

Being a mother with anorexia: A phenomenological study of seeking and receiving professional support for white heterosexual women in the UK

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Abstract

Mothers are currently under-represented in the literature on anorexia, including research on treatment, with most research focussed on female adolescents. This raises questions about how adult women and particularly those who are mothers, experience eating disorder treatment. This study provides a phenomenological exploration of lived experiences of seeking and receiving professional help and interactions with health professionals for six white heterosexual mothers who experienced anorexia while raising their children. Four themes are reported that capture the women's diverse experiences of seeking and receiving support for anorexia: (1) conflict between mothering and seeking help; (2) experiences of feeling blamed, poorly treated or misunderstood by health professionals; (3) positive experiences of seeking and receiving support; and (4) the importance of ongoing support. The women's experiences suggest that healthcare professionals should adopt a more holistic approach that acknowledges the subjective reality of the client (including their mother status) when working with mothers experiencing anorexia.

KEYWORDS

eating disorders, interpretative phenomenological analysis, interviews, therapy, treatment, women

1 | INTRODUCTION

Reports of the lifetime prevalence of anorexia for women in western countries vary, with some indicating a prevalence of up to 4% (Micali et al., 2017; van Eeden et al., 2021) and others reporting higher rates (e.g., 6.2% in Finland; Silén et al., 2020). Numerous cases of anorexia go unreported or undiagnosed, which means that rates of anorexia in adult women are likely to be higher than currently identified (Fursland & Watson, 2014).

Research on anorexia has been criticised for its focus on young white women and girls (Halbeisen et al., 2022), and although young adult women (typically university students) are included in some studies, particularly around treatment, adult women (aged 25 years and older) experiencing anorexia are under-researched (Ackard et al., 2014; Mangweth-Matzek et al., 2014). This is because anorexia is generally associated with adolescence (ages 10 to 19/20 years [APA, 2023; World Health Organization, 2023]), although some research on adolescent experiences of anorexia has extended the age

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range from 8 to 23 years [Bezance & Holliday, 2013; Kristeller, 2016; Wright & Hacking, 2012]), with higher prevalence in younger women and the age of greater risk for developing anorexia between 10 and 24 years (Martínez-González et al., 2020). Yet, while the typical trajectory is to develop anorexia as a teenager/young person, as noted above, anorexia may not be diagnosed or (if diagnosed) successfully treated at a young age, which means that older women do present for treatment (Scholtz et al., 2010). Thus, as anorexia will be experienced by some adult women who are or may become mothers, it is important to research the experiences of this group. Although some women become mothers in their teens, the standardised mean age of women giving birth in the UK is currently 30.7 years (Office for National Statistics, 2020).

1.1 | Mothers with anorexia

Some research indicates that motherhood may exacerbate experiences of anorexia for some women who have experienced it in the past—for example, causing someone who has achieved recovery to relapse (Arnold et al., 2019)—or who experienced it while becoming pregnant and having children (Burton, 2014; Tierney et al., 2011). Although there is a substantial body of largely feminist qualitative research exploring lived experiences of anorexia and other eating disorders (e.g., Bordo, 1993; Malson & Burns, 2009), the lived experiences of adult women who are mothers and living with anorexia are under-researched. Research that does exist on mothers with eating disorders often slips into implicitly or explicitly “mother-blaming” and pathologising, where the mother is held responsible for their children’s relationships with food and eating and with their bodies (Birch & Fisher, 2000). This tendency to mother-blame is exemplified by case reports of mothers with eating disorders restricting the amount of food in the house (e.g., Stein & Fairburn, 1989), not cooking for their children (e.g., Woodside & Shekter-Wolfson, 1990) and not eating in front of their children (e.g., Evans & Le Grange, 1995). Other research has reported children of mothers with eating disorders failing to thrive (e.g., Stein & Fairburn, 1989; Vignallou & Guedeny, 2006). It is evident that such studies are underpinned by an anxiety that women with eating disorders may fail in a key-assumed maternal role, by not adequately nourishing their children.

