Perceptions of the "anorexic voice": A qualitative study of

healthcare professionals

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Acknowledgements

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Executive summary

General introduction

This thesis explores the experiences and perceptions of healthcare professionals working with people with eating disorders (EDs). Paper 1 is a meta-ethnography on the lived experiences of healthcare professionals working with people with EDs; Paper 2 is a qualitative study exploring the perceptions of clinicians working in adult ED services towards the concept of the "anorexic voice" (AV), and Paper 3 is a critical examination of papers 1 and 2.

Paper 1 – The lived experience of working with people with eating disorders: A meta-ethnography

Introduction.

There is evidence that many clinicians have negative reactions when working with people with EDs, and that the relationships between healthcare professionals and service users affect engagement and outcomes in this field. Previous reviews on the experiences of clinicians working in EDs have been descriptive and/or lacking in detail. Therefore, a meta-ethnography was planned to update and extend their findings, and develop new understandings. The aim was to inform clinical practice and service development, with the broad goal of improving staff wellbeing and service-user outcomes.

Method.

The seven stages of meta-ethnography (Noblit & Hare, 1988) were followed: (a) choosing a topic; (b) deciding which studies to include; (c) reading the studies multiple times to extract key information; (d) determining how the studies are related; (e) translating the studies into one another by identifying overarching concepts and/or contradictions; (f) synthesising translations by creating a new framework for

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understanding, and (g) expressing the synthesis. A systematic search for literature was conducted in March 2018 using three databases, leading to the identification of 533 articles. After removing duplicates, applying inclusion and exclusion criteria, and manually searching reference lists of relevant studies, 35 peer-reviewed qualitative papers were included in the meta-ethnography. Critical appraisal was conducted to give readers a sense of the relative rigour of the included articles. Other members of the research team carried out independent screening and quality assessment for a proportion of studies.

Findings.

Characteristics of the included studies.

The 35 studies involved 724 clinicians from a range of professional backgrounds. All studies were judged to be of moderate to high quality. Twenty-four studies focused on experiences of working with EDs in general, and the remaining 11 on experiences of working with service users with anorexia nervosa (AN). Seven were mixed-methods studies in which the qualitative findings were reported separately. The most common method of data collection was semi-structured interviews, and the most prevalent form of data analysis was thematic analysis.

Meta-ethnography findings.

The findings indicated that lived experiences of work in this field are characterised by a painful dissonance due to a mismatch between clinicians' aspirations and the reality of caring for people with EDs, captured in the superordinate theme "Only human: Problems beyond our power to fix." This was elaborated via three themes and 10 sub-themes. The three themes were: (a) "The dissonance and discomfort of being a helper struggling to help," (b) "Defending against the dissonance," and (c) "Accepting the dissonance to navigate the 'golden middle way.'"

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"The dissonance and discomfort of being a helper struggling to help" encompasses feeling emotionally drained, deskilled, scrutinised, and morally conflicted in the context of this perceived loss of role. "Defending against the dissonance" refers to the tendency among some healthcare professionals to avoid, battle and/or blame service users to escape the sense of conflict, often resulting in further dissonance. "Accepting the dissonance to navigate the 'golden middle way'" captures some clinicians' commitment to a mindful, humane, humble and balanced stance towards the work, rather than striving to be an ideal carer or falling into the role of punitive prison guard. Feeling helpless seemed to be more common among clinicians without specialist experience, while nurses appeared to be more vulnerable to moral conflict, avoidance and blame.

Line of argument.

The interaction between clinicians who often self-identify as "fixers" and clients who frequently resist treatment leads to healthcare professionals feeling drained, deskilled and conflicted, and coping in a range of ways according to personal, interpersonal and systemic factors.

Discussion.

Being a professional helper who does not know how to help or has offers of help rejected can be painful, particularly for clinicians who aspire to the role of ideal carer. The findings of this metasynthesis supported quantitative research showing that frustration, helplessness and hopelessness are common responses among those working in this field. Similarly, the tendency among some professionals to avoid, battle and blame service users echoed questionnaire data showing clinicians often have stigmatised views of people with EDs. Blaming service users or "the system" for difficulties that are multifactorial can defend against feelings of personal

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inadequacy. However, in line with Weiner's (1986) model of helping behaviour, such negative attributions make helpful actions by clinicians less likely. Furthermore, the "culture of surveillance" identified in the data could be detrimental to therapeutic relationships.

The "golden middle way" involves showing self-awareness, humanity and humility to remain client-centred while acknowledging that ideal care is unattainable, and at times firm boundaries are vital in ED work. It evokes the flexible and fertile position of "safe-uncertainty" described by Mason (1993). Connecting to common humanity as a clinician is valuable given evidence that service users appreciate being treated as individuals, and that attuned relationships with healthcare professionals can be reparative. Previous research suggests that awareness and acceptance can reduce distress among clinicians working with challenging populations.

Clinical implications.

The findings could be used to support frontline clinicians to reflect on their experiences, and coping strategies. They point to a need to provide reflective spaces for healthcare professionals, to reduce the likelihood of avoidant and blaming responses. Alleviating systemic pressures could reduce demands on clinicians. Other potential applications of the findings include mindfulness courses, and self-care initiatives.

Strengths and limitations.

Strengths of this review include its breadth, and the involvement of four people in the screening and quality appraisal. Limitations include the over-representation of people with AN; the possible loss of data due to the exclusion of unpublished studies, and the potential sacrifice of depth in synthesising a large number of studies.

Recommendations for future research.

Future research could evaluate implementation of reflective spaces for healthcare professionals working with people with EDs. The lived experiences of clinicians working with other populations that may reject treatments – such as clients of assertive outreach teams – could also be investigated.

Paper 2 – Perceptions of the "anorexic voice": A qualitative study of healthcare professionals

Introduction.

Qualitative studies have highlighted that people with AN commonly report experiencing a non-psychotic, critical, inner voice focused on eating, shape, weight, and their implications for self-worth. The AV has been reported to provide a sense of identity and facilitate emotional avoidance, and can therefore account for the ambivalence many with AN feel towards treatment. Against a backdrop of no strongly evidenced treatments for adults with AN, emotion-focused therapy – which addresses the AV – has had promising results. The AV has been explored in studies with people with AN and critiqued by researchers, but no research has investigated the views of clinicians regarding the concept. Understanding staff perspectives was deemed important given that negative reactions towards people with EDs are common among clinicians, and it would not be possible for the AV to be incorporated into care and treatment without the support of healthcare professionals. The aim of the study was to explore clinicians' perspectives of the AV to inform clinical practice, training, and intervention development.

Method.

A qualitative descriptive design was employed to facilitate staying close to the data. Participants were recruited from four adult ED services, and purposive sampling

was employed. Semi-structured interviews were conducted with 15 healthcare

professionals from a range of backgrounds. Participants completed a demographic

questionnaire. Interviews were transcribed verbatim and analysed via inductive

thematic analysis (Braun & Clark, 2006). The analysis was audited by an

independent researcher. A research journal was kept to assist with bracketing

assumptions.

Results.

The analysis yielded two themes: "The AV is a vehicle for increasing

compassion" and "It's not a 'one-size-fits-all.'" The first theme described clinicians'

view of the AV as a tool to foster compassion among healthcare professionals, and

self-compassion among service users. The sub-themes were "Comprehending the

internal struggle," "A non-blaming stance," "Expressing empathy," and "Empowering

service users." Clinicians portrayed the AV as helping them to recognise service

users' distress and understand their ambivalence. They said the AV facilitated a non-

judgmental attitude, and was a means of demonstrating understanding. Participants

argued that they could use the AV as part of motivational work with clients; challenge

its messages directly using chair work or cognitive-behavioural techniques, or

undermine it indirectly by providing a more compassionate narrative. The second

theme articulated the fact that clinicians believed that the AV should be employed

only when it corresponded to service users' understanding of their experience, and

was likely to be helpful to them. This was captured in the sub-themes "Wary of

imposing the AV" and "Different words for the same thing." Many participants stated

that not all clients relate to the AV, and some were concerned that using it carried a

risk of reducing responsibility and/or fragmenting clients' sense of self. The AV was

generally portrayed as a metaphor rather than a literal truth and a potentially useful, but not vital, ingredient of successful care and treatment.

Discussion.

Clinicians' depiction of the qualities of the AV accorded with client accounts. Its perceived functions of companionship and providing a sense of identity reflect the prevalence of insecure attachment styles and under-developed identities among people with AN. Participants' view of the AV as a tool for cultivating compassion aligns with the Atkins and Parker (2012) model of acting compassionate, which involves noticing suffering; appraising it; feeling empathic concern, and responding to the suffering. Helping clinicians to comprehend service users' distress is important given evidence that the suffering of people with AN is often underestimated. Clinicians suggested that the AV facilitates appraisals of service users as deserving of help, and that by promoting empathy and its expression, it could reduce treatment resistance. The AV was also presented as a tool for reducing self-blame, and empowering service users. The emphasis on individual consideration corresponded with a formulation-driven approach, and respected client preferences. Some participants suggested that the concept of the observer self, from acceptance and commitment therapy, provided a means of acknowledging the AV without feeling entirely separate from, or conjoined to, it. Most clinicians portrayed the AV as a social construction, and argued that what mattered was whether it fitted for a particular individual.

Clinical implications.

The AV could be used to promote compassion among healthcare professionals in supervision and formulations, and to develop self-compassion among service users with whom it resonates.

Strengths and limitations.

Strengths of this study include the diversity of the sample, and the use of measures such as auditing to increase credibility. Limitations include the fact that the sample was self-selected.

Recommendations for future research.

Future research could investigate when it may be beneficial to use the AV in treatment. Perceptions of the AV among those caring for children and adolescents with AN, and less experienced clinicians, could also be examined.

Paper 3 – Integration, impact and dissemination summary

While both papers 1 and 2 relate to working with people with EDs, one is secondary research and one is primary; one examines all EDs and the other focuses on AN, and one centres on the lived experiences of healthcare professionals while the other relates to their perceptions of a specific concept/phenomenon. Potential impacts of Paper 1 include frontline clinicians seeking the golden middle way in their practice and service managers implementing reflective spaces, both of which could lead to improvements in wellbeing among staff and service users. Possible impacts of Paper 2 include services employing the AV in supervision and team meetings to foster a compassionate stance among staff and, where clinically indicated, with service users to promote self-compassion. The findings of the empirical study have been disseminated locally via presentations at Royal Holloway University and one of the recruitment sites, and submissions will be made to relevant journals and to present at a conference.

Paper 1 – The lived experience of working with people with eating disorders:

A meta-ethnography

Abstract

The aim of this paper was to synthesise qualitative studies relating to the lived experience of working with people with eating disorders (EDs). Work in this field is known to elicit strong emotional reactions in the context of high levels of treatment resistance, risk, and relapse. Therefore, awareness of healthcare professionals' experiences, and the range of factors influencing these, is important. It was hoped that the findings would inform clinical practice and service development, with the ultimate goal of supporting clinicians to maintain their wellbeing and achieve the best outcomes for service users. Relevant search terms were employed in key databases. Thirty-five studies, with a total of 724 participants, met the inclusion criteria and were critically appraised. All studies were deemed to be of moderate to high quality in relation to the CASP (2010) criteria. Noblit and Hare's (1988) meta-ethnographic method of metasynthesis was applied to the included articles, to generate new understandings. This generated a superordinate theme of "Only human: Problems beyond our power to fix." Three themes and 10 sub-themes explicated the emotional and psychological experience of working with people with EDs. The three themes were: (a) "The dissonance and discomfort of being a helper struggling to help," (b) "Defending against the dissonance," and (c) "Accepting the dissonance to navigate the 'golden middle way.'" While the conflict associated with being a helper struggling to help led some clinicians to engage in avoidance and blame, others navigated a "golden middle way" characterised by humanity, humility, balance, and awareness. Clinical implications, strengths and limitations of the meta-ethnography are discussed, and the findings are explored with reference to relevant empirical literature and theoretical models.

Key words: Metasynthesis, meta-ethnography, eating disorders, healthcare professionals, lived experience, staff wellbeing

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Introduction

Eating disorders (EDs) have a reputation for being challenging to treat in the context of high levels of complexity, risk, and resistance (Franko & Rolfe, 1996; Golan, Yaroslavski, & Stein, 2009; Herzog, Hamburg, & Brotman, 1987; Kaplan & Garfinkel, 1999). According to the American Psychiatric Association (2013), anorexia nervosa (AN) is characterised by low body weight, dietary restriction, intense fear of weight gain, and distorted body image; bulimia nervosa (BN) involves recurrent episodes of binge eating in combination with compensatory behaviours such as self-induced vomiting, and binge eating disorder (BED) is defined by repeated episodes of uncontrolled binge eating in the absence of compensatory behaviours. Other specified feeding or eating disorder and unspecified feeding or eating disorder refer to ED symptoms that cause clinically significant distress and/or functional impairment without meeting full criteria for the distinct disorders, with the latter used in situations where the clinician does not specify why full criteria are unmet (APA, 2013).

According to the ED charity Beat (2017), an estimated 1.25 million people in the United Kingdom (UK) are affected by EDs. In the United States (US), the lifetime prevalence estimates for AN, BN and BED are 0.9%, 1.5% and 3.5% respectively among females, and 0.3%, 0.5% and 2% respectively among males (Hudson, Hiripi, Pope, & Kessler, 2007). Prevalence varies significantly between countries, and – while rising – remains lower in non-Western nations (Makino, Tsuboi, & Dennerstein, 2004). Onset is typically early, with the highest incidence of EDs among females aged 15 to 19 (Micali, Hagberg, Petersen, & Treasure, 2013). Only 40-50 per cent of people with AN or BN fully recover (Joy, Wilson, & Varechok, 2003), and mortality rates are elevated across EDs and particularly

pronounced in AN (Arcelus, Mitchell, Wales, & Nielsen, 2011). EDs are frequently

comorbid with mood and personality disorders (Kaplan & Garfinkel, 1999), and carry

a risk of serious medical complications such as electrolyte abnormalities, cardiac

arrhythmia, and gastric rupture (Rome & Ammerman, 2003). The prevalence of

denial, inaccurate self-report, relapse and avoidance of treatment among those with

AN reflects the ego-syntonic nature of the disorder; in contrast, people with BN are

typically distressed by their experiences (Vitousek, Watson, & Wilson, 1998), though

shame and secretiveness around symptoms can be a barrier to disclosure (Kaplan &

Garfinkel, 1999).

People with EDs present in a range of specialist and non-specialist inpatient

and community settings (Walker & Lloyd, 2011). Despite the low prevalence of AN

and its association with treatment avoidance, it is over-represented in inpatient

environments due to the risks associated with malnourishment (Hage, Rø, & Moen,

2017[a]; Ryan et al., 2006), which include potentially fatal cardiac complications

(Rome & Ammerman, 2003); a significant minority (13-44%) of AN admissions are

involuntary (Clausen & Jones, 2014). People with AN and BN may be treated as

inpatients or outpatients, while those with BED are generally seen on an outpatient

basis (Land, 2004). NICE (2017) recommends first-line psychological therapy and

multidisciplinary treatment for adults and children with AN; psychological therapy for

children with BN, and guided self-help for people with BED and adults with BN.

However, external barriers to accessing treatment have been identified in the UK

(Beat, 2015), US (Hewitt, 2013), Australia (The Butterfly Foundation, 2012), and

non-Western countries such as Sudan (Lau & Ambrosino, 2017). For example, a

recent report by Beat identified long waiting times and geographical variation in the

availability of specialist services in the UK (Beat, 2015).

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While clinicians caring for people with EDs may value the "intellectual interest" (Land, 2004, p.392) of the work and feel warmly towards service users (Satir, Thompson-Brenner, Boisseau, & Crisafulli, 2009), they frequently report feelings of anxiety, distress, anger, and exasperation (Golan et al., 2009; Land, 2004). Working with high levels of risk is linked to emotional exhaustion, particularly where professionals have unrealistic self-expectations (Kleespies & Dettmer, 2000). Surveys of the general public show that people with EDs are more likely to be blamed for their symptoms than those with depression and schizophrenia (Crisp, 2005), and healthcare professionals often have stigmatising views of these clients (Fleming & Szmukler, 1992). Lower functioning and higher levels of dysregulation among service users (Satir et al., 2009), therapist inexperience, and larger caseloads (Franko & Rolfe, 1996) are all independently associated with more negative reactions to ED clients among professionals. Negative responses, which can reflect the discomfort associated with unfulfilled rescue fantasies (Golan et al., 2009), are more common when working with AN than BN (Franko & Rolfe, 1996). Managing these reactions via methods such as externalisation of EDs, self-monitoring and discussion in supervision can reduce staff turnover and burnout, and avert both invalidating over-control and collusive under-control of service users (Golan et al., 2009).

Understanding the lived experiences of staff in ED services is important given that the clinician-client alliance has been shown to affect treatment engagement (Gallop, Kennedy, & Stern, 1993) and outcome (Graves et al., 2017; Loeb et al., 2005; Pereira, Lock, & Oggins, 2006) in this field. Several existing reviews have examined this topic. In a mixed-methods review, Seah et al. (2017) explored knowledge, attitudes and perceived challenges among clinicians working with people with EDs; they identified limited knowledge and confidence, negative attitudes, and

difficulties such as service-user non-adherence, high workloads, miscommunication among treatment teams, and being personally affected by the work. Perhaps because of the broad scope of this investigation, the qualitative section was brief and included few illustrative quotations. Thompson-Brenner, Satir, Franko, and Herzog (2012) conducted a mixed-methods review on clinicians' reactions to people with EDs and highlighted feelings of worry, frustration, hopelessness and incompetence; these authors did not incorporate any illustrative quotations in their write-up. Employing thematic synthesis, Sibeoni, Orri, Lachal, Moro, and Revah-Levy (2017) explored views of the treatment of adolescent AN, and found that professionals reported focusing on weight gain and behaviours; removing control to maintain physical safety, and struggling to develop therapeutic relationships due to mistrust, perceived manipulation, and a battle for control. This was another ambitious study, which incorporated the perspectives of parents and service users, and lacked depth and detail in its synthesis of clinicians' views. In a descriptive synthesis that included no participant quotations, Salzmann-Erikson and Dahlén (2017) focused on factors that contribute to nurses developing "health-promoting" relationships with service users with AN (noted to be solidarity, authenticity, and honesty).

Given that all but one of these reviews were aggregative rather than interpretative and Sibeoni et al.'s (2017) synthesis lacked detail and focused on one ED and age group, a meta-ethnography was planned. The aim was to update and extend findings from previous reviews by developing new knowledge via fine-grained consideration of the lived experiences of diverse healthcare professionals caring for service users of all ages and with different EDs. Thus, a greater breadth of cases was examined. Whereas aggregative reviews summarise existing literature, meta-ethnography goes beyond the original data to develop new understandings (Barnett-

Page & Thomas, 2009) by critiquing and integrating the findings of qualitative studies to build an explanatory theory or model (Bondas & Hall, 2007; Walsh & Downe, 2005).

All EDs were incorporated in the search terms because they are often grouped together in the literature. This grouping reflects the fact that people diagnosed with one ED frequently go on to meet criteria for another (Fairburn, Cooper, & Shafran, 2003), leading to the proposal by Fairburn (2008) of a transdiagnostic model of EDs. The model is based on the idea that all EDs share a core psychopathology of over-evaluation of the importance of eating, shape and weight, and their control (Fairburn et al., 2003).

Therefore, the aim of the present review was to synthesise existing qualitative research on the lived experiences of work with people with EDs. The definition of lived experience that guided study selection was: "The detailed, nuanced, and subjective experience, including individual perceptions, meanings, understandings, descriptions, and felt somatic sense of an experience from the first hand point of view of a particular person" (Mertens, 2005, as cited in Palmer, 2015, p.123). The objectives of this meta-ethnography were to theoretically extend a rich body of literature and render findings into a more concise format to make them accessible to busy healthcare professionals. This would involve generating a model of the processes involved in working with people with EDs, drawn from the lived experiences of clinicians. This model could then be used to develop clinical practice, and inform service development.

Method

Systematic literature search

To identify relevant studies, the following databases were systematically searched in March 2018: PsycINFO, PubMed, and Web of Science. Three categories of search terms were combined using Boolean operators. Searches were limited to articles in peer-reviewed journals written in English. No date restriction was placed on the search. Search terms can be viewed in Table 1. Reference lists of relevant studies were manually searched for additional, relevant papers.

Table 1

Search terms

Search category	Terms used
Eating disorders	anorexi* OR eating disorder* OR bulimi*
Experiences	experience* OR view* OR perception* OR attitude* OR perspective* OR qualitative OR interview* OR grounded OR interpret* OR explor* OR thema* OR theme* OR focus group* OR account* OR letter* OR diary OR diaries OR understanding* OR feeling* OR reaction* OR emotion* OR countertransference OR alliance* OR relationship* OR phenomenolog*

Professionals	staff* OR clinician* OR worker* OR professional* OR nurse*
	OR psychiatrist* OR psychologist* OR therapist* OR doctor*
	OR physician* OR provider* OR setting* OR practitioner*
	OR primary care OR dietician* OR dietitian* or dietetic
	OR healthcare assistant* OR health care assistant*
	OR psychotherapist* OR specialist* OR personnel*

Inclusion and exclusion criteria

To ensure rigour and in line with the health-research community's expectations of high-quality reviews (Toye et al., 2014), inclusion and exclusion criteria were applied to identify relevant studies. The inclusion criteria were as follows: (a) peer-reviewed empirical studies written in English; (b) studies employing a qualitative method (e.g., interviews, focus groups) or mixed design (provided the qualitative results were reported separately); (c) studies focusing on EDs (AN, BN, BED, Other Specified Feeding or Eating Disorder and/or Unspecified Feeding or Eating Disorder); (d) studies whose participants included healthcare professionals from a range of settings (including inpatient and primary care) working with people with EDs of all ages, and (e) studies focusing on the lived experience of working with people with EDs. The exclusion criteria were: (a) studies in languages other than English; (b) studies employing an exclusively quantitative method; (c) studies that did not focus on EDs; (d) studies in which the sample did not include healthcare professionals working with people with EDs; (e) studies that did not explore healthcare professionals' lived experiences of their work, and (f) book chapters, books, book reviews, dissertations, opinion pieces, conference presentations, and

meeting abstracts. Only peer-reviewed studies were included given that their quality had already been favourably assessed.

Search results

As Figure 1 illustrates, 530 articles were identified via database searches. Three additional relevant articles were identified from other sources prior to screening. Following the removal of 198 duplicates, there were 335 articles. The titles and abstracts of these articles were read, leading to the exclusion of 279 studies (see Figure 1 for details). The remaining 56 articles were read in full and, of these, 29 met the inclusion criteria. Six additional studies were identified via manual searching of the reference lists of these 29 studies. Thus, 35 studies were included in the meta-ethnography. Two articles used a duplicate sample to others included in the review but were retained on the basis that they made an independent contribution to the research question.

Thirty per cent of the titles and abstracts left after removing duplicates, and thirty per cent of articles selected to be read in full, were independently screened by the three other members of the research team. Two discrepancies in decisions were resolved via discussion and re-reading articles, leading to the exclusion of an additional article. Having more than one person read abstracts and full papers helped to ensure rigour within the review. To create an audit trail of decisions regarding inclusion and exclusion, references were tracked using four Microsoft Word documents: one for all search results; one for results left following the removal of duplicate studies; one with articles remaining following the removal of papers excluded on the basis of titles and abstracts, and one with articles included in the meta-ethnography following the full-text screening and manual reference search.
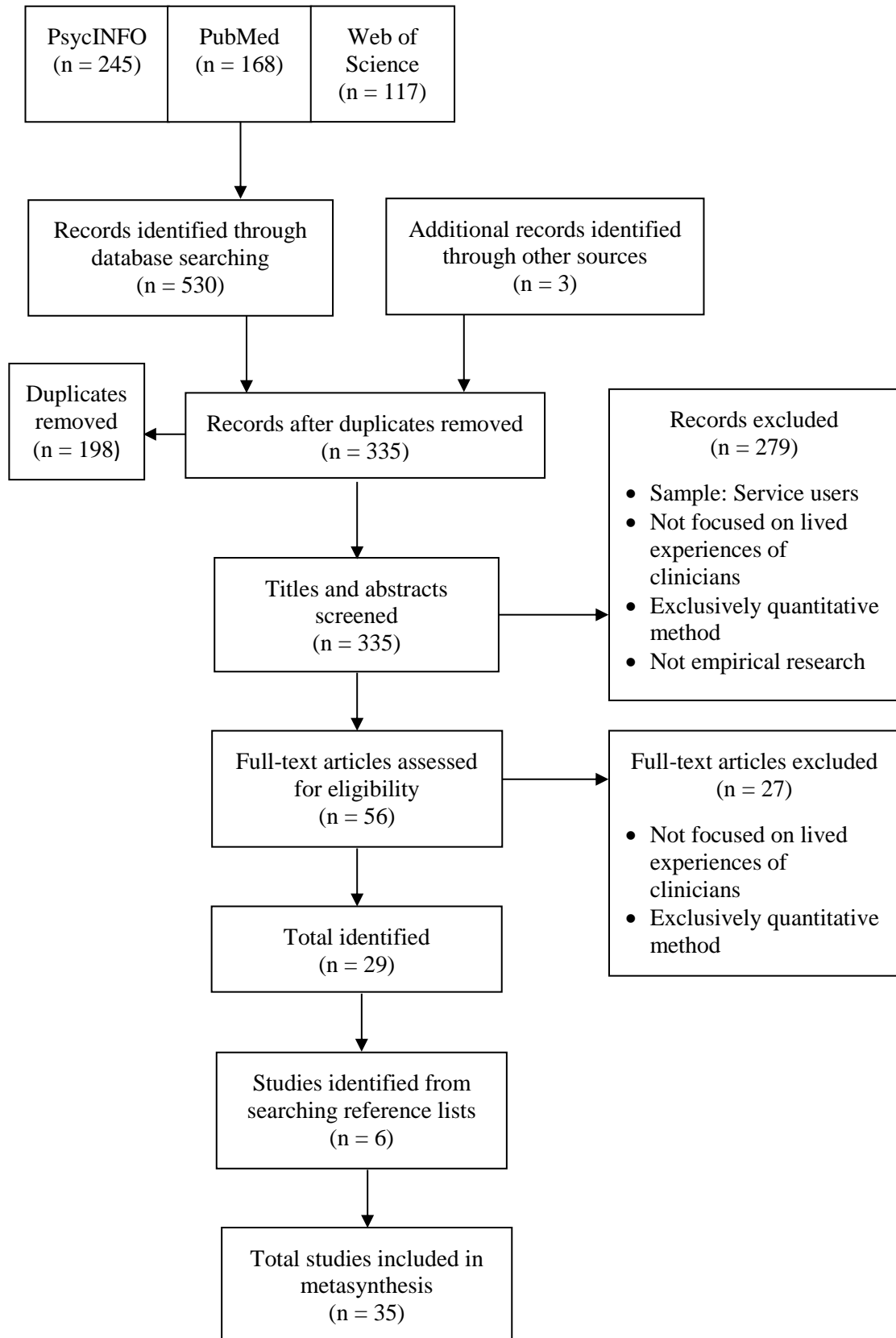
Figure 1. Flow chart of search process and study selection (Moher, Liberati, Tetzlaff, & Altman, 2009)

Assessment of quality

The methodological quality of the 35 included studies was assessed via the Critical Appraisal Skills Programme (CASP; 2010) checklist for qualitative research to ascertain, and give the reader a flavour of, their relative rigour. This tool has been employed in previous syntheses of qualitative ED studies (Espindola & Blay, 2009; Fox, Dean, & Whittlesea, 2015; Thapliyal & Hay, 2014; Tierney, McGlone, & Furber, 2013). Given that the checklist has 10 criteria, the 35 studies were each awarded a score out of 10, with half-points granted if a criterion were partially fulfilled. In the absence of standard protocols for mixed-methods studies, the qualitative components of the seven studies of this type were evaluated using the CASP checklist for qualitative studies, since it was these portions of the papers that were relevant to the meta-ethnography.

This review followed Fox et al. (2015) in classifying studies from A to C, with A denoting studies scoring 8.5 or above and carrying a low likelihood of methodological flaws; B denoting studies scoring five to eight and having a moderate likelihood of methodological flaws, and C indicating a score of less than five and a high likelihood of methodological flaws. A randomly selected proportion (20 per cent) of included studies were independently rated by other members of the research team using the CASP checklist. There was unanimous agreement on five studies and minor discrepancies with two; these discrepancies were resolved via discussion.

While critical appraisal has come to be an expected element of qualitative-evidence synthesis, it is contentious because of the epistemological variety of qualitative research, the diversity of appraisal tools, and the variability in ratings within as well as between tools (Carroll & Booth, 2015; Dixon-Woods et al., 2007). Methodological rigour and value are related but not synonymous in qualitative

research (Barbour & Barbour, 2003), and appraisal tools do not measure conceptual quality (Toye et al., 2014). Furthermore, applying the CASP checklist for qualitative studies to mixed-methods studies is problematic because the latter should be evaluated as a whole, given that the strengths of one strand can compensate for deficiencies of the other (Heyvaert, Hannes, Maes, & Onghena, 2013).

In light of these limitations and following the precedent of other metasyntheses in the field (Espindola & Blay, 2009; Sibeoni et al., 2017), no studies were excluded on the basis of the quality ratings. However, studies of lower methodological quality tend to contribute less to the overall synthesis (Atkins et al., 2008).

Data synthesis

Noblit and Hare's (1988) seven-phase meta-ethnographic method of metasynthesis was employed because it is a well-established approach (Bondas & Hall, 2009) with clear guidelines that seeks to translate findings from primary research to produce a richer understanding of a topic. The seven phases are as follows:

1. Getting started: An area of intellectual interest was identified (i.e., the lived experiences of healthcare professionals working with people with EDs).

2. Deciding which studies to include: Inclusion and exclusion criteria were applied, and relevant search terms employed in a range of databases.

3. Reading the studies: The 35 articles were read multiple times to identify and extract the methodological features, demographic information (Table 2), and key concepts/metaphors (Appendix 1). This information was tabulated.

4. Determining how the studies are related: The key metaphors/concepts in each study were juxtaposed and closely compared to decide relationships between

them. At this stage, accounts are either deemed directly comparable and

capable of being "reciprocally translated" into one another; in opposition to

each other and therefore suited to "refutational translation," and/or

cumulatively representative of a "line of argument" that "puts any similarities

and dissimilarities into a new interpretive context" (Noblit & Hare, 1988,

p.64).

5. Translating the studies into one another: Reciprocal translation was used to

    identify overarching concepts that captured similarities across studies.

    Concepts were present in many but not all studies. As there were no

    contradictions between study findings, refutational translation was not

    necessary.

6. Synthesising translations: Following reciprocal translation, the concepts were

    clustered and organised into a conceptual framework, which represented a new

    interpretation and line of argument.

7. Expressing the synthesis: The synthesis was elaborated via narrative and

    diagram (Figure 2) to elucidate the different aspects of professionals' lived

    experiences of ED work, and potential mechanisms to promote staff wellbeing

    and service-user satisfaction.

Within meta-ethnography, first-order constructs are the participants' own

interpretations in their own words; second-order constructs are the authors'

interpretations based on first-order constructs, and third-order constructs are the

researchers' interpretations of the original authors' interpretations (Schütz, 1962, as

cited in Toye et al., 2014). Thus, phases four and five involved second-order

interpretations (i.e., identifying and translating key concepts for each study), and

phases six and seven entailed third-order interpretation (i.e., going beyond the

meaning of the original results and authors' interpretations with a new reading that represented a conceptual advancement) (Espindola & Blay, 2009). To guard against a single perspective having undue influence on findings, the meta-ethnography was regularly discussed with other members of the research team, who introduced alternative understandings. Changes were made in response to their feedback. The final line of argument was the third draft. The earlier versions can be viewed in Appendix 2.

Findings

Quality assessment

All studies were classified as A or B, with an average rating of 7.84. The primary reasons for losing points were not stating/justifying the research design; not providing a rationale for the method of data collection; lack of reflexivity, and providing insufficient data to support findings; these omissions may reflect limited word-counts rather than deficiencies in execution (Walsh & Downe, 2006). The overall score and classification for each study are included in Table 2, and Appendix 3 shows all scores for each study and criterion.

Characteristics of the included studies

Across the 35 studies, data were collected from 724 healthcare professionals (298 of these were from one questionnaire study with open-ended questions), reported to be aged from 21 to 66. They included nurses, psychologists, psychiatrists, occupational therapists (OTs), social workers, dieticians, healthcare assistants, general practitioners, and medical providers such as gynaecologists. A minority of studies involved participants who all had the same professional background, while a majority included professionals from a range of disciplines. Some studies involved staff from several settings and others recruited all participants from the same service. Nurses

were well represented in studies with mixed samples and there were nine studies with solely nurse participants. Across the studies in which the gender composition of participants was reported, 86.6% were female. Two studies exclusively involved professionals with a history of an ED. Across the studies that did not specify personal experience as an inclusion criterion and reported the number of participants who disclosed such experience, 43.6% of healthcare professionals were stated to have lived experience.

Included studies were undertaken in the US, Australia, the UK, Norway, Canada, New Zealand, and Singapore. Sixteen studies recruited exclusively from an inpatient setting. Eight related specifically to work with adolescent service users. One study centred on clinicians working with service users with comorbid diabetes. Five studies included service-user as well as staff participants, and reported the findings separately. Most studies had a broad focus on professionals' experiences with people with EDs; a minority explored particular aspects of the work, such as collaborating with colleagues and meal times. Twenty-four studies centred on experiences working with people with EDs; the remaining 11 focused on experiences working with AN.

In the seven mixed-methods studies, qualitative findings were reported separately. Most data collection proceeded via interview (generally semi-structured), but focus groups and open-ended questionnaires were also utilised. Authors most commonly employed thematic analysis, followed by phenomenological approaches, but other methods such as grounded theory and content analysis were utilised.

Characteristics of included studies are shown in Table 2; not all studies provided fulsome information, for example regarding the composition of mixed groups of professionals.

