

VOLUME I

Research Component

**The Role of Fathers in the Development of Eating Disorders: A
Systematic Review of the Evidence**

and

**A Phenomenological Exploration of the Influence of Anorexia Nervosa
upon the Interactional Dynamics within the Family System**

By

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Abstract

This thesis was submitted in partial fulfilment of a doctorate in Clinical Psychology and is composed of two volumes. Volume One contains the research component of this thesis which includes a systematic literature review that investigates the role of fathers in the development of eating disorders, and an empirical study which explores the influence of Anorexia Nervosa upon the interactional dynamics within the family system.

The clinical component of the thesis is presented in Volume Two in the form of five clinical practice reports. The first clinical practice report describes the case of a 78 year old woman suffering from agoraphobia and panic attacks that was formulated from Psychodynamic and Cognitive-behavioural approaches. The second report outlines a service evaluation that explored the staff's adherence to new policy within a dementia assessment and intervention service. The third report describes a case study of a brief course of Person-centred Therapy with a 31 year old woman suffering from social anxiety and low mood. The fourth report describes an AB single case experimental design of Schema Therapy with a 17 year old girl diagnosed with Anorexia Nervosa. The fifth and final report outlines the abstract of a case study of Psychodynamic assessment and indirect intervention of a 56 year old man diagnosed with a mild learning disability and Bipolar Affective Disorder.

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The Role of Fathers in the Development of Eating Disorders: A Systematic Review of the Evidence

Abstract

Background

The role of fathers in the development of eating disorders is an under-researched area. The literature on the subject is sparse, largely theoretical and only loosely based upon the empirical evidence.

Aims

The aim of this report is to systematically review the current empirical research regarding the fathers of individuals who suffer from eating disorders, and their possible role in the development, maintenance and amelioration of such difficulties.

Methods

The databases PsychINFO, PubMed, MEDLINE, and PsycArticles were screened for studies reporting quantitative empirical data on the role of fathers in the development and maintenance of eating disorders. The methodological quality of the selected studies was evaluated using a checklist of critical appraisal criteria derived from the systems proposed by Downs and Black (1998) and Sale and Brazil (2004).

Results

Twelve studies met the selection criteria and were included in the review, and revealed five main themes that related to uninvolved, distant or rejecting fathering; highly controlling fathering which is lacking in care; a lack of assertive communication and conflict resolution with fathers; paternal dissatisfaction with his own weight; and the father-daughter relationship as a product of the parents' relationship. The implications of these findings are discussed in light of current views and theoretical approaches to the role of fathers in the development and maintenance of eating disorders. Similarly, the noticeable pattern of implicating parents in the development of eating disorders in a seemingly blaming manner within the reviewed literature was also discussed.

Conclusions

The findings of the review suggest that a variety of different fathering styles may contribute to the development and maintenance of eating disorders, many of which closely resemble the dysfunctional patterns of maternal parenting which have been repeatedly implicated as being influential to the development of eating disorders.

Introduction

Eating disorders are intricately complex and multi-faceted conditions which pose a particular challenge for clinical treatment (Polivy and Herman, 2002). Within the ICD-10 diagnostic framework, two main diagnostic categories of eating disorder exist; Anorexia Nervosa (AN), Bulimia Nervosa (BN), both of which have typical and atypical subtypes (World Health Organisation, 1992). AN is characterised principally by a persistent refusal to maintain a healthy body weight, the self-induced avoidance of “fattening foods”, significant perceptual distortions relating to body-image, and a widespread endocrine disturbance causing a loss of sexual interests and potency, coupled with the delay or arrest of pubertal events such as menstruation and the development of secondary sexual characteristics (World Health Organisation, 1992). Patterns of extreme dietary restriction coupled with the use of compensatory behaviours such as excessive exercise, self-induced vomiting and laxative abuse are common in AN, and lead to drastic weight loss coupled with a wide range of associated physical health problems. BN is also characterised by a preoccupation with body weight and shape as well as patterns of dietary restriction and exercise intended to facilitate weight loss (World Health Organisation, 1992). However in cases of BN these periods of restriction and exercise are interspersed with episodes of binge eating in which individuals consume large quantities of food in an uncontrollable manner over a short time. Such behaviours are typically followed by purging compensatory behaviours in the form of self-induced vomiting or laxative usage, and oscillate with binge episodes in a cyclical pattern. In cases where notable eating disturbances and compensatory behaviours are present but the clinical presentation does not meet the specific diagnostic criteria for AN or BN, a diagnosis of atypical AN, BN or “Eating Disorder Unspecified” is typically given (Ricca et al., 2001).

Although AN and BN have traditionally been conceptualised as distinct diagnostic categories, both disorders display clear similarities in their clinical presentation such as difficulties with affect regulation, bodily dissatisfaction, a preoccupation with body weight, shape and food, and a variety of behaviours intended to reduce body weight (Polivy and Herman, 2002). The presence of these commonalities suggests that there may be little conceptual difference between the two

main types of eating disorders, and has led many researchers and clinicians to believe that these two diagnoses may represent different stages in the course of a single eating disorder “core pathology” (Van der Ham et al. 1997; Fairburn, Cooper and Shafran, 2003). Indeed, the typical course of eating disorders involves a progression from dietary restriction during adolescence to binge eating and purging compensatory behaviours in early adulthood (Eckert et al., 1995; Eddy et al., 2002). It is therefore common for eating disorders to begin with patterns of extreme dietary restriction and weight loss that are characteristic of AN, but over time the individual’s capacity to maintain such high levels of control over their eating behaviours often becomes compromised and entails intermittent episodes of binge eating and compensatory behaviours, as are characteristic of BN (Sullivan et al., 1998; Fairburn, 2008). Research suggests that between 20-50% of individuals diagnosed with AN go on to develop BN within five years of initial diagnosis (Bulik et al., 1997; Eckert et al., 1995). Following this, many sufferers go on to experience intermittent problems with dietary restriction, binge-eating, compensatory behaviours and bodily dissatisfaction, but no longer meet diagnostic criteria for AN or BN, and consequently receive a diagnosis of atypical AN or BN, or Eating Disorder Unspecified (Fairburn and Walsh, 2002; Fairburn, Cooper and Shafran, 2003).

The high levels of similarity between diagnostic categories of eating disorder and apparent fluctuation between diagnoses over time therefore limits the meaningfulness of diagnostic labels such as AN and BN in clinical practice (Eddy et al., 2002). This has led many researchers and clinicians to adopt a transdiagnostic approach which asserts that rather than constituting diagnostically distinct disorders, that AN, BN and eating disorder unspecified may represent different stages in the progression of a single core pathology (Eddy et al., 2002; Fairburn, Cooper and Shafran, 2003). The conceptualisation of eating disorders in this way has provided valuable insight into the course and progression of such disorders, as well as informing treatment practices (Fairburn, Cooper and Shafran, 2003). As a result of this there is a current trend for clinicians to adopt a transdiagnostic approach when working therapeutically with eating disorders which addresses the features of the core pathology underlying such conditions (Waller, 2008). In accordance with current research trends and clinical practices, a

transdiagnostic approach to eating disorders will also be utilised within this systematic review.

The Role of Parent-Child Relationships in Eating Disorders

It was Selvini-Palazzoli (1974) who first reported that the families of individuals suffering from eating disorders appeared to display notably different dynamics and patterns of interaction when contrasted to the families of individuals without eating disturbances. The presence of these dysfunctional patterns of interaction and communication led researchers and clinicians to consider whether family dynamics could be influential to the development and perpetuation of disordered patterns of eating. Yager (1982) described the traditional characteristics of the families of individuals who develop AN as middle class, white, achievement orientated, and excessively concerned with external appearances and portraying the family as conforming closely to social conventions. However beneath this façade of congeniality and “normality”, several important problems regarding the structure, relationships and communication within such families are typically present. On this subject, Minuchin et al. (1978) proposed the existence of a characteristic family type termed the “Psychosomatic Family” which was suggested to be prototypical of the families of adolescents suffering from eating disorders. Such families were believed to be characterised by pervasive patterns enmeshment, overprotection and control, rigidity, and a lack of conflict resolution. Throughout the literature on the subject, the parents of individuals suffering from eating disorders have been characterised as intrusive and over-involved in their children’s affairs, having little respect for interpersonal boundaries, and dismissive of their children’s emotions and emotional needs (Lane, 2002). Parents within Psychosomatic Families were also suggested to be characteristically overprotective of their children, exhibiting an excessive concern with parenting and family members’ welfare, which is often perceived by the children as over-protective, coercive and controlling (Levenkron, 1982; Shoebridge and Gowers 2000).

Throughout the research literature the mothers of individuals suffering from eating disorders have been consistently and strongly implicated in the pathogenesis of

the disorder, and have been characterised as domineering, controlling and intrusively over-involved in their children's lives (Brusch, 1978; Brumberg, 1988). The main focus of the research on this subject has been upon the security of attachment that exists between the child and their mothers during early development, as well as their developmental progression from symbiosis to individuation (e.g. Bruch, 1978; Korb, 1994; Lane, 2002). Ward et al. (2000) suggest that the mothers of Anorexic individuals often experience unresolved losses, to which they respond by engaging in compulsive care giving towards their children, manifest in the form of the pervasive over-involvement in their children's lives and functioning. As a result of this maternal over-involvement, Anorexic individuals are hypothesised to experience difficulties negotiating the developmental transition between symbiosis and individuation. Ward et al. (2000) suggest that the mothers of Anorexic individuals fail to encourage their developing child's strivings for exploration and autonomy due to their own difficulties with separation and loss. The child's difficulties with successfully individuating from their mother consequently entails that they do not develop a coherent sense of self as individually distinct from attachment figures, or the capacity to function autonomously and self-regulate (Mahler, 1979). Bruch (1982) asserts that upon reaching puberty, the individual is confronted by the challenges of adolescence in light of their lack of self-definition and autonomy, thereby giving rise to overwhelming feelings of incompetence, self-doubt, and fears of losing control. Patterns of dietary restriction and its resultant weight-loss therefore serve as a maladaptive attempt to relieve this distress and establish a perceived sense of identity, self-worth, and control.

In contrast to the research literature on the subject of mothers and eating disorders, the role of fathers and paternal relationships in the development of eating disorders has received noticeably less attention. Studies exploring the relationships between individuals suffering from eating disorders and their fathers have been gradually accumulating over the past thirty years (Phares, 1997). Such fathers have been traditionally characterised as being emotionally distant, preoccupied with work matters, and prone to alcohol abuse (Beresin et al., 1989). Lawrence (2002) asserts that the fathers of individuals who develop eating disorders often exhibit a lack of significance in the family system in which their role, identity, value, and sense of

connection to others within the family is not clearly defined or experienced by any of its members. The notion that such fathers are distant and uninvolved in their children's lives has been the basis for several theories relating to the development of eating disorders, most notably Maine's (1991) theory on "Father hunger", and Fitzgerald and Lane's (2000) theory regarding the role of fathers in psychosexual development in eating disorders, and their developmental progression towards independence and autonomy.

A small amount of qualitative research exploring the role of fathers in the development of eating disorders has been performed, mainly in the form of psychotherapeutic case studies. Wold (1973) published three case studies of AN exploring the role of the fathers in the development of such eating difficulties, in which participants described their fathers as being rigidly compulsive individuals with anger management issues manifest in their tendency to behave aggressively, particularly towards women. Similarly, in a case study of psychotherapeutic treatment of an 11 year old girl suffering from AN, Miller (1997) noted the apparent role of paternal absence in inhibiting the child's separation from their mother and subsequent development of independence. In a narrative analysis exploring the nature and meaning of father-daughter relationships amongst women with AN, Elliot (2010) found that participants typically characterised the relationships with their fathers in terms of uncertainty and experienced unsettling sporadic involvement with them throughout their lives. The lack or inconsistency of the fathers' fortifying presence and support was said to give rise to a lack of confidence and felt security, consequently resulting in difficulties adjusting to developmental transitions.

Maine (1991) proposed the concept of "father hunger" in relation to the role of fathers in the development of eating disorders, which she characterised as being the emptiness experienced by children whose fathers were physically or emotionally absent during their early development. The term "father hunger" therefore refers to an unconscious longing experienced by many children for an emotionally involved father figure. Maine (1991) asserts that fathers may unknowingly starve their daughters of the acceptance they require, and consequently induce a pressure to look "thin and pretty" in

an attempt to gain the acceptance or attention of men. Due to the manner in which women are socialised in Western cultures, such daughters may develop the belief that in order to gain the approval and attention of men that they need to look physically attractive and thin. This father hunger therefore leaves the daughter with a tendency to derive self-esteem from external sources, particularly physical appearance and the validation of others. Maine (1991) also asserts that the unavailability of their partners leads the mothers of individuals with eating disorders to experience ungratified dependency needs, which consequently results in patterns of overinvolvement and intolerance of separation from their children.

Fitzgerald and Lane (2000) provide a similar theoretical perspective, and assert that the father's presence and acceptance during the onset of puberty is essential for adolescent girls due to their need of affirmation regarding the changes occurring to their bodies. They assert that when the child moves from childhood to puberty it is essential that the opposite sex parent expresses support and does not withdraw from them as they mature and develop sexuality. The role and validation of the father is therefore crucial to the developing girl's acceptance of their new feminine identity and body during puberty. Rejection of the developing girl at this time can therefore have important consequences upon their psychosexual development. Fathers may withdraw from their daughters during puberty due to their difficulties accepting their daughters' sexual maturation, and fears that expressing affection towards their child may be misinterpreted as incestuous. This withdrawal may leave the adolescent girl feeling rejected and consequently lead them to develop negative beliefs about their bodies as being unattractive or defective. The lack of approval and validation that such girls experience from their fathers during puberty may therefore serve to impede the development of their confidence in their maturing bodies, along with their growing independence, and consequently lead to the ongoing preoccupation with physical appearance and dysfunctional eating behaviours which are characteristic of eating disorders.

Furthermore, the lack of an involved and consistently present father has also been hypothesised to be influential to the separation-individuation process amongst

individuals who develop eating disorders (Rhodes and Kroger, 1992). Mahler (1979) postulated that from birth infants exist in relation to their mother (termed symbiosis), but over the course of their development they gradually undergo a process of separation in which they develop certain capacities relating to autonomous functioning, self-regulation, self-control, and the development of the self as distinct from the caregiver (termed individuation). Smith (1996) asserts that within Western nuclear families, the father typically serves as the catalyst for the separation of the symbiotic bond between mother and child, and encourages the growing individuation and independence of the child. The absence of an involved father figure to encourage this separation may therefore undermine this process, and inhibit the daughter's attempts to individuate and develop an identity that is distinct from her mother (Humphrey, 1989). In such situations, the mother and child may experience an inappropriately elongated symbiotic relationship which endures beyond an age that is appropriate or advantageous to the developing adolescent. The result of this is an enmeshed relationship in which the daughter experiences an underdeveloped sense of self, identity and capacity for autonomy that gives rise to patterns of dietary restriction and weight loss which serve as a compensatory attempt to assert self-definition, independence and control (Bruch, 1978).

The two main theories regarding the roles of fathers in the development of eating disorders implicate their physical or emotional absence as being influential, particularly in relation to psychosexual development and the separation-individuation process. Although such theories provide elegant and intriguing accounts of the possible roles of fathers in the development of eating disorders, they appear to have little empirical basis and lack the support of current research evidence. Indeed the current thinking on the role of fathers in the development of eating disorders is largely theoretical in its nature, and appears to be principally based upon anecdotal evidence rather than empirical research.

Aims of the Review

The aim of this report is to review the current empirical research regarding the fathers of individuals who suffer from eating disorders, and their possible role in the development and maintenance of such difficulties.

Method

Search Strategy

The databases used to search for the current research relating to the role of fathers in the development of eating disorders in this review were PsychINFO, PubMed, MEDLINE, and PsycArticles. These databases were searched for articles pertaining to the role of fathers in the development of eating disorders in September 2014 using all possible combinations of the following search terms:

“Anorexia” OR “Anorexia Nervosa” OR “Anorexic” OR “Bulimia” OR “Bulimia Nervosa” OR “Bulimic” OR “Eating Disorder Unspecified” OR “Eating disorder” AND “Father” OR “Dad” OR “Paternal” OR “Parent”

Due to the relative lack of research in this subject area, no date limits were imposed upon the search results. Additional articles were also identified through manual searches of the reference sections of relevant articles. Due to the extremely limited quantity and poor quality of qualitative research in the area of fathers and their role in eating disorders, only quantitative research studies were included in the systematic review. The following exclusion criteria were implemented to narrow down the results of the literature search:

Inclusion Criteria

- Articles written in the English language
- Articles published in peer reviewed journals
- Articles concerning the fathers of individuals who suffer from eating disorders
- Articles reporting empirical quantitative data

Exclusion Criteria

- Articles reporting qualitative data
- Results from unpublished sources, academic dissertations or books
- Articles focused upon reviewing evidence or outlining theories

Results

The search of PubMed, MEDLINE, PsychINFO and PsycARTICLES identified 145 articles, however 78 of these were duplicates, 21 were on unrelated topics, 8 were review and theoretical articles that did not report any empirical data, 17 were not written in the English language, 7 did not originate from peer reviewed sources, and 3 articles only reported qualitative data. The remaining 11 articles were deemed to be suitable for inclusion in this review, however 2 of these were not accessible in paper or electronic formats. The references of the remaining articles were screened for any other relevant articles, which revealed 3 additional results. The final 12 articles were therefore included in this systematic review. A flow chart of the selection process used in this systematic review is illustrated in Appendix 1. The details of the design, sample, and outcome measures used in these selected studies are outlined in Table 1.