Some qualitative studies offer a more holistic sense of the experience of being a mother with anorexia. Fogarty et al.’s (2018) meta-ethnographic systematic review explored the experience of the perinatal period for women with eating disorders—including anorexia—and reported that pregnancy represented a period of stress and anxiety for many of the women in terms of managing the eating disorder and the needs of the unborn child. Another study on “treading the tightrope” between motherhood and an eating disorder reported that participants faced a challenge of maintaining a balance in which they were able to respond to their eating disorder, while putting the needs of their child first (Tierney et al., 2011). Motherhood has also been shown to have a positive impact on the experience of an eating disorder. Tuval-Mashiach et al. (2013) explored how mothers with eating disorders—including four diagnosed with

Implications for practice

- Being a mother can be variously supporting and/or triggering of anorexia, and this should be empathically responded to in assessment, formulation and treatment.
- Mothers require flexibility around treatment that accommodates childcare responsibilities.
- Some mothers want tailored support and advice around their parental role (such as non-judgemental and practical support with feeding children).

Implications for policy

- Training for healthcare professionals should present the experience of anorexia as a communication of distress and in doing so, foster empathy for clients.

anorexia—perceived the impact that their eating disorder might have upon their children. Although some of the themes in this study highlighted beliefs around not being good enough, involving the children in the eating disorder and coping strategies employed by the mothers, the idea that motherhood could be a positive catalyst for recovery from the eating disorder was also reported (Fogarty et al., 2018).

These qualitative studies highlighting a positive change support findings from quantitative research by von Soest and Wichstrøm (2008) that demonstrated that motherhood can have a positive effect on eating problems. In addition to this, three clinical cases presented of mothers with bulimia and anorexia by Franzen and Gerlinghoff (1997) demonstrated that, although for some mothers becoming a parent can prove a major obstacle to recovery, perceptions of the potential negative impact of the eating disorder on children can also act as a catalyst for seeking treatment and making positive life changes. Quantitative analysis of data from a large clinical sample ($N=5251$) by Papadopoulos et al. (2013) also echoed the protective aspects of childbearing for women experiencing anorexia. What these studies have in common is that they offer multidimensional pictures of the lives of mothers with anorexia (and in some cases, others eating disorders), emphasising the positive and protective impact that motherhood can have upon the experience of anorexia, alongside the more challenging aspects of being a mother with anorexia. Further qualitative research into mothers with anorexia will serve to promote a more comprehensive understanding of these experiences for women, through offering a space in the literature for their narratives to be spoken and heard (Bryant-Waugh et al., 2007).

1.2 | Professional support for mothers experiencing anorexia

Because the (stereo)typical anorexia client is a white, adolescent woman, it is unlikely that interventions are developed with mothers of any age in mind, and it is not clear how mothers experience

these interventions. Although evidence on interventions specifically for mothers with anorexia is limited, there is a sense that anorexia in middle-aged and older women can be difficult to treat (Podfigurna-Stopa et al., 2015). A small number of studies, focussing on mothers' experiences, offer specific ideas for supporting women in their role as mothers in the context of their eating disorder. In a meta-ethnography examining the experiences of women with an eating disorder—including anorexia—during pregnancy and 2 years after birth, Fogarty et al. (2018) recommended educating maternity healthcare professionals about eating disorders and providing ongoing support for mothers. Bryant-Waugh et al. (2007) developed a group intervention for mothers with eating disorders who had been given a diagnosis of anorexia or eating disorder not otherwise specified, using focus groups and interview data. They suggested that further research into the lived experiences of mothers with eating disorders would support the development of novel interventions for this group of women.

The aim of this study was to contribute to the qualitative literature on the treatment experiences of mothers with anorexia by exploring the experiences of a group of white British mothers seeking and receiving therapy and other kinds of professional support for anorexia, and their interactions with healthcare professionals, in the NHS and in the private sector.

2 | METHODOLOGY

This study used interpretative phenomenological analysis (IPA; Smith et al., 2009) to explore the experiences of mothers who lived with anorexia while bringing up their children. IPA facilitates a detailed examination of lived experiences, drawing on ideas and concepts from both phenomenology and hermeneutics, and combining interpretative and idiographic components (Eatough & Smith, 2017).

2.1 | Researcher personal statement

The project was led and the interviews were conducted by the first author. The first author identifies as cisgender, heterosexual, white and middle-class, is the mother of three children and has not experienced an eating disorder. The project was prompted by her clinical work with women experiencing (or having previously experienced) anorexia and a common theme of not feeling “understood” or treated well in NHS settings for anorexia. While being interested in the fact that this appeared to be a common narrative, she tried to bracket the assumption that mainstream therapies for anorexia are not always helpful when conducting the research, and kept a research journal for personal reflection. The other authors identify as white and middle-class, two identify as heterosexual and cisgender, have children and have worked therapeutically with eating disorders, one identifies as queer and does not have children and is not a therapeutic practitioner. They have varied experiences of disordered eating.

