‘Renegotiating the Bubble of Normality’: A Modified Grounded Theory Study of Adult Children’s Experiences of Growing Up Alongside a Parent with an Eating Disorder or Disordered Eating.

Megan Georgia Stratford

Submitted in accordance with the requirements for the degree of Doctor of Clinical Psychology

(D. Clin. Psychol.)

The University of Leeds

School of Medicine

Division of Psychological and Social Medicine

August 2023

Acknowledgements

Firstly, I would like to acknowledge the participants who took part in this research. Thank you for sharing your stories and offering an emotional, rich and candid account of your experiences. Without your input, this research would not have gained traction and I would not have had any words to put on the page. I hope this work does your experiences justice and leaves you feeling like your voices have been heard. Special thank you to Suzanne and Helen for their contributions as Experts by Experience. Your support and enthusiasm, particularly during the early stages of the research, was invaluable.

I would also like to thank my supervisors: Dr Krysia Canvin, Dr Pam Birtill and Dr Jessica Green for pursuing this project and supporting me from the outset. Thank you for your words of wisdom, encouragement and reassurance, including during more personally challenging times. I have learnt many things from you, not least the art of being "good enough"!

To mum, dad and Josh, "our little family", words cannot express how grateful I am for your unwavering support, compassion and love over the years. You have and continue to be my anchors and I would not where I am today without you. Things have not been easy, but we will continue to stand together. To Nana, I dedicate this to you. You were one of my biggest cheerleaders and I am eternally grateful for your humour, love and support (and reminders that doing too much work will make me a boring person!). You were so close to being here to see me cross the finishing line, I am sorry you were not able to stay. I hope I have done and continue to do you proud.

A shout out to my DClinPsych family, thank you for being such a wonderful group of people. I have loved travelling this journey with you and I wish you all the best for your futures. Thank you for all the conversations, laughs and tears we have shared, I have no doubt you are all going to change the world in some capacity (first things first though, time for a holiday)! And last but not least, a massive thank you to Katy (aka Bub One) for being a truly amazing best friend for the last twelve years. I don't know what I would have done without you and our three plus hour WhatsApp calls!

Abstract

Background: There is growing recognition that eating disorder occur during adulthood. Research suggests that, for parents who have an eating disorder, they are likely to encounter unique challenges and dilemmas relating to family life and parenting. However, research has not considered the voices of the children who have grown up alongside a parent with an eating disorder. This study aimed to explore how adult children, who have grown up alongside a parent with an eating disorder or disordered eating, make sense of their experiences.

Method: A Modified Grounded Theory methodology based on Charmaz' social constructivist approach was adopted. Nine adult children who self-identified as growing up alongside a parent with an eating disorder or disordered eating participated in a semi-structured interview. Interviews were transcribed and analysed, using a process of coding, constant comparison, theoretical sampling and memo-writing.

Results: Participants described their 'Bubble of Normality' in terms of food, eating, weight and relationship norms. They appeared to respond to their bubble of normality at two levels. A cognitive level, divided into '(re)absorption', 'recognition' and 'reflection' and a behavioural level, divided into 're-enactment' and 'rebellion'. The core process of 'renegotiating the bubble of normality' was identified, which captures participants experiences of seeking the middle ground between these responses and ultimately creating an alternative, more positive bubble of normality as adults.

Conclusion: This study offers an account of the process adult children go through when making sense of their parent's eating disorder or disordered eating, as well as the factors contributing to how their sense making evolved over time. The results are considered within the context of the existing literature, alongside the clinical and research implications.

Table of Contents

CHAPTER ONE: INTRODUCTION

This thesis aims to explore how adult children make sense of growing up alongside a parent with an eating disorder (ED) or disordered eating (DE). I will begin by broadly introducing this topic, followed by the current context surrounding ED and DE, their definitions and prevalence in adulthood. Following this, I will provide an overview of the trajectories thought to underpin ED in adulthood.

1.1 Defining ED and DE

Despite many definitions existing within the literature, there is a consensus that ED's involve non-typical eating related thoughts, feelings and behaviours that evoke distress and negatively impact an individual's physical, psychological and social functioning (American Psychiatric Association, 2015; Fairburn & Brownell, 2002). The Diagnostic and Statistical Manual (DSM; American Psychiatric Association, 2022) is widely used within mental health settings and conceptualises ED from a medical and diagnostic lens. As a Trainee Clinical Psychologist, I do not subscribe to this approach. Instead, I am allied with The Power Threat Meaning Framework (Johnstone & Boyle, 2018), which proposes that the question we should be asking is not "what is wrong with you?" (i.e. diagnosis) but "what has happened to you?". For this reason, I experience diagnoses to position the difficulty within an individual, which not only compounds feelings of shame and stigma, but overlooks the wider systemic factors contributing to their mental health. However, I also acknowledge that the literature I will be discussing refers to diagnoses and, for this reason, it is important to provide an overview of the DSM framework.

The DSM delineates ED into "Anorexia Nervosa" (AN), "Bulimia Nervosa" (BN), "Binge Eating Disorder" (BED), "Other Specified Feeding and Eating Disorder" (OSFED) which was historically termed 'Eating Disorder Not Otherwise Specified' (EDNOS), "Avoidant and Restrictive Feeding Intake Disorder" (ARFID), PICA and Rumination Disorder (RD). Given that the final three diagnosis are not referenced in the literature I will be referring to, I have not included their definitions.

In terms of AN, BN, BED and OSFED, each diagnoses carries a different set of criteria and symptoms. For example, individuals with AN maintain a low weight driven by an intense fear of gaining weight, alongside a misrepresentation of body image. Those experiencing BN consume large amounts of food, which is then counteracted by purging behaviours (e.g. self-induced vomiting, exercising, laxative use) whilst individuals with BED also consume large amounts of food but do not employ purging behaviours. OSFED, in contrast, accounts for individuals who present with difficulties within the clinical threshold, in terms of symptom severity, duration and impact, but do not meet all the criteria indicative of AN, BN or BED (American Psychiatric Association, 2022). In recognition of this, the literature refers to DE, which Reba-Haeeleson et al. (2009) defines as "endorsing unhealthy or maladaptive eating behaviours, such as restricting, binging, purging, or use of other compensatory behaviours, without meeting criteria for an eating disorder" (p.2; Pereira & Alvarenga, 2007).

Although diagnoses are beneficial in ensuring individuals access the most appropriate, specialist support, they are not without criticism (Johnstone & Boyle, 2018). For example, Weissman et al. (2016) expressed concern that focusing on diagnoses risks individuals' who are distressed and in need of support but do not meet the full diagnostic criteria 'falling through the net' and being denied access to services.

1.1.1 The Transdiagnostic Model of ED's

Despite the aforementioned diagnostic criteria indicates that each type of ED presents differently, research argues that there are fundamental processes underpinning all ED's (Fairburn et al., 2003). Conceptualised as the Transdiagnostic Model of ED's, Fairburn et al (2003) proposed that this key process involves the tendency for individuals with an ED to determine their self-worth based on their perceived levels of control they exert around eating, weight and appearance. Alongside this, the Transdiagnostic Model argues that core mechanisms, including perfectionism, poor self-esteem, mood and relational difficulties serve to perpetuate ED presentations. Based on this model, a psychological intervention referred to as ‘Enhanced Cognitive Behavioural Therapy’ (E-CBT; Fairburn, 2008), which aims to address these core processes was developed.

To explore the empirical basis for this model, research has assessed the effectiveness of E-CBT compared to alternative psychological interventions. Randomized Controlled Trials (RCT) comparing E-CBT with a waitlist, non-transdiagnostic CBT or interpersonal therapy intervention established that the former intervention produces faster improvements in ED symptoms indicative of BN, BED and EDNOS, which are maintained at sixty weeks follow up (Fairburn et al., 2009; Fairburn et al., 2015; Jong et al., 2020). However, it is worth noting that these studies often rely on statistical rather than clinically significant change, which makes it challenging to discern whether any improvements resulted in individuals no longer meeting the ED clinical threshold in terms of symptoms, impact and levels of distress (Ranganathan et al., 2015). Additional support for this model derives from the observation that an increase in weight and appearance concern predicts relapse rates in individuals with a previous diagnosis of both AN and BN and individuals often transition between diagnoses over the course of their experience with an ED (Grave, 2011; Fairburn et al., 2003; Fichter & Quadflieg, 2007; Milos et al., 2005). These findings are presented as evidence that there are likely to be core similarities that exists between all ED’s.

Despite this support, alternative research suggests that a combination of shared and distinctive processes exist across ED diagnoses (Birmingham et al., 2008; Curzio et al., 2017). For example, Lampard et al (2012) established that mood difficulties, an overappraisal of weight and appearance and self-esteem were present across all diagnoses yet relational difficulties were unique to EDNOS and perfectionism was unique to AN and BN. Moreover, Treasure et al (2018) argued that the Transdiagnostic Model cannot account for all of the psychological processes involved in ED as recovery rates following CBT interventions do not produce consistent significant recovery outcomes.

1.2 The prevalence and incidence of ED and DE

Systematic reviews conducted by Galmiche et al. (2018) and Hay et al. (2023) report that up to 2.2% of males and 8.4% of females will experience an ED during their lifetime, with EDNOS identified as the most prevalent diagnosis, followed by BED, BN and AN. It is estimated that the Covid-19 pandemic may have contributed to a 15% increase in incidence rates between 2020-2022 (Meier et al., 2022). Although females are typically identified as experiencing higher rates of ED, research emphasises that factors such as the use of standardized diagnostic measures geared towards females and lower rates of help-seeking behaviours in males may contribute to this difference (Bomben et al., 2022; Murray et al., 2017).

1.3 ED and DE in adulthood

Although adolescence is considered a risk factor for the development of ED and DE, research emphasises that older individuals are also vulnerable (Pike et al., 2013; Rohde et al., 2014). For example, Micali et al (2017) established a 3.6% prevalence rate for ED in a sample of women averaging 47 years old. Focusing on participants aged between 25-45, Reba-Harreleson et al. (2009) established that, of a sample of women in the general population who averaged 35 years old, 31% self-report DE cognitions and behaviours. Samuels et al. (2019) reviewed the evidence concerning ED across the lifespan and noted an increase in requests for support from women averaging 50 years old.

The observation that referral rates to adult community and inpatient ED services have increased is also noteworthy. For example, in comparing admissions between 1989-2006, Ackard et al. (2013) established that the rates of women over the age of 40 have increased by nearly 7%. More recent research suggests that referrals to adult ED services increased by 21% between 2018-2021 (Ayton et al., 2021; Viljoen et al., 2022). The Health Survey for England (2019) support these findings, reporting some of the highest referral rates for males and females between the ages of 25-34.

1.4 ED trajectories during adulthood

As outlined above, ED and DE can present during adulthood (Ackard et al, 2013; Ayton et al., 2021; Pike et al., 2013; Reba-Harreleson et al., 2009; Rhode et al., 2015; Samuels et al., 2019; Viljoen et al., 2022). The literature proposes there are different pathways from which an ED can present in adulthood: continuing from adolescence to adulthood, developing for the first time during adulthood or reemerging following a period of recovery (Filipponi et al., 2022; Potterton et al., 2020).

Longitudinal research has explored the continuation of difficulties from adolescence to adulthood. For example, a systematic review conducted by Filipponi et al. (2022) established that approximately 40% of adolescents who meet the criteria for an ED diagnosis continue to experience difficulties in early adulthood. Similar findings have been noted in systematic reviews, with up to 30% of individuals presenting with BN and EDNOS continuing to exhibit difficulties up to twenty years later (Keel & Brown, 2010; Keel & Mitchell, 1997; Steinhausen et al., 2009). Research comparing diagnoses argues that individuals are more likely to continue to experience BED than BN and even those deemed to have recovered continue to self-report disordered eating cognitions and compensatory behaviours (Fichter et al., 2008; Slane et al., 2014; Stewart et al., 2022).

However, it would be reductionist to conclude that the presence of an ED during adolescence alone determines whether an individual will continue to experience an ED in adulthood. Studies assessing the factors that contribute to a positive or less promising longer term outcome suggest that the age of initial onset of ED, the need for inpatient admission, trauma experiences, parental attachment, access to specialist services and mental health co-morbidities such as depression can increase the likelihood that an ED will persist (Austin et al., 2020; Pearson et al., 2017).

The second trajectory involves the development of an ED during adulthood, despite the individual not presenting with an ED during adolescence. Of the limited research available, statistics concerning a UK based sample indicate a 3.6% probability that ED will develop in adults between the ages of 40-50. A similar incidence rate of 4% for AN and 6% for BN was noted in an Austrian sample of females aged between 35-64 (Mangweth-Matzek & Hoek, 2017). In studies comparing child and adult-onset ED, Brewerton et al. (2014) and Elran-Barak et al. (2015) concluded that individuals who develop an ED in adulthood are more likely to receive a diagnosis of BED and OSFED. However, adulthood was conceptualised differently across these studies, with Brewerton et al. (2014) classifying adults as those over the age of 18 whereas Elran-Barak et al. (2015) categorised adult as those over 25.

The third trajectory proposes that ED in adulthood may re-emerge following a period of stability and recovery (Bulik et al., 2007). It is thought that an accumulation of biological, social and psychological factors may serve as risk factors for this re-emergence (Barakat et al., 2023). One such life event includes pregnancy and parenthood, which has been found to alter hormone regulation and the psychosocial profiles of prospective parents (Sommerfeldt et al., 2022; Westrupp et al., 2022).

In summary, the above literature offers an introduction to ED's, including their definitions and prevalence. The literature indicates that individuals are not immune from experiencing an ED in adulthood and the trajectories leading to an ED in later years is threefold; difficulties persist from childhood and adolescence into adulthood, develop for the first time in adulthood or re-emerge following a period of stability. The next section of this thesis will offer a more detailed literature review of the impact of pregnancy and parenthood on ED.

CHAPTER TWO: LITERATURE REVIEW

In the previous chapter, I introduced the area of ED and DE, including the main diagnostic terms used within the literature. I also outlined research pertaining to the incidence of prevalence of ED and presented evidence for the continuation, initial onset of re-emergence of ED during adulthood. This chapter will now focus on the impact of pregnancy and parenthood on ED, followed by a discussion regarding the impact of parental ED on parenting and feeding styles. I will then move on to explore adult children's experience of growing up alongside a parent with a mental health difficulty and the impact of living with a family member with an ED. I conducted a narrative literature review whilst also drawing on elements of a systematic review, such as using key search terms, to support the process (Paré & Kitsiou, 2017; see appendix A). Databases such as PubMed, Scopus, Google Scholar, Embase and PsychInfo were reviewed and I set up an alert on my emails in the event new and relevant research was published.

2.1. The impact of pregnancy on ED

Research estimates that 4.3% of women experience an ED during pregnancy (Öztürk et al., 2023). It is reported that individuals with an existing diagnoses of BN are more likely to experience improvements in their symptoms, compared to those with BED (Bulik et al., 2007; Watson et al., 2012). Easter et al. (2013) noted similar outcomes, concluding that symptoms of BED and EDNOS are more likely to deteriorate during the first three months of pregnancy, whilst compensatory behaviours indicative of BN, such as over exercising, restriction and laxative use, reduce. A systematic review by Dorsam et al. (2019) supported this, concluding that mothers with a history of AN and BN report similar eating patterns to controls yet mothers with a history of BED indicate a higher dietary intake and increase in symptoms over the course of pregnancy. Despite evidence that BED increases and BN and AN symptoms reduce during pregnancy, these studies did not explore the trajectory of ED symptoms over the postpartum period. This is important to consider as mothers have reported an internal conflict between meeting the needs of their child and the demands of the ED, during and post pregnancy (Tierney et al., 2013; Stitt & Reupert, 2013).

To address this limitation, research has employed a longitudinal design. Evidence suggests that the improvements in ED symptoms observed during pregnancy are not maintained, with difficulties re-emerging within the post-partum period (Bye et al., 2021; Makino et al., 2020). When considering whether this outcome is impacted by diagnoses, it appears that individuals with BED and EDNOS are more likely to experience a re-emergence of their ED, compared to individuals with AN or BN (Knoph et al., 2013; Sollid et al., 2021). However, other factors are evidenced to impact this outcome, including emotional wellbeing, historical symptom severity and relational stability (Knoph et al., 2013). It is also difficult to determine whether historical or current ED impact symptoms during pregnancy as studies have produced inconsistent results (Dorsam et al., 2020; Easter et al., 2015; Rocco et al., 2005). These inconsistencies may, in part, be due to how the studies operationalised the terms ‘relapse’ and ‘recovery’ (Bardone-Cone et al., 2010; Khalsa et al., 2017).

Overall, the research I have discussed above indicates that, over the course of pregnancy, individuals with BN and AN are more likely to experience improvements in their difficulties, compared to those with BED or EDNOS. However, these improvements are often not sustained, as evidenced by a return of difficulties post-partum, unless certain psychosocial protective factors are in place. In the following section, I will focus on the impact of ED on parenting and feeding practices.

2.2 ED and parenting styles

‘Parenting style’ is a broad construct which describes the general approach a parent adopts when interacting with their child (Kuppens & Ceulemans, 2018; Shloim et al., 2015). Due to the literature using a range of terminology, it is challenging to provide a standardized definition of each parenting style (Power, 2013). This being said, there appears to be an overall consensus that parenting styles differ on the basis of how boundaried and responsive a parent is to their child’s needs (Baumrind, 1971; Maccoby & Martin, 1983; Shloim et al., 2015). Broadly speaking, parents who adopt an ‘authoritative’ style are appropriately boundaried yet willing to adapt to meet the needs of their child, whilst a parent who adopts an ‘authoritarian’ style may prioritise boundaries and discipline. A parent who adopts an ‘indulgent’ style is likely to prioritise the preferences of their child at the expense of appropriate boundaries, whereas a parent who adopts an 'uninvolved' style provides minimal input or scaffolding during interactions (Shloim et al., 2015).

There is a considerable lack of evidence exploring the impact of parental ED on parenting styles. Chapman et al. (2021) conducted a systematic review and concluded that mothers with an ED are more invasive and less supportive when interacting with their child in non-food related contexts and express greater anxiety about their child's size and shape, than mothers without an ED. Interestingly, there are mixed conclusions as to whether this parenting style is evident in non-eating related contexts, as Sadeh-Sharvit et al. (2015) refuted Stein et al. (1994) observations that mothers without an ED display a similar parenting style to mothers with an ED. Such inconsistencies may be due to the nature of the task, as Sadeh-Sharvit et al. (2016) observed free play whereas Stein et al. (1994) requested for mothers to educate their child about an unfamiliar toy. Therefore, mothers may have felt more confident connecting with their child during a task that required a more dyadic and parent led approach.

2.3 ED, feeding styles and feeding practices

The term feeding styles is considered a specific branch of parenting styles and relates to the approach parents take when interacting with their child in feeding and eating situations (Shloim et al., 2015). These styles are constructed in a similar manner to parenting style, in terms of being underpinned by a continuum of control and responsivity and are divided into four approaches (Hughes et al., 2005; Shloim et al., 2015). The first of these, termed 'authoritative' involves the parent maintaining a structured mealtime environment whilst making reasonable adjustments to meet the needs and requests of their child. In contrast, an 'authoritarian' approach involves the parent imposing high levels of control and rules onto mealtimes, with little adjustment based on the child's needs or wishes. An 'indulgent' approach is characterised by a parent imposing minimal structure and control, with the child making the majority of food related decisions, whereas an 'uninvolved' approach is characterised by a lack of parental input with minimal structure during mealtimes (Hughes et al., 2005; Shloim et al., 2015). Linked to this is the concept of feeding practices, which are defined as “the strategies used by parents to control or modify what, when, and how much their child eats” (Costa & Oliveira, 2023, p.4; Shloim et al., 2015). These methods typically include how accessible and available food is to the child, parents’ use of coercion to influence the content, quantity and types of foods their child eats, the extent to which parents’ scrutinise their child’s eating and food choices and the use of positive role modelling around food and eating (Costa & Oliveira, 2023; Gevers et al., 2014; Shloim et al., 2015; Ventura & Birch, 2008).

In contrast to the literature concerning parenting styles, research surrounding the impact of parental ED on feeding practices is more substantial. For example, Hoffman et al. (2013) established that mothers of children between the ages of six months and three years with a history of an ED were less likely to adopt restrictive feeding practices overall yet self-reported higher levels of restriction around certain food groups, such as processed foods. Additional research by De Barse et al. (2005) offered a similar outcome with regards to the use of coercion, with a history of AN reducing the likelihood that mothers who had a child averaging four years old, would employ this approach. Research involving children averaging nine years old paralleled these results, with both mothers and fathers with symptoms of AN, BN and BED not displaying increased restrictive approaches compared to parents without an ED (Lydecker & Grilo, 2016).

However, alternative research conducted with mothers with BN, BED and sub-clinical ED asserts that parents are at greater risk of employing restrictive approaches (Reba-Harrelson et al., 2010). This finding has received support from studies adopting observational in addition to self-report methods. For example, Stein et al. (1994) concluded that mothers who met the diagnostic criteria for EDNOS and BN demonstrated more negative emotion towards their child aged between twelve and fourteen months during mealtimes and were more authoritarian in their approach compared to mothers’ without an ED. Based on the mothers’ feedback, these practices appeared to be influenced by their anxiety about cleanliness, the amount their child had consumed and their child declining their offers of food. Similarly, Blissett & Haycraft (2011) and Saltzman et al. (2016) established that mothers with sub-clinical symptoms of BED were more likely to use food to regulate their child’s emotions, pressure their child to eat and restrict food items. It was also noted that mothers were more likely to prioritise their own discomfort above their child's needs during feeding interactions. Interestingly, Blissett and Haycraft (2011) noted an interaction between parental feeding practices when both parents displayed DE, with mothers adopting more restrictive practices when their partner self-reported higher levels of DE.

In summary, the literature presented above indicates that parents with ED and DE may employ different parenting and feeding styles compared to those without an ED or DE. This is not a unanimous outcome, however, with some studies noting no differences across mealtime and play contexts. Systematic reviews by Martini et al. (2020) and McPhie et al. (2012) highlight that these discrepancies may be the result of heterogeneous samples across studies and compromised validity due to a lack of standardization of assessment and diagnostic tools. It is also worth noting that the majority of studies recruited mothers from a range of countries and populations. Therefore, the sociocultural expectations and traditions relating to parenting responsibilities, feeding, eating and mealtimes approaches may differ between not only mothers but also mothers and fathers (Blissett & Bennett, 2012; Yaffe, 2020).

A further limitation of this research is its reliance on quantitative methodologies, parental feedback and researcher rated observations. This means that the voice of the child is often missing. The aim of the next section of this thesis is to widen the developmental and methodological lens, by focusing on the experiences of individuals who have experience of growing up alongside a parent with a mental health difficulty. In line with the sample recruited for this thesis, the following research will prioritise the experiences of adult children. To embed the results of this thesis within the wider literature, research involving a range of parental mental health difficulties will be included.

2.4 Adult children's experiences of growing up with a parent with a mental health difficulty

The term 'adult children' refers to individuals who grew up experiencing or living with the phenomenon of interest during their childhood but have since reached adulthood. There is a plethora of qualitative research exploring adult children's experiences of living alongside a parent with a mental health difficulty, although meta-analyses indicate that this is largely in relation to parents who have received a diagnosis of schizophrenia, bipolar disorder, depression and substance misuse (Murphy et al., 2011; Källquist & Salzmann-Erikson, 2019; Simpson-Adkins & Daiches, 2018).

2.4.1 The emotional impact

Within the existing literature, consistent reference is made to the emotional implications of growing up alongside a parent with a mental health difficulty (Murray et al., 2011). Informed by Interpretative Phenomenological Analysis (IPA) and Content Analysis, these studies highlight how turbulent and unpredictable adult children's lives were growing up and the sense of fear, anxiety and uncertainty they experienced (Foster, 2010; Metz & Jungbauer, 2021; Murphy et al., 2011; Murphy et al., 2015; Murphy et al., 2016; Patrick et al., 2019). They recalled experiences of abuse and neglect as a result of their parent not being able to be fully present in their lives and the impact this had not only on their sense of self but the parent-child attachment (Foster, 2010; McCormack et al., 2016). Dunkley-Smith et al. (2021) captured adult children's capacity for self-compassion, describing how this is often difficult to implement due to the trauma of their early life experiences.

Notwithstanding the evidence of trauma and adversity, participants alluded to a process of posttraumatic growth. They recognised how their early experiences equipped them with the resilience to overcome difficult life events in their later years and greater interpersonal skills to advocate for their own needs and manage other people's distress (Dam & Hall, 2020; Drost et al., 2015; McCormack et al., 2016).

2.4.2 The impact on relationships and family dynamics

An additional theme identified within the literature is the impact of parental mental health on relationships. The literature suggests that, from a very young age, adult children were aware that their experience of the parent-child relationship and family dynamics were different from their peers yet struggled to pinpoint in what way. It was only when they encountered seemingly inconsequential events, such as staying at friends' houses, that their understanding of these differences increased (Murphy et al., 2015; Murphy et al., 2016). Adult children emphasised that, as a consequence of their parent's inconsistent availability, they often adopted a parent rather than child role. This was experienced as an expected yet unspoken aspect of their lives and mirrored broader themes relating to secrecy, non-disclosure and a lack of communication within the family dynamic (McCormack et al., 2016; Murphy et al., 2015, Murphy et al., 2016; Patrick et al., 2019). The occasions in which they felt they had not met these role and family dynamic expectations appeared to compound beliefs around being a failure, alongside feelings of self-criticism and shame (McCormack et al., 2016). As a result, there was a pattern of adult children striving to please their parent and considerable investment on their behalf to improve the relationship (McCormack et al., 2016).

Many adult children referred to the impact of their experiences on their confidence forming meaningful and trusting relationships with others, including romantic relationships as adults (Foster, 2010). For those who were parents themselves, they expressed a lack of trust in their abilities to be a 'good' parent due to not having a parental role model, although this was accompanied by a desire to use their experiences to build a more positive relationship with their own child (Patrick et al., 2019).

2.4.3 Coping strategies

Adult children employed many coping strategies to manage the impact of their experiences. These included filtering what they discussed with their parent, non-disclosure, offering to take on responsibilities, distraction and temporarily escaping the family home (Foster, 2010; McCormack et al., 2016; Metz & Jungbauer, 2021; Yamamoto & Keogh, 2017). Mordoch and Hall (2008) described how adult children were continuously assessing their parent's presentation and wider family dynamics to determine which strategy would be most effective.

Although the above research offers insight into participant's lived experiences, it is equally important to develop a conceptual framework from which to understand these narratives. Employing a grounded theory methodology, Patrick et al. (2020) sought to develop a model to account for how adult children with their own offspring process their parent's mental health difficulties and its impact on the intergenerational transmission of parenting practices. Referred to as the 'Relational Trajectory Model', this model proposes that individual's cycle through different emotional states, depending upon their developmental stage. During childhood, individuals described a state of 'Confusion', owing to a lack of transparency about their parent's difficulties and conflictual family relationships. As they neared adulthood, this state progresses to one of 'Contemplation', in which the individual reflected on the impact of these experiences on their sense of identity and ideal future relationships, including with their parent. The extent to which an individual sought to preserve their relationship with their parent was heavily influenced by systemic and internal factors, including societal and cultural norms and a willingness to honour their own emotional needs alongside the needs of the wider family system. The final phase, termed 'Reconciliation' signalled the beginning of an individual becoming a parent themselves. Participants engaged in reflection, whereby they considered their experience of being parented and identified the practices they wished to preserve or abandon as part of their own parenting style. Patrick et al (2020) proposed that individuals progress through these states sequentially. However, certain 'subprocesses' operating within these states influence whether the individual focuses on their past experiences or future intentions.

Overall, research consistently highlights that living alongside a parent with a mental health difficulty has far reaching implications for adult children, both during their childhood and later years. These experiences have a significant impact upon an individual's psychological and emotional wellbeing, alongside their roles, responsibilities and identities within their family system. Patrick et al. (2020) model indicates that an individual's awareness and sense making of these experiences evolves over time. Having considered mental health difficulties more broadly, the following section will concentrate on the impact of living alongside a family member with eating difficulties.

