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A psychoanalytic exploration of CAMHS clinicians' experiences with children and young people who do not feed. An interpretive phenomenological analysis.

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A thesis submitted for the degree of Professional Doctorate

in

Child and Adolescent Psychoanalytic Psychotherapy

Tavistock and Portman NHS Foundation Trust

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ABSTRACT

This research project explores the experiences of four Child and Adolescent Mental Health (CAMHS) clinicians who have worked with children and young people who restrict or refuse food. The participants were identified through purposeful sampling and the data was collected through semi-structured interviews. The interviews were transcribed and coded using Interpretive Phenomenological Analysis. The findings are arranged in 4 Group Experiential Themes that reflect the experiential themes the participants described in undertaking this work: their internal experiences, their experiences of the patient, their experiences of the patient's parents and their experience of the network and their professional context.

The analysis of the findings indicates that clinicians need to feel meaningful connections and have supportive relationships. The success of the work is connected to the clinician supporting the patient to build a new type of relationship that is more realistic and allows for vulnerability and dependence. To do so the clinician has to manage painful feelings in both the patient and in themselves. Clinicians are in contact with projections of extreme anxiety and aggression from both the patient and the patient's parents and therefore the patient's parents' history influences the trajectory of the work. The professional context of "not feeling alone" is highly influential in clinicians' decision to keep working in this area. Physical recovery is important, but not the main focus.

INTRODUCTION

The vision for this study emerged in the initial year of the COVID-19 pandemic. The researcher became aware of an increase in the number of children and young people refusing food whilst confined to the home and lacking access to the usual resources that had helped them cope with anxiety and stress. This led to the question of whether there was a correlation between the increase in social restrictions and the occurrence of eating restrictions. This timing of this questioning corresponded with press articles about increases in eating disorder-based admissions to hospitals, and so it appeared there could be a relationship between different types of restriction experiences.

As NHS were services being staffed by clinicians working through the same circumstances of restriction the researcher began to wonder about the personal and professional impact of this work. If more clinicians were now being required to work with children and young people who refused or restricted food, how was this being experienced in clinics by the staff who worked there? Specifically, the researcher wanted to explore how clinicians understood and experienced working with patients who had these issues. Whilst this began to the backdrop of the Covid-19 pandemic it developed into a genuine interest in this specific type of clinician-patient relationship.

In many cultures and throughout history there are examples of individuals who starved themselves for reasons such as protest or faith. For example, hunger strikes remain a last and desperate protest for those who have no other way of being recognised or heard. It was used as a form of protest by suffragettes in the quest for female suffrage and also during internment in Northern Ireland and by detainees in Guantanamo Bay.

Some religions view controlled food restriction as a form of devotion: such as lent in the Christian tradition and Ramadan in Islamic tradition. There are examples in the Christian tradition of self-starvation being rewarded with sainthood. According to Bell (2017), there are clear parallels between medieval behaviour and anorexia nervosa today. In both cases, individuals obsess over a culturally specific goal: beauty or slimness in present-day society, and austerity or deprivation in medieval society.

In today's society, the media often depicts being thin as a desirable trait, and social media can reinforce this idea as a symbol of self-control. There are popular social media accounts dedicated to controlling the intake and elimination of specific foods. Some young people appear to be able to consume this content with minimum harm and others can ignore it altogether. However, for some, it appears to be encouragement for self-starvation. Some people develop a pattern of food restriction to an extreme level and the absence of a clear and shared understanding of why this happens indicates an inadequacy of empirical research in this area, a reluctance to investigate or an incomprehension of the issues involved.

Some data is available on occurrence. Galmiche et al (2019) noted a worldwide increase in the diagnosis of eating disorders in the period between 2013–2018. They found it to be 7.8%, up from 3.5% for the previous 2000–2006 period. As the rate of occurrence had more than doubled, they identified this as a challenge for public health and healthcare providers.

The NHS Digital's survey on the Mental Health of Children and Young People in England (2022) collates recent information for the UK. This study collated the self-screening data from the participants rather than that of professional diagnosis. In the 2017 survey, eating disorders were identified in 0.4% of 5 to 19-year-olds who took part and as a result, NHS Digital estimated the prevalence of eating disorders amongst all children in the population was likely to have been between 0.2% and 0.6%. Eating disorders were found to be more common among girls (0.7%) than boys (0.1%). Prevalence was also higher in older age groups: 0.1% of 5 to 10-year-olds, compared with 0.6% of 11 to 16-year-olds and 0.8% of 17 to 19 to 19-year-olds. Estimated rates of eating disorders were higher among girls aged 17 to 19 (1.6%) than in any other demographic group.

The same data was not collected again until 2022 when the study found that children and young people of both sexes who screened positive for possible eating problems in England by age group were: 11 to 16-year-olds: 12.9%, 17 to 19-year-olds: 60.3% and 20 to 23-year-olds: 62.2%. This indicates a significant rise in prevalence in the 5 years between 2017 and 2022. In addition, the differences between the Galmiche 2019 study and the NHS digital study 2022 demonstrate a gap between the self-report of eating issues and the rate of a professional diagnosis, and the massive change between reporting in 2017 and 2022 could indicate a low level of reliability regarding the figures. It also warrants thinking about the impact of COVID-19 restrictions which took place in the interim.

Having established that food restriction is increasing, the researcher was curious about how treatment was offered to patients by CAMHS. Psychoanalytic theory suggests that food restriction is correlated to emotional and psychological restrictions. Since emotional and psychological nourishment is obtained through relationships, this can affect the therapeutic alliance. If a patient refuses to accept help through a relationship, even if they acknowledge their suffering, how can the treatment continue? As Jeanne Magagna (2022) pointed out, "People with eating disorders do not simply reject food. Along with food, they also withdraw from intimacy and emotional aspects of their life.”

This is closely related to the idea of food being a primitive need and therefore the feeding relationship carries within it the most powerful type of unspoken communication. Communication of all types of primitive human emotion. This idea is related to the belief that receiving food is seen as an act of aggression when in an infantile state of mind. Taking anything is viewed as stealing, and it raised the question of whether writing about evidence of deficits in early feeding relationships was an attack on the concept of good enough parenting.

This study explores the role of blame, subjectivity, and feelings of resistance around the idea that patients have internalised experiences of neglect. Additionally, it examines the factors that may have caused food restriction or refusal, and whether children may sense that taking food will result in depletion of the feeder, especially if they believe that the feeder is limited due to illness such as anxiety or depression, as mentioned by some participants.

Aims and Objectives of Study

Aims

To explore the experiences of clinicians who work with children and young people who do not feed. To understand the impact of this on the clinician during the clinical treatment process.

Objectives

To learn from clinicians about the experience of working with children who refuse or restrict food intake. There is no requirement for the patient in treatment to have a diagnosis of an eating disorder, but they must have at least a 6-month history of refusing or restricting food.

The data will be collected via semi-structured interviews with four front-line CAMHS clinicians from two NHS services: a specialist eating disorder team and an outpatient CAMHS team.

To complete an interpretative phenomenological analysis of the data to explore the meaning for the professionals involved. To explore how the refusal or restriction affects the individual and network around the case and to see what commonalities there are across professionals' experiences.

LITERATURE REVIEW

This literature review is presented in four sections. The first is a review of the current professional and institutional context for CAMHS clinicians in the NHS. The second is a review of extant research, primarily into clinician experiences followed by a review of relevant studies on the treatment of children and young people who refuse or restrict food. The third section describes psychoanalytic theory on the unconscious dynamics that impact clinical experiences and how feeding relationships impact personality development. The final section reflects the researcher's subjective experiences of conducting this review.

Review of professional and institutional context

This study will use the terms ‘clinical work’ and ‘clinician’ as these are purposefully broad terms. A clinician is any professional deemed competent to work in this context in the NHS: nurses, social workers, doctors, psychologists or any other professional group. Clinical work in this instance may involve individual therapy, family therapy, dyadic therapy, physical monitoring, dietary advice, working with the network and any other clinical intervention deemed in the patient's interest. In this context, clinicians are expected to be aware of the evidence base for their area of work, the requirements of the registering bodies and the guidelines to which their employing institution subscribes.

Clinicians in the NHS are expected to be aware of the evidence base for their area of work, a term which comprises research, outcome/user feedback, and clinician experience with the clinician's experience being disproportionately under-investigated. Titler (2008) advised that when a body of research evidence is available, healthcare decisions should be guided by this, along with clinical expertise and patient values. However, in cases where there is not a large body of available research, healthcare decision-making may rely more on non-research evidence sources such as expert opinion and scientific principles. As more research is conducted in a specific area, it should be incorporated, which suggests that clinicians might be required to suspend their experience and expertise in the face of new research. This appears to create a hierarchy within the evidence base and indicates that external evidence should take priority, which could undermine the clinicians' understanding of the patient's unique set of circumstances and this illustrates the complexities of providing evidence-based care. Whilst turning to research to form a care plan makes sense for most physical interventions, it could be less helpful for relational treatments such as CAMHs treatments or psychotherapies if it were to impact on the clinician's confidence about what they could know from the therapeutic rapport.

Haynes et al (2002) write about the tasks which encompass the ideal of clinical expertise should be informed by the patient's clinical state and circumstances, relevant research and the patient's preferences. They warn that accomplishing this often involves making tradeoffs and that clinicians need to be aware of and continually balance the weight of the research evidence along with patient feedback and their professional experiences and adapt appropriately to the circumstances.

Whilst this study is about the experiences of clinicians who work with children and young people who restrict food, a patient with a diagnosis of an eating disorder is not a mandatory criterion for inclusion.

As highlighted in the introduction, self-reported rates of eating issues are higher than diagnostic rates (Galmiche et al, 2019 and The NHS Digital's survey on the Mental Health of Children and Young People in England, 2022). If a professional diagnosis was a requirement for inclusion, it could exclude groups of patients who are not eating for a range of reasons. Despite this, it is expected that most patients will have a diagnosis as this will be most obvious for clinicians working in step 3 CAHMS and specialist eating disorder services to discuss. The diagnostic criteria and resultant categories for eating disorders defined by the NICE (2020, guideline [NG69]), are contained in Appendix 1 for reference.

Although eating problems may have roots in early childhood, children under the age of 7 are usually treated for eating issues in other services, typically pediatrics, and so will not be included. Additionally, diagnosis of bulimia and binge eating will be excluded as these issues are characterised by different food-related behaviours, however, Avoidant Restrictive Food Intake Disorder (ARFID), the recent diagnostic category of approx. 10 years, is receiving research attention and does fit with the concept of restriction. ARFID shares many diagnostic features with Anorexia Nervosa, but not a distorted body image or focus on thinness.

Anorexia Nervosa (AN) is the diagnosis most commonly associated with restricted eating and has existed as a specific diagnosis since 1874. In the past identification of AN has been reliant on observations of physical deterioration and past treatments have included institutionalisation, force-feeding and separating children from their parents when the parents were held responsible for the restriction. The modern focus is on treating young patients who continue to live with their families unless the physical risk necessitates the need for admission to the hospital. The NICE guidelines speak to the expectation of how CAMHS clinicians should work with their patients in this context. So although this study does not specifically address AN, ARFID or other eating disorder diagnostic categories, these labels are described here as they are often used for individuals who struggle with food intake.

Review of relevant research literature

Clinicians' experiences are not well researched. Furthermore, there is a lack of research as to how the rejection of "psychological feed" in the therapeutic exchange affects the progress of clinical work. That is: clinicians' experiences of working with patients who are more severely unwell, show higher levels of resistance and are likely less compliant with treatment and care plans.

The meta-synthesis approach, where there is a systematic review and integration of findings from a collection of qualitative studies, is a promising way to collate findings from a collection of small studies in a particular area. For example, there was a recent meta-synthesis of patients' experiences of family therapy for eating anorexia carried out by Kiely, Conti and Hay (2023). This team found 36 papers, comprising 382 voices of patients with experiences of Family Therapy (FT) for anorexia to inform the meta-ethnographic findings. Of relevance to this research, the first and third themes identified: relinquishing control ambivalently (initial treatment resistance, authoritative care, and recovery not done alone) and neglect of underlying issues (cause of AN, issues other than AN, and need for individual work) are particularly relevant to the experiences of the clinician providing treatment as they provide a context for understanding some of the inner struggles the patients are trying to manage. Initial treatment resistance and the need for individual work are of particular importance as they relate to the kind of relationships that can be formed.

Geller et al (2023) suggest a significant factor contributing to the care clinicians provide, is their experience of distress and how they respond to their own and others' distress in times of difficulty. In this study, self-compassion and compassion for others were measured and higher scores in these areas were associated with greater use of collaborative care, with compassion for others being the stronger predictor. In this study clinicians' own experience of distress was not related to how they offered support suggesting that they have developed ways of managing complex and difficult feelings whilst continuing to provide collaborative care. This study ends with a recommendation for more research in this area, a relatively common occurrence.

A study by Warren et al (2013) investigated the experiences of treatment providers for patients with eating disorders and stated: "Emotional exhaustion is the most common aspect of burnout experienced by eating disorder treatment providers". Cynicism and lack of personal accomplishment were also investigated and the data suggested that whilst these were at high levels, it was not as significant as the researchers had initially anticipated. This study is very relevant to the current study and the findings about patient vigilance of their clinician's appearance and their patient difficulties with trust are of note. Warren et al's use of questionnaires may have somewhat limited the range of responses that could be gathered but it did indicate that 30% of the treatment providers surveyed had suffered some form of eating-disordered behaviour in the past.

Zerb (2013) wrote a response to the Warren et al study and suggested that a "sophisticated qualitative study may shed additional light on what goes on in the hearts and minds of those professionals who find meaning and avoid burnout, as well as those who have both personal and professional insights on eating disorder recovery". Thompson-Brenner, Satir, Franko, & Herzog, 2012 wrote a further response to the Warren et al study proposing that the analysis of experienced clinician samples reports far more positive experiences treating patients with eating disorders than negative ones. Whilst further research was strongly indicated in reality it has been slow to emerge with no direct follow-up to Warren et al in the last decade.

Richard-Kasser (2021) looked at drift in adherence to treatment modalities in patients with an eating disorder and found the majority (59.6%) of participants (clinicians) engaged in treatment drift and were aware of such deviations (71.8%). Though findings did not reveal the anticipated relationships between clinician factors and treatment drift, the results did demonstrate conscientiousness and intentionality on behalf of the clinicians related to their clinical experiences. This suggests that clinicians may intentionally adjust treatment outside the remit of the manualised treatment formats based on their experience with the individual patient with whom they are working.

Groth et al. (2020) found that therapist treatment decisions may be related to aspects of the patient's trauma history and symptomatology when treating adolescents with a diagnosis of an eating disorder. In addition, therapists used more psychodynamic and interpersonal techniques with patients who had more severe trauma histories, particularly when they were victims of a major parental upheaval, childhood sexual abuse and serious injury, suggesting that the therapist had awareness they were treating more than the symptoms described.

In their 2008 study, Egan and Carr investigated body-centered countertransference in Irish female trauma therapists and clinical psychologists. The study found that somatic or embodied countertransference, which they suggest might be related to the impact of mirror neurons, was present in 80% of the sample who had experienced muscle tension in the last six months. They suggested body-centered counter-transference can be encouraged by postural mirroring by the therapist. A finding of this study was that this aspect of clinical work was normal and measurable, however, as the method of data collection was the use of questionnaires, this likely limited what experiential information could be collected.

Haynes et al (2018) conducted 3 meta-analyses of 13, 14 and 9 studies respectively, into the impact of countertransference management on effective psychotherapy. Their definition of countertransference was "best understood in terms of an interaction between the therapist's unresolved conflicts and aspects of the client that touch upon or stir up the therapist's conflicts". They found that better countertransference management helped achieve better outcomes in therapy and made a list of suggestions to support therapists in understanding their role in this regard.

AN, despite it being the least common diagnosis, was the diagnostic category with the highest volume of available research. The most frequently used diagnosis is atypical anorexia, which is often treated outside of specialist services according to NICE guidelines (2017). It is likely that patients with a diagnosis of AN receive more research attention due to the higher risk of death and the need for physical intervention to save lives. This diagnosis requires the highest amount of physical intervention among psychiatric illnesses. As van Eeden, A. E., van Hoeken, D., &

Hoek, H. W. (2021) state “Anorexia Nervosa has one of the highest premature mortality rates, with a risk of premature death approximately five times greater than that of peers.”

Webb et al. (2022) interviewed twenty-one clinicians working in specialist inpatient and day-patient eating disorder services to explore their views on supporting people with severe AN during the pandemic. They analysed the transcripts using thematic analysis and the findings challenged assumptions about the delivery of multidisciplinary treatment for people with severe AN. Clinicians emphasised how important they rated being part of a team. Clinicians also highlighted the importance of offering various types of family and psychological support, even for individuals who are severely medically compromised. The study identified some opportunities as a result of the pandemic: in particular in day patient services offering virtual support. This last finding links to Couturier et al. (2022) who completed qualitative research on how families experienced the move to internet-based CAMHS treatment during the outbreak of Covid 19. 11 out of the 12 participants strongly preferred treatment in person. This suggests whilst there are increased opportunities for working remotely and this provides an option if travel to the clinic is not possible, the experience for families working with a therapist is better in person. Research that linked this to experiences of transference and countertransference where not available but appear to be worthy of investigation.

Datta et al. (2022) updated their 2015 summary of treatments for anorexia and restricted eating in children and adolescents and concluded that more research in this area is needed. They were able to include an additional 31 studies (to the 2015 review) and found that behavioural family-based treatments met well-established treatment criteria for AN and ARFID. The researchers listed cognitive behavioural, interaction-based treatment and psychotherapeutic approaches as being treatments of interest for future large-scale investigation.

The current NICE guidelines (Appendix 1) are informed by the Lock et al (2010) RCT which evaluated the relative efficacy of family-based treatment (FTB) and adolescent-focused individual therapy (AFT) for adolescents with anorexia nervosa who were in full remission (defined as 95% of normal weight as expected for sex, age and height at the end of treatment). This 2010 study created the manuals for both treatments and found that both FBT and AFT were similarly effective in producing full remission and rates of improvement remained good at both 6 and 12-month follow-ups, although levels of full remission were higher in the FBT group. FBT was seen to be the more effective treatment due to the higher efficacy at follow-up and became the first-line recommendation. It is an inconsistency that parents were offered only 8-10 parent sessions in AFT, whilst they were involved in 18-20 in the FBT model. This might have been for valid reasons, but it is not perhaps a surprise that the patients who did best at follow-up had the benefit of more parental involvement in the treatment and had the approaches been matched in this aspect (if parents had as many parent sessions in AFT as in FBT) the outcomes might have been different. That is, the level of parental involvement may make the difference rather than the therapeutic modality.

FBT is referred to as FT-AN in the UK and recruits parents to the treatment as a resource. The parents are supported by the clinician to take control of feeding back from the child, then gradually return control to the child when they have re-established healthy independence. FBT has 5 tenets;

> The therapist holds an agnostic view of the cause of the illness; (2) the therapist takes a non-authoritarian stance in treatment; (3) parents are empowered to bring about the recovery of their child; (4) the eating disorder is separated from the patient and externalized; and (5) FBT utilizes a pragmatic approach to treatment (Lock et al, 2010).

Lock, J. (2015) in an update on Evidence-Based Psychosocial Treatments for Eating Disorders in Children and Adolescents, stated that more research was required as FBT remained the only level one efficacious treatment based on current research while AFT, having the benefit of 2 RCT's as effective as a level two treatment. Hagan et al. (2021) broke down some of the components of FBT in their study and concluded that "Parental beliefs about their responsibility to re-nourish their child may maintain associations between parental self-efficacy and AN psychopathology". They suggest that parents who do not perceive themselves as having efficacy in their child's recovery could benefit from direct coaching and support on how to help them eat at family mealtimes. They recommended this finding be included in thinking about future clinical work, with more emphasis being placed in clinical work on understanding the parent's position.