2.2 | Participants and recruitment

Six women who were mothers, aged 18 or older, self-defined as “recovered” from anorexia, had received a diagnosis of anorexia from a health professional and had experienced anorexia while raising their children were recruited. Some of the women were diagnosed before having children ($N=2$) and some after ($N=4$); of the women who were diagnosed after, three thought anorexia or disordered eating had been part of their lives since adolescence. Five women were recruited through the UK eating disorder charity, Beat, and the sixth through snowballing from the first author's contacts. The relatively small participant group size recommended for IPA (Smith et al., 2009) allows for a deeper and richer analysis of individual experiences than typically possible in qualitative research and is oriented to developing patterns of meaning across data (the thematic) as well as the unique features of individual experience (the idiographic).

Participants were asked to self-report their age; five provided a precise age and one reported as aged 40+. Of the five who provided a precise age, they were aged between 20 and 55 years (thus, one participant was in her 20s, one in her 30s, three in their 40s and one in her 50s). All of the women identified as white British. Five were married to or in a relationship with a man, and one was divorced from a man and single. They each had between one and four children. As a group, they had experience of both NHS and private treatment and a variety of interventions, including inpatient and outpatient weight management and psychotherapy, counselling and psychological therapies such as cognitive behavioural therapy (CBT). They were allocated pseudonyms to protect their anonymity.

2.3 | Data generation

Participants were given the choice of a face-to-face, telephone or Skype interview; all chose telephone. Participants were asked planned and responsive, open-ended questions about their experiences of seeking and receiving therapy and treatment for anorexia, and other forms of support, and their interactions with healthcare professionals. Interview length ranged from 52 to 70 (mean 63) min. Participants were all in their homes when the interview took place. They were sent a participant information sheet, consent form and demographic form via email, and returned a signed consent form before their interview. The study received ethics approval from the first, second and third authors' Faculty Research Ethics Committee.

2.4 | Data analysis

The first author transcribed the data and led the analysis, following the six-step process of IPA (Smith et al., 2009). The first, second and fourth authors met to discuss their initial impressions, then the first author immersed herself in the data through reading repeatedly the interview transcripts, listening to the audio-recordings and making notes on features of analytic interest. These notes were reviewed and discussed with the other authors before organising and

interpreting the data to identify emergent themes. These emergent themes were reviewed and discussed, and superordinate themes developed. This process was repeated on a case-by-case basis, for each interview. Patterns of similarities and differences were then identified across all transcripts and final themes developed.

3 | ANALYSIS

This paper reports on four themes that capture the women's diverse experiences of seeking and receiving support for their eating disorder and their interactions with health professionals. The themes are as follows: (1) conflict between mothering and seeking help; (2) feeling blamed, poorly treated or misunderstood by health professionals; (3) positive experiences of seeking support from and interactions with health professionals; and (4) the importance of ongoing support.

3.1 | Conflict between mothering and seeking help

A common theme running throughout the women's accounts was that many aspects of seeking and receiving help were experienced as challenging within the context of motherhood. Jane described how difficult it was for her to access support:

I do think there's a case where, for mums anyway – you do always have to put other people first, you know – regardless, erm, of whether you're anorexic or not, but I think that's very much, erm, a case of, in the fact that you do feel worthless, and you don't feel you deserve to get help. And then also you have the anorexic thing that won't let you ask for help.

Here, Jane referenced an awareness of a wider social narrative about the “selfless” mother. Engaging with this narrative enabled her to make sense of her own experience of not asking for, or feeling deserving of, help. There was the sense that anorexia and motherhood conspired together to prevent her from accessing treatment. Gail also articulated this idea:

The guilt as a mother, that you're being so selfish to put yourself first. As well, I mean, I used to feel so guilty about going to this counselling, like because you do just put your kids first naturally, but why would I be thinking about myself? This wasn't right.