Table 1. Overview of the Articles Included in the Systematic Review

Study	Sample	Sample Demographics	Study Design	Control Group	Outcome Measures	Main Findings
1. Bers (2013) (USA)	n =77 All female (daughters)	Mean age: 18.3 Age range: 14-24	Matched case-control design (ANOVA)	Anorexic inpatients, psychiatric inpatients, and non-clinical controls	- Differentiation Relatedness Scale (D-RS) - Object Relations Inventory (ORI) - Depressive Experiences Questionnaire (DEQ) Eating Attitudes Test (EAT-26)	Anorexic participants perceived their fathers to be significantly more distant and uninvolved in their lives than other groups, and were more likely to defensively deny their desires for closeness and intimacy with their fathers.
2. Lobera, Rios & Casals (2011) (Spain)	n = 70 Male: 10 Female: 60	Mean age: 21.3 Age range: not reported	Survey of eating disorder outpatients (Correlation)	No comparison between groups	- Parental Bonding Instrument (PBI) - Rosenberg Self-Esteem Scale (SES) - Coping Strategies Inventory (CSI) - State-Trait Anxiety Inventory (STAI) - Beck Depression Inventory (BDI) - Eating Disorders Inventory-2 (EDI-2)	Significant positive correlations were found between the availability and presence of fathers and their daughter's self-esteem. Scores on trait anxiety and depression were positively correlated with affectionless and controlling fathering.
3. Enten & Golan (2009) (Israel)	n = 176 Daughters: 53 Mothers: 52 Fathers: 51 Siblings: 20	Mean age: 18.9 Age range: not reported	Survey of daughters and their parents and siblings (Correlation)	No comparison between groups	- Parental Authority Questionnaire (PAQ) - Eating Disorders Inventory (EDI-II) - Eating Attitudes Test (EAT-26)	The amount of time fathers spent at work correlated negatively with their daughter's Body Mass Index score. Scores on paternal authoritarianism were found to be negatively correlated with participant's scores on self- esteem.

Study	Sample	Sample Demographics	Study Design	Control Group	Outcome Measures	Main Findings
4. Latzer, Lavee & Gal (2009) (Israel)	n = 180 Daughters: 60 Mothers: 30 Fathers: 30	Mean age: 20.2 Age range: 15-26	Matched case-control design (MANOVA)	Family triads of anorexic and bulimic patients, and family triads of non-clinical controls	- Family Functioning Questionnaire (FFQ) - Perceived Marital Quality Questionnaire (PMQQ) - Level of Intimacy Questionnaire (LIQ) - Eating Disorder Inventory (EDI)	Father's involvement with their daughter was found to be positively correlated with the strength and satisfaction with their marital relationship. Participants whose parents experienced more marital difficulties reported having significantly lower quality relationships with their parents.
5. McEwen & Flouri (2009) (UK)	n = 203 78 male 125 female	Mean age: 14.04 Age range: not reported	Cross sectional survey (Correlation)	No comparison between groups	- Strengths and Difficulties Questionnaire (SDQ) - Eating Attitudes Test (EAT-26) - Difficulties in Emotion Regulation Scale (DERS) - Parental Bonding Inventory (PBI)	Both paternal overprotection and control were found to be positively correlated with eating disorder symptoms. Paternal patterns of psychological control were also found to be associated with increased difficulties with affect regulation in their children.
6. Soenes et al. (2008) (Belgium)	n = 145 All female (daughters)	Mean age: 19.3 Age range: 15-25	Matched case-control design (ANOVA)	Anorexic and Bulimic inpatients, and non-clinical controls	- Children's Report on Parent Behaviour Inventory (CRPBI) - Multidimensional Perfectionism Scale (MPS) - Eating Disorder Inventory (EDI-II)	Participants with eating disorders reported experiencing significantly more intrusive and controlling fathering than controls. Paternal psychological control was also found to be positively correlated with eating disorder symptoms.

Study	Sample	Sample Demographics	Study Design	Control Group	Outcome Measures	Main Findings
7. Jones, Leung & Harris (2006) (UK)	n = 116 All female (daughters)	Mean age: 31.8 Age range: 12-62	Case-control design (Multiple regression)	Eating disordered patients, and non-clinical controls	- Eating Disorder Inventory (EDI) - Young Schema Questionnaire - short form (YSQ-S) - s-EMBU	Paternal patterns of rejection were found to be associated with participant's beliefs relating to defectiveness and vulnerability to harm, whereas paternal overprotection was found to be positively correlated with increased drive for thinness.
8. Gutzwiller, Oliver & Katz (2003) (USA)	n = 306 All female (daughters)	Mean age: 19.4 Age range: 17-42	Cross-sectional survey (Correlation)	No comparison between groups	- Parental Attachment Questionnaire (PAQ) - Inventory of Parent and Peer Attachment-Parent From (IPPA) - Parental Bonding Inventory (PBI) - Questionnaire for Eating Disorder Diagnoses (Q-EDD) - Beck Depression Inventory-II (BDI-II)	Participant's scores on alienation and insecure attachment with fathers were found to correlate positively with both eating disorder symptomology and depression.
9. Botta & Dumlao (2002) (USA)	n = 210 All female (daughters)	Mean age: not stated Age range: 18-24	Cross-sectional survey (Multiple regression)	No comparison between groups	- Revised Family Communication Pattern Instrument (RFCP) - Organisation Conflict Inventory (OCI) - Eating Disorder Inventory (EDI)	Participant's rating of their father's openness to communication and willingness to engage in conflict resolution was found to correlate negatively with Anorexic patterns of dietary restriction.

Study	Sample	Sample Demographics	Study Design	Control Group	Outcome Measures	Main Findings
10. Keel, Heatherton, Harnden & Hornig (1997) (USA)	n = 153 Daughters: 51 Mothers: 51 Fathers: 51	Mean age: 14.8 Age range: 12-18	Cross sectional survey (Correlation)	No comparison between groups	- Revised Restraint Scale (RRS) - Likert scales measuring eating and compensatory behaviours, weight perception and satisfaction, and diet frequency and stringency	Positive correlations were found between paternal expressions of bodily dissatisfaction towards themselves and family members, and eating disorder symptomology in their children.
11. Eme & Danielak (1995) (USA)	n = 110 All female (daughters)	Mean age: 15 Age range: 15	Survey of daughters and their parents (Correlation)	No comparison between groups	- Eating Attitudes Test (EAT-26) - Parent-Adolescent Relationship Questionnaire (PARQ)	Patterns of overly protective and controlling fathering were found to be significantly higher in cases of restrictive eating disorders than controls. Participants suffering from eating disorders reported experiencing significantly less communication, warmth, problem solving and autonomy from fathers than non-eating disordered controls.
12. Engel & Stienen (1988) (Germany)	n = 207 All male (fathers)	Mean age: not stated Age range: not stated	Case-control design (Chi-square)	Fathers of eating disordered women contrasted with the fathers of non-eating disordered controls	- Structured interview rating symptomology, intrafamily and partner relationships using 5 point scale	Fathers displaying patterns of affectionless and dominating, passive and absent, and aggressive achievement-orientated parenting were found to be significantly more frequently experienced by eating disordered participants than controls.

The Methodological Quality of the Included Studies

Due to diverse nature of the studies included in this systematic review, no existing appraisal tool was suitable to evaluate their methodological quality and validity. A checklist of critical appraisal criteria was therefore derived from the research appraisal tools proposed by Downs and Black (1998) and Sale and Brazil (2004). These criteria and the appraisal of the methodological quality of the studies included in this review are outlined in Table 2.

All but two of the studies included in this review provided clear outlines of the aims and objectives of what they intended to achieve, and the outcomes to be measured were clearly described and appropriate to the aims. However Eme and Danielak (1995) only provided a very general aim of their study which was simply to add to the literature on the subject of the fathers of individuals with disordered eating. Furthermore, Engel and Stienen (1988) did not include any description of the purpose of their study or the aims of what they hoped to achieve. Half of the studies provided clear and detailed descriptions of the design and methodological procedures used, whereas the other half only provided vague descriptions of these areas. Only three of the studies included detailed descriptions or justifications for why specific populations were selected for recruitment and participation in the study, whereas the remaining nine studies provided little consideration or rationale for why they targeted a specific population for recruitment, or whether they were representative of the population intended to be studied. Sample sizes ranged from 77-306 participants, and ages ranged from 12-62 years. Six of the studies only included females in their participant samples, one study only included males, and the remaining five studies had mixed samples of males and females. Seven of the studies included clinical samples of individuals diagnosed with eating disorders. Two of these studies specifically used in-patient samples, two included outpatient samples, and the remaining three studies did not specify whether participants were drawn from in-patient or out-patient samples. The remaining five studies included in this review did not recruit participants from clinical populations, but rather cross-sectional samples from high schools (McEwen and Flouri, 2009; Eme and Danielak, 1995), university undergraduates (Gutzwiller, Oliver and Katz, 2003; Botta and Dumalo, 2002) and a local middle class suburban community (Keel et al., 1997).

Five of the studies included in this review utilised control groups, whereas the remaining seven studies were surveys and did not involve any comparison between groups. Three of the studies recruited control participants from local university undergraduate and postgraduate (Jones et al. 2006; Soenens et al., 2008) and high school populations (Bers et al., 2013). Latzer et al. (2009) reportedly recruited control participants who were matched for their age and socioeconomic background to the eating disordered group, whereas Engel and Stienen, (1988) reportedly selected a “random” sample of young women from the local city population as a control group. Of the five studies which did use control groups, only two provided any clear rationale or description regarding the population from which they were drawn. The remaining three studies provided little or no discussion regarding the rationale for why control groups were recruited from the populations they were sourced from, thereby failing to address the possible issues associated with the representativeness of such samples and their comparability to the clinical groups.

All of the studies included in this review provided clear and detailed description of the data gathering procedures and instruments used. A total of 31 different psychometric measures were used in the studies included in this review, and there was a striking absence of repetition in the measures used in different studies. The main limitation associated with the use of self-report measures to rate paternal parenting styles relates to the subjectivity of such accounts which may not represent an accurate reflection of their father’s parenting behaviour. Indeed, Murphy, Troop and Treasure (2000) suggest that the reason why individuals suffering from eating disorders may experience their parents as being intrusive and controlling is as a result of personality traits commonly associated with eating disorders such as control, rigidity and introversion. The presence of these traits may predispose such individuals to be highly sensitive to intrusion and influence from others, and lead them to experience relatively normal concern and influence from their mothers as being highly controlling and intrusive. As a result of this it is possible that many of the self-report measures employed in the reviewed studies may not have accurately reflected the parenting styles or behaviours objectively experienced by participants suffering from eating disorders.

Half of the studies reviewed in this report were correlational in design and involved comparing either participants' or different groups' scores on different psychometric measures. Due to the nature of correlational studies, it is not possible to infer a causal relationship between measured variables, or discount the influence of confounding variables on the apparent relationship between them. Indeed on this subject, Ward et al. (2000) speculate that many of the dysfunctional characteristics and patterns of behaviour that are observed within the families of individuals suffering from eating disorders can be regarded as secondary to the presence of an ill family member, rather than causative of the disorder itself. Similarly, Polivy and Herman (2002) assert that due to the correlational nature of most studies exploring family functioning in eating disorders, it is not possible to determine whether a causative relationship exists between family dysfunction and eating disturbance, or whether a common factor may contribute to both. As a result of this, it is therefore not possible to determine whether the patterns of paternal behaviour and parenting recorded in many of these studies are causative or a result of having a daughter suffering from an eating disorder. Similarly, it is also not clear from many of the reviewed studies whether eating disordered behaviour and dysfunctional fathering may both arise as a result of the influence of some third variable, such as maternal behaviour.

In most cases the studies included in this review provided insightful and realistic appraisals of the methodological issues associated with their research, and discussed the potential influence of these limitations upon the reliability and validity of the findings. Issues relating to the representativeness of samples, small sample sizes and the potential for Type 1 errors, difficulties establishing causality from correlations, and the potential for response bias when using subjective self-report measures to assess parenting styles were repeatedly cited as limitations. However the studies conducted by Botta and Dumlao (2002), Eme and Danielak (1995), Engel and Stienen (1988) entirely failed to include any discussion of the limitations associated with their studies, despite the notable methodological issues associated with their research design and procedures.

The appraisal of the methodological quality of the studies included in this review is outlined in Table 2.

Table 2. The Methodological Quality of the Included Studies

Studies	Critical Appraisal Criteria										Total Score
	1	2	3	4	5	6	7	8	9	10	
1. Bers (2013)	2	2	2	2	2	1	2	2	2	2	19/20
2. Lobera, Rios & Casals (2011)	2	2	2	2	1	0	2	2	1	1	15/20
3. Enten & Golan (2009)	2	1	2	2	1	0	2	2	1	1	14/20
4. Latzer, Lavee & Gal (2009)	2	2	2	2	2	2	2	2	2	2	20/20
5. McEwen & Flouri (2009)	2	2	2	2	1	0	1	2	2	2	16/20
6. Soenens et al. (2008)	2	1	2	2	2	2	2	2	2	2	19/20
7. Jones, Leung & Harris (2006)	2	2	2	2	1	1	2	2	1	2	17/20
8. Gutzwiller, Oliver & Katz (2003)	2	1	2	2	1	0	2	1	2	2	15/20
9. Botta & Dumlao (2002)	2	1	1	2	1	0	2	2	2	0	13/20
10. Keel, Heatherton, Harnden & Hornig (1997)	2	1	2	2	1	0	2	1	1	2	14/20
11. Eme & Danielak (1995)	1	2	1	2	1	0	2	2	1	0	12/20
12. Engel & Stienen (1988)	0	1	1	2	1	1	2	2	2	0	12/20
Criteria Totals	21/24	18/24	21/24	24/24	15/24	7/24	23/24	22/24	19/24	16/24	186/240

1. The aims and objectives of the study are clearly stated and described.
2. The design and methodological procedures of the study are clearly outlined and appropriate.
3. The main outcomes to be measured in the study are appropriate to the aims and clearly described.
4. The data gathering procedures and instruments are appropriate and clearly described.
5. The participant selection process is clearly justified, described and representative of the desired population.
6. The selection and source of control groups is described and justified.
7. The demographic characteristics of the study sample are clearly described.
8. The main outcome data and its analysis is clearly presented.
9. The conclusions reached are clearly supported by the outcome data.
10. The limitations of the study are clearly identified and discussed.

2 = Well addressed

1 = Poorly addressed

0 = Not addressed, reported or applicable

Overview of the Findings

The purpose of this report was to systematically review the current empirical research regarding the fathers of individuals who suffer from eating disorders, and their possible role in the development of such difficulties. The main findings of this review can be categorised into five main themes:

1. Uninvolved, distant or rejecting fathering.
2. Highly controlling fathering which is lacking in care.
3. A lack of assertive communication and conflict resolution with fathers.
4. Paternal dissatisfaction with their own body weight and shape.
5. The father-daughter relationship as a product of the parents' relationship.

The details of these main themes will now be individually outlined.

1. Uninvolved, Distant or Rejecting Fathering

Five of the reviewed studies reported that a distant, rejecting and emotionally or physically uninvolved relationship with fathers was significantly associated with the emotional, cognitive and behavioural difficulties inherent to eating disorders. Indeed, Engel and Stienen (1988) proposed the existence of a “weak father” prototype of such fathers who are characterised by patterns of passivity, emotional absence, and are dominated and not respected by the females in the family. Similarly, “weak fathers” are also noted to play no conspicuous role in essential family tasks and decisions, and display no particular concern with problems within the family or their children. Engel and Stienen (1988) asserted that such fathers typically suffer from physical health problems, and difficulties with depression or alcoholism which lead to their characteristic patterns of withdrawal and resignation, as well as their lack of personal goals and low expectations of their children. Bers (2013) found that in cases where young women perceived their fathers to be pervasively distant and uninvolved in their lives, they came to defensively deny their underlying desire for intimacy and closeness with them, manifesting in patterns of interpersonal avoidance. Experiences of an emotionally distant and uninvolved father were internalised into the child's representation of others, manifest in the form of inherent beliefs and expectations that

others (particularly males) will not be available to willing to meet the child's needs for intimacy and support. Bers reported that these beliefs were significantly more frequent amongst young women suffering from eating disorders in contrast to non-clinical controls, and had frequently been generalised and manifest in the avoidance of interpersonal closeness, which is also common amongst those suffering from eating disorders.

In their cross-sectional survey, Gutzwiller et al. (2003) recorded that alienation and insecure attachment with fathers correlated positively with both eating disorder symptomology and depression. Similarly, Lobera et al. (2011) recorded a positive correlation between paternal emotional neglect and low self-esteem. Furthermore, Enten and Golan (2009) reported that the amount of time fathers spent at work correlated negatively with their daughter's body mass index score. The authors subsequently asserted that this connection may be explained by the notion of "father hunger" in which the child may use their restrictive dietary intake and low body weight as a means of soliciting the attention and care of their otherwise distant and uninvolved father. However the relatively low methodological quality of these three particular studies suggests that such findings must be interpreted with caution and may not be entirely representative of the fathers of individuals who develop difficulties with AN. Jones et al. (2006) recorded that paternal rejection was particularly prominent amongst women suffering from eating disorders, and that such experiences were predictive of beliefs of personal defectiveness and shame. The authors reasoned that that paternal rejection and neglect during development may be interpreted by the child as an indication of personal flaws and undesirability, leading to the development of core beliefs relating to defectiveness and shame which manifest in the form of negative self-appraisal and bodily dissatisfaction. Furthermore, Jones et al. found that the father's intermittent availability and presence in the child's life was also positively correlated to fears of abandonment. The authors speculated that this distressing uncertainty may entail that the child develops a compensatory need for high levels of control in their lives, which ultimately manifests in the drive for thinness and control that is characteristic of eating disorders.

