











## **List of Figures and Tables**

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## Chapter 1: Introduction

There are many different types of eating disorders, although they are all categorized by disturbances of eating behaviors and attitudes (Shapiro, 2012). Eating disorders are frequently diagnosed using the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). The DSM-5 is a widely used diagnostic manual, which defines diagnostic criteria for mental health disorders. The DSM-5 identifies the three main eating disorders; Anorexia Nervosa (AN), Bulimia Nervosa (BN), and Binge Eating Disorder (BED), which are considered to be the most common eating disorders (National Health Service – NHS, 2018). However, the DSM-5 also identifies other eating disorders including; Pica, Avoidant/Restrictive Food Intake Disorder, and Other Specified Feeding or Eating Disorder (OSFED). It is estimated that out of those diagnosed with eating disorders; forty percent have BN, ten percent have AN, and the remainder are commonly diagnosed with BED or OSFED (BEAT, 2018). Anorexia Nervosa and Bulimia Nervosa are most likely to occur in adolescence, whereas BED is most likely to occur at the age of twenty-one (NIMH, 2018). Binge Eating Disorder was not formally recognised as an eating disorder until the DSM-5, therefore it can be argued that there is a lack awareness in comparison to AN and BN (Reas, 2017).

The DSM-5 indicates that Anorexia Nervosa is characterized by three criteria: restriction of energy intake leading to significantly low body weight, intense fear of gaining weight, and disturbance in how body weight or shape is experienced (American Psychological Association - APA, 2013). Bulimia Nervosa is characterized by five criteria according to the DSM-5; recurrent episodes of binge eating, recurrent inappropriate behavior to prevent weight gain, these must be present at least once a week for three months, self-evaluation is unduly influenced by body shape and weight, and the disturbance does not occur only during episodes of anorexia (APA, 2013). Consequently, in order to be diagnosed with either Anorexia or Bulimia, a person must meet all the criteria proposed by the DSM-5. The DSM-5 is used extensively across the world to assist clinicians in giving accurate psychiatric diagnosis and treatment to those with eating disorders (Eating Disorders Victoria, 2018), and other mental health disorders. Therefore, the DSM has serious

implications for diagnosis and treatment. There are also many people with eating disorders who are undiagnosed, as many people do not seek help (Anorexia Bulimia Care, 2018). Furthermore, research indicates that only twenty percent of adolescents seek help (Walden, 2018), and for those who seek help it often takes years for them to do so (BEAT, 2018). This could be due to a number of factors, for example; people may not recognise their symptoms as an eating disorder. Consequently, many people go undiagnosed and untreated despite the services and diagnostic tools available.

Eating disorders can develop for a number of different reasons, especially because each case is different; consequently, no one cause has been identified. Although, the National Institute of Mental Health (NIMH, 2016, p.1) have suggested there are a number of complex and wide-ranging factors which influence the development of eating disorders, including; “genetic factors, biological factors, behavioural factors, psychological factors, and social factors”. For example, eating disorders can develop for reasons such as; bullying, not wanting to grow up, issues within the family, and genetics (NIMH, 2016). This can make people feel like they have a lack of control over their lives, potentially resulting in mental health disorders including Anorexia Nervosa, and Bulimia Nervosa. Consequently, adolescence is considered to be a ‘special risk period’ in terms of the development of eating disorders, due to adaptations, which occur within this period (Smolak, Striegel-Moore & Levine, 1996, p. 207). Although eating disorders can develop in childhood or at later stages of life, they most commonly develop in adolescent women, aged thirteen to seventeen (NHS, 2018).

Eating disorders are considered to be some of the most debilitating mental health conditions (Klein & Walsh, 2003). This is due to the serious, and sometimes irreversible health and psychological complications eating disorders can cause; including kidney damage, infertility, death, depression and anxiety (ANRED, 2017), which are identified as particularly dangerous for children and adolescents. In addition, eating disorders have the highest mortality rates of all mental illnesses



(Smink, van Hoeken & Hoek, 2012), with anorexia having the one of the highest suicide rates of any psychiatric disorder (NIMH, 2018). This highlights the serious implications of eating disorders and indicates that the support people with eating disorders receive from those around them could be key in terms of their wellbeing (Eisler, Dale, Hodes et al, 2000). Furthermore, these serious implications highlight the need for continuous research to ensure that the most effective diagnosis, treatment and support is available.

There are many different types of treatment available to those with eating disorders. For example, some treatments that are frequently offered to people with eating disorders are; psychotherapy, medication and nutritional counseling (NIMH, 2018). However, treatment often only allows for patient involvement, and does not consider the beneficial factors of involving family and friends. Therefore, treatments for eating disorders should involve people around the patient rather than looking at them individually. This assumption is supported by research into family therapy, which identified a positive impact on those with Anorexia, in terms of; increased expressed emotion, reduced critical comments from parents, and increased warmth from parents (Eisler, Dale, Hodes et al, 2000). Therefore, it has been argued that health professionals should see family and carers as a key resource in treatment (Hillege, Beale & McMaster, 2006). For example, if family members were trained to gain skills in managing eating disorders, as suggested by Whitney, Murray, Gavan et al (2005), they could help to reduce the negative consequences faced by patients, whilst also enhancing their understanding. This is supported by Treasure and Nazar (2016) who found that carers are now gradually receiving expert training in managing their role, which is equipping families and others to manage eating disorder behaviours. In addition to this, research has shown that the quality of patient's relationships with their siblings is an indicator of recovery (Zohar, Ari & Bachner-Melman, 2016). Thus, highlighting the potential of improving outcomes of those with eating disorders through family intervention.

Family and friends are usually a part of the small group of people, who spend the most time with those with eating disorders. They are often be the first to recognize

the initial signs of eating disorders, meaning they are usually the first to attempt to support patients or try to encourage treatment or diagnosis (Treasure & Nazar, 2016). Therefore, family and friends around those with eating disorders are likely to have a substantial impact on whether patients receive support, diagnosis, or treatment. This is especially relevant in the early onset of AN and BN, as parents are likely to have control over whether children or adolescents go to the doctors or engage in treatment. However, family should not just be seen as a resource in terms of treatment, as it can also be difficult for them to understand and cope. This is highlighted by research, which argues that caring for individuals with both anorexia nervosa and bulimia nervosa can have a significant impact on parent's lives and other aspects of family life. For example, research has found that eating disorders can cause negative emotions, stressful home environments and psychological challenges for the whole family (Papathomas, Smith & Lavalley, 2015; Whitney, Murray, Gavan et al, 2005). Parents also report increased negative perceptions of their children in terms of increased compulsivity, increased dependence, and abnormal eating behaviour (Treasure, Sepulveda and MacDonald et al, 2008; Whitney et al, 2005). Consequently, it is argued that providing support to those around people with an eating disorder should be considered essential (Treasure & Nazar, 2016). Past research indicates that the support available for family and carers is limited, with the impact on carers rarely being acknowledged, and their needs overlooked and neglected by health professionals (Highet, Thompson & King, 2006). However, this research is quite dated, and recently there has been an increase in awareness in the need for family support, which has been demonstrated in terms of online support (Anorexia Bulimia Care, 2018). Research indicates that parents report this online support as helpful in terms of coping (Hopf, Le Grange, Moessner et al, 2012). However, it is indicated by Whitney et al (2005) that online support may not be efficient support, as they believe parents need to receive training in order to managing eating disorders and improve outcomes. Recent research identifies that carers still find managing their role difficult, and that coping resources are strained (Treasure & Nazar, 2016). This is a significant issue as increased support for parents of those with eating disorders, could help them deal with the eating disorder, and help to increase the support they give.

