia a long while before they met, and David did not know much about it when they first got together, although was aware that Sally was experiencing some kind of mental health difficulty, akin to depression.

David himself has experienced depression, having peaks and troughs in his mood. Sally and David met through work, when David joined the company Sally worked for. They *'hit it off quite well'* (line 15) after what seems to have been a slow start. This was due to Sally being on long term sick leave shortly after David's arrival at work, and her reluctance to allow someone to get close to her initially; especially as she had been David's superior at work.

7.2.3.1 Main Characters

The Relationship - positioned as a main character, with a strong role of holding everything together, continually having to deal with Anorexia, understand it and work around it or with it as well as having to do the same with David's depression. The Relationship is portrayed as strong, committed and long term, with emphasis placed on how quickly and how well it became established. Although the focus remains on Sally and Anorexia, there is a strong sense of reciprocation with both narrators discussing how they have individually had difficult times, but support each other, as demonstrated with *Extract 4*:

Extract 4

> ***Sally:*** *"...while I was in hospital you had a breakdown*
> ***David:*** *yep*
> ***Sally:*** *partly to do with that and partly to do with your own things, and David went into inpatient care, so I was in day care and as soon as I'd finished I went to hospital to see you. It wasn't really at all conducive to getting better really*
> ***David:*** *to recovery for either of us.*
> ***Sally:*** *it was a pretty horrible time for both of us but I suppose the thing is that we stayed together*
> ***David:*** *made us stronger" (lines250-262)*

Communication is also presented as an important part of The Relationship, as David illustrates with Sally's agreement in *Extract 5*:

Extract 5:

> ***David:*** *"...and that's still the fight today is against the need to lose the weight and a regular pattern of weighing yourself and sometimes being angry about the results, sometimes she was quite secretive about what the weight was*
> ***Sally:*** *mm*
> ***David****: wouldn't tell me*
> ***Sally:*** *mm*
> ***David:*** *um but since then we've talked about it and a lot and I've said "ok well I'm not happy about the fact you're sometimes weighing yourself 3 or 4 times a day but um I want you to tell me what the weight is and how you feel about it"*
> ***Sally:*** *mm" (lines 842-856)*

Sally (Narrator) - is positioned as vulnerable initially – demonstrated by *Extracts 6* and *7*, but demonstrates as time goes along in the story a quiet persistence and strength that keeps her going.

Extract 6

> *"...I was quite vulnerable really...someone could have taken advantage of me..."* (line 49-51)

Extract 7

> "*...I didn't really have a reason for life because so much stuff had happened"* (line 130).

Sally puts herself in the position of victim, particularly of external factors initially. This is illustrated with *Extract 8* where Sally is talking about data protection issues preventing her therapist talking to her mum and David despite her saying she wanted this to happen (as she felt they would be more able to illustrate what was happening for her at the time):

Extract 8

> *"I said the people I'm happy for you to speak to are my mum and my partner, "...that was really frustrating because really I think that caused more stress because it just felt like we weren't getting anywhere." (lines 206-208).*

However through the story Sally is positioned as stronger and in more of a position of ownership of her situation, as *Extract 9* illustrates:

Extract 9

> *"so basically I'd done all that work and I was gonna be made redundant, and I remember just crying at our head of services saying "I've tried so hard and this is what you are doing to me", but then when I thought about it I actually applied for voluntary redundancy because it was the job that really wasn't helping me recover..." (lines 326-331).*

David (Narrator) - positioned as supportive despite his own vulnerability and struggles. He is portrayed as initially quite clueless about anorexia or eating disorders, gaining knowledge and understanding throughout. In the beginning of The Relationship he is positioned as being patient, persistent and persuasive in getting Sally to agree to meet him.

David is portrayed by both, but especially Sally, as providing much hidden support for her, and providing an essential role, as demonstrated with *Extracts 10* and *11*. *Extract 4* above demonstrates the difficulty David had at times with being there sufficiently for Sally. As the narrative progresses however this seems to become easier for him, when he says *"it's never been an issue for me"* (line 574) in reference to having to do the shopping because Sally finds going to the supermarket overwhelming at times.

Extract 10

> *"It still scares me what would have happened to me without meeting David ...' cause I have to say for me it's I mean he's like given me a reason for life..."(line 127)*

Extract 11

> *"People on the outside probably think oh you know it's all really fine, but there's all these things and actually it's weird when you're talking about it to realise it 'cause most of the time I do think 'there's nothing wrong with me', but I actually do think if David was taken out of the equation I think I would really struggle massively. There is a lot of hidden support I think because if David wasn't there I would struggle still, so I think he does prop me up quite a lot and again people on the outside people don't realise how much that is." (lines 421-423)*

Anorexia/ Eating Disorder - Eating Disorder's story started *'way back'* (line 8) before The Relationship, and therefore before the story Sally and David tell to me - indicating it has a long history with Sally. Throughout the stories Sally and David tell, Eating Disorder, or Anorexia (it is referred to as both interchangeably throughout) is discussed in a matter of fact way, the effects of it and its ever present nature are alluded to often. In this way it is positioned as a character that affects many aspects of Sally's, David's, and The Relationship's stories.

Sally's Initial Job – I interpret this character to be positioned as a main and fairly villainous character, having the important role of increasing Eating Disorder's presence. It is given much recognition for the role it plays in how Sally feels, and in her forcing herself to appear 'better' although this was not the case, and in her ultimate decision to leave when given the opportunity of redundancy (see *Extract 9* above).

When Sally's Initial Job is removed from the story, Sally begins to get better, and it opens the way for one of the supporting characters - Sally's New Job - to enter the story.

7.2.3.2 Supporting Characters

Sally's New Job -enters as Sally's Initial Job exits the story, is positioned as being a pivotal character in helping Sally to feel better; illustrated by Extract 12:

Extract 12

> ***Sally:*** *"...within a couple of weeks I got a new job and that's really been a huge turning point*
> ***David:*** *best decision you made wasn't it..." (lines 334-337)*
> ***David:*** *"...you started your new job and it was almost like a new lease of life for you wasn't it...the change of job was what really helped you wasn't it*
> ***Sally:*** *to sort of stabilise stuff ..." (lines 385-388)*

Eating Disorder Services, and Psychotherapist – positioned as not understanding, not listening, not giving enough relevant support to Sally, and not taking The Relationship seriously. Their role is that of leaving Sally and David feeling frustrated and restricted by rules and regulations, as described in *Extract 13**:***

Extract 13

> ***Sally:*** *"I was receiving treatment, going in for therapy and seeing a dietician but it wasn't really getting anywhere*
> ***David:*** *you weren't really getting the support you needed...*
> ***Sally:****... it was another year 'cause I kept going every week, then stopped for a while*
> ***David****: you stopped for a while*
> ***Sally:*** *'cause they said I wasn't engaging or whatever, then I had to write but I don't know if I really believed it, just sort of did it. So it was a year later and was using other behaviours, then they took me into day care because by then I wasn't really eating a lot*
> ***David:*** *well we got to a stage where I was getting really worried and so was your family particularly your mum about the lack of support you were getting...I remember we got really frustrated with the eating disorders unit because they weren't in our opinion taking things seriously. Sally was having some counselling with someone, who despite Sally saying that she was more than happy for him to talk openly with me and her mum, I felt he wasn't taking Sally seriously. It was really scary*
> ***Sally:*** *they had this policy in place for data protection, and I understand all that you know, but if I say I'm happy , because sometimes I couldn't really sort of talk about what was going on so my mum and David were better paced. I still thought I wasn't ill enough to be taken seriously because I was still getting up in the morning and sort of functioning, but I look back now and realise mentally I wasn't really functioning...."*

Beat - the eating disorder organisation, given a role of being very supportive, and positioned as an open and helpful character in a way that perhaps suggests David may not have managed as well in providing support for Sally without this help. *Extract 14* is an example of David explaining this:

Extract 14

> *"and as a sort of thank you in a way I've...been accepted into the ballot for the London marathon I've chosen to raise money for Beat charity that means a lot to Sally and I, and I think the work they do is amazing and the support that they give is fantastic under a tight budget, and I'd like to pay them back you know..."*

7.2.4 Character summary

The victim role that Sally presents herself in could be in order to create an image of being helpless and unable to change the situation, justifying this occurring earlier on, and giving further credit to herself and David for managing the difficulties as time goes on.

There is a mirroring with David's persistence and Sally's persistence, as David's is presented in a gentle unassuming way in a similar way to Sally's being presented as quiet. This could be mirroring Sally's recovery from Anorexia which is presented as steady and gradual. It feels to me as though a less gentle approach from David in attempting to help Sally would be too

strong, that it would result in Sally being more resistant and defensive retreating further into Anorexia.

The support that David provides for Sally is presented in a contradictory way in terms of David's perspective as I understand it. There are times David emphasises the naturalness and ease with which he takes on certain tasks but then other times when his own mental health suffered. Perhaps this is a suggestion that he had reached burn out in terms of being unable to find all the resources necessary for helping Sally, and therefore retreated into his own problems. I interpret this contradiction to be David demonstrating the difficulties he has had despite his and Sally's co-creation of them being able to get on easily with managing Anorexia.

The matter of fact way in which Sally and David present Anorexia seems to me to be necessary for Sally and David to be able to talk about it with others and between themselves. This interpretation is based on them presenting themselves as being overwhelmed at times with emotion; therefore this helps them to detach from the emotional aspect of it. While this co-creation between them may be helpful for them dealing with Anorexia on a day-to-day level, it could also be a collusion that allows Anorexia to remain present. The minimising of the emotional aspects of the situation perhaps lessens their impact, making it easier to be accepted as part of their story.

David does however on occasion refer to Anorexia as *"your eating disorder"* (lines 8, 475, 648) in relation to Sally, perhaps at those times giving the responsibility to her for its presence and effects, in an implicit way. This could be a reflection of David's unexpressed feelings about the Eating Disorder, which as the voices of individuals without their partners are not heard here may be present without my awareness. It could however also be a reflection of the way in which David and Sally discuss Anorexia together, which could mean that it is less pressure for Sally if it is presented as 'her' responsibility in an implicit way and therefore help it be less overwhelming to deal with. Conversely, it may remove some of the responsibility for Sally making it less likely that she will take the lead in managing it.

The emphasis placed on the Sally's Jobs regarding their importance to Anorexia demonstrates that there are many potential elements within a person's life that can impact an eating disorder as well as relationships which are being focused on within this research. I understand Sally's presentation of this to be that a job can add or reduce stress levels, which in turn impact the course of maintenance or recovery. It is not possible to assume cause and effect as this was not what was being analysed here, but it demonstrates the potential that all areas of life can impact upon an eating disorder, highlighting possibilities for relapse if a stressor were to return.

My understanding of Sally and David's positioning of Services as a character within their story demonstrates that I have recognised an emphasis on this aspect. This demonstrates how co-creating can create the meaning in a story, as I am presenting it here as a story of David and Sally succeeding mostly by themselves despite other characters potentially acting in an unhelpful manner.

There is of course another perspective, an unknown one of Services themselves. They will have formed their version of Sally as a 'character', perhaps that she was unwilling to engage, difficult to work with, or maybe felt hopeless about the chance of working successfully with her. Of course as this voice is not present I can only speculate as to these possibilities. What it does demonstrate however is that Sally and David felt strongly enough about their experiences of not being provided with what they believed they needed that it has come across with an emphasis that I have picked up on within their story.

My focusing on Sally's perspective here demonstrates how much I was drawn in to her story and experiencing of what happened. Perhaps this is because for her this aspect is an important message she is trying to get across in order that Services experiences are better for others.

That David positions Beat as such a helpful character is in contrast to the unhelpful way in which they present Services. This raises questions about what was the difference between them that one was able to seemingly provide that the other was lacking. Could it be that Beat is a charitable organisation that involves many other people who are living with or have lived with an eating disorder? This could mean that they are seen more to be working alongside people such as Sally and David, rather than 'doing to' in the way Services are presented as doing?

Positioning themselves in the way they do in relation to Anorexia, Sally's Jobs, each other and The Relationship creates in my understanding a story of teamwork, of struggling against external obstacles (that despite knowing what some of them were – Initial Job, Services – being clueless at least initially in how to change or manage them) and of succeeding. It seems that they are trying to put across that they have successfully managed Anorexia and its effects on them and The Relationship but are not quite able to position themselves as completely separate from Anorexia yet.

7.2.5 Mel and Ben

Mel is in her mid-twenties and Ben a few years older; they have been together for ten years, are engaged, although they do not explain how they met or became a couple. Mel moved in with Ben when she was 16, and there appears to be a back story of family issues on her part that had a bearing on the decision to move in together at such a young age, but this is not expanded on.

Mel's eating difficulties have been present since she was a child, although her anorexia was not apparent and diagnosed until she was at university. This is where her problems with eating got worse and developed into anorexia. At this point she alludes to other mental health difficulties such as self-harm and post-traumatic stress disorder.

7.2.6 Main Characters

The Relationship - starts off as clueless as to how to manage Anorexia, and as passive in the hands of Eating Disorder Services. The Relationship gains understanding throughout the story, ending up as triumphant in terms of working out without external help how to get through the difficulties and come out stronger as a result.

***Mel* (narrator)** - takes on a main role, again initially quite clueless and perhaps in denial of having any problems, becoming - as described by both Mel and Ben and other supporting characters in the story - a strong, determined, stubborn, driven, ambitious character, at times frail and vulnerable. Ultimately Mel is triumphant and recovered from Anorexia, fuelled by a situation described in *Extract 15*:

Extract 15

> *"I realised in that moment that I didn't need my food to cope with my feelings any-more...I think that realisation helped me kind of speed up my recovery quite a bit, and after that I kind of did it myself..." (lines 703-708).*

Mel positions herself initially in a child role: needing her tutor to take her to the doctor, and being very reliant on Ben for support, in a parental role. Mel demonstrates initially a position of victim, somewhat of the system more than the anorexia itself. The strength she describes then becomes apparent, being built up due to feeling unsupported elsewhere, determined to get better, working together with Ben to do so. Mel appears quite possessive of her Anorexia, referring to it as *"my eating disorder"* (lines 400, 585, 692 736).

I observe twice with Mel when she is presenting a situation in which she is protected, that she views this as being due to her threat to others, where it is likely that it was more for her own protection, as illustrated here (see Appendix 7 for a key to transcription symbols):

Extract 16

> *"um the psychiatrist said if I self-harmed while in hospital I would be moved from the eating disorders unit to the secure ward {>'cause clearly I'm a threat to people<} (line 297-298)*
>
> *"...clinical psychologist who did the assessment...with a panic alarm under her foot and a panic alarm around her neck and I'm sitting there four and a half stone like really... I couldn't kill a fly heheh..." (lines 356-361)*

Ben - positioned by both himself and Mel as 'carer', having an important and quite parental role in supporting Mel and often taking a role of responsibility, frequently taking an authoritative role, something which comes across strongly throughout the story. Ben is portrayed as being very protective of Mel.

Ben places himself in a position of giving advice to other people, mainly carers, in his situation, positioning himself in an 'expert' role. *Extract 17* demonstrates this along with the idea that Mel was reliant on Ben, and the idea that this could get too much if he did not practice self-care.

This links with the idea of carer burnout (Miller, Stiff & Ellis, 1988; Burleson, 1990; Barbee, 1990) – that sometimes carers can run out of resources to help their partner.

Extract 17

> *"I think that's one thing I'd recommend to sort of other carers really is make sure you are looking after yourself as well, 'cause more than anything I know if I'd fell apart there's no way on earth Mel would have been able to keep things together and progress in her treatment." (line 814-817)*

Anorexia/Eating Disorder - it is almost as though Eating Disorder is a sub-character of Mel, as it does not appear to be given a role of its own so much as the focus being on Mel being ill, making it difficult to get a sense of the character it has. Perhaps this has contributed to Mel's recovery, in that Anorexia is not the sole focus. It is positioned almost as a possession, and personified at times; *Extract 18* provides an example of this:

Extract 18

> ***Ben:*** *"I don't want to talk to the Eating Disorder I want to talk to Mel" (line 819).*

Eating Disorder Services - is given a leading negative role. It is positioned as being extremely unhelpful - not supportive of Mel, her specific needs, or of Ben's role/position as Mel's partner - and not recognising the significance of The Relationship. Mel and Ben both portray Eating Disorder Services as being shortsighted, and as viewing them as children.

Inter-linked with this character is one I understand to be a villain - that of *Psychiatrist*; positioned as incompetent, not compassionate, and as sharing many of the traits described for Eating Disorder Services. Mel and Ben position themselves as determined towards the end, to show Psychiatrist that they had managed the situation better by themselves.

Kate - a Counselling Psychologist, who is positioned in my view as the heroine of the story, illustrated by *Extract 19*:

Extract 19

> ***Ben:*** *"and then one [therapist,] who I can only describe as an amazing lady who definitely saved Mel's life" (line 460).*
> ***Ben:*** *"...Mel came out [from the first appointment with Kate] and just had this instant glow about her of you know 'yes I can do this' and 'oh my god someone's actually listened to me and I think that was the key point really wasn't it*
> ***Mel:*** *yeah, I think that whole time the psychiatrist had been saying "this is something you learn to manage"... nobody had ever said you could get better..." (Lines 514-520 & 553)*

7.2.6.1 Supporting Characters

Accompanying Mental Health Issues *(Post-traumatic Stress Disorder (PTSD), Obsessive Compulsive Disorder (OCD) and Self Harm)* - I have grouped these characters into one as

they are mentioned numerous times as other presenting issues Mel was struggling with alongside her Anorexia, but are not talked about in depth. They are discussed by Mel and Ben as issues that Eating Disorder Service and Psychiatrist did not seem to take into account - they were only looking at Anorexia - supporting the position given to Eating Disorder Services as being incompetent.

7.2.7 Character summary

Mel and Ben use their characters to present a story of triumph as I interpret it. Their characters are positioned in a way that demonstrates they had obstacles to overcome and were not taken seriously by services. This leads to me wondering about the absent voices, those of Services and of Kate – how would they position themselves in the story? An element that comes across strongly to me is that Mel and Ben feel as though they were not listened to sufficiently, other than by Kate. I wonder though what would have helped them to feel listened to? Mel talks about The Psychiatrist initially not taking Mel as seriously as she was trying to convey, and her comments about her hurt obviously not showing enough therefore she needed to get thinner demonstrate that she wanted someone to take it seriously and hear this message. Perhaps the timing makes a difference; when Mel saw Kate she said it was Kate's belief that she would get better that made a difference to her. Maybe in the earlier stages Mel was not ready to get better, or that she needed someone to acknowledge to her that they saw how much she was hurting and that in itself was sufficient for her.

Mel's positioning of herself initially in a child role, and Ben's continuing role presented as being protective of Mel leads me to understand attachment relationships between them could be around Mel needing the caring protective reaction of someone, especially as she mentions (without detail) difficult relationships and long term estrangement from her family since her teenage years. Perhaps Anorexia provided an explicit reason for this need and meant that it was forthcoming from Ben and perhaps adds reason to why she presents as being possessive of it. My interpretation is that as the story develops Mel realises that she does not need the extreme situation of Anorexia to be sure of this from Ben. Indeed, perhaps also receiving unconditional positive regard from Kate helped Mel to realise that she could still have this care without having Anorexia.

Mel's positioning of herself as understanding the measures taken for safety to be about her being a danger seems to me to give the assumption that Mel believes others think badly of her. This suggests a lack of self-esteem or a core belief that she is in the wrong, which in terms of my meaning-making is incongruous with how strong and successful Mel is towards the end. Perhaps this is why there is such an emphasis for her on this aspect, as though she and Ben are creating together a new self-concept for Mel. Maybe this new self-concept that is being produced by them as a couple is one that fits more with Mel's ideal-self, resulting in her being happier. As Ben seems complicit in this re-storying it suggests to me that he is also happy with this, although they both make it clear that it is a period of transition and learning how their roles work together now.

7.2.8 Beth and Adam

Beth and Adam are in their early thirties, having been together for thirteen years – following meeting through friends - married for ten years, and have two young children (the only couple within this research with children).

Beth's eating difficulties have been present for a long while without her realising that she had any problems, but that when she got together with Adam she wanted to sort her difficulties out, as she was concerned about the effect on the relationship. This was when Beth discovered that her eating difficulties were Anorexia.

7.2.8.1 Main characters

The Relationship – presented as strong, enduring and *"amazing"* (line 162); although with the realisation that without Anorexia they would potentially have an even better relationship, as illustrated by *Extract 20*:

Extract 20

> ***Beth: "****my counsellor said to me once "I feel sad you won't experience a relationship without this, think about how good your relationship is now and how much you love each other now, imagine how wonderful your relationship could be if you didn't have this issue restricting you" and she's so right...*
> ***Adam:*** *...It is frustrating because what we have in our relationship I think it is amazing I really do think it's incredible and I think in some way maybe we owe what we are to anorexia in a certain extent because maybe we wouldn't be this strong or this solid if it wasn't for the tests you know and the trials and stuff we've been through. I don't really wanna give any positive feelings towards anorexia so it kind of leaves a bad taste in my mouth but erm it is strange to think that was we have is so incredible and yet it could potentially be even better, even more valuable if it wasn't tainted or worsened slightly all the time by anorexia..." (lines 582-586 &608-617)*

Communication is presented as an important aspect of The Relationship, as illustrated with Beth's words in *Extract 21*:

Extract 21

> a) ***Beth:*** *"...so communication was always really important for our relationship to survive if it was negative even if we were arguing or he was having to listen to me explain things that were upsetting um it was still wholly important that he did otherwise I would have just felt disconnected to him...so we kind of made a pact that we would always tell each other the truth. If I said "oh I wanna eat I just wanna eat peas and sweetcorn for dinner" he wouldn't say "well that's ok that's better than nothing he'd say "well that's not really good enough" (.) "you know that's not really ok, and if I looked really skinny and really ill he would say "oh no you look really ill I don't think you should wear that because you'll go out and people will stare at you"" (lines 467-470 & 476-487"*
>
> b) ***Beth:*** *"...and we said you know ok we wanna have children but it was a really big decision for us 'cause kind of like taking that step to say no I really am well enough and Adam saying I agree you're well enough" (lines 159-161).*

Beth – I interpret that Beth identifies strongly with 'Ed', being quite defined by it, especially in the way she thinks, and her anxieties, that has a significant impact large impact on her emotionally and behaviourally. *Extract 22* illustrates one of Beth's reasons for her developing an eating disorder. Throughout her narrative Beth asserts her knowledge and experience of anorexia, and her position of being able to advise others in a similar situation.