Table 2

Study characteristics

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
1.	Brinchmann, Moe, Valvik, Balmbra, Lyngmo, and Skarbø (2017)	Explore therapists' practices in multifamily therapy (MFT)	8 MFT therapists working with adults with severe EDs and their families • Convenience sampling • 2 psychologists and 6 nurses • 2 males, 6 females • Aged 40-66 • 1-10 years' experience with MFT	Norway (regional centre for EDs)	Qualitative interviews (alongside field observations in 2 groups)	Grounded theory (findings discussed in the frame of Aristotle's virtue ethics)	5 (B)
2.	Carter, Webb,	Explore	21 healthcare	Canada	Focus groups	Sandelowski's	8.5

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
	Findlay, Grant, and Blyderveen (2012)	healthcare providers' experiences caring for youths with EDs, and understand the barriers and facilitators to integrating a new specialist ED nurse role in a general inpatient nursing unit	providers • Convenience sampling • 8 registered nurses, 3 specialist ED nurses, MDs, social workers, psychologists, a dietician, a child life specialist, a clinical educator and a clinical leader	(academic regional children's hospital)	and interviews	(2000) qualitative description method	(A)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
3.	Davey, Arcelus, and Munir (2014)	Explore the work demands experienced by healthcare workers in an adult ED inpatient service	12 healthcare workers from an ED inpatient ward (primarily service users with AN) • Purposive sampling • 7 nurses, 3 healthcare support workers, 2 OTs • 2 males, 10 females • Aged 21-55 • All white British	UK (specialist adult ED inpatient ward)	Semi-structured interviews	Thematic analysis	9 (A)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
			• <1-16 years' experience working with EDs				
4.	Dejesse and Zelman (2013)	Understand collaboration between dieticians and mental health professionals, and consider sources of conflict, their prevention and resolution	22 care providers recruited from international online community of ED professionals • Purposive sampling • 10 dieticians, 12 mental health providers • All female • 2-25 years' professional	US-based researchers; sample is international	Semi-structured interviews	Critical incident qualitative methodology	8 (B)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
			practice				
			• Inpatient and outpatient experience				
5.	Hage, Rø, and Moen (2017[a])	Identify inpatient staff perspectives on teamwork during meal times on EDUs	20 milieu therapists • Convenience sampling • 9 nurses; rest of sample were social workers, child welfare officers "or similar" • 18 females, 2 males • Aged 26-52	Norway (psychiatric inpatient EDU)	Semi-structured interviews	Cultural historical activity theory	9.5 (A)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
			• 0.5-5.5 years' experience at the EDU				
6.	Hage, Rø, and Moen (2017[b])	Explore staff deliberations and actions during mealtimes at an EDU	20 healthcare professionals • Convenience sampling • 9 nurses, some social workers and child welfare officers • 18 females, 2 males • Aged 26-52 • 0.5-5.5 years' experience	Norway (psychiatric inpatient EDU)	Semi-structured interviews (and video observation of meals)	Inductive content analysis	8.5 (A)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
			• Sample appears to be the same as in Hage, Rø, and Moen (2017[a])				
7.	Harken, Maxwell, Hainline, Pollack, and Roberts (2017)	Describe the perceptions of paediatric hospital physicians, nurses and care assistants regarding caring for adolescents with EDs and elicit feedback about changes to service	20 hospital staff who had cared for at least 1 person with an ED • Purposive sampling • 9 nurses, 7 physicians, 4 care assistants • 17 females, 3 males • <1 to >7 years'	US (2 paediatric hospitals and outpatient care facilities)	Semi-structured interviews	Content analysis	8.5 (A)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
			employment				
8.	Hunt and Churchill (2013)	Explore GPs' understandings and experiences of diagnosing and managing people with AN in primary care	12 GPs • Convenience sampling • 6 females, 6 males • Aged 30-49 • 1-21 years' experience	UK (3 practices in the East Midlands)	Focus groups	Corpus linguistic and discourse analytic approaches	7.5 (B)
9.	Jarman, Smith, and Walsh (1997)	Examine clinicians' experiences and understandings of treating young people with AN,	5 clinicians • Purposive sampling • 2 nurses, 2 social workers and 1 clinical	UK (community based MDT in CAMHS)	Semi-structured interviews	Interpretative phenomenological analysis (IPA)	7.5 (B)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
		with a particular focus on control as part of the condition and within the therapeutic relationship	psychologist • 3 females, 2 males				
10.	King and Turner (2000)	Explore the lived experiences of registered nurses caring for adolescents with AN on paediatric wards	5 registered nurses who had cared for adolescent females with AN in the previous 6 months • Purposive sampling • All female • None had	Australia (general hospitals)	In-depth interviews	Colaizzi's procedural steps of analysis (design underpinned by phenomenological philosophy of Husserl)	8.5 (A)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
			psychiatric nursing or mental-health qualifications				
			• 2 had limited experience working in mental health settings				
			• Cultural backgrounds Anglo-Celtic, European, and Eastern				
11.	Linville, Aoyama,	Qualitative component:	5 primary-care providers	US (primary	Qualitative component:	Qualitative component:	7.5 (B)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
	Knoble, and Gau (2013) (Mixed-methods study)	Provide a description and meaning-making of how the training had affected their perceived knowledge, skills and attitudes regarding ED screening and intervention	• Purposive sampling • 2 family physicians, 2 family nurse practitioners, 1 paediatrician	care practices)	Interviews	Sandelowski's (2000) qualitative description method	
12.	Linville, Benton, O'Neil, and Sturm (2010)	To identify the screening and intervention practices of medical	12 medical providers • Purposive sampling • 2 worked in	US	Qualitative component: Semi-structured interviews	Qualitative component: Thematic analysis	7 (B)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
	(Mixed-methods study)	providers for detecting and diagnosing EDs, and the kinds of continuing education programmes that are needed for medical providers to effectively detect and treat EDs	paediatrics, 8 in general or family practice, and 2 in obstetrics/ gynaecology • 4 males, 8 females • 2 ED survivors • All Caucasian				
13.	Long, Wallis, Leung, Arcelus, and Meyer (2012)	Qualitative component: Investigate staff perspectives of	16 staff members • Convenience sampling	UK (2 specialist NHS ED units and	Qualitative component: Semi-structured interviews	Qualitative component: Thematic analysis	7 (B)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
	(Mixed-methods study)	mealtimes within UK ED units	• "Variety of disciplines" • 14 females, 2 males • "Varying length of experience"	independent specialist ED unit)			
14.	Macdonald et al. (2018)	Explore the experiential perspective of people with type-1 diabetes and EDs, and that of the healthcare professionals treating them	8 healthcare professionals (in addition to 9 service users) • Purposive sampling • 3 psychologists, 2 diabetes dieticians, consultant	UK (from 2 NHS trusts and large tertiary care centres)	Semi-structured interviews	Thematic analysis	7 (B)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
			psychiatrist/ professor in psychiatry, ED nurse, specialist diabetes nurse • 3-20 years' experience; 2 N/A				
15.	Masson and Sheeshka (2009)	Explore clinicians' perspectives regarding the premature termination of treatment in an inpatient ED programme	7 clinicians in inpatient ED programme • Convenience sampling • 5 females, 2 males • Average 7 years' experience of	Canada	In-depth interviews	Inductive analytic approach based on grounded theory	7.5 (B)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
			programme and average 17 years' experience of working in mental health				
16.	Micevski and McCann (2005)	Describe the strategies paediatric nurses use to develop professional interpersonal relationships with adolescents with AN	10 paediatric nurses • Theoretical sampling	Australia (major hospital)	Unstructured in-depth interviews	Grounded theory	7.5 (B)
17.	Oyer, O'Halloran,	Explore perceptions and	7 therapists (in addition to 8 clients)	US	Semi-structured interviews	Moustakas's (1994)	7.5 (B)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
	and Christoe-Frazier (2016)	experiences of clients with AN and their therapists regarding how the working alliance was formed and challenged during individual psychotherapy	• Purposive sampling • 6 female, 1 male • Aged 28-63 • All Caucasian • 2-30 years' experience			phenomenological method of analysis	
18.	Palmer (2015)	Highlight the lived experience of dance/movement therapists who work with people with EDs	5 dance/movement therapists • Purposive sampling • 5 females • Various treatment	US	Semi-structured interviews	Kvale's interview analysis	8 (B)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
			settings				
			• 8 months to >40 years' experience				
19.	Ramjan (2004)	Explore the difficulties and obstacles hindering the formation of therapeutic relationships for nurses caring for adolescents with AN	10 registered nurses • Purposive sampling • 6 from adolescent ward, 4 from general medical ward • 7 females, 3 males • Aged 26-48 • 5-26 years' experience as nurses; 2-6 years'	Australia (acute wards of children's hospital)	Semi-structured interviews	Thematic analysis	9.5 (A)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
			experience working with adolescents with AN • None had formal mental health training				
20.	Ramjan and Gill (2012)	To explore the experiences of adolescents and nurses within an inpatient behavioural programme for AN	10 paediatric nurses (in addition to 10 service users) • Purposive sampling • 8 registered nurses and 2 trainee nurses • 6 females,	Australia (acute care paediatric ward)	Semi-structured interviews	Thematic analysis (hermeneutic-dialectic approach)	9 (A)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
			4 males				
			• Aged 23-42				
			• 3-20 years' experience as nurses; 2-8.5 years' experience working with adolescents with AN				
21.	Rance, Moller, and Douglas (2010)	Explore recovered ED practitioners' experiences of countertransference regarding their weight, body image and	7 counsellors with ED history who had not disclosed this at work • Purposive sampling • All female	UK	Semi-structured interviews	IPA (constructivist-interpretivist paradigm)	9(A)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
		relationship with food, and their perceptions about the impact of these experiences and their ED history	• Working in specialist ED services • Aged 32-52 • Theoretical orientations: cognitive behavioural therapy, cognitive analytic therapy, person-centred counselling, motivational interviewing and psychosynthesis • 2-17 years' practice				

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
22.	Reid, Williams, and Burr (2010)	Identify staff perspectives and experiences of providing services to those with EDs	18 professionals • Total sampling • Psychiatrist, psychologist, 2 OTs, GP on placement, dietician, dietician manager, senior nurse, consultant endocrinologist, consultant psychiatrist, matron, 3 mental health nurses, arts therapist,	UK (outpatient NHS service, general medical ward, and private residential service in same city)	Semi-structured interviews	Thematic analysis	8.5 (A)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
			3 support workers				
23.	Reid, Williams, and Hammersley (2010)	Investigate GPs' perspectives and experiences of assessing, and facilitating care for, ED patients	20 GPs • Purposive sampling • 10 females, 10 males	UK	Semi-structured interviews	Thematic analysis	6.5 (B)
24.	Ryan, Malson, Clarke, Anderson, and Kohn (2006)	Explore the ways in which "ED nursing" is constituted in nurses' accounts of nursing children and adolescents with EDs	15 nurses • Purposive sampling • 13 females, 2 males • Including nurse unit managers and clinical nurse	Australia (2 children's and 1 adolescent ward in two large hospitals)	Semi-structured interviews	Discourse analysis	8 (B)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
			consultants				
25.	Seah, Tham, Kamaruzaman, and Yobas (2018) (Mixed-methods study)	Explore the further training needs of nurses working with people with EDs and the nurses' perceptions towards their work	19 nurses (qualitative parts of questionnaire) • Census/total sampling • 14 females, 5 males • ≤2 to >10 years' experience 8 nurses (interview) • 7 females, 1 male • Aged 23-38 • 1 year plus to 8 years' experience in EDU	Singapore (tertiary general hospital)	Qualitative components: Open-ended questions and semi-structured interviews	Qualitative components: Content analysis and thematic analysis	9.5 (A)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
			• 6 trained in mental health				
26.	Snell, Crowe, and Jordan (2010)	Investigate and theorise the experiences of nurses in developing a therapeutic relationship with patients at an ED inpatient service	7 registered psychiatric or comprehensive (registered to practice in general and mental health settings) nurses • Convenience sampling • Aged 30-50 • 2.5-20 years' experience of mental health nursing	New Zealand (specialist inpatient EDU)	Interviews	Grounded theory	6 (B)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
27.	Trammell, Reed, and Boylan (2016)	Explore the self-efficacy of registered dietitian nutritionists working with clients with EDs	16 dietitian nutritionists • Purposive sampling • All female • 1-27 years' professional practice	US	Focus groups	Open coding guided by social cognitive theory	8 (B)
28.	Walker and Lloyd (2011)	Explore the attitudes of health professionals towards treating clients with EDs	15 health professionals • Purposive sampling • 10 females, 5 males • 3 psychologists,	Australia	Focus group	Consensual qualitative research	7.5 (B)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
			2 OTs, 2 medical registrars, 1 consultant psychiatrist, 3 social workers and 4 mental health nurses				
			• 9 had worked with people with EDs in acute settings, 2 had worked with people with EDs in outpatient settings and 4 had no experience of				

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
			working with people with EDs				
29.	Warren, Crowley, Olivardia, and Schoen (2008) (Mixed-methods study)	Explore treatment providers' experiences working with people with EDs	43 ED treatment providers • Convenience sampling • 39 females, 4 males • Mean age 50 • 6 months' to 31 years' experience treating people with EDs • Mainly integrative, cognitive-behavioural and psychodynamic/	US	Qualitative component: Open-ended questions on questionnaire	Qualitative component: General inductive approach	7.5 (B)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
			psychoanalytic approaches • 13 reported ED history				
30.	Warren, Schafer, Crowley, and Olivardia (2012)	Examine perceived contributors to burnout, efforts to personally avoid or manage burnout, and recommendations for early-career ED practitioners about managing burnout	298 participants • Convenience sampling • 273 females, 23 males, 2 unknown • 8 months' to 37 years' experience treating people with EDs • Mainly	US	Qualitative component: Open-ended questions on questionnaire	General inductive approach	6.5 (B)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
			integrative, cognitive-behavioural and psychodynamic/ psychoanalytic approaches • 139 reported ED history				
31.	Williams and Haverkamp (2015)	Investigate ED therapists' perceptions of whether and how their personal ED histories have ethical relevance	11 ED therapists • Purposive sampling • All female • Aged 28-61 • 2.5-22 years' experience • Backgrounds	Canada	Semi-structured interviews	Interpretive description	10 (A)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
			including social work, family therapy, counselling psychology, clinical psychology and educational psychology				
			• Histories of AN, BN and/or eating disorder not otherwise specified				
			• Duration of EDs from 2 to 28 years				

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
			• Recovered from 3 to 29 years • None reported a current ED • Theoretical orientations included eclectic, cognitive-behavioural, psychodynamic and humanistic				
32.	Wright (2015)	Explore the lived experience of the therapeutic relationship between people	13 care workers (in addition to 12 women with AN) • Purposive sampling	UK	Semi-structured interviews	IPA	7 (B)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
		with AN and their care workers	• 7 nurses (2 of whom were also therapists), 2 doctors, 2 dietitians, 1 therapist, 1 healthcare assistant • 3 months' to 7 years' experience in current service				
33.	Wright and Hacking (2012)	Explore the therapeutic relationship among healthcare	7 healthcare professionals (in addition to 6 SUs with AN)	UK	Semi-structured interviews	IPA	7.5 (B)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
		providers and adults who access day care services for AN	• Convenience sampling • 5 nurses, 1 dietitian, 1 cognitive behavioural therapist • All females • Aged 33-51 • All white British • 3 nurses had additional counselling qualifications				

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
34.	Zugai, Stein-Parbury, and Roche (2018[a]) (Mixed-methods study)	Develop a greater understanding of the inpatient therapeutic alliance between nurses and consumers with AN	20 nurses for qualitative component • Convenience sampling • 16 females, 4 males • 14 registered nurses, 4 enrolled nurses, 2 assistants in nursing	Australia (5 hospitals)	Qualitative component: Semi-structured interviews	Qualitative component: Thematic analysis	8.5 (A)
35.	Zugai, Stein-Parbury, and Roche (2018[b])	Understand the context of the inpatient setting for the treatment	20 nurses for qualitative component • Convenience	Australia (5 hospitals)	Qualitative component: Semi-structured interviews	Qualitative component: Thematic analysis	6.5 (B)

Study	Authors	Aim	Participants and sampling	Country	Data collection	Analysis	CASP rating
	(Mixed-methods study)	of AN and the implications for the therapeutic alliance between nurses and service users	sampling • 16 females, 4 males • 14 registered nurses, 4 enrolled nurses, 2 nursing assistants • 0.5-30 years' nursing experience • 0.5-17 years' ED-specific experience • Sample appears to be the same as in Zugai et al. (2018[a])				

Meta-ethnography findings

The stages of analysis outlined above led to the development of the overarching theme to describe the lived experience of working with people with EDs: "Only human: Problems beyond our power to fix." This described how a combination of treatment refusal, chronicity and systemic challenges confronted healthcare professionals with the painful fact that they are "only human" and what help they can offer people with EDs may be unwanted and/or insufficient. This resulted in a sense of dissonance that clinicians could either defend against, or draw on their courage and humanity to face without indulging in rescue fantasies or being punitive. This overarching theme was comprised of three themes and 10 sub-themes. The three themes were: "The dissonance and discomfort of being a helper struggling to help," "Defending against the dissonance," and "Accepting the dissonance to navigate the 'golden middle way.'" Despite the variety in the methodologies of the included studies and the range of disciplines, settings and geographical locations represented, there was considerable concordance between the accounts of the lived experience of working with people with EDs. However, some differences were apparent according to factors such as experience level, setting and professional background, and these are discussed below.

Theme 1: The dissonance and discomfort of being a helper struggling to help.

This theme, identified in 31 studies, describes the "emotionally draining" nature of working with people with EDs; the helplessness and hopelessness that often resulted from thwarted efforts to assist, and a perpetual sense of scrutiny linked to surveillance of others and oneself. Together, these experiences represented a painful dissonance between the expectation and reality of caregiving. Implicit in this theme

was a comparison of people with EDs with other service users who were experienced as more cooperative and easier to help. There was a sense that people with EDs were not conforming to their expected role within the client-professional dyad because of their frequent reluctance to engage in treatment, meaning that professionals were unable to fulfil their "helper" role.

Sub-theme 1: "Emotionally draining" work.

Participants reported that their work with individuals with EDs was "emotionally draining" (treatment provider; Warren et al., 2012, p.183). Many clinicians described experiencing frustration, and some reported anger, in response to service users' rejection of treatment, denial, and relapse:

> I looked after a girl who used to rip out the naso[gastric feeding] tube….After some time, you would get feelings of immense anger and frustration. (health professional; Walker & Lloyd, 2011, p.142)

> We get the others that fall down as soon as they go home….That's very frustrating when you've put so much effort in. (nurse; Ryan et al., 2006, p.129)

Some participants felt manipulated and/or personally attacked by service users, creating a difficult dynamic that contributed to the depletion of their emotional resources and sense of being a helper unable to help: "It's the manipulation. You think it's a personal attack against you and it's not; it's all part of the disease process" (nurse; Carter et al., 2012, p.551).

Interactions with service users' families could be stressful if, for example, they were in denial about the ED. Difficulties with other professionals were reported in several studies to add to the emotional demands of the work. In some cases, nurses regarded decisions by doctors as arbitrary, which caused confusion and resentment.

Perceptions of the "anorexic voice" among clinicians

Poor communication within teams and perceived lack of understanding among peers also caused frustration: "The most uncomfortable thing for me is the lack of education of other people around me….in particular the physicians" (dietician nutritionist; Trammell et al., 2016, p.79). Conflicts with other staff were portrayed as arising from dedication to care, and feeling helpless in the face of severe and risky presentations (see next sub-theme).

The emaciation of service users was a source of shock for some participants, and elicited fear for clients' physical safety:

I have only seen such skeletons walking in those countries without food. I have never really seen with my own eyes, so very scary first experience. (nurse; Seah et al., 2018, p.139)

I can be scared and sad for not only their quality of life but the risk of a patient dying. (treatment provider; Warren et al., 2008, p.39)

In three studies, clinicians discussed the impact of service-user death. Hopelessness could result from "caring without curing" (King & Turner, 2000, p.145) for chronically ill service users who frequently relapse: "When they come back 6 months later and they are just emaciated, they have a BMI of 11, that can be the biggest stab in the heart….It's disheartening" (OT; Davey et al., 2014, p.64). The fact that many people with EDs resisted the prescription meant that healthcare professionals could work hard on behalf of service users with no observable signs of progress:

Medicine is easy when you can just prescribe something and then they are better and they don't have to come back again but difficult sometimes when you have to put a lot of emotion into looking after them and sometimes you don't seem to get anywhere. (GP; Reid, Williams, & Hammersley, 2010, p.6)

This lack of reinforcement for their efforts could exacerbate clinicians' sense of depletion.

> ### *Sub-theme 2: Feeling helpless and deskilled.*

Linked to the high levels of relapse and resistance to the "prescription", clinicians described feeling deskilled and ill-equipped to help service users:

> I'm not sure that there's anything very much that I do that actually helps move people on. (GP; Reid, Williams, & Hammersley, 2010, p.6)

> When I got to my internship and I did see EDs, it sort of scared me. I didn't know what to do. (dietician nutritionist; Trammell et al., 2016, p.78)

A sense of helplessness was more apparent in studies involving staff without specialist ED experience, such as GPs and those working in paediatrics. For a minority of clinicians, this led to self-judgment: "Most of the time you feel you are going round and round in circles so it makes you feel like a useless therapist" (health professional; Walker & Lloyd, 2011, p.386).

The data suggested that organisational and sociocultural factors contributed to participants' sense that what they could achieve was limited. Lack of time, the most common systemic problem, particularly affected those in primary care: "You've got a certain pressure of seven minutes and it isn't anything like, you can't even scratch the surface" (GP; Reid, Williams, & Hammersley, 2010, p.7). This was not helped by staff shortages. At a macro-level, sociocultural pressure to be thin was seen as inhibiting progress, adding to clinicians' sense of helplessness to effect change: "We often feel like we are fighting a losing battle when they are exposed much more consistently to messages that contradict what we promote" (treatment provider; Warren et al., 2012, p.188).

Sub-theme 3: Watching and being watched.

The necessity of close observation of service users – particularly in inpatient environments – and a sense of being observed in turn, resulted in interpersonal mistrust. Participants described intently monitoring service users in case they tried to hide food or engage in compensatory behaviours, and this sometimes feeling awkward or unpleasant: "They have to have somebody sitting in their room all day long with them….I feel uncomfortable for them" (registered nurse; Harken et al., 2017, p.e38). In four studies in inpatient settings, this surveillance culture evoked the metaphor of professionals as prison guards, setting up a dynamic of "us and them".

Some participants also articulated a feeling that their behaviours and/or appearance were being scrutinised by service users. There was a fearfulness about saying or doing the wrong thing, particularly when inexperienced. For a minority of healthcare professionals, the sense that their own dietary behaviours, shape and weight were monitored led to increased self-consciousness: "I feel like they are really watching me. I was trying to drink really normal but it was really hot" (staff member of ED unit; Long et al., 2012, p.244). Professionals with lived experience reported an additional layer of feeling scrutinised, by other professionals, for signs of wellness – or otherwise; some of Williams and Haverkamp's (2015) participants described unhelpful interactions with colleagues relating to their ED history, such as being questioned about observable weight loss.

Sub-theme 4: Moral distress.

Feeling unable to help and at odds with service users generated a sense of "dissonance" (ED therapist; Williams & Haverkamp, 2015, p.405) for healthcare professionals accustomed to providing valuable and valued care underpinned by feelings of competence and warmth: "We are fixers and doers by our nature, that's

why we get into the profession that we do, so to not have an immediate answer is difficult" (medical provider; Linville et al., 2010, p.119). In the context of feeling drained and distrustful, some clinicians lost their unconditional positive regard for service users, which led to self-judgment for the perceived violation of their core values: "My heart just doesn't warm to them any more....Disgusting – sad you know, that's not a nurse" (nurse; King & Turner, 2000, p.142). In some cases, disempowering service users to preserve their physical safety led to self-questioning:

> I have to justify it to myself at times, that this is the right way. I don't always feel that it's the right way. (community nurse; Jarman et al, 1997, p.146)

> I didn't want this role, I've always fancied myself as being quite therapeutic and collaborative. (nurse; Snell et al., 2010, p.354)

This reflected an awareness that EDs served positive functions for many service users.

Moral distress was most prevalent among, but not unique to, nurses, which perhaps reflects their central role in implementing behavioural treatment protocols. Ramjan and Gill (2012) argued that there is an inherent conflict between administering treatment based on behaviour modification and developing therapeutic relationships. Furthermore, the intimacy of the nursing role, which Ryan et al. (2006) depicted as "ever present care," can foster a closeness that makes enacting such protocols even more difficult: "Because you get closer to them, it does influence their care because then you feel bad, like providing discipline and that to them, because then they've befriended you" (nurse; Zugai et al., 2018[a], p.422).

Theme 2: Defending against the dissonance.

This theme, evident in 20 studies, conveyed the experience of some healthcare professionals of avoiding, blaming, and battling service users. These coping strategies could defend against the dissonance of caring without curing, and self-

judgment, by blocking them out or attributing "the problem" to service users, but simultaneously could exacerbate the dissonance due to the violation of the principle of unconditional positive regard.

Sub-theme 1: Avoidance.

There was a tendency among some healthcare professionals to unconsciously or consciously avoid emotional pain and conflict in their work with people with EDs. This was achieved by limiting time spent with these individuals; shutting off and being task-oriented; distancing themselves from unwanted interventions; having an "us/them" mentality; trying to maintain a high level of control, and/or using food, substances or self-injury to cope.

Avoidance was apparent in a number of accounts of nurses' experiences, perhaps due to the emotional intensity of their work. Ramjan (2004) reported that some of the nurses in her study requested not to work with adolescents with AN, and others chose not to trust service users due to the expectation they would be let down. Shutting off and being task-oriented was a strategy employed by some nurses: "You just close off everything else and just take that fixed view that yes, you're going to eat" (clinical nurse specialist; Jarman et al., 1997, p.148). This could reduce frustration and distress temporarily, but sometimes led to dehumanisation of service users: "That's probably some sort of psychological defence against the awfulness of the situation….they become a set of symptoms and things to monitor and measure" (nurse; Davey et al., 2014, p.63).

Some clinicians reported binge-eating to avoid burnout (Warren et al., 2012), which can be understood as a means of avoiding emotional pain. Other healthcare professionals appeared to use their diet to distance themselves from service users, and disown their shared humanity:

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> I find myself going to an extreme, at times, of eating whatever I want and
> thinking it is bad to "eat healthy." I feel like I try to compensate for my
> clients' eating disordered views. (treatment provider; Warren et al., 2008,
> p.37)

Similarly, some professionals with lived experience emphasised the "normality" of their relationships with food and their bodies (Rance et al., 2010; Trammell et al., 2017), in what was interpreted by Rance et al. (2010) as signifying cognitive rigidity about what it means to be recovered, and attentional blind-spots about the risks associated with their own histories. Rance et al. (2010) argued that these participants adopted a binary view of recovery that entailed avoidance of their common humanity with service users. Other clinicians with lived experience reported that they avoided connecting with this aspect of themselves due to fearing the consequences of disclosure; one therapist described how for her this avoidance fostered "dissonance" – rather than defending against it – due to the mismatch between her secrecy and her anti-stigma messages to service users (Williams & Haverkamp, 2015, p.405).

Sub-theme 2: Battle and blame.

A more extreme form of othering was manifest in the perception of some healthcare professionals that they were waging battle with "rebellious and dominating" service users (Long et al., 2012, p.244). Their objective in this "war" was for clients to follow their treatment recommendations. Comparisons of clinicians to authority figures jarred with the notion of collaborative care: "We were just like sergeant majors, we thought we were. Standing over them telling them what to do" (nurse; King & Turner, 2000, p.142). While being the face of unwanted interventions led to distress for some healthcare professionals, a minority appeared conspicuously comfortable with their authority: "Some we crack within a week" (healthcare

professional; Long et al., 2012, p.244). While five of the studies in which the theme of battle was manifest involved clinicians caring for children and adolescents with EDs, two featured professionals working with all ages.

Blaming was evident in a small proportion of studies. King and Turner (2000) remarked that staff were pathologising typical adolescent behaviours, and service users were dismissed as "vain" by a participant in Walker and Lloyd (2011). Ramjan (2004) noted that a tendency among her nurse participants to judge service users as responsible for their harm was reflected in the prison metaphor they employed, which cast clients as criminals. Blame justified the battle, and the experience of battle could lead to further blame: "They're very cunning, and manipulative. You just have to let them know who's the boss but sometimes if there are so many of them it's a battle" (nurse; Ryan et al., 2006, p.130. While a minority of clinicians were unperturbed by this dynamic, for many it was inimical to their view of themselves as caring professionals.

Theme 3: Accepting the dissonance to navigate the "golden middle way".

This theme, in 32 studies, described some clinicians' efforts to face the reality of caring without curing, without blaming or avoiding service users, or indulging in rescue fantasies. The "golden middle way" entailed tolerating uncertainty and fallibility, to provide compassionate care in the knowledge that it may not always be experienced as helpful.

Sub-theme 1: The golden middle way.

Clinicians stressed the importance of taking a balanced approach in their work. Brinchmann et al. (2017) described the therapists in their study as navigating a "golden middle way" (p.8) between extremes (e.g., active and passive, connected and theoretical) to create an environment for service users that was safe but promoted

development. The golden middle way involved being a carer rather than a prison guard, but acknowledging that ideal care is illusory and that in the context of risk and resistance at times it may be necessary to be guard-like. The balance between compassion and boundaries was conveyed evocatively as "having one arm around the client while kicking them in the butt with your foot" (therapist; Oyer et al., 2016, p.128-9). Clinicians identified a danger in being overly permissive as well as too harsh: "If I don't push my patients to try new things and I give in to their resistance, I'm not helping them" (treatment provider; Warren et al., 2008, p.40-41). The golden middle way involved "taking control" where necessary and then "gradually giv[ing] service users] bits of control back, as and when we think [they] can cope with that" (social worker; Jarman et al., 1997, p.145); it meant assuming control to preserve safety, without being punitive.

While rules were seen as important to preserve the safety of service users, the therapeutic value of flexibility was emphasised. However, the flexibility of the golden middle way was a source of anxiety because it meant that clinicians could not "hide behind a method which can provide them with the safety and security of being in control" in the context of high rates of treatment refusal and physical complications (Jarman et al., 1997, p.147). The concept was also relevant to professionals' self-management. A need for both boundaries and flexibility was articulated in relation to defining professional roles and respecting the expertise of other clinicians, while accepting the inevitable occasional overlap in remit (Dejesse & Zelman, 2013).

The golden middle way was also evident in healthcare professionals holding on to hope and small successes without having unrealistic expectations – remaining motivated without succumbing to rescue fantasies. It involved an appreciation of the multifactorial influences on their experiences (Reid, Williams, & Burr, 2010). Some

clinicians noted that they were able to recognise that they did not bear sole

responsibility for outcomes while continuing to work hard on behalf of service users,

but this was highlighted as difficult:

> It's a constant challenge to find the balance between appropriate attention to
>
> my clients/doing everything I should and can for them, and letting go/bearing
>
> in mind that I can't control what they do/what happens to them. (treatment
>
> provider; Warren et al., 2012, p.184)

Sub-theme 2: Mindful awareness and acceptance.

The golden middle way was facilitated by a stance of mindful awareness and

acceptance. This manifested in healthcare professionals taking an objective and non-

judgmental perspective; facing and responding to reality; feeling more accepting of

outcomes that may not be viewed as traditional successes, and trying to monitor,

tolerate, reflect on and regulate their own behaviours, reactions and relationships:

> At the end of the session, I reflected and realized that 70% of the session was
>
> me talking AT them [the client]. I am a model of relationships, and if I am
>
> doing that….that is not therapeutic. (therapist; Oyer et al., 2016, p.132)
>
> I try to be very aware of the language I use so even using [words like] weight,
>
> heavy, light….because some of that can really tie into an ED pretty quickly.
>
> (dance therapist; Palmer, 2015, p.126)

Some clinicians mindfully observed, tolerated, and positively framed the

watchfulness of service users as affording an opportunity to model a healthy

relationship with one's body (Palmer, 2015; Seah et al., 2018). Unlike those who

maintained "mindless" attentional blind-spots, some healthcare professionals with

lived experience emphasised the need for self-awareness, including knowing one's

residual symptoms to avoid these becoming "predatory" and leaking out (therapist;

Williams & Haverkamp, 2015, p.402). Supervision, team meetings and personal

therapy were presented as fora that could promote this mindful stance.

Sub-theme 3: Connecting with common humanity.

Many clinicians described connecting with their own humanity, and that of

service users, in their work, in opposition to an us/them mentality and in line with the

golden middle way. Connecting with common humanity comprised a recognition of

the individuality of both clients and therapists; attuned responses; self-care;

considered self-disclosure; a maternal stance, and finding reward in service users'

steps towards recovery.

Some therapists reported drawing on their own experiences of the menstrual

cycle to empathise with service users' negative body thoughts (Palmer, 2015), which

– as well as mindful awareness of their own reactions – entailed a recognition of the

parallels between them and clients. Appreciation of common humanity was also

reflected in clinicians treating service users as individuals: "I would have trouble

following a given protocol. To me, it's more like artwork, and each person is totally

different" (dietician nutritionist, Trammell et al., 2016, p.81). One means of

acknowledging the individuality of service users, and developing relationships

founded on respect, was talking to them about topics other than their ED. Humanity

was also evident in attuned responses to service users' body language, facial

expressions, and words:

> I'll just carry on walking beside them….that's helped me slow down and have
>
> that sort of metaphor of sort of walking alongside at their pace and using their
>
> language and just try to get into their life world. (nurse; Snell et al., 2010,
>
> p.354)

Perceptions of the "anorexic voice" among clinicians

Some recovered clinicians felt they were more attuned to service users than colleagues without lived experience, though it was noted this carried a risk of over-identification: "I can REALLY clearly remember thinking about the psychiatrist....'Yeah but I don't think you REALLY understand, because you're fat'" (counsellor; Rance et al., 2012, p.382).

The respect and care implicit in attunement was echoed in clinician accounts of viewing themselves as engaged in battle alongside, rather than with, service users via externalising the ED and viewing it as separate from the client. Humanity was embodied by "not seek[ing] to take control away from the individual, rather to empower them" (psychiatrist; Reid, Williams, & Burr, 2010, p.395). Meanwhile, self-care encompassed respect for one's own humanity, and awareness of the need to preserve wellbeing to be able to show humanity to service users. Limited self-disclosure was seen as normalising and facilitating relational safety: "I have talked about things going on in my life, in very basic ways....it....puts them on your level" (nurse; Micevski & McCann, 2005, p.107).

For some healthcare professionals, predominantly nurses, maternalism functioned to facilitate unconditional positive regard (Wright, 2015), and manage vulnerability in the presence of a power differential (Zugai et al., 2018[a]). Maternalism was portrayed as a means of reconciling the need for both empathetic support and boundaries given that the parental role entails providing loving care and discipline. However, these aspects of ED nursing were acknowledged to be "potentially conflictual," and it was suggested that nurses should be supported to negotiate them through supervision and training (Ryan et al., 2006, p.132).

As well as the interesting nature of the work, some clinicians noted how rewarding it was to form positive therapeutic relationships through skill and

perseverance, and see service users improve: "I end up really enjoying the experience because it's something really great to see them overcome it" (care assistant; Harken et al., 2017, p.e.39).

Sub-theme 4: Humbly open to learning and support.

For some clinicians, awareness of their own fallibility promoted efforts to self-improve and engage with service users as equals in accordance with the golden middle way. Humility was demonstrated by healthcare professionals acknowledging their own limitations; valuing support from their teams, supervisors and specialist services; demonstrating a desire for more training; showing openness to learning from conflict and mistakes; being willing to provide a rationale for rules, and collaborating with service users and their families:

> I couldn't imagine just doing it on my own….You need support. (healthcare professional; Macdonald et al., 2018, p.229)
>
> [Conflict] gives me the opportunity for self-reflection. I always appreciate it when the dietician that I work with, challenges my thinking. (mental health professional; Dejesse & Zelman, 2013, p.198)

Having lived experience was portrayed as facilitating humility and guarding against "an us/them kind of perspective" (therapist; Williams & Haverkamp, 2015, p.404). While clinicians commonly reported wanting more training in EDs, Carter et al. (2012) noted that training was offered at their recruitment site and uptake was low.

Line of argument

A line of argument was developed from synthesising the 35 studies and reflecting on the resulting themes. Central to this line of argument, which is illustrated in Figure 2, is that the lived experience of working with people with EDs is characterised by feeling drained, demoralised and on edge due to the subversion of

clinicians' usual role as helpers against a backdrop of complexity, chronicity, and treatment refusal. Working with this client group foregrounds the limits of clinicians' powers to help, highlighting that they are only human and that what they can offer may not match the needs and/or wishes of people with EDs, or their own desire to assist. Problems may be beyond their power to resolve due to their own personal resources, systemic factors, and/or the client's readiness to change. For "fixers and doers" – who in some cases may aspire to the role of rescuer or ideal carer – the resulting sense of powerlessness and loss of role can create a painful dissonance. One response is to defend against this by avoiding, battling, and blaming service users. While this may provide temporary relief, it can exacerbate the dissonance by violating the principle of unconditional positive regard, and is unlikely to be conducive to productive alliances with service users. Another response is to face the dissonance of caring without curing by being mindful, humane and humble to seek the golden middle way. This involves remaining emotionally connected and compassionate, and acknowledging that at times actions that may make clinicians seem, and feel, like prison guards are clinically necessary to preserve service users' wellbeing. While this approach entails tolerance of uncertainty and means not always being perceived as helpful, it facilitates the connection with service users that was the source of many clinicians' enjoyment of the work, and overcomes the inhumane rigidity of avoidance and blame.
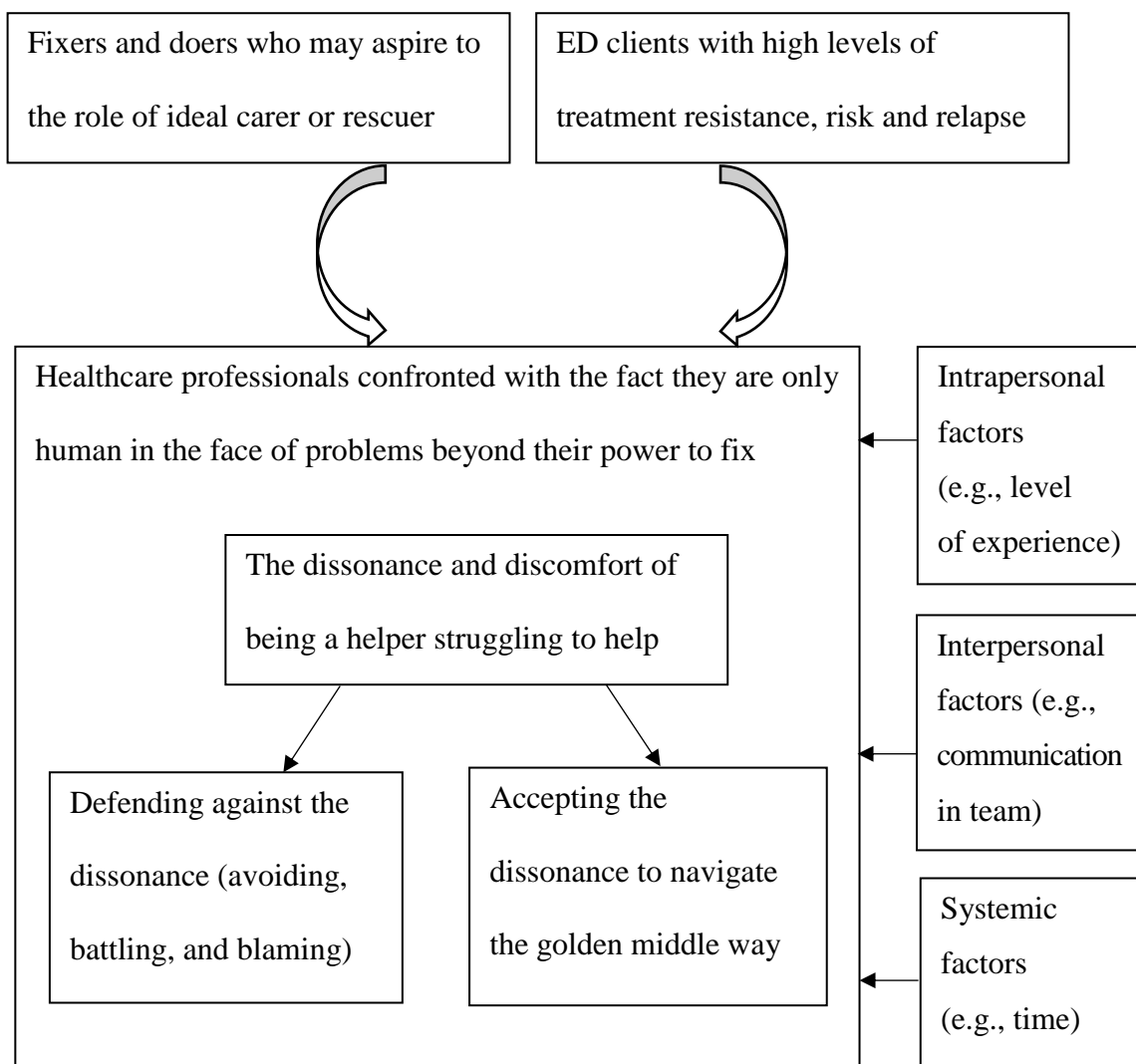
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┌────────────────────────────┐  ┌────────────────────────────┐
│ Fixers and doers who may    │  │ ED clients with high levels │
│ aspire to                    │  │ of                          │
│ the role of ideal carer or  │  │ treatment resistance, risk  │
│ rescuer                      │  │ and relapse                 │
└────────────────────────────┘  └────────────────────────────┘
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┌────────────────────────────────────────────────────────┐  ┌──────────────────┐
│ Healthcare professionals confronted with the fact they   │  │ Intrapersonal    │
│ are only                                                  │  │ factors          │
│ human in the face of problems beyond their power to fix   │  │ (e.g., level     │
│                                                           │  │ of experience)   │
│     ┌──────────────────────────────────┐                 │  └──────────────────┘
│     │ The dissonance and discomfort of │                 │
│     │ being a helper struggling to help│                 │  ┌──────────────────┐
│     └──────────────────────────────────┘                 │  │ Interpersonal    │
│                                                           │  │ factors (e.g.,   │
│  ┌──────────────────┐      ┌──────────────────┐           │  │ communication    │
│  │ Defending against│      │ Accepting the    │           │  │ in team)         │
│  │ the              │      │ dissonance to    │           │  └──────────────────┘
│  │ dissonance       │      │ navigate         │           │
│  │ (avoiding,       │      │ the golden middle│           │  ┌──────────────────┐
│  │ battling, and    │      │ way              │           │  │ Systemic         │
│  │ blaming)         │      │                  │           │  │ factors          │
│  └──────────────────┘      └──────────────────┘           │  │ (e.g., time)     │
└────────────────────────────────────────────────────────┘  └──────────────────┘
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Figure 2. Diagrammatic formulation of healthcare professionals' lived experiences of working with people with EDs

Discussion

This was the first meta-ethnography to focus exclusively on clinicians' lived experiences of working with people with EDs. As well as supporting the findings of previous reviews (Salzmann-Erikson & Dahlén, 2017; Seah et al., 2017; Sibeoni et al., 2017; Thompson-Brenner et al., 2012), it yielded new insights regarding the experiences and impacts of this work, and approaches to managing challenges in clinical practice. The findings support a multifactorial view of the influences on clinicians' experiences as reflecting an interaction between behaviours of individual

clients and colleagues, systemic factors (Franko & Rolfe, 1996), and clinicians'

practices and internal conflicts (Walker & Lloyd, 2011).