The research above gives an insight into the experiences of family, and what could be helpful to both; the family and the patient. However, it is focused on family members, and does not consider other people who may have close relationships, or support those with eating disorders. As mentioned previously, eating disorders most commonly develop in adolescence (NIMH, 2016), which is known as the highest risk period (Bardick, Bernes, McCulloch et al, 2004). In the period of adolescence, people are usually in school, and it is likely that they would be spending significant time with friends rather than their parents or carers. Furthermore, people often have very different relationships with their families compared to their friends (Noller & Callan, 2015). In addition, a part of adolescence involves increasing separation and independence from parents, which often leads to increased reliance on friends for multiple things, including support for mental health (Hazen, Goldstein & Goldstein, 2010). This indicates that friends experience may result in a different insight into eating disorders than parents. Family often feel more responsibility and pressure, whereas friends may care but feel less responsibility, resulting in people with eating disorders being more open and trusting of their friends. Consequently, research focusing on friends could provide a valuable insight and new perspective into eating disorders, where research is lacking. The only research that has explored the experiences of friends of those with eating disorders comes from Galloway, Power, Newman et al (2014). Galloway et al (2014) found that eating disorder development can; create distance in adolescent friendships, negatively influence the amount of time friends spend together, and challenge emotional connections. This is supported by research into family experience which found that eating disorders usually result in unification or disintegration of family relationships (Hillege, Beale, and McMaster, 2006). Therefore, it is important; to acknowledge the impact eating disorder development has on adolescent relationships, and to ensure young people get support in order to preserve their friendships and avoid negative consequences (Galloway et al, 2014). This research suggests that eating disorders do have a significant impact on friendships, indicating that there is a need for further support in order to maintain them.

Previous research indicates that friendships in adolescence contribute positively to emotional, cognitive, and behavioural functioning (Vitaro, Bolvin & Bukowski, 2009). Therefore, lack of friendships can be detrimental in development (Leonidas & Santos, 2014). This indicates that friendship plays a key role in development, and could influence the development of mental illnesses, such as eating disorders. This suggests that friendship could have both positive and negative influences on eating disorders in development, and possibly in treatment. Consequently, friendship and peer interaction have been considered promising tools for supporting and improving the outcomes of troubled adolescents (Youniss & Haynie, 1992). This information has not been applied to prevention or treatment of eating disorders, and other mental illnesses. This is supported by Leonidas and Santos (2014) who found that social support and social networks for eating disorders are still unavailable. In addition to this, a lack of research looking at support outside the family has been identified (Leonidas and Santos, 2014), despite the known benefits it could have for limiting development of eating disorders and improving treatment. Although, in more recent years, online support forums have increased across many websites, including the National Eating Disorder Association (2018), nevertheless support is still considered to be limited. Therefore, further expansion beyond family networks still needs to occur to include friends, and further research and investment should be considered in terms of social support and networks (Leonidas & Santos, 2014). Friends could therefore act as a beneficial resource for those with eating disorders, and more research should be undertaken to explore the likely beneficial impact that friends could have on those with eating disorders.

It has been found, that friendship can prevent an escalating cycle of bullying in school, and victimization of individuals increases when they have no mutual best friendship (Hodges, Boivin, Vitaro et al, 1999). This indicates that strong friendships may act as a buffer for bullying and victimization in school. This is crucial, as being a victim of bullying has been linked to low psychological wellbeing such as body dissatisfaction, psychological distress such as anxiety, and health problems including Anorexia and Bulimia (Rigby, 2003; Sanone & Sansone, 2008; Sweetingham & Waller, 2007). It has also been found that bullying in school can act an indicator of whether

adolescents are at risk of developing eating disorders, and symptoms of Anorexia Nervosa and Bulimia Nervosa (Copeland, Bulik, Zucker et al, 2015; Kaltiala-Heino, Rimpela, Rantanen et al, 2002). Therefore, bullying should be seen as an indicator of risk of various mental health disorders in adolescents (Kaltiala-Heino, Rimpela, Rantanen et al, 2002). This research highlights there is a clear link between bullying and the development of Anorexia, or Bulimia. Therefore, it has been argued that clinicians need to consider bullying as a risk factor in terms of Anorexia, and Bulimia (Sweetingham & Waller, 2007). The past research above highlights the importance of friendships in reducing the incidence of bullying at school, as they could be preventing many other problems including eating disorders. In addition to this, if friendship in school is maintained throughout the development of an eating disorder it could act as a buffer and improve the outcomes for those with eating disorders. If this is the case, friendships should be considered more important, and increased support should be given to preserve friendships and limit negative consequences that can occur (Galloway et al, 2014).

Overall, the research into the experiences of friends of those with eating disorders is very limited. It is likely that further research into friend's experiences could provide valuable insight into eating disorders. In addition to this, research shows a links between; friendship and bullying, and bullying and eating disorders (Hodges, Boivin, Vitaro et al, 1999; Sweetingham & Waller, 2007). It would therefore be beneficial to gain insight into the experiences of friends of those with eating disorders; to try and increase understanding of the way eating disorders influence friendships and consider additional support in terms of school and social life. Due to the prevalence, and early onset of AN and BN, these eating disorders will be focused on for this study. Consequently, the aim of the present study is to explore the experiences of friends of people with eating disorders, with specific focus on school and social life, due to the lack of past research in these areas.

Qualitative research offers rich and compelling insights into the real world (Braun and Clarke, 2014), making it an appropriate method to explore the experiences of friends of those with eating disorders. Furthermore, semi-structured interviews are

viewed as the most suitable method for this study, as other methods such as focus groups may limit the openness of participants, due to the sensitive nature of eating disorders. Finally, the data will be analysed using thematic analysis, being the most appropriate method for this research. Thematic analysis identifies participants; experiences, meanings, and reality (Braun and Clarke, 2006), which made it suitable for this study. Braun and Clarke's (2006) phases of thematic analysis will be used due to its consistency and ability to create high quality results (Willig & Stainton Rogers, 2017).

The present study aims to explore the experiences of being a friend of someone with an eating disorder (AN or BN), it will look at many aspects of eating disorders and friendship but will have a specific focus on school years. The study will explore eating disorders in terms of many aspects of life including; school, social life, and friendship.