Extract 22

> *"..my mum suffered – still suffers – with serious depression, and when I was younger that had a massive affect on my childhood responsibilities, but also I heard distorted sort of messages or comments when I was very vulnerable very young age maybe 10, 11 about sex and pornography sort of unwanted male attention, not to me but I heard about those kind of things from my mum and from a friend, and that had a really negative impact on my opinion of men and pornography or sexual sort of attention and everything, and that dictated a lot of my morals and challenges with relationships, trust and things like that. It almost impacted me in a similar way to people who develop eating disorders after having been sexually abused."*

Beth displays anger and frustration towards herself for not being *"able to shake off the anorexia"* (line 620) and towards others for their reactions to her because she has a history of anorexia. Beth is very open about her thoughts and emotions throughout the narrative.

Adam – Adam presents himself as wondering initially *"whether I felt I was strong enough"* or whether the situation with Anorexia would *"make us both drown"* (lines 78&79). However as the story progresses, Adam presents himself as being determined to stick with it as he loves Beth. *Extract 23* demonstrates the constant struggle in terms of managing 'Ed' despite being very knowledgeable about it. This is in the context that his self-described characteristics are incongruous with Anorexia.

Extract 23

> *"I'm quite a pedantic dogmatic person which you know is really quite detrimental to er us and to anorexia to me dealing with stuff because you know anorexia's really illogical..but the pedantic side of me is saying "but it doesn't make sense" and I'll have to bite my lip on that. But then I think if I wasn't that kind of dogmatic persistent pragmatic person then I might not have stuck around at the beginning, but because I had decided Beth was the one that pedantic and dogmatic side of me stuck it, so I suppose there are pros and cons of that sort of character trait..."*

Ed/E-D – the name given to Anorexia, which is personified and presented clearly as a third, disruptive person in The Relationship, as demonstrated with *Extract 24*:

Extract 24

a) ***Adam***: *"...there has always been kind of 3 people or 3 bodies in this relationship obviously there's me and Beth and then there's Ed, E-D...it's like this other character third person, who if Beth is having a good day will eventually come out towards the end of the day and basically sabotage the day because she doesn't feel worthy of ...being so happy. If the anorexia was strong in Beth's head then she would need me to help her argue against Ed...like two against one...if having an argument she would interpret that as me and Ed ganging up on her and being two against one in the wrong direction and obviously the anorexia would use that to its advantage and then make her feel bad etc etc..".(line216-230)*

b) ***Beth***: *"...because anorexia's telling me I shouldn't feel that I shouldn't want...it almost persuades me that I need to be subservient about everything and have no opinion about anything..." (lines 244-245 & 248).*

Beth and Adam put across an acceptance of Ed, suggesting they expect it will always be present in their lives and The Relationship, as demonstrated with *Extract 25*:

Extract 25

Adam*: "I'm not sure with your self esteem, your own personal opinions obviously of your self esteem and body image I'm not sure we'll ever go on a beach holiday ever again*
Beth*: No*
Adam*: And I don't think we'll ever go on a cruise 'cause there's too much food available so it is restrictive, and ultimately it would be great if Beth was 100% over this at some point but as horrible as it sounds I think we're probably accepting that that probably isn't gonna be the case which is um frustrating*
Beth*: You say to me sometimes don't you 'even if you're 60 or 70 years old and I'm still having to listen to you bang on about what you've eaten today I'll still be here and it'll still be ok, I'll be bored of it but'. My counsellor once said to me, and it was upsetting to hear it, she said 'I feel sad that you won't experience a relationship without this, think about how good your relationship is now and how much you love each other, now imagine how wonderful your relationship could be if you didn't have this issue restricting you and prohibiting and inhibiting the things that you can do and enjoy and feel and experience.'. And she's so right, but I can't see a way out of it. You know it's hard to comprehend it being completely gone."*

The Children - although they don't enter the story until later, they are positioned as being in an important role, especially in relation to Beth's feelings, and her behaviour with Anorexia. Beth appears to position herself as an anxious mother, mainly in relation to not wanting The Children to pick up her anxieties and behaviours regarding food, body image and self-esteem. *Extract 26* demonstrates Beth and Adam reflecting on how they may be affecting their children, by perhaps fostering in them the same need for intensity within relationships as Beth has developed from her parents:

Extract 26

> ***Adam**: "...we do have a relatively normal life I think ad we have good times the kids are good I mean we try and keep I mean they're quite young - 4 and 6 - and they're probably more aware of stuff than we realise but Beth's a vegetarian but that's as far as it goes you know she eats different things because of that*
> ***Beth**: yeah so even if I have vegetarian spaghetti bolognaise they have normal spaghetti bolognaise. I think having children in the picture puts on added pressure but also motivation to be well because you feel a parental responsibility to set a good example and show healthy eating and exercise and not be obsessive on one thing because you don't want to have a negative effect on them". (lines 679-692)*

7.2.8.2 Supporting Characters

Counsellor – given the important role of identifying Beth's difficulties as Anorexia, although not discussed much in the narrative. This labelling of Beth's difficulty helped Beth and Adam learn more about it and how to manage it.

Other People - they are scattered throughout the narrative, sometimes specific others but more often generalised, used to position Beth and Adam as more knowledgeable, 'expert' in the area of knowing much about Anorexia and how it affects relationships and partners, and to position The Relationship as superior to many others that do not survive difficulties like Anorexia. Other People are also positioned throughout to help back up or justify what Beth and Adam are narrating, to compare themselves with the Other People to this end. *Extract 27* provides one of a few examples of this:

Extract 27

> **Beth:** *"...which I think is often the case for people in our situation. But ironically we do know some people who-where she has had anorexia or has anorexia and has got much better to the point where she thinks she is ready to have a baby but I can see she's not because obviously I've been through all those ups and downs so it can be frustrating to see someone else going through similar situations and knowing your own mistakes and what advice you wanna give them but knowing it's none of your business..." (lines 150-156).*

Beth's vividness with detail regarding her emotions and how explicit they are throughout her narration leads me to understand that they are very 'raw' and present. This strikes me as a potential obstacle regarding recovery from Anorexia as Beth is very much immersed in 'living it'; very attached to 'Ed' and the situation she and Adam are in regarding 'Ed's' presence. It may be difficult for her to see where Beth ends and 'Ed' begins, especially considering my understanding that she identifies strongly with 'Ed' in the sense that her thoughts and moods are dependent and reliant on 'Ed'.

Adam's initial struggle to know whether he would be able to continue his relationship with Beth suggests he was aware there was a potential for him to burn out. I interpret him wondering if he would be able to provide sufficient support for Beth with Anorexia present. It almost seems to

me as though this was a stage where he was wondering about his own self-concept, by which I mean contemplation on his part of who he wanted to be. Did he want to be the person who walked away from someone who was struggling, the person who stayed and let the difficulties defeat him, or the person who was able to be there for Beth? As we know from the story he chose to be with Beth.

I am lead here to questioning what this might mean for power relationship and the course of The Relationship – Adam is clearly stating that *he* chose to stay with Beth, especially as Beth is explicit about her low self-esteem and her worries earlier on that Adam would leave her. I wonder about expectations for the Relationship from both individuals; did Adam have hope that Anorexia would eventually not be present, or did the acceptance they discuss together start for him at the stage when he decided he did want to be with Beth?

Beth and Adam present themselves as very accepting and in some ways accommodating of 'Ed', the third 'entity' or 'character' in their relationship. As relating with, around and through 'Ed' throughout their relationship, I am lead to wondering if they would know how to relate without this presence. This perhaps adds to their acceptance, even if not a conscious reason. Beth is explicit about the difficulty in letting something go if has been a way of being for such a long time. It is as though she no longer knows her own mind; there is a need for Ed to be there so that she can recognise her own thoughts as different to 'Ed', rather than recognising them for what they are alone**.**

I wonder if Beth and Adam would view The Relationship as 'amazing' if it were not for 'Ed'. Maybe 'Ed's' presence allows them to focus more on ensuring it is of good quality because there is always a threat to it, and perhaps their opinion of it being 'amazing' is because they know there is something trying to ruin it for them. If there were no obstacles would they still feel this way?

7.3 Observations and findings between the narrators and their characters

Here I present my observations and interpretations across the narratives, how they seem to me to compare with each other in regard to the characters presented, their positioning and their roles.

7.3.1 Eating Disorder/Anorexia

This is presented as a main character across all of the narratives, demonstrating the central role it plays within the lives and stories of all the narrators. The way Eating Disorder is presented and positioned differs across the narratives however, with these positions detailed here:

- **Personification of Anorexia**

Beth and Adam in particular present 'Ed' as a third character or entity within their relationship. Mel and Ben also do this to an extent but not to the same degree. It does seem as though Beth

and Adam see ‘Ed’ as a permanent character in their relationship, potentially hindering chances of reducing the impact Anorexia has on Beth herself and the relationship. Simon’s narrative presents perhaps the opposite of this, that the eating disorder was not externalised enough which lead to difficulties in the relationship. Simon positions it as Jane’s behaviour and her responsibility – perhaps this is the meaning he created with Jane as she positioned it as such within the relationship. It could also be however that because Simon was telling his story alone that he felt more able to attribute responsibility to Jane, whereas the other partners were telling their story with their partner.

This meaning-making may differ between Simon and the other narrating couples also because of the commitment and long term element of the relationships. For the couple narrators, their relationships are committed; the men have ‘opted in’ to help with the eating disorder, and the women are willing to have this help. This perhaps then leads the couples to position Anorexia as something they were tackling together, as a team, and so positioning it as a character in their story enabled them to do so. It seems from Simon’s narrative that he was willing but Jane was not accepting of help and therefore it became an impossible situation.

Beth and Adam explicitly state their awareness of the potential that Ed’s presence as a third entity within their relationship could be an obstacle to full genuine intimacy. Sally and David, and Mel and Ben, however, do not allude to this in their narratives, rather they discuss that they know they are one of few couples who survive living with an eating disorder and talk about their closeness. Simon’s descriptions of his relationship with Jane give the impression that it was a toxic relationship, as there were many obstacles, difficulties and issues that were not discussed or that affected the relationship they had with each other. This difference in awareness of such potential toxicity is intertwined with how a couple make meaning between them within their relationship and how they contextualise their experiences. Perhaps if there are too many differences in how the individuals are influenced by their context this is harder to reconcile as a couple.

- **Possessiveness of Anorexia**

I understand Sally and David to have more difficulty in letting go of Anorexia than Mel and Ben. A difference I notice between these narratives is that Sally and David describe Anorexia more as a possession, whereas Mel and Ben are more detached in their language around it, allowing perhaps for easier disengagement. Simon’s presentation of Jane is that she was possessive, controlling and secretive about her eating difficulties, which lead to it being hard for her to let go and for Simon to get near to help her. Maybe Jane did not have another way of coping with the situations which she controlled by using her eating disorder. Mel alludes to this too, realising that she no longer needed Anorexia as a coping mechanism. Perhaps then it could be that personifying and externalising the eating disorder may be more helpful than possessiveness, but if taken too far it could lead to acceptance and prolong its existence.

It is also relevant to think about what ownership of the eating disorder means to the women. If it is a possession in this way and such an all-consuming possession, what do they own without it? Do the men own anything to the same degree? If they do, what would that mean for the woman if she no longer had the eating disorder, and how would this affect the relationship? What would their individual and couple stories be without the eating disorder?

Perhaps this leads to a maintenance of the eating disorder, particularly as the longer Anorexia is present the more focus is placed on it and the harder it is to have something else going on as well. The women then may find it harder to let go of Anorexia, the relationship would be affected as the increased focus on the third entity becomes apparent. It could be that it is a way for the women to gain some authority or power, in that they are always in need of help, support or are able to dominate situations if the eating disorder is present. Without the eating disorder, how would a story to this theme play out? Would the couple functioning remain the same or even survive without this main storyline?

- **Acceptance of Anorexia/Eating Disorder**

Beth and Adam seem to be the couple most accepting of Anorexia/Ed continuing to be in their life; Mel and Ben are talking about Mel being recovered, Sally and David tentatively discuss this, seemingly less confident than Ben and Mel but much more so than Beth and Adam.

Could this be linked to how they view the eating disorder? For example Beth and Adam allow the eating disorder a space in their relationship, they accommodate it and it seems to have a big role to play in conflict for them and is always present to ruin Beth's good mood. Maybe she is not ready to allow herself to feel good, and so Ed is useful in preventing that, and perhaps as a couple they have not ever had to communicate or experience conflict without it and so would not know how to without Ed's presence.

However all the narrators seem to have had Eating Disorder present from the beginning of The Relationship. Beth and Adam though seemed to be more aware of it from the beginning; both Sally and Mel talk of it being a surprise for them or being in denial about it initially and the men are presented as having been clueless.

Simon's narrative of him attempting to provide space for the difficulties and Jane avoiding it, perhaps provides an opposing thought that not allowing any room in the relationship for the eating disorder can also be a problematic situation. This therefore raises a suggestion that balance is the key – allowing space for the eating disorder within the relationship and for both individuals to acknowledge its presence, whilst not allowing it to take up the most space within the relationship.

Perhaps however Simon and Jane viewed Eating Disorder differently than the other couples narrating here. Simon very much positions Eating Disorder as Jane's behaviour and responsibility. Therefore whilst demonstrating acceptance of its presence and attempting to help Jane, it seems to have been more from the perspective of helping Jane to help herself

rather than tackling it together. It is impossible to know from the limited data I have for this research whether this is due to Simon's own understanding of the behaviours, Jane's possessiveness and secretiveness, or a mixture of these.

The narratives within this research differ in that two of the couples place Anorexia as a character that will be in their life story forever (Sally and David, Beth and Adam), with Beth and Adam being quite definite about this as described above, and Sally and David almost allowing for it to re-surface despite feeling as though they are managing it at present. The third couple tell their story of recovery, their lives without Anorexia (Mel and Ben). Indeed Simon talks about only now, having put a voice to his experience, being able to 'close the chapter' on the story of his relationship with Jane and the eating disorder. This suggests that he has thus far had difficulty in doing so, that he has positioned himself among the characters from this story for some time.

Mel and Ben's story of recovery is signalled by Mel discussing a turning point, which for her was when she realised she did not need Anorexia anymore. In this way, she re-storied her life to exclude the character of Anorexia. It remains a main character of her back-story in relation to how she got to where she is now, personally and professionally, and as part of her and Ben's back-story as a couple. However it is no longer a main character in either her individual or their joint present story. The other difference with Mel and Ben's story compared with the others is that they talk of other difficulties (PTSD and self-harm) as well as Anorexia. Perhaps this made it easier for Mel to let go of her difficulties because all of the focus was not only on Anorexia.

7.3.2 The Relationship

I interpret The Relationship to be positioned by all of the narrators as a – if not the – main character in the stories. There is an intertwining of The Relationship and Eating Disorder. Understanding this poses questions about how possible it would be for the narrators to lose one of these main characters and for the other characters to continue in a story, or if the individuals position characters differently to each other. None of the couples have experienced their relationship without Anorexia, and Simon's story demonstrates the outcome of different positioning of the same characters.

Putting the relationship in a strong position in this way could be the narrators' attempts to ensure their listener understands that despite a difficult time their relationship is surviving and is strong. It may also be a way of reinforcing the idea to themselves. My presenting it as a main character within this research demonstrates that I have co-created this importance of this character based on how the narrators have presented their stories to me.

Ultimately, for Simon there was not enough emphasis on either character from Jane, and so he removed the character of The Relationship. Simon introduces the character of The Relationship because Eating Disorder is present, with expectations about his and Jane's roles. However

Jane not welcoming the role he wanted to fill lead to consequences of their preferred stories being too different to marry up.

All of the narrators tell stories about them as a couple having to find their way through what comes across as a minefield regarding Anorexia. They all position it as somewhat of a fight, and describe battling their way through. Perhaps this is a way they can make sense of how difficult it felt at times and how they were against an external force, something outside of their control. Narrative ideas around meaning being made from societal and cultural influences is in evidence here, in the sense that the narrators are within a society that understands if one is ill they are unable to fulfil 'normal' obligations (such as working, studying, providing support for a partner and engaging socially). Perhaps then in this way the partners are colluding with the women, maintaining that it is acceptable for them to be 'sick'.

With Simon's narrative it could be understood that he was attempting to fulfil this colluding role but was unable to. Perhaps Jane was not willing to allow herself to be given exemption from such obligations. Sally and David talk of the adjustments they are making – Sally now working part time and them having a smaller house but smaller mortgage. Mel presents herself as being determined to finish her dissertation despite being 'sick' – maybe this for her is a way to demonstrate how determined she can be and how well she has done in spite of being ill. It seems with Beth that remaining in this 'sick' role to an extent allows her to have an accepted 'fall back' option if situations are difficult for her, and for her and Adam to maintain the 'expert' roles they position themselves in.

As well as love, affection and enjoying each other, which is evident in all of the narratives as being part of all the couples' stories, there is in evidence a genuine care for each other and for wanting each other to be well. This reciprocal desire and care is most apparent in Sally and David's story, as they discuss David's difficulties with depression and how Sally cared for him while he was simultaneously caring for her.

All of the couples allude to their relationship being stronger, and they as individuals being closer, because of the eating disorder, While all of the couples within their narrations emphasise how good they perceive their relationship to be, they also describe ways in which they feel it could be better, or that they make sacrifices regarding some of the things they would like to happen. I wonder then which character is in control – The Relationship or Eating Disorder?

- Commitment – just to the women or to Eating Disorder too?

The presentation of the relationships as being strong and enduring leads to the discussion of the commitment of each partner to the women and The Relationship. Ben, Adam and David present their commitment as being definite, despite the difficulties they face with Anorexia. Adam demonstrates this by acknowledging that he knew he was committing to a life with

Anorexia as well as Beth when wanting to marry her. I wonder if this is also communicating that he loves Beth and wants to marry her as she is, therefore validating the eating disorder. Does this then make it harder for Beth to want to be rid of it if it means changing who she is? This comes across from all of the men, although more implicitly from Ben and David.

I feel a sense of commitment from the women, although not so explicit, but it is highlighted in Sally and David's case. David comments that his previous wife did not support him when he struggled with depression, but that he now feels secure in the knowledge that Sally will support him. Perhaps for the other women it is more about needing their partner to be there for them, and as David is the only partner who also has a mental health difficulty this is why it is more apparent with him and Sally. Perhaps this commitment from the beginning of The Relationship helps it to survive. The subject of commitment to each other is of interest regarding couples who survive mental health difficulties, especially eating disorders, as it suggests that couples who do survive such an experience are strong from the beginning, and make a real commitment to help each other no matter what. In line with my beliefs about individual agency this can be seen as a choice that is made by the individuals. It does lead me to wonder though whether Eating Disorder is then necessary for this to continue – this is what the individuals were committing to at the beginning so perhaps there is fear from both sides of what would happen if it were not there.

- Communication

Within The Relationship the importance of communication being open and honest is presented by all the narrators as necessity for the success of The Relationship and to help recovery from Anorexia. This is reinforced with Simon's story telling of his unsuccessful relationship with Jane due in his perspective to a lack of this.

I understand from the narratives that this honesty is something the women will only accept from their partners, and therefore becomes a need; casting their partner in leading role. The partners appear to want to take on this role – including Simon, despite Jane not wanting him to - and while they do discuss difficulties perhaps it can be understood that they relish being in a role of such importance. It could also be understood that reinforcing these aspects justifies the necessity of the partners, and demonstrates a feeling of being unable to deal with Anorexia alone.

It seems that this communication and openness allows for more focus on The Relationship and not just Anorexia, as there is room then for the partner as well as the women or Anorexia. This means that whilst the narrators are working together to overcome the difficulties they are dealing with due to Anorexia, they are also building up the foundations and strength of their Relationship without Anorexia. Simon presents his relationship with Jane as having been unsuccessful because of the lack of such foundations.

All of the narrators present themselves as having developed communication strategies and methods within their couples that help them to manage difficult situations. In this way there is an element of 'expert' – in that they are demonstrating their knowledge and almost suggesting ways to be with Anorexia present. Simon's narrative demonstrates the difficulties when the members of a couple do not work together on this as these strategies cannot be carried out. This raises the point however that there is little talk within some of the narratives about this being reciprocated to find out how the partner is feeling or coping. The exception to this is Sally and David as they discuss David's depressive episode and how they supported each other during this time. While Ben and Mel describe Ben going for counselling, this is done as though from his point of view rather than Mel finding out what he needs to do for self-care.