Findings from 35 studies, which spanned 21 years and were of moderate to

high quality, were synthesised to produce an overarching theme of "Only human:

Problems beyond our power to fix." This theme describes how those working in ED

services are limited in how much they can help, which creates a painful dissonance

that can impact on their enjoyment of their work, and perceptions of service users.

This key and novel finding captures the tension inherent in being a professional helper

and either not knowing how to help, or having your offer of help rejected. Clinicians

reported further ethical conflict due to wanting to be client-centred but having to

implement behavioural treatment protocols. They also experienced moral distress as a

result of their negative judgments of service users conflicting with a personal belief in

the importance of unconditional positive regard. Inherent in the overarching theme is

a judgment that, compared with many service users with mental or physical health

problems, people with EDs are harder to assist. This reflects them presenting with

both physical and psychological risks (Seah et al., 2017; Walker & Lloyd, 2011), as

well as high levels of complexity and treatment refusal (Franko & Rolfe, 1996; Golan

et al., 2009; Herzog et al., 1987; Kaplan & Garfinkel, 1999).

Feeling unable to help is particularly challenging for clinicians with rescue

fantasies who may identify with the role of ideal carer (Golan et al., 2009). Such

identification is arguably understandable in the context of a popular press that tends to

depict healthcare professionals as either selfless heroes or heartless villains (Barker,

Cornwell, & Gishen, 2016). Moreover, people with EDs commonly seek ideal care

(Bell, 1999; DeLucia-Waack, 1999) and family members are frequently desperate for

a "cure", which can result in unrealistic expectations on all sides (Fox, Woodrow, &

Leonard, 2012). Such expectations may be more common for female healthcare professionals given the cultural trope that women are nurturers and caregivers (DeLucia-Waack, 1999).

Organisational pressures, such as inadequate staffing, contributed to the conflict between clinicians' desire to provide valued care, and feeling that they were unable to do so. The capacity of systemic factors to compromise quality of care and generate ethical conflict has been documented previously (Austin, 2007). While emotional intelligence is associated with less work-related stress (Nikolaou & Tsaousis, 2002), distress and dissatisfaction at work is affected by the climate of the organisation as well as the personality of the employee (Cotton & Hart, 2003), and higher caseloads are associated with more negative staff reactions towards people with EDs (Franko & Rolfe, 1996). Organisations that prioritise staff wellbeing have better outcomes, and higher rates of service-user satisfaction (Boorman, 2009), and there is evidence that educational, psychosocial and organisational interventions can improve the morale of staff working in psychiatric units (Gilbody et al., 2009).

The findings that many healthcare professionals experience their work in EDs as emotionally draining, and feel hopeless and helpless, support Thompson-Brenner et al.'s (2012) review. Frustration was the predominant emotion identified by this meta-ethnography, in line with previous questionnaire-based research (Burket & Schramm, 1995). Similarly, the feelings of helplessness and hopelessness that emerged from the data have been reported as common even among highly experienced therapists working in EDs (Franko & Rolfe, 1996). Given that the sociocultural pressure to be thin, which was highlighted in the data, is focused on females, women working with people with EDs may have different experiences of bodily countertransference to their male colleagues (DeLucia-Waack, 1999).

Perceptions of the "anorexic voice" among clinicians

The concrete thinking underlying some clinicians' behaviours, such as avoiding healthy food, could be understood within a psychoanalytic framework as a consequence of service users' discomfort and pain being forced into healthcare professionals via a process of projective identification (Zerbe, 1993, as cited in DeLucia-Waack, 1999). Furthermore, the perfectionism inherent in striving to be an ideal carer, and clinicians' avoidance of painful emotions, mirror the experiences of many people with EDs (DeLucia-Waack, 1999). It is possible that this parallel links to the high levels of lived experience among the clinicians in the included studies.

The current synthesis differed from previous reviews in identifying that some healthcare professionals, particularly those working in inpatient environments, experience a "culture of surveillance" in their work with this client group that can compromise interpersonal safety; this sense of being judged and scrutinised could lead to paranoia and infuse perceptions with hostility and anxiety, to the detriment of relationships (Cromby & Harper, 2009). Clinicians' sense of being monitored closely by others mirrored their self-surveillance in interrogating their role, purpose and morality; they felt scrutinised from without, and within.

As in Sibeoni et al. (2017), the data of this meta-ethnography suggested that professionals generally believed that they should demonstrate empathy, non-judgment and respect in their interactions with service users, but sometimes struggled to do so in practice. The pull towards avoiding, blaming and battling accords with quantitative research showing that many clinicians have stigmatised views of people with EDs (Fleming & Szmukler, 1992; Raveneau, Feinstein, Rosen, & Fisher, 2014; Tan, Doll, Fitzpatrick, Stewart, & Hope, 2008), and often prefer not to treat this client group in the context of pessimism about outcomes and low levels of empathy (Burket & Schramm, 1995). Service users value availability, empathy and collaboration in

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healthcare professionals (Bezance & Holliday, 2013), so avoiding, blaming and battling them is not conducive to productive therapeutic relationships. Moreover, blaming service users overlooks the roles of systemic factors and individual qualities of therapists (Goodwin, 2003). It could be understood, in psychoanalytic terms, as a projection of clinicians' own feelings of inadequacy outside of themselves to protect their self-conception as an "ideal carer" (Halton, 2003).

A desire for more training in the data echoes the findings of some survey-based research (Jones, Saeidi, & Morgan, 2013). It also accords with evidence that educational interventions can improve the working experience of staff on psychiatric units (Gilbody et al., 2009), and a recent report by the Parliamentary and Health Service Ombudsman (2017) identifying a lack of knowledge of EDs among UK medical professionals. However, given that the data indicated that in a small number of cases training was offered but was not attended or did not feel sufficient, it is tentatively suggested that some clinicians may have been defensively locating the "problem" purely in systemic factors rather than regarding it as multifactorial. Thus, it is possible that some healthcare professionals may unconsciously project their sense of inadequacy on to the "system" that has denied them resources that they fantasise would render them the perfect carer (Halton, 2003).

The loss of role, interpersonal mistrust and defensive responding detailed in the data can have devastating consequences for clinicians and clients. Experiencing a lack of purpose at work, and engaging in avoidant behaviours, are risk factors for burnout (Fearon & Nicol, 2011). Meanwhile, according to the model of helping behaviour proposed by Weiner (1986, as cited in Fox et al. 2012), negative attributions of service users' actions – such as those underlying blame and paranoia – render helpful interventions by healthcare professionals less likely. Furthermore,

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defensiveness was implicated by Francis (2013) as part of the culture at Mid-Staffordshire NHS Foundation Trust that led to "appalling conditions of care" (p.7).

It has been suggested that psychologists have an important role in helping multi-disciplinary teams to manage their distress and frustration via reflective spaces; foregrounding the individuality and humanity of clients, and providing training to enhance clinical practice (Fox et al., 2012). Previous research in Sweden identified that moral distress is common in healthcare settings, and highlighted the need for reflective spaces in which to process it (Kälvemark, Höglund, Hansson, Westerholm, & Arnetz, 2004), and to maintain awareness of the common humanity of oneself and service users. This meta-ethnography, like that of Sibeoni et al. (2017), identified that healthcare professionals generally focus on physical aspects of EDs while service users have called for consideration of their psychosocial wellbeing (Rance, Moller, & Clarke, 2015; Tierney, 2008). Thus, a holistic approach to care that attends to psychological and social needs, as well as maintaining physical safety, could reduce the sense of dissonance for staff, and improve service-user engagement. In a context of similarly high levels of denial and treatment resistance, Williamson et al. (2002) called for clinicians working in assertive outreach teams to incorporate more of the practical support that their clients valued to render their work more ethical.

This meta-ethnography also highlighted coping strategies which appear conducive to the wellbeing of clinicians and service users. The emphasis on connecting with common humanity and being humbly open to learning and support are similar to the findings of Salzmann-Erikson and Dahlén (2017) and Seah et al. (2017). What is novel is the notion of drawing on this humanity and humility alongside mindfulness to navigate a golden middle way. The importance of connecting with common humanity is suggested by research showing that service

users appreciate being treated as individuals (Gulliksen et al., 2012; Offord, Turner, & Cooper, 2006) as opposed to "a walking, talking illness" (Pemberton & Fox, 2013, p.232). Moreover, the attunement that characterises common humanity is valuable given that people with EDs have high levels of insecure attachment (Zachrisson & Skårderud, 2010) linked to misattunement in childhood (Tasca & Balfour, 2014), and that the negative effects of this on their emotional landscape, reflective function and sense of self can be mitigated by healthy, attuned therapeutic relationships (Ardovini, 2002). The capacity of staff to be attuned and provide relational safety depends in part on their own attachment security (Goodwin, 2003).

The golden middle way, constituting imperfect but responsive care, represents an alternative to rigid adherence to rules by staff that serve to mimic and perpetuate service users' dietary practices (Hage et al., 2017[b]), and promote resistance (Moulding, 2006). A clinician who has successfully navigated the golden middle way is neither positioned as an ideal carer nor as a punitive prison guard, and instead allows space for fallibility and humanity in others and themselves. In this way, the middle way is inextricably linked with common humanity. The notion that "the human condition is imperfect, and…we can't always be who we want to be" has been articulated in the literature on self-compassion (Germer & Neff, 2013, p.857). Tolerating imperfection is important given that the self-expectations of staff have been identified as the most critical factor in the development of burnout (Scully, 1983; Freudenberger, 1980, as cited in Kleespies & Dettmer, 2000).

The golden middle way recalls the position of safe-uncertainty outlined by Mason (1993) in his model of safety and certainty in clinical practice. According to the model, teams are motivated to remain in the safe-certain position, as opposed to unsafe-certain, unsafe-uncertain or safe-uncertain. The pressure to provide ideal care

among clinicians working with people with EDs could push the team towards approaches seen as safe and certain (e.g., standardised protocols and strict rules around mealtimes). This attachment to safe-certainty was arguably evident among the nurses in the synthesis who resented bespoke treatment plans. Mason (1993) contended that a position of safe-uncertainty, "which is always in a state of flow" (p.35), facilitates new ideas and understandings. It has been suggested that this position can free practitioners from the bind of needing to know the "final answer," while supervision and consultation keep them contained and safe in their practice (Fox et al., 2012). Balancing safety and empowerment is important in the context of evidence that the decision of those with AN to drop out of treatment can be linked to a sense of loss of control (Eivors, Button, Warner, & Turner, 2003).

Intertwined with the golden middle way, mindful awareness and acceptance involved clinicians accepting service users for who and where they are, and themselves as human. One example of this stance was provided by clinicians who reported acknowledging that service users were observing them; accepting this rather than becoming attached to the thought that they were being negatively evaluated, and framing the experience as an opportunity to model a healthy relationship with their body. There is some evidence that acceptance-based interventions are helpful for staff working with challenging populations; attending workshops informed by acceptance and commitment therapy led to reductions in distress among staff working in intellectual-disability services (Noone & Hastings, 2009). It has been suggested that mindfulness, which is a key component of Neff's (2003) conception of self-compassion, involves seeing negative thoughts and emotions as they are, without avoiding or battling them, and that this facilitates the acknowledgment of pain, provision of self-comfort, and a more balanced perspective (Germer & Neff, 2013).

Perceptions of the "anorexic voice" among clinicians

Such self-awareness is valuable in the context of evidence from this synthesis and a previous quantitative study (Shisslak, Gray, & Crago, 1989) that working with people with EDs is often accompanied by changes in diet and awareness of appearance among clinicians.

Despite high levels of concordance among the included studies, some important differences emerged in relation to professional background, setting, experience level, and whether or not clinicians had lived experience of an ED. Based on the reported findings, nurses were more likely to experience moral conflict, engage in blaming and avoidance, and adopt a maternal stance than other professionals. This may reflect the fact that nurses spend more time with people with EDs than other clinicians and are more involved in implementing – often unwanted – treatment protocols, positioning them both for intimacy with service users and becoming the object of their anger (Ryan et al., 2006; Zugai et al., 2018[a]; Zugai et al., 2018[b]).

In the included studies, fear of saying the wrong thing and shock were portrayed as more common among less experienced staff, and helplessness as more prevalent among generalist as opposed to specialist practitioners. Inexperience has been linked to more negative reactions to service users with EDs in previous research (Franko & Rolfe, 1996). Fox et al. (2012) highlighted the irony that it is generally the least experienced staff who spend the most time with service users and who receive the least containment in the form of space to formulate, process, and reflect. The authors argued that the resulting stress could lead to staff depersonalising service users and ceasing to regard them as individuals, in line with the "shutting off" described in this meta-ethnography.

The systemic pressure of lack of time seemed to be felt most keenly by those in primary care in the synthesised studies; such pressures may be alleviated by closer

links between primary-care and specialist services, including the provision of consultation. The surveillance culture and frustrations around communication were predominantly reported in studies with inpatient settings, suggesting the importance of reflective spaces and case conferences in these environments, for the purposes of emotional processing and information sharing, respectively (Fox et al., 2012). Based on the included studies, clinicians with lived experience of EDs noted a particular sense of dissonance in relation to non-disclosure of this experience, indicating that it would be helpful for managers of ED services to promote an environment in which sharing feels safe, perhaps by role modelling and asking in supervision about personal impacts of the work.

Given that the clinician-client relationship is known to affect treatment engagement (Gallop et al., 1993) and outcome (Graves et al., 2017; Loeb et al., 2005; Pereira et al., 2006) in this field, and low levels of wellbeing among healthcare professionals are associated with poor safety outcomes for service users (Hall, Johnson, Watt, Tsipa, & O'Connor, 2016), staff experiences of the work are a vital consideration for ED services. The findings of this meta-ethnography suggest that healthcare professionals can find reward and make a valuable contribution in their work with ED clients if, rather than unrealistically aspiring to be an ideal carer or embracing the punitive role of a prison guard, they pursue the golden middle way. However, they are likely to need support in the form of high-quality supervision and adequate resources to tolerate the resulting uncertainty and ongoing internal conflict (Halton, 2003).

Methodological considerations

The range of methodological frameworks, sampling approaches and data-collection methods employed by the included articles were considered when

synthesising the data. While most studies included in the synthesis employed purposive sampling, over one-third used convenience sampling, which limits the validity of findings (Ritchie, Lewis, Elam, Tennant, & Rahim, 2013). Furthermore, the use of focus groups in three studies may have led to certain voices being marginalised (Barker, Pistrang & Elliott, 2002).

Most studies employed thematic analysis, content analysis or inductive analytic approaches involving a low level of interpretation relative to grounded theory and IPA (Vaismoradi, Turunen, & Bondas, 2013). While the design and/or theoretical framework of the included studies were frequently not specified, most appeared to have a descriptive design and either realist or critical-realist ontological underpinnings (as opposed to relativist) (Clarke, Braun & Hayfield, 2015). Given that descriptive approaches remain close to the data (Sandelowski, 2000, 2010), this arguably renders less problematic the lack of direct access to the original datasets when conducting a meta-ethnography.

A minority of the included studies had a phenomenological framework, which is associated with the lived experience that the meta-ethnography sought to probe (Smith & Osborn, 2015); however, the data in the other studies satisfied the definition of lived experience employed (Mertens, 2005, as cited in Palmer, 2015). The studies that utilised grounded theory or phenomenological frameworks were arguably more liable to misrepresentation in the synthesis: the theory that is developed in the former, and the idiographic focus of the latter, may be compromised by the abstraction entailed in third-order interpretation (Charmaz, 2015; Smith & Osborn, 2015).

While there is no consensus as to whether it is legitimate to synthesise studies using different qualitative methods (Bondas & Hall, 2007), it has been suggested that the influence of theoretical frameworks on what is produced is frequently overstated

(Sandelowski, 2010). It appeared that in some cases the authors of studies included in the meta-ethnography did not follow their specified method; for example, in two of the three grounded theory studies, theoretical sampling was not conducted (Brinchmann et al., 2017; Snell et al., 2010).

Clinical implications

The findings of this meta-ethnography can be used to inform clinical practice by supporting healthcare professionals to understand, reflect on, and potentially modify their experience of caring for and treating people with EDs. The resulting framework could help clinicians to consider the personal impact of their work, for example whether they are experiencing a sense of dissonance. It could also raise awareness of the coping strategies they employ, and help them to assess the effectiveness of these; this process could lead to improvements in their wellbeing, and treatment outcomes.

There are opportunities for psychologists to support teams to manage distress and frustration via providing supervision, consultation, and training (Fox et al., 2012). As well as promoting safe practice and providing containment, clinical supervision can make clinicians feel valued and listened to (Fearon & Nicol, 2011), which could serve to mitigate against the damage to their self-concept associated with caring without curing and support them to adopt positions of safe-uncertainty. The findings of this meta-ethnography point to a need for time and space for staff working in EDs to reflect on and process the dissonance they experience. Alongside supervision, this could be provided via Balint groups for primary-care staff to discuss stressors in a supportive environment (Rabinowitz, Kushnir, & Ribak, 1996), and Schwartz rounds for multidisciplinary teams to make sense of the emotional and social challenges of their work (Barker et al., 2016).

Introducing mindfulness courses for clinicians would promote the aware and accepting stance underpinning the golden middle way. Other applications of the findings include initiatives to promote self-care, such as free Pilates classes or massages (Boorman, 2009), and using team formulation meetings to foreground the individuality of service users and collectively support each other to maintain the golden middle way. It is possible that a more holistic approach to care, in line with service-user wishes (Rance et al., 2015), could reduce the dissonance experienced by professionals. The findings also suggest that alleviating systemic pressures (e.g., by increasing staffing levels) could reduce demands on healthcare professionals and mitigate against them feeling emotionally drained and powerless.

Strengths and limitations

A key strength of this paper is the breadth of the studies synthesised, which is conducive to developing theory as it renders the analysis more transferable (Bondas & Hall, 2007). Another strength was the involvement of four people in the screening decisions, quality ratings and discussion of the emerging themes, which increased the rigour of the review.

This meta-ethnography has several limitations. The findings are most pertinent to those working with people with AN given that almost one-third of the included studies focused exclusively on people working with this diagnosis; almost half were solely in inpatient settings in which people with AN are over-represented (Hage et al., 2017[a]; Ryan et al., 2006), and across the studies there were numerous references to characteristics strongly associated with AN such as refusal to eat and emaciation. The exclusion of unpublished studies may have led to the loss of information and risks publication bias (Petticrew et al., 2008). While it promotes the development of theory, synthesising a large number of studies can limit analytic depth

due to the volume of data (Bondas & Hall, 2007). The diversity of the publication dates of the included studies could be a limitation if there has been a change in attitudes and/or delivery of services over time.

The fact that searching reference lists of included studies yielded six additional papers may indicate deficiencies in the search strategy. The authors of the original studies were not consulted, so it may be that the translations and third-order interpretations did not align with their conceptualisations of their data (Toye et al., 2014). As previously acknowledged, the use of the CASP checklist (CASP, 2010) to evaluate mixed-method studies is problematic (Heyvaert et al., 2013).

Based on the available data, more than 40% of the participants in the included studies disclosed a personal history of ED, which is a higher proportion than the one-third reported in a survey-based study of clinicians working in the field (Johnston, Smethurst, & Gowers, 2005). This could reflect people with lived experience being more likely to volunteer to participate in research on this topic, which would compromise the transferability of the findings. The fact that most participants were female could have skewed the findings given that negative reactions are less common among female clinicians (Thompson-Brenner et al., 2012); however, this is unlikely to compromise ecological validity given that women are over-represented in healthcare settings in general (NHS Digital, 2016), and in ED services (e.g., Waterman-Collins et al., 2014).

Future research

Future research could evaluate support mechanisms for clinicians working with people with EDs, for example a pre-post evaluation of a reflective space such as a Balint group (Rabinowitz et al., 1996) or a Schwartz round (Barker et al., 2016), measuring both staff wellbeing and service-user outcomes. Another area of study

could be whether paying greater attention to psychosocial wellbeing in inpatient environments reduces clinicians' experience of moral conflict. A further potential area of research is exploring the lived experiences of healthcare professionals working with other populations that may reject recommended treatments, such as those with a diagnosis of Personality Disorder, those who experience grandiose delusions, or clients of assertive outreach teams (Van Putten Crumpton, & Yale, 1976; Widiger, 2003; Williamson, 2002).

Conclusion

This meta-ethnography highlights how healthcare professionals experience working with people with EDs, namely the painful dissonance the work can entail and how this can be managed in practice. The synthesis provides an interpretation that can help frontline staff and managers to understand and tackle the barriers to thriving in this work, and making a positive difference to service users.

Paper 2 – Perceptions of the "anorexic voice": A qualitative study of

healthcare professionals

Perceptions of the "anorexic voice" among clinicians

Abstract

Many people with anorexia nervosa (AN) have reported experiencing a highly critical inner voice focused on their eating, shape and weight. This "anorexic voice" (AV) has been explored in qualitative studies with service users, and there are promising preliminary findings for its role in the treatment of AN. The support of staff is vital for the AV to be embedded in care and treatment, yet their views on the concept remain unknown. Therefore, this study explored the perceptions of the AV among clinicians in specialist eating disorder (ED) services. Semi-structured interviews were conducted with 15 participants from a range of professional backgrounds. Interview transcripts were analysed using thematic analysis. The analysis yielded two themes – "The AV is a vehicle for increasing compassion" and "It's not a one-size-fits-all" – and six sub-themes. Participants presented the AV as a means of developing and sustaining compassion as a clinician and promoting self-compassion among people with AN, while emphasising that the AV does not resonate for all clients and it is important to be guided by their individual understandings of AN.

Key words: Anorexia nervosa, anorexic voice, staff perceptions, qualitative interviews, thematic analysis, compassion

Introduction

Many people with anorexia nervosa (AN), an eating disorder (ED) characterised by very low weight, intense fear of weight gain, and dietary restriction (APA, 2013), have reported experiencing an inner voice with common characteristics. An inner voice has been described as "an identifiable system of thoughts experienced much as an actual voice," as opposed to a sensory perception or an acoustic hallucination (Firestone, 1986, as cited in Noordenbos, Aliakbari, & Campbell, 2014, p.439). People with AN have described experiencing a distinct "anorexic voice" (AV), a highly critical inner voice that dominates them (Higbed & Fox, 2010; Jenkins & Ogden, 2012; Lamoureux & Bottorff, 2005; Rawal, Park, Enayati, & Williams, 2010; Tierney & Fox, 2010; Williams, King, & Fox, 2016; Williams & Reid, 2012; Wright & Hacking, 2011) and is "orientated around shape, weight, eating and their implications for self-worth" (Pugh, 2016, p.1). Research suggests that the AV emerges during illness onset (Pugh, 2016) and it has been suggested that it could represent an introjection of the external demands by which people with AN often feel driven (Fox, Federici, & Power, 2012). It has been proposed that the AV is non-psychotic because individuals with AN recognise it as internally generated (Pugh & Waller, 2016), though distinguishing between psychotic and non-psychotic voices is of questionable validity given the self-reported experience often appears identical (Moskowitz & Corstens, 2008; Yee, Korner, McSwiggan, Meares, & Stevenson, 2005). In practice, people with AN have used various terms – including "ana" and "anorexic mind" – to refer to the AV (Williams & Reid, 2012, p.807).

Questionnaire-based studies using measures designed for psychotic symptoms indicate that self-reported experience of a critical inner voice is a common, but neither a necessary nor a unique, feature of EDs. In a survey of 74 females with EDs and no

history of psychosis, of whom 63.4% had a diagnosis of AN, 94.5% reported

experiencing a critical inner voice; this compared with 29.3% of healthy controls

(Noordenbos et al., 2014). In another questionnaire-based study, women with ED

symptoms reported experiencing a wider variety of, and more frequent, negative self-

talk focused on eating, weight and self-worth compared with controls (Scott,

Hanstock, & Thornton, 2014). However, ED self-talk was defined more broadly than

the AV, and the first-person examples contrasted with descriptions of a second-person

AV (Higbed & Fox, 2010; Tierney & Fox, 2010). In studies of adults with AN, more

powerful self-reported "voices" were found to be positively associated with illness

chronicity and negative eating attitudes (Pugh & Waller, 2016, 2017). Researchers

are developing a measure of the AV (Gant et al., in press), which will help with

estimating its prevalence and differentiating it from the critical inner voices reported

by other groups, including individuals with bulimia nervosa (Broussard, 2005) and

some healthy controls (Noordenbos et al., 2014). A tailored measure should address

concerns that experience of it may be under-reported due to the stigma associated

with psychosis (Noordenbos et al., 2014).

Alongside their accounts of its aggressive rhetoric, people with AN have

identified positive qualities of the AV, including conferring a sense of identity and

superiority (Higbed & Fox, 2010), providing companionship, and facilitating

emotional avoidance (Tierney & Fox, 2010). This is in the context of evidence that

individuals with AN often have under-developed identities (Espindola & Blay, 2009;

Stein & Corte, 2007); low self-esteem (Duker & Slade, 1990); an insecure attachment

style (Zachrisson & Skårderud, 2010), and difficulties identifying, regulating and

expressing emotions (Pemberton & Fox, 2013; Troop, Schmidt, & Treasure, 1995).

Perceptions of the "anorexic voice" among clinicians

Based on service-user accounts, the AV appears to become more critical and dominating over time, often in line with attempts to recover (Tierney & Fox, 2010; Williams & Reid, 2012). It has been suggested that its increasingly negative impact on health, relationships and work can motivate treatment-seeking and engagement (Maisel, Epston, & Borden, 2004). However, despite depicting its growing vindictiveness, service users often continue to value the AV (Higbed & Fox, 2010; Tierney & Fox, 2010; Williams et al., 2016). Its seductive power has been compared to that of an abusive partner who erodes a victim's self-esteem and turns her against significant others so that she is afraid to leave (Tierney & Fox, 2011; Williams & Reid, 2012). Thus, the AV can help to account for the high rates of treatment-resistance and relapse among people with AN (Higbed & Fox, 2010; Tierney & Fox, 2010; Williams et al., 2016).

Service users have described viewing AN as part of oneself as inimical to recovery (Keski-Rahkonen & Tozzi, 2005; Lamoureux & Bottorff, 2005), and it has been proposed that the AV arises in their narratives as a means of separating AN from the self (Higbed & Fox, 2010; Williams & Reid, 2012). In this respect, it can be viewed as a form of externalisation, a technique used in narrative and family therapy in which the presenting problem is considered as independent of the person and thus rendered more amenable to change (White & Epston, 1990, p.38). Externalisation of EDs has been identified in the accounts of both service users and clinicians (Wright & Hacking, 2012; Zugai, Stein-Parbury, & Roche, 2018[a]). Young people with AN have reported that externalising the illness helped parents and carers to empathise with them, and enabled them to reflect on the impacts of AN on their lives (Medway & Rhodes, 2016).

Perceptions of the "anorexic voice" among clinicians

The question of how the AV relates to identity is complex, with service users often regarding the AV or AN both as separate and part of them (Higbed & Fox, 2010; Williams & Reid, 2012). In line with dialogical theory (Hermans, 1996, 2002), which postulates that each individual mind contains multiple positions in dialogue, it has been argued that the AV is a position within the self that comes to dominate unhelpfully (Williams & Reid, 2012). This accords with the view that it is "theoretically invalid" to distinguish between a mental illness and the self, because the two are intertwined (Kinderman, Setzu, Lobban, & Salmon, 2006). On this basis, Higbed and Fox (2010) advocated interventions that enable individuals to live with AN rather than be cured of it. This would parallel treatments for psychosis that target distress and responses to the symptoms, rather than symptoms themselves (Abba, Chadwick, & Stevenson, 2008; Gaudiano & Herbert, 2006).

Interventions addressing the AV include cognitive and behavioural challenging of its messages, and developing more compassionate internal dialogues (Pugh & Waller, 2016). Promising preliminary findings have been reported for emotion-focused therapy (EFT), which employs the AV (Dolhanty & Greenberg, 2009) and is rooted in attachment theory (Johnson & Greenberg, 1995). In the two-chair dialogue, one of several tasks used in EFT, an empty chair signifies the AV or a critical significant other, and an "experiencing chair" foregrounds its emotional impact and facilitates responding (Dolhanty, 2006). Thus, EFT establishes dialogues between internal voices or positions, undermining the dominance of the AV (Williams & Reid, 2012), increasing self-integration (Dimaggio, Hermans, & Lysaker, 2010), and promoting awareness and tolerance of emotional experience (Dolhanty & Greenberg, 2009). It has been suggested that treatments incorporating the AV will be most profitably employed with individuals reporting a powerful voice (Pugh &

Waller, 2016). However, ongoing motivational work may be required to engage and

keep people in treatment given that the AV often continues to be alluring to service

users throughout the recovery journey (Higbed & Fox, 2010).

Developing and successfully implementing evidence-based psychological

therapies is imperative given the lack of effective treatments for AN (Bulik, Berkman,

Brownley, Sedway, & Lohr, 2007; Suarez-Pinilla et al., 2015); high dropout rates

from inpatient treatments (Wallier et al., 2009); the perception among clients that care

is too focused on physical safety at the expense of psychosocial wellbeing (Rance,

Moller, & Clarke, 2015; Tierney, 2008), and the high risk of mortality associated with

this diagnosis (Arcelus, Mitchell, Wales, & Nielsen, 2011).

A number of criticisms of the AV have been raised, and elaborated in depth

elsewhere (see Pugh, 2016). It has been proposed that it is an artefact of externalising

AN in therapy (Maisel et al., 2004). However, all participants interviewed by

Williams et al. (2016) reported experiencing the AV prior to contact with health

services. It has also been argued that the AV sets up a dichotomy between the AV

and the "real self", which can promote the unsustainable notion of an "ideal real self",

and risks demonising and invalidating aspects of the service user's experience

(Vitousek, 2005). Yet this does not fit with client accounts of the AV being

experienced as part of the self (Higbed & Fox, 2010; Williams & Reid, 2012). It has

been suggested that externalising can reduce individual responsibility for recovery by

positioning AN as something separate to oneself that cannot be overcome (Wright &

Hacking, 2012; Vitousek, 2005). However, this is challenged by service users'

depictions of "fighting a battle" with the AV (Williams et al., 2016, p.220). It has

also been proposed that the AV is merely a rebranding of concepts such as self-

criticism (Fairburn, Shafran & Cooper, 1999). Yet people with EDs appear able to

distinguish between critical thoughts and an inner voice (Noordenbos et al., 2014).

Moreover, it has been argued that what matters is whether the AV is more conducive

to understanding and recovery than alternative constructions of AN such as medical

descriptions (Pugh, 2016).

Thus, the AV can be understood as both (a) how some people with AN

independently understand aspects of their experience, and (b) a concept that can be

employed by healthcare professionals in the care and treatment of these individuals.

While the AV has been explored in studies involving people with AN, the attitudes of

staff in ED services towards the concept have not been sought. To facilitate

empathising with service users, it is important that clinicians are aware of the AV

given that it seems to be integral to the experience of many clients prior to contact

with health services (Williams et al., 2016). Empathy – which involves appreciating

the meaning and significance of another individual's inner experience and behaviour

(Burket & Schramm, 1995) – enhances all helping relationships (Reynolds & Scott,

1999); predicts psychotherapy outcome (Elliott, Bohart, Watson, & Greenberg, 2011);

assists with softening treatment-resistance among people with AN (Abbate-Daga,

Amianto, Delsedime, De-Bacco, & Fassino, 2013), and is associated with more

positive attitudes towards those with EDs among staff (Walker & Lloyd, 2011).

Increasing staff understanding is vital in light of evidence that working with

people with AN elicits strong emotions (Ramjan, 2004; Thompson-Brenner, Satir,

Franko, & Herzog, 2012); many clinicians have stigmatising views of this client

group (Bannatyne & Stapleton, 2017; Fleming & Szmukler, 1992; Ramjan, 2004),

and some service users report negative experiences with professionals (Gulliksen et

al., 2012; Pemberton & Fox, 2013). Clinicians have highlighted the rewards of

working with people with EDs (e.g. Harken, Maxwell, Hainline, Pollack, & Roberts,

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2017), but more often report anger, frustration and a sense of professional failure due to the non-adherence of service users with AN (Burket & Schramm, 1995; Franko & Rolfe, 1996; King & Turner, 2000). Some have admitted that they struggle to understand fear of food (Walker & Lloyd, 2011) and view AN as self-inflicted (Ramjan, 2004). Negative responses – which are more common among less experienced clinicians, males (Thompson-Brenner et al., 2012), and therapists with higher caseloads (Franko & Rolfe, 1996) – increase the risk that professionals will replicate and reinforce the abusive relationship some clients experience with the AV (Treasure et al., 2011).

Given that contact with people with AN does not reduce the tendency to regard the disorder as self-inflicted (Bannatyne & Stapleton, 2017), it is vital that staff receive sufficient education and regular training updates regarding the nature and experience of AN, and the drivers of its development and maintenance (George, 1997; King & Turner, 2000), which for many appear to include experience of a critical and demanding voice. Yet concerns have been raised that the training of psychiatrists and nurses working with these clients is inadequate (Jones, Saeidi, & Morgan, 2013; Ramjan, 2004).

Providing an etiological model of AN has been found to reduce blame among medical (Bannatyne & Stapleton, 2017), nursing (Crisafulli, Von Holle, & Bulik, 2008) and psychology students (Crisafulli, Thompson-Brenner, Franko, Eddy, & Herzog, 2010). Experiential exercises are another means of increasing understanding of AN. Simulations, such as listening to taped voices, are associated with increased empathy for psychotic experiences (Ando, Clement, Barley, & Thornicroft, 2011), which like AN "[test] the limits of comprehensibility" (Lorem & Hem, 2012, p.119). Research indicates that psychologically informed consultation can increase clinician

empathy towards other service users whose symptoms are often ego-syntonic (Van Putten Crumpton, & Yale, 1976; Widiger, 2003): team consultation based on cognitive analytic therapy (CAT) was associated with improved empathy and reduced blame among staff working with people with schizophrenia (Kellett, Wilbram, Davis, & Hardy, 2014), and increased understanding and "conceptual containment" for clinicians in Personality Disorder services (Kerr, 1999, p.425). Thus, by providing an etiological framework the AV has the potential to reduce blame of service users among clinicians, and could be used in simulations and consultation to increase the empathy of healthcare professionals for those with AN.

There is a need to explore clinicians' perceptions of the AV and how these influence their practice. A clinician with no awareness of the AV may struggle to fully appreciate the ambivalence those with AN feel, and to sensitively support them to take painful steps towards recovery that can feel "like killing your best friend" (Tierney & Fox, 2010, p.249). They would thus risk violating NHS core values, which according to the Department of Health (2015) include "seeking to understand [clients'] priorities, needs, abilities and limits." In light of the development of a promising treatment that employs the AV in EFT, it is vital to ascertain clinicians' perspectives because the AV cannot be incorporated into care and treatment without their endorsement. Moreover, staff working in ED services are at high risk of burnout unless they receive adequate support (Treasure et al., 1995), which could include consultation employing the AV.

The present study aimed to address this gap in the literature by exploring the perspectives of clinicians working in specialist ED services towards the AV. It sought to inform clinical practice, staff training, and intervention development. It aimed to help ensure that the care and treatment of people with AN accords with client

understandings, and to contribute to the development of a theory of the AV that incorporates interpersonal as well as intrapersonal factors.

Method

Setting and participants

Participants were recruited from four NHS ED services: two in the North of England and two in London. The research team had links to three of the services, and were aware that staff at two of them were familiar with the AV. Recruitment was facilitated via internal staff emailing the information sheet to their teams; brief presentations by the first author at team meetings, and the display of a study poster (Appendix 4) on noticeboards. Clinicians interested in taking part contacted the first author via email. Twenty-seven clinicians agreed to take part. Purposive sampling was employed: attempts were made to ensure variety within the sample in terms of familiarity with the AV, professional background, geographical location and gender, to provide a range of perspectives. The inclusion criteria were: routine involvement in the direct care of adults with AN in a specialist ED service; at least six months' experience of direct work with people with AN, and ability to speak English fluently. These criteria were chosen to ensure that participants had sufficient breadth and depth of experience to consider the internal worlds of people with AN. Availability was also a factor when selecting participants. As data collection progressed, respondents from under-represented disciplines were prioritised when arranging interviews to ensure a variety of perspectives. Following the 15th interview, the research team collectively agreed that saturation had been reached, and recruitment was terminated. The sample size was in line with established recommendations for an interview-based doctoral study (Clarke et al., 2015). The volunteers who were not invited to interview were thanked for their interest, and offered a summary of the findings.