2.5 Family members with an ED or DE

Mirroring the themes mentioned previously, qualitative systematic reviews emphasise the emotional, psychological and relational impact of caring for or living alongside someone with an ED (Anastasiadou et al., 2014; Fox et al., 2015; Zabala et al., 2009). The majority of this research focuses on the experiences of parents caring for a child with an ED, siblings and partners. In a meta-synthesis of parents, partners and siblings experiences, Fox et al. (2015) argued that parents and siblings rarely conceptualised their family members difficulties as an ED initially, instead misattributing their presentation to developmental factors (e.g. being a teenager). Becoming aware of their family members difficulties was a slow process that elicited feelings of confusion, sadness, anger, anxiety and self-blame. In offering support, family members were constantly negotiating their desire to reduce distress with the risk of inadvertently colluding with the ED. They drew on many strategies to cope with their experiences, including acquiring information, co-ordinating professional input for the family member, setting boundaries and seeking external support.

Subsequent research not captured in the above meta-synthesis lends support to Fox et al. (2015) conclusions. Using photo elicitation methods, Lecomte et al. (2019) revealed that, among parents caring for a child with an ED, their relationship was heavily influenced by the stress and conflict associated with food and eating. For some parent-child dyads, food and eating was experienced as a strategy to negotiate power and control within the relationship. Parents spoke of their attempts to achieve a balance between offering support and reducing distress whilst imposing boundaries and not colluding with the ED. Informed by grounded theory, Karlstad et al. (2022) concept of ‘wearing all the hats’ collaborates this dynamic and represents the challenges parents encountered when trying to fulfil multiple, often competing demands to support their child’s recovery. To cope with their experiences, parents identified that they attempted to make alterations to mealtimes to reduce conflict and promote communication among family members.

2.5.1 The experience of siblings

The evidence base regarding the experiences of living with a sibling with an ED offers a similar account of these emotional and systemic challenges (Maon et al., 2020). Adopting content and thematic analysis, findings have revealed that siblings experience similar feelings to those expressed by parents, particularly in relation to anxiety, anger and helplessness (Fjermestad et al., 2020; Jungbauer et al., 2016). Many described their siblings ED to dominate the family, often resulting in their needs being deprioritised or unacknowledged (Hutchison et al., 2022; Jungbauer et al., 2016). This narrative was often internalised by siblings, leading them to sacrifice their own needs (Hutchison et al., 2022). In terms of their own relationship with food, eating and body image, participants identified their siblings' difficulties as both protective, in terms of motivating them to maintain a positive relationship with food and body image, and a risk factor due to sibling rivalry and adopting some of the behaviours of their sibling (Scutt et al., 2022).

In one study, siblings shared feeling pressured to maintain the ‘healthy’ sibling role, despite struggling with their own relationship with food and eating (Scutt et al., 2022). Dimitropoulos et al. (2009) work, using a grounded theory methodology highlighted that siblings also feel compelled to adopt the ‘mediator’ role within the family, in an attempt to reduce conflict between their sibling and parents. This conflict was exacerbated by parents struggling to come to terms with their child’s difficulties, ambivalence and a tendency to accommodate the demands of the ED. Adopting a constructivist grounded theory methodology, Karlstad et al. (2021) noted similar experiences in adult siblings, with participants describing how the presence of an ED altered boundaries and norms within the family, particularly regarding higher levels of conflict.

In addition, the evidence base highlighted the use of a number of coping strategies to manage the demands and challenges of living with a sibling with an ED. These strategies largely involved distancing themselves from their sibling to reduce the emotional burden, attempting to preserve a supportive relationship with their sibling by externalising ED driven behaviours and drawing on external support networks (Dimitropoulos et al., 2009; Hutchison et al., 2022). Both Karlstad et al.

(2021) and Fjermestad et al. (2020) noted how siblings often grappled with finding the balance between being flexible yet boundaried and present yet not too involved, mainly to protect their own wellbeing.

2.5.2 The experience of partners

Research concerning partners' experiences appears to identify similar themes to those described by parents and siblings. For example, using IPA, Huke and Slade (2006) established that partners also feel helpless, struggle to make sense of their partner's difficulties and experience conflict around the level of control they believe their partner to have over ED driven behaviours. In line with parental coping strategies, partners sought to increase their knowledge of ED yet they also expressed the importance of accepting that the ED may remain part of the relationship in the long term.

O'Connor et al. (2019) extended this research by adopting a grounded theory methodology to create a model termed 'Reconstructing Liveability'. This theory argued that partners embark on a four-stage process to adjust to and manage the impact of their partners' ED on their relationship. The first stage involves 'Encountering a Disruption' whereby the partner becomes more aware of the impact of an ED on their own wellbeing, their partner and the overall relationship. The next stage, termed 'Informed Self' involves the partner seeking to process, understand and improve their ability to manage their partner's ED. Following this, partners begin to use the strategies they have acquired from becoming more informed to support, challenge and promote their partner's recovery. The final stage, termed 'Reconstructing Liveability' represents partners' experiences of preserving and pursuing their own life goals amidst the needs of their partner. To achieve this, partners adopted strategies such as seeking support, maintaining a positive perspective, making reasonable adjustments and increasing their self-reflexivity. O'Connor et al. (2019) argued that this process is recurring, in that individuals transition through this cycle (i.e. four phases) multiple times throughout their lives.

The model proposed by Connor et al. (2019) highlights the interactive and evolving nature of living with a partner with an ED. Linville et al. (2015) supports this, although their grounded theory model pinpointed relational stability as the key ingredient underpinning the extent to which the ED impacts the relationship. Their model mirrored the feelings of confusion and uncertainty described by Huke and Slade (2006) and drew parallels with the consequences and strategies identified by O'Connor et al. (2019). These included experiencing reduced closeness, increased conflict and challenges around food related activities, alongside the adoption of strategies such as seeking mutual support, acquiring knowledge, developing distress tolerance skills and maintaining communication.

2.5.3 The experience of parents with an ED

A small body of qualitative literature exists surrounding the perspectives of parents with an ED and their experiences of raising a child. For example, in applying narrative analysis to focus group of mothers with an ED raising children between the ages of eighteen months and three years old, Tuval-Mashiach et al. (2013), identified four key themes. The first of these, conceptualised as 'discussing the illness with the child' referred to a dilemma disclosure, in terms transparency and openness around their children. Despite their age, mothers described how aware their children were to their distress and ED. The theme 'the child as the caregiver' refers to mothers' experiences of their child adopting a parental role, particularly the offer of emotional support, whilst 'concerns about providing bad role modelling to the child' captured their feelings of anxiety, shame and incompetence that may contribute to their child developing an ED. Although parents felt able to fulfil their parenting role in areas unrelated to weight and body image, this proved challenging at times due to the all-consuming nature of their ED. Mothers further shared that they worked hard to create a family environment in which their child felt able to seek support from other family members, in the event they were not available due to a deterioration in their mental health. They also drew upon their own insight into the development of their ED to limit their child's exposure to potential triggers (e.g. reinforcing the child's strengths and qualities).

Employing Interpretative Phenomenological Analysis of semi structured interviews, Sadeh-Sharvit et al. (2015) and Stitt and Reupert (2014) identified similar themes, including anxiety regarding intergenerational transmission of ED's and susceptibility for their child to adopt the parent role within the family system. Alongside this, mothers shared that their own preoccupation with their physique and nutrition led to excessive monitoring of their child's weight and health status, anxiety surrounding their parenting decisions and avoidance of food-oriented family events. If their child's status did not meet the mother's hopes and expectations, they experienced difficulties connecting and showing unconditional positive regard for their child.

As evidenced above, research exploring the experiences of living with and supporting a family member with an ED prioritise the perspectives of parents with children with an ED, partners and siblings. Of note is that the majority of participants, regardless of their role and relationship with the individual with the ED, spoke of the significant impact these difficulties had on their emotional wellbeing and relationships. Although the literature concerning parents with ED is limited, there appears to be a consensus that parenting whilst experiencing an ED is shrouded with challenges and anxieties, including the risk of their child developing an ED. The following section will address this topic is more detail and consider research into the mechanisms underlying this risk.

2.6 Intergenerational transmission

The anxieties expressed by mothers with an ED that their child may also develop an ED reflects the wider topic of 'intergenerational transmission'. This concept is defined as "the extent to which behaviours and characteristics of individuals from one generation are recurring in offspring" (Branje et al., 2020, p.1).

2.6.1 Environmental mechanisms of transmission

According to Brun et al. (2020), the mechanisms contributing to the transmission of ED from parent to child are largely environmental and can be divided into "direct" and "indirect" influences; "direct" refers to parents initiating conversations about their offspring's weight, body image or eating practices whereas "indirect" influences refers to parents modelling ED related thoughts and behaviours which are observed but not directly related to the young person (e.g. parents expressing their own weight loss intentions or commenting on the weight and eating tendencies of other members of society). Research suggests that direct rather than indirect influences serve as the greater risk factor in the severity and outcome of ED in young people who have a parent with an ED (Claydon et al., 2020; Rodgers & Chabrol, 2009).

Presenting these mechanisms within a Revised Obesity and Diet Proneness Theoretical Model, Claydon et al. (2020) proposed that intergenerational transmission begins with a parent's belief system regarding weight, which initiates concern regarding their offspring's weight. Parents employ direct and indirect methods of modelling their belief system to their child, such as offering direct observations of their child's appearance, stigmatizing those who do not adhere to their belief system or endorsing their own dieting practices. It is the content of these mechanisms which are subsequently internalised by the child, resulting in weight related anxieties and difficulties modulating their own eating preferences.

As proposed by Claydon et al. (2020), this model draws many parallels with Social Cognitive Theory (SCT; Bandura., 1986) and Operant Conditioning Theory (Skinner., 1971). SCT is based on the premise of "reciprocal determinism", which argues that internal (e.g. developmental stage, cognitive style) and external factors (such as an individual's environment, interactions with others) interact to influence an individual's thoughts, feelings and behaviours towards a particular phenomenon (Bandura, 1986). Complementing the behavioural component of SCT, operant conditioning refers to whether an individual experiences an affirmative or negative outcome as a result of a behavioural choice. Positive and/or negative reinforcement involves the addition of an affirmative consequence (e.g praise for choosing a food option a parent perceives as healthy) or the removal of an unfavourable consequence (e.g reduced criticism for choosing a food option a parent perceives as unhealthy) to increase the likelihood of a certain behavioural choice. Alternatively, positive and negative punishment involves the addition of an unfavourable consequence (e.g increased reference to weight control strategies in response to weight gain) or removal of a favourable consequence (e.g reduced access to dessert after evening meal in response to weight gain) to reduce the likelihood of a certain behaviour.

Sim and Peterson (2021) proposed the Differential Sensitivity Model, which argues that individuals who have experienced ED related environmental influences (e.g. parents with an ED) show an equal propensity for adverse outcomes as they do positive outcomes. That is, although an individual may be at increased risk of developing an ED due to their parent's difficulties, they are also more sensitive to protective environmental factors. As such, it is not necessarily inevitable that a child will develop an ED, providing there are protective environmental influences in place. The importance of building the protective capacity of an individuals environment is evident in interventive studies (Sadeh-Sharvit et al., 2019). These interventions, which focus on supporting parents with an ED, have been found to improve family dynamics and reduce the negative outcomes of ED on parenting and feeding practices (Levine & Sadeh-Sharvit, 2022; Sadeh-Sharvit et al., 2016).

Although Claydon's (2020) and Sim and Peterson (2021) offer insight into the environmental mechanisms underpinning the transmission of ED between parent and child, it could be argued that these models exclude wider environmental factors. Bronfenbrenner (1992) Ecological Systems Theory proposes that five environmental systems operate around and interact with an individual. These include the 'microsystem', 'mesosystem', 'exosystem', 'macrosystem' and 'chronosystem' level. The former systems are considered to operate within the individual's immediate environment and refer to the influence of family, friends and education whilst the latter systems refer to the influence of wider sociocultural, political and lifespan factors.

The role of wider environmental factors in the development of ED and DE is acknowledged in the literature. For example, systematic reviews have consistently reported the influence of societal norms and expectations regarding body image and weight on the development of ED, which are further compounded by increased access to social media and peer relationships (Barakat et al., 2023; Ioannidis et al., 2021; Keel & Forney, 2013; Marcos et al., 2021; So & Kwon., 2023; Song et al., 2023; Rounsefell et al., 2019). It is equally important to recognise that at a cultural, racial and societal level, experiences of discrimination, oppression and food insecurity arising from socioeconomic disadvantage have been identified as risk factors for the development of ED's (Brown et al., 2022; Hazzard et al., 2022; Mason et al., 2021; Nelson et al., 2023).

2.6.2 Genetic and environmental interaction

Alongside the myriad of environmental factors contributing to the development of ED, the role of genetics and their interaction with an individual's environment cannot be excluded (Bulik et al., 2005; Culbert & Klump, 2015; Himmerich et al., 2019). Bulik et al. (2005) referred to this interaction as a "double disadvantage" (p.37) for the offspring of parents with an ED. Their model proposes that children are biologically vulnerable due to the likelihood that parents with an ED are physically and nutritionally compromised during pregnancy, which increases the risk of pre and post-natal complications which may serve as further risk factors for the development of an ED. These genetic and biological risks are then compounded by environmental factors, such as observing their parents' behaviour and distress in food and body image related contexts. In line with Sim and Peterson (2021) Differential Sensitivity Model, Bulik et al. (2005) emphasises that these genetic risks can be fortified against by the environment.

As outlined above, the concept of intergenerational transmission can be formulated as a complex interplay of psychological, environmental and biological factors rather than one entity operating in silos to determine the outcome of an individual's relationship with food, eating and body image. It is also evident how important it is to not only minimise the risk factors, if possible, but strengthen any protective factors, potentially through psychological interventions. Within the context of the research presented above, the final component of this section will offer a rationale for the current project.

2.7 Rationale for current research

There is growing acknowledgement that the prevalence of ED and DE during and following pregnancy is increasing. This appears to influence how a parent raises their child, alongside how the family system operates. To date, children and young people recruited within ED research has focused on the impact of parental ED on feeding experiences, psychosocial development and the risk of intergenerational transmission. Although these facets are of great importance, there has been little opportunity for these individuals to share their experiences as to what it has been like to grow up alongside a parent with this difficulty. Of the studies which have explored adult children's experiences of living alongside a parent with a mental health difficulty, this is within the context of schizophrenia, bipolar disorder and substance misuse presentations. The research aims to complement the existing literature by exploring how adult children, who have grown up alongside a parent with an ED or DE, make sense of their experiences.

CHAPTER THREE: METHODOLOGY

This chapter will begin by providing an overview of the design and methodology I employed during this study, including my rationale for the use of Constructivist Grounded Theory. It will then outline the procedure participants engaged in, address the main ethical considerations and consider the debate surrounding 'quality' in qualitative research.

3.1 Design

Due to the lack of existing literature regarding growing up with a parent with an ED or DE, this study aimed to construct a nuanced and in-depth understanding of adult children's experiences of this phenomenon (Agius, 2013; Gelo et al., 2008). I deemed a qualitative research design most appropriate to gain insight into the meaning and processes underpinning participants' experiences (Fossey et al., 2002; Stuckey et al., 2013). Specifically, I chose Modified Grounded Theory, based on Charmaz (2006) social constructivist approach.

3.2 Grounded Theory approaches

Grounded Theory (Glaser & Strauss, 1967) aims to generate new theories relating to social phenomenon, rather than focusing on confirming or discounting existing empirical evidence (Mediani, 2017). There are many versions of Grounded Theory but, for the purpose of this thesis, I will focus on Classic Grounded Theory (Glaser & Strauss, 1967) Constructivist Grounded Theory (Charmaz, 2006, 2014) and Modified Grounded Theory (Cutcliffe, 2005).

Classic Grounded Theory endorses a positivist epistemological and realist ontological position. These positions argue that there is one objective reality that can be predicted and proved through hypothesis testing, every individual views reality from the same lens and the way in which the researcher interacts with the data is not influenced by their own values or ideas (Glaser & Strauss, 1967; Goertz, & Mahoney, 2012; Killam, 2013; Rohleder & Lyons, 2015; Snape & Spencer, 2003). This edition of Grounded Theory proposes that, by acknowledging their own assumptions and experiences, researchers will make biased decisions regarding data collection and analysis (Rieger, 2018). To minimise this risk, Glaser and Strauss (1967) recommend that researchers' do not consult the existing literature and maintain a detached role during the research process.

Directly opposing Glaser and Strauss (1976) position, Charmaz (2006, 2014) developed Constructivist Grounded Theory. Positioned within a social constructivist epistemology and idealist ontology, Charmaz argues that there is not a single construct of reality and the research process will inevitably be influenced by the researchers' own ever-changing perception of reality (Rieger, 2018; Tie et al., 2019). As such, it is not possible or realistic for a researcher to maintain impartiality, as their own experiences and belief systems will undoubtedly influence how they interact with and make meaning from the data (Snape & Spencer, 2003). Consequently, the nature of reality and generation of knowledge are co-produced by the researcher and participant (Charmaz, 2006).

As outlined above, Grounded Theory has undergone substantial alterations over time (Cutcliffe, 2005). This has provoked a wider debate as to how researchers can ensure rigour and consistency despite such variations in approaches (Turner & Astin, 2021). Cutcliffe (2005) maintains that "methodological transgressions" (p.421) are to be expected, whereby researchers alter aspects of the Grounded Theory process to account for the context and scope of the research. In these instances, Cutcliffe (2005) recommends that the term 'modified grounded theory' is employed.

3.3 Rationale for choosing modified social constructivist grounded theory

The rationale for employing social constructivist grounded theory methodology specifically was based on the following considerations. As mentioned above, classic grounded theory (Strauss & Glaser, 1967) argues that there is one reality which is exempt from environmental and social influences, whereas a social constructivist approach embraces and encourages the reciprocal nature of the researcher, participant and wider social context. Given the systemic and relational nature of growing up alongside a parent with an ED or DE, I considered a constructivist approach most suitable. Additionally, Classic Grounded Theory would recommend that I do not consider the existing literature and maintain a detached position during the research process. As Mills et al. (2006) recommends, I considered my personal standpoint and did not feel, given my personal experiences and professional identity as a Trainee Clinical Psychologist, that it was feasible to detach myself from the research area. I was also mindful that completing a literature review was a necessary part of this thesis and felt it was important to contextualise this research within the existing literature (McCallin, 2003). My decision to describe the methodology as 'modified' is in acknowledgement that, due to the scope of this thesis, it was not possible to pursue all elements of the grounded theory process. This is discussed in the coding section of this chapter.

3.4 Considering alternative methodologies

Alongside Grounded Theory, I considered the merits of adopting an Interpretative Phenomenological Analysis (IPA, Smith, 1996) methodology. However, I decided to pursue grounded theory for the following reasons. Firstly, in line with the aims of this research, Grounded Theory aims to generate a conceptual framework or theory to explain a psychosocial process (Charmaz, 2006; Stauss & Glaser, 1967). Although IPA provides an in-depth account of a participant's lived experience, the focus is on the essence of the experience rather than the processes underpinning the experience (Smith & Osborn, 2007; Starks & Trinidad, 2008). Furthermore, Tie et al. (2019) and Wuest (2007) recommend that Grounded Theory is adopted when there is limited literature regarding the phenomenon of interest, which is evidenced in chapter two. Finally, Grounded Theory has been praised for its ability to draw theory-practice links, therefore strengthening its application to clinical settings (Burns et al., 2022; Charmaz, 2017; Starks & Trinidad, 2007).

3.5 Reflexivity in qualitative research

A core tenant of qualitative research is the researcher's ability to reflect on their own experiences and consider how these may influence their position in relation to the research process (Olmos-Vega et al., 2022). With this in mind, it feels important to acknowledge my own position. I identify as a White British thirty year old female currently training to become a Clinical Psychologist. I have personal experience of an ED, having received a diagnosis of AN in my teenage years and accessed specialist services. When I moved to Leeds, I accessed support from the Leeds Connect ED Service. I was not formally referred to the service, rather I accessed their Instagram support groups. Although this was the same service who supported my NHS recruitment, I was not accessing their services at the time of the study. In the spirit of transparency, I enquired about the potential for a conflict of interest with my supervisor and Academic Tutor.

Having parents who have a largely positive relationship with food and eating was and continues to be important in my recovery. My experiences of working as a Trainee Clinical Psychologist in community and inpatient child and adolescent mental health services with young people presenting with an ED has confirmed systemic and family-based approaches as the 'gold standard' intervention. However, these interventions arguably rely on parents being in a place to support recovery, by promoting a positive relationship with food and eating. It was my curiosity about young people's experiences of growing up with a parent with an ED that initiated the aims of this research.

3.6 Quality assessments in qualitative research

The topic of quality within qualitative research is a contentious issue (Busetto et al., 2020; Charmaz & Thornberg, 2020; Chowdhry, 2015). Due to the range of methodologies on offer, Lester & O'Reilly (2021) emphasise that specific frameworks for each methodology are needed to ensure quality is assessed appropriately. In line with my methodological decision, I chose to draw on Charmaz and Thornberg (2020) quality framework.

This framework is divided into four areas: 'credibility' refers to how trustworthy research is and the "confidence that can be placed in the truth of the research findings" (Korstjens & Moser, 2017, p.121). This involves the adequate collection of data which allows the researcher to constantly compare datasets and devise theoretical models which are grounded in and evidenced by the data (Charmaz, 2006). It also involves researchers monitoring their own assumptions and discussing the research process with additional sources (Charmaz, 2006; Korstjens & Moser, 2017). 'Originality' pertains to the uniqueness of research and the potential for a study to expand the current understanding of a phenomenon whilst ‘resonance’ refers to the extent to which the researcher offers an in-depth account of a phenomenon, which enables the reader to gain greater insight into and feel connected to the participant’s experience (Charmaz & Thornberg, 2020; Tracy & Hinrichs, 2017). Finally, ‘usefulness’ refers to the extent to which findings transcend beyond the research world to influence future research, clinical, policy and operational decisions (Charmaz & Thornberg, 2020). I will return to this framework in chapter nine, to scaffold my discussion regarding the strengths and limitations of this study.

3.7 Ethical considerations

3.7.1 Gaining ethical approval

I approached two boards of ethics for the purpose of maximizing recruitment. These included the School of Psychology Ethics Committee at the University of Leeds and NHS Bromley Research Ethical Committee. The University of Leeds Ethics Committee were approached, and approval was granted in April 2022. Following this, NHS approval was gained in October 2022, which allowed the study to be advertised by the ED Service as part of Leeds and York Partnership Foundation Trust (See Appendix B and C). In accordance with the British Psychological Society (BPS) Code of Ethics and Conduct (2021) guidelines, I addressed the following ethical considerations.

3.7.2 Informed consent and right to withdraw

I invited participants to read the participant information sheet on two occasions; these included the first time they emailed me to express an interest in the project and prior to the interview. The information sheet outlined the aim and procedure of the research, data protection and security, confidentiality and their right to withdraw. I also invited participants to attend an introductory meeting prior to confirming their interest in participating in an interview, to ensure they had the opportunity to ask any questions and were fully informed about the research process. Informed consent was confirmed verbally and in writing. Due to technical problems and upon advice from the School of

Psychology Ethics Committee, participants who provided verbal consent but did not state their name for the recording were emailed after their participation to re-confirm their consent in writing.

3.7.3 Confidentiality and sensitive data

I requested for participants to complete a personal information form and demographic questionnaire. The personal information form requested the participant's real name, their preferred pseudonym, date of birth, home address, email and telephone number. This information is not referenced in the write up of the study and I made participants aware that their details would only be passed on to relevant services in the event of risk concerns. The demographic questionnaire invited participants to provide information regarding their age, gender identity, ethnicity, whether they have ever received an ED diagnosis or identified with the term DE (See Appendix B).

Interviews were recorded by an encrypted Dictaphone or Zoom. I stored the data on the university approved OneDrive, in line with the University of Leeds Date Protection Policy. As per university guidelines, I shared the recordings with the professional transcriber, who signed a confidentiality agreement, via OneDrive. Identifiable and non-identifiable data were stored in separate folders on OneDrive. Only my supervisors were provided with copies of the anonymised transcripts via email, for the purpose of supporting the analysis process.

3.7.4 Potential for distress

I created a distress protocol to address the potential for distress. I prompted participants to consider their own emotional safety and wellbeing and advised that they were not obliged to answer questions they do not wish to, at the start of the interview. I also informed them of their right to pause or terminate the interview at any point and the option to withdraw up to two weeks after the interview. Additionally, I invited participants to complete a safety plan which outlined their signs of distress and the coping strategies they had in place. At the end of the interview, I facilitated a verbal debrief, provided participants with a debrief form which reiterated the aim of the study, their right to withdraw and the details of support services (e.g. B-eat, Samaritans, seeking support from GP) and invited them to engage in mindfulness activity. Experts of Experience (one person identified as an adult child who had grown up with a parent with an ED and one parent who identified as having an ED) reviewed my documents and example interview questions to ensure I used appropriate and accessible language.

3.8 Participants

3.8.1 Justification for recruiting adult children

My decision to recruit adult children rather than young people is influenced by ethical considerations, previous research and developmental theory. In line with the British Psychological Society (BPS) Human Ethics recommendations, when children under the age of sixteen are the intended participants, additional consent from a family member with parental responsibility should be sought. Given the time frame and scope of this thesis, I was hesitant to recruit individuals under the age of sixteen on the basis that I may not have the resources to implement these additional consent processes. I also acknowledged that this age group would not be compatible with my intention to recruit from a university population currently studying at the University of Leeds. Further support for my decision was based on the research accumulated during the literature review process, in which an exploration of young people's experiences of living alongside a parent with a mental health difficulty was dominated by the recruitment of adult children.

In addition, I was mindful of the influence of psychosocial and cognitive development on autobiographical memory. According to Fivush et al. (2011), autobiographical memory is defined as "the memory of the self interacting with others in the service of both short-term and long-term goals that define our being and our purpose in the world" (p.560). Research proposes that, as cognitive and psychosocial abilities develop, individuals' transition from focusing on factual and episodic details to reflecting upon their experiences within the context of their historical, current and future identity (Bluck & Haberman, 2001; Grysman & Hudson, 2010; Kober et al., 2015; Larkina et al., 2016). I felt that adult children would be better equipped cognitively and in terms of having more experiences to draw on, to address the aims of the study.

A further consideration for recruiting adult children relates to Erikson's Theory of Psychosocial Development (1950). This theory denotes that every individual transcends through eight stages of development from infancy to old age, each of which demands the navigation of a key developmental milestone. Two of these milestones pertain to "identity versus role confusion" and "intimacy versus isolation", which involve an exploration of current and future identity, alongside the building of personal connections with others during adolescence and early adulthood. As depicted in the qualitative research, mothers experiencing an ED express concern that their child may be susceptible to adopting a parental role with the family and have less opportunity to develop secure attachments (Stitt and Reupert., 2014; Tuval-Mashiach et al., 2013). These concerns correspond to the above milestones and indicate that adolescence and adulthood may be key developmental periods impacted by parental ED. Recruiting adult children will offer a unique opportunity to contextualise their experiences within developmental theory.

3.8.2 Sampling strategy

Initially, I employed a purposive sampling strategy to recruit participants (Charmaz, 2006; Sbaraini et al., 2011). Charmaz (2006) refers to this as 'initial sampling' and advises that it is based on an inclusion criteria for the purpose of starting to explore the phenomenon of interest. As described in the analysis section, this evolved to theoretical sampling as data collection and analysis progressed (Charmaz, 2006).

3.8.3 Inclusion and exclusions criteria

In line with the aims of this research, I chose to apply a broad inclusion criteria. Participants were invited to participate if they were (a) over the age of 18, (b) had at least one parent who has a formal diagnosis of an ED or meets the definition for DE, as confirmed by the participant and (c) lived with the parent with an ED or DE as they were growing up. Due to the importance of verbal communication during interviews, those who were not fluent in the English Language were exempt from participating.