2. Highly Controlling Fathering which is Lacking in Care

Patterns of highly controlling fathering which lacks care and emotional warmth was recorded in five of the reviewed studies, and found to be significantly more prevalent amongst individuals with eating disorders than non-clinical controls. Engel and Stienen (1988) proposed the existence of a “brutal father” prototype to describe such individuals who are characterised by patterns of aggressively externalising their own difficulties in the form of dominating or arguing with other family members. Such fathers display noticeable egocentricity and a lack of awareness of their child’s emotions, are demanding of achievement and obedience, and prone to aggressive outbursts of anger, particularly towards female family members. Engel and Stienen recorded that this affectionless and dominating fathering style was significantly more frequently exhibited by the fathers of individuals suffering from eating disorders than non-clinical controls. Lobera et al. (2011) found that such fathers typically exhibited more externalising strategies to cope with their emotional difficulties, manifesting in the form of dominating and aggressive parenting. Similarly, McEwen and Flouri (2009) recorded that over-involved and controlling strategies such as intrusion and inducing guilt were significantly more prominent amongst the fathers of young women suffering from eating disorders than non-clinical controls. The authors found that this parenting style was also significantly positively correlated with the child’s needs for autonomy and self-identity, manifest in their highly controlled and rigid eating habits and patterns of exercise. Indeed, Eme and Danielak (1995) recorded that overly protective and controlling fathering was significantly higher in cases of restrictive eating disorders characterised by over-control, in contrast to non-disordered eating patterns. The authors postulated that in such cases, high paternal standards for achievement and rule-following may become internalised by the child and consequently lead to the development of maladaptive patterns of perfectionism and rigidity associated with eating disorders.

Three of the reviewed studies reported finding a significant positive correlation between affectionless and controlling fathering and the daughter’s scores on anxiety and low mood. Similarly, McEwen and Flouri (2009) found that paternal over-protectiveness and psychological control significantly decreased the child’s ability to

regulate their emotions, leading to difficulties with affect regulation and expression. The authors asserted that these impairments made it particularly difficult for such individuals to manage transitional life events, which became emotionally overwhelming and led to the adoption of internalising behaviours in a maladaptive attempt to regulate these emotions and reinstate a sense of control. Entern and Golan (2009) found that body dissatisfaction and negative self-appraisal both correlated positively with authoritative fathering amongst eating disordered women. The authors speculated that this extremely rigid and controlling style of fathering may contribute to the adoption of highly controlling behaviour and rigid adherence to routine in eating disordered women through the Social Learning Theory process of modelling. In such cases it is therefore possible that daughters observe their fathers pervasively engaging in highly controlling and inflexible behaviours as a means to manage emotionally difficult and challenging situations, and consequently adopt a similar strategy in their own lives, manifesting in the form of overly controlled eating patterns and rigid adherence to routine.

Jones et al. (2006) found that levels of paternal overprotection was positively correlated with beliefs of vulnerability to harm amongst women with eating disorders, consequently leading to increased needs for control. The authors suggested that these formative experiences of paternal overprotection and control consequently frustrated the developing child's needs for autonomy, competence and spontaneity, and consequently instilled beliefs of vulnerability to harm and ineffectiveness. These beliefs were hypothesised to ultimately necessitate the adoption of compensatory patterns of control and adherence to routine in the form of extreme dietary restriction and drive for thinness. Soenens et al. (2008) also found higher levels of paternal control in eating disordered women than non-clinical controls. In this study paternal control was found to be positively correlated with maladaptive perfectionism and eating disorder pathology. The authors concluded that psychologically intrusive and controlling fathering may create a vulnerability towards maladaptive perfectionism, as it is positively correlated with drive for thinness and negative evaluation of appearance. The two studies reporting these findings on paternal overprotection and the development of

maladaptive perfectionism scored particularly highly in terms of their methodological quality, therefore positively reflecting upon their validity and generalisability.

3. A Lack of Assertive Communication and Conflict Resolution with Fathers

Two of the reviewed studies implicated the lack of open communication and conflict resolution with fathers in the development of pathological patterns of eating. This was particularly associated with the effective expression and communication of emotional distress. Eme and Danielak (1995) found that individuals suffering from eating disorders reported experiencing significantly less communication, warmth, problem solving and autonomy from fathers than non-eating disordered individuals. Similarly, Botta and Dumlao (2002) found that open communication with fathers was negatively correlated with restrictive eating behaviours and pathology, and individuals who experienced disrupted communication patterns with their fathers exhibited a significantly increased likelihood of engaging in maladaptive patterns of dietary restriction. The authors found that the lack of conflict resolution experienced by such individuals entailed that unresolved or expressed hostility towards their fathers became inwardly directed, taking the form of low mood, self-hatred and both restrictive and bulimic eating patterns. Botta and Dumlao postulated that the absence of overt communication and conflict resolution with their fathers may therefore lead such individuals to internalise rather than express or resolve their emotional conflicts. This pattern of internalising negative feelings of anger and hostility also results in a negative self-appraisal and a sense of powerlessness, ultimately giving rise to patterns of disordered eating which represent a maladaptive attempt to reassert a sense of control, express self-punishment and atone feelings of self-directed anger and frustration in the form of dietary restriction, excessive exercise, and binge-purge behaviours. Indeed the authors suggest that such individuals may experience a perpetuating cycle of interaction characterised by an absence of opportunity for open communication or conflict resolution with their fathers, which consequently evokes further frustration that cannot be openly expressed or resolved. Both of the studies suggesting that a lack of assertive communication and conflict resolution may be influential in the development of eating disorders scored poorly in terms of their methodological quality, suggesting that such

findings may not be valid or generalisable representations of the experiences of individuals suffering from eating disorders.

4. Paternal Dissatisfaction with their Own Body Weight and Shape

Two of the studies included in this review cite the father's own difficulties with body dissatisfaction as being influential in the development of eating disorders in their children. In their study, Keel et al. (1997) recorded that the daughter's satisfaction with her own body is positively correlated with their father's bodily satisfaction. The authors assert that such fathers may consequently model bodily dissatisfaction as well as high standards for physical appearance to their children which they consequently internalise and imitate, leading to the characteristic patterns of body dissatisfaction and perfectionism associated with eating disorders. As was outlined earlier, Engel and Stienen (1988) found that individuals suffering from eating disorders were significantly more likely than controls to have experienced "brutal fathers" who are characteristically achievement-orientated and exhibit a pervasive pattern of aggressively externalising their difficulties onto other family members. Due to their high internalised standards, "brutal fathers" are prone to body image concerns as well as problems with managing their emotional difficulties. As a result of this, such fathers exhibit a tendency to externalise their conflicts and may come to defensively project their disowned bodily dissatisfaction onto their children in the form of negative and critical comments regarding their appearance, body weight and shape. However as was the case with the previously described theme, both of these studies were notable for their poor methodological quality, thereby casting doubt upon the validity of such findings.

5. The Father-daughter Relationship as a product of the Parents' Relationship

Three of the reviewed studies recorded that the father-daughter relationship experienced by individuals suffering from eating disorders was strongly associated to the quality of their parent's relationship. Latzer et al. (2009) found that a father's involvement with his daughter was positively correlated with the strength and satisfaction with their marital relationship. In a similar sense, Eme and Danielak (1995) found that young women caught in the middle of disputes between their mothers and fathers experienced significantly increased eating disturbances than participants who

were not involved in their parents' disputes. The findings of this review also suggest that patterns of paternal over-involvement are also frequently present in cases of eating disorders. Indeed, Engel and Stienen (1988) proposed the prototype of the "bonding father" who experiences an excessively close and symbiotic relationship with his daughter, principally due to the unfulfilling relationship that they experience with their partners. Such fathers consequently compensate for their lack of emotional connection with their partners by creating an over-involved and pseudo-symbiotic relationship with their daughters which is characteristically overprotective, controlling and inhibits the child's strivings for independence. Engel and Stinenen found that individuals suffering from eating disorders were significantly more likely to have experienced "bonding fathers" than non-clinical controls. However the findings from this particular study should be viewed with caution due to the notable presence of several important methodological limitations and oversights within its design and analysis.

Discussion and Synthesis

The findings of this review have revealed several patterns of fathering and paternal interaction which are more commonly experienced by individuals suffering from eating disorders than those from a non-clinical population. In contrast to current opinion and theories, the findings of this review suggest that no one particular pattern of fathering can be considered to be singly implicated in the pathogenesis of eating disorders, but rather than a variety of fathering styles may potentially have an important role and damaging effect.

The studies included in this review provide considerable support for current theoretical conceptualisations of the role of fathers in the development of eating disorders, particularly the influence of distant, rejecting and uninvolved fathering. The reviewed findings suggest that the lack of a father's continued emotional and physical presence in their child's life during infancy and adolescence is highly influential to the development of the core pathology associated with eating disorders (Jones et al., 2006; Lobera et al., 2011). Experiences of uninvolved, distant and rejecting fathering may therefore contribute directly to difficulties with maintaining a positive self-view and increased need for control, both of which are central features of eating disorders. These

developmental experiences appear to be influential in the genesis of an innate sense of defectiveness which manifests as bodily dissatisfaction and self-beliefs relating to incompetence and inadequacy. These findings provide support for Fitzgerald and Lane's (2000) theory which asserts that a father's presence and consistent involvement is essential for the adolescent girl's needs for affirmation regarding the changes occurring to their body during puberty, and her acceptance of her new feminine identity. A lack of paternal involvement at this time is theorised to leave the adolescent girl feeling rejected and instils negative beliefs regarding personal defectiveness and physical unattractiveness. The reviewed research suggests that paternal patterns of withdrawal and resignation were typically attributable to physical health problems, difficulties with depression or alcoholism, or preoccupation with work matters (Beresin et al., 1989; Engel and Stienen, 1988). Such children interpreted their father's intermittent involvement, neglect and apparent lack of interest in their lives as a reflection of their inherent undesirability, defectiveness, and personal flaws, leading to a negative self-appraisal, bodily dissatisfaction and feelings of shame which is characteristic in eating disorders (Enten and Golan, 2009; Jones et al., 2006).

The findings of this review suggest that several of the elements of the core pathology underlying eating disorders may develop as a result of fathers being intermittently present or available within the family system, but not entirely absent. Indeed, Engel and Stienen (1988) found that "absent fathers" who were characterised simply in terms of their physical absence from the family due to their death, divorce, separation or estrangement were significantly more frequent amongst non-eating disordered individuals than those with eating disorders. These findings therefore suggest that a father's sporadic, distant or unpredictable presence in a child's life may contribute towards their development of a negative self-image as defective or somehow undesirable, whereas an entirely absent father who has absolutely no involvement in the child's life does not have the same effect. This may potentially be explained by the notion that a physically present father who displays little interest or involvement with his children may be understood to be a reflection of the child's own lack of value and personal defectiveness. In contrast, an entirely absent father who has no involvement in their child's life may be understood in a less personalised manner by the child, and seen

to be a negative reflection of their father's personal qualities rather than of the child. The studies included in this review also reported significant positive correlations between the availability and presence of fathers, and their daughter's self-esteem (Lobera et al., 2011) and body weight (Enten and Golan, 2009). These findings provide partial support for Maine's (1991) theory relating to "father hunger" which asserts that individuals suffering from eating disorders experience a longing for an emotionally involved father figure, and consequently use their patterns of dietary restriction and weight loss as a means of soliciting the attention and care of her otherwise distant and inconsistent father.

The findings of this review also suggest that a father's unpredictability or intermittent presence in their daughter's lives may contribute to the development of problems with fears of abandonment, and a subsequent need for control which may manifest in highly restrictive eating patterns (Jones et al., 2006). In support of this notion, Ross and Hill (2002) found the presence of unpredictability in parental relationships to be the most influential factor in the development of a child's need for control. Furthermore experiences of paternal neglect and rejection are often reported by Anorexic individuals as being influential to engendering fears that important others may not be consistently available to provide emotional support (Parente, 1998). Similarly, research by Kiernan (2006) revealed that a father's presence and interaction during the child's development plays a crucial role in engendering feelings of safety, security, and competency in the developing child. Amongst individuals suffering from eating disorders, the lack or inconsistency of the father's fortifying presence and support may therefore serve to undermine this process, and entail that they experience a lack of confidence and felt security, consequently resulting in difficulties adjusting to developmental transitions and compensatory attempts to reassert control over their lives through patterns of dietary restriction and weight loss. These findings also support those recorded by Elliot's narrative analysis (2010) which found that individuals who develop eating disorders often report that the inconsistent involvement of their fathers during their development engenders a lack of confidence and felt security, and leads to difficulties adjusting to developmental transitions.

Another particularly striking finding of this systematic review is the notable similarities between the paternal patterns of parenting that are associated with the development of eating disorders, and the maternal characteristics and parenting styles repeatedly cited in research literature as being implicated in the development of such disorders. Within the current research literature, the mothers of individuals suffering from eating disorders have been consistently characterised as controlling, highly critical, and intrusively over-involved in their children's lives (Bruch, 1978; Brumberg, 1988; Hill and Franklin, 1998). However the findings of this review repeatedly implicate highly controlling fathering which lacks emotional care in the development of the core features of eating disorder pathology. The reviewed research suggests that the fathers of individuals who suffer from eating disorders experience prominent difficulties with control and interpersonal aggression which manifest in the form of domineering, over-protective and controlling parenting (Engel and Stienen, 1988; Lobera et al., 2011). Such patterns of aggressive and rigidly controlling fathering were also recorded by Wold's (1973) early qualitative case studies exploring the role of the fathers in the development of eating disorders. The findings of this review suggest that psychologically controlling fathering often leads to the development of a negative appraisal of physical appearance and a strong drive for thinness in children (Jones et al., 2006). There appear to be several possible routes by which these formative experiences may give rise to the core pathology associated with eating disorders. Such fathers may inadvertently model highly controlling and inflexible ways of coping with emotional difficulties to their daughters; or their overly controlling and protective parenting may potentially frustrate several of their child's core developmental needs resulting in difficulties with perceived self-efficacy, competence and vulnerability to harm. Either of these developmental processes could potentially result in the adoption of a variety of overly controlling behaviours and negative self-perceptions that are characteristic of eating disorders.

The studies included in this review also suggest that an over-involved and pseudo-symbiotic relationship with fathers may be associated with the development of eating disorder symptoms and pathology (Engel and Stienen, 1988). Previous research has suggested that the mothers of eating disordered individuals engage in overly

involved and symbiotic relationships with their daughters as a result of unresolved issues relating to loss and separation (Ward et al., 2000). This has been hypothesised to lead such mothers to become intrusively involved in their children's lives, and render them unable to tolerate their growth, maturation and separation (Brusch, 1978). Furthermore, Maine (1991) also asserts that the mothers of individuals with eating disorders may experience ungratified dependency needs due to the emotional or physical unavailability of their partners, thereby leading to compensatory patterns of overinvolvement and intolerance of separation from their children. However several of the studies included in this review reported highly similar patterns amongst the fathers of individuals suffering from eating disorders, who experienced distant and unfulfilling relationships with their partners which they compensated for through developing highly involved and symbiotic relationships with their daughters in an attempt to address their unfulfilled intimacy and dependency needs (Engel and Stienen, 1988; Latzer et al., 2009). It is therefore possible that this pattern of paternal over-involvement and intolerance of separation may also hinder the child's attempts to separate and individuate, resulting in an inappropriately symbiotic and enmeshed relationship with their father which inhibits the child's developing sense of self, identity and capacity for autonomy. As was theorised to be the case with over-involved mothers, this may give rise to patterns of dietary restriction and weight loss which serve as a compensatory attempt to assert self-definition, independence and control (Bruch, 1978).

The notion that the mothers of individuals who develop eating disorders also experienced difficulties associated with their body weight and shape is well documented in the research literature. Such mothers have been found to frequently model dysfunctional eating patterns for their children through expressing perpetual dissatisfaction with their own bodies and engaging in continual unsuccessful dieting attempts intended to alter their body weight and shape (Whelan and Cooper, 2000). On this subject Birch and Fisher (2000) found that mothers who experience a preoccupation with their own eating patterns and body weight are also more actively involved in commenting and influencing their children's weight and eating patterns. The findings of this review have revealed that the fathers of individuals suffering from eating disorders may also experience a variety of concerns regarding their body weight and

shape, leading to overt expressions of bodily dissatisfaction and patterns of dysfunctional eating that are intended to induce weight loss (Engel and Stienen, 1988; Keel et al., 1997). These fathers were found to model their dysfunctional patterns of self-appraisal to their children, and engage in patterns of defensively projecting their own insecurities regarding their body weight and shape onto their children. Either of these processes could be influential in the development of the core features of eating disorders in their daughters relating to negative self-appraisal and preoccupation with body weight and shape. These findings suggest that if either of a child's parents express overt dissatisfaction with their own physical appearance and model certain dysfunctional attitudes and eating behaviours that it may have a predisposing effect towards the development of eating disorders in later life.

A small number of studies included in this review reported that a lack of assertive communication and conflict resolution with fathers may be a contributing factor to the development of eating disorder symptoms and pathology (Botta and Dumlao, 2002; Eme and Danielak, 1995). The absence of an open channel for the communication of negative emotions or the resolution of conflicts with father has therefore been implicated in engendering feelings of powerlessness, anger and frustration, which may give rise to eating disordered behaviours as a maladaptive attempt to express or manage such feelings (Botta and Dumlao, 2002). A lack of overt communication and conflict resolution within the families of individuals suffering from eating disorders is well documented in existing research (e.g. Haworth-Hoepfner 2000; Van Furth et al., 1996) and typically leads such families to either exist in a continual state of conflict, or for family members to avoid overt conflict and habitually engaging in passive expressions of aggression (Yager, 1982). The absence of open communication and conflict resolution within the family may therefore lead such children to adopt more passive-aggressive means of expressing their feelings of anger and hostility towards their fathers (Minuchin et al., 1978). This may potentially explain the patterns of self-starvation and its resultant weight loss that are characteristic of Anorexia Nervosa, which may serve as a passive-aggressive means of inflicting punishment upon parents through evoking feelings of intense concern, fear, self-blame and guilt for their child's eating disorder (Highet et al., 2005; Treasure et al., 2001).

