‘I’m no more your mother or father...’ Parents’ experiences of having a child hospitalised for an eating disorder

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Abstract

This thesis explores parents’ experiences of having a child hospitalised for an eating disorder. It is a qualitative study based on clinical parent work sessions, undertaken by a child psychotherapist in an inpatient unit treating young people aged 8 – 17. There is a review of the relevant literature, which outlines themes that have arisen in similar studies, as well as defines the terms used in this study. The methodology section explains how the research was carried out and provides details about the sample group of the eight parents who were recruited to the study. Parents were asked about their experiences in an open and unstructured way and explored with the child psychotherapist. These sessions were written up and analysed, using Interpretive Phenomenological Analysis.

The main preoccupations of the parents were around transitions, their states’ of mind and their relationships, both inside the unit and outside of it. Each of these themes is explored in detail in the findings section. Of particular interest was that some parents seemed to have developed what were termed ‘eating disorder states’ of mind’, which are states of mind that have been written about previously in patients with eating disorders. Furthermore, it was found that previous parental experiences played a significant role in all three areas of parental preoccupations. The thesis then draws together the main conclusions from this study. The limitations of this study are discussed as well as reflecting on the process of undertaking the research. Recommendations for practice are made, as well as considering the role of the child psychotherapist supporting parents in this context.

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Finally, I would like to thank my daughter for providing me with so many experiences of what it feels like to be a parent.

Confidentiality

All names and identifying details in this thesis have been changed in order to protect the parents' confidentiality.

Introduction

I'm no more your mother

Than the cloud that distills a mirror to reflect its own slow

Effacement at the wind's hand'[1]

Sylvia Plath, Morning Song (1961)

In the poem 'Morning Song', Plath captures the experiences of a new mother caring for her infant. Her poetry is known for articulating maternal ambivalence, which has historically been difficult to voice, and is expressed in this poem. This theme of ambivalence relates to this study, as there was something rather ambivalent about the disowning of parents' maternal and paternal identities. By having a child admitted into hospital for a long time, parents understandably felt out of role as mother or father, and many parents had been rejected by their ill children, leaving them feeling insecure about their parental capacities. Yet underlying this, for some parents, there seemed to be a deeper ambivalence and instability about their parental identity, which was exacerbated by their child's hospitalisation. These are issues I will endeavor to explore in this thesis.

First, I will explain the background to this thesis and outline the aims and research questions. I will then describe the unit where the research took place, which I shall call *Woodlands.* I will outline the unit's expectations of parents and will describe the staffing of the unit. Finally, I will discuss the plan of work for the thesis, which includes a review of the relevant literature, devising an appropriate methodology, and then relating the findings and conclusions of the study.

Background

During my child psychotherapy training, I was based in an adolescent inpatient unit, specialising in eating disorders (including anorexia and pervasive refusal syndrome). I was involved in one patient's transition from inpatient treatment to

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[1] The full poem can be found on p.241 as Appendix 5.

outpatient treatment. The patient's mother needed a lot of support from the outpatient team over the course of the transition and beyond. This reflected the change in the amount of support that both she and her daughter received on moving from inpatient to outpatient care. The mother and daughter had to find ways of managing difficulties, as there was no longer a member of staff on hand. This led me to wonder what it might be like for parents whose children had been admitted to an inpatient unit, in which the child's care was shared with professionals, but were then expected to resume full care for their child when he/she was discharged. It was particularly interesting that the patients in *Woodlands* were hospitalised due to eating disorders, because ensuring children are fed is a fundamental parental concern from the beginning of life. Daws (1985) writes:

> The moment of weighing the baby can symbolically represent, rationally or not, the total state of development of the baby. A gain of weight can confirm for a mother that her feeding and care have done the baby good; a loss of weight may set the alarm bells going for all concerned (p.79).

It is known amongst health visitors that parents often weigh their babies more frequently than they need to, which suggests the anxiety that feeding a child creates. Whilst this might be appropriate in infancy, one wonders what it is like for parents of adolescents to revisit these anxieties, particularly when developmentally their child should be becoming more independent.

There is some psychoanalytic literature on the impact for parents of having neonates and children hospitalised (e.g. Mendelsohn, 2005 and Cohen, 1995, 2003), which I will consider in the literature review. These papers highlight that having a child admitted to hospital can have an impact on the parents' identities. I wondered if a similar process happened for the parents at *Woodlands*. Although there is some literature about parental experiences of having a child hospitalised for eating disorders, which I will explore in the literature review (e.g. Cottee-Lane et al., 2004, Whitney et al., 2005 and Davenport, 2008), this is not psychoanalytic and generally consists of single session interviews or questionnaires, which is limited. Therefore, I designed a study that would look closely at parental experiences of having a child hospitalised in an inpatient unit for an eating disorder, drawing on a psychoanalytic approach, which I will outline below.

Furthermore, this study correlated with recent government guidelines about research.

> Feedback from patients and their families is increasingly being seen as essential to the assessment of service provision quality, in addition to being a central feature of NHS policy and service development, as highlighted by the Care Quality Commission (Hilton et al., 2012, p.31).

I intended for the findings of this study to be disseminated, which could have an impact of better service provision for the parents and consequently their children.

Aims of the research:

I was particularly interested in considering the impact that the child's admission[2] has on the parent's perception of his/her role as a parent, and to consider this in terms of the parent's internal world, as well as their external world. In order to access parents' internal worlds, I planned to use clinical parent work sessions, as in this setting one can gain a clearer picture of parents' internal worlds, including unconscious thoughts, feelings and patterns of relating.

This was an exploratory study, using qualitative methods. I sought to answer the following research questions:

- What is the impact of the child's admission on parents' states of mind?
- Do parents' perceptions of themselves alter over the course of the admission?

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[2] I will use the term admission in its general sense to refer to the child's entire hospital stay, rather than the specific admission process, as is common practice in inpatient units.

- How do parents understand their child's hospitalisation? Does this change over time?
- How do parents view their role in the hospitalisation?
- How do parents view their child's discharge?
- How do parents view their relationships with the staff?

The context

I will now describe the unit in which the research took place, which was a routine clinical setting. *Woodlands* was a ten bedded inpatient unit, located close to London. It accepted referrals from all over the UK, of young people aged between 8 and 18 who had an eating disorder, including anorexia nervosa, bulimia nervosa and pervasive refusal syndrome. I will explain and define these terms in the literature review, but will outline some general data on the prevalence of eating disorders and hospitalisation. Nicholls et al. (2011) found a prevalence rate of early onset eating disorders of 3/100 000 in children under 13 years old.[3] In girls aged between 15 – 19, the prevalence of eating disorders rises to 2/1000, which is the highest prevalence in any age group across the lifespan[4] (Micali et al., 2013), and is the time when adolescent girls are most likely to be hospitalised for an eating disorder (HSCIC, 2014). Overall, the incidence of eating disorders among females is higher, with 62.6 per 100,000 compared with a male rate of 7.1 per 100,000 (Micali et al., 2013). Similarly there were nine times as many females admitted to hospital because of an eating disorder, compared with males (HSCIC, 2014). These statistics reflected the patients at *Woodlands* as there were routinely far fewer boys than girls, and most patients were approximately 15 years old.

Woodlands was open 24 hours a day, 7 days a week, which meant that there were always nurses on shift, and a doctor on call. As *Woodlands* did not have a catchment area, most patients were far away from their families and

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[3] This meant that children were displaying clinical symptoms of an eating disorder. For further description of the criteria used for diagnosing eating disorders see the literature review, where definitions are provided.

[4] This includes, anorexia, bulimia and eating disorder not otherwise specified, see literature review for an outline and definition of these diagnoses.

communities. Therefore, families had to travel great distances to visit and they were unfamiliar with the local area.

The unit did not accept patients who needed detainment under the Mental Health Act. All patients were referred by consultant psychiatrists in the NHS, and were usually referred because outpatient treatment had been unsuccessful, and there was no suitable provision locally. Patients were frequently admitted from paediatric wards, after they were physically stabilised, and where it was clear that they were unable to go home. All young people were assessed by senior members of staff before an admission, although in some cases, the assessment happened on the same day as the patient's admission.

The Approach

The philosophy at *Woodlands* was that eating disorders were related to difficulties in emotional regulation, which were underpinned by the interaction between psychological, social and biological factors. Therefore, attention was paid to the psychological and physical aspects of treatment.

Therapeutic Milieu

More specifically, *Woodlands* was a 'therapeutic milieu' programme. Crouch (1998) defines a therapeutic milieu as 'a clinical setting in which the child's peer group, facilitated by staff, help to emphasize the strength of the individual's capacity to cope with difficulties' (p.116). Therefore, the group aspect of treatment was very important because every interaction was thought about. Furthermore, therapeutic milieus should provide 'containment/safety, structure, support, involvement, and validation' (Crouch, 1998). This was achieved by the highly structured programme which I will describe, and meant that life on the unit was predictable and consequently containing. For example, patients knew in advance which staff were working for the week, and were notified of any changes. Heede et al. (2009, p.280) also emphasize the importance of 'sticking to task, time, territory and role' in therapeutic milieus so that boundaries are clear, which was another aspect of containment.

There is some emerging evidence to support the effectiveness of therapeutic milieus in bringing about changes in the personality, but this is only in certain domains of personality development, and the study was not carried out with eating disorder patients (Heede et al., 2009).

PRS approach

Woodlands also specialised in treating young people with Pervasive Refusal Syndrome (PRS)[5], which is a rare and complex eating disorder affecting all aspects of a young person's functioning, including refusal to eat, drink, talk and move and therefore requires a particular approach. The approach is based on 'an acceptance of the child's current state of withdrawal from a terrifying world and the minimising of expectations placed on him over and above non-negotiables, that are clearly delineated, predictable and consistent' (Guiney, 2012, p.140). Guiney argued that in the initial stages 'the slightest hint of praise or even a fleeting recognition of change can trigger its disappearance. In this sense, the usual ways of working therapeutically with a child, using encouragement, incentives and praise, are not simply rendered useless, but apparently toxic' (p.142). The pace of change must be set by the child, otherwise goals will remain unobtainable. Initially staff devise a timetable for children with PRS, which includes some non negotiable meetings, as well as allocated 'rest periods'. Guiney spoke about the importance of recognising the feelings that such children stir up in staff, and speaking to other team members and parents about these feelings. She found that parents were often relieved that they were not alone in feeling frustrated or drained by their child.

As the child progresses, Guiney draws attention to the importance of not allowing oneself to get excited about the child's progress and rush the child, as this may cause the child to regress. She points out that at times the child wants to rush forward and takes a manic flight to health, but progress should be slow and steady. She argues

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[5] See p.17 for a fuller description of this diagnosis.

> the pressure to send such children home once they are “better” neglects to take into account the inner psychic development that needs to be consolidated alongside their physical progress…It is vital the child’s family are involved in thinking about the pace of the child’s recovery and in considering the familial adjustments that will need to be made when the child is back home again. Long months of anguish and feeling that one has “lost” a child can lead to a natural impatience to finally have the child home again. However, in thinking with the parents about the advantages of a child remaining an inpatient a little longer, in order that he might develop more adequate internal capacities to have a better chance of recovery, was in my experience, well received, even if a little reluctantly’ (p.155).

This was an issue for the families in this study as they had had lengthy admissions. Physiotherapy may also be part of the treatment that is on offer for such children (Magagna and Bladen, 2012). At *Woodlands*, there was only a visiting physiotherapist who offered assessments and recommendations, rather than regular treatment.

Life on the unit

When the patient was admitted he/she was allocated to a nurse, and was initially placed on constant observations. This meant that the nurse observed the patient throughout the day and night, including the patient’s use of the toilet and shower and the patient’s sleep. This was because many of the patients secretly exercised, vomited, or ‘water loaded’[6] to manipulate their weight. Some patients were also at risk of deliberate self harm, or absconding. After an initial period, the observations were usually reduced, and patients gained toilet and shower privacy and moved towards general observations, which meant that they could move about the unit as they pleased, but were expected to stay in

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[6] Patients consumed excessive amounts of water to give the impression that they had gained weight.

the communal areas[7]. In exceptional circumstances, if staff became very worried about a patient's risk, he/she would be placed on close observations, which meant that a nurse would be within 'arm's reach' of the patient.

All patients were offered individual therapy, family therapy, group therapy, and keywork with nurses. They also had individual meal plans and case management with a member of senior staff. Many patients were also prescribed various psychotropic medications[8], and some were prescribed vitamin supplements. There was a school on site which patients were expected to attend. The rest of the week was organised into a structured programme with group meetings, such as a community meeting, an activity group, a topic group and a review group.[9] Some patients were allowed to have their mobile phones with them throughout the day to text their parents.

Meals were at set times, and all patients were expected to attend meals and finish their serving. If patients did not finish their meals they would have an opportunity to 'make up' their missed calories, with food or high calorie milkshakes. If they were unable to do this, the possibility of nasogastric feeding was considered. Several patients in this study experienced nasogastric feeds at various points, and some had a nasogastric tube 'in situ' for ongoing nasogastic feeding.

Patients were encouraged to participate in meetings, and all patients chaired the community meeting, so that they became involved in the programme. Patients were also invited to their care plan reviews, and had opportunities to make requests about their care. Any of the patients or staff could call a 'special meeting', in which staff and patients attended to think about the issue being

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[7] These included a 'quiet' room and the lounge. Young people were not allowed in the dining room, or their bedrooms without staff supervision. Most young people shared bedrooms with at least one other young person.

[8] These included antidepressants, anxiolytics and atypical antipsychotics.

[9] These groups varied in approach, but were designed to help young people raise relevant issues that might be impacting upon them both immediately as a member of a community, as well as longer term issues relating to their eating disorder.

raised. For example, if a patient left the dining table before another, which was not allowed, patients or staff were encouraged to call a special meeting to address this. Staff also noted patients' birthdays, and presented them with a cake and card, which was intended to help the patient feel held in mind.

Parents

Parents were expected to accompany their child to the assessment and admission. During the admission day, they and their child met with a doctor and nurse to establish the goals of the admission. Parents helped the child unpack his/her belongings and the child was expected to have lunch with the other patients, whilst parents had lunch outside. Parents then returned to *Woodlands* to say goodbye to their child, and were requested to have left by 3pm. Parents were not expected to eat with their child until the staff and parents felt that the patient was ready. For some families this happened within six weeks, but for other families it was a period of many months. Many of the parents in this study had not had a meal with their child for over six months. Meals with parents were initially 'supervised', which meant that a nurse was present and offered support. Once this was established, meals were 'unsupervised', but took place in *Woodlands*, before the family progressed to having meals out together. During this time, parents were expected to use a 'meal plan'[10] which was given to them by the nursing staff, to help them feed their child.

To monitor the patient's weight, all patients were weighed twice a week, once on a Monday after their weekend leave, and once on a Thursday, to plan for the coming weekend. The 'weigh in' on Monday was anxiety provoking for parents, as much as for the child, as parents felt it reflected their care of their child over the weekend. Furthermore, parents would not know the weekend plans until the Thursday before, which was also anxiety provoking.

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[10] This was based on the required calorific intake that the child needed to either gain weight, or maintain his/her weight. There were some suggestions about foods and portion sizes, but there was some flexibility within this.

Parental contact was structured at *Woodlands.* Initially the staff and the family agreed times for visits and phone-calls. Phone-calls with parents took place for 15 minutes, two or three times per week. Visits happened at the weekend between 10am – 1pm, and 2pm – 5.30pm, although there was some flexibility. For example, the youngest patient had an additional visit on a Wednesday evening. Visits usually took place in communal areas, rather than in patients' bedrooms, and nursing staff were available. The patients' siblings were allowed to visit on a Saturday. When staff and parents felt that the patient was able to go outside the unit, this was arranged. This was initially for short periods of time e.g. – a walk, a trip to the park or local shops, but was increased when these visits were going well. When staff, parents and the patient felt that the patient was ready, a home visit was organised, and the patient worked towards staying at home overnight. Once patients could manage overnight stays, they spent weekends at home, but were expected to return to *Woodlands* during the week. When the patient was ready to be discharged to the community team, a six week reintegration plan was put in place. This meant that the patient started attending his/her home school and was at *Woodlands* for less time during the week. However, the six week reintegration plan was often shortened because of funding issues, or because the parents and patients wanted the child to be at home more quickly.

Parents were given a written guide to the unit. The guide emphasised the importance of staff working with parents and parents were encouraged to discuss any disagreements that may arise. The guide also advised against patients missing the therapeutic programme, for things such as family holidays, birthday treats or school trips because these were seen as unhelpful. The guide also detailed what parents were expected to bring for their child and listed the rules on the unit, including bed times, as well as the expectations about not bringing drugs or alcohol into the unit.

Parents were expected to attend fortnightly family therapy, although in some cases weekly family therapy was offered. Parents were also expected to have contact with their child's case manager, where the child's care plan was discussed. This was either conducted on the telephone or in person. Parents also received regular updates from the nursing staff on the telephone, once or twice a week. If there were changes to patients' care plans, such as a change in meal plan, observation levels, or increased risk, parents would be notified, and in certain instances they had to give consent (e.g. if a child needed to have a nasogastric tube passed).

The staff

The unit was staffed by a multidisciplinary team. The clinical director was a consultant child psychiatrist, and there was another child psychiatrist in post. The nursing team was run by a nurse consultant and a senior nurse. The nurses were a mixture of paediatric and psychiatric trained nurses. Each patient was allocated a named nurse and a therapeutic care-worker (TCW) who worked alongside the nurses. Many TCWs were psychology graduates who were gaining further experience before undertaking professional training. The nurses and TCWs worked to a shift pattern, with the day shift starting at 7.30am and finishing at 8pm, and the night shift starting at 8pm and finishing at 7.30am. The nurses and TCWs also worked over the weekends and holidays, and so it was often the nurses and TCWs who observed the patients eating with their families, and the family visits. There was also a small therapeutic team, who carried out the therapeutic work, which included a psychologist, a child psychotherapist, a trainee child psychotherapist and a family therapist.

Plan of Work

Having outlined the setting, and the aims of the research I will describe how this thesis is ordered. I will firstly review the existing relevant literature. I will consider general clinical literature about eating disorders and define the terms. I will then look further at psychoanalytic parent work and review the themes that have arisen from this work in different contexts, as there are no published accounts of psychoanalytic parent work in inpatient eating disorder units. The final section of the literature review will look at the literature on hospitalising young people with eating disorders, but will also consider literature on adolescent psychiatric admissions and paediatric admissions, as the current literature on the hospitalisation of eating disorders for young people is limited, especially considering parental perspectives.

I will then outline my methodology. I will explain how I recruited my sample and illustrate the characteristics of the sample more fully. I will proceed to describe the methods I used to collect and interpret data. I will consider the advantages and limitations of these methods.

The findings of the thesis will follow in three chapters, in which I will explore and discuss the themes and categories that arose in the data. Finally, I will conclude the thesis by outlining the main findings and relating them to the research questions I had formulated. I will also reflect on the process of carrying out this study and consider its limitations. I will make several recommendations for practice, in order to improve parental experiences. I will give particular thought to the role of the child psychotherapist in supporting parents whose children have been hospitalised for an eating disorder.

Literature Review

I will first look at the literature on eating disorders and define the terms I have used in the study. I will draw on literature from a range of clinical approaches as this thesis is based on clinical work undertaken in a clinical setting. I will then consider the literature on psychoanalytic parent work, as this was the approach I used. Finally, I will consider literature specifically related to parental experiences of having a child hospitalised.

Eating Disorders

Eating disorders have been understood theoretically many ways, including models looking at the issues more broadly, such as feminism and sociology. However, as this is a clinical thesis, I will focus on clinical models. The most prevalent eating disorder in *Woodlands* was anorexia nervosa. I will outline a definition of this, as well as outlining other eating disorder diagnoses. I will then focus on psychoanalytic formulations of eating disorders, given that I used a psychoanalytic framework. I will also consider views from systemic psychotherapy, as working with parents, family issues emerged. Additionally, I will refer to other clinical approaches to eating disorders, including psychiatric, medical and cognitive approaches, as many of the families in *Woodlands* received such treatments.

Anorexia Nervosa

Bryant-Waugh and Lask (2008) have published widely on the subject of eating disorders in children and adolescents and are recognised as experts in the field. They come from the backgrounds of clinical psychology and psychiatry respectively. They define anorexia as:

> determined attempts to lose weight or avoid weight gain. This can be achieved through avoiding or otherwise restricting normal food intake, self-induced vomiting, laxative abuse, excessive exercise, or more

> usually a combination of one or more of these. Weight and/or body mass index drop to a level well below that necessary to allow the child to continue to grow and develop…Children with anorexia have characteristic thoughts about weight and/or shape, often believing that they are fat when they are underweight, or displaying a pronounced fear of becoming overweight, which directly influences their eating behaviour and attempts to manage their weight. They tend to have a tremendous sense of dissatisfaction regarding their bodily appearance…Many children with anorexia suffer from a preoccupation with their weight, shape, food and/or eating, to the extent that their concentration can be significantly impaired (pp.40 - 41).

They explain that children become adept at calorie counting and exercising secretly. They believe that children can develop anorexia from the age of eight, and that childhood anorexia is similar to the presentation of adult anorexia, the only difference being that some girls will not have started their periods, meaning amenorrhea is not a useful diagnostic criterion, as it is with adults. They argue that boys may fulfil the criteria for childhood anorexia, although have noticed that boys seem to be more concerned with avoiding 'becoming fat, unfit or unhealthy, and may not be so much set on losing weight as on preventing the development of a flabby shape' (p.41). This could mean that boys are overlooked when it comes to hospitalisation and treatment programmes, as their weight loss may not be as dangerous. However, some boys go to extreme lengths to lose weight, just as girls do. In *Woodlands*, there was always at least one male inpatient, and at times, two or three. Bryant-Waugh and Lask (2008) also highlight that many children with anorexia present with other psychiatric symptoms, including depression, and boys in particular, often present with obsessive compulsive disorder.

Anorexia nervosa can lead to a range of physical complications for the young person, including cardiovascular complications, metabolic abnormalities, nutritional deficiencies, gastrointestinal difficulties and endocrine malfunction with resulting damage to bone density (Pinhas et al., 2008). Some of these issues resolve as the young person gains weight, however, some will have an impact on the young person's health even after they have recovered. It is important to add that some of these complications, particularly cardiovascular difficulties and metabolic abnormalities can be life threatening, and need urgent medical treatment. This can result in young people being hospitalised in paediatric wards and was a common experience for many patients in this study, prior to their admission to *Woodlands*.

The outcome for young people with anorexia nervosa is variable. Gowers and Doherty (2008) suggest that 'a good outcome is achieved in over half of young people with adolescent onset anorexia, and the literature suggests that further improvements occur with time…the very young (particularly pre-pubertal cases) appear to have poor outcomes' (p.80). They define good outcomes in terms of nutritional state, menstruation, mental state, psychosexual state and psychosocial adjustment at various follow up times. Therefore, some young people are able to lead ordinary lives; remain healthy, have their fertility and hormonal function restored, be psychologically well, return to education/employment and have ordinary social and sexual relations. Yet, the research also suggests that there are a significant proportion of young people who will not make a good recovery across these domains, and will struggle with their mental health and/or their physical health for a prolonged time, particularly those diagnosed before puberty. It is important to remember that anorexia carries a risk of death, which is higher than for other adolescent psychiatric disorders (Gowers and Doherty, 2008). For a parent, grappling with these statistics, anorexia presents a worrying picture. Furthermore, Stein (2006 and 1996) found that mothers who have had eating disorders previously, place their infants at greater risk of developing concerning eating patterns. These eating patterns in infancy persisted when Stein followed up the same mothers and infants, ten years later. Therefore, the legacy of anorexia can be far reaching.

Bulimia Nervosa

Bulimia nervosa is another eating disorder commonly diagnosed in young people. Bryant-Waugh and Lask (2008) explain that it is:

> Characterised by episodes of overeating in which the person experiences a sense of loss of control, with accompanying attempts to avoid weight gain by self-induced vomiting, laxative abuse, diuretic abuse, dietary restriction or excessive exercise. Weight and shape concern are core features, as in the case of anorexia, and are manifested by attempts to control weight and minimise the weight gain that might normally result from overeating…Bulimia nervosa is often accompanied by other forms of self harm, such as wrist scratching, burning the skin with lighted cigarettes, alcohol and drug abuse, overdosing and other risk-taking behaviour (p.42).

They explain that bulimia is rare in childhood and early adolescence and the physical risks associated with bulimia[11]do not pose the same acute risk to life as anorexia (Pinhas et al., 2008 and Gowers and Doherty, 2008). Therefore, patients with bulimia are hospitalised less frequently. When they are hospitalised, it is usually due to concerns about accompanying self harm, and so they are often admitted to general adolescent units. None of the young people in this study had bulimia, and so I will not focus on this diagnosis.

Other Eating Disorders

Bryant-Waugh and Lask (2008) outline several other eating disorders, including food avoidance emotional disorder (FAED), selective eating, food refusal, restrictive eating, specific food phobias, and pervasive refusal syndrome (PRS). I will discuss PRS, as both anorexia and PRS were treated in *Woodlands*, whereas the other diagnoses were not.

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[11] such as dental enamel erosion, dry lips and tongue, arrhythmias and hypotension,

Lask (2004) defines PRS as:

> a condition involving varying degrees of refusal across several different domains, accompanied by dramatic social withdrawal and a determined resistance to treatment, leading to a seriously disabling and potentially life threatening condition (p.153).

It is most common in girls aged between eight and sixteen, but can affect boys. Bryant-Waugh and Lask (2008) explain that when children with PRS present to professionals, they can be misdiagnosed with anorexia, as they are often underweight and dehydrated and refuse food and drink. However, as the child may not be communicating, it is impossible to know whether the child fulfils the cognitive criteria for anorexia[12] (Becker et al., 2009). Bryant-Waugh and Lask (2008) found that the refusal extends across all areas of social and personal functioning, unlike anorexia. As this is a relatively recent diagnosis,[13] little is known about the outcome of PRS. Guirguis et al. (2011) recently carried out a small follow up study and found that two out of four children made a recovery. Many of the young people with PRS are physically at risk of the same complications as patients with anorexia. Again, for parents, this presents a very worrying picture, both for the child's health and for the child's future.

Understanding Eating Disorders

There are competing views about the causes of eating disorders and the best treatments. As the patients in *Woodlands* were diagnosed by a psychiatrist as having an eating disorder, I will explore how psychiatry has understood and treated eating disorders. As I am a child psychotherapist, and my work with the parents was psychoanalytic, I will then consider psychoanalytic formulations of eating disorders. Finally, I will consider other clinical approaches to eating

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[12] Such as the refusal to maintain normal body weight, fear of gaining weight or becoming fat, and undue influence of body shape on self-evaluation

[13] The first paper was only written in 1991 by Lask et al.

disorders, including systemic approaches, as systemic therapists firmly keep in mind the role of parents in understanding and treating the disorders.

Psychiatric approaches

Anorexia came to the attention of psychiatrists when Gull (1874) and Lasegue, (1873) wrote accounts of the disorder. Anorexia in childhood was recognised later by Collins (1894) and Marshall (1895). Appignanesi (2008) has taken a historical interest in approaches to mental illness, and described the treatments for anorexia in the late 19th Century, which were predominantly medical and included the patient being removed from her family, being prescribed rest, and being force fed. She explained that Lasegue linked anorexia with hysteria, which was often understood as a nervous or neurological disorder, although Lasegue became interested in the psychological aspects of anorexia. She argued that Freud too was aware of the psychological aspects of anorexia and linked it with fear of sexual development. However, he also linked anorexia with other mental illnesses such as melancholia, depression or hysteria.

In the second half of the twentieth century, psychiatrists relied on neuroleptics as a treatment for anorexia (Steinhausen, 2002). However, there was also an increasing willingness to treat anorexia with psychological therapy. Bruch (1978) linked eating disorders with the mother - child relationship. She argued that anorexia 'was most often a child's neurotic response to an unnatural rejecting or over-nurturing mother' (as cited in Appignanesi, 2008, p.439).

Contemporary psychiatric approaches to eating disorders in the UK are guided by NICE (NCCMH, 2004) whom emphasise the importance of patients receiving psychological therapy, alongside physiological management. NICE do not specify a particular psychological therapy, as there is insufficient evidence to suggest that any one therapy is more beneficial than any other. They do recommend however, that children and adolescents should receive family therapy as that has been found to be effective. NICE also emphasise offering the patient and his/her family psycho-education about eating disorders.

Treasure et al. (2007) have developed psychoeducation programmes for carers, which many services have adopted. These are not specifically designed for parents of children, but aim to develop carers' coping mechanisms, reduce levels of expressed emotion and other maladaptive communication styles, reduce their perceived burden and help them to shape and reinforce non eating disorder behaviour. Treasure feels that if carers are more able to support the patient, there is less need for hospitalisation. Rockwell et al. (2011), who have used the carers' programme, explain that 'in the Carers' Program, families gain greater understanding about natural tendencies and reactions to patients with eating disorders and learn how to channel that energy into effective management strategies' (p.363).

NICE recommend that outpatient treatment is preferable, unless there is significant concern about a patient's weight, or another psychiatric risk such as self harm, in which case hospitalisation should be considered. Current guidelines specify that a hospital admission should have 'a focus on eating behaviour and attitudes to weight and shape and wider psychosocial issues, with the expectation of weight gain' (NCCMH, 2004, p.65). If the patient is not gaining sufficient weight, the guidelines suggest that a physician or psychiatrist may consider starting nasogastric feeding. The patient receives nutritional intake via a liquid feed, fed through a tube. Bryant-Waugh and Lask (2008) recommend that nasogastric feeding should be a short term measure, and if the child is too resistant to the tube, gastronomy feeds should be considered. Many of the patients at *Woodlands* were fed nasogastrically and for some, this became a long term measure.

NICE guidelines argue that there is no evidence to suggest that medication is effective for treating anorexia.[14] Bryant-Waugh and Lask (2008) disagree, and explain that medication can play a limited role in treatment. They suggest that antidepressants, particularly Selective Serotonin Reuptake Inhibitors (SSRIs), may have a role in eating disorders associated with depression. They acknowledge that there is no evidence base for the use of anxiolytics and atypical antipsychotics in the treatment of eating disorders, but argue that they may be used for a short time when patients are suffering from associated extreme anxiety and distress. Patients at *Woodlands* were routinely prescribed both antidepressants and anxiolytics/atypical antipsychotics.

More recently, certain psychiatrists have become interested in the role of neuroscience and neurobiological mechanisms in eating disorders (Frampton and Hutchinson, 2008). Neuroimaging techniques have suggested that patients with anorexia have certain deficits in areas of the brain. These deficits are associated with neuropsychological difficulties that many patients with anorexia have, such as the rigidity in their thinking. Furthermore, certain psychiatrists are also interested in understanding the role of molecular genetics as a cause of anorexia (Nicholls, 2008). This is outside the scope of this thesis, but such research is leading to new treatments such as cognitive remediation therapy and has a bearing on how parents understand the illness.

Psychoanalytic approaches

Lawrence (2008) has written extensively on anorexia, and argues that:

> from the beginning of life, eating - the taking in of food – is closely associated with the taking in of love and the primary relationship offered by the mother. This leads me to suppose that all feeding difficulties and eating disorders are associated with relationship difficulties: specifically,

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[14] Although for Bulimia there is some evidence to suggest that antidepressants may be of benefit for adult patients.

> that there is a difficulty in feeling open and receptive to the good things that relationships with others might have to offer (p.17).

Therefore, Lawrence views eating disorders as a difficultly with the individual's state of mind. Drawing on Kleinian theory, she considers how the concept of a relationship is developed in infancy. Most infants introject something good from the breast[15], including a feeling of being loved. There will be times when it is not possible for infants to do this, when they are too upset, or cannot have access to the breast when they desire. Tolerating these ordinary frustrations is part of developing a relationship with the breast and the parent. However, some infants struggle to tolerate these frustrations more so than other infants, perhaps because of excessive greed or envy towards the breast, or strong destructive feelings, which can lead to difficulties in the feeding relationship. Whilst some of these difficulties are ordinary and resolve quickly, in other families these difficulties become entrenched. This does not necessarily mean that the infant will have a feeding difficulty, but a less than optimal model of relationships becomes internalised in the infant's mind, which makes it hard for an infant to be receptive. In her work with adults with anorexia, Lawrence argues that patients frequently have internalised a mother, who is 'a beautiful, unavailable mother, locked into her own concerns about herself and how she appears to others, her own superiority over others, with father on the sidelines admiring her' (p.39). This is not a reality, but a psychic reality, which means that the individual can find it hard to turn to his/her mother for support, and may lead to feelings of competition with the mother.

Williams (1997) also draws attention to the difficultly of introjection in the development of eating disorders. She builds on Bion's concept of the relationship between the mother and the infant functioning as a container for the infant's distress. Bion (1962) explains that the mother, through maternal 'reverie', can digest the infant's anxieties, and return them to him/her in a more modified state. This provides the infant with an experience of being understood

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[15] Although the term breast is used in the literature, she explains that she also means the bottle, for babies which are fed that way.

and is the beginning of the infant internalising a space to think about his/her experiences. If the mother is unable to contain the infant's anxieties, the infant can be left with a feeling of 'nameless dread'. Williams became interested in situations in which the infant lacked a container for his/her distress, but was used as a 'receptacle' for the mother's distress. Therefore, not only is the infant left to deal with his/her unbearable anxieties and 'nameless dread', but the infant is filled with the mother's projections. Williams uses the word 'receptacle' because the infant lacks the psychological equipment to process these projections and they are experienced 'as persecutory foreign bodies.' Consequently, the infant develops 'no entry' defences to keep these 'foreign bodies' out. However, the 'no-entry' syndrome performs the defensive function of blocking any input experienced as 'potentially intrusive and persecutory' (1997, p.121). This means that the infant may block out benign and nurturing input too.

It may feel safer for these infants to retreat into a 'shut down' state; not wanting to take anything in from adults, such as learning, comfort or food, lest it contain something toxic. This may be associated with children who develop what Magagna (2008, p.260) terms 'the pseudo autonomous self'. Magagna, in her work with children with eating disorders, has drawn attention to children who turn to this 'pseudo autonomous self', which often has a 'superior' quality, rather than turning to a dependent relationship with adults.

In one case, Williams (1997) points out that the patient was conceived shortly after a miscarriage. This detail was prevalent in sessional material. It is likely that the surviving child was filled up with maternal projections about the dead baby and the mother's depression, which led to the child creating a 'no entry defence.' O'Dwyer (2010, unpublished) has written about a similar case, in which the surviving child developed PRS, which can be seen as a 'no entry' defence. Shoebridge and Gowers (2000) writing from a different perspective, also found a higher percentage of parents who had experienced a perinatal bereavement, went on to have a child with anorexia.

Psychoanalytic views also link eating disorders with further problems with introjection, in terms of what the individual does with the introjected object. Bruch (1978) linked the wish to control with anorexia. Lawrence (2008) understood this in terms of wanting to control the body, other people and internal figures. There is a fear that the internal parents could link up and be creative, and individuals with eating disorders find growth and development anxiety provoking. Therefore, internal figures become strictly controlled and thoughts about sexuality are unthinkable. Lawrence found that this resulted in patients with anorexia presenting their relationships with their mother in an idealised way. Patients imply that:

> only mother understands them and that the relationship is close and without conflict. All too often when one meets mother, one finds someone who feels enslaved and terrified of her daughter's constant demands and threats. Often she is aware that she is neglecting her other children and her relationship with her husband, but she feels powerless to do otherwise (p.56).

The mother is given a special position, but is imprisoned because she is not in her role as a creative mother, available to support her daughter or the rest of her family. Lawrence is less clear about why individuals with anorexia have such a need to be in control of their objects and argues that it is likely to be because of specific details in a patient's life. She links the need to be in control with the hyperactivity that many young people with anorexia display, such as excessive exercise and scholastic overachievement, as this prevents creative thinking.

Other child psychotherapists have drawn more attention to the pattern of the child's internal object relationships (Segal, 1993, Likerman, 1997, Magagna, 2008). Segal noticed that her patient developed an allegiance to a perverse object relationship, which was ‘anti-life’ and therefore rejecting of food and other nurturing elements. Parker (2000) has also spoken about the patient’s merged identity with the mother, and in particular, the difficulties of separating from the mother and expressing ordinary hostility to facilitate the separation.

In terms of treatment, psychoanalytic approaches offer individual therapy, often with accompanying parent work. The aim of the treatment is to explore the patient’s internal world to help the patient gain insight into the psychological difficulties that underlie the eating disorder, and then modify the patient’s internal world, so that he/she has less need to create rigid defences. Magagna (2008 and 2012) has written about modifying psychoanalytic technique particularly when working with children who are silent or have PRS. She has discussed reducing the session time, and seeing the child more frequently, and not necessarily waiting until the child is able to come to a therapy room. She also spoke about working closely with the nursing team. Additionally, psychoanalytic approaches have emphasised thinking with the wider multidisciplinary team around the child, to further understand how the child or family’s conflict can become enacted within the team (Lawrence, 2008).

Systemic perspectives

Systemic views believe that the family is central to understanding eating disorders. Asen (2002) explains that:

> The family was seen as a system with homeostatic tendencies and a variety of properties, such as hierarchies, boundaries, overt and covert conflicts between specific members, and coalitions. The various parts of the system, the family members, were seen as behaving according to a set of explicit and implicit rules that govern interpersonal behaviours and communications. Family systems therapy was invented to challenge and disrupt unhelpful interaction patterns and dysfunctional communications, allowing new ways of relating to emerge (p.230).

Clinicians observed that when the patient began to recover, other members in the family began having difficulties, making it difficult for the patient to recover. Therefore, family therapy approaches have understood that a symptom in one family member has arisen in the context of family relationships. There is research to support this understanding of eating disorders, for example, Cooper (1995) has found that in families in which a young person has an eating disorder, the rate of a close family member having a pre-existing mood disorder, is three times as much compared with a control group. Canetti et al. (2008) also found that parental characteristics of grandparents may have an impact on their grandchild developing an eating disorder. However, this brings it own difficulties as Russo argues (2012) as 'the whole prospect of a family meeting suggests to family members that they are to blame in some way for the young person's difficulties' (p.245).

There is evidence to suggest the effectiveness of systemic approaches (Lock et al., 2010). Eisler et al. (2000) explain that the family are encouraged to view themselves as a resource to help their child recover. Families are frequently in conflict, with parents disagreeing about how to approach their child's eating. Family therapy treatments initially focus on nutritional intake, as this is often urgent. However, they move towards discussions about relationships within the family:

> to help the family to disentangle individual psychological issues (e.g. self-esteem, individuation, psychosocial functioning) and family relationship issues from the eating disorder behaviour and the interactional patterns that have developed around it (p.729).

The emphasis in family therapy is on building parental strengths, as well as understanding the patterns that emerge in family life, often to do with separation and leaving home.

Cognitive Behavioural approaches

Psychologists and CBT therapists have looked at the role of behaviour and cognition in eating disorders. They argue that if a child has had negative or traumatic experiences with food, they avoid food to reduce the risk of the negative event recurring. Therapists devise behaviour programmes to reward the desired behaviours – such as eating, and negatively reinforce the undesired behaviour[16]. Christie (2008) recognises that this approach is best used with selective eating and phobic avoidance of food. Historically, behavioural approaches have been used for the treatment of anorexia in hospital. Patients have been denied privileges if they do not eat. Christie (2008) argues that these programmes have limited success for anorexia, and become ethically objectionable when working with deeply disturbed young people. NCCMH (2004) also do not recommend the sole use of behavioural techniques in the treatment of patients who are hospitalised. However, behavioural programmes are likely to form part of a hospital programme.

CBT also offers an explanation for the development of eating disorders. CBT therapists argue that a set of thoughts and beliefs about the self lead to a certain set of feelings and behaviours, including restricted eating or excessive exercising. Fairburn et al. (1999) argued that control was often a maintaining factor in eating disorders and CBT should focus on this core feature. The therapist helps the patient trace thoughts and feelings to behaviours and then to challenge these thoughts, which should lead to a change in feelings and behaviours. Relaxation exercises, guided imagery and art can be used to explore the link between thoughts and feelings. The main evidence base for the use of CBT in eating disorders is with adult patients with bulimia, rather than with child patients with anorexia. However, CBT is routinely used as an intervention for patients with eating disorders.

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[16] For example, a gradual programme of new foods to try may be introduced, with clear rewards for the child on completion, and possible sanctions if these goals are not met

Other factors

Clinicians from a variety of backgrounds have considered whether certain events may account for the presence of an eating disorder. Some researchers have suggested that sexual abuse may precipitate the development of an eating disorder (Smolak and Murnen, 2002) However, the evidence does not suggest that sexual abuse is a contributory factor for eating disorders, rather than any general psychiatric disorder (NCCMH, 2004) In this study, one child disclosed sexual abuse, and another child made a partial disclosure[17].

Therefore, there are a range of clinical approaches to understanding and treating eating disorders, and more specifically anorexia. In a hospital setting, children and their parents experience a range of treatments because they are receiving intensive multidisciplinary interventions. However, I will be using a psychoanalytic framework, as that is how I am trained to work.

Parent Work

I will now look at the literature on psychoanalytic parent work, which was the clinical model for this study. Parent work, as carried out by child psychotherapists is an established intervention. I will outline its development and summarise how therapists have defined this work. I will then consider how parent work has been used in a range of settings, and the themes that have arisen.

Rustin (1998) argues that parent work was developed because when children were in individual treatment and the parents were not seen, there was a risk that the children's therapy would be interrupted and could break down. Parent work was initially carried out by psychiatric social workers, often with a psychoanalytic training. However, in the 1970s and 1980s many psychiatric

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[17] Scarlett had been abused by a man outside the family, Caroline had described being drawn into sexual acts against her will by older young people.

social workers trained in systemic psychotherapy, which created a need for child psychotherapists to undertake this work themselves.

Hughes and Sutton (2005, p.170) feel that parent work is seen as ‘peripheral or optional’ in CAMHS teams. This may be due to overstretched services lacking the resources to provide individual treatment and parent work. However, it is being included in the current randomised control trial of short term psychotherapy for adolescents with depression (Goodyer et al., in progress), which suggests that it is recognised as an important element of treatment. Magagna, who has many years of experience in the field of eating disorders, argues that ‘parental work should accompany all individual therapeutic work with a child. Parents are with a young child at least 17 hours daily and potentially can be very well placed to effect deeper and more lasting transformation in the child’s personality’ (2012, p.77). Although most children in this study were adolescents, the severity of their illness meant that their needs were similar to younger children.

Rustin explained that child psychotherapists are involved in a range of parent work, and she defined the work into four categories, although acknowledged that these definitions are not exhaustive, nor mutually exclusive. The first category is work that is supportive to the child’s therapy, which may involve infrequent contact with the parent and is aimed at keeping the child in treatment. In the second category, parents receive support in their parental functioning. The contact with the parent may be more regular, although it can be a time limited piece of work. The aim is to help parents understand their children’s behaviour and support them in their parenting role. The third category is when ‘the explicit aim of the work is change in family functioning, and this has been agreed by the parents as part of the treatment as a whole’ (1998, p.235). This work could include marital therapy, family work, and regular individual work with a parent. The final category is individual psychotherapy for a parent, or both parents, in which ‘the parents have committed themselves as patients in their own right’ (1998, p.235).In this last category the therapist would focus on transference issues.

Hughes and Sutton (2005) have also categorised different forms of parent work. The first level of work is an ‘information exchange’, which limits the work to practical matters. Another level of work is termed as ‘child guidance’ (p.174), in which parents are given supportive advice, or helped to think about issues. A more in depth contact would be a ‘supportive evaluation of day to day parenting.’ This is aimed to help the parent reflect upon ‘what needs maintaining, what needs changing, and what may simply have to be managed and coped with in terms of competing and conflicting demands’ (p.174). The fourth category is exploratory work aiming for a therapeutic change directed towards the family and other relationships. The final category is therapeutic work with a parent, focusing on previous relationships and how these might be impacting on their current relationships.

There are general principles about parent work, whichever category of work is undertaken. Magagna talked about the amount of supportive work one has to do, explaining that in the first stage parents need to ‘“intrude into us”, pouring into us, all their anger, their hatred…to allow ourselves to be the container of all sorts of repressed and unacceptable feelings’ (2012, p.80). She argues that in order to do this the therapist must be ‘emotionally present to receive and contain the parent’s distress’ (p.81). Magagna believes that once the parents’ more difficult feelings are accepted, parents can ‘initiate the process of internalising perceptive, emotionally containing therapists’, which can better help the parents to think about their child’s distress (p.82). Rustin argues (2000) that the therapist must balance the amount of listening and supportive work that a parent needs, with more interpretative or insight giving work, because there is a risk that if too much interpretive work is carried out with a deprived and fragile parent, this places the parent at risk of a break down. Creating a reliable setting is integral to this work as it helps the parent to feel contained. Another key aspect of parent work is helping the parent to distinguish between adults and children, which often results in discussions around boundaries.