- Attachment

All of the narrators present the women as exhibiting attachment cues, through the eating disorder or related behaviours, resulting in the men being motivated to provide care giving functions. Adam is explicit in his decision process as to whether he was willing and able to do this; David presents himself as offering himself for this purpose from the beginning with Sally actually initially being reluctant to accept. Ben and Mel, from my interpretation, present it as a given in the initial aspects of their story, and initially present it as a difficulty in their transition to recovery story. Mel presents herself as becoming more able and independent as she recovered from Anorexia, and Ben's worry and difficulty in letting her do so. Perhaps this is a demonstration that needing the explicit attachment behaviour from the partners is an element of behaviour with the Anorexia and as Mel moved towards recovery she did not have as strong a need for it as previously.

I also wonder if this has a part to play in the difficulty that some of the narrators had with Services, in that they were receiving what they needed, from an attachment point of view, from their partners. This could then mean that Services were unable to reach the women in an effective way relationally, so they were unable to realise the help they could receive from them.

Most of the narrators discuss elements of the women's early caregiver attachment difficulties, although none give details of these difficulties. It comes across that some of these attachment issues are continuing within their adult relationships: Beth explaining explicitly some of her behaviours intended to push Adam away or test his commitment, Mel and Sally in a more implicit way mentioning some behaviours that I understand to be testing of affection and boundaries of their partner, and Simon's presentation of Jane as very forthcoming for physical intimacy yet averse to emotional intimacy. This suggests anxious and avoidant attachment difficulties from the women, with their partners attempting with mixed results to reassure and respond to these cues.

This can be expanded further by understanding the way the narrators take on 'adult' 'child' or 'parent' roles (Berne 1964). Mel especially presents initially in 'child' role; Ben seemed to take on the 'parent' role in order to compliment this, with them moving – albeit with difficulty – into

'adult' roles towards the end of their story. It seems that fundamentally Beth and Adam function within 'adult' mode but revert respectively to 'child' and 'parent' when necessary to manage 'Ed'. Sally and David seem to have to adapt often regarding who is in 'parent' role due to them both having difficulties and needing care. I acknowledge that in placing such labels on these ways of relating I am imposing my narrative on the stories informed by my knowledge of literature on this topic.

7.3.3 Eating disorder services experience

I understand the narrators to be presenting themselves as not being listened to or valued as individuals in relation to their contact with Services. Perhaps my person-centred stance and experience of working with individuals with the aim of hearing them completely has influenced this and lead to me positioning this as an important aspect of the stories.

Presenting Services in this way so strongly could be a way for the couples to reinforce to listeners and perhaps to themselves how well they have managed despite the lack of support they felt they received; they are subsequently positioned in a stronger and more successful way. It could be a way they help themselves make sense of the time it took them to get Anorexia under control, and serves a function of highlighting the importance of The Relationship due to the lack of acknowledgment from Services of their relationship and the partners. I wonder as well that if the narrators believe they can prevent other people having the same negative experiences they did, that they can feel that it was not in vain. This could be the meaning they are giving to their experience – in order not to feel it was a waste of time or effort on their part and to give value to it despite it not turning out as they had expected or hoped.

Maybe the 'enemy' of Services had a part to play in the closeness the couples describe – that they had to work together to try to combat Anorexia, and that they had a common enemy – one that could be viewed as more external than Anorexia. However, Beth and Adam talk vehemently about the closeness present in their relationship although they did not access Services in the same way; perhaps the 'common enemy' of services is less of a reason for the closeness than the need to work together to fight and manage Anorexia.

The elements that the narrators report to have been lacking in the care and treatment they received from Services point towards a lack of the nurturing element of care. It appears that technical aspects were present but that this was not sufficient for the women. The partners however seem to have been, and continue to be, able to provide the nurturing factor, and have learned – or are still learning - the technical aspects. This is something they pride themselves on and their partners are aware and appreciative of this.

The women seem to be trying to re-tell and re-cast their story; positioning the characters as they view them and want them to be. Services were not casting them or their partners in an important or central enough role, especially the partners. Perhaps this is why there is such an

emphasis on the importance and necessity of the partners in order that this version of the story is what others hear.

7.3.4 Clueless - expert

A transition from ‘clueless’ to ‘expert’ is something that I have labelled as a way I have understood the stories. Initially most of the narrators did not know much, if anything, about eating disorders, with Sally, Mel and Beth describing either not knowing, or not being able to admit to themselves or others, that they did have an eating disorder. As the stories progress the couple narratives demonstrate a gradual learning process of understanding Anorexia and its effects.

Perhaps this is to justify to themselves and others that they could not have done anything different initially, and to reinforce how well they have done, or are doing, to either be moving on from Anorexia or managing it. Perhaps demonstrating how much they know about Anorexia and how difficult it is to manage is also a way for them to organise their experience so allowing themselves sometimes to make mistakes.

I also understand it to be demonstrating how far the individuals and couples have come, how much they know and to stake their claim now as being someone who can inform others. There is a pride that comes across in all of the narratives about this success and perhaps the initial stage of ‘clueless’ is to demonstrate their powerlessness over Anorexia, their lack of choice and autonomy over what was happening to them, their partners and even the relationship. This could be seen as an obstacle to recovery if the belief is that they have no power over Anorexia, they may not be able to see what they are able to do to challenge its presence. However, the way the couples go on to portray themselves as ‘experts’ perhaps suggests that they have been able to take control in some ways.

This ‘expert’ stance is in relation to others, placing them in a position to be able to inform - Beth and Adam running a support group, Mel and Ben in being ambassadors for an organisation, and Sally and David participating in this research to help spread their ‘messages’. Again I wonder if this is in order to help them feel their struggles have not been in vain, to create meaning and a purpose from them. I wonder also if there is a defensive element to this, protecting themselves from questioning their knowledge or ability to manage Anorexia. This could extend to themselves too, they are creating a meaning that helps them feel more confident about what they are doing so as to enable them to continue to manage their situations. In this way they are presenting themselves as more socially acceptable – not knowing what to do (initially) is more acceptable than knowing and not doing it. Beth highlights this idea with her expression of desperation that she cannot ‘shake off’ Anorexia. It seems that an awareness of the wider social context is evident and the narrators are positioning themselves accordingly.

7.4 Interpersonal-performative elements

Here I present the elements of the narratives that are focused on how the narrators performed their stories. This is with focus on how the couples do so as a unit, with an awareness of my presence and the knowledge the narrators had of potential audiences for their information.

7.4.1 Co-creating

Table 1 shows the number of utterances and lines by each narrator. I have included only the couple narratives for this comparison as the purpose of this specific analysis is to look at how the couple together talk about their experiences.

Table 1

Narrator	Number of Utterances	Number of lines
Sally	512	542
David	375	480
Mel	402	642
Ben	350	420
Beth	68	480
Adam	70	376

The most striking aspect of this table is the low numbers of utterances that Beth and Adam present compared to the other two couples, and how matched the amount they speak is. Beth and Adam mainly talk in monologues incorporating the others' perspective, with little interruption from each other suggesting they agree with each others' understanding of events.

Sally and David conversely have the most overlaps within their narrative. They seem to be telling the same stories most of the time, but are keen to jump in to finish the story off or tell another part of it. Sally corrects David on a few occasions, mainly regarding dates or timescales that she tells him aren't quite accurate. It appears with Sally and David that these overlaps could reflect an equal positioning of each other, or conversely a competing nature between them, especially as they both experience mental health difficulties. This could be competing for power, within the relationship and against their respective mental health difficulties. I wonder if this is in some way a help to them each to keep pushing, to keep getting better. An example of such overlapping is illustrated with *Extract 28*:

Extract 28

Sally: *"...and within a couple of weeks I got a new job that's [really been]*
David: *[best decision you] made [wasn't it]*
Sally: *[a huge tu]rning point*
David: *huge amount of [turning point]*
Sally: *[because] they're brilliant they're a disability charity and um it's=*
David: *=you know we went through..." (lines 334-341)*

This extract is a representative section of Sally and David's narrative that demonstrates their overlaps occur when they are talking about issues that affect them both, or each other. This demonstrates that they are talking about an experience they have gone through together and are aware of how the other may have experienced it or felt about it, rather than being them focused on their own aspects. This could be another way of demonstrating their relationship strength and their compatibility for each other.

Mel and Ben, although not differing hugely in the number of utterances, do differ in how much they actually say, with Mel having 222 lines more than Ben. This is a reflection on how Mel takes the lead in their narrative, often starting first and staking her claim to an utterance seemingly before she has decided what she will say. This is done by her uttering *"um"* and *"err"* followed by a pause. It is, however, an obviously collaborative effort; they check facts with each other and interject details.

The way the couples narrate also seems to me to be a reflection of how their relationship plays out. For example Sally and David have the most disruption within their narrative similarly as to their relationship – both of them struggling with their own difficulties and needing to go to hospital or day care. Mel mostly takes the lead within her and Ben's narrative, with Ben taking over as lead narrator when describing situations when he took the lead. The enmeshment of stories that Beth and Adam present seems to reflect their relationship: they discuss it as being very intense (see *Extract 26* above). It could be that their stories have merged into one – more so than the other couples – perhaps as they have been together longer, or have children, unifying them as a team. Perhaps also this is a demonstration or reflection of them working as a team, against Ed.

Further to this, it is evident to me that the couples present themselves at a dyadic level of intimacy, that is that they implicitly show that they are a unit. This is done with agreements, validation of ideas and statements and collaborative consensus about their interactions. This further demonstrates the co-creation aspect of narrative.

7.4.2 Prosody

There are elements of speech such as intonation, volume, and stress that seem to convey much meaning within the narratives. For example I feel a sense of calm exuding from Beth and Adam's story, despite the demonstrations of emotion. It flows in a gentle rhythm that is easy to engage with, perhaps because they speak more in monologues than the other narrators and so it is more continuous. I wonder if this sense of calm reflects that they are in a place of acceptance of Anorexia, almost that they are at peace with its presence.

Beth especially presents her emotions very vividly, with her tone, volume and stress seemingly reflective of the emotions described. *Extract 29* demonstrates some examples of this, with the following symbols:

Underlining – stressed words

°Degree signs° – quiet words within the signs

>Inward arrows< – faster speech.

Extract 29

> ***Beth:*** *"...my own inabilities to shake it [Anorexia] off completely you know I get so angry and frustrated with myself sometimes..." (line 620)*
>
> *"...it was just awful" (line140)*
>
> *"...sometimes I feel able to overcome it and then sometimes >°I just feel like I'm drowning from it°<..." (line250).*
>
> ***Adam:*** *"...it was a long holiday and by the end Beth was in a °really bad way°..." (line 101).*
>
> *"we're nowhere near the bad state we were in at the beginning and that's when I found it so unbelievably difficult to deal with...(lines 269-270)*
>
> *...whatever I'm going through no matter how frustrating it is it's ten or a hundred times worse for Beth..." (lines 284-285)*

This accessibility of emotions and the observation that much of the narrative is spent 'inside their heads' - i.e. focused on thoughts and emotions more than physical scenes - reinforces to me the idea that they are still very much emotionally engaged with the experience of living with Anorexia.

There are different ways in which the narrators provide space for their partner to help them create the story – by softening their voice or drifting away at the end of sentences, asking a question or raising their intonation as though questioning. My suggestion is that this could be a parallel process demonstrating how they function as a couple.

Mel and Ben do this by verifying with each other a statement they are making or checking the facts with each other, such as the examples in *Extract 30:*

Extract 30

> ***Mel:*** *"at the time I was already living with you wasn't I?*
> ***Ben:*** *you were yeah" (lines 17&18)*
>
> ***Mel:*** *"I got ill fast over Christmas and you didn't notice did ya?*
> ***Ben:*** *I don't think I did at first no I think it was that quick really..." (lines 25-29)*
>
> ***Mel:*** *"...she referred me to the uni counseller. How long did I see her for?*
> ***Ben:*** *...was it about a year in total? Two semesters I think*
> ***Mel****: she saw me for a while anyway" (lines 36-43)*

Beth and Adam do bring each other in with questions on some occasions, but it is more often that they simply come in after each other, or even interrupt each other. When this occurs the main pattern is that the narrator who was speaking relinquishes the narration to the interrupter, as demonstrated in *Extract 31:*

Extract 31

> ***Beth:*** *"...but not because the relationship was wrong, more the other way round*
> ***Adam:*** *and just to give you a bit of context we've been together now for thirteen years and been married for ten... " (lines 31-35)*
>
> ***Beth:*** *"...but this time with two children in the background and you're just the frightened about how it affect them, you feel guilty*
> ***Adam:*** *well that's one of the things you know sufferers really suffer with isn't it, is the guilt handling guilt it's something you've always been very bad at or very susceptible to...(lines 207-211)*

Sally and David's way of narrating together is exemplified well with *Extract 27* above, this overlapping style is typical of their whole narration. Sally puts forward her agreement with what David is saying frequently by muttering "*mm*" as he continues his narration. I understand this to be her communicating that she is happy for him to be taking the lead at that time and is in agreement with what he says. Sally does correct David on occasion to which he responds positively.

These observations demonstrate that there are a variety of ways in which people co-creating a narrative can do so. Following a narrative perspective - assuming people present experiences in a way that demonstrates how they want their identity to be seen and understood - it can be argued that within their relationships these ways of co-creation exist. It seems that the narrators have taken their roles and are playing them out together. I wonder if this leads to collusion in terms of the eating disorder, i.e. the narrators have positioned themselves in a way that fits with their partner to support them and create a meaning together of what it does mean to them to have Anorexia in their life as a couple. Does this enable the eating disorder to continue existing in the context of their relationship, perhaps my exploration into this topic is adding to this meaning making – am I creating it as an experience to be labelled by framing it as a research topic?

Mel and Ben have a dramatic overtone to their story, although there is a marked difference to the other stories in that there is a strong comedy tone also present, using shock tactics at times in more of a performative sense than the other stories.

I wonder if this humour element is a way in which Mel and Ben are able to cope with the more painful aspects of their story when they re-tell it, and if they are more detached from these elements due to their positioning being in a story of recovery. This maybe helps them see more humorous elements or it could be that because they are able to understand their story in this way that this is the reason they are in more of a recovery story than the other narrators. There could be social elements to this too, in that it may be that Mel and Ben present their story with elements of humour in this way to make it more palatable for people listening to their story, or indeed to make it more engaging and therefore garner the attention of a wider audience.

Contrastingly, Sally and David have a matter of fact tone to their story; I wonder if this contributes to them being able to discuss how they are managing in an open way, and prevent it feeling too personal for Sally. It seems that this makes it easier for David to help her – for David saying "*I have to get you breakfast 'cause otherwise you wouldn't get any for yourself..."* (line 420), which could be felt as pushing Sally if it were less matter of fact. I also wonder if without this tone Sally and David would find the experience overwhelming emotionally; they both allude to strong emotions and David indicating he can get emotionally overwhelmed.

7.4.3 Stories of Individuation

All the individual narrators present narratives throughout the main couple narrative that illustrate what seem initially to be individual experiences. However, using negative case analysis – looking for exceptions – I observe that there are very few that are purely individual. For example Beth discusses wanting to kill herself while on honeymoon which initially seems as though it is purely involving and about herself, but then she goes on to say the reasons she didn't go through with it were due to her concern about what it would mean for Adam. This is one demonstration of how the narrators implicitly join themselves in their experiences with their partner.

Mel does begin to present an individual story regarding her counselling training, and Ben presents the idea of an individual story emerging; both are illustrated by *Extract 32:*

Extract 32

> ***Mel:*** *" ...it's been interesting heheh...I guess if it hadn't gone so horribly wrong though I wouldn't be training as a counsellor, gone full circle now" (lines 1325-1331)*
>
> ***Ben:*** *"...it took me sort of quite a long time really to actually let go of the eating disorder. I suppose in some ways I had become as disordered as Mel had been." (lines 846-849).*

These suggest that Ben and Mel are beginning to separate out their experiences slightly more from each other, yet are still aware of maintaining the relationship and therefore how the other fits in or is affected. This is perhaps more evident with Ben in that he is relinquishing the role of carer.

As Mel and Ben are presenting towards the end a story of recovery, perhaps there is a link here regarding individuation and the impact of this on the recovery from Eating Disorder. Mel is the narrator who positions herself as being the most individual of the women narrators, and she is the character most recovered. However initially she was very reliant on Ben. Comparing this with Simon's positioning of Jane I wonder if because she was so independent initially this prevented her accepting the support and help from someone close to her. Perhaps a gradual individuation process is more helpful, providing someone with support initially, with a gradual process of becoming more individual and to a point where the eating disorder is no longer

required to maintain a relationship. Sally and Beth present as being independent in some ways, and in varying degrees, yet still very reliant on their partners.

I also wonder to what extent individual stories are possible when in a couple – are stories always shared, or involving the partner? It seems with the data here that individual stories can be helpful and important in terms of aiding recovery from an eating disorder. However Mel makes it clear that she is now involving Ben more in 'her story' in order that they retain their closeness and 'coupleness'. Perhaps, then, this actually suggests that shared stories are necessary for relationship success. Even with Simon's narrative he presents seemingly individual stories as being related to Jane despite her absence. This suggests that even when a couple is not telling their story together they are still telling a joint story.

7.4.4 The 'never-ending' story?

Temporal positioning of how the narrators present their story gives meaning to where they see themselves in the story of Anorexia, and how they relate to the potential ending of the - very differing – relationships they have with Eating Disorder. There are of course multiple relationships at play here: the women and the eating disorder, the partner and the eating disorder, and The Relationship and Eating Disorder. Therefore endings involving any of these combinations of relationships are likely to be a complicated process and require thought and consideration in terms of what the consequences would be. As this would be involving multiple people it complicates this process further, perhaps making it even harder for endings to occur.

Beth and Adam seem firmly embedded in a never-ending story of Anorexia, illustrated by *Extract 25* above and *Extract 33* here:

Extract 33:

> **Adam:** *"Is there anything else you think we should say Beth? I mean we've talked about the beginning, the middle and well not the end we'll probably live with this for the rest of our lives*
> ***Beth:*** *it's like the longer that it is a part of you the harder it is to shake off but the more frustrated you get about it, it's like you get to a level of acceptance, but it's not really happy acceptance that it is the way it is...if I was told I only had 6 months left to live would I still care about how much I weigh or not, I dunno, ironically what's awful is I think I probably would." (lines 838-849)*

As put forward within the characters section of this chapter above, Beth and Adam's acceptance of Anorexia is evident throughout their narrative. This suggests that they are envisioning their life as a couple and a family as always involving Anorexia. They talk about this acceptance explicitly, and about how they base a lot of their choices such as where to go on holiday around its presence. In this way they are positioning themselves in an ongoing story of living with Anorexia, as unable to foresee or manage an ending of this relationship.

Sally and David appear to position themselves in a story that is moving towards recovery. They do not seem ready to commit to ending the relationship with Anorexia and therefore recovery

for Sally, but present it as a tentative and hopeful possibility. This seems to relate to the steady, quiet persistence that I put forward earlier as being a theme that comes across within their narrative.

Towards the end of their story Sally and David discuss the position they are now in, with Sally explaining that she does not want any more therapeutic input at present, that she wants them to have a more settled time now things are calmer for them as a couple, further demonstrating her own persistence and determination to get better at her own pace.

In contrast, Mel and Ben position themselves in a story of recovery. While there is acknowledgment from Mel about ongoing health issues related to Anorexia and both about 'sick' and 'carer' roles continuing to an extent, they shift this into a new story. This seems to reflect that they have been more able than the other narrators to end the relationship with Anorexia, although they still want to 'keep in touch' with it, not fully able to say goodbye to it or its effects. This is illustrated with *Extract 34:*

Extract 34

> ***Mel:*** *"I found out when I got discharged from the eating disorder service that I'd got osteoporosis as well. I think that was another big thing for us 'cause once I'd started to get better I was like "ok how do we have a normal relationship now?" 'cause obviously Ben's my carer and I was sick, it almost becomes quite parental. I think we're still figuring that out*
>
> ***Ben:*** *I think we are yeah I can agree with that*
>
> ***Mel:*** *...so when I found out I had osteoporosis that was like 'ok, great so you're always gonna have to take care of me...". (lines 948-965)*

I wonder then what the potential implications for such positioning are in terms of recovery; whether positioning in this way aids recovery, or recovery enables such positioning. It is difficult to know from the limited data present here but it represents an opportunity to explore this idea with clients in similar situations and highlights the importance of understanding where in their story an individual or a couple places themselves.

7.4.5 Ordering of the story

The couples all present their story in chronological order. They seemingly move relatively quickly through their story from when they got together (with some back story of the eating disorder) until the present (at the time of the interview). They then all dip back in to different points within this story to elaborate on some of the events and situations within the main story.

Simon on the other hand presents his story in a much more chaotic style, jumping around to different points in the relationship and after Jane and he broke up. This is perhaps due to it being the first time Simon has talked about his experience in depth and detail – he did not have in vivo supporting characters with whom to co-create his story and so has been unable to

consolidate his experience with the eating disorder and with Jane. Therefore when talking to me he is trying to order his experiences and make sense of them. This is in contrast to the other narratives that have been 'practised' numerous times as the couples have all spoken about their experience to different audiences.

The chaotic element of Simon's narrative also seems to reflect how things were for him and Jane during their relationship; Simon presents this as a time of ups and downs, some calmer and more ordered times but more chaotic times when he especially was not sure what was happening or the best way to go about helping the situation and helping Jane.

8 DISCUSSION

8.1 Introduction

This chapter is presented as a discussion of the main ideas and observations put forward in the analysis chapter above, with reference to relevant literature. Strengths and limitations of this research are discussed followed by ideas of applicability to Counselling Psychology and implications for practice. I then put forward ideas for future research, and end with a reflection on the research process.

