An exploration of the role of nursing in the inpatient treatment of anorexic adolescents: reworking the infantile feeding relationship as a template for recovery.

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Abstract

The aim of this study is to explore how nursing professionals, working in a specialist adolescent inpatient eating disorder setting, experience their role in emotionally supporting the young people in their care and managing the demands of their working role.

Data was gathered using semi-structured interviews of two nurses and five nursing assistants and this was analysed using IPA (Interpretative Phenomenological Analysis). Six emergent themes will be considered:

Regulating appetite for life
Active waiting
Digesting experiences
Cleaning up
Connecting as a team
Preparing for an ending and letting go

Comparison will then be made to the infantile feeding relationship and how, through reworking this, the nursing staff facilitate the patients to develop a healthier approach to relationships, experience and life. Recommendations are made regarding how nurses can be supported in their work and the importance of recognising and valuing the difficulty of the emotional aspects of the work.

Keywords: adolescent, Anorexia, cleaning, connection, digestion, distress, emotion, ending, experience, feeding, inpatient, leaving, maternal, nursing, parenting, paternal, patience, processing, regulation, support, team, termination, relationship, waiting

Contents

1. Introduction

My interest in eating disorder has been longstanding, and prior to undertaking the child psychotherapy training I gravitated repeatedly to work with adolescents, children and infants who were struggling with intake. This study initially grew from interest in understanding more about underlying difficulties in disordered eating and wanting to explore how symbolism around food may become linked to the concrete process of taking in nourishment and thus difficult for these patients. I had noticed that, in the English language, food and digestive processes are often used as symbols to describe situations in everyday life. We say, for example, “I have a lot on my plate” or “I couldn’t stomach it”. In psychotherapy literature also these connections are made, for example Williams (1997) stated in her description of one anorexic patient after a period of work:

> *In the countertransference, I was less worried…feeling rather like a parent who puts a plate on the table: the child is free to take the food or not (p.120)*

And so I wondered whether this link might be clearly observed in this population if a way could be found to bring it into focus.

I had initially thought of interviewing and observing how anorexic adolescents were managing through ritualistic behaviours in regard to eating and exercise. I theorised that developing a system of managing within the ward environment would elicit coping mechanisms that might tell us something more about the underlying issues. Unfortunately, it quickly became apparent that this was a group of young people who, even aside from the ethical considerations of whether they could be considered well enough to take part in research, were unlikely to consent to research given their condition.

The research thus evolved to thinking about who might be said to have insight into the internal worlds of these young people. From my own experiences as a nursing assistant, prior to my child psychotherapy training, it seemed that there would be significant value in looking to the nursing staff involved in the care of these young people. I wondered whether nursing staff experienced something akin to countertransference in their working with these young people (perhaps a “gut instinct” evoked by the work) and whether this was felt to be of use in guiding their responses or whether it interfered with the structure and rules that maintained a working unit. This research idea then evolved further to a more exploratory stance of seeking to understand how nursing staff feel when working on the ward, how they use their feelings, or not, in the work and how they manage their emotions in order to withstand this difficult work.

The two years I spent as a nursing assistant on a generic mental health ward had been difficult. On the ward the nursing assistants would often be referred to as the “unqualifieds”. It seemed we were defined not by our capacities but by what we did not have and what we could not do. The nurses seemed also, however, to be viewed separately from the wider team, which sat upstairs whilst the nurses sat down on the ward. Attempts to build a space on the ward for nurses to think and meet together was frowned upon, as this was viewed as avoidant of the work of “being with” the young people. This study grew from a wish to validate the emotional work I felt I was doing as a member of that nursing team, although this wish was not apparent to me as I prepared the study.

When I began my training placement on an eating disorders ward, I observed again the difficult relationship between nursing and wider team. The focus during ward rounds seemed to be on whether nursing paperwork was complete, with one nurse held accountable for this regardless of her not being constantly present on the ward to oversee its completion: as though nurses were seen as interchangeable rather than as separate individuals. Again, I observed what seemed to be a phantasy that nursing staff avoided or neglected the young people, rather than a recognition of the almost impossible nature of the role: with many tasks being held by the nursing team, which perhaps led to the need to prioritise some above others in the moment. When paperwork was incomplete it seemed that context and deeper meaning was lost, and no one knew what had happened that had prevented the completion.

I wanted this study to be an opportunity to think about that deeper meaning: to look at the ward dynamics and perhaps the aggression and rebellion in not completing paperwork (perhaps in identification with the patient group) or perhaps the communication of overwhelm, exhaustion, panic and confusion leading to the loss of the ability to think, let alone remember the routine tasks. This study, however, also seeks to give nursing staff a voice, see more clearly what they do, recognise the value of the observational information they gather about the young people in their care and suggest a framework which may help nursing staff to process this data.

In my work as a nursing assistant there was little opportunity to really think about what my observations might mean; what part I might be playing in a wider picture and what insights I might add to the understanding of the patient based on my unique position of spending so much time with them on a day-to-day basis. I hope, therefore, that this study might further thinking about the dynamics in eating disorder units, highlight the importance of thinking spaces for nursing staff to make sense of the work and also highlight to psychotherapy colleagues the value of the nursing contribution to care of eating disordered young people and the wealth of understanding that may come from gathering their observations and insights.

2. Literature Review

This literature review was undertaken using PsychINFO as a starting point and using the search terms:

- Objective OR Rationale OR Task OR Function OR Purpose OR Job OR Role
- "Eating disorder" OR Anorexia OR Anorectic OR Bulimia OR Bulimic
- Nurse OR Nursing OR "Support staff" OR "Support worker" OR "Care worker"
- inpatient OR ward

which were then combined using the Boolean operator “AND” (see Appendix J for a picture of the original search). This produced 36 results, which were screened for relevance, of which 7 were found to have relevance. Looking then to the bibliographies of these papers brought further relevant research articles and nursing theory texts. Reading the bibliographies of these further papers again brought more results. This process was concluded when I recognised repetition in the bibliographies, suggesting that relevant articles had been exhausted. Additionally, authors were approached for copies of texts and these authors provided several of their other works, some of which also had relevance.

2.1. How is Anorexia Nervosa defined and understood?

According to NICE (The National Institute for Health and Care Excellence), anorexia nervosa is defined as “restriction of food intake or persistent behaviour which interferes with weight gain and leads to low body weight” and “Anorexia nervosa is associated with body image disturbance and an intense fear of gaining weight” (Eating disorders | Topics A to Z | CKS |

NICE, 2020). They report the most common age of onset of Anorexia Nervosa as 15-19 years.

Anorexia Nervosa is a condition which frustrates care and treatment. The young person does not, at least initially, comply with the help offered and this can create a bewilderment and stuckness in the system around the young person. Ensuring the young person's safety can necessitate a degree of forcing and a taking back of control around food, which can lead to an increasing battle of wills and, in severe cases, admission to hospital where the young person's free will may be completely overridden through tube feeding against their will. Whilst this might break the deadlock and whilst feeding is clearly a physical necessity for some of these young people, it is not clear whether this "treatment" leads to genuine "recovery" or merely compliance (Wright & Hacking, 2012).

In order to think further about what elements of treatment are actually aiding in recovery it is first important to develop a clear understanding of the condition and what thoughts there are about what causes or underlies it so that a logical progression to a treatment model can be developed.

2.1.1. Child psychotherapy models

2.1.1.1. Freud

Psychoanalysis considers anorexia to be a disorder of extreme narcissism: thus in Freud's (1911) terms a disorder in which libido has been withdrawn from the external world and placed into the ego.

However, Freud (1911), in his discussion of the case of Schreber, also made the link that external symptomatology expresses internal preoccupations and repressions: that symptoms may therefore tell us about the aetiology of the condition, prior to the of advent of extreme narcissism. In terms of anorexia this might suggest that a difficulty with the symbolic meaning of the food, act of eating or some other connection interferes with the sufferer's capacity to take in nourishment.

Schreber was described as otherwise functional but

> *full of ideas of pathological origin…more or less fixed, and…inaccessible to correction by means of …judgement of the external facts* (p.15)

Likewise the anorexic patient is not always amenable to evidence of their poor physical state and does not see themselves as thin or ill. Even those who are able to recognise their predicament remain driven to limit their intake: finding it very difficult to change their behaviour. As with Schreber, the difficulty cannot be solved by intellectualisation of the problem: the symbol of food being too heavily connected to the underlying difficulty.

Freud (1917) also described the patient's enjoyment of torturing their object through their illness noting that

> *…the patients usually succeed, by the circuitous path of self-punishment, in taking revenge on the original object and in tormenting their loved one through their illness* (p.251)

and recognising that behaving in this way avoided the need to be more openly hostile. In regards the anorexic patient hostility is often expressed, but the focus on food perhaps removes the need to express hostility regarding some other grievance which may or may not be consciously recognised.

Denial can also arise that asserts anything from the outside: be it relationship, object or non-self item, has any value at all. This acts to evade feelings of envy, greed or loss of the object. Freud (1917), however, suggested that greed or envy might still be evaded even if there is some recognition of the object's value. In this situation the close dyadic relationships created by the anorexic young person can be seen as an attempt to devour the object and thus incorporate its desired elements. Continuing to do so thus evades loss or envy as the object is felt to be inside the patient, albeit in a damaged state, and greed is sated.

2.1.1.2. Klein

Klein (1929) described that the child's first anxiety is that of the coming together of the parents in cruel and sadistic union and, in response to this, the child phantasies an attack on the mother's body and the penis felt to be within it. However, this leads to further anxiety as mother is felt to be injured and retribution is expected.

Symbol-formation and the capacity to play out these anxieties in an arena removed from the direct anxiety in relation to mother was described by Klein (1930) as a developmental process in which the child is able to sublimate their anxiety regarding their desires towards mother's body and displace interest symbolically into the world.

In her patient Dick (1930), however, this process was halted because his symbols remained concretely attached to their original source and thus he remained too anxious to play out his phantasies in a symbolic arena. She describes, in fact, that he was

> *Absolutely incapable of any act of aggression…clearly indicated at a very early period in his refusal to bite up food.* (p.224)

So, in terms of an anorexic patient, this would suggest that the symbolism behind the act of eating has not been successfully disconnected from the original anxiety.

Klein (1935) elucidated these anxieties and described the consequent inhibition in taking in: that the object is bad and would poison what is good inside or is good but will be destroyed by the process of taking in or damaged by something bad inside. Where the object is felt to be bad this is due to it's being retaliatory following the aggressive attacks of the child or poisonous from having been "sadistically destroyed" (p.264). Klein drew attention to these anxieties leading to difficulties with introjection and even concretely with the taking in of food. However, as the child becomes more secure in their sense of a good object, so they become driven to take in. Klein (1935) described the phantasy of the good object being preserved inside the self and safe from dangers which are then projected. However, again, this leads to a fear of further introjection (and potential consequent impact on consumption for an anorexic patient) as the fear becomes that projected persecutors would be again introjected and endanger the good object. Alternatively, projection of the bad may be inhibited by concern that the good would be lost alongside, and thus bad objects are maintained internally in order that good not be lost However, in doing so the good is felt to be attacked and endangered by the bad and again the drive to introjection for the anorexic may be inhibited through fear of the newly introjected good object being damaged by this bad inside. Finally, anxiety may arise that the very process of introjection, particularly where the child feels greedy and cannibalistic towards the good object, has damaged it, broken it to pieces, chewed it up or destroyed it. So, again, the child may inhibit their intake and deny their greed as a way of protecting the good object.

However, Klein (1935) suggested that regardless of attempts to control these worrying introjections and projections they continue in phantasy and lead to unbearable anxiety and fear that the object is destroyed as well as increasing demands from the internal good object in order to preserve it: demands for the anorexic which may be around severe limitations to intake.

Manic defences may also arise in order to escape this anxiety situation. Klein (1935) described that denial is one sign of a manic response such that the child denies

> *…the importance of its good objects and also of the dangers with which it is menaced from its bad object* (p.277)

and this can be seen in the anorexic who denies both need of food and the danger of their emaciated state. Additionally, if concern for the object's survival does arise, Klein (1935) described that this is obliterated through contempt and scorn: through insinuation that the object is irrelevant and that other objects will fill the space should this one be lost.

Alongside this, Klein (1935) described that the child employs omnipotence as an attempt to "master and control all its objects" (p.277), preventing intercourse between the internalised parents through keeping them apart. Again, for the anorexic, this internal phantasy can be observed externally through the assertion that they are completely in control of their bodily needs. Finally, Klein (1940) describes the use of idealisation as a way of manically retaining faith in the survival of the good object. Again, for the anorexic, the anorexia is idealised as a means of ensuring that the individual will survive despite the risks to health, as long as they adhere to the demands of this exacting object.

2.1.1.3. Post Kleinian

Joseph (1982) described a particular type of sado-masochistic patient she termed “addicted to near death” (p.449) for whom,

> *no ordinary pleasure…offered such delight as this type of terrible and exciting self-annihilation* *(p.451)*

These patients are pulled towards seeing themselves destroyed and even though they might wish for liberation, the addictive nature of their predicament is stronger they any wish to recover. This would seem to be a very good description of the anorexic, who works against their treatment and against health. Joseph (1982) described that, in therapy this patient was

“pulling back towards the silent kind of deadly paralysis and near complete passivity.”
(p.454)

and that the therapist is unconsciously invited to join in endless criticism of the patient, whilst silently the patient mocks their interpretations and treats them with contempt: appearing to listen, but in fact not taking anything in.

Rosenfeld (1987) investigated the aetiology of the “input blocking” child, and suggested that projections from mother, perhaps even prenatally may lead to this outcome. He described that, when mother has repressed feelings of intense disturbance or embarrassment, these can be reactivated during pregnancy such that child is felt to contain these repressed or hidden feelings. This led to the infant, from the beginning of life being terrified

> *that they may at any moment have to guard against something very frightening which is being forced into them” resulting in the “need to block the mother’s influence (p.276)*

Rosenfeld (1987) describes such patients as appearing not to care about anything, instead:

> *constantly attacking anything and everything which might be likely to satisfy their libidinal needs (p.22)*

and Steiner (1993) described a position of “psychic retreat … where the patient is dominated by feelings of resentment and grievance” (p.74). However, he also described that objects are denigrated such that they are: “tormented, disabled, and held onto in a half dead state” (p.75). The patient, therefore, does not resolve the difficulty by freeing themselves of the object, but rather devaluing and weakening it as a way of holding onto it in some form and ensuring it cannot leave. In eating disorder, the patient ensures they have the constant attention of their object through their refusal to eat and yet the object is never rewarded for their ministrations: rather they are taken to the point of exhaustion and never permitted to make amends for their perceived failings. It would, therefore, seem that the patient cannot imagine an object who might stay with them, and thus ongoing illness is needed to hold the object in a close but disabled state.

Britton (1989) described this “input blocking” as a turning away from knowledge of the parental relationship: that what is being blocked out is the child’s knowledge about their exclusion from the parental relationship which is too unbearable to face as:

“the notion of a third always murders the dyadic relationship.” (p.100)

In this view, the anorexic child’s position is thus to deny the parental relationship and this denial then may be played out in reality: the illness creating a situation in which one parent is drawn close while the other is excluded, thus splitting the parents in such a way that the intolerable parental relationship is annihilated.

Summing up all these preceding thoughts around blocking of knowledge of parent’s relationship and appropriation of the object in a controlling manner, Meltzer (1992) described the deterioration towards the claustrum: a position of increasing sado-masochistic delight in phantasied ownership of the good breast. Anorexia might be understood as a delusion of self-sufficient ownership of the breast and sadistic torturing of the object, claiming no need and denigrating the good breast whilst simultaneously in phantasy imagining that the individual contains everything they need to survive.

Williams (1997) described this “input blocking” as the “no-entry” defence

> *developed by a child who has perceived himself/herself (early in infancy), to have been invaded by projections ...The ‘no-entry’ syndrome performs the defensive function of blocking access to any input experienced as potentially intrusive and persecutory. (p.121)*

Williams (1997) went on to name this type of intrusion convex (the child being used as a receptacle for parental anxiety rather than the child’s anxiety being contained): a process she called “omega function” as a direct opposite to Bion’s (1962) alpha function. These young people have thus been projected into in such an extreme and frightening way (or have experienced their caregiver in this way) that they have learned to treat anything coming in as dangerous and needing defence against. This leads to a blocking of any taking in, including that which could be positive for the child.

Whilst anorectic patients are essentially recognised to be unreachable for long stretches of therapeutic work, Williams (2002) describes the helpless and hopeless “whimper” (p.56) of “the voice that asks for release” (p.56), the part of the patient who is suffering and trapped in the anorexic claustrum. However, this “is immediately followed by an identification with the killers” (p.56) and return to sado-masochistic delight. Here the patient is momentarily aware that they are trapped but cannot sustain this vulnerability and is pulled back into claustrum functioning.

Waddell (1998) suggests that in late adolescence there is a goal of separating from parents and moving towards development of their own dyadic relationship. This is, therefore, perhaps a moment of change at which, if developmental work in the internal world has not been sufficiently successful then development cannot occur and it is thus a tipping point where the pathological pathway described above can be activated. This may explain the adolescent onset common to anorexia.

Waddell (1998) describes that some relationships, whilst they might appear developmental are in fact defensive: relationships developed superficially and pre-emptively rather than because the individual has reached a stage of readiness. Anorexia might be seen in this way: a defensive coupling with the self to the exclusion of others, which puts a halt on development, separation and moving on. This would suggest that the anxiety around development has been too much for the individual: the separation and also perhaps the fear of remaining alone rather than finding the new dyadic relationship which Waddell (1998) describes. Thus, the anorexia both puts development on hold, returning the child to a position prior to the feared change, remaining childlike in body and often emotionally close to mother whilst also creating an illusion that a dyadic relationship is already achieved, with the anorexia, so that the anxious developmental stage is circumvented.

Orbach (1998) draws attention to the pressure from society on women around body image, anxiety around pubertal development, lack of control over their drastically changing bodies and their change in status in society as they develop a sexual identity. She further describes that there may also be difficulties in the relationship with mother, perhaps related to feeling that a son would have been preferred, which leads to

> *…rejecting what her mother gives and hurting her in the most powerful way she knows how while simultaneously carrying out what she imagines to be her mother's wish, which is for her to disappear.* (p.160)

And Fairburn & Harrison (2003) report that around 90% of eating disorder cases arise in females which would seem to suggest that consideration of the particular pressures on women is important.

Segal (2001) described further the failure of symbol formation when the symbol remains linked to the original, anxiety provoking, object:

> *When symbols are formed by projective identification, the result is what I called a symbolic equation. A part of the ego becomes identified with the object and, as a consequence, the symbol is equated with the thing symbolized.* (p.150)

This led to her description of the man unable to play his violin because for him this was masturbatory. A broader possibility, for the anorexic child, then is that perhaps the process of eating is so linked, through projective identification, to various underlying anxieties that physical “taking in” becomes unmanageable through symbolic equation (e.g., it is felt to be the same as “eating up” the object). It seems that narcissism arises, therefore, to manage the impasse caused by the difficulty with symbolism, creating a situation in which the object is not “eaten up” because the individual does not eat.

Skogstad (2013) describes patients who experience the therapist as an intolerably impervious object. To use William’s (1997) language: they are not acquainted with an object who they feel might receive their projections. Skogstad suggested that these patients need to see that they have got through to someone and that the therapist has been genuinely moved. From Steiner’s [1993] perspective, however, these patients expel “unwanted mental contents” (p.132) but any attempt to process such projections is beyond the capacity and willingness of the patient to accept. Combining these two theoretical ideas, therefore, suggests that these patients may be in a double bind in which they cannot or will not take in from their therapist nor can they experience successfully capturing their therapist’s attention. The eating disordered patient in this predicament thus seems to imagine that their object rejects them just as they reject their object. They cannot believe in a mind that is receptive or interested in them. For these patients a sense of grievance is maintained, through feeling constantly rejected, which may lock them further into an angry, resentful state of mind.

This wealth of theory illustrates the great complexity of working with patients who are not often on the side of working towards health and have clearly undergone a psychic deterioration over a long period. Supporting the increasing recognition of the victim part which desires separation and strengthening the wish to fight and emerge from what Meltzer (1992) and Williams (2002) describe as the promised delights of the claustrum or “gang-like” constellation (which offers safety) is the purpose of therapy.

2.1.2. The family therapy model

Minuchin (1972) described the “psychosomatic family” in which rigidity and an overprotective attitude prevents the child from developing appropriate levels of autonomy. The family seeks to preserve the way things have always been and is resistant to change. Conflict is seen as dangerous and is avoided at all costs and he gives descriptions of treatment in which conflict is provoked in order to equip the family to begin managing this. He maintained that treatment of the child in individual therapy was potentially ineffective, if the “psychosomatic family” system was not treated, as the illness is used as a distraction from the family’s inability to resolve or even acknowledge conflict.

2.2. How is Anorexia Nervosa currently treated?

NICE recommend FT-AN (anorexia-nervosa-focused family therapy) as first line treatment for children and adolescents (18-20 sessions over 1 year) where focus is on empowering the family system. CBT-ED (Cognitive Behavioural Therapy for Eating disorders - 40 weekly individual or family sessions) or AFP-AN (Adolescent Focused Psychotherapy for Anorexia Nervosa – 32-40 individual sessions over 12-18 months alongside 8-12 family sessions) are then recognised in the NICE guidelines if FT-AN is “unacceptable, contraindicated or ineffective” (Eating disorders | Topics A to Z | CKS | NICE, 2020).

Inpatient treatment becomes indicated if weight loss is rapid and weight is below a safe range, there are heart complications such as bradycardia or tachycardia, hypothermia, infection, overall ill health or rapid deterioration, reduced muscle power, abnormal blood tests, risk of refeeding syndrome, suicidal ideation, serious self-harm or lack of support and management at home (Eating disorders | Topics A to Z | CKS | NICE, 2020).

2.2.1. The family therapy model of treatment

Eisler (2005) acknowledged that Minuchin’s (1972) theory regarding the “psychosomatic family”, which prevents the child from the development of autonomy, might hold true for some families. However, he highlighted that it did not seem to hold true for every case and confirmatory studies had not been able to show whether the rigidity and conflict avoidance observed predated the anorexia or was a result of the difficulty of living with an anorexic child. He felt that this theory was perhaps not sufficient to describe every family with an anorexic child and that perhaps further attempts to describe the “anorexogenic” family would not be successful. His interest, however, was in the apparent similarity of families’ experience of living with a child with anorexia. This shift from attempts to describe the aetiology of the condition to instead thinking about the maintenance of the condition within families led to the FT-AN treatment which is now the gold standard within the NICE guidelines.

This treatment focuses on making “use of the adaptive mechanisms that are available in the family both individually and in the family as a whole” (Eisler, 2005, p.118). This encourages the family to build on their own capacities to problem-solve the difficulties: capacities which have been obscured and overruled by the stress and panic associated with having a child who will not eat. This treatment acts to reframe family dynamics: as needed to help the child recover, rather than as pathological and causative of the difficulty.

Results of a randomised controlled trial (Eisler et al, 2016) have also suggested multi-family therapy as another viable and perhaps superior option to FT-AN (75% remission rate compared to 60% for FT-AN) in helping families to use each other as a resource to find answers for the eating difficulty rather than relying on professionals.

However, Simic et al (2017) focussed on the further work needed on what adjuncts might increase effectiveness of the treatment for those who did not respond to the family therapy approach (particularly highly anxious or dysregulated adolescents), suggesting that even within the success of the family therapy model of treatment there remains a role for other disciplines in treatment of more resistant cases.

2.2.2. Nursing models of treatment and recognised difficulties to overcome

The Royal College of Nursing describe 8 “principles of nursing practice” which set forth what a nurse in any setting would be expected to be doing (Principles of nursing practice | Royal College of Nursing, 2020). In summary these are:

- to treat everyone in their care with dignity and humanity: understanding individual needs with compassion and sensitivity

- to take responsibility for the care provided
- to manage risk and keep everyone safe in the places they receive care.
- to involve patients, families and carers in informed choice and decision making
- to assess, record and report on treatment and care with sensitivity and confidentiality, deal with complaints effectively, and conscientiously report concerns.
- to have up-to-date knowledge and skills, and use these with intelligence, insight and understanding in line with individual needs.
- to work closely with their own team and other professionals, making sure patients' care and treatment is co-ordinated, is of a high standard and has the best possible outcome.
- to lead by example, develop themselves and other staff, and influence the way care is given in a manner that is open and responds to individual needs.

Whilst these give an account of the overview of nursing care in a formalised way, much further research has been done trying to define nursing treatment, both more generally, and also specifically in regard to treatment of anorexia. Here I limit this review to only studies which seem to have relevance to the treatment of anorexia and relevant studies have been listed in date order.

Part of the nursing role would seem to be in how the nurse manages to sustain her own capacity to perform the role in the face of much stress and distress so that she can continue to provide patient care in the longer term. Menzies Lyth (1960), a psychotherapist who wrote about the stresses of the nursing role, described how, alongside their own anxieties, which she described as primitive, life or death anxieties, nurses were often in receipt of the anxieties of patients and their families. She described their being expected to take on responsibility for the patient in such a way as to free the family and patient of doing so. In order to reduce the impact of these anxieties, Menzies Lyth (1960) observed that the system introduced mechanisms to limit and routinize patient contact in order to discourage attachment and reduce responsibility through reducing decision making. In addition, anxiety is managed in the system by projecting “irresponsible” behaviour onto junior staff members and capability into seniors, which again discourages staff being seen as individuals but rather as “lazy juniors” or “omnipotently capable seniors”. It seemed that this enabled nursing staff to manage anxiety in the short term, as inadequacy could be projected into juniors, freeing staff from addressing their own anxieties about their capabilities. However ultimately this led to staff being overburdened because they dared not allocate work to the juniors. Likewise idealising capable seniors enabled staff to feel protected by those in more senior roles, but ultimately this would lead to staff again feeling inadequate in comparison to these idealised others and impotent from having projected their sense of capacity. Over time this system of nursing became increasingly untenable as nurses felt both overburdened and yet unable to perform.

Travelbee (1964) advocated for sympathy in the nursing role: suggesting that empathy is too distanced and pity potentially condescending with some patients or too collusive in a “poor me” attitude in others. She suggested that:

> *the sympathetic person feels another's distress; he is touched and moved by it and actively wants to do something to alleviate it* (p.69)

and that this genuine wish to help is what nurses should be striving for, highlighting that in sympathy the nurse does not respond simply because it is her job (as perhaps in empathy) or due to her own internal distress (as perhaps in pity). The reaction is towards the patient and their situation only.

Forchuk and Westwell (1987) theorised about the undermining of the therapeutic alliance if the nurse directly addresses denial: how this increases the patient's anxiety making the denial more necessary. They recommend strategies based on allowing time, working on less direct parts of the underlying issue and finding a balance which is neither challenging nor complicit with the denial.

Peplau (1999) theorised that:

> *The aim of nursing care of psychiatric patients is to assist the patient to struggle toward full development of his potential for productive living in the community* *(p.14)*

further highlighting the need for sustained effort over time in effecting change. In her paper she described two methods: firstly "disrupting" (p.16) replicated behaviour that has become pathological (which may be similar to what Joseph (1982) describes as "chuntering"), suggesting that the nursing role is in interrupting the cyclical nature of this. She secondly described discouraging linguistic generalisations and encouraging the patient to focus on detail. Peplau felt this helped the patient to recover meaning as well as recognising the separateness of the nurse's mind, because they need to explain what they are talking about. Here Peplau seems to be describing the nurses' role in supporting her patient to think and this would perhaps have value in eating disorder treatment, in encouraging the patient to recognise and begin to challenge their preoccupations and worries about food.

Snell et al (2010) in a New Zealand study, interviewed seven nurses and, using grounded theory, drew attention to the importance of connection in the treatment of anorexia: developing, negotiating and coordinating connection. Whilst this was a study which focussed on the connection between staff and patient, within "negotiating" the researchers noted how the staff used each other as a support in maintaining faith in the work and supervision to process the experiences, both of which maintained their capacity for the work. They also noted in "coordinating" how nurses acted as a conduit between the patients and the wider team: relaying information between the two. Given the splitting that is classically described by this patient group, being able to hold a place between the splits would clearly be of value and the description of using the wider team for support would seem to indicate the value of a robust and resilient team in meeting this difficult patient group.

Ross & Green (2011) interviewed two anorexic women about their experience of inpatient care in a UK unit and used narrative thematic analysis. They reported that the relationships built in inpatient settings were highly valued: facilitating expression of extreme emotions which, in containment, built a sense of a "secure base" (p.117) which was necessary before interpretative therapeutic work could begin.

In a UK based study, Wright & Hacking (2012) interviewed six adult anorexic women, following discharge from hospital, and seven healthcare professionals, five of whom were nurses. They found that the patients considered weight goals as irrelevant and valued more the security, nurturing, optimistic and maternalistic context. However, they noted that some patients were using the setting for respite rather than recovery, so the researchers recognised that it remains unclear whether the elements they valued were in fact elements that were aiding in recovery.

Zugai et al (2013) in an Australian study interviewed eight adolescents who had recovered from anorexia and found, among other things, that well timed interactions were prized in helping them to engage in the treatment programme. Interactions were also valued if they were positive and thoughtful, and the researchers encouraged nursing staff to take the time to build an individualised understanding of their patient to support the development of therapeutic alliance.

In a North England based study, Pemberton & Fox (2013) interviewed eight adult patients with anorexia and using IPA identified a role for nurses in being predictable, and in understanding and helping to name patients' emotions. Participants reported this encouraged them to be increasingly more open to revealing their emotions rather than suppressing them, which they tended to do. They also identified that these patients tended to adjust their initial emotional response in order to preserve a relationship with a nurse: blaming themselves instead of the nurse for a difficult encounter. This would seem to be a counter finding to theoretical suggestions that such patients tend to attack and break down relationships (Rosenfeld 1987) and may indicate the emotional progress that adult patients have made.

Davey et al (2014) interviewed twelve staff (seven nurses, three support workers and two occupational therapists) working in UK adult eating disorder units and identified that the complex and demanding work required “effective teamwork, communication, and support systems” (p.60). They identified that whilst group supervision was mostly valued, individual supervision was more so and immediately being able to speak to colleagues following an incident was the most valued support of all.

However, Wright & Schroeder (2016), in their UK based study using the same data from the 2012 study by Wright & Hacking, highlighted the vulnerability of nurses treating eating disorder patients to various abuses from this patient group including violence and verbal abuse which lacked respect. They highlighted the need within the role to establish a professional therapeutic relationship, establish boundaries around respect, not take things personally, calmly repeat instruction without engaging in bargaining and engage in regular supervision in order to ensure that the nurse is able to continue in the wider role without burnout or breakdown.