Klauber (1998) has written about long term parent work with parents of children who are very disturbed, namely autistic or psychotic children. She discusses the parents' preoccupations with the aetiology of their child's difficulties, and argues that therapists may feel that parents are responsible for these, rather than viewing the parent's state of mind as a result of the trauma and loss they have experienced through living with a psychologically ill child. She believes that parent work in this context is work with parents who are suffering from post traumatic stress. There may have been traumatic events in the pregnancy or birth or early infancy; there may have also been unrelated traumatic events afflicting the family during these vulnerable months. There is then the trauma of realising that there is something wrong with the child and the trauma of a professional diagnosis. Parents then experience 'the loss of the expected 'normal' child' and experience 'the constant daily strain of living with bizarre, avoidant strange or totally uncommunicative behaviour' (p.90). Although the diagnosis of autism or psychosis is different to an eating disorder, parents may have experienced a similar process.

Klauber explains that in this type of parent work, 'the tiniest set-back, perhaps after a good week or month or during the middle of a term (…) can be experienced as such a blow that the parents may not be able to recognise that there was any progress before'(p.88). She argues that boundaries are frequently a theme of this work because parents 'become worn out with the effort of trying to understand, encourage and stimulate. The response of some is to become entangled, over-close and intrusive, so that there is no space, others distance themselves or give way to despair' (p.89). Parents find it difficult to think about their needs, or the needs of other children in the family, which leads to 'the abnormalisation of life' (p.97). This work is likely to be long term, and using the transference may be helpful. She states that it is important for parents to be helped to develop their relationship with their child, and their sense of potency as a parent.

Other contexts

Parent work is also used as a solo intervention when adolescents will not engage with therapy (Jarvis, 2005 and Trevatt, 2005). Jarvis explains that the work tends to have a short or medium term framework, and does not make use of transference interpretations. When children reach adolescence, developmentally this creates a huge shift, which has an impact on parents, 'particularly when this coincides with the psychological issues of midlife and transition into middle age' (p.211). Trevatt adds that 'the parent may not have fully realised the implications of their son or daughter becoming an adolescent' (p.222). Oedipal issues in families may re-emerge as the child's sexuality is more pronounced. Both authors point out that parent work can be particularly helpful for single parents, or parents who are isolated or depressed. They acknowledge that parents of adolescents may feel easily criticised, both by clinicians, but also by a part of themselves. They draw attention to the theme of authority in parent work with adolescents. Some parents become authoritarian and try to set many limits on their adolescents' behaviour, whereas other parents, afraid of the friction that may ensue, become a friend or confidant. This may be particularly pertinent for parents who have an adolescent with an eating disorder, as parents may fluctuate between insisting that their child eats everything or fearing the ensuing distress and choose to avoid the issue. Trevatt explains that in the work, the therapist is 'trying to keep a balance between support for the parent and support for the best interests of the adolescent' (2005, p.223). Jarvis emphasises the importance of helping parents find a way to 'talk and think about their feelings of loss, guilt, anger and sorrow in their relationship with their adolescent' (p.215).

Jarvis (2005) evaluated parent work in this context and found that at the outset of treatment both parents and therapists 'frequently report clinical range stress levels, feelings of hopelessness, despair, anger, fear, confusion, loneliness, high levels of guilt, low self esteem, and loss of parental identity' (p.213). At the end of the intervention, although there were statistical shifts in several areas, parents' levels of guilt did not shift. Jarvis felt that this may be because both persecutory guilt and depressive position guilt are in operation, but were only picked up on the research instrument[18] as one entity. Clinically, Jarvis felt that parents' persecutory guilt was ameliorated, although the depressive guilt may have remained because it is motivated by feelings of love, responsibility and concern.

Many child psychotherapists have used applied parent work when carrying out parent-infant psychotherapy (Barrows, 1997, Schmidt Neven, 2005, Sorenson, 2005, Urwin, 2003, Emanuel, 2006 and 2010). This is slightly different, as the infant or young child is usually in the room, however there may be several parent only sessions, and the work often focuses on supporting parents in their parental functioning. This work again tends to be brief. [19] Separation difficulties are a common feature, which although may be located in the child, frequently originate in the parents' histories. This is relevant for this study, because adolescents usually have brief hospital admissions, therefore accompanying parent work tends to be brief and separations are a major feature. Furthermore, interventions in parent-infant work are frequently helpful because there is a recognition that the infant's symptoms have arisen from a developmental crisis. An adolescent being admitted to hospital can also be seen as a developmental crisis, albeit a very serious one, which the family must negotiate.

There have also been several more specialised developments of parent-infant work. Daws (1985) saw parents and infants in a baby clinic alongside health visitors. Although her work is similar to the parent-infant work described above, as Daws was based in a 'drop in' baby clinic, some of her work has been single session consultations. This can be similar to working with parents whose children are inpatients, because there is uncertainty about how long the child and family will be in the unit, and what the parents can commit to. Furthermore, as she was working in a health clinic, some of the babies were presenting with feeding difficulties, which stirred up parental anxieties about life and death, albeit at a very different developmental stage. Her description of finding her place in the baby clinic and maintaining therapeutic boundaries also captures

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[18] Stress Index for Parents of Adolescents, (SIPA) (Sheras et al., 1998).

[19] Therapists often offer a six session model, although this can often be extended if necessary

the dilemma of being a therapist in a medical setting, in which there are public areas and a range of staff to negotiate with. Although this is not a focus of this thesis, it is an issue in this type of work that requires further thought.

Reid (2003) has also developed a specialist area of parent work. She has offered ongoing sessions to mothers who have experienced a perinatal bereavement, and have subsequently had another baby. Sometimes the infant attends the session with the mother, but in other sessions it is only the mother who attends. Reid wanted to explore how the mother's inner world might have impacted on the mourning process and links this with the developing relationship with the infant. Reid uses the transference as a tool for understanding the mother's internal world. Previous perinatal bereavements are potentially a risk factor in the aetiology of eating disorders (Nicholls, 2008). Therefore, aspects of this work could be relevant for the parents in this study, even though it is likely that their bereavement will be further removed in time.

Mc Fadyen (1994) and Mendelsohn (2005) have written about their experiences of offering parent work in neonatal units. They comment on parents' guilt, and their concern that they will be blamed for what has happened. Mendelsohn says that the guilt can be particularly difficult when the needs of siblings have to be considered. Mc Fadyen argues that the continuing admission on the unit, 'tends to constrain' parents abilities 'rather than promote them' (p.169), as they feel exposed. Mendelsohn argues that because 'the nurses do their work so well ... mothers find it hard to believe that their baby is theirs or indeed that their baby needs them' (p.200). She also explains that many parents of babies in neonatal units have been traumatised by their experiences of birth, and there is uncertainty around their baby's prognosis. Issues of closeness and distance between the parent and infant can be difficult to regulate, as some parents seeing no stimulation, will tend to over stimulate their infants, whereas, other parents will feel their infant is too fragile and become distant. This could be relevant for adolescents who have been hospitalised, as some parents feel that their child is 'fragile' and are uncertain about appropriate interaction.

Both Mc Fadyen and Mendolsohn believe that parents can be helped at this difficult time to make sense of their experiences. Mendelsohn draws attention to the value of interventions based on psychoanalytic observation of a mother with her baby in these circumstances. The work is less formalised in terms of the setting and number of sessions, as it is often unclear how long parents and babies will be on the unit. Although neonatal units are very different to adolescent eating disorder units, the uncertainty about both the length of the admission and the prognosis is similar. Furthermore, the nurses' care of the patients in *Woodlands*, including providing them with adequate nutrition, may also leave parents feeling that their child has become the unit's child. Although parents of older children and adolescents are more experienced parents, they may have been so traumatised by the experience of having a very ill child hospitalised, that they also became unsure about their parental identities.

Nicholls and Magagna (1997) have written about running a parent group for parents of young people who were hospitalised with an eating disorder. The group was an open group so that when young people were discharged parents did not necessarily continue to attend, and parents of new admissions could join. They commented on similar themes that have arisen in parent work in other contexts, including parents feeling guilty, blamed and deskilled. They noticed that parents' lives had become abnormalised; with parents often feeling preoccupied by food, and controlled by their children. Magagna and Nicholls also explain that 'a number of children go through periods of totally rejecting their parents, refusing to speak to them, throwing away or refusing to open presents, screaming continuously during their parent's visits '(p.569), which is extremely difficult to bear. When the group was evaluated, parents reported that they found it helpful to share their experiences, and to have the facilitators' perspectives to help them think about relevant issues. Nicholls and Magagna also noticed that certain issues arose for the parents in certain phases of the child's admission. When parents joined the group, they looked to the group leaders for guidance. As the parents became more confident, they could verbalise their experiences and seek support from one another. Towards the end of their child's admission they were more able to think about their children's difficulties and offer support to others.

Therefore, a range of interesting themes have emerged in psychoanalytic parent work in other contexts, although these were not in relation to eating disorders. These themes include separation issues, difficulties setting boundaries, guilt, trauma, blame, difficulties regulating parent child relationships, and parental feelings of being deskilled. Importantly, this work has captured parents' less conscious feelings, highlighting some of the internal conflicts that parents face, as well as the external conflicts. These themes will guide my thinking in the sessions with the parents.

Hospitalisation for an eating disorder

Finally, I will look at the literature on the hospitalisation of children and young people for eating disorders. I will consider the reasons that necessitate such admissions, and the advantages and disadvantages of hospitalisation for this group of patients. As literature about the hospitalisation of young people with eating disorders is limited, especially from parental and experiential perspectives, I will also consider literature covering adolescent psychiatric admissions and paediatric admissions. This is relevant for this study as some parents experienced more than one type of admission for their child. I will focus on studies which consider parental perspectives of hospitalisation.

House et al. (2012) argue that UK national figures show that prolonged inpatient treatment for children and adolescents is relatively common, with admission rates of over 35% for adolescents and over 50% for younger patients[20]. Bryant-Waugh and Lask (2008) outline the following criteria for hospitalising a child with an eating disorder.

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[20] Of those young people already receiving treatment for an Eating Disorder.

1. There is a rapid deterioration in physical status as manifested by: severe weight loss, dehydration, circulatory failure as shown by low blood pressure, slow or irregular pulse rate, or poor peripheral circulation, electrolyte deficiency, persistent vomiting or vomiting blood.
2. Marked depression, suicidal ideation or intent
3. Other major psychiatric disturbance
4. Failed outpatient treatment (p.170)

Some children are hospitalised on a paediatric ward to be physically stabilised. However, paediatric wards are inappropriate for longer term psychiatric patients and so the child must either be discharged home, or transferred to another unit. Some young people will be admitted to a specialist eating disorder unit, which is recommended (NCCMH, 2004) and *Woodlands* was such a unit, yet, these units are scarce. The alternative is an adolescent psychiatric ward, which includes young people with varying psychiatric diagnoses, such as depression or schizophrenia.

Advantages of hospitalisation

Crouch (1998) argues that having structured contact with a parent can break the antagonistic cycle between the child and parent. Some accounts by parents (Anonymous, 2001 and Davenport, 2008) confirm this. Furthermore, there is some evidence to suggest that hospitalisation can be effective in stabilising patients' weight (Offord et al., 2006). Some adolescents valued the contact in hospital with other young people who had anorexia (Westwood Bnurs and Kendal, 2011, and Coltan and Pistrang, 2004) and found the rigidity of the units helpful when they were first admitted (Offord et al., 2006).

The literature on the advantages of hospitalisation for this patient group is sparse. This may reflect the current unpopularity of hospitalisation amongst professionals and commissioners. This is partly due to clinical reasons which I will explore below, but may also be for financial reasons, as hospital admissions are expensive. New intensive outpatient approaches are being devised, including family therapy based treatments (Lock et al., 2001) and other assertive outreach and day patient services (Lamb, 2009, Birchall et al., 2002 and Freeman, 1991), which offer alternatives to hospitalisation.

Disadvantages of hospitalisation

Much of the literature pointing out the disadvantages of hospitalising young people with eating disorders has highlighted staff attitudes towards parents as an issue. Staff can collude with patients about the idea of ‘bad parents’. Furthermore, as many staff are young adults, they can harbour unresolved issues from their adolescence (Donnellan, 1986). Staff have also been found to exclude parents, feeling them to be a nuisance and interfering with their therapeutic work (Scholz et al., 2005). Although I am not looking at staff attitudes in this study, it will be interesting to see how parents perceive staff attitudes towards them. Scholz et al. (2005) also argue that during inpatient admissions, staff are responsible for patient care, which means that parents are not encouraged to develop their skills in caring for their child. This can result in patients losing weight during home leave, which in turn reinforces the staff’s negative perception of parents. Gowers et al. (2000) argue that inpatient admissions also suggest that eating disorders can be treated by someone doing something to the patient, rather than helping the patient to find his/her own motivation to change.

Furthermore, although hospitalisation is often arranged due to medical need, Menzies (1960) argues that there are also unconscious reasons for hospitalising patients. She found that an admission can free the family and the patient ‘from certain aspects of the emotional problems aroused by the patient and his illness’ (p.99). Although she was not writing specifically about eating disorders or adolescents, she noted that many patients did not warrant ongoing admission on medical grounds, but seemed to remain in hospital because caring for the patient at home placed too much stress on the family. For children and adolescents, this is especially worrying, as developmentally they would be missing out on an ordinary home life, and the emotional difficulties in the family would remain unresolved.

Treasure et al. (2011) have written about the disadvantages of inpatient treatment for anorexia. They argue that the small closed environment of a ward does not equip patients to make changes outside of the ward, especially in terms of meal plans and portion sizes. Gowers et al. (2000) agree that the inpatient environment shelters patients from the outside world. There is a lot of emotional and practical support available, and schools tend to be smaller, which reinforces the patient's views that he/she cannot cope with the outside world.

Treasure et al. (2011) also draw attention to the issues for parents. Parents are often unclear about care plans, and so are unclear about their tasks. Furthermore, parents can feel guilty when professionals try to think about underlying causes of anorexia and locate these in the family. They also argue that:

> complete removal followed by an abrupt reintegration upon discharge to the family is fraught with its own problems and may expedite a relapse. This is an especially dangerous situation for patients attending hospitals a long distance from their home, which do not have 'step-down' from inpatient care' (p.4, 2011).

This was pertinent for families in this study. Although gradual reintegration to home was planned, patients could not become day patients or receive an intensive outpatient service due to funding and distance. Care was usually transferred to the local CAMHS team, but the outpatient treatment on offer varied. Often it only consisted of fortnightly family therapy meetings and a weekly weigh in. This was a huge change for the family.

Furthermore, the evidence base for the effectiveness of inpatient admissions is not strong (Gowers et al., 2000 and Offord, 2006). Many young people are reported to lose weight after discharge and require readmissions (Steinhausen et al., 2008), which was certainly true for the families in this study.

Additionally, Magagna (2012) argues that children with PRS often initially had a virus, as well as having been depressed or worried. She explains that when these children are hospitalised it can be ‘traumatic in itself when the ill child does not have the psychological capacities to be separate from the parents. When the sense of despair is overwhelming the child collapses into dissociation, bodily limpness’ (p.123). Therefore, hospitalisation can be particularly traumatic for some children and can make them worse, rather than better. A similar finding was noted by Offord et al. (2006) when patients reported finding the loneliness in hospital difficult to cope with, and their removal from home a struggle.

Hospitalisation and the role of parents

I will consider parental perspectives on hospitalisation further in this chapter, but first will consider the role that parents have played historically in hospital admissions. The thinking about the hospitalisation of children and young people has changed dramatically over the last century. Much of the literature on the subject is written from a paediatric perspective, rather than a psychiatric perspective, and especially not from an eating disorder perspective. However, some families in this study experienced paediatric and psychiatric admissions. Furthermore, many of the issues that arose in relation to hospitalising children are relevant for both paediatric and psychiatric admissions. This may be especially the case with patients with eating disorders, because they are psychologically and physically unwell.

In the 19th century and early twentieth century, there was a view that children settled better without their parents. Alsop-Shields and Mohay (2001) argue:

> Parents were excluded from hospital wards, often from fear of cross-infection (Aubuchon,1958), but also because most nurses and doctors of the time subscribed to the belief that a child who became upset when the parent left was experiencing psychological trauma (Robertson, 1970). Consequently, it was thought best if the parents did not visit and the child was left to 'settle in'. The combination of these beliefs about cross-infection and the adverse effects of parental visits meant that some children did not see their parents for years at a time (p.52).

This is a very concerning picture, and one could imagine how such practices would undermine and disturb the parent-child relationship. In 1959, the Platt report was published (Great Britain, Ministry of Health, 1959) which made several important recommendations about the hospitalisation of children. These included allowing parents to stay in hospital with their children, providing accommodation for parents and providing school and recreational play for hospitalised children.

Currently, most hospitals advocate the involvement of parents in their child’s admission. However, Alsop-Shields and Mohay (2001) argue that there are several difficulties with the involvement of parents in practice. They found that staff do not always welcome parent involvement. Furthermore, Darbyshire (1993) found that parents often felt that they were ‘parenting in public’ under the judgemental eye of nurses. Parents have voiced feelings of guilt, anxiety, fear and self blame (Palmer, 1993), and boredom, anxiety, lack of sleep and food, and lack of information about their child’s condition (Carpenter, 1980). Furthermore, some mothers who were resident in the hospital complained of feeling uncomfortable in an unfamiliar environment, which led to feelings of inferiority (Cleary et al., 1986). One of the major stresses for parents was the realization that their child’s care must be shared with other carers (Hayes and

Knox, 1984). Therefore, the impact of having a child cared for by other carers for a year or more, which was the case for some of the parents in this study, was likely to be extremely stressful. There was also confusion between the parents’ perceptions of what they were allowed to do, and the staff’s perceptions of what parents should be doing. Both parents and staff felt that parents could do more, but something prevented them (Webb et al., 1985). Jay (1978) identified three stages in parents adapting to their role in relation to their hospitalised child.

> They display grief for their lost role, mimicry when they observe and copy how other parents act towards their children and how nurses perform procedures, and identity when they recognize the role they have to adopt as 'parent of a sick child'. Once identified, role fulfilment can take place (p.202).

This will be relevant for parents whose children have had lengthy admissions, as they have to find ways of coping with an almost permanently changed situation. Palmer (1993) concluded that the success of parent participation in hospital admissions depends on the willingness of the staff to involve parents and the enthusiasm of parents to be involved.

However, it is important not just to consider what parents have said in interviews to researchers. Menzies (1960) who has studied hospitals from a psychoanalytic perspective, argued that patients and their relatives harbour many unconscious feelings towards the hospital. Although she was not focusing on parents, her research is relevant for parents. She says:

> patients and relatives show appreciation, gratitude, affection, respect; a touching relief that the hospital copes; helpfulness and concern for nurses in their difficult task. But patients often resent their dependence; accept grudgingly the discipline imposed by treatment and hospital

> routine; envy nurses their health and skills; are demanding, possessive, and jealous…relatives may also be demanding and critical, the more so because they resent the feeling that hospitalisation implies inadequacies in themselves. They envy nurses their skill and jealously resent the nurse's intimate contact with 'their' patient (p.99).

These feelings of envy and resentment are not necessarily conscious. Menzies' research was carried out using psychoanalytic observation as well as psychoanalytic interviews in a teaching hospital, which identified and explored unconscious processes. Although this study will not use observation between parents and staff or children, I will be carefully observing parents' unconscious communications in our sessions.

Research on adolescent psychiatric wards found that parents are often unclear about the goals of admission (Chesson et al., 1997); this was the case, even after children had been hospitalised for six weeks. Parents also found the six weekly review meeting daunting, and were unclear about their child's treatment and staff roles. Chesson et al. (1997) recommended that parents are more involved in their child's hospitalisation by playing an increased role in the treatment.

More recently there has been research about parental experiences of attending a specialist child mental health service (Hilton et al., 2012, Kingston et al., 2013). Neither of these studies related to an inpatient service, but took place in a tier 4 highly specialist outpatient CAMHS, and patients had either obsessive compulsive disorder or autism. Hilton et al. (2012) highlighted relatively high levels of satisfaction, and found that parents valued being given a clear diagnosis, and information about the diagnosis, as well as having staff who undertook a thorough assessment. Kingston et al. (2013) also found that parents valued the knowledge and experience that a specialist service offered. However, it is important to note that both studies were carried out using questionnaires, although Kingston's study also used a semi structured interview on the phone. These methods may have made it difficult for parents to identify more negative and ambivalent feelings, as these may be more subtle and take time to emerge.

Experiences of parents who have had children hospitalised for eating disorders

Cottee-Lane et al. (2004) argue that there is a lack of research on parents' experiences of having a child with anorexia. Most of the studies are not systematic and do not directly detail parents' views, especially fathers' views. Cottee-Lane et al. interviewed parents of children who had received inpatient and/or outpatient treatment for anorexia. Although the interviews were detailed, because they were single interviews they were limited and did not capture changes in the parental experience.

They found that parents felt that they should have sought help sooner. Many parents were preoccupied and puzzled by the reasons for their child's eating disorder. Parents reported that the eating disorder changed their child's personality, and took over their child's thoughts and behaviours. This resulted in parents feeling that they could not trust their children as they found ways to disguise the anorexia, such as hiding food. Parents were worried about the physical risks to their child, as well as being concerned about their children missing out on social activities. Parents' personal lives were disrupted and family life was changed, with the focus often on helping their child recover. The parents felt that the eating disorder had an impact on siblings' lives, despite trying to prevent this. Parents reported receiving conflicting advice from professionals, as to how to manage the anorexia, although at the same time, felt that the support from specialist services was helpful.

Cottee-Lane et al. (2004) recommended that parents receive more help from clinicians to manage their child's eating disorder at home. Parents were uncertain about setting limits with their children, and the researchers thought that this was because parents were confused about what was developmentally appropriate for their child, as the child should be becoming more independent, yet was functioning as a much younger child. Support from other parents who had children with an eating disorder, books and information written by parents, were all found to be helpful. Cottee-Lane et al. recommended that services should find ways of enabling parents to support one another, such as online forums, parent groups or a national register of parents. These authors wondered whether the severity of the child's illness and the stage of the illness had an impact on the parent's experience. This is a question that I hope to consider, by tracking parents over time.

Whitney et al. (2005) also carried out a qualitative study of parents' experiences of having a child hospitalised for an eating disorder. Parents who were already in family treatment were asked to write a therapeutic letter about their experiences. Although detailed data was gathered, there was no possibility of capturing changes over time and furthermore, as there was no interview, specific areas of data could not be clarified or explored.

They found that guilt and blame featured heavily for parents. They recommended that more information was given to parents so that they were less likely to blame themselves. They also suggested that parents should be taught coping skills, both to help them manage their thinking patterns and distress, as well as help them to manage their child's eating disorder. Whilst such strategies may be helpful for some parents, they do not take into account unconscious processes. Although some parents may have information about their child's illness, they could struggle to digest this because of complicated relationships with staff, their children or their states of mind.

Perkins et al. (2004a, 2004b) looked at carers' experiences of caring for a patient with bulimia, using a qualitative approach. They found that carers were greatly affected, both by 'discovering' the illness and coping with it. They again recommended more support, information and advice for carers. This was a different patient group as the patients were not hospitalised and the carers were not specifically parents, yet similar recommendations were made.

Additionally, there are some accounts of parents who have had a child hospitalised for an eating disorder. These accounts were not designed as research, and were retrospective, written after both children had recovered. Therefore, they may not capture what the experience was like at the time, especially when there was more uncertainty about recovery. Both accounts were written from the mothers' perspectives. One child was hospitalised for PRS (Anonymous, 2001 and 2012) and the other child was hospitalised for anorexia (Davenport, 2008).

Both parents described receiving the initial diagnosis and trying to understand the illness as terrifying. Both parents were also preoccupied with reasons for their child's illness and wondered whether it was their fault. Even though both children had recovered, the mothers remained uncertain as to why their child had become ill, which links with Cottee-Lane et al.'s (2004) findings.

Both parents felt helped by the specialist unit, rather than the paediatric ward, or local services. They also both commented on finding it easier to talk to professionals about their child, rather than friends. Socially, they commented on feeling isolated, although Davenport (2008) found that speaking to other parents of children with anorexia relieved the loneliness.

Feelings about the hospitalisation were mixed. They described feeling observed and exposed in the hospital, especially by the assessment procedure, but also in family therapy and review meetings. There were also feelings of rivalry with the staff. Both parents were upset that their children were away from home, however, they were also relieved that their children were being helped. They felt that the change of environment and the specialist help from emotionally detached professionals was helpful. Yet one parent felt that she had betrayed her child when she was admitted to hospital. Davenport (2008) felt that the continuing support of the unit post discharge was helpful as she felt that discharge was the point in which there would be another battle with the anorexia.

Therefore, the literature on hospitalisation of children and adolescents generally, is mixed, especially from parental perspectives. Parents appear to find the experience confusing and distressing. Much of what has been written considers issues from mothers' perspectives, rather than fathers. This is also true when considering literature on hospital admissions for eating disorders. There are some advantages of hospitalising young people with eating disorders, but it is also clearly a very stressful event for the parents, and not always clinically effective.

Conclusion

There is a wide range of literature on the topics of eating disorders, parent work and hospitalisation of young people. There is much less research specifically on parental experiences of having a child hospitalised for an eating disorder, especially from a psychoanalytic perspective. The existing research seemed to be based on single interviews, which only provides a snapshot of the parents' experiences at a point in time. By gathering detailed data from parents over time, I hope to capture the parents' experiences in a richer way, as I anticipate that certain themes will only emerge over time.

Methodology

In this section I will explain the design of the study, and the thinking behind this. I will also discuss the ethical issues involved. I will then explain how I collected the data and the characteristics of the sample and consider some of the difficulties I encountered when collecting the data. The next section explains the processes and methods I used to analyse the data and finally I consider issues of validity in relation to the data.

Research Design

As I was aiming to understand parents' experiences, I chose a qualitative method, because this is better suited 'to obtain the intricate details about phenomena such as feelings, thought processes, and emotions that are difficult to extract or learn about through more conventional research methods' (Strauss and Corbin, 1990, p.11). I carried out a literature search, which is detailed in the previous chapter, and this guided my thinking about the topics that may arise in the sessions. I then developed some research questions, to focus my thinking. However, as Strauss and Corbin (1990) argue, in qualitative research it is important not to narrow the focus of the data collection method, as one cannot assume that one knows the participants' preoccupations. Therefore, it was important to allow data to emerge and to capture the range of data.

I planned to analyse the data using Interpretive Phenomenological Analysis (IPA) (Smith, 1996), which is well suited for data which attempts to explain experiences, and has been used in other studies focusing on patient experiences (e.g. Offord et al., 1996). I will explain this method more fully later.

The source of my data was from clinical sessions with parents who had children admitted to *Woodlands.* Using clinical sessions as research data has been undertaken by other child psychotherapists (e.g. Reid, 2003, Anderson, 2006). The clinical sessions were psychoanalytic parent work, from a post Kleinian framework. I have described this in the literature review, but will briefly outline the approach here as it was the basis for the data. It entailed offering parents a reliable and regular space to explore their feelings about their child. I followed ordinary psychoanalytic technique by keeping the sessions to the same room at the same time, keeping the session time fixed to 50 minutes, and rigorously protecting sessions from external disturbances (Rustin, 2000).

When undertaking qualitative research, Strauss and Corbin (1990, p.182) argue that it is not possible for the data collection to be carried out by relatively unskilled interviewers or fieldworkers. This is because in order to gather data that is as close as possible to the phenomenon that one is studying, the researcher must allow material to emerge, rather than having preconceived questions about the preoccupations of the participants. The researcher must also think on a conceptual level so he/she knows which data to explore further with the subject. These principles are similar to the way that child psychotherapists approach parent work sessions.

The parent sessions were unstructured as I hoped that parents could say whatever they wished, and that their communications would become 'the primary object of reflection in sessions' (Rustin, Michael, 2007, p.176). I also avoided sharing personal information about myself, which is unlike most kinds of relationships where some degree of reciprocity is expected.[21] This was so that the transference relationship could emerge, which is an essential part of any psychoanalytic session. Having said this, I was aware that the nature of the work with the parents could be brief, as it was dependent on the child's admission. Therefore, I asked parents some open questions to focus the work, as is common practice in brief work (Wittenburg, 2008, Emanuel and Bradley, 2008 and Daws, 1985). Furthermore, I did not focus on transference interpretations, as recommended in brief work (Jarvis, 2005, Barrows, 1997, Emanuel and Bradley, 2008), but made a note of the transference, and when relevant made broad transference comments. Shedler (2010) has identified criteria for psychoanalytic sessions, which I followed. These included identifying

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[21] The only exception was that one parent knew about my pregnancy as her sessions had continued when the pregnancy was visible.

recurring themes in the parent's experience; linking the parent's feelings and perceptions to past experiences; drawing attention to difficult feelings (e.g. – anger, envy, excitement), pointing out defensive manoeuvres; interpreting some unconscious wishes, feelings, or ideas.

Using clinical sessions in this way enables the researcher to access 'unconscious mental phenomena', which, being a child psychotherapist was something that I was interested in researching and formed part of the research questions. Michael Rustin (2002) argues that:

> It is inside, and only inside, the consulting room, that the phenomena postulated by psychoanalysts can be clearly observed and distinguished from background 'noise'. It is only here that relevant observations and 'experimental interventions' can be made (these are usually called 'interpretations') and their effects studied (p.22).

Therefore, it is important that psychoanalytic research can emerge from clinical settings.

Ethical issues

There are ethical issues involved in using clinical material as research data, which I considered. This research did not seek to address the clinical efficacy of parent work for parents who had a child hospitalised for an eating disorder, because in order to answer this question, there would have needed to be a control group, and a treatment group. This would have meant that some parents received parent work and others would not have, which is ethically more problematic. However, by using clinical sessions it was possible to gather qualitative data about parents' perceptions of receiving parent work.

There was a concern that the parents were already under strain in visiting *Woodlands* and participating in family therapy and other meetings. Adding another meeting for parents to attend may have been unhelpful. To address this, I made sure that the parents only attended sessions with me on days on which they already had meetings. Parents were told that they could choose to opt out of the study at any point, and that this would not influence their child's treatment in any way. The research was designed to be confidential from the work on the unit to help parents express more difficult feelings. However, there was a concern that parents may reveal safeguarding concerns, or serious concerns may arise about parents' mental health. In these circumstances, as a clinician, I have a duty of care to follow standard procedures in the unit and inform the consultant psychiatrist. This was made explicit to parents in the information sheet and consent form[22], and discussed with them during the introductory meeting, which I detail below. Furthermore, in a clinical setting, I could offer a high degree of confidentiality, however, in research, in order to disseminate the findings; certain details from the research would need to be shared within the wider professional community. This may be of concern to the parents. To minimise this, parents were told that their details would be anonymised, and no identifiable personal details would be used. Therefore, all names used in this thesis are pseudonyms and identifiable details have been removed.

I also sought ethical approval from a multidisciplinary NHS ethics board, which is standard practice when carrying out research in a clinical setting, before I began the study, to ensure that I had sufficiently addressed the ethical issues. The research was also approved by the university ethics board.[23]

Sample

I aimed to recruit six parents, or parent couples, for this study. This was because like Reid (2003), I wanted to understand the 'fine detail' of the parents' experiences in the way that one can in single case studies, but also to compare

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[22] See appendices
[23] See appendices for approval letters.

and contrast parents' experiences to see if common themes emerged. Furthermore, IPA is better suited to smaller samples. All parents were recruited from *Woodlands*, which I have described in the introduction. All parents were engaged to varying degrees in the treatment programme[24]. I had hoped to approach parents who had had a child admitted to *Woodlands* within that month, so that I could hear close to the time, what the experience was like and follow the parents through their journey of their child's hospitalisation. However, because of time pressures and the rate of admissions to *Woodlands*, it was not possible to recruit enough parents this way. Therefore, I approached all parents in the unit, apart from parents of children that I was already working with as the child's therapist. I used what is termed purposive sampling, where the participants all had experience of the topic I was researching, which is important when using IPA.

Parents were told by their case manager or family therapist that there was a piece of research being carried out involving parents, and they were asked if they were interested in taking part. If they were interested in participating, I met with them and explained that I was a child psychotherapist undertaking some research on parental experiences of having a child hospitalised with an eating disorder. I explained that this would involve meeting with me fortnightly, for a 50 minute clinical session, which would focus on their experiences as parents. I gave them the information sheet and consent form, and made certain that they had capacity to give informed consent. If they agreed to participate, I arranged a first meeting.

This was a complicated way of recruiting parents because although they were a clinical sample, in that they were in *Woodlands* because of their child's needs, they were not referred for parent work in the usual way that parents are referred – e.g. on the basis of clinical need. This was because at that time, there was no parent work on offer. [25]*Woodlands* had previously run an optional parent group, which was intended to have a therapeutic role. If parents needed individual

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[24] Some parents had more intensive family treatment than others depending on clinical need.

[25] However, parents were accessing family therapy, which at times offered parent only sessions.

psychotherapy, they were referred to their GP or to a local psychotherapist so that they could receive longer term support. However, the parent group in *Woodlands* had recently stopped due to staffing. Therefore, when I started the research project, the managers hoped that the parent sessions would be supportive for the parents. Yet, as the parents were approached by staff and explicitly asked to participate in research, rather than being referred to a specific clinical service, the meaning of the sessions was different in parents' minds. This was exacerbated by the fact that the information sheet pointed out that the research was for my professional doctorate. Parents viewed their involvement with the sessions as 'helping me' with 'my' study, rather than the sessions being supportive for them. It was possible to take this up to an extent in the sessions, which I will look at in the findings section. Over time, the parents that engaged in the sessions were able to move beyond this position. Nevertheless, it influenced the relationship that the parents had with me, certainly initially, as a researcher/clinician. When Midgely (2004) writes about the different types of research that child psychotherapists are involved with, he states that there is research that focuses on 'clinical practice as it is described by the participants…the most common form such research takes would be accounts of being in therapy' (2004, p.93). He identifies another category of research, which he terms 'research that would focus on investigating clinical practice as it actually takes place, through notes or verbatim transcripts of actual therapeutic encounters…This I call "therapy process research."' This study occupies a middle ground between these two categories. It also highlights the difficulties in occupying the researcher and clinician role.

In total, I approached seven parents, or parent couples, and although all agreed verbally to participate in the research, two parents cancelled a number of sessions, and so it felt inappropriate to pursue these two parents. Therefore, I worked with five sets of parents. Two were married couples, two were single mothers, where the father had no involvement with *Woodlands*, and minimal contact with the child. The fifth set of parents were divorced, and the child's main residence was with the father. Both mother and father were involved with the child's treatment, and so I saw both parents. They requested to be seen separately, which I arranged. In table 1 I have summarised the participants, but will first provide a brief outline of the families.

Pen portraits of families

Mr and Mrs Short were a married couple who had two daughters, Caroline, aged 15, and Lucy aged 18 who was preparing to go to University. Caroline looked different from her family, as she was extremely thin and gave the impression of taking meticulous care over her appearance, whereas her family seemed disinterested in physical appearances. She was a quiet member of the group, and presented as depressed. Mr Short was in his late forties and worked in public service, and Mrs Short was in her mid fifties and worked from home. Mrs Short had experienced depression since she was a young woman and had had a psychiatric hospitalisation. She had ongoing anxiety and depression and tried various medications, counselling and psychological therapy. Mrs Short had a very difficult relationship with her mother who was elderly and lived some distance away. Her father had died before either of her children were born. She had also had a miscarriage before Lucy was born. Mr Short seemed outwardly cheerful, yet his engagement with me felt as if it was on the surface. Mrs Short was more difficult to engage and often seemed preoccupied with her own thoughts, yet when she contributed to the sessions, her words were full of feeling.

Mr and Mrs Barnes were a married couple in their early forties, who had two daughters, Melanie who was 9 when she came to *Woodlands*, and Fiona who was 12. Melanie was the youngest patient in *Woodlands*, but also presented in a rather infantile way. Mr Barnes worked full time and Mrs Barnes had been a nanny and a childminder. They were an attractive family, who seemed to enjoy outdoor activities together. They appeared to be close to their extended family. There were no other known psychiatric difficulties in the family, although Mr Barnes' mother had bipolar disorder. The family appeared to have had a relatively settled life until Melanie became ill. Mr and Mrs Barnes presented as relatively attuned to one another and affectionate. As a couple, they had a capacity to communicate their experiences effectively.

Mrs James was a single mother in her early forties who had four children, Chantal, aged 13, Sarah, 11, Tiffany 10 and Dylan, 9. Her husband had left her very suddenly when Sarah was 4, when they had been living in temporary accommodation following a period of living abroad. He subsequently had very little contact with the family and drunk heavily. Mrs James and her children remained living in an isolated part of the country, without any extended family until Sarah became ill. Mrs James also abused alcohol for a time after her marriage broke up, although had stopped drinking before Sarah had become ill. Mrs James' father had left her family when she was a child. She had some contact with him as an adult, but this had lead to another rejection. Mrs James did not work and struggled financially. She had a rather strained relationship with her mother and there were other psychiatric difficulties in the wider family – for example her niece was looked after by Sarah's grandmother and had severe OCD. Dylan also had behavioural difficulties and was referred to CAMHS. Mrs James often presented as stressed, overwhelmed and preoccupied with the various practicalities on her mind. Sarah was a quieter member of the group, who was usually quite co-operative.

Mrs Roberts was a petite lady in her early forties. She had two daughters, Silvia, aged 14 and Charlotte, aged 16 (at the time of admission). She worked part time in a primary school. Silvia had lived with Mrs Roberts' parents from infancy until she was 12 years old, which was when Silvia was first hospitalised with anorexia. This was due to Mrs Roberts experiencing postnatal depression after Silvia was born and struggling to manage both children. However, both grandparents had also experienced mental health difficulties. Mr Roberts was depressed and had been violent towards Mrs Roberts, often when drunk. Charlotte continued to live with Mrs Roberts, whilst Mrs Roberts had contact with Silvia at her parents' house. Mrs Roberts' marriage subsequently broke down, and Silvia's father was criminally charged for a financial offence, although received a suspended sentence. The contact between Mr and Mrs Roberts was unclear, as although they did not live together he saw Mrs Roberts regularly. Mrs Roberts' relationship with her parents was strained and Charlotte had moved out of the family home when Silvia had been discharged from hospital previously. Silvia remained at home for approximately six months before she was readmitted to a Paediatric ward due to her low weight. Mrs Roberts' mental health was fragile and she also had a history of previous losses herself. Her brother had died in childhood and her sister had died when Silvia was born. Mrs Roberts often become tearful in the sessions, and although she had always been pleasant, I had witnessed her having an angry outburst on the unit, which felt frightening. Silvia was one of the thinnest young people in *Woodlands*, and liked to wear tight clothes to reveal her underweight frame. Although she was supportive to the young people, she could be very challenging to the staff and presented as rather 'hard'.

Mr and Mrs Harris were in their early forties and had divorced when Scarlett was four years old. Scarlett was 15 when she was admitted to *Woodlands*, following a previous inpatient admission. However, she was 17 at the time the parent work begun and her sister, Josie was 19. Scarlett was a popular member of the group, and individual in her appearance and ideas. Mrs Harris was from another country and the family had emigrated to this country when Scarlett was two. They lived there for three years before returning to the UK, by which point Mr and Mrs Harris had separated. Mrs Harris was unable to have residency in the UK because she was no longer married and had to return to her country of origin for six months. Scarlett and Josie lived with their father who had a long term partner for the past six years. He worked in the creative industries and his parents provided childcare. Mrs Harris moved to London and saw her daughters at weekends and holidays. She remarried when Scarlett was 12, and socialised with people who did not have children. She dressed in a fashionable urban style. She worked full time in a helping profession. Neither Mr nor Mrs Harris' partners had any contact with the study and very little contact with *Woodlands*. Mrs Harris had had bulimia nervosa with weight loss in her early twenties, and her sister also had bulimia nervosa. Mrs Harris had also had postnatal depression. She often presented as emotionally volatile, whilst Mr Harris presented as rather more reserved, relaxed and reflective. However, often this position served to distance himself from the emotions evolving around him.

Table 1: Details about the sample

Name	***Child***	***Age of child when admitted (this admission)***	***Parents separated?***	***Ethnicity of parents***	***No of siblings***	***Significant life events***
Mr and Mrs Short	*Caroline*	*15*	*No*	*White British*	*Older sister – 18*	*Mrs Short had had a psychiatric hospitalisation as a young woman for depression.*
Mr and Mrs Barnes	*Melanie*	*9*	*No*	*White British*	*Older sister – 12*	
Mrs James	*Sarah*	*12*	*Yes – no contact with father*	*White British*	*1 older sister 13* *1 younger sister 10* *1 younger brother 9*	*Had alcohol issues previously.* *Own father had been very rejecting.*
Mrs Roberts	*Silvia*	*14 (was 15 when parent work started)*	*Yes – some contact with father*	*White British*	*1 older sister – 17 (18 when parent work started)*	*History of PND. Silvia had lived with her maternal grandmother from a very early age until she was approx 12 and hospitalised for the first time.*
Mrs Harris	*Scarlett*	*15 (although 17 when parent work started)*	*Yes – lived with father. Mother remarried*	*White other*	*1 older sister – 19 (at time of study)*	*Had been out of the country for six months due to visa issues, when parents separated when patient was approximately 4. Also mother had a history of bulimia as a young person.*
Mr Harris	*Scarlett*	*15 (although 17 when parent work started)*	*Yes – father had a partner*	*White British*	*1 older sister 19 (at time of study)*	

The parents were not intended to be a representative sample, but many had characteristics in common. This is an important consideration when using IPA, because in order to find out about an experience, it is necessary to have people who have shared similar experiences. The age of the parents ranged from early forties to mid fifties. Most of the parents worked outside of the home, although there were two mothers who did not. All of the parents had a daughter in *Woodlands*, and all of the parents had more than one child, and had to manage visiting their child in hospital with looking after their other child or children. Most parents in the study had an older child who was not in hospital, although one mother had older and younger children, not in hospital. There were two boys in *Woodlands* during the study, but as I was their individual therapist, it would have been inappropriate to have recruited their parents to this study. It would be interesting to see if gender had any impact on parental experiences. The length of admission for each child varied, although all were considered long term admissions. One parent had had a child admitted within a month, one child had been admitted within the last three months, and the other three parents' children had been admitted to the unit for over six months. See Table two for further information:

Table 2: Details of admissions

Name	*Child*	*Length of current admission*	*No of parent sessions attended*	*Previous admissions?*	*Diagnosis*	*Discharged home*
Mr and Mrs Short	*Caroline*	*10 months*	*5 and 1 telephone follow up*	*No*	*Anorexia and self harm*	*No – transferred to another unit, discharged home and then readmitted to another unit*
Mr and Mrs Barnes	*Melanie*	*12 months*	*9*	*Yes – paediatric ward, 4 months*	*Pervasive refusal syndrome*	*No – transferred to another specialist unit. Discharged after 4 months*
Mrs James	*Sarah*	*7 months*	*4 and 1 telephone follow up call*	*Yes 2 separate admissions to a paediatric ward*	*Anorexia*	*Yes*
Mrs Roberts	*Silvia*	*12 months*	*9 and 1 telephone follow up*	*Yes two paediatric admissions, and 1 previous admission to Woodlands approx 12 months*	*Anorexia*	*Yes. Readmitted to paediatric ward 4 months later*
Mrs Harris	*Scarlett*	*26 months*	*4 and 1 telephone follow up call*	*Yes – previous psychiatric unit – 6 months*	*Anorexia and self harm*	*Yes. Readmitted to general adolescent unit 3 months later*
Mr Harris	*As above*		*3 and 1 telephone follow up call*			

The length of the admission of all children in the study was decided by the closure of *Woodlands.* This had not been planned at the outset of the study and I became aware of the closure three months into the study. At that point, parents and patients were told about the closure by the management and plans were put in place. Three out of the five patients were discharged home to outpatient care when the unit closed, and although this had been planned for one young person, the other two discharges were prompted by the closure. The remaining two young people were transferred to other units[26]. I had hoped to gain at least six to nine months of data, but the closure meant that the study was brought to an end sooner than anticipated, so the data collection took place over five months (from February to July, and the follow ups took place between October and December of the same year).It was not possible to continue to meet the parents fortnightly because geographically the parents were too far away, and there were ethical issues when the patients were involved with different clinical teams. However, all parents had agreed to a phone call follow up, and one parent couple whose child was transferred to a unit close by, agreed to follow up sessions[27]. It is likely that the parents' experiences around discharge and transfer were not typical. However, in today's financial climate, when long term admissions are being reduced and many inpatient units are closing, it could also be an important part of parents' experiences. I will discuss this further in the findings, as it arose in the data.

The frequency of meeting with the parents also varied. This was in line with similar clinical research, such as Reid's study (2003), and highlights the difficultly of both needing to be flexible clinically, whilst also trying to hold in mind a research framework. I had intended to meet with all parents fortnightly. However, this became difficult because all parents lived at great geographical distance from *Woodlands* and so they were unable to travel to the unit several times in a week. I tried to co-ordinate with the family therapist, so that parents were not making a separate journey for the parent session. However, if another

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[26] One patient was transferred to a specialist eating disorder unit, and the other patient was transferred to a general adolescent unit.