8.2 Main findings

8.2.1 The power of love?

The Relationship is positioned as a main character by all of the narrators, with emphasis on the strength of it. As well as explicitly stating this, the narrators use words such as 'we' and 'us' which according to Van den Broucke et al (1995a) suggests a dyadic identity. They suggest this reflects a long-term committed relationship. As this is a less conscious way of presenting themselves it can be understood that the narrators do view their relationships in this way, as opposed to choosing what to say in order to ensure the listener sees it as they want it to be seen.

The narrators describe how they work together to overcome issues – reflecting Dym and Glenn's (1993) 'resolution phase', which results in closeness being re-established. Dym and Glenn posit that couples tend to find a 'home base' within one phase; it would seem that the couples within this research have found theirs within 'resolution'. This suggests however that the focus on Eating Disorder and its management becomes a necessary focus as they need something to resolve in order to maintain this way of relating. If this has become familiar it may be difficult to alter the relating pattern, especially if the couple are unaware this is happening. Simon's story seems to reflect him and Jane being unable to leave 'contraction' stage, leading to relationship breakdown.

All of the couples allude to their relationship being stronger and themselves, as individuals, being closer because of the eating disorder, reflecting Levine's findings that this is the case within eating disorder marriages (1988). Within my research and Levine's, however, this is a self-reported outcome which could be argued to reduce the impact of the findings. Despite this, I believe that counselling psychology is working constantly with individual self-reports and so in that way it is of merit within this context. Conversely though, this closeness is in contrast to suggestions from other literature that mental health issues within a relationship reduce marital satisfaction (Holt-Lunstad, Birmingham & Jones, 2008; Mamun et al., 2009). Although Beth and Adam do acknowledge they might have an even better relationship without 'Ed', there is of

course no way of knowing whether this is the case or not; perhaps the quality of The Relationship is as good as it is for them *because* of 'Ed's' presence rather than in spite of it.

Potentially, there are advantages for the couple to Eating Disorder being a focus, in that it could be a way to divert attention away from other problems within a relationship, reinforcing the disordered eating behaviour. There could be benefits for both individuals within the relationship if they are not ready to face up to these other problems, as they can both focus on the eating disorder (Foster, 1986; Levine, 1988; Woodside et al., 1993). There are also suggestions that eating disorder behaviour can serve to maintain a balance of power and control within a relationship (Root et al, 1986; Barrett & Schwartz, 1987), and so the removal of the behaviour/symptoms could result in an upset of this balance, leading to other relational difficulties.

Van den Broucke and Vandereycken (1989a, b) discuss that among partners and husbands of women with eating disorders there tend to be more who present with neurotic and psychiatric difficulties than with couples not experiencing an eating disorder. In this research David is the only partner who discusses or presents such a difficulty, and due to the number involved in this research it is not possible to draw conclusions from this.

What is perhaps more evident within this research is the theory that partners of women with eating disorders may have a poor sense of self-identity and so can foster an identity by being the carer for their 'sick' wife or partner (Foster, 1986; Barrett & Schwartz, 1987). This relates to the idea of the 'sick role' (Parsons 1951). Mizo (2004) expanded this with findings of a belief that a 'sick' individual ought to be exempt from blame for their illness and from many usual social role obligations which is something that can be seen within the narratives – for example working part time, not going on certain holidays or social events. Mel seems to be motivated to not have to exempt herself from such obligations however, being keen to finish and do well in her degree despite being ill. Perhaps this helped her move towards recovery as it did not sit with her own narrative of who she is, and she did not want to have to conform to the role of not being able to manage what would 'normally' be expected of her.

My understanding of attachment issues within the relationships is that there are attachment issues from the women's' childhood that are continuing into their adult relationships (Root et al., 1986) and this is motivating the partners to provide care giving functions (Bowlby, 1969, 1988; Kunce & Shaver, 1994). Beth and Adam are explicit in recognising Beth's need for emotional intensity of affection as a mirroring of her parents' pattern of relating, reflecting Woodside et al., (1993) suggestions of similarities between generations' marriages.

Simon's narrative demonstrates that Jane wanted reassurance that he would not leave her, but she wanted this as a physical closeness and did not want to have emotional closeness, suggesting anxious avoidant attachment difficulties (Doi & Thelen, 1993; Rowe & Carnely, 2005; Kaitz, Bar-Hain, Lehrer & Grossman, 2004).

Engagement and distancing within the relationships is presented by all of the narrators, in that they describe times when the women would not communicate openly and other times when they were seeking engagement from their partner. This reflects suggestions from Newton et al. (2005), and supports my findings of the intertwining nature of the relationship and the eating disorder.

The 'child', 'adult' and 'parent' roles discussed - that the narrators seem to present as being their ways of relating throughout their stories - can be understood with Berne's Transactional Analysis theory (1964). The individuals present as taking on the roles that complemented the role their partner was in, with Simon's story demonstrating the consequences of 'crossed transactions' as their roles were not complementary.

All of the male partners are clearly committed to the women and demonstrate a lot of love for them. This reflects Lee's 'Agape' description of love (1973) of being committed and unconditional. Sally and Mel seem to present in line with 'Storge' love, based on friendship and care for a partner rather than passion. Perhaps this more steady approach to their relationships allows them to be more able to let go of the eating disorder behaviour than Beth, who is more reliant on it as a way of relating and seems to present with 'Mania'. This is described by Lee as often being present with mental health issues – with the individual using it to maintain a connection with their partner.

These ideas and the supporting literature leads to an understanding that while not straightforward, love is a powerful tool in the journey towards recovery from an eating disorder if it is understood and embraced by both individuals in the relationship.

8.2.2 Services – Friend or Foe?

The lack of involvement of the partners that the narrators who accessed Services present is something also noted by Bulik, Baucom and Kirk (2012), with suggestions that it can lead to further difficulties surrounding secrecy and taboo. As eating disorders can be a topic that is not fully understood by many it is a concern. It is also a cause for concern for relationships – if an individual is finding it hard to discuss their difficulties with their partner, such an influence of it being taboo and therefore needing to be kept from partners could be damaging. However the narrators within this research did not seem to have difficulties in talking to their partner about their eating disorder once they had accepted its presence – which would likely be the same regarding seeking help from Services. It seems the issue was more that Services did not allow the partners to be involved.

A further difference between what the narrators within my research are presenting and Bulik et al.'s work is that they suggest it would be unhealthy for the partner to be involved in the re-nourishment of the individual – as would occur with families when employing the Maudsley method (Lock et al., 2001). This appears to be what is happening, and effectively, for the couples within my research. Ben and Mel in particular discuss how they worked out a step-by-step dietary increase plan for Mel, and describe how Ben would come home at lunch time to

make sure Mel was eating. Adam and David are similarly described as encouraging, suggesting and monitoring regarding food intake. Perhaps, though, the partners taking on this role enables the focus of The Relationship to be Anorexia, therefore contributing to the never-ending story of its presence.

Not being listened to or taken seriously as a couple were the main issues with Services. Mel points out that it felt that the staff were treating the eating disorder but not her, echoing the sentiment of Petersen and Rosenvinge's participants who found therapy most effective when they felt the therapist was helping them understand underlying issues not just the symptoms (2002). Mel found this with Kate – she listened to Mel and saw her as a person, not just symptoms, seemingly the opposite to Services. That Mel found this helpful is encouraging for Counselling Psychology as these are key elements.

With regard to the care the partners were providing if they were aware of developing the technical aspects -was it a conscious decision, did they feel the nurturing elements were not sufficient? What about individuals who do not have a partner who is able to provide this sort of support for them - are the Services sufficient? Or do they find it even harder to recover as they do not have that nurturing element as much as they need? Perhaps it is due to the level of intensity of the nurturing the women were receiving from their partners that lead to them finding Services insufficient in their provision of this.

There is then here a question of how necessary would the women have found their partners if Services had been, in their view, more successful in helping them? This may be unanswerable as it leads to many possibilities of whether or not the partners would be included in this more successful help, and therefore this could help to maintain this importance.

The way the narrators seemed to approach me was with an acceptance, that I was on 'their side', wanting to understand their point of view. This was especially strong with Ben and Mel, and Sally and David, particularly I think because they had experienced difficulties with Services listening to them and understanding them as couples. In terms of therapist transference, this could be useful clinically by exploring what it means to the individual or couple to be heard, and how this may affect the necessity of the eating disorder. This is related to the idea that an eating disorder may be a means of gaining attention (Newton et al., 2005). It also seemed that I was seen as an 'insider' almost, as a professional on their side, who could get their 'message' heard by relevant people within Eating Disorder Services, which could be a reason why they were attracted to taking part in the research.

It seems then that for the narrators within this research Services played the part of 'foe' regarding Eating Disorder but this may actually be a 'friend' in how it has lead to The Relationship developing, and the strength the women recognise in themselves in having to manage in spite of the perceived lack of support.

8.2.3 Anorexia – friend for life?

The personification of Anorexia externalises it in a way that is similar to an aspect of narrative therapy (White & Epston, 1990). However, White & Epston caution that if externalisation is taken too far it can result in individuals not assuming any responsibility for the difficulty, and not acting to remove or reduce it. I understand this to be what is happening with Beth and Adam.

It is understandable that Anorexia is given such a prominent role in the stories, due to the nature of the disorder being something that affects the individual's everyday life, all day. It affects thoughts constantly, not just related to food, and when an individual is very underweight their cognitive functioning becomes impaired (Schulherr 2008). Tierney and Fox (2011) found that the inner voice of individuals with Anorexia is an ever-present experience that leaves them feeling as though they are imprisoned by it. This adds further support to the idea that Anorexia has a substantial impact on an individual's life, as their thoughts are so affected by it, meaning that most of their life during the time Anorexia is most prominent is based on what Anorexia is doing or saying. This is explicitly presented by Beth regarding how 'Ed' affects her, and Mel describes having no memory of a few months when her weight was extremely low.

This externalisation and personification suggests a relationship with Eating Disorder, one which the narrators present as difficult and often negative, similar to Tierney and Fox (2011) whose participants likened having anorexia to a toxic relationship. There are then complications for individuals who are in relationships with other people, as they are already struggling with one relationship. The presence of Eating Disorder within The Relationships of the narrators of my research is presented as toxic within itself, preventing the couples reaching their perceived potential and having to make adjustments to their everyday life. A relationship also forms between the partner and Eating Disorder. The couples are weaving the story of their relationship with Eating Disorder on a daily basis. It could be that this provides a focus for the couple – suggested by Van den Broucke and Vandereycken, (1989a, b) as a way to maintain a connection but avoid genuine intimacy and communication remains superficial, focused on the eating disorder. As the couples involved with this research have always had Eating Disorder present, perhaps it is difficult to know how to have genuine intimacy without it, increasing the likelihood it will always be present. Even Mel and Ben have a story of Anorexia's presence in their story of recovery.

This acceptance of the presence of Anorexia can be compared with hope – that one day the couples will not have Anorexia within their relationships, that they will not be as affected by it – mentally or physically for the women – and that life will be more enjoyable. I wonder though how much of a limit on hope the acceptance places. I wonder if there was more hope initially for some of the narrators, and as time has gone on it has become accepted that what was hoped for did not arise or was too difficult to obtain. Perhaps this has then lead to Anorexia becoming a presence for life, and in a way a friend, due to its familiarity and ability to affect the pattern of relating – as discussed above the couples may not know how to be without it.

8.2.4 It's all in the telling

The importance of communication is evident throughout this research, both explicitly and implicitly in the narratives themselves and in my telling of my interpretations of the narrators' stories. The narrators are explicit in discussing the importance of open and honest communication within their couples, as recognised by Bulik et al. (2011) also, and Simon's story demonstrates a consequence (as he says himself) of a lack of this, echoing Bulik, Bauman and Kirby's findings (2012) that such a lack when Anorexia is present leads to difficulty and potential further problems within a relationship.

Communication difficulties and behaviours have a circular relationship (Van den Broucke et al. 1997), with effective communication being essential for successful and enduring relationships, especially relation to conflict resolution and management, with the effectiveness of these skills determining relationship satisfaction (Bradbury & Karney, 1993; Gottman, 1994; Cohan & Karney, 1998; Bradbury, Keicolt-Glaser & Newton, 2001; Eğeci & Gençöz, 2006). The narrators within this research do not talk explicitly about their methods or patterns of conflict resolution, but it seems throughout their story that they learn between them what works and does not for them. With this there seems to be a willingness from both members of the couples to learn how to communicate with each other effectively.

The co-creation of the stories is another example of how communication is at play. The individuals within the couples are listening and reacting to what their partner is saying and how they are telling the story. In this way the communication is implicit, it is obvious they are telling their story to me as researcher, yet they are also talking to each other without directing what they are saying to each other. This telling of the story together is part of the couples' meaning making in action, a public extension of what I assume is a constant process for them alone. This meaning making will be influenced by their individual narratives, experiences and what they want their narratives to be (Atkinson, Coffey & Delamon, 2003).

The joint stories that are told throughout the narratives are evidence of how intertwined experience can become for individuals within a couple. Almost all the experiences presented were involving the partner or were affected by their presence. This is how the couples are choosing to present their stories – they are presenting their identity as a couple very firmly with explicit expressions and implicit communication.

Then there is the further audience, readers of this research, of whom the narrators are aware. Therefore they know they are communicating to people who are not present, yet they know who they might be – professionals within the field of psychology and eating disorders. Knowing this informs what the narrators tell and how they tell it, ensuring they put themselves and their experiences across in the way that they feel will convey what they want others to know. A lot can be interpreted from what is told and how it is told: the aim of narrative analysis. This

research is a demonstration of how we make sense of experience together and how we present it to others depending on what we want them to understand.

8.3 Strengths of this research

This research takes a novel approach to understanding how eating disorders affect adult relationships. Using a narrative approach to explore the stories couples tell is something that has not been done before. In this way this research provides new insight, producing new ideas and aspects of such an experience that are essential – it seems from the stories told here – for helping adults with eating disorders, especially when they are in a relationship.

There are also strengths in terms of understanding relationships themselves, how couples present themselves and tell their joint story together. Exploring the narratives in this way means that individual aspects are included. The focus is taking the perspective of the couple as the unit of analysis, which is an unusual and therefore enlightening approach.

Incorporating a narrator telling their story about a relationship that did not survive an eating disorder alongside the couples with stories of relationships that are surviving, provides an all round perspective. It enables comparisons and assumptions, suggestions and ideas around the differences that occur between the different relationships.

Using narrative analysis provides an in depth and detailed insight into experience. The nature of narrative requires analysing minute details, which can often be missed in pure content analysis. This is especially important for Counselling Psychology where the nuances and detail are important within the therapy room too.

8.4 Limitations of this research

Despite these strengths, there are of course limitations to consider regarding this research.

It is clear that the number of participants is small, which suited this particular research project due to the in-depth nature of the analysis. Nevertheless, as with any research findings, the more they can be explored and either validated or contradicted with evidence the better, and therefore the number of participants for this research could be seen as a limitation.

It is important to note the sampling bias that occurred as I specifically recruited couples who had lived or were living with the experience of an eating disorder. This therefore meant that the focus is very specific and does not focus on other issues that may affect relationships.

Despite intentionally inviting people with ‘eating difficulties’ in an attempt to encourage a wide spectrum of participants, only couples with experience of anorexia came forward to participate in the research. As recruitment was mainly through Beat, gyms and health food shops it could be that these are more likely to be places frequented by people with Anorexia. I had assumed that Beat was an organisation for all eating disorders, but I have since learned that it is mainly used by those with Anorexia.

The effect of my 'beingness' in the world will have impacted on my interpretations of the data. I am familiar with their context in that I, like them, am white, British and heterosexual, and of similar age. This will have affected how I understood their narratives, interpreted them and presented their stories within this thesis. This means the analysis is limited to my perceptions and understanding. However, this is how it would be within a therapy context.

Such awareness is necessary to understand where different views and ideas have come from, and to accept the compromise that is involved with the necessity of 'creating' the interview or therapeutic environment in which such experiences are explored.

8.1 Applicability to counselling psychology and Implications for practice

8.1.1 Narrative

While the couples are presenting their story to me, they are aware of my background in the field of counselling psychology and so are telling it in a way they want someone of that profession to hear and could mirror a more focused therapeutic setting.

From a narrative perspective this can be understood as them presenting their dominant narrative (Morgan, 2000). An understanding of the presence of such narratives can, it is hoped, help clinicians and others working within the field of counselling psychology gain further understanding of the experience of people in a similar position to the narrators represented within this study. By doing so, counselling psychologists especially can work with individuals to discover - through conversation - their preferred, more hopeful and perhaps previously unheard stories (Angus & McLeod, 2004).

Understanding that Anorexia is placed in such a prominent role in relation to the narrators is important for working 'narratively' with clients. An aim of narrative therapy is to help clients re-story their lives to be congruent with their ideal narrative (White & Epston, 1990). Exploring within therapy with similar couples, or indeed individuals, whether this positioning is how they want it to be would be important.

As the focus of my research is the eating disorder and the couples' experiences of living with it, it could be argued that this is the reason for these and the narrators being placed as such prominent characters. I view it as a demonstration however that the narrators placed these characters in such roles already, hence coming forward to be involved.

The exception to these characters however is Sally's emphasis on the role her job had to play in the worsening and maintenance of Anorexia. I think this is important to acknowledge regarding working with individuals in a similar position as it raises awareness that there may be other, less obvious, potential impacting factors for an individual when they are seeking help with an eating disorder. It is of importance to understand what is going on around the client, what they feel is helping, or hindering. From a narrative perspective, it highlights the

importance of understanding what a person's story is communicating, and what is potentially obstructing the story they actually want to be occurring. While I am advocating more awareness of partners and relationships as part of treatment, this exception demonstrates that even when a relationship is felt to be of central importance to an individual in this situation there can be other factors too that impact.

Observing the extent to which joint stories rather than individual stories dominate the narratives is a reminder of how important it is to understand the full picture that an individual is presenting in therapy or treatment. If we as professionals can really listen to the stories being told, really understand what is going on for someone and how other people can help or be affected it would, I believe, help individuals not only to feel understood but also to increase the chance of their recovery. This is also true of couples' therapy: understanding how intertwined stories can become could help them to view their difficulties differently and understand how they might be affecting each other.

Paying attention to the tone of a story could be a helpful focus - what does it mean to the narrator(s) that they are presenting it with such a tone? Linked to this is what kind of story and where in that story, individuals place themselves. What does this mean for the individual? It would, I believe, be more difficult for a client like Beth to realise they have the potential to change than for a client such as Sally or Mel – if they were to present for therapy with the same or similar story as they have within this research – due to (respectively) an ongoing entrenched story of acceptance, a tentative acceptance but not full belief that recovery is fully possible, and immersed in a recovery story.

The intricacies understood from analysing language within this research highlight the detail that can be uncovered within therapy if we are willing to notice language with all that it tells us. It can be seen from this research that there are potentially strong implications of language individuals use to describe something they are struggling with – as discussed in terms of how accepting and involving Beth and Adam were with 'Ed', and the potential implications of the possessiveness or personification of Anorexia could lead to a much more difficult process of letting go. As a therapist's job is to work with the story a client brings this is a relevant and important idea to take forward to practising as a counselling psychologist.

8.1.2 Service provision

When considering Troop et al.'s suggestion (1998) that further research is required exploring what sort of support is provided by family and carers living with someone with an eating disorder, it can be viewed that this research is giving an insight into this. Therefore it can be helpful for those within the field of counselling psychology working with couples and individuals when an eating disorder is present.

The strength of the narrators' attachment or possessiveness towards Anorexia, and their roles of 'sufferer' and 'carer' are significant factors for counselling psychologists working clinically with individuals and couples in this situation. It is evident through this research that it ranges

from difficult to impossible to remove or to alter characters within the couples' stories, and that there are potentially significant impacts on other characters, especially the narrators if and when this does occur. This highlights the importance of understanding what role the 'problem' fulfils for someone presenting with a mental health difficulty and of managing both client and therapist expectations around this.

There are Suggestions that viewing an individual as being in the 'sick role' can lead to a reduction in individual agency in relation to recovery (Mizo, 2004; Pearce & Pickard, 2010). Mel and Ben's seeming need for remaining in 'sick' and 'carer' roles, despite being in a story of recovery, suggest that for them the roles more than the reason for them are what is important in maintaining a status quo within their relationship. Awareness of such patterns would be worth exploring further and an awareness of these within therapy could be helpful in terms of individuals and couples moving on from a potentially life threatening situation. It could lead to thinking about how to maintain roles to an extent without requiring an illness.

I hope that for counselling psychologists working within eating disorder services it helps illuminate the experience of couples, and can help bring more of a voice to couples and partners when individuals are accessing such services. This would help the services to be more aware of the roles that partners and relationships play in the recovery process, so that the individuals feel they are taken seriously and that their needs are listened to. This is something I advocate strongly as a practitioner who highly values the person-centred approach. Recognising who the main characters in an individual's story are, their opinion and experience provides a means by which an individual can communicate what they feel to be the most helpful for them at that time. It can be detrimental to ignore, or not take seriously, these opinions – as is demonstrated within this study.

The patient-, or person-centred approach is endorsed by clinicians and researchers within the field of eating disorders (Waller, et al., 2007), and the narratives within this research appear to show that the couples would have benefited from such an approach. The view of this coming from the clinical, research and service-user level indicates the importance of this approach, in order to gain a deeper understanding of the individuals, and their support system and environment, to find the most effective method of treatment or support.