Fitzpatrick et al (2010) describe AFT (AFP-AN in the UK) for adolescents with Anorexia Nervosa as a psychodynamically informed self-psychology model designed to address key deficits in development associated with anorexia nervosa. This approach requires the clinician to have a solid understanding of adolescent development and work with the patient through three phases. The first is to establish rapport and formulate, the second is to explore individuation in adolescence and the final phase is to develop healthier coping strategies for their stage of development.

> Thus, while CBT for AN focuses centrally on thoughts, feelings and behaviours related to food and weight gain with a secondary focus on emotions and interpersonal process, AFP's central focus is on the emotional process, developmental adaptation to stressors and secondarily to the specific issues of food and weight gain. (Fitzpatrick, 2010)

The therapeutic process should last a year or at least 32 appointments, with up to 8 sessions for work with the parent. In AFT the parent has an important supportive role and is not as integral to the process. The book version of this treatment model was published in 2022.

There is limited research available on Cognitive Behavioral Therapy (CBT) for eating disorders, making it challenging to compare CBT with other treatments. The small amount of research that does exist uses different criteria to define full remission, making it difficult to make a direct comparison between different approaches. However, Dalle et al. (2013) conducted a study with forty-nine adolescent patients recruited from consecutive referrals to a community-based eating disorder clinic. Each patient was offered 40 sessions of CBT-E over 40 weeks with a single therapist. Two-thirds completed the full treatment with no additional input. The results showed that these patients experienced a significant increase in weight and a marked decrease in eating disorder psychopathology. There were no follow-up results to review.

A study to examine the efficacy of the Maudsley Model of Anorexia Nervosa Treatment for Adolescents and Young Adults (MANTRa) compared with the form of individual psychotherapy that can be considered as standard in Austria (TAU-O) was conducted by Wittek et al and published in 2023. This study compared 92 patients between 13 and 21 years suffering from full-syndrome, atypical or weight-restored AN, who received either 24-34 individual MANTRa sessions (n = 45) or TAU-O (n = 47). The study found that both treatments resulted in significant improvements in BMI and reductions in eating disorders and comorbid psychopathology over time, however the percentage of participants with fully remitted AN was significantly higher in the MANTRa group compared to TAU-O at 18-month follow-up (MANTRa: 46% vs. TAU-O: 16%, p = 0.006). Reported satisfaction with both treatments was high.

Parental involvement is more evident in recent research, suggesting that researchers are interested in measuring the interplay with recovery. Timko et al (2023) conducted a secondary analysis to investigate the prevalence of post-traumatic stress symptoms (PTSS) in parents of youth who were hospitalized for medical stabilization due to AN. The study found that a majority of mothers (55.9%) and fathers (61.5%) showed symptoms of PTSS. The severity of the child’s AN was not correlated to the severity of the parent's PTSS, however, PTSS symptoms were correlated with parental reports of mood symptoms, avoidance, inflexibility, and symptom accommodation. The findings suggest that parental PTSS negatively impacts the patient's weight gain post-discharge. The authors recommend that healthcare providers pay close attention to the needs of parents in such circumstances.

Lavender (2020) in her article "Rebooting 'failed' Family-based Treatment" described cases that appear not to have responded to standard FBT can be successfully treated with greater clinician adherence and fidelity to the manual. Lavender wrote "that therapist adherence to the model decreased over time, and that adherence was strong only on behavioural interventions focused on meals and eating but weaker on other elements of the treatment such as modification of parental criticism and attending to general family process issues". Lavendar recommended that "clinicians receive adequate training and ongoing expert supervision including the need to focus on the themes addressed in this paper". There is no exploration of the reasons why it was difficult for clinicians and families to address parental criticism and family process issues in the first instance. This stance appears to assume that the clinician has failed in some way rather than questioning if the treatment approach was the appropriate one or if something important is being communicated by the clinician's choices. The recommendation that things could improve with greater adherence to the treatment manual might be a defence against the impact of the painful emotions raised in the work and reduces the importance of the patient/clinician relationship. It also reduces the flexibility of the clinician to draw from a range of ideas and approaches which could be equally valid for that unique set of circumstances.

In a study on understanding gendered realities: mothers' and fathers' roles in FBT for adolescent eating disorders, Scarborough (2020) suggested that clinicians may unknowingly perpetuate gendered roles through assumptions about mothering and fathering roles. In doing so clinicians may not advocate for fathers' presence in treatment and would benefit from being mindful of their assumptions and expectations about the nature of mothering and fathering.

Godart et al. (2022) presented the results of a 54-month post-randomization follow-up of a previously reported randomized controlled trial that compared two post-hospitalization outpatient treatment programs. They reported that adding Systemic Family Therapy (not specifically FBT described above) and focusing on intra-familial dynamics to a multidimensional outpatient treatment program appeared to lead to a better long-term outcome in young women who suffered from severe anorexia nervosa during adolescence.

Van den Berg et al (2019) conducted a meta-analysis on the efficacy of psychological treatments for AN however, the efficacy of psychological treatment over an active control condition could not be established. The researchers state that outcomes are obscured by low quality and heterogeneous studies, however, they found studies including patients over 18 years of age showed more improvements in weight gain than studies including adolescents. They summarised that high quality research and studies that included reporting on clinician training had larger effects on patient weight gain and quality of life compared with low quality research and studies without reporting clinician training. This suggests that the nature of the clinician's training may have a measurable impact on patient recovery and outcome.

Lieberman et al. (2019) examined the medical and psychological characteristics of children under the age of 13 years with ARFID and AN in Canada and found that children diagnosed with ARFID had a longer length of illness, while those with AN had lower heart rates and were more likely to be admitted as inpatients. Children with ARFID had a history of abdominal pain and infections preceding their diagnoses and were more likely to be diagnosed with a comorbid anxiety disorder. Children with AN had a higher drive for thinness, and lower self-esteem, and scored higher on depression. The study concluded that timely and accurate diagnosis of eating disorders in younger children was important to ensure they were allocated to the clinical pathway for them.

Shimshoni, Y., Silverman, W. K., & Lebowitz, E. R (2020) provide preliminary evidence that SPACE ARFID, a parent based treatment that focuses on parental responses to the ARFID symptoms is a feasible, acceptable, satisfactory approach that produces improvement in clinical outcomes. Their entire sample showed a reduction in all ARFID symptoms following treatment, and most no longer met the criteria for a clinically impairing ARFID diagnosis. The study was not powered to examine specific predictors of outcomes, indicating a need for a future RCT, but echoes recent research into the impact of parenting on the recovery of children and young people with eating disorders.

Ornstein et al. (2017) compared the treatment outcomes of patients with ARFID in a family-centred partial hospital program (PHP) to those with other eating disorders (ED). Patients with ARFID spent significantly fewer weeks in the program than those with anorexia nervosa (AN) and experienced a similar increase in BMI as patients with AN and other specified/ unspecified feeding and eating disorders. All patients exhibited significant improvements in psychopathology throughout treatment as measured by scores on the ChEAT and RCMAS. The discussion suggested that patients with ARFID can be successfully treated in the same PHP as patients with other EDs, with comparable improvements in weight and psychopathology over a shorter treatment period. These results were limited to ARFID patients with an acute onset of severe food restriction rather than chronic or longer-term presentations.

Heesacker, R. S., and Neimeyer, G. J. (1991) conducted research into disordered eating behaviour in 183 female undergraduates and concluded that specific disturbances in object relations and cognitive structure were a factor and that women with more severe eating disorders had experienced more insecurity in early parental relationships. This has significance for the transference relationships developed in clinical work. This is an older piece of research that does not appear to have a published follow-up, despite the potential usefulness in understanding the clinician-patient relationship and helping assess the most helpful treatment pathway.

Cook-Darzens and Duclos (2023) researched multi-family therapy (MFT) for adolescent eating disorders and stated that two conceptual and practical paths have emerged from a common framework. The first path called ED-focused MFT, focuses on behavioural change and weight gain in the early stages of treatment, while the second, known as relationship-focused MFT, is less directly focused on symptom improvement and more on family relationship changes. Validation of relationship-focused MFT has lagged behind that of ED-focused MFT, despite being in frequent use in Europe. The relatively long time frame (18–24 sessions) of the relationship-focused approach seems to offer an ideal context for working on several family issues, such as gender roles, the long-term impact of externalization, family burden and grief, as well as broader individual and family life cycle issues. In recent years, there has been growing interest in the unique contributions of fathers and mothers in recovery, and the impact of the recovery process on parental functioning.

There was little research on the impact of the racial background of the patient on the treatment of young people and children who restrict or refuse food, however, Becker et al (2010) found that the majority of respondents from a minority background in the

USA, (78%) endorsed at least one social barrier to care for eating or weight concerns. Perceived stigma (or shame) and social stereotyping were identified both within social networks and among perceptions of clinicians and were seen to adversely impact care for 59% of respondents.

There were few research studies specifically on atypical eating disorders, despite this being the most common diagnosis made. These patients may reach the full diagnostic criteria for AN in time, but there is little to guide how this could be prevented. The available research, some of which have been described already, proposes that the models used for treating any eating issues would likely have a positive impact on atypical patients, but this is currently under researched. Most of the research available for review focuses on the outcomes of single interventions and symptom relief.

Review of relevant psychoanalytic theory

In this section of the literature review, the concepts of transference, countertransference, and projective identification are described. They are mediums of two way unconscious communication that occur in every human interaction and when used appropriately in clinical settings can be utilised to illuminate what is being unconsciously hidden. As these are present and indeed often amplified in institutional settings, social defence systems are also described. Although this study does not specifically focus on psychoanalytic psychotherapists, the researcher, having undergone this training, has been influenced by this viewpoint in conducting the study and analyzing the outcomes.

Transference

Transference occurs when someone projects internal representations from past relationships onto external new or current relationships without realising it and is commonplace in ordinary, everyday human relationships. Sigmund Freud discussed the usefulness of this dynamic early in the development of psychoanalysis and whilst it was temporally seen as a form of resistance, transference has come to be recognised as an essential component of the therapeutic relationship. Freud (1905) believed that the attachment of infantile phantasies to the real therapist was a copy of the original phantasy or experience and a source of vital information about the inner world of the patient. Klein (1952) believed that interpreting transference was crucial and should be done from the start of therapy. She introduced the term "the total situation" to describe how patients express their unconscious experiences, emotions, defences and object relations via transference relationships. Acknowledgement of transference is accepted in many therapeutic modalities and professional trainings without necessarily including techniques of how to interpret it with the patient. This is a limited definition of the mechanism of transference, the content and the quality of the transference vary and are unique to the individual or group situation.

Countertransference

In the early development of psychoanalysis, therapists' feelings about the patient were viewed as something to be avoided, early analysts believed that presenting a blank screen to the patient was the best approach. However, particularly since the 1950s, countertransference has been viewed as an essential therapeutic tool incorporating all of the analyst's perceptions of the patient, both correct and distorted. In her 1950 paper "On Counter-Transference", Paula Heimann defined countertransference as “an instrument of research into the patient's unconscious".

Heimann (1950) describes the analyst's own experience as vital in sensing how the patient is drawing the analyst in:

> How our patients act on us for many varied reasons; how they try to draw us into their defensive systems; how they unconsciously act out with us in the transference, trying to get us to act out with them; how they convey aspects of their inner world built up from infancy ± elaborated in childhood and adulthood, experiences often beyond the use of words, which we can only capture through the feelings aroused in us, through our counter-transference. (Joseph, 1950, p. 82)

In her paper, "Working through the Countertransference," Irma Brenman Pick (1985) described how therapists are inevitably emotionally affected by their patients. Rather than ignore this, therapists should use their emotional responses as potential information about the patient's early life. This requires therapists to work on their unconscious reactions, especially when working with adolescents who experience intense emotions. By using their emotional responses carefully, therapists can avoid losing opportunities for a deeper understanding of the patient. Therefore, therapists should neither express their emotions carelessly nor deny them, but rather learn to work with them authentically and constructively.

> One is confronted with an actual management issue of how to deal with being helpless and at the mercy of the vengeful exploitative part of the patient who indulges in imperviousness, while at the same time remaining in contact with that

> part of the patient that is genuinely defective and needs to be helped and supported (Pick, 1975 pg. 161)

Projective Identification

Rosenfeld (1971), in his work with psychotic patients, distinguished between projective identification used to communicate something unbearable in psychic reality and projective identification used as a form of denial of psychic reality. Projective identification involves unconscious interacting phantasy from the minds of both the patient and the therapist. Despite the multiple personal and environmental variables, there are relatively stable and predictable effects when it comes to everyday human communication.

Bion (1962) emphasised how the therapist's use of primitive experiences can be transformative for the patient, especially if they can be thought about while located within the therapist via projective identification. Meltzer (1982) distinguished between communicative projective identification, which is essential for development, and pathological attempts to control the mother or object. Anne Alvarez (1997) stressed the importance of projective identification as a form of communication and highlighted how sensitive interpretation in a therapeutic setting can lead to growth and change by enabling the patient to develop and experience new introjections.

Social defence systems

In 1953, Elliott Jacques built upon Freud's ideas on group psychology, especially the relationship between the group and its leader, and incorporated Klein's introjection and projective identification theories. Jacques (1971) coined the term "social defence system" to describe how individuals use institutions to reinforce their psychic defences.

Isabel Menzies Lyth (1959) developed this concept by studying nurses in a general training hospital. She observed that the splitting of primary nursing tasks into impersonal elements systematically deprived nurses of job satisfaction. Menzies Lyth attributed this to the unconscious need to keep human suffering at a distance within the institution. The pattern developed during the first experience of the paranoid-schizoid position is repeated throughout the baby's life, from childhood to adulthood. Consequently, when people come together as a group: splitting and projective identification could come to the fore especially when the group is under stress. Wilfred Bion (1961) described how the paranoid-schizoid position appears in adult group members, who, when faced with anxiety, become a "Basic Assumption Group." In this state, the group, on an unconscious level, acts as a closed system, ignoring external realities while collective dynamics rule. The group oscillates between positions of dependency, pairing, and fight or flight. Bion differentiated this type of group from a workgroup, which is focused on the task it was formed for.

Margot Waddell (1989) described the difficulties of keeping young and vulnerable clients in mind in the presence of pressure from organizations and groups. Waddell emphasized the importance of clinicians in public service being supported to think about their clients, as having space in someone's mind can be a unique experience for some deprived children. In 2002, Louise Emmanuel investigated how professionals within organizations are unconsciously influenced by the troubled families they work with. She explored whether the disorganized attachment category for babies could help us understand why professionals may feel paralyzed when faced with contradictory impulses and demands from the families they work with.

Psychoanalytic theory relating to feeding and personality development

There are developmental forces that impact our unconscious relationship with food and eating. Freud (1905) wrote about feeding in infancy and adulthood, and in identifying the psychosexual stages of development, indicated that unresolved issues at the oral stage (in the first 18 months of life) would have an impact that could be revisited in later life. Whilst Freud does not directly link this to eating and feeding disorders, he strongly links the sensory, mental and emotional developmental processes at work in the early feeding relationship at an unconscious level to later personality and psychopathology.

In Freud's dynamic model, how the id, ego, and superego interact can give an insight into an individual's relationship with food. For example, the id might have a desire for food, and the ego might try to satisfy that desire practically by going to the kitchen and selecting something to eat. However, the superego, which contains the moral and prohibitive aspects of a person's personality, may introduce a different viewpoint, leading to inner conflict about eating food. Depending on an individual's experiences, the superego may try to withhold food (or other forms of satiation) as a form of punishment, due to feelings of unworthiness, anxiety about lack of control and other overwhelming emotions. By considering these factors, we can understand that individuals who struggle with "taking in" food often have a highly critical superego. According to Freud, food is a symbol of a mother's love and care. He expressed this idea in his book, The Interpretation of Dreams (1900), by saying, "Love and hunger meet at the woman's breast." (pg. 106). Therefore, in therapy, Freud felt it was crucial to focus on maternal transference to establish a strong therapeutic connection.

Melanie Klein proposed that the act of eating, via breast or bottle, contained the core of the primal human connection (Klein, 1946). Klein believed that being fed as an infant is not only a physical necessity but also a source of emotional satisfaction as feeding helps to build trust, security and a sense of parental accessibility for an infant. However, in not being fed, at the times when the breast (parent) is absent, the infant is forced to experience feelings of discomfort, hunger, anxiety, and pain. To cope the infant resorts to perceiving the absent breast, as a separate entity whilst in a paranoid-schizoid state of mind. The absence of the breast whilst still needing it as a source of comfort, causes the infant to develop a negative perception of it, therefore the absent breast is experienced as a bad, denying and attacking object by the baby.

In 1957 Klein described in the early stages of development, the absence of a breast brings up feelings of aggression in infants. Mis-attunement in understanding the infants' hunger and needs, or deprivation of access to the breast can lead to even higher levels of aggression. This manifests by attacking the feeder when sustenance is eventually offered, despite the sensation of hunger and desire to feed. The external attack is mirrored by an internal attack on the infant's developing maternal object, leaving the infant internally and externally depleted.

Projective identification becomes both a defensive strategy and a form of communication which can vary in intensity. According to Klein (1946), many adult pathologies stem from the infant projecting their self-destructive hatred onto the breast rather than actual neglect or abuse. The survival of this fragmented and turbulent stage, along with the development of the depressive position around 6 months of age, helps create more unified relationships with feeding and a good object. However, the tendency towards paranoid-schizoid states of mind varies depending on the innate characteristics of the infant and their experiences during this stage of development and later life (Klein, 1946).

Like Klein, Esther Bick observed that having the presence of the breast during the primitive stage of development was crucial for creating a good enough internal object in the baby. This, in turn, was necessary to enable a later healthy emotional and psychological life for the infant. Bick (1968) stated that "the optimal object is the nipple in the mouth, together with the mother's touch (holding), speech, and familiar odour". Early feeding experiences set the foundation for building an unconscious blueprint of what to expect from relationships. Bick formulated that deficits in this foundation relationship could prompt the formation of a second skin defence. This is an omnipotent pseudo-independent form of protection using muscular tension to hold the self together and prevent disintegration. When it occurs an observer might see:

> the infant to cling adhesively to the surface of objects, parts of the body, a noise, become rigid, motionless, or get involved in non-stop leg and arm movements to ‘hold the self together’. (Bick, 1968. Pg. 485.)

Ronald Fairbairn (1952) observed that the schizoid aspect of the paranoid-schizoid phase can have a significant impact on the development of eating disorders. Fairbairn suggests that when a child feels emotional frustration and develops a belief that they are not loved as an individual by their mother, nor is their love appreciated, they tend to regress. The child might then believe that outward expressions of love are bad, leading them to retain feelings of love within themselves. With repetitions, this type of experience, the child may also develop negative views of love relationships with external objects. Furthermore, early feeding relationships are developed when the infant is dependent on its caregiver for survival, and any disruptions during this phase can lead to a pathological defence against dependency, associated with feeding, eating, and taking in. Fairburn wrote that parents must manage their unconscious projections, along with the infant's projective identifications, to negotiate this critical time successfully.

Wilfred Bion (1962), wrote that a parent's ability to effectively receive, identify and hold difficult emotional experiences until they can be safely returned to the infant is essential for growth and development. Bion refers to this parental ability as being a "container," which can be a function later revisited by the clinician. In instances where difficulties arise in containment, infants can develop faults in the inner psychic apparatus required to connect with others. Subsequently, they could struggle to internalize the experience of being contained which causes issues when needing the experience at later stages of development. Bion saw it was necessary to put experiences into thoughts, then words in a chain of links to establish a sense of knowledge (usually with another person) about what is real and what is not. The antithesis of this, to which Bion gave the symbol minus K, is a psychic activity that prevents linkages between events and experiences from taking place. Bion was attempting to describe individuals' lifelong struggle to connect with the reality of knowledge, hate and love, with these aspects varying throughout life. These observable aspects of internal life are relevant to the personality development of the individual as well as the act of research. This is because research requires the researcher to link or chain ideas together in an attempt to gain new knowledge.