Within the literature on the subject of eating disorders there appears to be a noticeable tendency towards implicating parents in the development of eating disorders in a causal and seemingly blaming manner. On this subject Rabinor (1996) suggests that the pattern of ‘mother-blaming’ in the fields of developmental psychology and psychoanalysis is particularly noticeable in the literature relating to eating disorders. The literature included in this review also exhibits this tendency to blame fathers for the development of eating disorders in their daughters through their lack of consistent involvement and attention (e.g. Beresin et al., 1989; Fitzgerald and Lane, 2000; Maine, 1991). Similarly, the use of terms such as “brutal” or “weak” to describe the fathers of individuals who develop eating disorders (Engel and Stienen, 1988) strongly communicates a message of inadequate and self-involved fathering as being central to the development of eating disorders. It is possible that the seemingly blaming approach and language used in the area of eating disorders may influence how both researchers and clinicians interact with the parents of individuals diagnosed with eating disorders. Indeed this may explain the feelings of guilt, shame, and personal responsibility that such parents often reportedly experience for their child’s eating difficulties (Highet et al., 2005; Treasure et al., 2001; Whitney et al., 2005).

Another noticeable trend within the literature included in this systematic review is the lack of research focusing on eating disorders in males. Strother et al. (2012) suggest that despite males constituting around 10% of cases of eating disorders that the subject of eating disorders in males has been pervasively neglected and significantly under-researched. Indeed, the theoretical approaches proposed by Maine (1991) and Fitzgerald and Lane (2000) are specifically focused upon the role of fathers in the development of eating disorders in females and are not applicable to males. In a review on the subject, Weltzin et al. (2005) revealed that in contrast to their female counterparts, males with eating disorders are more likely to desire a more muscular body, engage in excessive exercise rather than purging compensatory behaviours such as vomiting, and are less likely to seek treatment than women with similar difficulties. The differences in how eating disorders present in males has been suggested to potentially explain the lack of recognition and diagnosis of such difficulties in men (Hsu, 1996). The studies included in this systematic literature review also demonstrate this same lack of

acknowledgement of the subject of males and eating disorders, as only two of these studies included male participants experiencing eating difficulties. As a consequence of this the findings of this review do not provide any insight into the differential role of fathers in the development of their sons' eating disorders.

Limitations of the Review

There are several limitations associated with this systematic review which relate principally to the quality and quantity of research included in it. The amount of empirical research focused on the topic of fathers and their role in the development of eating disorders appears to be extremely limited and varied in quality. The majority of the research conducted in this area is correlational in its nature which introduces problems with inferring causation between paternal parenting patterns and eating disorder symptomology. The small amount of experimental research that has been conducted in this area also displays an absence of control groups, as well as problems relating to the representativeness of the participants used in such studies. The presence of these limitations consequently restricts the potential for valid and generalisable conclusions to be drawn regarding to the role of fathers in the development and maintenance of eating disorders from the studies included in this review.

Clinical Implications and Future Research

The findings of this review suggest that the role of fathers and paternal relationships in the development of eating disorder symptomology has been grossly underestimated in contrast to the influence of maternal relationships. These findings suggest that an increased focus and emphasis upon the role of paternal relationships within clinical practice in the area of eating disorders can provide valuable insight into the developmental factors that lead to the onset of eating disordered symptomology, as well as potential areas for intervention. The notion that patterns of overinvolvement, excessive control, bodily dissatisfaction and criticism from either parent can increase a child's vulnerability to developing eating difficulties suggest that past approaches that focused largely upon maternal relationships and their role may have been erroneous. Indeed the findings of this review suggest that clear links may exist between paternal relationships and the development of the core pathology underlying eating disorders,

highlighting the importance of fathers in the understanding and treatment of eating disorders. Clearly the role of fathers in eating disorders is an area that requires further research in order to expand and consolidate the little empirical data that does exist on the subject. The findings of this review suggest that an area of particular importance to explore in future research may be the influence of paternal behaviour upon the development of the child's self-view in cases of eating disorders, as well as the influence of male attachment figures upon the developing female's perception and appraisal of their body image.

Summary and Conclusions

Within the vast research literature on eating disorders the subject of fathers and their role in the development of such problems has received surprisingly little attention. The findings of this review suggest that this oversight has been erroneous. Although the studies included in this review did provide support for the traditionally accepted notion that distant and uninvolved fathering contributes heavily to the development of eating disorders, a variety of other paternal parental styles were also implicated in the genesis of the core pathology associated with such disorders. Patterns of paternal hostility, criticism, rejection, conflict, inconsistency, enmeshed over-involvement, and expressions of bodily dissatisfaction were all found to be significantly more frequently experienced by individuals suffering from eating disorders than non-clinical controls. Clear connections can be made between these fathering styles and the development of the core features of eating disorders relating to a negative self-view, bodily dissatisfaction, intense needs for control, and problems with affect regulation. The findings of this review also suggest that the fathers of individuals suffering from eating disorders exhibit highly similar parenting styles to the mothers who have received extensive research attention and responsibility for the development of eating disorders. This consequently suggests that patterns of highly controlling, critical, enmeshed, and inconsistent parenting which involve frequent expressions of bodily dissatisfaction may increase susceptibility to the development of eating disorder pathology in children regardless of the gender of the parent exhibiting such behaviours. The conspicuous lack of empirical research in the area clearly illustrates the need for further exploration of the role of fathers in the development of eating disorders, as well as a wider recognition of

the importance of paternal relationships in the development of eating disorders. Indeed, the current research evidence relating to the role of fathers in the development of eating disorders appears to be characterised in a similar way as such fathers within the family system; sporadic, lacking in significance, and notable by its absence.

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A Phenomenological Exploration of the Influence of Anorexia Nervosa upon the Interactional Dynamics within the Family System

Abstract

Objectives

Within this study the perceptions of individuals diagnosed with Anorexia and the first degree family members of individuals diagnosed with Anorexia were explored regarding any changes that occurred in family dynamics following the onset of such eating difficulties.

Method

Semi structured interviews were used to collect data from eight participants, half had been diagnosed with Anorexia and the other half were first degree relatives of individuals diagnosed with Anorexia. The data was analysed using Interpretative Phenomenological Analysis (IPA).

Results and Analysis

The findings of this study revealed that numerous changes in family dynamics and functioning were perceived to have occurred following the development of Anorexia in one of its members. Such changes particularly related to areas of family functioning such as family cohesion, role and dynamic changes, and “Contaminations” and deteriorations. Although the themes relevant to perceived changes reported by both groups of participants were highly similar, participants suffering from Anorexia reported experiencing more positive changes in family functioning than family member participants, who described experiencing more negative changes and deteriorations in wellbeing.

Conclusions

The findings of this study not only support the existence of a pattern of reciprocal influence between Anorexic symptomology and family functioning, but also suggest that the changes in interactional dynamics brought about by such difficulties are often perceived as adaptive. However such changes in family functioning appear to principally benefit the individual suffering from Anorexia, often at the expense of the wellbeing of other family members.

Introduction

Anorexia Nervosa (AN) is a severe and complex psychiatric disorder that remains highly resistant to treatment despite receiving decades of research attention (Watson and Bulik, 2013). Within the ICD-10 Classification of Mental and Behavioural Disorders, AN is characterised principally by a persistent refusal to maintain a healthy body weight, the self-induced avoidance of “fattening foods”, significant perceptual distortions relating to body-image, and a widespread endocrine disturbance causing a loss of sexual interest coupled with the delay or arrest of pubertal events such as menstruation and the development of secondary sexual characteristics (World Health Organisation, 1992). Biological, social, and psychological factors have all been implicated as being influential in the development and maintenance of AN (Halmi, 2013). The role of family functioning in the development of AN is an area that has received extensive research over the past forty years, the majority of which has focused upon the causative role that family dynamics have upon the development of such patterns of dietary restriction and weight loss. Indeed, early research exploring the aetiology of AN emphasised the role of dysfunctional family dynamics and patterns of relating (Hsu, 1983). This was principally due to the early recognition that the styles and patterns of interaction within the families of individuals suffering from AN differ markedly from those without severe eating disturbances (Selvini-Palazzoli, 1974), and may therefore play an important role in the development of such difficulties.

Minuchin et al. (1978) famously proposed the existence of a characteristic prototype of the families of adolescents suffering from AN termed the “Psychosomatic Family”, a notion that has remained prominent within the research literature since it was introduced. Such families are said to be characterised by prominent and pervasive patterns of intrusive and enmeshed parenting that displays little respect for interpersonal boundaries, overprotection and control, rigidity, and a lack of conflict resolution. The term enmeshment is used to describe families in which parents are intrusive and over-involved in their children’s affairs, have little respect for interpersonal boundaries, and are dismissive of their children’s emotions and emotional needs (Minuchin et al., 1978). Patterns of enmeshment and over-involvement within such families often result in boundary dissolution in which members lack differentiation and individuality (Rowa,

Kerig and Geller, 2001). The absence of clear boundaries typically manifests in the form of unusually high levels of interpersonal dependency and involvement between family members (Kagan and Squires, 1983), as well as the disappearance of clear boundaries between parents' and children's roles, resulting in the absence of a perceived family hierarchy (Szabo, Goldin, and Le Grange, 1999). Werner et al. (2001) assert that within such families the dissolution of interpersonal boundaries between family members typically occurs because of the parents' tendency to perceive their children as an extension of themselves rather than individual and distinct entities. Similarly, parents within Psychosomatic Families are also characterised by patterns of over-involvement and excessive protection of their children, exhibiting a disproportionate amount of concern regarding the welfare of other family members that is often perceived by their children as over-protective, coercive and controlling (Levenkron, 1982; Shoebridge and Gowers, 2000).

Within Psychosomatic families patterns of rigidity are also said to be typically present, characterised by the tendency to maintain the status quo within the family and manifesting principally in the form of adherence to routines and a lack of flexibility in the adaptation to the ever changing family life-cycle as it progresses over time (Selvini-Palazzoli, 1974). Such patterns of rigidity are evident in a lack of flexibility and apparent need to maintain appearances of conforming to conventional social roles (Lieberman, 1995). This is accompanied by an absence of overt communication that has been hypothesised to give rise to a general lack of conflict resolution in which such families either exist in a continual state of conflict, or avoid overt conflict and for family members to habitually engage in passive expressions of aggression (Yager, 1982; Vidovic et al., 2005; Cunha et al., 2009). The collection of these prototypical family characteristics and patterns of interaction have been repeatedly hypothesised to give rise to Anorexic behaviour within developing adolescents, which have been suggested to serve some adaptive psychological or interpersonal function for the individual within the context of such family dynamics (Bruch, 1978; Minuchin et al., 1978; Maine, 1991; Korb, 1994; Fitzgerald and Lane, 2000).

The notion that AN and the bodily changes inherent to the disorder serve an adaptive interpersonal function within the family matrix is the underlying basis for many family systems approaches to AN (Minuchin et al., 1978; Lock and le Grange, 2005; Ringer and Crittenden, 2007). Indeed, Minuchin et al. (1978) originally conceptualised Anorexic behaviour and family processes as being “bound together in a self-regulating cycle that serves to minimise conflict and maintain homeostasis.” This approach therefore postulates that AN often serves functions such as facilitating family stabilisation, preserving enmeshment or diverting attention away from other sources of discord within the family by uniting them in concern for the affected individual (Lock and le Grange, 2005). It is for this reason that family therapy is a frequently used and clinically recommended treatment for children and adolescents diagnosed with AN (NICE, 2004). Such approaches emphasise the role of circularities characterised by repetitive and reciprocal patterns of interaction between family members which serve to preserve homeostasis with family functioning and dyadic interactions (Watzlawick et al., 1974). Furthermore, the concept of functionalism is also central to family system approaches in which the roles and behaviours exhibited by individuals experiencing mental health difficulties are explored for their possible adaptive function within the family or social matrix of their occurrence (Carr, 2006). From this perspective an individual’s eating disorder is viewed as serving a regulatory and functional role within the family system. Moreover, such approaches also imply that the changes within the family system brought about Anorexic symptomatology serve in some way to meet the sufferer’s otherwise ungratified emotional and interpersonal needs, thereby serving to perpetuate dysfunctional patterns of dietary restriction and weight loss (Bruch, 1978; Minuchin et al., 1978; Maine, 1991; Fitzgerald and Lane, 2000).

Despite the considerable research evidence regarding the role of family functioning in the development of AN and widespread use of family systems approaches for its treatment, there is presently a lack of research exploring the reciprocal influence that AN may have upon family functioning. Indeed the notion that the dysfunctional patterns of interaction and communication often observed in the families of individuals suffering from AN play a causative role in the development of such eating difficulties is widely adopted by researchers and clinicians in the area of

eating disorders (Lacey and Price, 2004). However the possibility that a family member presenting with AN may be influential in the development of the dysfunctional patterns of family functioning that have been repeatedly reported within the literature has not received any particular research attention. On this subject Ward et al. (2000) speculate that many of the dysfunctional characteristics and patterns of behaviour that are observed within the families of adolescents suffering from AN could be regarded as secondary to the presence of an ill family member, rather than causative of the disorder itself. Indeed, Polivy and Herman (2002) assert that due to the correlational nature of most studies exploring family functioning in AN that it is not possible to determine whether a causative relationship exists between family dysfunction and AN, or whether a common factor may contribute to both. Fitzgerald and Lane (2000) also postulate that the families of Anorexic individuals do not typically receive any particular attention until the disorder has progressed significantly, thereby making it difficult to determine whether dysfunctional family dynamics are the cause or consequence of the individual's dysfunctional patterns of eating and weight loss.

Despite the widespread use of family systems approaches in formulating and treating AN, there is presently a lack of empirical research to support the premise of such approaches, that a reciprocal relationship exists between AN and family functioning. Similarly, there is also currently a lack of research to support the notion that the behaviours and bodily changes inherent to the disorder serve an adaptive function within the sufferer's family system. Indirect support for the notion that AN has an influence upon family functioning and relationships exists in the form of research which suggests that the development of such eating difficulties often evokes intense emotional reactions within parents or caregivers in the form of feelings of guilt, shame (Highet et al., 2005; Treasure et al., 2001), helplessness, self-blame, and anxiety (Whitney et al., 2005). However the possible influence of such emotions on the patterns of behaviour and interactional dynamics within the family system have not yet been investigated. An exploration of the changes in family functioning and relationships and how such changes are perceived may provide valuable insight into some of the possible processes that may serve to perpetuate and maintain the dysfunctional patterns of dietary restriction and weight loss inherent to AN.

Within this study the notion that AN may have some influence upon patterns of interaction and communication within the family system will be explored from the perspectives of individuals suffering from AN and first degree relatives of those suffering from AN. Such an exploration from the perspectives of both individuals suffering from AN and family members may not only throw light on the possible influence of Anorexic symptomology upon family dynamics, but will also provide insight into whether any changes facilitated by such eating disturbances serve an adaptive function for the affected individual or their family as a whole.

Aims of the Study

The principle aim of this study is to explore if and how the onset of AN is perceived to influence patterns of family functioning and interactional dynamics from the perspectives of individuals suffering from AN and first degree relatives of individuals suffering from AN. The two main objectives of this study are therefore to:

1. Explore the perceptions and interpretations of individuals with AN and the family members of individuals affected by AN regarding any changes that occurred in family dynamics and relationships following the development of their own or family members' difficulties with AN.
2. Compare and contrast any differences or similarities in how individuals suffering from AN and family members perceive and interpret any changes in family dynamics that they report to have experienced.

Method

Participants

Two separate groups of participants were recruited in this study, individuals diagnosed with AN (termed 'participants with AN'), and first degree relatives of individuals diagnosed with AN, such as parents and siblings (termed 'family member participants'). For ethical reasons, specific efforts were made to ensure that the participants with AN and family member participants who took part in the study were unrelated, meaning that all participants were individually recruited and had no family

connections with one another. Inclusion criteria for both groups required that participants or the first degree relative had received a formal diagnosis of AN in the past five years. This criterion was used in order to ensure that all participants or their family members had experienced eating disorders of sufficient severity to meet ICD-10 diagnostic criteria (World Health Organisation, 1992), and therefore could be considered to suffer from AN. The requirement for participants or their family members to have not been diagnosed with AN for longer than five years was implemented in order to increase the likelihood that participants were able to accurately recall their perceptions of any changes that occurred in their family dynamics following the development of their own or family member's difficulties with AN. Any participants younger than the age of sixteen years were excluded from the study for ethical reasons, as were any potential participants who did not speak English fluently in order to ensure that sufficiently rich and detailed qualitative data would be obtained from the interview process, as well as reducing the likelihood of any communication problems occurring during interviews.

An overview of the demographic details of participants with AN is shown in Table 1, and details of family member participants are shown in Table 2. All participants in this study were female and their ages ranged from 17-41 years (mean age 23 years). All of the participants with AN were undergoing treatment at the local eating disorder service at the time of the study, one was an in-patient and the remaining three were day patients. One of the family member participants was the mother of a patient receiving treatment at the service, and the remaining three were siblings of patients diagnosed with AN who were undergoing treatment elsewhere. Two of the family member participants were non-identical twins of their family member diagnosed with AN, and the remaining one was the younger sister of a young woman diagnosed with AN.

Table 1. Descriptive Details of Participants with AN

Participant	Gender	Age	Status of Participants with AN
P1	Female	22	In-patient diagnosed with AN 4 years ago
P2	Female	20	Day patient diagnosed with AN 3 years ago
P3	Female	17	Day patient diagnosed with AN 2 years ago
P4	Female	26	Day patient diagnosed with AN 4 years ago

Table 2. Descriptive Details of Family Member Participants

Participant	Gender	Age	Relationship to Family Member Diagnosed with AN
F1	Female	20	Non-identical twin sister of out-patient diagnosed with AN 4 years ago
F2	Female	41	Mother of out-patient diagnosed with AN 1 year ago
F3	Female	20	Younger sister of out-patient diagnosed with AN 5 years ago
F4	Female	20	Non-identical twin sister of out-patient diagnosed with AN 4 years ago

Participant Recruitment Process

Participants in this study were recruited through two channels. Participants with AN were sourced from the local specialist eating disorder service in which the clinical lead of the service would provide information (Appendix 1) on the study to potential participants who met selection criteria. Those patients who were interested in taking part were encouraged to contact the chief researcher in order to seek further information on the study (Appendix 2) and potentially make arrangements regarding their participation. Family member participants were recruited via posters advertising the study (Appendix 3) placed around a large West Midlands university campus and the local eating disorder service premises. These posters provided a brief outline of the study, selection criteria for family member participants, and the contact details of the

chief researcher for anyone wanting to seek further information on the study (Appendix 1) and potentially make arrangements regarding their participation.