3.8.4 Recruitment process

Following approval from the University of Leeds Ethics Committee, I advertised the recruitment poster via social media (including Facebook, Instagram and Microsoft Teams, Twitter) and placed it around the University of Leeds campus. I requested support from third sector organisations, such as B-eat but unfortunately this did not come to fruition. Once NHS ethical approval was granted, the recruitment poster was advertised via Leeds and York Partnership Foundation Trust ED Service Instagram page and distributed to clinicians via email. I also attended a team meeting to explain the research and request support with recruitment. One of my supervisors working in the inpatient service discussed the research with potential participants and brought the study to the attention of the Service User Involvement group. I was not involved in approaching participants accessing the ED Service. Unfortunately, I did not receive any expressions of interest via NHS recruitment (See Appendix B and C).

3.9 Procedure

3.9.1 Introductory meeting

As per the instructions on the recruitment poster, participants were invited to email me to express an interest in the study. Having received an expression of interest, I emailed the participant information sheet and arranged an introductory meeting. The purpose of the meeting was to build rapport, confirm eligibility and answer any questions about the research. Having confirmed the participant wished to take part, I then arranged a convenient day, time and location (e.g in person or remote) for the interview to take place.

3.9.2 Interview process

Prior to the interview, I invited participants to re-read the participant information sheet. I then read out or participants read the consent form, following which they confirmed their consent verbally or in writing. I then requested for participants to complete the person information form and reiterated that this information would only be used in the event of risk concerns. Participants were then invited to complete an optional demographic questionnaire and safety plan. Every participant completed the questionnaire but no-one felt it was necessary to complete a safety plan.

In line with Charmaz (2006, 2014) recommendations, the aim of the study and the importance of being led by participants to inform the generation of a theory, semi-structured interviews were deemed most appropriate. I began the interview by asking participants about their family set up, including who they grew up with. I asked this question to support my understanding of the family context surrounding their experiences. I also asked participants how they would like me to refer to their parent's ED (for example, ED, DE or another term) to ensure I used their language and remained grounded in their experiences. Using an open-ended interview style, I then invited participants to share their experiences of growing up alongside a parent with an ED or DE. This question was deliberately broad to allow the participant an element of control and flexibility in choosing what to discuss and in what direction to take the interview. To encourage the participant to elaborate, I used follow up questions. For example, when participants broadly referred to mealtimes, I asked further questions about their typical family routine and encouraged discussions around the emotional aspects of their experiences. I did refer to the interview topic guide to scaffold the interview but the pace and content of the conversation was guided by the participant. The topic guide also evolved over time, as I completed more interviews and additional topics came to light. At the end of the interview, I encouraged participants to feedback their experiences of the interview and checked in with their overall wellbeing. I then reviewed the debrief form and invited the participant to engage in a mindfulness activity to bring the interview process to a close.

I facilitated a total of ten interviews, due to inviting one participant to a second interview. This was well considered and discussed with my supervisor to ensure my reasoning was research rather than therapeutically motivated. Eight interviews were conducted remotely via Zoom and two were conducted in person on University of Leeds campus. In person interviews were recorded via encrypted Dictaphone and those completed remotely were recorded via Zoom. The interviews lasted between approximately 70-135 minutes.

3.9.3 Participant demographics

To preserve anonymity, participant demographics are presented in a collated format and pseudonyms have been used. A total of nine participants were recruited. Ten semi-structured interviews were completed as one participant was interviewed twice. All participants identified as female and ages ranged from 25-40 years old. In terms of ethnicity, five (55%) participants identified as White British, two (22%) participants identified as Mixed Race, one (11%) participant identified as Greek and one (11%) participant identified as White and Black African. Of the nine participants, two (22%) disclosed having received a formal diagnosis of an ED (AN and BN). Of those who had not received a formal diagnosis, five (55%) felt the definition of DE fitted with their overall relationship with food, eating and body image. In terms of the parent they wished to talk about, seven participants (77%) requested to talk about their experiences of growing up alongside their mother, one (11%) participant identified their father and one (11%) participant identified both their mother and father.

3.10 Data analysis

One of the fundamental characteristics of Grounded Theory, irrespective of the version adopted, is its iterative and cyclical nature (Charmaz, 2006; Glaser & Strauss, 1967). However, for ease of reading, I will describe this process in a linear manner, referring to the key areas of the process as advised by Charmaz (2006) and any modifications I applied.

3.10.1 Transcription

Firstly, the interviews were listened to and transcribed verbatim. I transcribed seven interviews and a university approved member of staff transcribed the remaining three. Efforts were made to transcribe and analyse the most recent transcript and compare this to previous datasets before the next interview but, due to time constraints and availability, this was not possible on every occasion. However, I endeavoured to listen to the recording before the next interview and make notes, even if transcription was not feasible.

3.10.2 Coding process

Following transcription, I applied ‘initial coding’ to each dataset, which involved applying a code to each line of the transcript. I used “in vivo” codes where appropriate, which involves preserving the participant’s words (Charmaz, 2006). Although alternative coding approaches are referenced by Charmaz (2006), I deemed line-by-line most beneficial in supporting my immersion in the data, confidence in the coding process and the generation of initial hypotheses. I considered the use of computer software, such as NVivo, but decided not to pursue this as I believed navigating a new software may impact my ability to fully attend to the data. As an alternative, I placed initial codes in an excel document, assigning each participant a tab (See Appendix D).

Following initial coding, I embarked on developing focused codes. This involved identifying and consolidating what I interpreted as the most noteworthy concepts and categories within the data (Charmaz, 2006). By constantly comparing, analysing and re-analysing the data, I began refining these codes (Charmaz, 2006; Glazer & Strauss, 1967). These codes subsequently informed ‘axial coding’, whereby I began to develop a conceptual framework of participants experiences (Charmaz, 2006). To support ‘axial coding’, I drew upon Strauss and Corbin’s (1998) Paradigm Model. This model highlights the importance of identifying the central phenomenon or core process within the data, alongside the ‘causes’, ‘intervening conditions’, ‘consequences’ and ‘context’ underpinning this process. In using this model to scaffold my thinking, I began to identify interactions between core concepts and categories, which supported the generation of the proposed theory (Charmaz, 2006; Strauss & Corbin, 1998).

Alongside recruitment and ongoing analysis, I began to pursue theoretical sampling (Charmaz, 2006). The purpose of theoretical sampling is to expand upon these initial concepts and categories, identify new avenues of interest and direct future research decisions (Butler et al., 2018; Charmaz 2006, 2014; Strauss & Corbin, 1998). The aim is to achieve 'theoretical saturation', which Charmaz (2006) defines as the point at which "gathering fresh data no longer sparks new theoretical insights nor reveals new properties of these core theoretical categories' (p.113). Although the limited timeframe and sample size of this study made this challenging to achieve, elements of theoretical sampling were pursued. These included refining the interview topics as interviews progressed and returning to previous datasets to recode in light of new hypotheses.

3.10.3 Memo writing

Memo-writing is a key asset of Grounded Theory which serves to not only support theory generation but enhance researcher self-reflexivity (Charmaz, 2006; Tie, 2019). I created memos throughout the research process which supported me to consider my own experiences of the interviews, constantly compare the data and formulate hypotheses (Charmaz, 2006; Strauss & Glaser, 1967). In many instances, this involved drawing diagrams and discussing these during supervision. By doing so, I provided a space to reflect on the process of being a researcher, from a content and process perspective (See Appendix D).

CHAPTER FOUR: RESULTS

This chapter presents the modified grounded theory I have generated from interviewing nine adult children who self-identified as growing up alongside a parent with an ED or DE. I will start by providing an overview of the findings, which are complemented by a diagram (see Figure.1). This will then be followed by a detailed account of each of the findings, in turn. I have included participant quotes throughout to ensure that my interpretations are embedded within the data. For the purpose of readability and confidentiality, I have inserted or altered words (e.g. replaced 'her' or names with 'parent'). These occasions are marked with a square bracket.

4.1 Overall description of the model

The following model offers an account of how adult children made sense of and responded to growing up alongside a parent with an ED or DE. Firstly, participants described the typical routines, norms and rules they encountered whilst growing up. These mainly related to food, eating and weight. Alongside this, participants offered an account of their relationship with their parent. Based on participant descriptions and my own reflections whilst memo-writing, I generated the concept of the *'Bubble of Normality'*. Participants appeared to describe these routines, norms and rules to fluctuate across the course of their lives.

Throughout their lives, participants appeared to respond to their bubble of normality on two levels. I have referred to the first level as 'cognitive responses'. This is because the priority for participants seemed to be making sense of and understanding their bubble of normality. At this level, participants appeared to move between *'(re)absorption', 'recognition'* and *'reflection'*. During *'(re)absorption'*, participants expressed being accepting and unquestioning of their experiences. During *'recognition'*, they began to notice and question the discrepancies between their own and other people's bubbles of normality. Finally, during *'reflection'*, participants reflected on alternative reasons for their bubble of normality and the personal impact of their experiences.

Alongside making sense of their experiences, participants also appeared to respond by 'doing'. I have referred to this level as the 'behavioural level' because the focus for participants seemed to be on their actions and behaviour. At this level, participants seemed to move between *'re-enactment'* and *'rebellion'*. *'Re-enactment'* captures participants descriptions of imitating their parent's attitudes and behaviour in an attempt to meet the expectations of their bubble of normality. In contrast, '*rebellion*' captures their attempts to resist their bubble of normality and the associated norms, routines and rules.

By navigating these two levels, participants appeared to work towards the core process of *'renegotiating the bubble of normality'*. This process captures their attempts to find the middle ground between these levels, in order to create an alternative, more positive bubble of normality as adults.

Based on participants' accounts, their movements between and within these levels is not linear. Instead, they described the process as fluid and variable, often revisiting levels at different points in their lives. For example, participants described revisiting *'re-enactment'* despite sustained periods of '*renegotiation'*. This being said, their movements appeared to be influenced by certain factors. For example, participants experiences of *'reabsorption'* were influenced by *'systemic reinforcers'* and *'attributions'* whereas *'rebellion'* appeared to be influenced by '*childhood allies'*, *'adulthood allies'* and '*internal motivations'*.

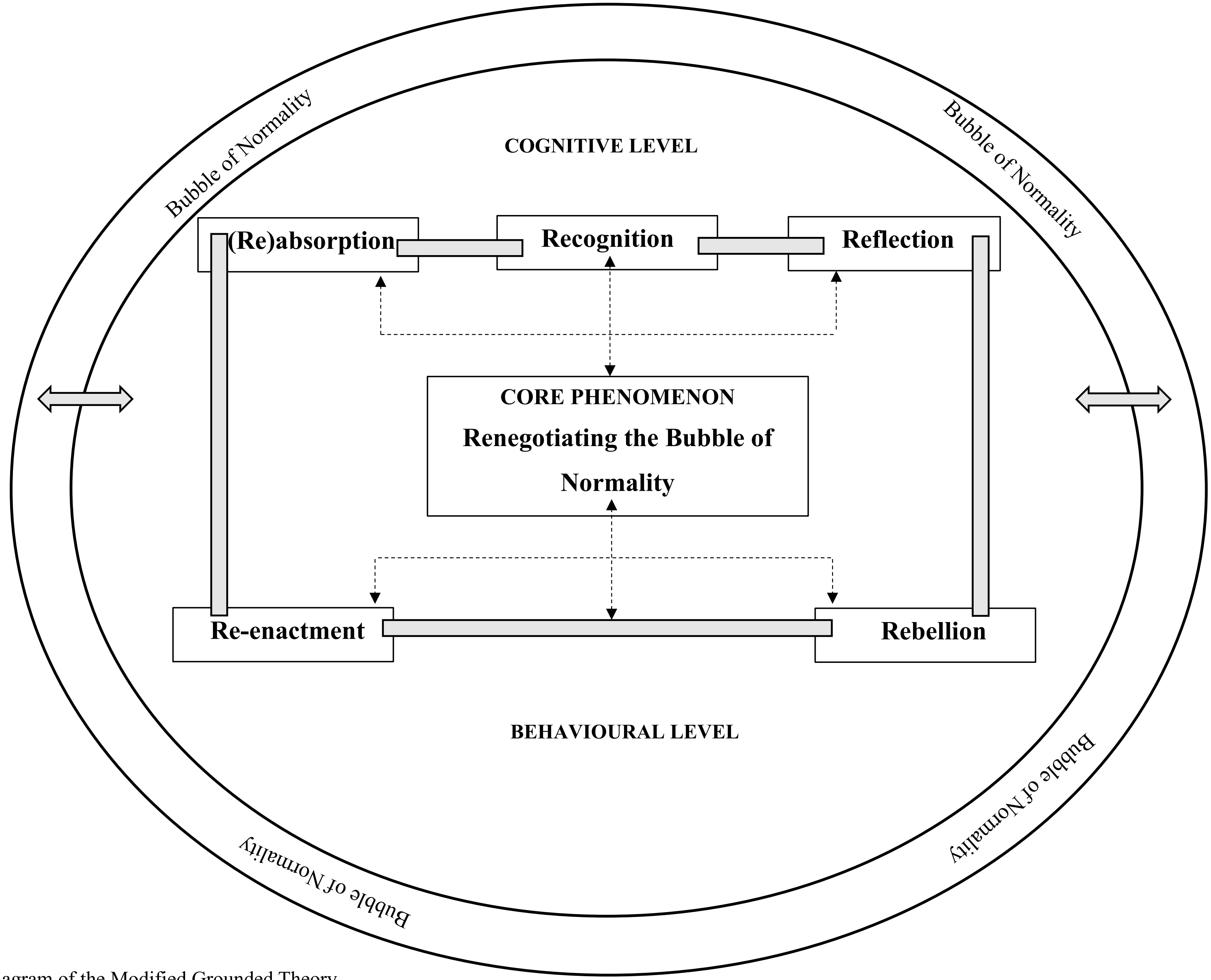

Figure 1: Diagram of the Modified Grounded Theory.

CHAPTER FIVE: THE BUBBLE OF NORMALITY

As outlined previously, the '*Bubble of Normality'* captures participants' accounts of their typical lives as they grew up alongside a parent with an ED or DE. This chapter will describe the main aspects of their lives to be affected. These are broadly divided into *'food, eating and weight related norms'* and *'relationship norms'*.

5.1 Food, eating and weight related norms

5.1.1 A functional norm

Many participants described their parent as having a purely "*functional"* (Lily) relationship with food, which is based on "*survival not pleasure"* (Freya). They shared their perspective that their parent does not give "*a crap about food"* (Emily) and food is "*literally just there because you have to eat"* (Sarah). Participants described how this narrative dominated their childhood and continues to be vocalised by their parent now.

> *"My mum always says all the time that she is like if she could just take a pill that gives her all the fats all the protein all the sugar that she needs and then that would mean that she wouldn't have to deal with food and eating and supermarkets she would 100% just take a pill.*" *(Amelia)*

Many participants noted that everyday food related activities were impacted by their parent's functional approach to food and eating. For example, they recalled how their parent would rely on *"a few standard meals"* (Lily), *"just chuck us something in that was simple*" (Emily) and *"would never be in the kitchen for long"* (Katie), whilst another joked *"if you can't put it in the oven at 200 degrees for half an hour and leave it and get it out like that was the kind of cooking"* (Amelia). This led participants to experience mealtimes as unappetising and repetitive.

> *"Say we were having like salmon and boiled potatoes for the third time in like two weeks you'd just like push it around the plate like this is so bland and this is so boring like where's the seasoning?" (Sarah)*

Additionally, participants struggled to recall going food shopping with their parent "*unless [they] desperately had to"* (Sarah) whilst another noted that their mother *"always went shopping by herself and so did my dad"* (Megan). For another participant, their parents functional approach appeared to elicit feelings of confusion and curiosity about how meals were actually made.

> *"You'd have boiled potatoes on the plate they were literally just boiled but like how did the salmon get there and how do you cook broccoli or peas or whatever it is?" (Sarah)*

Participants also commented that they would rarely "*eat together as a family"* (Katie), eat *"by ourselves in our rooms"* (Lily) or family members would *"eat at different times"* (Emily). On the rare occasions family mealtimes took place, participants shared that their parent with DE was absent or *"no matter what would happen [mum] would always get up before us [from the table]"* (Sarah).

> *"Even when he would have things like Christmas dinner erm he'd either eat before us or he'd eat after us." (Megan)*

However, this was not the experience of all participants as some described their parent as over-involved and intrusive during mealtimes. For example, some participants expressed *"being watched by mum as to how much we were eating"* (Zara) and likened their parent to an *"annoying girlfriend who always said they didn't want any food and then would steal food off of your plate"* (Megan). Another participant felt their parent imposed food onto them despite their feedback that they were not hungry.

> *"She always used to make sure that, even if we wasn't hungry, she would be like you need to eat your breakfast and I'd be like mum I'm literally not hungry." (Emily)*

5.1.2 A hazardous norm

Moreover, participants described their parents as adopting a hazardous way of being around food and eating. For example, one participant communicated that their parent is overly concerned about food safety and the risk that the participant may "*get salmonella and chicken is not safe and things like that" (Amelia)*. Alternatively, one participant commented that their parent attributes food to increasing the risk of certain health conditions.

"She is very, very healthy conscious and she always says well I've got patients that are my [participants] age and they've got diabetes." (Megan)

For other participants, they recalled food and eating to represent a financial hazard to their parent, commenting "*there was a level of like you need to restrict control yourselves a bit more because like I can't afford this"* (Amelia). In contrast, another participant understood the source of threat to come from their parent's view that engaging in food related tasks would reinforce gender stereotypes and power imbalances.

"She feels like she will be controlled by men if she stays in the kitchen." (Freya)

Two participants, who described themselves as overweight as children, felt their weight was perceived by their parent as a threat to their reputation and competence as a mother. One of these participants felt their parent *"was a little bit horrified by the fact that she had a child that was overweight"* (Natalie).

"She thinks that how I look reflects on her, she's a bad parent if I'm overweight, she's overfed me." (Megan)

5.1.3 A competitive norm

The topic of weight dominated participants' lives growing up, with one participant stating "*I can't ever remember my mum not talking about how large she was or always being on a diet"* (Emily).

Another participant described their parent as being *"fixated on like she wanted to lose x amount of weight"* (Natalie). This appeared to fuel a sense of competition between participants, their parent and siblings.

> *"When I do lose weight she'll say, well have you done it correctly because you know you are just gonna gain weight back if you haven't and she'd almost be frustrated that I'd lost the weight because she hasn't erm so there is still, the competition hasn't really ended I don't think."*
>
> *(Megan)*

Another participant described their parent as needing to *"eat healthier than other people or eat less than other people"* (Natalie) whilst others experienced their parent to instil competition between them and their siblings due to offering comments that their sibling *"goes out and she eats and she doesn't put this weight on"* (Sarah). One participant noted that their parent appeared to provoke competition by refusing to offer clothing advice because the participants *"body shape was so different"* (Zara) to theirs.

> *"I remember being a teenager and she would say numerous times, 'Oh my gosh! You know 30 years younger than you, 20/30 years younger than you and I'm, and I'm a similar weight."*
>
> *(Lily)*

Participants reflected on the occasions they felt they had either won or lost the competition with their parent or sibling. For instance, having learnt their sister was purging one participant recalled *"this feeling of envy of like, 'Oh my gosh! It's like. . . so, she's managed to, to do something to, to manage her weight that I've never been able to do"* (Lily). Alternately, another participant recalled an occasion in which they felt they had 'won' the competition with their parent by fitting into an item of clothing that no longer fitted their parent.

"The look of absolute horror on her face erm that and I couldn't decide whether it was that [sigh] that she was horrified that she was fatter than somebody who is usual, who she associated with being fat in her mind erm or that I'd won effectively and finally become thinner than her."

(Zara)

In the event they were 'winning' the competition to lose weight, participants described how their parent would attempt to sabotage their success or encourage them to deviate from their diet.

"I would be dieting because I wasn't happy but she, she would have to diet more or she would encourage me to break my diet…if she did break her diet or if she eat something she did not want to eat or was a bit naughty she would try and convince me to do it too."

(Sarah)

For one participant who received a diagnosis of AN during their teenage years, they felt the differences in their own and their father's ED (BED) minimised the potential for competition.

"I didn't feel like threatened by his eating disorder because if I'd have had a parent who'd had anorexia, I would have found that really hard because it would have almost become like competitive."

(Katie)

5.1.4 A rule-based norm

Informed by these relationships and narratives participants recalled being exposed to the rule that that there are *"bad foods and good foods"* (Zara). Bad foods, defined as those containing a higher calorific or processed content, were communicated to the participant as *"a bit naughty"* and seen as *"a treat"'* (Emily).

"Definitely a sense that there were like foods that were bad and, and I always had a sense of that."

(Natalie)

Some noted how foods considered bad were not permitted within the home, with one participant commenting that they grew up in *"such a healthy household and we had no access to kind of junk food or anything like that"* (Megan). However, this was not the case for all participants, one of whom described unregulated access to sweets. This set up was attributed to their parent's tendency to snack rather than eat meals.

> *"We always had like a sweet cupboard and we still have it now but when we were kids we always had like a thing like it was almost like a free for all so there were no really rules in it."*
> *(Sarah)*

In contrast, good foods were those deemed to be *"low in calories and everything"* (Sarah). Participants recalled how certain items, particularly "*like flora light or skimmed milk"* (Emily) were endorsed by their parent. One participant observed their mother becoming distressed when foods fitting their chosen specification were not available, whilst another encouraged them to combine *"certain food groups at one time because that would somehow lessen the calorific content"* (Zara).

To increase the likelihood that 'bad' foods would not be consumed, participants recalled rules around "*not going food shopping hungry"* (Sarah) and only having food items in the house that "*took* s*o long to prepare that you had to really want it to eat it in the first place"* (Zara). These rules appeared to be linked to increasing self-control and restraint around food.

> *"All bread went into the freezer because if its not in the freezer you would eat it all immediately and nobody wants to defrost it so you would have some more self control" (Megan).*

Two participants shared that they grew up with the rule that they needed to exercise in order to earn food, commenting that it was linked with *"the right to eat something"* (Zara). Being active was communicated as a priority and means to control weight, with one participant expressing that they had little influence over their level of participation. This was not, however, the experience of all participants, with one person viewing exercise as an enjoyable activity and "*something we'd often do as a family" (Katie).*

"My mum would, would sign me up for gymnastic classes or she, she would ask me to go to the gym to ke*ep my weight under control." (Freya)*

In addition, two participants described rules around compensating for perceived lapses in self control around food. One participant shared how their parent would "*not eat the whole day to like compensate having a meal [e.g takeaway] in the evening"* (Emily). Another participant recalled receiving feedback from their parent that they should restrict their dietary intake to compensate for eating 'bad' food at their friend's house.

"I'd tell her what I'd eaten and, and then she'd tell me that I'd probably need to not each as much for the next few days to make up for it." (Zara)

Accompanying the above rules, participants described growing up with the rule that they could not exceed a certain weight and needed to *"fit in this prototype of being thinner"* (Freya). Another participant recalled how their *"mum would always say like I can't be in double digits"* and attempted to maintain a lower weight by attending *"weightwatchers despite being a size ten or a size eight"* (Emily). Rules surrounding weight monitoring were also present, with participants recalling how their parent *"used to weigh himself like all the time"* (Katie).

"I was aware from a fairly young age that it was important that I wasn't fat."

(Zara).

Two participants described growing up with the rule that perceived flaws in appearance needed to be resolved, mainly via cosmetic interventions. For example, one participant recalled their parent commenting "*as soon as I have enough money I'm going to get a tummy tuck, as soon as I've got* *enough money I'm going to have this, I'm going to have that"* (Emily). For one participant, this resulted in a sense that the discomfort associated with imperfection was only temporary and could be 'fixed' with surgery.

"It's almost like, 'Oh well, I only have to put up with this for so long, and like I only have to put up with the way that I look for so long. Umm, because I can fix it." (Lily).

5.1.5 Influencing factors

Although these rules featured heavily in their lives, some participants emphasised that there *"wasn't one set of rules, it was a constantly changing"* (Zara). They described the tightening or relaxation of these rules to be influenced by a number of factors.

5.1.5.1 Relaxation of the rules

Participants described their parent's emotional state and whether they were *"having a good week"* (Megan) as one factor influencing the relaxation of the rules. In these instances, they shared that their parent imposed less boundaries and restriction onto their own eating and food choices, which subsequently led to participants being afforded more freedom.

"She was like oh well I got this box of chocolates from a patient at work, let's have this box of chocolates, she had a box of cho-if she had a piece of chocolate we all were allowed a piece of chocolate." (Megan)

A further factor included special occasions, such as Christmas and eating out. This was described as a "*notable example in that you know Christmas we were allowed to eat what we wanted"* (Zara).

"One of the newspapers used to do some kind of voucher thing where you could cut out tokens from the newspaper and if you got so many tokens that you can have a meal at a relatively nice restaurant for… that was like the only time that she'd, she'd eat without any of the rules."

(Zara)

One participant described gender as a factor, describing how "*the same sort of eating rules weren't, weren't put on him [brother] as a boy"* (Zara), whilst another felt that their brother developing an ED served as a catalyst for the rules to be relaxed.

"I think when my brother got diagnosed with an eating disorder that was when she kind of flipped and was like oh my God, it's impacting him and I think she kind of clocked and then we had like biscuits and crisps and you know like normal things in the house."

(Emily)

5.1.5.2 Tightening of the rules

In contrast, participants referenced a number of factors which led to a tightening of the rules. These included their parent imposing more restrictions upon themselves and the introduction of new diets.

"Nobody else was allowed to do the things that she wasn't allowing herself to do so she decided you know this week I am only going to eat protein and veggies because I need to give my body a carb break, we were all eating protein and veggies that week erm because you don't eat them either, if I don't need them, you don't need them" (Megan)

"He was constantly going through like phases erm diets so he'd always be like yeah I'm going to do the keto diet or I'm going to completely cut out sugar or I'm going to go vegan or he would always be trying something new…"(Katie)

Another participant felt the rules applied more stringently to them as their parent "*felt that my body reflected hers more whereas [sister's name] could just eat anything and she'd stay very slim"* (Megan). Similarly, two participants recalled noticing an increase in restrictions in response to "*getting into-to adolescence and obviously you know gaining some weight like all girls"* (Freya).

"She'd restrict, she'd restrict the volume erm and then as, as I became a teenager er then that would then apply to me as well." (Zara)

5.2 Relationship norms

Accompanying food, eating and weight related norms, participants shared their experiences of their relationship with their parent. These experiences include *'a supportive relationship ', 'a critical relationship', 'blurred boundaries', 'emotional misattunement'* and *'emotional inconsistency'.*

5.2.1 A supportive relationship

Seven participants described a "*really close"* (Amelia) and supportive relationship, commenting "*I've always grown up thinking that I could be literally anything I wanted to be"* (Emily). Another participant expressed feeling loved and identified their parent as their *"best friend"* and "*the person I would call when I'm bored or when something major comes up"* (Freya). Although this closeness was present for one participant, this was felt "*very intensely erm which sometimes was lovely and sometimes was a little bit frightening"* (Zara).

"I've always felt and still to this day that I can go to my mum like; and I know that she loves me so much. So, I have like a very secure base with her." (Natalie)

Four of these participants experienced this dynamic most strongly in school and career contexts. They expressed feeling that their parent "*consistently erm believed in like my academic abilities or my erm external activities"* (Emily), "*was heavily involved in you know umm, school homework"* (Freya) and "*was there like fighting my corner"* (Natalie) in response to experiences of bullying. Interestingly, one participant described their parent as very involved in the academic side of school yet "*food and lunches were probably the one area where she is almost like don't care what you do, just sort yourself out"* (Amelia). For another participant, they experienced their parent's involvement as disingenuous and largely for the purpose of improving their social status.

"She didn't take an active role in like my schooling or an interest in like my schooling or anything like that. But then when I did really well, would tell all her friends and make a big deal out of it. And-and even as a kid I knew this isn't about me; this is about how this makes you look."