Table 3 summarises demographic data for participants, whose names have been changed to maintain anonymity. None reported a history of ED. Therapists reported a range of theoretical orientations, including integrative, psychodynamic and cognitive-behavioural.

Table 3: Participant demographic and questionnaire data

Participant pseudonym	Professional role	Gender	Age range (in years)	Years working with AN	Work in inpatient, outpatient or both
Sarah	Art psychotherapist	Female	45-64	>5	Both
Tina	Nurse	Female	25-44	2-5	Inpatient
Victoria	Consultant psychiatrist	Female	25-44	>5	Inpatient
Michelle	Clinical psychologist	Female	25-44	>5	Both
Yvette	Occupational therapist	Female	25-44	2-5	Both
Rosie	Nurse	Female	45-64	>5	Inpatient
Laura	Dietetic assistant	Female	25-44	>5	Inpatient
Elizabeth	Nurse	Female	45-64	>5	Outpatient
Lisa	Healthcare assistant	Female	18-24	2-5	Outpatient
Susan	Clinical psychologist	Female	25-44	2-5	Outpatient

Katherine	Counselling psychologist	Female	25-44	2-5	Both
Lucy	Drama therapist	Female	25-44	2-5	Outpatient
Selena	Consultant psychiatrist	Female	45-64	2-5	Outpatient
Thomas	Consultant psychiatrist	Male	25-44	>5	Both
Jessica	Clinical psychologist	Female	25-44	>5	Both

Design

Given that there is no existing research on clinicians' views of the AV, a qualitative description design (Sandelowski, 2000, 2010) was chosen to facilitate staying close to the data when exploring participants' perceptions of this complex concept (Kim, Sefcik, & Bradway, 2017). The study was conducted within a critical-realist framework, according to which there is an independent reality that is only accessible through individual perceptions (Ormston, Spencer, Barnard, & Snape, 2013).

Procedure

Before data collection commenced, Health Research Authority (Appendix 5), ethical (Appendix 6) and local research and development approvals were obtained. The latter are not included in the appendices to avoid identification of participants via triangulation.

Perceptions of the "anorexic voice" among clinicians

Prior to interview, all participants were given an information sheet (Appendix 7), and provided written consent (Appendix 8). In the information sheet and verbally prior to interviews, the confidentiality of responses and right to withdraw from the study were emphasised. Participants completed a brief questionnaire (Appendix 9), which was designed to ascertain their age, gender, professional role and length of time working with people with AN, to facilitate reflection on possible links between the findings and characteristics of participants (Braun & Clarke, 2013). The questionnaire included a question relating to whether they had first-hand experience of an ED, because this could influence responses; in a survey by Johnston and colleagues (2005), one-third of those working in ED services reported a history of an ED.

Semi-structured interviews were used to facilitate exploration, via follow-up questions, of issues that had not been considered in advance. They were chosen over focus groups as they enable more detailed exploration of individual views, and were more appropriate given the heterogeneity of the sample in terms of professional background, training, and knowledge of the AV, which in a focus group could contribute to certain voices being marginalised (Barker et al., 2002). Furthermore, it would have been logistically difficult to arrange focus groups for busy professionals given that it requires them to be simultaneously available (Braun & Clarke, 2013).

In line with recommendations of the Research Governance Framework for Health and Social Care (Department of Health, 2005), seven service users with a diagnosis of AN co-designed the interview topic guide (Appendix 10) during a one-hour discussion with the first author in a specialist adult ED service. The topic guide was designed to be used flexibly to account for the fact that participants might have different views on the AV, for example some may be sceptical of it. As part of the

interview, a definition of the AV was read, and given, to all participants in case any were not familiar with the concept (Appendix 11). A pilot interview was conducted with a fellow trainee who met the inclusion criteria, to gauge whether the format was accessible; she was comfortable with the definition of the AV being read, and said she thought that participants would relate to the concept through their clinical work even if they had not read about it.

The topic guide underwent several revisions over the course of data collection. For example, following the first three interviews and discussion among the research team, the third question was changed to reflect the fact that participants were portraying the AV as a useful concept rather than a literal truth.

To minimise demands on participants, they were all interviewed in a private room at their workplaces by the first author. The interviews, which lasted between 32 and 67 minutes (average = 47 minutes), were carried out between May and September 2017. All interviews were audio-recorded, transcribed verbatim, and anonymised.

Analysis

Thematic analysis (Braun & Clarke, 2006) was conducted because it best fitted the research question, which focused on patterns across data rather than social processes, explanatory accounts or profound personal meanings (Larkin, 2015). As thematic analysis is not tied to a particular ontology or epistemology (Braun & Clarke, 2013), it was compatible with the study's critical-realist and inductive frameworks (Ormston et al., 2013). The software program NVivo 11 facilitated data management.

A bottom-up, inductive analysis was employed to generate themes grounded in the data, enriched by reference to relevant literature (Braun & Clarke, 2013). To ensure rigour and replicability, the six-phase process recommended by Braun and

Clarke (2006) was observed: (a) all transcripts were read and re-read to facilitate immersion in the data, and initial ideas noted; (b) each transcript was coded in its entirety using NVivo (see Appendix 12 for a sample of the coding); (c) the most salient codes were clustered to generate potential themes and sub-themes; (d) the candidate themes and sub-themes were reviewed with reference to relevant collated excerpts and the original transcripts; (e) the themes and sub-themes were defined, and (f) the themes were elaborated in the analytic narrative. Throughout, the analysis was reviewed and discussed within the research team, whom collectively have extensive experience of conducting and publishing studies using thematic analysis; hence, codes and emerging themes were interrogated and refined. The final themes were the third draft. The first and second versions are shown in Appendix 13.

Methodological integrity

Elliott, Fischer, and Rennie's (1999) guidelines for qualitative research were adhered to, to ensure study quality: (a) disclosure of the authors' values and assumptions; (b) provision of demographic information about participants; (c) the use of several illustrative excerpts for each sub-theme; (d) conclusions which were coherent and grounded in the data, and (e) auditing of the analysis by an independent researcher. A researcher with no involvement in the study assessed the coding on a randomly-selected transcript, reporting 91% agreement with the principal investigator. Changes were made to the coding to resolve discrepancies, and her comments informed the analytic narrative and discussion. To increase the credibility of the analysis (Birt, Scott, Cavers, Campbell, & Walter, 2016) and in line with the descriptive design (Kim, Sefcik, & Bradway, 2017), member checking was conducted: the results section was emailed to all participants to give them an opportunity to verify whether it captured their experiences, and offer feedback. One

participant fed back that she felt her experiences were reflected in the analysis; no

other feedback was received.

Reflexivity

The first author (M.G.) is a white British, 31-year-old female trainee clinical

psychologist who subscribes to the biopsychosocial model of distress and has no

direct experience of working with people with AN. To assist with owning her

perspective and bracketing assumptions, she kept a research journal to record

reflections on reviewing the literature, designing the study, recruitment, data

collection, and analysis. As an orientation exercise, she spent two days observing the

work of staff at one of the recruitment sites prior to commencing data collection. The

second author (S.T.) and fourth author (J.F.) have conducted many studies on AN, and

the third author, A.C., and J.F. have experience of working with people with AN.

Given that J.F. and S.T. have a history of researching the AV and view it as an

important component of the experience and treatment of AN, the fact that the first

author had not employed the AV in treatment or research was regarded as conducive

to an open-minded stance in relation to data collection and analysis. The research

team regularly discussed ways of maintaining this stance in supervision.

The trainee was mindful that there was a risk that participants would feel that

they were being tested and/or judged during interviews, given that their

understandings of the AV were explored prior to the definition being read as well as

after, and in light of the trainee's dual status as a clinician and a researcher. Attempts

were made to establish rapport and create a non-threatening atmosphere by including

an undemanding introductory question; specifying that not all interviewees would be

familiar with the AV when providing the definition; emphasising the confidentiality

of responses, and using friendly non-verbal communication (e.g., smiling and eye contact).

Results

There was significant consistency in participants' perspectives across professional, geographical, and service divides. All presented the AV as a potentially useful and powerful means of developing and sustaining compassion as a clinician, and supporting highly self-critical anorexic clients to cultivate self-compassion. Many participants also emphasised that the concept was not applicable to all service users, and most portrayed it as synonymous with other terms. The analysis yielded two themes and six sub-themes, which are visually represented in Figure 3. Additional illustrative quotations are shown in Appendix 14.
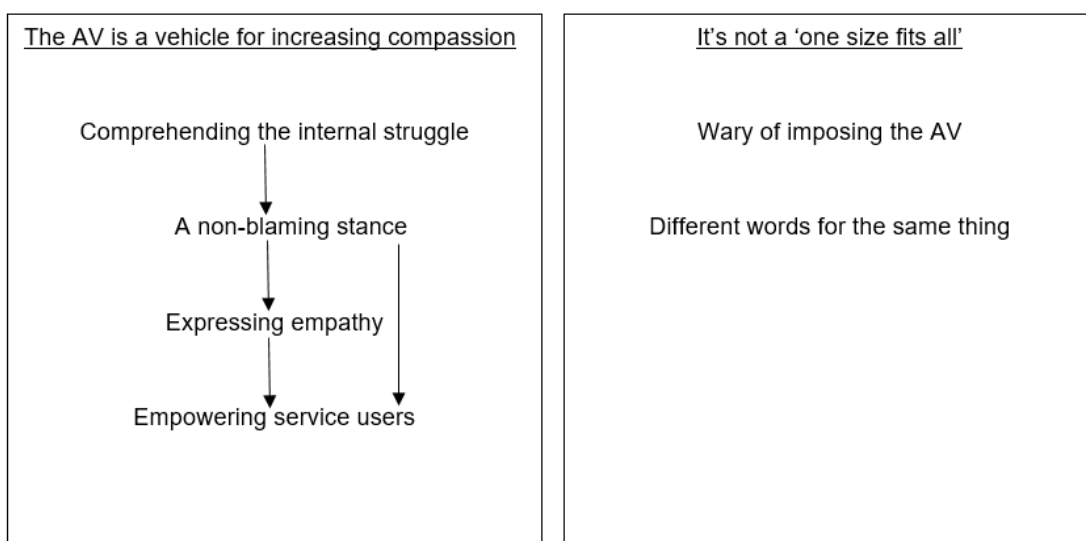
The AV is a vehicle for increasing compassion	It's not a 'one size fits all'
Comprehending the internal struggle	Wary of imposing the AV
A non-blaming stance	Different words for the same thing
Expressing empathy	
Empowering service users	

Figure 3. Illustration of themes and sub-themes

Theme 1: The Anorexic Voice is a vehicle for increasing compassion

Participants described the AV as a means of helping clinicians to be more compassionate towards people with AN by enabling them to comprehend clients'

internal struggle, adopt a non-blaming stance, express empathy, and empower service users to make changes.

Sub-theme 1: Comprehending the internal struggle.

Clinicians described the AV as helping them to appreciate the distress that people with AN report experiencing:

[The anorexic voice says] really, really horrible, horrible things. Like really bullying. Really abusive. (Susan, clinical psychologist)

When that anorexic voice really starts to activate, you see their mood just completely nosedive. (Laura, dietetic assistant)

Participants highlighted how the concept of the AV helped clinicians to empathise with service users in the context of behaviours and reactions that can seem incomprehensible to those without lived experience: "I'm imagining if you're trying to eat a baked potato and this voice is screaming at the front of your head, 'Don't eat that, you don't deserve that; you're going to get fat'" (Yvette, occupational therapist). Clinicians described how extreme dietary restriction and over-exercise could be understood as being driven by the AV's unyielding demands, which caused immense suffering: "The shin splints and the fractured pelvis and the compressed discs and the broken toes, they're still running, running, running on the treadmill, to get away from the voice" (Sarah, art psychotherapist). By helping participants to appreciate service users' pain and vulnerability, the AV was presented as supporting them and their colleagues to appraise people with AN as deserving of help even when service users did not follow their advice.

The AV was also portrayed as a means of understanding the ambivalence that most service users feel towards treatment. Clinicians identified numerous positive functions of the AV for someone with AN, including conferring a sense of control;

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blocking negative emotions; providing reinforcement, and furnishing a sense of identity. It was noted that these qualities were particularly prominent in the initial stages of the illness:

> I think early on it's that whisper of: "You can control something in your otherwise difficult and challenging life." (Sarah, art psychotherapist)
>
> Some people will describe it as a friend, as a comforter, as "Oh well, if I do this, I don't have to experience the anxiety." (Rosie, nurse)
>
> I think they sometimes feel that it's part of their identity, this anorexic voice, and without it then what are they? (Elizabeth, nurse)

Therefore, despite the distress evoked by its criticism, participants noted that the AV is frequently experienced by people with AN as an ally: "As critical as that voice is, it is reliable, it is there, it doesn't not pick up when you call it to comfort you" (Michelle, clinical psychologist). Clinicians reflected on how clients' attachment to the AV, and/or identification with it, explained why they might hold on to their behaviours: "Having a bully is better than having no one and people have talked to me a lot about, 'If I take that voice away, what I'm left with is kind of emptiness'" (Jessica, clinical psychologist). Thus, the AV was presented as rendering "anorexic behaviours" more explicable for those without lived experience by providing an insight into service users' inner turmoil.

Sub-theme 2: A non-blaming stance.

Participants argued that the concept of the AV could support service users to recognise that they are not to blame for their behaviours:

> The feedback I've had from people is it's like it's not another criticism of them, it's almost something different that's happening to them rather than they're creating it. (Elizabeth, nurse)

> When you're talking about this anorexic voice, it's highlighting that it's a
>
> separate thing to them and it's not their fault. (Lisa, healthcare assistant)

Clinicians suggested that this non-judgmental framing of service users' experience

could increase self-compassion, and empower service users to make positive changes.

Similarly, participants reported that blaming the AV or AN rather than service users

for non-adherence helped staff and loved ones to remain compassionate in the context

of high levels of frustration: "It reduces blame and frustration. There's a sense that

it's coming from a disorder, from something separate that they're fighting with rather

than from them personally" (Jessica, clinical psychologist). The AV was presented as

a tool that clinicians could use themselves, with colleagues, and with family/carers to

counteract negative emotions and judgments.

Sub-theme 3: Expressing empathy.

While clinicians emphasised that they would be led by clients' views of their

experiences (see theme 2), the AV was perceived as a means for clinicians and

significant others to communicate to the client that they have some understanding:

> People think, "Yeah she does get this, she understands what it is." And then
>
> you start to get more stuff out. (Victoria, consultant psychiatrist)
>
> People will come in and they'll feel really embarrassed or ashamed or guilty,
>
> or "People can't understand why I would get upset about having a white
>
> sandwich as opposed to a brown-bread sandwich." So to validate that for
>
> somebody is really important. (Rosie, nurse)

Participants contrasted the value of clinicians expressing empathy via the AV with the

reality that clients are frequently met by incomprehension and stigmatisation: "I've

heard staff before saying things like, 'Well there's people dying of cancer and they'll

just not allow themselves to eat'" (Tina, nurse). The AV was thus presented as a

"helpful shared language" (Victoria, consultant psychiatrist) for healthcare professionals to demonstrate understanding of how criticised service users can feel and how conflicted about the recovery process they may be, thereby increasing clients' confidence that clinicians can help them and empowering them to engage with treatment.

        Sub-theme 4: Empowering service users.

        Alongside identifying how the AV could be used to reduce self-blame and promote engagement, clinicians argued that the concept could be employed to help clients recognise that they have a choice regarding whether to engage in the anorexic behaviours it was seen to promote: "Being able to start externalising it and get distance on it may mean that they might be able to be a bit more judgemental of it, or critical of the critical voice in itself" (Michelle, clinical psychologist). Clinicians described using the concept to help clients separate from the AV/AN and appreciate themselves as having a range of qualities, interests, and options. In this way, participants argued the AV could be employed to enhance motivation and help clients reconnect with the "bits of them that want something more" (Victoria, consultant psychiatrist). They noted that when service users build up other aspects of their lives, "the voice becomes less important" (Susan, clinical psychologist).

        Participants also described how they could support clients "to make the AV the annoying little thing in the back of your head that you can bat away and not compulsively respond to" (Laura, dietetic assistant) by challenging the voice themselves, or coaching the client to do so via chair work or strategies borrowed from cognitive behavioural therapy for psychosis: "You might be able to use it as a tool to turn the volume down, to maybe change the dialogue, to learn assertiveness skills to speak back to the voice" (Michelle, clinical psychologist). Linked to this notion of

relating differently to the AV, clinicians highlighted the importance of providing a secure, compassionate therapeutic relationship that the client can internalise:

> They interiorise the therapeutic dialogue….This can help soften the voice. (Selena, consultant psychiatrist)

> Part of the therapy is modelling and creating a relationship that's not all of those things that the anorexic voice is….so they begin to generate an internal narrative that's not so punitive. (Jessica, clinical psychologist)

Participants argued that, by showing consistent compassion through a non-blaming stance and expressing empathy, clinicians could increase clients' self-compassion and empower them against the AV.

Theme 2: "It's not a one-size-fits-all"

While the AV was presented as a helpful tool for understanding, and responding with compassion to, people with AN, participants emphasised that it was not applicable in all cases. Most portrayed the AV as more of a potentially helpful construction than a real entity, and one of several metaphors for AN. The importance of listening to clients and being led by their experience was emphasised. Participants suggested that to not do so would be uncompassionate – because it would be imposing the clinician's view, rather than taking steps to understand the client's perception.

Sub-theme 1: Wary of imposing the AV.

Many clinicians stated that while the AV resonated with some clients, others did not relate to it: "She went through therapy and they were talking about the anorexic voice and she came home really upset saying, 'I don't think I've got anorexia because I don't have the anorexic voice'" (Lisa, healthcare assistant). Reasons suggested for some clients not relating to the AV were: viewing their experience in different terms (e.g. as thoughts or as biologically based); seeing AN as

part of their identity; regarding the AV as an over-simplified concept; not wanting to be exposed to stigma, and struggling to think in abstract terms:

> Patients with psychosomatic disease….don't recognise the anorexic thought or voice and it's always expressed with the body. (Selena, consultant psychiatrist)
>
> People who assume the identity of anorexia nervosa maybe wouldn't experience an anorexic voice. (Lisa, healthcare assistant)
>
> I think people think, "Gosh, am I going mad? And what will this individual think if I say I am hearing a voice?" (Elizabeth, nurse)

Clinicians argued that while the AV can be usefully employed to promote compassion, using the concept with clients who do not relate to it would be uncompassionate.

Concern was also expressed that the AV, or externalisation in general, could lead to clients disowning responsibility for changing their behaviour: "As long as it doesn't get too externalised….to the point: 'Well it's nothing to do with me or I can't take responsibility for it'" (Susan, clinical psychologist). Some participants suggested that using the AV carried a risk of fragmenting service users' sense of self, which linked to a wider point about not unnecessarily imposing your will as a clinician because to do so could evoke extreme distress and disengagement:

> I hear the voice of one client who's going, "….It is just part of me so actually to separate it from me feels a bit….dissecting." (Yvette, occupational therapist)
>
> It can be very, very risky if you….push someone too far, because their self can become fragmented. They lose sight of who they are. (Thomas, consultant psychiatrist)

Related to this, some participants reflected that it is important to highlight to clients who identify as having an AV that while it may feel separate it is ultimately coming from them:

> I would probably not work so much on pushing that voice out, but acknowledging that that voice….is part of them. (Katherine, counselling psychologist)

> Let's talk about the anorexic voice, let's talk about this wasp, this Labrador, this monster, but then let's bring your attention to the fact that this is coming from you; this is not an actual bully, this is your thinking. (Lucy, drama therapist)

Two participants raised the notion of the self as a transcendent "observer" of experiences – be they conceived as voices, thoughts, or otherwise. Above all, clinicians stressed that it was important to be guided by individual understandings: "If they don't relate to it, then try something else….It's not a one-size-fits-all" (Yvette, occupational therapist).

Sub-theme 2: Different words for the same thing.

Most clinicians used the terms "anorexic voice," "anorexia" and "anorexic thoughts" interchangeably, or highlighted that they viewed them as the same concept: "Whether you call them 'thoughts' or 'the voice' or whatever you refer to it as, I guess we're talking about the same kind of thing" (Rosie, nurse). Another noteworthy feature of the accounts was the prevalence of metaphor to elucidate AN:

> Like the abusive ex-boyfriend who can be lovely and safe and something that's familiar….but that can also completely turn around and be vicious and mean and cruel and not let you do things. (Laura, dietetic assistant)

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I'm thinking about a patient who has described her eating disorder as a

wasp.... So it's like, "It's there. It stings me. I can't get away from it; it's in

my head and it's just easier to keep still and do what it says." (Lucy, drama

therapist)

Other images used by participants included a battle, a pit you have fallen in, and an

aggressive plant. Hence, the AV was presented by clinicians as one of many

metaphors for the experience of AN, and in this regard more as a potentially helpful

construction than a literal truth.

Some participants questioned the concept of the AV, arguing that it was not an

external voice and/or questioning how it differed from a psychotic experience:

A voice is....thoughts going through your windpipe, through your larynx and

being projected out there....It's not a voice, so it is a metaphor. (Thomas,

consultant psychiatrist)

It can get to such a strength that you think, if you're really talking about

hearing an external voice, what is it that makes that not psychotic? (Katherine,

counselling psychologist)

Several clinicians noted that professionals may have introduced the AV to

clients. Many adopted the pragmatic stance that it is a concept "that works" (Victoria,

consultant psychiatrist) for staff and some service users in terms of promoting

understanding, engagement, and positive changes:

It's a technique to improve communication, improve engagement, improve

understanding of staff. (Victoria, consultant psychiatrist)

It is really good to use in your toolbox. (Tina, nurse)

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The fact that effective therapy is possible without using the AV was raised during the interviews, and it was suggested that certain therapeutic models incorporate similar ideas with different names:

> I don't come from a standpoint of if you're not considering that in the treatment then you're missing something huge. (Jessica, clinical psychologist)
>
> In compassion-focused therapy, the talk is very much of the inner self-critic and that's the same sort of concept. And then….[in] a CAT [cognitive analytic therapy] approach, you're thinking about self-to-self relating. (Susan, clinical psychologist)

Discussion

This study sought to explore the perceptions of clinicians in ED services regarding the AV. In accordance with client accounts (e.g. Williams & Reid, 2012), clinicians depicted the AV as highly critical and demanding but also a source of comfort and companionship. Given that people with AN are more likely to have an insecure attachment style (Zachrisson & Skårderud, 2010), which is associated with a preoccupation with the availability of others and/or the avoidance of human relationships (Gander, Sevecke, & Buchheim, 2015), the reliability and relative predictability of the AV could render it an enticing attachment figure. Clinicians suggested that many service users see the AV or AN as part of their identity, which echoes service-user accounts (e.g. Higbed & Fox, 2010) and may reflect the prevalence of identity-related issues among this cohort (Espindola & Blay, 2009; Stein & Corte, 2007). However, while all participants engaged in describing the characteristics of the AV, most depicted it as a potentially useful construct rather than a real entity.

Perceptions of the "anorexic voice" among clinicians

Participants presented the AV as an important therapeutic tool for developing, maintaining and conveying compassion as a clinician, and supporting service users to show greater self-compassion. Clinicians' views of these functions of the AV corresponded closely to Atkins and Parker's (2012) model of acting compassionate, which involves noticing suffering; appraising it (deciding whether those suffering are deserving of help, whether they and their suffering are relevant to oneself, and whether one has the resources to provide assistance); feeling empathic concern, and responding to the suffering. From this perspective, compassion is an active response to suffering.

In line with first stage of Atkins and Parker's (2012) model, clinicians portrayed the AV as a means of appreciating the distress service users experience and the immense courage they must show to engage in treatment (Vitousek, Watson, & Wilson, 1998), given reports of the voice's abusive commentary and relentless demands. This is important in light of evidence that people who do not have lived experience of AN underestimate the suffering experienced by those who do (Bailey & Frampton, in press, as cited in Gregertsen, Serpell, & Mandy, 2017) in the context of experiences that can be difficult to relate to, such as fear of food (Walker & Lloyd, 2011).

The second element of Atkins and Parker's (2012) model is appraisals that determine whether one has an empathetic emotional response to suffering and acts to alleviate it. In accordance with this, appraisals were found to determine whether compassionate care was provided by clinicians working with non-adherent patients with diabetes (Tierney, Seers, Reeve & Tutton, 2017), another client group that healthcare professionals may experience as exasperating (Wens, Vermeire, Van Royen, Sabbe, & Denekens, 2005). In the present study, all participants demonstrated

compassion towards service users. However, in line with some previous research (Gulliksen et al., 2012; Ramjan, 2004), some reported experiencing frustration and many described high levels of frustration, judgment and misunderstanding among their colleagues. Furthermore, it is possible that participants had experienced negative reactions to service users but did not disclose them because they were not asked directly about them or because they did not feel safe to voice pejorative views; in accordance with the findings of this study, it is also feasible that thinking about the AV made clinicians adopt a more compassionate stance during the interviews than they would generally.

Given that appraising others as responsible for their distress leads to anger rather than compassion and promotes aggression rather than supportiveness (Rudolph, Roesch, Greitemeyer, & Weiner, 2004), it is unhelpful for staff to view service-user non-adherence as a consequence of wilfulness (Gregertsen et al., 2017). Accordingly, clinicians argued that by blaming relentless pressure from the AV for non-adherence to treatment plans, via a process of externalisation, they were able to appraise clients as deserving of help, thereby remaining compassionate. By providing an explanatory framework and an alternative target for their blame, participants argued that the AV helped them to maintain a non-judgmental stance towards service users. This is in line with evidence that externalisation is commonly employed with AN to this effect (e.g. Wright & Hacking, 2012; Zugai et al., 2018[a]), and that having a framework for understanding promotes less blaming attitudes among clinicians towards people with AN (Bannatyne & Stapleton, 2017; Crisafulli et al., 2008; Crisafulli et al., 2010), and individuals with other stigmatised mental-health diagnoses such as schizophrenia (Kellett et al., 2014) and Personality Disorder (Kerr, 1999). "Reframing resistance as an understandable response to threat gives both therapists and clients an alternative

explanation that reduces conflict and enhances empathy" (Vitousek et al., 1998, p.399).

In promoting a non-judgmental stance, the AV is conducive to the authenticity and transparency that people with AN desire in their therapeutic relationships (Rance et al., 2015). However, care is needed to honour the understandable ambivalence of many people with AN, given that portraying EDs as the "enemy" risks invalidating the positive functions they are perceived to fulfil by many service users (Oyer, O'Halloran, & Christoe-Frazier, 2016, p127). Another potential risk of externalisation in general is that if the AN is viewed as entirely separate from the service user, it could perpetuate the tendency for professionals to solely focus on physical and behavioural aspects of the condition and elide the internal conflict, rather than follow service-user preference and consider psychological functioning (Duncan, Sebar, & Lee, 2015; Sibeoni et al., 2017). However, in the present study the AV was portrayed as a means of facilitating consideration of psychological functioning.

In addition to the question of whether an individual deserves help, the Atkins and Parker (2012) model suggests that another appraisal that can promote or inhibit a compassionate response is whether one has the resources to help. Compassion can be compromised by stress in healthcare settings (Sinclair, Raffin-Bouchal, Venturato, Mijovic-Kondejewski, & Smith-MacDonald, 2017), with higher therapist caseloads associated with negative reactions towards people with EDs (Franko & Rolfe, 1996). Compassion is also positively associated with a secure attachment style (Shiota, Keltner, & John, 2006), indicating that the personal qualities of clinicians will influence whether they show compassion towards service users.

In the present study, the AV was presented as a "helpful shared language" to express empathy, corresponding with the third phase of the Atkins and Parker (2012)

model. Empathy has been found to reduce treatment-resistance among people with AN (Abbate-Daga et al., 2013), and is valued by clients (Gulliksen et al., 2012). Clinicians reported that they used the concept of the AV to empower service users to make positive changes, which fits with the emphasis on acting to prevent and alleviate suffering in Atkins and Parker's (2012) model and other contemporary accounts of compassion (e.g., Gilbert, 2005, 2017). Participants presented the AV as a means of helping clients to gain some distance from anorexic behaviours and connect with other interests and qualities, in line with previous research (Scott, Hanstock, & Patterson-Kane, 2013). They also suggested that its use facilitated service users becoming "critical of the critical voice itself"; this accords with previous proposals that the AV could be used to "[mobilise] anger towards the illness" (Forsén Mantilla, Clinton, & Birgegård, 2017, p.12) and help service users to mount a "resistance" to it (Maisel et al., 2004, p.12).

Participants also described the AV as a tool to promote self-compassion, being kind rather than critical towards oneself (Neff, 2003), in the context of the low self-esteem that characterises AN, which can lead to service users feeling unworthy of help (Duker & Slade, 1990). Participants argued that the AV can facilitate self-compassion by enabling service users to regard themselves as victims of a force beyond them, in line with previous reports of the effect of externalisation of AN (Wright & Hacking, 2012). This can empower service users to reject the punishing demands associated with AN and be kinder towards themselves (Forsén Mantilla et al., 2017). This use of the concept aligns with the goals of compassion-focused therapy for eating disorders (Goss & Allan, 2014), and evidence that higher levels of self-compassion are associated with lower levels of psychopathology (MacBeth &

Gurnley, 2012). Some clinicians also described supporting clients to "speak back" to the voice, a key task within EFT (Dolhanty, 2006).

More generally, clinicians contended that nurturing therapeutic relationships promote self-compassion by providing a kinder narrative that the client can internalise, an idea that originates in psychoanalytic theory (Blatt & Behrends, 1987) and is supported by evidence that people with AN regard relationships with others as sources of self-worth (Duncan et al., 2015). Compassion in the form of acceptance, validation and kindness has been found to mitigate shame (Gilbert, 2017), which mediates the link between self-criticism and ED symptoms (Kelly & Carter, 2013).

Clinicians emphasised that all clients are different and stressed the importance of listening to them, in line with a formulation-driven approach that incorporates consideration of individual meaning and context (Johnstone, 2017), and in accordance with previous research with specialists in this field (Couturier et al., 2013; Holmes, 2017; Reid et al., 2010). The experience of AN varies (Gregertsen et al., 2017), and service users value being treated as individuals (Bruch, 1982; Gulliksen et al., 2012; Offord, Turner, & Cooper, 2006). Correspondingly, participants were wary of imposing the AV or any other framework on clients. They also highlighted that successful treatment is possible without the AV, reflected in the fact that many established therapies – for example, ED-focused cognitive-behaviour therapy (Fairburn et al., 2013) – do not invoke the concept.

Concerns among clinicians about use of the AV fragmenting clients' sense of self link to evidence from qualitative studies that service users regard AN as part of who they are (Higbed & Fox, 2010; Williams & Reid, 2012), at least intermittently, and the notion that it is theoretically invalid (Kinderman et al., 2006) and potentially harmful (Vitousek, 2005) to distinguish between a mental illness and the self.

Perceptions of the "anorexic voice" among clinicians

Participants also highlighted that just as it is limiting to view oneself as defined by the AV or AN, it is damaging to view the problem as so separate that one is disempowered to do anything about it, a concern raised in previous research (Vitousek, 2005; Wright & Hacking, 2012). One solution to both concerns about fragmentation and reduced responsibility was offered by participants who suggested conveying to service users that they are not the AV, nor their thoughts, but the observer of both, a concept from acceptance and commitment therapy (Fletcher & Hayes, 2005). A key component of this therapy is mindfulness, which as defined by Neff (2003) could be a means of acknowledging the AV without seeing oneself as fused with, or completely separate from, it. Similarly, the AV could be understood as a form of self-to-self relating within a cognitive-analytic framework (Ryle, 1985).

In adopting a pragmatic view of the AV as a "concept that works" for many clients rather than a literal truth or demonstrably different from anorexic thoughts, AN or psychotic voices, most clinicians presented the AV as a social construction. The AV was portrayed as one way of understanding AN and its treatment in the context of multiple, simultaneously occurring perspectives (Goren-Watts, 2011; Maisel et al., 2004). Participants argued that what matters is whether a construction is conducive to understanding and recovery for individual clients. However, both the other metaphors employed by participants (e.g., an aggressive plant) and concepts from other therapies (e.g., compassion-focused therapy's inner self-critic) arguably differ from the AV, which in client accounts appears more connected to the individual and encountered as a real entity that has invaded clients' being (Tierney & Fox, 2010; Williams & Reid, 2012).

Clinicians' perception that some people with AN do not identify with the AV is in line with previous research with people with EDs (Noordenbos et al., 2014).

Perceptions of the "anorexic voice" among clinicians

While the prevalence of this experience remains unclear, this finding could reflect clients being at different stages in the illness trajectory; service users have reported how, in the early stages, the AV is often experienced like a friend and coach, becoming increasingly harsh and dominant as the condition progresses (Tierney & Fox, 2010). Drawing on the stages-of-change model (Prochaska & DiClemente, 1983), serious contemplation of change is associated with greater insight into the costs and benefits of AN than pre-contemplation (Gregertsen et al., 2017). Therefore, it could be that the concept of a seductive but punitive AV does not resonate with clients in the pre-contemplation stage, when they are focused on the voice's positive functions. It is also possible that experience of the AV may be under-reported to clinicians due to the stigma associated with psychosis (Noordenbos et al., 2014).

The AV is an emergent research area and relatively little is known about this concept. There is the potential that differences between the AV and anorexic thoughts, such as in the intensity of the experience, will emerge in future research. It is possible that clinicians regard the AV as a construct but for clients it can be a real entity. Either way, the findings of this study suggest that it can be a useful means of developing and sustaining compassion when working with people with AN.

Clinical implications

The high levels of ambivalence towards, and dropout from, treatment for AN point to a need to find new ways of engaging this client group (Gulliksen et al., 2012). In line with evidence of the importance of non-specific clinical factors in therapy (McIntosh et al., 2005), the AV could be employed by professionals in supervision, consultation and team formulations to promote compassion, and with service users to build self-compassion. It may also be productively used in psychological treatment, such as via chair work in EFT (Dolhanty & Greenberg, 2009) and cognitive-

behavioural challenging of its messages in cognitive behavioural therapy (Pugh & Waller, 2016). Alongside discussions with clients, clinical supervision and team formulation could be used to decide if, when and how to use the AV in the care and treatment of individuals with AN, and to review its effectiveness when it is employed.

Strengths and limitations

This study has three main strengths: it is the first to explore the concept of the AV from the perspective of clinicians; the sample is diverse in terms of professional background and service location, and measures such as auditing and member checking were implemented to increase the credibility of the findings. Another strength is the multidisciplinary nature of the research team, which included a nurse as well as psychologists, meaning a broader store of experience and insights could be invoked (Barbour & Barbour, 2003).

A limitation of the study is that the participants were all employed by specialist ED services, so their views may be different to clinicians involved in the care of people of AN in more generic settings, such as GPs or school nurses. The sample was self-selected so it may be that those who offered to participate were more sympathetic to the concept of the AV. Despite assurances of confidentiality, it is possible that participants did not feel able to share negative views, for fear of judgment from a fellow mental-health professional. The fact that all participants had worked with people with AN for at least two years – and most for more than five years – and all but one were female could have promoted more compassionate responses given that negative reactions are more common among less experienced, and male, clinicians (Thompson-Brenner et al., 2012). The limited representation of males is in line with some previous research with ED clinicians (e.g. Waterman-Collins et al., 2014) and reflects the gender composition of the NHS, in which women

comprise 77 per cent of the workforce (NHS Digital, 2016). None of the participants reported first-hand experience of an ED, which is out of keeping with previous research suggesting one-third of employees of ED services have personal experience of an ED (Johnston et al., 2005). Another limitation of this research was that clinicians were not asked to consider the AV in relation to clients' stage of change (Prochaska & DiClemente, 1983).

It is possible that the first author's lack of relevant clinical experience constrained her ability to ask insightful follow-up questions during data collection; however, any risk of omissions was mitigated via regular discussion within the research team throughout the study.

A further limitation is that this was a western-centric study, from the research team to the participants to the theoretical underpinnings, and findings may not be transferable to non-western settings given that there is evidence that perceptions of voice experience differ across cultures (Luhrmann, Padmavati, Tharoor, & Osei, 2015).

Recommendations for further research

Future research could explore at what point it is helpful to employ the concept of the AV in terms of stage of change. It would be informative to explore experiences of the AV among clients in the pre-contemplation stage, such as those with severe and enduring AN or those detained under the Mental Health Act. It would also be interesting to qualitatively examine service users' experiences of use of the AV in treatment, and evaluate outcomes. Another avenue of research is the relationship between experience of the AV and locus of control (i.e., external or internal). Another possible area of study is exploring whether the AV could be used to help clinicians appraise non-adherence as a reflection of the strength of the AV rather than

a professional failure, and thereby increase their self-compassion and resilience when working with this challenging client group. Other studies could examine perceptions of the AV among clinicians working with children and adolescents with AN, those with less experience of working with AN, and those from different cultures.

Conclusions

The AV was portrayed by clinicians as a welcome addition to their toolbox that can help them foster the empathy that is the foundation of a productive therapeutic alliance. Furthermore, they suggested that the AV could be used to empower some clients to be more self-compassionate, and mount a resistance to their disordered eating.

Paper 3 – Integration, impact and dissemination summary

Perceptions of the "anorexic voice" among clinicians

Introduction

This paper, which is not intended for publication, critically reviews (a) my experience of planning and conducting the research, and the extent to which papers 1 and 2 form a unified whole; (b) the potential impact of the findings and how these can be maximised, and (c) avenues for dissemination of the findings. The experience of the research is evaluated sequentially, in accordance with the chronological order in which it was conducted.

Integration

Interest in the research topic.

Clinically, I am interested in emotion regulation and issues around identity, which are both relevant to the concept of the "anorexic voice" (AV) and people with eating disorders (EDs). The AV has been described as providing a sense of identity (Higbed & Fox, 2010) and enabling emotional avoidance (Tierney & Fox, 2010), and there is evidence that individuals with EDs often have under-developed identities (Stein & Corte, 2007) and difficulties identifying and expressing emotions (Troop, Schmidt, & Treasure, 1995). My interest in qualitative approaches stems from their capacity to generate rich and detailed understandings of experiences and meanings; their respect for the complexity and individuality of each participant; their acknowledgement of the role of the researcher in the research process; their attention to language, and their capacity to give voice to marginalised groups (Ormston et al., 2013).