Whilst observable, minus K can be difficult to detect, however, it is likely to be present when there are difficulties with linkages, with bringing things together and where paranoid-schizoid states of mind are evident. This is relevant to food refusal and restriction as the link between the need to eat to survive becomes distorted or lost. The knowledge that food is desirable, safe and healthy can be lost. For Bion this a paralleled in patient's ability to make links with their clinicians and form new relationships. Bion describes the work psychoanalysts might undertake with such patients, what an analyst might have to hold on behalf of the patient, and the impact is felt whether the clinician is psychoanalytically trained or not. For clinicians in these circumstances, it can be unclear who owns the strong feelings of love and hate, with hate being particularly difficult in professional relationships when not viewed as a symptom of the patient's predicament. Minus K is likely present when a clinician finds it difficult to think about their patients, to remember details of sessions, to keep track of their thoughts about patients and to create new ideas in the sessions.

In 1971, Rosenfeld theorised the deceptive promises made by the narcissistic parts of the self, which he described as resembling an internal mafia. In his paper 'Investigation into the Aggressive Aspects of Narcissism', he stated that these internal promises paint a picture of a life without the risk of loss or anxiety. These are lies that present themselves as a genuine alternative to the harsh realities of the external world. While these ideas may seem appealing, they involve an unconscious deception:

> These ruthless and deadly parts are disguised as helpful and friendly phantasy, like unconscious sirens. In this way, contact with others is equated with anxiety or nameless dread and the ruthless and omnipotent parts of the self-create a delusion of control" (Rosenfeld, 1971. pg. 173)

This description of pathological narcissism discusses how a desire for power and independence can lead to denying one's own needs as it provides an illusion of triumphing over the weaker, dependent and more vulnerable parts of the self. This is relevant in relationships but can be seen in the concrete manifestation of not eating which links directly to this area of study as the need to eat creates dependency.

Within psychoanalytic theory, the connection between narcissism and refusal or restriction of food is well established. Ronald Britton summarises theoretical positions within psychoanalysis particularly well:

> As I see it, the term narcissism is used in the literature in three ways. First, to denote the phenomenon of clinical narcissism, in which there is a turning from interest in external objects to self-preoccupation. Second, the word is used to refer to a specific group of personality dysfunctional cases called narcissistic disorders, third, the word narcissism is used to describe a force within the personality that opposes relationships to any objects other than the self.
> (Britton, 2008)

While not every narcissistic structure involves an eating disorder, every eating disorder involves a narcissistic structure. There are vacillations between the desire for isolation of narcissism and the desire for closeness to others, which is further discussed in the findings.

In her book Internal Landscape and Foreign Objects, Gianna Williams (1997) identifies two types of defence mechanisms commonly observed in patients with eating disorders. Anorexics tend to adopt a "no entry" defence, while bulimics tend to adopt a more "porous" defence. This book synthesises many vital ideas about the treatment of patients who struggle with the impact of overreliance on narcissistic defences and the predicament this creates in later life.

Williams explains how clinicians may experience a particular form of countertransference while working with patients who are anorexic as these patients can project their intense fear of invasion. This experience can be powerful and overwhelming. She writes that she has often noticed that her countertransference with her patients contains powerful projections of a dread of being invaded. Williams's insights for treatment include the idea of very small doses of the therapeutic relationship, as the patient's capacity for taking in is so compromised. If too much is offered, this can lead to the patient feeling fear of invasion and therefore incur more restrictions in a hopeless attempt to protect themselves. Williams does not say to limit the amount of therapeutic time offered to the patient but requires the clinician to be realistic about what the patient can use the time for, particularly in the early stages of work.

Patients who struggle to take in both conscious and unconscious communication from others in turn struggle to form relationships with a healthy amount of mutual dependence. Individuals appear to have developed internal relationship-receiving structures that distort the communication of others to fit with existing poor expectations. The protective element of this defence means the world feels predictable, albeit negative. When this is perpetuated it alleviates the feeling that other people or the whole of the external world is unreliable as it perpetuates a feeling of control and safety. One of the risks for people who become too dependent on their internal narcissistic structure is that this style of being could impact of all aspects of need, including food, and therefore risk the occurrence of food refusal or eating disorders.

Williams uses the term "Omega function" to describe how negative experiences can become internalized and relates this closely to an infant's early experience of containment. The Omega function is a term to describe the introjection of an object that feels both impervious to change and yet overflowing with projections. This convergent and confusing type of object relations can disrupt and fragment personality development. It has the opposite effect of the Alpha function (Bion, 1962), which helps organize structure and establish links. The Omega function disrupts and fragments aspects of the development of personality (Williams, 1997).

Comment on researchers' subjectivity

I will write this section in the first person, not in the third person research convention as I believe it cannot effectively convey my unique and subjective relationship with this research. Before starting child psychotherapy training, I had already spent time working with children and young people who restrict or refuse food and had observed powerful and conflictual emotional reactions to the work in myself and others. A colleague who had been involved with tube feeding a distressed patient had once remarked to me that she would rather have been assaulted by the patient than bear the extremely difficult and painful feelings brought up in the discharge of that particular task. When the COVID restrictions reignited my interest, I approached this project with openness in trying to understand how clinicians without psychoanalytic training experience this work without reacting to acting out the projective identifications

In conducting the review of relevant research literature” I noted the language used when describing the relationship between a clinician and a child or young person. The words "resource" and "delivery" were commonly used. Referring to the clinician as a "resource" suggests a non-human entity, such as a robot, and the term "delivery" evokes for me the image of a package being sent through a post box. These words were observed in the research literature and I thought they may be used to create distance from challenging emotions. This suggests a degree of defensiveness involved as little is researched about the impact of human relationships in clinical work. The treatment of patients who have starved themselves involves focusing on the body in the short term, this focus on the physical has an impact on a patient who is defending against pain by setting external relationships aside in a narcissistic defence. There may be a connection to later clinical relationship work.

The literature review on personality development is at its core, a timeline of the progression of psychoanalytic theory, however, psychoanalytic theory has faced criticism in the past due to the perception of blaming mothers for early feeding relationship difficulties. The question relates to the nature of connections between the establishment of feeding, its impact on relational experiences and therefore personality development and later eating disorder-type problems. I feared that even discussing this topic could lead others to perceive that I was engaged in attacking parents.

It is hard to write about minus K, as it is connected to states of blankness, nameless dread and extreme splitting. States of minus K were evident throughout the project both in myself and the participant's albeit that these incidents were difficult to formulate thoughts about. This sense of incoherent thinking made the subsequent writing complex and I found I needed to come back again and again to build the ideas of the missing links into coherent concepts in the writing of the project.

METHODOLOGY

This section describes process of designing the study, the philosophical considerations underpinning the use of the Interpretative phenomenological analysis, details of methods used to select, collect and analyse the data as well as the major ethical considerations.

Philosophical position

The researcher took a relativist ontological approach to this project, believing this to be the best way to capture the diverse realities of each participant. This approach acknowledges the complexity surrounding different individual experiences of the same external phenomena. The researcher acknowledges her subjectivity in this regard from the outset. In addition, a ‘constructivist’ epistemological stance was adopted, meaning the researcher hoped to uncover meaning inductively rather than using a theory-driven positivism approach. Again the researcher acknowledges the subjectivity of her perspective from the outset and will write about it in more detail at the end of the section.

Literature review

The literature review was initially conducted through the discovery database using the advance search feature to filter for relevance. Further searches were carried out using psychinfo and PEPachive databases. Research that appeared relevant was read and either used or discarded, allowing the researcher to begin to accumulate an overview of extant research in the areas of clinician experience and food restriction or refusal. This began in the early stages of the study and was revisited up until the day before submission to check for recent publications that could be related.

As there were not many studies about clinician’s experiences available to review, the researcher used the aims of the study as a basis for the interview schedule with a hope of understanding the lived experience of clinicians who have therapeutic relationships with patients with food restriction. The questionnaire was drafted at the research proposal stage and an additional sub-question was added after the literature review about supervision. After the pilot a sub question on risk based on feedback”.

The rationale for using Interpretative Phenomenological Analysis (IPA)

Interpretative Phenomenological Analysis (IPA) was selected due to the emphasis on personal meaning-making and individual experiences that are inherent in the approach. The researcher considered these aspects matched the objectives and philosophical standpoint of the project and are amenable for use in a psychoanalytic analysis in the discussion. Deciding to use IPA meant that ensuing decisions about study design were all made with the IPA protocol in mind.

IPA has an inbuilt dual hermeneutic as it requires the researcher to recognise the effect of their own identity on the research process. Furthermore, IPA accommodated the analysis of unconscious interpretations that were expected to be part of the findings and discussion. Other methods were considered but ultimately not pursued. Narrative analysis primarily focuses on how stories are told rather than delving into their underlying significance to the person. In contrast, the use of semi-structured interviews and the overall experience provided by IPA offers more opportunity for the researcher to develop their particular line of inquiry. Discourse Analysis has merits, but did not delve deeply enough into the unconscious processes involved in psychoanalytic research. As Smith et al (2021) state “The difference lies in the fact that while (in IPA) we are indeed conducting a detailed linguistic analysis, it is to inform our understanding of the cognitive and affective state of the person”. Therefore IPA offered further opportunities to explore the idiographic meaning for the participants and the researcher. Thematic Analysis was the third option and was discounted as in common with discourse analysis, it did not allow for the same development of insight into unconscious meaning as IPA.

Historically qualitative research methods were assumed to be more impacted by subjectivity and bias than quantitative research methods. However, the development of qualitative approaches that have mechanisms for acknowledging and managing the impact of subjectivity, such as IPA, is changing this perception. In this study, subjectivity is considered a fundamental aspect of the investigation and is addressed at the end of each section in a first-person style, which is not the usual convention in research writing. The researcher has chosen to do this to better convey the experience of researching this subject and to more fully embrace the dual hermeneutic.

IPA and psychoanalytic theory

In IPA, the double hermeneutic refers to the researcher thoughts and interpretations of the participant's thoughts, that is, the researcher’s attempts at finding the meaning of the participants attempts at finding meaning (Smith et al., 2009, p. 80). This emphasizes that the findings relate to the researcher's understanding of what participants' understanding is. In this study, psychoanalytic techniques like transference and countertransference are essential tools to enable the researcher to understand the meaning made of experiences by the participants. These ideas are described in detail in the literature review, but briefly, Marmarosh (2012) states that transference occurs when internal representations from past relationships are transferred onto new or current relationships without the patient realizing it. Alvarez (2007) states that countertransference pertains to an emotional reaction to a patient's communication. When reading through each interview, the researcher documented ideas related to the impact on the participant and the communication of the participant's feelings about all aspects of their work. This form of countertransference from the text enabled the researcher to develop a more profound comprehension of the participant's emotional communication and facilitated in-depth analysis in the discussion section.

However, Smith et al (2009) have stated that using a psychoanalytic approach in research may not be fully compatible with the parameters of IPA in all research. The authors state that a pre-existing theoretical position may influence data interpretation and selection. Midgley (2006) raised similar concerns and emphasised the need for awareness and caution, stating that a psychoanalytic approach may lead to self-fulfilling results as interpretations can be stated as absolutes rather than perspectives. These are valid critiques and the researcher attempted to be mindful of this throughout.

Ethical considerations

This small-scale qualitative could not be considered central NHS research, therefore it was appropriate that ethical approval was sought through the Tavistock Research

Ethics Committee (TREC). The NHS research tool verified that this is the appropriate way and the TREC approval letter that was obtained as a result is contained in Appendix 2.

Confidentiality

The interviews were recorded and transcribed anonymously with either numeric or alphabetic symbols used to refer to each interview from the time of recording up to the analysis and discussion in the final paper. All data has been and will continue to be stored in a manner that meets GMDR requirements.

Consent

Each participant was provided with an outline of how the data generated from their interviews would be used to enable them to be in a position to give informed consent before proceeding. The researcher also made particpants aware that they had the right to withdraw from the process at any point up until the analysis was undertaken.

Data storage

After the interview recording process was completed, no identifying information was kept with the data regarding the source (although voices may identify the subjects on the recording). The recordings were digitally encoded on a secure server where they remained for the duration of the project and will remain for a short time afterwards in case any significant amendments were required. After this, they will be permanently deleted. The transcripts were created anonymously with a code as an identifier and could be kept for up to 10 years post-completion of the project.

P*sychological safety in the interview process*.

The researcher was aware that engaging in the interview could raise unconscious defences in the participants. They may have become upset to remember some experiences and it was important to be sensitive to signs of this. As such, the researcher addressed this in person before beginning the interview and a debriefing letter was prepared and sent after, reiterating information about follow-up support should this be needed.

Initially, the plan was to conduct the research with the patient population but after beginning the initial literature review, the focus shifted to the clinician population. Whilst this decision was in part to simplify the ethical approval process, most importantly the researcher noted the small number of research projects into clinicians' experiences of working in mental health services in general and with patients who restrict food in particular. As clinicians are an available expert population for investigation in this regard, it was hard to understand the dearth of research in this area. It appeared to be even more relevant when considering the growing emphasis on evidence-based practice. Samonte and Vallente (2023) describe the evidence base to be a combination of research evidence, experience, and expertise, as well as patient preferences in the decision-making process around clinical patient care. Thus the researcher became interested in the experiences of clinicians.

Sample and recruitment

A total of 4 clinicians were recruited through purposive sampling. This means of sampling was used as the pool of suitable subjects was significantly limited by the project criteria. CAMHS clinicians are a small group within the geographical area and not all have experience working with children who exhibit the specific characteristics required. Although a formal diagnosis of an eating disorder was not required for the child or young person being treated, there had to be evidence of disordered eating such as food restriction or refusal for at least 6 months and each clinician had to have worked therapeutically with a child or young person meeting these conditions for at least 6 months.

As such, two clinicians from a specialist eating disorder team and two clinicians from a CAMHS community team were selected. The researcher had preexisting professional relationships with all participants due to working within the same network.

To ensure that the participants did not feel obligated to say yes, contact was made first by email. The email provided a brief description of the study and asked if they were interested in participating. Four subjects responded positively and agreed to take part. Once this was accepted the forward-facing pack was sent for their consideration and the interview was offered either in person or remotely. Full copies of the information sent out are contained in Appendix 5. The researcher was prepared to link in with service managers and team leads to explain the research rationale and procedure if required, but this was unnecessary.

Diversity Awareness

The researcher had hoped to have a more balanced sample in terms of diversity. However, it is a reality that the vast majority of CAMHS practitioners in this area are white and female which greatly limited the opportunities of a more racially and gender diverse sample. In addition, the patients with whom the clinicians work are likely white adolescent females. The researcher did not seek information about the religious, political or sexual orientation of the subjects, though with hindsight, this may have been useful to inform discussion of the findings. This geographical area has a history of sectarian aggression which has made a significant impact. Every family is very likely to have a history of intergenerational violence and trauma, patient and clinician alike.

Given the geopolitical context, there was little that could be done to mitigate the lack of diversity apart from proceeding with an awareness of intersectionality. The Oxford Dictionary (2023) defines intersectionality as “The interconnected nature of social categorizations such as race, class, and gender as they apply to a given individual or group, is regarded as creating overlapping and interdependent systems of discrimination or disadvantage”. Through an awareness of intersectionality, it is possible to acknowledge and understand differences within and between groups and how this impacts on individuals.

All subjects are white European females between the ages of 38 and 50. Their professional backgrounds include a consultant psychiatrist, a principal psychologist, a senior nurse who completed post-graduate training grounded in psychoanalytic theory and a senior social worker who was a CBT therapist. It is possible that professional backgrounds and training may have an impact on the participant’s ideology when it comes to understanding and treating food refusal and restriction. This is referred to in the limitations section as future research may focus more on this aspect.

The interview process including design of questionnaire

The data was collected using semi-structured, one-to-one interviews. This approach facilitated the need to have boundaries around and within the interview, yet allowed the process to flex to pursue any interesting or novel ideas that arose. The interviews took place over three months between December 2022 and March 2023. It turned out to be impossible to find a time that suited one of the original professionals, their reluctance only becoming obvious when it proved impossible to agree on an interview date and time. Therefore, another clinician from the same service was approached and the interview, once the agreement was made, took place within a week. The difficulty with the fourth subject drew attention to potential feelings of rejection and obligation that might be unconsciously held within the sample group.

The semi-structured questionnaire was designed to keep the focus on the clinician's experience of their clinical work while still allowing flexibility and space to think creatively and make links in the process of the interview.

Questions were phrased for them to describe how they felt and what came into their mind about specific aspects of the cases such as the modality of the work, what stayed with them about the case and how they were supported. Follow-up questions that could be used to focus in on these areas were included. It was designed in this way to encourage a form of free association throughout the interview process. The last question was for them to bring anything that hadn't been brought in before. The main stimulus for the questions used was the aims and objectives of the research project, but the literature review also informed its design by raising awareness of some aspects of the work that might be interesting. Space was left for the participants to remember and analyse their own thoughts and feelings as the interviews progressed.

The researcher conducted a pilot of the semi structured questionnaire with a colleague and confirmed that it functioned to generate the kind of free associative thinking that was hoped for although a sub question was added about risk as this had not been included originally. This pilot was also conducted online, confirming that the working through the schedule took around 45 minutes and it would be possible to go ahead using remote methods. Online interviewing was adaptation that would have seemed inconceivable before lockdown but had become standard to remove the necessity to book rooms and travel between different sites. In this circumstance it was the preference of the participants. The full impact of the interviews being online cannot be known, however it being the participant's preference could indicate some reticence about the subject being researched.

The questions below are contained in the interview schedule. The full schedule is available in Appendix 5.

What is their professional experience to date including professional background, previous positions, current position, and relevant cases?

Ask about what cases come to mind when they think about the research topic.

A particular case, if so what is/was it about the case that comes to mind?

How long was the length of treatment, and how frequently were the appointments?

How long ago?

  - What feelings come up about the work?
- What was the treatment modality?
  - Did they work to a model?
  - If so, was there a drift?
  - Was it patient-led?
- What can be remembered about how it felt to work with the patient/patients?
  - Before, during and after appointments?
  - What seemed to go well?
  - What seemed to be difficult?
- What comes to mind about the supervision of these cases/this case?
- What feelings come to mind about the patient/patients?
  - What feelings about the families and networks?
  - What comes to mind about risk?
  - Was medical intervention a factor?
  - Was co-working available?
- How do you feel about continuing to work with these patients?
- Anything not asked but would like to mention?

Each interview lasted between 40 and 60 minutes with an average of 50 minutes duration. There was variation in how long each subject spent answering each part of the semi-structured interview, reflecting their styles and preferences. All the interviews were conducted remotely using either the internet communication apps Zoom or Microsoft Teams (MST) for scheduling reasons. This meant that for two of the interviews, an automatic transcript was generated via MST. The other two interviews were completed on Zoom for which the account did not permit transcription. In addition, an audio recording was made for each interview. The impact of having the interviews online is unknown, however, it links to the themes of the research project in that it restricts some aspects of human communication.

The audio for all the interviews was reviewed several times by the researcher. For the interviews that had computer-generated transcripts, the researcher listened to the audio recording and corrected any faults or mis-recording. The second set of two interviews where transcribed manually: the recordings were played over a few times and a carefully typed document was made. The audio recordings were coded for confidentiality, encrypted, and then stored on a secure device, the transcripts were produced anonymously with only codes for identification. These are also encrypted and stored securely with any paper versions disposed of via the confidential waste procedures.

Data Analysis

The IPA manual (Smith et al, 2021) gives clear descriptions of how the data should be approached and therefore, after transcription, the researcher read and re-read the data whilst making initial exploratory notes. These thoughts reflected what came to the researcher's mind with an attempt to withhold any internal censorship or examination, and were handwritten on the margins of the paper copies of the transcripts. This was an opportunity to identify subjective bias and note strong emotional reactions to the material. When this process was exhausted the researcher began to formulate the experiential statements directly from the material and began to record them onto an electronic spreadsheet. These statements were linked directly to the data in the transcripts and accompanied by direct quotes from the participants. After this, it was possible to begin to link and group the data to identify emerging themes for each participant. As such after this time, the work with the original transcripts stopped and attention moved solely to the grids which had been created.