(Lily)

5.2.2 A critical relationship

In direct contrast to feeling supported, many participants described a critical relationship with their parent. They recalled their parent offering direct criticism, using language such as *"you're gorging yourself or you're like gannets gorging yourself"* (Amelia) and responding disproportionately to the food decisions they made. A further two participants recalled how their parent would comment when they had a *"slightly bigger portion than you needed and would quote guidelines…"* (Megan) as well as drawing similarities between their and their parent's problematic eating traits.

"I had like a pack of biscuits and I just wanted to eat the whole pack because, just like as a child would, I just wanted to finish the whole pack of biscuits and I would say it was just greediness erm and then my mum, my mum made the comment, she said to me like oh you know you can't do that because you're gonna end up like your dad." (Katie)

Alongside food related criticism, participants shared that they felt criticised regarding their weight and activity levels. For example, participants recalled their parent offering comments such as "oh come on. You need to lose weight" (Natalie) and referring to *"being lazy and things and being bone idle"* (Sarah).

"Sometimes when I would just call her to pick me up from, from school she would answer well, it might be better if you, if you just walk home, you know if, if you haven't moved today."

(Freya)

Alternatively, four participants indicated that they experienced indirect criticism regarding their food and eating choices. Although their parent never *"commented on what we were eating"* (Emily) and was not *"judging what we ate or anything like that"* (Lily), they did observe their parent criticising their own and other people's food choices. This included observing their parent without an ED criticising their father with BED about *"being greedy"* and questioning him as to why he was *"eating all that again?"* (Katie).

"She didn't hide us from comments she would make about herself or her own meals oh this is really fattening or I can only have this much or oh there's loads of calories in this."
(Emily)

A similar experience was described in the context of weight related discussions, with participants remembering comments made by their parent, such as *'I've gotten fatter, so I need to, I need to cut- I'm cutting down on what I'm eating"* (Lily) and *"oh my God I've put on so much weight"* (Emily). Another participant shared how their parent expressed disgust towards their body if they believed they had gained weight. Expressions of disgust were also present towards members of the public, with one parent offering remarks such as *"oh look at them, they've got a fat bum or you know they have got quite a round belly"* (Megan).

"If she ever thought that she'd gained weight, she'd sort of hold onto it, she'd sort of hold on to bits of her skin and sort of show you and go look at this, it's disgusting erm and she'd, she'd be appalled and repulsed by it." (Zara)

Having reached adulthood, many participants disclosed that they continue to feel criticised about their food choices and weight. One participant described how their mother is "*still disappointed if I, me or my brother gain weight…and she shows concern if my children look like they are gaining weight"* (Zara) whilst another recalled *"every time I enter the house after a long time…She will just scan me to see if, if I gained weight"* (Freya). For another participant, they shared their experiences of observing their mother *"zoom in on the photo's that [sister] put in Instagram and be like look at what she is eating, look at that, look at the lard on that"* (Amelia). One participant, who complemented themselves on a wedding photograph, recalled their parent informing them that they should only do so when they have returned to the weight they were at their wedding day.

"Our wedding was three years ago, amazing pictures. And I look at myself on those pictures and said, Oh my God! I look amazing…She came over and said how much did you weigh on your wedding day. I told her how much and she was like, will you go back to this weight? Then you can say that." (Freya)

5.2.3 Blurred boundaries

Although many participants felt and continue to feel close to their parent, some described how the dynamic has "n*ever really felt like a mother-child relationship"* (Megan). They shared that they were and continue to be relied upon to help resolve family difficulties and conflict, with one participant noting that when *"mum and dad were having like relationship problems, they'd come to me about each other"* (Katie). Other participants recalled their parent seeking support from them and disclosing things they "*shouldn't really be hearing…"* (Amelia).

"She used to lean on me for a lot of support more than I did on her, I remember that from being a really, really young age." (Emily).

Participants reflected that this dynamic also involved being placed in a parent rather than child role. They described their parent and themselves as *"the manager and like deputy manager of the family"* (Amelia), as well as the "*quick coparent"* (Megan).

"I would always say I've been like the family therapist (laugh) like I've always been, since a child." (*Katie)*

Alongside this, some participants described their experience of being placed in a reassuring role, particularly with regards to their parents' appearance and body image. They recalled their parent seeking confirmation that they did not look overweight and their response *"of course you're not fat, of course you're not fat you look lovely"* (Emily).

> *"My mum would-would get changed and then she would come and say, 'Do I look okay?' 'Yes. You look nice.' 'Not fat?' 'No. You don't look fat.' 'Are you sure?' and she'd turn aside, 'I don't look fat?' 'No. You don't.' and I was young! (Lily)*

For one participant who grew up with a parent experiencing BN, they recalled taking responsibility for trying to resolve their mother's sickness whilst encouraging her to seek medical advice.

> *"I asked mum a lot of questions when she was like being sick and trying to be really sensible about it like especially when we got to a better age where we would ask those questions of being like so why, why are you sick? Do you think it is something we are eating? Do you think you are allergic to something and should you go to the doctors…" (Emily)*

Another participant recalled receiving little guidance or input from their parent regarding aspects of self care and, as a result, became self-sufficient in locating this information themselves.

> *"…I remember going on the internet and realising, you know, you know you get those polls of like how often do you brush your teeth or whatever. And people were saying like twice a day. Like, okay twice a day that's normal; that's what people do. So, I have to brush my teeth twice a day." (Lily)*

For those participants who identified themselves as being on the 'safer side' of their parent, they described taking on a protective parental role towards their sibling. This involved "*jumping in and trying to offer a different perspective"* and ultimately attempting to rescue their sibling from the emotional impact of their parent's criticism.

> *"We have really taken it upon ourselves me and brother to be like we need to catch her because if you just hear that from your mother and you don't have an alternative perspective that is really, really toxic." (Amelia)*

5.2.4 Emotional misattunement

Alongside these dynamics, participants felt their parent did not and continues to find it difficult to recognise their expression of distress, particularly if they are not communicated explicitly. One participant noted "u*nless something catastrophic or like a crisis point happened, I don't think she might have been tuned in to the really little things"* (Emily). Although some parents recognised distress, participants described their responses as mis-attuned and somewhat unhelpful, particularly within the context of weight loss.

> *"When I had a flare up with my ED last year she had a sit down chat with me saying [name] this is not sustainable, you know when you start eating again you're going to damage your metabolism and you're gonna gain triple the weight, is that what you want? And I was like that is probably not the best way to go about this but thanks…" (Megan)*

> "*My mum knew that I was going through this horrific breakup; she was visiting me you know I'd been crying and hadn't been myself and blah, blah. And I said to my mum, 'Oh, you know I've lost 4 kilos,' and she said, 'Well done.' (Lily)*

5.2.5 Emotional inconsistency

Participants also shared their experiences of their parent's emotional inconsistency, describing it as *"a bit of an emotional minefield at the best of times"* (Zara). One participant reported their parent's emotional investment to oscillate between *"see you in a few months, good luck with your life, catch you later and then very like what have you got going on, tell me what you did at work like very* *involved" (Amelia).* For one participant, they observed their parent to experience *"depressive cycles"* (Natalie), which exacerbated boundary difficulties within the relationship.

> *"I remember seeing like a kind of cycle with my mum…She'd be like feeling quite motivated and stuff like that. And then it was almost like crash and then she'd feel like really bad and be smoking loads of weed…"(Natalie)*

CHAPTER SIX

COGNITIVE RESPONSES: (RE)ABSORPTION, RECOGNITION AND REFLECTION

The previous chapter offered an overview of participants' descriptions of their bubble of normality. They described the norms and rules they were surrounded by as they grew up, in relation to food, eating, weight and the parent-child dynamic. In this chapter, I will describe how participants appeared to respond to their bubble of normality at the cognitive level. This level is divided into *'(re)absorption', 'recognition'* and *'reflection'.* In addition, I will explore the factors which seemed to contribute to participants' movement within this level.

6.1 Defining (re)absorption

During '*(re)absorption'*, every participant described a non-questioning and accepting stance towards their bubble of normality. They expressed an overwhelming feeling that *"it was just really normal"* (Katie) and, at this point in their lives, they had no reason to question the norms and rules they were exposed to.

"It was really normal and I didn't really think otherwise." (Amelia).

6.1.2 Influencing factors

Participants descriptions of being absorbed in their bubble of normality appeared to be influenced by a number of factors. These factors strengthened and reinforced their accepting and non-questioning stance. They included *'attributions', 'systemic reinforcers'* and *'competing priorities'.*

6.1.2.1 Attributions

Of the participants who identified as growing up alongside a mother with restrictive eating or AN, many attributed their parent's behaviour to their gender and being a mother. They described a sense of inevitability that this is "*just what mothers were like. That was just what women were like" (Lily)* and, as they got older, anticipated they would follow the same path.

"I just assumed that men eat like a big dinner and women, eventually when you get to a certain age, you just eat salad and you just eat smaller portions." (Sarah)

Other participants attributed their experiences to their parent's work commitments, commenting *"it was always because she was too busy, mum's busy she is on nights"* (Amelia) whilst another participant *"justified it in [their] head as* o*h, we're just all really busy!'* (Lily).

"There is always somewhere to be or something to do so mealtimes weren't really a time to sit down and chat and enjoy the food and mindfully chew, they were you know it was very much eat to live apart, as opposed to live to eat." (Megan)

For participants who grew up with a mother and father with BN and BED, they attributed incidents of purging to their parent being "*really sick when we were kids"* (Sarah). Another participant interpreted episodes of bingeing as their parent appreciating and enjoying food.

> *"I was just like oh my dad just loves food." (Katie)*

Other participants attributed their experiences to being "*fussy"* (Emily), which was communicated to them by their parent, or difficulties accommodating their dietary preferences. In these examples, there was a sense that participants were taking some responsibility for their parent's approach to cooking and mealtimes.

> *"I went vegetarian when I was twelve or thirteen, it was like, ohh, like they don't know how to you know they don't know how to cook for me." (Lily)*

Some participants believed their parent's approach was motivated by protection, care and supporting them to "*move closer to my goal and make me look more beautiful"* (Freya).

> *"I really did see it as she was just trying to protect me and she was trying to help me…I thought oh she, I, she gets me she is just trying to help me and she knows what is feels like to carry larger than you know other people do." (Megan)*

6.1.2.2 Systemic reinforcers

Participants referred to a number of wider societal, social and cultural reinforcers. For example, many recalled that *"dieting was so normalised"* (Lily) in society, meaning that *"my mum's attitudes towards food didn't stand out that much because it was, it was a fairly common thing for people to talk about"* (Zara). One participant expressed that *"the way that society treats fat people as a whole"* and the medias influence on "*fear mongering about being fat"* (Natalie) further contributed to their attributions.

> *"It was all of my surrounding you know circle like they would all just think about weight all the time and they were equal how worthy you are with your weight."*
> *(Freya)*

Some participants, who grew up outside the United Kingdom for periods of their childhood, emphasised how the culture was "*very image focused, very bigger, better, glamourous, a lot of money"* (Lily). This participant questioned whether, had they not been exposed to these norms, their parent's relationship with food and eating "*would've raised more red flags"* (Lily).

> *"I grew up with the sort of like the culture and the feeling of it being umm, of certain foods being like better and like signifying that you live a better life." (Natalie)*

Two participants shared that being "*in the extremes of very clear kind of anorexia"* (Lily) socially contributed to their perception that their parent's relationship with food, eating and body image was "*innocent, like not an issue"* (Lily). For another participant, their attributions regarding busyness were reinforced by their experiences paralleling a similar "*set up as my friends, you know we were raised quite working class, it was quite fast paced."* (Megan)

> *"A lot of my friends had very similar problems. One of them was, and still is er, diagnosed with er, anorexia so, you know to me all of those kind of very problematic traits were normal up to a certain age." (Freya)*

6.1.2.3 Competing priorities

Alongside attributions and reinforcers, participants described that it was often necessary to navigate and manage more acute difficulties within the family system. For example, many participants shared that their parent *"really struggled with [their] mental health anyway"* (Natalie), referring to anxiety, depression and alcohol dependence difficulties. Some participants described how wider systemic challenges, such as the long-term physical health, additional learning needs and marital conflict overshadowed their parents ED.

"I feel like my family in general is very complex in the sense that we, my brother has a disability, my dad has a disability, my other brother was just in and out of trouble with the police so I was very aware from like a really young age that I probably didn't have like the nuclear family set up and I don't ever think mum's eating was the biggest issue at the time." (Emily)

6.2 Defining recognition

Participants described that they remained absorbed in their bubble of normality for the majority of their early childhood, however transitioned to *'recognition'* as they matured. This captures the moments participants became aware that their bubble of normality was different to other people's. Participants initially described these moments as *"weirdness"* (Amelia) and *"wild"* (Sarah).

…being like that's weird like that's not what my family does." (Amelia)

6.2.1 Influencing factors

Similar to (re)absorption, there appeared to be a number of factors that prompted participants to become more aware of the differences between their own and other people's norms and relationships. These included *'social exposure'*, *'new relationships'* and *'parental confirmation'*.

6.2.1.1 Social exposure

Many participants identified childhood social situations, in which they spent time with other families and parents, as a key factor. For many, these events were described as a revelation, where they felt as though they were temporarily "*living like some kind of like TV fantasy of what it was to be a family"*

(Zara). Other participants recalled key moments in which they observed their friends' parents investing time in meal preparation and cooking.

> *"I remember once I was maybe nine and I went round to my friend's house and her mum was making this like tomato risotto I remember everything about it and I remember her mum like chopping up garlic and I was like what the hell is that [laugh] and she was like proper cooking and it was amazing." (Amelia)*

Another participant recalled the moment they became aware that, unlike their mother who "*eats salad and eats like smaller portions and is like ill after meals"* (Sarah), their friend's parent ate the same meal portions as other members of the family. The same participant also described the *"wild"* (Sarah) moment in which their friend's mother consulted them about meal options and every member of the family ate the same meal with similar portions. One participant noted that the emotional temperature of mealtimes felt more positive as *"there wasn't any eggshells to walk on so it just felt comfortable and easier"* (Zara).

> *"We would sit down and everyone ate the same portions and everyone was like, her mum was like do you want cheese on it or you know this is what we are going to have today, is that ok? And then we would sit down like me, her dad, her mum and her and then like her little sister who obviously didn't eat the same but her mum was just eating what we were."*
>
> *(Sarah)*

A further example relates to a participants first experience of venturing out socially without their parent and learning that fast food exists. They described how "*all of my er sights opened up and it was like this, this tastes great, this is fantastic"* (Zara).

> *"It was the first time I'd been out without my mum erm and she [friend] said you know shall we go to McDonalds and get a happy meal and I had no idea what one was erm because I'd never had one…"*
>
> *(Zara)*

Although these social situations prompted participants to recognise that differences existed, one participant expressed uncertainty as to whether they "*would have gone oh are we the odd ones are they the odd ones"* (Sarah). In these instances, it appeared that participants became absorbed in their own bubble of normality once again.

> *"I just thought you know, they're just uneducated, they are just hurting their bodies, they just don't know what it's doing to them. It was a cheeky treat for me, I never really thought oh the issue is my house." (Megan)*

6.2.1.2 New relationships

For other participants, these moments of recognition were '*a fairly recent revelation"* (Lily) and one they only really started engaging with as adults. They described new relationships with their partners as particularly significant, noting how "*this whole thing changed when I started being with my husband"* (Freya).

> *"I remember watching him cook and he would like of know how to cook things know how to like chop onion and things like that and I remember saying to him like oh how do you know how to do, do you like watch it on TV and he was sort of like well your mum like tell you how to do this stuff and I'm like no and it was just stuff that was completely alien."*
>
> *(Amelia)*

One participant shared that, although they experienced the social exposure during childhood, the depth of their recognition gained traction as they moved to university. This participant described that it was only when "*people were calling me out" (Sarah)* for *"replicating the same behaviours mum* *used to do"* and drawing similarities between their own and their peers' behaviours that they recognised the atypicality of their early experiences.

> *"She lived opposite me in halls and she was, she has the exact same relationship with her mum, it's exactly the same as mine, she was doing the same behaviours I was doing, so if anything we should have been like oh ok we are even more normal like we have found like a kindred spirit but what we actually realised what that we actually were really weird like really abnormal."*
>
> *(Sarah)*

6.2.1.3 Parental confirmation

Alongside social exposure and new relationships, participants spoke of the impact of receiving confirmation from their parent without an ED. One participant highlighted their mother's feedback about their father's ED as one of the main reasons they began to understand their father's behaviours in a different light.

> *"I mean I feel like I wouldn't have thought much of it if it wasn't for my mum's comments about it erm so I feel like as a young child that, that very much influenced me…"*
>
> *(Katie)*

Other participants echoed similar experiences, describing how their mother's openness in naming their father's difficulties allowed them to connect pieces of the puzzle.

> *"I think I never really thought about my dad's eating until my mum had pointed out that he was in fact bulimic erm I just never really linked it to anything, never really thought about anything."*
>
> *(Megan)*

6.3 Defining ‘reflection’

‘Reflection’ captures participants experiences of contemplating their childhood more widely, where the focus is not just on recognising that differences existed but the reasons and impact for these differences. This deeper level of understanding is divided into *‘parent focused reflections’* and *‘personal reflections’*.

6.3.1 Parent focused reflections

6.3.1.1 Compassionate re-attribution

As a consequence of these turning points, participants began to consider alternative reasons and explanations for their experiences. Whereas previously participants attributed their parent’s relationship with food and eating to factors such as busyness and gender roles, they described a shift towards a more compassionate, mental health oriented attribution which emphasised their parent’s distress. For example, one participant shared their increased awareness as they have matured that their parent is an “*incredibly anxious person”* (Emily) .

> *“In hindsight that of course that was such a trigger for her because it was like you know I’m feeding you and this is difficult for me” (Amelia)*

When reflecting on their experiences, another participant reattributed their parent’s lack of motivation to produce healthy meals for them to being *“so consumed in making her own adult healthy meals”* (Emily) to attend to their needs. One participant, who grew up with a father with bulimia, explained how their clinical knowledge of ED’s allowed them to reframe instances of purging as a way for their parent to “*keep feeling confident, to keep feeling good about himself and that was just a strategy that he had learnt”* (Megan).

Three participants reflected that their parent’s difficulties were likely to be intertwined with other trauma and adverse life experiences, commenting that “*the disordered eating, the body issues are not* *the only thing that are going on for my mum and you know she had a difficult childhood and stuff like that"* (Lily).

"I feel like a lot of the difficult things that mum does and says and behaviours can all pretty much be brought back to how she was treated by her dad." (Amelia)

One participant hypothesised that the adverse social circumstances their parent experienced may have left them with feelings of low self worth and shame. They suggested that their parent may have overcompensated and criticised others as a way to cope with these feelings.

"She's always felt sort of that other people were looking down on her…that she was in some way less because of where we lived and that she was having to clean houses for a living and that the other mums didn't think very much of her so she'd compare herself to them in that she was more attractive than they were and that they'd all let themselves go and she hadn't." (Zara)

Considering their relationship with their parent more generally, participants appeared to re-attribute how available their parents were during their childhood to their mental health, commenting "*he wasn't maybe always able to be there for me because he was trying to deal with what he was struggling with…"* (Katie). Another participant, who understood their parent to be autistic, acknowledged that their parent's tendency to advise rather than comfort is" *not malicious on her side, she just, that's her way of helping and comforting by trying to fix it"* (Megan).

"I am very confident that [parent] is probably autistic so I, I look at it differently now as an adult when she says things I'm like it's fine, she doesn't mean to hurt me…"

(Megan)

For participant one, they have come to understand their experience of the parent-child dynamic to be the result of their mother not having the emotional support network they needed from their partner and other adults in their lives.

"I think her choice is either which of my three kids do I ring today rather than it's like do I kinda keep stuff like quote and quote to myself as in like me and my marriage or do I bring in an external party as in like child and yeah I think she just doesn't, doesn't really have the option of keeping everything at home because she just doesn't have the kind of marriage that allows that."

(Amelia)

6.4 Personal reflections

6.4.1. Childhood losses

Many participants reflecting on the lost elements of their childhood. They described lacking opportunities to develop a close bond with their parent during childhood, describing "*an extremely close friendship"* (Katie) rather than a parent-child relationship. One participant expressed feeling uncared for, angry and resentful towards their parent, although anticipated that they "*will never get what I want from my mum. I will never get the answers that I want…"* (Lily).

Additionally, many participants acknowledged that "*a lot of [their] emotional needs weren't met"* during their childhood and felt, at times, like their parents *"psychological punching bag"* (Megan). Participants described observing and experiencing *"emotional abuse"* (Freya) whilst another shared how their parent continues to withdraw from conversation involving emotions.

"Whenever we start to talk about anything remotely more than surface level, you can, you can physically see her retreat and almost shut down; not be present, not want to talk about it, not want to be involved in it." (Lily)

Another participant recalled missed opportunities to receive comfort from their parent and be the child of the family during upsetting family events.

"When my grandma died I remember my mum she got so drunk, just very drunk and she was like crying on my lap, sat on the sofa and I thought this should definitely be the other way round, [this] should definitely (laugh), I should be crying on you"
(Emily)

Alongside emotional losses, two participants described the practical losses they experienced and their impact on adulthood. This included their ability to cook independently, with one participant commenting that their sibling questions "*how do you boil spaghetti I don't know how to do it*" (Amelia) despite being in her mid twenties.

"When we left for uni I was like pftt I don't know how to cook (laugh) I sit down and I'm like ok my food arrives now so (laugh) how do I get to this process and it was really strange"
(Sarah)

6.4.2 Internalised narratives

A third consequence participants described related to the internalised narratives that have become engrained over time. Participants shared that, due to adopting an adult role as children, they now hold a narrative about prioritising others. Although this was described as a positive trait in some respects, participants acknowledged that it comes at a cost. For example, some noted that they *"one hundred percent downplay my own stuff"* (Emily), *"minimise [their] own personal experience"* (Lily) and are *"always looking out for other people's mental health"* (Sarah) which can feel overwhelming at times.

"Although I'm really, really happy to help him erm almost it is sometimes almost like you need to get to a therapist (laugh) like I can't support you, you are my dad, you know, I can't, I can't give you the help all the time" (Katie)

Participants also shared that, in line with putting others first, they often struggle to give themselves permission to seek support from others. One participant described that they "*don't offer information willingly"* (Lily), particularly regarding their emotional wellbeing, whilst another commented that "*the thought of like seeking out and being like oh I'm struggling, I find it so hard, I have to like push myself to do it"* (Emily).

> *"I think it's ergh a lack of ability to kind of let people in and trust them and allow them to see what happ- what's going on in my life and what's going on for me and what's going on for my family"*
>
> *(Megan)*

Moreover, participants described how they have internalised their parent's critical voice. One participant shared that "*can just hear my mum's voice in my head going you're lazy, you're bone idle"* (Sarah) whilst another described a *"chronic inability to relax"* (Megan) due to feeling criticised for being unproductive as a child. Another participant reflected that their parent's tendency to associate weight with self-worth has resulted in them automatically comparing themselves to determine their place in the *"pecking order"* (Lily).

> *"I would be looking at people's weight. Are they skinnier than me. Are they bigger than me. Are they prettier, are they prettier, what do they look like; how do they do their hair…"*
>
> *(Lily)*

Some participants described internalising a narrative relating to being a "*failure"* and feeling there is "*something wrong"* with them for not exercising the same "*will power to not eat like my mum did"* (Emily). One participant shared how *"it kind of sits with you like why can't I, why am I not like [parent]"* (Sarah). These experience have led participants to feel that they are *"never happy with whatever I'm doing, it is never quite good enough"* (Sarah).

6.4.3 Feeling vulnerable

Due to these internalised narratives, participants shared that they feel vulnerable to developing an ED and following in the footsteps of their parent. One participant identified that they have *"tip-toed on the, on the tight rope"* (Lily) between a healthy and more problematic relationship with food and eating in the past, whilst another expressed concern that they have the potential to develop an ED, despite having a largely positive relationship with food, eating and body image.

> *"I think it is very much more an irrational fear about having one, it is not like I'm going to relapse because there is nothing to relapse into…" (Emily)*

Similarly, participants who disclosed experiencing an ED in the past expressed feeling vulnerable to relapsing. One participant identified that the automatic thoughts they experience surrounding restriction "*are like rooted in my childhood"* (Katie) and increase their risk of relapse, whist another described feeling anxious about embracing their enthusiasm for food during recovery due to the risk of returning to bingeing.

> *"The issues that I had with food was around bingeing. Umm, I never purged; it was binge, it was bingeing. Umm, so definitely in terms of that like there was of like umm, a real worry about it being unhealthy." (Natalie)*

One of these participants shared that they do not feel able to have children due to feeling vulnerable to imposing the parenting practices they experienced onto their children. Although one participant was not against becoming a parent themselves, they expressed concern as to "w*hat is [parent] gonna do, what is she gonna say?"* which may place their child at risk of counterproductive and potentially harmful narratives.

"I have picked up habits from my mum and erm yeah I just wouldn't want to put that onto another child so I, I think that's one of the biggest things is that I absolutely (laugh) do not want children erm because I don't want to hurt them and I, I can't be sure that I'm gonna be the best parent…" *(Megan)*

However, all participants did not share this vulnerability, some of whom expressed an intention to have children in the future. They indicated that they would approach parenting differently by not attaching *"morality"* (Lily) to food or body image. For one participant, they believed having children would provide an opportunity to *"break the cycle that mum maybe didn't break"* (Sarah).

"When I have kids, and I hope I have kids and if I do have kids that I want to raise them to have no insecurities and no secrets about food and I want to raise them so they don't feel like how I feel because you just wouldn't want that for somebody else." (Sarah)

6.4.4 Navigating an internal battle

In addition to feeling vulnerable, participants described experiencing a *"war in [their] own brain"* (Emily). This war was characterised by self-doubt, second guessing their judgements and intentions, alongside struggling to find the middle ground when making food, eating and weight related decisions. One participant shared that, although they are able to complement themselves, they are constantly second guessing their judgement, stating *"my fear is that I see myself more positively than other people see me"* (Lily). For another participant, their experience centres around anxiety that their decision making may be driven by restriction and disordered eating rather than preference.

"Sometimes I won't want a dessert but then I'm like oh but why don't want I want the desert? Do I actually not want the desert or is it because I feel like shouldn't have the desert?" *(Emily).*

Similarly, participants described an internal battle to maintain a balanced and intuitive relationship with food and eating, commenting that they cannot make health related changes "*without going to the extreme"* (Megan). Another participant likened their experience to having "*the devil and the angel on your shoulder all the time"* (Emily) and expressed confusion that it is possible to "*healthily want to lose a bit of weight or you can healthily want to be fitter"* (Emily).

"It's always like, 'Oh, I can eat whatever I want now because then when I'm careful it will, you know my weight won't change so it, I do swing between those two and I don't think I'm ever in the middle." (Lily)

Alongside this, participants spoke about their experiences of eating larger quantities of food, typically following a period of prolonged restriction. They described this as a tendency to "*completely turn sometimes"* (Sarah). For two participants, they felt food in general and consuming more was linked to comfort and "*something that filled what I wasn't getting elsewhere" (Lily).*

"I used to skip meals all the time and then that would lead me to just eat loads in the evening, basically; that was kind of my habit." (Natalie)

6.4.5 Influencing factors

Participants described three factors that appeared to contribute to them reaching the point of 'reflection'. These included *'maturing', 'transferable knowledge'* and *'collective unpacking'*.

6.4.5.1 Maturing

Participants noted that "*it was only really getting older"* (Amelia) that prompted a reconsideration of their parent's relationship with food and their overall relationship with their parent. One participant described that getting older prompted them to recognise their parent's flaws, within both the context of their relationship with food and their parenting practices.

"I don't know if like something switches when you get older and you start to see your parents not as these like perfect embodiments of humans that can do no wrong (laugh)."

(Emily)

6.4.5.2 Transferable knowledge

Many participants shared that they are currently pursuing a career in mental health, including working in the field of ED's. They described their career as the catalyst to gaining more mental health related knowledge and becoming more *"psychologically minded"* (Katie), which subsequently led them to "*look at [parent] from a different, I guess a professional view"* (Emily), see them *"in a different light"* (Natalie). Participants noted that, having supported clients with an ED in a professional capacity, they felt equipped with "*the right questions to ask"* (Katie) and therefore more confident initiating conversations with their parent.