I feel confident that on a broader scale, further understanding of the role played by the partner and the importance that the individuals placed on this could help systemic approaches to treating eating disorders – especially with adults. In understanding why the affected individuals place such an importance on their partner's efforts to understand, listen to, and help them, knowledge could be passed to other carers and support systems that exist for people with eating disorders.

I believe that this research could aid understanding for counselling psychologists working outside the field of eating disorders with couples, because of the focus on the couple fighting an individual difficulty together, learning to live with it, manage it, or recover from it. Lessons learned from this could be useful in couple or marital therapy, providing insights into how

couples can work together. Understanding more about the motivation for working together in this way could be helpful and will be discussed in the following section on recommendations for further research.

It may be of course that a partner presents for therapy, as Ben discussed seeking counselling for himself as he was finding the situation difficult. In this case, an awareness of potential underlying attachments to the eating disorder or the situation remaining unchanged ought to be present.

A couple presenting themselves as a 'team' of experts against Anorexia could be a very useful tool, clinically speaking; the 'team' behaviour could be encouraged in order to help them diminish the impact of Anorexia on their lives. Using this technique, the focus could be shifted from 'carer' and 'patient' to 'team', giving them more autonomy over the situation, and helping to equalise their positions within the relationship. However, it is possible that this 'team' approach could be detrimental to their relationship, which may only be surviving on the basis that they are in these unbalanced roles. Therefore a therapist could take the role of helping the individuals in a couple to see where their behaviour could be helpful in terms of reducing the impact of Anorexia on their lives. Whilst doing so it would be important that the therapist helped the individuals become aware of how their behaviours are focused on this task, and build in an understanding of the temporary nature of them, with the aim of the couple coming to a place where they no longer need to engage in such behaviours.

In order for this to happen it would be important for the therapist to facilitate communication within the couple to ensure they remain mindful of this and to be able to recognise if they are becoming too dependent on this pattern of relating and therefore potentially maintaining Anorexia. An important aspect of this work would be for the therapist to help a couple understand what they would like their pattern of relating to look like without Anorexia, and help them move towards this. There may be difficulties with letting go of the old patterns, and this would be something a therapist could help with.

The lack of awareness of choice regarding treatment is of concern I feel to counselling psychology. Ben and Mel, and David and Sally discuss not being aware of other options other than Services, and it was only after some time that Ben – with a lot of research – found a counselling psychologist working privately who was able to help them. This has implications not only for individuals who may end up missing out on care they could have, but also for counselling psychologists working privately. Potentially there are many people who could benefit from this and generate more work within this area.

The ability of the partners to provide what an individual might need to help them recover might interfere with the work of the services. From the women's point of view if there is someone who is seemingly providing the nurturing attachment element along with the boundaries, why would they be satisfied with what feels like a more restrictive approach from Services when only one person in their mind is listening and understanding them (in Mel's case the counselling psychologist)? Perhaps if their partners were not present the services provided by

professionals would be felt to be sufficient? There is currently a paucity of literature around this topic within the United Kingdom, although a study by Newton, Robinson & Hartley (1993) discusses participants as having stated, amongst other aspects, that an increase in family support would make for a more suitable and effective process within eating disorder services.

8.1.3 The Relationship

I feel it is especially important to acknowledge the Relationship, as it is emphasised by two of the couples as not being paid enough attention or acknowledged fully by the Eating Disorder Services that they were involved with. It therefore appears to be an area that Services and those providing support to people with eating disorders could find helpful to be aware of, and perhaps to be more open to involving a partner if this was deemed necessary and of value to the individual presenting with the eating disorder.

It is apparent from these narratives that if The Relationship were taken more seriously, then the individuals would have felt more supported, and may have a more successful treatment process. It is extremely obvious from the narratives that there may be much that a partner could do in order to help the individual with the eating disorder, but there is little support or guidance of what to do, how to do it, or where to find such information.

There is however caution to be taken with this idea, as there is the argument that the narrators involved with this research had a message to vocalise about their experiences with services not paying what felt to them like sufficient attention to their partners and their role in the eating disorder, and how their relationship affects it and is affected. It could be that some individuals accessing services find that their hobby, or job, or religion that is the main factor for them, and that they may find this to be overlooked.

I think this demonstrates the need to collaboratively explore with each individual what is important for them in relation to their eating disorder or mental health difficulty. In terms of the findings from this research, it could be suggested that the inclusion of partners could expedite the treatment focus, leading to cost and time benefits for services. It would be valuable to have an understanding of what other aspects of an individual's life are important for involving in the treatment to be of greater benefit.

This could mean they would be able to offer services to more people, and perhaps improve quality of service with money being saved. It could be argued that as all three couples appear to have succeeded in fostering improvement in eating disorder symptoms (or in Mel's case, recovery), that there may not be the necessity to involve partners further in treatment processes, as they all seemed to manage without this. However, it is clear through the narratives that this is not an easy task.

The hope is that increased understanding of the need to be aware of such elements to a person's eating disorder progress may be especially helpful if the individual does not bring forward this information. This may be due to them not feeling it is important or do not recognise its presence. It could, for example, be helpful if therapists are aware of the potential ways

individuals feel about their partners' role in the eating disorder so they can be alert for signs of it within their work.

8.2 Recommendations for future research

As I have put forward above I had a small sample for this research. Therefore in order to further the understandings gained here it would be beneficial to conduct similar research with a larger sample.

Another way to expand on the data here could be to re-visit the analysis, either myself, using peers or returning to the narrators after a period of time. This would allow for different perspectives on the data (Andrews, 2008) and could lead to further ideas. In terms of re-visiting the narrators it would give insight into how their interpretations and presentations of their experiences have changed over time, especially if this was looked at along with what they perceive to have contributed to any changes or otherwise.

The dynamic of The Relationship would benefit from further exploration to understand more fully how couples can approach eating disorders. As my research is broad in its focus, more detailed exploration such as this could further aid our understanding.

In terms of treatment, it would be relevant to explore further what individuals with eating disorders and a partner feel would be most helpful for their recovery or management of their difficulties regarding their partner. Would they prefer more joint sessions, more opportunity for the partner to be involved in meetings or sessions, or more liaisons between services and partners? Would more guidance to partners in terms of how to manage Anorexia, and therefore how to help their partner be welcomed? This was an issue that all of the partners discussed in their narratives, that they did not know how to help. Therefore this would be a valuable area for research. Perhaps trials of providing such guidance and support to partners, and exploring the effects of this for the individual with the eating disorder, the relationship and the amount of service input required would be in order

I feel it would be beneficial to understand if the experience within Eating Disorder Services described by the narrators within this research is widespread. Due to the small number of participants, it is not possible to assume that this is always the case for people accessing such services. However, a larger scale exploration of this could help inform services of potential changes that could make for more effective therapy environments. It would also be useful to understand how widespread the lack of knowledge about options for treatment is and to improve awareness of options alternative to NHS services.

In my clinical work I have experienced a splitting of sorts between myself as the listener - the person trying to understand the individual and their experiences, validate their feelings and being non-judgemental - being viewed positively and members of the team - who are enforcing boundaries and rules - are viewed negatively. This is something that professionals working within eating disorder services have informed me is often the case within their work. The

narrators within this research present their story of the partners somehow being able to integrate these elements and remain in a positive relationship with the women; research focusing on this would be very valuable to enlighten services how this can be done more effectively from a professional perspective.

The focus of this from a clinical perspective could be exploring questions such as: how do they manage to do this without damaging the relationship? From a couples' perspective how does the individual make the decision to involve their partner in the fight against an eating disorder and how does this affect or is affected by the relationship? Does the ability of the partner to do this interfere with the work of the services?

Newton (2001) also presents a case for further research to be conducted into the perceived quality of treatment for individuals with eating disorders, from the perspective of families and carers along with the individuals themselves. This, along with the aforementioned lack of literature in the area, demonstrates the necessity of such research.

Other literature within this area is focused in different countries, such as Sweden (Clinton, Björck, Sohlberg & Norring, 2004); Norway (Rosenvinge, Kuhlefelt-Klusmeier, 2000) and Australia and New Zealand (Swain-Campbell, Surgenor & Snell, 2001). This literature suggests that there are mixed views among individuals who access eating disorder services within the respective countries, again illustrating the need for further, perhaps more qualitative and in depth, understanding of such experiences. Exploration of partners accessing therapy or counselling would, as mentioned previously, be an interesting area of research, as Would discovering how aware partners are of this option and what leads them to choose to take this option. Are there differences between partners who do and do not, or differences in the relationship? Understanding these elements could help further the understanding of couples living with an eating disorder – or perhaps even more broadly with mental health difficulties or even physical health difficulties. It is clear that there is an effect mentally on partners in such situations and so care for them would be a fruitful avenue to follow in terms of how counselling psychology can contribute to this.

8.3 Reflection

I was mindful in conducting the analysis that there could be many discoveries to make, many more than would be possible within the time and word limit constraints of my research. This appeared initially somewhat overwhelming, I did not know where to begin, how much, or what, I ought to be looking for, and if I would know when to stop. Ensuring that I remained focused on the aim of exploring couples' experiences of living with an eating disorder, in a way that would be helpful to the field of counselling psychology, helped me to move in the right direction.

It was very helpful to have a support network. While there were very few of my colleagues in training using narrative analysis, those of us who were remained in close contact, enabling us to reassure each other and share ideas about how best to approach the daunting task of analysis. As there are very few 'instructions' of how to carry out narrative analysis, it was

extremely useful to discuss this with each other, and to be excited about the different and creative ways we were managing to employ the approach. Added to this was a very helpful workshop run by Professor Carla Willig, again enabling discussion and a flow of ideas.

Conducting narrative analysis can at times feel lonely, and I felt as though I might have been missing some crucial information that would make it all clear to me. However, as I progressed through the research, I began to enjoy the process and the freedom that comes along with using such a creative method of analysis. I also feel that I have learned so much more from this method than I would have using a purely content analysis method. It has helped me see the potential depth of any interaction I have with others, both professionally and personally.

One benefit of the limitations within which this research is situated is that it enables my interpretations to remain balanced in terms of my own situation and context and how that influences my interpretation and understanding of the narrator's words. My interpretation is likely to change over time, and I'm sure that it will have done even in the short time I have been concentrating on this analysis.

I have presented my findings in an open and transparent way, with awareness of the impact that myself, my knowledge and my context have on the process. I have tried to maintain awareness of this and the effects it may have – including that as the information is aimed to be of use within the field of counselling psychology, and presenting myself as a counselling psychologist (in training) conducting research, it is a close match to the context in which the information is hopefully to be used.

I have found through conducting this research that I have become much more attuned to the detail in what clients are saying, and also in how they say it. Using narrative analysis has enabled me to pay detailed attention to words, language, tone, and so on, which has helped me to see how much more there is that we can understand from people’s discourses and narratives than at first seems possible. I do acknowledge that I have likely only touched the surface of the potential for discovery within language and discourse. However, I know that the skills I have gained from analysing narratives in such detail will remain with me in my professional work, especially within the therapy room, giving me an increased awareness of the words used by my clients. I have faith that this will lead me to working more effectively and in tune with my clients, helping them to see what kind of story they are telling me, the meaning of that story for them, and what it would mean if it were different.

9 CLIENT STUDY: AN EXPLORATION OF THE INTEGRATION OF COGNITIVE AND BEHAVIOURAL TECHNIQUES INTO NON DIRECTIVE THERAPY.

9.1 Introduction

I have chosen to write a client study focusing on a client whom I shall name Sam[1], as the work was some of my most complex, challenging and interesting, being an early attempt to integrate cognitive and behavioural techniques into person-centred counselling. While at times this may be construed as inconsistent, it can be reframed as a theoretically consistent fashion in that the aim is to help the client in a way that works best for them. This is an approach I am developing, especially following my learning from this work with Sam. Reflecting on this work has also highlighted issues regarding the use of theory at the price of actual or perceived benefit for the client, if, and how, as a counselling psychologist, I can make a decision about what is 'right', 'better' or 'best' for my clients, and how to use myself in this process. Use of self has been an important area of discussion during final year lectures, so I feel it is pertinent to explore such issues within my own work. This is with hope of creating more understanding for myself initially, and to demonstrate the very real nature of this dilemma.

9.2 Context, referral, presenting problem(s), convening the first session and negotiating therapeutic aims.

This work is set within a specialist autism service, which Sam entered from a care home within a different service, which did not specialise in Autistic spectrum disorders (ASD), as he has a diagnosis of Aspergers' Syndrome (AS). I first met him following a multi-disciplinary team (MDT) meeting, when he communicated with the supervisor who I was with at the time. Sam was non-verbal, writing down what he wanted to communicate to us. He was rocking, holding himself close and appeared distressed. My supervisor arranged a meeting with him on another day, following which he referred him to me, giving me Sam's history and referral information. Whilst I initially found it challenging to bracket off this information in order to have an open mind and allow Sam to tell me his story, I felt it important to hold this value to ensure a non-judgemental approach (Rogers 1969).

[1] all names and identifying information have been altered to ensure anonymity for the client to retain confidentiality

Sam and I met in a private room of the staffed, eight bed ASD specific care home in which he lived. In our initial meeting we discussed what he felt he needed and wanted to work on. Sam again was non verbal, communicating in writing. I asked if he preferred me responding verbally or in writing, to which he replied he did not mind, so I used a mixture. I felt it was important to communicate with Sam in a way that matched how he did with me, as Turan & Stemburger (2000) found language matching can help enhance perceived empathy in therapy. As empathy is a core condition for therapy, as proposed by Rogers (1951, 1961, 1974, 1979 & 1980a), and reiterated by Mearns & Thorne (2007), I was keen to demonstrate this, especially in our initial meeting to convey my understanding.

In the first few sessions, I mainly focused on hearing Sam's story. Sam stated he had waited a while to see a psychologist, and appeared to have lots of stored up information he wanted to tell me about himself, for me to be aware of before we went any further. Therefore, during this time, I began formulating a general idea of what the issues were, and how best to work with Sam. Sam and I agreed to explore these issues more fully. We discussed and agreed meeting weekly, keeping it open ended in duration, agreeing to review after 12 weeks. While it can be difficult for people with ASD to understand a less structured approach, Sam appeared to find this more helpful, and I felt that imposing too much structure regarding time at this stage could increase Sam's anxiety and have a detrimental effect on our relationship as he seemed to have so much to say. There was also an element of funding authority control as they expected Sam to be engaged in psychological therapy for the duration of his stay with the company. Sam expressed his keenness for such input, due to him having waited a long time for a psychologist, and saying he had a lot to talk about in sessions, so long term work was to his liking. This notion seemed to reflect what Mearns & Thorne (1998) suggest, that some clients need contact over many months, to help them reorient themselves and the way they live their lives.

9.3 Summary of theoretical orientation

When I began working with Sam, we discussed how we might work together. Sam described a void which he felt existed between his thoughts and his feelings, resulting in no change of feelings even when he would alter his thoughts about a situation or event, and stated a preference for a more nondirective approach. I felt this was appropriate at this stage, due to the link between thoughts and feelings being central to the cognitive behavioural paradigm (Person, 1989). It was also apparent early on that Sam was looking for solutions to his problems to come from other people, and that he did not seem willing to change. I therefore felt that being directive could be detrimental both to our relationship and Sam's perception of therapists, and so decided that working from a person-centred perspective could be suitable to help Sam achieve heightened awareness of his role in how things happen for him, encouraging his 'self-agency' (Bohart, 2004: Bohart & Tallman, 1999).

I began working with Sam in a person-centred way. I attempted to convey empathy in order to help Sam feel understood, especially as this was his main concern. I also felt that being non judgemental and having unconditional positive regard for Sam might help him feel more comfortable with himself, as he spoke about feeling that he could not be himself most of the time. It seemed to me that there was much incongruence between what Sam was saying he wanted to be, and how he perceived himself to be at the time. Therefore I felt this approach could help reflect that to him, in order for him to become more aware of it, and make changes to become more as he wanted to be or accept more of how he was.

I discussed in supervision the difficulties I felt I was facing in terms of helping Sam understand what his 'ideal self' would look like, and how it differed from his 'self' as he viewed it. This made me wonder if self-actualisation would be possible for him, and therefore if it is possible for everyone. This lead to supervision discussions about therapist limitations, and how I may have had ideas of what would have been best for Sam, but if his ideas were dramatically different it poses the question of who knows best, and which direction to go in. It seemed that Sam had an idea of what he *did not* want his 'ideal self' to be, rather than what he would like it to be. Rogers (1951) talks of having not met any client who does not want to remove their dependency and move forward. However, I was aware that there were many limitations in Sam's life that may make it very difficult, such as his need for support and care on a daily basis, and his difficulty to think in certain ways due to his AS. It was becoming clear something more was needed to be able to reach Sam, following the initial period of support. I understood the concept that everyone has the potential to achieve what they want to, and that the right environment, provided by the therapist, can be conducive to this. However, I wondered if this would be possible with Sam, if he would recognise what it was he could achieve without more direction, and if he would be able to come out of his long held belief and thoughts of needing someone else to help him get there.

I began to think about integrating some cognitive and behavioural techniques - such as thought records and behavioural experiments - into the work we were doing. This was with the aim of helping us find out in more detail what Sam's thoughts were regarding certain situations, and to try to highlight to him the difference I was aware of between his opinions of situations and what other's opinions were of those situations. I began to become aware of how strong an idea Sam had of 'ideal others' despite having little idea of his 'ideal self', and therefore how much he expected others to be exactly as he wanted them to be, which seemed to be related to his AS and to a lifelong reinforcement of this. Integrating such techniques into person-centred work has been shown to be compatible (Prochaska & Norcross, 1994), due to the view that therapies agree on the process of change but disagree on the content, and so combining the awareness and action therapies can be beneficial. Gale, in Papadopolous, Cross & Bor (2003), suggests that a cognitive behavioural approach is dealing with the 'how' of change, and that person-centred with the 'what', allowing person-centred to provide the theory of personality, origins and explanations of clients' difficulties and cognitive behavioural to provide the tools to bring change about.

9.4 Summary of client's biographic details

Sam is a 40 year old man, who lived with his parents – whom he would continue to have regular contact with - and two sisters and a brother. Sam was diagnosed with Aspergers' syndrome at age 17, following what he reported to be a growing self-awareness of being different during his teens, and describing himself as an isolative but content child. Sam attended college for young people with autism spectrum conditions in his 20s, and following this has lived in residential support. Sam is of medium height and build, with blond hair. Sam would dress casually in jeans t-shirt and trainers. Sam is intelligent, with an interest in psychology, and good insight into his condition and autism in general.

9.5 Initial assessment and formulation

Humanistic approaches to therapy consider assessment to suggest a power imbalance between therapist and client, whereas it ought to be person-to-person meeting (McLeod, 2003). Therefore assessment should consist of therapist and client finding out if they think they can work together, and our initial meetings were based on this, looking at the issues Sam wanted to raise and how we might work with them together.

Sam's initial presenting problems appeared to be persistent low mood, difficulty communicating with others, including being mute and withdrawing, which would involve shutting himself in his bedroom and declining the company of staff. Sam expressed a desire for other people to understand him more, so I thought a place to start could be with me trying to understand him as he does, and to go from there, in a collaborative manner.

It appeared that Sam had lived with the thoughts regarding no one understanding him for most of his life, and a desire for him to feel as he did before learning language in a way that gave a different meaning to everything for him, and this appeared to have been reinforced by significant people throughout his life, adding to the strength of the thoughts and beliefs. I thought that this could be a difficult thought pattern to change, due partly to his difficulty with flexibility of thinking related to his Aspergers', and partly due to them being so long held and reinforced and therefore well entrenched. Linked to this was an apparent suppression of Sam's development of an ability to self-actualise, as he appeared to find it difficult to accept himself or his situations, to understand that he had any role to play in making things different. Sam stated a belief that it was the responsibility of others to change things to suit him, demonstrating an inaccurate perception of reality. I was mindful however throughout the work that this could be a biological difficulty, meaning he could not think in certain ways, and so was careful not to push him too hard.

I also thought that as Sam had lived in residential support for many years that this could have added to his sense of entitlement for people to do things for him or react to him in certain ways, due to the nature of such systems. It appeared that Sam had developed few coping

mechanisms or self-soothing abilities following his developed awareness of his 'difference' from other people, and the overanalysing insight he also developed from this. This therefore lead to Sam maintaining a consistent state of anxiety and low mood, which seemed to have become so familiar to him that I was unsure if he would be able to recognise when he was feeling more positive or less anxious and if he would allow himself these feelings. It also seemed that Sam had low self-esteem and having not reached a stage of bridging the gap between 'self' and 'ideal self', his belief in himself that he could manage situations was low, leading him to develop a 'self' derived from a desire for regard, which was conditional.

It appeared to me that Sam demonstrated a lack of personal congruence (Rogers 1961), as he often said he felt he could not be fully himself with others, due to being acutely aware of his difficulties, how he believed other people would perceive him, and not wanting them to be aware of his difficulties. Sam stated that he wanted to be different, less stressed and lighter in mood. Yet whenever I commented on his mood being lighter, or him appearing happier, he would explain it as him being stressed and trying to distract himself. This suggested to me that his self-concept was that of a depressed, highly anxious and stressed man, as he would often describe himself, and therefore his behaviours and moods were attributed to this.

I felt that Sam had strengths in that he appeared intelligent and well read, especially in the areas of autism and basic psychology. Sam also demonstrated a good sense of humour, and an ability to distract himself temporarily from anxiety, usually with humour or intelligent conversation, so I was keen to highlight these for him to help him have more belief in himself.