Gail expressed her belief in the idea that it was “selfish” to put oneself first as a mother and that this belief was a trigger for feelings of guilt. She references the socially dominant notion that a “good mother” never puts herself first, to the point where any amount of self-reflection was frowned upon. Vicky also talked about the difficulty of reconciling her identity as a mother with treatment offered to her by her therapist:

All she kept wanting was for me to be admitted erm to erm, to a hospital and I didn't want to go obviously, 'cos I didn't want to leave my children.

Vicky clearly related the sense that the inpatient eating disorder treatment on offer was unacceptable to her as a mother in that it did not take account of the fact that living apart from her children (as a single parent) for any extended period of time was inconceivable to her. This idea was further reiterated when she related how difficult therapy became:

Every time I knew I had an appointment with her [the therapist] I almost dreaded going, because I was just like, you know, every time I went, I knew that she would badger me about going to the eating disorder unit, and I just thought “it's not gonna happen.” There was no way I was gonna go in there as an in-patient. So I just said to her, “look,” you know, “don't worry” and “I think I'll just leave it.”

Therapy became a vehicle for opposition and resistance for Vicky. She conveyed her sense of the therapist persistently pursuing her idea of what Vicky should be doing (with her use of the word “badger”), highlighting the perceived power imbalance and lack of alliance between therapist and client. The reason she gave for the opposition was her status as a mother, where it was unthinkable for her to leave her children. This resulted in a state of deadlock where Vicky was left on her own, unable to accept the offered help.

3.2 | Experiences of feeling blamed, poorly treated or misunderstood by health professionals

Some of the stories the participants told referenced feeling blamed, poorly treated or misunderstood by therapists and other healthcare professionals. Alison described an interaction with her health visitor, after her daughter was born, where she felt blamed for “putting her issues” onto her child. This incident occurred in a context of Alison feeling blamed by her mother, and others generally, for her son's “fussy” eating habits (voicing her mother, Alison said, “they'll know it's your fault”) and asking the health visitor to weigh her daughter regularly “cos I thought everyone's going to be looking at me like, ‘you can't feed your child properly.’” Alison experienced a heightened sense of surveillance of her mothering, particularly in relation to feeding her children:

And then the health visitor made me feel crap. So when I had Sally [daughter] and she's got a similar erm frame, I used to get really stressed about weight like, “Oh, God, she's put on too much, hasn't she?” and the health visitor was all a bit sort of like, “stop trying to put your issues onto her.”

There was the sense of Alison experiencing the process of weighing her child as a stress-inducing test of “good mothering” that she

feared she would fail. She communicated that she felt unable to judge for herself what was “normal” in terms of weight gain. In revealing her uncertainty to the health visitor, she felt shut down in a way that was judgemental and blaming. The perceived power differential was strongly communicated through Alison's narrative. The health visitor was experienced as a harsh, condescending weight “expert” who “made” Alison feel “crap.” Gail also shared the difficulties she experienced with a therapist:

I had this very, erm, she was a larger-than-life character, I'd imagine in real life, and she was quite – I felt like she was quite a bully with me – very big lady, and she was always late. So, erm, anyway, she was always late and, erm, I had to get back and I found it quite rude. I was like, you know, “I'm a mother,” I can't. I have to look after my daughter today, and I haven't got any other childcare. I can't stay for the whole hour now, so, you know, quite often I'd only have a twenty-minute appointment because she'd been forty minutes late. It was crazy, and erm, in fact I only saw her twice in the end, and she signed me off because I think she sort of knew I'd had enough of her. She said, “Oh, we're fine” and signed me off (laughing).

There is the sense of Gail experiencing the therapist's embodiment as overbearing, overwhelming and suggestive of an aggressor (in her use of the word “bully”). Her use of the terms “larger-than-life,” “character” and “in real life” created a sense of the therapist as a caricature or cartoon-like in an imposing way. Gail's comments about the therapist being a “bully” and a “very big lady” created a physical, corporeal impression of Gail feeling smaller and less powerful in relation to her. Gail described her lateness as being “rude” and dismissive of her identity as a mother. There is the sense that she felt that her “mother-identity” should confer respect and a boundary for therapy when she stated, “I'm a mother.” Engaging with this “mother” identity felt protective for Gail, in that it allowed her to maintain a positive idea of herself, while vilifying the therapist as a bully who did not share her value of respect and boundaries around motherhood.