Alongside their career, participants described their own "*self-help jour-journey"* (Natalie) and recovery from an ED as contributing to their transferable knowledge. They felt that their openness surrounding their recovery promoted an honest and reflective space to learn more about their parent's difficulties.

"I think like openly like openly talking about my own recovery with my dad and my family, I think maybe that made him feel like he could speak about it more."

(Katie)

For another participant, learning about wider societal issues relating to the health industry prompted a deeper understanding of their parent's relationship with food and eating.

"And I started listening to a podcast… it's about like the diet and wellness industry. And then like through that see I then started like thinking where that's come from and then got to the kinda realisation that actually. . . I think my mum's got an eating disorder!" (Natalie)

6.4.5.3 Collective unpacking

Many participants emphasised that the opportunity to discuss their experiences with others, including professionals, siblings and friends facilitated reflection. One participant described this process as *"collective unpacking"* (Amelia) whilst another acknowledged that, without therapy, they would still be "*just kind of like tanking along"* (Emily) not connecting on an emotional level with their experiences.

> *"We were raised by the same person erm even though [sister] had a slightly different experience erm as an adult when I'm finding things difficult it has been quite nice to kind of speak to her and have chats and she remembers things in similar ways to me, or she'll remember things completely differently erm so that has been quite helpful." (Megan)*

Another participant identified talking to someone with similar experiences whilst at university served as a catalyst to reconsider the conclusions they had arrived at as a child.

> *"It is nice to have someone to talk to, who gets it because her mum is exactly the same and I wonder if I didn't have her or she hadn't had the same experience would I have come to the conclusions I have come to." (Sarah)*

CHAPTER SEVEN

BEHAVIOURAL RESPONSES: RE-ENACTMENT AND REBELLION

The previous chapter offered an account of how participants appeared to make sense of and arrive at an understanding (i.e. cognitive responses) of their bubble of normality. In this chapter, I will move on to explore how participants responded at the behavioural level. This level is divided into *'re-enactment'* and *'rebellion'*. Similar to the previous chapter, I will also discuss the factors which appeared to contribute to participants moving within this level.

7.1 Defining re-enactment

The first behavioural response is termed *'re-enactment'* and captures how, particularly during their childhood and teenage years, participants responded by striving to replicate and meet the expectations of their bubble of normality, by modelling their parent's behaviours and attitudes.

7.1.1 Parental imitation

To varying extents, every participant described modelling their parents' attitudes and behaviours towards food, eating, weight and body image. For example, one participant recalled using Slim Fast as a meal replacement due to wanting to lose weight and thinking "o*h, my mum uses those shakes or whatever to lose weight"* (Lily) whilst another participant commented "*I would like make myself eat [bran flakes] because I'd be like well that is the healthy breakfast option to have"* (Katie) despite not liking the food. This participant also recalled implementing weight monitoring strategies from a young age due to observing their father weighing themselves regularly.

> *"He used to erm he used to weigh himself like all the time, so we'd have a scale, we had a scales in the bathroom and in my parent's bedroom so from such a young age I got into a habit of weighing myself…"(Katie)*

Participants emphasised that they continue to re-enact many of these attitudes and behaviour as adults. They offered examples of placing time restrictions on themselves to eat something within a certain time, as this is what their parent did, and "*still trying to choose the biggest thing erm regardless of whether or not that was what I wanted to eat"* (Zara) at restaurants, due to their parent only eating more freely when eating out.

> *"I still have that attitude of oh if you don't eat them in the first ten minutes then you probably don't need to eat them." (Megan)*

This participant also shared that they continue to replicate their parent's attitude that 'more' is unacceptable and therefore do not allow themselves what they perceive to be unnecessary additions during meals.

> *"If you have a jacket potato with like cheese on, I'm not putting butter on as well because I have got cheese on it, you don't need the butter because it is just more, it is just more you don't need it erm and I do still do that even though butter on a jacket potato is delicious with cheese on top of it as well." (Sarah)*

In additional, participants described a tendency to imitate their parent's weight monitoring behaviours throughout their child and adulthood. They commented on their tendency to weigh themselves regularly, with one participant sharing that they "*cannot live without having a scale in my apartment"* (Freya). During childhood, this behaviour took place despite participants not necessarily understanding or caring about the number on the scales.

> *"He used to weigh himself like all the time, so we'd have a scale, we had a scales in the bathroom and in my parent's bedroom erm so from such a young age I got into a habit of weighing myself like when I didn't really care (laugh) I didn't really understand that I was you know." (Katie)*

Another participant described how hard they worked to remain under ten stone, due to their parent's attitude towards reaching 'double digits.' As evidenced below, it is apparent just how much power their parent's views held in motivating this participant to remain at a certain weight.

"I remember for ages thinking I could not be over ten stone, I absolutely could not be over ten stone erm and would sit at like nine stone twelve for a very long time."

(Emily)

A further area of parental imitation involved participants lack of investment in cooking. They shared how they relied on others to take on this role, with one participant recalling how their grandma "*would just send me a load of stuff and I would freeze them"* (Freya) when they moved countries for their degree. Another participant expressed how they re-enacted their parent's avoidance of cooking until their late twenties due to a belief that they held the same abilities as their mother.

"You have it ingrained in you that like argh I can't cook it and I just kind of just model all my behaviours on mum well I won't be able to cook it either."

(Sarah)

For another participant, their experience of re-enactment came in the form of imposing structure and routine around mealtimes with their father, who did not have an ED. They recalled feeling frustrated with their father for sabotaging their attempts to create a formal mealtime environment, which they had become accustomed to when living with their mother.

"I remember having this thing for a while with dad like you don't take meals seriously enough I want to have like a black tie dinner at the age of like ten, he was like oh ok everyone is going to dress for dinner and we're going to have a really nice meal and because that is what mealtimes are it's this event and then like dad walking in with like a stupid outfit trying to make me laugh and I was like no you're not taking this seriously." (Amelia)

7.1.2 Influencing factors

Participants described four factors that appeared to influence the likelihood that they would re-enact rather than rebel against their bubble of normality. These included *'seeking approval', 'seeking connection'*, *'parental admiration'* and *'seeking emotional and relational safety'.*

7.1.2.1 Seeking approval

Many participants described how, particularly as children, they often questioned whether they were liked by their parent. One participant expressed this as a "*feeling and a sense rather than anything concrete"* (Lily) whilst another noted that they *"just wanting mum to like me"* (Sarah). Choosing the 'correct' food and imitating their parent's attitudes and behaviours appeared to be linked to a desire to gain approval from their parent, with one participant commenting *"I wanted to please her so I wanted to sort of get it right and have the, the right foods"* (Zara)

> *"There was always a thing for me of wanting to, I feel strange to say it, but just wanting mum to like me, not that she didn't like me but just doing stuff that she would like or like or just doing stuff that's similar to her, really, really seeking that approval."*
>
> *(Sarah)*

For this participant, the desire to receive approval remains a core part of their relationship with their parent as an adult. They shared a tendency to inform their parent about their meal choices in an attempt to receive praise.

> *"Still now I'll come back home and I'll say well I had a salad today and she'd be like why are you telling me this, I don't care, I'm like I thought you'd be proud of me…"*
>
> *(Sarah)*

Many participants recalled that the instances they modelled their parent's behaviors were met with approval and praise. For example, two participants who developed AN, recalled that "*it was almost* *applauded that I was able to restrict erm it was very much the idea of oh I wish I had your self control"* (Megan) and their parent would be the most likely to "*jump to help me, you know if I said I wanna lose weight"* (Katie). One participant who attempted to lose weight as a child by drinking their parent's slim fast shakes recollected how their parent did not discourage this, commenting it was "*never you know this is for adults. This is, you know I wouldn't recommend"* (Lily).

Similarly, participants described being exposed to indirect praise. This included their parent commenting on how much weight they had lost, how their restrictive approaches were "*working great"* (Lily) and reminiscing on their weight and shape achievements, particularly when they were younger.

7.1.2.2 Seeking connection

Accompanying approval, participants linked instances of re-enactment to a desire to forge an emotional connection with their parent. This appeared to be linked to a motivation to counteract the disconnection and parent-offspring dynamic elements of *'reabsorption'*. Participants described feeling "*part of a club"* (Lily) when they replicated their parent's restrictive eating behaviours.

> *"I think when I first started restricting it was very much oh I've got something to talk about with my mum, we've got something in common and erm this is something that is important to her and it can be important to me too and we can do this together."*
>
> *(Megan)*

For another participant, their attempt to forge a connection was further motivated by differences in ethnicity between themselves and their parent. For this participant, eating the same foods offered a sense of allyship with their mother.

> *"As a little girl you wanna be like mum and so like so my mum is white and my dad is black and obviously me and my sister we are mixed race and it is like another thing that you wanna be more like*

> *mum so how do you like you don't look like mum erm so it is like how else do you be like mum like we would eat different foods and I was like oh we should eat the same because we are like the same people." (Sarah)*

Similarly, when recalling their ED and DE experiences during adolescence, two participants suggested that their return to purging as adults may be underpinned by a desire to create a shared experience and sense of togetherness between themselves and their parent.

> *"I was like sixteen and I was like tiny and like not in a good place and I was like throwing up food and I'd be like why am I doing it? Oh because mum does it and that's, I want mum to like me and I want to be like mum so I'll do it too then we will have something in common." (Sarah)*

7.1.2.3 Parental admiration

A large proportion of participants expressed being in awe of their parent during their childhood, commenting *"I wanted to look like mum and I wanted to be like mum and I wanted to sound like mum and act like mum"* (Sarah). They described their parent as their role model, perceiving them as "*really cool, that she was really. . . different to other mums"* (Lily). One of these participants recalled how their admiration extended to a desire to 'be anorexic' like their mother.

> *"I remember being maybe nine and (laughs) I wrote this list and I remember it now like things that I wanted and my mum (laughs) my mum has got really big boobs now and I remember thinking I want really big boobs erm and then thinking I really, really wish I could be anorexic." (Emily)*

In contrast, one participant described feeling a lack of admiration towards their parent and a desire to not be like them in the future. This participant shared that their father's binge eating was perceived as a *"shameful thing to be hidden"* (Katie). This appeared to be compounded by the reinforcers referenced in the *'reabsorption'* chapter.

7.1.2.4 Seeking emotional and relational safety

Alongside seeking approval and connection, some participants described how, in re-enacting the bubble of normality, their position within the family and the overall relationship with their parent felt safer and more secure. One participant described that they felt *"on the safe side"* of their parent and maintained their position as "*the good example in, in the family"* (Freya) due to being the slim child. Another participant, who referred to gaining weight recently, expressed concern that they would lose their safe position and receive similar treatment to their sister.

> *"It's really interesting kind of like what that does with my relationship with my mum because I'm like oh I am now gonna get the same treatment as my little sister gets…"*
>
> *(Amelia)*

One participant shared that, as an adult, they are more likely to re-enact their bubble of normality when their relationship with their parent is strained. In this way, it appeared that participants imitated their parent's behaviour to repair and stabilize their relationship.

> *"I haven't made myself be sick in like I don't know, I want to say a couple of years but it is kind of something I just go back to when I am really stressed or especially if mum has been on at me about my weight or like what I have been eating, it just comes back and it is like I'll go back to this because we used to get on really well (chuckle) and this is what we used to do." (Sarah)*

In addition, participants shared that, by imitating their parents' attitudes and behaviours, they minimised the likelihood of conflict which, in turn, protected them from their parent's emotional unpredictability. This appeared to be accompanied by anxiety that they would "*make people feel uncomfortable"* (Sarah) or get "*[their] head bitten off"* (Megan). if they initiated a discussion about their parent's ED.

"She erm you know had quite a difficult temper and struggled emotionally with quite a lot of things erm so if she could be kept calm and pleased and generally satiated then that was better for, for everybody."(Zara)

7.2 Defining rebellion

In tandem with *re-enactment*, participants described moments of *'rebellion'*. One participant described this as *"breaking free"* (Amelia) from their bubble of normality and doing things differently. This response is divided into *'covert rebellion'* and *'overt rebellion'*.

7.2.1 Covert rebellion

During childhood, some participants emphasised that their attempts to rebel against their bubble of normality were underpinned by secrecy and often took place out of sight of their parent with an ED. For example, participants shared how they *"learnt to kind of hide my food from my mum or scoff it down before she got home"* (Megan) whilst another spoke of an unspoken agreement they had with their siblings to hide the evidence of having eaten.

"It didn't really feel like oh don't tell mum it will be a secret but in hindsight there probably was a bit of like if you're going to put like a packet in the bin shove it right to the bottom of the bin and don't let mum see like that kind of thing." (Amelia)

For another participant, their involvement in preparing meals provided an opportunity to rebel against small portion sizes by secretly eating part of the meal before it was served.

"I could try and eat some of it whilst I was cooking it erm that wouldn't be seen then because it wasn't on the plate so if I could, could make sure that I'd made enough then I could eat some of it before it got plated up for anybody to eat." (Zara)

The same participant shared that they resorted to stealing food whilst they out with their friends and therefore unsupervised by their parent. They commented on the differences in priorities between themselves and their peers.

> *"We'd go round as a gang with a trolley and we'd buy whatever we could with whatever money we had and then we'd just steal the rest erm but while everyone else was like trying to steal toiletries erm and sort of shampoos and nail vanishes erm I was stealing Swiss rolls and bags of marshmallows and biscuits…" (Zara)*

7.2.2 Overt rebellion

In contrast to secrecy, participants also engaged in more visible and spoken acts of rebellion. This involved challenging and calling their parents out on unhelpful attitudes and behaviours. For example, one participant recalled telling their parent "*we are not cutting out carbs mum, we are not doing that"* (Emily) when they suggested removing carbohydrates from their diet, whilst another participant reminded their parent *"that you can't restrict something out [their] diet"* (Katie) due to the risk of bingeing.

> *"Last week she had eaten at weird times but she was like oh I'm not going to have tea and I was like well you have to eat something because you can't not have any food for tea and she's like oh well I had some like fish fingers at like three and I'm like ok but like that is not enough, that is not ok and just like tryna challenge it…" (Sarah).*

A further example of overt rebellion involved participants descriptions of creating distance between themselves and their parent. One participant described this as "*opting out"* (Amelia) of unhelpful discussions, whilst another described creating physical distance by *"[leaving] home to go and study and be in a different city"* (Freya) and later moving abroad. For other participants, they described "*trying to just make those changes"* (Sarah) to everyday routines such as cooking, or intentionally defying their parent's food choices.

*"We bought us like chocolate cake oh well and honestly she was like argh disgusting like I had mine in the microwave with loads of cream and she's like and it is that kind of stuff that feels almost like quite intentional for me actually like quite intentional little sort of moments of, I don't really know the word, kind of rebelliousness almost…It's a bit like f**k you I'm going to put mine in the microwave and have a topping on it if I want one." (Amelia)*

7.2.3 Influencing factors

Participants described four factors that appeared to increase the likelihood that they would rebel rather than re-enact their bubble of normality. These included '*childhood allies'*, *'adulthood allies', 'internal motivations'* and *'emotional and relational safety'*.

7.2.3.1 Childhood allies

Participants described how influential having allies was during their childhood. These allies were mainly other family members, including their parent without an ED, who modelled acts of rebellion. For example, participants recalled how family members would "*give us things and tell us not to tell mum that we'd had them"* (Zara) or suggest "*lets have these before your mum gets home"* (Megan) in relation to food that were deemed 'bad'. Other participants recalled their grandparent providing *"a huge plate full of food"* (Freya), whilst another, who spent time in the kitchen with their grandmother, observed her to "*cook all day and like really enjoyed it"* (Sarah).

"He'd ask us to come over and smell the food and to do the tasting with him" (Megan)

Three participants shared memories of their parent without an ED modelling a playful, unstructured and experimental approach towards mealtimes. They recalled their parent encouraging "*fun things with food let's like let's put food dye in our macaroni cheese and have green macaroni cheese…"* (Amelia) whilst another referred to their father defying the rules of low calorie ingredients. One participant referred to their father's encouragement of rebellion as a *"relief"* (Sarah) from the rules and norms they were usually absorbed in.

Other participants provided examples of other family members rebelling against restrictive eating by allowing them to "*order everything off the menu"* (Zara) and encouraging them to *"have that chocolate bar or make a sandwich, it doesn't matter if it is your second sandwich."* (Sarah). Interestingly, one participant who grew up alongside their father with BED described an opposite dynamic, whereby their mother would seemingly rebel against their father's approach by imposing more restrictions and monitoring around the participant's food choices.

> *"We'd be out shopping and she'd [mother]be like (laugh) if I, if I picked something up and I'm like can I have this she'd like have to look at the back and she'd be like no it's got, it's got vegetable oil in you can't have that you know things like that" (Katie)*

7.2.3.2 Adulthood allies

As participants matured, the allies they drew upon for support altered. Many spoke of the role their partners, husbands and family in laws played, rather than immediate family members. For example, participants described their partners to *"always bring cake; he would bring ice-cream home"*, with the shared intention to "*not make food a scary topic"* and not feel obliged *"to work out"* (Freya) after eating. Another participant shared that their husband upholds *"such a different view on food"* and challenges their childhood narrative that processed foods are *"an evil thing"* (Natalie), whilst another person reflected that, as a result of their partner's support, mealtimes are now *"these long drawn out really happy, really lovely"* (Amelia) occasions.

> *"We went out for dinner a lot just for the pure like just joy of it and it's fun and it's nice and yes you can make that food at home technically but the point is that someone else has made it and it is nicer and that whole stuff was like completely new to me completely new to me and really lovely and fun [laugh] and still is you know?" (Amelia)*

Some participants referred to their in-laws specifically, commenting that they have provided a substantially different experience *"enjoyment wise and food wise"* (Amelia). Another participant described how their mother in law promotes the narrative that mealtimes are "*kind of family time, we're here to talk it's not even really about the food"* (Megan).

Another participant referred to the impact of having a friend with similar experiences. They identified this friendship as the catalyst that prompted both of them "*push each other to eat more stuff and try more stuff and just be healthier…"* (Sarah).

7.2.3.3 Internal motivations

Alongside allies, participants described an internal motivation to rebel. This appeared to be driven by a desire for their parent to 'own' their difficulties, stop avoiding uncomfortable conversations and acknowledge food and eating as a source of distress.

"I kind of wish that she would like name it, spot it so that we don't have to dance around it a bit and I want her to say oh I don't like sushi and what is it about it and [indecipherable word] just say with me like if you have a problem with food and you find it difficult." (Amelia)

Another participant shared that their motivation to rebel stems from a desire to separate themselves from their parent, create their own identity and reduce parental control.

"I think I love it so much cause it's something different from my mum. I think it's so clearly linked to that, it's something of my own. Something that she cannot control…" (Freya)

Another participant shared that their motivation to rebel by *"using food as a weapon"* came from a desire to challenge the *"power play"* between them and their parent and create *"easy wins"* (Amelia) whereby they provoked a reaction from their parent.

"Sushi is like her worst nightmare like eat this raw fish, she hates it and she had just been really irritating that day and really like really chaotic, just really difficult…and so I like ah we should go, I think we should go to the sushi bar, I was like that would be really nice erm completely intentionally to like wind her up." (Amelia)

However, some participants expressed feeling less motivation to rebel. This appeared to be due to anticipating that their efforts would not make a difference, alongside the emotional toll of not observing any progress. One participant commented *"I just can't put myself through that conversation again, I can't tell you [mother] again that I don't want to talk about it"* (Sarah).

"I'm not that biting back like holding back in a sense that I'm like worried about having an argument or worrying about upsetting them because I don't think it's that, I just think it's that I don't know what positive impact that would have." (Emily)

7.2.3.4 Emotional and relational safety

Participants emphasised how instrumental their partner's unconditional love and support was and continues to be. They described feeling more confident to rebel as they felt secure that their emotional needs would be met by their partner. In this way, it seemed that their desire for their parent's approval held less power.

"'It's like actually worst case scenario, which is her saying I can't believe you've done this [buying chocolate cake], I never want to speak to you again like I'm not like oh that's a positive, I'm good but like if I, everything that I need out of another human being, I can get from the person that I live with." (Amelia)

CHAPTER EIGHT: RENEGOTIATION

Having presented the cognitive and behavioural levels of the model, this chapter will now describe participants' experiences of *'renegotiation'*. This process is divided into *'renegotiating food, eating and weight related norms', 'renegotiating relationship norms'* and *'renegotiating behavioural responses'*. I will also explore the factors that appeared to support participants to reach this point in the process.

8.1 Defining renegotiation

'Renegotiation' captures participants' accounts of seeking the middle ground between (re)absorption, recognition, reflection, re-enactment and rebellion. It focuses on the dilemmas and conflict participants experienced when navigating this process.

8.1.1 Renegotiating food, eating and weight related norms

The first area of '*renegotiation'* related to participants experiences of maintaining an unconditional relationship with food, eating, exercise and body image. Participants referred to "*trying to not link working out to weight"* (Freya) and prioritising wellbeing and *"wellness"* (Megan) rather than weight loss and restriction to inform health related decisions. Another participant referred to their experience of renegotiating the practical aspects of eating, in terms of "*regular eating throughout the day"* (Natalie) rather than restricting and bingeing. A further participant shared how, with the support of their husband, they are trying to renegotiate the norm that food is a threat.

"We're [participant and husband] trying to you know not penalise-I don't know. Not make food a scary topic." (Freya)

8.1.2 Renegotiating relationship norms

Additionally, participants identified the renegotiation of boundaries with their parent as important. They described a process of working out how physically and emotionally close they wished to be to their parent,. One participant captured how difficult this process is, describing how they want to differentiate themselves "*from essentially family which in a way, maybe without wanting to alienate my family"* (Amelia). Another participant spoke of their desire to spend time with their family whilst balancing this with periods of respite.

"I would live with my husband's family in the holidays. I'm not fully going back to my place. I will just spend a couple of nights there…" (Freya)

Additionally, participants spoke of their experiences negotiating emotional boundaries with their parents. They spoke of their desire to support their parent yet needing to look after their own emotional needs as *"it can be really draining sometimes, especially if you are struggling yourself"* (Katie). For other participants, they described grappling with the level of involvement their parent plays in offering emotional support, particularly when they feel their needs may be better met by someone else.

"It was like you know do I let her have this one, do I kinda give her what I think she wants which is an opportunity to provide support, the opportunity to listen to me and all this or do I do what actually I'd probably prefer to do which is to say oh I'll call you tomorrow and then go home and like cry to my partner." (Amelia)

Similarly, other participants recalled their experiences of negotiating levels of disclosure with their parent. One participant shared that they rarely disclose personal information about their relationships as, in not doing so, they maintain *'control'* (Freya) over this part of their life. For another participant, negotiating disclosure appeared to be about communicating the impact of their experiences whilst protecting their parent from distress.

"I think that if she knew how much I struggled she would be so sad that it wouldn't be worth me

having a conversation about it because I would be like what am I going to get out of that, I mean I probably would feel better but I think that she would just feel really like guilty and really bad that it just would not be worth the conversation about it." (Sarah).

Another participant described how they have gained confidence disclosing their experiences to their parent. Similar to participant three, they described an initial hesitancy and reluctance to be honest with their parent, however acknowledged that this has become less daunting over time.

"At first it was really, really difficult. I found it quite uncomfortable actually. Umm, I didn't kind of want to talk about it. I sort of like dropped the bomb of like, like what I was going through, and then like quickly changed the subject. I really didn't want to get into it….and then like over time gradually it's become easier." (Natalie).

8.1.3 Renegotiating behavioural responses

The third area of renegotiation involved participants' experiences of challenging and rebelling against their parent's food, eating and weight related norms whilst protecting themselves from criticism. For example, one participant commented that they need to monitor how they talk to their parent about their ED because *"If I push too hard then [parent/participant] relationship is gonna to take a backwards you know or it's gonna feel awkward or it's gonna feel like I'm the mean one…"* (Lily).

"It's like this really difficult negotiation of using food as a way of being like I can do what I want, I'm independent, I can eat what I want but then also not playing into her idea of I'm really unhealthy and I'm putting on loads of weight and I am not responsible for myself." (Amelia).

Another participant described their experiences of needing to re-enact certain behaviours (e.g. having scales in their house) to manage their anxiety whilst renegotiating the power the number on the scales holds.

> *"I cannot live without having a scale in my apartment. Umm, I would love to not have a scale in my apartment, but I cannot do that but what I see on the scale it doesn't necessarily affect me…" (Freya)*

Participants described three factors that appeared to support them to find the middle ground. These included *'experiential learning'*, *'acknowledging limits'* and *'supportive others'*.

> *"I just try and like give myself physical reasons to just be in recovery because that is how I see it, like I don't do it, I still have the thoughts but I don't do it anymore but it is just like continuing to like give yourself good reasons to why you won't slip up or it won't revert back to how you used to be." (Sarah)*

8.1.4 Influencing factors

8.1.4.1. Experiential learning

Participants described how the renegotiation process was influenced by experimenting with and learning where to 'pitch' the middle ground. For example, one participant shared that they have learnt their parent responds better to feedback (including being challenged about unhelpful comments) when this is presented in an educational manner rather than a conversation.

> *"I've got my handbooks here and sometimes I throw a book at her when she's being annoying (laugh)." (Megan)*

Another participant described learning when and when not to disclose information about their personal lives to their parent. This learning came from making mistakes (i.e. over disclosing) and noticing that offering too much information fuels their parent's criticism.

> *"I would share something but then I would reflect and say, but it was definitely not a good idea to share it cause I had this urge to speak about everything with her and then I gradually learnt that I cannot really because then comes all the judgement and stuff and I don't want that." (Freya)*

One participant spoke about the importance of learning to notice when unhelpful thoughts arise. They described how influential this noticing is in helping them to challenge their thoughts relating to appearance and body image.

"It is just like clocking when you do have them like sometimes I'll look at a picture and be like oh my God I look awful, I'm like um it's just a weird angle, doesn't matter." (Emily)

8.1.4.2 Acknowledging limits

Additionally, participants described the importance of acknowledging their own and their parent's limits. For example, one participant spoke of knowing how much time to spend with their parent before needing respite whilst another acknowledged the importance of being *"in a well enough place to recognise that [they're]not there yet"* (Megan), in terms of their ideal relationship with food, eating and weight.

"I spent a week back at mum and dad's and I always kind of regress a little bit so a week is kind of a week is fine, two weeks is too much." (Sarah)

Alongside their own limits, participants emphasised the importance of acknowledging their parent's limits. This appeared to support participants to find a middle ground that was realistic and respectful. For one participant, this involved accepting that they may have to reduce their expectations and continue to "*skate very superficially"* (Lily) when talking to their parent, in order to preserve their current relationship. Another participant spoke of the importance of reminding themselves about their parent's capacity to make changes.

"I have to sit there and go she's not gonna change, she is not gonna change, she is fifty seven." (Emily)

8.1.4.4 Supportive others

As well as learning through experience and acknowledging their own and their parent's limits, many participants emphasised the importance of *"surrounding [themselves] with people who have really healthy attitudes around food and body image"* (Zara). For example, one participant described the value of having a partner who "*loves [them] for who [they are]"* (Freya) regardless of their weight, whilst another commented that their sibling encourages body positivity by not "*being critical or negative about appearance at all. Not for others; not for herself"* (Lily). Similarly, another participant, who described themselves and their partner as overweight, shared the importance of their parent modelling a positive relationship with food despite *"being put into this societal, societal category of being then like bad and overweight."* (Natalie).

> *"The way he is or his image or his relationship with food is so different to mine…[he has] such a different view on food; a much more healthier view I mean." (Natalie)*

It also appeared to be valuable for participants to be surrounded by friends who had the self-reflexivity and willingness to notice when they made unhelpful comments. For one participant, they appeared to appreciate their friend's candour in recognising and correcting their mistake.