## Chapter 2: Method

### **Design:**

A qualitative design method was used in this study to explore the experiences of friends of individuals with eating disorders in school. This was explored using a semi-structured interview.

### **Participants:**

Participants were recruited for this study using quota sampling, which was used to recruit any individual who met each criterion (Flanagan, 2008), until the desired number of participants were recruited. All participants were university students over the age of eighteen. Each participant was friends in school with at least one individual diagnosed with either; anorexia nervosa or bulimia nervosa (Table 1). All participants discussed friends who were female. Exclusion criteria included that participants had no history of an eating disorder diagnosis. All six of the participants were recruited via Cardiff Metropolitan University's Psychology Participant Panel.

Table 1 – Participant Information

Name*	Sex	Number of Friends Discussed	Friends ED
Pam	Female	One	Bulimia Nervosa
Jack	Male	One	Anorexia Nervosa
Jane	Female	One	Anorexia Nervosa
Lucy	Female	Two	Bulimia Nervosa Anorexia Nervosa
Katie	Female	One	Anorexia Nervosa
Ben	Male	One	Bulimia Nervosa

\* Pseudonyms have been used to ensure anonymity

### **Materials:**

The materials used in this study included; a semi-structured interview schedule, a participant information sheet, an informed consent form and a voice recorder.

### *Development of Interview Schedule:*

A semi-structured interview (SSI) schedule was developed and consisted of fifteen questions. In order to ascertain what topics should be explored, the findings from past research were utilised. 'Illness perceptions, was included as a topic in the interview schedule, and was an identified theme in past research (Whitney, Murray, Gavan et al, 2005). The second topic explored was 'psychological impact', as past research indicates that eating disorders can be psychologically challenging for those around patients (Papathomas, Smith & Lavalley, 2015). The third topic was 'isolation', as research has shown that eating disorder development can create distance in adolescent friendships (Galloway, Power, Newman et al, 2014). The fourth topic explored was 'friendship unification or disintegration', which was an identified theme in research from Hillege, Beale and McMaster (2006). The fifth and final topic explored was 'school environment', which looked at attendance and achievement, due to the first-hand experience of friends in school.

Each question in the schedule aimed to encourage open ended responses and allow participants to speak as freely as possible. Furthermore, the questions developed were made as clear as possible to avoid confusing participants with long questions, and complex language. Three people reviewed the questions before the schedule was finalised in order to ensure they were clear.

At the end of SSI schedule, a number of possible prompts and probes were listed. These were used throughout the interviews to encourage participants to give additional information. For example, one probe used during the interviews was 'could you tell me more about that?'

### ***Procedure:***

All semi-structured interviews were conducted in a private room within the university; all interviews involved one participant and the researcher. Interviews were conducted in this way to; limit distractions, ensure the interview was private, and encourage participants to speak openly. All interview times and dates were arranged through the Participant Panel.



Before the interview took place, participants were given a participant information sheet, which included; information about the study, the exclusion criteria, information about their rights, and relevant support information and online links. Each participant was given time to read the information sheet, and the informed consent form. If they agreed to take part they were required to sign the informed consent form and hand it to the researcher before the interview took place. After this they were reminded that they had the right to withdraw at any point during the interview, and that they were allowed a break if it was needed throughout the interview. The voice recorder was then switched on, and the interview began using the semi-structured interview schedule. When the interview was finished, the participant was allowed to ask any questions. Each interview recording was transferred onto a password protected computer, to ensure confidentiality, and each interview was transcribed using Microsoft word.

Following the interview all participants were sent their interview transcripts via email and given two weeks to review it. This allowed participants to identify if they wanted to change or remove anything in the interview transcript.

### ***Method of Analysis:***

Thematic analysis was the method of analysis used in this research. Thematic analysis was chosen as it helps to identify participants; experiences, meanings, and reality (Braun and Clarke, 2006), therefore making it the most suitable analysis for this research. Clear guidelines of conducting thematic analysis were developed by Braun and Clarke (2006), these guidelines made thematic analysis more consistent and resulted in higher quality results (Willig & Stainton Rogers, 2017). Consequently, the six phases of thematic analysis identified by Braun and Clarke (2006) were used to analyse the data collected in this study.

Analysis commenced after all the interview transcripts were finished. The first phase of analysis was 'familiarising yourself with the data', in order to complete this stage,

the interview transcript was read multiple times to search for patterns and meanings. The second phase of analysis completed was 'generating initial codes', this involved coding each transcript line by line, and identifying relevant and interesting elements. The third phase of analysis completed was 'searching for themes', this involved considering broader themes, by arranging codes into potential themes. The fourth phase was to 'review themes', to identify whether the potential themes were consistent across the interview transcripts. The review in phase four also allowed for some themes to be merged, discarded, or grouped together in subthemes, which ensured all the themes were representative of the data. The fifth phase completed was 'defining and naming themes'; each theme was defined in terms of what it represented. The final and sixth phase completed was 'producing the report', which presented the complicated story of the data (Braun and Clarke, 2006).

***Ethical Considerations:***

Ethical approval was granted by the Cardiff Metropolitan University Ethics Panel (reference number: 9453). Each participant read the information sheet and signed the informed consent form if they agreed to take part before each interview commenced. One ethical consideration was that the sample could have become emotionally distressed due to the nature of the interview. In order to minimise this risk, participants were given the option to have a break at any time during the interview, and reminded that they had the right to withdraw at any time during the interview. Participants were also given relevant support information, such as the 'BEAT' website, and were advised to contact student services or their GP if they had any concerns about their mental health. Lone working was also an ethical consideration in this study; lone working guidance was adhered to minimise this risk. Finally, to ensure each participant remained anonymous they were given pseudonyms (e.g. Sam), and any relevant personal information was changed (e.g. place names). Thus, reducing the likelihood of them being identified from the data (Kindt, 2013).

## Chapter 3: Results

The data collected was analysed using Thematic Analysis (TA). This analysis identified five overarching themes: (1) Interactions with Others, (2) Family, (3) Impact on School Life, (4) Characteristics Observed, and (5) Knowledge and Support. Each main theme consisted of two to four subthemes. A thematic map of the themes and sub-themes is shown below (figure 1). Each theme and sub-theme displayed in figure 1 is discussed below, and references supporting quotes from the interview transcripts.