Ethics

The study received full NHS ethical approval from the South Birmingham Ethics Committee (see Appendix 4).

Semi-structured Interviews

The data collected within this study was sourced from semi-structured interviews based upon a predetermined schedule (Appendix 5) that focused upon the participants' perception of any changes that occurred in their family relationships in terms of patterns of communication, intimacy, amount of involvement and boundaries, power, and roles following the development of AN in one of the family members. These five specific areas of family functioning constitute the main focus of Structural approaches to family therapy (Minuchin, 1974) which aim to explore how family systems are organised in terms of roles, boundaries, hierarchies, and repeated patterns of interaction. It was due to the relevance of such concepts to the aims of this study that these five areas were used as a basis for the interview schedule. The way in which the terms of communication, intimacy, involvement and boundaries, power, and roles were defined and operationalised within this study will be outlined in the next section of the report. All of the interviews took place at the local eating disorders service and were electronically recorded. The duration varied from 31 to 73 minutes (mean 44 minutes). Before commencing the interviews all participants were required to complete and sign a consent form (Appendix 6) thereby formally confirming their understanding of the study and their willingness to participate. After completing the interview, all participants were fully debriefed and provided with information regarding the next stages of the study and how the interview data would be handled (Appendix 7).

Operationalisation and Definition of Terms

Within this study the central focus was upon the interactional dynamics within the families of individuals diagnosed with AN and how such patterns were perceived to change following the onset of the eating difficulties. In order to gain insight into how

these patterns of interaction changed over time within the participants' families the areas of communication, intimacy, involvement and boundaries, power, and roles were explored during interviews. The way in which each of these key terms were operationalised and defined within this study will now be outlined.

1. Communication

The term communication was used to describe the habitual patterns by which family members exchange information in both a verbal and non-verbal manner. More specifically participants were asked during interviews to reflect upon how openly and directly their family communicate information to one another, and discuss their perceptions and interpretations of any changes in this aspect of their family functioning following the development of their own or family member's difficulties with AN.

2. Intimacy

The term intimacy was used in this study to describe the manner and frequency by which family members expressed both verbal and behavioural affection for one another. Participants were asked to reflect upon their perception of the amount and manner in which affection was expressed within their families, and their perceptions and interpretations of any changes that occurred in this area since the onset of their own or family member's eating disorder.

3. Involvement and Boundaries

The term involvement was used to describe the amount of time family members spent with one another and perceived participation in each others' affairs. Similarly, the term boundaries was used to describe the participants' perceived sense of separation or connection with other family members. Participants were asked to reflect upon their perception of any changes in these areas since their own or family members difficulties with AN.

4. Power

The term power was used in this study to describe the amount of influence that participants and their family members were perceived to have upon the activities and

decisions made by the family as a whole. During interviews, participants were encouraged to reflect upon any changes that they perceived to occur regarding the status of themselves or family members within their family system following the onset of their own or family member's eating disorder.

5. Role

The term role was used to describe the perceived position and function that any family member served or occupied within the family as a whole, and within dyadic interactions with other family members. During interviews, participants were asked to discuss any perceived changes in this area following the development of their own or family member's difficulties with AN.

Data Analysis

The focus of this study is upon the participants' subjective perceptions and interpretations of any changes that occurred within their family dynamics and relationships following the onset of their own or family member's difficulties with AN. The use of such an epistemological standpoint necessitates the use of a research method that prioritises subjective phenomenology over positivist objectivity in its focus. Although approaches such as Grounded Theory (Corbin and Strauss, 1990) and Thematic Analysis (Braun and Clarke, 2006) were considered as potential methods for analysing the data collected within this study, Interpretative Phenomenological Analysis (IPA; Smith, 1996) was ultimately deemed to be the most appropriate. The selection of IPA was chosen because of the relativist focus upon the subjective process by which participants experience and interpret external events, rather than upon the objective qualities of events themselves (Smith, Flowers and Larkin, 2009). As a method of analysing qualitative data, IPA was therefore deemed to be well suited to the goals of this study which related to understanding the participants' subjective experiences and perceptions of any changes that occurred within their family functioning following the development of AN in one of its members.

Within this study the process by which the data was analysed was based upon the protocol proposed by Smith and Osborn (2003). Firstly the interviews were each

transcribed into a written format and read by the chief researcher in order to ensure familiarity with the data set. Secondly the interview transcripts were individually screened for participants' perspectives and interpretations of any changes that occurred in their families following one of its members developing AN. Such disclosures were coded and given basic descriptions according to their features. Thirdly, commonalities and patterns within the codes were sought out for the purpose of establishing the existence of emergent themes from the data. Appropriate and concise descriptive labels were given to the themes identified in this process in an attempt to encapsulate the common features of the codes of which they were composed. These subordinate themes were then categorised into wider superordinate themes based upon their commonalities and relationships that were judged to exist between them. Such superordinate themes were also given appropriate labels to describe the common features that united all of the subordinate themes within them. Finally the connections and interactions that appeared to exist between each of the subordinate and superordinate themes generated during the analysis process were explored and identified. In accordance with the aims of the study, the data collected from both groups of participants was coded and analysed separately, and then compared and contrasted in order to determine the presence of any differences or similarities in how the two groups experienced and perceived any changes in interactional dynamics with their families. A sample of a coded transcript is presented in Appendix 8.

In order to increase the interpretative rigour and confirmability of the analysis of the data within the study, triangulation techniques were used to provide another researcher the opportunity to independently code and analyse a selection of the interview transcripts. The initial codes and themes generated by the chief researcher were then compared and discussed with another researcher experienced in IPA in order to assess their reliability and interpretation. Following this exchange, amendments were then made to the codes and themes generated on the basis of this feedback.

Researcher Reflexivity

Smith et al. (1999) assert that the principle goal of IPA is to attempt to gain an insight into how phenomena are subjectively perceived and interpreted by those

experiencing them, whilst also acknowledging the researcher's particular perceptual standpoint and the influence this has upon their interpretation of the data. This approach therefore recognises the unavoidable influence that the researcher's beliefs, personal experiences and subjective interpretations have upon their interpretation and analysis of the qualitative data collected in interviews. The process of IPA therefore requires a high level of personal awareness and reflexivity by researchers in order to recognise their own subjective perspectives and beliefs and acknowledge the influence that these may have upon their analysis of the data.

Throughout this study the researcher was particularly mindful of his previous research experience in the area of eating disorders, coupled with a recently completed six month placement at the local eating disorder service, and how these experiences may have shaped his expectations and interpretations of the data collected. This was particularly the case for the researcher's expectations regarding the role of attachment difficulties and emotionally misattuned caregiving in the development of eating disorders. Indeed the researcher was aware that this perspective may have created an expectation of disclosures of family dysfunction from participants relating to patterns of parental criticism, over-involvement, and emotional mis-attunement. Similarly, during the course of the study the researcher was mindful of his interest in Psychodynamic and Humanistic models of psychopathology which emphasise functional connections between the signs and symptoms of psychological disorders and the gratification of emotional and interpersonal needs. Throughout the data analysis the researcher was aware that his interest in such psychological approaches may have led him to infer the presence of adaptive functional associations between the Anorexic symptomology discussed by participants and any changes that they perceived to occur within their family system after the emergence of such difficulties.

Results and Analysis

The findings of this study and their analysis will be presented in two sections, the first of which outlines the perceptions and interpretations of participants with AN regarding the influence of their difficulties with eating upon the interactional dynamics within their families. The second section outlines these same areas from the perspectives of family member participants. Each subordinate theme presented within this section will be accompanied with extracts from participant transcripts that illustrate their main features and adequately represent the themes identified within the data.

1. Perceptions of Change within the Family System by Participants with AN

Within the data collected from participants with AN, two superordinate themes relating to changes that occurred within their family dynamics were evident, ‘The Achievement of Family Unity’, and ‘Breaking Old Patterns’. Both of these superordinate themes contained several subordinate themes, as listed in Table 3.

Table 3. Perceptions of Change in Family Dynamics Reported by Participants with AN

Superordinate Themes	Subordinate Themes
‘The Achievement of Family Unity’	<ul style="list-style-type: none">- increased attention, contact and care from the family- increased family communication and openness- increased emotional expressivity within the family
‘Breaking Old Patterns’	<ul style="list-style-type: none">- changes in the mother-child dynamic- father became more involved, caring, and expressive- siblings adopted more parental roles- increased influence over family decisions- parents became more unified and had fewer conflicts

‘The Achievement of Family Unity’

The theme of ‘Achievement of Family Unity’ related to generalised changes within the family system regarding the amount and quality of communication, engagement, affection and perceived sense of connection within the family as a whole. Participants reported noticing the important and apparently successful role of AN in facilitating changes in areas of family functioning that they previously experienced as being unfulfilling and unsatisfying, particularly relating to communication, intimacy, attention, emotional expressivity and conflict. For this reason, participants described the changes in family dynamics and cohesion following the onset of their difficulties with AN as an “achievement” or “victory”, as they had precipitated useful and adaptive changes to their family functioning. Indeed participants reported perceiving their family functioning to have improved and become more unified since the onset of their difficulties with AN, often giving rise to concerns about the potential loss of this newly achieved cohesion should they experience an improvement in their difficulties with AN.

1. Increased Attention, Contact and Care from the Family

An increase in the amount of attention, contact and expressed care from family members was reported by all participants with AN within this study following the development of their eating difficulties. The increased attention and prioritisation that participants experienced following the development of their difficulties was reportedly felt to be in stark contrast to a family that was previously inattentive and preoccupied with other matters. Indeed, participants with AN reported experiencing the increased levels of involvement, attention and care from family members to be so gratifying that the prospect of it ending interfered with their perceived capacity to recover from their eating difficulties.

Extract 1 (Participant P1)

“when you do get ill, everyone does show you more attention, everyone does come and visit you. Everyone does look at you and feel really really sorry for you, and then gradually as you start getting better, less visitors come and my family relationships become more normal and we talk about normal things, and I have to look out for them as well as them looking out for me... when I get recovered I’m not going to have all the attention, I’m not going to have all the sympathy, I’m going to have to stand on my own two feet and support other people.”

2. Increased Family Communication and Openness

All participants with AN in this study reported noticing an increase in communication and openness between family members following the onset of their difficulties with eating. Participants typically reported that prior to the onset of their problems with AN, communication was highly inhibited and closed within their families. However the development of their difficulties with eating was perceived to have forced their family members to communicate more openly with one another. This change was experienced in a positive way by participants with AN as a welcomed relief to the previous patterns of inhibition and aversion towards openly discussing family issues and problems. As was the case with the previous theme, participants also expressed concerns whether such patterns of increased openness and communication within the family would maintain over time should they experience a remission in their Anorexic symptomology.

Extract 2 (Participant P1)

“I feel like there’s a bit more honesty and openness, which is something that I really really value... I feel like you are closer to someone if they’re being honest and open. I think that part of the difficulty in getting better is that, well what if I get better and that honesty and openness isn’t still there, and they end up hiding things again?”

This increased pattern of communication between family members was not exclusively focused upon the affected individual’s eating difficulties, but was often described as being a generalised increase in interest and communication between all family members.

Extract 3 (Participant P3)

“now yeah I think maybe we do talk more, not just about each other but general news debates or anything. We call each other, my parents call their parents and my siblings call my grandparents every day... Umm, so yeah we have become a lot more communicative as the time has gone on... I think me and my siblings have become a lot more like open and talkative with each other, and interested in each other’s plans than we were before.”

3. Increased Emotional Expressivity within the Family

In a related manner to the previous two themes, participants with AN also reported noticing an increase in emotional expressivity within their family following the onset of their difficulties with AN. This perceived increase in expressed emotion and affection was reportedly both verbal and behavioural in its nature, and represented a noticeable diversion from the previous family dynamic that was described as being emotionally reserved and inhibited. In some cases, such changes were interpreted by participants to have occurred as a result of conscious attempts by family members of express more affection towards one another. However, other participants reportedly felt that the increased expressions of emotion occurred because family members were unable to sustain previous patterns of inhibition. In all cases the increase in emotional expressivity was welcomed by participants and was accompanied by an increased sense of honesty and connection with their family members.

Extract 4 (Participant P4)

“I think up until me and my sister became ill we, well I always felt like I was showing too much emotion because everybody else would keep it in and not show very much... But then since we’ve been ill they’ve probably shown more emotion, I think it was less easy to keep it in.”

Such increases in emotional expressivity were typically described to manifest not only in a verbal manner but also physically, in which participants reported noticing an increase in the amount of physical affection expressed by family members. However, in all cases this increase in physical affection was reportedly directed towards the participant with AN, rather than between all family members.

Extract 5 (Participant P2)

“I think she has become, this is not in a critical way to her but if I’m being totally honest then I think she has become a lot more protective. And like, probably a bit more touchy feely affectionate as well, and when I leave in the morning, like on a Monday morning we leave really early and my dad will give me a lift back into PLACE to get here in time like for half eight, so I leave quite early, she sometimes gets a bit emotional.”

‘Breaking Old Patterns’

The theme of ‘Breaking Old Patterns’ relates to prominent changes in relationships within the family and the roles occupied by different members, or the manner in which two particular family members interact with each other. Participants reported experiencing notable changes in the ways in which they and different family members interacted with one another following the onset of their difficulties with AN. Such changes were described as being prominent alterations to previously established patterns of interaction that previously had been experienced as unsatisfying or unhelpful. Changes within this superordinate theme did not just relate to the participant’s individual relationships with specific family members, but also the dynamics between other family members. As was the case with the previously described superordinate theme, these changes were largely conceptualised by participants as being the ‘benefit’ of their eating difficulties, and with only one exception were perceived to reflect positive and adaptive changes to family functioning.

1. Changes in the Mother-child Dynamic

Three participants with AN reported experiencing changes in the dynamic between themselves and their mothers following the development of their difficulties with AN. In some cases, the dynamic between the participant and their mother was perceived to become more mature and resembled an adult to adult interaction in which participants felt that they were no longer being perceived and treated as children but rather as adults of equal status. Such changes were interpreted positively by participants with AN and served to promote an increased sense of emotional closeness between themselves and their mothers.

Extract 6 (Participant P2)

“I did notice that something did seem to have changed, but it’s hard to put your finger on. But yeah sometimes it was like she was treating me like I was another adult and like taking stock of my opinions on things, rather than just seeing them as just a child’s opinion and like not really valid... just really listening to my opinions on things and thinking about them and responding to them in the kind of way that you would in conversations with another adult friend. It did feel like that, I felt very close with her.”

In other cases, participants with AN reported experiencing the opposite change in their interpersonal dynamic with their mother in which they felt that they had regressed to a more child-like and dependent role following the development of their difficulties with AN. Such participants reported feeling that the emotional difficulties associated with their AN increased their reliance upon others, particularly their mothers and lead to an uneasy loss of autonomy and increased dependency upon them for emotional support.

Extract 7 (Participant P4)

“as soon as I became ill my role became more child-like because I needed her whereas before it was more of an adult relationship. I think that’s probably what went wrong, I reverted back to needing her like a child needs their mum. And that’s been difficult for her to cope with I think... I don’t like it really, I wish we could have an adult relationship and I didn’t need her in the way that I do.”

2. Father became more Involved, Caring, and Expressive

All of the participants with AN within this study reported experiencing noticeable changes in the dynamics of their relationships with their fathers, which prior to the onset of their difficulties with AN were characterised by emotional distance and a lack of involvement. Following the development of their difficulties with AN, participants reported perceiving a prominent and welcomed increase in involvement, attention, and emotional expressivity and care from their fathers.

Extract 8 (Participant P1)

“he tries to mask his emotions. But since I’ve come into hospital the amount of times I’ve made him cry has been quite a success... But yeah, now I do see him being far more emotional towards me and stuff”

Extract 9 (Participant P4)

“With my dad again he will give me a kiss and a hug, which he never used to do so much actually, he’s done it more now he knows I need more support I think... It’s been really nice recently actually, it’s only since I’ve confided in him about the eating problems, I never really spoke to him about it before I came in here. And he’s just been really really good.”

3. Siblings Adopted More Parental Roles

Those participants with AN who had siblings all reported noticing prominent changes within the dynamics of their relationships with them since the development of their eating difficulties. In such cases participants perceived their siblings to have adopted more caregiving and parental roles in their relationships than before the onset of their difficulties, and this was often interpreted to have been motivated by the sibling's attempt to compensate for the lack of emotional support or care from their parents. In all cases this change was positively received by participants and reportedly provided them with a gratifying and much needed sense of emotional connection with another person.

Extract 10 (Participant P4)

“Umm, my brother's definitely more affectionate, so when I was at home at Christmas and I was quite upset after Christmas dinner, umm he was really good, he just, well I just lay against him and he hugged me while I was crying. That was probably the most affectionate that he's been towards me actually, so he's definitely matured and is more affectionate now... It was really nice actually, it was really helpful. It definitely made me less upset and it was nice to know that I had somebody else who kind of understood what I was going through.”

4. Increased Influence over Family Decisions and Actions

Half of the participants with AN in this study reported experiencing a new role within their family system in which they exerted more influence over the direction taken by the family in decisions and activities than before the onset of their eating difficulties. Although the increased status and influence experienced by participants was generalised to most areas of family functioning, it was reportedly particularly prominent in relation to food, such as the selection, preparation and timing of family meals.