> *"I had a friend who I'd, I'd gone to see and you she commented that I looked nice erm and then followed it up with I looked like I'd lost weight erm but in a slightly positive way and she immediately took it back and said you know I'm really sorry that was completely inappropriate…I'd literally never come across anybody who'd been aware, self-aware enough to be able to correct themselves." (Zara)*

For one participant who accessed therapy, they appeared to appreciate the therapeutic relationship. It seemed as though this relationship offered a space to be supported yet challenged, which helped them identify and work with the factors contributing to their difficulties.

“She was like, she was so like pfttt not harsh but she was very blunt and that is what I needed, I just needed someone to be very much like (interviewee makes popping noise) this is, she was very straight me like called me out on my like crap (laugh).” (Emily)

CHAPTER NINE: DISCUSSION

The following chapter will offer an overview of the results of this project within the context of the existing literature. As there are many facets to the proposed model, I will discuss each one in turn and relate this to existing literature and theory. The chapter will then explore the clinical implications of this study, acknowledge the strengths and limitations and suggest recommendations for future research.

9.1 Study results

9.1.1 The bubble of normality

A key finding to arise from this study was the concept of the *'Bubble of Normality'*, which represented the routines, norms and rules participants were surrounded by as they grew up. The bubble of normality comprised of '*food, eating and weight related norms'* and *'relationship norms'*.

9.1.1.1 Food, eating and weight related norms

Adult children described their parent's relationship with food as functional and hazardous, which appeared to be attributed to financial, health and gender stereotype reasons. The impact of financial security on ED is cited by Hazzard et al. (2022), as is the role of domestic responsibilities in reinforcing gender and power imbalances (Meah, 2013). The feelings of anxiety participants appeared to pick up on is similar to parents' accounts, in which they described high levels of anxiety in food related contexts (Sadeh-Sharvit et al., 2015). Participants' accounts of being surrounded by food, eating and weight related norms is consistent with Sadeh-Sharvit et al. (2015) and Stitt and Reupert (2014) findings that mothers with an ED report a preoccupation with both their own and their child's weight and food related decisions.

Additionally, participants accounts of not having access to certain foods at home and feeling pressured to eat even when they were not hungry draws parallels with the existing literature in which mothers with an ED self-reported and were observed to use more restrictive and pressuring feeding practices

(Blissett & Haycraft, 2011; Reba-Harrelson et al., 2010; Saltzman et al., 2016; Stein et al., 1994). Although the existing literature indicates that parents with an ED adopt a rule-bound approach towards food, eating and weight, this study offers insight into the factors, from adult children's perspectives, that contribute to their parent tightening or relaxing these rules. Participants' experiences of their parent competing with them and others around weight and eating is consistent with Osborn (2023) scoping review, which identified rivalry is a core feature in ED. However, this study extends this literature by suggesting that, based on adult children's experiences, there is a competitive element to the parent-child relationship.

9.1.1.2 Relationship norms

In terms of their overall relationship with their parent, participants described a critical dynamic. They recalled their parent's criticism to come from direct and indirect means (e.g. their parent criticising the participants weight and eating habits or their parent criticising themselves or others). This corresponds with Brun et al. (2020) and Claydon et al. (2020) models regarding intergenerational transmission, in which they identified direct and indirect pathways in which parents may transfer their eating and weight related beliefs onto their children. However, this study extends these models by highlighting the impact of direct and indirect praise on adult children's experiences. This may also indicate that both positive and negative reinforcement need to be explored as potential mechanisms contributing to intergenerational transmission (Claydon et al., 2020; Rodgers & Chabrol, 2009).

Additionally, many participants described being placed in an adult rather than child role, whilst also experiencing their parent as unpredictable and mis-attuned. Their reference to role-reversal and emotional unpredictability replicates the findings from several studies, who have focused on adult children's experiences of living alongside a parent with a mental health difficulty, not specific to an ED (McCormack et al., 2017; Murphy et al., 2015, Murphy et al., 2017; Patrick et al., 2019). These accounts also echo the anxieties expressed by parents with an ED that their children are at risk of and often take on a parent role within the family (Sadeh-Sharvit et al., 2015; Stitt & Reupert, 2014; Tuval-Mashiach et al., 2013). Siblings of young people with an ED have described similar shifts in roles and responsibilities, although they described their role as a 'mediator' and 'well sibling' rather than parental (Dimitropoulos et al., 2009; Scutt et al., 2022).

Family Systems Theory (FST; Bowen, 1966, 1976) proposes that family members strive to maintain the optimum functioning of their family system by alleviating potential causes of dysfunction and distress (Bowen, 1979). When a family is functioning well, Bowen (1976) considered there to be an appropriate level of proximity, distance and boundaries between family members. In contrast, disruptions such as the presence of mental health difficulties, are thought to place strain on the system and lead to the reorganisation of roles and responsibilities to maintain 'homeostasis' (Jackson, 1981); that is, the stability of the family system. The existing literature referenced above and the experiences of adult children from this research not only supports the impact of parental mental health difficulties on family dynamics but highlight the application of FST within the field of parental ED and DE.

Alongside the challenging aspects of the parent-child relationship, some participants described feeling supported by their parent, although this appeared to be within non-food and weight related contexts, such as school and careers. This experience is not widely cited in the existing literature; for example, the adult children in Foster et al. (2010) and McCormack et al. (2017) studies described feeling isolated and unsupported due to their parent's mental health difficulties. It is interesting to note, however, that participants' experiences of feeling isolated and disconnected from their parent appeared to be most prominent in food related contexts, such as the family not eating together, their parent eating a different meal or being absent from mealtimes. This is similar to Sadeh-Sharvit et al. (2015) and Stitt and Reupert (2014) accounts of mothers with an ED avoiding food related activities. This discrepancy may also relate to findings that mothers felt more confident in aspects of parenting that did not involve weight and body image yet found it difficult to maintain a supportive parent-child relationship if their child did not meet their weight and appearance standards (Sadeh-Sharvit et al., 2015; Stitt and Reupert, 2014; Tuval-Mashiach et al., 2013).

Attachment Theory asserts that the interactions a child has with significant others during childhood sets the foundations for their 'internal working model', which informs how they relate to themselves, others and the world more generally (Ainsworth, 1964; Bowlby, 1969). The feeding experience during infancy and mealtime experiences in a child's later years have been identified as instrumental in promoting a secure parent-child relationship, supporting connectedness and cohesion within the family system and contributing to child and adolescent psychosocial wellbeing (Fiese et al., 2006 ; Hamilton & Wilson, 2009; Robson et al., 2020). Adult children's descriptions of feeling disconnected supports the importance of mealtimes in family functioning and relationships.

9.1.2 Cognitive responses

9.1.2.1 Reabsorption

'Reabsorption' reflects adult children's acceptance of their bubble of normality during childhood. Participants identified that their *'attributions'* of their parents' relationship with food, eating and body image, alongside *'systemic reinforcers'*, strengthened their acceptance. This finding is not in keeping with the existing literature. For example, adult children supporting parents with other mental health difficulties describe an awareness from a young age that there is something atypical about their childhood, even if they could not identify the reason for this (Murphy et al., 2015; Murphy et al., 2017). Patrick et al. (2020) 'Relational Trajectory Model' proposes that, during childhood, adult children living alongside a parent with a mental health difficulty experience confusion, yet this was not a key feature for the participants in this study. Interestingly, the parents in Fox et al. (2015) study described misattributing their children's ED symptoms to typical development. This may suggest that, despite the difference in position within the family system, adult children may experience attributional biases, alongside parents of children with an ED.

These findings may be understood within the context of key psychological theories, such as Social Cognitive Theory (Bandura, 1986) and Piaget's (1952) Theory of Cognitive Development. For example, participants' descriptions that the environment, culture and interactions they experienced during their childhood reinforced their *'reabsorption'* is in keeping with Bandura's argument that environment factors influence how an individual makes sense of their experiences. Piaget (1952) argued that, alongside the environment, children engage in two cognitive processes, termed ‘assimilation’ and ‘accommodation’ . The first of these involves an individual applying their existing knowledge to make sense of their current experiences. Participants’ accounts of not questioning their parent’s behaviours as they matched the norms endorsed by society (e.g. *‘systemic reinforcers’*) may be indicative of this process.

9.1.2.2 Recognition

‘Recognition’ accounts for the process in which participants begin to make comparisons between their own and other people’s bubble of normality. This process appeared to capture a shift from acceptance to a sense of ‘weirdness’. Participants descriptions that factors such as *‘social exposure’* and *‘new relationships’* prompted this shift in understanding is similar to Murphy et al. (2015) and Murphy et al. (2017) findings, in which adult children described spending time with peers’ families as a factor which helped them pinpoint how unusual their parents behaviour was.

Referring again to psychological theory, Piaget (1952) argued that individuals experience ‘disequilibrium’ when they are exposed to events that are incongruent with their existing knowledge and understanding of the world. For children who have grown up alongside a parent with an ED and other mental health difficulties, it seems that exposure to alternative family dynamics and ways of interacting around food throughout childhood and in their later years, prompted this state. However, despite these events, many participants reverted to *‘reabsorption’* due to the power of their original attributions. This suggests that the interaction between cognitive and environmental factors are important mechanisms contributing to adult children’s experience of the renegotiation process. Some participants referred to having conversations with their parent who did not have an ED. This is not in keeping with experiences of adult children who grew up alongside a parent with other mental health difficulties, who described family members as avoidant of topics surrounding mental health (McCormack et al., 2017; Murphy et al., 2015, Murphy et al., 2017).

9.1.2.3 Reflection

‘Reflection’ captures participants accounts of looking back on their experiences and acknowledging the impact of their bubble of normality. This included an acknowledgement of the personal losses they experienced with regards to their ideal relationship with their parent and their emotional needs not being met. Such reflections link heavily to Patrick et al. (2020) ‘Contemplation’ phase of the Relational Trajectory Model, O’Connor et al. (2019) ‘Encountering a Disruption’ stage of their Reconstructing Liveability Model and the broader evidence concerning the emotional and relational impact of growing up alongside a parent with a mental health difficulty (Foster et al., 2010; McCormack et al., 2017; Murray et al., 2011). These findings also corroborate the experiences of other family members, such as parents, partners and siblings, who have supported a family member with an ED (Anastasiadou et al., 2014; Fox et al., 2015; Moan et al., 2020; O’Connor et al., 2019; Zabala et al., 2009).

A further personal reflection described by participants included their experiences of *‘internalised narratives’*. These narratives included their needs not being as important as others, difficulties sharing their vulnerabilities and a tendency to not request support. This links to Dunkley-Smith et al. (2021) findings that adult children of parents with a mental health difficulty struggle with self-compassion and Hutchison et al. (2022) theme that siblings of young people with an ED minimise their own needs. Participants in the current study also described feeling like a failure, particularly in relation to self-control around food. McCormack et al. (2017) noted a similar theme when interviewing adult children caring for a parent with a mental health difficulty, although this was within the context of feeling they had failed to fulfil their caring responsibilities. The concept of self-criticism and shame feature heavily as potential precipitating and perpetuating factors in the development and maintenance of ED and overall wellbeing (Duarte et al., 2014; Nechita et al., 2021; Williams & Levinson, 2022) Therefore it is important to recognise that internalised narratives may compromise overall wellbeing and serve as a risk factor for the development of ED in adult children who have grown up alongside a parent with an ED.

Participants descriptions of *'feeling vulnerable'* lends further support to the power of internalised narratives. Their fear of developing an ED or relapsing corresponds with the anxieties of parents with an ED, who report concern that they may unintentionally impart their difficulties onto their children (Sadeh-Sharvit et al., 2015; Stitt & Reupert, 2014), and the experiences of adult children who express concerns regarding the heritability of their parent's mental health difficulties (McCormack et al., 2017). Participants in this study also shared the impact of these internalised narratives on their parenting intentions and confidence. Some participants were clear in their intention to not have children, due to fears of harming their child by inadvertently modelling their parent. For others, they expressed a desire to have children in the future, potentially as a way to 'break the cycle' of ED within the family. These findings resemble the anxieties expressed by adult children in Patrick et al. (2019) regarding their parenting abilities and the 'Reconciliation' phase of Patrick et al.. (2020) model, in which expectant parents who have grown up with a parent with a mental health difficulty use their experiences of being parented to inform their own parenting intentions.

Furthermore, *'navigating an internal battle'* demonstrates the ambivalence adult children experience when trying to decipher their motivations surrounding food, eating, exercise and body image. For some, this battle reflected their fear of developing an ED whilst for others it reflected their battle to not get pulled into ED related behaviours (e.g compensatory behaviours, restriction). This may relate more widely to the concept of an Eating Disorder Voice (EDV), which Pugh & Waller (2016) conceptualise as "a second or third person commentary on actions and consequences relating to eating, weight, and shape" (p.622). Although many participants described the battle as a prompt to consider the intention behind their food related choices, it is important to note that the EDV has been described as supportive initially yet later transcends into a "powerful, negative and omnipotent" entity (Aya et al., 2019, p.347).

In terms of parent focused reflections, participants described a process of *'compassionate reattribution'* in which they questioned their original explanations for their parent's behaviour. For many participants, they began to consider the role of trauma and adversity. It is interesting that this process took place in their later years, as the existing literature suggests that adult children are aware from a young age that their parents' difficulties are likely to be related to wider biopsychosocial factors (Simpson-Adkins & Daiches, 2018). Although this interaction cannot be confirmed based on this research alone, it may be that the '*attributions'* and *'systemic factors'* mentioned previously contributed to this difference.

Participants described *'maturing'*, *'transferable knowledge'* and *'collective unpacking'* as factors which supported their reflective capacity. In line with Huke and Slade (2006) and Fox et al. (2015) research with parents and siblings caring for a young person with an ED, gaining information from a range of sources appeared to support adult children to gain a deeper understanding of their parents' difficulties. These factors also connect with O'Connor et al. (2019) 'Informed Self' stage of their Grounded Theory Model, in which partners sought to gain more knowledge about ED. However, it is interesting to note that the intention to seek information differed between participants. For example, in the current study, participants described the knowledge they acquired to be a byproduct of their careers in mental health and pursuing their own recovery whereas the partners, siblings and parents in the above studies made intentional steps to seek more knowledge. Participants reference to '*collective unpacking'*, including professionals and siblings, is testament to how imperative support networks are in processing and gaining greater insight into a family members mental health difficulties (Fox et al., 2015; O'Connor et al., 2019; Patrick et al., 2020).

As mentioned previously, Piaget (1952) coined the process 'accommodation', which describes an individual altering their existing knowledge base in response to novel situations and environments (Hanfstingl et al., 2022). In this respect, it may be that participants experiences of reattributing their parents' difficulties to distress, trauma and an ED as a result of gaining knowledge from their careers, own recovery and support networks reflects a wider shift in cognition during adulthood.

9.1.3 Behavioural responses

9.1.3.1 Re-enactment

'Re-enactment' is one of the behavioural responses described by participants and reflects their attempts to imitate their parents attitudes, rules and behaviours within the domains of food, eating, weight and body image. Social Learning and Social Cognitive Theory (Bandura, 1971, 1986) asserts that children learn behaviours by observing and subsequently modelling the actions of significant others. Research highlights that this process often occurs in relation to eating behaviours (Paroche et al., 2017; Rodgers & Chabrol, 2009; Savage et al., 2007). Participants recognition that they modelled their parents eating and weight monitoring behaviours as children and continue to do so as adults echoes these findings. The perspectives of adult children further correlates with concerns expressed by parents with an ED, who are mindful of their potential to be an unhelpful role model regarding food and eating (Tuval-Mashiach et al., 2013).

Additionally, the findings that a desire for *'approval'*, *'connection'* and *'emotional and relational safety'* influenced the process of re-enactment links with Bandura (1989) argument that motivation is a key ingredient underpinning the process of modelling. These findings correspond with the literature in which adult children sought safety and attempted to please their parent during childhood (Foster., 2010; McCormack et al., 2017; Metz & Jungbauer, 2021; Yamamoto et al., 2017). However, it is interesting to note that participants in this study described a desire for approval in food, eating and weight contexts whereas the participants in the existing literature described this in more general contexts (e.g. supporting the family, domestic responsibilities). One participant who did not identify with this feeling referred to their father's binge eating as "shameful" as it deviated from societal norms. This appeared to be influenced by the critical responses they observed from their parent without an ED towards their father. These findings highlight the importance of considering how the interactions between the parent with and without an ED may impact adult children, as opposed to focusing solely on the parent-child relationship.

9.1.3.2 Rebellion

In contrast to re-enactment, adult children described occasions of rebellion. In their earlier years, these instances were *'covert'*, meaning they were shrouded in secrecy and engaged in with little knowledge from their parent. Participants described being resourceful to make the best use of a difficult situation (e.g. eating whilst cooking in anticipation of small portion sizes) and, in some instances, resorting to more extreme measures, such as stealing. However, as they got older, these acts became more *'overt',* which appeared to be driven by a desire to build their own identity, strengthen their independence and promote openness around their parent's ED. Participants descriptions of increasing distance, not disclosing information and limiting the time they spent with family echoes the coping strategies adult children with parents with other mental health difficulties employ (Foster, 2010; McCormack et al., 2017; Metz & Jungbauer, 2021; Patrick et al., 2020; Yamamoto et al., 2017).

The factors referred to as *'childhood allies'* and *'adulthood allies'* connects with Bowen (1976) work around Family Systems Theory. This theory argues that, when a family's homeostasis is challenged, the parent without the difficulty employs "over adequate-inadequate reciprocity" (p.352) and "triangling" strategies to counteract the reduced functioning of the other parent. This concept draws similarities with the experiences of many participants in this study, who described their parent without an ED as more relaxed, spontaneous and unboundaried around food and eating. This dynamic was also present for the participant who grew up alongside their father with BED, who described their mother as imposing more restriction and monitoring around their food choices.

Erickson's (1950) Stages of Psychosocial Development argues that every individual navigates eight psychosocial challenges between infancy and adulthood. Each psychosocial challenge represents an individual's struggle to balance their own needs with the expectations of wider society. Participants descriptions of taking steps to separate themselves from their parents and pursuing their own identities may reflect the 'identity versus role confusion' stage (Erickson, 1950), in which an individual is motivated to explore and develop their own sense of self without their parent's influence.

9.1.4 Renegotiation

‘Renegotiation’ captures participants’ experiences of trying to negotiate the closeness of the parent-child relationship, the level of emotional support they offer and calm the internal battle they experience regarding food, eating, weight and exercise. These findings draw some parallels with those described by adult children who grew up alongside a parent with other mental health difficulties. For example, participants in the existing literature spoke of trying to preserve their relationship with their parent, whilst pursuing independence and maintaining boundaries (Foster, 2010; McCormack et al., 2017; Metz & Jungbauer, 2021; Yamamoto et al., 2017). Participants experiences of balancing an internal battle is not referenced in the literature and potentially represents a unique point of negotiation for adult children who have grown up alongside a parent with an ED or DE.

Participants referred to a number of factors which supported them towards renegotiation. Their description of *‘supportive others’* links with the existing literature, in terms of adult children and family members supporting an individual with an ED seeking support from friends, family and other social networks (Dimitropoulos et al., 2009; Hutchison et al., 2022; O’Connor et al., 2019; Patrick et al., 2020). It also reinforces how influential and protective environmental factors are, as outlined in Sim and Peterson (2021) Differential Sensitivity Model. The *‘acknowledging limits’* finding, particularly in relation to their parent’s limits, is novel and offers further insight into participants attempts to balance their own and their parents needs.

In terms of transitioning through these responses, participants described this as a non-linear process. For example, they described revisiting (re)absorption and re-enactment despite having taken steps to reach re-negotiation. They also described continuing to experience moments of recognition and reflection as adults. This is not in keeping with Patrick et al. (2020) ‘Relational Trajectory Model’ which proposes that adult children make sense of their experiences of growing up alongside a parent with a mental health difficulty in a linear, age-specific manner. The findings also diverge from O’Connor et al. (2019) ‘Reconstructing Liveability Model’, which argues that partners of individuals with an ED engage in a recurring four stage cycle. This being said, Patrick et al. (2020) noted that certain cognitive subprocesses influence the process, which are reminiscent of the influencing factors outlined in this study.

9.2 Clinical implications

The findings from this research carry a number of clinical implications for adult and children's services. The model highlights that professionals need to maintain a systemic lens when completing a psychological assessment with an adult who has children or adult children. This may involve the professional prompting a discussion about the impact of their client's difficulties on family life, dynamics and relationships. Depending on the wellbeing and preference of the family, this discussion may involve talking to family members together or separately. Given that the model identified the bubble of normality to include food, eating, weight related norms and overall parent-child relationships, these topics are potential starting points for discussion. By encouraging these conversations, professionals may be able to identify not only the needs of the referring adult, but the individual needs of family members and collective needs of the family. For example, if the child or adult child describes adopting a parent role, this may prompt the professional to consider if they qualify as young/adult carers. As outlined in the model, being surrounded by '*supportive others'* is important for adult children of parents with an ED, for both their own wellbeing and to help make sense of their parent's difficulties.

Additionally, the *'reflection'* component of the model emphasises the emotional and psychological impact of growing up alongside a parent with an ED or DE. Of note, is participants reference to *'internalised narratives'*, including the impact of their parent's difficulties on their own relationship with food, eating and body image. By scaffolding the above discussions, professionals may be able to assess the risk of intergenerational transmission and identify other family members who are displaying indicators of an ED. This is particularly important given that early intervention significantly improves the likelihood of recovery and is well received by those experiencing ED symptoms (Austin et al., 2021; Brown et al., 2016; Grange & Loeb, 2007).

Additionally, the model provides a number of potential avenues for psychological intervention. When supporting children and adult children who have grown up alongside a parent with an ED, professionals may consider the application of Compassion Focused Therapy (CFT; Gilbert, 2009). This is particularly in relation to their experiences of perfectionism, alongside feelings of self-doubt and failure as a result of comparing themselves to their parent and other family members (e.g. siblings). It may also be helpful to consider the use of Dialectical Behavioural Therapy (DBT; Lineham,1993), particularly the interpersonal effectiveness module, to address the parent-child relationship and support children to communicate their needs. Similarly, DBT emphasises the importance of the 'middle path' (e.g the middle ground between two dialectics) which may support individuals to negotiate their experiences of *'re-enactment'* and *'rebellion'* alongside their relationship with food and eating. Moreover, many participants spoke of the importance of pursing their own interests and values. Drawing on Acceptance and Commitment Therapy (ACT; Hayes, 1999) approaches may be beneficial in allowing children and adult children to pursue a value based life amidst the challenges of the family system. Finally, participant descriptions that their understanding evolved over time may lend itself to the use of Narrative Therapy (White & Epston, 1989) which encourages individuals to process and re-author the stories they have developed about themselves and others, as a result of their experiences.

It is important to acknowledge that systemically informed interventions already exist within the field of ED's. For example, Family Therapy for Anorexia Nervosa (FT-AN; Lock & De Grange, 2015) and Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA; Schmidt et al., 2015; Schmidt et al., 2018) are widely endorsed within child and adult ED guidelines (National Institute for Health and Care Excellence; NICE, 2023). Given the proposed model, phases two and three of FT-AN, which focus on the family managing the impact of the ED on family dynamics, as well as the 'working with support networks', 'thinking styles' (i.e. perfectionism), 'understanding emotions' and 'developing identity' modules within MANTRA may be particularly beneficial.

9.3 Strengths and limitations

As is the case in any research context, it is important to identify the strengths and limitations of the study. The strengths I have identified are informed by Charmaz and Thornberg (2020) quality assessment framework. Firstly, this study is original as, according to my literature review, it is the first to explore experiences of adult children who have grown up alongside a parent with an ED and elucidate the process they go through to make sense of their experiences. Secondly, I endeavoured to implement credibility checks through the research process. These included recruiting two Experts by Experience to review the documents and offer feedback on the proposed interview topic guide. I also participated in regular supervision with my supervisors, participated in ‘check in’ sessions with a fellow Trainee Clinical Psychologist also pursuing Constructivist Grounded Theory and completed memos to support self-reflexivity

In terms of resonance, I included illustrative quotes from a range of participants in the results chapter and sought feedback from my supervisor regarding my writing style to ensure that the stories of participants were not overshadowed by the academic demands of the write-up or ambiguous language. I was also mindful to capture a range of experiences, rather than only selecting data that illustrated one narrative and remained attuned to my preconceptions that the renegotiation process would be sequential and chronological. Finally, I have addressed the usefulness criteria of this framework by discussing the clinical and research implications of this study.

There was some evidence of heterogeneity across the sample, in terms of participants ages, life stage and their parents eating presentation (e.g. presence of formal ED diagnosis or DE, symptoms of AN, BN and BED). The study also recruited participants with and without their own experiences of an ED and DE. This elicited unique discussions around not only the experience of intergenerational transition but participants experience of feeling vulnerable to developing an ED. This is important given that my initial interest in this study was prompted by not only my own experiences of an ED but the impact of parents’ relationship with food, eating and body image on children’s eating behaviours.

Despite the advantage of recruiting participants with experience of a range of parental ED and DE, this decision may also serve as a limitation. For example, although a broad inclusion criteria supported recruitment, such variance within a small sample means that more nuanced differences in adult children's experiences may become diluted. This reflects the wider challenge of attending to both the detail and expanse of the data when completing qualitative research (Urquhart, 2013). Additionally, the majority of participants identified as White British and all were female, whilst the majority identified their mother as experiencing an ED or DE. Given the relevance of wider systemic factors, including culture, to the overall model, it may be that these findings lack cultural sensitivity and therefore may not resonate with adult children identifying with alternative cultural and ethnic backgrounds. It may also be that the mother-daughter dyad influenced participants' experiences, which means that these findings do not account for the impact of gender or the parent-child relationship (e.g gender of parent and child). This is noteworthy given that females represent the majority of participants in the current ED literature (Halbeisen et al., 2022).

Furthermore, the majority of the participants reported studying Psychology in higher education, with many currently working in the field of mental health, including ED's. As such, the sense-making process may be different for adult children who have not gained mental health specialist knowledge through education and work opportunities. Finally, although I met with a fellow trainee also completing GT to discuss evolving concepts, sought regular supervision and adhered to Charmaz's (2008) recommendations regarding memo writing and enlisted the support of an Expert By Experience to review the study documents and interview topics, there was not the scope to embark on more in-depth credibility checks. As such, I am mindful that the model I have proposed is based on my own interpretation of the data and discussions I had during the process and is therefore subject to the influence of my own experiences and construction of reality.

9.4 Future research

Future research regarding the experiences of adult children who have grown up alongside a parent with an ED or DE would benefit from recruiting a larger sample population. This includes not only the quantity of the sample but the recruitment of adult children not identifying as female, alongside those who have grown up with a father with an ED or DE. This is particularly important to consider given the findings that gender related expectations and societal norms impacted how participants initially made sense of their parent's ED. Moreover, as it stands research has focused on the experiences of a single family member, such as parents. It may be interesting to conduct a joint interview or draw on creative methodologies such as photo-elicitation to support family members to participate in a discussion around the impact of parental ED on family life. This may help research take a more systemic approach, rather than focusing on the experiences of one family member.

Future research should also consider how the experiences of adult children may inform interventions to support families where a parent has an ED. This will strengthen the voice of adult children and ensure that interventions are not just based on professional and parent experiences. It is important to consider the experiences of adult children who do and do not identify as experiencing an ED or DE as a result of their parents' difficulties. This may contribute to the evidence base concerning the protective and risk factors linked to intergenerational transmission of ED.

It would also be interesting to explore how applicable these findings are to other mental health difficulties that may be impacted by societal norms, for example, problem gambling. This may support a greater understanding as to how adult children make sense of their experiences of their parent's mental health difficulties, in contexts where societal factors may be more or less influential.

9.5 Conclusion

The aim of this study was to explore how adult children, who identify as growing up alongside a parent with an ED or DE, make sense of their experiences. This study captures participants accounts of this process. It has expanded the existing literature by addressing the as of yet unheard accounts of adult children and identifies a number of factors which may contribute to how this sense-making process evolves over time. These findings hold clinical relevance, in terms of identifying potential ways to intervene and support parents with an ED or DE and their children. As acknowledged, this study does carry limitations and it will be necessary for future research to address these in order to expand this area of research.