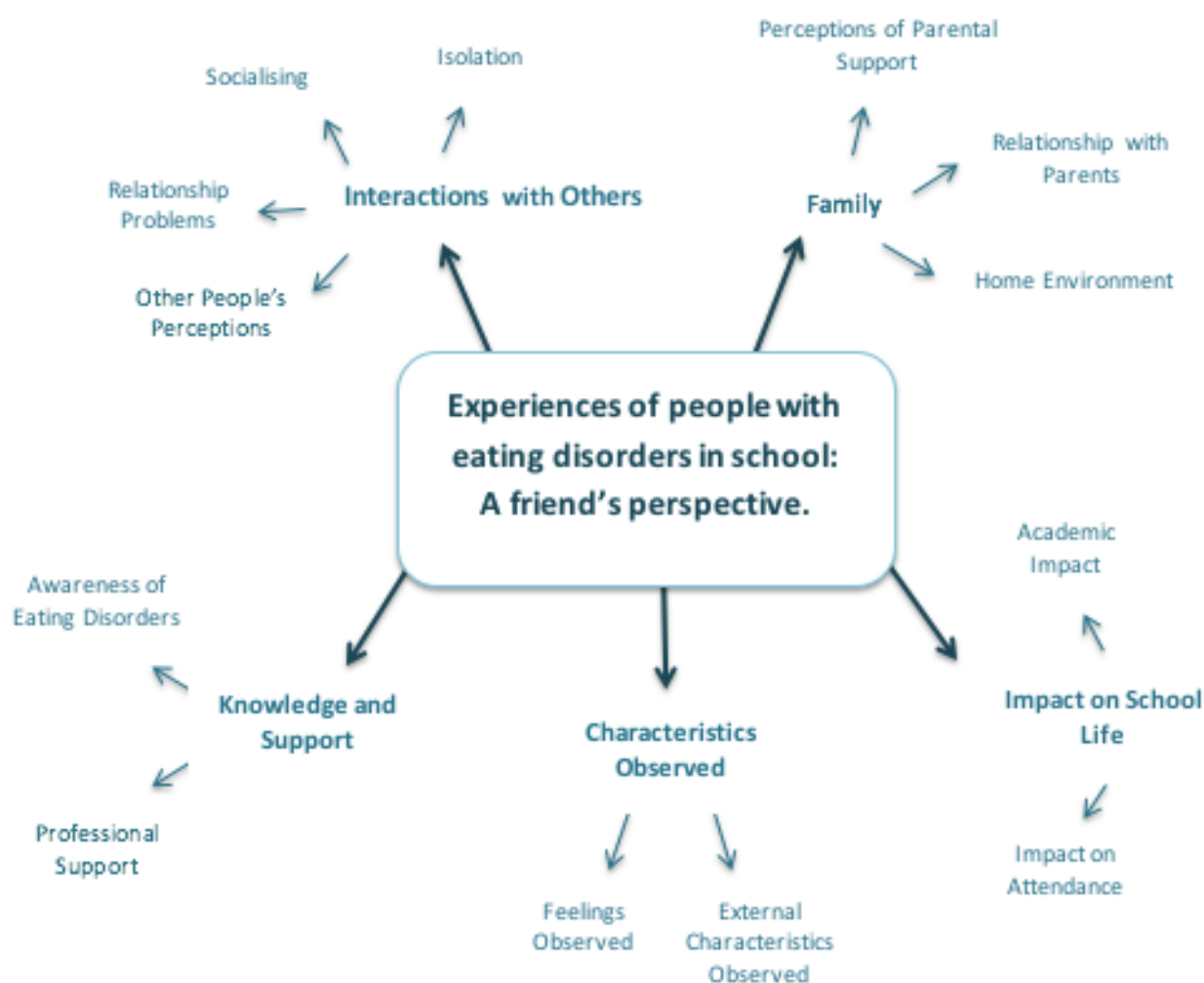


Figure 1 – Thematic map showing overarching and sub-themes

**Key – interview quotes:**

word- sharp cut off

(.) pause

word underlining indicating emphasis – pitch or volume

1.7 page number and line

[Beth] Name/word replacement for anonymity

### **3.1 Interactions with Others**

The overarching theme ‘Interactions with Others’ consists of four subthemes; ‘Relationship Problems’, ‘Isolation’, ‘Socialising’, and ‘Other People’s Perceptions’. All participants expressed that their friend’s eating disorder had a negative impact on their relationships and interactions with others, with all participants indicating that their friend isolated themselves at some point during their eating disorder (ED). All participants spoke about these topics in varying levels of negativity; all implied that their friends eating disorder had a negative impact in terms of their overall interactions with others.

#### ***Relationship Problems***

Participants expressed how their friends often struggled to connect with others around them, which resulted in problems in forming relationships:

*“she’s never been able to create very deep relationships with other people”*

*(Katie, p.44, 110-111)*

In addition to this, specific struggles faced by friends due to their eating disorders resulted in relationships breaking down and friends drifting apart:

*“she was somewhere else and then rushing off to throw up and things like that, so we sort of just drifted apart” (Lucy, p.35, 173-174)*

Participants reported that their friends eating disorder created tension in their relationships, which caused emotional issues for those involved:

*“they would get angry that why she’s not eating- obviously they were quite upset about her not eating” (Jane, p.23, 81-82)*

### **Isolation**

All participants expressed that their friends isolated themselves in some way during their ED, particularly from social situations:

*“she used to isolate herself from social situations” (Ben, Interview 6, p.52, 81-82)*

*“she was very withdrawn, where, when we were teenagers we used to all call for each other, all hang round over the shops or something...it was very rare she come out and done anything” (Pam, p.5 – 6, 69 – 70)*

This meant that friends felt they had to make more effort and adapt to these situations, in order to maintain their friendships:

*“she started to became a bit reclusive, once we finished school she’d go home, wouldn’t go out...she would always stay in, so we’d all have to go to her house” (Lucy, p.29, 56-58)*

### **Socialising**

Some participants expressed that their friends became more engaged and sociable after their eating disorders were revealed, as everyone knew, and they were able to be more open:

*“more engaged with her friends because it was more- she could speak- she knew we knew” (Ben, p.52, 74 – 75)*

Other participants indicated that their friends began to socialise more due to people commenting on their weight which resulted in increased confidence and a desire to socialise:

*“but she liked it when someone said ‘oh you look like’ I don’t know ‘like you have anorexia’...and she became even more sociable and she wanted to go out more- like at first I remember she- she didn’t want to go anywhere” (Katie, p.42, 76 – 79)*

### ***Other People’s Perceptions***

Participants stated that peers were easily impressionable, which created emotional issues for their friends:

*“other kids impressionable and with that- with an eating disorder, I can only imagine she was under a lot of confusion and stress to be fair” (Lucy, p.28, 39 – 41)*

Participants reported that others had a lack of understanding and empathy in terms of their friend’s eating disorder, which caused negative and distorted reactions:

*“kids are nasty- kids would just be like ‘oh she’s just bunking off school’, and...the teachers kind of explained where she was...we didn’t realise at all” (Jack, P.14, 51 – 53)*

## **3.2 Family**

This overarching theme consists of three subthemes; ‘Perceptions of Parental Support’, ‘Relationship with Parents’ and ‘Home Environment’. The majority of participants highlighted that their friends family played a significant role in terms of their friend’s wellbeing throughout their eating disorder; with the majority of participants emphasising that their friend’s family had a negative impact.