Keeping a reflective journal.

Keeping a reflective journal helped me to remain alert to my preconceptions and biases, and to ensure that these did not compromise the rigour of the research. The journal was used to record observations about the experience of planning and

conducting the research, and is the source of many of the discussion points in this paper. As highlighted below, it charted changes in my thinking over the life-span of the thesis.

Orientation and developing the topic guide for Paper 2.

Observing staff at one of the recruitment sites, a specialist adult ED service, for two days prior to commencing data collection was informative and underlined the intensity of work with EDs. This experience increased my empathy for clinicians, and may have assisted with the development of rapport during interviews. During this observation period, I met with seven service-user consultants to co-design the topic guide for the interviews. I found them to be insightful and reflective; their questions (e.g., "what is the best way to overcome the AV?") were among those that yielded the richest data.

Ethics and recruitment.

Due to the fact that the participants of Paper 2 were healthcare professionals, I found it relatively straightforward to gain the relevant approvals and recruit participants compared with peers whose research involved service-user participants. I was grateful to avoid this additional stress in the context of the other demands of the course, and my caring role at home.

Conducting the interviews for Paper 2.

Conducting 15 interviews with busy clinicians at four sites across the country required high levels of organisation, and tested my communication skills. As a novice researcher, I was nervous before the first interview. However, I soon relaxed into the role, in part thanks to the friendliness and eloquence of the interviewee, and was able to draw on the interpersonal skills that have been honed through my clinical training. My supervisors listened to audio-recordings of the first two interviews; while they

were encouraging in their feedback, they noted that I spent too long on the warm-up questions and missed opportunities to probe ambiguous responses. In subsequent interviews, I was mindful to progress to the core questions as soon as possible, and to follow up for the sake of clarity and completeness.

During the interviews, a minority of participants expressed uncertainty linked to the fact that they did not have first-hand knowledge of the AV. Ultimately, the data gathered related predominantly to if, when, how and why the concept should be used in clinical practice – and was thus grounded in clinicians' direct experience.

Transcribing, coding and analysing the data for Paper 2.

While at times I found transcribing and coding the interview transcripts arduous, doing so facilitated immersion in the data (Braun & Clarke, 2006). As a novice researcher, following the six-stage process set out by Braun and Clark (2006) was containing. Having my analysis audited not only increased its credibility but also helped to motivate me to be meticulous throughout the coding process. Furthermore, the high level of agreement between my codes, and those of the independent researcher, were reassuring. While I was clustering the codes and reviewing candidate themes, supervision proved a valuable forum to interrogate emerging understandings, and be exposed to alternative readings of the data. Writing up the analysis was my favourite aspect of the empirical study because it was gratifying to have something tangible to show for the many hours of planning, interviewing, transcribing, and coding.

Reflections on the design and analysis of Paper 2.

While all qualitative research is interpretative to a degree, qualitative description is less so than approaches such as grounded theory and phenomenology, remaining closer to the data (Sandelowski, 2000, 2010). Linked to this, I initially felt

concerned that thematic analysis represented too "basic" an approach for a doctoral-level study. However, given the research question's focus on patterns across data, it was the most suitable analytic method for Paper 2 (Larkin, 2015). Moreover, having since read hundreds of qualitative articles for the two papers, I have been reassured by the number of rigorous and conceptually rich papers that have used thematic analysis.

How my conceptualisation of the AV changed over time.

The reflective journal charted how initially I conceptualised the AV as an aspect of some service users' lived experience. Through discussion in supervision and self-monitoring, I endeavoured to ensure that this view of the AV did not influence the conduct of the interviews and analysis. By the time of writing Paper 2, I had begun to regard the AV as both a clinically useful construction and an aspect of some service users' lived experience, seemingly influenced by the views of my participants. I sought to maintain a neutral stance in the write-up of the findings, to both accurately represent what participants had told me and honour previous research with service users. Supervision was helpful in promoting neutrality, and supporting me to clarify the change in my perspective and why it may have occurred.

Deciding on a topic for the review.

After completing Paper 2, I spent many hours conducting preliminary searches on Google Scholar before selecting a topic for Paper 1 that appeared both sufficiently related to my empirical article, and to have the potential to contribute to the knowledge base. Given that Paper 2 focused on clinician perspectives and in light of my interest in qualitative approaches, a metasynthesis on the experiences of clinicians working in the field seemed the most relevant choice. However, EDs are a popular topic and metasynthesis has proved to be an appealing approach (Bondas & Hall, 2007), so I struggled to identify a novel angle. Ultimately, in line with other

published metasyntheses (e.g., Kowlessar, Fox, & Wittkowski, 2014), I opted to update and extend previous reviews.

Deciding to do a meta-ethnography.

Of the different synthesis methods, meta-ethnography (Noblit & Hare, 1988) appealed to me because it goes beyond the original data to develop new understandings (Barnett-Page & Thomas, 2009) and is a well-established approach (Bondas & Hall, 2009) with clear guidelines. However, I had some initial concerns. The fact that the third-order interpretations are three times removed from the target experiences (Bondas & Hall, 2007) called to mind the children's game Chinese whispers, in which the original message is frequently mangled on its journey between ears. Furthermore, given that I have a first degree in English Literature, the question posed by Sandelowski and colleagues (1997) resonated: "Can you sum up a poem?" (p.366). Idiography and synthesis seemed inimical. However, I was and remain persuaded that there is value in metasynthesis, which carries greater potential to influence practice and policy than isolated qualitative studies, and "[opens] up spaces for new insights and understandings to emerge" (Walsh & Downe, 2005, p.205).

Defining the parameters of Paper 1.

Despite having carried out an initial scoping exercise, I significantly under-estimated the number of studies my search terms and inclusion criteria would yield. Synthesising 35 studies as a novice researcher was daunting and, at times, I felt overwhelmed by the amount of data.

When it became clear that there would be more than 30 studies, my supervisors and I discussed the possibility of narrowing the inclusion criteria, for example by limiting the remit to professionals working with people with anorexia nervosa (AN), or those working with adults with EDs. However, I decided against

this as to do so would have felt arbitrary given that most studies grouped the ED diagnoses together, and many did not specify the age of clients. Moreover, many published metasyntheses have included a similar number of papers (e.g., Sibeoni et al., 2017), and some have included substantially more (e.g., Toye, Seers, & Barker, 2017).

Upon reflection, a research question with a narrower focus – that would have generated a smaller number of papers to synthesise – would have been more appropriate for a doctoral-level project by a novice researcher with limited time and resources.

Synthesising the studies and discussing the findings of Paper 1.

Once I had decided on a topic and completed the systematic search, I enjoyed working on Paper 1 more than Paper 2; this may have been due to greater familiarity with the qualitative paradigm by this point.

I found translating the papers into one another challenging; I was concerned that some of the resulting overarching concepts, such as the "golden middle way," were too broad; it felt as though I was trying to navigate my own golden middle way between a reductive synthesis that misrepresented the data, and one that was too piecemeal to qualify as a synthesis. My supervisors helped me to recognise that concepts can overlap but remain distinct and true to the data. Through supervision, the meanings of the overarching concepts, and their relationships with each other, were clarified: this resulted in the line of argument being reconfigured on two occasions (see Appendix 2).

Regularly discussing the synthesis with my supervisors helped to limit the influence of my interests and experiences. For example, during a preliminary discussion about the translation and line of argument, in which I labelled some of the

overarching concepts "defence mechanisms," my supervisors supported me to reflect that I was at risk of applying a theoretical lens to the data due to my fascination with psychoanalytic theory.

However, as Noblit and Hare argued (1988), the findings of any metasynthesis inevitably bear the imprint of the synthesiser. Given that I am training to be a clinical psychologist, it is possible that I overstated the importance of psychologists in the discussion of the meta-ethnography. Similarly, the positive impression I formed of the clinicians I observed during my two-day orientation, and my own experience of working with treatment-resistant clients, may have led me to take a more sympathetic view of healthcare professionals' motivations in my third-order interpretations.

Ontological and epistemological positioning.

The process of producing these two papers led me to interrogate my theoretical framework, and those of my chosen approaches. As a critical-realist, I believe that there is an independent reality that is only accessible through individual perceptions (Ormston, Spencer, Barnard, & Sharpe, 2013). Thematic analysis is a method rather than a methodology, and is thus compatible with a range of ontological assumptions, including critical realism (Clarke et al., 2015). While it has been suggested that meta-ethnography (Noblit & Hare, 1988) is underpinned by objective idealism, according to which there is a world of shared understandings (Tong, Flemming, McInnes, Oliver, & Craig, 2012), its emphasis on interpretation entails a somewhat constructivist view of knowledge in line with the critical-realist view (Barnett-Page & Thomas, 2009).

Points of concordance and discordance, and overall unity.

Both papers 1 and 2 focus on the accounts of healthcare professionals working with people with EDs. By highlighting the challenging nature of working with this

client group and the risk of uncompassionate responses such as blaming and avoidance, Paper 1 lays the foundations for Paper 2's exposition of the AV as a tool to promote compassion among clinicians towards people with AN. Both papers highlighted the demands associated with working with people with EDs: this was the key finding of the meta-ethnography, and was reflected in the introduction to Paper 2; it was also implicit in the findings of Paper 2 given that the challenges of working with people with AN necessitated active attempts to maintain a compassionate stance as a clinician.

Despite this synergy, the papers differed in important ways. Most obviously, Paper 1 is secondary research, drawing on the work of others, and Paper 2 is primary research. Importantly, Paper 1 related to the lived experiences of clinicians, whereas Paper 2 explored the perceptions of healthcare professionals regarding a concept that appears in the first-hand accounts of some service users. Furthermore, while Paper 1 examined healthcare professionals' experiences of working with people with all EDs, Paper 2 centred on clinicians' work with those with a diagnosis of AN; however, this distinction appeared less firm following completion of the meta-ethnography due to the over-representation of people with AN in the included studies.

It was notable that the participants of Paper 2 all presented as highly compassionate and client-centred, unlike many of the participants in the studies synthesised for Paper 1. It is possible that this reflects change over time in clinicians' attitudes, given that some of the papers in the synthesis are more than 10 years old. It may be that healthcare professionals who volunteer to participate in research for free are more compassionate than the typical clinician working in ED services. As discussed in Paper 2, it is possible that the clinicians interviewed for Paper 2 did hold negative views but did not disclose them due to fear of judgment from me; concerns

about confidentiality; not having been directly asked about such views, and/or feeling more compassionate in the moment due to reflecting on the AV.

Impact

At a micro-level, the conduct of this research has led me to reflect on my own experiences of working with high levels of complexity and treatment-resistance within a community mental health team, and prompted me to incorporate more self-care into my weekly routine. It has also reinforced the fact that clinical challenges tend to be multifactorial rather than, for example, the sole result of systemic issues such as lack of funding.

The research has the potential to change clinical practice in ED services if accessed by frontline clinicians, and service managers. Viewing the findings of Paper 1 could lead healthcare professionals to be more aware of their experiences; normalise any negative reactions, and reduce the stigma of disclosing such reactions in supervision. The findings could also induce clinicians to alter their coping strategies, and take a more realistic view of what they can achieve in line with the golden middle way. Exposure to Paper 2 could encourage clinicians to use the concept of the AV to manage their countertransference and remain compassionate; support colleagues to do so, and – where clinically indicated – foster self-compassion among service users. Service managers or clinical supervisors may be induced to provide training on the AV and/or embed it in the language of staff in team meetings, to promote compassion.

Paper 1 provides evidence of the importance of reflective spaces for staff to process their experiences and reactions, and of team formulation to aid understanding and promote personalised care. If accessed by sympathetic service managers, Paper 1 could lead to systemic changes. However, the capacity of managers to implement such measures is dependent on the resources of the service, which would also affect

the likelihood of frontline staff and managers examining the research in the first place.

If such reflective spaces or changes to care were implemented, they could be

evaluated via pre-post quantitative measures of staff and service-user wellbeing,

alongside qualitative feedback. This could help to assess the impact of Paper 1.

The findings of both papers may be of interest to service users with EDs.

Paper 1 could help them to make sense of negative encounters they may have had

with healthcare professionals. The findings of the meta-ethnography may generate a

range of emotions for those with lived experience, from anger at the blaming stance

adopted by some professionals to guilt if they judge themselves to be responsible for

the distress of clinicians. They may be relieved by the fact that the clinicians

presented the source of their frustration as feeling unable to help, rather than the

personal qualities of service users. The findings of Paper 2 are less likely to provoke

negative emotions given the compassionate stance of all participants. Service users

may be heartened that the participants in Paper 2 strove to understand their

experiences, and by the fact that the AV appears to be a promising tool to promote

compassion.

If disseminated via the popular media, social networking sites and/or

professional publications, the findings could significantly increase awareness and

understanding of EDs, and the issues raised by their treatment. Paper 2, in particular,

could challenge stigma via its emphasis on compassion and individual consideration.

Reading papers 1 and 2 could persuade policymakers to call for supervision as

part of the working week of healthcare professionals caring for people with EDs, to

ensure that they have opportunities to process experiences and discuss clinical

phenomena such as the AV with colleagues. Paper 1 could also prompt them to

allocate additional funds to NHS services given that it highlights the contribution of

staff shortages to the demands on clinicians; however, given the ongoing emphasis on "efficiency savings" (Roberts, Marshall, & Charlesworth, 2012; Maynard, 2017), this outcome appears unlikely.

Given that Paper 2 is the first research examining clinicians' perceptions of the AV and Paper 1 is the first meta-ethnography to focus in detail on clinicians' experiences of working with adult as well as adolescent service users with EDs, the findings extend the knowledge base. Paper 1, which contributes to the literature on burnout and wellbeing, provides a model of the lived experiences of working with people with EDs, including the coping mechanisms employed by healthcare professionals. Paper 2 contributes to the emerging literature on the AV by highlighting that in addition to its therapeutic applications (e.g., Dolhanty & Greenberg, 2009), it can be usefully employed by clinicians to maintain a non-blaming stance, and to better understand the distress and ambivalence service users experience. Paper 2 is also grounded in the theoretical literature on compassion. Other researchers would be more likely to access the findings and be influenced by them if they were published in high-impact journals, and/or presented at conferences.

The findings could be used to inform teaching modules on EDs in training courses for healthcare professionals, including nursing degrees and clinical psychology doctorates; this could lead to improvements in wellbeing for the next generation of clinicians, and those for whom they care.

Dissemination

Thus far, the findings of the empirical study have been disseminated locally via presentations to staff and students at Royal Holloway University, and to clinicians during a Continuing Professional Development session at one of the recruitment sites.

Perceptions of the "anorexic voice" among clinicians

All participants and service-user consultants have been offered a summary of the findings.

In order of preference, the empirical study will be submitted to *Clinical Psychology and Psychotherapy*, *Psychology and Psychotherapy*, *Journal of Eating Disorders* and *Advances in Eating Disorders* given that these journals (a) have previously published research in this area, and (b) are receptive to qualitative submissions. This order of preference is based on these journals' impact ratings according to the h-index (SCImago, 2018). An application will be made to present the findings at the *Eating Disorders International Conference*.

In order of preference, again according to impact ratings, the meta-ethnography will be submitted to *Psychiatric Services, International Journal of Nursing Studies*, *Clinical Psychology and Psychotherapy*, *Psychopathology*, and/or *Archives of Psychiatric Nursing*. These journals have been selected because they have previously published metasyntheses, or literature reviews on EDs.

I will seek a broader audience for the findings. Given the media interest in EDs, it is possible that editors of newspapers, magazines, television and radio programmes would be willing to feature them; I intend to contact BBC Radio 4's *All in the mind* and *Psychologies* magazine as the most obvious candidates. When contacting media outlets, I would emphasise the implications of the findings for the care of people with EDs as this is likely to be of most interest to the general public. I would also endeavour to adopt the "house style" of newspapers and magazines when pitching the research to them, to maximise the likelihood of them publishing it.

I will seek to publicise the findings via publications targeted at professionals, such as the *Nursing Times* and the British Psychological Society's *The Psychologist*.

Perceptions of the "anorexic voice" among clinicians

Again, I would consider the target audience and emphasise the relevance of the

findings to the professional group in question.

I will request that the findings be featured in the "News and research" section

of the ED charity Beat's website. Blogging and social media could be used to

promote the research; for example, a short summary of the research with a link to a

blog entry could be added to Twitter, and disseminated via retweeting.

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Appendices

Appendix 1: Reciprocal translation

Reference	Detailed summary of findings	Main concepts	Main concepts following reciprocal translation
1. Brinchmann, Moe, Valvik, Balmbra, Lyngmo, and Skarbø (2017)	• One theme: Having many strings to one's bow. Sub-themes: "planning and readjusting", "developing as a therapist and team", and "regulating the temperature of the group". • Therapists engaged in process of trying to problem solve and improve communication among families. • Having many strings to one's bow reflects therapists being versatile and resourceful, and using themselves as instruments. Able to improvise and draw on different instruments and scores as a team. "None of us knows what the melody will be until we start to play – we just take it from there" (Elinor, p.5). Includes reading and understanding group processes, changing position and perspective all the time. Need to retain overview and not get bogged down in detail, and achieve balance between active and laidback etc. "Using yourself as an instrument, a clear, clean tone. Sometimes you are restrained, at times more to the fore" (Sophie, p.5)	1. Need for team-work 2. Using self in work 3. Work as art, requiring high level of skill, nuance and flexibility; balance between active and laidback 4. Creating a safe but productive environment 5. Therapists being human and modelling	1. Humbly open to learning and support 2. Connecting with common humanity 3. The golden middle way 4. The golden middle way 5. Connecting with common humanity 6. The golden middle way

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• Valuing work and one's skill: "To bring out the unique capabilities that each family has, and the abilities emerging from the interaction between the families is probably the most special thing" (Sophie, p.4)	imperfection 6. Finding the middle way/balance between extremes

• Planning and readjusting. Aiming to create an environment that is safe but fosters development: "like a playpen, with a frame around it, a safe environment" (Sophie. p.5).

• Developing as a therapist and team: ongoing self-development, including increasing tolerance for unease upon which therapeutic change is predicated. "Experience has taught me that it's not so dangerous, we come out of it in one piece" (Sophie, p.6). Role requires courage to show oneself and model imperfection. Valuing attunement with colleagues.

• Regulating the temperature of the group: Monitoring energy and engagement levels in group to ensure therapeutic climate. Balancing the needs of group members. Use of humour/playfulness to regulate emotional temperature. Degree of risk involved. Needs to be a level of discomfort in the group to create "room for growth" (p.7; analytic narrative).

Discussion

• Presents findings in relation to Aristotelian virtue ethics.

• "MFT practice represents the full range of human possibilities; sometimes joyful but not always so. It is

	about coping with life: encountering and dealing with different life situations" (p.8; analytic narrative). • Therapists deploy "moral virtues", which are developed through experience and practice and reflect the sort of person the therapist is rather than their skills • MFT therapists finding the golden middle way between extremes e.g. active and passive, connected and theoretical.		
2. Carter, Webb, Findlay, Grant, and Blyderveen (2012)	• Theme 1: Perspectives on caring for youth with ED on a general paediatric unit. Sub-themes: "youths with EDs have unique needs", "provision of adequate nursing care", "balancing priorities" and "inconsistencies" • Youths with ED have unique needs – not accustomed to providing emotional support and meal supervision and preferred more active work e.g. administering medication, performing physical assessments. Also more emotional and less rewarding as families less grateful. "It's very emotional work. And it doesn't have the same gratification. The families in general aren't as grateful for the care they're receiving from the team…Not as if their child has diabetes, cancer or bowel problems" (physician, p.551). "It's the constant struggles of them refusing. She didn't want to eat. It's just constant. It's just mentally draining" (nurse, p.551). Taking the behaviour personally. "It's the manipulation. You think it's a personal attack against you and it's not; it's all part of the disease process"	1. Struggling with less active, more emotional and less rewarding nature of work 2. Draining nature of work 3. Lack of empathy in quote about NG tube? Not understanding magnitude of distress this would cause? 4. Complain of lack of training though authors note opportunities were provided	1. Emotionally draining work 2. Emotionally draining work 3. Avoidance 4. Emotionally draining work (systemic challenge) 5. Emotionally draining work 6. Emotionally draining work 7. Emotionally draining work 8. Feeling helpless and deskilled 9. Emotionally draining work

(nurse, p.551)

- Provision of adequate nursing care: lack of confidence in ability to provide necessary support due to lack of training. Authors note that opportunities for such training were provided but some nurses seemed to select more medically focused training. Few strong reactions to having to insert NG tubes. "It sucks, but it's comparable to putting in an IV in another kid who needs an IV and doesn't want it done" (nurse, p.552). Trusting in doctors' judgments. Some nurses reported the process of restraining SUs to insert tubes was highly distressing. "It's horrible. It's a lot of screaming and we were shoved… And it's just the whole mental thing – psychologically it was a horrible thing" (p.552). Some nurses felt decisions by the ED team were arbitrary.
- Balancing priorities. Frustration at amount of time meal support takes when you have other, medical SUs to look after. "You're sitting there for half an hour watching these kids eat and you're thinking, "my chemo is going off, my blood transfusion needs to be started, and I know my patient is calling me right now" (nurse, p.552). Feeling unneeded. Feeling dissatisfied that cannot provide optimal care: "So at the end of the day you kind of feel like a lacklustre nurse because you're not able to spend time with this patient who needs your care. And just as much as one of our cancer kids needs that chemo or blood transfusion, this child needs someone to speak to. So it was very frustrating" (nurse, p.552).

5. Another participant found it traumatic to insert NG tube
6. Feeling decisions by team are arbitrary
7. Frustration at the amount of time meal support takes
8. Feeling unneeded
9. Feeling dissatisfied at not being able to provide optimal care due to time constraints
10. Feeling manipulated (though reflecting on this)
11. Personalisation of care causing confusion
12. New ED role meaning other

10. Emotionally draining work
11. Emotionally draining work (systemic challenge)
12. Emotionally draining work
13. Connecting with common humanity

- Inconsistencies: Personalisation of care by other MDT members led to confusion and difficulties with planning.
- Other theme "Introduction of the new specialized ED-RN role" generally not relevant. Some coverage of how being allocated only aversive tasks e.g. inserting tube, rather than full range of caring tasks, led to feeling like "the bad guys" (nurse, p.553). Not seeing emotional support as demanding as other nurse tasks.
- Other theme "Positive impacts of the ED-RN role'. Sub-themes "experiences of ED-RNs" and "Improved patient care'. Satisfaction of specialisation and having scope to form relationship. "I like how we can form a relationship with them. It's not always right away or anything that, but it's nice working through it with them, forming a bond with them and helping them bit by bit" (specialist ED nurse, p.554)

Discussion

- Difficulties in general setting of focusing on individual care amid competing priorities
- Nurses wanting strict implementation of guidelines
- Increased autonomy, job satisfaction and skills development with specialisation

nurses seen as bad guys
13. Valuing being able to develop a therapeutic relationship

| 3. Davey, Arcelus, and Munir (2014) | - Theme 1: Work demands (sub-themes "therapeutic care", "physical care" and "organizational demands"). | 1. Draining nature of work
2. Being seen as a | 1. Emotionally draining work
2. Connecting |

- Therapeutic care: Managing ambivalence. "The hardest challenge is non-compliance…when the say they will do it, they want to do it, but they're secretly kind of sabotaging it as they go along…it's very difficult to work with people that…they want to get better, but without letting go of their eating disorder" (participant 9, OT, p.62). Being seen as either a mother or a friend - some saw this as barrier to relationship, others as opportunity. "I'm aware, being an older person, I may fall into that 'mummy' category, and maybe sometimes I get the transference to do with their relationship with their mums…It has its uses, definitely, because sometimes they work through things that are associated with the mum through me" (participant 11, nurse, p.62). Difficulty working with perfectionistic clients: "They desperately want people to get it right all the time and are very intolerant of failings, which is quite hard" (participant 7, nurse, p.62). Differences of opinion among staff in response to SUs' behaviours.
- Physical care: Unique nature of work as requiring physical and mental healthcare. Shocking nature of physical emaciation, particularly for those with less experience. "I am still shocked at times...it's so emotionally and psychologically draining the intensity of that type of work that actually there has to be things that give" (participant 7, nurse, p.63). Psychological defence of focusing on physical needs: "That's probably some sort of psychological defence against the awfulness of the situation…the emphasis on the

(continued) mother or a friend
3. Perfectionistic, intolerant clients
4. Shocking nature of physical emaciation
5. Coping by regarding SUs as set of symptoms
6. Lack of time and staff shortages; never all together as team
7. Importance of supervision and team support
8. Valuing being able to develop a therapeutic relationship
9. Disheartened by "revolving door" clients
10. Dissatisfaction with organisational factors, particularly time constraints and

(continued) with common humanity
3. Emotionally draining work
4. Emotionally draining work
5. Avoidance/othering
6. Emotionally draining work (systemic challenges)
7. Humbly open to learning and support
8. Connecting with common humanity
9. Emotionally draining work
10. Emotionally draining work (systemic challenges)
11. Emotionally draining work

physical characteristics of the patient, in that state become the focus, so what their bloods are doing, what their heart rate is doing…they become a set of symptoms and things to monitor and measure" (participant 8, nurse, p.63).

- Organisational demands. Difficulties performing responsibilities due to time constraints or limited staffing. Importance of team communication and barriers to this in terms of team not all being together at any one time.
- Theme 2: Social support (sub-theme "formal and informal support")
- Formal and informal support: Valuing 1:1 supervision but not always receiving it. Mixed views on group supervision. Valuing being able to seek informal supervision from peers immediately after supervision.
- Theme 3: Job satisfaction (sub-themes: "patient-related factors" and "organizational factors")
- Patient-related factors: valuing the work. Some particularly valued developing productive therapeutic alliances. "Feeling like you have connected with a patient, that you do feel that the patient trusts you, wants to talk to you, and is prepared to work with you towards the goal of getting them well, that has to come top of the list" (Participant 10, nurse, p.64). Some valued getting to know patients and talking to them about things other than their ED. Difficulties associated with "revolving door" SUs – disheartening. Some were accepting off this aspect, particularly more experienced

paperwork
11. Difficult building therapeutic relationships in context of ambivalence

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staff. "When they come back 6 months later and they are just emaciated, they have a BMI of 11, that can be the biggest stab in the heart…I don't think that gets any easier. It's disheartening" (participant 3, OT, p. 64). Some described having to hold on to hope.

- Organizational factors. Seen as most significant source of dissatisfaction, especially time constraints and volume of paperwork. "It is that constant frustration of knowing that that side has to be taken care of, but actually I just don't know the purpose of it a lot of the time" (participant 7, nurse, p.64). Other organizational stressors were staffing levels, poor team communication, shift work, finances and limited therapeutic activities. Staff sickness identified as the source of staffing issues. Poor communication not just due to lack of time. Some participants reported strong dislike of night shifts. Often these organizational factors were attributed to NHS context and seen to be representative across different areas of healthcare.

Discussion

- Difficulties managing ambivalence and building a therapeutic relationship
- Desensitisation to SUs" physical condition as a coping mechanism
- Participants reported feeling generally well supported and valuing this support

4. Dejesse and Zelman (2013)	• Critical incident themes: Encroachment, putting the patient in the middle, lack of expertise in EDs, clashing treatment strategy, lack of communication and attempted resolution • Encroachment: Participants described how they and their counterparts would sometimes overlap in their roles. Seen as unavoidable to certain extent but also caused upset e.g. when nutritionists provided psychotherapeutic input and when MHPs provided nutritional advice. Sometimes this led to conflicting messages being given to clients. • Putting the patient in the middle: feelings of hurt and anger when SU and/or family used as intermediary. • Lack of expertise of other professionals: Most common concern. Not feeling role is valued; not being given opportunities to do work; not trusting other professionals. • Clashing strategies: Nutritionists frustrated with MHPs who focus on psychosocial aspects and some MHPs frustrated by viewing nutritionists as overly rigid and anxious. • Lack of communication: Perceiving other professionals as defensive of their work. • Attempted resolution themes: Communication and confrontation, interventions via the patient and family, discontinuing collaboration, and organizational-level approach. Communication and confrontation: Trying to get on the same page. Easier to address differences of opinion in context of long-term professional	1. Overlap in professional roles 2. Lack of expertise of other professionals 3. Not feeling role is valued 4. Not feeling able to use expertise 5. Not able to trust other professionals 6. Lack of communication with other professionals 7. Avoidance of relational difficulties by terminating collaboration vs seeing conflict as an opportunity to learn 8. Cultivating a network 9. Building good fences	1. Emotionally draining work 2. Emotionally draining work 3. Feeling helpless and deskilled 4. Feeling helpless and deskilled 5. Emotionally draining work 6. Emotionally draining work 7. Avoidance vs humbly open to learning and support 8. Humbly open to learning and support 9. The golden middle way

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relationships. Interventions via the patient and family – bypassing other professionals. Discontinuing collaboration – with SUs and other professionals (9 out of 22). Organizational-level approach – putting in place policies to avoid conflicts/get needs met as professional. Educating others in team on one's role.

- Best practices themes: Cultivating a provider network, accepting differences, building good fences, ongoing communication, valuing counterparts, seeking team consensus.
- Cultivating a provider network: Most experienced providers described building contacts of trusted providers who have same philosophy. Developing a "dream team" (outpatient nutritionist, p.197)
- Accepting differences: Some participants acknowledged that conflict can be fruitful and need not be taken personally. "It gives me the opportunity for self-reflection. I always appreciate it when the dietician that I work with, challenges my thinking. Perhaps I'm missing something, or I am caught up in my own countertransference., and they can ask what is going on" (MHP, p.198).
- Building good fences: Experienced professionals emphasised the value of defining roles at the outset and respecting others' expertise but also not feeling threatened by the inevitable occasional overlap.
- Ongoing communication: With colleagues. Including regarding differences.
- Valuing counterparts: Valuing colleagues who are open

to different perspectives and learning from them. "You need to be open to new data, always open to the possibility that you don't know, and that you may be wrong" (MHP. p.199).

- Seeking team consensus (rather than SU functioning as middle man)
- Education: Imparting and providing education on roles.

Discussion

- Conflicts arise from dedication to quality SU care and helplessness in presence of severe pathology and potentially serious medical consequences
- Power struggle for respect, trust and boundary maintenance
- Putting the SU in the middle described as both a solution and source of resentment
- Desire for more training in communication and collaboration
- Contrast between collaborative care and multidisciplinary care in which work is primarily parallel

5. Hage, Rø, and Moen (2017[a])	- Three themes: strategic seating arrangements mediates division of labour between staff members; the use of verbal and nonverbal communication as collaborative tools, and the importance of education as a collaborative resource. - Strategic seating…: Sitting strategically to facilitate	1. Using colleagues for support; calling on collective skill and expertise	1. Humbly open to learning and support

monitoring. A well-established rule. Usually unspoken.

- The use of verbal and nonverbal communication: Some things can be spoken but others can't. Yes for practical issues, no for specific issues re SUs. They might use eye contact e.g. to make a colleague aware a SU is struggling. "We see things from different angles based on where we are sitting, we can see things others don't. As if I was asking: did you get that?…I try to show her with my eyes that something has happened" (Susan, nurse, p.5). Some staff expressed caution about the risk of misunderstanding with non-verbal communication.

- The importance of experience as a collaborative resource: experience with EDs and working with specific staff. "It is a bit like this: all of us have worked here for a long time. You know what the other is thinking without talking" (unattributed). Shared experience facilitates trust and safety, and means things are known without being stated (the system/unspoken rules and structures). Less "natural" and more explicit with inexperienced staff.

Discussion - Focused on collective knowledge and

expertise within a complex environment, rather than

individual experience

| 6. Hage, Rø, and Moen (2017[b]) | • Content analysis revealed two outcomes: Rule adherence and rule bending. | 1. Surveillance
2. Importance of | 1. Watching and being watched |

- Rule adherence. Challenge of mealtimes; predictable patterns; concern that the SU will hide food; non-verbal interactions with other staff; safety of knowing you have the support of other staff. "I became very focused on how much food she is trying to hide. This is my first meal with her. I do not know her well. I don't know how best to reach out to her. You get a bit more 'on' in meals like this. You're sitting there, eating your own meal, but you have no idea what you're having, because you're over there, on the other side of the table. I didn't get angry in such a way that I raised my voice. I don't think it's possible to tell that it affects me emotionally. But it feels like: 'Here we go again.' It does something to you. Maybe because it was my first meal with her. And you get a bit more nervous or stressed, than if you know a patient well…Then a colleague opened the door to the living room and said: I'm right outside. And there's a lot of support in that" (staff member, p.141).
- Rule bending: Labelling self as cowardly for not challenging rule transgression. Also need to balance need to restore weight with preserving the therapeutic relationship. "I took the easy way out…I should have asked her to remove the covers on the packets. And I didn't. Out of pure cowardice. I felt that she would experience that as unpleasant. But it was really me that thought it would be unpleasant…I also noticed that she struggled with eating her sandwich. It's a balance. How are you supposed to address her at a table with several people present?...That wasn't me being a coward. Let

team-work
3. Nervous and stressed at mealtimes
4. Rules applied flexibly – respect for structure but value flexibility

2. Humbly open to learning and support
3. Emotionally draining work
4. The golden middle way

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her feel a bit more at home before…" (staff member, p.143).

Discussion

- Respect for structure but also value flexibility
- Postponing sharing of reflections and experiences until after the meal to avoid battles
- Sticking to structure where these related directly to calorie content and medical issues but some flexibility elsewhere

| 7. Harken, Maxwell, Hainline, Pollack, and Roberts (2017) | • Four themes: Awkwardness and uncertainties of care, navigating family dynamics, establishing therapeutic boundaries, and finding rewards in ED care
 • Awkwardness and uncertainties of care: Physical awkwardness of having to observe clients at all times. "…You know they can't wear any underwear [during weigh in] and they have to have somebody sitting in their room all day long with them…I feel uncomfortable for them" (RN, p.e38). Frustration with clients when they are negotiating, bargaining, battling and playing games. "At one point I was just saying 'just eat it.' She was literally spinning my head trying to negotiate" (RN, p.e38). Awkward and uncertain trying to speak with SUs due to their high reactivity. Wish for better communication from consulting team. Also unsure about their role. "It's an odd feeling in that they are patients that need a lot of help, but not | 1. Awkwardness of observations
 2. Frustration due to negotiating and battling
 3. Unsure about role and ability to help
 4. Worried about and upset for service users
 5. Valuing consistency
 6. Difficult interactions with family vs | 1. Watching and being watched
 2. Emotionally draining work
 3. Feeling helpless and deskilled
 4. Emotionally draining work
 5. Avoidance (of flexibility?)
 6. Emotionally draining work vs common humanity |

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necessarily from me" (physician, pe38). "I wish I could do more" (physician) p.e38. Worrying about future of SUs and upset by their struggle. "To see someone struggling with an ED is upsetting…especially because it's not like a kid who broke his arm or [who has] more time-defined illnesses…we worry about when they leave and are we really setting them up to succeed when they go home" RN, (p.e39). Lack of confidence in own capacity to help: "How much can I really help them? They've had this disease for months, if not years, and they're going to have it for the rest of their lives" (physician, p.e39). Valuing consistency provided by order sets (structured outline of treatment, with scope for individual care).

- Navigating family dynamics. Discomfort around family interactions that seem to maintain the ED. Some participants noted that they experienced working with families and SUs as positive.
- Establishing therapeutic boundaries: Variety in responses. Care assistants and physicians expressed uncertainty about boundaries, while nurses reflected on becoming attached. "Sometimes I get confused not what my role is, but…where the guidelines are…in regards to me, because sometimes I just like to talk to them…but at what point, where is that line drawn?" (care assistant, p.e39).
- Finding rewards in ED care: Majority said work was rewarding. "I end up really enjoying the experience because it's something really great to see them

positive relationships
7. Boundaries and being human
8. Work as rewarding
9. Desire for more training and consultation

7. Common humanity
8. Common humanity
9. Humbly open to learning and support

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overcome it, overcome every day, eating a bit more" (care assistant, e.39)
- Wanted more training, more therapy interventions, and more support from consult team even after service changes

Discussion

- Physicians have more conflicted feelings than nurses and care assistants but reported more enjoyment following organisational changes
- No participants expressed strong negative feelings
- Authors conclude that enjoyment of work among nursing staff is linked to training and support

8. Hunt and Churchill (2013)	• Diagnosis, "eating disorder" and "anorexia": Difficulty diagnosing AN in context of cultural pressures to be thin and common experience of dieting. GPs must work with binary categories. • Treatment and referral: Management of AN challenging. Uncertain about their ability to be helpful: "I suppose the other thing is you know when [pause] what kind of help are we able to offer? Is something I sometimes find difficult and also when they should be referred and not referred" (S7F), p.463 • Concerned about reinforcing weight concern: "I sometimes worry about checking people's weights and things about how what influence that's having on their eating disorder" (p.463)	1. Sense of helplessness 2. Uncertainty 3. Physical tests as a rhetorical device – working with reality 4. Struggling with what to say 5. Service users described as manipulative	1. Feeling helpless and deskilled 2. Feeling helpless and deskilled 3. Mindful awareness and acceptance 4. Emotionally draining work 5. Battle and blame

| | 6. Identified need for specialist skills | 6. Humbly open to learning and support |

- Difficulties in communication when GP thinks a referral would be helpful but SU denies there is a problem. "It's difficult to know how to approach" discussions with people with AN and admission would be "really quite a difficult thing to talk about" (S5F, p.463)
- Using physical tests e.g. blood and ECG tests as a "hook" or "tools" for persuading SUs there is a problem. Rhetorical devices offering objective evidence to challenge subjective beliefs.

Discussion

- Hesitancy in descriptions could reflect low knowledge but authors reflect could be due to context of focus group
- SUs repeatedly described as "manipulative" and unwilling to engage
- GPs anxious about the diagnosis and treatment of EDs
- Underdiagnosis not just due to client characteristics but also due to GPs being reluctant to pursue diagnosis
- Pragmatic attempts to overcome resistance in the absence of specialist communicative skills
- Difficulty of relying on categorical diagnoses while regarding AN as continuous with non-pathological dieting; needing to make a weight-based referral while being anxious about weighing SUs and identifying a need for specialist skills.