Kate's narrative also referred to the negative impact of her therapist's changing body shape and size, which Kate felt interfered with the therapeutic relationship and left her feeling frustrated. This happened when her therapist “lost a lot, all her weight and became very slim.” This weight loss was experienced by Kate as representing a “conflict of interests” and “unfair” for Kate having to watch her therapist “losing” as she “gained,” where “losing” represented what Kate desired for herself. People with eating disorders are known to observe and assess bodily related stimuli (Lowell & Meader, 2005), and a study exploring these behaviours in the therapy room reported that anorexic clients' assumptions and speculations about their therapists' body potentially influence their beliefs about their therapists' ability to help them and their willingness to engage in therapy (Rance et al., 2014).

Jane's narrative highlighted her sense of feeling misunderstood by her GP:

There's this kind of myth that anorexics are not aware that they're ill and that was very much what my doctor felt he had to do to me – he kept turning me back, he kept weighing me and he kept pointing out to me. I remember thinking, “why is he keeping on doing this?” And it was later on when I spoke to him again, he thought my problem was that I didn't know I was thin and didn't know I was ill. But you do know that you're thin, you do know you're ill.

In this extract, Jane described her doctor's assumption about her perceived lack of awareness of her being thin and ill. She referenced and rejected the “anorexic myth” of having no awareness of being ill. She conveyed the sense of her doctor “doing” things to her that did not make sense. This created a sense of Jane feeling physically objectified, rather than attended to as a sentient being. In not communicating what he was “doing,” there is the sense of the doctor infantilising Jane or conceiving her as a problem that he was dealing with, without her consent.

3.3 | Positive experiences of seeking and receiving support

Other narratives referenced more positive experiences of support. In the following extract, Jess talked about the value of having continuity of care:

You know, it worked very well that I saw her [the consultant psychiatrist] for so long because we were able to build up a very good relationship, erm, sort of, knew what to do when things sort of started to go bad, it was very, just very, very good. Well obviously being a consultant psychiatrist she really knew her stuff.

Jess described how important the relationship was and how valuable it was to feel confident in her psychiatrist's expertise. Alison similarly appreciated continuity of care:

It's kind of having the continuity and the regularity of it and I know that I can, that, at the moment, I can save up all the crap and dump it at her once a week.

Alison's use of the words “crap” and “dump” was visceral in their evocation of bodily functions and served to describe how she felt able to expel the excrement of her week “at” her therapist. Her language suggested that therapy might be functioning as a depository for “crap” she had saved up over the week. Her use of the word “at” rather than “on” indicated an element of dynamism in the relationship, where the

therapist might have some autonomy over whether to take the “crap” or leave it. Her inclusion of “at the moment” suggested that therapy might stop at some point—begging the question of what happens when Alison has nowhere to dump the “crap?”

3.4 | The importance of ongoing support

Although the mothers self-reported as recovered, recovery was not black and white, and they variously reported how ongoing support would be helpful. Gail felt that having someone there to check in with on an ongoing basis would be helpful:

You just have this series of counselling, you have this series of, erm, series of nutrition and that bit that stopped, and that, that is a really big problem I think, erm when you're, when you're, when that's what you've realised especially when you're an adult, you know, with kids. I really needed that, someone checking up on me, and my doctor did nothing. Nothing at all. I actually asked if the nurse, if I could be weighed every other week. So I was, but that involved me having to walk down a really long hill, and then virtually run up it to get to school so it was just defeating the object really, and erm, it was just ridiculous. But I just felt that I needed somebody to, I needed to be checked up on, you know, like a kid would, and without asking for it, I didn't get it.

Gail describes the “stopping” of support as problematic in the context of her role as a mother. She communicated that combining treatment with school runs was not practical; thus, concluding that eating disorder care is not designed for mothers. Gail's GP is represented as being inactive and absent in her ongoing care, illustrated in the statement “my doctor did nothing. Nothing at all.” What is created is a narrative of wanting to be cared for. Gail was left feeling alone with this responsibility and communicated clearly how difficult this was. When support was offered (the nurse agreeing for her to be weighed regularly), it was not in a way that was ultimately helpful. She was aware that there was a childlike element to her desire for the support she requested, but crucially, this need was not met. There was a sense of her doctor as an unresponsive parent, and the nurse responding in a way that did not meet her needs. Both were experienced as being emotionally unavailable. Gail experienced herself as both parent and child, in relation to anorexia, where the parent was watchful and on guard for danger but where the child sought attention and care.