The grids that had been created contained hundreds of statements that formed the basis of the experiential themes found across the four interviews. The researcher began painstakingly to group these themes via similarities and connections across all four participants to form group experiential themes. Smith et al (2021) describe group experiential themes emerging from rigorous attention to individual tables of personal experiential themes.   It requires the researcher to identify links via intuitive scrutiny of the tables as a whole. The process was not a linear one as the researcher attempted to consider tables of personal experiential themes holistically. Once this was complete the data could be organised and written formally to create the findings section and then analysed later in the discussion section.

Comment on researchers' subjectivity

As in the literature review, I will write the section in the first person: I recognise that I have been, and arguably still am, in the category of clinicians being researched and as such have conscious and unconscious identifications with the participants and their material. It is evident that when I observed the increase in number of young people with food restriction this reminded me of my own endeavors in this area and this research project is also an attempt to make sense of my own past experience.

I understand that in my research subjectivity is influential, particularly in my professional relationships with the participants. Due to the limited number of participants I could sample, it was inevitable that I had preexisting relationships with some of them. Therefore, I chose to use purposive sampling, and I believe that having established relationships allowed for more personal and in-depth discussions to emerge than would have been possible otherwise.

Throughout the process, I was aware that my preexisting relationship with the participants might lead to more positive descriptions of cases and feelings, but this was not reflected in the data. It's possible that the participants felt enough trust to be open about the more painful aspects of their work. However, I have to acknowledge that I may have had an unconscious bias in selecting the participants. Knowing the clinicians I selected to be reflective practitioners, I may have unintentionally avoided skilled clinicians who may not have been as interested in talking reflectively about their work.

I want to make it clear in the context of my research have been regularly and rigorously examining the process with my research supervisor to try and discover and address any biases that may have impacted the study. One of my assumptions was that my own experience would be somewhat similar to the experience of the participants. This was a reason why IPA was helpful, as I found the process of breaking the interviews apart into statements and therefore chunks of meaning allowed me the opportunity to separate better my experiences from theirs. However, this process was still completed by my own individual mind and therefore subjectivity can never be fully removed. In addition I was aware that my unconscious micro responses during the interview process will have had an impact on the participants.

Whilst I attempted to keep a calm and interested demeanor throughout, things like my pace of speech, tone of voice, volume and speed of response will have had an impact.

My experience of data analysis was frustrating but ultimately rewarding. I was able to see that I had underestimated how much the participant's had spoken about the impact of the parents and was able to confront my assumption that more would be about the patient. This method also allowed the themes around the network to emerge fully as they appeared in a fragmented form to me on my first reading and exploratory noting.

In relation the data analysis, as I created the themes, I felt a strong connection with the hundreds of pieces of paper fragments scattered across the floor and table. Each group of papers felt delicate, as if a small gust of wind could scatter them and the forming idea would be lost forever. However, as I continued to work, the groups became more stable. I noticed a point where I became attached to a forming idea and felt reluctant to give it up or reconstruct it as a clearer picture emerged from the totality of data. The fragmented feeling dissipated once the ideas were formed and solidified, and the project could be experienced as a connected whole again.

I wondered about the usefulness of the structure of IPA against an in-depth 'traditional' psychoanalytical analysis of the same material or the use of a case study. At the end of the data analysis process, I returned to my initial comments and found that they largely stood up to scrutiny and held the core of what was to become my findings. I cannot ignore the fact that I had studied psychoanalytical theory related to this area in preparation for writing the literature review and this will have influenced my reactions and my processing via the IPA method. Whilst I had mixed feelings about the use of the IPA methodology, ultimately I appreciated the structure it provided to organise the findings. I learned from separating the interviews into fragments, then reorganising and linking together across all four participants, a new way of making sense of their experience's and ultimately the discovery of the four GET's. I believe this gave me an informed position from which to advocate for better support for clinicians in this area.

FINDINGS

Introduction

In this chapter, the researcher will share findings and use verbatim extracts from the four interviews to illustrate the Group Experiential Themes (GETs). Four GETs were identified from the analysis and are presented below along with a short introduction to each. After this, each separate subtheme is described followed by participants' statements. The interview schedule contained eight areas of investigation with a total of fourteen sub-questions and was designed to obtain an expansive range of responses. The questions were open and in reality, not all the sub-questions were asked if the participant had spoken about the topic spontaneously by following their train of thought from other questions or ideas.

There were multiple ways in which the data could have been organized, so finally deciding on these GETs was a difficult and time-consuming task. The data was complex and fascinating, so it has to be acknowledged that these GETs are rather oversimplified. Nonetheless, they represent a useful way of presenting and later discussing the findings from this small piece of research.

Table 1: Group Experiential themes and subthemes

Group experiential themes	Subthemes
Group Experiential Theme 1: The clinicians' experience of themselves in the work.	Feeling the difficulty Anxiety and doubt How does she know what she knows? The patient inside the clinician The meaning of the clinical role The meaning of time Feelings about continuing to work in this area
Group Experiential Theme 2: Clinician's experience of the patient in the work	Trying to understand the patient's perspective Experience of resistance and avoidance The body as a conduit for expressing emotion and danger.
Group Experiential Theme 3: clinician's experience of the parent in the work.	Managing parental projections Parental pain and avoidance of pain The parent in the clinician
Group Experiential Theme 4: Clinician's experience of team and network	Not being alone with it Where are the resources? The team around the participant

Some statements selected to illustrate a particular subtheme could also have been used to illustrate another subtheme, which created a dilemma. The researcher has dealt with this by selecting statements that fit best overall for each subtheme whilst acknowledging that in the writing of this section, some statements could illustrate other themes from the sample. Subthemes that occurred in only one interview but had relevance were subsumed into other categories whenever possible to include the widest range of experiences. Each participant had a unique experience with a unique group of patients.

Repetitions were incorporated using a best-fit policy with the weaker examples being set aside for the stronger evidence. Some subthemes have more than one quote from each participant. This occurred when something compelling and relevant was said and the inclusion of the quote helped to develop a better understanding overall.

Group Experiential Theme 1: The clinicians' experience of themselves in the work.

This GET contains a cluster of subthemes connected to the participant's experiences of their mind about their clinical work. It is the largest GET with the most experiential statements resulting in the most subthemes. The participants described a range of emotional experiences connected to the work. Among the emotions described, a significant amount is related to anxiety. Therefore anxiety, along with doubt, is described in a separate subtheme due to the frequency with which it arose and the depth of feeling conveyed by the participants. Other emotions such as fear, hopelessness and frustration are gathered into a sub-theme that reflects the difficulty in the clinical work. Other subthemes collated into this GET describe how the clinicians made meaning of their role and how understood their knowledge and experience. Finally, this GET conceptualised the idea of the patient inside the clinician: who the participant felt the patient was and what this meant.

Feeling the difficulty

This subtheme describes participants' experiences of difficult feelings that come up in the work, participants spoke about their feelings of frustration, hopelessness, struggle, pain and tiredness.

P1: Yeah, times were that things were frustrating. I had a lot of frustration

P2: they're really difficult, but they make you feel a lot, and I am, and whether it is the ones that make you feel horrendous because they are doing things in a much more feeling level, and I respond based on a feeling, am I avoiding the fact that there's a lack of thinking there? That this person really struggles to think or to verbalise things in any words and that so much harder kind of path to go down….I probably do avoid talking about those people too much. (2.6.4)

P3: Oh, it always felt like really hard work. It was, you know, it felt tiring (3.17.1)

P4: Then that brings a sense of hopelessness and the sense of holding and waiting, or, you know, as opposed to (trails off).. Another feeling I have is a bit exasperated. (4.28.1)

Anxiety and doubt

Anxiety was spoken about frequently and was often linked to feelings of doubt. Whilst every participant acknowledged feelings of anxiety, some were quicker to place them in the patient, family or network. Participants also referenced feeling deskilled, linked to self-doubt and not knowing what to do.

P1: There is always a bit of anxiety, you know, managing young people with eating difficulties….you ask yourself are your skills still good enough. (1.9.3)

P1:I think we are all anxious (1.1.4)

P2: I have to think oh my God, it could exhaust you, could end up quite drained. It could suck the whole life out of you. (2.7.9)

P3: It feels like now you're almost trapped, you can't change it for fear of the fallout from it, the criticism or whatever. (3.11.2)

P3: I think more when something is not resolved… resolved or understood. I don't like it. (3.17.5)

P4: That part of it is just sitting with people. (Pause)…And not knowing and… um. (4.14.1)

P4:I found it quite frustrating in the beginning. (4.4.5)

P4: You have to be really careful about labelling things, I think. (4.17.5)

P4: I find bits of it really hard to understand (4.6.1)

P4: That usually you know, the issues are anxiety-based issues. It is an anxiety-based issue. (4.5.2)

How does she know what she knows?

Two participants took time to think about how they obtained the information that informed their understanding of the patient during the clinical work. The process ended with the participants reflecting that they did not fully understand their acquisition of information about their case, suggesting this is an unconscious process. The other two participants appeared to move quickly through the question: P1 spoke about how she needed space to think along with the physical monitoring, demonstrating that the physical observations on their own did not give a clear enough picture of the health of the patient. P3 referenced the defensive part of the patient and P4 referenced how their growing experience leads them to see a degree of expertise in themselves.

P1: You really need to have a thinking space about the whole case along with the physical monitoring, you end up feeling left with that bit of it. (1.8.3)

P2:I am, for the …emm, I know I'm waffling now…trailed off. (Pause) I'm not sure that I really took time to think about how I made a decision. (2.4.7)

P3: I really have an interest in young people and that you know, that whole real defence. You know…that I don't need anybody kind of armour that a lot of them have, or I don't care about anybody. I got to really work with something that really drew me in, I'm not sure why. (3.2.2)

P4: I like the idea of like, you know, getting really knowledgeable and really experienced and a small area and kind of, you know, having a lot of you know confidence and and your ability to kind of help people (4.27.2)

P4: When things have shifted with somebody that they come into the session that they, they contribute more…It seems less of me trying to drag information out…. more than bringing stuff and us making sense of it. They're coming with their stuff and they're trying to make sense of it. And the structure of what we are doing together rather than, you know it being me against them. (4.20.1)

The patient inside the clinician

This sub-theme relates to the participant's identification with the patient. It addresses how the patient 'shows up' in the participant's mind and body and how they make sense of it. P1 struggled to remember the patient she had selected for discussion at the times she described him as lost, tormented and distressed. P3 experienced feelings of hunger in connection with a patient who was denying the existence of hunger. In this instance, the clinician becomes the hungry one, not the starving patient.   P4 also felt an empathetic connection to food with a patient who was self-punishing. P2 spoke about telling the patient about what she understands about them and her understanding of the patient's state of mind.

P1: That's funny I really can't remember him that clearly during that time, he was really being tormented, actually. (1.6.4)

P2: So, until I became a bit braver, in myself, kind of verbalised, with a young person, of what I thought, my experience of them was that I thought their experience of therapeutic time was, and I'm actually put a bit more credence on there onto the therapeutic relationship. (2.4.6)

P3: I, well, we used to sort of laugh about it in a way because it was like this family make me so hungry…it was just anytime I thought about them I was just my stomach would rumble and I would just really think I need to feed my body. I need sustenance. (3.7.4)

P4:I would find it hard to deny myself food that I want….I make sense of it in that way that it's self-punishment, that it's punitive, that it's a form of self-harm. (4.6.3)

The meaning of time

Time was raised in three interviews but there was variation in how it was represented: P1: spoke about the frequency she might see a patient and the intensity of this appointment, saying that a lot had to be managed in a short time. P1 also spoke about the acceptance of working with the patient's idea of time, which to her felt like working with a part of the patient that was stuck in the past. P2 spoke about the overall length of the clinical treatment period, noting the fastest recovery that she had facilitated. P4 spoke about the importance of time offered to the patient, that she believed the clinical work could last as long as it needed to last, but this felt like a luxury.

P1: Yeah, well, you’re only really able to see somebody once a week. It’s a lot to manage in one appointment a week (1.1.7)

P1: Something with that first child with his attachment to his mum, he just said couldn't seem to go through those normal stages, he couldn't get that separation, as he kind of reverted back to being, that baby that wouldn't move forward (1.5.2)

P2: so there isn't a set an exact set period of time, I know that for some services you get like six sessions or 12 sessions a year, but for me, I think the quickest I've seen someone go from a very anorexic state to discharge is nine months. (2.3.4)

P4: And sitting in silence. I think part of there's a luxury in that in the sense that there's an acceptance that it's going to take time for people to recover. (4.13.3)

P4: What I like about working in this sort of team is that there's an acceptance from the outset that this work going to take a long time. (4.12.7)

The meaning of the clinical role

This subtheme describes the participant's understanding of their role and the boundaries and meaning of the role not being neatly restricted by time and place. There was a reflective element that came through when the participants reviewed some personal strengths and weaknesses and how they perceived these to have changed over time. P1 spoke about the boundary between her professional and personal life, referencing how she continued to have thoughts about her patients when she was at home. P3 also referenced this, speaking about a case that stayed in her mind despite feeling the patient was not engaged. P2 spoke about how she perceived her understanding of her role to have changed as she became more experienced. P4 spoke about how she found it difficult to think about herself in her professional role.

P1: Young people in particular do get into your mind and I don't know if that's something, that is something more that you will take the work home…with you (1.4.3)

P2: As I get more experienced, I'm more sure about the job I'm less sure about giving a clear diagnosis. Pause. (2.2.3)

P2: I can feel at times like a real maternal role (2.5.7)

P2: Historically, at the start, I would've had real issues letting go. I thought if I was moving away then I was starving the child of something. I think the cure is their relationship, well, not the cure but the shift is the relationship, having a different sort of relationship. (2.5.4)

P3: but there was this really challenging case and it's one that actually, unfortunately, they disengaged and it was like I often wonder how she is. (3.5.2)

P4: It is a complex area and I think, I feel like when I am talking about it, my head's been all over the place and I don't know, maybe what that says a lot about how it feels.

Feelings about continuing to work in this area

Three participants spoke about continuing with this kind of clinical work. P2 was sure she wanted to keep working and had a new idea about where she wanted to focus. P3 was optimistic about the impact that she could have on the entirety of the patient's life. P1 said it was hard to think about and instead spoke about the uncertainty in the system, perhaps suggesting underlying concerns that she was not supported in the way she needed to be to continue.

P1: The young people lack a lot of support just in general, there's just a huge amount of complexity. (1.8.2)

P2: I do want to keep working in the area, even though I kind of expect to be hated for a while, I guess that I'm kind of used to that. But I would like to have the scope to do a lot more parent work, which is interesting because this is the thing that I probably would have avoided at the start. (2.11.2)

P3: If I can help, make a difference here. This is going to make a difference for you until you die kind of thing. It's not just to get you through this small portion of your life or whatever. It can have a lasting impact. (3.19.3)

Group Experiential Theme 2: Clinician's experience of the patient in the work

The participants described conflicted feelings about the children and young people they work with and the data is presented via 3 subthemes. The first reflects the complexity of seeing things from the patient's perspective, the second relates to the difficulties around resistance and avoidance and the third subtheme focuses on the bodies of the patients as a conduit for communication.

Trying to understand the patient's perspective

All the participants described eagerness to make a good relationship with their patients and to help them. In the process of this, they made contact with each patient's relational history and beliefs about help, which were filled with complexity and difficulty. P1 speaks about her patient's confusion, and P2 reflects on how the patient has an inner world made up of different parts and the work depends on which part she is in contact with at that time. P3 speaks about contact with her patient's anger and hostility. P4 spoke about how eating was not what she most talked about with patients, as she found that patients were struggling with a range of serious emotional difficulties.

P1: Sometimes I had to really work doing the understanding…He wasn't pushing it away with the same anger, he just couldn’t, he just didn't know what to do with it. He really just didn't know what to do. (1.4.6)

P2: But it feels like I'm not really talking to them. It's like I am talking to a split-off part of them…it feels the more that you talk to that part of them about food, the more I am missing the fragile, vulnerable child part of them, what's underneath that, and that part does have a lot to say, but has sort of lost its voice. (2.1.7)

P3: She was so hostile, but I never really saw it as like well to begin with. Well, I used to dread the sessions and think ohh she's so angry… she's just going to start shouting. I think she was looking for someone to take control and stop it and it was really hard (3.13.4)

P3. I think there was a part of her that was just desperate for connection, but also some part of her just didn't know how to do that…I think I think there was a part of her that knew that this is not healthy (3.11.7)

P4: I tend to talk more about the ones that aren't going well, we're stuck or there's, you know, here is complexity. So, you know, I think there's a sense of trying to understand and figure out, you know like we've got. (Pause) I think for me it's just like the sense of how hard I feel that I have to work in the session. (4.19.1)

P4: But really, it's not about eating, you know. The things that I usually spend time talking about are, you know, self-esteem, perfectionism, emotional regulation, relationships with other people and usually making sense of that. (4.29.4)

Experience of resistance and avoidance

Each participant spoke about experiencing resistance and avoidance from the patient. P1 spoke about how hard it was to hold on to memories of the child when he was in his most starved and distressed state, P3 spoke about a type of disguised compliance, where the patient appeared to work, but actually, this was a guise to keep people away from her. P4 also spoke about this type of resistance, describing the patient as paying"'lip service" which is an interesting image considering the subject matter.

P2 described how she understood she was holding something for the patient that was not a part of her, but the patient could not know this about themselves at the time. This statement links to the understanding of the patient subtheme but it is ultimately included in this subtheme to show the complexity of resistance.

P1: he was crying and wailing. But I think because I still see him now, and he's changed so much and actually is hard to remember, and actually seems like such a different child. (1.6.3)

P2: It's part of their illness, this is the pathology, and it's not mine. I know I'm holding it for now, and I know how shit the young person must be feeling, and they must feel that a lot of the time, considering I think for half an hour, and it feels awful but, it's not mine to hold forever… (2.8.2)

P3: But now and again, you know she, you'd sort of felt like maybe it made a bit of connection and she did agree to increase it to her eating so that her weight went up a little bit, but I think that was mainly, it wasn't really to nourish her, it was more to get people off her back. (3.10.3)

P3: As soon as they leave they do not think about it until they come in the door next week. There's nothing kept in mind. (3.20.2)

P4: I didn't really understand it because I didn't think the girl and I had a particularly good alliance. She definitely came in paid lip service…didn't want to recover (4.16.2)

The body as a conduit for expressing emotions and danger.

This subtheme describes the participant's thoughts about the risk to the patient's body as well as mind. It is based on the recognition that the body is a vehicle for expression of unspoken communication. All participants had worries about their patients' short and long-term physical health due to starvation in adolescence and childhood, and this was well expressed by P1. P4 referred to suicide, stating one of the outcomes of untreated food refusal is death. P4 also spoke about the differences in services when she felt relief when a patient could be sent to the hospital and have a treatment that would, at least temporarily, reduce the risk. However, it was difficult to then link and think about the patient with the hospital staff. P2 describes starvation as a disguise, and whilst part of the clinical work is to stop the starvation, it is also to look at the whole of the person and their struggles.