Extract 11 (Participant P2)

“So like I like to have more of a plan at the weekends of when we're eating and what we're having so I can plan it all out so I can get all of the my meals in that I'm supposed to be. So I'm just like no, I need to have like lunch now so we need to, we went for a walk last weekend just around the village and I was like no we really need to leave now because I need to get back to have lunch like at a reasonable time”

5. Parents became More Unified and had Fewer Conflicts

Two participants with AN in this study reported noticing that their eating difficulties had brought about a noticeable reduction in their parents' conflicts and marital difficulties. In such cases the participants' parents were reported to have become more united due to their shared desire to help facilitate their child's convalescence by reducing the amount of interpersonal conflict surrounding them. These participants reported experiencing a sense that their difficulties with AN may have served an important role in stabilising their parents' relationship and consequently increased family cohesion.

Extract 12 (Participant P2)

“I don't remember quite why it came up but I think because they'd been arguing less and my mum pointed this out to me and then like yeah... And mum has said recently that they've got on quite well, they haven't been arguing very much, because they do argue a lot... they've both put like a lot of time and energy into me and I think when they have gone through rough patches, like rougher patches or whatever, then I think I have noticed that like I think I'm a bit of a glue that keeps them together”

2. Perceptions of Change within the Family System by Family Members

Three main superordinate themes emerged from the data collected from the family member participants regarding the changes that they perceived to occur within their families following the development of AN in one of its members. The first two superordinate themes closely resembled the themes recorded with participants with AN relating to changes in family cohesion, and role and dynamic changes. However, another theme emerged from the data collected from family member participants that was not reported by participants with AN, which related to “Contaminations” in relationships and wellbeing that were introduced into the family following their relative's development of AN. An outline of these superordinate and subordinate themes are listed in Table 4. Each of these superordinate themes contained several subordinate themes, all of which will be discussed.

Table 4. Family Member Participant’s Perceptions of Change in their Family Dynamics

Superordinate Themes	Subordinate Themes
‘Necessary Cooperation’	<ul style="list-style-type: none"> - increased family communication and openness - increased emotional expressivity within the family - increased time and attention given to the unwell family member
‘Priority Changes’	<ul style="list-style-type: none"> - unwell family member gained more importance and influence within the family - siblings became a low priority and were overlooked by the family - father became more involved, caring and expressive - siblings adopted more parental roles
‘Contaminations’	<ul style="list-style-type: none"> - increased tension, stress and conflicts within the family - family disintegration, separation and isolation - sibling’s wellbeing deteriorated due to the unwell family member’s difficulties - the family felt unable to enjoy things due to the unwell individual’s suffering

‘Necessary Cooperation’

As was the case with participants with AN, the family member participants in this study reported perceiving generalised changes within the family system regarding the amount and quality of communication, engagement, affection and perceived sense of connection that was present within the family as a whole following the onset of their relative’s eating difficulties. Such participants therefore felt it necessary to increase the amount of open communication, intimacy and attention given to their affected relative in order to prevent their relative’s emotional and physical wellbeing from further deteriorating. The increase in family unity and cohesion reported by participants was therefore brought about by the increasing pressure imposed by their relative’s eating difficulties, which necessitated an increase in cooperation between previously disparate and otherwise engaged family members.

1. Increased Family Communication and Openness

All of the family member participants in this study reported noticing an increase in communication and openness within their families following the onset of their relative's difficulties with AN. This change was generally interpreted to have occurred due to the need for open exchanges of information between family members regarding the affected individual's condition, treatment and recommendations from healthcare professionals. In all cases participants reported that this increased communication and openness between family members was in stark contrast to the previous family dynamic that was characteristically lacking in communication and the sharing of information.

Extract 13 (Participant F3)

“obviously some of it's quite sad and you would like to think that my sister is back how she was before but I think bits of it have probably worked out for the better because I don't think it's a bad thing that we have to talk to each other a bit more or try and make more of an effort with everyone. Umm, and like think more about each other's feelings and stuff, I don't think that's necessarily a bad thing.”

In two cases participants reported that their relative's difficulties with AN provided them with a focus for their communications with other family members, which had previously been lacking or unclear. In such cases the topic of their relative's difficulties provided participants with a new and valid reason to communicate with other with family members.

Extract 14 (Participant F4)

“Yeah, like I'd always try and speak to my mum as much as possible like when I've got time and stuff but because of this thing, this actual problem it gave me actually something concrete to talk to her about, so it wouldn't just be like hi how's your day, we'd have a reason to be calling each other and you know, communicating.”

2. Increased Emotional Expressivity within the Family

As was the case with the participants with AN in this study, family member participants all reported noticing an increase in expressed emotion and affection within the family since the onset of their relative's difficulties with AN. In most cases this increase in affection was directed towards the family member suffering from AN, and

was purposefully intended to convey warmth and care, thereby helping to facilitate their recovery from their psychological difficulties.

Extract 15 (Participant F1)

“I think it’s become more apparent, or we’ve made it become more overt since my sister’s illness, just because we need to let her know that we are there for her... And I think recently it has become, you know, we’ll send each other texts, and I’ll e-mail my sister saying something nice, like I love you or whatever... But definitely more recently over the last two years, umm yeah, we’re better with showing signs of love or closeness, as just a way of support really, it’s all we can do”

3. Increased Time and Attention given to the Unwell Family Member

All family member participants reported perceiving an increase in the amount of time and attention given to their affected relative following the onset of their difficulties. In a similar sense to theme two above, this increased attention and was intended to provide the individual with a sense of being cared for, in the hope that this may aid their convalescence.

Extract 16 (Participant F3)

“I think yeah I was definitely more involved with my sister when she was ill I think my mum’s probably, yeah my mum’s definitely got more involved in my sister’s life and wants to try and be as involved.”

In two cases participants reported that the increased time and attention given to the unwell individual became a preoccupation for one or more of the family members, who experienced a sense that they had to be with and support their relative at all times during the time of their illness.

Extract 17 (Participant F2)

“It made me want to spend more time with her, if I was out I always wanted to get back to be with DAUGHTER. She wanted me with her all the time, I don’t know why, but every time she was eating she had to hold my hand... So it made me want to be with her more... I didn’t want to leave her.”

‘Priority Changes’

Family member participants in this study reported noticing prominent changes in the priorities held by themselves and other members of their families following the onset of their relative’s difficulties with AN. Such changes were manifest most noticeably in changes in the roles adopted by different family members. In such cases participants noted that their relative’s eating disorder necessitated a shift in the priorities of the other family members which reflected their increasing concerns regarding the affected individual’s wellbeing. As was the case with the previous superordinate theme, these changes were not experienced as being chosen but rather obligated by their relative’s progressively declining physical condition, which compelled them to make drastic alterations to their priorities in order to prevent further deterioration. These priority changes were typically reported by participants to have served some positive function for their unwell relative, but occasionally to the detriment of other family members.

1. The Unwell Family Member Gained More Importance and Influence within the Family

All of the family member participants in this study reported perceiving that their relative had become the centre of the family system since the development of their difficulties, and that their wellbeing had become the main priority for all the family members. Participants reported feeling that any decisions or actions taken by the family became influenced by their family member’s preferences and desires, and whether such actions or decisions would be beneficial for her wellbeing.

Extract 18 (Participant F1)

“My twin sister pretty much controls everything, I think because of what she's going through we don't have power over her and every decision is pretty much in favour of my sister and how that will be good or bad for her... We've completely changed in that aspect, so all of the focus and concentration is on her.”

2. Siblings Became a Low Priority and were Overlooked by the Family

As an extension to the above theme, those participants who were the siblings of individuals suffering from AN reported experiencing a sense that they became

overlooked and ‘deprioritised’ by the rest of the family since the onset of their sibling’s difficulties. In such cases, participants reported feeling that the increased focus and prioritisation given to their unwell sibling occurred to their own detriment as they became overlooked by the rest of their family.

Extract 19 (Participant F3)

“So I think me and my brother got a bit, not like forgotten but like not really, they weren’t really focusing on us that much because obviously they were trying to figure out what to do about my sister and how to help her.”

Furthermore, siblings also reported experiencing a sense of unease about expressing their feelings about the situation due to their concerns that such expressions may have served to burden or overwhelm the already-stressed other members of their family.

Extract 20 (Participant F4)

“But I know myself that I have boundaries over what I would share with them, and part of that I suppose, I know that my mum has a lot to worry about anyway with my sister so I wouldn’t want to burden her with more stuff. Like I know that a lot of her attention and worries are spent on my sister so I don’t want to kind of, unless something was really serious I just wouldn’t want to worry her with that.”

3. Father Became more Involved, Caring and Expressive

As was the case with the participants with AN, all of the family member participants reported noticing increased involvement, care and emotional expressivity between the unwell family member and their father since the onset of their difficulties with AN. This increase in involvement and expressed emotion was preceded by patterns of paternal disengagement and emotional distance and was interpreted as being highly valued and welcomed by the affected family member. Such increase in paternal attention, involvement and expressiveness was typically interpreted to have been motivated by the father’s increased concerns for his child’s overt deterioration in emotional and physical wellbeing.

Extract 21 (Participant F1)

“I think my dad doesn’t really do, or didn’t used to do the whole emotional aspect of things, I think because he didn’t really understand. So he’s learnt to show his affection and caring that my mum would usually do... So he’s taken on more of a supportive role than he did previously.”

This increased involvement, care and expressivity by fathers was not only reportedly limited to their interactions with their child suffering from AN, but extended to other family members who they also began to support during the course of their child’s illness.

Extract 22 (Participant F3)

“I think my dad probably spent more time with my sister... I think he was quite good at talking to her because at the time she was, the thing she was most worried about was missing school and so he was quite good at calming her down about that and kind of reasoning with her on that kind of thing... I think because my mum took it really hard when my sister went into hospital but my dad was there to support her through that so he kind of took on that supportive role as well.”

4. Siblings Adopted More Parental Roles

Further to theme four above, all of the family member participants in this study reported perceiving the siblings in the family to have adopted parental roles in their interactions with their relative following the onset of their difficulties with AN. This change was perceived to have been brought about by the unwell family member’s increased reliance upon others for support, which led siblings to become more parental in their manner towards them. Similarly the increased stress and conflict created within the family by the affected relative’s difficulties was also reported to motivate siblings to adopt more caregiving roles towards other family members, such as younger siblings, in an attempt to comfort and protect them.

Extract 23 (Participant F3)

“I don’t think I was ever like as parently to them until my sister was ill, but obviously then I was like trying to help her but also I didn’t want my brother to get hurt so I was trying to protect him from it in a way.”

‘Contaminations’

Within this study the theme of ‘Contaminations’ refers to those negative changes within the family and its individual members that are characterised by a deterioration in wellbeing and functioning following the onset of the family member’s difficulties with AN. Such deteriorations were typically cited by participants to be due to long-term exposure to their family member’s difficulties, and the emotional consequences of witnessing their progressive deterioration and its effects upon other family members. Participants reported noticing deteriorations in areas of family functioning that were previously perceived as working well, as well as areas that were already problematic but became exacerbated by the onset of their family member’s difficulties with AN. The enduring and highly emotive nature of such a situation was also reported by participants to have a ‘contaminating’ effect upon other family members whose emotional wellbeing was perceived to have declined due to their prolonged involvement with their unwell relative.

1. Increased Tension, Stress and Conflicts within the Family

In all cases, family member participants reported experiencing a pronounced increase in conflict and stress within their families since the onset of their relative’s difficulties with AN. This pattern of conflict was typically cited as being due to their relative’s persistent refusal to eat and the other family members’ emotional reactions to this. Indeed all of the family member participants in this study reported experiencing a sense of helplessness regarding their inability to influence their relative’s patterns of dietary restriction and weight loss. This sense of helplessness reportedly led to numerous and repeated conflicts within the family, and contributed to a generally tense atmosphere.

Extract 24 (Participant F2)

“I think tensions have just run really high, I was on the edge because you’re just watching them starve, there’s nothing you can do. You can’t make them eat... It was not a happy household, you could feel it. And people stopped coming around because you could feel it.”

In some cases, the sense of helplessness and tension created by the individual’s persistent patterns of dietary restriction and weight loss reportedly led family members

to blame one another for their relative's difficulties, thereby escalating the amount of conflict within the household. In all cases this atmosphere of tension, conflict and blame became so unpleasant that participants reported experiencing a sense of relief when their unwell family member was eventually hospitalised and removed from the family home, as this was perceived to provide them with a sense of separation and respite from the immediacy of their relative's extremely distressing illness.

Extract 25 (Participant F3)

“But then obviously by like blaming it on everyone then everyone just started being like oh you did this and you did this and it just kind of broke down... But there was definitely like a really conflict at one point where it was like just trying to pick fault with what everyone had done wrong and that kind of thing... So there was kind of quite a lot of tension because there was always like shouting and arguments and everything, and everyone was like always on edge and always upset... I think when she went into hospital it was quite like, as horrible as it was it was a relief that she wasn't in the house to kind of like create all of the immediate drama.”

2. Family Disintegration, Separation and Isolation

Related to the previously described theme, family member participants in this study reported perceiving an increased sense of separation and distance between family members as a result of their relative's difficulties with AN. Increased conflict and tension created by the presence of their relative's difficulties with AN was interpreted to give rise to a generalised pattern of disintegration and separation within the family system in which family members began to avoid contact and spending time with one another.

Extract 26 (Participant F1)

“Yeah, I don't think we spend time at all with each other. My older sister has now moved away and I am at uni. When I was at home no one really comes together, for like eating, it's incredibly hard because before her eating disorder we all sat down and it was all like a family time I guess, where everyone could come together. But no, that doesn't happen any more.”

Siblings of family members suffering from AN reported eventually engaging in a deliberate separation from their family and unwell sibling for the purpose of self-protection, due to the intense emotional burden due to previous intense involvement in

the situation. In such cases participants reported experiencing a sense that their previous efforts to help support their affected sibling were not only not effective at bringing about any positive change in their condition, but also that their high levels of contact and involvement with them had adversely affected their own emotional wellbeing. As a result of this, such participants reportedly made the decision to distance themselves from their affected relative due to the perceived sense that their involvement was not advantageous for their relative or themselves.

Extract 27 (Participant F3)

“I’ve got to a stage where I’m like I need to have my own life and not being involved in it because I was completely miserable when I was so involved. And like I had a gap year after I finished my A-levels because I was just at the point where I couldn’t do stress anymore and couldn’t really cope with it... but since I’ve been at university I just don’t, not like want to be involved but kind of want to have my own life and be quite separate... So I don’t really have that much contact with my family when I’m here because I just kind of choose to have a bit of time out and separate myself from it, which I think works better”

3. Siblings’ Wellbeing Deteriorated due to the Unwell Family Member’s Difficulties

All of the family member participants in this study reported noticing that the onset of their relative’s difficulties with AN led to a progressive deterioration in emotional wellbeing amongst the affected individual’s siblings. Participants reported perceiving that long-term exposure to their family member’s ongoing and unremitting difficulties with AN took a heavy emotional toll on siblings. Indeed the process of witnessing the gradual emaciation, social isolation and eventual hospitalisation of their unwell family member was reported to induce intense feelings of helplessness, despair and responsibility in siblings. Similarly, witnessing the effect that their relative’s eating disorder was having upon other family members’ wellbeing also contributed to siblings’ emotional distress and suffering.

Extract 28 (Participant F1)

“I’ve been completely silent about really what’s going on or how I feel about the situation to try and make things a bit better for everyone when I am home so, yeah. I think it’s better for my parents, probably not so good for me, because it hurts me to be in that situation, seeing my parents like that, for my sister to be so ill, so yeah... Yeah that’s kind of got a bit too much for me I guess over the years, and I think its built up quite recently, and over the summer I was diagnosed with depression, so I think its had quite a major impact on me because I don’t feel like I’ve been able to really cope as such with the situation”

In some cases participants reported noticing their family member’s distorted bodily perception and dietary restriction were gradually adopted and exhibited by younger siblings. In such cases participants perceived their unwell family member to have modelled dysfunctional patterns of eating and a preoccupation with body weight which younger siblings subsequently internalised and began to imitate.

Extract 29 (Participant F4)

“it’s influenced my brother because he’s very conscious about what he eats and other people in the family have noticed... you wouldn’t think that a teenage boy would turn down junk food like chocolate but he is very conscious about what he eats, so that’s definitely influenced him because he didn’t care before... he wouldn’t have been so aware of body image I don’t think if it wasn’t for hearing her, like she is constantly going on about it and saying like do I look fat and all this, so he hears that and that has obviously influenced him to think oh do I need to be worrying about this, should I be watching what I’m eating and stuff.”

4. The Family Felt Unable to Enjoy Activities due to their Relative’s Suffering

All of the family member participants in this study reported experiencing a sense that their relative’s difficulties with AN created an atmosphere within the family that interfered with their ability to enjoy themselves or engage in pleasurable activities. Participants described a tendency for themselves and family members to feel guilty for enjoying themselves whilst their relative was suffering from their difficulties with AN, leading to a progressive reduction in such family activities over time.

Extract 30 (Participant F3)

“when she was in hospital we never wanted to go out and do anything together because it was like you couldn’t really go out without her because it was like mean, because she was in hospital and she couldn’t do anything about it.”

This was typically accompanied by a perceived sense that the family as a whole had become contaminated with AN, and that all of its members were suffering from its effects. Indeed participants reported experiencing a sense that, as their family member’s difficulties with AN progressed over time, the eating disorder became an entity or additional family member that was the main focus and priority within the family.

Extract 31 (Participant F1)

“I guess Anorexia has completely taken over so in that sense we are all kind of living with it, completely and utterly, so it’s a bit of a struggle... I think her Anorexia has literally taken over all of our lives.”