Alison also communicated the belief that ongoing support would be helpful for her:

There needs to be something, I think, help in supporting you feeding your children, erm, because they ought to know. I was so scared that I wouldn't feed my children enough or feed them too much, 'cos I was trying to compensate for the fact that I might

not feed them enough, and it would just to be nice to have somewhere that you could either phone or, just get that support so like my children being really fussy, the health visitor's been useless, the GP is like, “well, speak to the health visitor” and there is nowhere to go, and you just want to say, “my kids just won't eat anything I give them and my son's not eating his school dinners and he won't eat anything for packed lunch. I just want to cry.”

This extract illustrated just how difficult Alison experienced being a mother, in the context of the practice of feeding her children. She expressed how unsure she felt about what she did with her children around food, as a direct result of her own experiences of what food has meant to her. When she stated: “they ought to know,” she communicated her belief that someone should have access to an answer that was beyond her knowledge, with regard to what was “right” for her children to eat. This served to increase her sense of impotence and desire for answers that she felt were being withheld. She was aware that support with this would help, but felt that no one was taking responsibility for this, which left her feeling worried and lost. The GP and health visitor were experienced by her as unresponsive in a way that felt evocative of neglect. What was obvious was that food and feeding her children were challenging emotional experiences for Alison. She was left feeling upset, alone and unsupported. Her final statement in this extract: “I just want to cry,” perfectly encapsulated her distress, invoking an image of a small child who has no one to comfort her.

Kate also communicated her experience of recovery as something that was ongoing:

In January I'm starting another six months, twenty-four sessions of treatment. As, as I've tried to explain to you when the weight is restored and our brain works properly there are a lot of issues, as, for example, why we maintain an eating disorder - what spurs us on, don't necessarily get addressed along the way - the CBT doesn't cover that, and the NHS funds are that they like to leave us at a point where at least our weight is stable. But with some people, particularly when you've had it for forty-something years, the facts that maintain the eating disorder are still there, the psychological patterns, the self-worth, self-esteem - they still remain. So and that, all of us, we have a peer group that's been set up for people who've been discharged at a stable weight. We all struggle now that we all feel fat, and that we're living in a new world with all these new feelings, that we struggle very much with. I mean, not a day goes past that I just think, “oh, I just want to be the way I used to be - this is just too difficult.”

Kate separated out the strands of what “recovery” meant to her: physical and neurological recovery (attended to in CBT), but also with a deeper focus on what might have caused and maintained the eating

disorder in the first place. Her use of “we” rather than “I” implied her belief in it being a universal experience that she shared with other mothers who have experienced anorexia. Her description of her experience of the peer group underlined this sense of “belonging” to a tribe of women who feel the same. She presented herself as a spokesperson for her tribe, confidently stating that she knew how it was for them and that this was the same as how it was for her. She described how “feeling fat” was experienced as a struggle. She communicated a sense of finding herself in a foreign land where everything was new, different and difficult, and where a desire for a return to the old familiar was a daily experience. She created a sense of nostalgia for a past, seemingly easier self, in a world that was known and where feelings were not a struggle. Her account evoked a feeling of “otherness” that she believed she shared with the women in her peer group and that ongoing care was essential to help with the challenges of the new world of “recovery.”

4 | DISCUSSION

4.1 | Disparate experiences of therapy and support for mothers with anorexia

The women's accounts in this study illuminate how difficult it could sometimes be to achieve and maintain a good “fit” between being a client experiencing anorexia and being a mother. Some of the women felt undeserving of help, particularly in the context of being a mother where “other people” have to come first. They described difficulty with accessing treatment (as a mother), suggesting the problematic nature of maintaining an “idealized mother” status alongside that of being a “distressed woman” in need and want of support. This resonates with oppressive dominant “mother” narratives, where a mother's needs are secondary to those of her children (Hays, 1996). The women in this study highlighted other difficulties experienced in reconciling aspects of therapy with their mother status (e.g., where an inpatient intervention was recommended for Vicky and where the therapist did not take Gail's childcare responsibilities into account). In these cases, the women felt they were experienced as oppositional and resistant to “treatment” (Holmes, 2016).