9. Jarman, Smith, and Walsh (1997)

- Themes: The anorexic child's desire for control, the treatment process – caretaking and redistributing control, negotiating the caretaking role, the redistribution process, the therapist's personal experience of control (disempowering the child, directing the treatment process), and a different experience of taking control
- The anorexic child's desire for control: Not lived experience
- The treatment process – caretaking and redistributing control: Therapists take on the role of caretakers and responsibility for redistributing control.
- Negotiating the caretaking role: If the child has not lost too much weight, the parents will be supported to assume more control; however, if the child is dangerously underweight, the professionals take control by admitting the child to a paediatric ward.
- The redistribution process: Different views on whether control should be returned to the child following discharge or to the parents. "We're going to make you safe and we're taking control and we will gradually give you bits of control back, as and when we think you can cope with that" (Christine, social worker, p.145). Another participant – Jack, a social worker, presented the treatment as reducing the child's "power" (p.145).
- The therapist's personal experience of control: Disempowering the child. Some participants struggled with their sense the child was disempowered in the context of recognising the ED served a positive

1. Power struggle - how much control to take, at what point, how to return control to the child afterwards
2. Morality issues
3. Distancing self from weight-gain side of treatment; not taking responsibility for unwanted interventions
4. Need to be flexible and this is anxiety provoking
5. Immense sense of responsibility
6. Individual differences among therapists
7. Seeing treatment as involving manipulation and disempowerment (1 participant)

1. Battle and blame vs the golden middle way
2. Moral distress
3. Avoidance
4. The golden middle way
5. Emotionally draining work
6. Connecting with common humanity
7. Battle and blame

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function. "I have to justify it to myself at times, that this is the right way. I don't always feel that it's the right way" (Lisa, Community Nurse, p.146). Described distancing themselves from involvement in the behavioural weight-gain aspect of treatment. Psychological distance more difficult to achieve: "Sometimes you have to take that fixed establishment stance that, you know, we're not going to let you starve yourself to death, or we're not going to let you be thin like you really want to be….and sometimes you feel bad about that, that you're actually forcing the young people to do things they don't want to do" (Mark, a clinical nurse specialist, p. 146). Taking on a position endorsed by more powerful institution.

- The therapist's personal experience of control: Directing the treatment process. Flexibility in method as helpful in terms of being client-centred but as a cause of anxiety because they cannot "hide behind a method which can provide them with the safety and security of being in control" (p.147). Immense sense of responsibility. Use of dissociation and rigidity: "You just close off everything else and just take that fixed view that yes, you're going to eat and we're going to make you eat" (Mark, a clinical nurse specialist, p.148)
- A different experience of taking control: Jack, male social worker, reported a different perspective. Did not experience same conflict as others and felt confident and in control. Described "manipulating" families

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(p.148). Viewed disempowering the child as the aim of treatment. More pragmatic and less personally affected.

Discussion

- Treating anorexic children personally demanding
- Phenomenological differences among therapists working with anorexic children
- Some clinicians feel subjectively in control; others do not

| 10. King and Turner (2000) | - Themes: Personal core values of nurses, core values challenged, emotional turmoil, frustration, turning points, and resolution
- Personal core values: Not lived experience of work
- Core values challenged: Discontent at not being able to remain true to their values (of trust, privacy, non-judgment, confidentiality) in context of SUs being dishonest. "I guess, because I've seen so many of them sabotage their meals…I find I don't trust them as easy" (Rebecca, p.142)
- Emotional turmoil: Reduced self-belief in their own capacity to care and inner turmoil. "It makes me feel…I'm a bit of a failure because I like to think you can build up that trusting relationship" (Rebecca, p.142). Self-judgment: "My heart just doesn't warm to them any more… Disgusting – sad you know, that's not a nurse" (Ann, p.142) | 1. Core values challenged - work being a threat to professional identity as a nurse
2. Inner turmoil
3. Feeling like a failure
4. Self-judgment for not warming to service users
5. Frustration
6. Sergeant majors fighting
7. Watchful | 1. Moral distress
2. Emotionally draining work
3. Feeling helpless and deskilled
4. Moral distress
5. Emotionally draining work
6. Battle and blame
7. Watching and being watched
8. Avoidance
9. Mindful awareness and acceptance |

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- Frustration: Metaphors of sabotage, sergeant majors and fighting. Sense of us against them. "We were just like sergeant majors, we thought we were. Standing over them telling them what to do. They were 16- and 17-year-old girls that we had [to] treat like 4- and 5-year-olds" (Joanne, p.143). "All of us were really, really tired of…fighting with these girls" (Joanne, p.143). Watchful and weary.
- Turning points: Resilience eroded to point that participants "turned off" to protect themselves. "At the time I thought I really don't need to go through this again… So I've backed down…which is a bit awful. A bit of self-protection I guess" (Sabrina, p.143). "Just stick to the rules and maintain the care…I've switched off" (Joanne, p143)
- Resolution: Viewing situation more objectively and not blaming their quality of care. Increased acceptance and open-mindedness to SU perspective over time. Work can be pleasurable: "When they reach the bottom of the barrel and start coming up and you see them blossom. And I do, I really do enjoy that and get a buzz out of that" (Sabrina, p.143)

8. "Turning off" to protect themselves
9. Becoming more objective and accepting over time
10. Finding reward in work
11. Struggling to reconcile ideals to reality
12. Pathologising normal adolescent behaviours
13. Behaviours as an affront to professional identity
14. Caring without curing

10. Common humanity
11. Dissonance of being a helper struggling to help
12. Battle and blame
13. Moral distress
14. Moral distress

Discussion

- Caring for anorexics as a journey – values eroded, causing suspicious, distrust, judgment and lack of care
- Participants displayed naivety and lack of knowledge
- Struggled to reconcile ideals to reality

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- Pathologising normal adolescent behaviours
- Experienced behaviours as affront to professional identity
- Initial frustration with rigid protocols of care
- Experienced pain due to loss of core values and in response distanced themselves from SUs
- Caring without curing

11. Linville, Aoyama, Knoble, and Gau (2013)	• Category 1: Barriers to regular screening of eating disorders (theme: limited time to screen and have conversations with patients). Opening up conversations that may take more time than allotted. "If you don't have 15 minutes, sometimes you don't want to ask the question" (p.553) • Category 2: Impacts of eating disorder training on provider awareness (theme: awareness of eating disorders and prevalence rates): Increased awareness following brief training. Misperceptions righted: "It had never crossed my mind that they had any eating issues, so, it just raises my awareness that you don't know. There are no identifying marks with it, you know?" (p.553) • Category 3: Eating disorder intervention (themes: Eating Disorder Screen Questionnaire and referrals). Brief screening tool as facilitator of conversations. "I've used it sometimes when I was suspicious about an eating disorder and kind of wanted to have something more formal than just me talking about it" (p.554). Value of referrals in context of complexity. "I think	1. Limited time so not starting the conversation 2. Valuing training 3. Value of specialist services – knowing you are not on your own	1. Feeling helpless and deskilled 2. Humbly open to learning and support 3. Humbly open to learning and support

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realizing my role, it makes it easier for me to realise that I don't have to try to sort this all out, help this person get well like I do with high blood pressure or something else that might not be so psychologically intense you know? I feel like my biggest role is to try to get them to go and connecting with a counsellor would be their best help" (p.554)

Discussion

- No further relevant data

| 12. Linville, Benton, O'Neil, and Sturm (2010) | • Four themes: Reasons to avoid screening for EDs; ED training needs identified by participants; challenges and barriers when working with EDs, and myths and assumptions that hinder medical providers' ability to effectively screen for EDs
• Reasons to avoid screening for EDs (6 sub-themes: ED treatment difficulties; lack of treatment options; lack of time; perceived helplessness of provider; difficulty of treating EDs and provider discomfort). Difficult to treat. "One thing that really stuck out was just how difficult it was to treat them (patients with EDs); we had two patients that died and they were young, otherwise healthy folks. This was a pretty awful experience to go through" (p.115). Helplessness: "Basically, I was trained to think that there is nothing I can do for them so just refer them off to the counsellors and psychologists…" (p.117). Frustration linked to lack | 1. Difficult to treat/death of service users
2. Helplessness
3. Lack of treatment options locally; people with no or poor health insurance (US study); time constraints
4. Previous experiences of very ill service users could compromise ability to work | 1. Emotionally draining work
2. Feeling helpless and deskilled
3. Feeling helpless and deskilled
4. Emotionally draining work
5. Feeling helpless and deskilled
6. Humbly open to learning and support |

of treatment options. Lack of time: "Time is a big problem…you kind of have to pick and choose your battles with people with multiple issues. Eating disorders often fall to the bottom [of] mental health in general" (p.117). Helplessness: "I don't feel like anything will help these patients so I don't even ask them about it. I would rather ask them about a treatment issue I can help" (p.117). How previous experiences with very ill ED patients can make you "brittle" and less patient and "freaked out" and can compromise ability to work with other SUs (p.117). Fear of offending/uncomfortable when asking about EDs – not sure of what to say in way they are with medical conditions.

- Training needs (sub-themes: hands-on training; brief screening tool, collaborative treatment). Lack of training in medical school. Missing less-visible EDs e.g. bulimia. Training in communication. "We're not very good at being in the moment where it is so uncomfortable that people come to us to fix it and we are fixers and doers by our nature that's why we get into the profession that we do, so to not have an immediate answer is difficult" (p.119). Unsure how to manage weigh-ins. Want to be part of MDT approach.

- Challenges and barriers to working with EDs: Sadness at lack of motivation. Hopelessness: "You get this idea in your head that nothing out there is going to help…you don't see the recovering people, you see the people who are more terminal and that is sad" (p.120).

with others with EDs
5. Fear of saying the wrong thing
6. Desire for more training
7. Fixers and doers so not to have answer is difficult
8. Need for team approach
9. Hopelessness
10. Family interactions can be challenging
11. Overwhelmed

7. Dissonance of being a helper struggling to help
8. Humbly open to learning and support
9. Emotionally draining work
10. Emotionally draining work
11. Emotionally draining work

Family denial challenging too. Not accustomed to such emotionally charged work: "we're used to just writing a prescription and then maybe we hear back from them that it worked or didn't work, but not the rest" (p.120). Uncertain what to do to help.

- Myths and assumptions hindering effective screening (sub-themes: EDs are a mental health issue and doctors are not part of the treatment team; EDs are just a phase; recovery is not possible; individuals with EDs also have Personality Disorder, and doctors cannot help anyway). Feeling overwhelmed: "I sometimes think as a physician this is just too much to take on and they are not going to make a difference" (p.121)

Discussion

- Feel ill prepared
- Desire to understand role as part of an MDT

| 13. Long, Wallis, Leung, Arcelus, and Meyer (2012) | • Three themes: Preparation, role during mealtime and barriers.
 • Preparation (sub-themes: mealtime training and premeal preparation): Need for training to be prepared for behaviours and avoid frustration. Individual differences: "Each girl has got a different approach…you just have to be prepared in yourself" (participant 11, p.244). Need to be firm – participant 11 noted this did not come naturally as not something they have to do normally in nursing. | 1. Need for training; reduces frustration
 2. Need to be firm – not something they ordinarily have to do in nursing | 1. Humbly open to learning and support
 2. Moral distress
 3. Common humanity
 4. Humbly open to learning and support |

- Role during mealtime (sub-themes: team-work, successful supportive strategies). Need for knowledge and empathy. Need for teamwork, and assigning roles and responsibilities. Support from other staff reduces anxiety of less experienced staff. Have to be firm but also flexible.
- Barriers (sub-themes: personal difficulties, uncertainties of provision of care, and frustration regarding implementing change): Some participants did not find meals particularly difficult but others attached strong emotions to them – feeling daunted and like a prison officer punishing people. "I feel like they are really watching me. I was trying to drink really normal but it was really hot…You are also aware of what you're doing" (participant 8, p.244). Mealtimes depicted as battles by some staff, with an "us" and "them" culture, and SUs experienced as rebellious and dominating. Uncertainty when start about what do and anxiety about upsetting SUs. Staff discomfort during mealtimes. Not knowing what to say: "I was told to distract them by talking…I didn't really know what to say" (participant 8, p.245). Insufficient staff adversely affecting care during mealtimes.

3. Need for knowledge and empathy
4. Teamwork reduces staff anxiety
5. Getting balance between firm and flexible
6. Feeling daunted
7. Surveillance (like a prison officer and also sense of being watched)
8. Battle (mealtimes, us and them)
9. Scared of saying the wrong thing
10. Organisational factors – insufficient staff

5. Golden middle way
6. Emotionally draining work
7. Watching and being watched
8. Battle and blame
9. Watching and being watched
10. Feeling helpless and deskilled

Discussion

- Staff discomfort with acting as surveillance
- "It seems possible that through a process of transference, frustrations of the staff resulting from

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having to care for those who are seemingly unrespondent are transferred into negativity toward the patients" (p.246).

14. Macdonald et al. (2018)	• Themes: Reflections on role requirements from a professional perspective; challenges of working with dual diagnoses, and insights into current and future service provision. • Reflections on role requirements from a professional perspective: High levels of empathy required. • Challenges of working with dual diagnoses: "Prepare yourself for the challenge because it's not easy! Because your patient is resistant to both: resistant to having diabetes and resistant to having an eating disorder…so it's a double whammy" (HCP7, EDs, p.227). Described systemic factors such as lack of time, local services, bureaucracy, knowledge and training (even as experts). "I definitely need some assistance most of the time. If I feel like that, then I guess some novice is going to feel even worse" (HCP3, p.227). Dealing with inaccurate SU accounts. Frustration with other professionals: "I do get quite frustrated when a professional says, 'from now on, instead of taking no insulin, you're going to take 20 units, three times a day.' In what world is that ever going to happen?! I think it's a discussion with the patient" (HCP6, diabetes, p.228). Disagreements among the team. • Insight into current and future service provision: Importance of collaboration and support within the	1. Need for empathy 2. Challenging nature of work (in context of comorbidity, which is common among people with EDs) 3. Systemic factors causing frustration (time constraints, proximity to adequate service provision, NHS bureaucracy, gaps in training and knowledge) 4. Gaps in knowledge. Ongoing need for supervision and support.	1. Connecting with common humanity 2. Emotionally draining work 3. Feeling helpless and deskilled 4. Humbly open to learning and support 5. Emotionally draining work 6. Humbly open to learning and support 7. Humbly open to learning and support

	MDT: "I couldn't imagine just doing it on my own. There is no way I'd be able to. I don't have the skills. You need support" (HCP3, diabetes, p.229). Wanted more training. Discussion – no further data pertaining to lived experience of clinicians	5. Frustration with other professionals who do not get it 6. Need for MDT 7. Desire for more training	
15. Masson and Sheeshka (2009)	• Themes: The differences between patients who DO and patients who are AD'd; secondary gains; self-awareness of treatment progress; progress on other issues; administrative discharge shifts the blame; what completion means; determinants of completion; motivation must be internal; weighing the pros and cons of the ED; trust; AD as a necessary process; there's no book of rules for this; the difficulties of inconsistency (not all relevant) • What completion means: Evolving definition. "I've really changed that view over the last five, six years, in the sense of the definition of what completion is…the definition of helping someone and affecting their ability to be more therapeutic, and make a change in their lives, doesn't necessarily correlate to completing the program" (p.115-116). • There's no book of rules for this: Difficult asking SUs to leave treatment – worry and sadness: "I feel sad about it, like I feel sad about the people who were very, very ill, and I think they're in danger…eventually down	1. Managing one's expectations 2. Fear for service users' safety 3. Stress of decisions not being clear-cut 4. Inconsistent decision-making due to SU personality	1. The golden middle way 2. Emotionally draining work 3. The golden middle way (brings anxiety and uncertainty) AND draining 4. Avoidance (of humanity of all service users)

the road like, a couple of years from now or so they're really putting themselves at risk by continuing in what they're doing…so that's hard, to watch someone like that not be able to make it in the program" (p.120). Stress where decisions are not clear-cut/individualised: "It isn't black and white. Nine times out of ten there's a whole bunch of questions around the person…and it becomes like more of a debate as opposed to a clean, clear, clinical decision. And that's the hardest part" (p.120). Sometimes disagreements in team.

- The difficulties of inconsistency: Some clinicians reported that they were sometimes inconsistent in decision-making between SUs due to SU characteristics such as their personality.

Discussion: No further relevant data

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16. Micevski and McCann (2005)

- Overarching theme: Strategies used to develop professional and interpersonal relationship; two themes: interacting with nurses and interacting with patients.
- Interacting with nurses (sub-themes: supporting nurses (sharing information), and learning from experience (reflecting on clinical experience)): Collegial support helped develop relationships with SUs and mitigate negative perceptions. Sharing information to ensure individual approach but also consistency, particularly when difficulties in

1. Importance of team-work
2. Individual approach
3. Less trusting
4. Being human – meeting SUs at their level as individuals (finding an angle, interpreting signals and self-disclosing)

1. Humbly open to learning and support
2. Connecting with common humanity
3. Emotionally draining work AND moral distress

interpersonal relationships with SUs arose. Learning from experience: "I [am] not as trusting as…I used to be" (James, p.106). Less trusting.

- Interacting with patients (building rapport (finding an angle, interpreting the signals, self-disclosing, using distraction). Finding an angle – something that they have an interest in; treating SUs as individuals. Learning to interpret signals to show attentiveness – body language and facial expression as well as speech. Self-disclosure as a tool to develop relationship; mutuality: "I have talked about things going on in my life, in very basic ways…I think it [is] just a part of the…reciprocal…relationship…I think it…puts them on your level and helps develop a relationship (Julie, p.107). But being mindful that self-disclosure shifts focus. Influence of personality of SU – if perceived as similar to own, feel more able to talk to them about personal things – using your comfort level as a guide.
- Being supportive (being encouraging, valuing and enabling control): Providing positive feedback where you expect this to be helpful. Demonstrating thoughtfulness and consideration, showing that you care. Facilitating control/choice where possible.
- Developing trust (listening to patients' stories, being honest, maintaining confidentiality, and taking time). Being attentive to SU accounts of their lives. Maintaining confidentiality wherever possible. Being honest. Providing consistency and clarity, and

5. Being attuned and attentive (interpreting signals; also in self-disclosure being self attuned in using comfort level)
6. Being supportive
7. Facilitating control/choice where possible – difficult in context of high rates of treatment refusal
8. Developing trust (linked to consistency, honesty and clarity) – but can be difficult to maintain confidentiality with minors
9. Individual focus – not just about rules but about way of being with clients – attunement
10. Inflexible protocols

4. Connecting with common humanity
5. Connecting with common humanity
6. Connecting with common humanity
7. The golden middle way
8. Connecting with common humanity
9. Connecting with common humanity
10. Emotionally draining work
11. Emotionally draining work
12. Feeling helpless and deskilled
13. Humbly open to learning and support

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communicating well to maintain trust. Taking time with developing relationships.

- Core category – instigating an individual focus – helps to provide care consistent with needs. "Search[ing] beyond the illness in an attempt to discover the individual" (p.109).
- Context of developing professional interpersonal relationships (unit protocols, treatment plans, nurses' workloads, insufficient education for nurses, and nurses' perceptions of patients). Unit protocols provide framework for care – participants described them as inflexible. Implementing rules others have devised and being seen as restrictive by SUs. Frustration around plans they had not devised and were often not explained to them. Led them to feel their care was inadequate: "We are…forcing…kids to do [things] that we do [not understand]…[The doctors are]…making these decisions [without nurses]...I then feel frustrated and find it difficult to develop relationships" (Maggie, p.110). High workloads diminishing capacity to form therapeutic relationships. Noted lack of education in undergraduate courses and workplaces – learned from more experienced staff.

11. Frustration around plans they had not devised
12. Systemic issues including high workloads impacting ability to form therapeutic relationships
13. Learning from more experienced staff
14. Emotional overinvolvement
15. Mutuality
16. Moving beyond treating SUs as an illness
17. Values compromised (by contextual factors)

14. Emotionally draining work (another coping mechanism in emotional over-involvement?)
15. Connecting with common humanity
16. Connecting with common humanity
17. Moral distress

Discussion

- Sometimes become emotionally over-involved, which can make it harder to cope and lead to

burnout, and less investment in relationships with SUs
- Opening up conversations to create vehicle for SU self-expression
- Mutuality in relationship development
- Using humour to strengthen relationships
- Valuing – respect and acceptance
- Moving beyond treating SUs as an illness
- Difficult to enable control in context of high rates of treatment refusal
- Instigating an individual focus: focusing on the whole person, developing reciprocal relationships
- Expected to conform to rigid protocols even when not convinced they are useful and they do not accord with values – risk that these frustrations may be "projected towards patients" (p.113).

| 17. Oyer, O'Halloran, and Christoe-Frazier (2016) | • Similarities between participant descriptions (i.e. where therapists and clients agreed). Not all discussed as not all relevant to lived experience of therapists. Under "strengths-based approach" theme: Therapists argued it is important to redefine success because recovery is different for each client and might take years: "Let go of outcome…look for markers of success smaller and more intangible…anytime you evoke emotion from them [clients] is a good thing. Sometimes getting screamed at by a client is GREAT. It means they are safe enough with you to be angry with you" (Sally, therapist, p.127-8). "Collaboration with external | 1. Redefining success (to avoid invalidating SUs but also appreciating what represents a positive outcome/event)
 2. Benefit of teamwork
 3. Need for diplomacy | 1. Connecting with common humanity AND golden middle way
 2. Humbly open to learning and support
 3. Emotionally draining work
 4. Connecting |

systems" – benefits of communication and collaboration and also the need for diplomacy/professionalism when working with professionals with different approaches/agendas/minimal understanding. "Therapist self-disclosure" (how therapists felt when working with clients and topics such as vacations; not personal history): to normalise, improve therapeutic relationship and increase relational safety. "Expertise and experience treating EDs": Balance between boundaries and compassion: "Having one arm around the client while kicking them in the butt with your foot" Mary, therapist, p.128-9). "Individualized treatment": Considering factors such as stage of change, knowing when to push etc. Also being attuned to non-verbal communication as well as collaborating on and prioritising treatment goals, and respecting physical distance.

- Unhelpful therapist factors: Non-attunement in the form of being too pushy and inflexible, or creating boundaries that were either too rigid or too flexible (not following through), or focusing too much on ED as opposed to other stressors. Being judgmental.
- Just therapists: Need to work on personal struggles and be aware of your reactions to clients. Need to be objective and a role model: "At the end of the session, I reflected and realized that 70% of the session was me talking AT them [the client]. I am a model of relationships, and if I am doing that, that's exactly what

(frustration) to collaborate
4. Limited self-disclosure helpful
5. Balance between boundaries and compassion
6. Individualised treatment
7. Attunement (to non-verbal communication) vs non-attunement
8. Need to be self-aware and a role model

with common humanity
5. The golden middle way
6. Connecting with common humanity
7. Connecting with common humanity vs battle and blame
8. Mindful awareness and acceptance

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they are getting from everybody else in their life, and that is not therapeutic" (Sally, therapist, p.132).

Discussion

- Quotation that captures lived experience of attunement and going at SU's pace: "There's a scene in the movie [The Horse Whisperer] where…the horse runs off. What the horse whisperer then does feels like my experience working with clients with anorexia ... the horse went out into the field and they were a great distance apart. The horse whisperer sat and watched and just held the space while the horse was recovering, doing what it needed to do. Figuring out what was next. Gradually, he took a couple of steps closer and then stopped ... it's on the horse's terms. It's never on my terms" (Mary, therapist, p.135-6).

| 18. Palmer (2015) | • Themes: Kinesthetic awareness, countertransference, somatic countertransference, boundaries, therapist's body image, and both negative and positive experiences.
• Kinesthetic awareness: No specific to EDs.
• Countertransference: Emotional responses of fear, anger, hopelessness and frustration. Risk of burnout. Client resistance experienced somatically: "I was actually almost meeting them where they were at, but kind of getting stuck a little bit with them" (p.125) through personal experience (recovered clinician?). | 1. Fear, anger, hopelessness and frustration (experiencing resistance somatically)
2. Controlling one's emotional reactions
3. Balance between being human and | 1. Emotionally draining work
2. Mindful acceptance and awareness
3. The golden middle way
4. Connecting with common humanity |

Controlling one's extreme reactions. Finding the balance between interacting as a human in a relationship and as a therapist. Need to be grounded and have compassion for oneself.

- Somatic countertransference: Bodily tensions and emotional states e.g. warming sensations, anxiety, headaches. Monitoring changes in self and client: "As I witness a client beginning to dysregulate, I can sense my body activating with her" (p.126). Modulating hope to prevent sabotage of recovery and unrealistic expectations.
- Boundaries: Increase in anxiety when clients challenge boundaries. Creating guidelines. Bring careful about language: "I try to be very aware of the language I use so even using [words like] weight, heavy, light…trying to be a little more aware…because some of that can really tie into an eating disorder pretty quickly" (p.126). Sexuality as a common topic of discussion that may require special attention. Balance between being flexible with boundaries without enabling client dependence.
- Therapist's body image: Some participants discussed the importance of modelling positive body image: "As a therapist, you're also a role model. How comfortable you are in your own body…at least nonverbally, impacts your client" (p.127). Using experience of menstrual cycle to empathise with negative body thoughts. Pilates as a tool to be a better, wiser therapist.

being a therapist in relationship
4. Need to be grounded and self-compassionate
5. Monitoring bodily changes in self and client
6. Modulating hope
7. Careful about language
8. Balance needed in setting boundaries
9. Modelling positive body image
10. Using menstrual cycle to empathise with negative body thoughts
11. Need for self-care e.g. Pilates, balancing workload
12. Negative emotions
13. Helplessness

5. Mindful awareness and acceptance
6. The golden middle way
7. Mindful awareness and acceptance
8. The golden middle way
9. Mindful awareness and acceptance
10. Connecting with common humanity
11. Connecting with common humanity
12. Emotionally draining work
13. Feeling helpless and deskilled
14. The golden middle way
15. The golden middle way

- Negative experiences: Anger, fear, frustration, incompetency, boredom, hopelessness, worry, fear, helplessness, disheartenment, sadness, feeling overwhelmed. Over time, worry decreased. Not taking on all of responsibility.
- Positive experiences: Micro-movements towards recovery, insights etc. Being mindful not to show strong positive reaction in order not to sabotage recovery.
- 2 additional themes, one relevant: self-care, burnout, and remaining centred: e.g. balancing workload so not all EDs, resetting goal expectations, not taking it as a personal failure if clients do not get better. Need to remain grounded/centred.

14. Not taking on all responsibility /taking it as personal failure if clients do not get better
15. Appreciating micro movements towards recovery
16. Self-care
17. Movement foregrounds personal stuff

16. Connecting with common humanity
17. Mindful awareness and acceptance
-

Discussion

- Dance/movement therapists "speak the language of the body" (p.131)
- Dance therapy as "inherently restorative" (p.131)
- Attunement: "for some, dance/movement therapy is scary and very activating, so I have to sensitively attune to signs of activation" (p.131-2).
- Movement bringing one's personal stuff to one's attention

19. Ramjan (2004)

- Three themes: Struggling for understanding, struggling for control and struggling to develop therapeutic relationships

1. Blaming SUs as a defence

1. Battle and blame

- Struggling for understanding: Believing SUs caused their own harm and thus feeling frustrated and judging them. Resulting in pessimism and scepticism and therefore disillusionment. Regarding themselves as "failures" because they did not feel in control of the recovery process. Stressful and distressing: "…it's all a question…of…an emotional and psychological battle with them and that constant battle can be…quite…distressing for some staff" (Julie, p.498).
- Struggling for control (Struggling for power and mutual mistrust: the issue of manipulation): Resistance by SUs experienced as manipulative and leading to struggled to reassert control even though sometimes behaviour modification did not accord with their values. Power play, mutual mistrust. Seeing SUs as acting like 3-year-olds. Nurses unconsciously acting as jailers. Barrier to developing an alliance. Anguish. Feeling manipulated by SUs – expecting manipulation, dreading it and being unwilling to give "a clean slate again" (p.499). Occupying role of "baddy" etc. Seeing manipulation as means of SUs gaining control and causing them frustration and grief. One participant saw manipulation as a "survival instinct" (Mike. p.499). Choosing not to trust. Stress and burnout. Avoiding caring for SUs. "Manipulation" leading to feeling like a failure or betrayed, then distancing and evasion of responsibility. Mistrust could escalate if professionals did the wrong thing.

2. Viewing self as failure due to not being in control of the recovery process
3. Stressful and distressing
4. Battle
5. Struggle for control
6. Acting as jailers
7. Feeling anguished by battle
8. Service users seen as manipulative
9. Unforgiving of service users
10. Occupying role of baddie
11. Choosing not to trust (to defend against pain of having trust broken)
12. Avoiding caring for SUs

2. Dissonance of being a helper struggling to help
3. Emotionally draining work
4. Battle and blame
5. Battle and blame
6. Watching and being watched
7. Moral distress
8. Battle and blame
9. Battle and blame
10. Moral distress
11. Avoidance
12. Avoidance
13. Dissonance of being a helper struggling to help
14. Watching and being

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	• Struggling to develop therapeutic relationships (blaming the victim, labelling and favourites: pros and cons): Viewing AN as a choice. Struggling to have compassion in context of viewing SUs as responsible. Exacerbated by systemic pressures of understaffing and pressure for a quick recovery. Labelling: The term "anorexic" placing SU outside the range of normal behaviour and marking them as "bad'. Use of prison terminology – SUs as criminals. Having favourites who are compliant.	13. Manipulation leading to feeling like a failure 14. Mistrust escalates when professionals do the wrong thing 15. Viewing SUs as responsible 16. Systemic pressures of understaffing and pressure for quick recovery 17. Labelling as bad and use of prison terminology 18. Having favourites	watched 15. Battle and blame 16. Emotionally draining work 17. Battle and blame 18. Avoidance
20. Ramjan and Gill (2012)	• Three themes depicting inpatient ward as a prison (entering the system, doing time, and on parole or release) • Entering the system: No relevant data on lived experience • Doing time within the system: Experience of engaging in "surveillance" - "watching and wondering" (p.29). Infringing privacy. Monitoring "the parts of [of the job	1. Jailer/prison warden role 2. Violating (privacy) – transgressing boundaries 3. Going into policeman mode,	1. Watching and being watched 2. Watching and being watched 3. Avoidance 4. Emotionally draining work

they hated most" (p.30). Life as a prison warden. Nurse Oliver described "shutting down…going into …policeman mode" (p.30) – understood as self-defence to avoid cracking under strain. Work "very routine" and "monotonous" (p.31) – go into autopilot. Monotony linked to difficulty forming therapeutic relationships. Nurse Gabriel: "It is such a challenge…to interact with [the patients] or get them to interact with you and [to] build a rapport…Because you're doing things to them that they are against" (p.31)

- Discussion:
- Nurses dutifully implementing sanctions to change behaviours labelled deviant; nurses as task-oriented and protocol driven; "custodial care, being a passive watcher and guardian" (p.32); attending to physical health needs may be a means of avoiding more frustrating/challenging work. Inherent conflict between administering treatment based on behaviour modification and developing therapeutic relationships.

shutting down; attending to physical health needs to avoid more frustrating or challenging work
4. Work routine and monotonous
5. Inherent conflict between administering treatment based on behaviour modification and developing therapeutic relationships

5. Moral distress

21. Rance, Moller and Douglas (2010)

- Themes: Double-edged history, emphasis on normality and selective attention
- Double-edged history: Feeling more in tune: "I can REALLY clearly remember thinking about the psychiatrist.... "Yeah but I don't think you REALLY understand, because you're fat" (Martha, p.382). Holding hope for SUs' recovery and freeing them from the "cage" of an ED because of their own recovery (p.383): "[I have] that feeling of wanting, ridiculously but somehow, to kind of, you know, give

1. Attunement
2. Holding on to hope
3. Increased risk of overidentification, projection and enmeshment
4. Discomfort that they may be judged

1. Connecting with common humanity
2. The golden middle way
3. Emotionally demanding work
4. Watching and being judged

somebody the key to the cage and release them because…because, you know, one kind of knows it is possible" (Martha, p.383). Increased risk of overidentification, projection and enmeshment (p.383) – "There is more countertransferential reaction on my part when I'm working with someone whose experience may be similar to the one that I had, and I have to be careful about that because she's not me" (Sophie, p.383). Discomfort that they may be judged e.g. in interview (p.383).

- Emphasis on normality: Normalisation and minimisation. Feeling at ease with their bodies, and stating that their relationship with body image and food not changed by work (p.385). Analysis that participants are communicating "I am normal'. Different to previous research.
- Selective attention: Black-and-white thinking about recovery as binary, and not thinking about impact of their appearance/considering disclosing. "People don't want to face it…I think if you get, really honest responses you could uncover stuff that could be quite complicated" (Martha, p.387). Cognitive rigidity and attentional blind spots serve to protect participants from the dangers of their double-edged ED history. Authors note that this stance "puts female eating disorder practitioners with an eating disorder history into the impossible position of claiming normality in a world where the norm is not 'normal'" (p.387).

5. "I am normal", black-and-white thinking, cognitive rigidity and attentional blind spots

5. Surveillance
6. Avoidance ("us and them")

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Discussion

- Context of tendency towards non-disclosure
- Participants making a pre-emptive strike against any questioning of their competence
- Adopted "them and us" mentality

| 22. Reid, Williams, and Burr (2010) | • Two overarching themes: "unmet needs: practical issues in the management of eating disorders" and "'everyone is different': the nature of eating disorders"

• Unmet need…: Too many referrals and not enough resources or time. Desire for more training. Expected to learn on the job. Some attended to their own training needs.

• "Everybody is different": Need for individual and holistic approach. Empower rather than control: "To not seek to take control away from the individual, rather to empower them" (psychiatrist, p.395). Need for MDT and trusting therapeutic relationship. ED patients as difficult (linked to noncompliance). Demand a lot of time. "Some of them have been very demanding and that has been quite difficult" (P9, NHS medical ward, p.396). Frustrated if other staff say there's nothing they can do for SUs.

Discussion:

• Difficulties due to both complexity of EDs but also those of providing appropriate services | 1. Systemic pressures - under-resourced, under-trained, lack of time
2. Need for individual approach
3. To empower rather than to control
4. Need for MDT
5. Non-compliance difficult
6. Frustration if other staff say there is nothing they can do for SUs
7. Challenging nature of work is multifactorial | 1. Emotionally draining work
2. Connecting with common humanity
3. Connecting with common humanity
4. Humbly open to learning and support
5. Emotionally draining work
6. Emotionally draining work
7. Emotionally draining work AND mindful awareness and acceptance
8. Dissonance of |

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	• "As these participants understood it, the 'difficulty' of eating disorder patients was a systemic problem to do with a complex interaction between patient characteristics, staff training and competence and service resources" (p.396) • Frustration in context of not feeling fully competent and not being able to work in sufficient depth with individuals due to time constraints.	8. Frustration of not feeling able to help due to lacking full competence and time	being a helper struggling to help
23. Reid, Williams, and Hammersley (2010)	• Impact of EDs on general practice: low prevalence of EDs, lack of GP experience and expertise, holding and referral, hard to recognise EDs, complex nature of EDs, need for specialist services, waiting times and scarce places. 2 clusters – rarity of cases but high demand when known. • Few cases lead to little relevant experience, which could make recognition of future cases more difficult. • Rarity of known cases in primary care: Wondering whether they are only seeing the tip of the iceberg or under-diagnosing. Hard to recognise ED cases. Also denial frustrating. "They're just so frustrating because they just don't, they don't see they have a problem" (p.5). • High demands of ED cases in primary care. Repudiation makes EDs difficult to manage. Comparison to alcoholics: "I think, to some extent, because they, a bit like alcoholics, they're rarely straightforward and, in terms of how they perceive their illness, there's a certain amount of denial usually	1. Limited experience due to few cases 2. Denial frustrating 3. Reject help 4. Demand a lot of input 5. Feeling they lack expertise and experience 6. Desire for more training 7. Want to refer to specialist service 8. Lack of time in GP consultation; long waits for specialist services	1. Feeling helpless and deskilled 2. Emotionally draining work 3. Emotionally draining work/the dissonance of being a helper struggling to help 4. Emotionally draining work 5. Feeling helpless and deskilled 6. Humbly open to learning

involved. So that's the biggest hurdle really in working with them to identify that there is a problem and specifically what the problem is" (p.5). Demand a lot of time, and psychological/emotional input: "Medicine is easy when you can just prescribe something and then they are better and they don't have to come back again but difficult sometimes when you have to put a lot of emotion into looking after them and sometimes you don't seem to get anywhere" (p.6). Feeling they lack the experience/expertise to recognise/manage EDs: "Since it's something that we see fairly infrequently I don't feel a huge amount of confidence in dealing with it, I have to say, in terms of experience" (p.6); "I'm well equipped to be sympathetic and to understand about other symptoms that get presented and to be supportive. But I'm not sure that there's anything very much that I do that actually helps move people on" (p.6). Desire for more training. Desire to refer to specialist services but dependent on availability and motivation. Need for specialist services. Feeling like they have too little time: "you've got a certain pressure of seven minutes and it isn't anything like, you can't even scratch the surface" (p.7). Frustration with long waiting lists.

and support
7. Humbly open to learning and support
8. Feeling helpless and deskilled

Discussion

- No further relevant data

| 24. Ryan, Malson, Clarke, Anderson, and Kohn (2006) | • Three prominent constructions of ED nursing: loving or empathetic support; surveillance and disciplining, and constant and ever-present care.
• ED nursing as "loving" or empathetic support: Praising, loving and supporting SUs and developing warm relationships with them. Becoming attached: "You can become quite attached to some of these kids" (Casey, p.129). Giving SUs "love". "I've been called a lot of things, like probably the mother of the ward is the one that I like the best, because I try to be kind all of the time" (Philippa, p.129).
• ED nursing as discipline and surveillance: Frustration when SUs relapse. "We get the others that fall down as soon as they go home…And then that's very frustrating when you've put so much effort in…and you've just, you've just spent [sighs] you know, all week watching every mouthful they put in their mouth, watch that they don't exercise" (Casey, p.129). Surveillance and discipline more problematic than maternalism. Not prison guards: "We're not the authority, prison guards but we're there; they know that we're there" (Charlie, p.129). Battle: "And [patients are] challenging. They're very cunning, and manipulative. You just have to let them know who's the boss but sometimes if there are so many of them it's a battle" (Sally, p.130).
• ED nursing as constant and ever-present care: A valued part of role. Intensity of nursing role: "You're not the psychologist, which comes down twice a week to talk about how they're feeling today…you're the nurse | 1. Loving and empathetic support
2. Maternal quality
3. Frustration when service users relapse
4. Surveillance
5. Prison guards – dissociation from this; authors suggest reference indicates this is a potential accusation
6. Battling "manipulative" service users
7. Intensity and proximity of nursing role – also value of it relative to other disciplines
8. Loving care and discipline both elements of parenting role but can be seen as conflictual | 1. Connecting with common humanity
2. Connecting with common humanity
3. Emotionally draining work
4. Watching and being watched
5. Watching and being watched
6. Battle and blame
7. Connecting with common humanity
8. Connecting with common humanity |

that's making the bed with them or hassling them about something you know, and all of a sudden you can turn conversations around or pick things up which are totally different" (Charlie, p.130).