[27] This was agreed with the new unit that their daughter was being transferred to.

meeting was scheduled, such as a Care Plan Approach meeting, the family therapy session was often changed or cancelled, which meant that it was not possible for me to meet with the parents. Furthermore, there were holiday periods, which made it difficult to maintain the fortnightly frequency. I discussed this in supervision, and for some parents where it became clear that fortnightly meetings were not possible, we renegotiated to meet monthly, whereas with other parents we tried to stick to the fortnightly times, but were aware that there would be missed sessions. Mrs Roberts attended regularly, and through discussion in supervision, we felt that clinically it would be preferable to offer her weekly meetings, which I did. As we approached the ending of the study, and the closure of the unit, parents missed or cancelled sessions. This was in part for practical reasons, as they had to visit alternative units, but as a clinician, one could understand this emotionally. Many child psychotherapists have written about the impact of endings for families and patients (e.g. Salztberger Wittenburg, 2013). It is well known that parents can miss final appointments to avoid difficult feelings of saying goodbye. The therapist is then left to struggle with feelings of anger, guilt, sadness and disappointment about the work ending.

Data Collection

As discussed, I planned to use unstructured clinical sessions with the parents to gather data. I wrote up the sessions in full, as soon as each session was over. I later analysed every session in its entirety, rather than selecting certain parts. I was trying to capture data that was as close as possible to the parents' experiences. Tuckett argues:

> A great deal more takes place in a session than we can deduce from a verbal transcript alone – even if the session were tape recorded and fully annotated to take account of gesture, tone of voice, and so on. The words used by the two participants and how they said them, is central to a degree, but the essence of the situation is that the immediacy of the meaning of what is said is subjective and also that unconscious meaning

> is to be inferred according to highly subjective principles, in which the apprehension and comprehension of affects play a leading part (1994, p.1180).

Therefore, I chose not to tape record the sessions, as this is not usual clinical practice and could alter the parents' ways of responding when using psychoanalytic sessions as research data. Michael Rustin (2001) has pointed out that often when data is presented by psychotherapists, it is not clear what is the direct evidence from the patient and what has been inferred by the analyst's understanding of theory. He has suggested that there is a greater need to separate the two. I have endeavoured to keep the two things distinct.

I had also planned to use a short standardised questionnaire – either the Parent Stress Index (Abiden, 1995) or the Stress Index for Parents of Adolescents (Sheras et al., 1998) depending on the age of the child. I had planned to use this three times – during the first session, and towards the middle of the work and in the final session. However, I used it with two parents in the initial sessions and it felt clinically inappropriate. One of the parents felt that questionnaires were insensitive because they could not begin to capture the breadth of their experience. There were also several statements on the questionnaire that were difficult for parents to respond to. For example, one statement was: 'my child's behaviour concerns me.' At times when the child was at the unit he/she was generally well behaved, and if the family were not eating together, the parents did not necessarily experience difficult behaviour. Yet, if the family were to eat with the child or to intervene when the child was trying to exercise, the child's behaviour could be very difficult. Terms such as 'difficult behaviour' were too reductionist for this group of parents, who had very specific experiences and so I decided not to use this questionnaire.

Data Analysis

Once I had collected the data, I analysed it using IPA. I will briefly explain the background to IPA, before describing how I used it in this study. IPA was developed by Smith (1996) and is a stance and process for analysing qualitative data that draws on phenomenology, which is the philosophy of being or experience. Smith explains that early phenomenologists such as Husserl, believed that if there was a rigorous approach to studying phenomenon, experiences could be reduced to their core transcending personal or contextual factors and would give a clear understanding of the phenomena under study. In order to do this, one must put aside every day thoughts about the matter, or one's assumptions, and examine the phenomena under study as objectively as possible. Later phenomenologists, such as Heidegger believed that it was impossible to reduce things to their core in an objective way, because we all look at things subjectively and so interpret what we see. He became interested in the study of hermeneutics, which is the study of interpretation.

IPA allows for the fact that data is an interpretation of what we see and hear, and so when we are seeking to study experiences we are never accessing direct experience, but instead create an intersubjective account of the experience with the participant. Gallagher (2004) argues that 'interpretations are biased in a very productive way to the tradition to which they belong, and the specific types of questions that they ask' (p.164). Bias is not seen as detrimental to the research, but something that can be helpful in adding to a body of knowledge. As I am a child psychotherapist, my observations will be coming from a psychoanalytic perspective. Desmarais (2007) argues that there is a danger in this hermeneutic approach to psychoanalytic research, because it can be seen to permit all interpretations, rather than to ground interpretations in psychoanalytic theory. To ameliorate this, I followed ordinary clinical practice when it came to interpretations, which meant basing them on the post Kleinian psychoanalytic model of parent work that I have outlined here and in the literature review. Furthermore, the data was reviewed by two supervising child psychotherapists, to ensure that I was not making wild interpretations. However, it is likely that I looked at the data through my own lens. When using IPA, it is recommended that the researcher reflects on their interpretations, as this helps to ground them in the data as far as possible. Therefore, as part of the data analysis I paid attention to my interpretations. This was something that also emerged in supervision.

As I was using a qualitative method, my aim was not to generalise about parents' experiences, but to understand the experiences of these parents in this situation. The purpose of this, as Midgely argues, is to build 'models of understanding that go beyond the individual case' (2004, p.92). This helps to build a theoretical understanding of phenomena, which adds to knowledge on the subject. This is important for developing practice, as other qualitative research has demonstrated. For example, Thomas and Beckford's study (1999) about the experiences of adopted children during the adoption process had an impact on social work practice. Therefore, my findings may be relevant to parents, child psychotherapists and staff in other units and may help to develop professional practice.

Desmarais (2007) points out that there are some concerns about psychoanalytic research using qualitative methods, because qualitative methods focus on conscious experience and the views of the participant, whereas psychoanalytic work is interested in unconscious experience, and the understanding that emerges between the participant and the analyst. However, she argues that it is the same conscious experience that is the starting point in any analysis, therefore, qualitative methods are a way of researching in a naturalistic way, what happens in the consulting room.

I analysed each case, as Smith (1996) recommended, and then looked across cases to compare and contrast themes. I analysed the data by coding it, which had several stages. Initially I noted down my preoccupations from the data, which was also a way of recognising my assumptions and biases. I then carried out the close analysis by coding the data sentence by sentence, or chunk of meaning by chunk of meaning. I felt that this was the most appropriate method because coding the data line by line would have placed it out of context, but coding paragraph by paragraph risked missing the detail. I followed the guidelines by Smith (1996) on coding, which explain that the researcher should be looking for the concerns and understanding of each participant. Following this process I identified similarities and themes in the data. I then returned to the data, as Smith suggests and moved to interpretive coding, which is the researcher's interpretation of the data and the experiences. As part of this, I generated new questions, which related to theory and meant that I had to carry out further literature searches. Finally, having coded the data into various themes and grouping them into three main areas of focus, I developed a structure, including some diagrams which illustrated the relationships between themes which can be found in the concluding section. I again returned to the data to test it, using the structure that I had developed. Where there were anomalies, this revised these structures, until all of the data could be understood.

Validity

It has been argued that analysing one's own material is not sufficiently objective, as one might be looking to prove or disprove a hypothesis. Strauss and Corbin point out that this can be particularly the case when 'researchers are also practitioners who are doing research in the area of their practice' (1990, p.122). Yet, Strauss and Corbin also argue that subjectivity is inevitable. They argue 'what is important is to recognise that subjectivity is an issue that researchers should take appropriate measures to minimise its intrusion into their analyses' (1998, p.43). Supervision was an important way of reducing the subjectivity of my data.

The issue of subjectivity was problematic in a multidisciplinary inpatient unit, when I was routinely exposed to information about families, before I had recruited the subjects. Observations and professionals' views were frequently shared in meetings and emails. I was aware that this would influence my perceptions of the families and risk moving away from the parents' experiences.

I therefore endeavoured to keep the research separate from the general clinical work, and so avoided using material from other sources. However, Smith (1996) recommends gathering additional cross referencing material, as this helps to locate the participants in their contexts. I decided to look at the admission letters for all the patients to cross reference the material that the parents had discussed, and to provide additional contextual details. I did not analyse this, using the IPA method, as it was not research data and would not necessarily help me to understand the parents' experiences.

The design of the research intended to collect data with high validity, that is data that was close to the parents' experiences. The fact that the patients were receiving treatment in *Woodlands*, and parents knew that I was a member of the clinical team could have prevented parents from being entirely truthful. Parents could fear that I would break confidentiality and speak to the multidisciplinary team about their complaints or their difficult feelings, which in turn would impact on their child's care and result in a longer admission, or alternative care being found for their child. This could have been particularly relevant for Mrs Roberts, as the team planned for her daughter to be discharged to foster carers. Furthermore, as parents were aware that this study was for a professional doctorate, they perhaps felt that they were helping me and improving the experiences of other parents in the future. Such factors can impact on the truthfulness or authenticity of the account as they may have selected topics that they thought other people would want to know about. It was also possible that despite explaining that I was a child psychotherapist, parents were uncertain of my position, and viewed me as a student or researcher and so less able to help them with their difficult feelings, which in turn led them to withhold such feelings.

To reduce this reactivity, I met with the parents several times, as reactivity tends to decrease over time. As the parents felt more comfortable within our relationship, it was likely that they were more able to trust me and speak candidly. Some parents commented that they had found the sessions helpful, which suggests that they had begun to view the sessions in a therapeutic manner. Listening for the negative transference was also important, as when I could voice their negative feelings in a straightforward way, parents felt that it was safe to talk about them. Some of the parents' responses towards the end of the sessions, when the parents were aware of *Woodlands*' closure, are also likely to have been reactive as it was not what they had expected. It could have been difficult for them to voice anger or concern about this, in case their child was left without a placement. Furthermore, parents were aware that staff were being made redundant, which probably impacted on their ability to express their feelings of frustration and anger. Again, it was important to listen for this in the material and take it up when appropriate.

When collecting the data and analysing it, I endeavoured to be as rigorous as possible. I allowed time to write up the sessions straight away. I also followed a well established method of data analysis (IPA). I received supervision from two child psychotherapists, as well as academic supervision. This meant that the interpretations in the sessions were reviewed by senior colleagues who had extensive clinical experience in this field. The academic supervisor, coming from a different discipline meant that the themes and interpretations were not purely psychoanalytic conjecture, but were based in the material. It also enabled other views from outside the psychoanalytic paradigm to be considered. Having academic supervision further ensured that I used the method of data analysis correctly.

Although the data was more limited than I had hoped, in total, I collected 34 sessions, from 5 sets of parents, which were rich in data. By analysing the data carefully and closely I arrived at a set of themes and a structure that could be used to make sense of the parents' experiences. Although there were issues of validity about the data, I think that the measures I took to address this, as described above, reduced reactivity and increased the validity of the data.

Conclusion

Therefore, I intended to carry out a qualitative study in a clinical context, looking in detail at parents' experiences of having a child hospitalised for an eating disorder. In order to generate meaningful findings, I used a rigorous method of data collection and analysis. In the chapters which follow, the main thematic structure is discussed in relation to the data and its theoretical significance. In the concluding chapter, I will further reflect on the advantages and disadvantages of the methods that I used.

Findings: Chapter One

Transitions

Every hospital admission is an enormous separation for the child and her[28] parents. However, psychiatric admissions are usually temporary so that parents and children are aware that they will be transitioning home. This was mirrored by my sessions with the parents being limited to the child's hospitalisation and so the ending of the sessions was always present. Such transitions preoccupied parents. In this chapter, I will look at the main points of transition, which followed a similar pattern for most families. Initially, there was the transition into hospital. For some families this admission followed previous admissions, for other families, this was their first experience of their child living away from home and left the family grappling with issues of loss and separation. Each time parents visited their child there was the transition to becoming a family again, and the separation at the end of the visit. At discharge, there was another significant transition as the young people prepared to go home or to another unit. For some families this was eagerly anticipated, however, because of the unit closing, some families had to move to another unit. All families had to think about the transition to another CAMHS team, as all the young people needed further psychiatric support. I was interested in how parents processed these transitions emotionally.

Loss, Grief and Bereavement

The themes of loss, grief and bereavement came up for most parents. The literature suggests that initially when children are hospitalised parents experience grief for their lost role, as they are no longer actively caring for their child on a daily basis (Jay, 1978). Interestingly, this did not arise as a topic for these parents, which may have been because their children had been hospitalised for some time, and looking after their children had become so difficult. As well as parents experiencing the loss of their child to the hospital, there was also the potential for a catastrophic loss given that anorexia has the highest mortality rate of psychiatric illnesses (Gowers and Doherty, 2008). Most

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[28] I will use her in the text as the patients in the study were all female and it avoids the clumsiness of his/her. However, many statements would also be relevant for boys.

parents found this unspeakable, but Mrs Barnes voiced her concerns when Melanie became unwell.

> *She said that they kept her in hospital[29] for a week and then sent her home. Mrs Barnes said that the problem was that Melanie was no better, if anything she was worse. She was eating nothing and barely drinking. She said that one day she walked into the lounge and saw Melanie on the sofa and realised that if she did not do something – she was actually going to die. I felt shocked by this, as it was hard to think about this possibility. Tears welled in Mrs Barnes' eyes. She said that then she knew that she would have to take her to A and E and insist that she was admitted.*
>
> *(S.1, 16th March)*

My feeling of shock suggested that there was an immediate projection into the therapist, and that the potential loss had remained unprocessed in Mrs Barnes. This should probably have been explored more both in the session and in the wider team. Many parents felt close to losing their child and this could explain the relief that some parents felt towards the hospital, which I will examine in the chapter on relationships.

As well as the initial sense of loss around hospitalisation, there was an ongoing process of loss. Although Melanie started to make progress with various tasks, this was painful for Mrs Barnes.

> *Mrs Barnes said that you build things up in your head and then when you reach the milestone, there is no sense of euphoria – because it does not change that she is still here, and not at home, and still very far away from being home.*
>
> *(S.4, 18th May)*

Freud (1917) described the process of mourning, in which 'each single one of the memories and expectations in which the libido is bound to the object, is

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[29] Previous general paediatric ward

brought up and hypercathected, and detachment of the libido is accomplished in respect of it' (p.245). Mrs Barnes seemed to be experiencing this process, because when Melanie made progress, it reminded her of the limitations of Melanie's current abilities, and required her to mourn the Melanie she had known.

For some parents, their sense of loss was in relation to losing their child to the illness, rather than to the hospital. Mr and Mrs Short described feeling distanced from their daughter at home, as Caroline became more secretive and involved with anorexia. It was as if she had become attached to anorexia and death, rather than her parents and life. This correlated with Cottee-Lane et al.'s research (2004), which found that parents felt that the eating disorder had taken over their daughter's minds. Caroline's mother described finding it painful seeing Caroline's peers:

> *Mrs Short said that she could hardly bear to see the girls in Caroline's year in town looking happy. She keeps thinking that this could have been Caroline, and then she is so upset as she is reminded of where she is. I said that seeing Caroline's peers connects her with a feeling of loss. She nodded and said that she felt that she needed to grieve for Caroline – the daughter that she would have liked to have – that she has not got... at least not right now…I said that it was as if she had lost her daughter. She nodded.*
>
> *(S.2, 23rd March)*

The way that Mrs Short described seeing the other children resembled the way that bereaved parents feel. She did not simply feel the loss of her daughter at home, but she felt a permanent and irreparable loss of her daughter in her mind. Caroline's anorexia confronted Mrs Short with the difficultly that Caroline was not the daughter that she thought she had. This phenomenon has been described in other psychoanalytic parent work with parents who have very ill children (Klauber, 1998).

Mrs Roberts' sense of loss was connected both to her daughter's admission to the unit, but also to the transition at discharge, because she was being placed with foster carers[30]. Mrs Roberts disagreed with this decision, but felt she had little choice in the matter. It was particularly painful because it resonated with previous losses and separations that she had experienced. Silvia had already had a lengthy admission to *Woodlands* some months previously and had been in a paediatric ward. More significantly, Silvia had lived with her grandparents since she was an infant. This was an informal arrangement between Mrs Roberts and her parents and was due to parental depression and domestic violence. Mrs Roberts was preoccupied with Silvia's discharge, which entailed an enormous loss for her.

> *Mrs Roberts said that she was worried that Silvia could be discharged suddenly. I wondered if she was worried or whether it was hard to think about this discharge which was to the foster carers. She said that it is hard, she felt that Silvia should be coming home to her....She knew that this was for the best, because the foster carers could give Silvia the consistency that she had been unable to. She became tearful and said that Silvia had been to and fro from her grandparents' house since she was a baby. I spoke about this transition reminding her of the transitions that had happened before. She nodded and said that when Silvia was born she had had postnatal depression and was not coping. Her mother used to help by taking Silvia's sister for a while. This then switched to taking Silvia for a while to give her a break and then suddenly she was at her mother's house all the time.... and everyone thought that this was better for her.... Her mother had said that she was not coping.*
>
> *(S.2, 30th March)*

Mrs Roberts' memories of this loss remained unprocessed. Whilst Silvia was in the unit and Mrs Roberts was in role as a parent, paradoxically, the loss was partly avoided. However, Silvia's discharge presented Mrs Roberts with a more permanent loss, which for Mrs Roberts was a re-enactment of what had happened previously. This reinforced her sense of being unable to mother her child.

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[30] This was because there was substantial concern in the network about Mrs Roberts' abilities to manage Silvia. When she had been discharged home previously, she had rapidly lost weight, and Mrs Roberts had not sought help quickly about this.

Mrs Roberts had also experienced further losses. Her relationship with her parents was poor, as she was angry with them for ‘taking’ Silvia. Her partner had left her, and her older daughter had chosen to live with her father. Mrs Roberts’ sister had also died from cancer before Silvia was born. One can imagine her despair in mourning her sister and her marriage, when also trying to welcome an infant into the world. This perhaps made it difficult for her to ‘hold onto’ Silvia, as everyone had left her. Yet, I think that it also made it difficult for her to let go of Silvia to the carers, as she feared that separations were permanent. This needed further thinking about as a team, because it was impossible for Mrs Roberts to support foster care, which led to the failure of this plan. I will explore this further in the chapter on relationships.

Mrs Roberts also thought about the loss of her daughter to the illness – similar to Mrs Short.

> *She said that it is hard because Silvia will be in year 11, and she has missed so much school. Already she has lost three years. She added that she never knew the illness would take so long. I said that she feels sad that Silvia has lost so much time in school, but I wondered if it was not just school that saddened her. Mrs Roberts replied that she had not done much as a teenager – and she did not want Silvia to have the same experience. It’s so frustrating! I acknowledged that she too knew what it felt like to miss out on things, but perhaps she felt she has missed out on things as a mother. Mrs Roberts nodded and said – yes – I was always there, people said that I missed out on things but I visited Silvia every day.... but yes there are things that I thought we would do together and now......I commented that she feared that there might be things that they would never do together. She spoke about feeling that she had messed up her chance to have her family together.*
>
> *(S.5, 11th May)*

Silvia’s final year of schooling marked the ending of childhood. Mrs Roberts was very identified with the feeling of missing out. This seemed related to things she had missed out on as a teenager, including a better relationship with her mother, which she may have felt her mother had offered Silvia. Helping parents to face their own losses in their adolescence is common in parent work (Briggs, 2008). However, Mrs Roberts also felt she had missed out on being a parent to Silvia. Therefore, like Mrs Short, she was mourning her role as a mother. This mourning was complicated, because she had struggled to be a mother to Silvia, which was painful and hard to face in the limited time we had available.

Mrs Harris also described a sense of loss in terms of the daughter she might have had.

> *Mrs Harris said that all her expectations had changed. She did not even know - has Scarlett kissed a boy, would she go to a Prom? She has very little expectations of Scarlett – other than being alive – if she has to be supported all through her life, that is ok… She trailed off. I commented that she had had to readjust her expectations and perhaps give some up. She agreed - all the ideas she had about Scarlett going off to college or any of those things are forgotten about. I thought there was a sense of sadness.*
>
> *(S.1, 9th March)*

Mrs Harris had lost hope in having a daughter who would have an independent life. This was a huge loss for her, both in terms of her idea of Scarlett, and her own life. Raphael-Leff (1993) describes how pregnant women give their developing foetuses an ‘inside story’ which is infused with the mother’s hopes, feelings and unconscious phantasies. Although this ‘inside story’ is modified as the actual baby arrives, for many parents a continuation of this process happens as they imagine their child’s future, and the relationship that they may have with him/her. The hospitalisation forced Mrs Harris to relinquish her thoughts of the mother that she might have been, and to mourn the teenage daughter that she might have had.

What was complicated, as with Silvia, was that Scarlett had not lived with her mother for many years. Following her parents’ divorce when Scarlett was aged four, the family returned to the UK, but Mrs Harris had had to return to her country of origin for six months[31]. Mrs Harris then lived in a city, seeing Scarlett and her sister at weekends, whilst Scarlett lived with her father and sister, and later, her father's partner, in a town. Like Mrs Roberts, there was a period of active parenting that she had not been immersed in. Mrs Harris commented that:

> *I used to analyse things a lot and wonder what I had done wrong, and would think that I had done lots of things wrong – was it that time I said that.... or was it that time I did not let Scarlett stay up to watch the end of the film. I noticed that she did not include Scarlett living with her father in these examples.*
>
> *(S.3, 1st June)*

Mrs Harris had some awareness that she may have played some role in Scarlett's illness, but she gave examples of obviously insignificant events. She did not wonder about the impact of her separation from Scarlett. It was likely that this was too painful to think about. I also 'forgot' about this detail until after the session. It was as if something unmentionable had been projected into the therapist and I too could not find words to talk about this loss. I feared if I mentioned this separation that I would be blaming her, which suggested that unconsciously there was an idea of blame. Mrs Harris was also a mother who had also experienced a great deal of loss. Neither of her children lived with her, and her marriage had ended. She was from another country very far away, where her family still lived, and her father was ill. Furthermore, her comment in Session 1, suggested that she too was aware that Scarlett was fighting to stay alive, as her self harm and anorexia were severe. All of this loss was difficult to process and think about.

Separations

As well as the sense of loss, all the families experienced repeated separations after each visit. Many of the patients were enmeshed with their parents, particularly their mothers, which made separations difficult. This links with previous research (Parker, 2000, Lawrence, 2008), which found that patients with anorexia found it difficult to enter into the ordinary conflict with their

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[31] There was an issue with Mrs Harris' visa, following the parents' divorce.

mothers that is necessary for separation, or to make new alliances that could aid separation, such as boyfriends. Therefore, the admission into hospital was a drastic measure to aid separation. For some parents, the separations seemed too difficult to think about, but for other parents it was an opportunity to reflect on their relationships with their child. Like parent work (e.g. Daws, 1989, Fraiberg et al., 1980) carried out in other settings, the parents' histories of separations were connected to the current separation difficulties. Fraiberg argued that:

> intruders from the parental past may break through the magic circle and a parent and his child may find themselves re-enacting a moment or a scene from another time with another set of characters (1980, p.100).

Parents may have responded to their child in a way that was incongruent with the current situation, but was connected with previous experiences.

Mrs James spoke about the difficulties in saying goodbye to her daughter.

> *Sarah got upset at the end of their visit. She is aware that five minutes afterwards, Sarah is fine, but she has to wait until she speaks to her on the phone to know that she is alright. I spoke about her carrying this with her. She agreed and added that Sarah forgets about her. I wondered why she thought that Sarah forgot about her. She said - she has distractions. I commented that it seemed hard to believe that she was still significant for Sarah.*
>
> *(S.2, 9th March)*

Mrs James had experienced a number of difficult separations. Her husband had left her and her four children suddenly, leaving her in an unknown area. Mrs James' father had also left her when she was a child. As an adult, she had contacted him, and although he had responded, he ended this contact when his current family found out, and Mrs James felt terribly rejected. Mrs James had previously used alcohol to help her cope, and had left the children in the evenings to go drinking. She may have identified with Sarah's feelings of being left behind and equated the separation with abandonment, which made it difficult to leave Sarah, which Sarah may have sensed. Mrs James' reassurance that Sarah was fine, may also link with her guilt about having left her children to go drinking. It may be easier to think that they had not noticed and had distracted themselves. She cannot think about what this might have been like for them, and she struggled to think what it might be like for Sarah to be left in hospital. Mrs James had unconsciously repeated some of the separation difficulties she had experienced. For all these reasons, separations remained painful. Although our work together was brief, it provided Mrs James with some experience of processing these traumatic separations and making links between what had happened to her and what was happening to Sarah.

Mr and Mrs Short seemed more preoccupied with the psychological separation from their daughter, rather than the physical separations. Caroline refused to show or discuss her self harm with her parents.

> *Mrs Short said that she was not sure why Caroline self harmed, but she thinks that it has to be something she [Mrs Short] has done. I felt my heart sink. She knows that this annoys Caroline because Caroline wants the self harm to be her thing and Caroline felt that Mrs Short was taking responsibility for it. I wondered about this. Mrs Short said that maybe she likes to think that it is her fault because she does not have to accept that Caroline is making a choice.*
>
> *(S.3, 20th April)*

Mrs Short found it difficult to think about Caroline as a separate being. She was not curious about why Caroline cuts herself or the meaning of the cuts, but almost engaged in her own self harm with her continued reproaches against herself. Hawton et al. (2012) discuss self harm, particularly cutting, as an escape from an intolerable situation. One wondered whether for Caroline, the cutting functioned as an escape from a mother that struggled to separate, and so she had to literally 'cut her out' with her self harm and anorexia. Mother, having also been hospitalised for psychiatric difficulties as a young woman, may have identified with Caroline's position and could have felt that a psychiatric hospitalisation was the only way to separate from one's family.

Mrs Short's separation difficulties with Caroline seemed linked with Mrs Short's separation difficulties with her mother.

> *She said that her mother is 95 and frail, but still so controlling of her and her sister. When her mother dies, she and her sister have vowed to blow up the house. She smiled gleefully. I was surprised by the vehemence in her voice. I said that there were very strong feelings about her mother. She said that there were – really strong. Mr Short laughed. I asked if her sister felt the same. She replied that she did and explained that her sister lived on her mother's small holding. She said that they went back to visit. I commented that despite some explosive feelings about their mother, it was hard to talk about them. She said that there was no point.*
>
> *(S.3, 20th April)*

Although Mrs Short had separated from her mother by moving away, internally there was little separation. Conflict, which is a necessary part of any separation, seemed to be avoided (as in many families with anorexia, Parker, 2000 and Lawrence, 2008). The only way that she could separate from her mother was for her to be obliterated. Mr Short did not help Mrs Short with her feelings towards her mother. I also found it difficult to take up Mrs Short's feelings about her mother, as one could not 'get into' their relationship as a third person.

Some parents were aware that there was a need for more separation between themselves and their daughters. Some parents could think about this, whilst other parents found it more difficult. Mrs Roberts struggled to separate from Silvia.

> *Mrs Roberts said that although Silvia is almost 15, she is also younger in some ways. Previously, she did a lot of things with Silvia and the old team told her that Silvia needed to be independent. It was hard though because the team also advised her that Silvia needs support when the illness is bad. She did not want to go back to cocooning her, but she wanted to offer support if she needed it. I spoke about this being a balancing act – and one that many parents of teenagers struggle with – both the teenagers' need for independence, as well as their need for*

> *dependency, and with a child with an Eating Disorder it was more confusing. She agreed. I said that perhaps for them it was particularly confusing. She said that she felt that she still needed to make up for things.*
>
> *(S.9, 27th July)*

Mrs Roberts was haunted by her guilt of abandoning Silvia previously, which meant that she could not allow Silvia to be independent. Furthermore, her wish to keep Silvia in a more dependent role may unconsciously be driven by Silvia representing her needy child self, and her wish to always have someone there. It was unsurprising that separation remained a difficulty for this family, given that Mrs Roberts had experienced major traumatic separations herself, which I have discussed. Although Mrs Roberts had little contact with her mother, she was a feature of our sessions, suggesting that there was little internal separation.

Mr and Mrs Barnes were able to use the admission to think about separations between themselves and Melanie. This has been found to be an advantage of inpatient admissions (Bryant-Waugh et al., 1988, Coltan and Pistang, 2004). Mrs Barnes initially found it difficult both to leave Melanie at *Woodlands* and being less involved with Melanie's life. However, over the course of the admission Mrs Barnes increasingly recognised their separateness:

> *She said that when the children were little they were so much her focus. Mr Barnes had played with them, but she was always thinking about them and focused on their needs, and she could do it all. The girls were more compliant or she was more in control. Now her girls wanted to do their own things with friends, rather than family, and that's ok. She sounded rather sad.*
>
> *(S.8, 16th October)*

Mrs Barnes recognised that her relationships with her daughters had significantly shifted and she could not prevent this. Trevatt (2005) and Jarivs (2005) both argue that the psychological changes that happen in families as children reach adolescence and parents reach middle age, can be dramatic, and many parents can benefit from parent work at this time.

Mrs Barnes was able to move beyond the idea that this separation was simply a loss, and think about her life.

> *She said that when she goes out, the girls say – Mum don't go out. When she was at her Mother's house and had plans to meet a friend, the girls had said stay at home… Previously she would have said ok – I'll stay in, but this time she thought – no you are going out with your friends and I need to see my friends.*
>
> *(S.9, 7th November)*

Mrs Barnes' previous response to her daughters was a reaction to their demands. It was possible that she had not wanted to go out, or feared getting into conflict with the girls, which links with Lawrence's findings about anorexic girls and their mothers, in which the mother is 'enslaved and terrified of her daughter's constant demands' (2008, p.56). When I wondered further about this with her, she explained that she felt that mothers should not leave their children.

> *She said that she did everything she could to be the perfect Mum – she was a textbook of providing for her children. She did not put them in day-care and was at home with them all the time...I wondered where this pressure came from. She looked flustered and embarrassed and said that she supposed that it was from herself. She was a child minder, she had trained as a nursery nurse and had always wanted to have children and then when she was pregnant at 32, she had thrown herself into motherhood. She had totally embraced it, because she felt that she should be good at it, and because it was something that she always wanted to do. She said that she wasn't in competition with anyone, she was just conscientious and wanted to try her hardest. I was surprised she commented about competitiveness, as I had not asked about this. I commented that she recalled having competitive feelings. I wondered about the idea of being a perfect mother in terms of her mother. She said that her mother worked, but only in the evenings when her Dad was*

> *there. This meant that she was never aware of her mother working. It was only later that she found out. I was surprised that she had used the phrase 'found out', as if there was something secretive about a mother working. I commented that in her family there was an idea that mothers were meant to be there.*
>
> *(S.9, 7th November)*

It was not possible to understand Mrs Barnes' ideas about motherhood more fully, which were complex. However, she perceived her mother's life outside the home almost as a secret activity, which avoided any conflict about separations between mothers and children. This linked with Lawrence's findings about idealised mothers (2008).

Hopkins (1996) argued that when mothers stay in a prolonged state of primary maternal preoccupation, it leaves little room for conscious resentment, which is problematic for the child. One wondered about Mrs Barnes' resentment about constantly giving into her daughters' demands. Her hostility was perhaps split off and projected elsewhere, possibly in Melanie's fear of things that emphasised their separation. Furthermore, it also placed the children in a powerful position, which could have made them feel less safe and fuelled their neediness for her. Having had some time apart, Mrs Barnes could get in touch with her hostility towards Melanie, and own her needs.

> *She said that it felt a relief to be freer. I said that she no longer felt that she had to be always available for Melanie. She agreed. She said that she was ready for a change, and she would look for a job. She spoke about doing something connected with care for the elderly. I asked her more about this. She said that she had decided not to return to childminding. There was too much paperwork and added – that as the girls were getting older, it was hard having all the baby stuff around…. They needed more space. I acknowledged this and said that perhaps she also wanted to move away from looking after young children – as that stage in her life was changing. She agreed - although looked upset.*
>
> *(S.9, 7th November)*

Mrs Barnes felt her relationship with Melanie had changed for the better. However, I wondered if some of her enthusiasm for going out with her friends was defensive. For example, when Melanie elected to go on a school trip[32], mother had arranged to go to a spa so that she was unavailable should there be problems. I wondered whether for mother there was something unbearable in being left behind. I wondered whether her decision to work with the elderly was a reaction to the change in her relationship with her children. This may have been heightened given that I was noticeably pregnant during these sessions. Working with the elderly may have reinforced her liveliness and vitality, whereas being a childminder may have reminded her of a life stage that had passed. Her comments about having baby toys in the house, perhaps reflected an emotional difficulty of having reminders of babies. However, the fact that Mrs Barnes wanted a change, suggested that there was some internal shift about her role. Unlike Mrs Short and Mrs James, Mrs Barnes had not experienced major traumatic separations in the past that made the possibility of development more problematic.

Boundaries

Another factor that complicated the parents' abilities to separate from their children, and encourage them to be independent, was that it was difficult for parents to set appropriate boundaries. This preoccupied parents when they were at home trying to manage their ill children, suggesting that it was connected with the child's illness, rather than the hospitalisation, although it was exacerbated by the hospitalisation. Parents were confused about who should set boundaries, which I will consider in the section on relationships with staff. Parents were uncertain whether it was safe to set boundaries with an ill child, or whether it was cruel to insist on certain boundaries. Klauber (1998) pointed out that because the children's behaviour could be so difficult, parents felt ineffectual and were less likely to set limits. Although she was talking about a different group of parents, she was talking about parents who had chronically disturbed children. She said that parents had:

> become worn out with the effort of trying to understand, encourage and stimulate. The response of some is to become entangled, over-close and

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[32] This was when she was transitioning back to her home school, just prior to discharge.

> intrusive, so that there is no space. Others distance themselves or give way to despair' (p.89).

These sentiments relate to the parents in this study. Additionally, Cottee-Lane et al. (2004) have argued, developmentally patients are unable to carry out age appropriate tasks and so parents find it confusing to set boundaries appropriate for younger children with their teenagers. Furthermore, because the children had been hospitalised for a long time, parents lacked the experience of developing appropriate boundaries alongside their child. Interestingly, adjusting to boundaries at home was also an issue that young people struggled with (Offord et al., 2006 and Coltan and Pistang, 2004). This perhaps explains why it was difficult for parents too.

Mrs Roberts found it difficult to set boundaries with Silvia, especially in the context of Silvia's age. She had commented that she could '*no longer carry her to her room, if she did not do what she was told' (S.8, 12th June).* However, Mrs Roberts' guilt impacted on her ability to set boundaries. She was worried that Silvia would not eat because she had not allowed Silvia to do something.

> *I commented that Mrs Roberts was full up with Silvia's anxiety about how Silvia would manage the meal. She nodded and said that Silvia was getting herself more stressed. I wondered if the worry about Silvia's physical state gets into her mind and Silvia becomes a fragile Silvia that cannot cope when Mrs Roberts says 'no'. Mrs Roberts agreed and looked distracted and worried. She said – I mean giving into her does not help either, it makes it worse. I said that it was hard to feel that she could maintain a boundary in an ordinary way.*
>
> *(S.8, 12th June)*

Mrs Roberts acknowledged that she had struggled to set boundaries, because of her guilt about her absence. This situation was replicated by the hospitalisation, as Mrs Roberts was again absent. When Silvia was angry about a boundary, Mrs Roberts heard Silvia complaining about her mother's absence, and felt persecuted. What was more complicated was that Mrs Roberts at times felt furious with Silvia. Unconsciously Mrs Roberts feared the damage that her aggression may have done to Silvia, which reinforced her sense of Silvia's fragility and made it difficult for Mrs Roberts to maintain boundaries.

Scarlett, like Silvia, had been hospitalised for a long time. Mr Harris was also anxious about setting boundaries with Scarlett.

> *He said that on the first trip home they had had an easy meal, which she had managed. The next weekend, she had suggested this same meal. He had said – no, we need to think about this, because this is going to be a pattern. They had then had something else. I commented on him being able to challenge Scarlett. He said 'yeah you can now, because you are not worried that she will get so distraught and turn it all in on herself.' I said when she is more robust – he can be more robust. He agreed and said – plus at the beginning, she was so controlling of anything that he tried, she would draw him into an argument, because he did not know any better. So to avoid these repetitive arguments, he ended up saying nothing, but that is not good either. I spoke about the illness meaning that he had lost confidence in ordinary limit setting.*
>
> *(S.2, 18th May)*

This correlates with Klauber's (1998) argument that parents of children with chronic difficulties become less effective parents, because of the day to day struggles of dealing with an ill child. Mr Harris' guilt about the relief he experienced from Scarlett's hospitalisation, further complicated his limit setting, which I will look at in the section on relationships.

Mrs Barnes also had difficulties with boundaries. When Melanie moved to the new unit, Mrs Barnes was anxious about the rules.

> *Mrs Barnes had thought that it would have been better to settle Melanie in, rather than go straight to the rules, but the consultant had said that it*

> *is better to be clear from the beginning. Melanie got upset, because she was still using pads*[33]*, and they told her that she would be expected to use the toilet every two hours. The consultant had also said that Melanie had to sit at the table with the other patients whether she was eating or not. Melanie was upset about this and then it was hard to leave her.*
>
> *(S.7, 25th September)*

The way that Mrs Barnes presented the rules, suggested a lack ownership of them. She wanted to avoid the rules because she knew rules would upset Melanie and potentially make her angry, which she found difficult. This resonated with Mrs Barnes' sense of guilt that mothers should make things better for their children. Interestingly, Melanie coped well with these rules and quickly made progress in both these areas. Mrs Barnes also seemed more confident with Melanie, because she later told me that Melanie complained about having another nasogastric tube passed. Rather than advocate for Melanie, Mrs Barnes reminded Melanie that nasogastric tubes were a consequence of not eating. That night Melanie ate tea, which was the first meal she had eaten in over a year. One wondered if previously, the staff had become identified with Melanie and Mrs Barnes' state of mind; that rules are cruel, and had been reticent in setting clearer boundaries, which may have reinforced Melanie's fear of rules. [34]

Feeling clearer about boundaries helped Mrs Barnes implement emotional boundaries at home.

> *Mrs Barnes said that she was beginning to recognise that Melanie needed space, but she found it hard – it was her instinct to make things better for Melanie. She added that the other day Melanie had been cross with her and wanted space to be cross.*

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[33] Incontinence pads, as Melanie was not using the toilet at *Woodlands*

[34] This was perhaps reflected by the fact that various nasogastric tubes had been in situ for over a year, which is not advised (Bryant –Waugh and Lask, 2008).

(S.8, 16th October)

On this occasion, Mrs Barnes had allowed Melanie some time alone in her room, before intervening. She had been helped to do this by Mr Barnes, suggesting the importance of a parental couple for setting boundaries.

Despite parents feeling more confident about setting boundaries whilst their child was an inpatient, post discharge this was problematic. Mrs James struggled to maintain boundaries with Sarah at home. When Sarah had problems at school, Mrs James removed her.

> *She said that they had had one hiccough about school. Sarah could not do drama, art and music, because of her confidence issues, and the school forced her. She said that she explained to the school that Sarah would find this too stressful. She had begun to notice signs that Sarah was not doing so well, and was getting stressed out by the school's attitude and so she withdrew Sarah.*
>
> *(TC, 5th October)*

Mrs James experienced the school maintaining a boundary as forcing Sarah to do an impossible task. Sarah's difficulties in reintegrating to school may have related to having been in a small hospital school, which Treasure et al. (2011) and Gowers et al. (2000) argue is another difficulty of inpatient treatment. By removing her from school, Sarah's idea that she could not manage, and that boundaries could be broken was reinforced. There was little sense that Mrs James had encouraged Sarah to cope with the lessons, or had negotiated with the school. Without the support of *Woodlands*, Mrs James found it harder to maintain boundaries and was terrified of another relapse.

Parents arguably needed more experience at setting boundaries with their children whilst they were inpatients and becoming outpatients. It was understandable that parents found it difficult to set boundaries with children who had been very ill, when the consequences of being firm were terrifying. When parents were identified with their child's predicament, or haunted by their guilt, it confused boundary issues and meant that their separation from their child psychically remained blurred.

Leaving the unit

All the families had to leave *Woodlands*, and either move to a new unit, or a new outpatient team. For some patients this was a planned transition, whereas for others, the transition was prompted by the closure of the unit. Treasure et al. (2011) have pointed out that patients are vulnerable during discharge, particularly those whose admissions have taken place at great distances from the home and are ended by an abrupt reintegration. Davenport (2008) found the transition to day patient care and then outpatient care helpful. However, this was not possible at *Woodlands*. Parents had varying responses to the process of leaving *Woodlands* and engaging with another team. From a psychoanalytic perspective, their reactions such as confusion, denial, anger and idealisation could be understood in terms of defences against loss, which I will consider. This group of parents, who had experienced traumatic separations in their own histories, were particularly vulnerable to finding endings difficult.

Confusion

Many of the parents were confused by the discharge. Scarlett's discharge had been planned for August. However, when I spoke with Mr Harris, he remained vague.

> *He said that he was excited about Scarlett's discharge. He thought that she was ready to come home, and it should be ok. The first few weeks would be taken up with her appointments and things, and then she would be back at school and that would keep her busy.*
>
> *(S.3, 22nd June)*

Mr Harris denied anxiety about Scarlett's discharge, despite the fact that she had been in hospital for two years and had self harmed during recent home visits. I expect that he felt terrified about her coming home, but it was impossible to think about this, because the task would have then been too overwhelming. He viewed Scarlett's outpatient appointments as her activity until she started school, rather than essential for the family. He also distanced himself from Scarlett's appointments. This was problematic, because emotionally she was much younger than seventeen and needed more parental involvement.

Mr Harris remained confused about the closure of *Woodlands*.

> *He asked me why the unit was closing, was it because they took overflow from other units? I felt surprised by his question. I asked him what he had been told. He said that he could not remember. I found myself explaining again.*
>
> *(S.3, 22nd June)*

Mr Harris had been told this information several times, but could not digest it because both he and Scarlett were losing their life line. I found myself breaking the news again, as if I did not think that he was able hold the information himself. It was understandably shocking news, however, because Mr Harris put it out of his mind, each time he thought about it he was shocked and confused, and so it was impossible to digest.

Mrs Barnes was also confused about how to respond to Melanie's discharge.

> *She said that she wanted to have a big party at home with their family and friends to celebrate Melanie coming home. She paused and added that she was aware that Melanie did not want that. I asked her about this and she thought that Melanie would not want the fuss and might not think there was anything to celebrate.*
>
> *(S.8, 16th October)*

Mrs Barnes felt that getting discharged was a celebration, but was aware that Melanie would not feel the same. This reflected Mrs Barnes' mixed feelings about the discharge. For Melanie, and for Mrs Barnes, the discharge could be experienced as a big loss, which a party may try to disguise and defend against.

Mrs Roberts was very unsettled in our final session, which was also the day of Silvia's discharge.

> *She shifted in her seat, as if it was hard to sit still. I acknowledged that it was a big day. She said that she was not sure how Silvia was today, it being such a big day. She had imagined it for so long, but it was not how she had imagined now that it was here. She said this with an air of disappointment.*
>
> *(S.9, 27th July)*

Mrs Roberts was unsure of her feelings. She had 'battled' to be responsible for Silvia, but this was an enormous pressure, because she felt that she had 'failed' previously in this task. She confided that she had hoped that Silvia would be 'a lot further on in her recovery'. In this context it was probably difficult to feel that she could celebrate Silvia's discharge, because she was aware that things were far from 'better' and there would be less support.[35]

Klein (1957) argued that confusional states are often a result of unsuccessful splitting when the infant is very young. She argued that it occurs when an infant cannot distinguish between good and bad and between love and hate. This makes it difficult to be clear about one's feelings and process these accordingly. These parents were unlikely to be in a 'confusional state' ordinarily, but when faced with a loss, their ordinary psychic structures may have collapsed and so it was difficult for them to be clear about their feelings. Klein (1957) also mentions the defensive use of confusion, which can guard against envy and destructive impulses. This was perhaps more the case with these parents, because their ambivalence about having their child home could leave them with destructive feelings, which were terrifying and made it difficult to be clear about their feelings. I will consider their ambivalence further in both the states of mind and the relationships chapters.

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[35] Mrs Roberts' confusion about her feelings in relation to the discharge were complicated by the fact that Silvia's discharge had been pre-empted by the unit's closure. Until the last moment, there had been a lot of uncertainty about whether she would be going home, or going to another unit.

Denial and avoidance

Many of the parents found it difficult to get in touch with feelings of loss about *Woodlands*. Mr Harris said:

> *Scarlett had such good relationships here and was so positive about the place, it would be really hard for her to leave. I commented that she had been here for a long time, but I wondered how he felt about it. He seemed surprised and said that it was very strange – he had no idea what it was going to be like not having to drive to the unit every weekend. You become so used to the area – you know the pubs, you go to the supermarkets, it is like another home. I said that the unit had become a second home for him too – he was very attached.*
>
> *(S.2, 18th May)*

Mr Harris located the attachment to *Woodlands* in Scarlett, yet the depth of his feelings towards the unit was clear. Leaving *Woodlands* would have been a great loss, especially as the unit was closing. Klein (1940, p.349) in her work about loss and mourning in infancy argues that the infant employs defences such as denial in order to avoid 'a slavish and perilous dependence upon its loved objects'. Mr Harris may have avoided getting in touch with his feelings of loss because he feared becoming dependent on *Woodlands.* It was then unsurprising that he struggled to engage with another team.