### ***Perceptions of Parental Support***

Most participants perceived that parents had a negative impact on their friend's wellbeing and some participants also reported a lack effective support or comfort:

*"when her mum found out, she came to school, came to school crying a lot and- and stressed over her mum knowing" (Lucy, p.33, 136– 138)*

*"they sort of made it worse for her" (Pam, p.10, 146 – 147)*

However, one participant acknowledged that her friends mum was avoidant of her eating disorder, due to being ashamed that she could not cope alone. Consequently, her friend perceived that very little parental support was provided:

*"she felt ashamed that she- she couldn't deal with that on her own, um she wasn't supportive, she would like shouting at her 'you need to eat" (Katie, p.46, 147 – 14)*

### ***Relationship with Parents***

Many participants reported that their friends would rather speak about their eating disorder to their friends, or siblings as opposed to their parents:

*"she'd much rather speak to me than- um and her sister...she'll speak to her sister and me more than her mum or her father" (Pam, Interview 1, p.9 -10, 142 – 144)*

Conversely, one participant suggested that due to isolation from society his friend had a close relationship with her parents. He indicated that it took a long period of time for her to open up to her parents, which could mean that her parents also had a lack of knowledge:

*"she's quite close with them, and open about it now but I do think it took a*

*long time” (Jack, Interview 2, p.18, 110 – 112)*

### **Home Environment**

The majority of participants indicated that their friend’s parents were either divorced, or separated:

*“she’s got a step dad” (Jack, Interview 2, p 18, 110)*

*“her parents got divorced she was brought up without a father” (Katie, p.44, 112 – 113)*

Other participants also indicated that their friends had difficult home environments, with varying problems, which were difficult for them:

*“her home environment was quite tense, they had lots of problems” (Jane, p.25, 112 – 113)*

### **3.3 Impact on School Life**

This theme consists of two subthemes; ‘Impact on Attendance’ and ‘Academic Impact’. Throughout the interviews participants consistently talked about the impact of their friends ED on school life, and vice versa. Most of the participants indicated that their friends ED negatively impacted them in school.

#### ***Impact on Attendance***

All participants expressed their friends had a lack of attendance at school; whether it was going to school and being absent from lessons, or being absent from school altogether. The majority of participants acknowledged that their friend’s eating disorders were the reason for their low attendance in school:

*“it was very common, like she’d take weeks off school at a time” (Jack, p.14, 47)*



*“it impacted badly on her school, because I think she was in school about thirty percent of the year” (Ben, p.50, 44 – 45)*

*“used to come to school, but she wouldn’t go to lessons” (Jane, p.21, 45)*

One participant indicated that her friend would attend school, however she would rarely attend lessons. She also indicated that school was in some ways a positive place for her friend as she could escape her home troubles;

*“I think school was like an escape route for her” (Jane, p.21, 54)*

### **Academic Impact**

All participants indicated that their friends ED had a negative impact on their academic performance, with most participants indicating that despite being capable their friends often did not reach their academic potential:

*“she wouldn’t do the work on time and she was like- she was capable of doing work, but what I noticed in her grades as well, they were quite lower down” (Jane, p.21, 37 – 38)*

This was reinforced by further participant, but she believed that due to her friends eating disorder the school had a lower expectation of her potential, which negatively impacted her attainment:

*“she would have been in a higher grade, and she would have learnt a lot more, but because of her mental problems she was put in a lower group when she was able to do much better” (Pam, p.5, 62 – 64)*

Other participants highlighted that their friends did not progress their education further than school, and indicated that their eating disorders may have played a role in this:

*“she didn’t progress into college or anything else like that” (Ben, p.50, 47 – 48)*

### **3.4 Characteristics Observed**

This theme consists of two subthemes; ‘Feelings Observed’, and ‘External Characteristics Observed’. All participants discussed the characteristics their friends had shown, both in terms of emotions and behaviours. These characteristics, were all acknowledged to be linked with their friend’s eating disorder.

#### ***Feelings Observed***

Many participants acknowledged the presence of negativity in terms on their friend’s moods, demonstrating their ED had a negative impact on them emotionally:

*“She was always moody and tired” (Lucy, p.26, 16)*

Participants acknowledged the impact of internal feelings, and highlighted the impact of this for their friends:

*“its completely in your head as well (.) so that would um stop her from going out, because, because of the way- how others perceived her” (Jack, p.16, 71 – 73)*

Participants discussed how negative internal feelings influenced how their friends believed they were perceived by others, and how this negatively impacted their emotional wellbeing:

*“she was afraid that people would judge her...she used to say she always felt really fat and was just waiting for someone to say that to her” (Katie, p.41, 66 – 70)*

*“she has always struggled with um confidence, low self-esteem, I believe this was the main reason she started dieting” (Katie, p.45, 138 – 140)*

### ***External Characteristics Observed***

Participants acknowledged physical and behavioural changes exhibited by their friends. Especially in terms of their weight and figure:

*“she was the tiniest she’d ever been in her life” (Pam, p.4, 46)*

*“had a slim figure if you know what I mean, and still childlike” (Ben, p.49, 19 – 20)*

*“everyone could tell noticeably she had lost weight, even I could tell that from a kind of outer point of view” (Jack, p.14, 36 – 37)*

Participants also discussed negative changes they had observed in their friends eating habits:

*“she wouldn’t eat anything at all” (Jane, p.24 106)*

### **3.5 Knowledge and Support**

This theme consists of two subthemes; ‘Awareness of Eating Disorders’, and ‘Professional Support’. Throughout the interviews participants compared past and present awareness of eating disorders and the support provided.

#### ***Awareness of Eating Disorders***

The majority of participants expressed their lack of awareness in relation to eating disorders, especially whilst they were in school and attempting to support their friends. Participants also began to highlight that awareness for eating disorders was limited in the past:

*“back then it wasn’t a big thing- well it didn’t seem like it was a big thing to what it is now (.) we didn’t have education in eating disorders” (Lucy, p.31, 93)*

– 94)

*“I only knew more about these eating disorders after sixth form, so yeah if we had more information we could have searched it up, and we thought it was a case only with her” (Jane, p.23, 87 – 89)*

Many participants compared past and present awareness, with some participants reinforcing past lack of awareness, and avoidance in terms of discussing eating disorders:

*“it was sort of brush it under the carpet, and they weren’t educated on the problem, so she didn’t get a lot of help at a young age” (Pam, p.3, 27 – 28)*

*“I think its more intense these days than it was back when we were young- but then we didn’t know much about it back when we were younger” (Pam, p.11, 168 – 170)*

Two participants who went to school more recently highlighted that they had been educated on eating disorders, which provided them with more awareness:

*“we had an assembly, like eating disorder things, and so just to be aware and what it entails sort of thing, so we were educated on it” (Ben, p.53, 102 – 104)*

### **Professional Support**

Participants reported contrasting levels of support received by their friends. A possible pattern identified was that the longer ago participants went to school, the less support their friends received in terms of their ED. Hence many participants reported a lack of support for their friends:

*“I can’t remember her ever getting any help to be fair” (Lucy, p.27, 27-28)*

Participants acknowledged that diagnosis increased perceived seriousness, and consequently resulted in support and increased understanding:

*“she didn’t get a lot of help at a young age- But as she grew older then, and things started to come to light that she was- when she was diagnosed, um everyone started taking it more seriously” (Pam, p. 3, 28-30)*

Two participants who went to school more recently acknowledged the support provided by the school, indicating again that eating disorder support is increasing:

*“the school was really good with it I remember...yeah the teachers were really, supportive of it... and kind of giving her help/offering her counseling, and everything” (Jack, p. 15, 55-59)*

## Chapter 4: Discussion

The aim of this study was to explore the experiences of being a friend, of someone in school with an eating disorder; anorexia nervosa (AN) or bulimia nervosa (BN).