P1: The physical of managing things in that way, the trickiest thing for those young people who are coming close to 18, he probably had a long history, very poor eating, working out where the risk is actually, how much of that is actually, going to be their way of going on, just how they are. And how much is actually changeable?: From a physical point of view you can't really get to the starved emotional state until you feed the body….Yeah, it is kind of sometimes like being asked to watch someone sort of self-destruct in some way. And it's really hard to hold, isn't it? (1.2.4)

P2: But I find that bad the type of madness that's pure anorexia is very short-lived. If you can get food into them and get their weight up then that really mad part of anorexia goes, and it is always something else. I don't know if that makes any sense. (2.2.5)

P2: It’s that starved, physical state that really does impact on the emotional state, that I think of is the really anorexic bit, but whenever the body is not starved, there is still a starved emotional state, you could call the anorexia, but really you could call that anything really (2.3.1)

P4: In some cases, it is like a slow suicide. (Pause) (3.6.5)

P4: You send them to the hospital and there will be a medical intervention. So I think in that way, the risks are much easier….but we don't have cohesion between physical and mental health (4.7.2)

Group Experiential Theme 3: clinician's experience of the parent in the work.

Clinical work with children and young people who refuse food nearly always requires parental work and every participant spoke at length about this aspect. There was a large amount of data generated within this GET and arranging the subthemes with appropriate supporting statements was a complex part of the project. The participants referenced that parents are not always involved in treatment for other mental health issues, so this could be different from other aspects of CAMHS work.

Managing parental projections

All participants worked with children, young people and parents: sometimes with the family as a whole group and at other times with the parents and child separately. P2 spoke about the maternal defences and P1 spoke about being the outsider to the parent/child relationship, someone who had unwelcome perspectives. P3 spoke about unbearable feelings when a parent could not feed their child and P4 spoke about the high expectations expressed by some parents regarding their children, the clinicians and the service.

P1: I could see it in the child's face. This real anger, you know, and then from the Mum this real frustration. All directed at me….actually, it felt quite hard because, it feels to them so punitive, and I think that that's the impression that I got back from them. But I think that that moment actually changed things, because things started to shift. (1.7.2)

P2: It’s the mothers who haven't been able to mother in the way that they wanted to. Whether it's due to postnatal depression, an illness or trauma. Ghosts from their own Nursery (coughing). The mums get to such a place where they're so defended. Well, those that are so defended, are the really critical ones. I have had so many different mums coming to shout at me that I am breaking their child. (2.8.9)

P3: It feels like it's so central to, you know, for some parents, so central to their success. If my child doesn't feed, then I have, you know….I have a feeling as a parent that is unbearable. You know to try and even deal with that..it is very difficult. (3.3.7)

P4: The families with big expectations, big expectations of their kids, big expectations of services and lots of complaining about services not being enough (4.2.4)

Parental pain and avoidance of pain.

Some participants observed that some parents struggled with their role in the process and did not appear to fully comprehend the danger to their children. Other participants expressed surprise by the extent of the parents' difficulties. P1 described holding the anxiety about the patient on the parent's behalf. P1 also noticed the parent's avoidance of feeding their child. P3 discussed parents who deny their role in the child's difficulty as this can cause unbearable feelings for them. P4 noticed that some parents seem to be stuck, and this highlights the participants’ attempts to understand the parents' perceptions of their role in their child's recovery. Overall, the participants described their work as containing a high level of parental suffering, accompanied by parent’s attempts to avoid these feelings.

P1: I was really concerned for the child, but the family really didn't seem to, get it, it was hard to push that idea, how important it was to get the nutrition into him. (1.6.4)

P2: Or that I haven't fixed their child quickly enough, really mad and ludicrous statements, but I never really feel angry with them, I don't really know why. I don't feel angry at the mother. I feel angry for them. I don't feel angry at the father either, but I just they are a bit more irritating. Because usually they're absent and then they turn up and give off. (2.8.9)

P3: I think that there's something about food that is so central, you know like it's so central to family life, but there's no getting away from it….it's much harder for parents to say that it's nothing to do with me…Whereas whenever it's food and you know you can't, parents can't really say ohh it's not my job to feed them. They are part of it. (3.3.2)

P3: We really needed to activate the parents and their parenting role and it just, that just where it all sort of got stuck. Mum was like she was, you know, she wasn't particularly affectionate parent either. (3.15.2)

P4: But I suppose they've never prioritised this child and her recovery, you know, and they've never prioritised tackling the eating disorder, there was always an excuse as to why they couldn't do those things. (4.15.5)

P4: You know the impact of the family and parenting is they (parents) can still be absent for the child. That's actually quite common with eating disorders and it makes it quite difficult to talk about. It has a big impact. (4.11.3)

Clinician's identification with the parents.

All the participants had identifications with the parents of their patients. This sub-theme is linked to the previous one, but the difference highlights how participants provided care to the parents, which was well-received, unlike the previous theme of avoidance. The participants aimed to comprehend the parents but found it challenging as they found that parental function was not always consistent.

P1 acknowledges the contrasting viewpoints between herself and the parent, specifically how the mother struggled to recognize what was important at a crucial moment. P2 relates to the sadness and loss experienced by a mother. P3 expresses support for a parent, wishing they could provide proper care for their child. P4 recounts meeting parents who appear to be oblivious to their own psychological and emotional needs, despite their children noticing and expressing concern.

P1: My worry seems so different from the worry that the family seem to have, I couldn’t get them to see the wood through the trees sometimes, (emm, trails off) (1.6.4)

P2: But there is a lot of maternal sorrow that has been masked in different ways or where it comes up in different ways, but it comes up really through their child so, so I feel desperate like I want to parent the mother as well. (2.9.1)

P3: I really want a mum to give her, you know, that nourishment, what she needed. (3.15.1)

P4: I would experience mothers with high levels of anxiety who have no idea that they're anxious. If you asked them would you ever be anxious? They say No, no, no.

And you can kind of see from their behaviour from their demeanor, from what their child describes that they're highly anxious. (4.26.1)

Group Experiential Theme 4: Clinician’s experience of team and network

During the discussion, all participants emphasized the significance of having a supportive and empathetic work environment due to the challenging and risky nature of this kind of clinical work. As clinicians, they had to present external reality, such as the importance of food and development, which was often rejected by patients and sometimes supported by parents. Therefore, having a safe space to share and feel acknowledged is essential.

About not being alone with it

This subtheme highlights the importance of ensuring clinicians feel supported and not isolated while working. The participants kept their colleagues in mind and made references to them during the interview process. P1 expressed anxiety about getting other professionals to work alongside her, P4 emphasized the importance of having a manager who was brave and supportive and described the support she perceived from her team. P3 reflects on how supervision helped her think about her feelings towards a parent and P2 describes how family relationships could be replicated in a team.

P1: So really the only experiences in the inpatient service. And that's quite a different experience from when you're at the outpatient service. (1.1.4)

P1: I don't think the issues are so much about working with children who don't eat or working with young people and their families. For me it's the feeling that you have the support around that's the most important. (1.7.6)

P2 When I started the team lead said she was the mummy and the other person was the daddy and I was the baby. And we will look after you, and I remember thinking that this was so lovely and I understood that I had a place and I knew where I was. I had a role and my role was valued. (2.10.5)

P3: We're also thinking a lot about the whole of it, you know what we were left with sitting with. What kind of feelings were evoked within the team? It wasn't always clear. (3.13.2)

P3: I would be talking about that in supervision because it was like ohh, I like these are very scathing words and thoughts I'm having about somebody (mum) (3.13.7)

P4:in the team we are probably more cohesive and our manager, you know our senior manager is not afraid of complaints. She's not afraid of and um, you know, there is a sense that you are backed up. (4.17.7)

P4: As a team, most of us have only been there for the last few years. And you know, two to three years. We're all women will know. I think that we as a team support each other quite well with what we're dealing with. (4.2.6)

Where are the resources?

The participants described awareness of resources or lack of resources in their respective systems. In this instance, resources could mean access to thinking with others, time and space to work. This may link with the idea of restrictions as the participants all work in the resource-pressed NHS. The participants in the generic CAMHS services thought that the specialist team might have more resources. However, participants in the specialist service described having a hard time working together due to pressure from the patients and differing experiences and perceptions among the clinicians. P2 describes how professionals from other teams come to her team's office to eat food. P3 says that part of her choice to work with children who refuse food was that it provided an opportunity for co-work. P1 and P2 describe competition within the networks for resources.

P1: It’s particularly pressing now because it is so challenging to get other staff on board (1.3.1)

P1: it feels like you get into a fight with the system to try and get all the stuff lined up around the child, there's a bit of uncertainty about whether or not you can get it. (1.7.6)

P2: People come from other teams to eat in our office whenever they need a bit of something. (2.8.5)

P3: Our co-working was sort of curtailed unless you were working in eating disorders. So in that way, we could see a lot of families and do a lot of co-work. (3.2.3)

P4: So it becomes this bun fight between services…is it a mental health crisis or is it a physical crisis? And then once the physical crisis is over, there is no mental health crisis. (4.7.3)

DISCUSSION

Introduction

This discussion of the findings uses each GET with subsequent subthemes as headings with statements for illustration as required. The GET titles were intentionally simplistic to demonstrate the connections between the experiences of the individual participants and provide a framework for this discussion. Yet the contents of each GET are not simplistic, and what follows is an attempt to understand some of the complexities of experiences that the participants described.

Since clinical work of this nature typically lasts from nine months to two years, participant comments and recollections relate to different time points throughout the treatment. Participants were not required to give chronological accounts and therefore this research acknowledges the impact of memory and recall as dimensions of experience. Different aspects of work were emphasised at different times, and the data indicates that participants have experienced periods of resistance, avoidance, and non-cooperation along with periods of cooperation, progression and recovery with their patients. Although resistance and avoidance might be temporary, there was no attempt to measure the duration or indeed assume they are stages, as they could have been more permanent aspects of a particular family pattern.

For this discussion, the researcher assumes that non-spoken communication in the forms of transference, countertransference and projective identification are present throughout and do not need further definition other than what is contained in the literature review and methodology.

The clinician's experience of themselves in the work

This section considers the findings that reflect the participant's understanding of themselves during their work with children and young people who do not feed. It is an attempt by the researcher to understand the participant's subjective experience of their minds in the context of their jobs.

Feeling the difficulty

Participants spoke about the emotional difficulty of the work as it put them in contact with conscious and unconscious communications of distress and pain. P1 and P4 named feelings of frustration, hopelessness and exasperation. P4 spoke about the difficulty of containing the more difficult feelings that arose out of the work. P3 spoke about how tired she felt about appointments with a patient as if the unspoken emotional experience was draining, requiring her to dig deep into inner resources to stay with the patient and keep thinking.

P2 reflected on the difficulties involved in meeting and understanding a patient in what she described as a “feeling place”. She subsequently came into contact with the “horrendous” feelings experienced by the patient. P2 statement:

> P2: they're really difficult, but they make you feel a lot, and I am, and whether it is the ones that make you feel horrendous because they are doing things in a much more feeling level, and I respond based on a feeling, am I avoiding the fact that there's a lack of thinking there? This person struggles to think or to verbalise things

> in any words and that is so much a harder kind of path to go down….I probably avoid talking about those people too much. (2.6.4)

This appears to describe a defence against the difficulty experienced and P2's way of avoiding talking about these moments with colleagues or in supervision, suggests that she has been affected at a profound level by this nonverbal communication from the patient. Through the impact of this powerful projective identification, P2 worries about colluding with the patient's avoidance whilst joining in the feeling states with the patient, which again may reflect the patient's unconscious defence mechanism via the participant's counter transference. P2's thoughts suggest that she perceives her role as helping the patient move from a feelings state to a thinking state where the feelings might be spoken about and understood. It is evident that she finds this a difficult path, and indeed finds it hard to articulate her experiences to colleagues or in supervision in the first instance. This suggests that the participant feels a barrier to putting emotional states into words and that she does not anticipate being properly understood. She may also feel a sense of shame or responsibility for the anticipated failure of communication and it seems very probable that these experiences may be a mirror, albeit a distorted one, of what happens in the patient's mind. Hayes et al (2018) conducted 3 meta-analyses of 13, 14 and 9 studies respectively, into the impact of countertransference management on effective psychotherapy and write about how better management of counter-transference leads to better outcomes in clinical work.

Patients use nonverbal communication when verbal expression is not available to them for any number of reasons. This links to Bion's (1962) description of containment. For containment to occur, the carer (parent/mother) must receive the primitive non-verbal, projections from the baby and find a way to take in, understand and make sense of them.

Once this has been done, the carer must find a way to give the baby an experience that the communication was understood and is manageable. P2 describes receiving this type of communication in her work but her experience highlights how problematic it can be to make a connection with her patients to communicate back that there has been understanding. Particularly if the patient is filled with anxiety about what they have projected out, as they may attempt to defend themselves against having to receive the same undigested anxiety back. This demonstrates how difficult it is for participants to form thoughts from their unspoken subjective experiences of patients, which they can share with the patient to show that they are understood. This also illustrates the dangers to the participants of being left alone with these experiences if they cannot be shared with colleagues, an important issue which will be revisited.

Anxiety and doubt

Anxiety and doubt are discussed in this separate subtheme due to the frequency with which they were referred to and the intensity of the supporting statements

> P1: I think we are all anxious (1.1.4)

In the statement above P1 locates the anxiety in herself and everyone else. This could be due to the level of denial described: that food is necessary for survival. Anxiety about this and fear that the patient might not recover could lead to difficulties in establishing a shared understanding of what is required for healthy human development with the patient. P1 appears to be in the predicament of experiencing her own anxieties about the treatment as well as the patient’s anxieties. It is possible she is also referring to anxieties from the parents and the network. The statements to support the presence of anxiety tended to be short and unelaborate suggesting that the participants may have felt uncomfortable revealing these things, or that the experiences were difficult to find words for. This reflects the difficulty of understanding experience: anxiety likely exists in everyone involved, and the task is to work out who feels it in each moment.

Participants described experiences when, despite their knowledge and expertise they felt uncertain about what was happening to them. They described the impact of the patient's mind on their minds. This links to Bion's (1962) description of minus K when the experience of linking things together to make a chain of meaning is attacked and understanding becomes lost. The participants describe having knowledge of what treatment should be like and this becoming lost in the interactions with the patients. P1 also spoke about feeling fear and doubt about how to proceed. P1 is an experienced clinician who was practiced at working with a high level of risk with her patients, therefore this comment seems significant.

> P1: There is always a bit of anxiety, you know, managing young people with eating difficulties….you ask yourself are your skills still good enough.

Her worry about her “skill’ could be a way of creating distance. In this instance, P1 prefers speaking about anxiety in the third person, perhaps due to an unconscious fear of being overwhelmed. This is likely linked to the projective quality of the communication of anxiety states, along with pragmatic fears that something might go wrong and worries about who would be held responsible. This is also evidenced in the statement made by P4 about being careful. Overall, in all the interviews there were many references to anxiety, guilt, fault and blame.

> P3: I think more when something is not resolved or understood. I don’t like it. That part of it is just sitting with people. (Pause). And not knowing and… um
> (trails off)

Throughout the interviews, there are also instances where the clinicians express doubts and fears about their competency. Although these statements were relatively short, they were quite powerful, indicating that this was meaningful for the participants. Some statements were accompanied by sighs or pauses, suggesting that the participants may have found it challenging to express themselves. It is possible that P3 expressed her frustration and not knowing in the past tense to make it easier to bear. P3 words trailed off suggesting difficulty in maintaining a link with painful experiences which could link with the idea of minus K (Bion, 1962). It is possible that it is overwhelming to be in contact with these feelings, and the experience of the participant is that the thoughts become unspeakable.

P3 describes the feeling of being trapped within herself, but could also reflect her experience of the inner world of the patient.

> P3: It feels like now you're almost trapped, you can't change it for fear of the fallout from it, the criticism or whatever.

In this instance P3 links fear of change to fear of being criticed. Given the participants are in contact with adolescents who must change in order to grow up and become adults, P3 seems to be in contact with a particular anxiety about change. This is likely to place the participant's desire to help the patient via changes in conflict with internal parts of the patient and relates to Rosenfeld's (1971) description of an inner gang dynamic.

How does she know what she knows?

Participants were asked about what came to mind about how they acquired a sense of knowledge about or understanding of a case, and a follow-up question was asked about how they used this to make treatment decisions. Two participants appeared to consider it carefully, to think about how they obtained this information and eventually replied that they did not fully understand how they came to know what they knew.

> P2: I am, for the emm, I know I'm waffling now…trailed off. (Pause) I'm not sure that I really took time to think about how I made a decision. (2.4.7)

A follow-up question was asked about how they make treatment decisions. Two participants appeared to consider it carefully, to think about how they obtained information and eventually replied that they did not fully understand how they came to know what they knew. This suggests that at least part of the process of acquiring this information is unconscious. However, participants were able to communicate an understanding of their perception of the patient, even if they were not able to explain the exact technique they had of acquiring it.   Paula Heimann (1950) emphasised the importance of therapists using their emotional responses to gain reliable information about their patient's unconscious. She suggested viewing emotional responses as correct interpretations of the situation, especially in the total transference situation. These extracts are evidence of countertransference, even though the participants were not specifically trained to use it and may have not felt confident in using their own emotions to understand a patient. Heimann's view is in juxtaposition with Midgley’s (2006) warning about using psychoanalytic theory to arrive at absolutes rather than perspectives. But perhaps it is best to use the experience of the self to understand the experience of another without assuming that there is an absolute truth. It takes a particular type of confidence in oneself to be comfortable with knowing that you don't know, but can still be a helpful person.

> P4: When things have shifted with somebody, that they come into the session that they, they contribute more…It seems less of me trying to drag information out…. more than bringing stuff and us making sense of it. They're coming with their stuff and they're trying to make sense of it. And the structure of what we are doing together rather than, you know it being me against them.

The awareness of conflict can also be influential as P4 described the quality of the work changing over time and she knows that she knows something new about her patient when she perceives their work together to be more of a collaboration instead of a battle. The emergence of something that feels new suggested that some form of minus K (Bion, 1962) has been worked through, a new link has been made that allows for a more realistic conversation. P4 recognises a difference in the experience where the patient is taking ownership of a part of themselves and bringing it to the clinical work with the intention of it being thought about.

The patient inside the clinician.

This subtheme relates to how the patient lives in the participant's mind, both during and outside of appointment times.

> P1: That's funny I really can't remember him that clearly during that time, he was really being tormented, actually. (1.6.4)

P1 had difficulty recalling the patient she had chosen for discussion at the time he was at his most distressed, it seemed his communication of distress was unbearable. This links again with containment as Bion (1962) describes situations where a child's non-verbal communication of fear and anxiety is not recognised by their carer. This means the child is left without help with their terrible feelings, leading to a sense of nameless dread in the child. If this occurs too frequently or at critical stages of development the child loses, or partially loses, the expectation of being understood. This can result in experiences of blankness and nameless dread, which appear to also impact P1's ability to think about the child after the moment has passed.

P1 felt that once the patient was in her head, they could stay there long after the hours of employment in her job were over. This connects with the unconscious aspects of the work and how little control we have over the mind, particularly if something has not been fully psychically understood and digested. P3 references digestion, albeit through the body when speaking about a case that was still on her mind years after the family had stopped coming to treatment.

> P3: I, well, we used to sort of laugh about it in a way because it was like this family make me so hungry…it was just anytime I thought about them I was just my stomach would rumble and I would just really think I need to feed my body. I need sustenance.

This aspect of the participant's experience with their patients links to the idea of body countertransference. Susie Orbach (2009) explanation of how environmental failure can result in a division between the mind and body, to include the idea of a False Body - a distorted perception of one's own body. Orbach intuited the false body is constructed through identifying with others, at the expense of genuine inner authenticity and dependability. Deconstructing this false body sense in therapy could permit genuine, albeit sometimes distressing, body sensations to emerge in the patient. This can be transferred to the clinician, P3 experience could be understood as bodily countertransference. Egan and Carr presented their findings about body-centred countertransference in Irish female trauma therapists and clinical psychologists in their 2008 study. Their findings support the statements of these participants and suggest that somatic or embodied countertransference relates to the potential impact of mirror neurons. They suggested that this could be conceived of as unconscious automatic somatic countertransference which links with what P3 describes.

The meaning of time

Participants mentioned the importance of time, albeit that time was significant to each participant in a different way. Participants spoke about the duration of clinical treatment and the timing of intervention stages.