Mrs Harris could acknowledge the loss of the unit, but had become very defended about it.

> *Mrs Harris said that she was not interested in building up emotional ties at the new unit. They had done this at Woodlands and it was heart wrenching to say goodbye so she could not bear to do that again. This felt very cold, and I thought about Scarlett being expected to do this again. I acknowledged how painful it was to say goodbye to people – and perhaps that got in the way of making new relationships, but then opportunities are missed. She said – yes exactly – and I can't face it.*
>
> . *(TC, 9th November)*

Mrs Harris would rather avoid staff, than face another loss. There seemed to be something unprocessed about the loss of the previous unit. It may have resonated for her strongly, as her family were abroad and so the staff at *Woodlands* were an important source of support, making the loss more significant.

Mrs James also found it difficult to get in touch with feelings of loss about the unit closing. Although Sarah also had a planned discharge, the closure of the unit brought Sarah's discharge forward.

> *Mrs James said that she could not believe that the unit was closing. I felt surprised, as she had been saying it would be a relief to stop coming. I said that she felt shocked by the decision. She agreed, but added that she was angry that there are so few people that deal with the illness – and it makes her cross that there is another place that will not exist, as if the illness is not important and does not matter to the government. She sounded upset. I said that she felt angry about the unit closing. She added that in general she was unhappy with mental health services. Her local CAMHS knew nothing about eating disorders… She said and the ignorance of the nurses on the ward really shocked her!*
>
> *(S.4, 10th July)*

Mrs James momentarily connected with a feeling of loss about the unit closing, but moved away from it, to a more generalised grievance. This avoided the importance for her of this unit closing. Williams (1997, p.39) argues that complaints or 'grievances' can feel reassuring and familiar to a patient, and the patient is in control of these. They do not threaten the patient's internal structure. It could be easier for Mrs James to get in touch with feelings of annoyance and anger with the old unit[36], rather than express feelings about *Woodlands'* closure.

Mrs Barnes' denial about the closure was apparent afterwards:

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[36] Sarah had been on a general paediatric ward previous to her admission here.

> *She said excitedly – so how is Woodlands? I felt confused, as if she was unaware that it had gone and I dreaded 'breaking' the news. I commented that I was unsure as Woodlands had closed shortly after Melanie had left. She seemed disappointed. I added that I had left about the same time that they had, and all the staff had left. She nodded and said that Melanie asked about the staff. I said that she was aware that Woodlands had shut, but perhaps it was hard to think about it not being there. Mrs Barnes seemed sad as she agreed and said that yes it was hard to think that it really was gone. She added that you get to know the staff. I said that perhaps she too wondered about the staff.*
>
> *(S.7, 25th September)*

This session occurred after a long summer break. Mrs Barnes seemed to have denied the closure of the unit, and responded to me as if there had been no break. The shock of the closure was projected into me and I had to process it for her. As I did this, she reconnected with her sadness about the loss.

Mrs Roberts, although acknowledging the closure of the unit, seemed confused by the timing.

> *Mrs Roberts said that Silvia needed more time here to gain weight. She said sadly, that to think that it is now that she has to go. I said that she felt disappointed and pushed out that Woodlands is closing and she has to manage an ill child on her own.*
>
> *(S.9, 27th July)*

Mrs Roberts had been preoccupied with Silvia not being in foster care, but had not thought about alternatives. Mrs Roberts could not believe the unit was closing. This was partly a difficulty of long admissions; in parents' minds there was always more time for things to improve. The unit became an endless feeding breast for the parent, and it was difficult for the parent to accept being weaned.

Anger

Many parents found it difficult to express anger with the unit about the closure, even after the unit had closed. I spoke with Mrs James after Sarah had been discharged and had experienced difficulties in school.

> *I said that perhaps it was difficult because the unit closed before the summer holidays, meaning there was a long gap and the staff were unavailable to liaise with school in September. She agreed, and it sounded as if this was a thought she had had. She said brusquely – still, Woodlands is all gone now, we just have to sort it out. She was contacting the head teacher of another school, the LEA and she would speak to her MP, but no one was doing anything and she felt frustrated.*
>
> *(TC, 5th October)*

Due to the closure, Sarah had only had one school visit before discharge[37]. Yet Mrs James struggled to articulate any anger towards *Woodlands* about this. I wondered if her current anger with the authority figures was a displacement of her anger with *Woodlands*. It seemed that it was too painful for Mrs James to acknowledge this anger, as that meant getting in touch with the loss.

Scarlett's discharge had also been difficult, as she had been readmitted to another psychiatric unit. The distance in time allowed Mr Harris to reflect on the process of the ending.

> *He had realised that they had received Scarlett's discharge date the day before the announcement had been made about Woodlands closing. Scarlett's discharge date was the last day that the centre was open, although it had to be brought forward, because everyone had been transferred. I felt that he was saying that Scarlett's discharge was not based entirely on her needs. He said - yes maybe. I commented that it was difficult that Woodlands closed, just as Scarlett was leaving and it seemed like it was a shock. He said that he supposed it was. He felt that*

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[37] This was not the usual practice, usually young people would have spent a day or two there a week for at least four weeks before being discharged.

> *events were dictated by circumstances – it was not anyone's fault, but the timing was difficult. I said that it might have felt that they were being pushed out, which may have left them feeling upset. He said that he was not sure, but the whole thing felt sudden.*
>
> (*TC, 23rd November)*

He had more critical thoughts about the discharge. Yet, when I took these up with him, he avoided them. Again, this might have been too painful to think about, but I think that it was also linked with his difficulties in digesting feelings, which I will discuss further in the states of mind chapter.

Mr and Mrs Short also had difficulties expressing anger and disappointment about *Woodlands* closing. Mrs Short said

> *You have to just get on with it, [the unit closing] you can't spend your time thinking about what might happen. She seemed agitated.*

Mr Short continued:

> *they can't say that they are surprised, in a friendly tone. I asked them about this. He said – well obviously there was the move[38], then Dr MacDonald left. You look around and you think hmmm. He worked for the public sector and the same things are going on there too, so you have an idea.*
>
> *(S.5, 12th July)*

Mr Short presented himself as already knowing about the closure, which was a defence against his shock and anger. He identified with the professionals, and distanced himself from his role as a father. He later spoke about Caroline being upset about the closure, and found it difficult when I wondered if it was not just Caroline that was upset. In this way, Caroline had to carry the feelings for the family.

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[38] The unit had moved premises during Caroline's admission, although not during the time of the study.

Caroline's discharge had also been problematic. She was transferred to another unit and then discharged home and then readmitted, as her weight decreased at home. Yet, Mrs Short found it difficult to express anger towards *Woodlands*.

> *She said it has been difficult getting used to somewhere new. The new unit has a very different approach and it is difficult to know what you are supposed to do. At Woodlands the staff were so lovely. They could not fault them. I said that it was difficult that they were not there to support her. She agreed. I said that perhaps it had been difficult with the unit closing, and she may have wished that Woodlands could have done things differently. She said no – they had done all they could... Caroline had fond memories of the groups and the trips.*
>
> *(TC, 19th October)*

Mrs Short idealised the *Woodlands* team. Her description felt empty, and did not reflect her feelings about staff at the time. Mrs Short denigrated the unit, by saying that it had done all it could. She suggested that its legacy had been to provide trips, which implied that it had been an ineffective treatment. However, her anger was passive and split off and Mrs Short remained in this disconnected state. She may have needed to idealise the unit to protect it from her attacks and to avoid processing the loss of *Woodlands* a meaningful object.

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A similar process happened during the phone-call; she said enthusiastically how lovely it was to hear from me, yet she then described her new support:

> *She said that a worker had visited her a few times – but she did not find her helpful. She said that she was not sure why – maybe it was a personality clash or something.....but she was more of a nuisance. I wondered to myself what Mrs Short made of my phoning her, and noticed I felt on edge, as if she was humouring me.*
>
> *(TC, 19th October)*

Mrs Short had been unable to voice anger with the staff at *Woodlands*, but her anger was located with the new team. It was perhaps difficult to feel that it was worthwhile linking with new staff as Caroline would again be discharged at some point, which would end these new relationships. I wondered too about Mrs Short's comments in the transference – her initial comments about it being lovely to hear from me may have been an attempt to protect me from her hostility, especially as I too had left her.

In contrast, Melanie's parents could express feelings of anger and disappointment about *Woodlands* closing.

> *Mrs Barnes said that she was at a friend's house when Dr Hinchley told her the news. She said that she had wanted to kick the table, but she could not, because she was at a friend's house. She laughed. I said that she felt really angry and upset about the closure. She said that she felt that they had been blown out of the water.*
>
> *(S.6, 13th July)*

Mrs Barnes felt that she needed to repress her anger because she feared the damage it might do both externally, but also internally. It was especially complicated because she was uncertain about who she could be cross with, as she was aware that the staff were losing their jobs. Therefore, she felt she had no container for her anger. After one of our sessions, she wrote to the chief executive voicing her complaint, as if she had some hope her anger could be tolerated.

Having been able to voice their anger, Mr and Mrs Barnes were able to think about Melanie's next admission. They had visited a potential unit and told me about the treatment:

> *Mr Barnes said that the new unit had a different approach and he thinks that this approach might be good. Mr Barnes said that there was a hydrotherapy pool, as well as a physio gym. Melanie loved swimming and so going to a hydrotherapy pool would be great. Mrs Barnes said and the gym would be good for her too. I said that they imagined that these changes could be helpful changes. Mr Barnes said – yeah the consultant said that they would start working on some different things,*

> *which I think she is ready for. He added that they seemed to have a firmer approach.*
>
> *(S.6, 13th July)*

It could be argued that Mr and Mrs Barnes' enthusiasm for the more novel aspects of the treatment, such as the gym, and the pool, were ways of avoiding the loss of services at *Woodlands*. However, they were thinking about Melanie's interests and there was a sense that they knew Melanie and had some confidence in making decisions. They also picked up the difference in approach and could think about it, which placed them in a better position to prepare Melanie and themselves for the next stage in her treatment.

New teams

The discharge to community based teams has been found to be difficult for patients (Treasure et al., 2011) and it has been highlighted as a difficultly in other studies when families transfer from specialist teams to CAMHS teams (Kingston et al., 2013). In this study, many parents avoided involvement with the new teams. It was perhaps difficult for parents to think about beginning new relationships when they faced a huge challenge and had to leave a service. Waddell (1998), when thinking about psychic defences in infancy, argued that when an infant is faced with overwhelming psychic pain, he/she can withdraw into a closed off state. The parents were not in a closed off state, but they struggled with their anxieties at this time and withdrew. This has some similarities with Szmukler et al.'s study (1985), which reported that parents with high expressed critical emotion had a greater rate of dropping out of follow up treatment.[39] Parents who were unable to think about their anxiety may have resorted to blaming others, which meant they were less likely to continue to engage in treatment.

Mr and Mrs Short found it difficult to think about which team Caroline would be transferred to. When a decision was made, they remained vague.

> *I asked how they felt about the new unit. Mr Short said that they have seen the new unit and it looks nice, and the staff seem friendly, but they*

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[39] This was also found to be linked with their children dropping out of treatment.

> *had no idea about the treatment plan. He laughed. I was puzzled. I said that there seemed to be some uncertainties. He said – yes we will just have to see....*
>
> *(S.5, 12th July)*

Despite having visited the new unit, they seemed disconnected to it. My curiosity was also killed off, as I asked them very little. It was difficult to imagine that parents agreed to their child being admitted to a unit where they had no idea of the treatment plan. I think that Mr Short was relieved that there was another unit that would 'take' Caroline, which meant that they did not have to look after her at home. This unit was their local unit, so they could be more involved in the treatment. Mrs Short insisted that the unit was not much closer. I think she needed to feel that she would not have to be more closely involved, as she felt ambivalent about parenting Caroline. Mr Short's statement also suggested his annoyance with the professionals, that they had not communicated their plan effectively, which his laughter attempted to cover.

Conclusion

Transitions are a major feature of the emotional life of parents when their children are inpatients. They had to bear feelings of loss and particularly a sense of loss about their changed relationship with their child. They also had to manage drastic separations, which for all parents were problematic. Their own histories of separation seemed to have a significant bearing on their ability to separate from their child in hospital. The separation from the unit also seemed difficult for parents and they engaged many defences to manage this. Interestingly, the defences employed in thinking about the loss of the unit were more striking than defences in relation to the loss of their child. This may be because the loss of the child was accompanied by more mixed feelings, which I will explore in later chapters. It may also be easier to think about the loss of something more tangible and permanent such as the unit, rather than that of their child, which was more elusive and terrifying.

Findings Chapter two:

States of Mind

In this chapter, I will look at the states of mind that the parents experienced, such as blame, guilt, helplessness, loss of confidence, and envy. I will draw on psychoanalytic theory to understand these states further. There were some psychic processes which resonated strongly with those of the young people, for example splitting and projection, parents' ambivalence about accepting help and their difficulties digesting emotional experiences, which I shall explore towards the end of this chapter. It was interesting to note the variation between parents in relation to these feelings, for example some parents blamed themselves for their child's eating disorder, whereas others were unable to think about this.

Blame

Many parents wondered why their daughter had developed an eating disorder. Treasure et al. (2011) found that parents often felt blamed when professionals asked them about the causes of their child's eating disorder, whilst other studies (Cottee-Lane et al., 2004, Anonymous, 2001 and 2012, and Davenport, 2008) found that parents were already preoccupied by this question. Issues of cause and blame are complex as historically anorexia has been linked to the mother's relationship with the child (Bruch, 1978).[40] Mothers' eating behaviours have also been linked with the development of eating difficulties in their children (Stein et al., 1996 and 2006). Furthermore, psychoanalytic approaches link eating disorders with the infant's feeding relationship, which colours the infant's internal world (Lawrence, 2008). Yet this can be misunderstood by parents and professionals. Other psychoanalytic writers have linked eating disorders with the child's relationships with his/her caregiver. Williams (1997) found that some patients with anorexia had experienced parents who had projected into them. Family therapy approaches have also linked eating disorders with family patterns of relating (Asen, 2002). Russo (2012) has argued that by recommending family therapy it can suggest that the family are to blame. Furthermore, there is research on the impact of postnatal depression on mother child relationships (Field, 2002 and Murray, 1991). Given that four out of the five

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[40] This is now outdated.

mothers raised their postnatal depression[41], this may have been on their minds. Therefore, it can be difficult to think about causes without issues of blame arising.

The parents in this study had different ways of conceptualising why their child had developed an eating disorder; some blamed themselves, whilst others located blame elsewhere. Parents also had different motivations, often unconsciously, for their attribution of blame. Some parents believed that staff blamed them for their child's illness, which could be their projection of their criticisms of themselves. However, Scholz (2005) pointed out that staff often held negative opinions of parents[42].

Scarlett disclosed that she had been sexually abused, which was shared with her parents.[43] Both Mr and Mrs Harris were upset on hearing this, yet Mrs Harris also felt this provided a cause for Scarlett's illness.

> *I commented that she had been very upset last time we met. She agreed and said that she had gone home and had a good cry. She said that knowing about the abuse was a relief. She added that she was obviously not glad that this had happened, but it made her understand…. She was always asking why had Scarlett developed anorexia, and she did not know, but now it makes sense. I sensed her relief. I wondered if she had spent a lot of time puzzling about why Scarlett had become ill. She nodded. She said that she had stopped feeling so much like 'it must be me, what have I done*?'
>
> *(S.3, 1st June)*

There is some evidence of sexual abuse causing eating disorders (Smolak and Murnan, 2002). However, on learning about Scarlett's abuse, Mrs Harris stopped thinking about her role in Scarlett's illness, or her divorce and the

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[41] Mrs Short had suffered from chronic depression, Mrs Harris, Mrs Roberts and Mrs James had all had postnatal depression.

[42] This was particularly because parents are deskilled by their child being in hospital and so when the child spends time at home with the parent, the child has often lost weight.

[43] The abuse was historical and the perpetrator was outside of the family.

separation from Scarlett, her postnatal depression, or her eating disorder[44]. Mrs Harris also avoided thinking about her role in protecting Scarlett from the abuse. I am not suggesting that these issues were Mrs Harris' fault, but because she wanted to locate an external 'cause', it limited her thinking.

Mrs James was also keen to find an external reason for Sarah's illness. She initially settled on the idea that there was a 'genetic' cause.

> *She said that 'you go through your head wondering why and what you did wrong – and the professionals do not tell you'. She said that she used to read books about anorexia – but they were difficult to understand. The only book that had helped, explained that anorexia was genetic.*
>
> *(S.1, 10th February)*

Mrs James wanted to find an external cause to reassure her that it was not her fault. She later linked Sarah's anorexia with bullying. Again, this was another 'cause' that did not involve thinking about family relationships. As I discussed in the transitions chapter, in this family there were stresses and separations early in Sarah's life[45]. Through our work and the work with the team, Mrs James was able to think more deeply about the reasons Sarah developed anorexia.

Yet her thinking about Sarah's emotional life was lost after Sarah was discharged and there was no further parent work. Mrs James explained:

> *She felt that school was the reason that Sarah got ill; she was bullied and Mrs James was not letting that happen again. I was disappointed that her thinking had reverted to an earlier explanation for Sarah's illness. Mrs James said that people at school think anorexia is just being skinny, but it is a serious mental illness. The school should have been able to accommodate Sarah – they take pupils with autism.*
>
> *(TC, 5th October)*

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[44] She was bulimic in her early twenties, but was never hospitalised.

[45] See table 2, in methodology chapter.

Mrs James had reverted to blaming others for Sarah’s illness. Although there are links between autism and anorexia (Baron-Cohen et al., 2013), autism and anorexia are understood as different conditions. I suspect that Mrs James placed them together when she thought about anorexia being caused by genetics. Furthermore, because Mrs James could not think about her role, she was not in touch with her guilt, which may have driven her protectiveness of Sarah in terms of school.

Other parents wondered directly about their role in their daughter’s eating disorder.

> *Mrs Short said that she thought that Caroline’s difficulties were her fault. She felt that when Caroline scratches herself, she is the one doing it. She knew that this was untrue and it was only in her maddest of moments that she thought that. I felt shocked, and wondered why she thought it was her fault. She said that she was unsure, but it has to be something she has done. In her madder moments she has to check that she was not….. she trailed off and said - no that sounds too mad. I again felt shocked about her confusion. I spoke about her fear about the damage that she had done to Caroline and I asked her about this. She looked pained and added that she thinks that if she was never born none of this would be happening. I commented that she felt that she had brought Caroline only bad things.*
>
> *(S.3, 20th April)*

Mrs Short was so despairing she had lost her grip on reality. I wondered if she held herself accountable because she had experienced mental health difficulties, and was aware that this may have had an impact on Caroline, or she may have feared that she had given Caroline her ‘bad genes’. This was complex as eating disorders have been linked with mood disorders in family members (Cooper, 1995), which we discussed. Mrs Short’s idea that she could be harming Caroline could also have been a result of her aggression towards Caroline, which she felt guilty about. This may have led to her own self harm, which was to remonstrate with herself for being a ‘bad’ mother.

Mr Short took a more distanced view about their role in Caroline's eating disorder.

> *He did not think they were to blame. They had two daughters, one is fine and the other has this problem. He believed that it was genetic, and maybe they had some role to play, but it was complicated and lots of factors were involved. I found myself agreeing mindlessly.*
>
> *(S.3, 20th April)*

Mr Short gave a 'professional' answer. He seemed to want to reassure his wife, yet he did not meet his wife's despair and confusion, which almost forced her to continue to be the receptacle for blame. His vague answer may have been his way of warding off his guilt.

Mrs Roberts also blamed herself for Silvia's predicament. This was likely to be exacerbated by Silvia being placed in foster care. Yet, what Mrs Roberts blamed herself for was complicated:

> *She explained that Silvia ended up living with her parents. She should not have let this happen and shook her head. This was her biggest mistake. There was a sense of sadness and anger. I said that she felt very bad about this and blamed herself. She agreed. She said she felt that she was rubbish. I acknowledged this, and said that she felt that she had been unable to manage Silvia.*
>
> *(S.2, 30th March)*

Mrs Roberts berated herself for allowing her mother to care for Silvia, yet she also implied that Silvia's difficulties were a product of living with her mother, and therefore not her fault. She was unable to think about her relationship with Silvia. For example, Mrs Roberts had not understood why Silvia panicked when she terminated their phone-calls. Dr Hinchley had had to explain that this was part of Silvia's attachment difficulties. It was unclear whether Mrs Roberts understood this explanation.

I wondered if she was unable to think about her role in Silvia's illness, because she felt blamed by others, and in response, projected blame into everyone else. This dynamic became enacted when she told me about a disagreement with Dr Hinchley.

> *He got her back up when he had said that foster care would have been best for Silvia. She added that he also said that she should have rung the unit back the previous night. She said – but no one rang me back. He had responded that she was Silvia's mother, she should have tried again. This had upset her and she accused him of not having Silvia's best interests at heart. He had left abruptly and she was cross. I said that she felt blamed by him and then blamed him.*
>
> *(S.7, 1st June)*

Mrs Roberts and Dr Hinchley were caught in a cycle of blame. This probably reflected Mrs Roberts' paranoid state of mind, which had been fed by her mother's criticisms of her and the professional network's lack of confidence in her, as well as her husband and older daughter's decision to leave her. Silvia's projections may also have contributed to her state of mind. Klein (1928) argued that some girls fear that they will be unable to become mothers because they are worried about their mothers' retaliation towards them for their aggressive attacks towards their mothers and their babies. Although I do not know enough about Mrs Roberts' history to comment on this in her case, she had a younger brother who died in childhood, so she may have experienced her mother taking custody of Silvia as retaliation for any destructive wishes she had harboured towards her brother. This blame was then re-enacted within the network.

As Mrs Roberts had a retaliatory pattern of relationships in her mind, she could get drawn into a similar pattern with Silvia.

> *She said that Silvia sometimes said – it's alright for Mrs Roberts - she can do things. I wondered how Mrs Roberts responded. She said that she felt cross. She had used to say - well that's because I haven't got an*

> *Eating Disorder. She seemed embarrassed and said that she should not have said this. I wondered if she felt cross that Silvia seemed to be blaming her.*
>
> *(S.6 18th May)*

Mrs Roberts' feeling of blame was so difficult to bear; she retaliated and blamed Silvia. Mrs Roberts' shame suggested that she felt guilty about her response. One imagined that Silvia was left feeling angry and bad about herself.

Melanie's mother also struggled to think about who was to blame for Melanie's illness.

> *She said that the last thing you want staff to think is that you are being insensitive, or making her worse. I spoke about their fear that someone thought that they were getting things wrong. They nodded. I wondered if they feared that they had made Melanie ill. I noticed my anxiety, as if I could be seen as blaming them. Mrs Barnes said – no, she knew it was not their fault. Mr Barnes said that you just don't want staff thinking we are not helping Melanie.*
>
> *(S.5, 1st June)*

A critical part of Mr and Mrs Barnes had become split off and projected into staff, so that they felt blamed. My anxiety suggested the difficulty of putting this into words. Given that there had been no external difficulties, it was hard to think that Melanie's illness was related to this family.

Because Mr and Mrs Barnes felt anxious around issues of blame, they were unable to help Melanie with this task.

> *Melanie had asked Mrs Barnes why did the illness happen to her. I asked Mrs Barnes what she thought Melanie might think. Mrs Barnes seemed surprised, as if she had not had that thought. She said that next time, she will ask Melanie. I commented that Melanie might have ideas and may think that it was something that she had done. Mrs Barnes agreed. She*

> *said that she had tried to say reassuring things like – illnesses can strike anyone, you were unlucky, we don't know why people get ill. I wondered if it was difficult to discuss. Mrs Barnes agreed because she did not understand either...*
>
> *(S.8, 16th October)*

Mrs Barnes spoke in clichés about the illness and the conversation could not develop so Melanie may have been left feeling that it was something that cannot be thought about. Mrs Barnes could also fear that if she stirred Melanie's curiosity, Melanie might voice an idea that it was Mrs Barnes' fault.

Mrs Barnes had considered reasons for Melanie becoming ill, but found it upsetting.

> *She had asked herself why us? She had done everything right. I commented that she felt that this was not supposed to happen. She said – exactly – this was not in my plan. She thought that Melanie was like her, she had high expectations of herself and when they do not materialise, she cannot cope. She still believed that she was right to stay at home with the girls and give them a stable upbringing...but it shakes your views. She added that maybe Melanie would not have made such a good recovery if she had not been there for her and if her family were more dysfunctional. I said that she felt that she had given her children something good, but the illness made her doubt that. She nodded and said you see other dysfunctional families and you think what did we do wrong?*
>
> *(S.7, 25th September)*

Mrs Barnes feared that she had done something to make Melanie ill. Mrs Barnes seemed to think that families were either 'dysfunctional' or not. It was harder for her to think that each family had 'dysfunctional' elements and that despite her efforts, they could not avoid difficulties.

Mrs Barnes later asked whether Melanie’s difficulties may be symptoms of bipolar disorder. Perhaps it would have been easier to think about Melanie having a mental illness that can have a genetic basis. Furthermore, Mr Barnes’ mother had bipolar disorder, therefore blame could be apportioned to that side of the family. Yet this question may also have revealed an anxiety about whether the illness was an ‘episode’ or the beginnings of an enduring mental health difficulty.

Many of the parents remained confused about the aetiology of their child’s illness. This correlated with other accounts of parents of children with eating disorders (Anonymous, 2001 and 2012 and Davenport, 2008). It was difficult to discuss aetiology without getting caught in issues of blame or self blame. Cottee-Lane et al. (2004) felt that clinicians needed to offer more help to parents with this task. However, for many parents there were unconscious reasons for apportioning blame, therefore, one would have to think about how help was offered.

Guilt

Some parents felt guilty about whether they were to blame for their child’s illness. This has been found in other studies of parents who have had children hospitalised for anorexia (Treasure et al., 2011 and Whitney et al., 2005), but guilt was also commonly reported by parents who have had children hospitalised for paediatric reasons (Palmer, 1993). Furthermore, parental guilt has been noted in parent work in other contexts (Jarvis, 2005). Some parents struggled to continue their lives outside the hospital, some parents felt guilty about treatment choices they had made, and some felt guilty about their interactions with their child. Feelings of guilt about siblings did not arise in this study, although have been found in parent work in other contexts (Mendelsohn, 2005). Parental ambivalence about the child seemed linked to the parents’ feelings of guilt. This correlated with Klein’s thoughts on guilt, which she argued arise when dealing with conflictual feelings of aggression and love, and is motivated by ‘a wish to make good’ (1937, p.310).

Parents struggled to feel that they could continue with their lives when their children were in hospital. Mr Harris said:

> *'There is that thing of not wanting to have too much fun, because you feel guilty...' how could he enjoy himself when Scarlett is so ill. I commented that he felt that he should not enjoy himself. He said 'it gets easier, you realise that life does not stop… but initially you cannot enjoy yourself, because you are so worried'.*
>
> *(S.1, 16th March)*

I wondered if Mr Harris' ambivalence about having Scarlett home complicated his guilt. Whilst Scarlett was in hospital, he could continue with his life and see Scarlett, but he did not have to look after her, which he found draining.

Mr and Mrs Short likewise felt guilty about continuing with their lives. They had visited Mrs Short's family, which was their first 'break' without Caroline, but had argued.

> *Mr Short wondered whether because they were away, they were not allowed to enjoy themselves. Mrs Short looked cross and disagreed – she never enjoyed visiting her family. Mr Short agreed but added that Mrs Short felt that they cannot take a holiday either, because they cannot have a nice time and leave Caroline. She said that this was totally beside the point. Mr Short said he was just wondering and sounded hurt. I commented that it sounded difficult to feel that they could have a break when Caroline was here. Mrs Harris said that she supposed that they could go out for the night, they don't, but they could….Mr Short said that they would have to check with the centre first and with plenty of notice they could maybe miss a phone-call with Caroline.*
>
> *(S. 3, 20th April)*

I think that if Mrs Short admitted feeling guilty about going away, that would equate to expressing relief about not seeing Caroline. She already felt guilty about causing Caroline's illness and so felt that she had to punish herself to make amends. Therefore, her guilt was narcissistic and its function was to relieve her of her bad feelings. Mr and Mrs Short's anxiety about having a night out was in relation to the staff, rather than Caroline, which suggested that their guilt was a persecutory guilt, where the concern was for the self rather than for the object. This could be a consequence of feeling marginalised by the unit, and losing sight of Caroline.

Mrs Short also felt guilty about her interactions with her daughter, which seemed closer to guilt, rather than the self blame I discussed earlier.

> *She said sadly that Caroline will barely drink a glass of water with them. I commented on her sadness about this and asked if they had eaten together since Caroline had been admitted. Mrs Short said – no and added that mealtimes were never easy, even before Caroline was ill. I wondered about this. She said 'trying to find something that pleased everyone and trying to keep them all happy, I don't know, it was just never easy' she snapped.*
>
> *(S.5, 12th July)*

It was likely that Mrs Short had found it difficult to emotionally feed her daughters too, without resentment, given that she had her own difficulties and her relationship with her mother was poor. It could be hard to allow them to receive the 'mothering' that she had not. Mrs Short's comments suggested that meeting her daughters' different needs was too demanding. She then felt persecuted by her daughter's rejection of her food. My questions were experienced as another demand.

Mrs Roberts also felt inhibited by her guilt in her life outside hospital:

> *She used to feel bad about doing things without Silvia. If someone invited her and her older daughter out, she declined because Silvia was not there. I wondered about this. She said that it is hard to do things thinking that Silvia is here – and that she [Mrs Roberts] should be looking after*

> *her. It is particularly hard when she is upset or has had a difficult week. It felt wrong.*
>
> *(S.6, 18th May)*

Mrs Roberts' guilt about doing things with her older daughter resembled what had happened when Silvia was born when she had wished to only manage one child. Her wish to look after Silvia now was perhaps to appease her sense that she had neglected Silvia previously.

Mrs Barnes' guilt seemed to relate to treatment choices she had made. Melanie had made slow progress at *Woodlands*. When she was transferred to the new unit, she made progress quickly. Her parents understood this as Melanie being ready to change, but they wondered about Melanie's treatment in *Woodlands*.

> *Mrs Barnes said that she was cross about the physiotherapist at Woodlands, who said that Melanie would not need physio, her walking would return once she was moving. This had made sense to them, as they knew there was nothing physically wrong, and like most things, they thought that Melanie's walking would return. She said whereas here Melanie has had lots of physio and that has helped. The physiotherapists said that they would have started physio months ago. Melanie may have been able to walk already, but now her recovery was going to take longer. I said that this was disappointing. She agreed and added – it's not something that cannot be fixed, it's just going to take longer. She said – but when someone makes a recommendation... I said that she did not know, but felt as if they should have known. She said – 'yes, it's silly really. I wonder what would have happened with her walking if she had stayed at Woodlands.' I felt that she was questioning their decision to have kept Melanie in Woodlands, but it felt too painful.*
>
> *(S.7, 25th September)*

Mrs Barnes seemed to feel guilty for not challenging staff views at *Woodlands*, which was complicated for many reasons, which I will explore in the relationships chapter, but her guilt could be due to her and Mr Barnes' ambivalence about having Melanie home, which meant that unconsciously, they did not challenge decisions that slowed Melanie's progress. However, it was also possible that Mrs Barnes felt a depressive guilt that Melanie missed out on something and wished to repair this.

Jarvis (2005), when writing about community based parent work, found that guilt showed little evidence of change over the course of parent work. She wondered if this was because the instrument that was used to measure this (SIPA, Sheras et al., 1998) did not distinguish between persecutory guilt and depressive guilt. She felt that depressive guilt may have remained because it was motivated by feelings of love and concern. I think that this might have been the case for Mrs Barnes.

Helplessness

Many of the parents felt helpless, in relation to the process of hospitalisation and their abilities to manage their child's eating disorder and reach their child emotionally. Feelings of helplessness have been found in other studies of parents who have had children with anorexia (Whitney et al., 2005). This is not unexpected given that the children presented with extreme difficulties, which Klauber (1998) found left parents of disturbed children feeling ineffectual. Nunn (2008) also found that parents of children with eating disorders often felt helpless at the point of seeking help, as they had already tried many treatments that had been unsuccessful. Feelings of helplessness and higher stress in parents have been associated with a longer duration of the child's illness (Whitney et al., 2005). Given that the patients in this study had been unwell for a long time, parental feelings of helplessness were unsurprising. The sense of helplessness spilled into the parents' lives outside the hospital. Feeding one's child is particularly emotive, as it is life giving and almost the first task one does as a parent. Therefore, when one cannot do this, it understandably left parents feeling adrift and lacking in resources.

Mr and Mrs Barnes felt powerless because the doctors did not know what was wrong with Melanie.

> *Mr Barnes said that the doctors did not understand their desperation – she was deteriorating! Mrs Barnes said that later that day - she could not get the TV to work. For some reason that made her so angry and she felt hopeless about everything. She could not even get the stupid TV to switch on! She laughed. She had then joked to the nurses that the only way that she was leaving the ward was to go to a psychiatric hospital.*
>
> *(S.1, 16th March)*

Mrs Barnes' anger and frustration with the doctors and herself, for also not knowing what to do, was displaced onto the TV. She felt impotent. Her comment to the nurses communicated that she felt so helpless she needed looking after.

Mr Harris felt helpless in relation to understanding Scarlett:

> *He said that the problem is that Scarlett will not tell us what she needs...it is impossible then to know what to do – what activities to do, or what she would eat. He is not a mind reader. I felt his crossness.*
>
> *(S.1, 16th March)*

Mr Harris had little sense that he could think about Scarlett's needs. [46] Scarlett may have felt unreachable, which possibly linked with her experiences of sexual abuse. The emotional distance he felt may also have been a consequence of Scarlett's lengthy hospitalisation and his feeling that the staff understood her, which I will look at further in the chapter on relationships.

Helplessness was also evident in relation to Mrs James' ability to understand Sarah.

> *She said that Sarah had always been particular. All her kids have had their things – Tweenies, Teletubbies, Bob the Builder, but Sarah didn't.*

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[46] One could argue that this was a difficultly bringing up a teenage girl as a single father, however this seemed unlikely as he had raised another daughter.

> *She encouraged Sarah into things, but nothing stuck. Her younger daughter's birthday was 4 weeks before Sarah's and Sarah had loved her sister's dolls, yet when she bought them for Sarah, she was not interested. She added that it was the same with hobbies. Sarah had tried swimming, dancing, taekwondo….She always gave up and lost interest. Mrs James seemed puzzled. She recalled that Sarah had had her room decorated a particular colour and wanted everything colour-matched. She chose a paint that was difficult to match and each time they tried Sarah was disappointed it didn't match. I spoke about Mrs James' feeling that it was hard to reach Sarah.*
>
> *(S.2, 9th March)*

Mrs James conveyed a feeling of a 'mismatch' between Sarah and herself. It was as if there were some missteps in the dance between them (Stern, 1977), which left Mrs James feeling at a loss in terms of helping her. Mrs James felt that it was impossible to understand Sarah's behaviour; she could not imagine how Sarah might have experienced receiving the same birthday present as a sibling.

This feeling of helplessness was apparent generally for Mrs James. She procrastinated about whether she and the children should move house.

> *She said that she was exhausted with the travelling between home, here and her mother's house. She explained that they could move to X town. Sarah would like to move schools and have a fresh start. However, her other children did not want to move. She did not want three unhappy children and Sarah being ok. I spoke about the pressure she felt to make this decision and to meet all of their needs. She agreed and acknowledged that she should take them to look around the schools, but she didn't have time. She sighed and said that she did not know what to do. I said that it was hard thinking about what would be best for their family.*
>
> *(S.2, 9th March)*

It was particularly difficult for Mrs James to make this decision as a single parent, and so she tried to draw me into the decision process. She had spoken of making ‘wrong decisions’ previously, and so her confidence was fragile. She doubted that she had enough resources for everyone, and got into this helpless state of mind.

Loss of confidence

Parents’ feelings of helplessness were linked with a loss of confidence in their parental skills. The fact that an admission was required suggested that the parents were unable to manage their child[47], which is a blow to one’s confidence. However, parents raised other experiences which added to their loss of confidence.

Mr Barnes explained that he found it difficult to adjust to new ways of doing things.

> *How to manage your child is the most natural thing. We are a family and she is our daughter. If she were any other 9 year old behaving like that – you would give her a swift talking to, but with the illness... He trailed off. I spoke about the illness constraining their skills and instincts. He said that ‘you lose confidence as a parent - you think - what about this, what about that….’ Mrs Barnes nodded and said that ‘you lose confidence; you have to learn all these other ways’.*
>
> *(S.3, 4th May)*

Melanie’s illness undermined their parenting and their identity as competent parents. When they felt unsure, they lost confidence in their experience. Their relationship with staff also had an impact on their confidence, which I will look at in the next chapter.

Mr and Mrs Barnes’ comments below reflected how much they had lost confidence in themselves as parents.

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[47] That is not a criticism of the parents, as many of these children were extremely ill and had already failed treatment in other institutions too.

> *Mrs Barnes said that when Melanie was so ill, you had to hand her over and let the staff take all responsibility, but now they needed to take more responsibility. I spoke about the confusion about whether Melanie was the hospital's child or whether she was their family child? They said yes exactly.*
>
> *(S.5, 1st June)*

Parents whose infants have been hospitalised in neonatal wards (Mendelsohn, 2005), have expressed similar sentiments, yet Mr and Mrs Barnes were experienced parents, but the illness and Melanie's hospitalisation had ruptured their confidence completely. Mrs Barnes could not think about how she could help Melanie to reintegrate into school and needed reassurance from professionals.

Mrs James also spoke about her loss of confidence as a parent.

> *She said – 'to be honest I could not cope, and I had no confidence. It was brilliant seeing the nurses deal with Sarah, and seeing how they responded to her.' She could not have done this.*
>
> *(S.3, 12th June)*

Mrs James, although needing help, felt that the professionals were right and that she had been wrong. She then became dependent on staff approval. Although she had managed the supervised meal with Sarah, she had wanted staff present to reassure her. This may have been because of her fear of her frustration with Sarah, should Sarah become difficult, or her ambivalence about taking on a full mothering role. However, it seemed largely connected with her need for support.

Narcissistic involvement

The parents' lack of confidence seemed connected with their sense that their children were reflections of their parenting. Child outcomes are often viewed as a consequence of parental input. This view recedes in adolescence when there are more variables in a child's life, yet when the parent and child had been unable to separate, as had many of these parent child dyads, parental input remained heavily weighted, which meant that when the child was struggling, parents viewed this as their failure.

Mr and Mrs Short viewed Caroline as a reflection of themselves.

> *Mr Short said that they felt smug about the teenagers that they had gotten – they did not have the nightmare teenagers that you hear of, they were well behaved and teenagers you wanted, which meant that they must have been doing things right. He looked pained as he said this and added but - no….*
>
> *(S.1, 9th March)*

Mr and Mrs Short's sense of their parental capacities was fragile. Whilst both daughters were doing well, they were reassured, but when they encountered difficulties it was hard to bear. I wondered if this also related to Mrs Short's anger about the decision to readmit Caroline to another unit after she had been at home for a short time. She may have experienced Caroline's readmission as a judgment of her parenting.

Mrs Harris had a similar struggle. She felt that Scarlett's progress was a reflection of her maternal abilities.

> *It was helpful having a second daughter that was doing ok. She did not know how she would have managed if Scarlett was her only daughter. Olivia always told her how great she was. A friend had asked her, why are you listening to the daughter with the mental health problem. This made her think, why was she listening to Scarlett about her failings, rather than to Olivia and everyone else who told her that she was a good mum.*
>
> *(S.3, 1st June)*

Mrs Harris needed reassurance. Olivia, whilst not in hospital, was also struggling in certain areas, but Mrs Harris was unable to recognise this, because it was too persecuting. Furthermore, when Scarlett's discharge had been premature and she was readmitted to another unit, Mrs Harris avoided thinking about this, because she felt persecuted by Scarlett requiring another admission.

Mrs Barnes had a similar narcissistic involvement in relation to Melanie's progress,

> *She said that one of the physios commented that she had had a mature eight year old stand up. Mrs Barnes said that she was furious as it made her feel that Melanie was not mature and she knew that she was; before the illness she was very mature.*
>
> *(S.1, 16th March)*

Mrs Barnes seemed to attribute this comment as a reflection that Melanie was immature because Mrs Barnes had not given her enough independence, or had spoiled her. However, over time, she was able to think about her separation from Melanie and was less dependent on Melanie's progress to feel reassured about her parental capacities.

Parker (1997) argued that mothers (and perhaps fathers too) need their children to prove that they are able to love, as well as that they are loved. Children's distress can then be interpreted as an accusation and revelation of their abilities to hate and their hatefulness. Clearly, this is very painful, which is perhaps why parents sought reassurance about their parental capacities elsewhere.

Envy

Another difficult dynamic that arose for parents, was their envy of their children's care.[48] Klein argued 'envy is the angry feeling that another person possesses and enjoys something desirable – the envious impulse being to spoil it' (1957, p.181). Parents could have felt that the young people were cared for

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[48] The parents' envy of the staff was also a theme, but I will look at that in the chapter on relationships.

very well whilst they were not, which perhaps led to parents unconsciously depriving their children of opportunities.

Mr Harris felt envious of Scarlett’s care.

> *He said that here if she cuts her finger, a trained nurse puts a plaster on it. If she drops something, it gets picked up. If she leaves her shoes on it does not matter - the floors are cleaned twice a day. They are wrapped up in cotton wool here – a bit spoilt, that is not how the real world works. At home, Scarlett did not take her shoes off. He had to tell her. He had also told her that if she leaves her clothes lying around, no one will pick them up, it is tough*.
>
> *(S.3, 22nd June)*

In Mr Harris’ mind, Scarlett seemed to be staying in a hotel. It was interesting that he gave an example of a cut resulting in care, as Scarlett self harmed, yet he minimised this. I think that he was envious of her care. He may also have felt exploited by Scarlett’s behaviour, and angry about having to make sacrifices, and so he attributed ordinary teenage behaviour to her care in hospital. His envy also seems also to have linked with his decision to avoid taking leave from work when Scarlett was discharged.

He had also applied to the health authority to fund twice weekly psychotherapy for Scarlett[49] upon discharge. This request was declined, and Mr Harris described himself as ‘phlegmatic’ about it. He agreed to fund once weekly therapy, even though twice weekly therapy had been recommended. This was probably a financial reality, however, in the light of his previous comments, one wondered if unconsciously twice weekly therapy for Scarlett felt like ‘too much’.

Mrs Roberts also struggled with her envy about Silvia’s treatment and the carers’ treatment.

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[49] This was because there was no local NHS psychotherapy provision.

> *She described the last meeting as horrendous - there were all these people, but they were for the carers or for Silvia. The social worker has to look after the carers, and the CAMHS team are providing an Eating Disorder specialist for the carers…Silvia has her therapist and the paediatrician. I said that she felt unsupported. She agreed and said that the family therapist could not come – the person that she knew. I said that this was disappointing and it perhaps felt unfair that everyone else was getting support whilst she was not.*
>
> *(S.3, 27th April)*

I suspect that Mrs Roberts felt envious of the carers, who were being praised by the professional network. They were married and had raised their children and had helped numerous foster children, which was in contrast to Mrs Roberts. Silvia was also being held in mind by the network, whilst Mrs Roberts felt that she was not. This was partly a difficultly when treatment is planned around the patient, rather than the family, particularly when parents are deprived. There may then be an unconscious wish to deprive the child of treatment. This could have been especially so around discharge when parents were losing their sessions, whilst their children gained new therapists.

A slightly similar pattern emerged in Mrs James' session.

> *She asked for a coffee. I felt surprised by her request, although parents were routinely offered a drink whilst they waited for meetings, and so this was organised. I commented that she sounded tired. She explained that she had been at the review and had had to leave home very early, which meant that her other children had to be dropped off at a friend's house, and then she got stuck in traffic. I felt that she needed to let me know how difficult her morning was and commented that she had had a lot to organise. She said yes – when the staff organise mid morning meetings, it might be suitable for them, but it is a rush for her. I acknowledged this. She said that that Sarah moaned if she was late, but she was not the one getting up.*
>
> *(S.4, 10th July)*

I think Mrs James was relieved that there was a group of professionals able to think about Sarah, but she also felt envious that Sarah was being thought about, when she felt she was not. She almost imagined Sarah and the professionals having a leisurely start, whilst she had to rush. Her request for a coffee was a demand for care. Her envy that Sarah's life was free from certain pressures meant that at times she struggled to have empathy for Sarah, for example, to imagine why her lateness might concern Sarah.