Qualitative research was utilised in order to gain rich and compelling insights into the real world (Braun and Clarke, 2014) of friends of those with eating disorders.

There has been extensive research into the experiences of family of people with eating disorders, but there is limited research exploring the experiences of friends. In addition to this, adolescence is considered to be the most likely period to develop anorexia nervosa or bulimia nervosa, which is also when people are spending significant time with their friends, both in and out of school. Subsequently, friends could provide valuable insight into those with eating disorders, especially as they often have less responsibility in comparison to family members. Therefore, the rationale for this study was established based on the limited past research available relating to the experiences of friends of those with an eating disorders.

Consequently, this research could provide invaluable insight and contribution to the limited existing research.

The study utilised semi-structured interviews to gather rich data; and thematic analysis to analyse the data collected. The thematic analysis identified five overarching themes: 'Interactions with Others', 'Family', 'Impact on School Life', 'Characteristics Observed', and 'Knowledge and Support'. Each theme identified four to two subthemes, for example: relationship with parents, feelings observed, and isolation. Despite the sensitive nature of eating disorders, during the interviews the six participants were very open regarding their experiences and they provided a clear insight in this area. The interviews indicated that those with eating disorders; often choose to confide in their friends over their parents, struggle to attend and achieve in school, and have a generally negative impact on many aspects of life. It also suggested that although there is support and awareness available for individuals with eating disorders and those around them, there is still a need for more improvement in these areas. These findings support a wide range of past research exploring the experiences of family members. However, the current study offers



found that parent's perceptions were more negative, for example, they reported their children as increasingly dependent and demanding.

A further theme identified in this study was 'Family'. Participants repeatedly spoke about their friend's family, especially their parents. Many participants indicated that their friend's parents had a negative influence on their wellbeing. This is in line with past research which indicated that eating disorders can cause negative emotions in the family, and can be psychologically challenging (Papathomas, Smith and Lavalley, 2015; Whitney et al, 2005). Furthermore, participants in the current study reported that their friends often had stressful and difficult home environments. This was concluded in past research, from Whitney et al (2005), who reported that eating disorders often result in stressful atmospheres in the home. In addition, most participants involved in the present study reported that their friend's parents were either separated or divorced, which was not identified in past research. This highlighted complications that can occur within the family of people with eating disorders. Consequently, it appears that additional support from friends could be beneficial for those with eating disorders, especially due to the differences in family and friend relationships highlighted in past research (Noller & Callan, 2015).

'Impact on School Life' was another overarching theme identified in this study, however past research on the impact of eating disorders on school life is limited. However, the findings of the present study highlight that eating disorders can have a negative impact on school life. Participants reported that their friend's eating disorder had a negative impact on their attendance and academic performance at school. Consequently, additional research into providing beneficial support in terms of school could be valuable.

'Characteristics Observed' was also identified as an overarching theme in this study. Participants discussed the characteristics they observed their friends as having in terms of feelings observed and external behaviours observed. Participants mostly considered these characteristics as negative and linked this to their friend's eating disorder. For example, many participants reported that their friend's eating disorder caused negative emotional impacts, which is reinforced by past research (Whitney et



al, 2005). In addition, participants identified negative changes in eating habits, and changes in their friend's weight. This has been echoed by Treasure, Sepulveda and MacDonald et al (2008) who highlighted the occurrence of abnormal eating habits.

A final subordinate theme identified in this research was 'Knowledge and Support'. This theme highlighted the lack of awareness and support of eating disorders in the past, whilst identifying that it was starting to be taken more seriously. Participants indicated that despite the increased in awareness of eating disorders in recent years, the support available is still limited, and needs to improve. This is reinforced by past research which highlighted that the support available for family and carers is limited (Highet, Thompson & King, 2006). Nevertheless, the present study did indicate more of an improvement in support than past research (Highet, Thompson & King, 2006), but still highlights the need for improvements, especially in terms of school, and parents.

#### ***4.2 Limitations and Future Research***

One possible limitation of the present study is the onset age of bulimia nervosa. The average onset of bulimia nervosa is eighteen to nineteen years of age, whereas the average onset age of anorexia nervosa is sixteen to seventeen years old (Anorexia Bulimia Care, 2018). This could be considered a problem in the present study as there was a particular focus on school years, and at the ages of eighteen or nineteen people would no longer be in school. Therefore, indicating that the average person with bulimia is unlikely to have developed it during their time at school.

Consequently, the present study could have been limited in its findings in terms of the experiences of friends with bulimia in school, and it is possible that if focusing on bulimia after school age would be beneficial. However, out of the six participants interviewed in this study, three discussed being friends with someone with bulimia. Thus, indicates that it was beneficial to involve bulimia nervosa in this study, as the number of participants who discussed bulimia compared to anorexia was similar, and it allowed an increased insight into both eating disorders.





I believe my experience, of having friends with these eating disorders, widened my interest and motivated me to undertake this research. Although, throughout this research I did try to remain unbiased by attempting to separate my experience from the participants. Despite these efforts to limit researcher bias, I was unable to be completely neutral as I naturally related to certain topics discussed. In contrast to this, I felt my experience with eating disorders helped me to engage more with participants when conducting the interviews, as I had some knowledge of the topic and possible questions that could be asked. Therefore, this led to me feeling more confident and comfortable when engaging with participants.

One way I think my role could have impacted the findings of this study is by asking leading questions. When creating the interview schedule, I was cautious in the wording the questions to ensure all questions were neutral, in order to limit my own influence of the participants responses. However, when completing the interviews and asking additional questions I occasionally used leading questions without realising. For example, “do you just think she became less engaged?”. Therefore, this may have influenced the way participants answered the questions as they could have thought I was indicating what I wanted them to say. However, when I noticed this, I made a conscious effort to make additional questions as neutral as possible.