In a Norwegian study, Hage et al (2017) observed nurses at a ward mealtime and conducted twenty interviews to explore mealtime “rules” and occasions when rules were “bent”, seeking to further elucidate what nurses were doing and perhaps why. They identified that nurses sometimes bent rules due to deeper understanding of a patients’ needs, i.e. with patients with whom they had a good therapeutic relationship and recognised that bending a rule would be emotionally helpful. Additionally, rules were sometimes bent if they did not impact the patient’s physical treatment or countermand their careplan, but where flexibility might positively impact the therapeutic alliance and patient experience: for example switching one milk drink for a similar one.

Salzmann-Erikson and Dahlén (2017) conducted a descriptive literature synthesis of fourteen articles and found that eating disorder patients’ adherence to treatment was likely to be increased when nurses treated them in a person-centred manner, treating each patient as an individual and not making generalisations about them as a patient group. They stressed “the importance of understanding the complex mechanisms that reach beyond the patient’s manifestations of symptoms in order to overcome negative spirals in the relationships” (p.10).

Fogarty & Ramjan (2018) used a questionnaire and received responses from 67 anorexic women in the UK and Australia aged 18 or over, about “the tipping point of change” (p.1050). They reported that recognition of losing or being about to lose something important and identifying something worth being well for were important factors in change. Whilst this study was not linked to nursing role, recommendations from the study were in encouraging staff to focus on helping patients to identify these factors on a personal level although also recognising the difficulty for staff and family in waiting for the anorexic patient to reach this point. Reaching a moment when the price of anorexic illness becomes too much was identified as an internal process and highly individual.

Ramjan & Gill (2018) interviewed ten nursing staff and ten adolescent anorexic patients in a highly behaviourally focussed ward in Australia and reported on themes of an experienced metaphorical prison set up, with nursing staff feeling like and experienced as prison officers and with patients as “inmates” considered to be “deviant” (p.31) to societal norms, whilst patients themselves resisted this definition. They thus reported that therapeutic relationships were difficult if not impossible to develop and that nursing tended to degrade from its philosophical and holistic aspirations to being task oriented and enforcing. Patients were then left with little recourse than rebellion against rules and seeking to undermine the system.

Zugai et al (2018), in Australia, employed a mixed method design, using first a survey followed by a semi-structured interview and reported that “AN as an illness has the potential to degrade the quality of the therapeutic alliance” (p.7) leading to exhaustion and demoralisation of nursing staff. Patients who undermine and sabotage care impacted nurses “motivation, confidence and hope” (p.8) leading to reduction in emotional investment and connection from nurses who protect themselves emotionally by withdrawing. Over time this can then lead to increased experience of punitiveness of the treatment, as the nurse perhaps adopts a more punitive stance and the therapeutic alliance is not in place which would mitigate the patient feeling punished.

Zugai et al (2019) interviewed ten nurses caring for adolescent anorexic patients in wards in Australia. They reported an experience of greater opposition and dislike when nurses followed rules closely and exercised their authority: with less experienced nurses finding it particularly difficult to maintain their authority due to developing friendship-like relationships rather than more maternalistic relationships. They noted that patients would not want to be nursed by these firmer staff and with less experienced staff could seek to be coercive: for example, trying to draw them into anorectic activities.

Graham et al (2020) looked at multiple qualitative studies which considered healthcare professionals’ attitudes to their role in working with eating disorder patients and identified that a part of the emotional work for the healthcare professionals was in “coping with caring without curing.” (p.422) and that successfully negotiating this led to workers being less likely to blame the patients: adopting a more compassion led way of working.

It seems that while there are many studies reporting direct roles for nursing staff with their patients, there is also significant consideration given to how the nurse safeguards her own capacity to continue in the work and the potential pitfalls in working with this very difficult and entrenched patient group. This self-management is considered to be a discrete role in itself, but research only refers to this in terms of enabling the nurse to continue in her work. This study, in confirmation of wider psychodynamic literature, however (e.g. Winnicott, 1971), considers the value to the patient in experiencing an object which survives attacks and thus the nurse's emotional survival is crucial to both nurse and patient.

2.2.3. The child psychotherapy model of treatment

Freud (1912) described that all psychodynamic work begins via the use of “evenly suspended attention” (p.111) in order to take in from the patient as much material as possible in an unfocussed way, where too much effort or focus could lead to choices being made over what is perceived. This is perhaps a struggle for the eating disorder unit as focus is, necessarily, strongly on the patient's physical wellbeing, and yet Freud is suggesting that therapeutic treatment of the young person must take in elements beyond the symptom of eating disorder if it is to be meaningful.

Winnicott (1953) described an ideal situation in which the maternal relationship has been “good enough” and the child is able to move forward having internalised the pre-requisite components for ongoing development. This would perhaps describe the hoped-for position of the ward: that something may be good enough which facilitates the patient to move on.

However, perhaps particularly for the anorexic patient, who has become highly entangled and entrenched in psychopathology, work needs to begin at a basic level: the patient developing a sense of being in the therapist's mind. Winnicott (1956) described the role of the new mother intuitively responding to her infant and holding them in mind through Primary

Maternal Preoccupation. He describes this as a state in which the mother adapts “delicately and sensitively to the infant’s needs at the very beginning” (p.62): recovering after a few weeks when “the infant releases her” (p.61).

Winnicott (1960) further described, however, a situation in which the child has been required to adapt to the needs of mother and the child feels that their emotions, such as hate and anger, are intolerable. He described then that a falsely compliant self can develop. This “false self” is a state, antithetical to recovery, often seen in eating disorder treatment: the child who eats in order to be released from the inpatient ward or who complies with the meal plan whilst not making genuine emotional progress.

Bion (1962) described the process of “containment” which was pre-requisite for the occurrence of “alpha function”. Containment is how mother receives the projections of her infant: reassuring the infant that his fears are manageable. Alpha function can then occur in which mother processes the infant’s projections and feeds back an experience of these terrible fears being understood and sense made of them. Bion (1962) described this as analogous to digestion and that it is mother’s “reverie”: her concern and interest towards the infant, which gives the infant first a sense of containment and then a feeling of having been understood. This process, however, requires a child to be receptive to the processed material which mother returns, in a way which anorexic patients may not be able to manage, and so this process is likely a struggle on the ward whilst still being a necessary part of supporting the patient to recover their sense of a supportive, benign and thoughtful object.

In 1965, Winnicott described the father’s function in the early relationship with the infant. This, he felt, was to deal with external reality for the mother until such time as the Primary

Maternal Preoccupation resolved and they are able to begin coming together as a family of three: allowing her to focus exclusively on the infant for this period. This is a description, in therapeutic terms, of the importance of a strong network which can support the therapeutic relationship.

Meltzer (1967) described a form of containment in his concept of the toilet breast. He described this as a development from massive projective identification to a position in which the patient conceives that these unwanted parts can be held by the toilet breast therapist. It is a position in which the therapist is conceived of as a part object: “only a toilet” (p.20) with goodness coming from other external sources. In this position the therapist cannot be conceived of as having anything to offer: only as a receptacle for excretion. Meltzer felt that the patient first had to recognise a container capable of containing all this evacuated material and that this was a position necessary as a pre-requisite to recognition that the analyst survives being filled with such material and must, therefore, be able to detoxify it. In regards eating disorder patients this would seem to suggest that there may be a role for nursing staff in purely surviving such patients and returning from one day to the next.

Bion (1970) describes the importance of eschewing memory and desire, in this work, as

> *if his mind is preoccupied with what is or is not said, or with what he does or does not hope, it must mean that he cannot allow the experience to obtrude* (p.41)

It seems that this is a particularly important part of treating the anorexic patient because to be too much involved with the “desire” for them to eat, or the “memory” of previously successful or unsuccessful meals is perhaps to lose touch with the immediate difficulty or state of mind.

Bion (1970) goes on to suggest that:

> *If the mind is preoccupied with elements perceptible to sense it will be that much less able to perceive elements that cannot be sensed.* (p.41)

further highlighting the importance of not being too fixated on the concrete (in this case whether or not the meal is eaten) and allowing the feelings of being with that patient to emerge, which may allow for a deeper recognition of mental state beneath potentially surface-based compliance. Likewise, for the mother preoccupied with her baby, she must be in touch with her baby rather than worrying about how many millilitres of feed have been taken.

Winnicott (1971) suggested that, by surviving phantasied attacks, the object can be recognised to exist “outside the patient’s omnipotent control” (p.84). Thus, the patient is able to leave feeling that the ward has survived them rather than been destroyed, and that this has occurred despite the relationship not having been under the patient’s omnipotent control. This would hopefully support the patient to begin to test whether control might be relinquished over other relationships and support an idea that they have not been so destructive to relationships and their objects as they fear.

Stern (2002) suggested a process of adaptation and “missteps” as mother and infant come together and gradually learn to understand each other: moments where mother offers too much and infant turns away, which leads to mother regulating her next interaction. It would seem that this would be particularly relevant to treatment of eating disorders where what can be taken in is limited and nursing staff perhaps carefully monitor and adjust how they approach the patient in order to find an attuned position to work from. Houzel (2010) drew attention to the importance of the conveying of attention in this way, for the analyst to refrain from interpretation, but rather to observe everything they can and to hold onto it until it becomes meaningful enough to be interpreted. Here, again, for the anorexic young person it seems that it would be important to help them to feel safe, contained, understood and not to rush to finding words, which may feel overwhelming.

2.2.4. Rationale for this study

It is important to think about the emotional treatment of these particularly unwell adolescents who require admission, and what they might need beyond the work of outpatient treatment. It would seem that the rationale for inpatient treatment is focussed primarily around physical health. Nursing theory, however, points strongly towards the building of a therapeutic alliance with patients in order to facilitate improvement, with the focus seeming to be on the need to support psychological improvement in order that physical improvement be sustained upon discharge. This study aims to address this gap by exploring unconscious aspects of the work of nursing staff and the therapeutic alliance with anorexic patients.

3. Methodology

3.1. Participants

In this study, seven participants provided consent: five moved straight to interview and three made appointments that they were not able to keep. Two of these completed their interviews on another day that I was on the ward and one withdrew their consent. Of the five who moved straight to interview, two were rota-ed to participate and were provided with a participant information sheet and consent documentation following this, whilst three consented following directly being approached by myself. This was a sample of convenience: these being the staff who agreed to participate and who were available on the days that I visited the ward. The sample is heavily skewed towards female staff due to the high proportion of female staff working on the ward.

No staff responded to posters displayed in the nursing office and there was no central meeting at which I might introduce myself and the study. Changes to the initial plan regarding recruitment were, therefore, required and recruitment took place as a chain from one staff member to the next: with my being initially introduced by senior staff to the nurse in charge who then support me in introducing myself individually to nursing staff on shift. This took place in approximately weekly three-hourly blocks in the nursing office over a period of around two months. This led to an issue around how far to pursue potential participants. Two staff members initially declined but later decided to participate when I approached them again, later on in my time on the ward. This second approach followed a period of getting to know them just as part of my significant time spent in the nursing office and flowed naturally from another conversation. Two staff members, on hindsight, were avoiding the office when

I was there and when I was able to ask if they were interested in participating it was clear that they were not willing and were not pursued further. I feel this method of recruitment remained ethical as I was sensitive to the willingness of potential participants.

Whilst it was initially envisaged that there would be an upper limit of twelve participants: due to staffing shortages, rota-ing, secondment and sick leave it became apparent that all nursing staff had been approached who would meet inclusion criteria and seven was the limit of available and willing staff.

Staff were considered viable participants if they had been working on the ward in excess of three months and for more than three shifts per week. The aim of this was to exclude occasional bank staff or new staff who might not have had an opportunity to build up sufficiently deep and meaningful relationships with the patients on the ward, but to include very regular bank staff. In addition, the Participant Information Sheet advised that staff who were involved in disciplinary proceedings or who were having their own mental health difficulties should not participate. The aim of this was to not stir up those who were perhaps more emotionally fragile than others. However, it was not possible to check on this and was left up to the discretion of participants.

3.2. Interview schedule

The interview was introduced as a study about the feelings evoked through working on the unit, with a sub question about how or if the use of these emotional responses to the work were seen as part of the nursing role. Participants were encouraged to think about a particular patient who had evoked intense emotion in them, either positively or negatively and to reflect on how these emotions had impacted the work. One pilot interview was undertaken with a psychotherapy colleague in order to practice the technique of interviewing and to identify whether the prompt questions evoked appropriate responses. Following this a question about working with family networks was added.

Whilst there were discrete questions identified (see Appendix H) due to the semi-structured nature of the interview they were rarely used: providing more of a structure for me to hold in mind as the interview flowed in a freer way. This allowed participants to talk spontaneously about their experience of working on the ward and to interpret the brief of the interview as they saw it.

Interviews were planned to last approximately one hour with the shortest interview being 28 minutes: 14 seconds and the longest 59 minutes: 58 seconds.

3.3. Procedures

Interviews took place in different therapy rooms and office spaces within the ward (wherever there was space). These were confidential spaces in so far as interviews would not have been overheard by anyone outside. However, other staff members would have been aware of who was participating as they were absent from the ward during their shift and would have been visible through the glass doors. No interviews, however, were interrupted by anyone external and participants were aware of the limits of confidentiality.

Interviews were recorded using a handheld device (Sony IC recorder – ICD-PX470) and the sound files were then downloaded to a personal laptop which remained in my home at all times. At the point of transcription all interviews were anonymised with numbering instead of names. In this paper pseudonyms are used when assigning direct quotations and in talking about participants. Participants were generally careful about not mentioning patient names, but occasional slips were edited out at the point of transcription. Where the ward name was mentioned this was also edited out. Stories about events on the ward or specific details about conversations between staff and patients have been anonymised whilst trying to hold on to the essence of the communication.

Interviews were transcribed over the course of the three months following the end of most interviewing (i.e. one further interview was done after the start of transcription and one further was outstanding although the participant then withdrew consent). This was done entirely by myself and used as a part of getting to know the data. Transcribed interviews were analysed using IPA (Interpretative Phenomenological Analysis): a method which, according to Pietkiewicz & Smith (2012), focuses on “how individuals make meaning of their life experiences” (p.361). Following transcription, notes were typed on the interviews: line by line, noticing alongside the details of what was being said, what seemed to be going on in the subtext, for example when participants seemed emotionally charged in various ways and my own reactions to the participants within the interviews. See Appendix I for an example of the initial coding. These notes were then extracted from the text into a Microsoft Excel document and loosely grouped into columns of initial super-ordinate themes, which were worked on both in supervision and independently to refine them further.

All data will be deleted at the conclusion of this study, including recordings, transcriptions and coding data.

3.4. Ethical issues

Ethical approval was sought through IRAS (Integrated Research Application System) as was required by the local R&D (Research and Development) department. After IRAS had provided approval (see Appendix A) this was taken to R&D who requested minor amendments. These were returned to IRAS and secondary approval was given (see Appendix B). Consent was then given by R&D to proceed (see Appendix C). The full protocol approved by IRAS can be seen in Appendix D.

Ethical considerations were in regard to ensuring time was not taken away from patient care. This was covered by clearly stating to participants that patient care would take precedence and interviews would be terminated if needed. Two participants ended their interviews expressly due to the needs of the ward. In addition, interview times were set by the nurse in charge so that convenient, less busy timeslots were allocated from their knowledge of the ward set up (for example outside of mealtimes or while the patients were offsite, in school.)

Further ethical considerations were regarding emotional wellbeing of the staff (i.e. the risk that asking them to think about feelings might put them in touch with difficult feelings for which they might need support.) Following interview, participants were provided with follow up information regarding available on-site counselling services and which encouraged them to contact me if they wished to discuss further or to approach the nurse in charge (see Appendix E). A Participant Information Sheet (PIS - see Appendix F) was provided when participants expressed interest or when they were rota-ed to participate and a Consent Form (see Appendix G) was provided and completed, after they read the PIS and prior to interview.

Initially, a cooling off period of one week had been set following signing of consent forms but this proved impractical. Staff who, for example, made appointments for me to return were then unable to find the time, on the day, to undertake the interview and further staff members were unwilling to make appointments despite being willing to participate. It was, therefore, decided to proceed straight from gathering consent to interview. To counterbalance the loss of the cooling off period, participants were reminded that they could withdraw their data following interview (up to 1 month, after which time potentially data would have begun to be analysed) and could stop the interview if they felt uncomfortable. Two participants did stop their interviews with the stated reason of needing to return to work and one declined to answer a particular question. It would seem, therefore, that participants did not feel unduly pressurised.

4. Findings

Following analysis of the data, 6 super-ordinate themes were identified. These were:

Regulating appetite for life

Active waiting

Digesting experiences

Cleaning up

Connecting as a team

Preparing for an ending and letting go

4.1. Regulating appetite for life

Inpatient treatment is the treatment of necessity and last resort. Wherever possible treatment takes place in a community setting, in order to keep the young people connected to their lives, which supports interest outside the eating disorder. Those who have reached the point of needing inpatient treatment therefore are those for whom this interest, or appetite for life, is potentially not sufficient to maintain outpatient treatment.

Bethan saw the anorexia as a concrete failure of hunger/appetite. She suggested this failure occurred due to deprivation of what the young person really wanted to eat, and that appetite was, therefore, reawakened by the good food of the ward

> *because if our children don't have what they want they won't eat. They will say I'm not hungry because all they want is not there ... [on the ward] they can see varieties of food and they like it.* (Lines 113-123)

Cathy, however, recognised a lack of appetite in areas outside food: a failure in appetite for life. She saw it as her role to inspire and interest the young people in the world outside

> *I try to throw it in whenever I see them, talk about normal things like ...birthday dinners ...so they'd be like "what did you eat?" and I'd be like "well, I have a picture, this is what I did and this is who came and" ...I would tell them all about the things.* (Lines 127-168)

Thus, as Bethan recognised that these were young people who had forgotten how to want food, Cathy could see that this lack extended to other areas and that they were easily satisfied by very little

> *Because they don't see it anymore ...and I constantly feel like I'm always reminding them like ...this is not where you live, this isn't going to be forever, like these four walls ...life extends so much bigger outside of here.* (Lines 120-125)

Bethan described finding motivators in what these young people could consciously recognise they were hungry for, in order to encourage engagement in mealtimes: fanning the flames of their appetite to leave

> *Well you want to go; we are quite happy for you to be discharged but ...you need to manage to see friends and family out there. It's good to be out there.* (Lines 198-200)

Here it seems that Bethan was able to work with young people who remained hungry for something outside the ward, reminding them of this appetite as a motivational tool and highlighting that this was a healthy appetite. Although it is questionable whether the patient really wants to leave to see family or just to get away from the ward, Bethan uses the example to consolidate for the young person that this is what a healthy wish would look like.

Felicity also described how, in a difficult moment, where her patient refused a snack and thus jeopardised her leave, she was able to remind her patient about how much she had genuinely looked forward to the leave

> *and I said … "just do the snack ...Do the snack and then just go. And …think about all the fresh air" because she told me that there's fresh air …where she's going …and then even though she was crying she ...started.* (Lines 176-180)

Here Felicity also fans the flames of her patient's appetite for the "fresh air": prompting her with it and giving her patient something to focus on beyond the snack. This seems to be a very genuine moment in which Felicity is able to take something from a previous conversation with her patient: a moment where her patient has been more aware of her appetite for life and brings it helpfully to a moment when the patient is struggling. This helps the patient to retain her appetite in a more constant way, rather than losing hold of it in a difficult moment.

However, there seemed to be another side to appetite regulation. Cathy, for example was mindful to keep information about her life minimal: noticing a ravenousness for more

> *But ...even when I tell them lots …there's always questions about how I live or what I do and … blah blah (clap): "I don't know: maybe if you got out of here you might bump into ...me …I feel like, if I kept giving them information …that would be enough, you know, for their curiousness.* (Lines 443-487)

Cathy describes this as "enough for their curiousness" but perhaps another way of viewing this is that it is not the world which interests the patients, but rather Cathy. Here Cathy seeks to provoke interest in the world but balances this against the other side of the patient: the side that would "eat her up". The patients seem to evade envy of Cathy's life by seeking to incorporate it and make it their own. Cathy is clear in her approach about what is on offer and what is not, giving the patients boundaries around an appetite that is insatiable once awoken.

Anne also, gave voice to the voracious appetite of these patients. That they could make endless demands that could not be satisfied. A way in which they were expressing starvation

> *…we have had …days where I'm literally I haven't gone to the toilet, I haven't ate, I haven't done anything that I'm supposed to do …they suck up all your energy and time.* (Lines 279-281)

Anne described that even seeing her at her limit did not stop the demands placed on her, that they extended until she felt emptied out and unable to give anything more

> *I'm doing a long day; it might be my third …and it's just repetitive and I'm tired and just like please just don't …and she just doesn't get it.* (Lines 135-136)

Thus, here, the nursing role involves being able to give in a way which helps the patient to want something more, but in a way which also puts boundaries around a more insatiable appetite.

4.2. Active waiting

Waiting was repeatedly named as a large part of the work of nursing adolescent eating disorder patients. Bethan, for example, described the need for tolerant perseverance

> *Let me take this child is not eating: you'll be feeling like "well let me try and you try to encourage, encourage, encourage ...and it might be the last 2 or 3 minutes that she makes a start.* (Lines 164-167)

Erica, however, described a more draining and difficult experience of having to work without knowing what to do and trying without reward

> *there have been days when it ...just feels like everything kind of runs the exact same and ... they don't allow you to give them support ...to know what you can even try to support with.* (Lines 165-168)

This waiting was certainly not described as a passive process. Cathy expressed an active and yet frustrating and tedious repetitiveness and that many active attempts at connection failed, with patients being non-responsive or "nodding along" passively

> *you ...get so tired repeating the same thing to a young person all day every day…but ...telling them to eat is the most important part of our job.* (Lines 337-346)

Erica described an experience beyond waiting, more of just surviving with a feeling of stuckness and having to manage for lack of any other option

"Yeah…it's literally just bearing, like bearing it. It's not even ..." (Lines 453-454)

However, it seemed that within these experiences there existed the role of keeping alive the hope that something would shift. Erica described holding with increasing desperateness to this hope

> *What I'm holding onto is…that people have worked with her in the past and are like "oh she'll kind of start soon ...all we can do now is wait for her to manage. I don't know what else to suggest. It's really difficult.* (Lines 594-598)

and thus, whilst Erica might try to have new ideas around careplans, she seemed aware that she was in fact waiting for something in the patient to shift internally.

Some participants seemed to manage this waiting more hopefully, suggesting a change of scenery might help or that therapy would be effective over time, whilst others like Erica found it difficult to remain hopeful: perhaps both in touch with patients in different states or with different parts of the patient. What was clear, however, was that there could be no short cut. In the same way that a mother must wait for her infant to open his mouth for a feed, it seemed these participants also recognised a need to wait. Against the backdrop of a ward where required caloric intake could not be given such space, this understanding of time needed for emotional receptivity to develop is profoundly important. Deborah described very clearly a situation with a patient who had been nasogastrically fed and yet how this intervention was not a short cut to change

> *After [the NG feed] it was really strange ...I would have been more kind of comfortable if she'd been like crying ...but there was just almost like, like she'd sort of erased the whole experience of it, erm, so that was quite jarring.* (Lines 342-345)

Thus, whilst there are feeding realities on the ward, the emotional feeding experience cannot be prescribed in the same way and this patient seems to erase that experience for which she was perhaps not ready.

Bethan described how this waiting and perseverance can suddenly pay-off, seeming to recognise that it was just a matter of waiting it out

> *I remember a patient who was here for a few months and one morning they say "oh I'm feeling hungry now."* (Lines 95-96)

and Anne recalled a shift when she was able to help her patient with self-care: a special moment between them after months of failed connection, which seemed to open up communication and from which a relationship was able to be built. These stories clearly stood out in the participants' minds as breakthrough moments: hard won and important but not, it seemed, based on the participants doing something different. Felicity described a long period of feeling she was in the wrong to ask questions of her patient, express concern or give praise. However, one day, the patient stopped exercising in order to answer a question.

4.3. Digesting experiences

In addition to being an illness in which there is primarily a difficulty in taking in, there seemed also to be a problem in processing. Cathy described having to spell out her points with the young people very clearly

> *I think I constantly remind her that there's loads of [people like me] in the world ...like "[ward name] doesn't give you the power to make friends…you have it in you to be friends with people".* (Lines 498-504)

It seemed that it was not sufficient for Cathy's patient to learn from developing good relationships on the ward that she was capable of this. Here Cathy seeks to help her patient to understand her own internal capacities rather than misinterpreting that all the goodness is in the kind Cathy: to reframe their relationship and help the patient to develop faith in her ability to make friends.

Cathy also described patients who could not imagine a life without their eating disorder and that she would take up the role of presenting a more hopeful picture

> *I just want them to know that you have hope: that you could be that person that easily grabs a tray of food and walks away and eats with their mates.* (Lines 142-144)

Here it seems important that Cathy really believes this is possible: that she genuinely believes that her patients could recover. Her digestion of their situation is combined with a hopeful outlook, which patients may connect to over time, and which perhaps helps to shift them out of a stuck position on the ward. Cathy described that she has experience of patients who have recovered and so she has the perspective to believe others can too.

Erica, however, described how a distressed patient may be unable to engage with what is happening at all. She described a patient hysterical with distress during a care-planned intervention and how deeply connected Erica felt to her patient's experience and thus also distressed herself

> *you're basically looking at her straight in the eye as you're doing it because you're looking at the tube to see where it goes in…and you're so connected with her* (Lines 509-512)

Erica then described being left needing to think about and digest this experience and evaluate her motivations: needing to be sure that she did the right thing

> *You really question yourself because it doesn't feel naturally right, but then you just need to think…why you need to do it and then you realise it is the right thing to do and that other person realises eventually as well hopefully.* (Lines 75-78)

Here Erica describes how she must first digest the experience before she can support the young person to hopefully understand.

Deborah described a patient who recovered disturbingly quickly from an intervention and how Deborah felt left trying to digest and make sense of this response. Unable, at this point, to engage the patient in this digestion, it seemed nevertheless an important process that occurred within Deborah and Deborah illustrated her thinking in the interview

> *I don't know if that's just her or whether she just doesn't think she can kind of explore exactly what that did to her and the effect it had on her emotions.* (Lines 345-347)

Both Deborah and Erica illustrated clearly how hard they were trying to understand their patients' experiences. Cathy, however, raised the perceived dangers of failure of this nursing digestion and if time for digestion was not supported

> *Like that's how it feels, pent up until I don't know, until people leave and people decide that they can't do this anymore.* (Lines 361-362)

And it seemed Erica was concerned that her own capacity to process or digest was being impacted by her patient's difficulties

> *other times she won't even be able to look at me, but I'll be looking at her to try to engage her and all I can just see is tears and distress and it just makes you kind of look away and just do what you need to do, which is awful.* (Lines 533-535)

Erica went on to describe how these experiences could seem indigestible and how this led to feeling increasingly stuck and unable to see a way forward

you don't know whether you can't think of [another option] because you just can't think… or whether there isn't anything else you can do. (Lines 612-614)

Here Erica recognises feeling that her mind's capacity to think is being impacted by the difficulty of the material she is trying to understand. Bethan also described vividly how stuck this work could feel

> *There’s no way out. It’s the procedure ...That is their treatment. You just get used to it. You just get used to it.* (Lines 368-369)

and Georgie described working instead to empower families: seeming to feel that little could be worked through with the young person.

Participants described their fear of a negative outcome and Cathy described her struggle with warding off feelings of despair

> *working in CAMHS you try to do as much as you can, while you can, but that time does run out really fast …and you can’t force someone to be better, you know.*
> (Lines 83-87)

Deborah also talked about the struggle of holding onto realistic hope and managing worries for the patients’ futures

> *it might not be like a simple cure for someone, but you also want to give them hope ...I don’t want to say to someone “it’s unlikely that you’ll get better”* (Lines 133-136)

Thus, in building relationships with the patients, nursing staff were consistently holding at bay their worries (knowing the statistics of poor outcomes for eating disorder patients and with the looming move to “adult services” where perhaps change seemed less likely) whilst putting forward the hopeful agenda that things can change: an agenda they must believe in, however, for it to be a digested expression rather than empty words.

Deborah described the need to put these worries and her own distress on hold in order to focus on her patient

> *you almost have to show that you're okay so that they can then, you know, focus on like how they're feeling about it rather than thinking like "oh this staff member is like freaking out" or something like that.* (Lines 359-360)

Thus, it seems the nursing staff are required to bracket their own feelings in order to provide care which focusses on the young person: holding back and holding onto that which is more than the young person can manage. Being "okay" here seems to be about giving the experience to the patient that the situation is manageable even if it cannot be understood or digested in that moment, but the clear expression of "freaking out" seems to exist just below the surface and it is clear that these feelings need digestion, or they risk unprocessed expression in some form.

4.4. Cleaning up

Explosive ejection of emotionally charged material seemed also to be a part of the ward experience (as might be expected following the "undigested meals" described above). Anne talked about feeling blamed by patients and how this could make her feel guilty

> *then she reverses it, "staff made me do it, you made me do it! It's not my fault, it's all your fault, this is why I'm here, this is why I can't leave". She has a way of reversing it onto you.* (Lines 57-59)

Whilst this might come across as a denial in the patient to acknowledge her own "fault", Anne's feelings of guilt speak to a more powerful projection in which the unwanted emotion is forcefully evacuated and located in Anne.

Anne further described the verbal abuse she had dealt with: words that had left her shocked and feeling these patients had no filter of common decency. She was unwilling even to speak the words in the interview. In addition, she talked about patients who would kick or punch staff and the self-preservation instinct that made her keep her distance.

Erica described the pain she experienced from patients' words: how they would accuse her of enjoying nasogastrically feeding them, implying that she was a monster who liked torturing children. She also described a deliberate-feeling teasing behaviour

> *part of me sometimes thinks "you're just doing that to kind of give me that sense of hope and then you're taking it away from me" because I've seen people kind of do that before* (Lines 102-103)

and Cathy described a deliberateness in food going uneaten

> *when you're asking them if they can eat and they're ignoring you …literally they will look at you in your eyes and will not touch their plate.* (Lines 342-344)

with Cathy going on to describe being made to feel worthless.

These descriptions are further examples of staff's needing to digest difficult experiences. However, here the description seems to be of a far more deliberate unpleasantness with no distress expressed on the part of the patient. So, whilst this seems to be a process of how nursing staff manage, here it is the deeply unpleasant, excretion-like projections: less, perhaps, an experience of a patient who is lost, confused and frightened, but more an experience of a patient who is consciously acting to hurt and upset. Consequently, in this situation, the participants describe more their anger and irritation, rather than pain and distress.