Parental Eating Disorder States of mind

Sohn (1985), in his work with adult patients with anorexia and bulimia, noticed that the transference relationship could be reflective of both eating disorders. For example, some anorexic patients had an insatiable greed, and some bulimic patients appeared to be very restrictive in their thinking. This led him to the importance of understanding the patients' anorexic or bulimic state of mind. He also noticed that these states of mind appeared in other patients without diagnoses of eating disorders. In my work with the parents, I noticed a similar phenomenon. Although I did not distinguish between anorexic and bulimic states of mind, many of the defences that parents used to help them manage their emotions, were similar to those that have been written about in relation to patients with eating disorders. For example, splitting and projection were noticeable. Furthermore, parents were ambivalent about accepting help. It was as if they had turned to their pseudo autonomous selves (Magagna, 2008), and displayed what Williams has termed 'no entry defences' (1997). Additionally, they found it difficult to emotionally digest feelings. This again posed the question whether young people develop eating disorders in families where there are difficulties processing emotions, or whether parents use certain defences because of the chronic difficulties they face.

Splitting

Segal (1957) argued that splitting off bad feelings about the self or the mother, and locating them in a third person, allows the child to have a good relationship with themselves or his/her mother. Splitting is often noticeable in patients with eating disorders. Patients make splits between their minds and their bodies, psychologically they do not acknowledge any difficulties and continue to live ordinary lives, yet are dangerously thin. Equally, patients with eating disorders often have rigid ideas about ‘good’ food and ‘bad’ food. Many parents had created splits about different teams. Three out of the six parents felt that the paediatric wards were terrible, and *Woodlands* was idealised. This discrepancy in parents’ feelings between paediatric wards and specialist units was found in other literature (Anonymous, 2001 and 2012, and Davenport, 2008). The ‘bad’ feelings may have needed to be projected into other units, so that parents could have a good relationship with *Woodlands*. Yet, this made it difficult for parents to express frustration with *Woodlands*. Many parents also understood their daughter’s illness by splitting the psychological and physical aspects, which meant that it was hard to integrate their understanding of their daughters. Furthermore, there was also a split between what the parents said and what they felt.

I will first look at the splits parents spoke about between teams. Mr and Mrs Barnes felt that Melanie’s treatment in the paediatric ward had been poor:

> *Mrs Barnes said that the nurses on the ward were awful. They knew nothing about mental health. She met a psychologist, but the psychologist did not know much about PRS. Mr Barnes said that only when the senior nurse from Woodlands assessed Melanie, things improved and the main problems disappeared. They then had a diagnosis and someone had seen it before. He added ‘and even better, there was a place that treated people with this, it was not untreatable – some children made a recovery’*
>
> *(S.1, 16th March)*

Mr Barnes’ relief about receiving a diagnosis, and information from the nurse, correlated with (Hilton et al.’s, 2012) research about what parents valued from mental health services. Mr and Mrs Barnes attributed their frightening experiences on the paediatric ward to the ‘bad’ staff. It was then difficult to voice critical feelings towards *Woodlands*, because they had decided that this was the ‘good’ place. I wondered about their feelings of disappointment that the admission was longer than expected, and whether they felt staff should be doing anything differently.

> *Mr Barnes quickly said that they are not interested in short cuts. They do not want to push things too quickly and they know what would happen. Mrs Barnes agreed – they wanted Melanie to have a full recovery.*
>
> *(S.4, 18th May)*

They found it difficult to think that *Woodlands* might also have limits, because that risked leaving them with another hospital that would fail Melanie.

Mrs James was scathing about their treatment in their previous CAMHS and the paediatric ward.

> *She thinks that it is so wrong that the ward took this attitude with Sarah that she was being naughty, it made her worse. Everything that they told her was wrong. Even CAMHS had not done much. She could not believe the lack of information about the illness in that team, it was terrible. She had had to learn everything here from the nurses.*
>
> *(S.3, 12th June)*

Like Mr and Mrs Barnes, she needed to trust that the current team were knowledgeable and could offer hope. The difficulty was that Mrs James also disagreed with things in *Woodlands*, but because this team was ‘the good team’, it was difficult to voice critical feelings.

Mrs Roberts too was unhappy about the paediatric ward and previous CAMHS support.

> *She said that Silvia was in the paediatric ward for 6 – 8 weeks. It was awful there. The staff were kind, but they did not know what they were doing. They did not know enough about anorexia. They were relieved that they could return to Woodlands. I said that she was pleased that Silvia could come somewhere familiar. She agreed and added that when*

> *Silvia saw Dr Hinchley, her face changed, something went, the anxiety and unhappiness melted away.*
>
> *(S.1, 23rd March)*

Mrs Roberts felt again that the staff on the ward lacked knowledge about anorexia, whereas there was almost a magical cure at *Woodlands*. Once the split was established, it was difficult for Mrs Roberts to express her anger with *Woodlands*, which was complicated when *Woodlands* involved social services, which resulted in foster care for Silvia. Mrs Roberts located her crossness with social services and the foster carers, which established an unhelpful split in the network. She was very critical of the carers and did not work with them. This split must have linked with her experiences of her mother 'getting' Silvia previously, which it made it impossible for her to join the network around Silvia.

When the plan to move Silvia to foster care broke down, Mrs Roberts was pleased.

> *She said that she knew that it would not work. Sue and Graham were not right, and they did not know enough about eating disorders.*
>
> *(S.7, 2nd June)*

The foster carers were a receptacle for Mrs Roberts' feelings of not knowing and 'failing' with an anorexic child, which meant that Mrs Roberts avoided those feelings. All parents were critical about 'the other' staff lacking knowledge about eating disorders, as if 'knowing' about anorexia could make their children better. The success or failure of their child's treatment was then located in the hospital, although that could be a consequence of parents feeling chronically incompetent.

Another form of splitting was striking with Melanie's family. Eating Disorders encompass a psychological and physical disorder, but Melanie's parents separated the two things.

> *Mr Barnes said that for a long time they had struggled with the physical because Melanie was so unwell…. But now she is a bit better, this is less urgent and they were focusing on the psychological. Mr Barnes said –‘ you don’t want to push on with the physical stuff if she is not psychologically ready’. He needed someone to tell him psychologically if she was better. I queried this, and wondered if they felt able to judge this themselves, whether they may notice changes in Melanie? He said that he did not want that part to be neglected. They wanted things to be sorted in her mind.*
>
> *(S.4, 18th May)*

Mr Barnes had lost his ordinary parental capacity to think about his child’s emotional life. He saw psychological treatment as ‘part’ of her treatment, rather than running throughout the treatment. He felt unable to assess Melanie’s psychological state, perhaps because he felt unable to recognise his child. He needed ‘the experts’ to do the psychological ‘part’, which may be a consequence of being in a medical system divided by professional boundaries. I tried to help Mr and Mrs Barnes link the physical and psychological aspects of Melanie’s treatment.

There was also a split between what parents felt and what parents said. Mr Harris often said that things were going well for Scarlett:

> *He said that it was nice to see that Scarlett is interested in things again, like friends and college, which is good. She really seems to be motivated to come home and is working hard. It is so good to see her like this, more positive. Each weekend had gotten better and better. My heart was sinking as he spoke, and I found myself smiling vacantly.*
>
> *(S.2, 18th May)*

My response suggested that there was a disconnection between what Mr Harris said and what he felt. This was partly because I had some knowledge of Scarlett through the team, but was also related to my feeling of vagueness that

Mr Harris projected. In the same session, I commented that he had said that things were going well, but I was unclear.

> *He said that Scarlett had been home a few weekends ago and had self harmed, but only told him when she was at Woodlands. He was upset and had spoken to Scarlett about this. He had pointed out that he had done the things that she had asked him to do when she was feeling like this – spend time with her, distract her, but still she had self harmed and he was cross.*
>
> *(S.2, 18th May)*

Mr Harris had cancelled a number of sessions with me prior to this, as if when there were difficulties, he avoided them. Perhaps it was only possible for him to return when he had something positive to report. The split between saying that Scarlett was getting better, yet she was self-harming and neither of them talked about it, was striking. Scarlett perhaps also made use of splitting by giving the impression that everything was fine, yet self-harming. The splitting off of her self-harm can be seen to replicate Mr Harris's splitting and function as the family's way of dealing with unpleasant experiences. This linked with the function of self-harm, which can be a way of expressing psychological pain without digesting it or communicating it, especially in the context of a perceived fragile caregiver (Pocock, 2011) so that there is again a split between the mind and the body.

Likewise, Mr Short also split off his feelings when talking about Caroline.

> *He said that his oldest daughter was fed up of coming here. She wants to see Caroline, she just doesn't like being here. I acknowledged this. He paused and then added that Caroline had tried to do a runner, which is always good fun. He smiled, but looked sad. I felt shocked, but confused by his response.*
>
> *(S.3, 20th April)*

I imagined that Mr Short was also ‘fed up’ of coming to *Woodlands*, but could not say this. He added the most ‘shocking’ news at the end, yet, his joking style meant that it was hard to respond to this and think about it with him. His body language also reflected a split, as he was smiling, yet he looked sad.

Melanie’s parents similarly tended to make a split between what they said and what they felt, although it was more possible to think with them about these splits, using my countertransference.

> *Mrs Barnes said that they were feeling upbeat. They both said that the review[50] had gone well and progress was being made. I acknowledged this. Mrs Barnes added that Melanie’s eye contact was better in therapy. Mr Barnes said it was gradual progress. Mrs Barnes said it was good, there were many changes, Melanie was bathing, going outside was a possibility, and she had written a letter. I felt stuck and flat. I commented that they said that things were going well, yet there was a feeling of flatness. Mrs Barnes said that they were struggling with their role in Melanie’s recovery. Mr Barnes added that they were struggling with this a lot.*
>
> *(S.5, 1st June)*

My feeling of flatness suggested that they felt disconnected to the positive changes they reported. It was probably difficult for them to have negative feelings after a ‘positive’ review. Melanie was progressing, yet these changes were minute and one wondered about Mr and Mrs Barnes’ despair and confusion. Mr and Mrs Barnes split off these feelings, losing an opportunity to think about them. It also left them feeling overwhelmed by their feelings.

> *Mr Barnes said that they found themselves getting more upset about things that they usually cope with. It was ok when he had had a bad day at work, or something difficult has happened, he could say – oh well that is why and cut himself some slack. On Saturday it was not like that – he*

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[50] CPA review held on average every 6 – 8 weeks with staff from *Woodlands* and staff from outpatient teams and the family.

> *could not work out why he was so upset. I commented that he had seen Melanie on Saturday. He said – yes – but it was before the visit, it was a sunny morning and he was really upset, tearful and it came out of the blue. He thought he was past all of this. He had thought that he was not going to get so upset by things again without knowing why, but then it happened and it was a shock.*
>
> *(S.4, 18th May)*

Because Melanie's parents had split off some of their feelings, they were shocked when these emerged. They had lost their ability to make links. Through the process of thinking with a therapist, they began to link their states of mind with their experiences.

These parents may have had a tendency to make splits, but making splits can also arise from living with a child who had an illness that tended to make large splits. Klauber (1998) looked at a similar issue in her work with parents who had children with diagnoses of autism and psychotic illnesses. Often professionals thought that the children had developed a disorder because of the parents' chaotic or cut off states, rather than the parents had actually become chaotic and cut off as a result of dealing with an ill child.

Some approaches to anorexia almost encourage splitting by externalising the child's illness[51] (Lock et al., 2004), which aims to prevent the family from blaming the child. Therefore, parents talked about 'illness behaviours' rather than viewing these as part of their children. In parents who already make psychic splits, this approach did not help parents to understand their child's behaviour as a communication. Mrs James felt that Sarah's difficulties were due to anorexia and was unable to be curious about why Sarah might have become ill or the meaning of her behaviour:

> *She had noticed that Sarah had a few anorectic thoughts, and that Sarah could get angry with her. These outbursts were getting fewer though.*

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[51] This is an approach from narrative therapy, and attempts to separate the illness from the person, so that the person's relationship with anorexia can be thought about.

> *She knew that when Sarah was angry like that, it was not really Sarah it was the anorexia.*
>
> *(TC, 5th October)*

Mrs James dismissed Sarah's anger rather than understanding it as a relational issue. This helped Mrs James to avoid reacting angrily to Sarah, but it did not help Sarah to feel understood. This was seemingly a longstanding difficultly in their relationship, which led to Sarah finding other ways to express her distress.

Other parents viewed their children in rather split ways. Mr Harris explained that weekends when Scarlett had come home were difficult:

> *He said that the drive was hard for her, because she found it hard to be in the car for a long time. She then had breakfast at home and then they would have to have lunch… I felt that each meal loomed in his mind. He said that Scarlett would be so stressed that they could not do anything else. I said that the weekends were difficult for both of them. He said – well for Scarlett. His tone changed and he added that Scarlett was so brave on so many levels, each morning she had to get up and face something that she did not want to do.*
>
> *(S.1, 16th March)*

When I pointed out that weekends were difficult for both of them, Mr Harris seemed anxious, as if I had heard his frustration with Scarlett and became sentimental towards her. In my countertransference, I suddenly felt bored and distant, as if he was disconnected from Scarlett's position. He seemed to need to see Scarlett in this light, to protect her from his rage, should he talk about how difficult these weekends had been. Scarlett then became split in his mind, and he felt 'bad' for being frustrated with the difficult Scarlett, and transformed her into a victim.

Furthermore, the child being labelled as ill creates another split – that it is the child that must change, rather than the family. Mr Harris placed all the responsibility with Scarlett for her recovery. He felt that she would change when she was ready. His ex-wife similarly commented that Scarlett needed to manage her eating disorder. It was perhaps unsurprising that this discharge was unsustainable. When I spoke with Mr Harris after Scarlett was discharged and had been readmitted to another unit, his position had slightly modified.

> *He said coming out of hospital is sink or swim, it should not be the same at home as it is in hospital, because Scarlett has to adjust. I said that it seemed that this adjustment was too much for Scarlett. He said yes – that is why he thought when she is discharged next time, he will make sure that he takes time off work. This will be easier all around. I felt pleased to hear him say this, and felt that he had learnt something from the experience*.
>
> *(TC, 23rd November)*

There was some acknowledgment that he also needed to make changes. He perhaps felt that he was left to sink or swim by *Woodlands* closing, and so took a more distant attitude towards Scarlett, which may not have occurred if he had experienced a more gradual discharge.

Given that the child is hospitalised, rather than the family, one wondered if this exacerbates the split; that it is the child who is ill. Family life can continue without the ill child, and the family's difficulties can be located in the ill child. This was one of Menzies' (1960) findings in her seminal paper on hospitalisation. This is a serious difficulty with hospitalisation as Gowers et al. (2000) have argued, and is why increasingly family work and parent work are offered.

Ambivalence about help

Many parents were uncertain about accepting help, which is also a feature of patients with eating disorders. Although this was not a view held only by parents of children with eating disorders, there was a quality about the way these parents felt about help, which suggested a dislike of dependency and need. Parents were uncertain about seeking support for themselves, whether this was with friends, family, other parents or professionals. The difficultly in seeking support from friends has been described previously (Anonymous, 2001 and 2012 and Davenport, 2008). However, in this study, parents did not rate support from other parents as helpful, which other studies have found (Cottee-Lane et al., 2004, Davenport, 2008).

Mr Harris was uncertain about needing help for himself and seemed ambivalent about the idea of help generally.

> *Scarlett had deteriorated in her new unit. He thought that is because she was trying at home, but when she is in hospital, she stops because there are other people to take care of things. I said so she is not having to work as hard. He said – yeah – they sit with you and make sure that you eat your meal and stop you from exercising, whereas Scarlett had to do that herself.*
>
> *(TC, 23rd November)*

Mr Harris had an idea that help made Scarlett worse, which was why he withheld some help from Scarlett at home. However, without help, Scarlett collapsed emotionally and physically. Her deterioration could be seen as a communication of her neediness. However, Mr Harris viewed her neediness almost as laziness. This belief that help was for the weak and that autonomy was better, is often found in patients with eating disorders.[52]

I explored with the parents how they had sought help for themselves. Mr and Mrs Short had found it difficult to confide in friends and family.

> *Mrs Short felt that it was hard to tell people. They have some friends – she seemed unsure and clarified – well not close friends...She spoke about not wanting to tell people, because she was afraid that it would be*

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[52] Magagna referred to it as the pseudo autonomous self (2008). This can be understood in terms of the refusal to eat, that it is much better to exist on thin air, rather than to need food to grow and develop.

> *spread around. It was also easier to tell people that are not close to the family.*
>
> *(S.1, 9th March)*

Mrs Short found it difficult to be emotionally intimate with others. She felt that there was something shameful about Caroline's illness, and that telling others would expose that. Mrs Short had a similar view about support from other parents.

> *She said, in a mocking voice, the staff told her that she should come in for more support... There is a parents' group, which she could attend, but she had not. She did not find it helpful. I asked her about it. She said that it was hard hearing other people's struggles – she had enough to manage.*
>
> *(TC, 19th October)*

Mrs Short mocked the idea of help. She may have experienced the offer of help as mocking, or felt that the idea of 'help' was impossible to imagine. She avoided opportunities for connecting with others, including her support worker. Help could be seen as emotional food, which Mrs Short rejected. Mrs Short did not want to hear about other parents' difficulties, as if she feared being projected into. She may also have feared that attending a parent group would get her in touch with painful realisations, which would be too overwhelming. Therefore, she had developed 'no entry defences' (Williams, 1997).

Mrs Barnes, who was more able to use her sessions with me, was also ambivalent about help from friends.

> *Mrs Barnes said that talking about Melanie with friends never made her feel better. Mr Barnes asked her why. She said – I have to explain what has happened and update them – it feels like harder work. I said that perhaps there was a worry that talking about it made it worse. Mrs Barnes nodded.*
>
> *(S.1, 16th March)*

Given that the couple were ambivalent about engaging with me, which I will explore in the relationships chapter, I think that there was an anxiety about whether talking to me would make things worse. Talking made the problem “concrete” and real. Mrs Barnes possibly thought that I wanted updates, particularly as they were aware that the sessions were for research. There was little idea that they may find relief from talking, although Mr Barnes voiced that later in the session.

Mrs James also said that she could not talk to friends about Sarah’s illness.

> *She said that she had no-one. She had two friends, but they both had a lot going on – one was divorced and her mother was unwell and she had three children. She could not expect her to help. The other friend had a son with ADHD and she needed support. She added that that child made her kids worse.*
>
> *(S.2, 9th March)*

Mrs James did not want to burden her friends, and there was an idea that seeing friends was unhelpful. It was interesting that Mrs James had selected friends who were unavailable, as if unconsciously she chose relationships where she would not become dependent.

Mrs Harris also did not confide in her friends for support.

> *She said that her friends don’t have kids and they do not understand – they do not know what it is like. On the outside she might seem calm, but inside it is eating away at her. She tends to keep it behind a door, she does not want to depress everyone by saying glum things, but some days the door bulges, but most of the time it is fine.*
>
> *(S.1, 9th March)*

The image of the door suggested that there were many unprocessed experiences that risked exploding from Mrs Harris, but she was terrified of thinking about them. In the transference, her comments about her friends were also a way of saying that I did not understand, and that in the session she continued to place her feelings behind a door.

Many of the parents said that they felt helped by engaging in physical activities. Mrs Harris did a sponsored cycle ride, Mr Barnes cycled, Mr Harris ran, and Mr and Mrs Short walked. In many ways this was ordinary, but it was significant that the young people engaged in excessive exercise, as do many patients with eating disorders (Bryant–Waugh and Lask, 2008), the purpose of which, seemed to be to block out thoughts.

Barrows (2008) argued that a tension with parent work is that parents have not requested help in their own right and one has to respect this. Some of the parents' ambivalence about seeking help may be connected to this. I will explore their ambivalence about engaging with myself and staff in the relationships chapter, but I think that there was a general reluctance to accept help, which fitted with theories on eating disorders.

Digestion

Some parents had a difficulty taking things in, which is a feature of patients with anorexia (Williams, 1997). Patients struggled to ingest and digest food, and struggled to emotionally digest experiences because they relied on other defences. Parents also had difficulties digesting their feelings and found other ways of managing them. Feelings of rejection and anger were projected towards staff or other parents, or at times, their child.

Mr Barnes struggled to digest the experience of Melanie's illness. He described Melanie's illness as a 'car crash'. He said:

> *'It is like you are on the Titanic and you are drowning. You are paddling so hard to keep yourself afloat and you're not sure if you can. You can't keep anyone else going – you have to say sorry – not sure I am going to make this myself – there is nothing I can do to help.' He looked at his wife sadly. I spoke about the experience being isolating for them both*

> *and how desperate they felt....Mr Barnes said that Melanie going into hospital was like being hit by a Tsunami. 'You can see this big wave coming and you know it's going to hit and you think – bugger – I don't know if I'm going to get out of this.' I felt his terror and spoke about this with them.*
>
> *(S.1 9th March)*

Klauber (1998) argued that the process of having a child diagnosed with autism and other psychotic illness was extremely traumatic, and the work with parents becomes like working with patients with post traumatic stress. I think that there was a strong element of this for Mr and Mrs Barnes. It was helpful for Mr and Mrs Barnes to talk about how horrific the experience had been and to have someone that could bear it, rather than reassure them. This helped them to digest their experiences.

Mr and Mrs Barnes' difficulties in digesting emotional experiences, impacted on their ongoing relationship with Melanie.

> *Mrs Barnes said that she had panicked and spent ages trying to comfort Melanie because Melanie telling her that she had abandoned her was what Melanie had said when she was first ill. I spoke about how that had been traumatic and it made it hard to keep in mind Melanie as she is now. Mrs Barnes nodded and said that she cannot get that out of her mind.*
>
> *(S.3, 4th May)*

Mrs Barnes was catapulted back to an earlier time when she was so worried about Melanie that she felt that she could not leave her. It was also possible that Mrs Barnes and Melanie were 're-enacting a moment or scene from another time' in terms of Mrs Barnes' history (Fraiberg et al., 1980). [53]

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[53] Mrs Barnes had recalled her mother going abroad for three months when Melanie was very small, which she had found very hard. It was possible she identified strongly with Melanie's feelings of abandonment and was responding to her abandoned self.

It was difficult for Mr and Mrs Barnes to digest the rejection that they had experienced from Melanie and so often projected this. Mr Barnes explained:

> *You look at a Eurodisney brochure with Melanie, and she will pick the hotel and laugh about it, but as soon as you mention a date, she clams up and shuts the brochure as if she never wanted to go. He did not get that. He would understand if she had no interest, but to have interest, yet there is a line you cannot cross. I spoke about feeling suddenly pushed away. They acknowledged this and said that they were getting cross with other things. Mrs Barnes said that they had arrived at the unit and a lady at the door had said that she did not know them and so shut the door on them. Mrs Barnes laughed and said that she was so cross, even though this lady did the right thing. I commented that they felt shut out, and it was perhaps easier to get cross with someone else.*
>
> *(S.2, 30th March)*

It was difficult for them to talk about their frustration and anger with their ill child, perhaps because they were worried that they would be judged for harbouring negative feelings towards Melanie. Rather than express their frustration with Melanie, they became frustrated with other parents and staff. We also discussed the difficulty of expressing anger with Melanie when their time together was limited as there was little chance to repair their relationship.

At other times, because their anger and aggression could not be digested, it became confused and was projected from one person to another. Mrs Barnes explained that Melanie had become upset when she had stopped a game of rough and tumble because she was worried that someone might get hurt.

> *Mrs Barnes said that Melanie was upset and hid behind the beanbags. She had tried to deflect on this, she corrected herself and said - reflect. The way this was said, was as if she was using her new technique – what she should be doing. She added ‘but it did not work’, and sounded confused.*
>
> *(S.3, 4th May)*

Mrs Barnes made a Freudian slip when she said ‘deflect’ instead of ‘reflect’. She wanted to deflect Melanie’s anger because it was difficult to digest. This was perhaps why she was unable to calm Melanie. The game of ‘rough and tumble’ was likely to contain aggression in either direction and one wondered whether Mr and Mrs Barnes stopped this game because they were unconsciously afraid of this aggression. Melanie may have sensed this, as well as wanting to express her aggression, which would explain her distress. All of this aggression was deflected and resulted in an argument between the parents.

Mr and Mrs Barnes also struggled to digest their anxiety. When thinking about Melanie beginning to eat again, they were remarkably relaxed.

> *Mrs Barnes thought that Melanie eating would be so gradual that they will hardly notice. She added, but eating was never the main issue for Melanie. She is not anorexic. I felt slightly reprimanded. Mrs Barnes said that when Melanie was first ill, she ate, it was only later she stopped eating, when she rapidly deteriorated.*
>
> *(S.6, 13th July)*

Given that Melanie had been fed nasogastrically for over a year, it was difficult to believe that Mr and Mrs Barnes were not anxious. They used denial to cope with their anxiety about Melanie’s eating. Although Melanie did not have a diagnosis of anorexia, she had an eating disorder and was in an eating disorder unit. Mr and Mrs Barnes could not think about this, and projected this feeling of something being unthinkable into me, so I was left feeling bad for having had this thought.

Because they had difficulties digesting their feelings, Mr and Mrs Barnes struggled when Melanie expressed difficult feelings:

> *Mr Barnes said that it was hard when Melanie said that she hated her sister. This upset Mrs Barnes. I said that it was difficult to hear Melanie’s*

> *strong feelings, but wondered about this. Mrs Barnes said that she felt torn when Melanie was angry with her husband and her other daughter because she felt protective of them. Mr Barnes said that it is water off a duck's back, he did not get upset, but when it was directed towards his other daughter that was different.*
>
> *(S.2, 30th March)*

Mr and Mrs Barnes struggled to hear aggression. This difficulty of mothers recognising hostility, has been noted in 'too good mothering' (Hopkins, 1996), and has been linked with later excessive rejection from the child. Mrs Barnes seemed frightened by Melanie's hatred, rather than viewing it as a transient feeling, which Melanie was entitled to express. Mrs Barnes perhaps felt protective towards her older daughter, feeling that she had betrayed her by having a second baby, which is a common fear amongst mothers (Bick, 1986), and would have been exacerbated by Melanie's illness, which had caused distress and disruption to the family.

Mrs Harris also struggled to digest her anxiety and her anger with Scarlett.

> *I wondered about her thoughts about Scarlett's self harm, as she had mentioned an overdose two weeks ago. She said that this was less worrying now. It was always in the back of her mind, but if Scarlett wanted to kill herself, she would have done it. She could have done it, as she was alone when she took the paracetamol. She did not take enough and phoned the ambulance. She felt that it was a cry for help. I suggested that it was hard having that in the back of her mind. She agreed and added that she did not mean to sound callous, but she could not spend her whole time worrying about that, if she did, she would drive herself mad… I felt that my trying to think with her was driving her mad.*
>
> *(S.4, 13th July)*

Mrs Harris was in denial about Scarlett's mental state. She had developed a thick skin in relation to her anxiety about her daughter. This was perhaps necessary in order to function, and was a result of chronic anxiety. However, this left her out of touch with Scarlett's anxieties and managing Scarlett's risk. It was too painful to think that Scarlett may have wanted to end her life, and that she might feel that way again.

Mrs Roberts also struggled to process difficult feelings. She spoke about being anxious about Silvia spending the weekend with the carers, whereas she was actually furious about this. As with Mr and Mrs Barnes, given that Mrs Roberts had difficulties digesting her feelings, this made it difficult to recognise Silvia's feelings.

> *Mrs Roberts said that Dr Hinchley thought that Silvia might be getting anxious which is causing arrhythmias. She is on constant observations to ensure that she does not get too anxious. This was hard because Silvia gets more anxious when she is on constant.*
>
> *(S.8, 8th June)*

Although Silvia may have been anxious, it was likely that Silvia was angry. [54] However, mother could not tolerate Silvia's anger, which perhaps compounded Silvia's difficulties in regulating her emotions, because in order to regulate emotions one needs a caregiver that can bear them. Silvia's anger must have been unbearable for Mrs Roberts because she felt fragile and experienced her anger as a consequence of having left Silvia.

Conclusion

Parents experienced a lot of distress in relation to their child's hospitalisation. There were complicated feelings about blame, guilt, envy and helplessness. Parents struggled to digest their feelings, and they employed various defences such as splitting and projection. Strikingly, these defences resembled those that patients with eating disorders have been found to exhibit, such as the 'no entry defences' (Williams, 1997). There was little conception of containment in their minds. It was unclear whether these defences arose in relation to their daughters, who functioned in this way, or whether this was a family style of

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[54] She did not want to go to foster care, and her visits were not going well with her mother. She had little control over her intake, and had been nasogastrically fed on several occasions. Increasing her observation levels was likely to have irritated her.

relating. Some parents were more able to use the sessions to process their difficult feelings, which meant that there was a lessening of defensive processes. When there had been major trauma in the parent’s history, their defensive structures seemed more entrenched. One could argue that the parents were ‘doubly depriving’ (Williams, 1997) themselves as they rejected opportunities which were available for support, such as their sessions, support from friends or other parents.

Findings - Chapter three:

Relationships

In this section, I will consider parents' relationships to the unit, as well as with Staff, myself, other parents and with their families. Parents were relieved that the hospital could admit their child, and this offered them hope. However, aspects of their relationships with the unit were difficult, such as authority and criticism, feelings of exclusion and competitive feelings with the staff. I will also discuss my relationship with the parents. Although I was not working in the transference[55], I was aware of my countertransference, and at times, this needed to be addressed explicitly. Parents' relationships with external figures, including their partners, other parents and their families, including siblings of the ill child, also featured in the sessions, which are examined.

Transference Dynamics to the Unit

Parents had mixed feelings towards the unit. They were relieved that the unit could help their child, and that they would have respite, which has been described by other authors (Crouch, 1998, Anonymous, 2001 and Davenport, 2008). Feelings of relief also related to parents' ambivalence about parenting their children. This phenomenon was found in Menzies' (1960) work about unconscious reasons for hospitalisation. It was impossible to know if this ambivalence was partly why these children were hospitalised, or whether parents had become ambivalent towards their children, having experienced them as extremely challenging.

Relief and Refuge

Hospital offered a safety net for parents who were seriously worried about their children. Mrs Barnes having acknowledged the possibility of her daughter's death said:

> *the relief when they finally put her on the drip! She no longer had to worry about keeping her alive, the drip would do this.*
>
> *(S.1, 16th March)*

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[55] As I have explained, this is not usually appropriate in brief parent work e.g. (Emanuel and Bradley, 2008)

Mrs Barnes felt unable to cope with Melanie's dependence on her. She did not mention Mr Barnes' role, which placed an enormous responsibility on her, and was perhaps why she needed the hospital to take over the parenting function.

Mrs James was also relieved about Sarah's admission.

> *Mrs James said she was worried that seeing Sarah one day a week would not be enough.*[56] *She said actually they needed a break from it, and when they saw each other for that one day, it was better.*
>
> *(S.3, 12th June)*

As an isolated single parent, Mrs James may have felt in need of a partner agency. Furthermore, she hoped that Sarah would make more progress in a specialist unit, rather than the paediatric ward she had been on.

Mrs Roberts was aware that *Woodlands* offered long term admissions which relieved her from facing the fact that Silvia returning home may be untenable.

> *Dr Hinchley had said 'what are you going to do – freeze her and keep her here.' I said she wished that things could stay the same – that Silvia could stay in hospital and she could be involved, but have help. She smiled and said that Silvia was safe here.*
>
> *(S.3, 27th April)*

The hospital had become a refuge for Mrs Roberts. She wanted to stay in this half separated state, with the hospital jointly parenting Silvia. As *Woodlands* was an institution, it did not threaten her identity as Silvia's mother, as much as foster care did.

Mrs Roberts' description of the weekend visiting also suggested the relief that the hospital offered.

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[56] This was the visiting arrangement initially suggested by staff.

> *Mrs Roberts said that she visited Saturday and Sunday, and by the Sunday they had had enough time together*[57]*.They were not allowed out and Silvia found it hard to settle. It was hard leaving on Sunday, and Silvia was upset, but Mrs Roberts told herself that Silvia needed space. She met a friend on Monday. I said that she needed space too. She agreed – it was nice and Silvia had had a nice day on Monday.*
>
> *(S.5, 11th May)*

Silvia and Mrs Roberts' time together seemed uncomfortable. Mrs Roberts struggled to acknowledge her ambivalence about spending time with Silvia, which left her feeling guilty that she was not spending Monday with Silvia. She then had to remind herself that Silvia had had a nice day on Monday.

Mr Harris mentioned a similar feeling of relief when Scarlett was admitted:

> *It had been so awful at home, he was relieved to find somewhere that she could be safe. Initially, it was hard leaving her, but because it was safe, he was relieved to get out. Sometimes he had worried because Scarlett had texted him and said 'I want to come home. Can I come home now?' He used to ring and think that she was dreadfully unhappy. He now recognised that this was when Scarlett wanted reassurance and just texted her back.*
>
> *(S.1, 16th March)*

Mr Harris needed respite. His reference to Scarlett's safety related to her self-harm. However, I wondered if he felt unsafe with Scarlett at home, in terms of his anger with her. Mr Harris seemed worried that he might have to take Scarlett home when she phoned. Unconsciously, he may have hated his sick daughter, which was difficult to explore, especially in our limited time. Furthermore, he was her main carer, which meant that the responsibility rested with him. Presumably, he had anticipated a life with older children who needed less parenting. His relief that the hospital undertook some of this function was substantial. Scarlett may have sensed this and consequently requested to

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[57] It was a bank holiday weekend, and so there was some possibility of a Monday visit.

spend less time at home, despite disliking the unit too. Hawton et al. (2012) have found that feelings of entrapment, defeat, lack of belonging and perceiving oneself as a burden are predictors of suicide. Scarlett had made two suicide attempts. Although I had not spoken with Scarlett, one could imagine in this situation that she had such feelings.

Scarlett was discharged home when the unit closed[58], but could not manage. Whilst she was in hospital, she had a reasonable relationship with her parents, as the hospital undertook the parenting functions. Cant (2005) described how a looked after child needed a placement in a therapeutic community before she could work towards being fostered. Although this was a different situation, Scarlett's parents' ambivalence about having her home meant that she needed a long term admission, with a plan of moving into alternative care.[59]

Mr and Mrs Short were relieved that the hospital made parental decisions.

> *Mr Short explained that Caroline wanted to sit her GCSEs, but staff thought that she was too ill. I wondered what they thought. Mrs Short said, matter of factly, that Caroline was miffed, but that was the way that it was. I commented that these were difficult decisions – was Caroline well enough....what were the advantages and disadvantages ....but wondered if it was hard to feel connected with these decisions as Caroline was in hospital. Mr Short agreed, but said he was happy to follow the professionals' recommendations. I said that perhaps they were anxious to follow staff's recommendations, but wondered too if they were relieved that the staff were making these difficult decisions.*
>
> *(S.4, 4th May)*

Mr and Mrs Short were probably pleased that Caroline had confided in them about 'the annoying' staff. Yet this did not help them connect to themselves as parents, nor feel confident about making decisions. It was as if with Silvia and

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[58] They had some weekends to practice this before discharge

[59] Current NHS service provision made this option problematic as NICE (NCCMH, 2004) guidelines argue that admissions for eating disorders should be brief with clear goals.

Scarlett, when the hospital was involved, there could be a positive relationship between the parents and children, but it collapsed without the hospital.[60]

Feelings of relief at handing over parenting tasks were problematic and seemed linked to the high rate of readmission, which is a widespread pattern following inpatient admissions for anorexia (Gowers et al., 2000 and Offord et al., 2006). The admission undermined the parents' sense that they could cope with their daughters. It reinforced a feeling that parents had failed, and that someone else could do it better. I will look at this further in the section on relationships with the staff, and have considered this in the parents' states of mind. Palmer (1993) concluded that the success of parental involvement in children's hospitalisation depended on both the staff's ability to allow them to be involved and the parents' willingness. 'Parents' willingness' does not consider the parent's lack of confidence or their guilt and issues of blame, which complicates their 'willingness'. Furthermore, in families in which a young person has an eating disorder, the rate of a close family member having a mood disorder, can be three times as much compared with a control group (Cooper, 1995). Many parents in this study experienced depression and trauma and so this group of parents can be in greater need of respite and less 'willing' to undertake the difficult tasks that parenting an adolescent with an eating disorder entails.

Containment

Research has highlighted the importance of staff containing parents when children are hospitalised (McFayden, 1994), or receiving treatment (Kingston et al., 2013). Containment has two aspects, both the maternal receptiveness, as well as a paternal penetrative aspect (Emanuel, 2006). As the staff were seen as experts, they offered a firm containment, which was integral to the therapeutic milieu approach (Crouch, 1998). Yet this was problematic, as parents could not internalise the containment and so when the unit was unavailable, there was an absence of containment. They became dependent on staff as an external container.

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[60] Caroline was also shortly readmitted to another unit, after her discharge home.

Mr and Mrs Barnes found the doctor's authority containing. As Melanie started to come home, her parents considered discharging her early.

> *Mrs Barnes said that their case manager was away for three weeks and they were unsure what to do. They rang the consultant. Mr Barnes did it because they wanted a straightforward conversation. The consultant told them bluntly that Melanie needed to return for the rest of her treatment so that she does not need more treatment later. This helped them to be clear. They knew that they had to be strong for Melanie and help her to return, but to do that, they needed someone to be strong for them. Mrs Barnes smiled and said that it was like a pyramid.*
>
> *(S.7, 25th September)*

The structure of Melanie's treatment disintegrated in Mr and Mrs Barnes' minds in the case manager's absence. [61] When they felt contained, they could contain Melanie. The image of a pyramid, as well as being a strong object, was a triad, which was what they were helping Melanie to negotiate.

In finding the staff authority containing, at times they depended on it.

> *Mr Barnes said that he thought that staff would plan for Melanie to go outside for two minutes, and then five minutes etc. I commented that he thought that staff would make a structured plan. Mrs Barnes said she was worried about going outside as she had bad memories of the first hospital taking Melanie outside. We spoke about how the trauma of the illness made them feel uncertain about what Melanie could manage, and how they as parents could help Melanie. Mr Barnes said that feedback was helpful. Mrs G gives good feedback – she says do more of that and less of that. This is concrete and he can work on it. Not having the feedback leaves you thinking was that right?*
>
> *(S.5, 1st June)*

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[61] It is possible that there was a pressure from Melanie to take 'flight to health', which Guiney (2012) has described.

Mr and Mrs Barnes were unable to trust their parental instincts, and had become dependent on things being planned for them. The more they relied on feedback, the less they trusted themselves, which eroded their parenting confidence. The unit assumed a parental transference for them, although they also resented this, which I look at later.

Parents also found it containing observing staff setting boundaries. Mrs Harris explained:

> *She felt more confident about challenging Scarlett, watching staff, you see how they do it. When they tell her off it is not the end of the world. At times Scarlett has been in a real spin, but 15 minutes later she apologies.*
>
> *(S.3, 1st June)*

I think that Mrs Harris felt that her relationship with Scarlett was fragile and if she enforced boundaries, she risked destroying their relationship. When she observed Scarlett with staff, Mrs Harris' perception of Scarlett changed, which helped her relate to a more robust Scarlett. However, this was in a containing and safe environment.

Mr and Mrs Short also found the presence of the unit containing, particularly when Caroline refused to eat at home. Mrs Short explained that they had contacted the nurses and returned Caroline to the unit. Caroline had not refused to eat again whilst an inpatient. However, when Caroline was discharged she refused to eat. Mr and Mrs Short had been unable to internalise the containment that the unit offered, and so when the unit was unavailable they were unable to contain Caroline's fears or set boundaries. They had become too dependent on the object, rather than being able to introject it.

Mrs Roberts experienced a similar difficulty. Silvia had refused to return to *Woodlands*:

> *Mrs Roberts had said – don't do this now! She had tried to talk to Silvia but she refused. She rang the centre and the nurse said – put things differently. She said that she had been saying to Silvia that she needed to go back otherwise she would have to go to X unit. Instead, she had said – Silvia you know what you need to do. You need to do this for yourself. Silvia heard this and got in the car.*
>
> *(S.9, 12th July)*

Mrs Roberts' threat was driven by her fear, which did not contain Silvia. When she was contained by the nurse's advice, Silvia responded to her. This was problematic at discharge, as Mrs Roberts had been unable to internalise 'a firm staff' herself and had become dependent on the unit. She had no way of containing Silvia.

The unit represented a supportive setting for the parents, which was helpful when the children were critically ill. However, the parents found it difficult to become independent from the unit and regain confidence. This linked with the parents' ambivalence about parenting their child, and their lack of confidence. It also linked with ideas about authority and exclusion, which I will discuss below.

Relationships with staff

Some parental attitudes towards staff have been explored in the 'States of Mind' chapter, as part of generalised feelings, such as blame. However, specific themes also arose in the parental relationships with staff, such as authority and criticism, rivalry and exclusion, which I will now look at.

Authority and criticism

Parents felt criticised and judged by staff. This has been found in other research with parents who have had children hospitalised (Darbyshire, 1993, Palmer, 1993 and Davenport, 2008). Although previous studies have suggested that parents found 'specialist' services helpful (Cottee-Lane et al. 2004, Davenport, 2008 and Anonymous, 2001), many parents in this study lost their authority. Davenport (2008) argued that finding her authority was difficult because she was vulnerable when her daughter was admitted and professionals did not explain things clearly. Parents have also commented that the strange environment contributed to feelings of inferiority (Cleary et al. 1986). Furthermore, locating authority in staff may link with Gowers' et al. (2000) argument that an inpatient admission suggested that a cure was located in staff doing something to a patient. Staff holding authority was problematic when there were disagreements, because parents struggled to raise their concerns. Haynes et al., (2011) found that young people felt controlled and restricted by staff authority. As some parents were identified with their children, they too may have experienced staff authority as controlling, rather than containing.

Mr Harris took a deferential attitude towards staff authority. At one point, there had been a discussion about whether Scarlett should go home at the weekends.

> *He said that Dr Hinchley was right, this was a good decision, even though his initial reaction was we should push on with it. I wondered what this decision did to his confidence as a parent. He said you learn to accept that what you think is not always right.*
>
> *(S.1, 16th March)*

Scarlett's refusal to go home may have been intended to provoke a response from Mr Harris, but Mr Harris accepted the staff's view. This was partly because of his ambivalence about having Scarlett home, which I have discussed, but it could also be related to feeling incompetent and allowing the staff to take authority. He even received literal directions from Dr Hinchley to get to the motorway. It was as if Dr Hinchley had become a parental figure for Mr Harris.

Mrs James also located authority with the medical establishment. She was unhappy that the outpatient team had not contacted her.

> *She was annoyed that Dr Hinchley had asked her why she had not called the new team. It was not her job, she had enough to do. I said that she had a lot on her mind, and she felt Dr Hinchley was suggesting that she should have done more. She agreed – she has not got the time. She said more calmly, though she had thought about it, and maybe he had a point.*
>
> *(S.3, 12th June)*

Mrs James was in a passive role with Dr Hinchley and the new team. Given that her relationships with her parents were difficult[62], she was understandably vulnerable to feeling criticised by authority figures. When she was given responsibility, she felt persecuted and was defensive. It seems that she projected a super-ego part of herself into Dr Hinchley, so that when he made a comment this was experienced as her superego chiding her.

Mrs Harris also felt criticised by the staff:

> *She said you try to do things and staff say – no you should have done things like this. And then you do things like this, thinking that you were getting it right and were told that you were still getting it wrong. I commented that she felt she could get nothing right. She agreed. It was worse when she felt that Mr Harris was getting things right. She smiled and said now she was getting things right and he was not. I said that it seemed as if there is a right or a wrong way.*
>
> *(S.3, 1st June)*

Again, Mrs Harris seemed to project a parental or super-ego part of herself into the staff, which meant that she experienced their comments as critical. The staff became a receptacle for her criticisms about herself. She then competed with her ex-husband to ‘prove’ that she was the better parent, which possibly linked with her guilt about leaving Scarlett.

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[62] Mrs James’ father had left her when she was nine years old, and she complained that her mother was always busy with her siblings’ children.

However, staff also had power. Mrs Harris explained that Dr Hinchley had sent a letter about lateness:

> *It would have been helpful if this letter had said – circular to all parents, she felt that she was the only one who had received it, and was upset. She was crying thinking that she was never late, but even that was not good enough, she could not do anything right. I said that she felt terribly told off. She nodded.*
>
> *(S.3, 1st June)*

When Mrs Harris felt so fragile and doubtful of her abilities, she experienced this letter as proof of her incompetence. Staff perhaps had not understood how much authority was projected into them, and how critical this letter could appear.

Mr and Mrs Barnes voiced a similar feeling of getting things wrong.

> *Mr Barnes said that you have such a feeling of no you should not do that, and so you wait to be told what to do. He said that the staff had said that Mr and Mrs Barnes should end their visits themselves, not wait to be told. Mrs Barnes said that she had not known this.*
>
> *(S.5, 1st June)*

Again, the authority was located with the staff. Ironically, Mr and Mrs Barnes felt reprimanded for not taking authority. They could not have an ordinary conversation with staff about the ending of the visits, which left them feeling controlled. As the unit was an eating disorder unit in which the patients were rigid in their thinking[63] staff may have unconsciously absorbed this state of mind and communicated it to parents.

Mrs Roberts too felt criticised, and tried to challenge staff authority.

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[63] E.g. some young people had ritualistic eating behaviours, heavily restricted diets etc.