In terms of analysing the data my own experience made it easy for me to relate to certain topics discussed in the interviews more than others. Consequently, I knew that I could not be completely neutral when analysing the interview transcripts and I may have interpreted some topics, as more important than others when completing my analysis. However, I feel this had minimal impact as when I felt I could relate to participants I was able to identify differences between their experience and my experience, which helped me to limit bias when analysing the data.

Prior to the interviews I felt nervous as I did not have much experience interviewing people, however I feel that my own experience enabled me to be sensitive when interviewing participants. This experience provided me with reassurance that I

would not say the wrong thing, and therefore I was more confident than I would have been if I had no prior experience.

Overall, I found interviewing friends of people with eating disorders thought provoking and rewarding. Although, I did find some of the interviews challenging in terms of some of the impact and struggles which participants discussed. However, this provided me with greater insight and I was humbled by the honesty and openness of the participants.

#### ***4.4 Conclusion***

To conclude, the present study provides a rich and valuable insight into the experience of people with anorexia nervosa (AN) and bulimia nervosa (BN) from a friend's perspective. Eating disorders, including AN and BN, are debilitating conditions (Klein & Walsh, 2003), that can impact numerous aspects of an individual's life.

The present study aimed to build on the existing research into the experiences of people with AN and BN, from a friend's perspective, with a focus on school and social life. This study highlighted that friends perceived most parents as having a negative influence on their friend's wellbeing which often resulted in those with ED's confiding in their friends. This emphasises the critical role of friends and the importance of educating friends of those with ED's, particularly as friends reported noticing negative characteristics associated with ED's early on in their development. Individuals that develop AN and BN often isolate themselves from school and social situations, which can have negative implications for relationships, school performance and attendance. This highlights the need for further support to ensure that people with ED's are not disadvantaged at school and friendships are not affected; which can provide vital support. Awareness and support was seen as improving in recent years, however, it was argued that support is still limited for those with ED's and people around them. This evidences the need for further support for those with ED's and people around them and provides a basis for further research in relation to the experiences of friend's. This could be instrumental in

identifying how friends could be educated to support those with eating disorders, which could offer numerous benefits and implications for treatment limiting the negative consequences associated ED's.

## **References:**

- Anorexia Bulimia Care. (2018). *Statistics | Anorexia & Bulimia Care*.  
*Anorexiabulimiacare.org.uk*. Retrieved March 2018, from  
<http://www.anorexiabulimiacare.org.uk/about/statistics>
- ANRED. (2017). Complications of Eating Disorders. Retrieved March, 2018, from  
<https://www.anred.com/medpsy.html>
- APA. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.).  
Washington, D.C.: American Psychiatric Publishing.
- Bardick, A., Bernes, K., McCulloch, A., Witko, K., Sprinddle, J., & Roest, A. (2004).  
Eating Disorder Intervention, Prevention, and Treatment: Recommendations for  
School Counselors. *Professional School Counseling*, 8(N), 168. Retrieved from  
<http://www.jstor.org/stable/42732619>
- BEAT. (2018). *Statistics for Journalists*. *Beat*. Retrieved March 2018, from  
<https://www.beateatingdisorders.org.uk/media-centre/eating-disorder-statistics>
- Berger, R. (2013). Now I see it, now I don't: researcher's position and reflexivity in  
qualitative research. *Qualitative Research*, 15(2), 219-234.  
<http://dx.doi.org/10.1177/1468794112468475>
- Braun, V., & Clarke, V. (2006). *Using thematic analysis in psychology*.
- Braun, V., & Clarke, V. (2014). What can "thematic analysis" offer health and  
wellbeing researchers?. *International Journal Of Qualitative Studies On Health And  
Well-Being*, 9(1), 26152. <http://dx.doi.org/10.3402/qhw.v9.26152>

Copeland, W., Bulik, C., Zucker, N., Wolke, D., Lereya, S., & Costello, E. (2015). Does childhood bullying predict eating disorder symptoms? A prospective, longitudinal analysis. *International Journal Of Eating Disorders, 48*(8), 1141-1149.  
<http://dx.doi.org/10.1002/eat.22459>

Eating Disorders Victoria. (2018). *DSM-5 | Eating Disorders Victoria. Eatingdisorders.org.au*. Retrieved March 2018, from <https://www.eatingdisorders.org.au/eating-disorders/what-is-an-eating-disorder/classifying-eating-disorders/dsm-5>

Eisler, I., Dare, C., Hodes, M., Russell, G., Dodge, E., & Le Grange, D. (2000). Family Therapy for Adolescent Anorexia Nervosa: The Results of a Controlled Comparison of Two Family Interventions. *Journal Of Child Psychology And Psychiatry, 41*(6), 727-736. <http://dx.doi.org/10.1017/s0021963099005922>

Fairburn, C. G., Cooper, Z., Shafran, R., & Wilson, G. T. (2008). Eating disorders: A transdiagnostic protocol. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders: A step-by-step treatment manual* (p. 578-614). New York, NY, US: Guilford Press.

Flanagan, C. (2008). *Psychology: Complete Study and Revision Guide* (p. 84). London: Letts and Lonsdale.

Galloway, L., Power, M., Newman, E., Schwannauer, M., & Taylor, E. (2014). Exploration of friendship experiences in adolescent eating disorders. *The University of Edinburgh*.

Hazen, E., Goldstein, M., & Goldstein, M. (2010). *Mental health disorders in adolescents* (p. 250). New Brunswick, N.J.: Rutgers University Press.



Highet, N., Thompson, M., & King, R. M. (2005). The Experience of Living with a Person with an Eating Disorder: The Impact on the Carers. *Eating Disorders, 13*(4), 327-344. doi:10.1080/10640260591005227

Hillege, S., Beale, B., & McMaster, R. (2006). Impact of eating disorders on family life: individual parents stories. *Journal of Clinical Nursing, 15*(8), 1016-1022. doi:10.1111/j.1365-2702.2006.01367.x

Hodges, E. V., Boivin, M., Vitaro, F., & Bukowski, W. M. (1999). The power of friendship: Protection against an escalating cycle of peer victimization. *Developmental Psychology, 35*(1), 94-101. doi:10.1037/0012-1649.35.1.94

Hopf, R. B., Grange, D. L., Moessner, M., & Bauer, S. (2012). Internet-Based Chat Support Groups for Parents in Family-Based Treatment for Adolescent Eating Disorders: A Pilot Study. *European Eating Disorders Review, 21*(3), 215-223. doi:10.1002/erv.2196

Kaltiala-Heino, R., Rimpela, M., Rantanen, P., & Rimpela, A. (2000). Bullying at school—an indicator of adolescents at risk for mental disorders. *Journal Of Adolescence, 23*(6), 661-674. <http://dx.doi.org/10.1006/jado.2000.0351>

Kindt, E. (2013). *Privacy and data protection issues of biometric applications* (p. 685). Dordrecht: Springer.