Conclusions

- Loving care and discipline can be viewed/experienced as complementary aspects of parenting or as conflictual

| 25. Seah, Tham, Kamaruzaman, and Yobas (2018) | • Questionnaires: Challenging nature of work. "Tough" to understand. "Watchful". Interesting but sad work. Desire for more training, and need for collaboration with family and broader team.

• Interviews: Eight themes: Initial perceptions of patients with eating disorders; current perceptions towards building a nurse-patient relationship; current perceptions of patients with EDs; current feelings towards patients with EDs; perceived influence of working experiences on self; perceptions towards care provision; perceived challenges faced in the unit; suggestions to improve care provision
• Initial perceptions: Disbelief. "I have only seen such skeletons walking in those countries without food. I have never really seen with my own eyes so very scary first experience" (P4, p.139). "I would be wondering why…why eating disorders actually exist, like how | 1. Disbelief and shock
2. Nervous initially/fear of triggering service users
3. Easier to make conversation if similar to service users
4. Need time to develop relationships
5. Experience service users as taking advantage
6. View people with EDs as harder to care for | 1. Emotionally draining work
2. Emotionally draining work
3. Connecting with common humanity
4. Connecting with common humanity
5. Battle and blame
6. Emotionally draining work
7. Watching and being watched
8. Emotionally |

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someone just dislike food" (P7, p.139-40). Nervous initially. Difficulties with communication: "I will be very stuck when they talk…what you say may trigger them" (P4, p.140). One participant said easy to make conversation as similar age to SUs.

- Current perceptions towards building… Importance of maintaining a professional distance. Mindful that many SUs have low self-esteem and/or find it difficult to trust. Need time to develop relationships
- Current perceptions of patients… Experience SUs as taking advantage e.g. of inexperienced staff. Harder to care for than other patients. Surveillance: "General psychiatric is easier la…there's lesser thing to look out for…Compared to the eating disorder is how you eat, what you eat, what you drink, how much you drink, where are you, what you doing…everything" (P4, p.141). Slow progress.
- Current feelings towards patients with EDs: Curiosity. Also frustration and anger (majority). "It is frustrating because you do as much as you can for the patient, then in the end they just go back to zero" (P4, p.142). Frustrated about non-compliance – fighting to avoid nasogastric tube (p.142). Stressed and burnt out: "They will just debate and debate. So often I will feel tired mentally but because keep telling and repeating the same thing all over and over again" (P3, p.142). Empathy among some nurses. Becoming more aware of body size and eating habits; for minority, they made

than other service users due to slow progress and surveillance
7. Observation of service users
8. Feeling frustrated and angry due to relapse and non-compliance
9. Empathy among some nurses
10. Becoming more aware of body size and eating habits, and observing non service users
11. Some nurses made effort to be role models
12. Time consuming work
13. Need to be careful what you say as can rebound on you
14. Demoralising effect of physical

draining work
9. Connecting with common humanity
10. Watching and being watched
11. Mindful awareness and acceptance
12. Emotionally draining work
13. Watching and being watched
14. Emotionally draining work
15. Emotionally draining work
16. Emotionally draining work
17. Emotionally draining work
18. Feeling helpless and deskilled
19. Humbly open to

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efforts to be role models. Watching non-SUs eat - more focused on diet; some not affected in this way.

- Perceptions towards care provision: High demands on time. "Sometimes one eating disorder patient can just can just (laughs)…kill you your time la half a day wasted just like that" (P2, p.143). Need for precise language: "I need to make sure that my words used are very clear and specific that doesn't bring a second meaning because they can use the words back on you…" (P1, p.143). Demoralising effect of physical complications and high mortality rates. Value of experience.

- Perceived challenges faced in the unit: Doctors deviating from standard guidelines creating inconsistency and resentment. Aggression from SUs. Devious behaviours to reduce calorie intake/inflate weight. Difficulties with parents e.g. lying on behalf of children. Short-staffed – reduced time to interact with SUs. Burnout. Resignation – worse shortages. Struggling to observe SUs due to ward layout. Not feeling supported by management.

- Suggestions to improve care provision: Collaborative working among team and family members. Standardisation. More training. Specialist ED unit rather than mixed with other SUs.

complications and mortality
15. Resentment when doctors deviate from guidelines
16. Aggression from service users and efforts to reduce calorie intake
17. Difficulties with parents
18. Staff shortages
19. Desire for more training
20. Not feeling supported by management
21. Become more empathetic and accepting over time

learning and support
20. Emotionally draining work
21. Connecting with common humanity (easier over time)

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Discussion

- Change over time from scared and unsure to more empathetic and accepting.
- SUs experienced as manipulative as in Ramjan (2004) – staff favour firmness as a result

26. Snell, Crowe, and Jordan (2010)

- Connecting: Developing the therapeutic connection, negotiating the therapeutic connection, and co-ordinating the connection
- Developing the therapeutic connection: Sharing knowledge, pacing and maintaining hope. "Often they don't feel that they have an eating disorder and it's very awkward…it's very difficult at times…I guess I try to prove that they actually do have an eating disorder" (p.354). Trying to keep to SU's pace. "I'll just carry on walking beside them and…saying 'we must never want it more than them' and that's helped me slow down and have that sort of metaphor of sort of walking alongside at their pace and using their language and just try to get into their life world" (p.354).
- Negotiating the therapeutic connection: Strong feelings in relation to implementing treatment protocols without necessarily being involved in the decision-making: "It's not a place that I want to be. It surprises me…probably I've acknowledged it more recently, it's not really where I want to be…you know, I didn't want this role, I've always fancied myself as being quite therapeutic and collaborative" (p.354). Feeling in battle with SUs. Doubting that they are helping SUs. Value of support from other nurses, knowledge, managing their own

1. Carrying hope and pacing
2. Walking alongside the client/empathy
3. Implementing rules/protocols that are not in line with values
4. Feeling in battle with service users
5. Doubting that they are helping
6. Valuing support from team
7. Managing their emotional reactions
8. Externalising to aid the relationship

1. The golden middle way
2. Connecting to common humanity
3. Moral distress
4. Battle and blame
5. Feeling helpless and deskilled
6. Humbly open to learning and support
7. Mindful awareness and acceptance
8. Connecting with common humanity

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emotional reactions/not taking things personally. Need for self-awareness and self-control.
- Coordinating the connection: Dual roles of team member and SU advocate. Intermediary. Needing clear rationales. Seen as authority figure by young SUs. Externalising to aid the relationship.
- Central category: Attempting to connect with SUs in a difficult context

Discussion:

- Nurse as go-between

27. Trammell, Reed, and Boylan (2016)	• Professional capability: Concern they are not comfortable or capable to treat due to fear of making ED worse: "We don't want to further trigger problems that may exacerbate the eating disorder" (p.78). Apprehension due to lack of experience and thinking clients too severe: "I think when I got to my internship and I did see eating disorders, it sort of scared me, I didn't know what to do, I didn't know how to approach it" (p.78). Blurred boundaries of practice – difficult to determine where their scope of practice ended and the scope of other therapists e.g. psychologists and psychiatrists began: "Food and therapy cannot be disconnected…There is no great dividing line, so you kind of talk about the psychology of food" (p.78). Clients not understanding these boundaries.	1. Concern about own capabilities 2. Apprehension and uncertainty due to lack of experience/severity of clients 3. Blurred boundaries/roles (does this reflect uniquely physical and psychological nature of EDs?)	1. Feeling helpless and deskilled 2. Feeling helpless and deskilled 3. Emotionally draining work 4. Emotionally draining work 5. Humbly open to learning and support 6. Feeling helpless and

- Barriers to treatment: Poor awareness of other professionals: "I always have to educate the doctors" (p.79); "The most uncomfortable thing for me is the lack of education of other people around me…in particular the physicians" (p.79).
- Resources: Value of mentors and colleague collaboration. Lack of education.
- Treatment and evaluation outcomes: Protocols not adequate nor holistic – desired shift to focus on overall healthy lifestyle (rather than a focus on weight. "I would have trouble following a given protocol. To me, it's more like artwork, and each person is totally different, but it gives you kind of a before and after checklist" (p.81). "You had a protocol, and everybody knew that to do (referring to a pediatric fellowship). And this (referring to eating disorder clients), it was totally the opposite and I couldn't believe it" (p.81).

4. Poor awareness of other professionals
5. Value of collaboration and mentoring
6. Lack of education
7. Need for individual approach
8. No impact of personal history

deskilled (insufficient education)
7. Connecting with common humanity
8. Avoidance?

Discussion

- Denied personal ED history had any impact on self-efficacy

| 28. Walker and Lloyd (2011) | • Three domains: Attitudes of health professionals; countertransference and barriers to providing treatment
 • Attitudes of health professionals: Struggling to understand why someone would develop a fear of food. Seeing service users as vain: "I know it's about control but I don't get it…why it's so difficult to eat. I don't | 1. Struggling to understand/lack of empathy (empathy gap)
 2. Judging service users as vain | 1. Feeling helpless and deskilled
 2. Battle and blame |

know why they hold onto it…I think they're just vain to start with" (p.385). Avoiding working with people with EDs due to feeling the clients know more and/or are not motivated: "You feel like your work is counterproductive…I'm scared of saying the wrong thing…so I avoid them…they know more about the disorder than you do" (p.385).

- Countertransference: Anger and frustration that contributes to resistance and slow progress: "I looked after a girl who used to rip out the naso tube…after some time, you would get feelings of immense anger and frustration" (p.386). "Most of the time you feel you are going round and round in circles so it makes you feel like a useless therapist" (p.386). Unrewarding. More aware of own body image: "You can see them evaluating you…it can be quite distressing on a bad day" (p.386). "It taps into my own body image issues" (p.386).

- Barriers to providing treatment: Insufficient training or time to manage complexities. Specialist case managers or supervision desired. "They take up so much time…they are intense…the medical complications are scary and I don't feel trained to manage them" (p.387). Risk of burnout. Some stressed the problem was their skills/context rather than the client (variant): "I have a moral and ethical duty to help but I don't have the skills" (p.387).

3. Avoiding working with people with EDs
4. Scared of saying the wrong thing
5. Anger and frustration
6. Feeling like a useless therapist
7. Sense of being evaluated
8. Insufficient training
9. Lack of time
10. Wanting specialist supervision/case managers
11. Time-consuming, intense and risky work
12. Minority view: Feeling have a moral duty to help but cannot as lack skills
13. Medics struggle with not being able to "fix it"

3. Avoidance
4. Watching and being watched
5. Emotionally draining work
6. Feeling helpless and deskilled
7. Watching and being watched
8. Feeling helpless and deskilled
9. Feeling helpless and deskilled
10. Humbly open to learning and support
11. Emotionally draining work
12. Moral distress
13. Feeling helpless and deskilled/the dissonance of

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	Discussion	with prescription of food	being a helper struggling to help
	• Health professionals perceive themselves as trying to do a good job but feeling inadequate and developing negative attitudes/avoidance due to insufficient training • Struggling to identify with fear of food • Lack of empathy • 'I can only have empathy for people who want help…these patients scream at us for helping them" (p.388) • Different to other disorders – medics struggle with not being able to "fix it" with prescription of food • Feeling as though you are just "band aiding'		
29. Warren, Crowley, Olivardia, and Schoen (2008)	• Effects on treatment providers: Food and eating, vigilance about other people's appearance, vigilance about own appearance, and recommendations for trainees and other treatment providers. • Food and eating: Becoming more self-aware and mindful: "I am more tuned into my choices than earlier in my life. I have 2 daughters and I am aware of being more vigilant to the messages I give them about the value of food as a pleasurable experience and a nutritional necessity" (p.37). Change in relationship with food – most positive, minority negative: "I've gained insight into my own issues with food through working in this field and I have a healthier relationship with food as a result" (p.37). Going to the opposite extreme: "I find myself going to an extreme, at times,	1. More self-aware due to work 2. Changes in diet – mostly for the positive. Minority going to opposite extreme – black-and-white, us and them defence? 3. Vigilance about other people's appearance	1. Mindful awareness and acceptance 2. Mindful awareness and acceptance vs Avoidance (food as comfort; us and them) 3. Watching and being watched 4. Connecting with common humanity

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of eating whatever I want and thinking it is bad to 'eat healthy'. I feel like I try to compensate for my clients' eating disordered views" (p.37)

- Vigilance about other people's appearance: Evaluating other people's clothing, body shape and weight. "I feel a bit hypocritical sometimes whenever I preach one thing and do another. I wish I didn't focus so much on appearance" (p.38). Some saw it as just part of working with client group. Some of those with personal history reported being less aware of other bodies. Said they used self-care and supervision to cope.
- Vigilance about own appearance: Increased awareness and hypervigilance regarding their weight and appearance. Some reported feeling offended, angry, vulnerable, self-critical, incompetent. "I'm sometimes self-conscious of being robust and curvy" (p.39); "I sometimes feel self-conscious about my weight (thinness). Makes me feel like an impostor. Makes me doubt my ability to empathize with clients, makes me feel hypocritical and doubt myself as a professional" (p.39).
- Recommendations for trainees and other treatment providers: Resistance challenging to work with. Emotional impact of severity. "It is hard to acknowledge that some may die. I can be scared and sad for not only their quality of life but the risk of a patient dying. I worry about who might/could die from this disorder and I have to sit with my powerlessness (at times) to help" (p.39). Difficulties forming

4. Importance of self-care and supervision
5. Self-consciousness
6. Feeling offended, angry, self-critical
7. Feeling incompetent
8. Emotional impact of severity
9. Helplessness in face of possible death
10. Difficulties maintaining healthy boundaries
11. Dealing with fearful families
12. Lack of time and resources
13. Disagreements with other staff
14. Hard to remain hopeful

5. Watching and being watched
6. Emotionally draining work
7. Feeling helpless and deskilled
8. Emotionally draining work
9. Feeling helpless and deskilled
10. Emotionally demanding work
11. Emotionally draining work
12. Feeling helpless and deskilled
13. Emotionally draining work
14. Emotionally draining work
15. Humbly open to learning and support

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	relationships with clients: "Their tendency to retreat from relationships can be very challenging" (p.40). Difficulties maintaining healthy boundaries. Dealing with fearful families. Lack of time and resources, disagreements with other staff, and remaining confident/hopeful: "I find the hardest part is staying hopeful and optimistic about recovery with the more entrenched eating disordered patients" (p.40). Need for regular supervision and consultation. Limit ED cases. Be realistic and not take responsibility for success and failure. Need to be a stern guide: "You must be stern and direct. Set clear boundaries. There needs to be a balance between support and encouragement, and assertive directiveness" (p.40). "If I don't push my patients to try new things and I give in to their resistance, I'm not helping them" (p.40-41). Reward of interest and complexity of work.	15. Need for supervision and consultation 16. Limit ED cases 17. Need for realistic expectations, including of self 18. Not taking on too much responsibility for outcome 19. Need balance between support and encouragement 20. Rewarding aspects	16. Avoidance OR the golden middle way? 17. The golden middle way 18. Balance AND mindful awareness 19. The golden middle way 20. Connecting with common humanity
30. Warren, Schafer, Crowley, and Olivardia (2012)	Primary contributors to burnout: • Nature of disorder i.e. chronicity and severity: "It is such a long process and you rarely feel 'finished' with a client" (p.182); "You grow to really care for the person and you see the big grasp that the eating disorder has on them. It's discouraging" (p.182). Work-related factors e.g. time commitment, lack of resources or support, lack of co-ordination. Countertransference: "It is emotionally draining" (p.183).	1. Chronicity and severity mean you rarely feel finished with a client 2. Lack of time, resources and support 3. Emotionally draining	1. Emotionally draining work 2. Feeling helpless and deskilled 3. Emotionally draining work 4. Emotionally draining work

- Worry about patient health: "Carrying that worry round is burdensome, heavy" (p.183); "It's hard for me to live my life when I know that my anorexic client is 'out there' in the world and on the brink of death" (p.183). Worry impacting approach to treatment, leading taking more control/action in relation to care. Acceptance of therapeutic limitations: "It's a constant challenge to find the balance between appropriate attention to my clients/doing everything I should and can for them, and letting go/bearing in mind that I can't control what they do/what happens to them" (p.184).
- Experience of patient death: Negative emotional response. Self-doubt, guilt or helplessness: "It made me question my ability in that I hadn't been able to help her'; "I was very sad and worried I hadn't done enough" (p.184). Some commented on increased awareness of the severity of the disorder: "I was confronted with the limits of my power" (p.184).

Efforts to avoid burnout:

- Self-care
- Use of consultation, supervision and treatment team
- Limiting time worked or amount of ED cases
- Potentially unhealthy coping mechanisms e.g. binge eating

Feedback to early-career therapists: Not lived experience

4. Fear for SUs' health
5. More active/controlling in response to anxiety
6. Acceptance that cannot control outcome
7. Emotional impact of service user death
8. Self-doubt
9. Self-care to avoid burnout
10. Use of consultation, supervision and team
11. Limiting number of ED cases
12. Binge eating to cope
13. Finding reward in the work
14. Systemic factors – sociocultural

5. Avoidance (of anxiety)
6. The golden middle way
7. Emotionally draining work
8. Feeling helpless and deskilled
9. Connecting with common humanity
10. Humbly open to learning and support
11. Avoidance OR the golden middle way
12. Avoidance (food as comfort/coping mechanism)
13. Connecting with common humanity
14. Feeling

	• Finding the work rewarding: "The patients, as a rule, are amazing individuals and I truly feel that I often get more from them than vice versa" (p.189) • Systemic barriers to effective work e.g. living in culture that promotes as well as stigmatises eating pathology: "We often feel like we are fighting a losing battle when they are exposed much more consistently to messages that contradict what we promote" (p.188) • Family work stressful	pressure to be thin 15. Family work stressful	helpless and deskilled 15. Emotionally draining work
31. Williams and Haverkamp (2015)	• Four categories: Boundary issues, therapist wellness, helpfulness of the therapist's ED, and openness regarding therapists' personal ED histories • Boundary issues: Centralising the client's experience; not over-identifying, nor meeting one's own needs in therapy. Bracketing one's experience. Range of disclosure decisions. Early errors in self-disclosing: "[The client] thought that if I could get that low and come back, then she had a ways to go before she had to worry about it…[It was] awful. Awful. Scary. I don't discuss those details anymore" (P5-1, p.399). Therapists with personal histories being favoured – impact on work climate. Coming across clients in 12-step meetings. • Therapist wellness: Mediator of the degree to which ED history can be helpful. Problematic if ED active. Need to be aware of any residual symptoms, including perfectionism. Difficult to decide if phenomena problematic in context of cultural norms of body-image	1. Boundaries (for safety) 2. Learning from early mistakes/value of experience 3. Need for self-awareness – knowing any residual symptoms and/or blind spots 4. Non-binary view of recovery in context of cultural norms of body image distress and picky eating	1. Mindful awareness and acceptance 2. Humbly open to learning and support 3. Mindful awareness and acceptance 4. Connecting with common humanity 5. Humbly open to learning and support 6. Connecting with common humanity

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distress and picky eating. Need to integrate ED history into sense of self and incorporate it safely in work: "[I]t's hard to do the work without integrating these pieces I feel are unfinished" (P4-3, p.401). Being mindful of one's blind spots: "Our stuff can become predatory if it's not dealt with…It slips out" (P10-1, p.402). Use of formal supervision, team meetings and personal therapy to identify blind spots. The work as motivational: "[W]orking with clients with EDs keeps me honest. I really don't like the idea of giving a piece of advice and then going out and doing the opposite" (P5-2, p.403). Being authentic and not othering clients.

- Helpfulness of the therapist's ED: Empathy, instilling hope as a positive role model, maintaining hope in themselves - buffering frustration and hopelessness: "There were many years where I didn't think I would ever recover. So, knowing that it's possible helps me to encourage them to believe that" (P8-2, p.404). Deepfelt respect and compassion: "Not practicing in an us/them kind of perspective, or seeing…[clients] as being those people over there with problems" (P1-2, p.404).

- Openness: Some participants reported feeling ED histories were accepted where they worked. Some described feeling observed or watched, or having experienced distressing interpersonal interactions. Some did not feel safe to disclose and either felt "this part of me is cut off" (P4-3, p.405) or triggered and therefore in need of support: "How can [we] not be triggered in this work?" (P10-1, p.p.405). Stigma

5. Use of supervision, team meetings and therapy to identify blind spots
6. Work motivational and keeps them honest
7. Not othering clients due to personal experience
8. Personal experience as source of hope in themselves and others
9. Some who had disclosed felt observed by others at work
10. Feeling either cut off or triggered if do not disclose
11. Stigma among clinicians creates a

7. Connecting with common humanity
8. Connecting with common humanity
9. Watching and being watched
10. Avoidance (alternative is to be triggered)
11. Moral distress
12. Watching and being watched

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despite prevalence among clinicians: "[H]alf the people I know in this field have personal histories….and it's neglected, it's avoided, it's stigmatized – even within our own field as we're trying to counter that stigma in the world and with our patients who are living with that. [That's] a dissonance I don't like to sit with" (P7-1, p.405); "It's like this secret conversation that we'll have…[It] feels hypocritical" (P7-1, p.406). Some participants reported having an off-site mentor they could talk to about anything.

Discussion

- Lack of interpersonal safety – risks of not getting support

32. Wright (2015)

- Maternalism and mothering: Productive, recovery-promoting relationships. Some care workers fell intuitively into mothering role. SUs as childlike. Mindfulness of boundaries: "You have to be constantly aware don't you, that this relationship, even though it can be very, very intense at times, it can only ever be what it is, it is a nurse:patient relationship" (Lizzie, nurse manager, p.435)

Discussion:

dissonance/sense of hypocrisy
12. Lack of interpersonal safety

1. Mothering role as a recovery promoting relationship
2. Mindfulness of boundaries in context of intense work
3. Enjoying providing nurture and care

1. Connecting with common humanity
2. Mindful awareness and acceptance
3. Connecting with common humanity
4. Connecting with common humanity

	• Appreciating aspects of what felt like a traditional mothering role in terms of its focus on comfort, nurture and care • Needing to be with and hold SUs – notion of being with rather than doing to • Acceptance of SU and their potential • Authenticity valued • SUs experienced as childlike (not othering as service users were aware and accepting of this as temporary dynamic) • Possible that the care workers, when responding to vulnerable individuals, drew on intuitive responses similar to a parental style of nurturing and protecting those in their care • Maternalism reflects caring about as well as caring for • Carrying hope for SUs • Maternalism facilitates unconditional positive regard	4. Being with rather than doing to 5. Acceptance 6. Authenticity valued 7. SUs experienced as childlike 8. Carrying hope	5. Mindful awareness and acceptance 6. Connecting with common humanity 7. Connecting with common humanity (relating as mother) 8. The golden middle way
33. Wright and Hacking (2012))	• Themes: Authenticity of the relationship, the importance of safety, externalization of the eating disorder, recovery measured in kilos, the power of hope and optimism, and the use and acceptance of maternalism in the care setting. • Authenticity in the relationship: Need to be genuine in context of exposing environment. Safety facilitates this. • The importance of safety: Providing safety. • Externalization of the eating disorder: Referring to the ED as a separate entity.	1. Exposing environment forces you to be genuine 2. Clinicians providing safety 3. Externalisation of the ED – seen as source of "oppositional behaviour'; in	1. Connecting with common humanity 2. Connecting with common humanity 3. Connecting with common humanity 4. Connecting

	• Recovery measured in kilos: Pervading belief that recovery was possible and profound sense of kindness and patience. • The power of hope and optimism: In battle together. Providing hope for SUs to borrow. "Sometimes and freely, with my permission, they borrow my hope. They borrow a belief when they just can't get hold of that belief of their own" (Gail, nurse therapist, p.112). • Maternalism: Professionals as mother figures (adult SUs) Discussion: • Maternalistic approach is personal and individual, caring, protective, nurturing • Tension between maternalism and notion of professional boundaries • Externalisation was seen as enabling SUs to fight AN but also could lead to "tolerance of unpleasant behaviour" (p.113) • Recognition of temporary and artificial nature of relationship	battle together against ED 4. Kindness, patience and hope 5. Maternalism as caring about as well as for (protective and nurturing) –in the context of service users not being signed up to treatment goals	with common humanity 5. Connecting with common humanity
34. Zugai, Stein-Parbury, and Roche (2018a)	• Love and limits, therapeutic separation, therapeutic maintenance of authority and boundaries • Love and limits (interpersonal connectedness in tandem with thoughtfully applied authority) – love (genuine caring; unconditional positive regard; empathy, understanding and sensitivity; motherly/sisterly	1. Being genuinely caring 2. Unconditional positive regard	1. Connecting with common humanity 2. Connecting with common

nursing): Being genuinely caring. Showing unconditional positive regard; difficult to maintain alongside need to assert authority: "You gotta be working with them, trying to catch up with them as often as you can and have a really good staff-patient relationship with them and then you have to do a room search. And it can be difficult" (Elaine, nurse, p.419). Showing empathy and sensitivity. Effective nursing as motherly or sisterly approach – warm and tactful

- Love and limits – limits (safety and predictability; fairness and rationalisation: nonpunitive intent; flexibility: individualised care): Viewing inconsistency negatively. Providing a rationale for rules. Valuing "thoughtful modifications to the ward protocols, to better enact the spirit of the law rather than the letter of the law" (p.420).

- Therapeutic separation: Clear distinctions between the consumer and AN as an illness. Making a conscious effort to view the SU as a person in need of care. Separating the healthy individual from the pathological eating disorder to manage frustrations and internal conflicts: "If you don't separate the eating disorder from the person, you're lost, and that really has to be the first port of call when you're first establishing a relationship with a patient, and this is where your non-judgemental response comes in" (Pamela, nurse, p,421). Assisting SUs in developing insight: "When someone's struggling with say, eating a meal, or something like that, and they're fighting against it,

3. Showing empathy and sensitivity
4. Motherly/sisterly approach – warm and tactful
5. Negative view of inconsistency but value thoughtful modifications
6. Externalisation - to manage internal conflicts/frustration
7. In battle together
8. Collaboration
9. Self-awareness
10. Befriending clients and feeling guilty when providing "discipline"
11. Individual approach
12. Understanding, acceptance and externalisation to manage inner turmoil of nurses

humanity
3. Connecting with common humanity
4. Connecting with common humanity
5. The golden middle way
6. Connecting with common humanity
7. Connecting with common humanity
8. Humbly open to learning and support
9. Mindful awareness and acceptance
10. Moral distress
11. Connecting with common humanity
12. Mindful awareness and

often you can say something like, 'Look, we're fighting against this together. I'm helping you'…" (Lucina, nurse, p.421). Giving message "you're ill" rather than "you're bad".

* Therapeutic maintenance of authority and professional boundaries: Approach of collaboration, supportiveness and patience beneficial. Maintaining professional boundaries to protect their professional authority. Need to ensure own personal needs do not impact upon judgments and interactions: "You always have to just remind yourself to remain professional and question that what you say to the patient and what you do with them is specifically for their benefit" (Isla, nurse, p.422). Rules give confidence. Being befriended by SUs; more likely for young nurses: "Because you get closer to them, it does influence their care because then you feel bad, like providing discipline and that to them, because then they've befriended you so then you feel like you're betraying their friendship and their trust if you do that" (Audrey, nurse, p.422)

13. Value of focusing on holistic goals
14. Power differential necessary so have to express mutuality in other ways
15. Maternalism means of managing vulnerability in presence of a power differential
16. Need for time to develop such relationships

acceptance AND connecting with common humanity
13. Connecting with common humanity
14. Connecting with common humanity AND the golden middle way
15. Connecting with common humanity
16. Connecting with common humanity/role of context

Discussion

* Balancing positive interpersonal engagement and therapeutic employment of their authority
* Validating the worth of individual SUs
* Recognising the value of genuine care - maintaining this via sensitivity, supportiveness and availability

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- Therapeutic separation of SU and AN – nurses established own internal separation before assisting the SU to separate
- Internal separation dependent on non-judgmental approach
- Value of focusing on holistic goals – expressing that the ED was not "a personally defining characteristic" (p.422) and affirming that the SU is a unique individual
- The risk is such that the nurses cannot share power – so mutuality has to be expressed through a demonstration that the power differential is trustworthy and forthright – achieved by nurses via consistency and consideration
- Modifying care to better meet individual needs without compromising weight gain – enhanced relationships
- Maternalistic approach for its therapeutic expediency – managing vulnerability in the presence of a power differential
- Need time to engage with SUs

35. Zugai, Stein-Parbury and Roche (2018[b])	- Anorexia Nervosa: Pathological sabotage: Nurses feeling demoralised when their efforts are not appreciated, and struggling to trust SUs in the context of deception resulting in a negative impact on the therapeutic relationship: "I think sometimes it can be counterproductive for the relationship…If somebody's been in here ten times and for whatever reason it hasn't worked: they've pushed the boundaries, they've done the wrong thing, they've gone off and got drunk, come back, abused things, hidden things – you start to	1. Demoralised 2. Defence – mind shutting down/ withholding emotional investment, against pain of perceived sabotage	1. Emotionally draining work 2. Avoidance 3. Connecting with common humanity 4. Connecting with common humanity

get…your mind shuts down a bit" (Evelyn, nurse, p.448)

- The nursing role as a therapeutic platform (positioned for closeness, feeling safe and secure, the inadequacies of hospitalisation): Being ever present and delivering most face-to-face care, nurses are well positioned for intimacy and engagement. Developing relationships takes time. Being a constant supportive presence.

Discussion

- Emotionally exhausting
- Sabotage an affront to nurses' motivation, confidence and hope
- Nurses withhold emotional investment to minimise frustration and disappointment
- Withdrawal of care and compassion antecedent to the assumption of punitive roles
- Inpatient setting and routine is designed to facilitate surveillance
- Positive relationships with nurses enhance experience of ward – normalising
- AN non-modifiable but the way nurses approach SUs and internalise stressors is modifiable

/frustration and disappointment

3. Nurses positioned for intimacy and engagement
4. Building relationships can take time (easier for nurses given intensity of contact)
5. Draining work
6. Surveillance – opportunity (for understanding /interaction) but also invasive
7. Humanising /normalising effect of positive interactions on the ward environment

5. Emotionally draining work
6. Watching and being watched
7. Connecting with common humanity

Appendix 2: Earlier drafts of line of argument

Version 1:
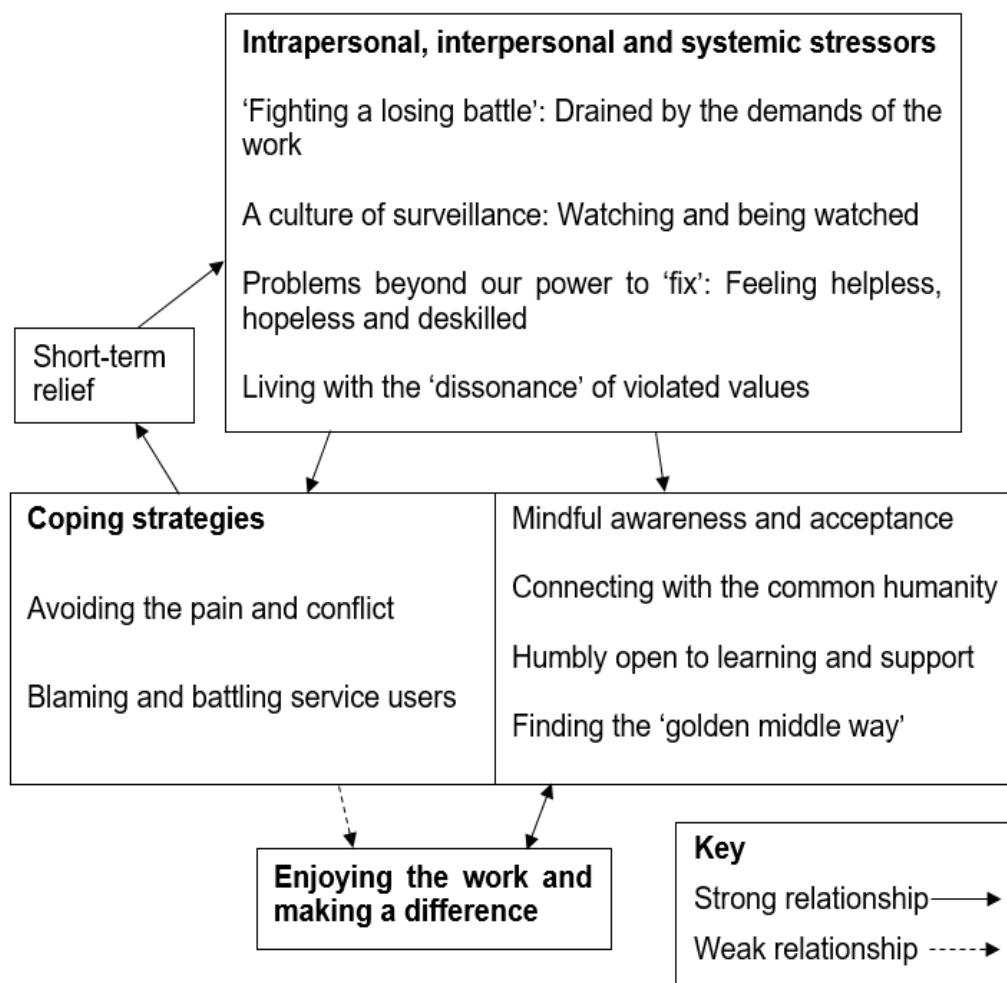
Version 2:

Superordinate theme: 'This is not how it's meant to be: The dissonance of caring without curing and violating one's values'

Core theme 1: Helpless, hopeless and drained vs finding reward through the golden middle way

Sub-theme 1: Feeling drained and deskilled by problems beyond our power to 'fix'

Sub-theme 2: Finding reward in the golden middle way

Core theme 2: Battle, avoidance and paranoia vs common humanity and mindfulness

Sub-theme 1: Battle, avoidance and paranoia.

Sub-theme 2: Connecting with common humanity and mindful awareness and acceptance

Appendix 3: Quality ratings using CASP (2010) checklist

CASP criterion	Included papers																	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1. Was there a clear statement of the aims of the research?	0.5	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
2. Is a qualitative methodology appropriate?	0.5	1	1	1	1	1	1	1	1	1	1	0.5	1	1	1	1	1	1
3. Was the research design appropriate to address the aims of the research?	0.5	1	1	1	1	0.5	1	0.5	1	1	1	0.5	0.5	0.5	0.5	1	1	1
4. Was the recruitment strategy appropriate to the aims of the research?	0	0.5	1	1	1	0.5	1	1	0.5	0.5	1	0.5	0.5	0.5	1	0.5	0.5	1
5. Was the data collected in a way that addressed the research issue?	0.5	1	1	1	0.5	0.5	0.5	1	1	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
6. Has the relationship between researcher & participants been adequately considered?	0	0.5	0	0	1	1	0	0	0	1	0	0	0	0	0	0	0	1
7. Have ethical issues been taken into consideration?	1	0.5	1	0.5	1	1	1	1	0.5	1	1	1	1	1	1	1	0.5	0
8. Was the data analysis sufficiently rigorous?	1	1	1	0.5	1	1	1	0.5	1	1	1	1	0.5	0.5	0.5	1	1	0.5
9. Is there a clear statement of findings?	0.5	1	1	1	1	1	1	0.5	0.5	0.5	0.5	1	1	1	1	0.5	1	1
10. How valuable is the research?	0.5	1	1	1	1	1	1	1	1	1	0.5	1	1	1	1	1	1	1
Total score	5	8.5	9	8	9.5	8.5	8.5	7.5	7.5	8.5	7.5	7	7	7	7.5	7.5	7.5	8
Category	B	A	A	B	A	A	A	B	B	A	B	B	B	B	B	B	B	B

CASP criterion	Included papers																
	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35
1. Was there a clear statement of the aims of the research?	1	1	1	1	1	1	1	0.5	1	0.5	1	1	1	1	1	1	1
2. Is a qualitative methodology appropriate?	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
3. Was the research design appropriate to address the aims of the research?	1	1	1	0.5	0.5	1	0.5	1	0.5	0.5	0.5	0.5	1	1	1	0.5	0.5
4. Was the recruitment strategy appropriate to the aims of the research?	1	1	0.5	1	0	1	1	0.5	1	1	0.5	0.5	1	1	0	1	1
5. Was the data collected in a way that addressed the research issue?	0.5	0.5	0.5	0.5	1	0.5	1	0.5	1	1	0.5	0.5	1	1	1	1	0.5
6. Has the relationship between researcher & participants been adequately considered?	1	1	1	1	0	0.5	1	0	0	0	0	0	1	0	0	0.5	0
7. Have ethical issues been taken into consideration?	1	1	1	1	1	0.5	1	1	1	1	1	0	1	1	1	1	1
8. Was the data analysis sufficiently rigorous?	1	0.5	1	0.5	0.5	0.5	1	0.5	0.5	0.5	1	1	1	0	0.5	0.5	0.5
9. Is there a clear statement of findings?	1	1	1	1	0.5	1	1	0.5	1	1	1	1	1	0.5	1	1	0.5
10. How valuable is the research?	1	1	1	1	1	1	1	0.5	1	1	1	1	1	0.5	1	1	0.5
Total score	9.5	9	9	8.5	6.5	8	9.5	6	8	7.5	7.5	6.5	10	7	7.5	8.5	6.5
Category	A	A	A	A	B	B	A	B	B	B	B	B	A	B	B	A	B

Appendix 4: Poster

ARE YOU WORKING WITH CLIENTS WITH ANOREXIA? INVITE TO PARTICIPATE IN RESEARCH

WHAT:

I am interviewing clinicians who work with people with Anorexia Nervosa to explore their understandings of the experience of Anorexia. If you decide to take part in my study, I would ask you to complete a short questionnaire and an interview at your workplace. All information will be stored confidentially. In total, the questionnaire and interview will take 45 to 60 minutes.