9.6 Pattern of the work

Bugental (1978) talks of the process of defining therapeutic goals, and matching the therapy to client goals as a process that takes some time, saying therapist and client ought to work together for some time in order to build up their relationship, and be able to work out to what extent they can, together, achieve the goals the client wishes to achieve. This is how Sam and I worked, as an on-going process throughout the work. We initially worked towards helping give a clearer picture of Sam for staff to understand his behaviours more. We went on to explore more deeply the meaning of this understanding for Sam and to consider possible alternative ways of thinking and reacting, leading to helping Sam gain more autonomy over difficulties such as others' understanding and persistent low mood.

9.6.1 Therapeutic plan, techniques used and key content issues

The initial plan was to explore the issues that Sam said he wanted to talk about. Sam stated he had waited a long time to have contact with a psychologist, so there was much he wanted to tell me in order for me to understand what he was talking about, and more importantly, to understand him. To try to help convey the understanding I was hoping I had, we drew up a collaborative formulation style report. The aim of this was to clarify the issues Sam thought were pertinent to him and for staff to be able to understand them, with the aim of increasing

their understanding of him. This seemed to help Sam feel reassured that he was being listened to and taken seriously, and that someone was trying to understand him. Although initially Sam had asked me to communicate this to staff, I was careful to ensure that he had a large part to play in the process, to help him see that he could achieve some of his aims himself, which is why I insisted we wrote it up together, using his words. For a period following this, Sam appeared appeased that people were more understanding of him, however this was not maintained. I therefore began reflecting on the apparent incongruence I could see, and the ideas mentioned previously regarding his self-concept. Sam did not at this stage in our work seem to notice these, or stated they were not the case. I did not want to push him too hard so was careful not to labour my point with this, hoping to be able to return to it later.

Following this, the plan developed to include exploring the possibility and meaning of being understood, bearing in mind he is 40 and states he has never been understood. I found it difficult to comprehend if the view he held about how others should understand him was stemming from his Aspergers', (and could therefore have been due to impairment in flexible thinking, and theory of mind, (Wing & Gould, 1979), meaning he would have difficulty realising and understanding that other people do not have the same thoughts as himself), or if it was an opinion he had developed over time. It appeared from what he would say to me that he had a history of being misunderstood, and of being unable to fully express his 'authentic self' in a way that was understandable by others. Partly due to his long held belief in this, his limitations with thinking outside of his opinion, and his reactions to previous reflections I thought that guided discovery would be more appropriate, helping Sam to reach his own conclusion regarding this. I found this difficult initially, and it required much more direction than I anticipated in order to help him see alternative views. It was nearer the end of our work that Sam began to accept that people may not understand everything about him, and to look at things he could do such as registering for an autism card, to help explain his difficulties to people who may not understand some of his behaviour.

We also explored over time the feelings Sam had in relation to how other people see him, particularly those who he used to know when he was younger and may not know about his Aspergers', due to him receiving his diagnosis after losing contact with them. This therefore led to us looking at what he thought these people may think about him, and the importance of this for him. It appeared that while he wanted to get back in touch with them, he felt ashamed at the fact he was living in a care home, with no job, at age 40. As he was asking my opinion about it, we established that it was his decision, and discussed why he was so affected by the concern of what they might think. We discovered that he was worried how they would react to him, and he admitted that it was more to do with how he felt about himself than what he thought they might be thinking. This lead us more to discussions about the apparent incongruence with how he wanted to see himself and how he thought others saw him, and towards working on alternative ways of being and thinking, by subtly using more cognitive techniques, based on the idea of a thought record (Padesky & Greenberger) in dialogue form rather than writing it down. I

decided to approach the technique in this way so as to not make it appear too 'task' like, which Sam had expressed dislike of early on in our work.

I felt that a main tool I used within the therapy was myself, as a gauge to help understand what might be going on for Sam. This is based on the theory that the relationship is the most important element of therapy (McLeod, 2005; Cohn, 2007; Strawbridge & Woolfe, 2003), more so than a chosen model of therapy. This meant that I was mindful of, and able to use, the relationship between Sam and me. For example, when I felt anxious or frustrated I looked for the potential parallel process(es) that could be going on for Sam, using supervision to help me do this safely and to work out how to use this knowledge to best help Sam. As we encountered some communication issues within our relationship, reflecting in this way enabled us to work through some of the communication issues he seemed to be having with other people, and help me to challenge some of Sam's conceptions that appeared to be holding him back.

I incorporated Socratic questioning (Padesky, Kuyken & Dudley 2009) to help Sam recognise his unhelpful thinking, in relation to his ideas about other people needing to understand him and act and react in ways that were what he wanted. Through doing this, we established that it may not be possible for anyone to be fully understood by others and it is likely there will be times that people do not behave how we would like them too. This technique also proved successful in helping Sam see that there were times he dismissed experiences and events that did not fit his self-concept, enabling him to re evaluate some of the assumptions he was making.

I also incorporated the downward arrow technique to help us explore the underlying meaning of thoughts, for example, the staff ought to understand that when he withdraws he actually wants company, how it could be perceived by others, and the difference there might be if people did or did not react in the way he would like. Again I approached this in the form of a discussion rather than a written exercise, in order that it did not feel too threatening for Sam.

9.6.2 Therapeutic process, difficulties, how these were overcome, and use of supervision

When I began working with Sam, I felt somewhat overwhelmed, as it appeared that this case would be more complex than any of my previous cases. I was also initially fascinated, as what Sam was presenting with regarding his difficulty speaking was something new to me. I had previously come across elective mutism, but this appeared to be different. It was almost a month before I actually heard Sam's voice. When Sam did eventually begin speaking in sessions, I felt this was a significant point in the therapy, as though I must have gained his trust in some way, or created a space in which he felt comfortable. This was based on the fact that in previous sessions, communicating with writing, Sam had explained that he finds it difficult to speak when he feels under pressure or in situations in which he feels uncomfortable. I explored with Sam some of the cognitions he had been experiencing around talking or remaining silent with me, and he explained that he began to talk because he felt I was listening

to him, trying to understand him and he felt more comfortable with me enough that he could trust me and not feel too anxious to speak. I wondered with him how he felt now that he was talking, and he explained that he felt slightly vulnerable but was becoming more comfortable with it. As my broaching of 'testing out' as in behavioural experiments within CBT (Mansell & Taylor, 2012) had been met with strong resistance previously by Sam, I did not want to push too hard to explore the possibilities regarding talking outside of our sessions at this point as I recognised we were at a delicate stage of the relationship that needed to be treated with gentle caution.

I began to feel more comfortable in the work I was doing with Sam, yet still seeking much guidance from my supervisor. This was especially the case as he appeared extremely low at some points, and he did carry out a para-suicidal act of tying a cord around his neck and looping it onto a tree. Sam maintained that this was not an attempt to kill himself, but a way to get people to notice him and to listen to him, and that he had no intention to take his feet off the ground and actually hang. Around this point I became aware that Sam was relying on me, perhaps too heavily, to be the one that 'understood him'. It appeared almost as if there was a splitting in his opinion, that everyone else did not understand him and I did. I found this a difficult concept to work out initially, as I felt almost honoured to be held in such a position, yet by discussing my feelings regarding the case with my supervisor, I recognised the feeling, and it helped me realise this may not actually be helpful for Sam and therefore enabling me to discuss it with him and for us to work on this. I continued to discuss with Sam the functions of his apparent avoidance of increased autonomy, but was met with strong resistance that left me aware that to push much more could be detrimental to our relationship and the work we were aiming to do. Instead I more cautiously observed when such patterns were emerging. Later in the work this was something that Sam became more open to discussing, as he became more self-aware in relation to other people.

I had ideas about what I thought would be most helpful, as I could see that by relying on me Sam was further still reducing his own autonomy. However, Sam had the opposite idea, and continued to state that for him this was a helpful set up. I found myself feeling stuck at this stage, unsure of whether following my ideas or what Sam stated he wanted would be more beneficial. I also felt frustration at these times, especially as Sam would describe situations which were unsatisfactory to him, yet appear reluctant to attempt to change it himself. I found supervision extremely helpful at these points, and would explore parallel processes to recognise that feelings I was experiencing may be reflecting what was going on for Sam, enabling me to be more empathic and patient, looking for other ways to approach the subject, such as using Socratic questioning. Mearns & Cooper (2005) discuss questions within person-centred therapy as being useful to help centre the decision process back with the client when they are trying to push it to the therapist, which is something Sam would often do.

I found exploring parallel processes in this way in individual supervision very helpful for reflecting on how I am and how I feel in relation to the sessions and work with Sam. This

process highlighted my apparent need to provide Sam with the answers, as I felt this was what he was asking for from me. This became clear through my supervisor noticing in our session that she was beginning to try to find answers for me. We discussed this, and how it seemed to reflect how I was being with Sam. This discussion gave me ideas and confidence to be able to take a position more of guiding him towards thinking about finding answers himself, giving him time to sit with ideas more to allow him time to think them through, which was especially important due to the difficulty he would have at times processing information, meaning that it can take him longer than it would appear, due to his AS. This taught me to be patient in my expectations of clients, and not to expect solutions and changes to happen immediately.

Sam began to question himself in regard to his morals. This was regarding the choices he had made and could make about his role in relation to others, and seemed to begin thinking more about what he wanted than what he thought he 'ought' to do. Initially I found myself questioning him about the choices, but realised I was getting caught up in the details. I therefore focused more on the presence of the dilemma, and how he was managing it as this fit more with our overall approach of exploring and understanding how Sam would make decisions and take responsibility for himself.

When I was feeling stuck with moving forward in the work, integrative group supervision helped me see that I could bring yet more of myself, and that I do not have to be 'nice' all of the time, allowing Sam at times to sit with frustration and to use this as a therapeutic exploration. These aspects of supervision have helped me to feel more confident in using myself, incorporating techniques from other models of therapy if I believe they would be helpful for my client, and not just sticking to exactly what textbooks say, but to use the ideas and philosophies I adhere to myself. I brought both of these points together when I had a day of annual leave due on the day I would see Sam. Previously, I had ensured that I rearranged our session for another day in the week if that was due to happen. However, this time I did not, and the following week Sam expressed his frustration and annoyance at me for not being there. This provided very rich and useful material for us to work with in the session, exploring his feeling of needing to be attended to by others, and getting what he wanted.

I found the group supervision invaluable for looking at these issues, as it meant there were ten people with fresh ideas about the work I was doing with Sam, It gave me other perspectives and helped me become aware of my blind spots, as I felt I was becoming stuck in too familiar a routine with him having been working with him for around 18 months at this point. It seems to me that following this, Sam and I were more able to talk about our relationship and how that might give us insight into his world outside of therapy.

9.6.3 Changes in the formulation, therapeutic plan and process over time, and the future of our work together.

Boswell, Nelson, Nordberg, McLeavey & Castonguay (2010) express their opinion that formulations and treatment plans are optimised when they are based in a specific theoretical

approach, incorporating techniques from other approaches, depending on what it seems would be best to approach the change process with a particular client. I found myself in a similar situation as Gale (in Papadopolous, Cross & Bor 2003) discusses, feeling that Sam could benefit from more directive cognitive and behavioural techniques yet knowing he had stated a preference for non-directive work. I felt this was an approach necessary with Sam, as a purely non-directive approach seemed to have got us so far but we were limited with the change process, and so I began to introduce cognitive and behavioural techniques. Initially I did this in an implicit way, until there was a useful stage in the therapy where a process discussion occurred. This enabled me to explain the changes I was attempting to make in my approach, and to explore these with Sam. I explained to Sam that it seemed he did not always recognise points I made in a more reflective manner, and so I thought that guiding him in a gentle way - so as not to be too incongruent with the person-centred model - could help him focus more. I wondered if I did not offer reflection in a 'diplomatic' way, as suggested by Leitar (1998), but I found that the direction using cognitive and behavioural techniques allowed me in this context provided this to an extent. Sam appeared to understand this, as he responded interestedly and was open to further exploration of this. This gave us some rich grounds for examining his relational processes outside of therapy and although Sam continued to be resistant to much change, he seemed more open to discuss his patterns of interacting and becoming more open to alternative ideas. In also helped me to feel more comfortable in exploring such issues with Sam.

Sam's main presenting issue was of placing himself in a position of not being understood, and having been in this position for most of his life. I wondered if there was something stronger holding him in that position that he maybe actually wanted or needed to be in that position, as that is how he could make sense of himself in relation to other people. This was something I began to explore with Sam, although it was difficult due to his rigidity of thinking, and therefore difficulty with seeing other ways of being. Gaus (2007) discusses some of the most common core beliefs of people with Aspergers' as being related to loneliness, difference, bound to be alone, and powerless – based on Beck's (1995) list of the most common maladaptive core beliefs. As it appeared to me that Sam held beliefs around these areas, I attempted to help him uncover his core beliefs, which was difficult as, similarly to many of my other clients with ASD, Sam had difficulty understanding that there could be thoughts 'deeper' than those most obvious to him, and how these might relate to his moods. As Sam's self-concept appeared to be so rigid, I wanted to help him see why his thoughts and feelings had developed as they had, but felt direction was necessary due to the difficulties mentioned above. I believe that had I continued this area of the work in a purely person-centred way that I would have found Sam to be less receptive to my reflections, therefore wanted to enable him to come up with his own answers, especially as his belief in his own opinion would mostly outweigh that of others.

What I felt was a significant point in the therapy came when we discussed the way we were working together, and decided to make some changes. We both discussed issues we felt were present in the therapeutic relationship, and then how these might give us insight into Sam's life

outside of the therapy, such as the difficulty Sam said he had with not always listening to others. Having worked on parallel processes in supervision I found this a useful way to relate what happened between Sam and me with his life outside therapy. This appeared to make sense to Sam, and I felt as though we had opened up a way of talking about relational issues more freely. I felt more able to challenge Sam, and he appeared more willing to listen to my insights or queries, which we would then explore together.

Towards the end of our work, Sam appeared to understand himself more, and his difficulty of understanding others. He thus developed more awareness of how others may have difficulty fully understanding him. Sam had also taken initiative to apply for an autism card, and to draw up communication cards, in order to help communicate his difficulties and needs to others. This appeared to me to be him taking more control of his life and situations within it, having gained more self-belief and autonomy. It seemed apparent that he continued to have a strong self-concept of being a man of low mood, often stressed and anxious, yet he demonstrated more ability to manage situations he felt were causing him such feelings.

9.7 Liaising with other professionals

I liaised with my supervisors, and when I attended MDT meetings, with the psychiatrist responsible for Sam. We would discuss together Sam's presentation and our understanding of his needs, ensuring that we were working towards the same aim for Sam, and that we knew what direction each of us was aiming in. I had a good working relationship with the staff team who worked with Sam, and would liaise with them closely regarding his care, and so I became aware of how much they make the decisions for residents, which can lead to dependency. I therefore began to encourage the staff to reduce this control, giving Sam more responsibility, and ensuring that they understood the reasoning for this.

9.8 Evaluation of the work, and what I have learned about the psychotherapeutic theory and myself as a therapist

Working with Sam has been thus far my most challenging case. I think this is partly due to the nature of his presenting issues, that they were complex and appeared to be very longstanding. Also, though, I feel it has been to do with how much I have noticed my use of 'self' within the therapy. This is something I feel I developed through the work with Sam, as initially I felt afraid to and unsure how I was 'supposed to' use myself. I began working with Sam early on in my training, and felt as though I had to work 'by the book', in terms of single models, and perhaps naively stuck rigidly with the idea of non-directiveness within person-centred therapy. On reflection I can see that this was potentially helpful in the very initial stages of our work together, allowing Sam the space to discuss the issues he wanted to and to feel listened to. However, as the work progressed I needed to be more directive and challenging, which I did not manage to do for some time. This was partly due to confidence and ended up with us repeating much of the same material as Sam continued to discuss the same issues. I also

realised that I was being sucked into the ‘providing solutions’ role which I felt Sam was putting me in. This is something which has taught me to be more aware of how I am reacting and responding to clients. During my work with Sam I became more alert to this, and have filtered this learning into my work with other clients.

I took on an integrative approach to the work with Sam, as I follow the belief that it is important to work in a way that is helpful for each client, with me, at each specific time, with a certain issue or issues, as Hollanders (2003) points out is an aim of integrative practitioners. I feel that this reflects the way I view therapy, and therefore that an integrative way of working is the right direction for me to be aiming with my work. However I have also realised that it can be confusing at times, to have lots of ideas or theories about how best to work with someone at a certain point. I discovered through writing this report that it can feel easier to try and incorporate everything I know, yet this can actually make things more confusing and less effective. I have therefore learned to slow down and consider each element carefully, yet also feel able to react quickly and dynamically when necessary.

I have learned that there are so many schools of therapy ‘available’, many of which have evidence for their effectiveness, yet also limitations. From this, I understand that to take one approach and apply it in a purist way may be a shortsighted way to approach therapy. I also feel that this would be to follow another person, or few people, rather than to look at my ‘self’ and understand what fits with my personality and values as a therapist, an element which Corey (2011) talks of as being very important. As the relationship is of primary importance in therapy (McLeod, 2005; Cohn, 2007; Strawbridge & Woolfe, 2003), I feel it is paramount to be true in that relationship, therefore bringing my ‘self’ rather than a 'toolbox’ of techniques. However, I still place value on using tools that seem appropriate and fit with my values when necessary.

This aspect of using ‘self’ has become clearer to me during this case in that using my ‘self’ can be the most important aspect of the therapy at times, and now feel more confident in doing so. I found that the times Sam was expressing dissatisfaction – for example him feeling that he was giving a lot but not receiving much in return – were the times when I was sticking very rigidly to ‘textbook’ therapy. This highlights to me an example of focusing on technique and theory at the expense of the relationship, as Stolk & Perlesz (1990) discovered.

I have also learned to ‘let go’ more, through the discussions I have had in specialist supervision. By this, I mean that I am realising that I do not have to make sure that I always make everything ok, for example, when I was due to be absent on the day that I see Sam, I would usually try to re-arrange for a different day, in order that he does not miss a session. However, I am realising that this came from my feeling of wanting to meet the demands and requests which Sam explicitly expressed, and that I perhaps perceived from some of his more implicit behaviour, and also created self-importance of me or my role as his therapist.

I have learned that I am not necessarily there to soothe anxiety, or to create a ‘perfect’ view of life. Initially I did not feel able to say that I would not be able to provide answers or solutions for

Sam, and it appeared that this was what he thought he wanted. As this is a main factor of person-centred therapy, as outlined by Mearns and Thorne (2007) this is an element I am aware is a weakness, and is an aspect I have since worked on finding that it is not as daunting as I first thought, and I have implemented this in the work with Sam since. This I feel links to the above comment, as I think that initially I felt I had to provide what a client was asking for, rather than looking to the edge of their awareness and thinking about what they really need to help them in their current situation.

Overall, I found working with Sam challenging, complex and interesting. I enjoyed the challenge it brought, and relished exploring new ideas that could have been helpful to him, and expanding my understanding of what therapy is, and how I am the tool, to use in ways that are helpful for the client. This felt like a liberating yet intimidating prospect, as it can feel quite safe to follow textbooks. I am learning to recognise my own core beliefs about needing to provide people with what I think they need, and about being 'nice' to people, recognising the importance of the 'self' within the therapeutic relationships. I have enjoyed learning about integrating theories and techniques in order to bring about change, and hope to continue to do so in my work.

10 PUBLISHABLE PAPER: THE COUPLE'S STORY: A NARRATIVE ANALYSIS OF COUPLES' EXPERIENCES OF LIVING WITH AN EATING DISORDER

10.1 Introduction

Anorexia has the highest mortality rate of all psychiatric illnesses (Martin, 2007). Adults with anorexia are often in relationships, and report that their partners are an essential part of their recovery process (Federica et al., 2003; Bulik, Baucom Kirby & Pisetsky, 2011). Furthermore, anorexia is associated with considerable and prolonged caregiver stress (Bulik, Baucom & Kirby, 2012). For these reasons I believe anorexia and relationships is an invaluable area to work on and attempt to increase understanding of, and therefore will be focusing on anorexia nervosa throughout this thesis. This is with the acknowledgment of the presence of eating disorders not expanded on here such as bulimia nervosa, binge eating disorder and eating disorder not otherwise specified.

Mental health issues and relationships can affect each other in many ways, such as high marital quality (self-reported) being significantly associated with lower stress, lower depression and lower blood pressure than single or low marital quality comparison groups (Holt-Lunstad, Birmingham & Jones, 2008). Self-esteem has also been explored regarding relational aspects of empathy, congruence and unconditional positive regard - Rogers' (1957) suggested facilitative qualities in a close relationship, with close friends (Cramer, 1987). This provides insight into relational qualities that may affect individual self-esteem, and the social support affecting individual mental health, leading to questions around the link of these qualities to marital relationships (Larned, 2007). Specific aspects of intimate relationships have also been explored in relation to mental health issues, such as women with anorexia or depression being more likely to have sexual difficulties than women with post-partum depression (Carter et al., 2007).

Specifically with eating disorders, there is an increase in the number of women presenting at a later age with an eating disorder, therefore they are more likely to be in long term or marital relationships (Dally, 1984; Garfinkel & Garner, 1982; Heavey et al., 1989; Hedblom, Hubbard & Anderson 1982). The average age of presentation is 40, ranging from 22 to 60, with women with bulimia tending to be older and more likely to be in a relationship than those with anorexia (Woodside, Shekter-Wolfon, Brandes & Lackstrom, 1993; Van den Broucke & Vandereycken, 1989c). Married women presenting for treatment with anorexia tend to be older than single women with anorexia, and tend to be ill for longer, but no evidence is present for the marital relationship altering the presentation of the anorexia (Heavey et al., 1989).