Some of the women in this study described feeling judged and blamed for their anorexia, and for passing their disordered eating onto their children and not feeding them appropriately. This echoes findings in a study of health providers' attitudes towards their patients (e.g., Crisafulli et al., 2008) and reinforces the idea that there might be an underlying blame culture in anorexia treatment (e.g., Crisp, 2005; Stewart et al., 2006). In addition to this, the women in this study reported sometimes feeling misunderstood or poorly treated by healthcare providers. This resonated with other accounts of the lived experiences of treatment for anorexia, where treatment has been variously described as blaming, inadequate, unhelpful and pathologising (e.g., Conti et al., 2017; Le Grange & Gelman, 1998). Furthermore, the findings of this study echo research on motherhood and mental health more broadly, with research emphasising

mothers' vulnerability, their fear of being perceived as not good enough and feeling monitored and judged, the challenges of navigating the competing demands of motherhood and mental health problems, and concerns about passing on mental health problems (Blegen et al., 2010).

Questioning *why* women with anorexia are experienced in negative ways, in the context of interventions, might help inform the development of more compassionate approaches, rather than blaming the women for “non-compliance.” In addition to this, pathologising discourses disseminating the idea of the “anorexic patient” as “needy” are unhelpful for women (in general) seeking help for anorexia, and particularly for women who are mothers (who might also be bound up in the “idealized mother” mythology). It is important for those of us who work therapeutically with these women to recognise the attendant relational aspects of the therapy dynamic, in pursuit of building a strong therapeutic alliance, where responsibility could be most helpfully conceived of as a shared endeavour (Sandoz et al., 2010; Zugai et al., 2018).

The women in this study also told more positive stories about their experiences of treatment. These resonated with the existing literature (e.g., Le Grange & Gelman, 1998; Zugai et al., 2013). Some women described the value they placed on having a continuity of care, allowing them the opportunity to build a “good relationship” with their therapist. This coheres with research that recognises the therapeutic alliance as an important aspect of “successful” treatment for eating disorders (e.g., Sly et al., 2013; Smith et al., 2016). Another aspect of treatment that was experienced as valuable was the sense of the therapist being a “specialist” in their field (Bezance & Holliday, 2013). Being taught practical coping strategies was also experienced as helpful (Brown et al., 2014).

4.2 | Implications for practice

Healthcare professionals are well-placed to begin to think about bridging the gaps in support for mothers experiencing anorexia. Although critical feminist approaches (e.g., Malson & Burns, 2009) offer helpful, empathic and nonpathologising lenses through which to view the experiences of mothers with eating disorders, it can be challenging to translate these theories into clinical practice, as “feminist work often takes place at considerable remove from treatment intervention” (Holmes, 2016, p. 465).

It is important to maintain an understanding that being a mother can be variously supporting and/or triggering of anorexia and that this should be empathically responded to in assessment, formulation and treatment. Empathy (and avoidance of mother blaming) could be fostered through the dissemination of the literature and training for healthcare professionals (at all levels and in different areas—such as primary care, perinatal and mental health) that presents the experience of anorexia (for men and women) as a communication of distress (Jenkins & Ogden, 2012). This would help to break down stigmas, assumptions and prejudices that remain prevalent across society towards people with anorexia (Stewart et al., 2006). Online

and in-person training for various healthcare professionals has been developed by the UK eating disorder charity, Beat, in some instances in partnership with other professional bodies (e.g., the training for nurses was developed in partnership with Health Education England and the Royal College of Psychiatrists' Faculty of Eating Disorders)—the training for nurses emphasises the importance of empathic, non-stigmatising communication (Beat, 2023). Unsurprisingly, given the prevalence of anorexia in adolescents, although the training refers to “people with eating disorders,” the emphasis is on adolescents as the typical eating disorder patient, with all the examples featuring young people, and particularly young white women.

Bryant-Waugh et al. (2007) additionally suggested that specifically tailored support and advice for mothers, around their parental role, might be beneficial in promoting positivity and self-esteem around being a parent. Arnold et al. (2019) also talked about the need for specific screening and treatment pathways for pregnant and post-partum women. In this current study, some of the women explicitly expressed how having practical support with feeding their children would have been helpful, while others related how they sought flexibility around treatment that accommodated school-runs and childcare. Using these observations to inform clinical practice and support would acknowledge the “experience-expert” alongside that of the “clinician-expert” (Smith et al., 2016). A dynamic formulation that can be multilayered, textured and sometimes contradictory would help avoid a “one-size-fits-all” approach to the experiences of and meanings ascribed to anorexia by these mothers.