Cathy gave an example of addressing this behaviour. Here she described a situation in which she was not the "victim" of a patient's outburst and so, perhaps as a "bystander", she was able to intervene once the nurse in receipt of the outburst had removed herself to the office. She describes expressing to the patient, in a calm, thoughtful manner, that the behaviour was unacceptable

> *"realistically you've upset so and so and how would you feel if it was yourself" and you know just a little conversation I think helps even in the moment.* (Lines 237-239)

Cathy, also, described her own process when she was the "victim" of patients' expulsions

> *at the end of the day you are in a job…so it's like thinking about ...going round to the office to take your time ...coz you are going to see that young person again, you can't hold grudges, they said something mean, you're not going to hate them forever now.* (Lines 556-560)

Here Cathy is describing tolerating the patient's expulsion and using the office to calmly clear up her own "hate" feelings.

Several participants additionally described coping by remembering that these patients were at perhaps the most difficult times of their lives and Cathy used knowing this to internally manage more challenging behaviour whilst still recognising and validating her own feelings.

> *so maybe they are rude but …it's not easy either to be a young person in hospital, it's like sympathising with that situation and knowing how to like validate their feelings as well as your own.* (Lines 562-564)

Anne took an approach more in line with behaviour and consequences, describing her refusal to take patients out on walks if they had been rude to her.

> *I said "I can't take you out and you're calling me that particular name. How am I sure for certain that you're going to listen to me when you go out there".* (Lines 213-215)

Anne is making clear that, whilst tolerating this unpleasantness might be a part of the job, toleration is not limitless. In her actions she makes clear the bounds of acceptable behaviour: a balance which neither allows free reign to the perversity and sadism of the patient (taking the patient for a walk as though nothing has happened) nor unrealistically expecting them to manage (the walk is not actually possible or safe for this patient) nor playing a tit for tat game of perversity and sadism (directly verbalising the power imbalance which means she is able to withdraw the walk as punishment.)

Some of these descriptions of participants' "calming down" (or even not seeming to feel angry in response to these patients) initially evoked admiration in me for these nursing staff who were so capable of "rising above it" and many of the participants stated the importance of "not letting it get to you" as though this was a mantra on the ward. On reflection, however, there was perhaps a rather saccharin and idealised description and it is perhaps questionable whether they reflect reality or an entrenched denial of "negative" emotions. It would seem that certain reactions or lack of reactions, are expected of staff: to be calm, polite and professional in response to the patients' outbursts at all times.

Anne's description above, therefore, may indicate a processing which is not finished, lacking open acknowledgement of the anger evoked, and whilst her concrete choice in not facilitating the walk is probably valid, it seems there is a lack of reparation between Anne and her patient. Anne describes that the patient approaches another staff member rather than asking Anne directly for the walk, which might suggest that the patient recognises Anne's anger and shies away from it. In the context of the interview, Anne seemed somewhat triumphant in the outcome of the example, whilst also seeming defensive, giving an excess of very reasonable and logical justification for refusing the walk, and thus perhaps recognising the tinges of punitiveness in her response. There is, therefore, a question of whether Anne reaches the decision not to facilitate the walk through a genuine "cleaning up" or processing of her anger and wish for retaliation, or is merely masking her aggression: giving an appearance of a reasonable response.

Deborah also described the need to be aware of the potential for movement towards punitiveness and perversity: describing how the work almost invites these in some of the necessary activities of the ward

> *I suppose it's not a natural thought to have to move someone in that way and have to put a tube down them. It's not what anyone would like to do hopefully.* (Lines 62-63)

Her addition of the word "hopefully" does seem to suggest an awareness of how this is a patient group who perhaps invite retaliation and punitiveness. One might even suggest that some of the behaviour comes from a belief that the staff must hate the patients (or recognition in the patients that staff indeed do hate the patients at times): a "nothing to lose" attitude, with further excesses as an inevitable consequence.

The risk of becoming retaliatory and the impact on the young people of being in receipt of retaliatory behaviour suggests that being able to "clean up" by internally managing angry or hurt feelings is important so that a way can be found to not get caught up in an endless cycle of retaliatory behaviour deleterious to the nurse/patient relationship. This is, however, a constantly demanding task and Erica described how, with the best of intentions and wanting to continue in supporting her patient, she was reaching the end of her capacities

> *It just makes you want to kind of shake her and be like "please manage" ...it sounds awful but it's like I want her to manage so …she can recover, but I also want her to manage really selfishly so I don't have to go through it.* (Lines 428-431)

Erica's awareness of this conflict inside herself opens Erica up to thinking about it and presumably not ultimately carrying out her desire to "shake" her patient. Cathy, however, describes that, when nursing staff reach their limits, there is a risk of their leaving. Perhaps this is the choice faced by nursing staff pushed to their limits: to act out their vengeful phantasies under a veneer of professionalism (or even not!) or to flee the source of these terrible phantasies. Participants described impressive capacities to tolerate these patients' outbursts but, as human beings, staff have limits and clearly significant support is needed to help them manage the work and genuinely detoxify the emotions evoked by these patients.

4.5. Connecting as a team

All participants referenced the importance of teamwork in carrying out the role. There seemed to be a strong sense of community and cooperation described by the participants, with everyone fulfilling a function so as not to burden someone elsewhere. Anne, for example, ended her interview abruptly saying

> *Sorry I'm looking at the time. It's an hour already ...I'm with (patient name) from 10 o'clock ...can I leave you now ...I don't want to leave someone else …*
> *(Lines 366-367)*

It was described that emotional support was first sought from nursing colleagues and that only the nursing team could understand. Erica, for example felt her family would be horrified to hear about life on the ward and Cathy said

> *if I wanted to talk about it, I might come in the next day and talk to someone else in the team, because it stems here so I should deal with it here.* *(Lines 176-178)*

Cathy was also able to describe an internalised sense of this supportive team, describing how she might go into the office

> *it's like thinking about ...how you respond ...going round to the office to take your time ...before you go back out and ...you're constantly reminding yourself of where you are, what you're doing and why you're doing.* *(Lines 556-561)*

This place, therefore, seemed to function as a place to be able to think and internally "regroup", reprioritise and regain her sense of her professional self within the team: a sort of personal supervision and stepping away to the team in her mind.

In this team, there seemed to be little competitiveness described. Some participants talked about, gladly and without envy, handing over to another staff member if their approach was not effective and successes seemed to be understood as a shared achievement, rather than as one staff member's "victory". Bethan described

> *it's just like when you are prompting a patient for something ...some people might go after you and you say "okay, okay, let that person try". That person might go and say "darling do you want to come with me?" ...and they might just respond.*
> *(Lines 389-392)*

Similarly, perhaps, Bethan talked about other disciplines being needed to perform other roles

> *everybody takes parts, different …division of labour. So, like here we have got therapists, we've got doctors, we've got nurses, we've got HCAs, and everybody has a different impact on them. So it's just, I think, it's all the same team, isn't it.*
> *(Lines 406-409)*

And then this sharing extended to the world outside the unit. Bethan described that sometimes patients made little progress on the ward but that perhaps a change of scenery was needed

> *Sometimes they go somewhere else. Sometimes when we've tried and they can get the child to another hospital they might get better in that hospital. Some people from another hospital they come and bring the child here and they got better here.*
> *(Lines 380-382)*

This equality and division of labour seemed however to make it difficult for individuals to take personal pleasure from successes. When I expressed to Felicity that her intervention sounded helpful she replied

> *I'm not the only one who will encourage her. Others have been trying to encourage her as well so it's actually a team effort* *(Lines 193-195)*

sounding rather scandalised that I had suggested her intervention might have had individual value.

It seemed that forgoing individual pleasure in achievements, however, may be the price of not having to feel individually responsible for "failure". Deborah, for example, described importance in not feeling solely responsible

> *You have to think like it's not just you, it's the whole team and just the person themself I suppose.* (Lines 283-284)

And Deborah also described a more isolated position: worrying about not doing enough or not doing things right and seeming to lose a sense of group accountability and togetherness

> *I suppose you try your best but just if someone …does not eat even though maybe you've sat with them for a long time …you kind of think "oh ...is it something I'm doing or I'm not doing" or like you can't help but second guess yourself. (Lines 318-321)*

Erica also described the loneliness and burden of feeling like the one to make decisions: losing her sense of the team around her in the crucial moment of being the one in charge and interpreting the careplan

> *it feels really difficult to be the one to make that decision to go ahead with the NG feed if they haven't managed the replacement. (Lines 54-56)*

And Erica, then, described feeling left out of more pleasant interaction with the young people which might mitigate the more difficult times

> *I think it's really difficult for them to allow you in to have fun with them if you've just restrained them for an NG feed …it's really difficult to have that and then go …and have a really happy-go-lucky environment. (Lines 211-214)*

And what seems to be strikingly missing from this last thought is a description of how those who are able to have "fun" with the young people might make space, in some way, for those who are feeling excluded. Perhaps, then, these participants are describing the difficulty of holding on to the sense of support of their colleagues: a faith that they will continue to be viewed positively by colleagues, even when the young people cannot hold onto this view of them, that they will not be judged for their interpretation of the careplan and seen as untherapeutic, unsupportive or straightforwardly mean. Perhaps they are also speaking of a reality of unhelpful moments of judgement, an underlying current of disapproval or their own judgement of themselves which make it difficult to believe in the genuine support and appreciation of their colleagues. Additionally, it sounds difficult to value all parts of care the same: idealising “nice” or “therapeutic” talking with the young people over the more difficult interventions and feeding which are, none the less, an important part of care, but which might be emotionally loaded as a failure of a less intrusive intervention.

It seems, then, that there is limited room in this team, at times, for a more genuine togetherness and one might wonder how much space there has really been to develop genuine supportive relationships. Like an army flung together in the emergency of war how much time has this team really had to develop strong trusting bonds? Coming through the “war” this team might emerge stronger but the sense here is of being right in the middle of battle and at times feeling unsure of whether colleagues are really behind them.

Perhaps as a consequence of this war-like emergency situation it seemed to be described that differences of opinion could not be tolerated. Anne, for example, described her absolute faith that her decisions would be supported by her colleagues

> *So …if they called me a name, they wouldn’t ask me because they know what my answer would be. So they go and ask the nurse and the nurse would agree with me.*
> *(Lines 230-232)*

What Anne does not describe, however, is any mediation of the difficulty between her and her patient. The nurse supports Anne but where might the space for thinking be: the opportunity for the child to experience being thought about? Participants, also, described discussion taking place in the nursing office, it seeming important not to display any difference of opinion in front of patients, but does this give the young person a feeling of a parental couple thinking about them or is the phantasy (or reality) of a more terrifying couple, coming together to bolster each other into carrying out a perverse plan.

Felicity also expressed this less positive side of the required “united front”: not always agreeing with decisions made and feeling that other staff might be over-harsh sometimes. She became uncomfortable in the interview however and quickly ended the topic of conversation: seeming to feel that any expression of discord was unsafe. Cathy voiced the difficulty inherent in this, when it becomes difficult to think and discuss and staff are “required” to feel and act according to some pre-defined system

> *you’re constantly in a state of “you should act this way” …but actually what if I actually feel sad, you’re just going to tell me that actually you shouldn’t be …and then that’s when I think it gets hard and that’s when I think people leave.* *(Lines 593-596)*

Perhaps then due to the rigidity of this system, Bethan described sometimes feeling identified with patients: that mealplans were too much, saying

> *you feel like you cannot manage what they manage so you feel sorry for them sometimes. But you can’t help it, it’s their mealplan, they’re in the hospital, this is the treatment.* *(Lines 316-318)*

Here she seems to be describing the struggle between seeing things from the perspective of patient and of the staff team and perhaps this is a useful balance which means that she does not become inaccessible to the patient’s need for sympathy and understanding but does not lose touch either with her position as professional figure in the team. Cathy also described how identified she could feel with patients when she felt not listened to in the wider team.

Georgie focussed on the difficulty of working with high numbers of bank staff and needing to give very clear and basic instruction because such workers could not be relied on to act spontaneously. It seemed that Georgie was talking about how the work becomes almost impossible when team connection is not available, with the staff who are not regular exemplifying action which is not fluid or creative: how action can, in fact, become frozen or clogged up in a situation in which the “right” action is not clear. Whilst Georgie was clearly frustrated with these bank staff members, one might wonder if their role was to hold the frustration in a way which prevented difficulties being looked at inside the team. Thus, these ideas about lack of motivation, effort and creative spontaneity, can be located in the bank staff and an idealised permanent team is preserved. This dream perhaps holds at bay the fear that actually nothing can improve the horror, difficulty and struggle of it and thus the team survives through anger and frustration at the inadequacy of provision rather than through acceptance of the horror: a paranoid schizoid rather than depressive survival.

However, a part of Cathy was able to retain a sense of the greater good and connection to the team and she was able to recognise

> *I definitely have a lot of love for this place and this ward and the work that they do. I think it’s incredible and I think it’s so important* *(Lines 382-383)*

and perhaps the struggle, capacity to keep struggling and hold on to a more overarching goodness, whether between members of the nursing team, between nursing team and bank staff or nursing team and wider team, holds at bay the collapse which feels palpably present at times.

4.6. Preparing for an ending and letting go

This last theme speaks to the culmination of the work of the ward: how relationships are brought to a close and how the staff manage these endings within themselves in order to support the leaving patient and be emotionally available to the next.

Bethan described patients who express their worry through re-emerging symptoms (although her description was of a healthy worry rather than a re-emergence of anorexic psychopathology: the patient soon making up the deficit of intake). Anne, however, described her struggle to support her patient who was clear that she had no wish to leave. Both staff here are talking about the highly individualised approach needed to support each young person towards discharge.

Deborah raised that then, after discharge, it is often not known what happens next to these young people and Georgie talked about managing this anxiety about whether the patient is truly “better” through work with the families of these patients

> *you have to be really, really, really good in empowering families because otherwise …the child will start to take control of the meals again* (Lines 55-57)

suggesting that worry about the child’s future might be managed by feeling you have equipped the network around the child

> *So if the family is there to support the child, so the child have good chance to, you know, achieve an excellent recovery.* (Lines 92-94)

This is not, however, a description of a child who is necessarily felt to be ready: having achieved a development into independence and resolved the underlying issues. This would seem to be potentially outside the remit of the unit. A compromise must be reached in which enough is done to facilitate the child returning to their everyday life. Staff are, therefore, left with a sense of work that is unfinished and without certainty that things will now go well. Thoughts about adult units, as the example of the ultimate poor outcome, therefore, seemed never far away and Cathy expressed her awareness of the stakes

> *working in CAMHS you try to do as much as you can, while you can, but that time does run out really fast* (Lines 83-84)

Against this worry Cathy reported a story which seemed to be held as a talisman against the fear of what became of the patients: an ex-patient who had been in touch and was reportedly doing well

> *she is actually like I think recovering and well and living the life she wants to live, like travelling and stuff so we've heard.* (Lines 47-48)

Generally, it seems that the nursing team have to bear the feelings of being left behind. Deborah recognised that:

> *I'm sure they don't want to think about their time in hospital …they might just want a complete clean break* (Lines 169-170)

and thus indicated how she has thought about and made sense of the complete break in the relationship. However, if she is right about this idea of a clean break, it does perhaps suggest that something may be cut off and left in the unit: something perhaps unresolved.

Other participants seemed to suppress pain by putting faith in the next treating team. However, Deborah went on to express the underlying pain of the work:

“but then I think that way you never really know how they’ve done.” *(Line 171)*

The nursing staff are in a difficult position of having engaged with the patients over long periods and deeply emotionally invested in their care. This is the value of their role and yet this clearly leaves them in the position of having to accept that they may never “know” how things turned out.

Whilst they will turn their attention to the next patient who joins the ward, it seems the staff continue to hold in mind those who have left: holding the memory of the relationships. How the nursing staff manage to bear these losses over the years of work: the not knowing and the multiple goodbyes, is the final role and it is clear that a simple cutting off is not what happens. The nursing staff remember their patients and manage the pain of saying goodbye which, if this is done successfully and sufficiently, perhaps leaves them able to greet the next patient as an individual rather than as a replacement.

5. Discussion

Here I explore and discuss the themes identified from the interviews and link them to the literature previously summarised.

5.1. Regulating appetite for life

Here, it is the patients' interest (which I am likening to appetite) that the nursing staff seek to awaken, and this seems particularly important in a patient group who have turned away from object-seeking interest to narcissistic functioning. It might also be called curiosity and it would seem that the nursing role here is to fan the embers of curiosity in something outside the self. Appetite regulation, however, as a role for the nursing team seems to fall into two parts: increasing and encouraging appetite but also then managing greed.

5.1.1. Increasing/encouraging appetite

Peplau (1999) described the importance of encouraging interest outside the self. She directed nurses to interrupt repetitive speech (which was internally focussed and unhelpfully ruminative) and to encourage explanation from patients who tended to forget the nurse did not already know: stressing the importance of the patient recognising that the nurse's mind is separate. Cathy stresses her separateness by not allowing the patients such information that might cause them to merge with her experience and in evading this merging she encourages her patients to see what they are missing and hopes over time to increase their interest in the world. Peplau (1999) believed this way of relating helped the patients to recover meaning and I would extend this idea to suggesting the staff, over time, help the patients to reconnect to a meaningful life outside the ward and outside their anorexia.

The participants in this study described patients at different stages of this process: Felicity, for example, described her patient who had some connection to the world: a wish to return home for the “fresh air”, and Felicity’s role here was to help her patient to hold on to this wish outside of the tricky snack. Bethan, however, gave a sense of her patient as much less connected to a genuine wish to leave: “I want to go home” seeming far more a statement of a wish to return to an unchallenged anorexic state. In this situation, Bethan models what a healthy wish might look like: helping to reframe the patient’s unhealthy anorexic wish. Cathy seems to be describing patients who are far more settled on the ward: who have made friends and a life in the environment. She describes a delicate balance of trying to interest them in life outside without feeding into their unhealthy preoccupations with the workings of the ward.

All these examples link to Fogarty and Ramjan’s (2018) suggestion that change in these patients comes with recognition of losing something. In order to lose something these patients must first want something, and it seems that the nursing role is to help the patient to recognise “want” as a first step towards being worried about losing something: a worry which may overcome the worries around the food and the relinquishing of the anorexic position.

5.1.2. Managing greed

Cathy brings this other side of appetite regulation to her interview: the need to manage greed once appetite has been evoked. As Britton (1989) describes in thinking about the child who must recognise their place outside the parental relationship, Cathy describes attempting to limit the patients to the position of observers of her (Cathy's) life: a position in which Cathy has outside relationships from which the patients are excluded. Britton suggests that recognising the parental couple and the child's exclusion from it is a necessary part of working through the Oedipus complex. This exclusion, however, seems to evoke greed for more information in the patients and Cathy describes how she responds by challenging this: refusing to give further access but suggesting that they could build their own relationships. She recognises that providing more information will not help them to face the reality of their exclusion from Cathy's life or the paucity of their lives on the ward and, in this way, she challenges the oedipal illusion situation described by Britton as when the "relationship has been registered but is now denied and defended against" (p.85).

To manage this exclusion whilst not being perceived as cruelly excluding clearly illustrates the development of the relationships between Cathy and her patients, who can retain an idea that she is good whilst also resisting their intrusive attempts. Thus, here, Cathy is regulating their interest: giving neither too much nor too little. She encourages them to be interested but does not feed their greed through allowing them to be intrusive.

Freud (1917) drew attention to the cannibalistic devouring of the object as a means of incorporating it, which these patients seem to be displaying. Klein (1935) however emphasises that this behaviour leads to such anxiety about the state of the object (its being “in bits” [p.269]) that illness not only results but cannot be emerged from. In putting in boundaries, Cathy facilitates the possibility that her patients recognise that she can withstand and survive their cannibalistic attacks.

Anne, however, describes more evocatively how incredibly greedy these patients can be: there being days when she does not get a moment to herself and even at her limit her patient continues to push for more. Cathy’s example presents a somewhat straightforward illustration of how to “just say no”. Anne’s, perhaps, describes how extreme the voraciousness of her patient can be and their refusal to recognise or back down from taking or asking too much. She further describes the struggle to put boundaries around this: how her “no” and “don’t” are not respected. This seems to coincide with Klein’s (1935) description of mania as a denial of concern for the destruction of the object. Anne’s patients do not seem to worry if they exhaust her as, coinciding with Klein’s (1935) description of mania, nursing staff are perhaps seen as equivalent, so that if one is exhausted another will be available. How Anne preserves her own space and internal resources in the face of this, with a patient who has not yet built a concern for Anne’s welfare as an individual, would seem to be a vital part of the nursing role: also highlighting the importance of a system that focuses on supporting individual nurses, by ensuring breaks are taken and prioritising supervision and time for training and learning.

5.2. Active waiting

Cathy’s description of the repetitiveness of the work with this patient group, Bethan’s description of the need to keep trying and Erica’s recognition that there is nothing more to do than to bear the awfulness of waiting for something to shift in the patient are all clear descriptions of the need for patience and perseverance with this group.

Freud (1911), Klein (1930) and Segal (2001) recognised the symbolic nature of symptoms, William's (1997) suggested these patients are victims of omega function and Rosenfeld (1987) drew attention to possible prenatal maternal projection. All these theories suggest a preliminary and perhaps less easily measurable stage to recovery: a waiting for something to shift, whether that be as the symbol is disconnected from the object or the nature of its connection is changed, or whether the patient gradually comes to experience nursing staff as non-projective and therefore safe. Obviously, this means that the nursing staff cannot rush, as being too friendly or too keen could be experienced by these patients as intrusive, invasive and frightening and thus interfere with this process of internal re-evaluation. The nursing staff must, therefore, be relatively blandly benign, hold their own anxieties in check and tolerate long periods of rejection as the patient slowly adjusts.

This "blandness" might be akin to what Freud (1912) encouraged in "evenly suspended attention" (p.111): a process of focussing on the patient without excessive effort to concentrate, which might lead to selective attention. Houzel (2010) described this as a process of taking in whatever is expressed without resort to interpretation, collecting up these impressions until they become meaningful. He called this "unconscious attention": speaking only in order to convey close attention rather than to pre-emptively claim understanding. It seems this is what is required within the nursing role: to convey interest and attention, but not too heavily, and to take in much more than they verbalise at this early stage of developing a therapeutic relationship. Bion (1970) described this as work undertaken without memory or desire: in this patient group perhaps, without a wish for more from the patient, either in regards connection or their eating, but rather a genuine interest in the patient, at the stage that they are at, which makes no demands. This might be seen as a relationship in stark contrast to the restrictive “psychosomatic family” which Minuchin (1972) describes: in which the child is prevented from choice or change regardless of their needs.

This waiting role is repeatedly highlighted in the nursing literature around eating disorders. Pemberton & Fox (2013) describe this as staff needing to be predictable, Zugai et al (2013) focussing on the “well-timed” interaction that is valued by this patient group and Forchuk & Westwell (1987) discussing the need to be careful in interactions: needing to allow time and to find ways of working that are not confrontational.

In waiting, it seems, recognition is built within the patient that here is someone who will wait, without requiring immediate gratification. This waiting is, however, perseverant: expressing interest without expectation for a long time, which allows the patient to emerge when they are ready.

There seems to be something truly serving the infantile part of the patient in this perseverant waiting. It brings to mind Winnicott’s (1956) theory of primary maternal preoccupation: the mother being interested and responsive to the infant’s needs and capacity to manage what is offered. In addition, when Felicity describes her patient’s anger at her questions, but yet how, over time, her patient becomes interested in Felicity’s question, this seems a description of Stern’s (2002) “missteps in the dance” observations of mother-infant pairing. Here, “wrong” moments in which mother and infant are out of step slowly resolve to better connection as infant develops and mother adjusts her offering. It seems that this relationship between nursing staff and patient is potentially reparative in a disorder that is perhaps increasingly entrenched by something not being timely: unavailable when needed and pushed into the patient when not wanted as Williams (2002) describes. The long period of waiting thus allows something to be relearned as an experience of something available but not forced: something that is truly for the patient’s benefit rather than for the ego of another.

Fogarty and Ramjan (2018) report that this waiting is eventually rewarded with the “tipping point of change”: when the patient identifies a wish to recover, linked to losing, risking or wanting something. They highlight that whilst staff can encourage the young person in identifying these things (through their previously described role of “regulating appetite for life” perhaps) the moment where the fight for recovery comes alive is very much out of the control of staff. Participants in this study do, however, seem to be reporting a tipping point in their relationships with these patients: when very suddenly a connection is made. Pemberton & Fox (2013) report that once the staff member is identified as good, these patients become keen to preserve the relationship at any cost: prepared to blame themselves when things go wrong. This might suggest that a powerful and helpful maternal, trusting attachment is made out of this long waiting period, which can then facilitate the work (although, of course, self-blame may be unhelpful in the longer term). Thus, although the moment when the patient begins to seek health is out of the hands of the staff member, it would seem that their present, attentive, interest is part of what helps move the patient towards this point.

5.3. Digesting experiences

Klein (1935) described that patients can experience anxieties which interrupt introjection: concern that taking in will lead to poison being absorbed or concern that objects will be destroyed by the process: being chewed up or because the inside is already a dangerous, poisoned place. In this study the participants described how sometimes they were able to help their patients to re-evaluate experience and thus take something in from them. Alternatively, however, there were descriptions of patients who were so unwell that no such process could take place: that the inner space of the patient was too heavily defended. In this instance nursing staff were left trying to at least understand themselves what had happened. It is suggested that this is also an important process, despite its not seeming so clearly to be connected to helping the emotionally absent patient.

5.3.1. Digesting alongside - reframing

Cathy describes an approach which is highly attuned to her individual patient, recognising their individual difficulty in believing they can make friends and being neither dismissive nor generalistic. Salzmann-Erikson and Dahlén (2017) talked about the importance of this kind of person-centred nursing. Here, Cathy takes in the skewed perspective of her patient, reprocesses, and then feeds back an alternative: giving another view. In psychodynamic terms, it seems that Bion’s (1962) concept of “Alpha Function” is being described. In Alpha Function the parent takes in the undigested “beta elements” of her child (in this case the patient’s belief that her relationship with Cathy is based more on Cathy’s kindness than on her own capacities) and through a process of alpha function (Cathy’s reprocessing and digestive thinking) returns them as “alpha elements” (Cathy’s understanding that the patient brings something to the relationship which would also be of use to her outside the ward). Minuchin's (1972) suggestion that family therapy ought to provoke conflict might be seen as a more contrived version of what happens between Cathy and her patient: provoking in both parent and patient the expression of a problem that needs to be thought about and thus an opportunity for this sort of thinking and digestion.

Hage et al (2017) also describe how the nurse uses her understanding of her patient, in their study in regard to bending mealtime rules. When this goes well, they suggest a digested experience is provided to the patient: neither arbitrary rule bending nor mindless rigidity. The patient is thus able to experience being thought about on an individual basis and this is the experience which is hopefully internalised over time: the experience of a thinking mind.

At this point, perhaps, Cathy's words will provide the patient with an alternative narrative of the situation which may allow a way out of the "chuntering" described by Joseph (1982) in which the patient turns over their beliefs in a repetitive, unhelpful way. However, what happens between Cathy and her patient seems also to be functioning on an unconscious level, in that Cathy's interest will, perhaps, wordlessly impart that the patient is worth Cathy's time. So, whilst the patient may not agree with Cathy's verbalised appraisal, it may be that over time the patient internalises, through the relationship with Cathy, the unspoken experience that she is of value. So, whilst there is on the surface a "feeding back" described here, the valuable alpha function is likely also something unspoken which goes on between Cathy and her patient.

5.3.2. Digesting on behalf of

Erica and Deborah, however, describe patients who seem unable to receive back this digesting, individualised experience. Deborah’s patient lacks distress, suggesting that she may evacuate her experience and thus making it inaccessible to Deborah’s capacity to think with her. Alternatively, Erica’s patient is so distressed that Erica feels she cannot reach her. Erica and Deborah are, therefore, both left trying to digest experiences on behalf of their patients.

Deborah suggests that she supports her distressed patients by first managing her own emotional distress internally, giving an outward appearance of confident calm. This would seem to be a description of how she begins processing the experience for herself. Travelbee (1964) stresses the importance of the nurse not exhibiting “pity” which she defines as having more to do with the distress of the nurse than the needs of the patient. Instead, she recommends “sympathy”: which she describes as genuine connection to the patient’s distress accompanied by an active wish to help. This seems to be describing a pre-requisite to Bion’s (1962) alpha function: a containment of experience such that the patient can feel that there is a mind, not filled with its own distress, but wishing to help. The patient must experience the nursing staff as attentive (“sympathetic”) and confident to manage/contain their distress.

Skogstad (2013) also writes about this need to feel there is an available mind when he says that the patient needs to feel they have “got through”. Erica’s description of how her patient’s distress affects her is evidence of this process of “getting through” and her vivid description of the difficulty of processing her experiences speaks to the struggle to focus on the patient and thus provide “sympathy” rather than “pity” as Travelbee (1964) recommends. Travelbee (1964) further describes the pain involved in truly connecting to the work and it seems that Erica is speaking about a genuine risk of being lost in what Bion (1967) called “nameless dread”: an experience so terrifying and deathly that it cannot be made meaningful. Erica’s capacity to survive the experience is another example of how she can speak to the unconscious of her patient that, in fact, this experience is survivable. Again, however, it is the genuine care and attention which makes Erica’s survival meaningful. If Erica’s patient can, consciously or unconsciously, come to recognise that Erica cares and struggles emotionally then she may make emotional progress through recognising that she has “got through” as Skogstad (2013) describes. Erica’s struggle, therefore, is part of her role: slowly and largely unconsciously imparting all these things to her patient so that hopefully in the longer term the patient will internally recognise the response of an engaged, containing mind that fights and struggles for her, rather than an absent, disconnected one which neglects or tortures her.

Cathy speaks more generally of the dangers of the failure to digest: the stuck and unshiftable which leads not just to failure to improve in the patient, but also may cause nursing staff to leave. Ramjan & Gill (2018) discussed a further alternative: a deterioration to rigidity and controlling “prison”-like conditions as a response to the difficulty of the work. This seems to describe a failure of digestion and thinking, and patients are viewed increasingly negatively such that they, in response, rebel against the system that should be helping them. Menzies Lyth (1960) also described how repression of aggression and frustration can lead to its re-emergence in an uncontrolled manner or how attempts are made to manage repressed aggression by resorting to obsessional mechanisms, such as attention to paperwork instead of the patient.

Given that this is a patient group which Wright (2010) describes as oppositional to treatment aims, it seems that this patient group may not often be amenable to the “digestive” thinking of the nursing staff. Thus perhaps much of the processing and making sense – an equivalent to physical digestion – occurs, as suggested here, within the minds of the nursing staff, to preserve their minds so that they remain emotionally available to their patients.