Women with recurring episodes of an eating disorder may choose a 'deserving' husband, who may be less appropriate than they may have chosen had they not been ill, with the eating

disorder behaviours serving to stabilise the marriage (Andersen, 1985). Barrett and Schwartz (1987) labelled a complementary dynamic of over-responsible/under-responsible as becoming a functional way of mediating power and control within the marriage, as neither partner is required to take responsibility for themselves or the relationship. However, other researchers have found no evidence of mutual dependency with eating disorder marriages, finding instead that marriages were reported to grow stronger and more positive as a result of eating disorders (Levine, 1988). This dynamic may reflect what Levine terms 'satisfying dependency' – a result of rather than cause of relationship power imbalance, therefore benefiting the relationship, supported by Van den Broucke and Vandereycken's (1989a,b) hierarchical pattern of relating, described as a mutually 'satisfying and cooperative' pattern. They suggest marriages with anorexia may be more likely to develop a pattern of stable distance, with difficulties in communication, and marriages with bulimia having more power imbalances.

Social support (the network around an individual such as friends and family) is a complex area for individuals with eating disorders and their friends and family. This is demonstrated by findings that friends and family often do not know how to help their loved one, with their attempts seemingly found to be unhelpful by the individual (Grisset & Norvell, 1992). Also individuals with eating disorders appear dissatisfied with the level of social support they receive related to their eating disorder (Tiller, Sloane, Schmidt, Troop & Treasure, 1997; Rorty, Yager, Buckwater & Rossotto, 1999). Further to this, family and friends of individuals with eating disorders often feel it is their role or responsibility to fix the situation or make things better for the individual with an eating disorder, and that if they cannot do this they perceive it as a failure on their part (Troop, Holbrey & Treasure, 1998), leading to potentially significant distress for the partner, and found to be greater than caring for an individual with psychoses (Treasure et al., 2001). With partners being a most frequent provider of support for individuals with eating disorders (Quiles & Terrol, 2009) it highlights the importance of the role of partners, and a need for an understanding of what is helpful and unhelpful for the individual, and understanding of the distress experienced by the partners (Whitney, Haigh, Weinman & Treasure, 2007).

Eating, weight and shape (EWS) issues are thought to affect relationships (Morrisson, Doss & Perez, 2009), suggesting that partner's assumptions and attitude towards weight can have an effect on how individuals feel about themselves and their attractiveness. Van den Broucke & Vendereycken's (1989b) findings that body image issues are significantly relevant for satisfaction within relationships and both partners' attitudes, values and beliefs towards body image found to be potentially significant factors in the development of an eating disorder further reinforce this idea.

The development of eating disorders is often viewed as a reaction to psycho-sexual maturity, linked to the stressors involved with sexual maturity, and fears of separation and individuation (Woodside et al., 1993; Crisp et al., 1977; Crisp, 1980). It is therefore unsurprising that sexual behaviour is closely linked with body and self-image, with women more comfortable with their bodies feeling more comfortable getting undressed in front of their partner, being more sexually

active, more easily reaching orgasm, initiating sex, and being more varied in their sexual behaviours with their partner (Ackard, Kearney-Cooke & Peterson , 2000; Faith & Schare, 1993; Murstein & Holden, 1979). Eating disorder couples have been found to avoid intimacy (Barrett & Schwartz, 1987). Communication skills are lacking with many eating disorder couples, as they use less meta-communication and neutral problem description compared to non-distressed couples, although they do avoid a critical, justifying and disagreeable communication style demonstrated by couples reporting marital distress, with them demonstrating more self-disclosure (Van den Broucke, Vandereycken & Norré, 1997). Communication difficulties such as these and eating disorder behaviour are involved in a circular existence, rather than there being a causal relationship present.

Kenyon (2007) found that emotional accessibility within an eating disorder relationship to be a key factor influencing the course and maintenance of the eating disorder. She also found this linked to the impact of the eating disorder on the relationship. As Kenyon comments on a void of research in this area it provides support for my research.

There are various possible precipitating factors for eating disorders in adults, including marital problems, separating from parents and difficulties with child rearing (Van den Brouke, Vandereycken & Norré, 1997). Also, eating symptoms may serve as a distraction from other problems within marriages (Woodside et al., 1993), especially with anorexia demonstrating a prominent interactional style of conflict avoidance. Life stresses have been suggested as another factor contributing to the development of eating disorders, as a way of coping with them (Carr and McNulty, 2006). This is important in looking at adult relationships, as there are many life stresses such as marriage, pregnancy and birth – eating disorder symptoms at conception have been reported to worsen during pregnancy in some individuals (Stewart et al., 1987) - house buying and moving, job changes and so on, that could contribute to both onset and course of an eating disorder.

Husbands of women with eating disorders have been defined as having poorly defined sense of self-identity - making them similar to their wives - and leading them to take on an identity through caring for their sick wives. This keeps him invested in her eating disorder, as it helps support his 'false self', with the potential of unresolved conflicts around individual or couple identity needing to be faced if the wife's eating disorder symptoms get worse or there are any health crises (Foster, 1986). Similar to this is the idea that both members of the couple have difficulty clearly defining themselves. This leads to them taking on inter-dependable marriage roles, allowing both partners to avoid their own neurotic issues, instead taking turns with their 'illnesses' and returning to care-taking mode when the other becomes overwhelmed with their symptoms (Barrett & Schwartz 1987). This is echoed by Woodside et al.'s (1993) suggestion that husbands of eating disordered women tend to either have severe psychological problems of their own, or are described as 'near saints'. Husbands of anorexic women have been described as having a need to have a 'sick' wife, in order to, through his ability to tolerate or

care for her, uphold his own self-esteem. The husband believes this stabilises the relationship temporarily, believing the wife also needs this (Barrett & Schwartz, 1987).

Marriages that involve eating disorders are likely to be influenced by attachment issues from childhood, particularly those issues and conflicts that are unresolved (Root et al., 1986), with relationship stresses potentially re-provoking these unresolved conflicts, and/or earlier difficulties with eating (Woodside et al., 1993; Levine, 1988; Heavey et al., 1989; Dally, 1984; Anderson, 1985; Van den Broucke & Vandereycken, 1989a,b).

There is a recognition for the need to include partners in treatment for eating disorders, in a way more suitable for adults than family approaches such as the Maudsley method (Lock et al., 2001), Gilbert (2000) suggests that it can be helpful to bring family members, friends or partners into therapy if they are aware of and involved with the symptoms and behaviour of the eating disorder. Likewise Atkins and Warner (2000) recognize the potential helpfulness of involving partners, suggesting they are often willing to help but are frustrated that efforts have not proved successful; there can be some who do not recognise their role in maintaining the behaviours.

Relationship therapies also demonstrate some specific areas of focus regarding eating disorders. For example Crowe and Ridley (1990) present a behavioural systems approach using reframing of the eating disorder as within the relationship rather than as an individual's behaviour. Stanton (2002; 2005) uses a behavioural couples' therapy (BCT) for addictive behaviours, working with a couple to understand and adapt unhelpful patterns of reacting to the addictive behaviour. Interpersonal therapy (Fairburn 1994) focuses on the interpersonal context of an eating disorder, and similarly Root, Fallion and Friedrich (1986) suggest that the system around an individual needs to be acknowledged and so recommend couples therapy.

It is clear that there are effects between relating and eating disorders, with a large amount of the literature focusing on attachment, issues of conflict resolution and independence beginning and developing in the family of origin, and with this continuing into adult relationships. However, despite the high volume of work in this area, there is little qualitative exploration of the experience of living as a couple when one has an eating disorder, or how couples present this experience and therefore themselves and their identity as a couple, to people outside of their relationship – specifically to someone within the field of counselling psychology. Therefore this research focuses on this area with the aim of stimulating thought and awareness of what is helpful or otherwise for this specific group of people who may be seeking our help.

10.2 Methodology

10.2.1 Participants

Participants were sought through purposive sampling, recruiting for participants meeting certain criteria:

- adults (over 18)
- a couple
- living together during the presence of an eating disorder or eating difficulties with at least one of the individuals
- for the individuals who had experienced an eating disorder to have Body Mass Index (BMI) of over 15, as advised by eating disorder specialists as a weight under which cognitive functioning can be impaired, thus making judgments individuals make about participating and data they may provide unreliable.
- if they had been in treatment, that this had terminated at least six months prior to the interview, in order to avoid contaminating the process of therapy.

Adverts were placed on online forums relating to eating disorders or relationships, fitness websites, health food shops, gyms, local newspapers, places viewed possible to attract people appropriate for the research. The adverts directed interested people to a specifically designed website, where there was more information about the research, and two questionnaires. These served as a basic screening tool to ascertain if interested individuals met the recruitment criteria, and were produced under the guidance of a practitioner who specialises in eating disorders. One was for individuals who had had or were having eating difficulties, and the other was for partners of such individuals.

Three couples and one single man - who had a previous relationship with a woman with an eating disorder - came forward agreeing to take part in the research. Two couples were married, one couple were engaged. Two of the couples were in their mid twenties, and the third couple were in their early thirties, and were the only couple with children.

10.2.2 Ethical considerations

Ethical approval was granted from the researcher's university ethics committee, and throughout the research process it was ensured that participants were clear about the intentions of the researcher to explore their experiences and they understood the potential to publish the research. Participants were given an information sheet prior to committing to the research, and signed a consent form at the beginning of the interview. Each couple was provided with a debriefing pack following the interview, including details again of the aims for the research, and information on eating disorder and relationship support organisations. Participants were also

reminded that they were free to withdraw at any stage, and all expressed an interest in receiving a brief overview of the research upon completion.

10.2.3 Data collection

Interviews were conducted in quiet, private places and at times convenient to the participants, and were audio recorded. I did not specify a time limit for the interviews but the narrators tended to tell their story until they said they had no more to say and they lasted between 50 and 60 minutes. Transcription of the audio data followed the interviews, annotated using the Jefferson system (Jefferson, 1994), to allow for detailed analysis of the performative aspects of the narratives as well as the content.

Interviews were asking the participants to tell their story, with as little interruption from myself as possible, following recommendations from Holloway & Freshwater (2007), Mishcler (1986), Reissman (1990) and Thompson (1978) of minimising questions and focusing rather on the flow of talk from participants. This results in a more productive interview, when the researcher suppresses their own desire to speak, as there is a danger if the researcher interrupts too often the flow of participants' story may be lost, agreed also by Kvale (1996) who describes an interview like this as a journey the researcher and participants travel on together, the participants telling of their 'lived world'. Similarly, Bauer (2000) advises interviewers not to pre-structure the talk within interviews, so that they have minimum control, which allows for the interviewees to be stimulated and encouraged to tell their stories how they want to.

10.2.4 Analytic procedure

The experience of mental illness has been described by Polkinghorne (1988:179) as similar to suffering from an 'incoherent story', or an 'inadequate narrative account of oneself' by Howard (1991) or a 'life story gone awry' by Showalter (1997:11). Important things that happen in life happen in relational encounters between people, in their dialogic exchanges (Shotter, 1997; Gergen, 2009). This is also based on the premise that people organise and construct their experiences in story form, bearing in mind the context of and in which they tell their stories (Sarbin, 1986). Therefore narrative analysis provides a naturalistic way of analysing the data, along with the assumption that these constructions of reality impact on and portray individual identity, and, in the specific case of this study, couple identity, functioning and dynamics. Narrative psychology assumes that human experience and behaviour are meaningful, and there is a need to explore 'meaning systems' and the structures of meaning that make up our minds and worlds (Polkinghorne, 1988).

Two of Reissman's (2006) main approaches to narrative analysis – thematic and performative were used as the basis for analysis of the narratives, due to the aims of exploring the content information about the couples' experiences and how they produce this together to an audience. Goffman's (1961; 1981) dramaturgical metaphors were useful for understanding the perfomative elements of the narratives, looking for characters, scenes, roles and positioning.

10.3 Results

Three couples (Mel and Ben; Sally and David; Beth and Adam), and one single man (Simon) who had previously been in a relationship with a woman (Jane) who was experiencing eating difficulties (undiagnosed but reported by Simon as mainly purging behaviour) participated in the research. The couples were heterosexual and it was the women who had the eating disorder, with all of them having been diagnosed with anorexia.

I will present here a brief overview of the themes and notable observations found through using narrative analysis.

- Eating disorder/Anorexia

I understand this to be presented as a main character by all of the narrators. There were differences between the narrators however, with personification, possessiveness and acceptance all being presented among them. Beth and Adam particularly presented a personification which seemed to lead to an acceptance - which, throughout their story, appears to influence their forecast of their life together with Anorexia. Simon presented Eating Disorder as Jane's possession – seemingly reflecting her desire to keep it a secretive behaviour and not allowing him in to help; a notable difference to the couple narratives.

- The Relationship

I interpret The Relationship to be positioned by all of the narrators as a – if not the – main character in the stories. There is an intertwining of The Relationship and Eating Disorder. Understanding this poses questions about how possible it would be for the narrators to lose one of these main characters and for the other characters to continue in a story, or if the individuals position characters differently to each other. None of the couples have experienced their Relationship without Anorexia, and Simon's story demonstrates the outcome of different positioning of the same characters, with not enough emphasis on the character of The Relationship.

Commitment is explicit and implicit throughout the narratives. The men make it clear that they have committed to their partners and The Relationship including Eating Disorder. Does this then make it harder to let go of Eating Disorder, if it is such a substantial part of The Relationship? What would it mean for The Relationship if Eating Disorder wasn't present? I also detect commitment from the women to the men, most explicitly from Sally describing her support of David when he was struggling with depression.

Within The Relationship, the importance of communication being open and honest is presented by all the narrators, as necessary for the success of The Relationship and to help recovery from Anorexia. This is reinforced by Simon's story of his unsuccessful relationship with Jane due, in his perspective, to a lack of this. Perhaps such open and honest communication allows for focus on The Relationship not just Eating Disorder, therefore enabling strong foundations to be built. Simon's story reflects the consequence of being unable to build such foundations as

he presents huge difficulties in communication with Jane, due to him feeling as though she would not 'let him in'.

All of the women are presented as exhibiting attachment cues to which the men responded with care giving functions – Ben and Mel present this as a difficulty when moving into a recovery story. I understand this to be due to them initially – as the other narrators seemed to be – being in 'child' (the women) and 'parent' (the partners) roles as described by Berne (1964). Moving into recovery Mel and Ben seem to be transitioning into 'adult' roles together. Perhaps receiving what they needed from partners from an attachment perspective reflects a reason for difficulties with services – there was less of a need for what services were trying to provide.

- Eating Disorder Services experiences

Services were presented by those who accessed them as a villainous but main character, not providing the level of help or support that the individuals felt they needed. This is presented as being exacerbated by the lack of acknowledgment, involvement and support for the partners. It is presented that the partners' involvement was a key part of the women's management of Eating Disorder and recovery process. I understand the narrators to be presenting themselves as not being listened to or valued as individuals in relation to their contact with Services. Maybe the 'enemy' of Services played a part in the closeness the couples describe, making them more determined to fight Anorexia together.

- Clueless - Expert

A transition from 'clueless' to 'expert' is something that I have labelled as a way I understand the stories to be unfolding. Initially most of the narrators did not know much if anything about eating disorders, with Sally, Mel and Beth describing either not knowing or not being able to admit to themselves or others that they did have an eating disorder. As the stories progress the couple narratives demonstrate a gradual learning process of understanding Anorexia and its effects. Perhaps this is a way to justify how well they have coped and to justify that they were not able to do anything more than they did. Perhaps also presenting themselves as experts and superior to others allows Eating Disorder to remain present longer, giving them justification for such a superior position that they may not be able to hold without it.

Here I will present the performative elements of the narratives that I found:

- Co-creating

I understand the way the narrators co-create and co-present their stories to me to be a reflection of how they function as a couple, and how their relationships play out. For example, Sally and David's narrative has the most disruption such as overlaps and jumping between narrators, which seems to reflect their more disrupted relationship with both of them being in and out of hospital for mental health related treatment. Mel takes the lead in her and Ben's story, which through what they say in their story seems to be how they function in everyday life,

and Beth and Adam demonstrate an enmeshment with their story telling that they portray through their story. The narrators also use words such as ‘we’ and ‘us’, reflecting a dyadic level of intimacy (Van den Broucke et al 1995a).

- Prosody

Looking at intonation, volume, stress and so on of the narratives there again seems a reflection of how the story impacts the narrators. For example Beth and Adam’s story is told in a gentle, calm rhythm, reflecting their acceptance of Eating Disorder and has raw, vivid emotions very available to the audience. This to me reflects how immersed in their story they are, and perhaps contributes to or is a result of their acceptance of Eating Disorder. The use of humour by Mel and Ben and the matter of fact tone of Sally and David’s stories are perhaps ways they are able to distance themselves more from the emotions involved, perhaps helping them move towards recovery more easily than Beth and Adam.

- Stories of Individuation

All the individual narrators present narratives throughout the main couple narrative that illustrate what seem initially to be individual experiences. However, using negative case analysis – looking for exceptions – I observe that there are very few that are purely individual. Mel presents the most obvious individual stories, regarding recovery, yet still finds a way to include Ben. As Mel is the most ‘recovered’ of the women, perhaps individual stories help this but joint stories are necessary for the survival and success of The Relationship.

- Never Ending Story?

The narrators all seem to position themselves in a story that is ongoing for as long as they can foresee, albeit in different ways. Mel and Ben present a story of recovery but Anorexia still has a role – causing Mel’s ongoing osteoporosis. Sally and David present a story of tentative recovery, perhaps allowing Anorexia to remain with them, and Beth and Adam are explicit in seeing Anorexia in their lives forever.

- Ordering of the story

Similarly to the above points I understand the way the narrators order their stories to reflect how they experience them. Simon’s story differs notably from the couple stories in that his feels much more chaotic, jumping around in time and subject, some parts of the story left unfinished before he begins telling about another. In contrast the couples begin when they got together and work chronologically through, going back at the end to expand on certain details. Perhaps because this was Simon’s first time telling his story he is using it as part of the process of organizing it, whereas the couples have told their story many times.

10.4 Discussion

I will present here a discussion of the main findings of the research, reflections on the strengths and limitations of the research, its applicability to eating disorder service provision with focus on counselling psychology, and recommendations for future research within this area.

The strength of The Relationship is something that is presented clearly through all of the couple narratives, and Simon's narrative is demonstrating what the consequence was for the lack of this. The couples seem keen to inform their audience of this strength and of how close they are – reflecting Levine's findings of this occurring in eating disorder marriages (1988). The dyadic identity mentioned above is an implicit way of demonstrating this closeness and unity (Van den Broucke et al, 1995a). Within this the couples discuss overcoming issues by working together, reflecting Dym and Glenn's (1993) 'Resolution' phase. Perhaps, though, this leads to Eating Disorder and its management becoming a necessary focus in order that the couple are able to stay in their 'home base' of this phase. Potentially there are advantages to this such as an avoidance of other problems and maintenance of a power balance within The Relationship (Foster; 1986, Levine, 1988; Wodside et al., 1993). These are potential issues to be aware of when working with individuals and couples regarding eating disorders, and maybe other difficulties that have a presence as strong as Eating Disorder seems to here. The lack of involvement of the partners that the narrators who accessed services present is something also noted by Bulik, Baucom and Kirk (2012), Mel described feeling listened to as a person by the private counselling psychologist was the most helpful aspect of her treatment - contrasting this with feeling as though Services were only interested in her symptoms. This reflects the sentiments of Petersen and Rosenvinge's participants (2002). This can be viewed as an important aspect in understanding the potential importance of The Relationship, when working with clients or individuals with eating disorders. If there is such a strong dyadic identity present, it demonstrates the need for acknowledgment and involvement of the partner and The Relationship, rather than just the individual, in treating an eating disorder.

Perhaps if Services had been more able to provide what the women felt they needed, would they have found their partner as necessary? Likewise perhaps it is because the partners are present and able to provide support that Services were not experienced positively? It seems then that for the narrators within this research Services played the part of 'foe' regarding Eating Disorder, but this may actually be a 'friend' in how it has lead to The Relationship developing, and the strength the women recognise in themselves in having to manage in spite of the perceived lack of support. This could provide a helpful perspective for professionals and services offering help to individuals in this situation – exploring what support they feel they are receiving from their partner, and how Services could complement this to be most effective. This is in line with taking a very person–centred approach to treatment and support.

The personification of Anorexia externalises it in a way that is similar to an aspect of narrative therapy (White & Epston, 1990). However, White & Epston caution that if externalisation is taken too far it can result in individuals not assuming any responsibility for the difficulty, and not

acting to remove or reduce it. This seems to have occurred especially with Beth and Adam. Again, this is an important aspect to be aware of when working with individuals and couples struggling with a similar situation; understanding and bringing to their awareness how they are perceiving the situation and Eating Disorder, if and to what extent they are externalising or personifying Eating Disorder, and helping them do so in the most helpful way.

This externalisation and personification suggests a relationship with Eating Disorder, one which the narrators present as difficult and often negative, similar to Tierney and Fox (2011) whose participants likened having anorexia to a being in a toxic relationship. The stories of the couple and each individual are being weaved with eating disorder on a daily basis, and The Relationships have never existed without Anorexia. This could mean it becomes a focus for the couple, leaving communication at a superficial level and creating an avoidance of genuine intimacy (Van den Broucke & Vandereycken, 1989a, b). Again this is an important factor for practitioners to consider when working with individuals in this situation, and helping them become aware of it and how they might be able to change this pattern.