Klein, D., & Walsh, B. (2003). Eating disorders. *International Review Of Psychiatry, 15*(3), 205-216. <http://dx.doi.org/10.1080/0954026031000136839>

Leonidas, C., & Santos, M. (2014). Social support networks and eating disorders: an integrative review of the literature. *Neuropsychiatric Disease and Treatment, 9*15. doi:10.2147/ndt.s60735

National Eating Disorder Association. (2018). *Friends in Support Roles*. National Eating Disorders Association. Retrieved March 2018, from <https://www.nationaleatingdisorders.org/forums/friends-support-roles>

NHS. (2018). *Eating disorders*. *nhs.uk*. Retrieved March 2018, from <https://www.nhs.uk/conditions/eating-disorders/>

NIMH. (2016). Eating Disorders. Retrieved March, 2018, from <https://www.nimh.nih.gov/health/topics/eating-disorders/index.shtml>

NIMH. (2018). *NIMH » Eating Disorders: About More Than Food*. *Nimh.nih.gov*. Retrieved March 2018, from <https://www.nimh.nih.gov/health/publications/eating-disorders/index.shtml>

Noller, P., & Callan, V. (2015). *The Adolescent in the Family* (p. 52). New York: Routledge.

Papathomas, A., Smith, B., & Lavalley, D. (2015). Family experiences of living with an eating disorder: A narrative analysis. *Journal of Health Psychology, 20*(3), 313-325. doi:10.1177/1359105314566608

Perkins, S., Winn, S., Murray, J., Murphy, R., & Schmidt, U. (2004). A qualitative study of the experience of caring for a person with bulimia nervosa. Part 1: The emotional impact of caring. *International Journal of Eating Disorders, 36*(3), 256-268. doi:10.1002/eat.20067

Reas, D. (2017). Public and Healthcare Professionals' Knowledge and Attitudes toward Binge Eating Disorder: A Narrative Review. *Nutrients, 9*(11), 1267. <http://dx.doi.org/10.3390/nu9111267>

Rigby, K. (2003). Consequences of Bullying in Schools. *The Canadian Journal Of Psychiatry, 48*(9), 583-590. <http://dx.doi.org/10.1177/070674370304800904>

- Sansone, R. A., & Sansone, L. A. (2008). Bully Victims: Psychological and Somatic Aftermaths. *Psychiatry (Edgmont)*, 5(6), 62–64.
- Shapiro, C. (2012). *Eating Disorders* (p. 1). New York: Nova Science Publishers, Inc.
- Smink, F. E., van Hoeken, D., & Hoek, H. W. (2012). Epidemiology of eating disorders: Incidence, prevalence and mortality rates. *Current Psychiatry Reports*, 14(4), 406-414
- Smolak, L., Levine, M. P., & Striegel-Moore, R. (1996). *The developmental psychopathology of eating disorders: implications for research, prevention, and treatment*.
- Sweetingham, R., & Waller, G. (2007). Childhood experiences of being bullied and teased in the eating disorders. *European Eating Disorders Review*, 16(5), 401-407. <http://dx.doi.org/10.1002/erv.839>
- Treasure, J., & Nazar, B. P. (2016). Interventions for the Carers of Patients with Eating Disorders. *Current Psychiatry Reports*, 18(2). doi:10.1007/s11920-015-0652-3
- Treasure, J., Sepulveda, A., MacDonald, P., Whitaker, W., Lopez, C., & Zabala, M. et al. (2008). The assessment of the family of people with eating disorders. *European Eating Disorders Review*, 16(4), 247-255. <http://dx.doi.org/10.1002/erv.859>
- Vitaro, F., Boivin, M., & Bukowski, W. M. (2009). The role of friendship in child and adolescent psychosocial development. In K. H. Rubin, W. M. Bukowski, & B. Laursen (Eds.), *Social, emotional, and personality development in context. Handbook of peer interactions, relationships, and groups* (p. 568-585). New York: Guilford Press.
- Walden. (2018). Retrieved March 2018, from <https://www.waldeneatingdisorders.com/why-arent-teens-seeking-eating-disorder-treatment/>

Whitney, J., Murray, J., Gavan, K., Todd, G., Whitaker, W., & Treasure, J. (2005). Experience of caring for someone with anorexia nervosa: qualitative study. *The British Journal of Psychiatry*, 187(5), 444-449. doi:10.1192/bjp.187.5.444

Willig, C., & Stainton Rogers, W. (2017). *The SAGE handbook of qualitative research in psychology* (p. 1-3). Los Angeles, California: SAGE Publications.

Youniss, J., & Haynie, D. (1992). Friendship in Adolescence. *Journal of Developmental & Behavioral Pediatrics*. Retrieved March, 2018, from [http://journals.lww.com/jrnldb/Abstract/1992/02000/Friendship\\_in\\_Adolescence.13.aspx](http://journals.lww.com/jrnldb/Abstract/1992/02000/Friendship_in_Adolescence.13.aspx)

Zohar, A., Lev Ari, L., & Bachner-Melman, R. (2016). My Sister Myself: A Controlled Study of the Relationship Between Women with a Lifetime Diagnosis of Anorexia Nervosa and Their Sisters. *European Eating Disorders Review*, 24(6), 466-473. <http://dx.doi.org/10.1002/erv.2465>

## Appendices

### *Appendix A: Semi-Structured Interview Schedule*

Questions	Prompts/thoughts
1. In school were you friends with one or more than one person with an eating disorder?	What type of eating disorder did they have?
2. What kind of relationship did you have with this person?	Close relationship?
3. How did you first find out about their eating disorder (ED)?	How old were you and they?
4. Did you notice any changes in their behaviour before you found out about their ED?	Examples/expand?
5. Are there any specific things you found difficult in terms of their ED and the changes it had on you/them?	Behaviour? Support?
6. How accepting do you feel they were of help and support, if they were offered any?	Both at first and throughout their ED
7. How do you feel their ED impacted them in terms of school?	Generally – if mention anything specific try to get them to expand.
8. Did you notice any changes in terms of their attendance and their school	

work?	
9. How you think their ED impacted how they perceived school life?	Eg. research suggests school can become a potentially threatening/frightening place.
10. Do you feel their ED had an impact on their social life?	How so? Expand?
11. Do you feel they became more or less engaged with others after they developed their ED?	How so?
12. How do you feel their ED impacted your friendship?	E.g. research suggests often distance/isolate themselves Closer or more distanced?
13. Do you feel their ED made any changes to your/their friendship group?	How so? Any specific difficulties?
14. Overall how do you think they found talking to you and others about their ED?	Closed or open? Did they struggle to tell people?
15. How open do you feel they were with their parents about their ED?	More or less open than with friends?

## Word Count Statement

Abstract	255
<hr/>	
Introduction	2720
Method	1152
Results	2247
Discussion	2815
Total (excluding abstract)	<hr/> 8934 <hr/>

Signed: \_\_\_\_\_

Date: 18/04/2018