5.4. Cleaning up

5.4.1. What is it that the nurse must clean up?

Cleaning up, here, is defined as the process by which the nursing staff manage more sadistic behaviours of their patients, for example the violence, verbal abuse and deliberate frustrations of care. However, it is also defined as their capacity to clear up their own feelings in response to their patients. This requires an ability to detoxify these behaviours and their own resultant feelings so that the relationship can move on, rather than being perceived as irrevocably damaged or stuck or deteriorating into retaliatory behaviour in which both parties, nurse and patient, act out their aggressive feelings.

A part of this process seems to enable the nurse to give a sense that tolerance is not boundless, and it seems that, with genuine processing, comes the capacity to set appropriate boundaries which are not tainted by a wish for revenge or punishment, but are also not avoided perhaps through fear of the aggressive feelings evoked by the patient’s behaviour.

Anorexic patients are known to be difficult to manage and the standardised “principles of nursing practice” (Principles of nursing practice | Royal College of Nursing, 2020) are strained by these patients’ resistance, as the guidance assumes a compliant patient interested in their own wellbeing. Rosenfeld (1987) suggests that anorexic patients will attack or undermine any attempts at care and Wright (2010) drew attention to the difficulty of nursing someone whose aims and goals do not tally with the accepted model of care. Thus, the nursing staff are set up in a role which they cannot complete, in opposition to their patients and in a position which invites distress, anger and frustration on both sides, as neither can come together to achieve a mutually acceptable outcome. Consequently, deterioration into violence and verbal aggression would seem a likely result of a patient feeling misunderstood or attacked instead of helped, or responding in kind to genuinely being hated by the staff at times.

Meltzer (1967) describes the use of massive projective identification in patients who have not yet conceived of a container: i.e. someone who might help and manage their more toxic unwanted feelings. He suggested that the development from this position was to understand the therapist as providing a containing function for this material, which he called the “toilet breast”. Perhaps, the nursing work under this theme is to gradually build a conception of a “toilet breast” within the patient by managing both the toxic projections from the patient and their own frustration.

Participants seemed also to describe patients perhaps functioning more in ways that appeared deliberately sadistic: enjoying a sense of the control in being able to upset or hurt the nursing staff. Wright & Schroeder (2016) reported on this also and described how nursing staff are vulnerable to what they termed “abuse” from this patient group. Steiner’s (1993) concept that some patients keep their objects in a half-dead, disabled state would seem to connect to how the staff describe being treated by the patients: feeling blamed, criticised and unable to think creatively. Erica described recognising a struggling patient as clearly different from a mocking patient, in that whilst both might be picking up their drink and then putting it down: one is clearly, genuinely tormented and the other is not.

Freud (1917) noted this enjoyment involved in sadistically torturing the loved object: through the patient's illness rather than expressing hostility more openly. His description, although suggesting an enjoyment that is not as conscious as that seeming to be described here, fits an anorexic presentation well, as it is an illness which tortures caregivers through refusal and withdrawal. Joseph (1982) also described patients who appear to enjoy their own self-destruction, whom she described as "addicted to near death". She describes a determination to remain in this state and to treat themselves with the same spite and contempt that may be directed towards the nursing staff. Over time this behaviour has the potential to degrade the possibility of therapeutic alliance as Zugai (2018) describes, leading to a loss of hope for the nursing staff that may lead to staff taking up an increasingly punitive stance.

Additionally, however, Zugai (2019) describes how these patients can develop "friendship-like" relationships with, particularly, the younger, more inexperienced staff and will then try to induct them into breaking the rules and careplans set out by the ward. This behaviour could be seen as an attempt to induct nursing staff into perverse, claustrum, functioning: joining them in an anorexic position in which the ward position of attempting to feed is redefined as "controlling" and joining in rule-breaking is confused with meaningful connection. In a ward environment in which so much forcing is necessitated to keep patients alive and moving towards managing at home, nursing staff are called upon constantly not to get pulled into feeling that they are doing wrong, feeling that their colleagues are doing wrong, or in reality supporting a colleague or a behaviour in themselves which has slipped into something more punitive or perverse.

A further possibility behind excesses of behaviour comes from Skogstad (2013), who described that some patients seem to need to feel they have really impacted the nursing staff in order to feel able to get through to their objects. These patients perhaps go too far because they find it difficult to recognise when they have got through and thus there is potentially something helpful in their seeing the upset or anger of their nurse as tangible evidence of having impacted them. Again, however, nurses are called upon to “clean up” their reactions to these excesses and express authentic but not punitive or perverse responses.

It is striking that psychodynamic theory suggests many possibilities for these patients’ immediate states of mind: perhaps they are functioning from the claustrum and “inviting” staff to join them in perversity, perhaps struggling with feeling they cannot access their object, perhaps seeking to control their object through stripping them of their agency, perhaps even engaging in a more psychically appropriate resistance to a perceived violent, aggressive object. In all likelihood, one patient may be in any or all of these states of mind from moment to moment and the complexity of these presentations would feel understandably intense and overwhelming. It would seem, then, that one of the very important roles in this work is how the “toxins” in these patient’s resultant projections are managed and “cleaned up” so that the staff are able to maintain thought about the underlying difficulties of the individual patients, as well as hope and an “alive” state which prevents emotional deterioration in themselves and in their patients.

5.4.2. How does the nurse go about cleaning up?

A theoretical understanding of nursing roles may not fully take account of how deeply “in it” the nurses feel they are, and this seems to come across from the participant’s interviews. The work described has the potential to profoundly affect and destabilise the nurses and may elicit wishes for retaliation which would be a challenge to consciously face. It seems it is difficult to hold on to thinking when in the midst of events on the ward.

The participants’ descriptions of their emotional reactions to the work suggest that managing these is part of the work for the staff. They must, it seems, feel genuinely disturbed as a distinct part of the work: whether that be angry, frightened, upset or any other form of distress. Ideally, Winnicott (1971) suggested that the value of the object is that it survives, allowing the child to feel that their object is robust, without crumbling or resorting to retaliation and perversity. So too, here, it seems the survival of the staff and the ward ultimately provides the patient with a sense of a strong foundation (as described by Ross & Green, 2011) which has held them through their struggles and has not been damaged by them. If there is nothing to survive, i.e. if the nurse is aloof and unaffected, if she acts out her aggressive phantasies in some way or if she is “broken” by the work and leaves, then there is not only no psychic benefit to treatment but potentially the anorexic state of mind may become more entrenched. The patient may gain weight purely from the feeding intervention, but their mental state will not have altered, having received nothing reparative from the relationships with the nursing staff.

It is, therefore, important to think about how the nurse can express her own emotions in the interest of the patient’s development, but this is complicated and dependent on the mental state of the patient. For example, a patient who struggles to feel they impact their object may be helped by seeing the nurse moved, but if the patient is sadistic, they may get profoundly unhelpful enjoyment from realising they have “got to” the nurse. It seems that part of the nursing role is to recognise the patient’s state of mind in order to find a response that might support growth. However, in order to do this the nurse must be supported to first recognise her own state of mind. She must have the time and space to work through how she is feeling in order to regain a thoughtful state of mind, which will inevitably come and go through the course of the work.

Cathy described a push to hold back emotions on the ward and other participants made reference to feeling unsure about whether expression of feelings was acceptable. It would seem that to hold back feelings, however, might be seen as a version of Winnicott’s (1960) “false self” in the nursing staff: presenting a veneer of care and coping which masks the underlying emotions. This may potentially lead to missed moments when connection might authentically be made: tipping points of change as described by Fogarty & Ramjan (2017) or moving away from the individualised care that Salzmann-Erikson and Dahlén (2017) reported to be most valued, and in the longer term this may prevent development.

Anorexia is a disorder associated with a wish for perfection and there is a risk of nursing staff being pulled into this: required to be boundlessly supportive, never angry or frustrated, certainly never vengeful and expecting similar of their colleagues in an unhelpfully judgemental way. One might imagine that an ideal situation is phantasised in which the nursing staff are able to react through understanding, in the moment, but Cathy recognises that sometimes it is not possible to process so quickly and arrive at the most therapeutic response. Cathy, therefore, describes stepping in to set boundaries, through challenging the patient verbally regarding their behaviour. Here the staff do not work alone, but rather support each other: able to do so from a more neutral place when they have not been directly impacted by a behaviour. Cathy is describing something very different from a retaliation or a “don’t let it get to you” or “don’t let them see” reaction, but rather a recognition of the distress caused and a containment of the situation through kindly, but firmly, addressing directly with the patient.

Questions remain about what is “good enough” treatment. Winnicott (1953) described that mothering should aspire to be “good enough” but what this is varies from patient to patient, with some being more and some less able to tolerate fluctuations in the state of mind of their nurse. Perhaps Cathy steps in intuitively, recognising that this patient cannot wait until the nurse regains her composure and can address the difficulty with her patient directly. Over the course of treatment, one might also hope that the patient becomes more able to tolerate periods of time when something does not feel “good enough”.

Winnicott’s (1949) description of “hate in the countertransference” makes explicit the reality of the mother hating her “ungrateful”, ruthless infant and the importance of the infant coming to understand this in a way which is tolerable and which recognises that the mother does not always hate him. Likewise, in working with anorexic adolescents, it would seem there is a balance in which the patient might recognise that at times they are hated but that the nurse who hates them is also the nurse who cares for and about them. This more authentic understanding potentially, over time, may lead to less “false self” (Winnicott, 1960), compliant behaviour and fewer outbursts of sadistic or retaliatory behaviour in both nurses and patients. It may also support a more open communication in which hate can be expressed without it leading to deterioration in the relationship.

Cathy’s thoughts about staff burning out underlines the importance of supporting staff to express their feelings in some way. Repressing their feelings may result in the nurses being more likely to retaliate. Anne’s description of her refusal to take patients on walks is an example of an arguably appropriate refusal that may be tinged with something more sadistic. The nurse “clears up” then through honestly looking to her feelings and working through them in order to respond to the patient, rather than through unprocessed “reaction”.

5.5. Connecting as a team

5.5.1. Positive connection

Under this theme participants described the importance of feeling they were going through this work together and that working together then facilitated useful work with patients. Ross & Green (2011) described this situation as the eating disorder unit being a place to build a “secure base”. By working together to present firm boundaries, clear rules and the team feeling they can rely on each other, the nurses aim to create an environment which feels safe and secure.

Participants described how they could hold different, but complementary, roles on the unit, relying on each other to carry out the different roles and taking over from each other if it seemed that a change of staff member might help break a deadlock with a patient. In this way it seems that the participants act like a parental couple for the child: taking over from each other to avoid burnout and other consequences of frustration.

Wright & Hacking (2012) described that patients valued maternalistic care, and certainly the participants described empathic moments with their patients which would seem to fit the idea of a motherly relationship. However, Anne, Deborah and Erica also described more difficult interactions, being in charge of restraints and nasogastric feeds and having to deal with abuse from the young people. Whilst the more nurturing, “therapeutic” work was more valued by the participants in this study, it would seem that this more difficult side is no less a part of the role in the same way as hard, unpleasant work is no less a part of motherhood. Winnicott (1965) described how the paternal function provides emotional support to the maternal role. Participants described how they felt only their colleagues would understand the experiences they had on the ward and they described using each other for debriefing and emotional support. Here they seem to describe a supportive parental couple and how it is only within this relationship that the true struggle of the work can be understood.

Receiving this support enables processing of experiences so that the more optimistic, maternalistic and caring staff member can re-emerge. Cathy describes how she arrives back at this position after she has taken some time out in the nursing office: recognising that she will not hate the patient forever following the difficult interaction: here the use of the team (or in this case the team in Cathy’s mind) allows the patient to be forgiven.

The “paternal” team also seems to provide protection and back-up for the maternalistic staff member: a “do not speak to your mother like that” kind of intervention that Anne describes when thinking about how she relies on the support of her colleague. Britton (1989) described how the paternal third comes into the relationship with mother and baby, in order for baby to experience being thought about within a relationship that he does not take part in: a relationship which is different to his relationship with mother or with father and from which he is excluded. The participants, in this study, described the value of discussion in the nursing office: a concrete symbol of the relationship in which the patient is thought about but excluded. Skogstad (2013) also described the value of using another mind to create distance from an enmeshed relationship and the participants in this study described the value of having this place to retreat to in order to receive support from colleagues or, as Cathy described, to find space and consult the third in her own mind. It seems that with this demanding group of young people, a physical space is needed to allow the nursing staff to regroup and think without the pressure of the presence of these young people.

The participants, however, seemed also to describe the importance of being able to hold their position in the team and support their colleagues (their position in the nursing office) whilst also retaining their empathy for the young people (their position on the ward). Snell et al (2010) described the nurse holding a “foot in each camp” position between the patients and the wider team, with Cathy and Bethan describing their recognition of the demands placed on the patients whilst also retaining their sense of ultimate “goodness” and value in the work. This capacity to see both sides hopefully prevents positions becoming too fixed: the nursing team’s bond prompting a controlling attitude or the nurse-patient relationship becoming too permissive.

5.5.2. Pseudo-connection

The above represents, however, an ideal description of team connectedness and there were indications that things did not always go so well. Many of my thoughts on “pseudo-connection” are to some extent supposition, speculation or based on my countertransference in the interviews, however, as it seems that this was difficult to talk about and could not be sufficiently thought about or processed within the confines of these interviews.

Davey et al (2014) reported on the need for support, from the team around the individual nurse, and reported frustrations when such supports were not in place. They described how the focus could then shift to paperwork and administration, which detracted from time with the patient. This would seem to be a description of avoidance in the work, and it may be that some of the examples given, which seem positive on the surface might, in reality, be less so. For example, might the retreat to the nursing office which Cathy describes indicate less of a helpful regrouping, at times, and more of an escape from the demanding infant/patient: the equivalent of leaving the baby to cry while busying oneself with activities that can be reasonably argued to be urgent but are nevertheless avoidant? Might, also, the coming together of the “parental” staff couple to “think about the child” be, at times, more about engaging in an activity with a mind that responds, as opposed to the work of trying to engage with the young person who does not? This respite is, at times, potentially necessary from the onslaught of anorexia, but might the young person have a genuine complaint in feeling that the staff sometimes avoid them, recognising that the retreat to the nursing office becomes overlong when the staff can no longer bear them: an avoidance rather than a regrouping? It is questionable whether hatred of the patient and of being with the patient can be helpfully acknowledged and thus addressed in the nursing team or whether it is hidden under a veneer of what might appear to be reasonable time spent in the office doing other tasks.

Dissemination of responsibility seemed also to be described by participants, in which one staff member could be replaced by another, and it seemed almost frowned on to think about the value of individual relationships. Menzies Lyth (1960) noticed that this sort of rotation, meant to discourage over-investment in the patient’s wellbeing, is meant to “protect” the nurses from an excess of emotional involvement. However, she found that it actually led to relationships not being strong enough to mitigate and work through difficulties. The participants in this study, thus, did not describe supporting a colleague/patient pairing in which there was struggle, but rather “replacing” the “struggling” nurse with another. It seems that the struggle is not viewed as meaningful or therapeutic by the participants: an opportunity to understand or work through a difficulty, but rather as an event which neither staff nor patient can be believed to have the capacity to emerge from.

It seems that the staff may align themselves with a manic view as Klein (1935) described: in which there is no need or place for individual relationships. Perhaps this may be the price of not having to feel personally responsible for these young people and their welfare, just as Klein describes that mania prevents worry about damage. Perhaps also the sense of being part of a much larger network in which there will be a “next hospital”, also supports the idea that no one person, or even one team, is responsible. It seems this can help to prevent a catastrophic persecutory state of mind in the face of entrenched mental health difficulty. This idea seems to chime with Eisler’s (2005) description of the FT-AN treatment model: moving away from a focus on blame and thinking instead about how the family (or, in this case, ward) system can operate to support and help the patient to eat. However, within FT-AN the family are empowered to see themselves as capable of finding solutions to struggles. The participants in this study seemed to have found a way to avoid the individual struggle between nurse and patient and Menzies Lyth (1960) saw equal responsibility and the downplaying of individual input as a way of reducing anxiety about one’s own input. Whilst the anxiety is reduced in this way, the staff member loses her individual sense of achievement which might help mitigate the anxiety in the longer term and increase her sense of capability.

However, an activity in which staff cannot “replace” each other is in the nasogastric feeding. This task requires “qualified” nursing status and, in this position, Erica described significant loneliness and anxiety, seeming to feel suddenly excluded from the team. Following this intervention, she felt there was little capacity in the role for her to follow up with “nice” or “therapeutic” time with the young people. Thus, it seems that Erica feels she loses her place in the team and does not then feel welcomed to return, supported to repair relationships with the young people or work through what has happened. Thus, beneath a veneer of togetherness there seemed to exist opportunities for splitting and it might be wondered whether these preferred “nice” staff make room for reparation and integration in the minds of the young people: supporting their colleagues, who have fallen on the other side of the split, to return, face the damaged relationships and work through anger or distress. These descriptions of “loneliness” would seem to suggest the loss of a sense of Britton’s (1989) triangular space in which a third can helpfully support and create space in the dyadic relationship.

Georgie described frustration with irregular bank staff who perhaps act as a receptacle for the staff group’s frustrations: with their “ejection” at the end of a shift acting to preserve the permanent staff’s perceived goodness. Again, this is a fragile position in which a more integrated “team” cannot be created, and potentially leading to a “catch 22” position in which the team continues to eject the very element which is needed to begin the process of integration. The team is thus held in a “young” state, idealising a more developed, stable consistent team, but never able to reach the level of permanence from which development might follow. Erica was also able to speak to the feeling of being the “failing” member of staff. In doing so she was perhaps speaking to an underlying split on the ward, in which she held the “failing” position at times.

Likewise young people who fail to improve are perhaps ejected into the next hospital. Participants in this study chose to describe this in more positive terms: for example as a “change of scenery”. The idea of the “next hospital” might be used by the team in a way which appears to connect the team to the wider provision of care, but perhaps may also reflect a pushing away of anger, frustration, and perceived inadequacy in the team. In this way, the role for the nursing staff here is maybe in how they break this cycle by integrating their difficult emotions and allowing a patient to be transferred in a way which acknowledges the pain of loss and perceived failure. How the team navigates between genuine and authentic connection and support of each other and avoids or emerges from more rigid or pseudo-connected functioning is perhaps an important part of how the patient can experience meaningful therapeutic treatment over the course of their admission.

Bethan was briefly able to mention more troubling emotions in feeling that staff were sometimes overharsh. Acknowledging this, however, seemed to make her deeply uncomfortable. Erica, further, described that her family would be horrified by the forcefulness of events on the ward. These very brief moments in the interviews of recognising something “horrifying” seem to draw attention to the question of whether the “cohesive nursing team”, at times, slips into a “gang” state, perhaps standing in opposition to the anorexic gang described by Williams (2002). Thus, does Erica’s hesitance to discuss her work with family (in, of course, broad, confidentiality-respecting terms) come from a wish not to come into contact with uncomfortable recognition of something disturbing within the team and do the nursing team instead come together to justify their actions rather than acknowledging they have perhaps satisfied aggressive or frustrated feelings through necessarily forceful interventions such as nasogastric feeds? Bethan’s description of going along with a decision she did not agree with may perhaps indicate that to question would feel too confrontational or might threaten the “togetherness” of the team. However, going along in this way may raise phantasies in the patients that the nursing staff are like a parental couple that is in constant union, inside each other’s minds as Britton (1989) describes as a phantasy of a horrifying parental couple imagined by the child to be constantly engaged in intercourse. Splitting may thus become inevitable as the patients seek to separate this phantasied perverse coupling.

Additionally an element of mindless or perhaps unthinking adherence to this team/gang position seemed to be described. Anne’s account of being supported by her colleague in not taking the “rude” young person for a walk would seem to suggest this. Anne does not describe that her colleague helped the young person and herself to think about the denied walk, supported Anne to acknowledge or move on from her anger and the young person to think about the reparation needed in the relationship with Anne. Anne’s description of the patient going to her colleague because they do not dare to ask Anne to take them for the walk suggests that the patient is too frightened to face the perceived damage to the relationship, has abandoned any hope of working on this or perhaps remains too angry with Anne. However, the colleague’s agreement with Anne seems to shut down any possibility for thinking and working through. This seems to describe a preoccupied rather than punitive response, however: perhaps indicative of a nurse who is too busy or overwhelmed to give over time to a more nuanced reply. However, in this way it seems the patient does not get to experience two staff thinking about her in a way similar to the containment described by Britton (1989), in which parents come together to think about the child.

It seems, therefore, that this study raises questions about how much it is possible for the nursing staff to maintain a sustainably supportive team experience rather than slipping into controlling “prison”-like defences, as described by Ramjan & Gill (2018) in their prison analogies, in order to attempt to control the behaviour of the patients, or slipping towards managing through emotional distancing, as described by Menzies-Lyth (1960). Cathy’s description of staff leaving and Bethan’s disturbance at the decision she did not agree with might also suggest a team fragmentation in response to difficulty, where staff perhaps leave when they feel no longer feel ethically or emotionally able to comply and do not, perhaps, feel supported to meaningfully address their reservations. Cathy spoke of the disparity between the ward “position” that one should not feel sad, versus the individual’s genuine emotional state, suggesting perhaps a gang-like rule that seeks to overrule the individual and their feelings.

My own difficulty in gaining access to the ward speaks perhaps to a hesitance to reach out and explore the nature of these relationships on the ward. I am aware that I spent significant time being supportive and empathic in the nursing office, so that potential participants might feel I was “one of them” and thus safe to talk to. Recognising the pull to a more secretive and potentially punitive functioning might be suggested as a role for the nursing team, in order that they resist this and continue to talk and think openly and honestly as a way of making uncomfortable feelings accessible to thinking about.

5.6. Preparing for an ending and letting go

Waddell (1998), in describing the task of late adolescence, spoke of an emergence from the

> *“addictive complexities of group-life and…of separating from parents and family”*
> (p.176-177)

It seems that the final and yet fundamental task of the ward is to support the patient to separate from the addictive world of anorexia and from the safe predictability of the ward: to enable the patient ultimately, as Waddell (1998) describes, to build their own mind and external relationships.

Participants in this study described that for some patients this separating is not possible; some patients seeking to remain in the ward by reactivating their symptoms. Bethan described patients who restrict the eating but make up the deficit later: seeming perhaps to be testing the boundaries and needing greater firmness. Anne described, however, a patient who seemed to have no wish to leave and whose reactivated symptoms were not responsive to the “greater firmness” approach. It seems that leaving is a particularly difficult moment for nursing staff whose role is to help the patient to move on and to be in tune with the patient’s state of mind, whether healthily or more catastrophically anxious about the future. It seems that this again requires an individualised approach, relying on the nursing staff’s recognition of different states of mind that may produce similar symptoms.

Wright (2010) posits the question about when there is genuine recovery or when the patient complies in order to be released from the ward. Waddell (1998) similarly draws attention to a form of defensive coupling which is not truly developmental. It seems that this question:

“has the treatment been good enough?” is a preoccupation to some of the participants in this study and perhaps the ward more generally: asking whether the child has been helped to genuinely, rather than defensively, move on. It seems, however, that this is a complicated question with no “black or white” answer. Certainly, for the patient, much work will remain, to be continued in outpatient care, and good outcomes cannot be guaranteed even if inpatient care has been “good enough”. Graham (2020) described a need to cope with “caring without curing” (p.422) and participants described a number of ways of managing this: from working with networks around the child, holding tight to known success stories and putting faith in the next hospital environment, therapist, or team to support the patient. In this way it seems the nursing staff managed to retain hope that “good enough” and good outcomes might be achieved at some point, rather than it having already been achieved: a more realistic and therefore less fragile stance.

Ultimately, however, the nursing staff do not know, and not knowing must be borne as an intrinsic part of the role. This is perhaps particularly difficult as, unlike a parent who generally has an ongoing role in their child’s life and gets to see how their child develops, the nursing staff have only bare minimum information, from a very few patients who remain in touch, with which to bolster their sense of doing what is right. It is clear from the participants that they are left with significant worry alongside their sadness. Waddell (1998) describes that part of the success of separating is connected to how much the parents can bear to let the child go. In managing their sadness and worry, rather than becoming overwhelmed by it, the nursing staff are thus able to let their patients go. The sense of relief in the interviews for some of the participants however, in finding a place where they might talk about these sad and worried feelings was striking. It seemed they were, at times, unsure whether these feelings were permitted or professional. This spoke to how much the nursing staff hold back their own feelings, which perhaps facilitates the progress of the patients through their not becoming receptacles for the feelings of the nurses (i.e. becoming victims of the “omega function” which Williams [1997] describes), and perhaps allows patients to leave them behind. However, it seems that work is needed “behind the scenes” in supervision on recognition and validation of the emotions of the nursing staff as an inevitable consequence of work that has been meaningful and thus evidence of professional working.

Freud (1917) describes the process of mourning as a normal process, but it is beyond the remit of this study to explore how patients manage their grief or whether they tend to resort to the more manic defences that Klein (1935) described: denying loss and the meaning of the relationships that are left behind. The nursing staff, however, do describe needing to find a way to grieve and manage their worry for their patients. It might be suggested that doing so successfully allows them to move on to treating the next patient rather than remaining preoccupied (through unresolved grief) by those who have moved on or conveying a manically positive attitude which does not meet the new patient (or indeed the leaving patient) where they are, emotionally. Some of the descriptions given by the participants might suggest a resort to mania at times however: using knowledge of patients who are doing well to stave off fears about others or relying on shifts in the familial systems around the young person which perhaps allows the nursing staff to cut themselves off from worried feelings about the patient’s ongoing state of mind. These defences are recognisably manic, as Klein (1935) describes when she defines mania’s lack of acknowledgement of the individual, as here these defensive manoeuvres move away from recognition of the individuality of the young people. Fixation on positives at the time of ending may not support the young person to overcome their own manic responses to leaving and thus to have a meaningful and connected goodbye. Alternatively, it might be wondered whether repeated experiences of grief and worry, which do not find sufficient support and processing might negatively impact the nursing team's capacity to function. As in all things it would seem that a depressive balance is needed in which nurses are not overcome by their worry or grief, but also do not deny it: a level of realistic hope and sense of having done one's part in the young person's journey and it seems from the participants interviews that their capacity to tolerate and think about the pain of the work naturally fluctuates between tolerance and thoughtfulness about worry followed by retreat and more manic defence. Reaching a balance of tolerance and acceptance which supports the patient and also the emotional wellbeing of the staff would seem to be part of the role of the nursing staff.

6. Conclusion

This study has described how, when their work is successful, the nursing staff seem to facilitate an infantile reworking of the feeding relationship, assisting the patients to have a different experience. This is perhaps required in order to move patients on more genuinely from an inpatient admission for Anorexia Nervosa, through developing a firmer foundation from which to grow and develop. The patient seems to bring, at every stage of emotional "ingestion", their difficulty with taking in: failure of appetite, failure of willingness, failure to digest or tendency to mis-digest experience, as well as explosively expulsive and/or sadistic behaviours. The nursing role is thus to facilitate improvement in these areas: a delicate interplay of emotional feeding, alongside the physical feeding, which, when successful, leads the patient to get on board with their treatment and to start working with, instead of against, the system.

With this particularly entrenched group of patients much of the work seems to be in how the nursing staff manage their own emotional states, in order to continue to bring their hopeful and engaged selves to the work: how they themselves do not become "starved" of connection and a sense of meaning. In addition, perhaps due to patients experiencing being heavily projected into, nursing staff are required to hold back their emotions and manage much internally in order not to overwhelm this group of patients as well as managing their own frustration and at times, perhaps, hatred of the patients.

To remain connected and emotionally available, the participants bought their need for support and vividly conveyed the frustration and distress which arises from failures in the support network around the staff. Participants reported seeking support from each other emotionally and relying on each other for support with the concrete tasks of the ward. More broadly they seemed to see themselves as part of a wider network, a part of the patient's journey, which seemed to serve the function of protecting the nursing staff from burnout, as responsibility is shared with all those who come into contact with the patient. However, this might also be seen as a defensive manoeuvre against distress and worry. Participants were clear that when support systems break down this can make the work untenable with participants either feeling blamed by staff and patients or perhaps resorting to more punitive behaviour.

At discharge, participants identified a lingering pain of not knowing what happens to their patients and this is something which is perhaps not given as much time in supervision as discussion of the feelings evoked by chronically unwell patients on the ward. Participants seemed to suggest feeling unsure about how to raise their emotional reactions to ending: questioning whether this is considered “professional”. It was clear, however, that discharged patients retain a place in the mind of the nursing staff, with their wondering what happened to them and their seeking to understand and come to terms with the ending of the relationship and the lack of ongoing contact.

This study identifies that the nursing staff have a number of roles in emotionally supporting and regulating patients, themselves, and each other and perhaps these roles are not so easily quantified as weight gain. Nevertheless, I would argue that these roles may be essential for a genuine and meaningful recovery of the patients. Anorexia is a condition which invites paperwork: numerical tallying, close observation recording and incident reporting. In this way, care risks becoming reductionistic, much like the illness itself: a perfectionistic interest in completed paperwork, and nursing staff may need support to manage their own ability to identify when paperwork has been completed to a good enough standard and to recognise when they are caught up in either avoidance of emotional nursing tasks as Menzies Lyth (1960) saw it or when paperwork has become a persecutory activity through perfectionism in the team or in the individual staff member which prevents meaningful emotional engagement in the work. It is vital that nursing staff are freed up, both practically and internally, to engage emotionally with their patients, and it would seem that the work has much potential for restoration of the patient's internal world when this is enabled, which would hopefully support their longer-term recovery. Additionally, prioritising the space for nursing staff to attend to their own emotional needs may facilitate effective and longer-term engagement in the work.

7. Strengths, limitations and recommendations for further research

This is a study that is limited by being very small scale. The nursing staff in this study were all working on one ward, and it is possible that the interviews picked up data that is specific to this ward. It would be of value for the work within this study to be shared more broadly and questions asked directly about the themes identified, to see whether it has resonance outside this one particular ward. It might also be wondered whether this study would have significance outside of work with eating disordered young people: whether these findings are perhaps particularly apparent in this patient group but might also be important in the treatment of other groups, particularly perhaps those tending towards narcissistic functioning and the professionals involved in treating and supporting them.

Alternatively, or additionally, observation of the ward milieu might be of use in determining whether these themes can be seen in daily interactions. It is possible that in interviews nursing staff may idealise the experience or describe the extremes of experience. A direct observational study might be of great use in gaining more day-to-day data.