WHO:

I am seeking clinicians who have been involved in the direct care of people with Anorexia in specialist Eating Disorder Services for at least 6 months, and who can speak English fluently.

WHY:

This research will help to ensure that the care and treatment of people with Anorexia Nervosa is client-centred and in line with client understandings. All participants will be entered into a prize draw for £40 worth of Amazon vouchers, and offered a summary of the findings.

INTERESTED?

Please email meghan.graham.2015@live.rhul.ac.uk if you are interested in taking part in the study.

Meghan Graham,
Trainee Clinical Psychologist,
Royal Holloway University

Appendix 5: Letter confirming Health Research Authority approval

NHS
Health Research Authority

Ms Meghan Graham
Clinical Psychology, Royal Holloway University
Egham Hill
Egham, Surrey
TW20 0EX

Email: hra.approval@nhs.net

06 April 2017

Dear Miss Graham,

Letter of HRA Approval

Study title:	Perceptions of the Anorexic Voice among Clinicians Working with Adults with Anorexia Nervosa
IRAS project ID:	221973
REC reference:	17/LO/0635
Sponsor	Royal Holloway, University of London

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details

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IRAS project ID	221973

and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Working with organisations hosting the research
- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **221973**. Please quote this on all correspondence.

IRAS project ID	221973

Yours sincerely

Rekha Keshvara
Assessor

Email: hra.approval@nhs.net

Copy to: Ms Annette Lock
           Ms Lynis Lewis, Noclor

Appendix A - List of Documents

The final document set assessed and approved by HRA Approval is listed below.

Document	Version	Date
Copies of advertisement materials for research participants [Poster 1]	Version 1	25 March 2017
Copies of advertisement materials for research participants [Poster 2]	Version 1	25 March 2017
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity for professional liability]	Version 1	11 March 2017
Interview schedules or topic guides for participants [Topic guide]	Version 1	19 March 2017
IRAS Application Form [IRAS_Form_28032017]		28 March 2017
Non-validated questionnaire [Brief questionnaire]	Version 1	25 March 2017
Other [IRAS Authorisation Academic Supervisor Email confirmation]		06 April 2017
Other [IRAS Authorisation CI Email confirmation]		06 April 2017
Other [HRA SoA]	1	05 April 2017
Other [HRA SoE]	1	05 April 2017
Participant consent form [Consent Form]	Version 1	25 March 2017
Participant information sheet (PIS) [Participant Information Sheet]	Version 1	25 March 2017
Referee's report or other scientific critique report [Feedback from Royal Holloway Research Sub-committee]	Version 1	11 March 2017
Referee's report or other scientific critique report [Responses to feedback from Royal Holloway Research Sub-committee]	Version 1	11 March 2017
Referee's report or other scientific critique report [Approval from Royal Holloway Research Sub-Committee]	Version 1	11 March 2017
Research protocol or project proposal [Research proposal]	Version 1	17 November 2016
Summary CV for Chief Investigator (CI) [Summary CV for Chief Investigator]	Version 1	25 March 2017
Summary CV for student [CV for student and Chief Investigator]	Version 1	25 March 2017
Summary CV for supervisor (student research) [CV for supervisor 1]	Version 1	11 March 2017
Summary CV for supervisor (student research) [CV for supervisor 2]	Version 1	11 March 2017
Summary CV for supervisor (student research) [CV for supervisor 3]	Version 1	11 March 2017

IRAS project ID	221973

Appendix B - Summary of HRA Assessment

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

For information on how the sponsor should be working with participating NHS organisations in England, please refer to the, *participating NHS organisations, capacity and capability* and *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* sections in this appendix.

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

Ms Annette Lock
Email: annette.lock@rhul.ac.uk
Tel: 01784414388

HRA assessment criteria

Section	HRA Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	IRAS Part D has not been signed by the CI and the academic supervisor. However, confirmation emails have been submitted by the CI and the academic supervisor authorising IRAS Part D.
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	Statement of activities will act as an agreement of an NHS organisation to participate.

IRAS project ID	221973

Section	HRA Assessment Criteria	Compliant with Standards	Comments
4.2	Insurance/indemnity arrangements assessed	Yes	Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the activities expected of them for this research study
4.3	Financial arrangements assessed	Yes	The applicant has confirmed in the statement of activities that the sponsor will not provide any funding to sites
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Not Applicable	No comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

(transcription error)

IRAS project ID	221973

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken

A Letter of Access (or equivalent) would be expected for any external NHS/research staff undertaking study activities at the participating sites where the research team will access areas where patient care is delivered. The pre-engagement checks should include DBS check and Occupational Health Clearance.

Where study activities will be carried out in non-clinical areas, away from where patient care is being delivered, a Letter of Access is not expected for this study.

For clarity, the term "if in NHS facilities", used in the Algorithm of Research Activity and Pre-Engagement Checks for the purposes of specifying when a letter of access is expected for research involving staff or their data, should be taken as referring to areas within NHS premises where care is provided. Offices and other non-care areas should be regarded as business premises and letters of access will therefore not be expected for access to such locations for staff research. External researchers working under such arrangements are expected to comply with the off-site working policies and procedures of their employing organisation.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.

- The applicant has indicated that they <u>do not intend</u> to apply for inclusion on the NIHR CRN Portfolio.

Appendix 6: RHUL ethics approval

Ethics Review Details

You have chosen to self certify your project.	
Name:	Graham, Meghan (2015)
Email:	Meghan.Graham.2015@live.rhul.ac.uk
Title of research project or grant:	Perceptions of the Anorexic Voice among Clinicians Working with Adults with Anorexia Nervosa
Project type:	Royal Holloway postgraduate research project/grant
Department:	Psychology
Academic Supervisor:	Dr John Fox
Funding Body Category:	No external funder
Funding Body:	
Start date:	24/04/2016
End date:	29/06/2018

Research Question Summary

The research will explore how clinicians working in specialist Eating Disorder services perceive the concept of the Anorexic Voice (Tierney & Fox, 2010). Based on the first-hand accounts of people with Anorexia Nervosa, the Anorexic Voice has been defined as a non-psychotic inner voice experienced by many people with Anorexia that provides a critical commentary focused on their diet, shape, weight, and personal qualities (Pugh, 2016). As yet, there is no published research on clinician views of this concept. Exploring clinicians' perceptions of the Anorexic Voice and their receptiveness to its inclusion in their work will facilitate understanding of the impact of their views on their practice. This is particularly important given that some studies have identified negative attitudes among staff towards clients with Eating Disorders, in part due to a lack of understanding (Walker & Lloyd, 2011). Moreover, Emotion-Focused Therapy (Dolhanty & Greenberg, 2009), which targets the Anorexic Voice, has yielded promising preliminary results, in the context of a general lack of effective treatments for Anorexia (Suarez-Pinilla et al., 2015). Staff at Eating Disorder services have a vital role in implementing such treatments and providing client-centred care. Fifteen clinicians who have worked closely with adults with Anorexia Nervosa in specialist NHS Eating Disorder services for at least six months will complete a brief questionnaire and 45-minute semi-structured interview in their places of work. The interviews will be transcribed, and the transcript data will be examined using thematic analysis (Braun & Clarke, 2006). It is anticipated that the data will yield themes and sub-themes relating to the perceived experience of Anorexia, and the perceived clinical utility of the Anorexic Voice. The findings of the research could be used to inform training to help ensure that the care and treatment of people with Anorexia is person-centred and consistent with client understandings.

Research Method Summary

This is a qualitative, cross-sectional, interview-based study with a sample of staff participants. A qualitative design will be employed given that this is the first piece of research to assess clinician understandings of the Anorexic Voice, and the aim is to explore understandings of a complex concept in detail.

Service users from the Yorkshire Centre for Eating Disorders were involved in the design of the topic guide for the semi-structured interviews.

The aim is to recruit a sample of approximately 15 clinicians, in accordance with the recommendation of Braun and Clarke (2013) for an interview-based doctoral study. English-speaking staff with at least six months' relevant clinical experience will be recruited. Purposive sampling will be employed, and attempts will be made to recruit some clinicians who are familiar with the Anorexic Voice and others who are not.

All participants will be given an information sheet and asked to sign a consent form. Participants will be asked to complete a brief background questionnaire. Face-to-face, semi-structured interviews will be conducted with all participants, and audio-recorded. All interviews will be conducted by the Chief Investigator in private rooms at clinicians' workplaces. Interviews will be semi?-structured in that each participant will be asked the 8 key questions on the topic guide, but follow-up questions and probes are likely to differ. At the end of the interview, a debrief will be conducted and participants will be asked whether they continue to consent to participation. They will also be asked whether they would be willing to member-check the completed analysis. In total, participation will take 45 minutes to 1 hour.

Following transcription of the interview data, thematic analysis (Braun & Clarke, 2006) will be employed because it best fits the research question due to its focus on patterns across data.

ID	481
Human Participants	Yes
Exposure To Harm	No
Animals	No
Personal Information	No
Environmental Risk	No
Other Issues	No
Negative Action	No
full review required	False
Submission Date	4/13/2017 4:26:18 PM
PDF Filename	Full-Review-481-2017-04-13-18-07-.pdf
UserId	PCVA057
SubmissionID	481
Start Date	24/04/2016
End Date	29/06/2018

Involve Children	No
Involve Impaired	No
Involve Vulnerable	No
Involve Become Vulnerable	No
Involve Unequal Relations	No
Involve Negative Consequences	No
Involve Details	
Design and Data Without Knowledge	No
Design and Data Identifiable	No
Design and Data Pain	No
Design and Data Stress	Yes
Design and Data NHS Approval	Yes
Design and Data NHS Number	
Design and Data Drugs	No
Design and Data Human Tissue	No
Design and Data Data	No
Design and Data Financial	No
Design and Data Ethically Unsound	No
Design and Data Details	The project (IRAS project ID 221973) has been approved by the Health Research Authority. There is a small risk that the questionnaire item enquiring about personal experience of an Eating Disorder could cause participants to experience stress and/or anxiety. However, this issue is ethically unproblematic because the risk is significantly mitigated by the fact that: participants can choose how much information they wish to share, the questionnaire format does not require an immediate or verbal response, and the confidentiality of responses is emphasised in the information sheet. I have

	sought to further mitigate the risk by providing a 'Prefer not to say' tick-box option on the questionnaire. In the event that a participant does disclose a current or historic Eating Disorder, no follow-up action would be required given that participants are staff rather than vulnerable individuals; furthermore, on the basis of the response to this item, there would be insufficient evidence to determine that there were any serious current risk to the health of the participant. There is a small risk that participants may be embarrassed by question 2 of the topic guide if they have not heard of the Anorexic Voice or believe that they are not able to define it satisfactorily. However, this issue is ethically unproblematic because the risk is significantly mitigated by the fact that a definition of the Anorexic Voice will be offered immediately thereafter. Moreover, if the participant appears embarrassed at this point in the interview, brief verbal reassurance will be offered by the Chief Investigator that 'it is not a problem if you are unsure' prior to the definition of the Anorexic Voice being read to the participant. Furthermore, the confidentiality of responses is emphasised in the information sheet, which should alleviate concerns about the perceived quality or accuracy of responses. The risk of embarrassment is further reduced by the fact that participants are unlikely to have subsequent contact with the Chief Investigator, unless they agree to member-check the analysis.
Risks to the Environment Environment	No
Risks to the Environment Permission	No
Risks to the Environment Samples	No
Risks to the Environment Artifacts	No
Risks to the Environment Details	
Risks to Researchers Vulnerable	No
Risks to Researchers Sensitive	No
Risks to Researchers Illegal	No
Risks to Researchers Failed Care	No
Risks to Researchers Reputation	No

Appendix 7: Information sheet

Participant Identification Number
(please make a note of this):

INFORMATION SHEET

ROYAL
HOLLOWAY
UNIVERSITY
OF LONDON

Research Title: Perceptions of the Anorexic Voice among Clinicians

IRAS Project ID: 221973

Date: 25.03.17
Version 1

Introduction

My name is Meghan Graham and I am a Trainee Clinical Psychologist at Royal Holloway, University of London. For my doctoral research, I am interviewing staff who work with people with Anorexia Nervosa to explore their understandings of the experience of Anorexia. This Information Sheet provides some information to help you decide whether you would like to be part of the research.

Purpose of the research

This research will help to ensure that the care and treatment of people with Anorexia Nervosa is client-centred and in line with client understandings.

Why am I being asked to take part in this research?

I am interviewing clinicians who have been involved in the direct care of people with Anorexia Nervosa in specialist Eating Disorder services for at least 6 months, and who are able to speak English fluently.

Do I have to take part?

No. It is entirely up to you to decide.

What will I need to do if I take part?

If you decide to take part and sign the consent form, I will ask you to complete a short questionnaire and an interview at your workplace. The interview will be audio-recorded. I will be as flexible as possible when arranging a time to meet. In total, the questionnaire and interview will take 45 to 60 minutes. You can withdraw from the study at any time.

What are the possible benefits of taking part?

There is no direct benefit but your participation will help us to find out more about how clinicians view the experience of Anorexia, and how this informs their work. All participants will be entered into a prize draw for £40 of Amazon vouchers, and offered a summary of the findings.

What are the disadvantages/risks?

The disadvantage is the time required to participate. There are no major risks but there is a small risk that you may feel uncomfortable about one question in the questionnaire. However, I do not wish for this to happen. You do not have to answer any question if it seems too personal or makes you uncomfortable.

What will happen to information collected about me during the study?

I would very much appreciate your honest opinions. All information that I collect will be stored confidentially. Consent forms will be stored in a locked cabinet. Other information will be stored electronically in an encrypted format, and will have a number on it instead of your name. Only the researchers will know your number and we will store it securely and destroy the record as soon as possible. Quotations from your interview will be included, in an anonymous form, in the write-up and may be presented at a conference and/or published in a journal article. For the purposes of audit, the collected data will be stored securely for a period of 10 years before being permanently deleted.

Who is organising and funding the research?

This study is being carried out by Meghan Graham and Dr John Fox of Royal Holloway, University of London; Stephanie Tierney, of Warwick Medical School, and Amy Chisholm, of Vincent Square Eating Disorder Service.

Thank you for reading this information and for considering taking part in this research. Please do not hesitate to email me if you have any questions, and/or wish to take part.

Contact Details:

Meghan Graham, Trainee Clinical Psychologist,
meghan.graham.2015@live.rhul.ac.uk

Appendix 8: Consent form

Participant Identification Number:

CONSENT FORM

Title of Project: Perceptions of the Anorexic Voice among Clinicians

IRAS Project ID: 221973

Date: 25.03.17

Version 1

Name of Researcher: Meghan Graham, Trainee Clinical Psychologist, meghan.graham.2015@live.rhul.ac.uk

Please tick

1. I confirm that I have read the information sheet dated 25.03.17 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time during the study without giving any reason. ☐

3. I understand that I am free to ask questions at any time before and during the study. ☐

4. I understand what will happen to the data collected from me for the research. ☐

5. I understand that the interview will be audio-recorded. ☐

6. I understand that anonymous quotations from me will be used in the dissemination of the research. ☐

7. I agree to take part in the above study. ☐

Name of Participant	Date	Signature

Name of Person taking consent	Date	Signature

Copy for participant, copy for researcher

Appendix 9: Questionnaire

Participant Identification Number:

Version 1, 25.03.17

QUESTIONNAIRE

Research Title: Perceptions of the Anorexic Voice among Clinicians
IRAS Project ID: 221973

1. What is your age? Please tick one box:

☐ 18-24   ☐ 25-44   ☐ 45-64   ☐ 65+   ☐ Prefer not to say

2. What is your gender?

☐ Female   ☐ Male   ☐ Trans   ☐ Other   ☐ Prefer not to say

3. What is your professional role?

☐ Health Care Assistant   ☐ Nurse   ☐ Clinical Psychologist

☐ Counselling Psychologist   ☐ Psychiatrist   ☐ Occupational Therapist

☐ Dietician   ☐ Dietetic Assistant

☐ Other (please specify below)

_____

4. For how long have you been working with people with Anorexia Nervosa?

☐ Less than one year   ☐ 1-2 years   ☐ 2-5 years   ☐ More than 5 years

5. Do you have or have you ever had an Eating Disorder?

☐ Yes   ☐ No   ☐ Prefer not to say

Appendix 10: Interview topic guide

PLEASE BASE YOUR ANSWERS ON PEOPLE YOU HAVE WORKED WITH WHO HAVE A PRIMARY DIAGNOSIS OF ANOREXIA NERVOSA

1. How do you find working with people with Anorexia?
P1: What do you enjoy about the work?

P2: What are the challenges?

2. Based on your clinical work experience, what comes to mind when I say 'the Anorexic Voice'?

•
A standardised description of the Anorexic Voice would be read to all participants at this point, and they would also be given the description in written form: 'Based on the accounts of people with Anorexia Nervosa, the Anorexic Voice has been defined as a non-psychotic inner voice experienced by people with Anorexia that provides a critical commentary focused on their diet, shape, weight, and personal qualities.'

3. How do you make sense of the Anorexic Voice?
P1: What evidence for or against the Anorexic Voice can you give from your clinical work?

P2 (if believe): What would be an example of what the Anorexic Voice might say?

P3 (if believe): What are the signs that someone is experiencing the Anorexic Voice? (What would you notice in their behaviour?)

P4 (if believe): What do you think happens to the Anorexic Voice at the end of treatment? (Do you think clients still experience it in the same way or differently, or do they stop hearing the voice altogether?)

P5: Some people I have interviewed have talked about the AV as different from Anorexia and others talked about it as the same as anorexic thoughts. How do you see it – as the same or different to anorexic thoughts/Anorexia?

P2 (if sceptical): How would you describe the experience of having Anorexia based on your clinical experience?

P3 (if sceptical): What is the evidence for this view from your clinical work?

4. Do you broach the topic of the Anorexic Voice with patients or do you wait for them to mention it themselves?

5. Do you ask clients if the Anorexic Voice is experienced internally?

6. Some people I have interviewed have said they think there may be a link between the voice and emotional abuse. What do you think?

7. (If believe) How do you think the Anorexic Voice could inform the work of clinicians caring for and treating people with Anorexia?

> P1: How could using the Anorexic Voice help with providing care and treatment?

> P2: What is the best way to overcome the Anorexic Voice?

8. What, if any, are the downsides to using the Anorexic Voice in clinical work?

9. Some of my participants have expressed concern that using the Anorexic Voice in treatment could lead to fragmentation of the self? What are your thoughts on this?

OR (If sceptical) Why do you think many clients report that they have experienced an Anorexic Voice?

10. What might people with Anorexia value about the Anorexic Voice?
P1: What might the positives be?

11. How could people with Anorexia get these benefits in a different way?
- P1: How could they get the positives that come with the Anorexic Voice in a different way?
12. How do you think your training or professional role has influenced your view of the Anorexic Voice?
P1: How might the role you have or training you received have affected what you think about the voice?

13. How do your colleagues view this concept?
   a. How do you think resistance to the concept could be overcome?

14. Is there anything else you would like to add? (Or ask me?)

Appendix 11: Description of the 'anorexic voice'

Based on the accounts of people with Anorexia Nervosa, the Anorexic Voice has been defined as a non-psychotic inner voice experienced by people with Anorexia that provides a critical commentary focused on their diet, shape, weight, and personal qualities.

Appendix 12: Extract of coded transcript

Transcript 40 ✕

And you've described how the Anorexic Voice, in your experience, is very aggressive and repetitive. Can you share some examples of what it's said to your clients, if they've shared that with you?

It has a lot to say about not deserving. 'You don't deserve this. You shouldn't have had this. You could have had something else. You're going to have to do X, Y and Z later. You'd be better off without this. You don't need them. Don't believe them. Don't listen to them.' There's a lot around the self-worth stuff. 'Why did you give yourself that? You'll be better if....' [pause] I mean I've had quite a lot of experiences about what's its reasoning for all these rules and comments and negative judgments, and things. And that can often be really harder for people to depict. So they'll be very clear that it's screaming 'You're useless, you're rubbish, don't do this, don't do that, do this, do that' but it's harder to get beyond that and ask, 'Well, why?' So, that can often be quite a useful piece of work as well to kind of say, 'Well why should I do that? Why are you thinking I should do this? And where have you got that from?' And that can actually be something that can come up in the course of treatment as well, that you can start to get some distance. I'm imagining if you're trying to eat a baked potato and this voice is screaming at the front of your head 'Don't eat that, you don't deserve that; you're going to get fat; you're ugly; you're this; you're that'. There is this kind of belief that you have one meal and suddenly you're going to balloon. So the rules become completely distorted and so, yeah, that must be terrifying. I mean I wouldn't and I would, but it's a bit like the seeing through the eyes of a schizophrenic; I would like to see for half a day, maybe ten minutes, through the eyes of an Anorexic, especially when we're doing food preparation stuff – you know, you think about something and it's one size and it's this and 'Yes I can appreciate that there's qualities in that, and it's not just the fats and the carbs and the things that are going to make me balloon', and then you cook it and it's a

Coding Density

Not deserving
Empathy
Dysmorphia
AV what it says
AV pseudo-psychotic
AV non-psychotic
AV critical

Coding Density

Not deserving
Empathy
Dysmorphia
Rules
Restriction
AV what it says
AV relating differently
AV role in treatment and assessment
AV pseudo-psychotic
AV provides answers and rules
AV non-psychotic
AV how to overcome
AV critical

Appendix 13: List of themes at various stages

First draft: Summary of themes as they stood on 19.12.17.

Theme 1: The Anorexic Voice increases empathy and understanding.

Sub-theme 1: Conveying suffering and reducing blame.

Clinicians regard the Anorexic Voice as a vehicle for people who do not have lived experience of Anorexia to appreciate the suffering that people with Anorexia often experience in the form of harsh criticism/abuse and relentless demands that are not limited in theme to diet and weight (and that are internally derived but sometimes linked to previous abuse from others). The Anorexic Voice was perceived as a means for clinicians (and significant others) to communicate to the client that they are aware of the magnitude of this suffering, which can aid the therapeutic alliance. Most clinicians argued that the concept of the Anorexic Voice can help clinicians to be more empathetic and compassionate towards people with Anorexia (in the context of high levels of frustration, judgment and misunderstanding). Clinicians also described how the Anorexic Voice would become more 'cruel' when clients disobeyed its injunctions: 'people have to get worse to get better'. Some clinicians also contended that using the Anorexic Voice in care and treatment can support clients to develop more self-compassion ('this is not who you are').

Understanding ambivalence.

The Anorexic Voice was presented by clinicians as a means of understanding the ambivalence that most people who meet criteria for Anorexia feel towards treatment because despite the distress evoked by its relentless, harsh criticism – which often worsens as clients engage in treatment and ignore its demands – the Anorexic Voice is frequently experienced as a friend, particularly in the early stages

of the illness trajectory. Clinicians described valued functions of the Anorexic Voice including conferring a sense of control and containment, blocking negative emotions, providing reinforcement, and furnishing a sense of identity. Clinicians said that these positive functions mean that the Anorexic Voice can be seductive to clients and they can become attached to it (in the context of higher levels of insecure attachment styles among people with a diagnosis of Anorexia). The Anorexic Voice thus makes behaviours that can be difficult to understand more explicable for those without lived experience, and can support a productive therapeutic alliance.

Theme 2: The Anorexic Voice as a tool for empowering clients to acknowledge and fight Anorexia.

Sub-theme 1: Creating a helpful distance

Clinicians proposed that the concept of the Anorexic Voice can support people with Anorexia to be more aware of the voice and its impacts. Clinicians argued that the concept could help people to recognise that they have a choice regarding whether to obey the Anorexic Voice i.e. engage in 'Anorexic behaviours' by highlighting that they are not their Anorexia/the Anorexic Voice but a person with a range of other qualities and interests; this does not mean that the Anorexic Voice is not an aspect of their phenomenology or actually separate from them, but that the Anorexic Voice or Anorexia does not constitute them in their entirety and does not define them. Clinicians suggested that the Anorexic Voice could be used to help clients reconnect with the 'bits of them that want something more', to access a wider repertoire of behaviours. Many clinicians framed the Anorexic Voice as an externalisation, a technique from narrative therapy.

Perceptions of the "anorexic voice" among clinicians

Sub-theme 2: Facilitating changes in self-to-self relating.

Clinicians reported that clients' relationship with their Anorexic Voice can change e.g. it can become quieter and less prominent in the context of them developing their ability to ignore/challenge the Anorexic Voice, and/or building up other aspects of their life/identity ('making Anorexia smaller by making life bigger'). Clinicians described a range of ways in which they could support this process, such as through providing a secure, compassionate therapeutic relationship/healthy voice that the client can internalise; directly challenging the Anorexic Voice or supporting the client to do so, and supporting the client to connect or reconnect to their interests and values beyond food and weight. The Anorexic Voice was also presented as relevant to relapse management, in the context of a consensus among clinicians that the Anorexic Voice will never completely go away and can become louder in presence of stressors. Clinicians argued that it was important to alert clients to their vulnerability to relapse and be proactive in managing this.

Sub-theme 3: Not for everyone/'not a one-size-fits-all'.

The majority of clinicians stated that while the Anorexic Voice was a helpful concept for some clients, not all clients related to it, and that clinicians should be guided by clients' understandings of their experience and broach the Anorexic Voice tentatively. Reasons suggested for some clients not relating to the Anorexic Voice were them viewing their experience in different terms e.g. thoughts or a personification other than the Anorexic Voice or as biologically based; them identifying closely with Anorexia/the Anorexic Voice and not viewing it as separable from them; them viewing the Anorexic Voice as an over-simplified concept; them not wanting to be exposed to stigma/shame, and them struggling to think in abstract terms (due to low IQ or a concrete thinking style). Some clinicians emphasised that it was

possible to do effective work without drawing on the concept of the Anorexic Voice. A concern was raised by a few clinicians that using the Anorexic Voice carried a risk of fragmentation, which related to a wider point about not pushing clients too hard as to do so could cause extreme psychological distress and prompt disengagement from services. Some clinicians also expressed concern that the Anorexic Voice could lead to clients disowning responsibility for changing their behaviour. Several clinicians questioned whether the Anorexic Voice was demonstrably different from 'Anorexic' thoughts or a psychotic experience.
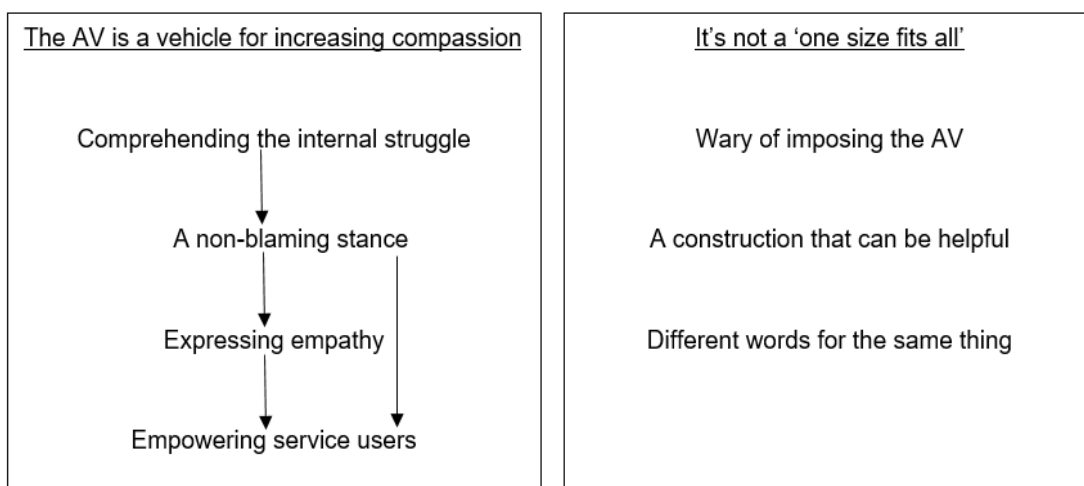
Sub-theme 4: A helpful tool/metaphor

Clinicians presented the Anorexic Voice as one of many possible metaphors for the experience of Anorexia Nervosa. Other metaphors included clients being in a battle with Anorexia, Anorexia as an aggressive plant (bindweed/ivy), Anorexia as an abusive partner, Anorexia as a sharded monster inside you, Anorexia as a pit you have fallen in, and Anorexia as a mini dictator. Many clinicians stated that they regarded the Anorexic Voice as the same as Anorexia or anorexic thoughts ('different words for the same experience'; 'using the idea but not insisting on the terminology'), and/or used the terms interchangeably. A minority felt that the Anorexic Voice constituted particularly powerful/constant/affect-laden thoughts that were experienced as a force. Clinicians also made the point that the Anorexic Voice is not a treatment in itself. However, the Anorexic Voice was presented as a powerful metaphor to convey the suffering and understand the ambivalence experienced by those with Anorexia, and to defuse the client from Anorexia, thus empowering them and helping to destigmatise their behaviour. Several clinicians said that professionals were the source of the concept or it was co-constructed in a 'joint process', and many clinicians presented it

as a concept 'that works'; this fits with a social constructionist framework: 'rather than the form, it's the content and impact I think is key' (Participant 50).

Second draft: Themes as of 19.02.17

At this stage, the themes were in the same form as in the third and final draft, apart from the fact that the second theme, 'It's not a "one-size-fits-all"', comprised three sub-themes. The sub-theme 'A construction that can be helpful', which is shown below, was subsequently subsumed into 'Different words for the same thing'. The themes were also elaborated further by reference to Atkins and Parker's (2012) model of acting compassionate.

```
┌─────────────────────────────────┐  ┌─────────────────────────────────┐
│ The AV is a vehicle for          │  │    It's not a 'one size fits all' │
│ increasing compassion            │  │                                   │
│                                  │  │                                   │
│ Comprehending the internal       │  │     Wary of imposing the AV       │
│ struggle                         │  │                                   │
│         │                        │  │                                   │
│         ▼                        │  │  A construction that can be helpful│
│  A non-blaming stance            │  │                                   │
│         │                        │  │                                   │
│         ▼                        │  │  Different words for the same thing│
│  Expressing empathy              │  │                                   │
│         │        │               │  │                                   │
│         ▼        ▼               │  │                                   │
│  Empowering service users        │  │                                   │
└─────────────────────────────────┘  └─────────────────────────────────┘
```

A construction that can be helpful.

The AV was portrayed as a potentially helpful construction rather than a literal truth. Some participants interrogated the concept, noting that it was not actually a voice and/or questioning how it differed from a psychotic experience:

'A voice is … thoughts going through your windpipe, through your larynx and being projected out there… It's not a voice, so it is a metaphor' (Thomas, Consultant Psychiatrist)

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'It can get to such a strength that you think, if you're really talking about hearing an external voice, what is it that makes that not psychotic?' (Katherine, Counselling Psychologist)

Several clinicians noted that professionals may have introduced the concept to clients and many adopted the pragmatic stance that it is a concept 'that works' (Victoria, Consultant Psychiatrist) in terms of understanding the experience of AN and equipping clients to make positive changes:

'It's a technique to improve communication, improve engagement, improve understanding of staff' (Victoria, Consultant Psychiatrist)

'It is really good to use in your toolbox to bring out: "Right, we need to do a bit of splitting here"' (Tina, Nurse)

Appendix 14: Additional illustrative quotations

Theme 1: The Anorexic Voice is a vehicle for increasing compassion.

Comprehending the internal struggle.

'To understand the importance of something like "Oh, they haven't sent up your sandwich today, they've sent up white bread instead of brown bread"' (Rosie, Nurse)

'It's a terrifying commentary on what will be if you don't' (Lucy, Drama Therapist)

'You are kind of saying to people, "Let go of this thing that keeps you safe, protected, secure and has loads of rules…and be really comfortable with uncertainty, anxiety and everything that life throws up"' (Yvette, Occupational Therapist)

'This is a friend, a friend that always is there' (Selena, Consultant Psychiatrist)

'The voice tells them, "People are trying to trick you, you don't really need to be here, they just want to fatten you up"' (Katherine, Counselling Psychologist)

'People often experience that shift when they're trying to get rid of the anorexia: the Anorexic Voice can become quite cruel' (Lisa, Healthcare Assistant)

A non-blaming stance.

'It's got to inform you who is in charge at this precise moment in time because I think they can be a very frustrating group of patients to work with' (Tina, Nurse)

'I think the most helpful thing about it is the non-blaming of it' (Victoria, Consultant Psychiatrist)

'It can be really good for some people who blame themselves for being ill because it does really help to separate it, and so when you're talking about this Anorexic Voice it's highlighting that it's a separate thing to them and it's not their fault' (Lisa, Healthcare Assistant)

Expressing empathy.

'Their experience in so many places not being understood – they're not understood at home, they're not understood at medical wards, they're not understood in GP practices, they're not understood in CMHTs – everywhere they go they're not understood' (Victoria, Consultant Psychiatrist)

'It can often be quite a shaming experience for people and something that they hide because it makes them feel a bit mad. So I think being able to share that with somebody else who can acknowledge that can be helpful' (Katherine, Counselling Psychologist)

Empowering service users.

'If you can get somebody to start thinking that way: "Okay, this is a part of me that is coming from an eating disordered place, still part of me but it's actually not my personality"' (Rosie, Nurse)

'I'm attacking the Anorexic Voice more head on because I'm constantly challenging those thoughts and feelings and fears about food' (Laura, Dietetic Assistant)

'Sitting and having a conversation with the Anorexic Voice can make it more quiet, or more muffled, or more distant, or less aggressive' (Yvette, Occupational Therapist)

'I…introduce the concept of the Anorexic Voice pretty early on so they have an awareness of it and what that does and how it affects them and how it limits them, so they can report back pretty quickly and we can start looking at that and try and remove any barriers for managing the voice' (Elizabeth, Nurse)

'[A colleague] does a lot of chair work with people, which I am no expert on whatsoever but I know that in terms of therapeutic techniques that can be quite helpful. You then have the sort of process of externalising but bringing together, because the person can be both their Anorexic Voice and also themselves' (Katherine, Counselling Psychologist)

Theme 2: A powerful metaphor but not a 'one size fits all'.

Wary of imposing the AV.

'I hear quite a lot of people saying, "Yeah someone mentioned that to me, but I didn't really get it". Or, "Yeah, but I don't have one"' (Susan, Clinical Psychologist)

'Sometimes the Anorexic Voice can be seen as an over-simplification for a very complex concept' (Thomas, Consultant Psychiatrist)

'The Anorexic Voice, someone with autism or a Learning Disability might not be able to really understand what that is…. So if it's something quite abstract they might not be able to connect to that or use it' (Laura, Dietetic Assistant)

'I think perhaps that it does fragment people, it doesn't enable them to have a more holistic experience of themselves' (Katherine, Counselling Psychologist)

'If you push too hard, the voice will get louder and you won't see them again' (Thomas, Consultant Psychiatrist)

'It's only a big deal if it's a big deal to them' (Thomas, Consultant Psychiatrist)

Different words for the same thing.

'We have to be open to new ways of thinking about it and new models…Look at it with medical glasses, and then use your biopsychosocial approach, psychotherapy, psychotherapeutic, psychodynamic perspective, spiritual aspect' (Thomas, Consultant Psychiatrist)

'Whatever model is being used, it's really important just to have some sense of what someone's inner experience might be' (Susan, Clinical Psychologist)

'People who've never heard of it very quickly understand what you mean when you use it' (Victoria, Consultant Psychiatrist)

'For some people it's helpful to divorce themselves from the Anorexic Voice, so to externalise the voice' (Michelle, Clinical Psychologist)

'The way that the Eating Disorder is and how it can kind of mess with people's heads, it's helpful sometimes for people to refer to it as the voice that's there' (Rosie, Nurse)

'It's a useful way of describing what a lot of people are experiencing and what a lot of people might have come saying: 'This is what's going on for me. This is what I'm battling with every day.' And trying to describe it. And it's a useful phrase to capture those experiences' (Susan, Clinical Psychologist)

'You can very quickly say, "What are the kinds of things that you hear from your Eating Disorder?" if you say that, nine times out of ten people will be able to answer straightaway' (Lucy, Drama Therapist)

'For some people, seeing it almost as a separate thing that you label as a thing that has a voice and has a plan is something that can be really, really useful' (Jessica, Clinical Psychologist)

'We talk about it being like an alcoholic – that it's there and it's something that's always going to be part of their life' (Sarah, Art Psychotherapist)

'Bindweed is so beautiful...But you take your eyes off it and it's up strangling everything in its path, and then you can't just pull it off because you snap and damage the plant underneath… You've got to nurture the plant, give it additional support' (Sarah, Art Psychotherapist)

'You don't want to just be in a position with Anorexia that it's like trench warfare so you're living with it and…it's just waiting for a chance to take over. You need to get to a point where you've actually defeated it' (Victoria, Consultant Psychiatrist)

'People have described it like a sharded monster inside, that actually just has nowhere to escape' (Yvette, Occupational Therapist)

'Think about your Eating Disorder as like we're digging a hole in the sand and if we don't put something in it all that's going to happen is the sand is just going to trickle straight back in' (Michelle, Clinical Psychologist)

'You see some people absolutely love talking about it. They're like, "Yeah it's like this. It's this giant monster. And we can think about it differently like this or I need to talk to it like this instead"' (Susan, Clinical Psychologist)

'We work with the Anorexic Voice but I don't usually call it the Anorexic Voice; we just talk about the anorexic thoughts and feelings' (Laura, Dietetic Assistant)