> P1:something with that first child with his attachment to his mum, he just couldn't seem to go through those normal stages, he couldn't get that separation, as he kind of reverted back to being, that baby that wouldn't move forward (1.5.2)

The emotional developmental stage of their patient was a significant area of consideration, with participants believing that there had been disruption to ordinary emotional development in their patient's lives. All participants in some way questioned the emotional developmental ages of their patients which impacted on how they experienced their patients in the work. Whilst clinical work provided an opportunity to address gaps and help patients move on with emotional development, the experience of the deficits appeared to have a powerful impact on the participants.

Close to the above statement, P1 advised that she works part-time, which means that she can see patients once a week at most. She expressed the pressure she feels to provide the right quality of care in that single appointment. P1 seems to suggest that it is challenging for her to provide a "therapeutic feed” within the limited time available and that it is equally challenging for the patient to take in what is being provided. P1’s awareness of her restrictions raises concern about what was communicated by her perceived lack of availability.

P4, from a different team than P1, spoke about how it was luxurious that she could offer a patient time. For P4, this might involve sitting in silence, allowing space for discovery with the patient. This contrasts with P1 who felt as if she might be forcing too much into the limited time of the appointment. This subtheme links to a later one about resources.

P2 spoke about how the quickest recovery by a patient was 9 months, linking Covid 19 to the onset of this patient's eating difficulty. P2 observed this patient resume a more ordinary developmental trajectory as lockdown restrictions eased. P4 links restriction or refusal of food to the freezing of adolescent development both physically and emotionally. Her patient's obsessions and subsequent restriction or refusal of food stopped her from growing. The growth that stopped was both emotional and physical. P4 stated that she thought it was a sign that the clinical work was effective when ordinary development appeared to resume.

The meaning of the clinical role

This subtheme describes how the clinicians' perception of their role is complex and constantly evolving. Initially, P4 expressed difficulty contemplating this topic and then felt overwhelmed with thoughts.

> P4: It is a complex area and I think, I feel like talking about it, and my head's been all that over the place and I don't know, maybe what that says a lot about how it feels

It is important to consider that this work is not limited to time spent with the patient, on the phone, or when writing up notes. The clinician's mind is constantly processing the experience in the way that minds do, even outside of working hours. Similarly, P1 mentioned the challenge of distinguishing between work and personal life, which indicates that the boundaries between clinical responsibilities and private time are not always clearly internally demarcated.

> P2: Historically, at the start, I would've had real issues letting go. I thought if I was moving away then I was starving the child of something. I think the cure is their relationship, well, not the cure but the shift is the relationship, having a different sort of relationship.

P2 spoke about how her understanding of her clinical role has evolved, having been shaped by her clinical experience and the supervision and feedback she has received. P2 emphasises the significance of the clinician-patient relationship in her work, regarding it as the key to the patient's recovery. As a clinician, she establishes a unique relationship with each patient, one that she intentionally makes different from the patient's previous relationship experiences. Patients often express their fear of abandonment, and P2 has learned to manage this without engaging in a reenactment. With experience, she has learned to incorporate discussion about abandonment into her work which she believes helps patients to understand that a different kind of relationship can be formed, maintained and appropriately ended.

> P3: but there was this really challenging case and it's one that actually, unfortunately, they disengaged and it was like I often wonder how she is. (3.5.2)

P3 believes that she has a responsibility to engage with both the patient and the family. She described regret about a particular case when she could not engage the patient or family to the degree she had hoped. This case has stayed in her mind for years and suggests that the feelings of responsibility linger.

Feelings about continuing to work in this area

Each participant said they wanted to continue working in this area, although not necessarily in the same service or in the same way. This aligns with the findings of Warren et al (2013) whose study reported higher-than-expected levels of job satisfaction among clinicians who work with patients with eating disorders.

> P2: I do want to keep working in the area, even though I kind of expect to be hated for a while, I guess that I'm kind of used to that. But I would like to have the scope to do a lot more parent work, which is interesting because this is the thing that I probably would have avoided at the start.

P2 believes that this change is due to learning through experience that working with parents is an essential part of any clinical work with children and young people who restrict or refuse food. P1 was the participant who was less certain, she appeared to transfer her concerns onto her patients, perhaps not feeling that she had the psychological safety to name her lack of support. She also names the complexity of the work in such a way that indicates that she feels overwhelmed working alone in an outpatient team.

> P1: The young people lack a lot of support, just in general, there's just a huge amount of complexity. (1.8.2)

P3 thought positively about the life-changing nature of this work, not just for the recovery period but for the patient's long-term life going forward. She links changing the patient's attitude toward food to changing their attitude towards life, and then to the whole life cycle. P2 wishes to continue working in this area but has a new idea about focus. She has grown to understand that by the very nature of the work, she will experience through unconscious communication, a sense that she is hated. Nonetheless, she believes that she can handle it. She also expresses surprise that her focus has shifted to working with parents.

The clinician's experience of the patient in the work

This GET is about the participant's experience with their patients and reflects the complexity of the clinician/patient relationship. Whilst there is some overlap with other GETs, having the findings arranged in this way allows for a deeper exploration of how the participants internalise and experience their patients.

Trying to understand the patient's perspective

> P1: Sometimes I had to really work doing the understanding…He wasn't pushing it away with the same anger, he just couldn’t, he just didn't know what to do with it. He really just didn't know what to do. (1.4.6)

The findings reflect the complexity inherent in clinicians’ attempts to make relational connections with patients who are defended against it. There are innate difficulties in working with patients who are ambivalent about their worthiness of help, and who have come to hold rigid and inflexible ways of understanding relationships. This was particularly evident in descriptions of the early stages of clinical work.   P1 reflects on how hard it was to understand her patient, however, because she persevered she was able to access the patient's feelings of not knowing what to do. The participant came into contact with a confusing passiveness within her patient.

The work requires participants to proactively engage with the patient with a spirit of openness and curiosity. After reflecting on the patient's responses, P1 concludes that although her patient appeared less angry, he continued to harbour strong resistance to moving forward due to his fear of the unknown. She notes the patient may be dissatisfied with his current state of mind, but seems frightened of change as he lacks trust, belief and the knowledge of what to do. Fairburn (1952) observed that difficulties in early feeding relationships could lead to the development of severe defences against dependency. Dependency is associated with being the recipient of feeding of any kind by another and P1's patient was in the latent stage of development when his eating restriction arose, a stage when children remain dependent on their parents for survival. P1, in attempting to provide a therapeutic feed, came into contact with part of the patient who did not appear to know what to do with the offer.

> P2: But it feels like I'm not really talking to them. It's like I am talking to a split-off part of them…it feels the more that you talk to that part of them about food, the more I am missing the fragile, vulnerable child part of them, what's underneath that, and that part does have a lot to say, but has sort of lost its voice. (2.1.7)

P2 reflects on her experience with her patient's mind in a way that links to object relations theory. P2 observes that the patient's responses in the work depend on which part (or object) P2 is in contact with at that moment. This suggests that P2 experiences her patient's states of mind as variable and changing. This statement suggests that whilst putting the patient in touch with painful and challenging aspects of their reality may be necessary for their treatment, it may cause both the clinician and patient distress to do so, making them aware of the more dangerous parts of the patient's mind. This leads to them both feeling unconsciously reluctant to proceed. The patient's inner world, organised into an object-relational gang (Rosenfeld, 1971), in contrast, can appear to be an appealing alternative that allows the patient to be in complete control. This is a delusion and the internal defensive gang requires a realistic resolution for the patient to recover. In reality, the patient will benefit from close and interdependent relationships with others, including their clinical worker, family, and friends. It is important to note that revisiting past experiences of inner deprivation may occur during therapy and this will have consequences for the clinician, not just the patient.

The participants all reference some degree of insight that patients may have suppressed rage, violence, hatred, frustration, loss, and grief. These emotions may come to the surface during the clinical relationship, and it may be necessary for the patient to express them to the clinician. In this instance, the clinician serves as a substitute (via transference), a stand-in for the person with whom the early relationships were less attuned. Clinicians experience the impact of this dynamic in a way that is original and unique to them, although there are commonalities across the findings

Psychoanalytic/psychodynamic therapists have analysis or personal therapy as part of their training and while it is not necessary for all clinicians to undergo personal therapy to be effective, it can provide valuable insight when striving to distinguish the patient's emotions from the clinician's own. The findings suggests that participants are working with patients who are terrified of intimacy and understanding and tend to push people away. It is likely part of the patient’s pathology to believe they can become a self-sustaining entity, relying solely on their inner narcissistic structure, without the need for external support including food. Participants’ descriptions of the complexity of being caught in this dynamic link to the particular kind of countertransference that Williams (1997) described.

Experience of resistance and avoidance

The subtheme aligns with the idea that patients have developed a narcissistic structure where they have withdrawn from external life and relationships, as described by Rosenfeld (1971) and Williams (1997) respectively. The predicament of the patients is to diminish the importance of external relationships, emotional nourishment and physical nourishment from their environment. Therefore, helping the patient discover the healthier aspects of themselves involves addressing their resistance and avoidance of relational contact. P4 describes a patient's lip service to the clinical work and the struggle she felt to understand the patient in the context of being asked to resume work with her after a break. The statement suggests that the participant had a different idea of meaningful connection from the patient.

> P4: I didn't really understand it because I didn't think the girl and I had a particularly good alliance. She definitely came in paid lip service…didn’t want to recover.(4.16.2)

The image of a patient paying 'lip service' is interesting to consider. It suggests that the patient is bringing the idea of making a relationship to their lips but not opening her lips to take in or digest them, much like with food. There is an impact on the participants, to have their offerings of a therapeutic relationship and clinical work be treated in this way, even though they may have an understanding of why it is so. P2 describes her experiences with this aspect of the work in a hopeful way:

> P2: It's part of their illness, this is the pathology, and it's not mine. I know I'm holding it for now, and I know how shit the young person must be feeling, and they must feel

> that a lot of the time, considering I think for half an hour, and it feels awful but, it's not mine to hold forever…(2.8.2)

As the patient begins to recover physically and begins to use the clinical work, they may go through further periods of avoidance and resistance, as further dilemmas and conflicts arise when they begin to recover and make decisions whether to return to their old ways in the face of external challenges or to take the difficult route towards self-actualisation and recovery.

The body as a conduit for emotional expression.

> P2: But I find that the bad, the type of madness that's pure anorexia is very short-lived. If you can get food into them and get their weight up then that really mad part of anorexia goes, and it is always something else. I don't know if that makes any sense. (2.2.5)

P2 spoke about her belief that the patient's starvation is a temporary state that serves to deflect attention away from the emotional pain, or other personal or developmental conflicts. P2 suggests a potential function of the consequences of starvation is that it simplifies life for the patient and provides a dangerous relief from the pressures associated with growing up. All participants saw the physical recovery and the cessation of starvation as necessary, not only for physical safety but also to allow past emotional difficulties to come to the fore. P2 suggests that the physical treatment is a pragmatic step in the process, a necessity, but not the only point of the clinical work. She states that there is always something more. P2 views the emotional content that emerges from the patient as starvation stops to be the real purpose of the clinical work. This could be linked to Groth et al (2020) findings that clinicians used more psychodynamic based approaches when there is an idea of underlying trauma. Whilst P2 does not explicitly call the “something else” trauma, she not exclude it. This is suggestive of disruption in the early feeding relationships described by Bick (1967). Bick suggested that early feeding experiences set the foundation for building an unconscious blueprint of what to expect from relationships.

> P4: In some cases, it is like a slow suicide (4.4.5)

P4 made references to starved emotional states which could be associated with but not exclusive to the physical states. This illustrates how difficult it is for her to contemplate that death might be the result of starvation. This short statement carries a huge emotional weight in the interview and the impact was felt by the researcher both during the interview and when analysing the data. It is significant and could be a factor as to why restricted eating and self-starvation are relatively under researched.

> P2: It’s that starved, physical state that really does impact on the emotional state, that I think of is the really anorexic bit, but whenever the body is not starved, there is still a starved emotional state, you could call the anorexia, but really you could call that anything really (2.3.1)

P4 speaks about the starved emotional state she encounters in her patients. In this kind of clinical work, addressing the bleak mental states behind physical starvation could be the most effective way to bring about change. It is not uncommon for clinicians working with children who restrict or refuse food to focus on emotional states while also managing the high-risk physical states of the patient. Each participant described how they had to adapt their input, the psychological feeding of the patient, to the stage of recovery the patient was at. There is a comparison to titration of the doses of medication in their descriptions.

P1 mentions that the patient's longer-term health and emotional states play on her mind. However, when reflecting on how challenging it is to handle these concerns and interrupts herself to express uncertainty about whether she has permission to feel this way. She even asks, "Isn't it?" as if to seek validation in the interview for her emotions.

3. The clinician's experience of the Parent in the work

Questions about parent work were limited to a single sub-question that combined family work and working with the network. Therefore the volume of data about working with parents was disproportionate to the emphasis given to the question asked, and suggests that it is an area for more intense scrutiny. Family work and parent work form part of the recommendations for first-line treatment. (NICE guideline [NG69], Eating disorders: recognition and treatment, updated 16 December 2020) and experiences with this part of the work were significant to the participants.

Managing parental projections

> P1: I could see it in the child's face. This real anger, you know, and then from the Mum this real frustration. All directed at me….actually, it felt quite hard because, it feels to them.. so punitive, and I think that that's the impression that I got back from

> them. But I think that that moment actually changed things because things started to shift. (1.7.2)

P1 described an incident when the patient displayed real anger toward her in a joint appointment with his parent. Whilst she was initially confused, during the interview and on analysing the situation further, she realised that both the parent and child perceived her as being punitive towards the child. It appeared that she had been put into the authoritative parental position by both the parent and the child. P1 had to convince both the parent and the patient that he needed to eat regularly, especially since the mother wanted to take him away from home and therefore out of his appointments to go on a holiday. P1 had to find a way to emphasise the importance of his eating regularly, despite the dyad's overwhelming desire to escape into a holiday fantasy. P1 pointed out that if the child did not eat, he would become unwell and might need hospital care again, something that she expected the parent to have understood and prioritised. It appeared at that moment the parent's capacity to function as a parent had broken down and P1 was left feeling vulnerable and uncertain of her position, it was temporarily unclear who had authority for what. P1 noted that after this encounter things improved, potentially because she was able to model a different type of thinking for the family, and model that it was possible to hold boundaries and to keep thinking whilst under emotional attack in a non-punitive way.

> P2: It's the mothers who haven't been able to mother in the way that they wanted to. Whether it's due to postnatal depression, an illness or trauma. Ghosts from their own Nursery (coughing). The mums get to such a place where they're so defended. Well, those that are so defended, are the really critical ones. I have had so many different mums coming to shout at me that I am breaking their child. (2.8.9)

P2 describes instances in which the patient's mother's mental health history appeared to be related to the patient's eating restrictions, which links to the significance of early feeding experiences described by Bick (1968). In P2's description, the mother's defensive behaviour could be related to the shame associated with things not being as they should have been between her and her child in the past. This is likely due to historic events beyond the parent's control such as postnatal depression, trauma or physical illness. If this were the case, it suggests the mother had developed a critical maternal superego and was stuck in a cycle of self-criticism and shame as described by Freud (1900). When P2 stated, "I have had so many different mums coming to shout at me that I am breaking their child" (2.8.9), an aggressive and painful accusation to receive, she appeared to attempt to minimise this, suggesting these experiences were very difficult for her, and not ones she wanted to revisit. In the interview P2 redirected her focus back to the patient and the parent, stating her understanding was that they were anxious about change and what the work might uncover. Geller et al (2023) suggest that the care clinicians provide relates to their own experience of distress. Factors that influence this are they respond to their own and others' distress in times of difficulty. P2 eloquently describes parental aggression in a way that tries to contain and put it in perspective in relation parents own suffering due to depression illness or trauma.

Three participants shared their experiences of verbal attacks from parents and that analysing the situation helped them manage the feelings that arose. The participants described their understanding that the parents have difficulties and unbearable feelings they are unable to manage. Whilst the participants described trying to make sense of the projections, this was very complicated and influenced by their personal and professional experiences. There is a risk inherent in identifying with these difficult projections that include clinicians feeling like they are damaging, aggressive, and punitive professionals, potentially a mirror of the deepest unconscious worries of the parents involved.

P3 expressed empathy for the unbearable feeling associated with a parent being unable to feed their child, something she sees as fundamental to feeling successful as a parent. P4 mentioned meeting very high parental expectations through her clinical work and the subsequent critical reactions from parents when their high expectations of her as a clinician were not met. This aspect of clinical work is challenging and requires participants to work extremely hard under the pressure of being shouted at by another adult, even when they can rationally see this as a conduit for the parent expressing their deeply unbearable pain.

Parental pain and avoidance of pain.

This subtheme addresses parental pain directly and separately from the other types of projection in the previous subtheme. In this instance, the pain is closely associated with avoidance observed by the participants.

P1 described a situation when her concerns for her patient appeared to be avoided by the parents. The reality appeared to cause them too much pain. She felt that she had to push the idea that an ordinary diet was essential, meeting a high level of parental avoidance. The use of the word ‘push” is meaningful as it might link with the child's experience of parental projections, that emotions that did not belong to them were being pushed into them. This suggests that the only defence available in their earlier experiences was to refuse or say no.

P2 described how parents are sometimes unrealistic about their child’s recovery. She believes that clinicians have to address this, and reflects that whilst she feels she could choose to be angry at parents for their avoidance, she feels angry for them instead. She cannot explain why she feels this but suggests that it may relate to her awareness of how parental sadness, and perhaps deprivations in parents’ childhoods affect their subsequent ability to feed their child. P2 makes a distinction between mothers and fathers, finding fathers to be more irritating due to their observed lack of involvement. P2 described her experience of fathers who make appearances to voice dissatisfaction. In these instances, the boundaries between the responsibilities of the clinical role and the parental role seem unclear in the parent's minds.

> P3:I think that there's something about food that is so central, you know like it's so central to family life, but there's no getting away from it….it's much harder for parents to say that it's nothing to do with me…Whereas whenever it's food and you know you can't, parents can't really say ohh it's not my job to feed them. They are part of it. (3.3.2)

P3 emphasises the symbolic importance of food in family life and believes that parents cannot simply claim their children's eating has nothing to do with them, suggesting she has experience with this. P3 believes that parents may avoid other difficulties related to their child's mental health because they cannot bear their child's pain. P3 asserts that it is parents’ responsibility to feed their children but acknowledges that parents’ difficulties can contribute to problems, even when it is not their intention. She gives an example where a lack of parental involvement hindered progress. In this instance, P3 felt it was her responsibility to try and activate the parents and was frustrated that this did not happen. She reflects that she thought the mother wasn't particularly affectionate.

> P4: You know the impact of the family and parenting is they (parents) can still be absent for the child. That's actually quite common with eating disorders and it makes it quite difficult to talk about. It has a big impact. (4.11.3)

P4 expressed her concerns about a child who did not appear to be a priority to her parents. She felt that the parents always made excuses and were resistant to making necessary changes. P4's tone conveyed frustration and anger towards the parents' inability to move forward. Additionally, P4 noticed a lack of parental involvement during the clinical work, despite the parents being physically present for the appointments. This emotional absence may have been due to the parents’ avoidance as a defence mechanism against the pain of the situation and P4 wished she could have done more to engage them. These statements and P4 demeanor during the interview suggest her frustration with the parents was mixed with sadness.

Parental wellbeing and function were of concern to the participants. This links with Timko et al (2023) secondary analysis into prevalence of post-traumatic stress symptoms (PTSS) in parents of youth who were hospitalized for AN. The seriousness of AN might translate to parents of some young people treated in the community who may have similar PTSS symptoms. Timko at all found that PTSS symptoms were correlated with parental reports of mood symptoms, avoidance, inflexibility, and symptom accommodation which all negatively affect the child’s weight gain post-discharge.

Clinician’s identifications with the parents.