In addition, this study is limited by the, perhaps, natural urge of participants to paint themselves and the ward in general in a good light. Wishing to “say the right thing” and backup the ward way of doing things may have obscured more difficult emotions and although some participants were able to explore their own distress and frustration, some were less so. Even those participants who were more willing to discuss their emotional state, seemed unsure about whether expressing emotions was considered “professional” and seemed relieved to have a space to do so. My urge, in response to this, was to be reassuring: a response grown from a wish not to upset participants and also to keep the interview as a positive experience for us both. This, however, limits the data and I would wonder whether, if multiple interviews were undertaken and trust grown to a level such that reassurance became less prominent, further understanding might be gleaned. Again, an observational study might uncover less sanitised data (although of course long observation would be needed, in order to reduce staff and patients “playacting” for the researcher). From observation it would also be possible to see whether emotional engagement is inhibited by worries about whether the building of emotionally authentic therapeutic alliance is considered “professional”, or whether it is only discussion of evoked feelings that is found to be difficult. Additionally, it may be more possible to observe whether emotionally engaged responses, with this particular patient group, broadly seem to help or hinder, although observation would not be able to comment on longer term value and consideration would need to be given to where the individual was in their treatment journey. I would suggest that close observation of very small numbers of patient-nurse relationships might provide more meaningful information than larger scale, broader observation, which could be heavily confounded by the huge numbers of case specific factors.

The themes of this study are very much a best-case scenario, and it seems unlikely that work always progresses well. Some of this more difficult side was picked up in the interviews and certainly within the literature review in which wards have been likened to prisons, but further work is required to look at the interplay between positive emotional feeding and a more defensive retreat to “prison-like” conditions, the “good-enough” balance point between these two positions, whether “positive” might sometimes be “unhelpful” (i.e. too soft) and “prison-like” might sometimes be “helpful” (i.e. boundaried towards the anorexic “gang”).

This study is further limited by my capacity to bracket my own thoughts and understanding. This is an important part of the IPA method, but my interest and experience in eating disorders is long standing, my reading on the subject significant and I have previously worked on this particular ward and so came to the study with preconceptions. I have also previously worked as a nursing assistant and am aware from my own experience how difficult this work can be. I came to this study with a wish to illuminate the nursing role and highlight the stresses and difficulty of the work, having felt myself, from within the system, that it is not a role always given equal standing in the ward professional milieu.

Strengths of this study were, however, in the “barely-structured” nature of the interview. Participants were largely invited to think about feelings and then to discuss however they felt moved to and the interview questions prepared were rarely referred to. My experience as a child psychotherapist allowed me to conduct the interviews somewhat as I would a therapy session: seeing what individual participants brought to their interviews and proceeding from there. I believe this allowed data to arise beyond preconceived ideas that may be implicit in a more structured interview, and I believe the data was less inhibited or directed than it perhaps would have been if participants had been asked to describe their role and use of feelings. I believe, further, that this may also have reduced resistance to talking about feelings as participants were able to talk from a starting point within their own “comfort zone” and the interview was able to build from there. Certainly, the literature is full of examples where more direct questions have been asked and a long list of roles for nursing staff has resulted. I feel the more distanced approach of this study and the subsequent IPA form of data analysis has allowed for a meta-list: something which rises above a direct “shopping list” of roles to an overarching suggestion of what is being attempted and achieved on the unit.

Whilst one must always wonder about limitations of bracketing, I do feel that during the interviews I had little sense of what I was getting at or asking for. I, therefore, feel the interviews were free to evolve independently and it was quite clear on listening back that I did not have an overarching agenda, such that each interview was very different. Additionally, although difficult to gain access to the ward, I feel that in the end my regular attendance probably facilitated the more open responses of some of the participants, who were more able to discuss how very difficult this work is, having built up a level of trust and familiarity through my regular attendance. I would certainly recommend further research be built into the ward in this way, to allow time for the staff to recognise the researchers and develop a sense of its being supported by the ward milieu.

In regards additional further research beyond that already described here, I would recommend an interview study with recovered anorexic patients to gain their reflections on inpatient treatment. I would hope that following recovery such reflection might be more possible. Alternatively, perhaps interviews with their families might be a place from which to gather further data: about what worked for their young people, what was gained through inpatient admission beyond weight restoration and how family dynamics changed following discharge. Additionally, studies exploring how the wider team view the work of the ward would be instructive in understanding some of the difficulties which may get played out between nursing staff and the rest of the team or between disciplines, as well as thinking about the emotional roles of multidisciplinary staff.

8. Recommendations for practice

This study might be a helpful framework within which to consider the work of eating disorder nursing staff. It may be helpful to the individual staff member who is in the thick of it to identify that unconscious processes underlie engagement with patients and to thus sustain hope that difficulties are part of the process of the treatment. This may help staff to feel less persecuted and potentially less likely to retreat to more punitive treatment and defence.

Using a framework which acknowledges all nursing responses as informative about the patient rather than “right” or “wrong” may help staff to feel more confident in attending thinking spaces and speaking out about their experiences. I would recommend a ward stance which explicitly, and repeatedly makes reference to holding this position, in order to support and validate its staff. Additionally, being consistently mindful of any deterioration to more binary “right/wrong” thinking and supporting staff to move away from this way of functioning through experientially informed, psychodynamically facilitated clinical reflection and case discussion would be important in embedding a more nuanced thinking about reported nursing experience and observation of patient/nurse relating. Over time, thinking spaces can then be used to build a strong team, not held together by dogmatic adherence to unit rules, but rather by an understanding and respect for each other’s thought processes and experiences, which may also lead to a better understanding of patients through the data of nursing staff’s experiences.

It would be hoped that use of the framework of this study would lead to a virtuous circle: in that staff who feel more confident to seek support, will ultimately be more able to continue engaging in the work. If this improved staff retention, less irregular bank staff would be needed. Participants raised the difficulty of working with bank staff, who are not part of the desired “strong team” needed for this work. Regular bank staff might, however, be incorporated into a “strong team” if time is taken to train and support them as though they were permanent members of staff, and this might be a compromise position: prioritising team building above divisions regarding employment status. Additionally, a “strong team” might be more able to incorporate less regular bank staff rather than using them to hold frustrations.

This study additionally highlights and calls for recognition of the mental strain of this work. Whilst working long, thirteen-hour, shifts is perhaps beneficial for continuity of care for patients this must be carefully balanced against consideration of whether nursing staff are becoming exhausted: particularly when distressing procedures, such as nasogastric feeds, are in high demand. Whilst it is detrimental to the emotional wellbeing of nursing staff to reach such levels of overwhelm, it stands to reason that it would additionally impact patient care to have a nurse functioning from a position of having reached their limit. At these particularly high stress times it becomes even more vital to incorporate support and thinking space away from patients, which would provide opportunities for the team to think about how their opinions of each other are impacted by these high stress procedures which only some of the staff are qualified to perform. Additionally lower stress, more gratifying activities with patients, may be helpful to incorporate, to give nursing staff an opportunity to recover both their mental equilibrium and their more positive, empathic connection to patients. Perhaps this might be facilitated through scheduled “post-NG” time: where nurses involved in the feed sit with the patient whilst a colleague who was not involved joins and supports the rebuilding of the relationship. Cathy described how her intervention with a patient on behalf of her colleague supported the patient’s thinking about what had happened. Might, for example, sitting all together to watch TV help to bring the difficulty starkly into focus for discussion and/or create an environment conducive to forgiveness and moving on if the nurse could be supported and wordlessly invited by her colleague to re-join the ward milieu. This sounds a rather contrived description, and ideally if the team strengthens so perhaps this sort of system could evolve through staff's generosity towards their colleagues.

Maximums need to also be considered with nursing staff: i.e. how many NG feeds is too many and likely to begin having a detrimental effect on the nursing staff's own emotional wellbeing and perhaps when drafting careplans for the young people there needs to be some thinking about reasonable limits for staff. Additionally how might thinking spaces around such activities help to adjust how they are viewed: emphasising not the physical necessity or mindless adherence to care plan, but rather the value in a thoughtfully firm boundary. This study identifies that some nursing staff struggle with digesting their experiences on the ward and this needs to be thought about to safeguard the nursing staff as well as their capacity to work. This is ultimately of vital importance to patient care if we truly accept that the patient needs to feel that they are not damaging their objects (i.e. the individual staff members) and nursing staff are not to resort to more punitive behaviour.

Whilst the participants in this study placed high value on a strong team managing things together, they seemed to value my role as an external person to talk to. Time was needed, however, for me to be accepted as a part of the ward and participants reported feeling hesitant about talking to "outsiders", believing they would not understand. External supervision, therefore, carries the opportunity for staff to speak freely, but trust must first be built and time for the supervisor to build an understanding of the ward. In some ways, how nursing staff come to speak about their experiences perhaps mirrors the difficulty of the patient group to do likewise and perhaps nursing staff also need to go through the stages described in this study as they work towards feeling ready to be more open about the impact of the work and their need for support. It is likely that dynamics played out in the patient group also play out in the staff group who may also need someone to fan the embers of their interest in supervision, wait for them to be ready and then help them to digest their experiences such that more evacuative behaviour does not occur (i.e. staff leaving or becoming punitive in their practice as described above). It is hoped that reference to this study may help nursing staff, in individual supervision and eventually in group settings, work towards a less persecuted understanding of the nursing role, in which their emotions are vital data which can aid in better understanding the patient. It is my experience of supervision that it is often approached by the supervisor with enthusiasm and profound belief that supervision is helpful. I would suggest that time, however, is needed to grow trust and readiness, just like for this patient group, in the value of the supervisory relationship.

Finally, I would hope this study would be informative to non-nursing staff in understanding the role more clearly: its intensity and its depth. I would hope it encourages non-nursing staff to take time to talk with nursing staff, who spend many hours with patients and hold a unique position in relation to them. In studying the dynamics between nurse and patient I believe we can understand more about the patient and the particular presentation of their psychopathology and in listening to the nurse and her experience of the patient we can take advantage of the many hours of observational data that the nurse can impart. A part of this will also, perhaps, be learning more about the particular issues which are triggered for the nurse in working with this patient group, but that also gives an opportunity to understand better how to support the nurse and one would hope over time to see the better supported nurse more able to provide more objective observations. I would particularly call upon my psychodynamic colleagues to take time to think with nursing staff, to gather and help make sense of their observations. I would liken this to the “parent work” which is so essential in work as a child psychotherapist and as such a valuable and valid use of time spent on the eating disorder unit. Additionally, I would wonder whether directly using parent work or family therapy space to think about and debrief the child’s experiences with nursing staff on the ward might provide a way of thinking about the child’s difficulties in a different way, slightly removed from the dynamics of the family. However, in order to do this, time would be required, as above, with the nursing team in order to understand their position so that family/parent work addressing difficulties on the ward is integrated, with both nurse and child held in the therapist’s mind through the work.

9. Bibliography

Bion, W., 1962. *Learning from experience*. London: William Heinemann Medical Books Limited

Bion, W., 1967. *Second thoughts*. London: William Heinemann Medical Books Limited

Bion, W., 1970. *Attention And Interpretation: A Scientific Approach To Insight In Psycho-Analysis*. London: Tavistock.

Britton, R., 1989. ‘The missing link: parental sexuality and the Oedipus complex’. In Britton, R., Feldman, M., O'Shaughnessy, E. and Steiner, J., *The Oedipus Complex Today*. London: Karnac Books, pp.83-102

Cks.nice.org.uk. 2020. *Eating Disorders | Topics A To Z | CKS | NICE*. [online] Available at: <https://cks.nice.org.uk/topics/eating-disorders/background-information/definition/> [Accessed 11 September 2020].

Cks.nice.org.uk. 2020. *Eating Disorders | Topics A To Z | CKS | NICE*. [online] Available at: (https://cks.nice.org.uk/topics/eating-disorders/management/confirmed-eating-disorder/> [Accessed 11 September 2020].

Davey, A., Arcelus, J. and Munir, F., 2014. Work demands, social support, and job satisfaction in eating disorder inpatient settings: A qualitative study. *International Journal of Mental Health Nursing*, 23(1), pp.60-68.

Eisler, I., 2005. The empirical and theoretical base of family therapy and multiple family day therapy for adolescent anorexia nervosa. *Journal of Family Therapy*, 27(2), pp.104-131.

Eisler, I., Simic, M., Hodsoll, J., Asen, E., Berelowitz, M., Connan, F., Ellis, G., Hugo, P., Schmidt, U., Treasure, J., Yi, I. and Landau, S., 2016. A pragmatic randomised multi-centre trial of multifamily and single family therapy for adolescent anorexia nervosa. *BMC Psychiatry*, 16(1).

Fairburn, C. G. and Harrison, P.J., 2003. Eating disorders. *Lancet*, 361, pp.407-16.

Fogarty, S. and Ramjan, L., 2017. The tipping point of change in Anorexia Nervosa (AN): Qualitative findings from an online study. *Women & Health*, 58(9), pp.1050-1061.

Forchuk, C. and Westwell, J., 1987. Denial. *Journal of Psychosocial Nursing and Mental Health Services*, 25(6), pp.9–13.

Freud, S., 1911. *The Standard Edition Of The Complete Psychological Works Of Sigmund Freud Volume 12*. London: Vintage, pp.3-82.

Freud, S., 1912. *The Standard Edition Of The Complete Psychological Works Of Sigmund Freud Volume 12*. London: Vintage, pp.109-120

Freud, S., 1917. *The Standard Edition Of The Complete Psychological Works Of Sigmund Freud Volume 14*. London: Vintage, pp.243-259.

Graham, M., Tierney, S., Chisholm, A. and Fox, J., 2020. The lived experience of working with people with eating disorders: A meta-ethnography. *International Journal of Eating Disorders*, 53(3), pp.422-441.

Hage, T., Rø, Ø. and Moen, A., 2017. To bend or not to bend? Rule adherence among staff at an eating disorder unit. *Eating Disorders: The Journal of Treatment & Prevention*, 25(2), pp.134-150.

Houzel, D., 2010. Infant observation and the receptive mind. *Infant Observation*, 13:2, pp.119-133.

Joseph, B., 1982. Addiction to Near-Death. *International Journal of Psycho-Analysis*, 63, pp.449–456.

Klein, M., 1929. ‘Infantile anxiety-situations reflected in a work of art and in the creative impulse.; In Klein, M., *Love, Guilt, And Reparation And Other Works, 1921-1945*. New York: The Free Press, pp.210-218.

Klein, M., 1930. ‘The importance of symbol-formation in the development of the ego.’ In Klein, M., *Love, Guilt, And Reparation And Other Works, 1921-1945*. New York: The Free Press, pp.219-232.

Klein, M., 1935. ‘A contribution to the psychogenesis of manic-depressive states.’ In Klein, M., *Love, Guilt, And Reparation And Other Works, 1921-1945*. New York: The Free Press, pp.262-289.

Klein, M., 1940. ‘Mourning and its relation to manic-depressive states.’ In Klein, M., *Love, Guilt, And Reparation And Other Works, 1921-1945*. New York: The Free Press, pp.344-369.

Klein, M., 1946 ‘Notes on some schizoid mechanisms’ In Klein, M., *Envy and Gratitude, 1946-1963*. London: Vintage, pp.1-24.

Meltzer, D., 1967. *The Psycho-Analytical Process*. Harris Meltzer Trust.

Meltzer, D., 1992. *The claustrum: an investigation of claustrophobic phenomena.* The Clunie Press for the Roland Harris Trust Library.

Menzies, I., 1960. A Case-Study in the Functioning of Social Systems as a Defence against Anxiety: A Report on a Study of the Nursing Service of a General Hospital. *Human Relations*, 13(2), pp.95-121.

Minuchin, S., Rosman, B., and Baker, L., 1978. *Psychosomatic families: Anorexia nervosa in context.* Cambridge, MA: Harvard University Press.

Orbach, S., 1998. *Fat is a feminist issue.* London: Arrow books

Pemberton, K. and Fox, J., 2013. The Experience and Management of Emotions on an Inpatient Setting for People with Anorexia Nervosa: A Qualitative Study. *Clinical Psychology & Psychotherapy*, 20(3), pp.226-238.

Peplau, H. E., 1999. ‘Psychotherapeutic strategies’, *Perspectives in Psychiatric Care*, 35(3), pp.14–19.

Ramjan, L. and Gill, B., 2012. Original research: an inpatient program for adolescents with anorexia experienced as a metaphoric prison. *AJN, American Journal of Nursing*, 112(8), pp.24-34.

Rosenfeld, H., 1987. *Impasse and Interpretation*. London and New York: Routledge

Ross, J. and Green, C., 2011. Inside the experience of anorexia nervosa: A narrative thematic analysis. *Counselling and Psychotherapy Research*, 11(2), pp.112-119.

The Royal College of Nursing. 2020. *Principles Of Nursing Practice | Royal College Of Nursing*. [online] Available at: <https://www.rcn.org.uk/professional-development/principles-of-nursing-practice> [Accessed 28 June 2020].

Salzmann-Erikson, M. and Dahlén, J., 2017. Nurses’ Establishment of Health Promoting Relationships: A Descriptive Synthesis of Anorexia Nervosa Research. *Journal of Child and Family Studies*, 26(1), pp.1-13.

Segal, H., 2001. ‘Symbolization’, in Bronstein, C. (ed.) *Kleinian theory: A contemporary perspective.* Philadelphia, PA: Whurr Publishers, pp.148–156.

Skogstad, W., 2013. Impervious and intrusive: The impenetrable object in transference and countertransference. *The International Journal of Psychoanalysis*, 94(2), pp.221-238.

Simic, M., Anderson, L. K., Berner, L. A., Peck, S. K., Hunt, K., Kaye, W. H., and Eisler, I., 2017. ‘When family therapy isn’t enough: New treatment directions for highly anxious and dysregulated adolescents with anorexia nervosa’, in Murray, S. B., Anderson, L. K., and Cohn, L. (eds) *Innovations in family therapy for eating disorders: Novel treatment developments, patient insights, and the role of carers.* New York, NY: Routledge/Taylor & Francis Group, pp.113–131.

Snell, L., Crowe, M. and Jordan, J., 2010. Maintaining a therapeutic connection: nursing in an inpatient eating disorder unit. *Journal of Clinical Nursing*, 19(3-4), pp.351-358.

Steiner, J., 1993. *Psychic Retreats*. London: Routledge.

Stern, D.N., 2002. *The First Relationship.* Cambridge, MA: Harvard University Press

Travelbee, J., 1964. What's Wrong with Sympathy?. *The American Journal of Nursing*, 64(1), pp.68-71.

Waddell, M., 1998. *Inside Lives.* London: Karnac

Williams, G. P., 1997. ‘The no entry system of defences. Reflections on the assessment of adolescents suffering from eating disorders’. in Williams, G. P.(ed.) *Internal Landscapes and Foreign Bodies: Eating Disorders and Other Pathologies.* Tavistock Clinic Series London: Karnac Books, pp.115-122.

Williams, G. P., 2002. ‘On gang dynamics’ in Williams, G. P.(ed.) *Internal Landscapes and Foreign Bodies: Eating Disorders and Other Pathologies.* Tavistock Clinic Series London: Karnac Books, pp.51-62.

Williams, G. P., 2002. ‘Reversal of the ‘Container/Contained’ Relationship’ in Williams, G. P.(ed.) *Internal Landscapes and Foreign Bodies: Eating Disorders and Other Pathologies.* Tavistock Clinic Series London: Karnac Books, pp.103-114.

Winnicott, D. W., 1949. ‘Hate in the counter-transference’, *The International Journal of Psychoanalysis*, 30, pp.69–74

Winnicott, D. W., 1953. ‘Transitional objects and transitional phenomena; a study of the first not-me possession’, *The International Journal of Psychoanalysis*, 34, pp.89–97.

Winnicott, D. W. (1956) ‘Primary maternal preoccupation’, in Mariotti, P.(ed.) *The maternal lineage: Identification, desire and transgenerational issues.* New York, NY: Routledge/Taylor & Francis Group (The new library of psychoanalysis), pp.59–66.

Winnicott, D. W., 1960. ‘Ego distortion in terms of true and false self’ In. *The Maturational Processes and the Facilitating Environment: Studies in the Theory of Emotional*

Development. London: The Hogarth Press and the Institute of Psycho-Analysis (The International Psycho-Analytical Library).

Winnicott, D.W., 1965. *The Maturational Processes and the Facilitating Environment: Studies in the Theory of Emotional Development*. London: The Hogarth Press and the Institute of Psycho-Analysis (The International Psycho-Analytical Library).

Winnicott, D. W. (1971). Playing and Reality. London: Tavistock Publications

Wright, K., 2010. Therapeutic relationship: Developing a new understanding for nurses and care workers within an eating disorder unit. *International Journal of Mental Health Nursing*, 19(3), pp.154-161.

Wright, K. and Hacking, S., 2012. An angel on my shoulder: a study of relationships between women with anorexia and healthcare professionals. *Journal of Psychiatric and Mental Health Nursing*, 19(2), pp.107-115.

Wright, K. and Schroeder, D., 2016. Turning the Tables. *Cambridge Quarterly of Healthcare Ethics*, 25(2), pp.219-227.

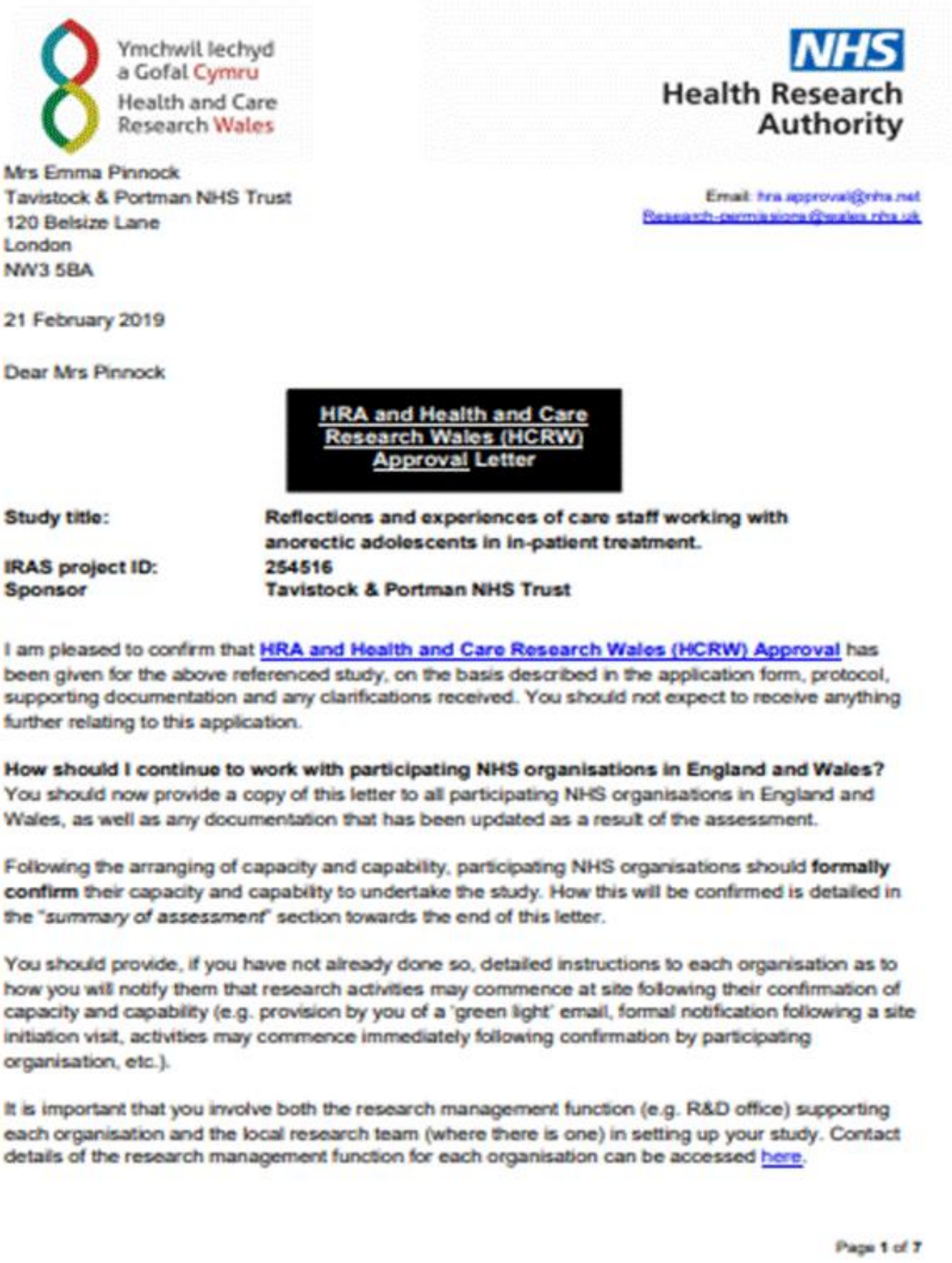
Zugai, J., Stein-Parbury, J. and Roche, M., 2013. Effective nursing care of adolescents with anorexia nervosa: a consumer perspective. *Journal of Clinical Nursing*, 22(13-14), pp.2020-2029.

Zugai, J., Stein-Parbury, J. and Roche, M., 2018. Therapeutic alliance, anorexia nervosa and the inpatient setting: A mixed methods study. *Journal of Advanced Nursing*, 74(2), pp.443-453.

Zugai, J., Stein-Parbury, J. and Roche, M., 2019. Dynamics of nurses' authority in the inpatient care of adolescent consumers with anorexia nervosa: A qualitative study of nursing perspectives. *International Journal of Mental Health Nursing*, 28(4), pp.940-949.

10. Appendices

A: Permission notification from IRAS



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Mrs Emma Pinnock
Tavistock & Portman NHS Trust
120 Belsize Lane
London
NW3 5BA

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

21 February 2019

Dear Mrs Pinnock

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title: **Reflections and experiences of care staff working with anorectic adolescents in in-patient treatment.**
IRAS project ID: **254516**
Sponsor **Tavistock & Portman NHS Trust**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important 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 of the research management function for each organisation can be accessed here.

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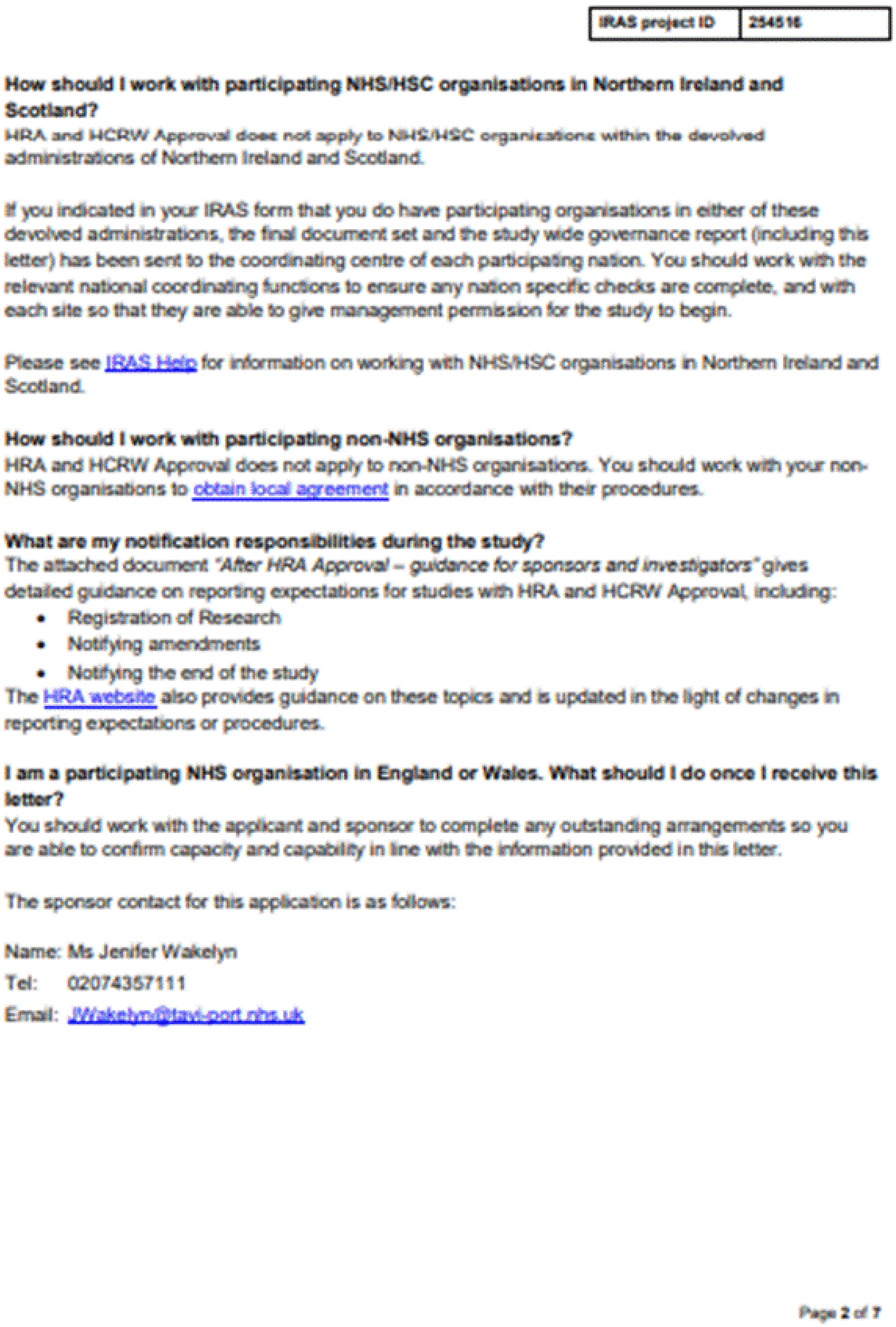


IRAS project ID	254516

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

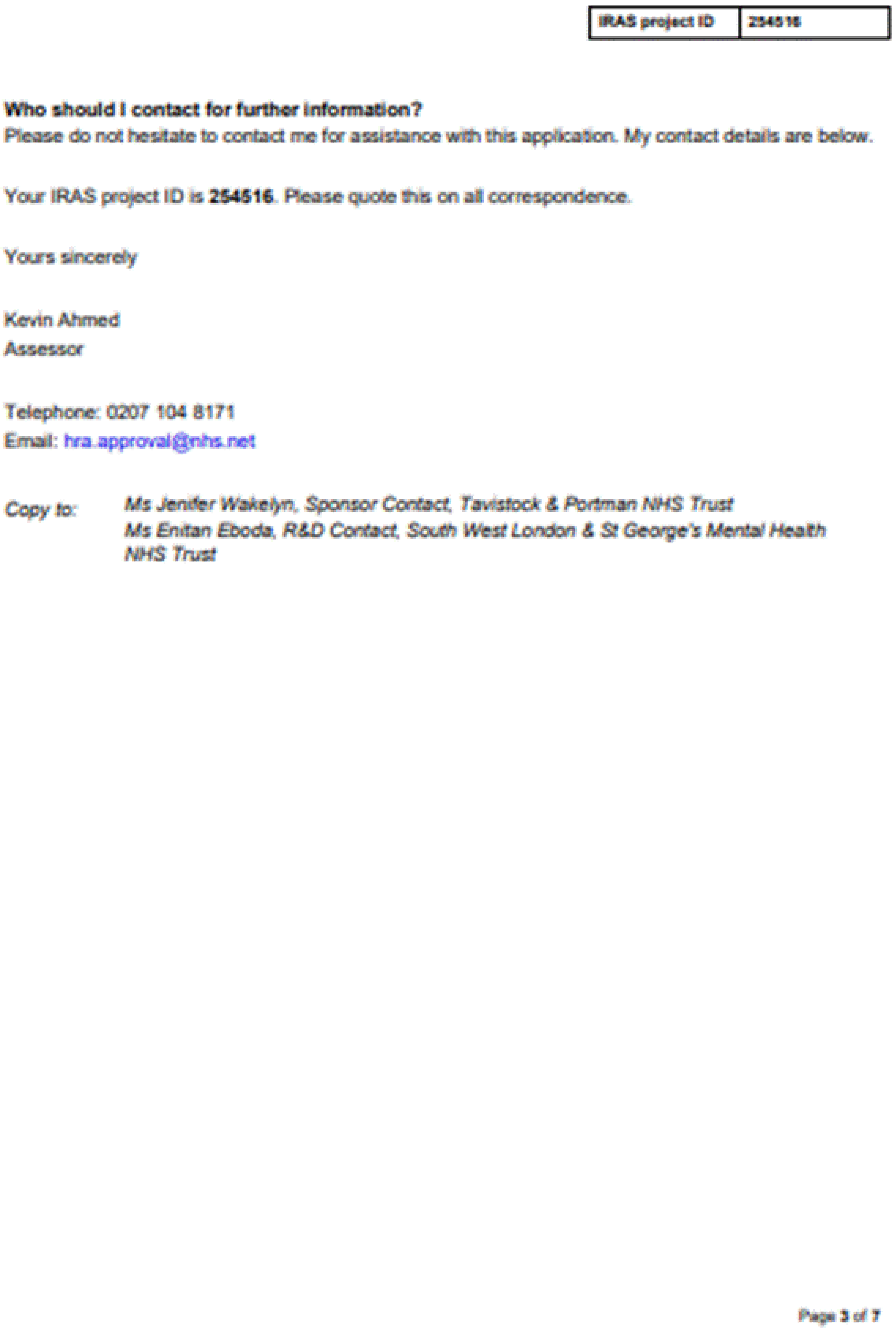
The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?