9.6 Reflections on the research process

Conducting this study was one of the most challenging aspects of my training to date. I have gained an awareness of not only the challenges and dilemmas inherent within the research process but also the complexities of occupying both a researcher and practitioner role, particularly as I have personal experience of the area. Learning to balance these roles was a key experience; for example, whilst interviewing, I noticed a pull to become a therapist and had to remind myself of my role as a researcher. This being said, I believe the clinical skills I have acquired pre and during training supported me to build a rapport with participants and hopefully create a safe and respectful interview space.

I also noticed a tendency to ally myself with participants over their parents and associate participants' descriptions of their parent's behaviour to an ED. Working alongside my supervisor allowed me to recognise this dynamic, not get drawn into a problem saturated narrative and remain mindful that I was only hearing and therefore interpreting one aspect of reality (e.g the participants' reality). I also valued supervision as a space to explore hypotheses, refine ideas and begin to make sense of what felt, at times, like an overwhelming amount of data.

Using the Paradigm Model (Strauss & Corbin, 1998) to support the analysis process came with its advantages and drawbacks. For example, I appreciated the structure of the model and its ability to guide my thinking yet also noticed that, at times, I became focused on trying to 'fit the data into boxes'. Refraining from doing this and trusting that the results would evolve as analysis progressed was a key part of the research process for me.

Finally, I admit to being somewhat surprised by the extent to which participants' experiences, particularly their internalised narratives and concerns about the future, resonated with me. This has reminded me of the importance of attending to the process as well as content aspects of research and the merits of memo-writing in facilitating this awareness.

REFERENCES

Ackard, D. M., Richter, S., Frisch, M. J., Mangham, D., & Cronemeyer, C. L. (2013). Eating disorder treatment among women forty and older: Increases in prevalence over time and comparisons to young adult patients. *Journal of Psychosomatic Research*, *74*(2), 175-178. https://doi.org/10.1016/j.jpsychores.2012.10.014

Agius, S. J. (2013). Qualitative research: Its value and applicability. *The Psychiatrist*, *37*(6), 204-206. https://doi.org/10.1192/pb.bp.113.042770

Ainsworth, M. D. (1964). Patterns of attachment behavior shown by the infant in interaction with his mother. Merrill-Palmer Quarterly, 10(1), 51-58. https://www.jstor.org/stable/pdf/23082925.pdf

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders*.

Anastasiadou, D., Medina-Pradas, C., Sepulveda, A. R., & Treasure, J. (2014). A systematic review of family caregiving in eating disorders. *Eating Behaviors*, *15*(3), 464-477. https://doi.org/10.1016/j.eatbeh.2014.06.001

Atwood, M. E., & Friedman, A. (2019). A systematic review of enhanced cognitive behavioral therapy (CBT-E) for eating disorders. *International Journal of Eating Disorders*, *53*(3), 311-330. https://doi.org/10.1002/eat.23206

Austin, A., Flynn, M., Richards, K., Hodsoll, J., Duarte, T. A., Robinson, P., Kelly, J., & Schmidt, U. (2020). Duration of untreated eating disorder and relationship to outcomes: A systematic review of the literature. *European Eating Disorders Review*, *29*(3), 329-345. https://doi.org/10.1002/erv.2745

Austin, A., Flynn, M., Richards, K., Hodsoll, J., Duarte, T. A., Robinson, P., Kelly, J., & Schmidt, U. (2020). Duration of untreated eating disorder and relationship to outcomes: A systematic review of the literature. *European Eating Disorders Review*, *29*(3), 329-345. https://doi.org/10.1002/erv.2745

Aya, V., Ulusoy, K., & Cardi, V. (2019). A systematic review of the ‘eating disorder voice’ experience. *International Review of Psychiatry, 31*(4), 347-366. https://doi.org/10.1080/09540261.2019.1593112

Ayton, A., David.Viljoen, Ryan, S., Ibrahim, A., & Ford, D. (2021). Risk, demand, capacity and outcomes in adult specialist eating disorder services in the south of England – before and since COVID-19. https://doi.org/10.31234/osf.io/z76qj

Bandura, A. (1986). Social foundations of thought and action: A social cognitive theory. Prentice Hall.

Bandura. (1971). *Social Learning Theory*. General Learning Press. http://www.asecib.ase.ro/mps/Bandura_SocialLearningTheory.pdf

Barakat, McLean, S. A., Bryant, E., Le, A., Marks, P., National Eating Disorder Research Consortium, Touyz, S., & Maguire, S. (2023). Risk factors for eating disorders: findings from a rapid review. *Journal of Eating Disorders, 11*(8), 1-31. https://doi.org/10.1186/s40337-022-00717-4

Bardone-Cone, A. M., Harney, M. B., Maldonado, C. R., Lawson, M. A., Robinson, D. P., Smith, R., & Tosh, A. (n.d.). Defining recovery from an eating disorder. *Behaviour research and therapy, 48*(3), 194-202. https://doi.org/10.1016/j.brat.2009.11.001

Baumrind, D. (1971). Current patterns of parental authority. *Developmental Psychology*, *4*(1, Pt.2), 1-103. https://doi.org/10.1037/h0030372

Birmingham, C. L., Touyz, S., & Harbottle, J. (2009). Are anorexia nervosa and bulimia nervosa separate disorders? Challenging the ‘transdiagnostic’ theory of eating disorders. European Eating Disorders Review, 17(1), 2-13. https://doi.org/10.1002/erv.896

Blissett, J., & Bennett, C. (2012). Cultural differences in parental feeding practices and children’s eating behaviours and their relationships with child BMI: A comparison of Black Afro-

Caribbean, white British and white German samples. *European Journal of Clinical Nutrition*, *67*(2), 180-184. https://doi.org/10.1038/ejcn.2012.198

Blissett, J., & Haycraft, E. (2011). Parental eating disorder symptoms and observations of mealtime interactions with children. *Journal of Psychosomatic Research*, *70*(4), 368-371. https://doi.org/10.1016/j.jpsychores.2010.07.006

Bluck, S., & Habermas, T. (2001). Extending the study of autobiographical memory: Thinking back about life across the life span. Review of General Psychology, 5(2), 135-147. https://doi.org/10.1037/1089-2680.5.2.135

Bomben, R., Robertson, N., & Allan, S. (2022). Barriers to help-seeking for eating disorders in men: A mixed-methods systematic review. *Psychology of Men & Masculinities*, *23*(2), 183-196. https://doi.org/10.1037/men0000382

Bowen, M. (1966). The use of family theory in clinical practice. *Comprehensive Psychiatry*, *7*(5), 345-374. https://doi.org/10.1016/s0010-440x(66)80065-2

Bowen. (1976). Theory in the practice of psychotherapy. In *Family therapy: Theory and practice* (pp. 42-90). Gardner Press. http://www.cflarchives.org/images/TheoryInThePractice.pdf

Bowlby, J. (1969). Attachment and loss: Attachment.

Branje, S., Geeraerts, S., De Zeeuw, E. L., Oerlemans, A. M., Koopman-Verhoeff, M. E., Schulz, S., Nelemans, S., Meeus, W., Hartman, C. A., Hillegers, M. H., Oldehinkel, A. J., & Boomsma, D. I. (2020). Intergenerational transmission: Theoretical and methodological issues and an introduction to four Dutch cohorts. *Developmental Cognitive Neuroscience*, *45*, 100835. https://doi.org/10.1016/j.dcn.2020.100835

Brewerton, T. D., Rance, S. J., Dansky, B. S., O'Neil, P. M., & Kilpatrick, D. G. (2014). A comparison of women with child-adolescent versus adult onset binge eating: Results from the national women's study. *International Journal of Eating Disorders*, *47*(7), 836-843. https://doi.org/10.1002/eat.22309

Bronfenbrenner, U. (1992). Ecological systems theory. In R. Vasta (Ed.), Six theories of child development: Revised formulations and current issues (pp. 187–249). Jessica Kingsley Publishers.

Brown, A., McClelland, J., Boysen, E., Mountford, V., Glennon, D., & Schmidt, U. (2016). The FREED project (first episode and rapid early intervention in eating disorders): Service model, feasibility and acceptability. *Early Intervention in Psychiatry*, *12*(2), 250-257. https://doi.org/10.1111/eip.12382

Brown, K. L., Graham, A. K., Perera, R. A., & LaRose, J. G. (2022). Eating to cope: Advancing our understanding of the effects of exposure to racial discrimination on maladaptive eating behaviors. *International Journal of Eating Disorders*, *55*(12), 1744-1752. https://doi.org/10.1002/eat.23820

British Psychological Society. (2021). BPS code of human research ethics. https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Human%20Research%20Ethics.pdf

Brun, I., Russell-Mayhew, S., & Mudry, T. (2020). Last word: Ending the intergenerational transmission of body dissatisfaction and disordered eating: a call to investigate the mother-daughter relationship. *Eating Disorders*, *29*(6), 591-598. https://doi.org/10.1080/10640266.2020.1712635

Bulik, C. M., Hebebrand, J., Keski-Rahkonen, A., Klump, K. L., Reichborn-Kjennerud, T., Mazzeo, S. E., & Wade, T. D. (2007). Genetic epidemiology, endophenotypes, and eating disorder classification. *International Journal of Eating Disorders*, *40*(S3), S52-S60. https://doi.org/10.1002/eat.20398

Bulik. (2005). Exploring the gene–environment nexus in eating disorders. *Journal of Psychiatry and Neuroscience*, *30*(5), 335-339.

Burns, M., Bally, J., Burles, M., Holtslander, L., & Peacock, S. (2022). Constructivist grounded theory or interpretive phenomenology? Methodological choices within specific study contexts. *International Journal of Qualitative Methods*, *21*, 160940692210777. https://doi.org/10.1177/16094069221077758

Busetto, L., Wick, W., & Gumbinger, C. (2020). How to use and assess qualitative research methods. *Neurological Research and Practice*, *2*(1). https://doi.org/10.1186/s42466-020-00059-z

Butler, A. E., Copnell, B., & Hall, H. (2018). The development of theoretical sampling in practice. *Collegian*, *25*(5), 561-566. https://doi.org/10.1016/j.colegn.2018.01.002

Bye, A., Martini, M. G., & Micali, N. (2021). Eating disorders, pregnancy and the postnatal period: A review of the recent literature. *Current Opinion in Psychiatry*, *34*(6), 563-568. https://doi.org/10.1097/yco.0000000000000748

Chapman, L., Cartwright-Hatton, S., Thomson, A., & Lester, K. J. (2021). Parental eating disorders: A systematic review of parenting attitudes, behaviours, and parent-child interactions. *Clinical Psychology Review*, *88*, 102031. https://doi.org/10.1016/j.cpr.2021.102031

Charmaz, K. (2014). *Constructing grounded theory*. SAGE.

Charmaz, K., & Thornberg, R. (2020). The pursuit of quality in grounded theory. *Qualitative Research in Psychology*, *18*(3), 305-327. https://doi.org/10.1080/14780887.2020.1780357

Charmaz. (2006). *Constucting grounded theory: A practical guide through qualitatitive analysis*. Sage Publications.

Chowdhury, I. A. (2015). Issue of quality in a qualitative research: An overview. *Innovative Issues and Approaches in Social Sciences*, *8*(1), 142-162. https://doi.org/10.12959/issn.1855-0541.iiass-2015-no1-art09

Claydon, E. A., Lilly, C. L., Zerwas, S. C., Zullig, K. J., Davidov, D. M., & Cottrell, L. (2020). An exploratory study on the intergenerational transmission of dieting proneness within an eating disorder population. *Eating and Weight Disorders - Studies on Anorexia, Bulimia and Obesity*, *25*(5), 1171-1181. https://doi.org/10.1007/s40519-019-00745-1

Costa, A., & Oliveira, A. (2023). Parental feeding practices and children's eating behaviours: An overview of their complex relationship. *Healthcare*, *11*(3), 400. https://doi.org/10.3390/healthcare11030400

Culbert, K. M., Racine, S. E., & Klump, K. L. (2015). Research review: What we have learned about the causes of eating disorders - a synthesis of sociocultural, psychological, and biological research. *Journal of Child Psychology and Psychiatry*, *56*(11), 1141-1164. https://doi.org/10.1111/jcpp.12441

Curzio, O., Maestro, S., Rossi, G., Calderoni, S., Giombini, L., Scardigli, S., Ragione, L. D., & Muratori, F. (2018). Transdiagnostic vs. disorder-focused perspective in children and adolescents with eating disorders: Findings from a large multisite exploratory study. European Psychiatry, 49, 81-93. https://doi.org/10.1016/j.eurpsy.2017.12.024

Cutcliffe, J. R. (2005). Adapt or adopt: Developing and transgressing the methodological boundaries of grounded theory. *Journal of Advanced Nursing*, *51*(4), 421-428. https://doi.org/10.1111/j.1365-2648.2005.03514.x

Dam, K., & Hall, E. O. (2020). Childhood experiences pursue adulthood for better and worse: A qualitative study of adults' experiences after growing up with a severely mentally ill parent in a small-scale society. *Journal of Research in Nursing*, *25*(6-7), 579-591. https://doi.org/10.1177/1744987120942272

De Barse, L. M., Tharner, A., Micali, N., Jaddoe, V. V., Hofman, A., Verhulst, F. C., Franco, O. H., Tiemeier, H., & Jansen, P. W. (2015). Does maternal history of eating disorders predict mothers' feeding practices and preschoolers' emotional eating? *Appetite*, *85*, 1-7. https://doi.org/10.1016/j.appet.2014.10.031

Dimitropoulos, G., Klopfer, K., Lazar, L., & Schacter, R. (2009). Caring for a sibling with anorexia nervosa: A qualitative study. *European Eating Disorders Review*, *17*(5), 350-365. https://doi.org/10.1002/erv.937

Drost, L. M., Van der Krieke, L., Sytema, S., & Schippers, G. M. (2015). Self-expressed strengths and resources of children of parents with a mental illness: A systematic review. *International Journal of Mental Health Nursing*, *25*(2), 102-115. https://doi.org/10.1111/inm.12176

Duarte, C., Ferreira, C., & Pinto-Gouveia, J. (2016). At the core of eating disorders: Overvaluation, social rank, self-criticism and shame in anorexia, bulimia and binge eating disorder. *Comprehensive Psychiatry*, *66*, 123-131. https://doi.org/10.1016/j.comppsych.2016.01.003

Dunkley-Smith, A. J., Reupert, A. E., Ling, M., & Sheen, J. A. (2021). Experiences and perspectives of self-compassion from young adult children of parents with mental illness. *Journal of Adolescence*, *89*(1), 183-193. https://doi.org/10.1016/j.adolescence.2021.05.001

Dörsam, A. F., Preißl, H., Micali, N., Lörcher, S. B., Zipfel, S., & Giel, K. E. (2019). The impact of maternal eating disorders on dietary intake and eating patterns during pregnancy: A systematic review. *Nutrients*, *11*(4), 840. https://doi.org/10.3390/nu11040840

Easter, A., Bye, A., Taborelli, E., Corfield, F., Schmidt, U., Treasure, J., & Micali, N. (2013). Recognising the symptoms: How common are eating disorders in pregnancy? *European Eating Disorders Review*, *21*(4), 340-344. https://doi.org/10.1002/erv.2229

Elran-Barak, R., Fitzsimmons-Craft, E. E., Benyamini, Y., Crow, S. C., Peterson, C. B., Hill, L. L., Crosby, R. D., Mitchell, J. E., & Le Grange, D. (2015). Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder in Midlife and Beyond. *The Journal of Nervous and Mental Disease*, *203*(8), 583-590. https://doi.org/10.1097/nmd.0000000000000333

Erikson, E. H. (1950). *Childhood and society*. Random House.

Fairburn, C. G., & Brownell, K. D. (2002). *Eating disorders and obesity: A comprehensive handbook* (2nd ed.). Guilford Press.

Fairburn, C. G. (2008). Cognitive behavior therapy and eating disorders. Guilford Press.

Fairburn, C. G., Bailey-Straebler, S., Basden, S., Doll, H. A., Jones, R., Murphy, R., O'Connor, M. E., & Cooper, Z. (2015). A transdiagnostic comparison of enhanced cognitive behaviour therapy (CBT-E) and interpersonal psychotherapy in the treatment of eating disorders. Behaviour Research and Therapy, 70, 64-71. https://doi.org/10.1016/j.brat.2015.04.010

Fairburn, C. G., Cooper, Z., & Shafran, R. (2003). Cognitive behaviour therapy for eating disorders: a "transdiagnostic" theory and treatment. Behaviour Research and Therapy, 41(5), 509-528. https://doi.org/10.1016/s0005-7967(02)00088-8

Fairburn, C. G., Cooper, Z., Doll, H. A., O’Connor, M. E., Bohn, K., Hawker, D. M., Wales, J. A., & Palmer, R. L. (2009). Transdiagnostic cognitive-behavioral therapy for patients with eating disorders: A two-site trial with 60-Week follow-up. American Journal of Psychiatry, 166(3), 311-319. https://doi.org/10.1176/appi.ajp.2008.08040608

Fichter, M. M., & Quadflieg, N. (2007). Long-term stability of eating disorder diagnoses. International Journal of Eating Disorders, 40(S3), S61-S66. https://doi.org/10.1002/eat.20443

Fichter, M. M., Quadflieg, N., & Hedlund, S. (2008). Long-term course of binge eating disorder and bulimia nervosa: Relevance for nosology and diagnostic criteria. *International Journal of Eating Disorders*, *41*(7), 577-586. https://doi.org/10.1002/eat.20539

Fiese, B. H., Foley, K. P., & Spagnola, M. (2006). Routine and ritual elements in family mealtimes: Contexts for child well-being and family identity. *New Directions for Child and Adolescent Development*, *2006*(111), 67-89. https://doi.org/10.1002/cd.156

Filipponi, C., Visentini, C., Filippini, T., Cutino, A., Ferri, P., Rovesti, S., Latella, E., & Di Lorenzo, R. (2022). The follow-up of eating disorders from adolescence to early adulthood: A systematic review. *International Journal of Environmental Research and Public Health*, *19*(23), 16237. https://doi.org/10.3390/ijerph192316237

Fivush, R. (2011). The development of autobiographical memory. Annual Review of Psychology, 62, 559-582. https://doi.org/10.1146/annurev.psych.121208.131702

Fjermestad, K. W., Rø, A. E., Espeland, K. E., Halvorsen, M., & Halvorsen, I. M. (2019). "Do I exist in this world, really, or is it just her?" youths' perspectives of living with a sibling with anorexia nervosa. *Eating Disorders*, *28*(1), 80-95. https://doi.org/10.1080/10640266.2019.1573046

Fossey, E., Harvey, C., Mcdermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research. *Australian & New Zealand Journal of Psychiatry*, *36*(6), 717-732. https://doi.org/10.1046/j.1440-1614.2002.01100.x

Foster, K. (2010). 'You'd think this roller coaster was never going to stop': Experiences of adult children of parents with serious mental illness. *Journal of Clinical Nursing*, *19*(21-22), 3143-3151. https://doi.org/10.1111/j.1365-2702.2010.03293.x

Fox, J. R., Dean, M., & Whittlesea, A. (2015). The experience of caring for or living with an individual with an eating disorder: A meta-synthesis of qualitative studies. *Clinical Psychology & Psychotherapy*, *24*(1), 103-125. https://doi.org/10.1002/cpp.1984

Galmiche, M., Déchelotte, P., Lambert, G., & Tavolacci, M. P. (2018). Prevalence of eating disorders over the 2000–2018 period: A systematic literature review. *The American Journal of Clinical Nutrition*, *109*(5), 1402-1413. https://doi.org/10.1093/ajcn/nqy342

Gelo, O., Braakmann, D., & Benetka, G. (2008). Quantitative and qualitative research: Beyond the debate. *Integrative Psychological and Behavioral Science*, *43*(4), 406-407. https://doi.org/10.1007/s12124-009-9107-x

Gevers, D., Kremers, S., De Vries, N., & Van Assema, P. (2014). Clarifying concepts of food parenting practices. A Delphi study with an application to snacking behavior. *Appetite*, *79*, 51-57. https://doi.org/10.1016/j.appet.2014.04.002

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitatitive research*. AldineTransaction.

Goertz, G., & Mahoney, J. (2012). Concepts and measurement: Ontology and epistemology. *Social Science Information*, *51*(2), 205-216. https://doi.org/10.1177/0539018412437108

Grange, D. L., & Loeb, K. L. (2007). Early identification and treatment of eating disorders: Prodrome to syndrome. *Early Intervention in Psychiatry*, *1*(1), 27-39. https://doi.org/10.1111/j.1751-7893.2007.00007.x

Grave, R. D. (2011). Eating disorders: Progress and challenges. European Journal of Internal Medicine, 22(2), 153-160. https://doi.org/10.1016/j.ejim.2010.12.010

Gilbert, P. (2009). Introducing compassion-focused therapy. Advances in Psychiatric Treatment, 15(3), 199-208. https://doi.org/10.1192/apt.bp.107.005264

Grilo, C. M., Masheb, R. M., & White, M. A. (2010). Significance of overvaluation of shape/Weight in binge-eating disorder: Comparative study with overweight and bulimia nervosa. *Obesity*, *18*(3), 499-504. https://doi.org/10.1038/oby.2009.280

Grysman, A., & Hudson, J. A. (2010). Abstracting and extracting: Causal coherence and the development of the life story. Memory, 18(6), 565-580. https://doi.org/10.1080/09658211.2010.493890

Halbeisen, G., Brandt, G., & Paslakis, G. (2022). A plea for diversity in eating disorders research. *Frontiers in Psychiatry*, *13*. https://doi.org/10.3389/fpsyt.2022.820043

Hamilton, S. K., & Hamilton Wilson, J. (2009). Family mealtimes. *ICAN: Infant, Child, & Adolescent Nutrition*, *1*(6), 346-350. https://doi.org/10.1177/1941406409353188

Hanfstingl, B., Arzenšek, A., Apschner, J., & Gölly, K. I. (2022). Assimilation and accommodation: A systematic review of the last two decades. *European Psychologist*, *27*(4), 320-337. https://doi.org/10.1027/1016-9040/a000463

Hay, P., Aouad, P., Le, A., Marks, P., Maloney, D., Touyz, S., & Maguire, S. (2023). Epidemiology of eating disorders: Population, prevalence, disease burden and quality of life informing public policy in Australia—a rapid review. *Journal of Eating Disorders*, *11*(1). https://doi.org/10.1186/s40337-023-00738-7

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). Acceptance and commitment therapy: An experiential approach to behavior change. Guilford Press.

Hazzard, V. M., Loth, K. A., Hooper, L., & Becker, C. B. (2020). Food insecurity and eating disorders: A review of emerging evidence. *Current Psychiatry Reports*, *22*(12). https://doi.org/10.1007/s11920-020-01200-0

Himmerich, H., Bentley, J., Kan, C., & Treasure, J. (2019). Genetic risk factors for eating disorders: An update and insights into pathophysiology. *Therapeutic Advances in Psychopharmacology, 9*, 204512531881473. https://doi.org/10.1177/2045125318814734

Hoffman, E. R., Bentley, M. E., Hamer, R. M., Hodges, E. A., Ward, D. S., & Bulik, C. M. (2012). A comparison of infant and toddler feeding practices of mothers with and without histories of eating disorders. *Maternal & Child Nutrition, 10*(3), 360-372. https://doi.org/10.1111/j.1740-8709.2012.00429.x

Hughes, S. O., Power, T. G., Orlet Fisher, J., Mueller, S., & Nicklas, T. A. (2005). Revisiting a neglected construct: Parenting styles in a child-feeding context. *Appetite*, *44*(1), 83-92. https://doi.org/10.1016/j.appet.2004.08.007

Huke, K., & Slade, P. (2006). An exploratory investigation of the experiences of partners living with people who have bulimia nervosa. *European Eating Disorders Review, 14*(6), 436-447. https://doi.org/10.1002/erv.744

Hutchison, S., House, J., McDermott, B., Simic, M., Baudinet, J., & Eisler, I. (2022). Silent witnesses: The experience of having a sibling with anorexia nervosa. *Journal of Eating Disorders, 10*(1). https://doi.org/10.1186/s40337-022-00655-1

Ioannidis, K., Taylor, C., Holt, L., Brown, K., Lochner, C., Fineberg, N. A., Corazza, O., Chamberlain, S. R., Roman-Urrestarazu, A., & Czabanowska, K. (2021). Problematic usage of the internet and eating disorder and related psychopathology: A multifaceted, systematic review and meta-analysis. *Neuroscience & Biobehavioral Reviews*, *125*, 569-581. https://doi.org/10.1016/j.neubiorev.2021.03.005

Jackson, D. D. (1981). The question of family homeostasis. *International Journal of Family Therapy*, *3*(1), 5-15. https://doi.org/10.1007/bf00936266

Johnstone, L., & Boyle, M. (2018). The power threat meaning framework: An alternative Nondiagnostic conceptual system. *Journal of Humanistic Psychology*, 002216781879328. https://doi.org/10.1177/0022167818793289

Jong, M., Spinhoven, P., Korrelboom, K., Deen, M., Van der Meer, I., Danner, U. N., Van der Schuur, S., Schoorl, M., & Hoek, H. W. (2020). Effectiveness of enhanced cognitive behavior therapy for eating disorders: A randomized controlled trial. International Journal of Eating Disorders, 53(5), 717-727. https://doi.org/10.1002/eat.23239

Jungbauer, J., Heibach, J., & Urban, K. (2015). Experiences, burdens, and support needs in siblings of girls and women with anorexia nervosa: Results from a qualitative interview study. *Clinical Social Work Journal*, *44*(1), 78-86. https://doi.org/10.1007/s10615-015-0569-7

Karlstad, J., Moe, C. F., Wattum, M., Adelsten Stokland, R., & Brinchmann, B. S. (2021). “Putting your own oxygen mask on first”: A qualitative study of siblings of adults with anorexia or bulimia. *Journal of Eating Disorders*, *9*(1). https://doi.org/10.1186/s40337-021-00440-6

Karlstad, J., Moe, C. F., Adelsten Stokland, R., & Brinchmann, B. S. (2022). “Balancing within a closed family system”: A grounded theory study of how family life is affected by having a family member with an eating disorder. *Journal of Eating Disorders, 10*(1). https://doi.org/10.1186/s40337-022-00669-9

Keel, P. K., & Brown, T. A. (2010). Update on course and outcome in eating disorders. *International Journal of Eating Disorders*, NA-NA. https://doi.org/10.1002/eat.20810

Keel, P. K., & Forney, K. J. (2013). Psychosocial risk factors for eating disorders. *International Journal of Eating Disorders*, *46*(5), 433-439. https://doi.org/10.1002/eat.22094

Keel, P. K., & Mitchell, J. E. (1997). Outcome in bulimia nervosa. *The American Journal of Psychiatry*, *154*(3), 313–321.. https://doi.org/10.1176/ajp.154.3.313

Khalsa, S. S., Portnoff, L. C., McCurdy-McKinnon, D., & Feusner, J. D. (2017). What happens after treatment? A systematic review of relapse, remission, and recovery in anorexia nervosa. *Journal of Eating Disorders*, *5*(1). https://doi.org/10.1186/s40337-017-0145-3

Killam, L. (2013). *Research terminology simplified: Paradigms, axiology, ontology, epistemology and methodology*. Laura Killam.