Discussion

Within this study the perceptions and interpretations of both participants with AN and first degree family members of individuals diagnosed with AN of any changes that occurred in family dynamics and relationships following the onset of such difficulties were explored. The purpose of this investigation was to examine the possibility that a circular pattern of reciprocal interaction between Anorexic symptomology and family functioning may exist. Similarly, the manner in which both individuals suffering from AN and family members perceived and interpreted any changes in family dynamics following the onset of such eating difficulties were also compared in order to investigate the notion that Anorexic symptomology may serve some adaptive function for the sufferer or their family as a whole. The findings of this study and their relevance to these two specific areas will now be discussed.

The Reciprocal Patterns of Influence between AN and Family Functioning

The findings of this study provide strong support for the existence of a reciprocal dynamic between AN and family functioning, as changes in patterns of family functioning and relationship dynamics were repeatedly described following the

onset of AN by all participants within this study. In many cases these changes were necessitated by the onset of the family member's illness and were interpreted to represent the family's adaptive response to its onset. Indeed many participants reported noticing prominent changes in areas of family functioning and dynamics that were previously perceived as problematic and inhibited such as emotional expression, affection, communication and involvement between family members. These findings contrast with models that emphasise linear pattern of causality between pre-existing dysfunctional family characteristics and patterns of functioning, and the development of AN (e.g. Selvini-Palazzoli, 1974). Indeed, the findings of this study suggest the presence of a more circular pattern of causality in which family dynamics and Anorexic symptomology interact in a reciprocal manner similar to that proposed by Minuchin et al. (1978).

Within this study, participants with AN and family member participants both reported noticing prominent changes in areas of family functioning relating to the amount of attention, involvement, care and support given to the affected individual, coupled with their increased prioritisation and status within the family system. Similarly, areas such as communication, expressions of emotion, affection and conflict within the family were also repeatedly reported to have prominently changed by all participants. Interestingly, the areas of change in family functioning reported by participants were frequently areas that they previously perceived to be problematic or inhibited prior to the onset of AN. Such findings provide support for the perspective that the patterns of behaviour and bodily changes associated with Anorexic pathologies serve adaptive systemic functions within the sufferer's family environment, particularly facilitating stabilisation and preserving enmeshment (Minuchin et al., 1978; Lock and Le Grange, 2005; Ringer and Crittenden, 2007). Indeed, amongst other changes, a decrease in the amount of conflict between parents and increased levels of involvement by family members were repeatedly reported by participants. The findings of this study therefore provide support for the perspective that AN can serve an adaptive interpersonal function within the family system, particularly by facilitating increased family cohesion, communication, contact and involvement, and emotional expression. However the onset of AN was not exclusively perceived to lead to positive changes, but

was reported to lead to the development of numerous pronounced negative changes within family functioning and interactional dynamics. A more detailed discussion of these and their relevance to the aims of this study will be outlined within the next section of the discussion.

One specific area that was repeatedly raised by participants with AN and family member participants in this study was the perceived increase in involvement from the affected individual's father following the onset of their difficulties with AN. In such cases participants reported noticing that the previously uninvolved and emotionally distant father became more involved, expressive and affectionate towards their unwell daughter. Participants perceived this change as motivated by the father's increased concerns for the overtly visible deterioration in his child's emotional and physical health. These findings provide support for the theory proposed by Maine (1991) relating to the concept of "father hunger" in eating disorders which asserts that patterns of Anorexic symptomology may represent unconscious efforts to evoke increased amounts of emotional and physical involvement from previously distant and uninvolved fathers. Maine asserts that the increased attention and involvement from such fathers may potentially serve to perpetuate patterns of dietary restriction and weight loss.

Differences between the Changes in Family Functioning Perceived by Participants with AN and Family Member Participants

Within this study the views of participants with AN and family member participants regarding the changes that occurred in family functioning and dynamics following the onset of AN in one of its members displayed striking similarities. The overlap between the two groups suggests commonality regarding the way in which the changes that occur in the family system following the development of AN are perceived and interpreted. The notable exception to this is the theme of 'Contaminations' that describes perceived deteriorations in family functioning and the emotional wellbeing of its members, which was only reported by family member participants. Indeed, the experiences of change within the family system reported by participants with AN were generally characterised by gain due to the perception that such changes occurred in areas that were previously experienced as lacking or ungratifying. This was in contrast

to the changes that were experienced by family members who reported experiencing changes characterised by loss and deterioration in areas that were either previously perceived as functioning well, or were already problematic but became exacerbated by the onset of their family member's difficulties with AN.

Both participants with AN and family member participants reported perceiving changes in family functioning that benefited the affected individual such as increased attention, involvement, support, prioritisation and status within the family system. However, many of these changes were reported to have occurred at the expense of other family members, as indicated by the theme of 'Contaminations' reported by family member participants. Themes relating to the gradual deterioration in other family members' emotional wellbeing, a progressive withdrawal from and reluctance by family members to engage in enjoyable activities, increased family disintegration and separation, and increased family conflict and stress were repeatedly and exclusively raised by family member participants. This discrepancy suggests that the changes in family dynamics facilitated by Anorexic symptomology are mainly experienced as positive and adaptive by individuals suffering from AN rather than by the family as a whole. These findings provide support for the perspective that the behaviours associated with AN can serve adaptive psychological or interpersonal functions for the individual within the context of their surrounding family dynamics (e.g. Bruch, 1978; Maine, 1991; Fitzgerald and Lane, 2000), rather than for the family in general (e.g. Minuchin et al., 1978; Lock and le Grange, 2005; Ringer and Crittenden, 2007). It is possible that such difficulties may become more pronounced at the later stages of Anorexic presentations after the main positive changes in family dynamics have subsided and the family members' ability and motivation to cope with the enduring and highly distressing nature of their relative's difficulties with AN has begun to reduce. This may potentially create a perpetuating situation of deterioration in family functioning and Anorexic symptomology and lead to the progressive deterioration in emotional wellbeing and weight loss that is characteristic of chronic Anorexic presentations (Strober, Freeman and Morrell, 1997).

Amongst the family member participants there was a noticeable difference regarding the way in which changes in family functioning were reported and interpreted by the three participants who were siblings of individuals suffering from AN in contrast to the one participant who was the mother of a young woman diagnosed with AN. Participants who were siblings of affected individuals typically attributed responsibility for their family member's eating difficulties towards the family system in general, and repeatedly implied on-going problems relating to areas such as communication, affection and conflict in their development. In contrast, the one participant who was a mother of a young woman suffering from AN was notable by her description of her parenting and family's functioning as being normal and lacking problems before the onset of her daughter's eating difficulties. This difference may potentially be explained by the perceived sense of responsibility and guilt often held by the parents of individuals who develop AN (Highet et al., 2005; Whitney et al., 2005) that often develop as a result of the widely held beliefs relating to the role of dysfunctional parenting in the development of eating disorders (Bruch, 1978; Brumberg, 1988; Rabinor, 1993). It is therefore possible that this participant's apparently normalising description of her parenting style, competence and the family dynamics may have been a product of her desire to defensively minimise her perceived role in the development of her daughter's eating difficulties.

Limitations of the Study

The principal limitation of this study relates to the generalisability of the findings due to the nature of the sample of participants who took part. The relatively low sample size used in this study arose as a result of ongoing difficulties with participant recruitment that was hypothesised to be a cumulative product of the general reluctance of individuals suffering from AN to participate in research and the specific nature and focus of the study. The difficulties associated with the recruitment of participants drawn from eating disordered population have been well documented within the literature on the subject (Norris et al., 2007). Similarly, the difficulties experienced with participant recruitment was also considered to be associated with the specific focus of the study relating to family functioning, which is an area that has been repeatedly identified to be of particularly difficulty and sensitivity for individuals

suffering from eating disorders (Lyke and Matsen, 2013). The sample of participants who did take part in the study are all female, with a narrow age range which with the exception of one participant, was between 17-26 years. This lack of diversity was particularly prominent amongst the group of family member participants who were comprised of three 20 year old siblings of individuals diagnosed with AN and one 41 year old mother of a young woman suffering from AN. Also, there were no male participants included in this study. The notable homogeneity of the sample of participants who took part in this study consequently restricted the richness and diversity in the perspectives of how the development of AN influences family dynamics. This was particularly the case for the parents of individuals diagnosed with AN whose perceptions of change were notably underrepresented in the current study.

Clinical Implications of the Study

The findings of this study have several important (although as yet tentative) clinical implications relating to the role of family processes in the prognosis and psychological treatment of AN. The notion that AN has an important and progressive influence upon interactional dynamics within the family system suggests that such changes may have an important role in perpetuating and even escalating eating difficulties. This is particularly the case when changes occur that improve previously problematic areas of family functioning such as communication, expressions of intimacy, and amounts of involvement between family members. The findings of this study suggest that interventions aimed at addressing the changes in family dynamics and functioning following the onset of AN in one of its members may be of value, particularly in cases of treatment-resistant and enduring cases of AN. The findings of this study also highlight the importance of providing family members with support during the course of their relative's difficulties with AN due to the deterioration in emotional wellbeing repeatedly reported by the family members of individuals suffering from AN. This pronounced deterioration in family member wellbeing has also been noted in previous research (e.g. De La Rie, 2005; Martin et al., 2011; Treasure et al., 2001), and suggests that psychological interventions aimed at supporting the family members of individuals suffering from AN may not only protect or enhance their emotional wellbeing but may also ensure that they remain able to support their relative

in their difficulties with AN, thereby potentially influencing the prognosis of their eating disorder.

Directions for Future Research

Future research in this area could explore the course of the changes that occur in family dynamics following the onset of AN in one of its members in more detail. Such an investigation could examine the possibility that positive changes in family dynamics such as increased attention, communication, emotional expressivity and prioritisation of the unwell family member may occur at the early stages of Anorexic presentations, thereby reinforcing patterns of dietary restriction and weight loss. Similarly, the possibility that more negative changes may develop within family dynamics during the later stages of the illness could also be explored, as such a pattern of deterioration in family support could potentially provide some insight into the interpersonal processes that serve to prolong the course and chronicity of AN.

Conclusions

Within this study the changes that were perceived to occur in family dynamics and relationships following the onset of AN in one of its members were explored from the perspectives of individuals diagnosed with AN and their family members. The findings provide support for the family systems perspective that a reciprocally influential pattern of interaction occurs between Anorexic symptomology and family functioning. Similarly, the notion that Anorexic symptomology facilitates changes in family functioning that serve some adaptive function for the individual suffering from AN was also supported. The onset of AN was perceived by all participants to facilitate prominent changes in patterns of interaction and communication within the surrounding family environment, although such changes were typically perceived as being more advantageous for individuals suffering from AN than their family members. The presence of such a reciprocally influential dynamic between Anorexic symptomology and family functioning suggests that changes in any one of these areas may have an important influence upon the other. Similarly, the notion that Anorexic symptomology may serve to facilitate adaptive changes within the family system and consequently gratify the sufferer's previously unmet emotional and interpersonal needs also has

important implications regarding the processes that may perpetuate dysfunctional patterns of dietary restriction and subsequent weight loss.

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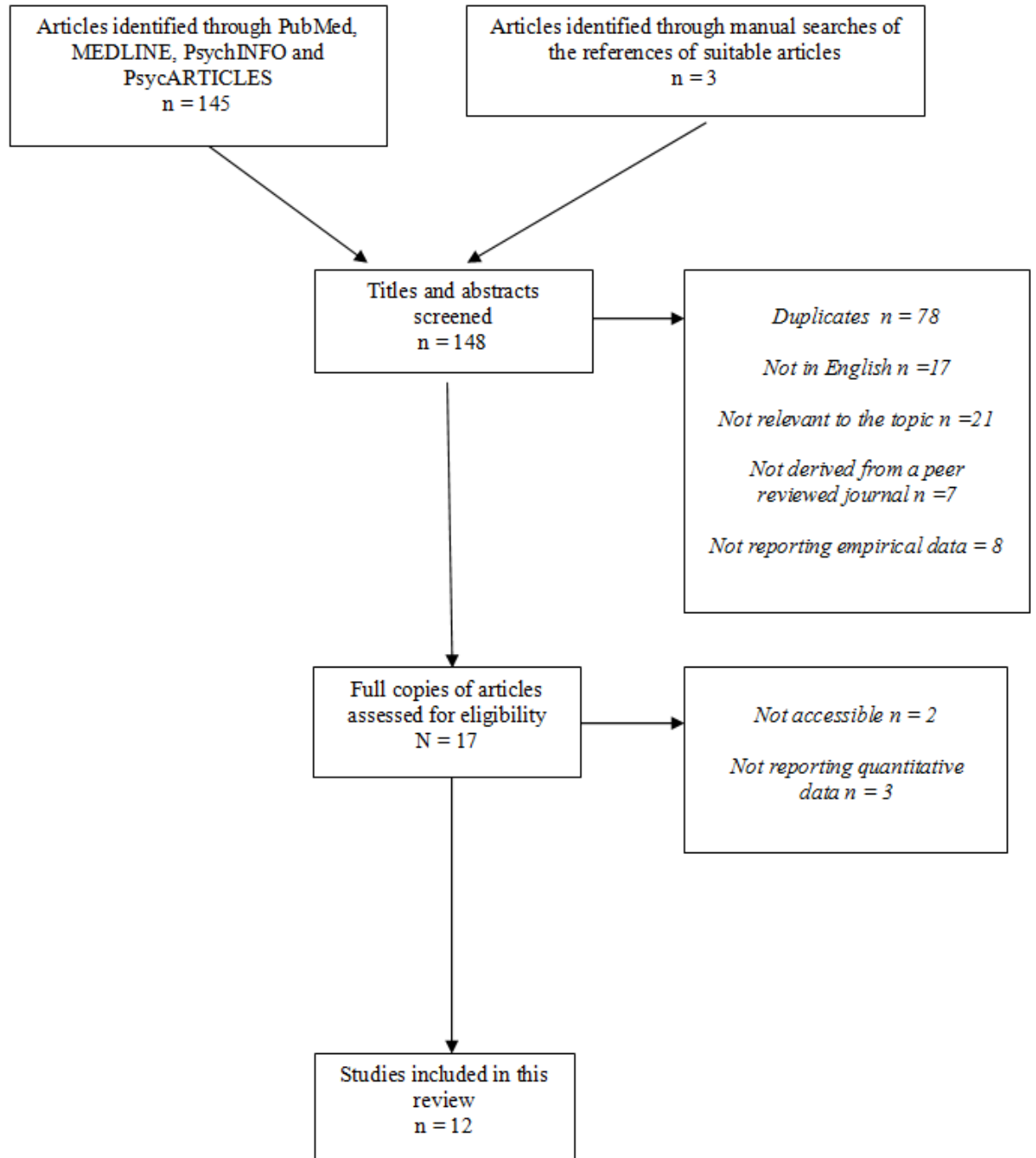
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Literature Review Appendices

Appendix 1 - Flowchart of Article Selection Process



Empirical Paper Appendices

Appendix 1 - Basic Participant Information Sheet

The Influence of Anorexia upon Family Relationships

My name is Peter Bandalli, I am a trainee Clinical Psychologist at the University of Birmingham researching the area of eating disorders. I am currently doing a study which aims to look at the effect of Anorexia upon family relationships. I am interested in talking to individuals who have had personal experience of Anorexia as well as their family members, particularly first degree relatives such as the parents, siblings or children of individuals who suffer from Anorexia.

If you agree to take part in this study, you will be asked to participate in an interview where we will discuss the details of your, or your loved one's eating disorder, and the effect that it has had upon your family and their relationships. This interview will last for around 1 hour. If you choose to take part in this study you can be assured that anything which we talk about will be treated in an extremely sympathetic, non-judgemental and understanding way. The wellbeing of the people who take part in my research is my highest priority.

If you decide to take part in my study your details will remain completely anonymous, all personal information relating to your identity and the identity of others mentioned during the course of your interview will be kept completely confidential. Some pieces of the interview may be used in the write-up and publication of the study, but all names and personal information will be made anonymous. After taking part in the study you will also have the chance to see your interview transcript and highlight any sections which you prefer to be removed before it is used in the study.

If you are interested in taking part in this study or would like more information then please contact me at E-mail address below.

Please take a moment to consider if you would like to participate in this study, as any input you can provide would be greatly appreciated.

Thanks for your time.

Appendix 2 - Detailed Participant Information Sheet

Research Study Exploring the Effect of Anorexia upon Family Relationships

Thank you for your interest in my research study looking at the effect of Anorexia upon family relationships. This information sheet contains the details of exactly what the study is about and what is involved to help you decide whether you would like to take part.

What is the purpose of the study?

In this study I am interested in talking to individuals who have had personal experience of Anorexia, and exploring if and how it may have influenced the way in which their family members interact and communicate with one another. The aim of the study is to provide some understanding about if Anorexia influences family relationships, and if so then in what way. This information will increase the current understanding of eating disorders, and the life areas affected by them.

What will happen if I take part in the study?

This study involves taking part in an interview where we will discuss the details of your eating disorder, and the influence that it may have had upon your family and their relationships over time. This interview will last for around 1 hour, and will be tape recorded. During the interview you do not have to answer any questions that you are not comfortable with, and you are free to withdraw from the study at any time you wish. Everything that we discuss during the interview will be treated in an understanding and non-judgemental way.

The types of things that we will be discussing in the interview are:

- Your family and their relationships.
- If and how your difficulties with Anorexia have influenced your family in any way.
- Any changes that have happened in your family over time since the development of your difficulties with Anorexia.

Where will the interview take place?

The interview will take place at the XXXXX

Will my information be kept confidential?

Yes. If you decide to take part in this study, your personal details will remain completely anonymous, and all information relating to your identity and the identity of others mentioned during the interview will be kept completely confidential. The tape recording of your interview will be written up into a paper transcript, and will only be available to yourself and the researchers involved in the study. Some pieces of the interview may be used in the write-up and publication of the study, but all names and personal information will be made anonymous.

What happens after I take part in the study?

After taking part in the study I will give you with a copy of your interview transcript so that you have the opportunity to look at it and highlight any parts which you prefer to be removed before it is used in the study. If after you have looked at your interview transcript you decide that you would prefer for it not to be used in my study, then I will give you the tape recording and transcript of our interview and not use it in the study.