You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Ms Jenifer Wakelyn
Tel: 02074357111
Email: JWakelyn@tavi-port.nhs.uk



Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

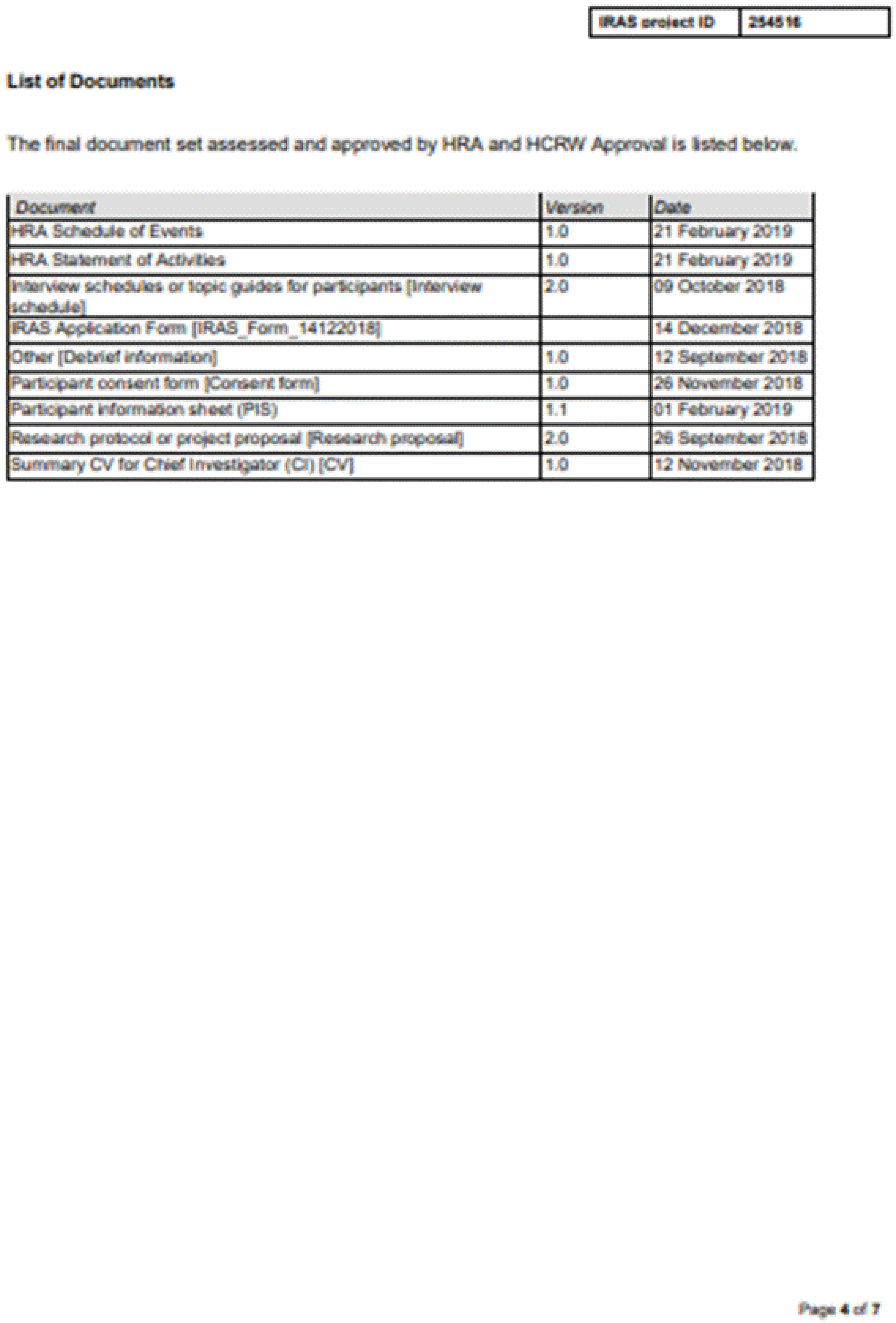
Your IRAS project ID is **254516**. Please quote this on all correspondence.

Yours sincerely

Kevin Ahmed
Assessor

Telephone: 0207 104 8171
Email: hra.approval@nhs.net

Copy to: *Ms Jenifer Wakelyn, Sponsor Contact, Tavistock & Portman NHS Trust*
Ms Enitan Eboda, R&D Contact, South West London & St George's Mental Health NHS Trust



IRAS project ID	**254516**

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
HRA Schedule of Events	1.0	21 February 2019
HRA Statement of Activities	1.0	21 February 2019
Interview schedules or topic guides for participants [Interview schedule]	2.0	09 October 2018
IRAS Application Form [IRAS_Form_14122018]		14 December 2018
Other [Debrief information]	1.0	12 September 2018
Participant consent form [Consent form]	1.0	26 November 2018
Participant information sheet (PIS)	1.1	01 February 2019
Research protocol or project proposal [Research proposal]	2.0	26 September 2018
Summary CV for Chief Investigator (CI) [CV]	1.0	12 November 2018

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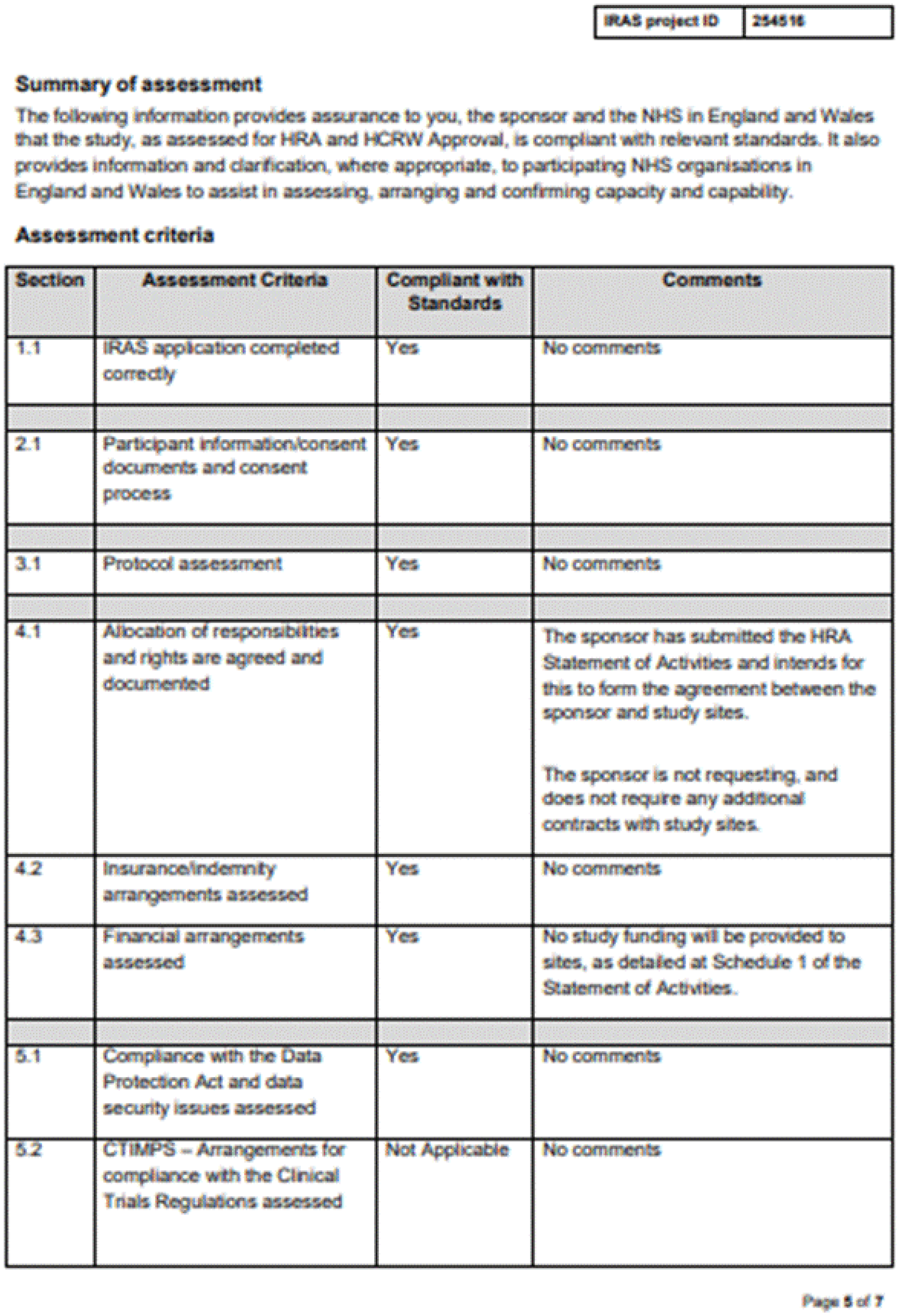

IRAS project ID	254516

Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

Assessment criteria

Section	Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
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	The sponsor has submitted the HRA Statement of Activities and intends for this to form the agreement between the sponsor and study sites. The sponsor is not requesting, and does not require any additional contracts with study sites.
4.2	Insurance/indemnity arrangements assessed	Yes	No comments
4.3	Financial arrangements assessed	Yes	No study funding will be provided to sites, as detailed at Schedule 1 of the Statement of Activities.
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

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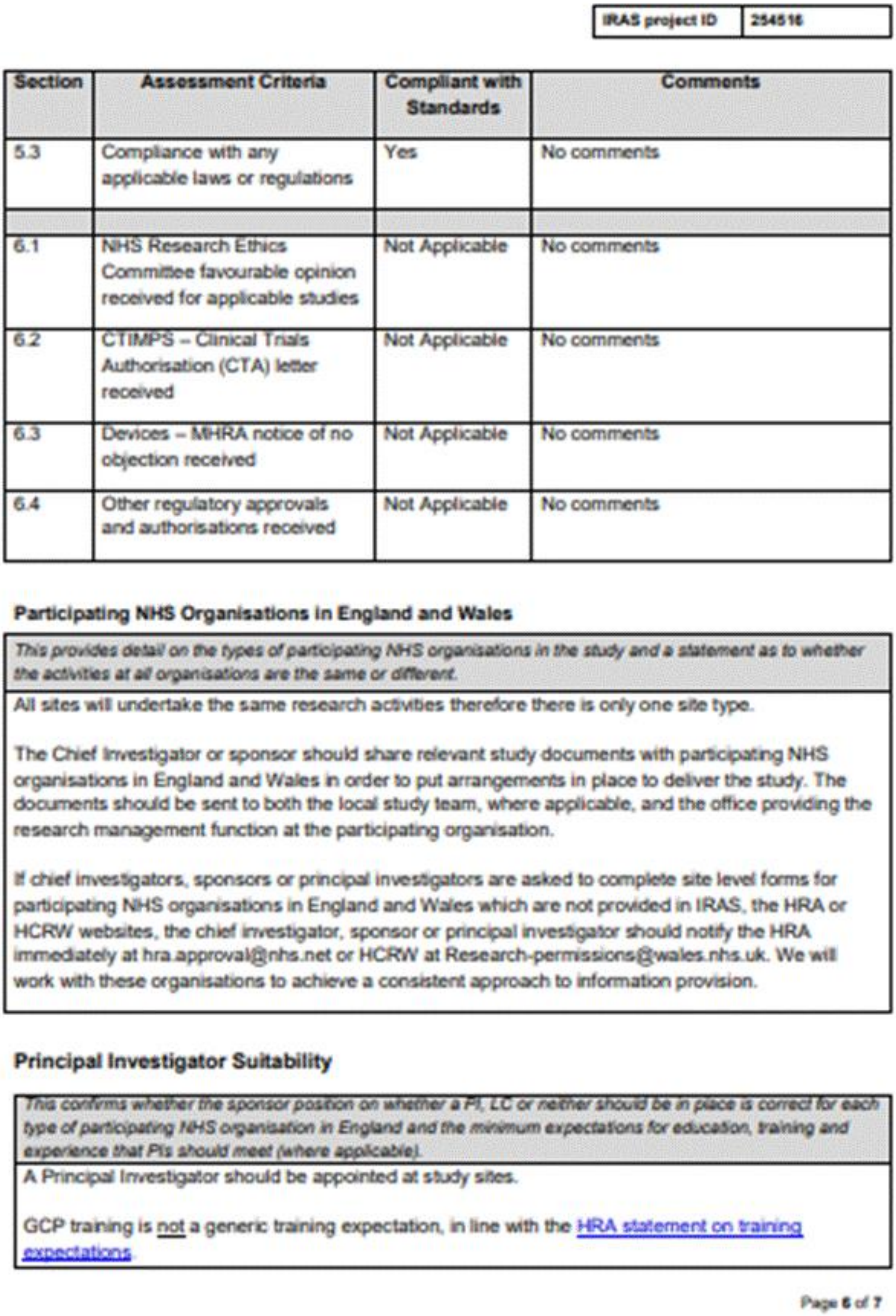


IRAS project ID	**254516**

Section	Assessment Criteria	Compliant with Standards	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

Participating NHS Organisations in England and Wales

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

All sites will undertake the same research activities therefore there is only one site type.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation.

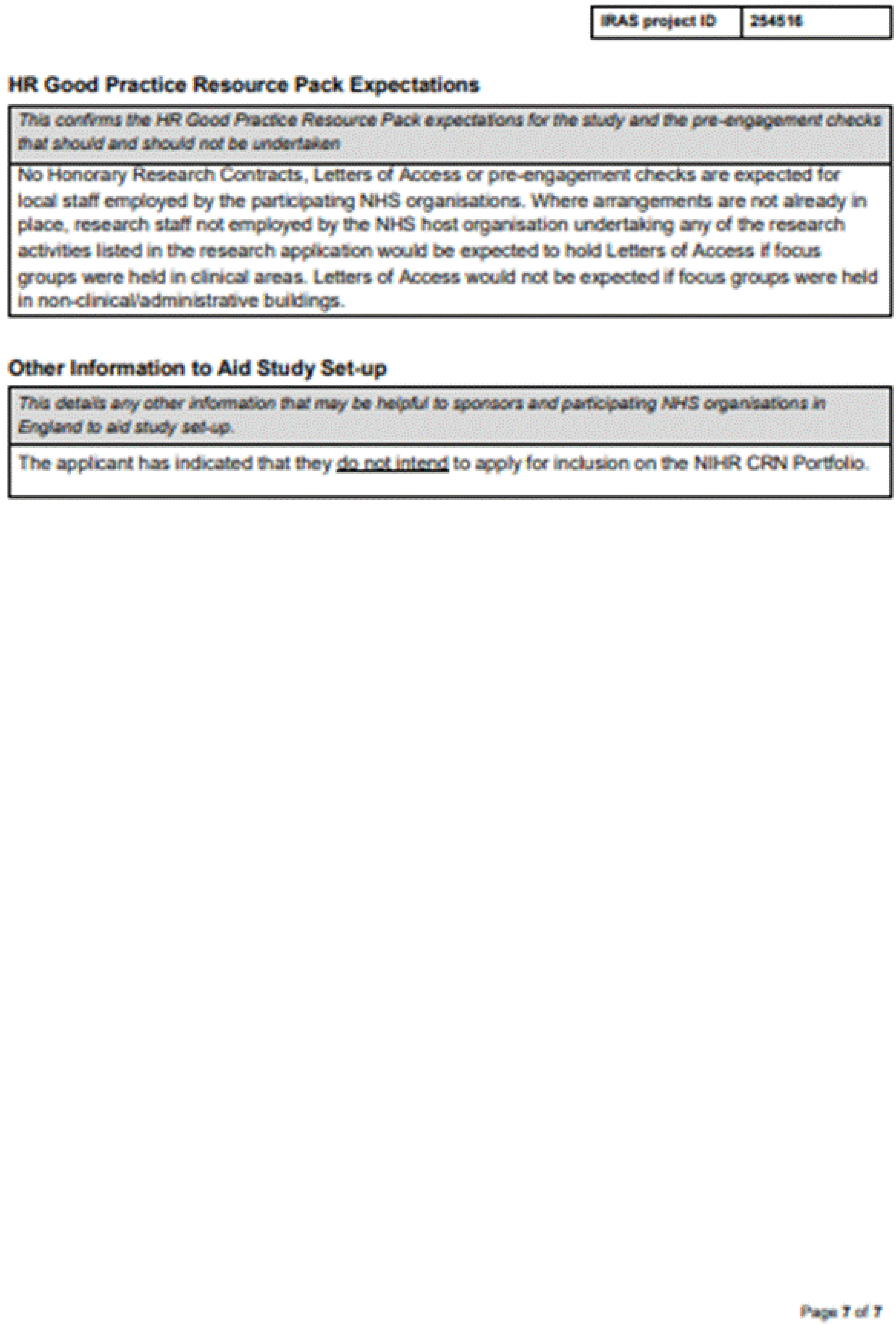
If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS, the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net or HCRW at Research-permissions@wales.nhs.uk. We will work with these organisations to achieve a consistent approach to information provision.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).

A Principal Investigator should be appointed at study sites.

GCP training is not a generic training expectation, in line with the HRA statement on training expectations.



IRAS project ID	254516

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
No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to hold Letters of Access if focus groups were held in clinical areas. Letters of Access would not be expected if focus groups were held in non-clinical/administrative buildings.

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 do not intend to apply for inclusion on the NIHR CRN Portfolio.

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B: Permission notification from IRAS following amendments

IRAS 254516. Amendment categorisation and implementation information

Sent: 3 April 2019 08:50
From: hra.approval@nhs.net
To: Emma Pinnock; Jenifer Wakelyn;

Amendment Categorisation and Implementation Information

Dear Mrs Pinnock,

IRAS Project ID:	254516
Short Study Title:	Reflections of nursing staff on working with anorectic adolescents
Date complete amendment submission received:	02 April 2019
Amendment No./ Sponsor Ref:	01
Amendment Date:	02 April 2019
Amendment Type:	Non-substantial
Outcome of HRA and HCRW Assessment	**This email also constitutes HRA and HCRW Approval for the amendment**, and you should not expect anything further.
For NHS/HSC R&D Office information	
Amendment Category	C

Thank you for submitting an amendment to your project. We have now categorised your amendment and please find this, as well as other relevant information, in the table above.

What should I do next?

If you have participating NHS/HSC organisations in any other UK nations that are affected by this amendment **we will** forward the information to the relevant national coordinating function(s).

You should now inform participating NHS/HSC organisations of the amendment.

- **For NHS organisations in England and/or Wales, this notification should include the NHS R&D Office, LCRN (where applicable) as well as the local research team.**

When can I implement this amendment?

You may implement this amendment **Immediately**. Please note that you may only implement changes described in the amendment notice.

Who should I contact if I have further questions about this amendment?

If you have any questions about this amendment please contact the relevant national coordinating centre for advice:

- England – hra.amendments@nhs.net
- Northern Ireland – research.gateway@hscni.net
- Scotland – nhsg.NRSPCC@nhs.net
- Wales – research-permissions@wales.nhs.uk

Additional information on the management of amendments can be found in the IRAS guidance.

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/.

Please do not hesitate to contact me if you require further information.

Kind regards

Kevin Ahmed
HRA Approvals Manager
Health Research Authority
Ground Floor | Skipton House | 80 London Road | London | SE1 6LH
E.hra.amendments@nhs.net
W. www.hra.nhs.uk

Sign up to receive our newsletter HRA Latest.

C: Permission notification from R&D

St George's
University of London

NHS
South West London and
St George's Mental Health
NHS Trust

Research & Development
R&D Director: Dr Robert M. Lawrence
Research Office, 1st Floor
Newton Building 7 (Entrance 11)
Springfield University Hospital
61 Glenburnie Road
London SW17 7DJ

R&D Manager: Ms Enitan Eboda
E-mail: enitan.eboda@swlstg.nhs.uk

Direct line: 020 3513 6420
Fax: 020 3513 6871

Mrs Emma Pinnock
Tavistock & Portman NHS Trust
120 Belsize Lane
London
NW3 5BA

23 April 2019

Dear Emma Pinnock,

Honorary research contract issued by South West London and St George's Mental Health NHS Trust

I am pleased to provide you with a Letter of Access with South West London and St George's Mental Health NHS Trust. We will send a copy of the letter to your substantive employer.

This letter will be effective immediately. Its duration is limited from 24 April 2019 to 20 December 2019. Please note that you cannot start the research until you have received written confirmation from us giving permission to conduct the project.

South West London and St George's Mental Health NHS Trust will not reimburse any expenses you incur unless subject to prior arrangement. Similarly, the Trust accepts no responsibility for damage to or loss of personal property, with the exception of small valuables handed to officials for safe custody.

Your Research Passport and Letter of Access may be subject to random checks carried out by NHS organisations within the lifetime of the project so accuracy of information is essential.

You are required to inform the Trust of any changes to the information provided on the Research Passport.

Yours sincerely,

Ms Enitan Eboda
Research & Development Manager.

St George's
University of London

NHS
South West London and
St George's Mental Health
NHS Trust

From: Research & Development Directorate

Date: 23 April 2019

Dear Emma Pinnock,

Letter of access for research

This letter should be presented to each participating organisation before you commence your research at that site. The participating organisation is:

- **South West London & St George's Mental Health NHS Trust (SWLStG)**

In accepting this letter, each participating organisation confirms your right of access to conduct research through their organisation for the purpose and on the terms and conditions set out below. **This right of access commences on 24 April 2019 and ends on 20 December 2019, unless terminated earlier in accordance with the clauses below.**

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from SWLStG. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving confirmation of our agreement to conduct the research.

The information supplied about your role in research at SWLStG has been reviewed and you do not require an honorary research contract with us. We are satisfied that such pre-engagement checks as we consider necessary have been carried out. Evidence of checks should be available on request to the organisation.

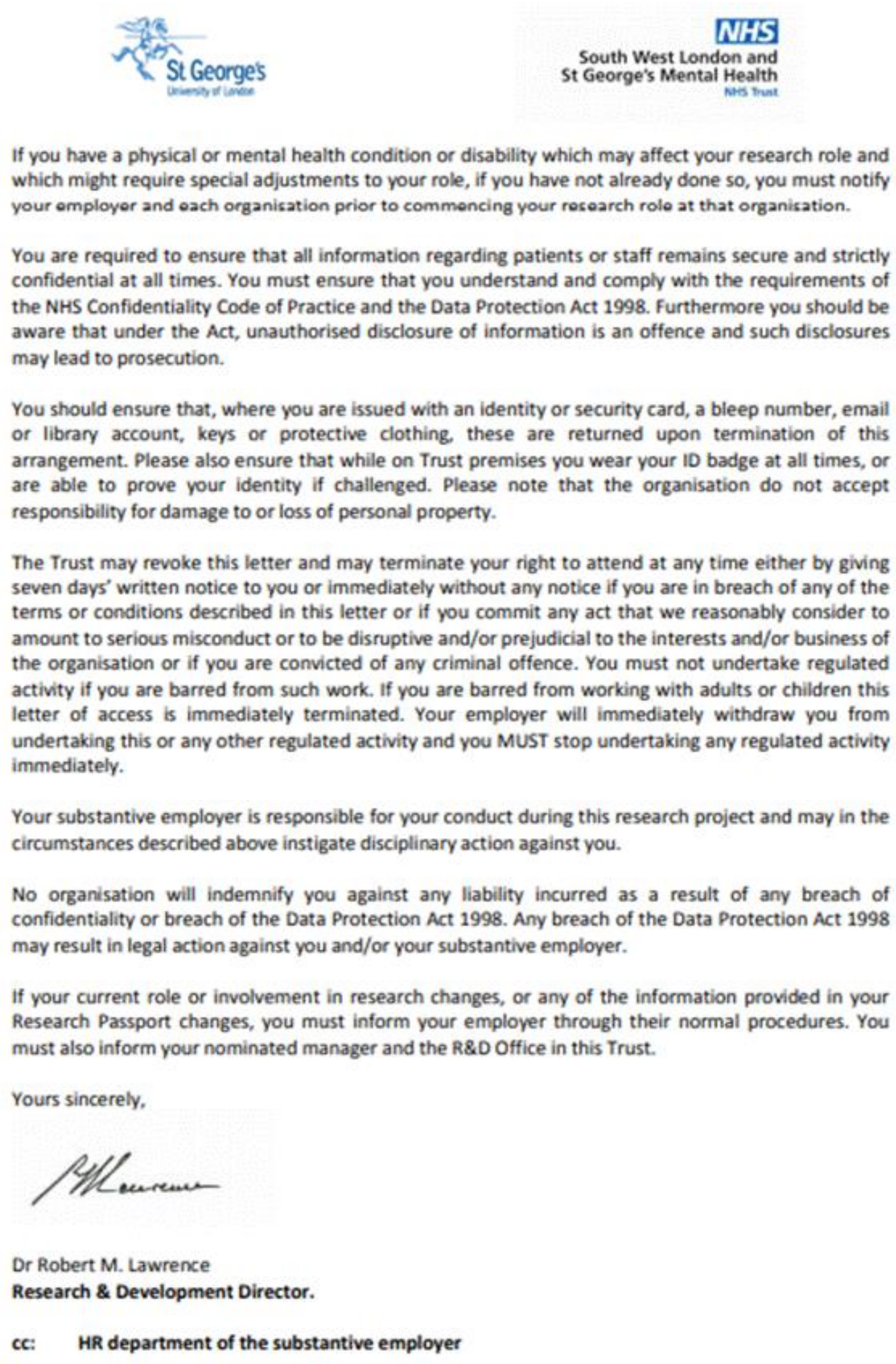
You are considered to be a legal visitor to the Trust's premises. You are not entitled to any form of payment or access to other benefits provided by SWLStG to employees and this letter does not give rise to any other relationship between you and the Trust, in particular that of an employee.

While undertaking research through the organisation you will remain accountable to your substantive employer but you are required to follow the reasonable instructions of SWLStG or those instructions given on our behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by the Trust in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with the Trust's policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with the Trust in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation, and to take reasonable care for the health and safety of yourself and others while on the Trust's premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.



St George's
University of London

NHS
South West London and
St George's Mental Health
NHS Trust

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and each organisation prior to commencing your research role at that organisation.

You are required to ensure that all information regarding patients or staff remains secure and strictly confidential at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on Trust premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that the organisation do not accept responsibility for damage to or loss of personal property.

The Trust may revoke this letter and may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of the organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

No organisation will indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager and the R&D Office in this Trust.

Yours sincerely,

Dr Robert M. Lawrence
Research & Development Director.

cc: **HR department of the substantive employer**

D: Research Protocol

Working Title: Reflections of care staff on working with anorectic adolescents

Summary

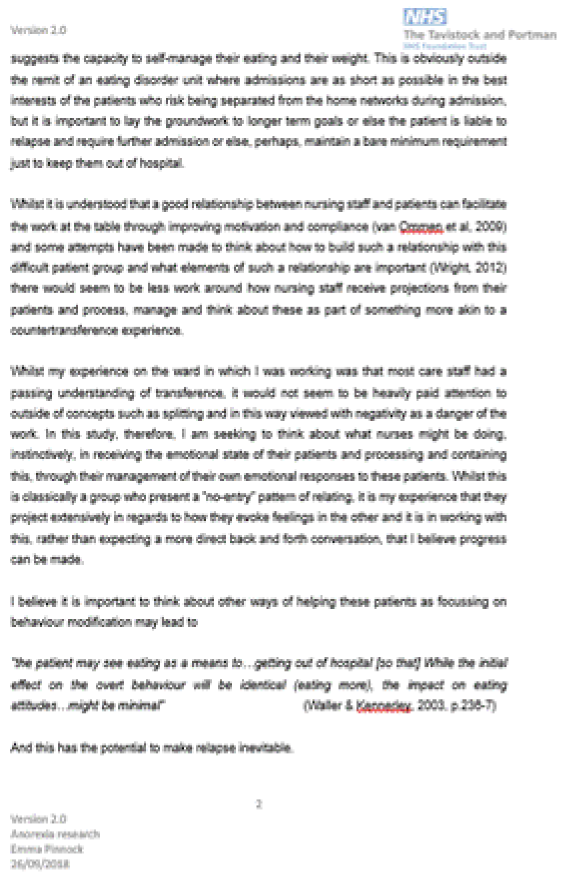
This study undertakes to gain information about the feelings of care staff working with hospitalised anorectic patients: the aim of which is to gain understanding of the experience of the intense relationships and feelings developed in this particular setting with this particular patient group. Interviews will be undertaken with staff and analysed using Interpretative Phenomenological Analysis (IPA) as described by Pietkiewicz & Smith (2012).