> *She had told Dr Hinchley that she needed to know why Silvia wasn't being listened to. He had said that they would discuss it when they met. When he explained things to her she said that she felt stupid for thinking otherwise. She got upset and felt that the staff thought 'this woman is up and down.'*
>
> *(S.5, 11th May)*

Mrs Roberts' confidence was likely to be so fragile, that when staff, particularly a male consultant, articulated a different thought, she collapsed. No doubt the feedback from staff, and the involvement of foster carers, made it impossible for her to feel confident in her capacities.

Mr and Mrs Barnes also struggled to challenge the staff's authority. They were disappointed that their visiting hours were unchanged.

> *Mr Barnes said if Melanie were closer they could visit after work. Despite Melanie improving over the last few months, they still only see her for 6 hours a week. I spoke about this being frustrating and disappointing. Mr Barnes agreed and added – but it can't happen….unless there were a Woodlands in our town.*
>
> *(S.4, 18th May)*

Mr and Mrs Barnes felt unable to discuss lengthening their visits, or home leave. This could be their ambivalence about spending time with Melanie, but I think that it was a result of becoming accustomed to being told visiting times, and accepting staff authority.

When Melanie's placement changed, Mr Barnes was freer to voice his concerns.[64]

> *He said that this approach of going slowly had helped Melanie, but she is ready for more. He is looking forward to the new unit's approach. He has*

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[64] This unit had followed the approach for PRS that I outlined (Guiney, 2012) in the introduction, which involved taking a slow and gradual approach, rather than setting targets.

> *always struggled that the approach here is so quiet, and not making a fuss. When Melanie does something good you want to say – great! Yet, here it is almost anti-parenting. Usually parents reward children and amplify their success. Here, this is completely avoided and he was meant to react as if he had not noticed, which felt wrong.*
>
> *(S.6, 13th July)*

His comments linked with other research, in which young people found the rigidity of units unhelpful as their admissions progressed (Offord et al., 2006). Mr Barnes seemed less worried about the consequences of being critical at this point, and able to question the authority of *Woodlands*, having seen a different approach.

Some parents found it difficult to think about feeling criticised by staff. Mrs Short felt criticised for her hand over.

> *The staff had asked her all these questions, as if she had done something wrong. She sighed and said that she didn't understand what the staff wanted. I commented on their confusion and wondered whether they needed clarification. Mr Short responded that all the staff were good – he could not complain at all. Mrs Short agreed, they were all very good, there was not one that she had been worried about. I felt confused.*
>
> *(S.2, 16th March)*

Mr and Mrs Short harboured critical thoughts about the staff, particularly having felt criticised, but were afraid to voice these thoughts. The staff's questions were experienced as a superego cross-examining the parents. Therefore, a scrutinising and judgemental part of themselves was projected into the staff, which other writers have described in work with parents of adolescent (Jarvis, 2005 and Trevatt, 2005). Furthermore, research (Magagna, 2003) has found that families, in which a child has anorexia, often have difficulties expressing conflict, which also explains their difficulties in thinking about their critical feelings.

Most parents found the staff critical, and the nature of the staff's task made it difficult to avoid being seen as critical. Urwin (2003) argued, if the worker contained and processed feelings of shock, remained non-judgemental and positive, it was possible to reduce the severity of the parent's internalised objects and allow 'something more nurturing to come to the fore' (p.124). Yet as staff often had to intervene, it was difficult to be non–judgemental. Furthermore, the fact that the child needed help may have played on an unconscious anxiety. Harris argues:

> Somewhere in every parent still exists the little girl…who is convinced that they can never become a proper mother...When things go wrong, this little girl in the mother feels found out and projects upon the therapist her super-ego picture of her own internal mother who is going to blame her and take the child away because of her presumption and bad management' (1968, p.22).

For Mrs Roberts this was a reality, and the fact that the staff were 'specialists' reinforced their authority. Yet, as staff were losing their jobs and seemed vulnerable, it made it more difficult for parents to express their critical feelings.

Rivalry and exclusion

The staff undertook many parental functions, which stirred up parental rivalry and exclusion. Menzies (1960) identified that parents envied the staff's skills and intimate contact with 'their' relatives. Staff helped the children recover, which the parents had failed to do, and is a difficultly of inpatient admissions that has been highlighted (Scholz, 2005 and Davenport, 2008). In one study, parents' realisation that they had to share their child's care was one of the major stressors of the hospitalisation (Hayes and Knox, 1984)[65]. Additionally, staff were privy to information about the young people that parents were not, which meant that parents felt excluded and rivalry developed (McMaster et al., 2004). Furthermore, Scholz and Asen (2001) found that staff in eating disorder units

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[65] This was not a study of parents who specifically had children admitted for an eating disorder or psychiatric disorder, but was a group of parents who had had children hospitalised for general paediatric reasons.

viewed parents as a nuisance and actively excluded them, which would contribute to parents' feelings of exclusion.

Mrs Harris commented on her feelings of exclusion.

> *She explained that Scarlett has used the staff to recover and help her talk about things. When there was less support, Scarlett would have to talk to her. I wondered how she had felt about this. She replied that she had found this hard, it felt as if she was the last person to know things. Last week, when the nurse said there were other things she could not tell her, she was annoyed. She was looking forward to not being in that position.*
>
> *(S.4, 13th July)*

Scarlett confiding in others highlighted Mrs Harris' distance from Scarlett, particularly in the light of their previous separations. Her rivalry with the staff meant that she could not understand the impact of the loss of staff for Scarlett.

Mrs Harris later spoke of her relationship with staff at the new unit.

> *Mrs Harris said that she was more confident. When the nurses are having trouble managing Scarlett, she makes suggestions because she had the tools from Woodlands. She added anxiously, 'I mean, I am not an expert or anything'.*
>
> *(TC, 9th November)*

Mrs Harris' relationship with the new nurses was perhaps a response to feeling inadequate previously. She wanted them to know what it felt like to be ineffective, whilst she identified with the confident staff. The loss of the old staff was avoided, because in her mind she had become them. This confidence seemed fragile because she suddenly became anxious that I would expose her lack of knowledge.

Mr and Mrs Short had a similar feeling of exclusion in relation to staff.

` *When Caroline was upset she had talked to a nurse and the nurse had told them what Caroline said. Mr Short wondered why Caroline had not told him. He sounded hurt. I said that hearing things through a third party was hard. He agreed and said that she was his daughter and he was told about her cutting on the phone. I asked them if they had seen the cuts. They had not. Mrs Short added that one cut was quite bad, according to the nurse. I wondered if they felt excluded from Caroline's life. Mr Short said he had not thought of this, but it was true. The longer Caroline was here, the more relationships she makes, which is good, but it is hard. He added especially when staff ask how it feels that she is opening up to staff.*

` *(S.3, 20th April)*

Caroline had cut out her parents. Although Mr and Mrs Short had not been absent from Caroline's life, they were ambivalent about their emotional contact with Caroline, as I have discussed. Their exclusion highlighted this emotional distance. Mr and Mrs Short felt daunted about getting closer to Caroline again. Some parents on neonatal wards withdrew from their infants because they felt that they were too fragile to manage stimulation (Mendelsohn, 2005). Mr and Mrs Short's tendency to withdraw was probably exacerbated by Caroline's hospitalisation where they felt Caroline was 'fragile' and they were uncertain about what they had to offer.

Mrs Roberts also felt excluded and rivalrous with the staff.

She said that sometimes they do not tell her things, which annoyed her. She was not told that Silvia was walking out of lunch! She paused and said that maybe she did not need to know that, but it was hard when there was so much that she didn't know. I said that not knowing felt difficult. She said that the staff tell her that Silvia is doing something because of the illness, but she disagreed. Silvia has been here for a long time, but she was her Mum and knew her best!

(S.1, 23rd March)

Mrs Roberts' feelings of exclusion must have resonated with her experiences of her mother looking after Silvia and her difficulties more generally of relating to a triad. A similar pattern emerged with the staff and foster carers. She felt it was either Silvia's illness or her personality that caused her behaviour rather than thinking about the interaction of factors.

When Mrs Roberts felt so rivalrous with the staff, she was pleased when Silvia was difficult.

> *She said that staff were seeing more of Silvia's cross behaviour, which is good. I asked her about this. She said that Silvia was finding her voice, which was better; a relief. Silvia had always been like this, but no one saw it and she thought –oh God – was it something she did. She was pleased staff saw how difficult Silvia could be.*

(S.1, 23rd March)

Parents often want professionals to experience what they experience at home. However, because Mrs Roberts felt so persecuted by Silvia's behaviour, she felt triumphant when Silvia was difficult towards staff as this 'proved' that Silvia's behaviour was not her fault. There were occasions where Mrs Roberts, albeit unconsciously, made it easy for Silvia to get cross with the staff. For example, she frequently disagreed with the staff and she also bought a dog. Silvia was then furious with the staff for not allowing her home.

This rivalrous pattern continued. Silvia was later readmitted to the paediatric ward and Mrs Roberts was in conflict with the doctors about Silvia having home leave. She was perhaps afraid of being excluded again. Furthermore, she may have continued to relate to the staff in terms of grievances and competitiveness, as that was familiar and meant that she did not have to think about issues of risk.

Silvia also played a role in Mrs Roberts' rivalry with the staff. She goaded Mrs Roberts into fighting with the staff by asking her if she was going 'to obey' staff. Having experienced her parents' separation and the family conflict, Silvia was likely to know how to manipulate situations as she had no experience of people working together.

Mr and Mrs Barnes also felt excluded by the staff. When the parents experienced a difficult incident with Melanie, a nurse spoke to mother.

> *She said that it sounded terrible, although the nurse was very helpful, nice and professional, she would not complain about her, but the first thing she wanted to say was " Go Away". I commented that she felt that she was Melanie's mother, and she wanted to sort it out. She nodded.*
>
> *(S 3 .4th May)*

Mrs Barnes felt the staff presence was intrusive and seemed to fear that the nurses' intervention would be 'better' and that Melanie would turn to the nurse. This was likely to have led to Mrs Barnes competing with the staff. On one occasion, she brought food for Melanie to play with[66], which staff queried. I wondered if Mrs Barnes had felt excluded that staff could feed Melanie.

Mrs Barnes struggled to think about her rivalry. She often praised the staff, but this seemed to be to hide her envious feelings.

> *Mrs Barnes spoke about how good the staff were – they could not find fault with them. They were all nice, and took the time to ring her, she couldn't fault the communication. Mrs Barnes said that Mrs S was so trustworthy, she rang to say that Melanie had been given too much Movicol in error. She explained that it was not dangerous, so Mrs S did not need to tell her, but she owned up to mistakes.*
>
> *(S.4, 18th May)*

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[66] Mrs Barnes had said that as a childminder she often gave children food to play with in terms of developing sensory play e.g. – dried pasta shapes and beans, and that her intention was not that Melanie should eat this food.

Mrs Barnes may have needed to remind herself of staff failings, as they seemed so capable in treating the children. Menzies (1960) found that whilst relatives often said positive things about the staff, like Mrs Barnes, unconsciously they were full of resentment about the staff looking after 'their' patient and envied the nurses' skill. Mrs Barnes' background as a childcare professional complicated her rivalry with the staff:

> *Mrs Barnes added 'and as Nanny and a child-minder – I should know what I am doing. I should be the expert. It is very hard for me to get help – but I realise that I need it.'*
>
> *(S.3, 4th May)*

Mrs Barnes' rivalry with staff led her to behave like the nurses, which is common when parenting an ill child (Jay, 1978). Mrs Barnes had tried to use the language that the staff had suggested. If she was the same as staff, she may have hoped to diminish their difference and her rivalry. Copley and Forryan (1987) argue that projective identification is a way to avoid separation. If parents, through projective identification, became staff, they may have felt less worried about coping with their children in staff's absence. Yet, because this identification was based on projective identification, rather than a genuine introjection of a helpful figure, parents were no more confident.

Parents' rivalry with staff was further complicated, as many of the staff were young women who may have represented an idealised parent to the patients. This was possibly projected into staff, unconsciously exacerbating rivalry with parents. Donnellan (1986) argued that this can be particularly problematic when young staff have unresolved issues with their parents. This was outside the scope of this dissertation, but further explains the difficulties in parents' relationships with staff.

Intrusiveness

Lawrence (2008) argued that therapists working with patients with anorexia cannot avoid being seen as intrusive, which was related to an intrusive object in the patient's mind[67]. Parents felt similarly about staff, which links to the concept of an 'eating disorder state of mind', which I have discussed in the previous chapter. The intrusiveness presented in different ways and linked with parents' previous experiences of 'help'.

Mrs Roberts felt that placing Silvia on constant observations[68] due to concerns about her safety was unhelpful.

> *Silvia cannot ask whether she looked like she had gained weight in front of staff, which made her more anxious. I said that she did not feel relieved by the staff's intervention; it was as if it was an intrusion. Mrs Roberts agreed and said that she felt staff's presence made Silvia worse. It was abnormal to have someone there all the time.*
>
> *(S.8, 8th June)*

Mrs Roberts identified with Silvia's position; that staff presence was unhelpful which related to her previous experiences of help. [69]

Mrs Harris also experienced the staff as intrusive.

> *She spoke about feeling scrutinised. If your family has never had involvement with social services, you are not used to loads of people knowing about your life. Everything is opened up. I felt that my talking with her was another 'opening up'.*
>
> *(S.3, 1st June)*

Mrs Harris could not imagine that families would choose to involve others in family life. I was also made to feel intrusive. Patients with eating disorders often experience help as intrusive (Lawrence, 2008). Mrs Harris had had bulimia and

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[67] See literature review for further explanation of this point.

[68] This was when the team decided that a nurse needed to be in view of the patient at all times, including using the toilet or showering.

[69] Her mother had 'helped' her with Silvia but had 'taken' Silvia. Likewise *Woodlands* had 'helped' Silvia but had involved social services, who in Mrs Roberts' mind were going to 'take' Silvia.

perhaps felt ambivalent about allowing something inside her, whether it was food, or professionals' thoughts.

Relationships between parents and staff were complicated. Although parents consciously spoke about staff being helpful, they also felt excluded, intruded upon and rivalrous with them. Some of these feelings arose from the positioning of the staff as 'experts', and the parents' feelings of incompetence, but they also stemmed from the parents' previous experiences with authority/help figures.

Relationship with therapist

Magagna (2008) argued that therapists working with inpatients should consider the 'total transference' which developed towards the institution, to avoid exacerbating splits in the team.[70] Although I was not working in the transference with the parents,[71] it was important that splits did not develop. Themes that arose in my relationship with the parents reflected their relationships with staff, which included rivalry and envy, exclusion and rejection, authority and criticism, ambivalence and containment. As I could observe my relationship with the parents closely, I gained a deeper understanding of the parents' patterns of relating.

Rivalry and Envy

As I was not giving advice, or looking after their child, the context of the parents' rivalry and envy with me was different. They were envious that I could be free of *Woodlands*, particularly around holidays. Furthermore, they were envious and rivalrous with me as a female therapist and doctoral student. Some parents made envious attacks on my role as a therapist, as if they could not tolerate that I had something to offer them.

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[70] For example, therapists being seen as nice, and the nurses being seen as cruel or vice versa.
[71] As has been advocated in short term parent work (Barrows, 1997, Emmanuel, 2008)

Parents found it difficult when I took holiday[72].

> *I was aware that I had gone over time with Mr and Mrs Barnes and said that it was time to finish, although I felt guilty. I reminded them about my Easter break, which meant that I was away for three weeks. I again felt guilty as I was aware their Easter would be difficult. Mrs Barnes said have a nice time if you are going away, or enjoy putting your feet up.*
>
> *(S. 2, 30th March)*

My guilt was a reflection of their envy that I could take a break. To avoid this difficulty, I ran over time, and gave them 'extra' time. Mr and Mrs Barnes cancelled the first session after the break, as if there was some anger and envy of my break. I then felt rejected. Despite not working in the transference, it would have been helpful to address this. These feelings were likely to be heightened by the wider staff's absence too.

Mrs Barnes was also aware that I was pregnant[73], which created further envy and rivalry with me as a mother to be.

> *Mrs Barnes commented that I had timed the pregnancy perfectly as I would have a baby for Christmas and I looked so well. I acknowledged this uncomfortably. Mrs Barnes said that she had had to stop work four weeks before the birth of her first daughter, due to her blood pressure and she was fed up. She smiled and said that she was sure I would be fine.*
>
> *(S.9, 7th November)*

Mrs Barnes was envious that I could work, because she had stopped working previously, and more recently because of Melanie's illness. She felt that I had it all – working and having a family. She dealt with her envy by telling me moments later, that I would 'come to know in time' the meaning of children's

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[72] This has been a phenomenon found in other parent work e.g. Klauber (1998).

[73] This was because I continued to meet with Mrs Barnes at the new unit, when my pregnancy began to show. There was no specific reason that I had chosen to continue with Mrs Barnes, other than geographically the distance made it possible for me to follow her up.

cries. She was the experienced parent and highlighted my inexperience. Being a pregnant therapist is a lengthy topic (Paluszny and Poznanski, 1971 and Cole, 1980) and is outside the scope of this thesis. However, the therapist's personal attributes had an impact on parents, perhaps particularly that of a female therapist. Mrs Barnes may have already had thoughts about whether I and staff were mothers. Therefore, there was a personal rivalry and competiveness.

The sessions also being research stirred up parents' envy.

> *Mr Short said he thought that the study was for a doctorate. He smiled sadly and said that he had had to drop out of his masters. I felt guilty. He said that his daughter was under special exemption for her A levels. I commented that perhaps it felt difficult to know that this was for a doctorate, when they had had to relinquish their studies.*
>
> *(S.1, 9th March)*

Mr Short was dealing with loss, whereas he felt I was 'gaining' something, which was a conflict for him. When Mr and Mrs Short were informed of the closure of the unit, Mr Short asked whether *'the closure had messed up my study' (S.5, 12th July).* I wonder if he was partly pleased that I had the experience of having my work spoilt.

Mrs Harris also seemed rivalrous towards me, which almost became an envious attack, particularly when hearing about the news of the closure.

> *She asked 'how I was? Was I going to pastures new?' I said that I would be leaving at the end of July. She spoke about feeling very sad for the staff who had to leave. It was so difficult. I felt annoyed and as if I had no space.*
>
> *(S.4, 13th July)*

Mrs Harris became the therapist. Unconsciously, she may have envied the staff's and my abilities to contain herself and Scarlett. She then launched an envious attack on me as a therapist.

Exclusion and rejection

Mrs Barnes and Mrs Roberts attended sessions regularly, however Mr and Mrs Harris[74], and Mrs James, struggled to attend regularly. Arrangements were often cancelled and I was left feeling rejected. They were probably ambivalent about engaging with me, which I will look at later, but their attendance was also a communication of their experiences of rejection or exclusion. This was a way of containing their experiences, as I could understand it and put it into words.

My initial session with Mr and Mrs Barnes was difficult. Their joint rejection of me was striking.

> *They laughed about the room. Mrs Barnes said that this building made her giggle – it was so uneven. She pointed out a cupboard. Mr Barnes said – there is no attempt to even that up. Mrs Barnes pointed to the uneven floor. Mr Barnes shook his head. I felt excluded and ridiculed.*
>
> *I reminded them that I had given them the consent forms last time. They looked at the forms again, and hesitated...Mr Barnes said they were under a lot of pressure and emotionally he wasn't sure if he had any more to give. He did not want to lose time with Melanie. I acknowledged this and said that it was important. I felt Mr Barnes' hostility. He said that he wanted to help, but felt that he had nothing left. I said that I understood what he was saying – and it was up to them. They had a long journey, it was a difficult time, and adding something else felt like too much. Mr Barnes agreed. Mrs Barnes asked how long I had been here. I replied that I had been here for almost four years. She said 'oh I thought you were a new girl on the block.' She asked me if I knew Melanie. I*

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[74] Who attended separately

> *explained that I was a child psychotherapist and saw Melanie in one of the groups.*
>
> *(S.1, 16th March)*

Mr and Mrs Barnes ganged up on me. Complexities of the couple relationships can be an issue when working with parent couples, as therapists have described (Cudmore and Judd, 2001). Mr and Mrs Barnes struggled to view the sessions as additional help. [75] They made me feel inadequate and excluded, which related to their experiences of hospitalisation. Their behaviour resonated with Magagna's (2012) thoughts about work with this group of parents. Initially parents needed to be allowed to ' "intrude into us", pouring into us, all their anger, their hatred… and therapists must allow themselves to be the container into all sorts of repressed and unacceptable feelings' (p.80). If the therapist can be receptive and contain the distress, this can 'initiate the process of internalising perceptive, emotionally containing therapists' (p.82), which can help the parents understand their child. This occurred with Mr and Mrs Barnes, which I will explain further.

Mr and Mrs Short also excluded me, which again was powerful as a parent couple. They explained that they had met Caroline's new team.

> *Mr Short added that things were changing and it was nice to meet the people that Caroline would be working with. I felt confused and asked them – did they mean on discharge or on transfer. Mr and Mrs Short laughed, and Mr Short said that Caroline would not be anywhere near ready for discharge. I felt silly. He said that staff have planned to move her to another unit closer to home*.
>
> *(S.4, 4th May)*

I was given an experience of being excluded from the decision making process. Mr and Mrs Short had not explained that the plan for Caroline had changed. I felt powerless and had to have things explained to me. I could then explore with Mr and Mrs Short what it felt like to be in this position.

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[75] I had arranged sessions so that they had minimal impact on parents and had no impact on their time with Melanie.

Mrs Harris also gave me an experience of being excluded:

> *She said that Scarlett has a lot on her mind. She paused and said that she is not sure whether I know, so she won't go into it. I felt rebuffed and as if she was withholding information.*
>
> *(S.4 13th July)*

This seemed likely to relate to Mrs Harris' feeling that staff had excluded her from Scarlett's self harm and disclosure of sexual abuse. She also had phantasies that staff discussed what a bad mother she was, which reflected her anxieties about her parenting and being excluded. Her relationships with me and with the staff were based on someone being left out. Here, I allowed myself to be excluded. I was anxious that if I asked more, something frightening would unfold. Therefore, being curious felt dangerous and persecutory, which I should have addressed. The part of Mrs Harris that may have wanted help with her parental role was excluded by myself and the defensive part of Mrs Harris.

Mrs James also rejected me at times. She discussed Sarah's rejection of her.

> *She said that Sarah did not really miss her – Sarah has chosen anorexia over her family. I commented that she felt rejected. She nodded. She said that she knew that it would take time…*
>
> *I said that it was time to finish. She said that she would prefer to leave our next meeting, because she had a review meeting that day. I wondered about this. She said that the review meeting was enough.*
>
> *(S.2, 9th March)*

Mrs James felt pushed out by Sarah and excluded from her life in *Woodlands*. I then had to know what it felt like to be excluded whilst she was busy with more important meetings. Mrs James missed several sessions after this one.

Holiday breaks, as I have discussed in terms of rivalry, were difficult for parents, but they were also difficult in terms of exclusion. I had felt guilty about taking a break with Mrs Roberts, as if I had become an abandoning object. This perhaps reflected Mrs Roberts' belief that separations equated to abandonment, which linked with her guilt about leaving Silvia. Mrs Roberts had been so confused by the break she arrived early for her first session back. I had been unable to see her, and she had been asked to return later.

> *I said that with the break it had been difficult to hold the time in mind, and then she had come back and was sent away, which was frustrating! She said - it was ok. There was a pause. I wondered what was on her mind. She started to speak about last week, but then stopped and said that I knew Silvia had not gone to Yorkshire, didn't I? I did not know.*
>
> *(S.3, 27th April)*

Mrs Roberts re-enacted her experience of me being unavailable, which had happened over the break. My uncertainty about whether she would return, perhaps reflected her feeling. She skipped over the three week break, which avoided the absence and I felt excluded.

Mr and Mrs Barnes also found it difficult to return after the holiday break.

> *They attended 20 minutes late and I had wondered whether they would come. They were apologetic. Mrs Barnes appeared pale. She wore a black jumper, rather than the bright colours that she had worn previously... I commented that we had had a long break and just had a short time left. They nodded. Mr Barnes said that things had plateaued; there were no changes. Mrs Barnes agreed and said that things were the same.*
>
> *(S.3, 4th May)*

I was rejected and made to wait, which may have been their experience. Mrs Barnes' appearance had changed and their depressed state of mind suggested that they had experienced a loss over the break. Many staff had also been absent, which added to their sense of bereavement. They conveyed that meeting was pointless, which perhaps reflected their feeling that I had not bothered to meet with them. I had to do a lot of gathering up, as if it was hard for Mr and Mrs Barnes to discuss what had happened.

Ambivalence

Parents were ambivalent about engaging with me. This was partly because of their confusion about the sessions, and the fact that the unit was closing.[76] However, their ambivalence towards me reflected an ambivalence about seeking help for themselves, which is an issue with parent work. Mrs James, and Mr and Mrs Short brought their older children into a session, perhaps to avoid voicing their experiences.

Mr and Mrs Barnes were ambivalent about opting into the sessions. After a lengthy discussion they agreed, but were uncertain about their commitment. I had to bear not knowing whether they would attend, and feeling that I was not their priority. They may have been relieved to exert some control over our contact, compared with their contact with Melanie. They did not think about the impact that coming on this basis had on them.

Mr and Mrs Barnes captured their ambivalence about engaging with professionals in a later session.

> *Mr Barnes said that many of the processes had been surprisingly helpful. He had thought – ugh – family therapy – he didn't want that, but actually it has been helpful. Mrs Barnes agreed and said that it is more than the session each week. You think about things that come up all the time.*
>
> *(S. 4, 18th May)*

In the transference, they were also perhaps talking about our sessions. Despite their initial reluctance, Mr and Mrs Barnes attended regularly and felt that their sessions were helpful.

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[76] Mrs Roberts had attended regularly, but missed several sessions once the closure was announced, as if it was too painful to engage in sessions when she knew that they would end.

Mrs Harris valued parent support, yet she could not use what was on offer.

> *She thought that it was important that parents were asked about things, because so much time was spent thinking about the child – parents were forgotten. 'You see parents coping so well and you think that everything is fine, but they are having mini-break downs, and paddling underwater.'*
>
> *(TC, 9th November)*

Ironically, Mrs Harris avoided discussing her 'mini break-downs' with me and getting help, but continued to 'paddle underwater', especially as she cancelled many sessions.

Likewise, Mr Harris was ambivalent about engaging with me and frequently cancelled sessions.

> *He was apologetic about the long gap between sessions. He hoped that it had not messed up my study. We waited for his tea and he apologised saying that it was not good to delay a session for a cup of tea, but he continued to wait.*
>
> *(S.2, 18th May)*

Mr Harris felt guilty about his attendance, as if I would reprimand him. Unconsciously he may have wanted to 'mess up' the study, reject me and make me wait, given that his life had been 'messed up'. Cancelling and delaying sessions was perhaps a safe way to express his hostility, although he could not think about the consequences of this for himself.

Mr Harris' later comments suggested that he had used the space to a degree.

> *He said that meeting with me had been good actually; it provided a space to reflect. Half of the things that he had said to me, he had not verbalised and it was helpful to put these thoughts into words.*
>
> *(TC, 23rd November)*

I do not think that Mr Harris was being placatory. He valued the help and had made some use of it, but there was also a more hostile and angry side of himself that spoilt the sessions. However, perhaps my tolerating his ambivalence helped to contain this part of himself.

I tried to take up his ambivalence.

> *He thought 'Oh family therapy again! That means I have to get up so early. But I shouldn't moan – it is an opportunity'. I said that he is grateful for opportunities, but they have an impact, which perhaps included seeing me. He said that he only worked four days a week, which meant that he could come. Everything has worked out.*
>
> *(S. 1, 9th March)*

I think that Mr Harris was also talking about our sessions. When I took up the negative transference, he retreated from this, concerned that I could not tolerate his ambivalence. Furthermore, when I voiced his conflict about the sessions, it was made conscious, which was perhaps difficult.

When I followed up the parents[77] many parents asked me to phone another time. Yet, when I rang back, parents found it difficult that this was the final phone call. Mrs James, Mr Harris and Mrs Harris all invited me to phone again. This may be everyday rhetoric to avoid saying goodbye, but these were the parents who had attended least regularly. Their guilt or regret at not having used the sessions made it more difficult to acknowledge the ending. Their comments reflected an ambivalence about engaging with 'helpers' – the wish for availability, but the difficultly in using them.

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[77] I had agreed that I would offer a telephone follow up with all the parents in their final sessions.

Authority

Despite the parents’ uncertainty about my role, they placed authority in me. At times, I acted in with this authority. However, other parents were resistant to me being a therapist and wanted to make us the same, so I had little authority.

Mrs Roberts looked to me for ‘answers’ about Silvia.

> *Mrs Roberts did not understand why Silva needed reassurance that she did not look any different. I wondered what Mrs Roberts thought. She said that it was the illness. I wondered about Silvia saying – nothing must change – my weight must not change, particularly in the context of many changes. Mrs Roberts said oh – is that what it is about?*
>
> *(S.6, 18th May)*

Mrs Roberts struggled to explore this idea. This was perhaps a consequence both of being in a medical system, where doctors shared ‘diagnosis’ and ‘treatment plans’ and of Mrs Roberts’ feelings of incompetence. Yet, locating the authority in me absolved her from responsibility, if Silvia’s comment had a different meaning, I could be blamed.

Mr Barnes also located authority with me about his feelings.

> *Mr Barnes said that people like me were good at listening, but he wanted someone to say something concrete. There must be different stages that parents pass through – like bereavement – they must have a feeling at X, Y and then Z – and if someone told them that, it would have helped.*
>
> *(S.2, 30th March)*

Mr Barnes found ‘not knowing’ difficult, which included his frustration that there was no ‘answer’ to Melanie’s illness. However, because he believed that professionals were experts, he felt information was withheld.

Sometimes I found myself taking up this authority and getting pulled out of my role.

> *Mrs Barnes wished that Melanie was talking in therapy. I suggested that by holding onto the illness in therapy, Melanie could let go of the illness elsewhere. Mrs Barnes said that this was what the therapist had said. I spoke about it being usual for children to behave differently in therapy.*
>
> *(S.5, 1st June)*

I avoided Mrs Barnes' despair about whether Melanie could use therapy, and her frustration that Melanie may 'waste' it. Mrs Barnes might have wished that she could speak more freely to me, which I avoided, by talking only about Melanie's therapy.

Yet this authority which was located in me was also the parents' superegos. Mrs Roberts described an argument with Silvia.

> *She said that she tried not to get drawn into it, but had said something that she regretted. She looked embarrassed. I spoke about things being either right or wrong. She said that she should not have said it, but did not explain. I asked her what she had said. She had asked Silvia why she ate with the carers? She felt that this was a bad thing to say, and she was not thinking.*
>
> *(S.2, 30th March)*

Mrs Roberts felt ashamed of what she had said, but this was likely to be in my presence. I became a critical superego that would reprimand her rather than understand. She quickly reprimanded herself, and justified herself, rather than thinking about it.

At other times, I was pulled out of my role as therapist, to become a friend. This occurred particularly with Mrs Barnes at the new unit.

> *She asked how long I had left of the pregnancy. I said that I would be finishing at Christmas. She asked if that was when I was stopping work. I agreed and felt uncomfortable, as if it was hard to be boundaried. Mrs Barnes asked if I was excited. I commented that she was aware that I was expecting a baby, which stirred up lots of feelings, but they too were having a new arrival, as this was their last week in hospital.*
>
> *(S.9, 7th November)*

It was difficult to maintain a firmer boundary, as I was not part of the staff team in this unit. I needed to have addressed these issues with Mrs Barnes. Furthermore, my pregnancy meant that she knew something about my personal life, and I became a mother to be, rather than a professional.

Containment

Bion (1962) has argued that therapists contain their patients, similar to the way that mothers contain their infants, through maternal reverie, absorbing projections and digesting them, so that they are returned to the infant in a modified form. This provides the infant with an experience of being understood and is the beginning of the infant being able to think about experiences. The parents found it difficult to be contained by me. This was partly linked to their confusion about the sessions[78] and the closure of the unit. However, parents also doubted whether I could bear their preoccupations, which may have related to their internal objects.

After Mr and Mrs Barnes had been rejecting, Mrs Barnes asked:

> *'Have we depressed you – do you want to work with us?' She was smiling, but seemed doubtful.*
>
> *(S.1, 16th March)*

Having brought strong feelings into the room, Mr and Mrs Barnes were anxious I would reject them. It was probably unusual for them to experience a containing object that could bear their rage and aggression.

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[78] Some parents had an idea that as the research was a study, I was a student, rather than a member of staff.

A similar difficulty happened during our final session. Mrs Barnes was more aware of her resentment of her mothering role, and knew about my pregnancy.

> *Mrs Barnes said that she hoped everything worked out with the pregnancy and that she had not put me off. I wondered if it had been difficult to say what was on her mind, knowing that I was pregnant. She said – no – it was like therapy for myself – so thank-you.*
>
> *(S.9, 7th November)*

Mrs Barnes worried that she had damaged me by talking about her aggression. Yet as many of her difficulties were around separation, it was helpful to reflect on her pregnancies and to mourn that stage of her life. Therefore, the containment I offered her was both helped and hindered by my pregnancy. Mrs Barnes voiced feelings of sadness about the ending of our sessions and was anxious that the study would be completed, which was also her anxiety about what would happen to her and the work we had done.

Mr Short was more uncertain about containment.

> *He said that he had told his colleagues about Caroline's admission, which was a relief – he could just leave when he had appointments, and no one asked questions. That was much simpler. He has to talk to people a lot and sometimes he wanted to go home and say nothing to anyone.*
>
> *(S.1, 9th March)*

Mr Short disclosed information on a need to know basis, rather than to emotionally connect. In the transference, I was like the colleagues. He often asked me what I 'needed' to know, rather than thinking about what he could bring.

Mrs Harris also struggled to be contained by me. When she discovered that Scarlett had been sexually abused, she requested to leave our session. I discussed this with her, but she felt too vulnerable in her upset state. Her default position seemed to be the ‘no entry’ defence (Williams, 1997). She was only prepared to talk about the last few weeks which had been better, but which left us out of touch emotionally.

There were times when it was possible to offer more containment to the parents. Mrs Roberts had moments when she could think.

> *She had a difficult relationship with her mother because of what had happened with Silvia. She brought Silvia to see her and she talks to her father, but...she recognised that she needed help with this. She and her mother ought to sort this out....I said that she seemed upset and angry, but aware that the relationship was unhealthy.*
>
> *(S.2, 30th March)*

At this point, the split in Mrs Roberts’ mind between her ‘bad’ mother and her ‘poor’ self had receded. There were other similar moments when she could acknowledge the foster carers’ efforts. However, it was difficult to maintain this thinking. She would need regular long term work before she could feel contained enough to explore her conflicts, which Klauber (1998) argued was essential for parents of chronically ill children. Mrs Roberts also had no experience of a containing object. Whilst she was furious with her mother, she felt that her mother was weak, which left her unable to voice her anger.

At other times, I offered a more paternal containment, which as Emanuel (2006, p.68) explained, incorporates a ‘‘structuring, penetrative’ role – a new thought, a transformation of what is received.’ I offered Mrs Roberts firmer interpretations, especially when she was muddled about her relationship with Silvia.

> *I said that when there were boundaries they became cruel and trapping, rather than caring. She nodded. I spoke about an idea that it was caring to say to Silvia that you are not well enough to be at school. She said – yes, if I didn’t care about her, I would let her go. I spoke about this being confused with her experiences of being prevented from doing things.*
>
> *(S.8, 8th June)*

The interpretation created a space in Mrs Roberts' mind between Silvia and herself. She was a single parent and perhaps needed the therapist to take a more paternal function. Trevatt (2005) and Jarvis (2005) highlighted the need for parent work for isolated and depressed single parents as their children approach adolescence. They also found that parents were uncertain about how to have authority with their teenagers and either became authoritarian or a confidante. Mrs Roberts was too identified with her adolescent self that hated authority. As *Woodlands* took on the parental authority, it highlighted this conflict for Mrs Roberts. The task in the sessions was as Barrows described in parent infant work;

> the [parent's] representations themselves remain unchanged but they are disconnected from the infant (in the present) and reconnected to their original source…modifying the representations themselves would be a much longer term undertaking (2008, p.76).

Mrs Roberts could not modify her view about boundaries, but when she understood that some of the conflict was linked with her issues, the conflict diminished.

Mrs Roberts spoke about the containing aspect of our sessions in the follow up:

> *She had found it helpful to have someone to talk to, feeling that she was not alone, because she felt that everyone was against her. It is helpful to talk and offload, get things off her chest and see things differently. I felt moved.*
>
> *(TC, 7th December)*

Mrs Roberts conveyed her vulnerability as single parent, who was faced with Silvia going into care. Much of our work was trying to gather up her conflicts and look at them together. In one session, she brought a bag of Silvia's dirty washing in. We discussed that the sessions were the place that she could air their 'dirty' washing.

The therapeutic relationships with the parents contained some of their distress and anxiety. However, this was limited, partly due to external circumstances, but also due to the parents' internal circumstances, which seemed related to the 'parental eating disorder states of mind' that I described in the previous chapter. They perhaps had no experience of a containing object, and had developed a 'no entry' state of mind so that it was difficult to introject anything from the sessions. The difficulties that parents encountered post discharge might also link to this. Furthermore, as Sohn (1985) noticed in his work with anorexic and bulimic patients, the analyst is often made to feel like 'one is an object that is allowed no role in their mental and emotional lives; one's assigned role is to produce spoiled food in the form of useless unwanted interpretations' (p.55). Therefore, the analyst can also lose his/her appetite for the analytic work. Although I was not undertaking psychoanalytic psychotherapy with the parents, given the parental eating disorder states of mind I described, as well as my awareness that at times my curiosity was curtailed and the work flattened, I wondered if this process occurred in the transference to some extent.

Relationships with other parents

Contact with other parents is a feature of parents' lives[79]. Parents often spoke informally to one another when visiting[80]. Previous studies have found that parents of children with eating disorders valued contact with other parents (Cottee-Lane et al., 2004, Davenport, 2008 and Nicholls and Magagna, 1997). However, I found a more mixed view, which could be because the young people in this study had chronic eating disorders. Some parents avoided contact with other parents, which related to the parents' ambivalence about seeking help, which I discussed in the previous chapter. However, there were issues around rivalry, envy and competition with other parents, so while the lack of contact was partly a relief, it was also isolating.

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[79] The success of online parent groups such as Mumsnet, illustrates how much parents value parent support.

[80] During this study, there were no formal parent groups at the unit.

Mrs Harris mentioned rivalrous feelings in a parent group.[81]

> *Mrs Harris remembered that a mother said that she had given up on her daughter. She had been judgemental and had thought, how could this woman say this! But now if there was a parent group, she would not go, because she might put parents off, if they knew how long Scarlett had been here. I spoke about her feeling isolated, as Scarlett had continued to struggle. She nodded. I wondered if her situation felt unique. She said – no that would imply something special about it and added anxiously –'I don't want you to get the impression that Scarlett is the most ill anorexic ever.'*
>
> *(S.1, 9th March)*

In '*One flew over the cuckoo's nest*' (Kesey, 1962) a group of patients are referred to as the 'chronics'. Mrs Harris felt that in *Woodlands* she was a 'chronic' parent. It was too painful to attend a group when she could not identify with thoughts about hope and recovery, and this also provoked her rivalry with other parents. Furthermore, she feared that she would be judged by other parents as she had judged other parents.

Mrs Harris spoke about envy amongst parents in the unit, when she was in the position of being envied.

> *It was hard with other parents, because although they are nice about things, she felt envious about other young people being discharged. She remembered a patient who was here for four months and now she was at college and doing ok....She had thought – why couldn't it be like that... She felt uncomfortable now being in the position of being envied.*
>
> *(S.4, 13th July)*

Mrs Harris had perhaps made envious attacks towards this patient and consequently feared other parents' envy. Mrs Harris seemed to have a retaliatory spoiling internal object, as she had previously said that

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[81] This had been run in the unit previously, before this study had begun.

> *She can't allow herself to feel hope when good things happen. It was as if the devil comes along and takes it away and says don't be stupid.*
>
> *(S.1, 9th March)*

Such a fear could extend to the possibility that other parents would spoil Scarlett's discharge with their envy.

Mrs Roberts voiced similar feelings of envy.

> *It was hard when she thinks of the other kids going home. Silvia's weight is not that different to their weights and some parents have lots of difficulties too, but they are allowed to have their children home. They have not got a social worker.*
>
> *(S.5, 11th May)*

This must have been painful for Mrs Roberts. Her envy was likely to have linked with her envy of her mother, who had kept Silvia previously. This led to her feeling resentful towards authority and other parents.

There was also an anxiety about sharing staff and the resources of the unit with other families. Many parents were anxious about finding parking spaces, which perhaps reflected an anxiety about whether there was space for everyone. This was particularly relevant for an eating disorder unit, as Lawrence (2008) has argued that patients with anorexia often worry about their greed, which might also be absorbed by the parents. Mr Short felt that there were 'too many other families' which led to disagreements. Mrs Roberts was angry with Dr Hinchley on one occasion, because he had had to meet another parent. Mrs Roberts felt that the other parent should have waited. These comments were made after a holiday when staff had been absent, and so there was a greater anxiety about resources. At this point, the announcement of the unit's closure had not been made, but unconsciously some anxiety about resources seemed to have been detected. [82]Menzies (1960) observed similar phenomena in her study, noticing that relatives and patients often became demanding, jealous and possessive of staff, which created tensions in relationships with other parents.

In contrast, some parents wanted more contact with parents. Mr Barnes said

> *'You are so isolated. You stick together, but you don't mix. In the dining room there might be other families, but no one speaks.' Mrs Barnes said that she thought that this was typical in psychiatric units. Mr Barnes said he thought that the other unit seemed more lively.*
>
> *(S.6, 13th July)*

Mr Barnes missed ordinary contact with other parents. Mrs Barnes' comment about being in a psychiatric unit suggested that there was something inhibiting about the setting. I do not know whether this was a message that was unconsciously communicated by the staff.

Relationships with the wider family

Relationships within families were under a lot of strain during the hospitalisation and preoccupied parents. Although I only met with three fathers, it was important to hear from fathers as other therapists have argued (Barrows, 1999). It was particularly interesting when couples attended, as I gained a fuller picture of the couple's life.

Parental Couple

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[82] It was perhaps more complicated, because to have come to this unit funding had had to be agreed by the local health authority. Some parents had had to argue why their child should be admitted to this unit, over other children, whereas in other cases, children had been admitted to this unit because local units were full. Therefore, the processes around admissions created an anxiety about whether the child would have a place that would meet their needs, which perhaps created an idea of competition amongst parents, rather than cooperation.

There was an anxiety about the parental relationship, which has been found in other studies of parents who have children with anorexia (Whitney et al., 2005). Mr and Mrs Short spoke about arguing about Caroline.

> *They were having fun with their older daughter and cousins and Mr Short wanted to take Caroline's phone-call in the room, but Mrs Short had disagreed. She didn't know what state of mind Caroline was in and if she was down, hearing people having fun would be unhelpful. She thought that it would be better to take the call separately. She worried when they can't agree on how to manage Caroline, and wondered whether they would separate. I said that she was worried about the impact that Caroline's illness was having on their relationship.*
>
> *(S.3, 20th April)*

There was an anxiety about whether their relationship could contain the distress of the illness. Cudmore and Judd (2001) found that the ability of the couple relationship to contain loss linked with the quality of the relationship. This anxiety about separating possibly linked with Mrs Short's hostility towards her husband. They often arrived separately and Mrs Short felt angry that she was left with the household chores. The atmosphere in the room often felt difficult, which was partly due to their relationship with me and their states of mind, but was also because talking together was unfamiliar. When Mrs Short voiced concerns that Caroline might die, and expressed some suicidality herself, Mr Short did not support her, leaving them both isolated.

Other parents avoided confiding in partners, similar to their avoidance of confiding in friends. Mr Harris said:

> *He used to tell his girlfriend and parents that Scarlett was fine, everything was fine, even when it wasn't. He disliked bringing bad news and upsetting people. I wondered if he felt that he needed to look after them too, if they were upset. He said – yes exactly... He was trying to keep things steady, but to have someone else upset was more of a burden.*
>
> *(S.1, 16th March)*

Mr Harris barely mentioned his girlfriend again, despite living together. It was as if she was a distraction for him, rather than someone who could help him, or someone who was also affected by Scarlett. I wondered if Scarlett's illness was so painful for many reasons, he could not speak about it to anyone.

Mrs Harris felt similarly, in relation to her second husband.

> *She said that her husband is supportive practically. When she had to go abroad[83] he visited Scarlett. But she does not talk to him about Scarlett – he cannot help. The night of the overdose – he was angry and kept asking – how did they let that happen? She accepted it. I asked her how she felt about his reaction. She felt that she had done something wrong and so now she says nothing. I asked in case she felt criticised. She said yes - the night of the overdose she needed him to say – go and see your daughter, but he didn't.*
>
> *(S.1, 9th March)*

Mrs Harris barely mentioned him in further sessions. His criticism of *Woodlands* left her feeling guilty and unable to confide in him. To avoid conflict in herself and within this relationship, she distanced herself from him. This was similar to her relationships with her friends and linked with what I termed 'parental eating disorder states of mind'.

However, some couple relationships seemed to improve through the experience. Initially, Mr and Mrs Barnes struggled to help each other.