This subtheme addresses the participants' identification of parents and it identifies the participants' warm feelings towards the parents and desire to help.

> P2: But there is a lot of maternal sorrow that has been masked in different ways or where it comes up in different ways, but it comes up really through their child so, so I feel desperate like I want to parent the mother as well. (2.9.1)

P2 describes how mothers may experience hidden sorrow, which makes them vulnerable when their child is receiving treatment. Although this sorrow may be disguised, it still affects family relationships and remains present in clinical work. P2 believes that helping the child also involves helping the parent. She recognises that her desire to parent is not just for the child, but also for the family as a whole, having perceived the lack of a good enough family maternal object. Later in the conversation, she links this to the need for stability and consistency in family relationships. P2 admits to feeling desperate sometimes about these types of situations, emphasising the importance of time and the potential risks to the child if things don't improve with the parent.

P1 expresses concerns about not being aligned with the family's concerns. She uses the phrase "can't see the wood for the trees" to indicate empathy towards the confusing and disorienting experience she observes in her patient's mother. P1 ends this statement with "em" and trails off, which suggests she continues to think about her experience with the parent but cannot speak about it. The tone of the statement is questioning about this parent, with a hint of sadness and wonder about how differently people can interpret situations. The trailing off links with Minus K (Bion, 1962) suggesting that something is being avoiding in making links for P1.

In her interview, P3 expresses support for the mother and hopes that she can learn to nurture her child in the way that the child needs. This is different from another part of the transcript where P3 expresses frustration with the same parents who weren't giving their child the necessary attention and care or following professional advice. In this section, P3 is more understanding of the parents' struggles, showing how her position changes over time, or perhaps reflecting different states of mind about family. This reflects the complexity: all families have strengths and weaknesses and the participants' states of mind may vary relating to the states of mind in both themselves and in the family.

> P4: I would experience mothers with high levels of anxiety who have no idea that they're anxious. If you asked them would you ever be anxious? They say No, no, no. And you can kind of see from their behaviour from their demeanor, from what their child describes that they're highly anxious. (4.26.1)

P4 discusses how she observed high levels of anxiety in mothers who are in denial about their anxiety. She notes how this can impact the child's understanding of their mother and worries this means the parent is less emotionally available. P4 seems to indicate she views that denial of this anxiety is a defence mechanism that helps mothers to keep going and might connect to the development of denial of reality as a coping mechanism for their child. P4 wonders if perhaps if a mother acknowledges her anxiety and its effect on her care of her child, the mother may need to find other coping mechanisms. This reinforces the importance of parent work whilst equally stating the complexity involved.

4. **The clinician's experience of the Network**

All participants expressed concerns about resources, including access to physical care, the network of support around them, and the interface between physical and mental/ emotional care for young people. They also discussed the benefits of being part of a team, even if the team was not functioning at its best. They believed that being in a team was better than working alone, especially in challenging cases. However, they acknowledged that the quality of the team around them was also crucial. One participant shared that it was important to her that her manager was not afraid of complaints and helped her feel internally equipped to handle conflicts because she had support.

About being in a team, not being alone with it

This subtheme focuses on participants' feelings towards their professional context and network, with particular emphasis on the types of relationships they consider important to have around them. Upon analysis, it appears to be a crucial part of the participants' work experience, which may impact the patient and parent, given the emphasis on interpersonal and unconscious dynamics.

> P2 When I started the team lead said she was the mummy and the other person was the daddy and I was the baby. And we will look after you, and I remember thinking that this was so lovely and I understood that I had a place and I knew where I was. I had a role and my role was valued. (2.10.5)

P2 speaks about how her early experiences in her team mirrored a family structure which allowed her to be in the role of the valued learner. She felt supported and cared for by two experienced clinicians while she was new and finding her professional identity. Despite being a junior member of the team, she felt valued and appreciated. She also appreciated the opportunity to reflect on her experiences with her supportive colleagues. Later in the interview, P2 expressed anxiety about how this was changing as the key people had left and team dynamics were changing as a result. She commented that the team bickers more and relates this to the bickering in the families they work with. This insight demonstrates the meaning that supervision and team reflection can have for clinicians and demonstrates that all aspects of the network can mirror each other and this can create difficulty if not understood and managed.

P1 notes that there are differences between working in inpatient services and outpatient services. Having trained in inpatient services, she finds the content of the clinical work to be similar, but the kind of support for the work differs at the outpatient level. P1 reflects on how challenging it can be to establish and maintain supportive colleague relationships in a generic outpatient team. She compares her experiences of this to the team mentality she felt part of in the inpatient service. Cook-Dazens and Dalcos (2023) research on multi-family therapy (MFT) noted two paths emerging from a common framework: behavioural change and relationship focused MFT, with the relational focused strand being less researched but showing promising outcomes. This is of relevance as MFT involves teams of clinicians working with multiple families at a time and suggests that there are strengths to be found in everyone working together to bring about relational change. This could be conceived as a community approach.

P3 found supervision necessary for her to reflect on difficult feelings towards her patient's parents. During a supervision session, she came to realise she had “scathing” feelings towards the parents of her patient, but due to this support, she was able to understand what was happening between them better. She also used the wider team as an opportunity to reflect on who was holding what. Although she found it complex, she felt that it was important to try to understand the dynamics even when there was no easy resolution.

During the interview, P4 described that the experience of having an understanding manager provided her with a sense of psychological security. She observes bravery in her manager, which instilled an inner strength for the more challenging aspects of her clinical work. It appears she has identified with the braver aspects of the manager in her work. P4 also valued the support she receives from her team, especially from colleagues who share similar experiences. Whilst the similarities were reassuring this raised the question of diversity in the team. Potentially reliance on similarities within a group could lead to groupthink, where there is unconscious pressure to agree and individuals feel that they cannot safely express dissenting opinions.

Where are the resources?

> P3: Our coworking was sort of curtailed unless you were working in eating disorders. So in that way, we could see a lot of families and do a lot of co-work. (3.2.3).

This subtheme could equally have been titled “who” are the resources? During the interviews, a pervasive type of anxiety was uncovered that the researcher attributed to the theme of resources. This anxiety seemed to be linked to the idea of restrictions and it is important to note that these clinicians are working with patients who are obsessed with restriction within a system that has its resources restrictions.

These interviews were conducted a few years after lockdown, but the participants still had the pandemic in their minds. When talking about the patients on their caseload, they mentioned how restrictions during the COVID-19 pandemic had long-term effects on the mental health of children and young people. Although the Covid-19 restrictions were an easy and obvious reference point, some participants noted the NHS had been struggling with inadequate resources for some time before the pandemic.

It was also suggested that the bigger resources were elsewhere or that things were not fairly distributed which appears to link with some states of mind of the patients. Participants wondered if other services had access to more resources, as P2 described how members of other teams would come to her team to eat their food. This gave the impression that there was more nourishment available within the eating disorder service.

> P1: it feels like you get into a fight with the system to try and get all the stuff lined up around the child there's a bit of uncertainty about whether or not you can get it. (1.7.6)

This subtheme relates to the challenges faced by participants in obtaining adequate resources for both themselves and their patients. P4 also referred to a similar type of competition for resources between mental health and physical health services, describing it as a "bunfight". While the term “bunfight” may be a flippant term to help disguise aggressive feelings towards colleagues in other services, it indicates that participants face rivalries in accessing physical care for their patients. Rivalry is a significant part of any interpersonal dynamic but can become overwhelming if not noticed and understood. Then sharing work on behalf of the patient becomes difficult and some participants appeared to feel shut out of the physical treatment of their patients.

P3 states that one of the reasons she chose to work with young people who restrict or refuse food was because it provided the opportunity for co-working. The solo working environment in her outpatient CAMHS services felt isolating and lonely, which links to the previous point. The NICE guidelines recommending co-working for both parents and young people allow clinicians to share the work, becoming resources for each other. By combining, clinicians can provide a better overall experience for the patient and themselves, but this data suggests they are finding this increasingly difficult to do, leading to the pressure of obtaining resources from both ends: the organisation and within the work with patients and families.

Comment on researchers' subjectivity

In my first draft, I had named the previous section results rather than findings. I changed it both due to the qualitative research convention and as it better reflected the contents. The section reflects what I found out about a particular sample of clinicians' experiences of working with children and young people who do not feed, in a particular service at a particular time point. It was a process of spiral discovery for me.

Outside of research conventions, a discussion is a communication process between two people who are exchanging ideas. This resonated with me as I had difficulty bringing the many strands of the findings together in one section and felt alone in the process of doing so. In writing the discussion in particular I missed the presence of another mind. I wanted someone to think with me. Therefore the creation of this section was a lonely and internal one and necessitated my making sense of the participants making sense of their experiences. The heading from the 4th GET: “not being alone with it” had a very personal resonance at the time.

Despite having completed the section, I was left feeling that it was still somewhat incomplete. Through discussion with my supervisor, I have come to understand this is an inevitable by-product of this type of investigation. I understand that another researcher would have approached it differently, designed it differently and analysed and discussed it differently. A wholly new set of themes would have been discovered and reflected upon. Indeed when revising the findings in preparation for submission, I equally could have organised and interpreted the transcripts in another way just with the passing of time.

CONCLUSION

The findings suggest that success for the clinician is achieved when the patient can establish a new type of relationship, which involves setting aside the self-depriving internal defence system that was unconsciously created to cope with earlier difficulty. This new relationship enables the patient to move beyond their previous limitations and experience a more fulfilling emotional and relational life. Though Clinician's speak about physical risk and weight gain, they are not the sole focus of the work and do not indicate complete recovery for their patients. The findings suggest that Clinicians observe and work with the links between different kinds of restricting experience: physical, emotional and relational.

Participants shared their experiences of working with patients who have internalized neglectful and abusive objects, leading to experiences of internal restriction and self-criticism. While expressing hope, the clinicians also faced difficult and painful emotions through establishing connections and coming into contact with their patient's pain. Clinicians can become the target of patient and parent projections of aggression and anxiety and the work can feel full of difficulty. Despite this, all participants planned to continue working with patients who restrict or refuse food, as well as their parents. However, they also expressed anxiety regarding the availability of resources to support both themselves and their patients and emphasised the importance of working collaboratively with access to other clinicians' minds as a resource.

Limitations

This study was limited due to the small sample size and restrictions restriction of time and function. Due to the small geopolitical area from which the sample was taken there is a lack of diversity across many domains. In addition, diversity could have been integrated better into the interview process to allow to better understanding of the impact of the lack of diversity. Also the different professional trainings could have been explored in this regard.

The study was qualitative, with subjective results that may not be transferable to other settings or groups. This highlights the current inadequacy of all qualitative/empirical methods of understanding very specific human experiences and the difficulty of achieving a sense of certainty about collective themes.

Further research

This research could be repeated with a group of participants who all work in the same service. Alternatively, the study could be replicated with participants who are all part of the same professional grouping, such as child psychotherapists who might manage the unconscious aspects of the work differently.

Additionally, the study could be repeated with participants who work with specific diagnostic categories of eating disorders, such as AN, BN, or ARFID.

This study could be expanded and refocused through changes in the semi structured interview. The fact that a question about whet the clinicians thought the patients and families thought about them was an unhelpful omission in in this IPA study.

Clinical Recommendations

The findings of this small scale study indicate that psychoanalytical supervision, be it individual or in groups, for clinicians working with food refusal or restriction would be helpful due to the significance of the unconscious communications in the work. Whilst the modality of treatment may not be intentionally psychoanalytic, understanding the impact of transference, counter transference, projection and introjection are inherently helpful. As is understanding psychoanalytic theories of personality development and the impact of too much anxiety in early feeding relationships"

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APPENDICES

Appendix 1

Eating disorders: recognition and treatment. NICE guideline [NG69] Published: 23 May 2017 Last updated: 16 December 2020.

Psychological treatment for anorexia nervosa in children and young people

1.3.10

Consider anorexia-nervosa-focused family therapy for children and young people (FT-AN), delivered as single-family therapy or a combination of single- and multi-family therapy. Give children and young people the option to have some single-family sessions:

separately from their family members or carers and

together with their family members or carers.

1.3.11

FT-AN for children and young people with anorexia nervosa should:

typically consist of 18 to 20 sessions over 1 year

review the needs of the person 4 weeks after treatment begins and then every 3 months, to establish how regular sessions should be and how long treatment should last

emphasise the role of the family in helping the person to recover

not blame the person or their family members or carers

include psychoeducation about nutrition and the effects of malnutrition

early in treatment, support the parents or carers to take a central role in helping the person manage their eating, and emphasise that this is a temporary role

in the first phase, aim to establish a good therapeutic alliance with the person, their parents or carers and other family members

in the second phase, support the person (with help from their parents or carers) to establish a level of independence appropriate for their level of development

in the final phase:

focus on plans for when treatment ends (including any concerns the person and their family have) and on relapse prevention

address how the person can get support if treatment is stopped.

1.3.12

Consider support for family members who are not involved in the family therapy, to help them cope with distress caused by the condition.

1.3.13

Consider giving children and young people with anorexia nervosa additional appointments separate from their family members or carers.

1.3.14

Assess whether family members or carers (as appropriate) need support if the child or young person with anorexia nervosa is having therapy on their own.

1.3.15

If FT-AN is unacceptable, contraindicated or ineffective for children or young people with anorexia nervosa, consider individual CBT-ED or adolescent-focused psychotherapy for anorexia nervosa (AFP-AN).

1.3.16

Individual CBT-ED for children and young people with anorexia nervosa should:

typically consist of up to 40 sessions over 40 weeks, with:

twice-weekly sessions in the first 2 or 3 weeks

8 to 12 additional brief family sessions with the person and their parents or carers (as appropriate)

in family sessions and in individual sessions, include psychoeducation about nutrition and the effects of malnutrition

in family sessions: identify anything in the person's home life that could make it difficult for them to change their behaviour, and find ways to address this

discuss meal plans

aim to reduce the risk to physical health and any other symptoms of the eating disorder

encourage reaching a healthy body weight and healthy eating

cover nutrition, relapse prevention, cognitive restructuring, mood regulation, social skills, body image concern and self-esteem

create a personalised treatment plan based on the processes that appear to be maintaining the eating problem

take into account the person's specific development needs explain the risks of malnutrition and being underweight

enhance self-efficacy

include self-monitoring of dietary intake and associated thoughts and feelings

include homework, to help the person practice what they have learned in their daily life

address how the person can get support if treatment is stopped.

1.3.17

AFP-AN for children and young people should:

typically consist of 32 to 40 individual sessions over 12 to 18 months, with:

more regular sessions early on, to help the person build a relationship with the practitioner and motivate them to change their behaviour

8 to 12 additional family sessions with the person and their parents or carers (as appropriate)

review the needs of the person 4 weeks after treatment begins and then every 3 months, to establish how regular sessions should be and how long treatment should last

in family sessions and in individual sessions, include psychoeducation about nutrition and the effects of malnutrition

focus on the person's self-image, emotions and interpersonal processes, and how these affect their eating disorder

develop a formulation of the person's psychological issues and how they use anorexic behaviour as a coping strategy

address fears about weight gain, and emphasise that weight gain and healthy eating is a critical part of therapy

find alternative strategies for the person to manage stress

in later stages of treatment, explore issues of identity and build independence

towards end of treatment, focus on transferring the therapy experience to situations in everyday life

in family sessions, help parents or carers support the person to change their behaviour

address how the person can get support if treatment is stopped.

1.6 Treating other specified feeding and eating disorders (OSFED)

1.6.1For people with OSFED, consider using the treatments for the eating disorder it most closely resembles

Appendix 2

Belfast Health and
Social Care Trust

The Tavistock and Portman NHS
NHS Foundation Trust

Quality Assurance & Enhancement
Directorate of Education & Training
Tavistock Centre
120 Belsize Lane
London
NW3 5BA

Tel: 020 8938 2699
Fax: 020 7447 3837

Deborah Hanna
By Email

15 August 2022

Dear Deborah,

Re: Trust Research Ethics Application

Title: What are clinicians' experiences of therapeutic work with children and young people when the patient won't feed?

Thank you for sending your response to the conditions set by the Assessor with regards to your TREC application. I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. This means you can proceed with your research.

Please note that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.

If you have any further questions or require any clarification do not hesitate to contact me.

I am copying this communication to your supervisor.

May I take this opportunity of wishing you every success with your research.

Yours sincerely,

Paru Jeram
Secretary to the Trust Research Degrees Subcommittee
T: 020 938 2699
E: academicquality@tavi-port.nhs.uk

cc. Course Lead, Supervisor, Course Administrator

xxxxxxxxxxxl
xxxxxxxxxx Road
Belfast xxxxxxxxx

1 August 2022

To whom it may concern:

RE: Ms Debbie Hanna Professional Doctorate in Child & Adolescent Psychoanalytic Psychotherapy training

I wish to confirm that BHSCT CAMHS approve the following research proposal submitted by Ms Hanna as part of her Professional Doctorate in Child & adolescent Psychoanalytic Psychotherapy training.

Title: What are clinicians' experiences of therapeutic work with children and young people when the patient won't feed?

If you should have any queries please do not hesitate to contact me on (028) 9615 0033.