Aims and objectives

- To collect interview data from care staff regarding patients who evoke strong feelings in them, what these feelings are like and how they affect the practice of caring for anorectic patients.
- To analyse the interview data collected, using IPA, to try to develop themes regarding the experience of nursing staff.
- To feedback to ward staff in order to facilitate a better understanding of how the feelings of staff are part of the work of the unit.

Rationale and Background

There has been much focus on treatment of eating disorders in regards behaviour modification and extinction of symptoms (eg Murray et al, 2016) and this would seem to be very much the case in regards inpatient treatment where work is done directly at the table in encouraging patients to manage their meals in a timely manner and without use of, often ingrained, avoidance strategies. Obviously, in this setting weight restoration is a clear and measurable target and is essential as a first step to the young person being well enough to continue treatment in the community but, whilst it is known that low body weight inhibits thinking, it is equally understood that weight restoration is a bare minimum requirement in the treatment of anorexia, with the ultimate goal being to help young people achieve a flexibility and naturalness to their eating, free of anorectic cognitions and behaviours which implicitly



suggests the capacity to self-manage their eating and their weight. This is obviously outside the remit of an eating disorder unit where admissions are as short as possible in the best interests of the patients who risk being separated from the home networks during admission, but it is important to lay the groundwork to longer term goals or else the patient is liable to relapse and require further admission or else, perhaps, maintain a bare minimum requirement just to keep them out of hospital.

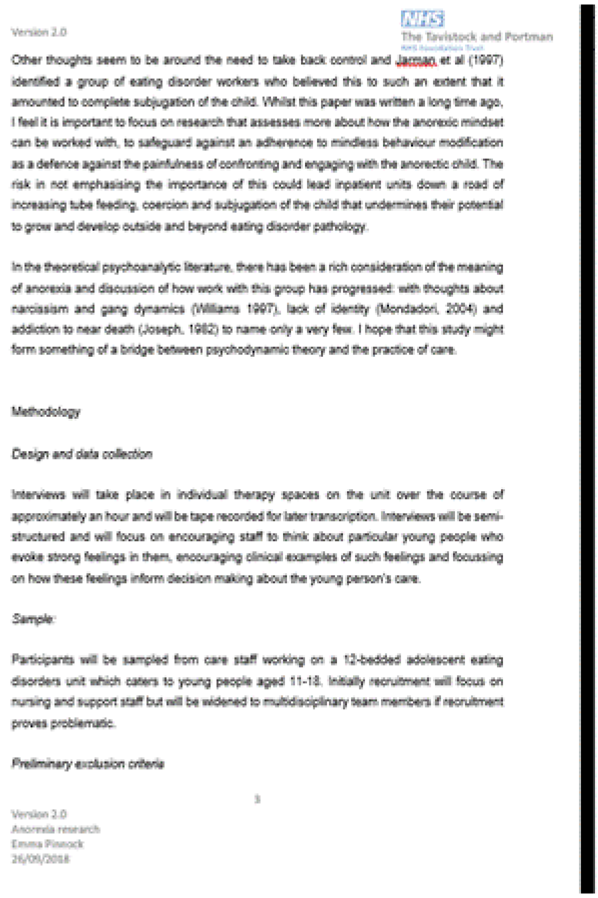
Whilst it is understood that a good relationship between nursing staff and patients can facilitate the work at the table through improving motivation and compliance (van Ommen et al, 2009) and some attempts have been made to think about how to build such a relationship with this difficult patient group and what elements of such a relationship are important (Wright, 2012) there would seem to be less work around how nursing staff receive projections from their patients and process, manage and think about these as part of something more akin to a countertransference experience.

Whilst my experience on the ward in which I was working was that most care staff had a passing understanding of transference, it would not seem to be heavily paid attention to outside of concepts such as splitting and in this way viewed with negativity as a danger of the work. In this study, therefore, I am seeking to think about what nurses might be doing, instinctively, in receiving the emotional state of their patients and processing and containing this, through their management of their own emotional responses to these patients. Whilst this is classically a group who present a "no-entry" pattern of relating, it is my experience that they project extensively in regards to how they evoke feelings in the other and it is in working with this, rather than expecting a more direct back and forth conversation, that I believe progress can be made.

I believe it is important to think about other ways of helping these patients as focussing on behaviour modification may lead to

"the patient may see eating as a means to…getting out of hospital [so that] While the initial effect on the overt behaviour will be identical (eating more), the impact on eating attitudes…might be minimal" (Waller & Kennerley, 2003, p.236-7)

And this has the potential to make relapse inevitable.



Other thoughts seem to be around the need to take back control and Jarman et al (1997) identified a group of eating disorder workers who believed this to such an extent that it amounted to complete subjugation of the child. Whilst this paper was written a long time ago, I feel it is important to focus on research that assesses more about how the anorexic mindset can be worked with, to safeguard against an adherence to mindless behaviour modification as a defence against the painfulness of confronting and engaging with the anorectic child. The risk in not emphasising the importance of this could lead inpatient units down a road of increasing tube feeding, coercion and subjugation of the child that undermines their potential to grow and develop outside and beyond eating disorder pathology.

In the theoretical psychoanalytic literature, there has been a rich consideration of the meaning of anorexia and discussion of how work with this group has progressed: with thoughts about narcissism and gang dynamics (Williams 1997), lack of identity (Mondadori, 2004) and addiction to near death (Joseph, 1982) to name only a very few. I hope that this study might form something of a bridge between psychodynamic theory and the practice of care.

Methodology

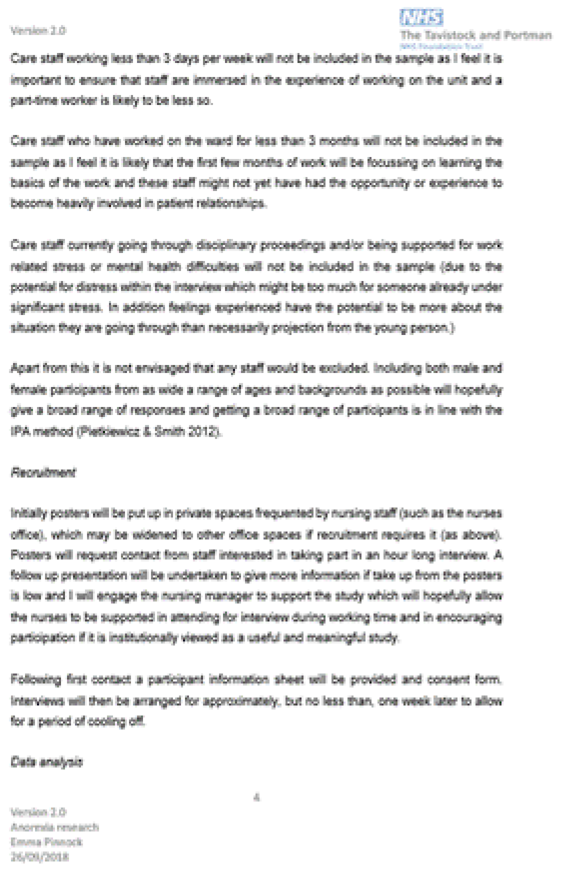
Design and data collection

Interviews will take place in individual therapy spaces on the unit over the course of approximately an hour and will be tape recorded for later transcription. Interviews will be semi-structured and will focus on encouraging staff to think about particular young people who evoke strong feelings in them, encouraging clinical examples of such feelings and focussing on how these feelings inform decision making about the young person's care.

Sample:

Participants will be sampled from care staff working on a 12-bedded adolescent eating disorders unit which caters to young people aged 11-18. Initially recruitment will focus on nursing and support staff but will be widened to multidisciplinary team members if recruitment proves problematic.

Preliminary exclusion criteria



Care staff working less than 3 days per week will not be included in the sample as I feel it is important to ensure that staff are immersed in the experience of working on the unit and a part-time worker is likely to be less so.

Care staff who have worked on the ward for less than 3 months will not be included in the sample as I feel it is likely that the first few months of work will be focussing on learning the basics of the work and these staff might not yet have had the opportunity or experience to become heavily involved in patient relationships.

Care staff currently going through disciplinary proceedings and/or being supported for work related stress or mental health difficulties will not be included in the sample (due to the potential for distress within the interview which might be too much for someone already under significant stress. In addition feelings experienced have the potential to be more about the situation they are going through than necessarily projection from the young person.)

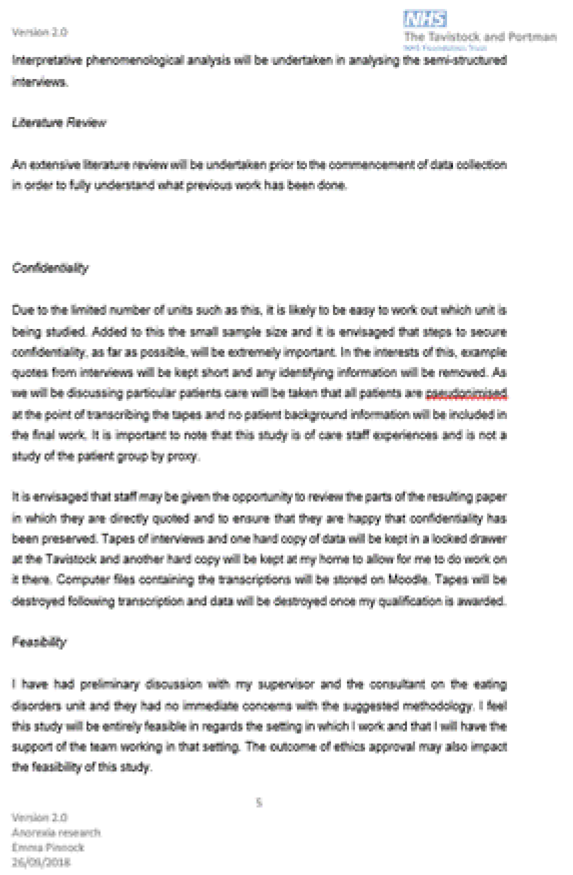
Apart from this it is not envisaged that any staff would be excluded. Including both male and female participants from as wide a range of ages and backgrounds as possible will hopefully give a broad range of responses and getting a broad range of participants is in line with the IPA method (Pietkiewicz & Smith 2012).

Recruitment

Initially posters will be put up in private spaces frequented by nursing staff (such as the nurses office), which may be widened to other office spaces if recruitment requires it (as above). Posters will request contact from staff interested in taking part in an hour long interview. A follow up presentation will be undertaken to give more information if take up from the posters is low and I will engage the nursing manager to support the study which will hopefully allow the nurses to be supported in attending for interview during working time and in encouraging participation if it is institutionally viewed as a useful and meaningful study.

Following first contact a participant information sheet will be provided and consent form. Interviews will then be arranged for approximately, but no less than, one week later to allow for a period of cooling off.

Data analysis



Interpretative phenomenological analysis will be undertaken in analysing the semi-structured interviews.

Literature Review

An extensive literature review will be undertaken prior to the commencement of data collection in order to fully understand what previous work has been done.

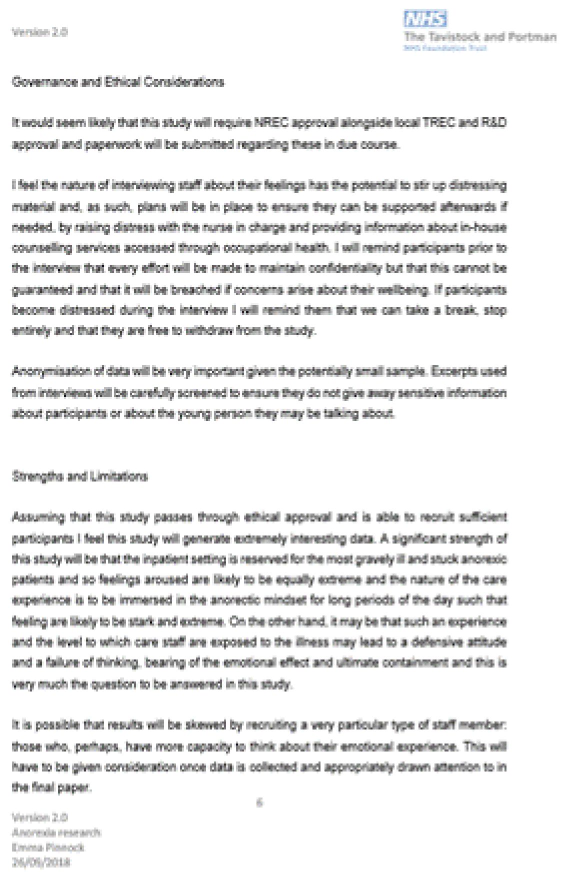
Confidentiality

Due to the limited number of units such as this, it is likely to be easy to work out which unit is being studied. Added to this the small sample size and it is envisaged that steps to secure confidentiality, as far as possible, will be extremely important. In the interests of this, example quotes from interviews will be kept short and any identifying information will be removed. As we will be discussing particular patients care will be taken that all patients are pseudonimised at the point of transcribing the tapes and no patient background information will be included in the final work. It is important to note that this study is of care staff experiences and is not a study of the patient group by proxy.

It is envisaged that staff may be given the opportunity to review the parts of the resulting paper in which they are directly quoted and to ensure that they are happy that confidentiality has been preserved. Tapes of interviews and one hard copy of data will be kept in a locked drawer at the Tavistock and another hard copy will be kept at my home to allow for me to do work on it there. Computer files containing the transcriptions will be stored on Moodle. Tapes will be destroyed following transcription and data will be destroyed once my qualification is awarded.

Feasibility

I have had preliminary discussion with my supervisor and the consultant on the eating disorders unit and they had no immediate concerns with the suggested methodology. I feel this study will be entirely feasible in regards the setting in which I work and that I will have the support of the team working in that setting. The outcome of ethics approval may also impact the feasibility of this study.



Governance and Ethical Considerations

It would seem likely that this study will require NREC approval alongside local TREC and R&D approval and paperwork will be submitted regarding these in due course.

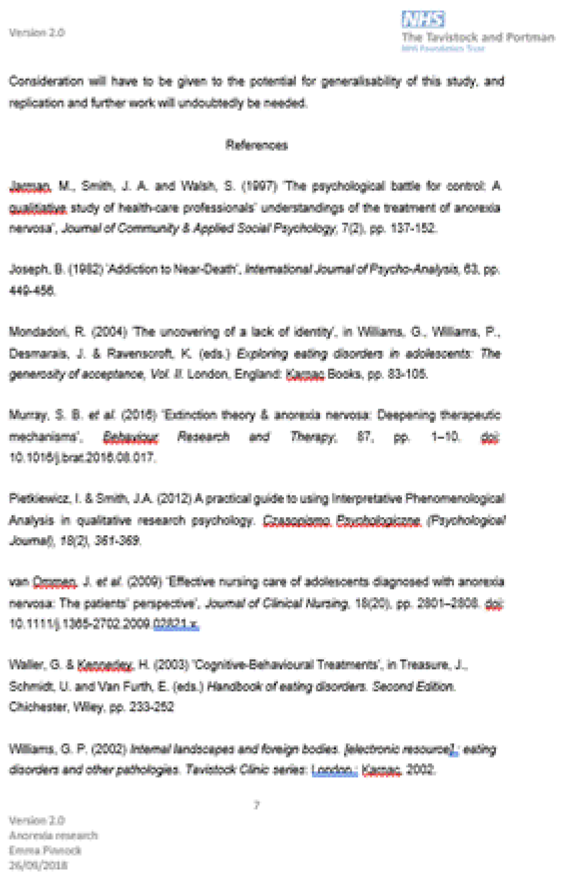
I feel the nature of interviewing staff about their feelings has the potential to stir up distressing material and, as such, plans will be in place to ensure they can be supported afterwards if needed, by raising distress with the nurse in charge and providing information about in-house counselling services accessed through occupational health. I will remind participants prior to the interview that every effort will be made to maintain confidentiality but that this cannot be guaranteed and that it will be breached if concerns arise about their wellbeing. If participants become distressed during the interview I will remind them that we can take a break, stop entirely and that they are free to withdraw from the study.

Anonymisation of data will be very important given the potentially small sample. Excerpts used from interviews will be carefully screened to ensure they do not give away sensitive information about participants or about the young person they may be talking about.

Strengths and Limitations

Assuming that this study passes through ethical approval and is able to recruit sufficient participants I feel this study will generate extremely interesting data. A significant strength of this study will be that the inpatient setting is reserved for the most gravely ill and stuck anorexic patients and so feelings aroused are likely to be equally extreme and the nature of the care experience is to be immersed in the anorectic mindset for long periods of the day such that feeling are likely to be stark and extreme. On the other hand, it may be that such an experience and the level to which care staff are exposed to the illness may lead to a defensive attitude and a failure of thinking, bearing of the emotional effect and ultimate containment and this is very much the question to be answered in this study.

It is possible that results will be skewed by recruiting a very particular type of staff member: those who, perhaps, have more capacity to think about their emotional experience. This will have to be given consideration once data is collected and appropriately drawn attention to in the final paper.



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Consideration will have to be given to the potential for generalisability of this study, and replication and further work will undoubtedly be needed.

References

Jarman, M., Smith, J. A. and Walsh, S. (1997) 'The psychological battle for control: A qualitative study of health-care professionals' understandings of the treatment of anorexia nervosa', *Journal of Community & Applied Social Psychology*, 7(2), pp. 137-152.

Joseph, B. (1982) 'Addiction to Near-Death', *International Journal of Psycho-Analysis*, 63, pp. 449-456.

Mondadori, R. (2004) 'The uncovering of a lack of identity', in Williams, G., Williams, P., Desmarais, J. & Ravenscroft, K. (eds.) *Exploring eating disorders in adolescents: The generosity of acceptance, Vol. II.* London, England: Karnac Books, pp. 83-105.

Murray, S. B. *et al.* (2016) 'Extinction theory & anorexia nervosa: Deepening therapeutic mechanisms', *Behaviour Research and Therapy*, 87, pp. 1–10. doi: 10.1016/j.brat.2016.08.017.

Pietkiewicz, I. & Smith, J.A. (2012) A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology. *Czasopismo Psychologiczne (Psychological Journal), 18(2), 361-369.*

van Ommen, J. *et al.* (2009) 'Effective nursing care of adolescents diagnosed with anorexia nervosa: The patients' perspective', *Journal of Clinical Nursing*, 18(20), pp. 2801–2808. doi: 10.1111/j.1365-2702.2009.02821.x.

Waller, G. & Kennerley, H. (2003) 'Cognitive-Behavioural Treatments', in Treasure, J., Schmidt, U. and Van Furth, E. (eds.) *Handbook of eating disorders. Second Edition.* Chichester, Wiley, pp. 233-252

Williams, G. P. (2002) *Internal landscapes and foreign bodies. [electronic resource] : eating disorders and other pathologies. Tavistock Clinic series:* London : Karnac, 2002.

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26/09/2018

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Wright, K. M. and Hacking, S. (2012) 'An angel on my shoulder: A study of relationships between women with anorexia and healthcare professionals', *Journal of Psychiatric and Mental Health Nursing*, 19(2), pp. 107–115. doi: 10.1111/j.1365-2850.2011.01760.x.

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E: Debrief sheet

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Post interview debrief

If you feel this interview has raised issues you would like to think about further please, in the first instance, approach the ward manager or nurse-in-charge who will have been aware of your interview today and will be able to support you as needed. The trust also provides a confidential counselling service. If you would like to access this please contact Occupational Health on 020 8725 3698.

If you have any concerns about my conduct over the course of this interview or any other aspect of this research project you can discuss this with me (epinnock@tavi-port.ac.uk), my supervisor (Komal Parekh) or Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk)

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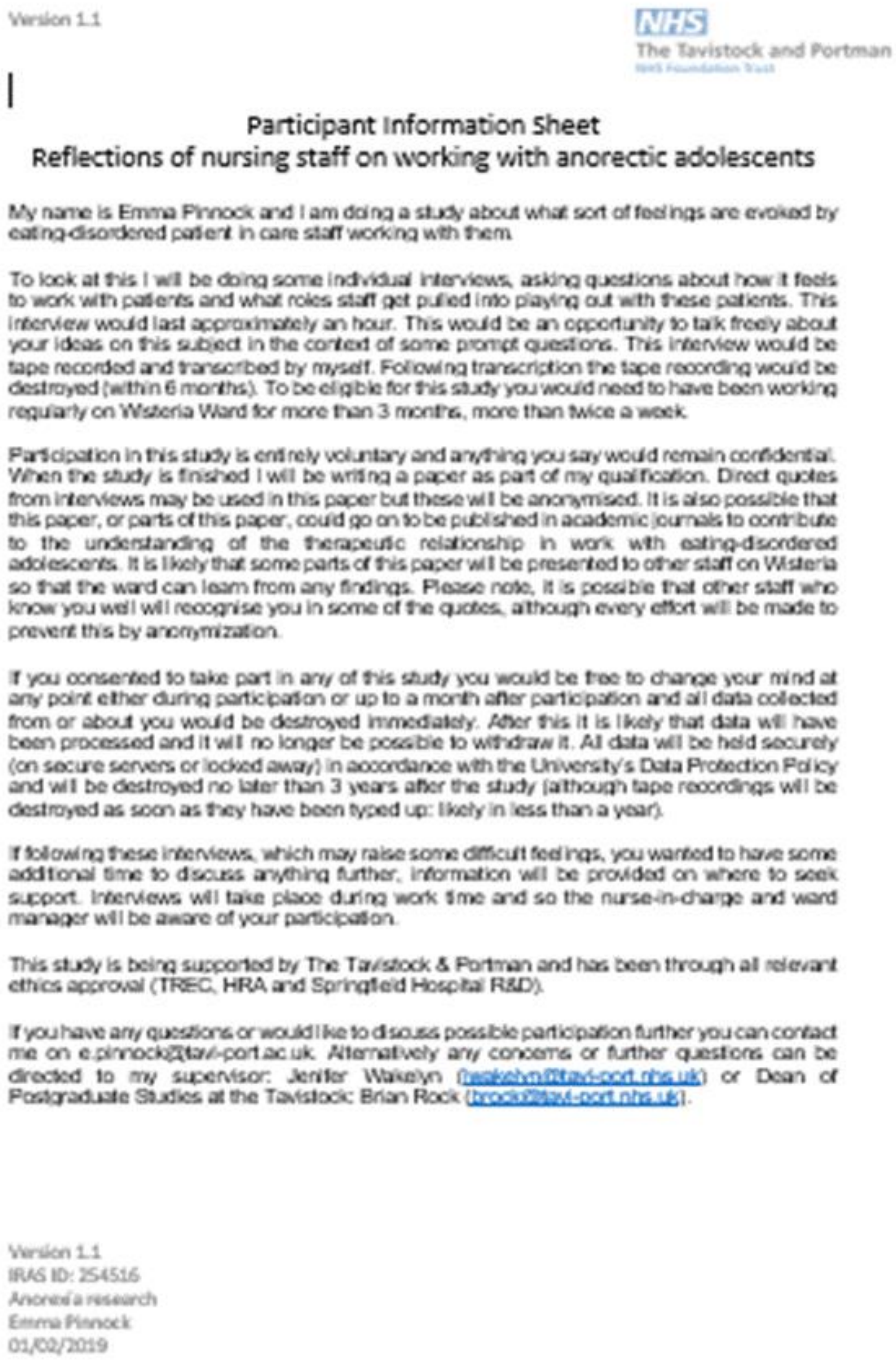
12/09/2018

F: Participant Information Sheet



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Participant Information Sheet
Reflections of nursing staff on working with anorectic adolescents

My name is Emma Pinnock and I am doing a study about what sort of feelings are evoked by eating-disordered patient in care staff working with them.

To look at this I will be doing some individual interviews, asking questions about how it feels to work with patients and what roles staff get pulled into playing out with these patients. This interview would last approximately an hour. This would be an opportunity to talk freely about your ideas on this subject in the context of some prompt questions. This interview would be tape recorded and transcribed by myself. Following transcription the tape recording would be destroyed (within 6 months). To be eligible for this study you would need to have been working regularly on Wisteria Ward for more than 3 months, more than twice a week.

Participation in this study is entirely voluntary and anything you say would remain confidential. When the study is finished I will be writing a paper as part of my qualification. Direct quotes from interviews may be used in this paper but these will be anonymised. It is also possible that this paper, or parts of this paper, could go on to be published in academic journals to contribute to the understanding of the therapeutic relationship in work with eating-disordered adolescents. It is likely that some parts of this paper will be presented to other staff on Wisteria so that the ward can learn from any findings. Please note, it is possible that other staff who know you well will recognise you in some of the quotes, although every effort will be made to prevent this by anonymization.

If you consented to take part in any of this study you would be free to change your mind at any point either during participation or up to a month after participation and all data collected from or about you would be destroyed immediately. After this it is likely that data will have been processed and it will no longer be possible to withdraw it. All data will be held securely (on secure servers or locked away) in accordance with the University's Data Protection Policy and will be destroyed no later than 3 years after the study (although tape recordings will be destroyed as soon as they have been typed up: likely in less than a year).

If following these interviews, which may raise some difficult feelings, you wanted to have some additional time to discuss anything further, information will be provided on where to seek support. Interviews will take place during work time and so the nurse-in-charge and ward manager will be aware of your participation.

This study is being supported by The Tavistock & Portman and has been through all relevant ethics approval (TREC, HRA and Springfield Hospital R&D).

If you have any questions or would like to discuss possible participation further you can contact me on e.pinnock@tavi-port.ac.uk. Alternatively any concerns or further questions can be directed to my supervisor: Jenifer Wakelyn (jwakelyn@tavi-port.nhs.uk) or Dean of Postgraduate Studies at the Tavistock: Brian Rock (brock@tavi-port.nhs.uk).

Version 1.1
IRAS ID: 254516
Anorexia research
Emma Pinnock
01/02/2019

Version 1.1

The Tavistock and Portman
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General Data Protection Regulation (2018) arrangements

The Tavistock and Portman NHS Foundation Trust is the sponsor for this study based in the United Kingdom. I will be using information from you in order to undertake this study and will act as the data controller for this study. This means that I am responsible for looking after your information and using it properly. I will keep identifiable information about you from this study for not more than 3 years after the study has finished.

Your rights to access, change or move your information are limited, as I need to manage your information in specific ways in order for the research to be reliable and accurate. To safeguard your rights, I will use the minimum personally identifiable information possible. I will use your name and the contact details you provide only to contact you about the research study. I am the only person who will have access to information that identifies you. I may be assisted in the analysis of this information by senior colleagues, but they will not be able to identify you and will not be able to find out your name or contact details.

You can find out more about the legal framework within which your information will be processed by contacting the sponsoring Trust's Clinical Governance and Quality Manager, Irene Henderson: IHenderson@tavi-port.nhs.ukGDPR

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Anorexia research
Emma Pinnock
01/02/2019

G: Consent form

Version 1.0

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Consent form

Please tick boxes and sign against the statements that apply to you

I (name) confirm that I have received, read and understood the participant information sheet for the research study carried out by Emma Pinnock regarding feelings evoked in work with eating-disordered patients.

Signed: ………………………………………………………… Date: ………………………… ☐

I (name) confirm that I would like to take part in the tape recorded interview as described in the participant information sheet received. ☐

Signed: ………………………………………………………… Date: …………………………

I (name) confirm that I understand that I may withdraw my consent for any or all of the above at any point during my participation in the study and up to one month after my participation. ☐

Signed: ………………………………………………………… Date: …………………………

I (name) confirm that I understand, whilst every effort will be made to anonymise the interview that I provide, that it is possible that quotes used in the final piece of work might be recognisable to myself or to staff I work closely with due to the nature of the work. I am aware that I may request at the time of interview or up to a month afterwards for particular quotes to be withheld from the final piece of work for this reason or any reason. ☐

Signed: ………………………………………………………… Date: …………………………

If you would like to discuss any of the above with me further before making your decision or if you have any questions, concerns or would like more clarification please make a note here or email me on epinnock@tavi-port.ac.uk and I will arrange to meet with you.

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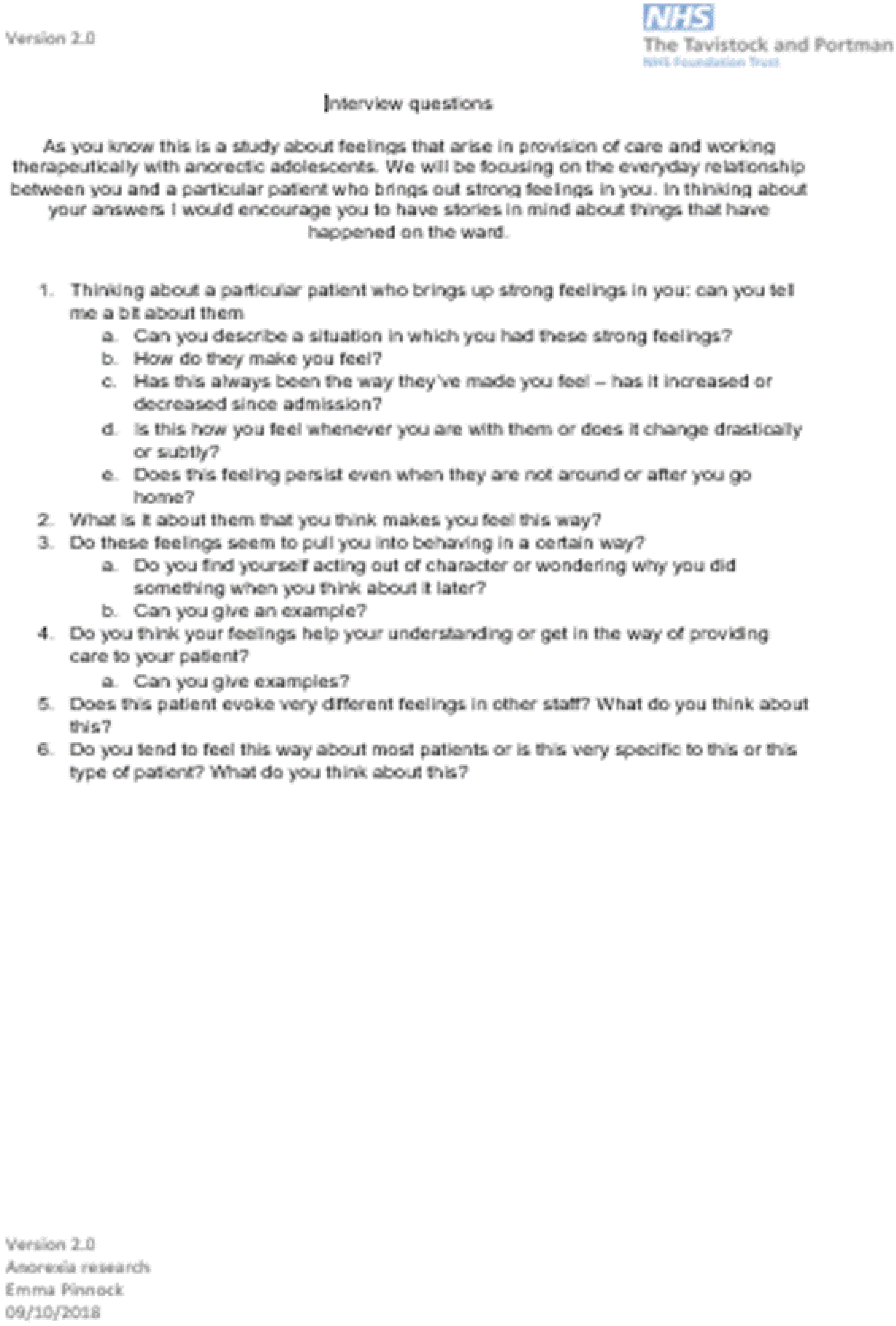
Emma Pinnock
26/11/2018

H: Interview questions



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Interview questions

As you know this is a study about feelings that arise in provision of care and working therapeutically with anorectic adolescents. We will be focusing on the everyday relationship between you and a particular patient who brings out strong feelings in you. In thinking about your answers I would encourage you to have stories in mind about things that have happened on the ward.