The importance of communication is evident throughout this research, both explicitly and implicitly in the narratives themselves and in my telling of my interpretations of the narrators' stories. Explicitly, the narrators discuss the importance of open and honest communication within their couples - as also recognised by Bulik et al. (2011). Simon's story demonstrates a consequence (as he says himself) of a lack of this, echoing Bulik, Bauman and Kirby's findings (2012) of difficulty within a relationship in such circumstances. Understanding communication can be such an important part of survival for a couple in a similar situation, and help in moving towards recovery, is something that can be incorporated as part of treatment, perhaps in a psycho-education manner, helping a couple to work out how they can best incorporate communication in a way that works for them.

Implicitly, the co-creation of the stories is communication at play: the narrators are listening and reacting to what their partner is saying and how they are telling the story. This is part of the couples' meaning making in action; a public extension of what I assume is a constant process for them alone. This will be influenced by their individual narratives, experiences and what they want their narratives to be (Atkinson, Coffey & Delamon, 2003). This is important to consider when working with individuals and couples, not just with eating disorders but any difficulty: what is their context, why are they telling their story in this way, to me, today? Understanding this is a key part of counselling psychology: looking at what is not said as well as what is and trying to make sense of it with the client(s).

Strengths of this research

Using a narrative approach to explore couple narratives of experiences of living with an eating disorder is a novel approach to this area, therefore new insight and ideas can be stimulated. Areas of importance for couples in this situation are highlighted from their point of view but as interpreted and understood by a professional in the field.

Exploring joint narratives in this way means that relational and individual aspects are included; the focus is taking the perspective of the couple as the unit of analysis, which is an unusual and therefore enlightening approach.

Incorporating the single narrator provides a balanced perspective and enables comparisons, assumptions, suggestions and ideas around potential differences for couples in this situation.

Using narrative analysis provides an in depth and detailed insight into experience. The nature of narrative requires analysing minute details, which can often be missed in pure content analysis. This is especially important for Counselling Psychology where the nuances and detail are important within the therapy room too.

Limitations of this research

Despite these strengths, there are of course limitations to consider also regarding this research.

While necessary for and suited to this research project due to the depth of the analysis, the number of participants is small on an impact scale. However I am not intending to generalise, more to stimulate ideas and awareness.

It is important to note the sampling bias that occurred as I specifically recruited couples who had lived or were living with the experience of an eating disorder. This therefore meant that the focus is very specific and does not focus on other issues that may have an effect on relationships.

Despite intentionally inviting people with 'eating difficulties' in an attempt to encourage a wide spectrum of participants, only couples with experience of anorexia came forward to participate in the research. As recruitment was mainly through Beat, gyms and health food shops it could be that these are more likely to be places frequented by people with Anorexia. I had assumed that Beat was an organisation for all eating disorders, but I have since learned that it is mainly used by those with Anorexia.

As narrative is so dependent on individual context, there is a definite affect from my context and the fact that I was interpreting the data. This could lead to the assumption that the findings are not particularly valid; however narrative is what occurs constantly between people and so it is a natural way to explore experience.

Recommendations for future research

As previously acknowledged the sample for this research is relatively small, therefore similar research on a larger scale would be beneficial in order to be more able to generalise findings and make more concrete assumptions.

My research is intentionally broad as I was looking for the stories the narrators wanted to tell, and has brought to light many potential areas for further, more specifically focused research. For example, more in depth exploring of the dynamics within a relationship, how a couple

approach an eating disorder, how they decide together how to tackle it, what helps motivate them or present an obstacle? With regard to Services, what would individuals feel would be most helpful to them and their partners? Are the feelings expressed by my participants regarding their experiences of Services widespread? Is the lack of awareness of alternative treatments and support widespread?

Understanding answers to these questions could help service providers tailor treatment and marketing to provide an efficient and effective service. If it is that the participants within this research are in the minority in terms of their experience it could help professionals be aware that this experience is a possibility, and perhaps tweak what is available to help it suit clients who seem to not be responding to the mainstream treatment.

Overall I would recommend that further research of the specific aspects that I have observed within this research would be helpful in understanding the experience of couples living with an eating disorder, and what the best and most efficient way of helping them could be. Not only would this provide a more person–centred, and therefore hopefully more positive, experience for those seeking treatment, but also cut down on costs if treatment can be shorter or more successful.

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12 APPENDICES

12.1 Appendix 1

DSM-IV diagnostic criteria for Anorexia Nervosa and Bulimia Nervosa

307.1 Anorexia Nervosa

Refusal to maintain body weight at or above a minimally normal weight for age and height, for example, weight loss leading to maintenance of body weight less than 85% of that expected or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected.

Intense fear of gaining weight or becoming fat, even though underweight.

Disturbance in the way one's body weight or shape is experienced, undue influence of body weight or shape on self evaluation, or denial of the seriousness of the current low body weight.

In postmenarcheal females, amenorrhoea, i.e., the absence of at least 3 consecutive menstrual cycles. A woman having periods only while on hormone medication (e.g. oestrogen) still qualifies as having amenorrhoea.

Restricting Type: During the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behaviour (self-induced vomiting or misuse of laxatives, diuretics, or enemas).

Binge Eating/Purging Type: During the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behaviour.

307.51 Bulimia Nervosa

Recurrent episodes of binge eating characterized by both:

Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.

A sense of lack of control over eating during the episode, (such as a feeling that one cannot stop eating or control what or how much one is eating).

Recurrent inappropriate compensatory behaviour to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, enemas, or other medications, fasting, or excessive exercise.

The binge eating and inappropriate compensatory behaviour both occur, on average, at least twice a week for 3 months.

Self evaluation is unduly influenced by body shape and weight.

The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Purging Type: During the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

Non-purging Type: During the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviour but has not regularly engaged in self-induced vomiting or misused laxatives, diuretics, or enemas.

12.2 Appendix 2

Copy of research advert on an eating disorders organisation website

Home | Our work | Support us

Search

beat
beating eating disorders

understanding eating disorders
and how you can help

beat Home
FYP - For Young People
Vacancies at Beat
About Eating Disorders
Help and Support
beat Cymru
Fundraising
Get Involved!
Training Services
Research and Media
Researchers
Join our Research and Media Database
Take Part in Research
General survey on eating disorders
Anxiety during mealtimes
Metacognitions, emotion and disordered eating in women
Self-conscious emotion study
Emotional processing and cognitions about the self
The experience of

You are here: Home > Research and Media > Take Part in Research > The couples' story

The couple's story

I am a student on the Counselling Psychology Doctoral course at City University, conducting research into eating disorders and relationships. I am recruiting participants who are 6 months post psychological therapy treatment for eating disorders (if at all), who are currently, and were living with their partner at the time of such therapy, or at the time of highest severity of their eating disorder. I am looking for couples who would be willing to be interviewed together about their experience of living together, their relationship and the eating disorder.

Participants are required to have a BMI higher than 15, and not currently b in treatment/therapy for their eating disorder or any relational issues.

I would initially speak with potential participants over the phone to conduct a screening, looking at BMI and also run through a short diagnostic screening, simply to aid the data collection. this woulod also be an opportunity for you to ask any questions and clarifyany queries.

Interviews would take approximately one hour, at a place and time mutually convenient. All information will be confidential, and there will be no problem should you decide you want to withdraw yourself and your information at any stage.

If you are interested in being involved, or for further details, please contact me on [redacted] and my supervisor – Dr. Jay Watts' contact details would be available upon request.

Page Last Modified: 06/05/2011

beat Helpline
0845 634 1414
> help@b-eat.co.uk

beat Youthline
0845 634 7650
> fyp@b-eat.co.uk
> Opening Hours

Make A Donation
> Support beat with your contribution

12.3 Appendix 3

Recruitment leaflet

My name is Zoé Dixon, I am a Trainee Counselling Psychologist at City University.

I am researching couples' experiences of living together whilst one of them suffered with eating difficulties.

I am looking for couples who would be willing to talk confidentially to me – in a place convenient to you, or via skype - about such experience, to give a voice to this little researched area, and increase understanding of eating difficulties and disorders, couple functioning and identity.

If you are interested, please take a look at www.thecouplesstory.co.uk for more information and how to be involved.

12.4 Appendix 4

Copy of The Couple's Story website – Page 1

Welcome to the Couple's Story

Thank you for visiting this website.

This website is an introduction to research into adult couples and eating disorders and eating difficulties.

It is also an invitation to adult couples (over 18) who have experienced living together during the time of an eating disorder to take part, giving valuable information to help all people in this situation, and helping them give a voice to their experience.

Disclaimer

This research is being carried out as part of a Professional Doctorate in Counselling Psychology at City University, London, and is conducted under supervision of Dr. Jay Watts, Clinical Psychologist: jay.watts.1@city.ac.uk.

Who am I?

My name is Zoé. I am a Trainee Counselling Psychologist, and a student at City University in London, on the doctoral programme in Counselling Psychology. I am currently conducting my research looking into eating disorders and relationships, for my final year thesis.

What is involved?

Completing the questionnaires on this website will help me gauge an idea about numbers of couples in this situation, giving details of such people.

If you do complete the questionnaire, I may contact you to see if you would be willing to talk to me about your experience, to get even more valuable details. This may be in person, or via skype.

All of this will be completely confidential. I will see the answers to the questionnaires, and should you agree to an interview, it will only be with myself. My supervisor may see the questions or interview transcripts, but this will be without names attached. Information from these will be used in my thesis, but will be anonymous, i.e. no one's names or other identifying information would be used. It is also absolutely fine if someone decides to pull out at any point, no questions asked.

12.5 Copy of The Couple's Story website – Page 2

Why research this?

There is lots of research looking at adolescents with eating disorders, and how this affect their relationship with their family, particularly parents. However, there is a lot less looking at adults, and especially with their partners.

I think this is a fascinating area to look at, to look at how couples experience difficulties such as these, to see how people really find it. Talking to people who have lived this experience gives such rich detailed information, that can help inform treatment in the future for other people in similar situations, it can give so much insight into this experience and these difficulties. It is fascinating to see how couples live through difficult times, and how it affects them as individuals and as a couple.

There are so many people with eating disorders, and in today's culture where there is so much influence on body image and how we should look. I think this is an important area to concentrate research into, to help as many people as possible in these situations.

I also hope that any information gained from this research could lead to support groups for couples in this situation.

By contributing to this research, you would be contributing to this important area, to help many other people in a similar situation to yourself.

Being involved in this research can help to give a voice to an experience which is not looked at very often, yet is an important one.

I will be happy to provide anyone interested with a brief overview of results when the research is complete.

12.6 Copy of The Couple's Story website – Page 3

If you are an individual who is experiencing, or has experienced eating difficulties and would like to be involved, please fill out the following questionnaire.

How old are you?

Are you in a relationship?
- yes
- no

If yes, do you live with your partner?
- yes
- no

do you feel you have or ave had difficulties with eating?
- yes
- no
- I don't but other people think I do

Do/did you engage in any of the following behaviours (please select all that apply)?
- very restrictive eating
- overeating
- bingeing
- compensatory behavour e.g. vomiting, excessive exercise
- spending a lot of time thinking about food

Were you living with your partner at the time of these difficulties?
- Yes
- No
- for some of the time

Are you, or have you been, in therapy/treatment for your eating difficulties?
- no, not at all
- yes, currently
- yes, previously - finished less then 6 months ago
- yes, previously - finished more than 6 months ago

Are, or have you and your partner been in therapy for relationship issues?
- no, never
- yes, currently
- yes, previously - less than 6 months ago
- yes, previously - more than 6 months ago

what is your BMI? (weight in kilograms divided by height in metres squared)

I may want to contact you for the potential of you being involved in a research interview along with your partner. If you are happy for this, please enter a suitable email address or phone number.

Send

If following this questionnaire you feel you have uncovered things you weren't aware of, please contact me, or refer to www.B-eat.co.uk (eating disorder specialist organisation), or www.Relate.org.uk (relationship specialist organisation).

12.7 Copy of The Couple's Story website – Page 4

If you are the partner of an individual who has current, or previous, eating difficulties, please fill out the following questionnaire:

How old are you?

Do you live with your partner?

- yes
- no

Wereyou living with them at the time of their eating difficulties?

- yes
- no

If so, how long ago did this finish?

Were you aware of their difficulties at the time?

- yes
- no

Is your partner currently in therapy/treatment for their eating difficulties?

- yes
- no

Has your partner been in therapy/treatment previously for their eating difficulties?

- yes
- no

If yes, how long ago did this finish?

Have you, as a couple, been in therapy for relationship issues?

- yes
- no

If yes, how long ago did this finish?

- ongoing
- less than 6 months ago
- more than 6 months ago

I may want to contact you for the potential of you being involved in a research interview along with your partner. If you are happy for this, please enter a suitable email address or phone number.

Send

If following this questionnaire you feel you have uncovered things you weren't aware of, please contact me, or refer to www.B-eat.co.uk (eating disorder specialist organisation), or www.Relate.org.uk (relationship specialist organisation).

12.8 Copy of the Couple's Story website – Page 5

Any queries, or comments, please contact me. Please ensure to leave an email address or phone number so that I can get back to you.

Name

Email

Phone

Message

Submit

This research is being carried out as part of a Professional Doctorate in Counselling Psychology at City University, London, and is conducted under supervision of Dr. Jay Watts, Clinical Psychologist: jay.watts.1@city.ac.uk.

12.9 Appendix 5

Information sheet and consent form given to potential and definite participants

The Couples' story: Their relationship with an eating disorder.

Consent form

Researcher: Zoé Dixon

T: [redacted]

E: [redacted]

Supervisor: Dr. Jay Watts

T: [redacted]

E: [redacted]

Aims and objectives of the research:

To understand the couples' experience of living with an eating disorder, the effects on the relationship and the eating disorder, and how a couple understand their joint reality in order to give a voice to this little researched area, to increase understanding and to inform counselling psychology practice with individuals and couples experiencing eating disorders.

What is involved?

An informal interview, taking approximately one hour, between the researcher and the couple, which will be audio recorded and then transcribed for analysis along with other transcriptions.

Agreement

I agree to take part in the above titled research, and understand that I will be talking about a period of time which is very personal.

I understand that by consenting, I am agreeing to my data being used for the purposes of this research. I understand that this data will be kept confidentially, and that there will be no identifying information connected with my data.

I understand that by consenting I agree to the information being used within the study which will be written up, and may be published, including the possibility of quotes from my data, all of which would be made anonymous.

I understand that any recorded material will be destroyed once the research has been marked.

I understand that participation is voluntary, that I have the right to withdraw at any point without judgement, and that if I choose to do so my data will be destroyed immediately.

Signed

Participant 1: Participant 2:

I, as the researcher, agree to maintain confidentiality at all times, and to ensure throughout that participants are fully informed and in agreement to continue, making no objections if they decide to withdraw at any point.

Signed:

12.10 Appendix 6

Debriefing form and information sheets

Research Title: The couples' story: an exploration of their experience of living with an eating disorder.

Researcher: Zoé Dixon MSc, BSc (Hons). Trainee Counselling Psychologist.

This research aimed to explore the joint experience of couples who have lived and/or are living with the experience of an eating disorder. Having been involved in this study, the information you have provided will go towards helping inform services for future clients with eating disorders, their partners and therapists, of what they could expect and what their experiences might be like. The process of analysis will identify themes in the narratives of all participants, and dynamics in telling the joint experience within the couples.

If you would like to be informed about the outcome of this study, which is due for completion August 2012, please inform the researcher, in order that a summary form may be produced. For later requests, please contact the researcher directly at [redacted]

If you have any queries about this research which you feel the researcher cannot answer, you are welcome to contact the research supervisor, Dr. Jay Watts:

Dr. Jay Watts, CPsychol., AFBPsS

Department of Psychology

School of Social Sciences

City University

Northampton Square

London, EC1V OHB

T[redacted]

E: [redacted]

If you feel that you would like further support for any of the issues talked about in your contribution, relating to eating disorders or relationships, the following are some recommended contacts:

Eating disorders

Beat: www.b-eat.co.uk

National eating disorders association: www.nationaleatingdisorders.org

Mind: http://www.mind.org.uk/help/diagnoses_and_conditions/eating_distress

women's therapy centre: www.womenstherapycentre.co.uk

Relationships:

Mind: http://www.mind.org.uk/help/diagnoses_and_conditions/relationship_problems

Relate: www.relate.org.uk

BBC: http://www.bbc.co.uk/health/support/family_relationships_usefulcontacts_index.shtml

12.11 Appendix 7

Jefferson System used in the transcription process to aid analysis

°word° quieter speech

<u>word</u> louder or emphasised speech

WORD even louder speech

word=

=word no discernible gap between turns of speech

↑word↓ indication of pitch difference

(.) pause, too short to time

(.1) timed pause, numbers reflect seconds

( ) indiscernible speech, or if words inside brackets, guessed speech

[word]

[word] overlaps in speakers turns, brackets indicate start and finish

wo:rd indication of drawn out syllables

>word< quicker speech

<word> slower speech

.hh intake of breath

.pt lip smack

((*sniff*)) non verbal element within transcription

Added by myself:

{ word } sarcastic tone

12.12 Appendix 8

Ethics Release Form for Student Research Projects

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor**, together with their research proposal clearly stating aims and methodology**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

An understanding of ethical considerations is central to planning and conducting research.

Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.

The published ethical guidelines of the British Psychological Society (2009) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.

Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc ↑ M.Phil ↑ M.Sc ↑ D.Psych X ↑ n/a ↑

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

The Couples' Story: Their relationship with an eating disorder.

2. Name of student researcher

Zoé Dixon.

3. Name of research supervisor

Dr. Jay Watts

4. Is a research proposal appended to this ethics release form? **YesX** No

5. Does the research involve the use of human subjects/participants? **YesX** No

If yes,

a. Approximately how many are planned to be involved? 16 (8 couples)

b. How will you recruit them?

Via organisations such as Beat, through their website and via specialist eating disorder therapists, online forums.

c. What are your recruitment criteria?

(Please append your recruitment material/advertisement/flyer)

Over 18, at least 6 months post therapy (if therapy received), Living with partner at time of eating disorder and at present, both members of couple willing to be involved, BMI of over 15.

d. Will the research involve the participation of minors (under 18 years of age) or vulnerable adults or those unable to give informed consent? Yes **NoX**

d1. If yes, will signed parental/carer consent be obtained? Yes **No**

d2. If yes, has a CRB check been obtained? Yes **No**

(Please append a copy of your CRB check)

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? (If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).

Brief screening questionnaire, one hour interview.

7. Is there any risk of physical or psychological harm to the subjects/participants?

X**Yes** No

If yes,

a. Please detail the possible harm?

Possibility of distress as they will be talking about a potentially difficult time in their lives.

b. How can this be justified?

Information they provide will hopefully help more people in the future. They will be aware of the aims and objectives of the study and therefore what they will be expecting to talk about.

c. What precautions are you taking to address the risks posed?

Providing information about the aims and objectives of the research, discussing with each participant before interview to ensure they understand and consent to the study, providing information post-interview for support if they require.

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

YesX No

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research?

Yes **NoX**

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

YesX No

If no, please justify

If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

Recordings of interviews, notes about nonverbal behaviour, transcription of interviews. Some hard copies, some electronic.

12. What provision will there be for the safe-keeping of these records?

Encryption/encoding of electronic information. Keeping hard copies in a locked cabinet. Names will be removed.

13. What will happen to the records at the end of the project?

Destroy/delete information once it is no longer required for project or marking. Recordings will be deleted from recorder immediately after putting them safely on a computer.

14. How will you protect the anonymity of the subjects/participants?

Numbers will be used so names are not attached to the data. Any names or other identifying information mentioned in the interviews will be altered in the transcription.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

Information sheet will be provided with contact details for useful support organisations for eating disorders and relationships.

Information leaflets will be provided for bulimia and anorexia, including management suggestions.

Discussion with all participants at the end of the interview to ensure they feel safe to leave and to contain any difficulties.

If you have circled an item in **underlined bold** print or wish to provide additional details of the research please provide further explanation here:

5. Human participants will be involved in face to face interviews with myself, the researcher. No deception or hidden information will be involved – it will be open with details of the study.

7. no physical harm will be involved. Psychological distress may occur due to participants discussing in depth about a possibly distressing time in their lives. I am specifying 6 months post therapy (if therapy involved) in order not to interfere with any therapy. Aims and objectives will be made clear from the outset, and I will discuss with all participants before interviews to ensure they are fully aware of what will be involved and are happy to continue.

Signature of student researcher Zoe Dixon---------- Date 27th January 2011

CHECKLIST: the following forms should be appended unless justified otherwise

Research Proposal ↑

Recruitment Material ↑

Information Sheet ↑

Consent Form ↑

De-brief Information ↑

Section B: Risks to the Researcher

1. Is there any risk of physical or psychological harm to yourself? YesX No

If yes,

a. Please detail possible harm?

I may find some details the participants disclose distressing, or some information may be similar to my own.

b. How can this be justified?

I feel the distress will be minimal. I hope the findings of the research will be informative for many people in the future.

c. What precautions are to be taken to address the risks posed?

Contact with research supervisor, personal therapist and strong support network. Training for therapy in terms of separating my issues form participants, and working through any issues that do some up.

Section C: To be completed by the research supervisor

(Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.)

Please mark the appropriate box below:

Ethical approval granted ↑

Refer to the Department's Research and Ethics Committee ↑

Refer to the School's Research and Ethics Committee ↑

Signature ---------- Date--------

Section D: To be completed by the 2nd Departmental staff member (Please read this ethics release form fully and pay particular attention to any answers on the form where **underlined bold** items have been circled and any relevant appendices.)

I agree with the decision of the research supervisor as indicated above ↑

Signature ---------- Date -------