> *Mr Barnes said that it is like you are on the Titanic and you are drowning. You are paddling so hard to keep yourself afloat, you're not sure if you can. You can't keep anyone else going – you have to say sorry – not sure I am going to make this – I cannot help you. He looked at his wife sadly. I spoke about the experience being isolating for them both.*
>
> *(S.1, 16th March)*

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[83] She had had to return to her country of origin to visit her father who had been unwell.

Mr and Mrs Barnes had an ordinary reaction to a traumatic situation. However, they discussed their experiences together, which helped them to reconnect. Emmanuel (2006, p.81) argued that the worker's role can be 'a *modulator* attempting to help parents begin to function as a containing parental couple, and to integrate the extreme positions which they have taken up.' This happened in our sessions. Mr Barnes, who was more distant from Melanie, could make observations which he shared with Mrs Barnes, which helped Mrs Barnes see things differently. Their relationship then supported Melanie's development.

As Melanie recovered, their relationship improved.

> *Mrs Barnes said that her relationship with Mr Barnes was much better. She asked him for advice, and was impressed with his abilities with teenagers... I wondered why she thought her relationship had improved. She said that they had gone through a difficult experience together and he had persisted with Melanie after all the rejection. Mrs Barnes said that one day her daughters will leave home, and she wanted to enjoy her time with her husband rather than think – who is this person*.
>
> *(S.8, 16th October)*

As Mrs Barnes found more pleasure in her couple relationship, Melanie could separate from Mrs Barnes, because she did not need to be Mother's partner.

Mrs James had little contact with Sarah's father. Although their relationship did not change, she developed an idea of a couple in her mind.

> *She said that she needs to be firmer, especially about eating – she has to tell Sarah - that is what you have to have. I said that it was hard being a single parent, being tough, as well as supportive. She agreed and said that she finds the soft Mummy bit easier, but someone had to do the Daddy bit. Sarah's father was never there for her. They did not have much contact. I said that this was very hard for her and the children.*

(S.4, 10th July)

Mrs James struggled with being both a maternal and paternal object. Emanuel (2006) argued that it is possible for single parents to embody the maternal and paternal aspects of containment, but it is necessary to hold a couple in mind. Mrs James had developed an idea of a couple in her mind and began to get in touch with the pain of the absence of Sarah's father.

For Mrs Roberts too, some idea of a parental couple began to emerge.

> *Mrs Roberts said that they went crabbing and she had a coffee with Silvia's father and left Silvia by the river. I felt surprised by the mention of Silvia's father as Mrs Roberts rarely mentioned him. She said that this was nice – Silvia was nearby – but she was able to do her own thing.*
>
> *(S.9, 27th July)*

Adamo and Magagna argue that fathers offer a widening of the containment process, so that the infant experiences 'a secure passage from mother's lap' (1998, p.10). The presence of a couple helped Silvia and her mother to separate briefly. This moment suggested that there was a wish for ordinary Oedipal configuration. Britton (1989, 1992) has written about the role of the father in the process of separation. He argued that fathers become a figure for identification for the child. When the infant becomes aware of the link between the father and mother, although this creates a loss of his/her dyadic relationship, it can be the beginning of creating a triangular space. The infant becomes a participant of a relationship, as well as an observer, which is important for the development of reflective thinking. Music (2004) has argued that some single parents can help their children with this task by moving between 'strictness and leniency, toughness and softness, empathic subjective presence and objective analytic observation' (p.22). However, Mrs Roberts did not sufficiently have a couple in her mind to do this.

Couple relationships were placed under stress through the process of having a child hospitalised. For some parents, this highlighted underlying conflicts in their relationships. For other parents, it was an opportunity to develop their relationship, even if this only happened in the minds of parents, as with Mrs James. It was interesting that the parental relationships correlated with the representation of parental couples in the minds of patients with anorexia – separated couples with little sexuality (Lawrence, 2008). This may have arisen in relation to the ill child, or may have been an underlying relationship difficulty in these families.

Family relationships

As the patients recovered from their eating disorder, I heard more about siblings' psychological difficulties. The patient may have been carrying something for the family, which linked with Menzies' (1960) argument that hospitalisation is a way of avoiding an emotional difficulty for the family. It also correlates with Asen's (2002) argument that when the patient recovers, other family members become ill. Additionally, there were specific issues which related to the child's hospitalisation, as parents spent less time with siblings. The impact of the child's eating disorder on siblings has been found in other studies, even when the child has not been hospitalised (Cottee-Lane et al., 2004).

Mrs James' son was referred to CAMHS and she described more sibling conflict. As Sarah recovered, the family had to face their issues. A similar pattern occurred with Mrs Barnes. As Melanie recovered, she spoke about her older daughter, Fiona's, difficult behaviour. Fiona may have postponed ordinary teenage rebellion, as she was aware of her parents' stress, and had experienced the pain of rejection herself. As Melanie recovered, the difficulties which she had been carrying for the family were redistributed.

Parents were also preoccupied with the consequences of having one child hospitalised. Mrs Barnes spoke about the family adjusting:

> *They had gotten used to life without Melanie at home, as much as they wanted her back. When there was only Fiona, the dynamics changed. I said that she was worried about having two children again. She agreed and said that they had to get used to being together again, which was not easy. I commented that she needed to get used to being the mother of two children at home, perhaps like when Melanie was born*.
>
> *(S.7, 25th September)*

Mrs Barnes' anxiety about how she would parent Fiona and Melanie was an anxiety that many second time parents share. Ordinarily a family adjust to accommodate a new arrival, but ordinary development had been interrupted. Mrs Barnes struggled to realign her identification as a mother of two children.

Parents also worried about managing siblings' feelings of jealousy. Mrs James reported that her daughter had called Sarah an 'anorexic cow' and Mrs Barnes said that Fiona had been difficult.

> *Fiona had said that maybe she should stop eating and go to hospital. Mrs Barnes looked upset. I said that this worried her. She said that she did not to let it get to her and had said to Fiona - that would not be very sensible. She hopes that Fiona does not feel too left out. They had talked to her about this all the time that Melanie was in hospital. She was aware that it was aimed to hurt her and she had to accept that Fiona might be angry with her.*
>
> *(S.8, 16th October)*

Mrs Barnes could tolerate Fiona's anger with her. She understood the meaning of the comment and thought about it.

Some families were unable to transition to having more than one child at home again. Mrs Roberts said that the most difficult aspect of having Silvia at home was managing both Silvia and her sister Charlotte. This situation was resolved by Silvia returning to hospital. Mrs Roberts did not believe that she could be a mother to two children. Charlotte then received the lion share of mothering, whilst Silvia felt deprived, which re-enacted what had happened previously.

Parents also relied on the patients' siblings to reassure them about their parenting capacities[84], but also to voice difficult feelings. Mr and Mrs Short relied upon Caroline's sister, Lucy, in this way.

> *Lucy spoke about feeling guilty for not visiting Caroline, but annoyed when she visited, and Caroline gave no indication that she was wanted or that she appreciated the visit. She might as well have stayed at home.*
>
> *(S.2, 16th March)*

I imagined that Mr and Mrs Short felt similarly to Lucy, but as parents, it was difficult to voice. Therefore, they may have felt pleased that Lucy could carry the ambivalence.

Lucy also spoke about her crossness with the staff.

> *Lucy said that she was annoyed that she was not allowed to take Caroline to the toilet. Mr and Mrs Short agreed. She felt that she was not trusted and she was family. Mr Short added that it was weird, because they as parents are not making the decisions, although they understood the concern about Caroline's self harm.*
>
> *(S.2, 16th March)*

Lucy could raise feeling excluded and annoyed by the staff, because she was not working with them. Mr Short used Lucy's complaint to express his frustration. One wondered whether she was brought to the session to voice this anger on their behalf.

Mrs James also brought her daughter to a session, and this felt as if she wanted me to know what it felt like to be in her position.

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[84] See p.109- 110 in 'States of mind' chapter.

> *She said that her daughter, Alice, could tell me how angry she was at having to miss school. I felt blamed. Alice looked down and I felt that I should appease Alice, but was aware that Mrs James seemed angry.*
>
> *(S.2, 9th March)*

Mrs James needed me to experience Alice's hostility and to have someone else for Alice to blame. Mrs James perhaps also wanted to temporarily hand over responsibility to me, to see how I coped.

Although Fiona did not attend sessions, she voiced difficult thoughts about Melanie. Fiona had said that she 'hated' Melanie and that she did not want Melanie to come home. I think that there was a part of Mrs Barnes which felt this too. Mrs Barnes was able to get in touch with her ambivalence about Melanie and this could be discussed, rather than having to be thought about through Fiona.

Relationships between siblings were an issue for parents. It was interesting that siblings were often used to voice difficult feelings, and that they too had their own issues. Whilst siblings could attend family therapy, in practice this varied.

Conclusion

The relationships that the parents developed and managed during their child's hospitalisation were complicated. As the relationships involved a triad, usually the parent, child and staff, one wondered about parents' ability to manage threesomes, which has been linked to the ability to self reflect (Britton, 1989) which parents struggled with.

Parental relationships to the therapist and staff were ambivalent. However, one needed to look beyond the words the parents said to understand their feelings. Issues of power and authority meant that it was difficult for parents to express their feelings about the staff and myself. These topics were complicated by their previous experiences of staff and of authority figures. When one analysed the material closely, one discovered powerful feelings of envy, rivalry and exclusion, as well as feelings of being contained and supported. Their relationships with other parents highlighted primitive feelings around envy and rivalry. In contrast, the parents' relationships with those outside of the centre, such as their partners and other children differed. All parents seemed to experience difficulties within these relationships, which related to their child's hospitalisation. However, one couple could develop their relationship, whilst others became more distant from partners. Furthermore, the sibling relationships highlighted other crises in the family, and suggested that some of the patients may have been carrying a conflict for the family.

Conclusion

I intended to explore parents' experiences of having their child hospitalised for an eating disorder. I developed several research questions to focus my thinking on this topic. In this section, I will consider how the data has answered each question. I will then summarise the findings of the study. I will also consider the limitations of this study, and reflect on the process of carrying out this research. Finally, I will consider recommendations for clinical practice that were linked to my findings and think further about the role of the child psychotherapist in supporting parents whose children have been hospitalised for an eating disorder.

Research Questions

What impact did the child's hospitalisation have on parents' states of mind?

On reflection, it is difficult to answer this question because the children's hospitalisations were part of a broader experience for the parents – e.g. first noticing the child was ill, managing the illness at home, seeking a diagnosis and receiving a diagnosis. It was impossible to separate the hospitalisation from their child's illness. Therefore, throughout the thesis I have not distinguished between the two, although here, I will firstly focus on aspects of the experience which were direct consequences of the hospitalisation, and then consider other factors that arose as a result of the child's illness.

Parents expressed loss and grief about their child, which was associated with the hospitalisation. More strikingly, parents were preoccupied with the loss of their idealised child and their imagined futures. This linked with their child's hospitalisation because *Woodlands* offered long term admissions to children who were severely ill, which confronted parents with the reality that their child had a chronic and serious illness. They had to acknowledge their child's withdrawal from ordinary life and the need for medical input. Two parents mentioned their fear that their child might die. This was prominent in parents' minds around admission; because at the time of admission many children were acutely ill. These fears correlate strongly with literature from child psychotherapists working with much younger children in neonatal units (Mc Fadyen, 1994 and Mendelsohn, 2005) and other child psychotherapists working in Paediatric settings (Judd, 1989). Therefore, it may be important for professionals working in both areas to link and share experiences about supporting parents to face these primitive anxieties.

Parents also thought about the loss of their futures when contemplating that their child may need a lot of support into adulthood. Their plans for their lives with more independent children had to be deferred. There were mixed feelings about this because the hospitalisation temporarily provided them with respite, which was a relief and meant that their lives could assume some normality – e.g. Mr Harris could play golf again and work because Scarlett was being looked after. At the same time parents felt guilty about 'enjoying' their lives outside of the unit, which related to the degree of ambivalence they felt about parenting their ill children.

Some parents experienced envy of their child's care, which was linked to the hospitalisation, as the patients received twenty four hour care, whilst the parents received little care in comparison. Although parents were not funding the admission, there were associated costs for parents, such as travel, childcare for other children and in one case, therapy, post discharge. There were also emotional costs, such as the tiredness and travelling. This was especially complicated when parents had been deprived themselves, as was the case with Mrs Roberts, and Mrs James.

Parents also struggled with feeling helpless, which was connected to the hospitalisation, as well as their child's illness. Parents felt helpless to reach their daughters emotionally, because they felt that staff could do this. Some parents also felt helpless in a medical system where there were delays and uncertainties. For some parents, this sense of helplessness spilled out into their lives outside of hospital so that they struggled to make decisions. The fact that the staff helped parents, or in some instances, made decisions for parents, meant that parents' ordinary confidence was eroded. This has been found in work with parents in neonatal units (Mc Fadyen, 1994, Mendelsohn, 2005) and again suggests that links between these areas of work may be helpful as child psychotherapists have had some experience in supporting parents to find their parental role in neonatal units, often using an observational approach. Loss of parental confidence was another theme that was closely related to their child's hospitalisation. Parents had to adapt to different ways of doing things, which made them feel that they had mismanaged things. Underlying this, the necessity of an admission led to a feeling that parents had failed their daughters. There was little material about parental confidence developing, which suggested that the hospitalisation had a negative impact on this.

Another reason for their lack of confidence was that some parents had a narcissistic involvement with their children's development. The fact that their child had been hospitalised altered the parents' belief in their parental capacities. Some parents reassured themselves about their parenting capacities by talking about their other children. Furthermore, parents did not have sufficient opportunity to carry out parenting tasks, and take greater responsibility for their children which impacted on their confidence. For example, the Shorts had had not eaten with Caroline throughout her hospitalisation. Yet, this study shows that this issue of parental involvement was complicated by parental ambivalence about taking up this responsibility, which meant that parents avoided opportunities to develop their confidence.

Following the admission, many parents became dependent on *Woodlands* for support and guidance. They were understandably relieved that *Woodlands* was a specialist unit and had expert staff, because their children were severely unwell and presented serious risks to themselves. However, their dependence on the unit was also a consequence of their lack of confidence in their abilities.

What impact did the child's illness have on the parents' states of mind?

I will now answer the first research question in its broader sense, thinking about the impact of the child's illness on the parents' states of mind. Parents sought to locate blame somewhere for their child's eating disorder, rather than their admission. (Issues of blame about the hospitalisation were absent, as parents were relieved about the admission.) Some parents located blame in external situations such as school, or genetics, or experiencing abuse, whereas some blamed themselves. Yet this self blame was complicated, and served almost to avoid thinking about their relationship with their child. Many parents felt guilty about why their child had become ill and felt that it was something that they had done. This guilt was complicated because at times it seemed to be a narcissistic guilt, aimed at relieving parents from their 'bad' feelings and was linked with their ambivalence about parenting their child. For some parents, there was more of a depressive guilt, in which there was genuine sadness for their child's suffering.

Throughout the material, it became clear that parents demonstrated what I termed, 'Parental Eating Disorder States of mind', which were ways of thinking that have been described in patients with eating disorders. For example, Williams (1997) has discussed patients' difficulties of taking things in. These parental states of mind seemed connected with the child's illness, as they appeared to be long standing and not directly caused by the hospitalisation, although were exacerbated by the hospitalisation. For example, parents had a tendency towards splitting and projection, which has been described in patients with eating disorders (Lawrence, 2008). The division of the different teams, such as the paediatric team, the inpatient team and the outpatient team, leant itself towards splitting. Parents also struggled to accept help and turned to an autonomous self, which is a familiar pattern in young people with eating disorders. They had developed what Williams (1997) termed 'no entry defences' and found it difficult to process their emotions. This could partly be the impact of being traumatised by their child's admission, but was likely to be because they felt that they needed to be seen as 'coping' which Mrs Harris alluded to. Parents then found it difficult to use the support on offer, particularly when they were aware that *Woodlands* was closing. ‘Parental Eating Disorder States of Mind’ were either a consequence of having a child with an eating disorder, and so parents became used to dealing with emotions in this way, or a pre-existing state of mind which perhaps increased the young people’s risk of developing these states of mind. This is an interesting question for further research. It also has implications for understanding why parents found it so difficult to internalise the support from the staff.

Do parents’ perceptions of themselves alter over the course of the admission?

I intended to look at whether parents’ perceptions of themselves changed over the course of the admission. However, this was difficult for several reasons; *Woodlands* closed, thus ending the study prematurely. Most parents attended between 4 and 6 sessions over the course of three to six months, which is not a significant time to study change, especially in comparison to the lengthy hospitalisations of their children. Furthermore, when patients were discharged home, this was because of resource and placement issues, rather than changes in the parents. Finally, as some parents had already been involved with the unit for a long time before the study began they may have already changed, but I would have been unaware of this.

There were some areas in which parents felt that they had changed. Some parents noticed that they had become firmer around setting boundaries, particularly as they saw their child becoming more robust. However, this was not sustained post discharge, which was closely connected with the amount of support the staff provided to parents.

There was evidence of parents feeling less enmeshed with their child and more able to separate. Mrs Barnes was most able to reflect on her changed relationships both with Melanie, and with Mr Barnes. Other parents had less sustained changes, such as Mrs Roberts’ reflections on her relationships with her parents. Given the degree of trauma and loss she had experienced, she would have needed a much longer term piece of work to help her think further about her relationships and the possibilities of repairing these.

There was some evidence of parents changing their expectations over time. Many parents initially hoped that their child would get better quickly in a specialist unit, but began to accept that their child may take much longer to recover, and may not make a ‘full’ recovery, which was a frightening prospect.

Parents’ perceptions of seeking help changed somewhat over time. As I have discussed, most parents were highly ambivalent about engaging with me and many remained so throughout the sessions. However, when I followed up the parents, some acknowledged that the sessions were helpful. Mrs Barnes was most able to comment on this, which may have reflected her regular attendance and follow up sessions, which meant that we had a greater opportunity to work together. Although this thesis was not designed to measure clinical effectiveness of parent work, this suggests that parent work is more effective if it is consistent and can be engaged in over a longer period of time.

How do parents understand their child’s admission? Does this change over time?

There was some discrepancy between the way that parents understood their child’s admission, and the way that they understood their child’s illness. I will firstly look at the themes that emerged in relation to the admission. Most parents were relieved that their child was admitted to a specialist unit. Reflecting on the data, parents omitted the specific reasons that their children were admitted. Some parents mentioned safety and a need for respite, and spoke about how acutely ill the children were. However, parents did not have a sense of the goals of admission. These may not have been communicated clearly to them, but the material I gathered suggested that parents were so relieved that their children were being cared for by the institution, they could not think about goals. This may have unconsciously fed into the long admissions that families experienced and made it more difficult for the parents to feel confident about their child’s discharge, because they were unclear about the changes that were necessary.

Mr and Mrs Barnes were the only parent couple who used Melanie's hospitalisation as an opportunity to think about their separation from Melanie and tried to do things differently. For example, Mr Barnes became more involved with Melanie, whilst Mrs Barnes gave Melanie more space, particularly to voice negative feelings. They were able to use the help on offer to do this and could maintain and develop their thinking about Melanie's emotional states over time.

In terms of understanding their child's illness, parents were confused. Parents fluctuated between blaming others, feeling blamed by others, and blaming themselves. There was little evidence to suggest that parents' perceptions of this altered over time. Mrs James briefly became more thoughtful about her daughter, Sarah, and the reasons for her illness, but this thinking vanished when our sessions ended. To see a sustained change in parents' perceptions of aetiology would have required a much longer follow up period, as well as more intensive work. Parents' confusion about aetiology was linked with their confusion about the reasons for the hospitalisation and their guilt and blame. This perhaps links with the Parental Eating Disorder states of Mind' which meant that it was difficult for them to digest and process their feelings and so uncomfortable feelings were split off and projected elsewhere.

***How do parents view their role in the admission**?*

Parents were confused about their role, because the hospitalisation required them to take up a new role, which has been found in studies about hospitalisation in other contexts (Hayes and Knox, 1984 and Jay, 1977). Parents were uncertain how to work with staff and whether staff should make decisions or whether they should. Underlying this confusion, was parents' ambivalence about taking up their full parenting role. It was impossible to know whether this was a longstanding difficulty for those parents, and preceded the child's illness, or whether this was the consequence of struggling with a very distressed, and distressing child for a long time.

The parents also lacked confidence about their parental abilities and their abilities to relate to their children. This was particularly in relation to the staff.

This resulted in parents taking up a more marginalised role and compounded their feelings of exclusion by staff.

Furthermore, as many of the parents understood their daughter's behaviour as 'anorexic', rather than understanding the behaviour in a relational way, parents felt that they did not have a big role in their child's illness. Some parents acknowledged that they needed to change certain things, such as setting boundaries, but felt that these were small changes. This also related to their reluctance to engage with new outpatient teams when their children were discharged. This was problematic because parents struggled to take on their full parenting role, and to make changes that may have helped their child to manage more effectively.

How did parents view their child's discharge?

Most parents experienced a sense of loss about leaving *Woodlands*, which was unsurprising given that most children had had long admissions and parents had become dependent on the unit. In many ways, parents had become 'institutionalised' as well as the patients. To avoid this sense of loss, parents spoke about being excited about the discharge, yet they seemed emotionally disconnected with this. The parents' sense of loss was complicated by the premature closure of the unit, and so they were shocked, angry and felt rejected. Parents then avoided getting in touch with other avenues of support at home. There was also some regret that parents had been unable to make use of the opportunities that had been offered.

Parents were ambivalent about their child's discharge as they were terrified about taking home an ill child, and taking responsibility for her. Even parents like Mrs Roberts, who had 'battled' to have Silvia home, was ambivalent about this. Parents were confused about what the discharge would be like. When I followed the parents up a few months after their child's discharge, of the five, only two remained out of hospital. This was likely to reflect parents' ambivalence about having these children home and the 'rushed' endings that occurred as a result of *Woodlands* closing.

Interestingly, more tensions between siblings were reported around the discharge, which was difficult for parents. Parents struggled to think about how they would adapt to having two or more children again, as well as how they would manage sibling conflicts. Furthermore, some siblings developed mental health issues as the patient approached discharge. This could be because the referred child had been carrying something for the family, and as she got better, the difficulties presented themselves elsewhere within the family.

How do parents view their relationships with the staff?

Relationships with the staff were complicated, as I have touched upon. Parents felt contained by staff and relieved that the staff could manage their children. Yet this too was problematic, because parents became dependent on the staff to hold the authority about their child and had a tendency to regress to a child-like state themselves. It was as if they were ‘no more’ the mother or father and had lost their parental capacities, which consequently made it hard for them to contain their children.

In locating authority with the staff, parents perceived that they were being criticised. I am uncertain what role the staff played in this, but parents felt that there was a ‘right’ and a ‘wrong’ way to do things. This may have been acted out by staff, yet the parents’ sense of being criticised by staff was likely to have been their self criticism. They could have viewed the child’s need for an admission as proof that their parenting had been fundamentally ‘wrong’. This was exacerbated by feeling that staff could care for the children better than they could.

Parents felt excluded by the staff, which led to feelings of rivalry and a perception that staff were intrusive. I did not look at the role that staff played in this feeling, but for many parents, this rivalry linked with previous experiences of either being excluded from their child’s life or excluding themselves from their child’s life. For some parents, such as Mrs Roberts and Mrs Harris, this exclusion or absence had arisen from complicated family situations, but for other parents, such as Mrs Short, there had been an emotional absence. The parents’ sense of the staff’s intrusiveness was also connected with parents’ ambivalence about accepting and making use of help, which formed part of the 'Parental Eating Disorder States of mind' I have discussed.

Within my relationship with the parents, similar feelings emerged. However, it was possible to gather detailed data about parents' relationships with me as I could closely observe our interactions. Parents felt envious and rivalrous towards me being able to have a life outside the unit. There was also some rivalry with me as a mother to be from Mrs Barnes. Additionally, there was some envy of my role as a therapist and researcher. Although these issues arose specifically in my sessions, they may be issues that parents had with the wider staff – albeit unconsciously, which have implications for staff interactions with parents.

Many of the parents gave me an experience of exclusion and rejection, which linked with their experiences, both as a parent who is partially excluded from their child's life, and as an adult who is partially excluded from staff dialogue.

Parents were ambivalent about engaging with me, as could be seen by their attendance and the data. Yet parents also valued the space, even if like Mr and Mrs Harris, they had struggled to use it. Therefore, the sessions had been containing for parents to an extent. Their ambivalence about engaging with me was relevant to the relationships that parents had with staff, but because the staff were directly involved with their children's care, it was harder for parents to voice this and so it was acted out in different ways e.g. with me, or other parents.

Parents were also keen to locate authority in me, and at times I acted in with this, rather than staying with an anxiety or helping parents to think about the issues. This was a pattern that had emerged with staff, but when I examined this in our sessions, I saw how quickly parents located authority elsewhere. One the one hand they seemed to want to be contained by the therapist and the institution; yet on the other, they resented this authority. I did not know the details of parents' relationships with their parents, but this may have had some bearing on their ambivalent relations towards the unit and myself and would be an area for further research.

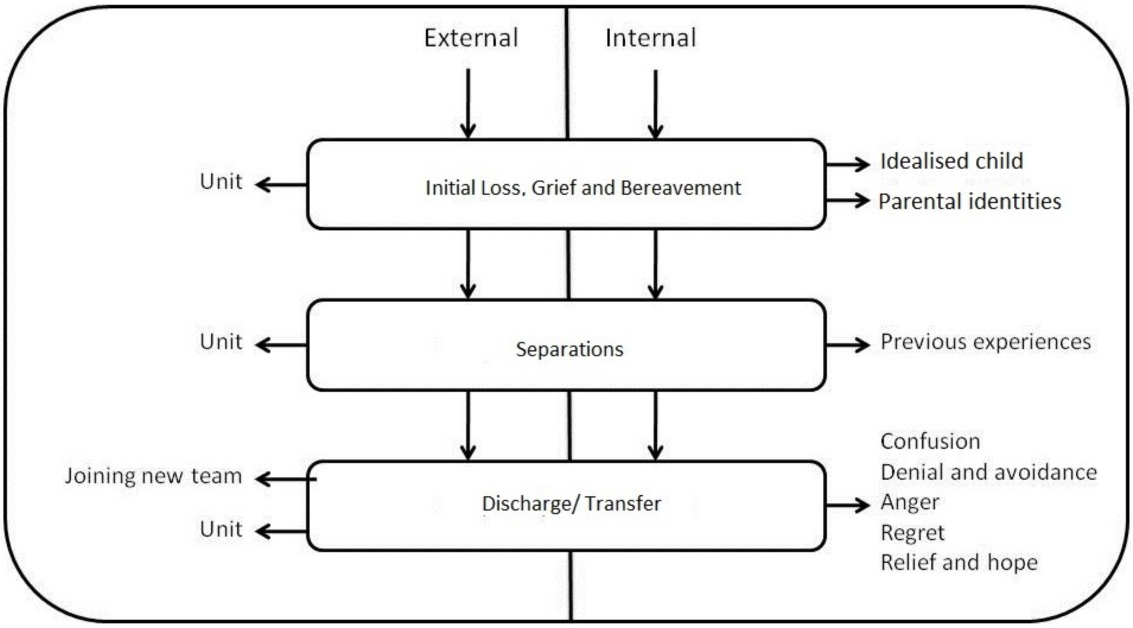
Many of the parents' more difficult feelings only arose when one looked closely at the material, as parents feared admitting to critical feelings. This is why questionnaires or structured interviews would have been unsuitable for this dissertation. Parents could have feared that the staff would retaliate, or that their child's care would be compromised, but they also needed *Woodlands* to remain a 'good' unit in their minds so that there was some hope of their child making a recovery.

Summary of main findings

Having answered the research questions, it is useful to consider the material that emerged in the study which fell outside the research questions, as there were some surprising findings. These findings were more embedded within the data, rather than extrapolated from the data and so were closer to the parental experiences.

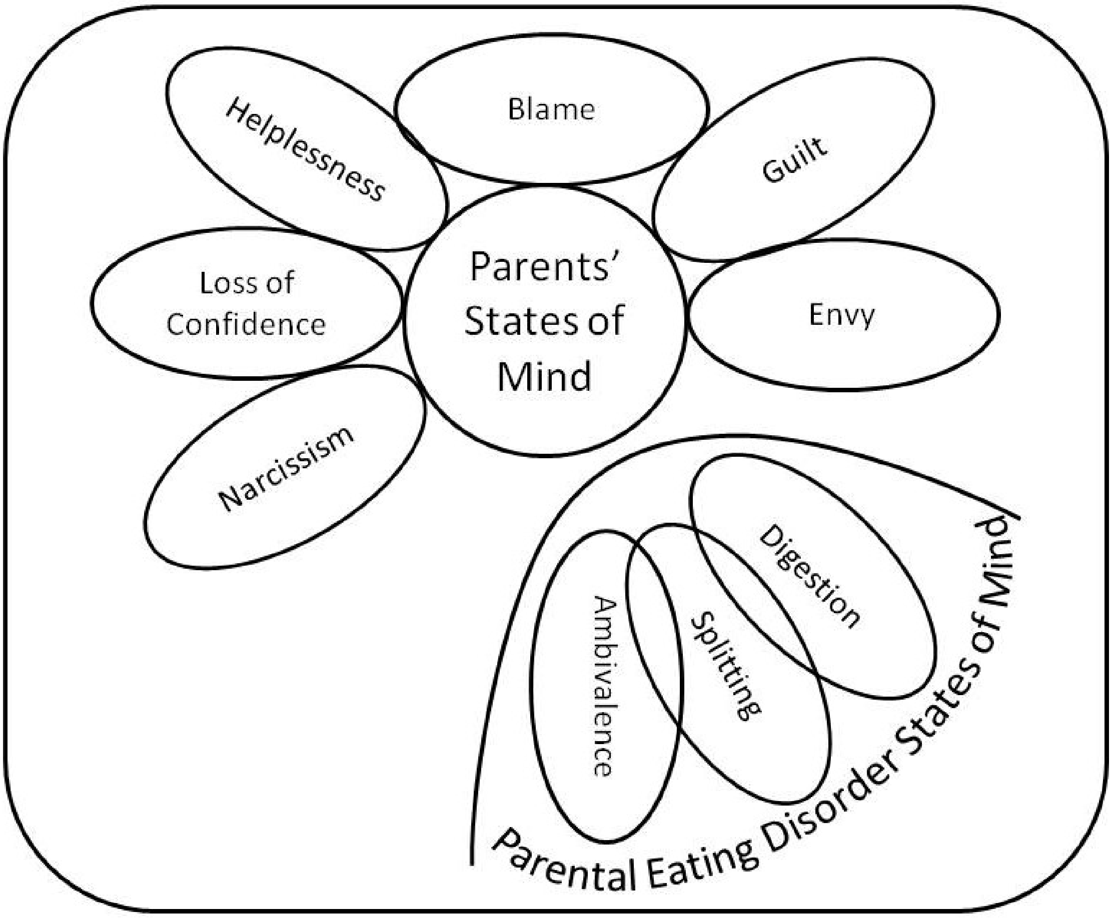
Parents were preoccupied with three main areas, transitions, their states of mind and relationships. I will summarise these areas briefly. Parents initially experienced loss, grief and bereavement when their child was admitted to *Woodlands*. Some of these losses were external losses, such as the loss of their child to the unit, and some were internal losses, which connected with the loss of their idealised child, and their identity as a parent, which has been found in psychoanalytic parent work in other contexts (Klauber,1998). Separations were another transition which parents experienced as the admission progressed. These again had an external aspect in terms of managing the actual separation from their child at the unit, as well as an internal aspect, which related to parents' previous experiences of separations. The final transition for parents was at discharge, which externally involved joining a new team and losing *Woodlands,* but internally involved processing their feelings about endings. I have illustrated this in diagram 1.

Diagram 1: Transitions



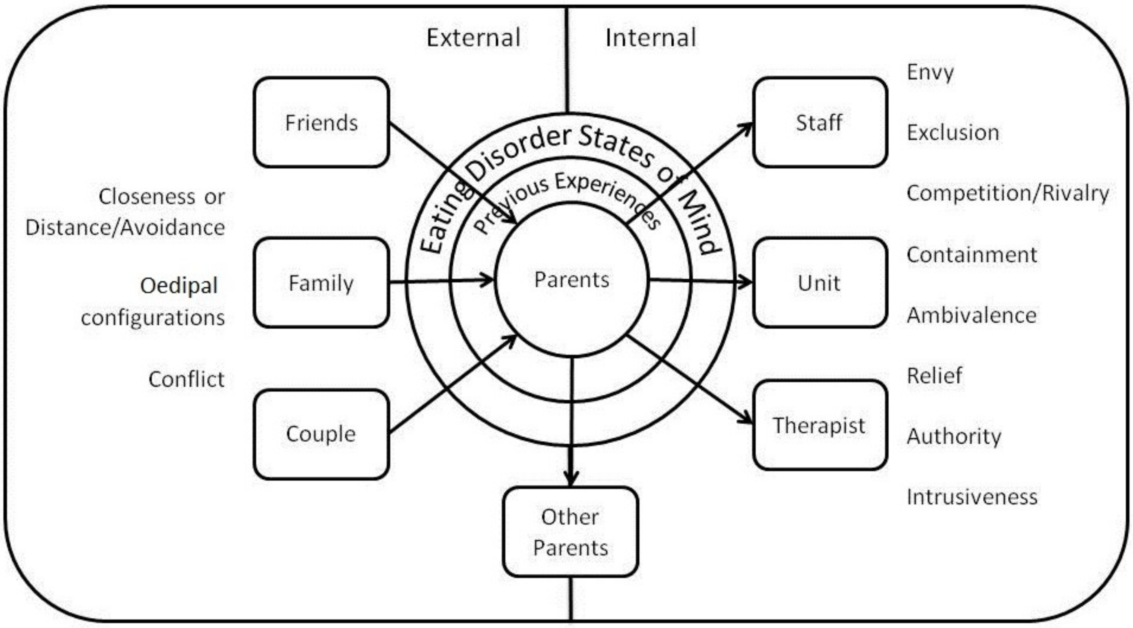
Parental states of mind were another preoccupation in the study. Parents expressed feelings of guilt and blame, envy of their child's care, helplessness and a loss of confidence in their parental capacities. These feelings correlated with findings in similar studies (Cottee-Lane et al., 2004, Treasure, et al., 2011, Whitney et al., 2005, Jarvis, 2005 and Klauber, 1998). Interestingly, as I have discussed, parents also illustrated several states of mind which have been previously described in patients with eating disorders (Lawrence, 2008 and Williams, 1997). These states of mind included splitting, difficulties in digesting feelings, and an ambivalence about seeking help. See diagram 2.

Diagram 2: Parents' states of mind



Parental relationships were another feature of the study. Inside the unit, parents related to the unit as a whole, the staff, and to me as the therapist. There were complicated feelings in these relationships, which I have outlined in diagram 3. Some of these feelings again correlate with previous research (e.g. Darbyshire, 1993, Davenport, 2008, Menzies, 1960 and Hayes and Knox, 1984). However, these relationships were influenced by parents' previous experiences, as well as the 'parental eating disorder states of mind', which seemed a core feature of their patterns of relating to themselves and others. Outside of the unit, parents managed relationships with friends, family and their partners or ex-partners. These relationships seemed to have a pattern of closeness, or distance and avoidance, and conflict also featured in these relationships, which has been found in other research (Whitney et al., 2005). Relationships with other parents resembled both their relationships inside the unit, as well as their relationships outside the unit. Additionally, contrary to previous studies (Cottee-Lane et al., 2004 and Nicholls and Magagna, 1997), I found that parents did not necessarily value relationships with other parents.

Diagram 3: Relationships



Prevalence of themes

To demonstrate the prevalence of the identified themes amongst the parents, I have provided three graphs. I have organised the graphs by chapter, and counted each parent, regardless of whether they attended individually or as a couple. Therefore, the most prevalent themes were those that featured in eight out of eight parents.

Diagram 4: Prevalence of themes in transitions

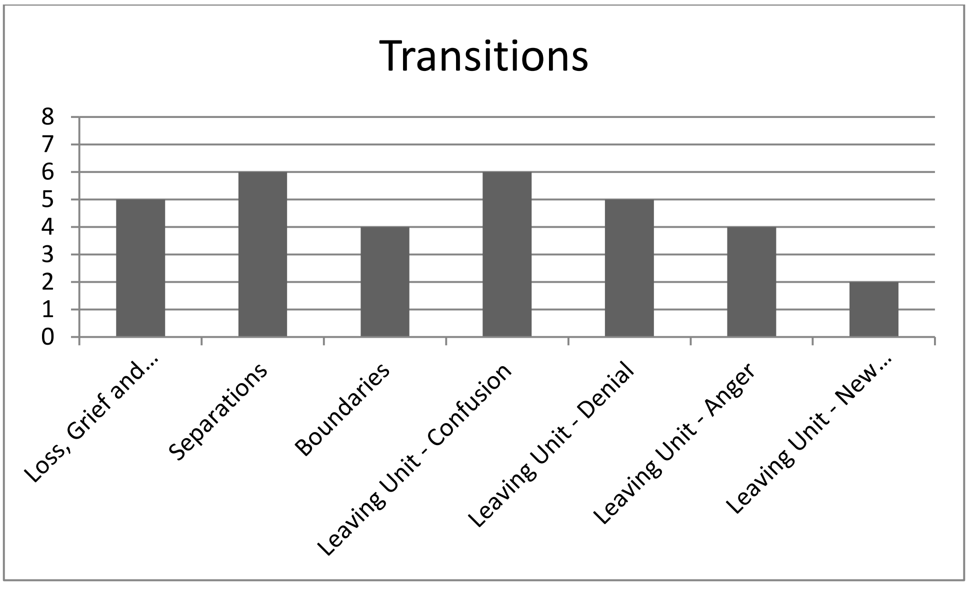
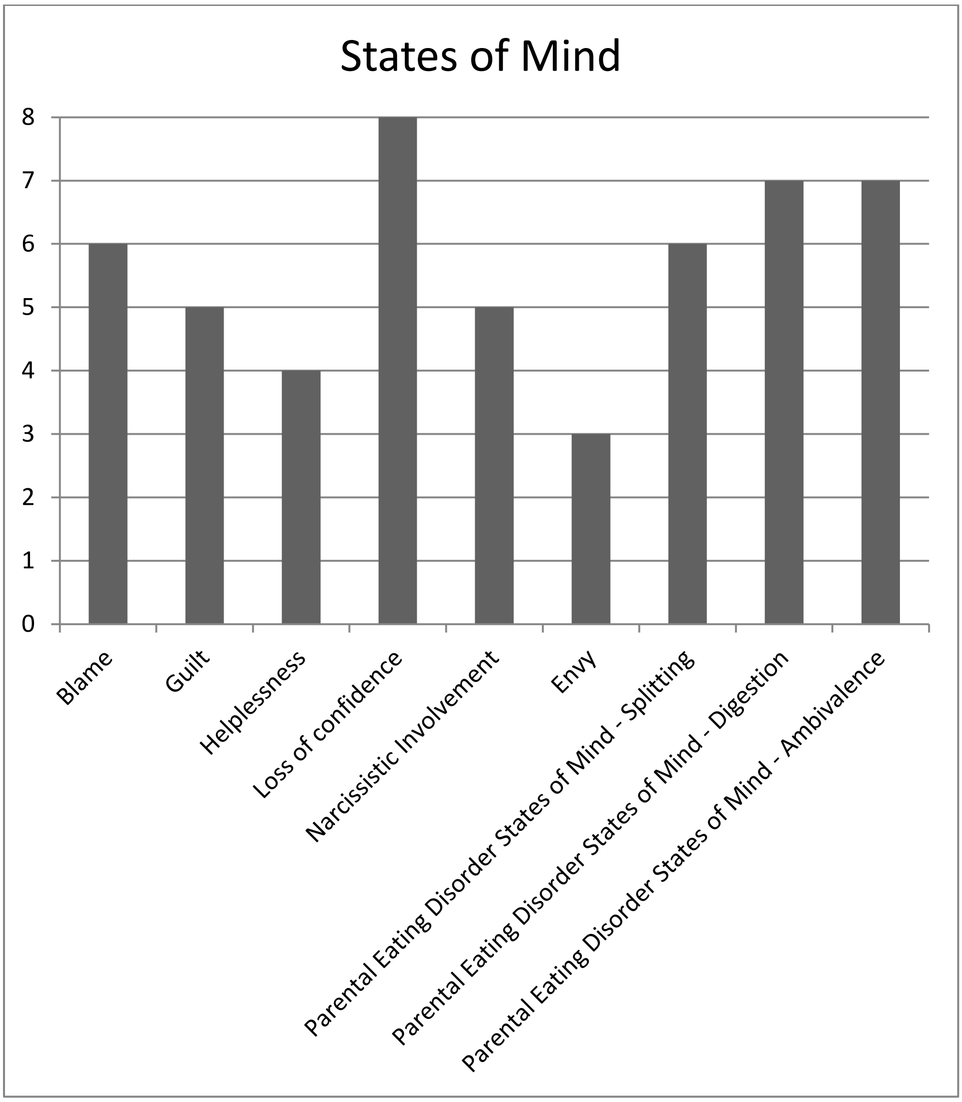
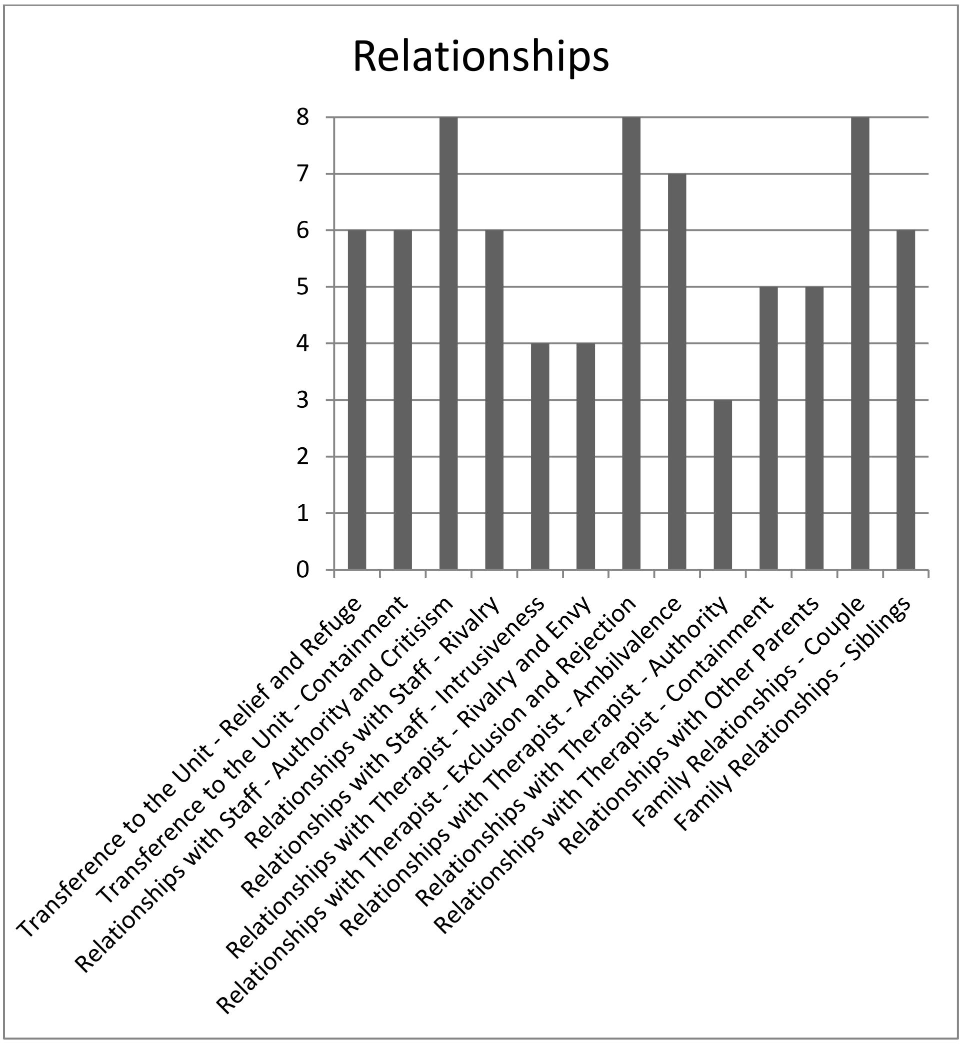


Diagram 5: Prevalence of themes in States of mind



It is interesting that loss of confidence was the most prevalent theme amongst the parents in diagram 5, given my argument that parents had lost their confidence in managing their child, which was compounded by staff intervention and their absence from their children's lives. This links with diagram 6, in which the relationships with staff – authority and criticism was very prevalent, as was the 'relationship with therapist - exclusion and rejection'. It is also interesting that the 'parental eating disorder states of mind' were very prevalent in the group, suggesting that this theme captures some shared states of mind. The prevalence of issues within the parental couple is also interesting in terms of treatment, as it would suggest that this is an important area for therapists to focus on in terms of supporting family functioning.