1. Thinking about a particular patient who brings up strong feelings in you: can you tell me a bit about them
    a. Can you describe a situation in which you had these strong feelings?
    b. How do they make you feel?
    c. Has this always been the way they've made you feel – has it increased or decreased since admission?
    d. Is this how you feel whenever you are with them or does it change drastically or subtly?
    e. Does this feeling persist even when they are not around or after you go home?
2. What is it about them that you think makes you feel this way?
3. Do these feelings seem to pull you into behaving in a certain way?
    a. Do you find yourself acting out of character or wondering why you did something when you think about it later?
    b. Can you give an example?
4. Do you think your feelings help your understanding or get in the way of providing care to your patient?
    a. Can you give examples?
5. Does this patient evoke very different feelings in other staff? What do you think about this?
6. Do you tend to feel this way about most patients or is this very specific to this or this type of patient? What do you think about this?

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I: Example of initial coding of interview transcripts

NAS1: (Participant aggressive, sets self up as in charge, wants to be interviewed right now or not at all, ultimatum)

I: So, how long have you worked here? (Interviewer responds to participant by asking straightforward non-thoughtful question. Possibly responding to concrete refusal to engage in emotional contact)

NAS1: It will be a year and ...August….a year and a month.

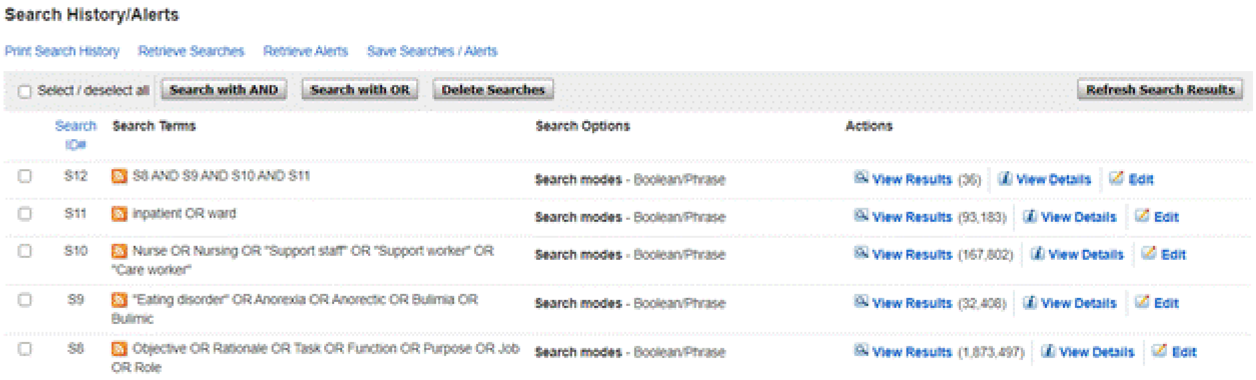
I: A year and a month. That's a long time (buttering up – interviewer a bit frightened of this participant) ...and are you a support worker here or…

[*Introduction of study]*

NAS1: OK, Um. There is a particular patient. We have a very interesting relationship. So I'm like her keyworker but before I was her keyworker we hardly spoke for almost a year and then as she got to know me we formed a really close relationship and I think it was due to the fact that I ...she had to go to a wedding with her mum and I did her makeup and her hair which she hasn't done in a very long time. (Need for a specific event, something from which to form a bond) At first she did not want to do it but I kind of persuaded her (wish to be effective) to do it because I think that when you have a mental health problem or an eating disorder you tend to forget about yourself (Lost). You get um how do they call it. You get so used to being in a hospital you don't know what it's like to be in the outside world (Lost, trapped). So there were all sort of feelings of why she didn't want to do her makeup: she is ugly, she is fat, doing her hair might make her feel like she's gained weight because, depending on the hairstyle that I give her, her face might be showing more or doing her make up might draw more attention to her so people watching her she might feel uncomfortable. These were the sorts of the things that while I was doing her makeup and hair she was talking about and she was like "I don't want the attention on me" (little girl voice) (to be able to do something – hair, makeup. Maternal relationship, approaching from a different side, intimacy). However I think doing her makeup and her hair created a bond and also it changed a lot of things about her. She came back a bit happier, more talkative (positive reinforcement of seeing a change). I saw a different patient since then (patient perceived as different, rather than relationship or participant – projection of feelings into patient). But the reason why I chose that particular patient is that she has been here, in the eating disorder ward for two years and it seems like it's a cycle that she goes through (hopelessness). Once she is getting better she finds negative coping mechanisms in order to stay (patient perceived as doesn't want to leave. How can she leave, participant doesn't leave either) and I'll give you an example: she's eating well, her mealplan is going well, family is trying and then we're looking for a discharge date or home leave or gradually getting her into a discharge date and she will start self-harming, badly to the point where we will feel unsafe to let her go home or she starts hiding food in her pockets, in different places in her mouth ...what else ...she starts exercising vigorously (participant gives examples of patient's behaviour rather than emotional state) . It stops everything (frozenness, timelessness) and it seems like it's another cycle. There is always some form of coping mechanism which doesn't help (patient not trying – anger, frustration) and always has to go to that extent um. That's my opinion and we have spoke about that and things have developed but I get to that point where things happen with that patient and we have more understanding of that particular patient but the things that she does sometimes get me annoyed (annoyance and pain when perceived emotional connection does not lead to change) (her voice sounds guilty as she says this) (guilt) or frustrated should I say is (pause) (modification of emotional experience to more socially acceptable) one of the mealplans is that if she exercises for more than 30 minutes she gets an extra snack with her PM snack or her AM snack and she exercises for 30 minutes and she knows she will get that extra snack then she kicks off about it and I think “you know! You know it’s going to happen” and it’s ...then she reverses it, “staff made me do it, you made me do it! It’s not my fault, it’s all your fault, this is why I’m here, this is why I can’t leave”. She has a way of reversing it onto you (projection, staff made to hold responsibility, denial of reality, madmaking) and you feel ...well I’ve got to the point where I feel bad (madmaking) and I think eating disorder is really good at making you feel like why should you be giving someone extra food because that’s all you hear from them “you’re making me eat. You’re making me put on weight. You, you, you” so in that sense it can be frustrating and sometimes you feel like the parents and sometimes you reflect the parents as well, depending on which patient you are working with you can reflect the parents sometimes (acting out parental role). Erm and when I spoke about the patient developing I had conversations with her about certain things which I don’t want to share her personal business but certain things and I remember one particular night I was doing night shifts and I said to her “do you want to get better?” and I said to her “you don’t need to answer this question, I think you need to think about it. You’ve been here for 2 years. It seems like it’s a continuous cycle. It’s then your mealplan decreases, it increases the extent that it is already. I said to her do you want to get better you don’t need to answer me now. You can think about it and I could get the answer next night, this week, it’s no pressure to answer I really want you to think your answer and she hesitated and before I left she said to me “actually I don’t want to get better”. (Needing to know, facing reality, engaging in a nonsense otherwise: staff push getting well and patients don't want to) At first I did not know. I think I wasn't expecting her to say I don't want to get better. No sorry I was expecting her to say I want to get better (hard to process reality) because I think she likes to please people so she will say exactly what you want to hear so I thought she would say but I know deep down inside that she doesn't want to get better that's why I asked her the question. (facing the painful truth) So when she said it to me I said that at the end of the day it's your choice. I understand that you don't want to get better. I will try and help you as much as I can but saying you don't want to get better leaves us in a difficult situation (awkwardness) and we haven't had a follow up conversation about it due to me being off for four days (hard to face) and coming back on the ward has been very busy so I haven't had the one to one conversation with her about how I feel (avoidance) about it or why did she say that or try to get to know what's behind that thought. She did say to me that eating disorder is like an erm safety for her. She feels safe when she is ...well she has an eating disorder, but it makes her feel very safe and I said to her in what way does it make you ...what about it makes you feel safe and she finds it very difficult to answer me (pretence at wanting to understand but actually wanting to change her mind. Patient is struck dumb) . She says she doesn't know or she's confused, but what she could say to me is that it makes her feel safe (concrete reality – ward is safe – how can she leave!). Erm, so we haven't had a chance to think about what safe means (retreats to concrete – away from feelings). I know that safe can mean many different things (trying to convince me of her capability – feelings of inadequacy) erm but I'd like to hear it from her because I feel like everybody's idea of a safety blanket might be different. Some might have a safety have a safety teddy or a safety blanket, some might feel safety in smoking or drinking or all sorts of things so I want to hear what she has to say (sounds like a telling off – veiled anger). But er that's the situation. Sometimes I think I reflect both the mum and the dad. Dad is very charming and "oh I want to be a nice dad" and mum is very much like strict kind of emotions. It comes across a bit tough and dad reflects ...is a bit more charming and loving and showing his emotions and so I think I do, I do both and I think she notices that I do ...that both parents are reflect ... that both of her parents erm at times, I can see it for sure because at times I feel so sorry for her (guilt, retreat from anger) but at other times I'm like no you need to have that extra snack because you knew it was going to happen (oscillation from anger to guilt – attempt to intellectualise this into parental relationship). You should have thought about the consequences of you exercising for 30 minutes or hiding food or stuff like this and so in that sense it could be really frustrating (wish to punish).

I: It sounds like she puts you on a real roller coaster of emotions actually. Sometimes you can feel really sorry for her, sometimes you can feel really cross with her (attempt to validate that it's okay to have feelings, contain).

J: Literature review



Search History/Alerts

	Search ID#	Search Terms	Search Options	Actions
☐	S12	S8 AND S9 AND S10 AND S11	**Search modes** - Boolean/Phrase	View Results (36) | View Details | Edit
☐	S11	inpatient OR ward	**Search modes** - Boolean/Phrase	View Results (93,183) | View Details | Edit
☐	S10	Nurse OR Nursing OR "Support staff" OR "Support worker" OR "Care worker"	**Search modes** - Boolean/Phrase	View Results (167,802) | View Details | Edit
☐	S9	"Eating disorder" OR Anorexia OR Anorectic OR Bulimia OR Bulimic	**Search modes** - Boolean/Phrase	View Results (32,408) | View Details | Edit
☐	S8	Objective OR Rationale OR Task OR Function OR Purpose OR Job OR Role	**Search modes** - Boolean/Phrase	View Results (1,873,497) | View Details | Edit

11. Framing Paper: Writing the Clinical Research Portfolio

Introduction

This paper will begin by discussing the first three years of preparation for the research task: a process which occurred in a concrete way, made up of discrete practice tasks, such as practicing a literature search and using the IPA method on some session notes. Alongside this was a similar process of preparation for the qualifying paper, writing several clinical essays, but also the clinical work itself. This, however, felt more fluid and seemed to build more naturally towards the final paper. Consideration will be given to how these two processes constitute the methodology of the resulting papers and the value in each despite the two differing processes as well as how they might be considered similar.

I will then move to considering the final year, the competing needs of these two pieces of work and the value of the resultant papers despite again the differing methods. I will suggest that, despite the differences between the two pieces of work, smaller struggles in the qualifying paper were magnified by the research and I will focus on the importance of time to allow slow but steady processing of the material in both, which contributed to an improved outcome. Within this I will think about the emotional resonance of finishing and experiencing the coming together of the work. Finally I will give consideration to the generalisability of this work and work of this type (small studies and single case studies) and consider whether generalisability is really the most desired objective and purpose of research work.

Summary of the first three years

Research always felt like an add-on to the training for me and not what I had set out to undertake. Whilst I was lucky to have a specialist placement and standing interest in eating disorders, so that it was clear from early on that my research would be in this area, I still saw it as a list of discrete tasks such as writing a proposal, seeking ethics and conducting interviews, rather than as something which built more fluidly to a finished whole. Certainly on hindsight I can see there was a more smooth development of my research ideas over time, so that it ultimately became a sum of my interest in eating disorders as well as my wish to say something about the nursing role from my own time as a nursing assistant, but this progression was not apparent to me as I passed through the process.

Building up my clinical knowledge felt a far more smooth progression and despite having discrete tasks to achieve here also: the 3 intensive cases to complete, the 6 once-weeklies, the parent work, STPP and written work, this felt more integrated. It was with some surprise, when I approached thinking about my qualifying paper, that I realised I knew enough to write it: that all the supervision and workshops had been developmental and summative. However, on reflection, I recognise that my qualifying paper had a similar methodology to my research in regards to the degree of bracketing that I achieved whilst carrying out the “data collection”. Although it was clear which child I would write about from relatively early on, I never thought of my notes from supervisions as part of my data collection. The work progressed without being tainted by an idea that I would one day have to write an essay. This allowed my data, in terms of my session notes, to grow independently of any overarching hypothesis. Although, certainly, I was guided by the reading that was current in theory seminars, my supervisor was not, and his introduction of counter theories helped to keep me from simply seeing that which was uppermost in my mind from my reading.

It is desirable to work without memory or desire and this is something akin to the bracketing required by the IPA method. I, however, was somewhat working in deliberate repression and ignoring of the knowledge that there would be written work to do. Perhaps, ultimately, these produce similar results, with the rejection of memory and desire being simply a more conscious and deliberate process. My refusal to acknowledge the coming written work allowed me to carry out both clinical work and research interviews without being hampered by anxiety (although it remained underlying) which might have led me to finding themes for my work too soon. Ideally, however, had I been kinder to myself, I could have allowed the data-gathering work to go on, trusting that the written work would develop in its own time.

It was, however, admittedly more difficult to completely block out research in this way, as there were a number of discrete tasks to carry out such as writing a protocol, seeking ethics and meeting with my supervisor with a very clear agenda of discussing the reality of the research. Nevertheless, I chose to manage by completing each task one at a time without too much consideration of the next step. This made the task manageable for me at a time where I could not concretely do much more: as it was impossible to begin my qualifying paper or analyse my data until I had finished the clinical work with the child and undertaken the interviews.

Reaching the point of conducting interviews was probably when the research came alive for me. As I began to collect consent forms from willing participants, I started to feel that this would actually become something. I think I had always believed, and tried to ignore, the possibility that no one would want to participate. I am aware now that I actively refused to think about my small potential sample group: refusing to find out such details as how many staff actually worked on the ward. I think this was another act of repression, as to acknowledge these small numbers would have been too anxiety provoking, particularly as I moved further and further along the research path, further and further from a point where I might do something else. Luckily this did not backfire and I did find participants.

The theme through both qualifying paper and research, therefore, was repression used to counter the constant fear of not developing and ultimately not completing the work. It was, however, important to hold this anxiety at bay through the first three years of training: to allow the pre-interview work to be completed for my research without becoming overwhelmed and for the sake of bracketing, in both qualifying paper and research, as I collected my data.

Entering the fourth year: writing up of the qualifying paper

The first term of my fourth year I focussed on finishing data collection and transcription of interviews. As was usual for me, this term felt like an extension of the third year. My preoccupation seemed tied still to that time: a time of preparation for the coming fourth year, collecting my data in readiness.

My qualifying paper was, however, in my mind and I began seriously doodling themes quite early in the year: feeling anxious to have a framework in mind on which I could build. In addition I finished the work with the child at Christmas and this signified the moment of moving from clinical work to written work. At Christmas, research was put to one side as I focussed on my qualifying paper and I came out of that holiday with a first draft. My anxiety to put pen to paper was, I think, an awareness of the coming storm of busyness but also typical of me: that I can ignore things very effectively for a certain length of time but, once they come fully into my mind, I find it hard to sit with work that is not done. In a larger way this was played out by my research too. For a long time, at the back of my mind, I was afraid that I would have nothing to say and a moment came when I could tolerate this worry no more and felt compelled to face the data and find out if my fears were grounded. To some extent even my coming to the training, after a break of 10 years, was because I could no longer bear the uncertainty of whether there would be a place for me.

Initially, I wrote a qualifying paper which taught me nothing more about my intensive than I already knew and my helpful supervisor, who read this first draft, suggested I put it to one side to give it some time to develop. I found this suggestion unusual as I was unused to an idea that things might develop without direct work. On hindsight, however, I feel this time was needed to disconnect me from the clinical work I had done and to allow my write-ups to evolve into a dataset.

I returned to it at half term and on reading through began working on some of the parts which seemed not to fit. I tried to be more honest with myself about what had been happening in the room: noticing where I had claimed countertransference rather than acknowledging my own difficulties and inexperience in challenging the child. The result was a more honest, less defensive piece of work. Here I was beginning to have confidence in allowing myself to have been inexperienced and not known. Also, however, I was beginning to feel less embarrassed about things I had labelled “wrong”, recognising that these were a part of the work and perhaps had their own value in making the process an authentic struggle we had undergone together. I feel this was the time when my qualifying paper began to develop into a piece of work which could be said to have research value.

Again I set it aside. Final consideration of my qualifying paper came in June when I thought that I would just be doing final edits and a proofread. I ended up changing parts of it substantially, as it seemed that time really had allowed me to deepen my understanding. I have come to believe that the extended time over which I wrote this essay, really allowing myself to leave it and come back to it, was of enormous value. From a personal standpoint, it allowed me to step back from the work and recognise how much I had learnt, how far I had come and how much value there had been in this child’s therapy overall. From a research position, coming back to it was almost like coming back to someone else’s work and evaluating it, allowing me the distance to be more critical of my work and my conclusions.

This final stage of adjustment and rethinking made the paper feel more finished and true, rather than just an intellectual exercise. I realised that whilst I could feasibly justify any position with theory, what I had ended up writing was something I believed. I believe this is part of the process of writing a paper in which only one patient is described, but which has research merit: the ability to disconnect from one’s ego sufficiently to look at the case objectively.

Turning to research

The next stage with research was highly anxiety provoking, as I felt concerned I would be unable to code my data or find themes within it. Perhaps there had been more going on unconsciously with my qualifying paper than I realised in regard to my feeling reassured that I would be able to write it. My research, however, had produced seven transcripts which I did not, at that point, know as well as I had known the child I had worked with intensively.

I made a start with coding over the Easter break and was pleasantly surprised that I had many thoughts about my data and coding was not as arduous as I had expected. Having left the data for several months, I again came to it fairly fresh and coded line by line with the thoughts that occurred to me. In this way, it was certainly a more thorough investigation of the data than my qualifying paper had been as, in my research, there was a manageable amount of data to consider in this way. For my qualifying paper there had been over 100 write-ups!

As I began to group my codes into themes, I was relieved that there did seem to be themes to the data. I am aware, however, that I rushed the process somewhat: finding it hard to stay with not knowing what my themes would be and wanting it finished to counteract the fear that it would never be finished or come together into something coherent. I quickly produced a lot of work, which seemed to give the appearance to my supervisor that I was getting on well. However, the defensive element behind my “getting on” always made it difficult to accept praise or reassurance, as I knew that the root of it was not so much industriousness as fear. In this way, it was perhaps similar to my first draft of my qualifying paper: a good start but something which needed significantly more work, redrafting and consideration before it could be said to be meaningful.

When my supervisor suggested reworking my themes I considered starting again and felt guilty for not doing so. At this point I was worried that starting again might have been helpful but that I was too anxious to return to such a position of not knowing. In the past I have restarted essays when I am unhappy with them, but this time, with so many competing pressures (finishing clinical work, the qualifying paper, log and Covid) I was unwilling to start again and return to a fragmented state. On hindsight, however, I struggle to fully condemn or condone this refusal, as not starting again, when this would be my usual way of managing my discontent, perhaps indicated an awareness that such drastic action was not really what was needed. As with my qualifying paper, my themes just needed some time to develop. So, instead, I struggled, procrastinated and avoided, but I have come to see that this was part of the work of the research: finding it hard to face the fragmentation and unfinished ideas but doing it little by painful little.

At the beginning of the summer, once clinical work was finished, I spoke to my supervisor about my concern around writing up: a task which felt insurmountable and impossible to break down as I had broken down the previous parts of it. She pointed out that actually this stage was no different and could also be broken down into the smaller tasks of writing up each section, which would eventually add up to a whole. So I began and holding to this “one step at a time” position was important for the research to develop without jumping too quickly to a “finished” position: allowing me to develop, modify and build towards something more meaningful.

While allowing my themes time to develop I began working on the literature review: something else which had been started but still needed a lot of work. Quickly this became overwhelming, as did each area I initially looked at: codes, themes, results, discussion. Each article I read seemed to lead to ten more and I had an idea that I had to cover everything that had ever been written. Holding, at this point, all the data inside my head in such a fragmented state, I felt that there was no way to bring it all together and approaching the literature review exacerbated this. Again my supervisor was invaluable in putting a boundary around my work. I approached her feeling that I had fallen down a rabbit hole of papers and she advised me to pick the ten most relevant and use only those in my literature review. She then reminded me that psychotherapy literature should also be included in my review. I realised I had discounted my existing knowledge from psychotherapy theory and in doing so had made myself feel incompetent. Considering psychotherapy theory helped me to feel that there was a structure to this part of the work: something already more integrated in my mind, and the literature review began to progress from that point.

Moving on to writing up my results, this seemed a fairly straightforward process of collecting quotations that I wanted to use to illustrate my themes. In my next supervision my supervisor acknowledged my efforts but recommended that I continue to consider my data and themes. I think I had still not sufficiently let go of the anxiety of having nothing to show and I needed to step back from the data to look at it as a whole. However, it still felt too big in my mind for me to see clearly. However, despite this I did feel that the quotations I had were relevant and that the process, at this point, was more about finding a better way of tying them together. I began to feel confident that I had themes, I just could not quite name them yet and I think this confidence meant that I was able to look again at my data and not feel so overwhelmed by it.

In doing this I listened to an internal thought which had been with me for a while as I had begun pulling together my data. It was a thought about a mother holding out a spoon and waiting for the infant to open their mouth. I was aware, from a previous role, that infant feeding was very much about this sort of waiting rather than attempting to push a spoon past closed lips or into a distractedly open mouth. I thought about how the anorexic mouth is closed and that perhaps similarly good emotional feeding came from waiting for receptivity. From this grew an idea that other parts of the nursing role were perhaps about how to emotionally prepare and help a child to take in and digest, and the more I thought about this the more coherent it felt. I rewrote my results section, feeling more confident in what I was writing. As with my qualifying paper, I reached a point where I felt something more honest and real was being produced.

Having developed something which felt more processed, I began approaching the writing differently: writing in a more integrated way. I broke my literature review down by theme and then, by looking at the appropriate sections of the literature review and results, I wrote thoughts for the discussion. This made the writing more manageable and seemed to indicate movement away from feeling that I had to hold every part of my work in my mind simultaneously, that it was okay to break it into manageable parts and focus on them one at a time. Slowly I found that I was more able to think of my work as a whole, although for a long time I wrote and thought in this “one theme at a time” way, which helped to make sure that what I wrote was coherent and inclusive of all the points I was making.

In the last proof-reading days I finally managed to read through the whole piece of work from start to finish. This indicated, not only that there were no major changes and thus it was possible to get through it in this way, but also that the work had reached a point where I could hold it all my mind as a coherent whole. This chimed strongly with the ending of the therapy of the child about whom I wrote my qualifying paper. In his final session he brought a phone to the room and showed me a large number of photographs from it. These photographs were of varying themes, some frightening, some poignant and seemed to summarise the whole of his therapy and the different themes we had covered. I wrote in my qualifying paper that it seemed he had reached a point where his emotions could be summarised in this way and that they had become of a size where they could fit within one session, rather than being the big and overwhelming monsters they had been. I feel very similarly about my research, which finally fit within a final read-through, where it had initially been too big and unwieldy to fit in my head.

Post viva amendments

Having reached a position in which my research felt finished, it was a struggle to make amendments. Whilst I could recognise that the work would be improved by the changes I was required to make, the process felt rather like trying to make changes to a finished garment: cutting holes into something in order to incorporate “pockets” which then did not quite seem to fit with the aesthetic of the design. It seemed that I had to pull my research apart at the seams in order to accommodate the new parts. However, as it began to feel again complete and cohesive so I became worried that I could no longer see the joins where changes had been made: concerned that my changes would not be sufficiently apparent, perhaps fearing that my underlying negativity about making them would be perceived.

I felt persecuted, and that I was writing to satisfy another rather than myself. Thus the hard-won ownership of my work and importance of my being satisfied with it was subsumed by the requirement to make these changes, and the pressures of a full-time job meant that my time was limited to really work this through. I struggled repeatedly with feeling judged by the viva, and it was difficult to maintain an attitude of my work having worth: a feeling which grew as the new deadline approached and I knew I would have to face a judgement again.

Reassurance came when I received amendments from my supervisor. It is not ideal that I needed this reassurance from a parental figure to again feel that my work was valid, but there is undoubted value from feeling that a benign parental figure can be satisfied, and I approached these last changes with an increasing sense of a final push towards the finish line. On my final day of amending, I realised that I had viewed the changes I had made and the process of pulling apart the work as catastrophic to its “life” and thus had struggled to face it and find it “dead”. It seemed, however, that recognising this, alongside receiving amendments from my supervisor which I was able to work through systematically, breathed life into the work and my own sense of capability once again, and this leads me to feel that I can let it go with some faith in its vitality.

However, I am aware that what has also arisen is a wish for more time or an opportunity to start again and write something unencumbered by the steep learning curve of a first piece of research. This brings to mind my final research theme: that of letting go and moving on, and the need for mother to tolerate this moving on. Like the anorexic patient who retreats from development or couples with the anorexia in order to overcome the fear of being left alone, I perhaps wish to pause or start again where six months ago I wished to skip the painful letting go and have it already done.

This period of amendment has thus held me in the painful ending position for a long time but, luckily, I am not afforded defensive manoeuvres as I approach the end: the hand-in date approaches and I must relinquish it in the hope that it will be good enough as the stepping-stone piece of work from which I leave my training. I once had a supervisor who reminded me, however, that reflection continues for many years beyond a final reflective paper, and I have no doubt that I will continue to evaluate my experience of this piece of work, and indeed my whole training, for a long time to come.

Reflections on generalisability and complexity

It is of general opinion that papers which discuss one patient are not generalisable, but I do not wholly agree with this position and certainly do not agree that they are without value. Of course, I cannot write about one child in a way which would tell someone how to work with another child, even if this was another child whose presentation was similar. My intensive was the child of a Bosnian refugee. Had I used the opportunity to make some hypotheses and generalisations about working with the children of Bosnian refugees this would have been a stretch from this single case study, although perhaps if several such papers were written a testable generalisation might emerge.

I feel the more important question, however, is what can we get from these single case study pieces if not a manual for work or generalisable conclusions. I feel these are an opportunity for the clinician, and certainly for me, to reconsider a piece of work outside the preoccupations and preconceptions that may have been around in the work, to take a step back, think again and learn. For the reader, it is an opportunity also to perhaps see snippets of their own work or thought processes, presented in a different way, which may aid their thinking, build their hope and confidence in the work or suggest a different approach that can be trialled.

In regards my research, generalisability remains an issue. If a single case study is considered as not much, then seven interviews is hardly better. Although I do see that the close consideration I was able to give the interviews would perhaps suggest greater rigour, the greater quantity of data from my intensive patient supplied a more exhaustive dataset, although obviously I could not look so closely at each writeup. There is a limit to how much data can be considered and so every dataset is ultimately incomplete. I could not write up every session I had with my intensive patient and I cannot interview every member of staff working on an eating disorder unit and even if I could, I would need hundreds of researchers to analyse the data and it would take years. Again, I feel the value in my study is in hearing these seven individual’s voices.

Further work is clearly required to see if the work could be generalisable. However, I feel some of the assessment of whether a piece of work has validity is in whether the idea becomes tenacious. If my work speaks to people they will pass it on and over time, through further studies but also just in its resonance within those who work with this client group, it may become part of the accepted lexicon of the disorder.

My position, therefore, is that neither of my works are generalisable on their own, but I question whether any study is necessarily generalisable no matter how big or inclusive it is. All research, however, adds in a summative way and sparks thoughts in the next researcher who makes their own additions. In this way we build up a literature review within ourselves which becomes coherent, and this was a process that took place in me. Within my literature review, some studies spoke to me and seemed highly relevant, others did not, and this was never a case of which studies were more well designed or large.

Ultimately, we might make generalisations which hold some value, but they will never hold totally true for every individual. The value of psychotherapy is in considering the individual and of course we have a body of theory with which to do this, but ultimately that theory must serve the individual rather than the other way around. Psychotherapy would become rapidly meaningless if we approached each new patient with preconceptions attached to generalisations from research. We must maintain a stance of not knowing.

Conclusion

In this essay I have considered the development of the two pieces of work which comprise the Clinical Research Portfolio: the qualifying paper and the research thesis. I have thought about how the methodologies of these two pieces differ: the research having a clearly defined methodology throughout its development and the qualifying paper having a no less clear methodology, but one which was not pre-defined, set out and submitted for ethical approval. I have further considered, however, how these methodologies are similar: both involving a bracketing of preconceptions and a collection of data in as unbiased a way as possible in order to create a data set for consideration.

I then moved on to thinking about the importance, in both pieces of work, of time: time for the data to develop within my mind and to move beyond a regurgitation of information to a formulation of themes with greater independent meaning. Within this, both pieces of work were repeatedly redeveloped in order to move towards a clearer understanding of themes. I feel this has led to both of my pieces of work being interesting and honest reflections of the data and that I worked hard to remove my own ego so that they could have tentative exploratory value.

Whilst I do not necessarily believe that these pieces are generalisable, I argue that this is perhaps not the most important aspect of research: that these pieces add to a body of research and that only with time will it be clear whether they fit and will lead to further development. Additionally, I argue that research pieces are of value to the individual, potentially sparking questions and interests within them which lead to further work and resonating with their own pre-existing experience and knowledge. I hope that my work will spark this sort of interest, but regardless of this it has had immense value to me, my learning, development and clinical understanding.