The results from this study will be written up and submitted to the XXXXXXXXXX as part of the lead researcher's Doctorate in Clinical Psychology, and may also be published in academic journals.

Taking part in this study is entirely voluntary, and your decision whether or not to take part will absolutely have no effect upon your current or future treatment.

If you are interested in taking part in this study then please complete the reply slip on the next page and provide me with your contact details so that we can arrange a convenient time and date for us to meet perform our interview.

Similarly, if you would like more information or to discuss any issues with me before agreeing to take part in the study then please complete the reply slip on the next page

and provide me with your contact details so that I can answer your questions about the study and whether you would like to take part.

Thanks for your time.

For further information on any aspect of this study please contact: XXXXXXXX

Reply Slip

Name: _____

Please contact me by (please tick as appropriate):

Telephone - my number is _____

E-mail - my e-mail address is _____

Please tick as appropriate:

I am interested in taking part in the study, please contact me and arrange a time to meet

I would like more information on this study, please contact me (I understand that by ticking this box I am not agreeing to take part in the study)

Appendix 3 - Participant Recruitment Poster

Anorexia Research

Research study exploring the effect of Anorexia upon family functioning and relationships

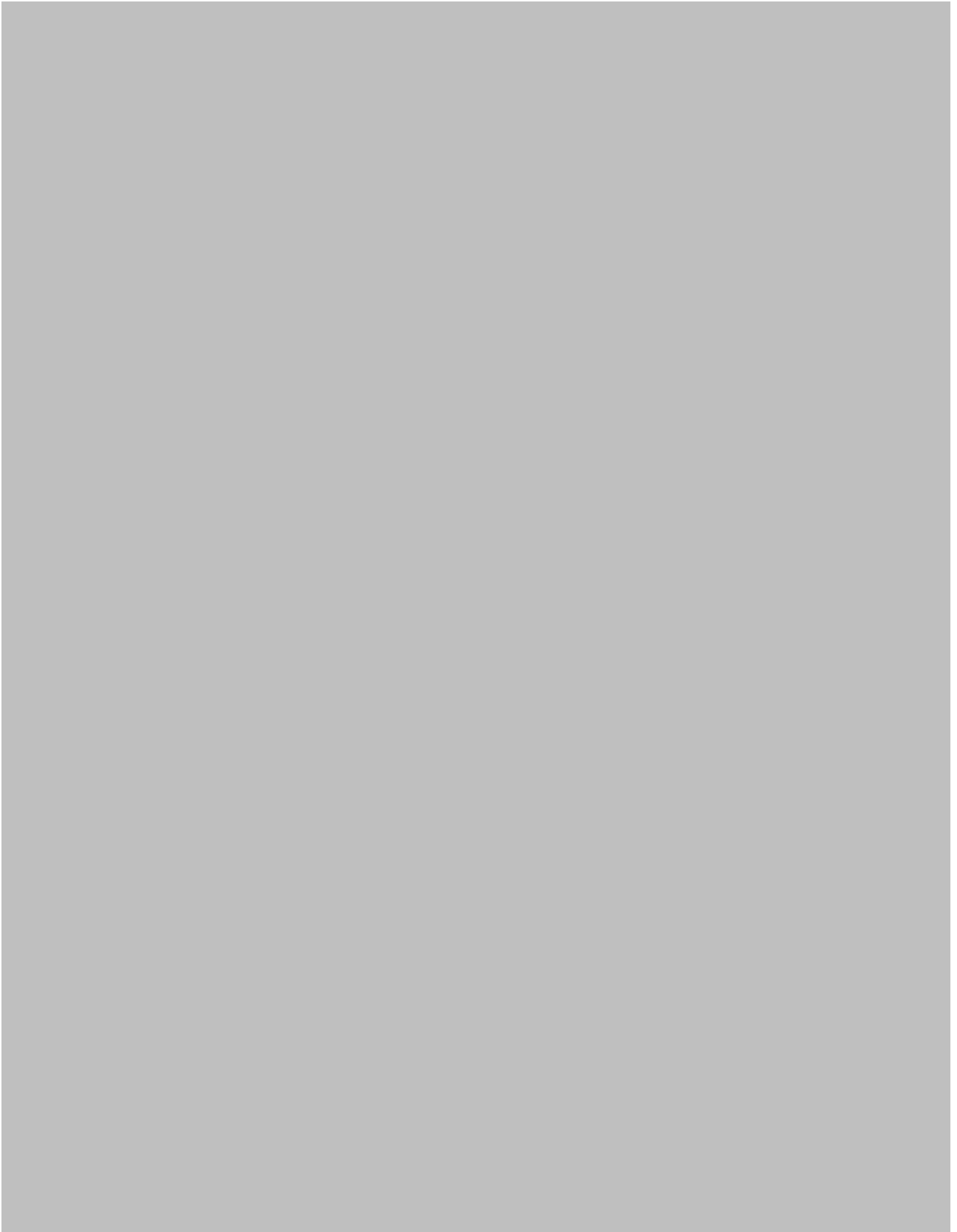
This study is aimed at those individuals who have had experience of a first degree family member (e.g. a parent, sibling or child) who suffers from Anorexia.

Participants will be asked to take part in an interview to discuss if and how Anorexia has influenced the relationships between their family members.

Interviews will take place at the [REDACTED] [REDACTED] at the [REDACTED]. The interviews will last for around 1 hour, and will be tape recorded. During the interview you do not have to answer any questions that you are not comfortable with.

If you are interested in taking part in this study or would like to know more then please contact [REDACTED] at [REDACTED]

Appendix 4 - NHS Ethical Approval Confirmation



Appendix 5 - Interview Schedule

1. An overview of the Participant's family functioning in general

- "Tell me a bit about your family and the people in it."
- "Tell me a bit about how your family members get on."
- "How did your family get on before you started experiencing problems with eating/your family member started experiencing problems with eating?"
- "Do you think that your/your family member's difficulties with Anorexia have had an effect upon the way that your family behaves with each other, and if so, how?"
- "If so then why do you think that this change happened?"

2. The influence of Anorexia upon patterns of communication between family members

- "Tell me a bit about the way that your family members communicate with each other."
- "When one of you have something on your mind in your family, do they let the other family members know about it? If so how? Is this different for different family members?"
- "Was it always this way in your family?"
- "Do you think that the way that your family members communicate has changed since you/your family member started having problems with Anorexia?"
- "If so then how has this changed, and why do you think this change happened?"

3. The influence of Anorexia upon the amount of contact between family members

- "How much time do your family members spend with each other?"
- "Was it always this way?"
- "Since you started having problems with eating, have you noticed any changes in the amount of time that your family members spend with each other?"
- "If so then how has this changed, and why do you think this change happened?"

4. The influence of Anorexia upon the amount and expression of intimacy between family members

- "Tell me a bit about who is closest to whom in your family."
- "How do your family members express their feelings towards one another?"

- “Have things always been this way?”
- “Do you think that this has changed since you/your family member started having problems with Anorexia?”
- “If so then how has this changed, and why do you think this change happened?”

5. The influence of Anorexia upon interactional dynamics between family members

Power

- “Tell me a bit about who makes the decisions in your family?”
- “Was that always the way?”
- “Has that changed since you/your family member started having problems with Anorexia?”
- “If so then how has this changed, and why do you think this change happened?”

Roles

- “In your family do you find that each family member has a specific role in terms of who does what?”
- “If so then what are your family member’s particular roles in your family?”
- “Was it always this way?”
- “Has that changed since you/your family member started having problems with Anorexia?”
- “If so then how has this changed, and why do you think this change happened?”

Boundaries

- “How much involvement do your family members have with eachothers lives?”
- “Was it always this way?”
- “Has that changed since you/your family member started having problems with Anorexia?”
- “If so then how has this changed, and why do you think this change happened?”

Appendix 6 - Participant Consent Form

CONSENT FORM

Research site

Study Number:

Participant Identification Number:.....

CONSENT FORM

Title of Project: A Phenomenological Exploration of the Influence of Anorexia Nervosa upon the Interactional Dynamics within the Family System

Researcher:

Please tick box

1. I confirm that I have understood the information sheet dated for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time during the research interview, without giving any reason, without my own or my loved one's medical/social care or legal rights being affected.
3. I understand that the research interview will be audio-recorded
4. I understand that following the research interview I will have a two-week period for reflection. The researcher will then contact me at which point I may withdraw my interview entirely or in part, without giving any reason, without my own or my loved one's medical/social care or legal rights being affected.
5. I understand that the data collected during this study will be looked at by the researcher and relevant others at the University of Birmingham to ensure that the analysis is a fair and reasonable representation of the data. Parts of the data may also be made available to the NHS team responsible for me or my family member's care but only if any previously undisclosed issues of risk to me or my family member's safety should be disclosed.
6. I understand that direct quotes from my interview may be published in any write-up of the data, but that my name will not be attributed to any such quotes and that I will not be identifiable by my comments.
7. I agree to take part in the above study.
8. I would like to receive a summary of the findings of the study when it has been completed.

.....
Name of participant

.....
Date

.....
Signature

.....
Name of researcher

.....
Date

.....
Signature

Appendix 7 - Participant Debriefing Information

Debriefing Information

Thank you for taking part in the study, your help is greatly appreciated! I am extremely grateful for your time and effort in helping me with this research study.

Now that the interview has been completed the tape recording will be transcribed onto paper, and E-mailed to you so that you can have a look at and check to see if you are happy for me to use it in this research study.

I will contact you via e-mail within the next four weeks with an electronic copy of your interview transcript so that you have the chance have a look at it and potentially highlight any sections that you would like to be removed before it is used in the study. Similarly, I will also give you the opportunity to ask any questions that you may have relating to the study and our interview.

As was mentioned at the beginning of the study, all of your personal details will be kept confidential, and none of your information relating to your identity and the identity of others mentioned during the interview will be used in the study. Some pieces of the interview may be used in the write-up and publication of the study, but all names and personal information will be made anonymous.

Below are my contact details if you would like to contact me at any point about the study or any issues related to it.

XXXXXXXXXXXXXXXXXXXXXXXXXXXX

If you would like to speak with someone involved with the study other than myself about any issues raised during the course of this study then please feel free to contact the clinical supervisor of this research study XXXXXXXX, whose contact details are below:

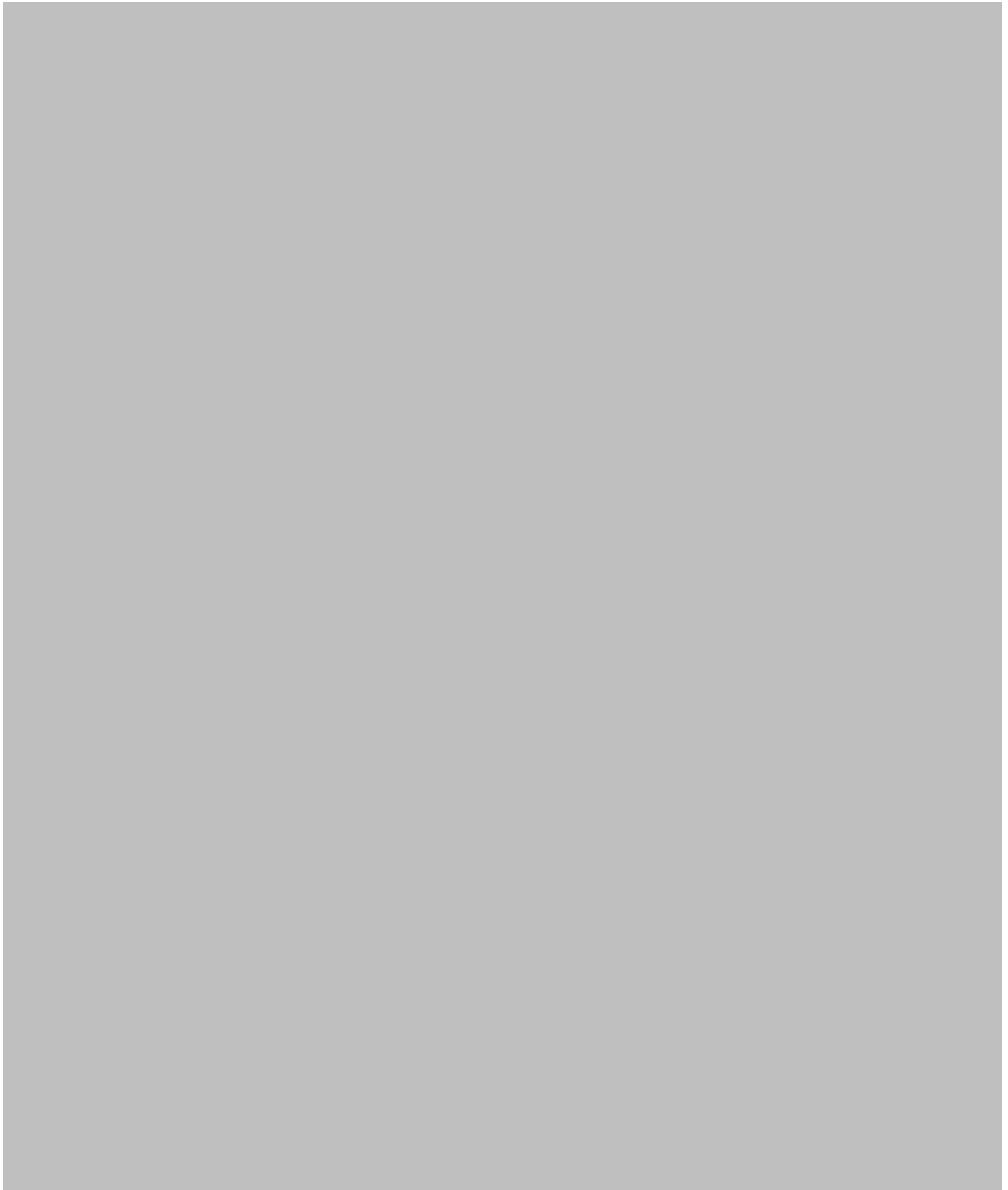
XXXXXXXXXXXXXXXXXXXXXXXXXXXX

If you would like to speak with someone not involved with this study about any issues about your experiences with Anorexia, I have included an information sheet which contains the details of several organisations who provide support and information for individuals affected by eating disorders.

Thanks again for taking part in the study, I will be in contact with you in the next few weeks.

XXXXXXXXXXXXXXXXXXXXXXXXXXXX

Appendix 8 - Sample Sections of Interview Transcripts





Appendix 9 - Public Domain Briefing Document

Literature Review

The role of fathers in the development of eating disorders is an under-researched area, as the current literature on the subject is sparse, largely theoretical and only loosely based upon the empirical evidence. The aim of this literature review was to systematically review the current empirical research regarding the fathers of individuals who suffer from eating disorders, and their possible role in the development, maintenance and amelioration of such difficulties. The databases PsychINFO, PubMed, MEDLINE, and PsycArticles were screened for studies reporting quantitative empirical data on the role of fathers in the development and maintenance of eating disorders. The methodological quality of the selected studies was evaluated using a checklist of critical appraisal criteria derived from the systems proposed by Downs and Black (1998) and Sale and Brazil (2004). Twelve studies met the selection criteria and were included in the review, and revealed five main themes that related to uninvolved, distant or rejecting fathering; highly controlling fathering which is lacking in care; a lack of assertive communication and conflict resolution with fathers; paternal dissatisfaction with his own weight; and the father-daughter relationship as a product of the parents' relationship.

The findings of the review suggest that a variety of different fathering styles may contribute to the development and maintenance of eating disorders, many of which closely resemble the dysfunctional patterns of maternal parenting which have been repeatedly implicated as being influential to the development of eating disorders. This consequently suggests that patterns of highly controlling, critical, enmeshed, and inconsistent parenting which involve frequent expressions of bodily dissatisfaction may increase susceptibility to the development of eating disorder pathology in children regardless of the gender of the parent exhibiting such behaviours. The notable lack of empirical research in the area clearly illustrates the need for further exploration of the role of fathers in the development of eating disorders, as well as a wider recognition of the importance of paternal relationships in the development of such dysfunctional patterns of eating.

Empirical Paper

Background

Within this study the changes that were perceived to occur in family dynamics and relationships following the onset of Anorexia Nervosa (AN) in one of its members were explored from the perspectives of Anorexic individuals and family members. The aim of this study was to explore if and how the onset of AN is perceived to influence patterns of family functioning and interactional dynamics from the perspectives of individuals suffering from AN and first degree relatives of individuals suffering from AN.

Method

Semi structured interviews were used to collect data from eight participants, half of whom had been diagnosed with Anorexia and the other half were first degree relatives of individuals diagnosed with Anorexia. All participants in this study were female and their ages ranged from 17-41 years (mean age 23 years). The data collected was analysed using Interpretative Phenomenological Analysis (IPA).

Results

The findings of this study revealed that numerous changes in family dynamics and functioning were perceived to have occurred following the development of Anorexia in one of its members. Such changes particularly related to areas of family functioning such as family cohesion, role and dynamic changes, and “Contaminations” and deteriorations. Although the themes relevant to perceived changes reported by both groups of participants were highly similar, Anorexic participants reported experiencing more positive changes in family functioning than family member participants, who described experiencing more negative changes and deteriorations in wellbeing.

Conclusions

The findings of this study not only support the existence of a pattern of reciprocal influence between Anorexic symptomology and family functioning, but also suggest that the changes in interactional dynamics brought about by such difficulties are

often perceived as adaptive. However such changes in family functioning appear to principally benefit the Anorexic individual, often at the expense of the wellbeing of other family members. The presence of such a reciprocally influential dynamic between Anorexic symptomology and family functioning suggests that changes in any one of these areas may have an important influence upon the other. Similarly, the notion that Anorexic symptomology may serve to facilitate adaptive changes within the family system and consequently gratify the sufferer's previously unmet emotional and interpersonal needs also has important implications regarding the processes that may perpetuate dysfunctional patterns of dietary restriction and subsequent weight loss.