An emphasis on acknowledging and minimising power differentials in the context of therapy is also desirable, regardless of the presenting problems (Sly et al., 2013). This is particularly important in the case of anorexia, where the power differential has traditionally, and anecdotally, been keenly felt by clients in relation to care providers (Malson et al., 2004). Experiences of this type of power imbalance were evident in the narratives of the women in this study. An emphasis on “the relational,” “transparent” and “collaborative” should be at the centre of all therapeutic interactions in managing distress that is embodied as well as psychological. It is also important to acknowledge and challenge the fact that treatment recommendations for “staying healthy,” in the context of the experience of anorexia, can contradict other dominant discourses around “eating healthily” (through focussing on eating and weight control; LaMarre & Rice, 2016) and that this is potentially confusing to those being treated, especially mothers with children to feed.

Responding to the stories the women told about their treatment, it is evident that flexibility with the practicalities of “treatment” would be helpful in creating a strong working alliance (Horvath et al., 2011). It has been evidenced that the therapeutic alliance is an important factor in therapeutic interventions with individuals experiencing eating disorders (Graves et al., 2017). On a practical level, building and maintaining a therapeutic alliance might involve the therapist responding to the potential impact of childcare on a mother's ability to engage with the therapeutic process. On a therapeutic level, using a dynamic formulation, that is a “recursive process of suggestion, discussion, reflection, feedback and revision as

part of the moment-to-moment process of therapy” (Johnstone & Dallos, 2013, p. 4), alongside a recognition of the particular function (or meaning) of anorexia for an individual might be a useful first step in thinking about what might be “helpful.” The diverse nature of what the women in this research found “helpful” suggests that a pluralistic and holistic approach might be usefully employed by clinicians (Murray et al., 2018).

4.3 | Limitations

It is important to acknowledge the characteristics and limitations of the participant group. The women varied in age—one was a younger mother, and the others were in their 30s, 40s or 50s at the time of the interview, although all but one reported experience with disordered eating since adolescence. It is possible that age and motherhood intersect in various ways in relation to anorexia that are beyond the scope of this study to explore. Age and motherhood certainly intersect, with younger mothers in particular viewed with suspicion (Sheeran et al., 2019). The women were all white, heterosexual mothers, and the analysis should be read with this in mind. Research on women of colour and queer women with eating disorders remains limited (Beauboeuf-Lafontant, 2003; Jones & Malson, 2013). We are not aware of any research exploring the lived experiences of Black and queer mothers with anorexia. Furthermore, most research on eating disorders has been conducted in western countries (van Eeden et al., 2021), and researchers in the Global South have highlighted the need to develop culturally specific understandings of anorexia (e.g., Chan & Ma, 2003). The lack of diversity in eating disorder research more broadly has been acknowledged, with calls to extend research beyond the SWAG—skinny, white, affluent girls (e.g., Halbeisen et al., 2022). It is also important to hold an awareness of the fact that this research includes accounts of participants who responded to a research request and were willing to share their stories and that there are many other women who fulfilled the inclusion criteria who chose not to participate, and who may have had very different stories to share.

5 | CONCLUSION

This study offers insight into the therapy and help-seeking experiences of mothers who have engaged with professional support for anorexia, and their experiences of interacting with healthcare professionals. Interventions and support were experienced by the participants in diverse ways, and the results of this study confirmed that developing a greater understanding of what helps will be beneficial to both clients and healthcare professionals. Healthcare professionals who take a narrow view of the experience of anorexia for mothers are potentially missing opportunities for developing holistic and supportive environments for recovery. Through hearing these women's stories and attending to what is

deemed important, it is hoped that this paper might help disseminate the message that a nuanced, sensitive and holistic approach to therapy for these women might improve the quality and experience of the care they receive.

AUTHOR CONTRIBUTIONS

Victoria Clarke: Writing – original draft; methodology; supervision; formal analysis; conceptualization. **Marie-Claire Fitzpatrick:** Conceptualization; investigation; writing – original draft; methodology; formal analysis; project administration; validation; data curation. **Christine Ramsey-Wade:** Supervision. **Naomi Moller:** Conceptualization; methodology; formal analysis; supervision.

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CONFLICT OF INTEREST STATEMENT

We have no known conflicts of interest to declare.

DATA AVAILABILITY STATEMENT

Permission was not sought from participants to share their data with third parties.

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