Knoph, C., Von Holle, A., Zerwas, S., Torgersen, L., Tambs, K., Stoltenberg, C., Bulik, C. M., & Reichborn-Kjennerud, T. (2013). Course and predictors of maternal eating disorders in the postpartum period. *International Journal of Eating Disorders, 46*(4), 355-368. https://doi.org/10.1002/eat.22088

Köber, C., Schmiedek, F., & Habermas, T. (2015). Characterizing lifespan development of three aspects of coherence in life narratives: A cohort-sequential study. Developmental Psychology, 51(2), 260-275. https://doi.org/10.1037/a0038668

Korstjens, I., & Moser, A. (2017). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice*, *24*(1), 120-124. https://doi.org/10.1080/13814788.2017.1375092

Korstjens, I., & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice*, *24*(1), 120-124. https://doi.org/10.1080/13814788.2017.1375092

Kuppens, S., & Ceulemans, E. (2018). Parenting styles: A closer look at a well-known concept. *Journal of Child and Family Studies*, *28*(1), 168-181. https://doi.org/10.1007/s10826-018-1242-x

Källquist, A., & Salzmann-Erikson, M. (2019). Experiences of having a parent with serious mental illness: An interpretive meta-synthesis of qualitative literature. *Journal of Child and Family Studies*, *28*(8), 2056-2068. https://doi.org/10.1007/s10826-019-01438-0

Lampard, A. M., Tasca, G. A., Balfour, L., & Bissada, H. (2012). An evaluation of the transdiagnostic cognitive-behavioural model of eating disorders. European Eating Disorders Review, 21(2), 99-107. https://doi.org/10.1002/erv.2214

Larkina, M., Merrill, N. A., & Bauer, P. J. (2016). Developmental changes in consistency of autobiographical memories: Adolescents' and young adults' repeated recall of recent and distance events. Memory, 25(8), 1036-1051. https://doi.org/10.1080/09658211.2016.1253750

Lecomte, A., Zerrouk, A., Sibeoni, J., Khan, S., Revah-Levy, A., & Lachal, J. (2019). The role of food in family relationships amongst adolescents with bulimia nervosa: A qualitative study using photo-elicitation. *Appetite*, *141*, 104305. https://doi.org/10.1016/j.appet.2019.05.036

Lester, J. N., & O'Reilly, M. (2021). Introduction to special issue quality in qualitative approaches: Celebrating heterogeneity. *Qualitative Research in Psychology*, *18*(3), 295-304. https://doi.org/10.1080/14780887.2021.1931734

Levine, M. P., & Sadeh-Sharvit, S. (2022). Preventing eating disorders and disordered eating in genetically vulnerable, high risk families. *International Journal of Eating Disorders*, *56*(3), 523-534. https://doi.org/10.1002/eat.23887

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. Guilford Press.

Linville, D., Cobb, E., Shen, F., & Stadelman, S. (2015). Reciprocal influence of couple dynamics and eating disorders. *Journal of Marital and Family Therapy*, *42*(2), 326-340. https://doi.org/10.1111/jmft.12133

Lock, J., & Grange, D. L. (2015). Treatment manual for anorexia nervosa: A family-based approach (2nd ed.). Guilford Publications.

Lydecker, J. A., & Grilo, C. M. (2016). Fathers and mothers with eating-disorder psychopathology: Associations with child eating-disorder behaviors. *Journal of Psychosomatic Research*, *86*, 63-69. https://doi.org/10.1016/j.jpsychores.2016.05.006

Makino, M., Yasushi, M., & Tsutsui, S. (2020). The risk of eating disorder relapse during pregnancy and after delivery and postpartum depression among women recovered from eating disorders. *BMC Pregnancy and Childbirth*, *20*(1). https://doi.org/10.1186/s12884-020-03006-7

Mangweth-Matzek, B., & Hoek, H. W. (2017). Epidemiology and treatment of eating disorders in men and women of middle and older age. *Current Opinion in Psychiatry*, *30*(6), 446-451. https://doi.org/10.1097/yco.0000000000000356

Maon, I., Horesh, D., & Gvion, Y. (2020). Siblings of individuals with eating disorders: A review of the literature. *Frontiers in Psychiatry*, *11*. https://doi.org/10.3389/fpsyt.2020.00604

Marcos, Y., Sebastián, M., Aubalat, L., Ausina, J., & Treasure, J. (2012). Peer and family influence in eating disorders: A meta-analysis. *European Psychiatry*, *28*(4), 199-206. https://doi.org/10.1016/j.eurpsy.2012.03.005

Martini, M. G., Barona-Martinez, M., & Micali, N. (2020). Eating disorders mothers and their children: A systematic review of the literature. *Archives of Women's Mental Health*, *23*(4), 449-467. https://doi.org/10.1007/s00737-020-01019-x

Mason, T. B., Mozdzierz, P., Wang, S., & Smith, K. E. (2021). Discrimination and eating disorder psychopathology: A meta-analysis. *Behavior Therapy*, *52*(2), 406-417. https://doi.org/10.1016/j.beth.2020.05.003

McCallin, A. M. (2003). Designing a grounded theory study: Some practicalities. *Nursing in Critical Care*, *8*(5), 203-208. https://doi.org/10.1046/j.1362-1017.2003.00033.x

McCormack, L., White, S., & Cuenca, J. (2016). A fractured journey of growth: Making meaning of a 'Broken' childhood and parental mental ill-health. *Community, Work & Family*, *20*(3), 327-345. https://doi.org/10.1080/13668803.2015.1117418

McPhie, S., Skouteris, H., Daniels, L., & Jansen, E. (2012). Maternal correlates of maternal child feeding practices: A systematic review. *Maternal & Child Nutrition*, *10*(1), 18-43. https://doi.org/10.1111/j.1740-8709.2012.00452.x

Meah, A. (2013). Reconceptualizing power and gendered subjectivities in domestic cooking spaces. *Progress in Human Geography*, *38*(5), 671-690. https://doi.org/10.1177/0309132513501404

Mediani, H. (2017). An introduction to classical grounded theory. SOJ Nursing & Health Care, 3(3), 1-5. https://doi.org/10.15226/2471-6529/3/3/00135

Meier, K., Van Hoeken, D., & Hoek, H. W. (2022). Review of the unprecedented impact of the COVID-19 pandemic on the occurrence of eating disorders. *Current Opinion in Psychiatry*, *35*(6), 353-361. https://doi.org/10.1097/yco.0000000000000815

Metz, D., & Jungbauer, J. (2021). "My scars remain forever": A qualitative study on biographical developments in adult children of parents with mental illness. *Clinical Social Work Journal*, *49*(1), 64-76. https://doi.org/10.1007/s10615-019-00722-2

Micali, N., Martini, M. G., Thomas, J. J., Eddy, K. T., Kothari, R., Russell, E., Bulik, C. M., & Treasure, J. (2017). Lifetime and 12-month prevalence of eating disorders amongst women in mid-life: A population-based study of diagnoses and risk factors. *BMC Medicine*, *15*(1). https://doi.org/10.1186/s12916-016-0766-4

Mills, J., Bonner, A., & Francis, K. (2006). The Development of Constructivist Grounded Theory. *International Journal of Qualitative Methods*, *5*(1), 25-35. https://journals.sagepub.com/doi/pdf/10.1177/160940690600500103

Milos, G., Spindler, A., Schnyder, U., & Fairburn, C. G. (2005). Instability of eating disorder diagnoses: Prospective study. British Journal of Psychiatry, 187(6), 573-578. https://doi.org/10.1192/bjp.187.6.573

Mitchison, D., Hay, P., Slewa-Younan, S., & Mond, J. (2014). The changing demographic profile of eating disorder behaviors in the community. *BMC Public Health*, *14*(1). https://doi.org/10.1186/1471-2458-14-943

Mordoch, E., & Hall, W. A. (2008). Children's perceptions of living with a parent with a mental illness: Finding the rhythm and maintaining the frame. Qualitative Health Research, 18(8), 1127-1144. https://doi.org/10.1177/1049732308320775

Murphy, G., Peters, K., Jackson, D., & Wilkes, L. (2011). A qualitative meta-synthesis of adult children of parents with a mental illness. *Journal of Clinical Nursing, 20*(23-24), 3430-3442. https://doi.org/10.1111/j.1365-2702.2010.03651.x

Murphy, G., Peters, K., Wilkes, L., & Jackson, D. (2015). Adult children of parents with mental illness: Navigating stigma. *Child & Family Social Work, 22*(1), 330-338. https://doi.org/10.1111/cfs.12246

Murphy, G., Peters, K., Wilkes, L. M., & Jackson, D. (2016). Adult children of parents with mental illness: Losing oneself. Who am I? *Issues in Mental Health Nursing*, *37*(9), 668-673. https://doi.org/10.1080/01612840.2016.1178359

Murray, S. B., Nagata, J. M., Griffiths, S., Calzo, J. P., Brown, T. A., Mitchison, D., Blashill, A. J., & Mond, J. M. (2017). The Enigma of male eating disorders: A critical review and synthesis. *Clinical Psychology Review*, *57*, 1-11. https://doi.org/10.1016/j.cpr.2017.08.001

National Institute of Clinical and Health Excellence. (2022). Eating disorders: Recognition and treatment. https://www.nice.org.uk/guidance/ng69/resources/eating-disorders-recognition-and-treatment-pdf-1837582159813

Nechita, D., Bud, S., & David, D. (2021). Shame and eating disorders symptoms: A meta-analysis. *International Journal of Eating Disorders*, *54*(11), 1899-1945. https://doi.org/10.1002/eat.23583

Nelson, J. D., Martin, L. N., Izquierdo, A., Kornienko, O., Cuellar, A. E., Cheskin, L. J., & Fischer, S. (2023). The role of discrimination and adverse childhood experiences in disordered eating. *Journal of Eating Disorders*, *11*(1). https://doi.org/10.1186/s40337-023-00753-8

O'Connor, P., Daly, L., & Higgins, A. (2019). Partners' experiences of living with a person with an eating disorder: A grounded theory study. *Journal of Advanced Nursing*. https://doi.org/10.1111/jan.14032

Olmos-Vega, F. M., Stalmeijer, R. E., Varpio, L., & Kahlke, R. (2022). A practical guide to reflexivity in qualitative research: AMEE guide No. 149. *Medical Teacher, 45*(3), 241-251. https://doi.org/10.1080/0142159x.2022.2057287

Osborn, K. D. (2023). Competing for perfection: A scoping review evaluating relationships between competitiveness and eating disorders or disordered eating behaviours. *European Eating Disorders Review*, *31*(5), 549-576. https://doi.org/10.1002/erv.2978

Öztürk, P., & Ouyaba, A. (2023). Prevalence and related factors of eating disorders in pregnancy: A systematic review and meta-analysis. Archives of Gynecology and Obstetrics. https://doi.org/10.1007/s00404-023-07051-3

Paré, G., & Kitsiou., S. (2017). Methods for Literature Reviews. In *Handbook of eHealth Evaluation: An Evidence-based Approach* (pp. 157-179). University of Victoria.

Paroche, M., Caton, S. J., Vereijken, C. M., Weenen, H., & Houston-Price, C. (2017). How infants and young children learn about food: A systematic review. Frontiers in Psychology, 8. https://doi.org/10.3389/fpsyg.2017.01046

Patrick, P. M., Reupert, A. E., & McLean, L. A. (2020). Relational trajectories in families with parental mental illness: A grounded theory approach. *BMC Psychology*, *8*(1). https://doi.org/10.1186/s40359-020-00432-2

Patrick, P., Reupert, A., & McLean, L. (2019). “We are more than our parents’ mental illness”: Narratives from adult children. *International Journal of Environmental Research and Public Health*, *16*(5), 839. https://doi.org/10.3390/ijerph16050839

Pearson, C. M., Miller, J., Ackard, D. M., Loth, K. A., Wall, M. M., Haynos, A. F., & Neumark-Sztainer, D. (2017). Stability and change in patterns of eating disorder symptoms from adolescence to young adulthood. *International Journal of Eating Disorders*, *50*(7), 748-757. https://doi.org/10.1002/eat.22692

Pereira, R. F., & Alvarenga, M. (2007). Disordered eating: Identifying, treating, preventing, and differentiating it from eating disorders. *Diabetes Spectrum*, *20*(3), 141-148. https://doi.org/10.2337/diaspect.20.3.141

Piaget, J. (1952). When thinking begins. In *The origins of intelligence in children* (1st ed., pp. 25-35). International University Press. https://doi.org/10.1037/11494-000

Pike, K. M., Dunne, P. E., & Addai, E. (2013). Expanding the boundaries: Reconfiguring the demographics of the “Typical” eating disordered patient. *Current Psychiatry Reports*, *15*(11). https://doi.org/10.1007/s11920-013-0411-2

Potterton, R., Richards, K., Allen, K., & Schmidt, U. (2020). Eating disorders during emerging adulthood: A systematic scoping review. *Frontiers in Psychology*, *10*. https://doi.org/10.3389/fpsyg.2019.03062

Power, T. G. (2013). Parenting dimensions and styles: A brief history and recommendations for future research. *Childhood Obesity*, *9*(s1), S-14-S-21. https://doi.org/10.1089/chi.2013.0034

Pugh, M., & Waller, G. (2016). Understanding the ‘Anorexic voice’ in anorexia nervosa. *Clinical Psychology & Psychotherapy, 24*(3), 670-676. https://doi.org/10.1002/cpp.2034

Ranganathan, P., Pramesh, C., & Buyse, M. (2015). Common pitfalls in statistical analysis: Clinical versus statistical significance. Perspectives in Clinical Research, 6(3), 169. https://doi.org/10.4103/2229-3485.159943

Reba-Harrelson, L., Von Holle, A., Hamer, R. M., Swann, R., Reyes, M. L., & Bulik, C. M. (2009). Patterns and prevalence of disordered eating and weight control behaviors in women ages 25–45. *Eating and Weight Disorders - Studies on Anorexia, Bulimia and Obesity, 14*(4), 190-198. https://doi.org/10.1007/bf03325116

Reba-Harrelson, L., Von Holle, A., Hamer, R. M., Torgersen, L., Reichborn-Kjennerud, T., & Bulik, C. M. (2010). Patterns of maternal feeding and child eating associated with eating disorders in the Norwegian mother and child cohort study (MoBa). Eating Behaviors, 11(1), 54-61. https://doi.org/10.1016/j.eatbeh.2009.09.004

Rieger, K. L. (2018). Discriminating among grounded theory approaches. *Nursing Inquiry, 26*(1), e12261. https://doi.org/10.1111/nin.12261

Robson, S. M., McCullough, M. B., Rex, S., Munafò, M. R., & Taylor, G. (2020). Family meal frequency, diet, and family functioning: A systematic review with meta-analyses. *Journal of Nutrition Education and Behavior*, *52*(5), 553-564. https://doi.org/10.1016/j.jneb.2019.12.012

Rocco, P. L., Orbitello, B., Perini, L., Pera, V., Ciano, R. P., & Balestrieri, M. (2005). Effects of pregnancy on eating attitudes and disorders. *Journal of Psychosomatic Research*, *59*(3), 175-179. https://doi.org/10.1016/j.jpsychores.2005.03.002

Rodgers, R., & Chabrol, H. (2009). Parental attitudes, body image disturbance and disordered eating amongst adolescents and young adults: A review. *European Eating Disorders Review*, *17*(2), 137-151. https://doi.org/10.1002/erv.907

Rohde, P., Stice, E., & Marti, C. N. (2014). Development and predictive effects of eating disorder risk factors during adolescence: Implications for prevention efforts. *International Journal of Eating Disorders*, *48*(2), 187-198. https://doi.org/10.1002/eat.22270

Rohleder, P., & Lyons, A. (2015). *Qualitative research in clinical and health psychology*. Bloomsbury Publishing.

Rounsefell, K., Gibson, S., McLean, S., Blair, M., Molenaar, A., Brennan, L., Truby, H., & McCaffrey, T. A. (2019). Social media, body image and food choices in healthy young adults: A mixed methods systematic review. *Nutrition & Dietetics*, *77*(1), 19-40. https://doi.org/10.1111/1747-0080.12581

Sadeh-Sharvit, S., Levy-Shiff, R., Feldman, T., Ram, A., Gur, E., Zubery, E., Steiner, E., Latzer, Y., & Lock, J. D. (2015). Child feeding perceptions among mothers with eating disorders. *Appetite*, *95*, 67-73. https://doi.org/10.1016/j.appet.2015.06.017

Sadeh-Sharvit, S., Zubery, E., Mankovski, E., Steiner, E., & Lock, J. D. (2016). Parent-based prevention program for the children of mothers with eating disorders: Feasibility and preliminary outcomes. *Eating Disorders*, *24*(4), 312-325. https://doi.org/10.1080/10640266.2016.1153400

Sadeh-Sharvit, S., Sacks, M. R., Runfola, C. D., Bulik, C. M., & Lock, J. D. (2019). Interventions to empower adults with eating disorders and their partners around the transition to parenthood. *Family Process*, *59*(4), 1407-1422. https://doi.org/10.1111/famp.12510

Saltzman, J. A., Pineros-Leano, M., Liechty, J. M., Bost, K. K., & Fiese, B. H. (2016). Eating, feeling, and feeding: Does maternal binge eating predict use of child feeding practices through emotional responsiveness? *The FASEB Journal*, *30*(S1). https://doi.org/10.1096/fasebj.30.1_supplement.1150.12

Samuels, K. L., Maine, M. M., & Tantillo, M. (2019). Disordered eating, eating disorders, and body image in midlife and older women. *Current Psychiatry Reports*, *21*(8). https://doi.org/10.1007/s11920-019-1057-5

Savage, J. S., Fisher, J. O., & Birch, L. L. (2007). Parental influence on eating behavior: Conception to adolescence. *Journal of Law, Medicine & Ethics*, *35*(1), 22-34. https://doi.org/10.1111/j.1748-720x.2007.00111.x

Sbaraini, A., Carter, S. M., Evans, R. W., & Blinkhorn, A. (2011). How to do a grounded theory study: A worked example of a study of dental practices. *BMC Medical Research Methodology*, *11*(1). https://doi.org/10.1186/1471-2288-11-128

Schmidt, U., Magill, N., Renwick, B., Keyes, A., Kenyon, M., Dejong, H., Lose, A., Broadbent, H., Loomes, R., Yasin, H., Watson, C., Ghelani, S., Bonin, E., Serpell, L., Richards, L., Johnson-Sabine, E., Boughton, N., Whitehead, L., Beecham, J., … Landau, S. (2015). The Maudsley outpatient study of treatments for anorexia nervosa and related conditions (MOSAIC): Comparison of the Maudsley model of anorexia nervosa treatment for adults (MANTRA) with specialist supportive clinical management (SSCM) in outpatients with broadly defined anorexia nervosa: A randomized controlled trial. Journal of Consulting and Clinical Psychology, 83(4), 796-807. https://doi.org/10.1037/ccp0000019

Schmidt, U., Startup, H., & Treasure, J. (2018). A cognitive-interpersonal therapy workbook for treating anorexia nervosa: The Maudsley model.

Scutt, E., Langdon-Daly, J., & Smithson, J. (2022). Experiences of eating difficulties in siblings of people with anorexia nervosa: A reflexive thematic analysis. https://doi.org/10.21203/rs.3.rs-1497405/v1

Shloim, N., Edelson, L. R., Martin, N., & Hetherington, M. M. (2015). Parenting styles, feeding styles, feeding practices, and weight status in 4–12 year-old children: A systematic review of the literature. *Frontiers in Psychology*, *6*. https://doi.org/10.3389/fpsyg.2015.01849

Sim, L., & Peterson, C. B. (2021). The peril and promise of sensitivity in eating disorders. *International Journal of Eating Disorders*, *54*(11), 2046-2056. https://doi.org/10.1002/eat.23606

Simpson-Adkins, G. J., & Daiches, A. (2018). How do children make sense of their parent's mental health difficulties: A meta-synthesis. *Journal of Child and Family Studies*, *27*(9), 2705-2716. https://doi.org/10.1007/s10826-018-1112-6

Skinner, B. F. (1971). Operant conditioning. *The encyclopedia of education*, *7*, 29-33.

Slane, J. D., Klump, K. L., McGue, M., & Iacono, W. G. (2014). Developmental trajectories of disordered eating from early adolescence to young adulthood: A longitudinal study. *International Journal of Eating Disorders*, *47*(7), 793-801. https://doi.org/10.1002/eat.22329

Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. Psychology & Health, 11(2), 261-271. https://doi.org/10.1080/08870449608400256

Smith, J. A., & Osborn, M. (2007). Interpretative Phenomenological Analysis. In *Qualitative Psychology* (pp. 53-80). Sage.

Snape, D., & Spencer, L. (2003). The Foundations of Qualitative Research. In *Qualitative research practice: A guide for social science students and researchers* (pp. 2-10). SAGE.

So, B., & Kwon, K. H. (2023). The impact of thin-ideal internalization, appearance comparison, social media use on body image and eating disorders: A literature review. *Journal of Evidence-Based Social Work*, *20*(1), 55-71. https://doi.org/10.1080/26408066.2022.2117582

Sollid, C., Clausen, L., & Maimburg, R. D. (2021). The first 20 weeks of pregnancy is a high-risk period for eating disorder relapse. *International Journal of Eating Disorders*, *54*(12), 2132-2142. https://doi.org/10.1002/eat.23620

Sommerfeldt, B., Skårderud, F., Kvalem, I. L., Gulliksen, K. S., & Holte, A. (2022). Bodies out of control: Relapse and worsening of eating disorders in pregnancy. *Frontiers in Psychology*, *13*. https://doi.org/10.3389/fpsyg.2022.986217

Song, S., Stern, C. M., Deitsch, T., & Sala, M. (2023). Acculturation and eating disorders: A systematic review. *Eating and Weight Disorders - Studies on Anorexia, Bulimia and Obesity*, *28*(1). https://doi.org/10.1007/s40519-023-01563-2

Starks, H., & Trinidad, S. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research*, *17*(10), 1372-1380. https://doi.org/10.1177/1049732307307031

Stein, A., Woolley, H., Cooper, S. D., & Fairburn, C. G. (1994). An observational study of mothers with eating disorders and their infants. *Journal of Child Psychology and Psychiatry*, *35*(4), 733-748. https://doi.org/10.1111/j.1469-7610.1994.tb01218.x

Steinhausen, H. (2002). The outcome of anorexia nervosa in the 20th century. *American Journal of Psychiatry*, *159*(8), 1284-1293. https://doi.org/10.1176/appi.ajp.159.8.1284

Stewart, C. S., Baudinet, J., Munuve, A., Bell, A., Konstantellou, A., Eisler, I., & Simic, M. (2022). From efficacy to effectiveness: Child and adolescent eating disorder treatments in the real world (Part 2): 7-year follow-up. *Journal of Eating Disorders*, *10*(1). https://doi.org/10.1186/s40337-022-00535-8

Stitt, N., & Reupert, A. (2014). Mothers with an eating disorder: ‘food comes before anything’. *Journal of Psychiatric and Mental Health Nursing*, *21*(6), 509-517. https://doi.org/10.1111/jpm.12104

Strauss, A. A., & Corbin, J. (1998). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory* (2nd ed.). Sage publications.

Stuckey, H. (2013). An overview of the rationale for qualitative research methods in social health. *Journal of Social Health and Diabetes*, *1*(1), 6. https://doi.org/10.4103/2321-0656.109828

Tie, Y., Birks, M., & Francis, K. (2019). Grounded theory research: A design framework for novice researchers. *SAGE Open Medicine*, *7*, 205031211882292. https://doi.org/10.1177/2050312118822927

Tierney, S., McGlone, C., & Furber, C. (2013). What can qualitative studies tell us about the experiences of women who are pregnant that have an eating disorder? *Midwifery*, *29*(5), 542-549. https://doi.org/10.1016/j.midw.2012.04.013

Tracy, S. J., & Hinrichs, M. M. (2017). Big tent criteria for qualitative quality. *The International Encyclopedia of Communication Research Methods*, 1-10. https://doi.org/10.1002/9781118901731.iecrm0016

Treasure, J., Leslie, M., Chami, R., & Fernández-Aranda, F. (2018). Are trans diagnostic models of eating disorders fit for purpose? A consideration of the evidence for food addiction. European Eating Disorders Review, 26(2), 83-91. https://doi.org/10.1002/erv.2578

Turner, C., & Astin, F. (2021). Grounded theory: What makes a grounded theory study? *European Journal of Cardiovascular Nursing*, *20*(3), 285-289. https://doi.org/10.1093/eurjcn/zvaa034

Tuval-Mashiach, R., Ram, A., Shapiro, T., Shenhav, S., & Gur, E. (2013). Negotiating maternal identity: Mothers with eating disorders discuss their coping. *Eating Disorders*, *21*(1), 37-52. https://doi.org/10.1080/10640266.2012.689210

Urquhart, C. (2013). Research design using GTM. In *Grounded theory for qualitative research: A practical guide*. SAGE.

Ventura, A. K., & Birch, L. L. (2008). Does parenting affect children's eating and weight status? *International Journal of Behavioral Nutrition and Physical Activity, 5*(1), 15. https://doi.org/10.1186/1479-5868-5-15

Viljoen, D., King, E., Harris, S., Hollyman, J., Costello, K., Galvin, E., Stock, M., Schmidt, U., Downs, J., Sekar, M., Newell, C., Clark-Stone, S., Wicksteed, A., Foster, C., Battisti, F., Williams, L., Jones, R., Beglin, S., Anderson, S., … Ayton, A. (2022). The alarms should no longer be ignored: A survey of the demand, capacity and provision of adult community eating disorder services in England and Scotland before COVID-19. https://doi.org/10.31234/osf.io/6eszj

Watson, H. J., Von Holle, A., Hamer, R. M., Knoph Berg, C., Torgersen, L., Magnus, P., Stoltenberg, C., Sullivan, P., Reichborn-Kjennerud, T., & Bulik, C. M. (2012). Remission, continuation and incidence of eating disorders during early pregnancy: A validation study in a population-based birth cohort. *Psychological Medicine, 43*(8), 1723-1734. https://doi.org/10.1017/s0033291712002516

Weissman, R. S., Becker, A. E., Bulik, C. M., Frank, G. K., Klump, K. L., Steiger, H., Strober, M., Thomas, J., Waller, G., & Walsh, B. T. (2016). Speaking of that: Terms to avoid or reconsider in the eating disorders field. *International Journal of Eating Disorders, 49*(4), 349-353. https://doi.org/10.1002/eat.22528

Westrupp, E. M., Macdonald, J., & Evans, S. (2022). Developmental gains and losses during parenthood. *Current Opinion in Psychology, 43*, 295-299. https://doi.org/10.1016/j.copsyc.2021.08.014

Williams, B. M., & Levinson, C. A. (2022). A model of self-criticism as a transdiagnostic mechanism of eating disorder comorbidity: A review. *New Ideas in Psychology*, *66*, 100949. https://doi.org/10.1016/j.newideapsych.2022.100949

Wuest, J. (2007). Grounded Theory: The method. In *Nursing research: A qualitative perspective* (5th ed., pp. 225-256). Jones & Bartlett Learning.

Yaffe, Y. (2020). Systematic review of the differences between mothers and fathers in parenting styles and practices. *Current Psychology*, *42*(19), 16011-16024. https://doi.org/10.1007/s12144-020-01014-6

Yamamoto, R., & Keogh, B. (2017). Children's experiences of living with a parent with mental illness: A systematic review of qualitative studies using thematic analysis. *Journal of Psychiatric and Mental Health Nursing*, *25*(2), 131-141. https://doi.org/10.1111/jpm.12415

Zabala, M. J., Macdonald, P., & Treasure, J. (2009). Appraisal of caregiving burden, expressed emotion and psychological distress in families of people with eating disorders: A systematic review. *European Eating Disorders Review*, *17*(5), 338-349. https://doi.org/10.1002/erv.925

APPENDICES

Please copy and paste this link into your browser to read the necessary documents.

Appendices A: https://www.dropbox.com/scl/fi/unbozf3o1w8k6rsubb641/Example-of-key-terms.docx?rlkey=g6rm307p2f80u0r911l4a805n&dl=0

Appendix B:

https://www.dropbox.com/scl/fo/re952ukqhwa6covopxiln/h?rlkey=5yg524l3a21ez1y1py7bycm51&dl=0

Appendix C

https://www.dropbox.com/scl/fo/y3b4kctaf6vep38mkgsxb/h?rlkey=72c8t16kmpbtwh82g8nu95gg8&dl=0

Appendix D

https://www.dropbox.com/scl/fo/7ryrctejn0vtu63mbskak/h?rlkey=5zlidrbufu0g6pl3u01wl362q&dl=0