Diagram 6: Prevalence of themes in relationships



Reflections on the research process

Parents were puzzled about the sessions, as they were the basis of a doctoral study, but also therapeutic. For those parents who engaged with the sessions more fully, this confusion diminished over time. Nevertheless, this is a difficulty with doing practice based research.

I also struggled with my authority at times. It was difficult to feel that I had permission to explore certain subjects. For example, I did not know the details of Mrs Short's psychiatric admission, or the circumstances around Scarlett's sexual abuse, or why Mrs Harris had emigrated, or the details of her previous eating disorder. This could be due to the work being short term, and less consistent than I had hoped, which made it difficult to explore issues. I also became inhibited by my role as a researcher and lost sight of myself as a therapist. At moments, I felt grateful that the parents were participating in the study and so avoided addressing difficult subjects. The nature of the patients' difficulties was also secretive, which at times pervaded the work in *Woodlands*, and my work with the parents.

One wondered about the impact that the unit's closure had on me, in terms of feeling contained so that I could contain the parents. However, I was on a fixed term contract that ended at the time the unit closed[85], and so I was less affected by the closure of *Woodlands*. Furthermore, my pregnancy was not something I was aware of when planning the research. Most parents remained unaware of this, apart from Mrs Barnes, which as I have explained, may have made it more difficult for her to be open with me and also introduced a different variable in her data.

Limitations of the Study

The group of parents in this study was small. There were six sets of parents (as Mr and Mrs Harris attended separately), which related to five young people. To gather richer data, one would have needed to have recruited more parents. Furthermore, all the parents in the study were parents of girls, were white, and except one, were British. Whilst, this created a more similar sample group, it did not capture the spectrum of parenting a child hospitalised with an eating disorder, which may have varied in different ethnic groups and in parents of boys. Different sub categories and themes may have arisen that were more culturally or gender specific if the group of parents was more diverse.

Woodlands was also a very specific unit, offering medium to long term admissions to young people, most of whom had chronic or severe eating disorders. It also had a specific way of working as I have described. It would be interesting to repeat the study in other institutions, to see whether similar

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[85] Although it would have been possible to return on an honorary basis to continue the study, if the unit had remained open.

themes emerged. One could argue that some of the themes that arose, such as parental exclusion and feeling easily criticised, were specific to this institution and the way that this staff group interacted with parents. Parents of children who are hospitalised in other units, with different durations of illness, may have had different experiences as the treatment approach is likely to differ.

Although the parents viewed me as separate from the clinical team, I was still a member of staff. Parents were uncertain about my relationship with the wider clinical team, which although had been explained, was likely to remain an anxiety for parents. This probably inhibited parents' criticisms for fear that I would report them to the wider team. This was mitigated partly by using psychoanalytic technique, which pays close attention to detecting unconscious hostility and exploring this with the parents.

Furthermore, it was difficult to capture changes in the parents' attitudes, because due to time pressures, I recruited parents at a similar time. Some parents such as Mr and Mrs Harris, and Mrs Roberts, had been at *Woodlands* for a long time, whereas Mrs James was a more recent arrival. Additionally, the sessions were terminated prematurely by the closure of the unit, which I had not anticipated. Therefore, I was unable to gather as much data as I had hoped, and the data about discharge was premature, as patients were being transferred or discharged in a rushed way. Yet, this reflects what happens in many inpatient units when funding is cut or units are closed.

There was also a discrepancy in the follow up timings. This was partly due to the practicalities of contacting parents, and some parents' requests. The parents, whom I contacted sooner, such as Mrs James, may have given a more positive outlook, as there had been less time for things to deteriorate, compared with Mrs Roberts, whom I spoke with five months post discharge.

Telephone follow ups were also problematic as it was not possible to understand what was being communicated over the phone in a short time. Due to the geographical distances, it was the only way of gathering any follow up data. As there had been a time delay between the sessions ending and the telephone call, and as there was no possibility of further sessions for the parents, it was difficult to explore the issues which parents brought, especially as I was no longer part of a clinical team. Therefore, I was unsure about their current support, and had no way of feeding back any concerns. However, the telephone calls did give some picture of what had happened post discharge.

The study may have benefited from a standardised measure to give a more objective measure of parental stress levels. I had planned to use the Stress Index for Parenting Adolescents (SIPA), which is a standardised questionnaire measuring parental stress levels. When I piloted this, parents felt it was inappropriate. However, a standardised measure could have been useful to cross reference the qualitative findings.

Finally, because the work was terminated prematurely, it was not possible to explore the issues that arose in the way that one would in longer term psychoanalytic parent work. This meant that some of the data was not as rich as it could have been. For example, it would have been interesting to have explored Mrs Harris' eating disorder or Mrs Short's mental health difficulties to have understood the impact of such factors. It would have also been helpful to know more directly about the parents' parents as this may have related to the parents' relationships with staff and their children.

Practice Recommendations

Service Level recommendations

Parents who had children hospitalised for an eating disorder felt marginalised. This has been found in other studies (Treasure et al., 2011) and is a major drawback of inpatient treatment. As I have said elsewhere, this marginalisation was linked to parents' ambivalence about parenting their children, yet the hospitalisation exacerbated this. Consequently, this placed the parents in a difficult position to care for their children when they were discharged. Engaging in family therapy during inpatient treatment and outpatient treatment is essential to address these issues, and is recommended by the government guidelines (NCCMH, 2004). Following inpatient treatment, parents and patients need to remain attached to a unit as day patients, or be placed within a service that can offer out of hours support. The discrepancy between the level of care that is offered in hospital, compared with the support available in outpatient CAMHS was too great, even when family therapy was offered in both places. Unfortunately, the funding arrangements and geographical distances made the possibility of ‘stepped down’ care impossible. However, until this is sufficiently addressed, lengthy inpatient admissions away from the local area are unlikely to be successful.

Kingston et al. (2013) have suggested the development of a network of specialist ‘hubs’ throughout the country to help families engage with community teams. Whilst that may be helpful to an extent, the underlying emotional issues around ending with one team, and the parents’ feelings of marginalisation, must be addressed in order for that to make a difference.

Unit level recommendations

The inpatient unit could do more to include parents, to mitigate their feelings of marginalisation. Some of the marginalisation that parents experienced was a result of parents’ experiences and states of mind, but when the environment re-enacted this, it was unhelpful. A parents’ room with facilities would have been useful, so that there was a space for parents. Parents could have been included more in the patients’ meal planning and preparation of the food. Additionally overnight accommodation for parents and families would alleviate parental feelings of exclusion and make it easier for them to contribute to treatment. Having a parents’ group, or a parent worker can help parents to feel part of their child’s treatment and would have aided addressing parental issues that negatively impacted on the children – for example – Mrs Short’s and Mrs Roberts’ depression. Family therapy in the unit partly fulfilled this task, but given the numerous tasks of family therapy and the limitations of this resource, there is a need for an additional ‘parent worker.’ If parents felt attended to, this may reduce their envy of their child's care. Parents could have continued to access a parent group post discharge, as this would help with the loss of the support from the unit, and may have prepared other parents for the discharge. This would require services to work together, to ensure this was safe. Clinically, this needs careful thought, as this data suggested that parents did not generally rate parent support more highly, because of parents' complicated feelings such as envy and jealousy. Yet if these feelings could be addressed within the group, it could bring relief and containment for the parents. Cottee-Lane et al. (2004) wondered about online forums to support parents. Parents might find this easier as it is more anonymous and offers the possibility of support post discharge. Yet this data suggests that it would not necessarily have attended to the issues of rivalry and envy.

The findings also indicate that a siblings' group would have been helpful. Mr and Mrs Short's and Mrs James' involvement of siblings in their sessions, suggests a request for help in this area. A group for siblings could also help the family to view the eating disorder as a 'family' concern. Such a group would need careful thought in terms of age groupings of siblings, and how to talk to the patients about the sibling group.

Parents experienced feelings of envy and exclusion, and a lack of containment around staff holidays. Staff perhaps need to think more about the impact that holiday breaks have on parents, both in terms of preparing them, and establishing cover arrangements. Many parents find it difficult to seek help themselves, so in staff's absence, it would be useful for other staff members to actively link up with parents, so that they feel held in mind.

The role of the child psychotherapist

As I outlined in the introduction and the literature review, child psychotherapists have an established tradition of working with parents in a variety of contexts. This study has shown that these parents whose children were hospitalised for an eating disorder experienced difficult states of mind associated with their child's illness and hospitalisation. They endured separations from their child, as well as psychic separations, in terms of feeling that their child was lost to them, which involved a degree of mourning. They also experienced a range of difficult feelings, such as blame, guilt and envy. These are difficult feelings to articulate, yet when parents were unable to think about them, there were consequences for them and for their children. Parents also had to manage complex relationships with the unit and the staff, as well as with their partners, other children and other parents in the unit, which were difficult given that the parents felt stressed, deskilled and marginalised. Although there were staff available to support parents, such as the family therapist and nurses, these complicated feelings that arose for parents are areas that child psychotherapists are well placed to support parents with. Firstly, given that child psychotherapists work relationally – they would think about the relationship between the therapist and the parent, and other relationships that the parents bring in order to help parents understand their patterns of relating. This potentially could bring change and relief. Second, child psychotherapists try to understand and identify unconscious feelings, which would reduce the need for parents to project such feelings elsewhere. Third, the reliable and containing framework that child psychotherapists offer to parents, and the fact that child psychotherapists are not 'giving advice' means that parents can begin to disclose more difficult feelings, rather than keep these hidden away. Therefore, a child psychotherapist working jointly with the family therapist or nurse may be very helpful. This has occurred in similar contexts when staff have been supporting parents facing life and death anxieties about their children, such as in neonatal intensive care units (Mendelsohn, 2005 and Mc Fadyen, 1994). I have suggested some practical measures that may reduce difficult parental feelings in this situation. Yet, as many of these feelings related to less conscious processes, practical solutions in isolation would be insufficient to improve the parental experience. One would need to address some of the unconscious feelings parents bring. This study demonstrates that child psychotherapists can make an important contribution to work with parents whose children have been hospitalised for an eating disorder.

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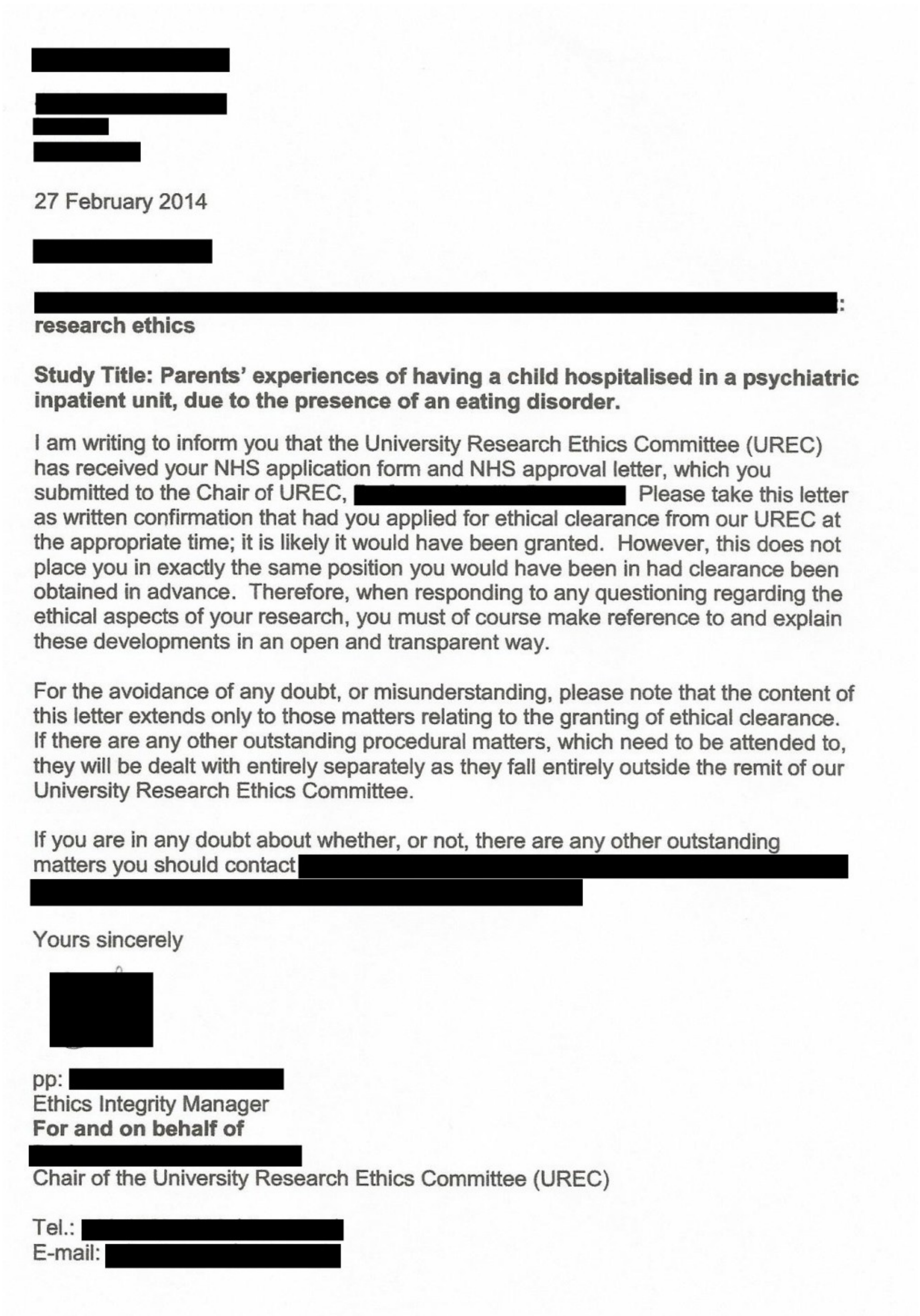

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27 February 2014

[redacted]

[redacted]: research ethics

Study Title: Parents' experiences of having a child hospitalised in a psychiatric inpatient unit, due to the presence of an eating disorder.

I am writing to inform you that the University Research Ethics Committee (UREC) has received your NHS application form and NHS approval letter, which you submitted to the Chair of UREC, [redacted] Please take this letter as written confirmation that had you applied for ethical clearance from our UREC at the appropriate time; it is likely it would have been granted. However, this does not place you in exactly the same position you would have been in had clearance been obtained in advance. Therefore, when responding to any questioning regarding the ethical aspects of your research, you must of course make reference to and explain these developments in an open and transparent way.

For the avoidance of any doubt, or misunderstanding, please note that the content of this letter extends only to those matters relating to the granting of ethical clearance. If there are any other outstanding procedural matters, which need to be attended to, they will be dealt with entirely separately as they fall entirely outside the remit of our University Research Ethics Committee.

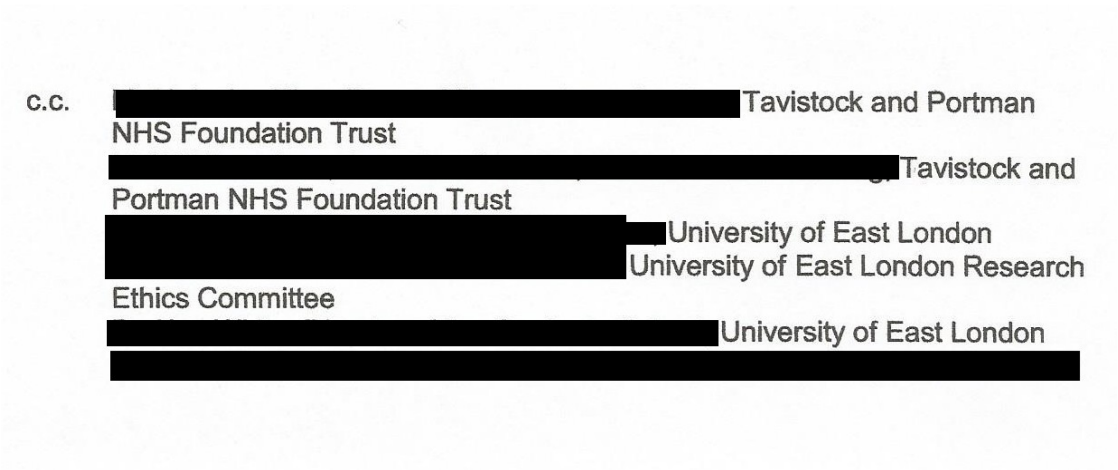
If you are in any doubt about whether, or not, there are any other outstanding matters you should contact [redacted]

Yours sincerely

[redacted]

pp: [redacted]
Ethics Integrity Manager
For and on behalf of
[redacted]
Chair of the University Research Ethics Committee (UREC)

Tel.: [redacted]
E-mail: [redacted]



c.c. [redacted] Tavistock and Portman NHS Foundation Trust

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University of East London Research Ethics Committee

[redacted] University of East London

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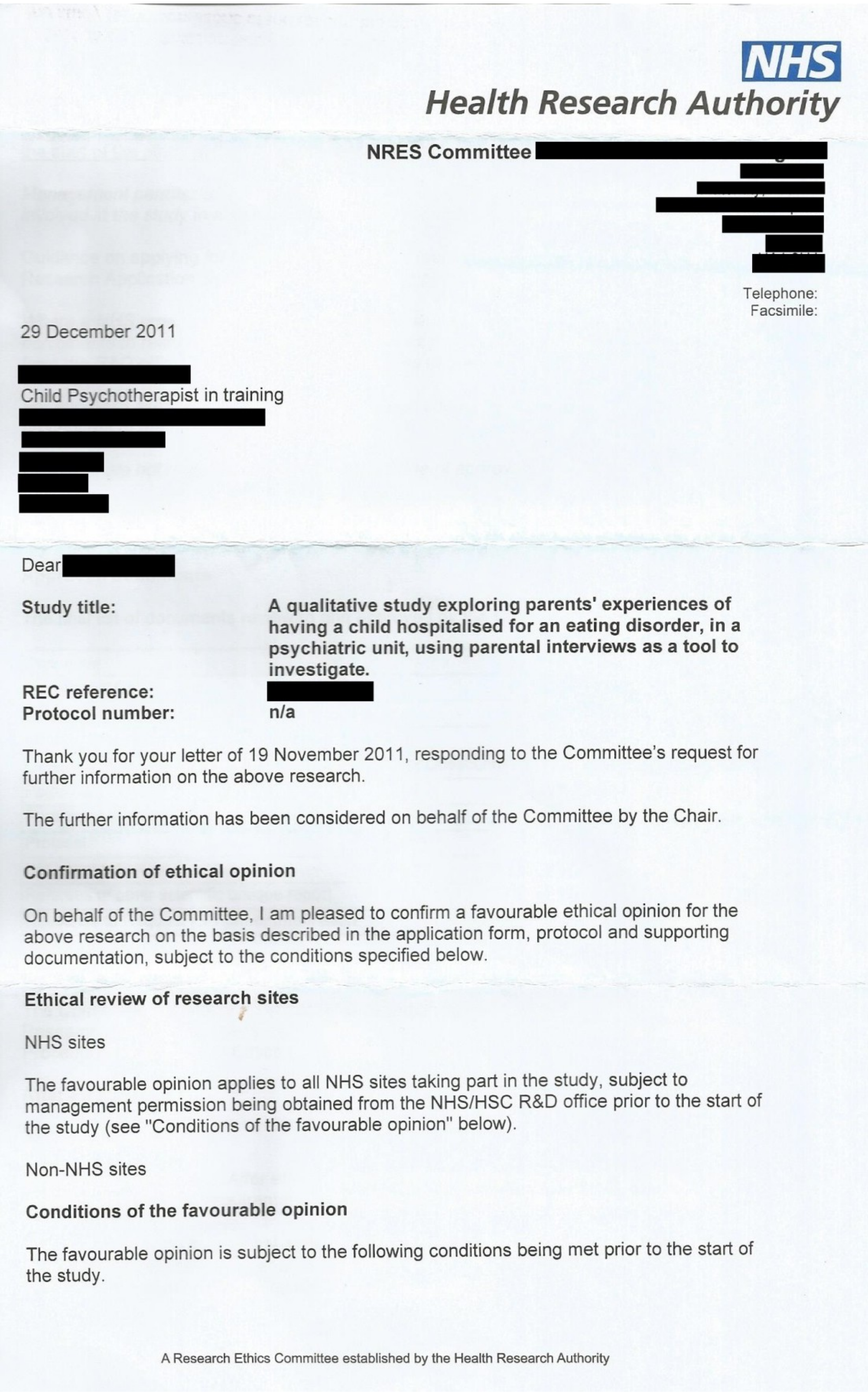


NHS
Health Research Authority

NRES Committee [redacted]
[redacted]

Telephone:
Facsimile:

29 December 2011

[redacted]
Child Psychotherapist in training
[redacted]

Dear [redacted]

Study title:	**A qualitative study exploring parents' experiences of having a child hospitalised for an eating disorder, in a psychiatric unit, using parental interviews as a tool to investigate.**
REC reference:	[redacted]
Protocol number:	**n/a**

Thank you for your letter of 19 November 2011, responding to the Committee's request for further information on the above research.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

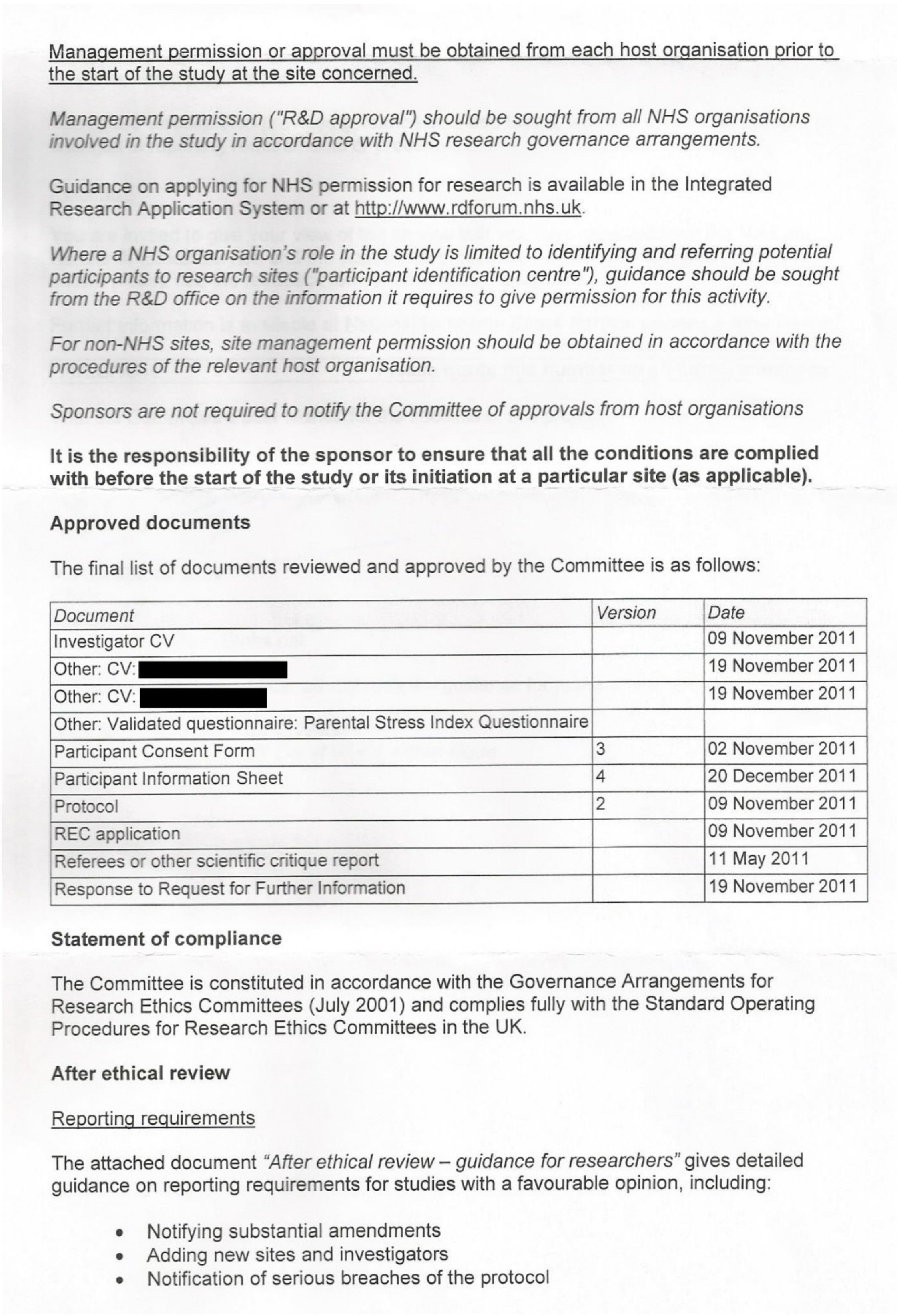
NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.



Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Investigator CV		09 November 2011
Other: CV: [redacted]		19 November 2011
Other: CV: [redacted]		19 November 2011
Other: Validated questionnaire: Parental Stress Index Questionnaire		
Participant Consent Form	3	02 November 2011
Participant Information Sheet	4	20 December 2011
Protocol	2	09 November 2011
REC application		09 November 2011
Referees or other scientific critique report		11 May 2011
Response to Request for Further Information		19 November 2011

Statement of compliance

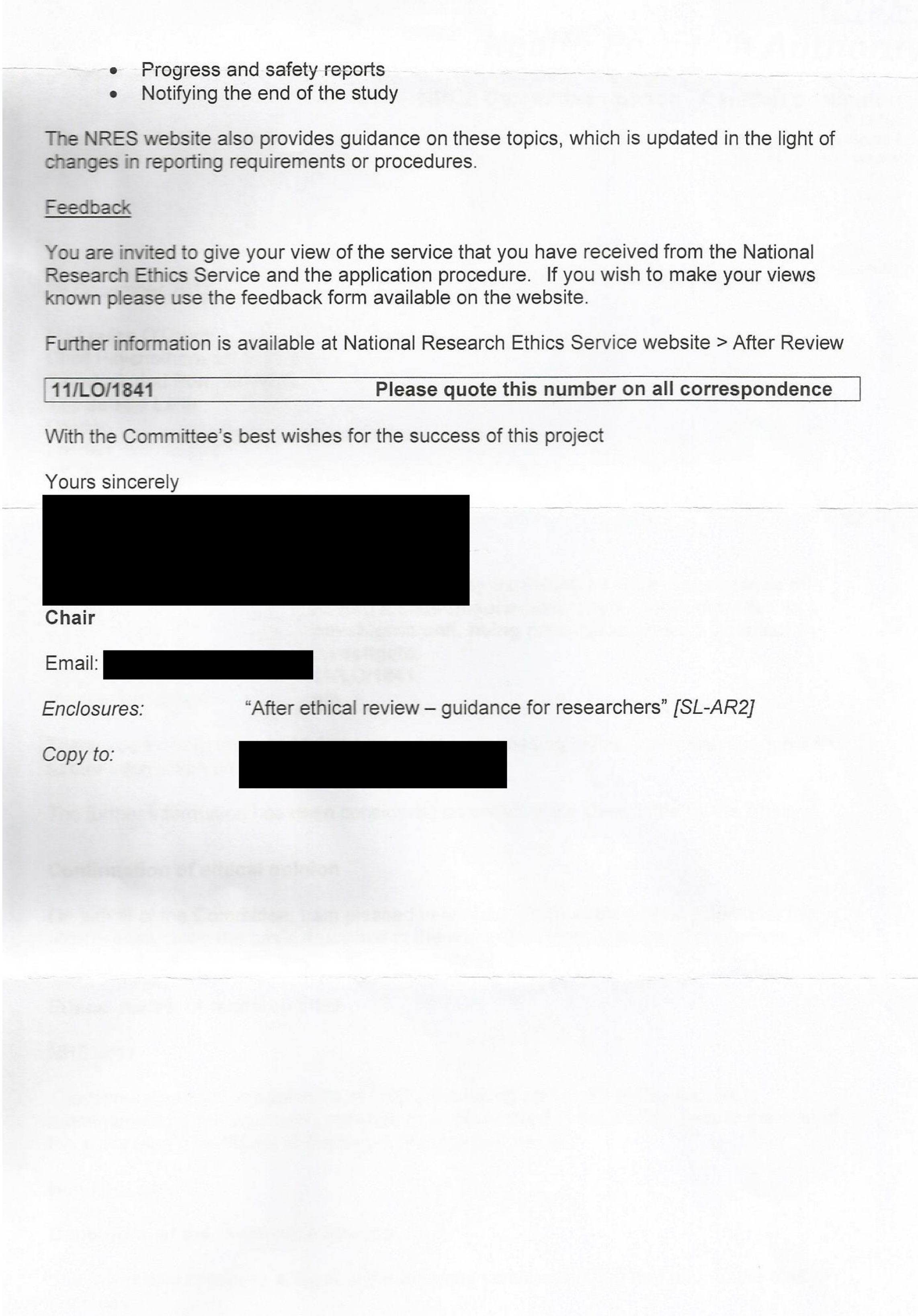
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol



- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

11/LO/1841	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

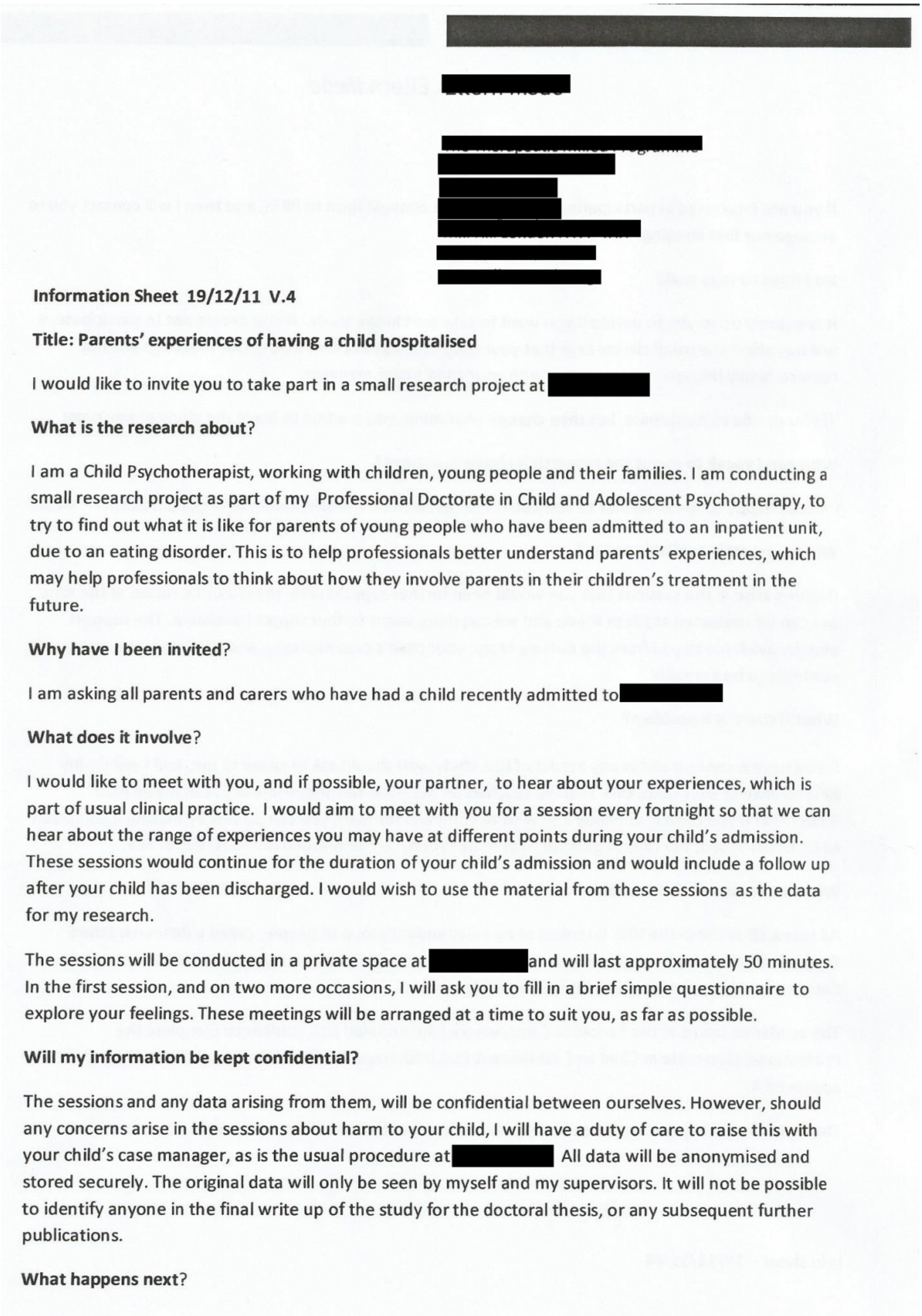
[redacted]

Chair

Email: [redacted]

Enclosures: "After ethical review – guidance for researchers" *[SL-AR2]*

Copy to: [redacted]



[redacted]

[redacted]

[redacted]

Information Sheet 19/12/11 V.4

Title: Parents' experiences of having a child hospitalised

I would like to invite you to take part in a small research project at [redacted]

What is the research about?

I am a Child Psychotherapist, working with children, young people and their families. I am conducting a small research project as part of my Professional Doctorate in Child and Adolescent Psychotherapy, to try to find out what it is like for parents of young people who have been admitted to an inpatient unit, due to an eating disorder. This is to help professionals better understand parents' experiences, which may help professionals to think about how they involve parents in their children's treatment in the future.

Why have I been invited?

I am asking all parents and carers who have had a child recently admitted to [redacted]

What does it involve?

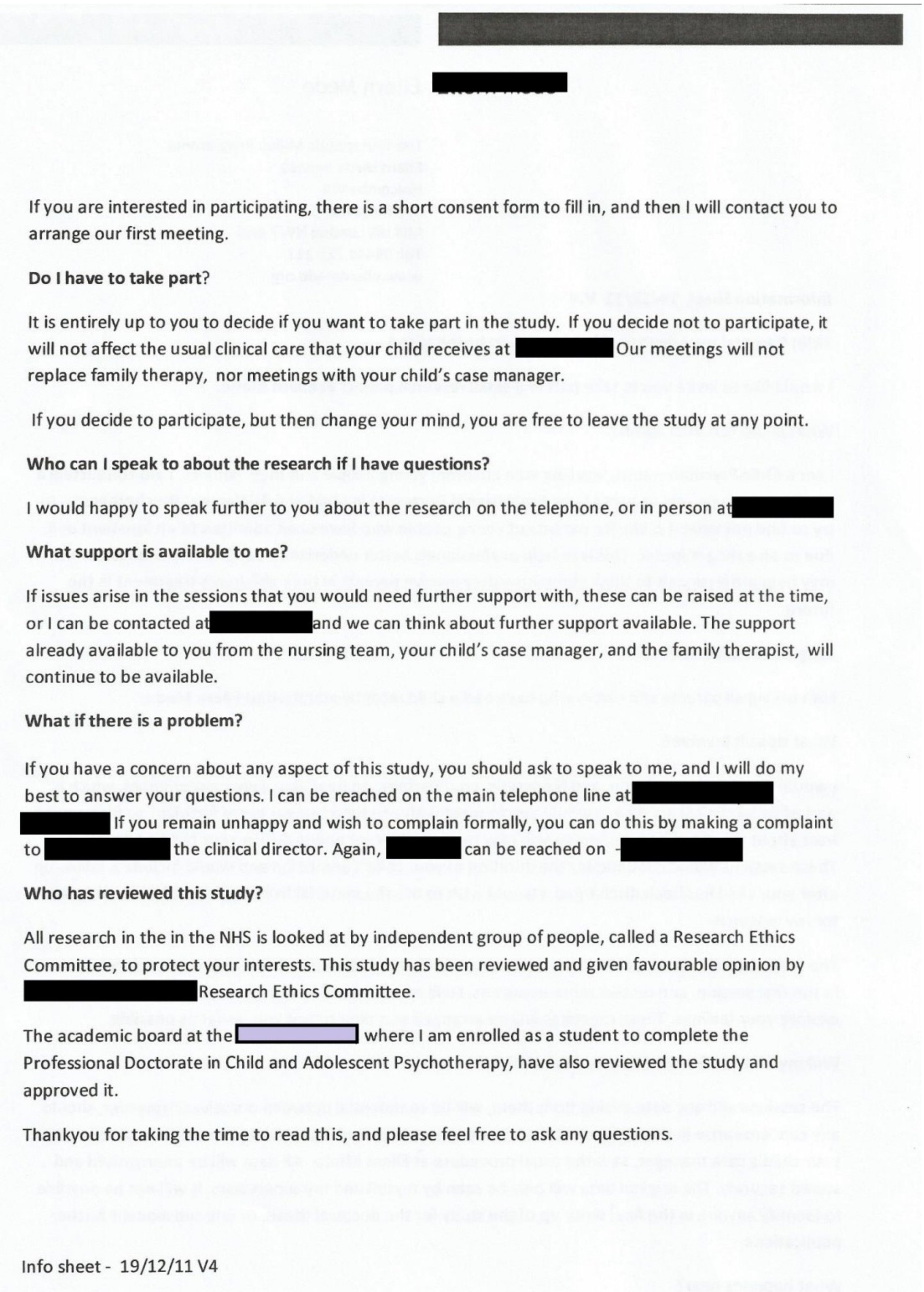
I would like to meet with you, and if possible, your partner, to hear about your experiences, which is part of usual clinical practice. I would aim to meet with you for a session every fortnight so that we can hear about the range of experiences you may have at different points during your child's admission. These sessions would continue for the duration of your child's admission and would include a follow up after your child has been discharged. I would wish to use the material from these sessions as the data for my research.

The sessions will be conducted in a private space at [redacted] and will last approximately 50 minutes. In the first session, and on two more occasions, I will ask you to fill in a brief simple questionnaire to explore your feelings. These meetings will be arranged at a time to suit you, as far as possible.

Will my information be kept confidential?

The sessions and any data arising from them, will be confidential between ourselves. However, should any concerns arise in the sessions about harm to your child, I will have a duty of care to raise this with your child's case manager, as is the usual procedure at [redacted] All data will be anonymised and stored securely. The original data will only be seen by myself and my supervisors. It will not be possible to identify anyone in the final write up of the study for the doctoral thesis, or any subsequent further publications.

What happens next?



[redacted]

[redacted]

If you are interested in participating, there is a short consent form to fill in, and then I will contact you to arrange our first meeting.

Do I have to take part?

It is entirely up to you to decide if you want to take part in the study. If you decide not to participate, it will not affect the usual clinical care that your child receives at [redacted] Our meetings will not replace family therapy, nor meetings with your child's case manager.

If you decide to participate, but then change your mind, you are free to leave the study at any point.

Who can I speak to about the research if I have questions?

I would happy to speak further to you about the research on the telephone, or in person at [redacted]

What support is available to me?

If issues arise in the sessions that you would need further support with, these can be raised at the time, or I can be contacted at [redacted] and we can think about further support available. The support already available to you from the nursing team, your child's case manager, and the family therapist, will continue to be available.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to me, and I will do my best to answer your questions. I can be reached on the main telephone line at [redacted] [redacted] If you remain unhappy and wish to complain formally, you can do this by making a complaint to [redacted] the clinical director. Again, [redacted] can be reached on - [redacted]

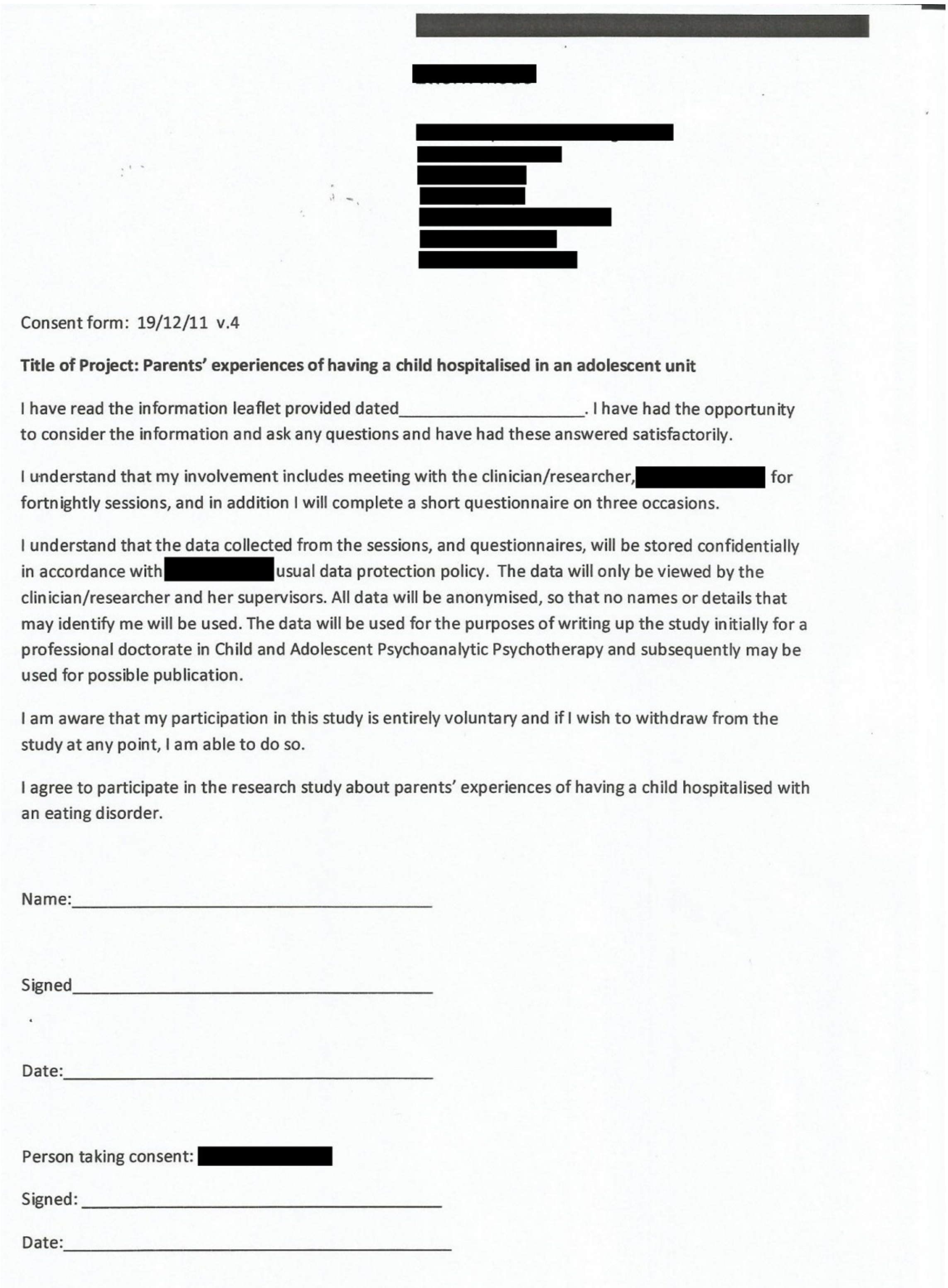
Who has reviewed this study?

All research in the in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by [redacted] Research Ethics Committee.

The academic board at the [redacted] where I am enrolled as a student to complete the Professional Doctorate in Child and Adolescent Psychotherapy, have also reviewed the study and approved it.

Thankyou for taking the time to read this, and please feel free to ask any questions.

Info sheet - 19/12/11 V4



[redacted]

[redacted]

[redacted]

Consent form: 19/12/11 v.4

Title of Project: Parents' experiences of having a child hospitalised in an adolescent unit

I have read the information leaflet provided dated____________________. I have had the opportunity to consider the information and ask any questions and have had these answered satisfactorily.

I understand that my involvement includes meeting with the clinician/researcher, [redacted] for fortnightly sessions, and in addition I will complete a short questionnaire on three occasions.

I understand that the data collected from the sessions, and questionnaires, will be stored confidentially in accordance with [redacted] usual data protection policy. The data will only be viewed by the clinician/researcher and her supervisors. All data will be anonymised, so that no names or details that may identify me will be used. The data will be used for the purposes of writing up the study initially for a professional doctorate in Child and Adolescent Psychoanalytic Psychotherapy and subsequently may be used for possible publication.

I am aware that my participation in this study is entirely voluntary and if I wish to withdraw from the study at any point, I am able to do so.

I agree to participate in the research study about parents' experiences of having a child hospitalised with an eating disorder.

Name:____

Signed____

Date:____

Person taking consent: [redacted]

Signed: ____

Date:____

‘Morning Song’ Sylvia Plath (1961)

Love set you going like a fat gold watch.

The midwife slapped your footsoles, and your bald cry

Took its place among the elements.

Our voices echo, magnifying your arrival. New statue.

In a drafty museum, your nakedness

Shadows our safety. We stand round blankly as walls.

I’m no more your mother

Than the cloud that distills a mirror to reflect its own slow

Effacement at the wind’s hand.

All night your moth-breath

Flickers among the flat pink roses. I wake to listen:

A far sea moves in my ear.

One cry, and I stumble from bed, cow-heavy and floral

In my Victorian nightgown.

Your mouth opens clean as a cat’s. The window square

Whitens and swallows its dull stars. And now you try

Your handful of notes;

The clear vowels rise like balloons.