Yours sincerely,

XXXXX XXXXX
Childrens Service Manager
CAMHS Regional Managed Care Network

Appendix 3

Experiential Statements. Subject 1 16.7.23.

the way the eating disorder services are managed here,	Noting differences in institutions and organizations. Thinking about the way that she is managed	1.3	
you've got that kind of safety net,	She has an idea that others are in a safer context. There is more safety somewhere else	1.3	
t's managing you know the physical side,	she makes a split, physical vs the rest.	1.3	
there are other reasons that means there with us and outpatients rather than with a specialist eating disorder service.	The grass is always greener. The idea that other services will do it better, rivalry and neglect?	2.3	
often that chasm between you know what the medical side of things the pediatricians are worried about, and what we are worried about	she is referring to splits, how she experience’s the splitting in the case…it is safer for others	3.3	
they and they have much more of a safety net than we do,	she is aware of the splitting and engaging in it, it is safer fro other people	3.3	
I think about this child, I don't think that he feels better even yet. He is able to do a lot more. He doesn't feel better he doesn't feel	subject is reflecting that even though things are better this does not mean that they are good. (Where is the good? Splitting)	7.3	
if the psychological side of it isn't moving along smoothly, it can end up literally just being your business.	Separation vs splitting…physical and psychological…the subject is left with body and the split of mind. This reflects the spilt between mind and body.	8.5	
when you doing just that medical side of things and it keeps you very much on the surface of things.	Split between the surface and the depth	9.1	

re you being cautious enough for are you being overly cautious	Anxiety about not knowing…	3.3	
there is always a bit of anxiety, you know managing young people with eating difficulties	She says she is anxious, indirectly, she speaks about managing	1.3	
they might have quite a lot of physical, complications.	Complications…it’s not easy. Dilemma over the focus…physical or emotional	1.7	
there's more uncertainty when you know when you don't have a diagnosis	the idea of there being a right thing, **and anxiety about not knowing or not having**.	2.4	
but the food as well, you know the food is nurturing and they are rejecting that I don't know which part of it that it is,	she wants to give something that is rejected…she is rejected. Anxiety about not knowing.	4.1	
And I suppose there's always a bit of uncertainty	the subject does not know. Lives with not knowing, uncertainty	7.6	
I think noone is too sure of what exactly psychological help is what's the most helpful.	There is uncertainty about what kind of help is actually helpful. It is not known about that specific patient.	8.1	
I think we're all anxious	Uses “we” again…speaking about her own anxiety, being part of a group as a defense.	1.4	
so really the only experiences in the inpatient service. And that's quite a different experience from when you're at the outpatient service.	Worried that she has not had the right kind of experiences before	1.4	
didn't get an awful lot of experience of that, really in training	Feeling that she lacks experience, indicates worry about this	1.3	
Yeah well you're only really able to see somebody once a week. It’s a lot to manage in one appointment a week	She has a feeling that it is just not enough	1.7	
It's a huge amount to manage.	Feeling small in the face of something big	2.1	

it's difficult to get that kind of balance of things	Thinking how hard it is to keep equal attention on everything at the same time.	2.1	
things can get really challenging	Will she be overwhelmed by the challenges? Not knowing what is going to happen.	2.1	
they don't have that correlating eating disorder pathology, and that can be much trickier to, eh, mangage.	the idea of management, a container for the subject? The idea of there being a right thing to do	2.3	
I'm part-time	Worries about not being enough	2.5	
people who have more classic eating disorders, they are much more pushing you away, and you can really feel that frustration	Feelings like her work is rejected and not wanted by the patient	4.6	
I only have two clinic days a week	Worries about own restrictions	2.5	
So I am really limited	Worries about own restrictions, what she knows and what she has to give	2.5	
It's particularly pressing now, because it is so much challenging to get	feeling the pressure to provide something by herself.	3.1	
But I think it becomes particularly challenging with people who are dealing with those risks around the physical, and it has to be me	Anxiety about being the only one, heavy responsibility	3.1	
probably for me I mean, the physical of managing things in that way, the trickiest thing for those young people who are coming close to 18, he probably had a really long history, a very poor eating, working out where the risk is actually, how much of that is actually, going to be their way of going on, just how they are. And how much is actually	The difficulty of managing, nor having enough time, feeling helpless and worried. Worried that there is no hope.	2.4	

But that constricted even more over that period of uncertainty over Covid, and then they came to us,	Constricted= restricted, less of something being referenced here. Something about a wave of people who had not had enough arriving at an already depleted service.	2.4	
I think we all feel a bit de-skilled	Use of “we” feeling she lacks the skills, distance as a defence.	1.3	
definitely times where these cases are popping into my mind at times when I'm not in work	Cannot escape from the case, the case ahs somehow gotten inside her		
So once a week kind of is the max for me.	Needing to hold something back or everything might be taken from her.	2.5	
So once a week kind of is the max for me.	Needing to hold something back or everything might be taken from her.	2.5	
Some young people in particular do get into your mind and I don't know if that's something that is something more that you will take, the work home…with you	The patient being on the inside of her, the patient has got ton in (passive) and she wonders what to do about that when she is at home. She has not asked the patient to come home with her.	4.3	
there was no other way	she felt that she had no choices	3.2	
ou can't put the baby down sometimes, can you, at any point but then when you're not at work that's difficult. Yeah…thats when it gets challenging.	she is connected to the baby parts of the patient and herself, cant forget, I like her mind is somehow keeping the baby well.	3.4	
aware of their risks around it, in eating disorders	she uses formal language to talk about the risk, and this likely to do with fear, is it fear the patient could die.	4.1	

Yeah, it is kind of sometimes like being asked to watch someone sort of self destruct in someway. And it's really hard to hold isn't it	Its so difficutl to be a witnsess to someone really harming themselves. Is this powerlessness	4.5	
ou know like some of these young people who have come up over the Covid period you don't really fit into the classical eating disorder pattern,	she is iin touch with an idea of something different, not the same a pre covid	4.6	
This was a case that came into us around the start of Covid, and maybe seem to be looking back the start of a wave	Reflections on the context, restrictions in the community due to Covid. What did Covid do? How did it change the context?	2.2	
I suppose I'm thinking about his weight was very very low but they had no eating disorder thoughts.	she feels confused by the symptoms	4.6	
He wasn't pushing it away with the same anger, he just couldn't he just really didn't know what to do with it. He really just didn't know what to do.	Something was different, she didn't feel not wanted, she felt not acknowledged, like her personhood could not be acknowledged	4.6	
Yeah, it's like there's a swerving away from something	It is similar to avoidance	5.1	
I was finding it really hard to manage	Past tense…to avoid tha tthe feelings might still be present		
because we think about the physical side of things, quite often that where a lot of attention will end up being focused	Dilemma about where her attention will be focused. Will it be in the right place, how will she know?	2.1	
yeah, back to something….yeah… not thriving.	Not going forward, not growing and developing	5.2	

Something with that first child with his attachment to his mum, he just said couldn't seem to go through those normal stages, he couldn't get that separation, as he kind of reverted back to being, that baby that wouldn't move	not going forward in an ordinary developmental way. Regression instead of progression when progression mean separation.	5.2	
I was finding it really hard to manage	Past tense…to avoid that the feelings might still be present		
You could just feel that his mum you know was, him and his mum were really struggling with that separation	Subjects reaction to what she observed. They couldn't get the growing up…the development right.	5.6	
because I think it had seemed quite impossible when we were back there that it would ever would he ever be able to separate?	Subject remembers that she was not always hopeful, there was a time when she felt it would not happen for this patient. Query that he would not developed or perhaps die.	6.2	
the idea that he needed regular nourishment to stay healthy and that if they went off on this holiday he wouldn't be able to do that.	the regularlity of intake, be it help or food. Things need to be repeatd over and over before they can change (be taken in)	7.5	
hose processes of how they manage being cared for, their attachments and all of that complexity or the relationships are more complicated.	its the relationships that are hrd to understand. Something has happened inthe development of the patients relationships	8.3	
it becomes by keeping them safe at the moment	Having to live in the Moment with the patient.	9.4	

that's always very connected in my head, I don't know how much I should be going into my stuff but, but I was weaning my own baby at the time. And I was doing a kind of well there was a kind of parallel between what was happening what we were doing in work and what I was doing at home. (Pause/ Laughter)	Referring to her own connections in comparison to the patients, the things the patient did nt now about her and the thinking that she did. Something about the ways of being together changing over the lifespan.	5.3	
it's kind of reassuring because I could see that it could still be achieved. I mean I was doing it in my own life and you can get that kind of normal stuff	Subject used her own experiences of things developing eventually to hold on to hope for the patient	5.6	
at that point seemed to seem so hugely off in the future. But he has been able to get through so much.	Recovery had seemed so very far away. Now things are more hopeful.	6.2	
he was crying and wailing. But I think because I still see him now, and he's changed so much and actually is hard to remember, and actually seems like such a different child.	she has put some distance beteen herslef and the crying and wailing…was it feeling too much? she now has a patient who is in a different place.	6.3	
Yeah, times were that things were frustrating. I had a lot of frustration	Naming her frustration, but frustration might be cover up for anger. The case, the patient made her angry.	6.4	
where I was really concerned for the child, but the family really didn't seem to, to get it, it was hard to push that that idea how important it was to get the nutrition into	She could see something that the family could not see	6.4	

I suppose they made some decisions that were really hard to understand.	noting the different types of thinking and priorities	6.4	
Sometimes I had to really work doing the understanding	she notes the gap. In understanding and work she had to do to see things they way tht the patient did.	6.4	
thinking they never had the space, they kept just reacting on instinct without you know, to be done to be able to think about you know what's going on,	subject notes the lack of space to think. Things are close off, full up, no entry	6.4	
My worry seems so different from the worry is that the family seem to have I couldn't get them to see the wood through the trees sometimes, emm	Notes the differences between them, how they think in different ways and have different priorities	6.4	
hat's funny I really can't remember him that clearly during that time He was really being tormented, actually	it is so hard to remember the difficulty, to remember the person… did he go inside the subject, was he held on to. How does the subject take in the torment of the patient.	6.4	
And I think that is quite tricky some of the time when you were trying to keep them safe.	She had to work hard, felt like she was the one to see the danger and work for the safety	7.1	
I could see it in the child's face. This real anger, you know, and then from the Mum this real frustration. All directed at me.actually, it felt quite hard because it feels to them so, punitive and I think that that's the impression that I got back from them.But I think that that moment actually change things because because things started to shift.	the subject was the recipient of the families anger and frustration	7.2	
Yeah, even though it felt horrible and awful.	the work made the subject feel very bad	7.3	

You know it's unexplored. There's so much more to come. And he's only going to be able to do it at the point where you can do it.	There is still so much to do. The subject has no say over the timing of when things will be taken in, be done.	7.4	
I don't think the issues so much about working with children who don't eat working with young people and their families. It for me it's a feeling that you have the support around that's the most important.	the key to keep doing this work is to have teh support around the subject. They need to fee supported to give the support.	7.6	
it feels like you get into a fight with the system to try and get all the stuff lined up around the childthere's a bit of uncertainty about whether or not you can get it.	it is a battle to get the right things in place the subject does not know if she will be supported or the patient will be supported by anyone other than her. Being left with it all.	7.6	
hey are your patient, then you are responsible	This is so much to hold on her own	8.1	
he young people lack a lot of support just in general,there's just a huge amount of complexity.	Other people don't have support either. There is just not a lot of support.	8.2	
you really need to have a thinking space along with with the physical monitoring You end up feeling left with that bit of it.	the need for space to understand, the need to get into the space of understanding	8.3	
think that it is a bit frustrating.	What is the term frustration covering? Anger and abandonment	9.2	
There is always a bit of anxiety, you know, managing young people with eating difficulties ask yourself are your skills still good enough	the subject is left struggling with her sense of worth also	9.3	

Experiential Statements. Subject 2			
I definitely had ideas of being some sort of therapeutic worker.	The subject wanted to help therapeutically in some way	1.3	
because underneath all the chat about food, I felt they were really up for conversations whenever you can get them to stop talking about food.	Subject was aware that there was something interesting underneath	1.4	
So I've been there for a while even though I keep thinking that I'm new, I'm really not (laughter) and can't even do the Maths.	Feeling new, like she might not know	1.5	
think it's easy to talk to kids about food, but what you're really talking to is a defense of theirs.	Subject recognizes that there are different parts to the patients.	1.6	
but it feels like I'm not really talking to them. It's like I am talking to a split-off part of them it feels the more that you talk to that part of them about food, the more I am missing the fragile, vulnerable child part of them, that's underneath that, and that part does have a lot to say, but has sort of lost its voice.	the subject recognizes the split, that the patient is made up of different parts	1.7	
I had so many sessions with kids that were just about food, and I don't really know where I worked out that this really wasn't going anywhere. Or is that I was missing something here.	Subject is anxious about what she missed in the past. And it was something in the patients past.	1.8	
I need to park that with somebody else and stop talking about it, that we started to get into way more interesting conversations. I find that they were really intelligent and insightful kids, well not everybody of course, but there's a voice that needs to be heard.	subject found herself wanting to know and listen to the parts of the patient that were hidden	1.8	
I suppose I've always got cases in my mind. And there are similar themes in them	the subject is thinking about all the links between her patients	2.2	
as I get more experienced, I'm more sure about the job I'm less sure about giving a clear diagnosis. Pause.	Pause. This might indicate thinking. Subject is thinking about time passing, how she is becoming more experienced.	2.3	
but I find that bad the type of madness that's pure anorexia is very short-lived. If you can get food into them and get their weight up then that really mad part of anorexia goes, and it is always something else. I don't know if that makes any sense?	Question at end might show alack of confidence that she will be heard, this is reflected in her comments about the unheard parts of her patients.	2.3	

Experiential Statements. Subject 2			
The type of really starved conversation, that you can have with someone whose brain is very shut down and very fixated on one thing. As soon as you can get food into them, and then the conversation really does shifts, to a different topic.	Split between physical and emotionally is linked. It is a linked split. The treatment of the body can be a short term thing and something the subject feels just needs to be gotten out of the way	2.5	
it's usually either trauma or attachment or mood or something else, there is a whole array of things and actually at that point, you could on diagnosed with anorexia, should you wish.	Subject is not sure about naming anorexia, she sees that as the thing on the surface	2.5	
whenever you move away from the starved body, you can really see though the emotional starvation, within the child,	the anorexia is on the surface, the child underneath is starved of something else.	2.6	
from a really physical point of you, you can't really get to the starved emotional state, until you feed the body.	split between the physical and the emotional, the personality under development	2.6	
It's that starved, physical state that really does impact on the emotional state, that I think of is the really anorexic bit, but whenever the body is not starved, there is still a starved emotional state, you could call the anorexia, but really you could call that anything really	subject is not sure about calling the not eating anorexia, however something has been starved	3.1	
I think like I think about their inner child that felt vulnerable.	the split of parts of the patient are acknowledged.	3.2	
I don't have a specific name and I think you could go into labelling it, but it's really hard to know what label sits or fits well with me	Split between herself and what is expected…the labeling. Does labeling give illusion that we know what we are working	3.2	
Feels quite damaged and fragile, but I don't know what the name is.	Subject is in contact with something she knows instinctually but has trouble naming.	3.2	
so there isn't a set an exact set period of time, I know that for some services you get like six sessions or or 12 sessions a year, but for me I think the quickest I've seen someone go from a very anorexic state to discharge is nine months.	Time s important…is it like rationing? Is it a race to resume development?	3.4	
so if I think about the quickest one, she was a young girl who was couldn't work out for ages and, she was maybe about 13 when I met her and we well I kind of see her as the accidental anorexic. Because she was actually from a very secure base with no significant not real childhood	subject notes how unusual it is to have a patient who does not have significant relational trauma.	3.4	

Experiential Statements. Subject 2		
but she ended up in quite a restrictive reading pattern in lockdown: whenever all the restrictions of lockdown came around and she was looking for something to do and very quickly became underweight	subject links patient restrictions to the restrictions of lockdown.	3.4
real life took over again, and it's not like the illness wasn't genuine, but there was pre-anorexia she was very well.	subject notes the patient was really unwell for a time. Once lockdown over and she had treatment she was able to recover easily. This is not the norm.	3.4
when she got physically and emotionally, more secure and understanding, and understood what had happened and why it happened.	subject notes that feeling secure and understanding were the keys to helping the patient recover.	3.5
She was absolutely ready to be discharged	Time, she was ready to go on with her life.	3.5
another young person who who who presented in a similar sort of way, pre-lockdown and I'm still seeing her,, when the eating better, the anorexia was sorted, you often find that when you do awaken, kind of physically awake in the brain this happens…she began to disclose childhood sexual abuse.	For another patient the anorexia was a cover for the pain of childhood sexual abuse.	3.5
anorexia had been very useful for her and numbing that, helped her to block out memories and provided a distraction.	Anorexia numbed and blocked out difficult feelings.	4.1
so her treatment is ongoing, because she creates to go back to the starved state where she didn't feel, and she didn't think.	the patient and the therapist are in a split. The patient losses the protection of anorexia if she improves.	4.2
We're in a much different place, and now she only gets seen once a month but there were times when she was seen twice a week. emmm, so it's one of those things it's quite hard	the subject pauses, says emmm when thinking of the difficulties brought up in her treatment of this patient.	4.3
Historically at the start I would've had real issues letting go. I thought if I was moving away then I was starving the child of something.	Subject reflects on how she used to worry that she would repeat harmful internal events for the patient, which lead to them	4.5
So, until I became a bit braver, in myself, kind of verbalised, with a young person, of what I thought, my experience of them washat I thought their experience of therapeutic time was, and I'm actually put a bit more credence on there onto the therapeutic relationship.	subject reflects on how she has changed, she is braver at facing the difficulties that cone up in the work..including things that are not to do with eating.	4.6

Experiential Statements. Subject 2			
I am, for the emm, I know I'm waffling now…trailed off. (Pause) I'm not sure that I really take time to think about how I made a decision.	the subject might be showing her underlying anxiety about herself. She has some doubts about her decisions making process. But she does make decisions	4.7	
Whenever I think, whenever I feel like something whenever there's something more secure within the young person	she uses both thinking and feeling to understand what is happening in the work.	5.1	
I talk, probably I mean it could be a week or a month, or five sessions about their own progress.	the subject thinks it has something to do with them understanding something together and it is not about the amount of time it take to get there.	5.1	
I think their perception of hearing me talk about the progress in the hope for a potential shift	the subject thinks the patent needs to think with her about themselves in order for change to happen.	5.2	
o maybe seeing them only once a week or once a fortnight, to beginning to think and make it different from the really rejecting experiences that they might have had before	subject tries to have endings that dont repeat or reenact old rejections.	5.3	
It's actually a really hard question like how you know why you know what you know	The subject is thinking about herself in her work, how she understands her feelings in term of countertransference.	5.4	
there is a sense that I have. I have a feeling of if if I withdraw something too early, it's going to feel like an abandonment and I predict that for everybody even though for some it doesn't actually, so whether that says more about me or them I don't know. Pause. Or maybe it does feel abandoning to everybody, but some people, they're brave enough to say it.	the pause suggests an uncertainty, not complete confidence, when the subject is thinking about endings. Themes or rejection and abandonment are around	5.5	
I can feel at times like a real maternal role	subject acknowledges her maternal countertransference.	5.7	
but letting in food, or letting in time between sessions, you know, the dietician, the doctor, the father, it's, it feels really daunting for me, which, which surely has to be a representation to me of how really daunting it has been for them at a much younger stage.	the subject holds the case close in the beginning, see them frequently and builds a close relationship, hard to start to let other professionals in, anxiety that something will be undone or ruined.	5.8	
went off my train of thought there. Was I talking rubbish? What question was I supposed to be answering?	subject doubts her mind, anxiety that she is not right, query lack of validation of her work. (Internal or external)	5.9	

Experiential Statements. Subject 2			
I was thinking about what you said about treatment drift in the idea that the treatment is, somehow the cure or something	the subject reflects on a clarifying question that I asked (subjectivity. How much to include)). She is thinking about what is the thing that actually changes things for the patient…she is not sure it is the (type of) treatment.	5.10	
I think the cure is their relationship, well, not the cure but the shift is the relationship having a different sort of relationship.	She is saying that hr patients get better through the type of relationship they have with her, a different kind of relationship they can take in and use.	6.1	
had a lot of young people in my head that I feel have have either progressed well or are in a good therapeutic process,	Subject is reflecting on the patients that she feels have done well, depersonalized now, taken out of direct relationship language.	6.2	
maybe my avoidance, because it's really painful,	subject reflects on herself, the work is painful, it hurt her at times. Because she is in that relationship with the patient.	6.2	
they're really difficult, but they make you feel a lot, and I am, and whether it is the ones that make you feel horrendous because they are doing things in a much more feeling level, and I respond based on a feeling,am I avoiding the fact that there's a lack of thinking there./That this person really struggles to think or to verbalise things in any words and that so much harder kind of path to go down….I probably do avoid talking about those people too much.	subject reflects on the patients that are not doing well. Her work with them brings up feelings that are horrendous for her at times.	6.4	
Well, I sometimes I just have to feel it.	Use of self…the subject uses her own feelings to understand what is happening in the work	6.5	
if you feel like you just want to cry, or like you could walk into the office, and have a hug I would. But I don't.	the feelings that arise through the work make the subject emotional and sad. She refrains from seeking hugs fro colleagues.	6.6	
Sometimes you just have to sit with it,	use of self, the subject find the feelings that come up in the work hard and but she understand that this is part f the work.	6.7	
inside myself I can manage that feeling. It's not nice but I can manage it. I can hold it.	Use fo self. The subject thinks about her own inner world and how she uses that to bear ideas and feelings that arise in he work through contact with another painful inner world.	6.7	
when things aren't as intensely felt, then maybe I can talk about it.	Sometimes the feels are so strong the subject cant speak about them. Instead she has to wait until the intensity has passed, then she might talk about the experience.	6.8	

Experiential Statements. Subject 2			
That kind of empty helpless feeling is yes, it's a risk,	the subject reflects on the danger of feeling empty, and feeling like there is nothing that can be done. She pauses, indicating	7.1	
here are other risks around and you feel them in a very different way clinically	Risk is a feeling. Is it fear? What is frightening for the subject?	7.1	
Where instead of going into the office and wanting a hug, you go in the office and say someone needs to help me fix this. And it feels like a more activated panicky risk.	the subject sets aside her own need for comfort and asks for help to manage the external risk…move between internal and external.	7.2	
at least I have a panicky feeling	the subject is very anxious and scared.	7.2	
I obviously have to work with other staff members who feel that risk a little bit more acutely. And they feel like they need to fix things. And then there's lots and lots of conversation about staff own anxieties which is as much easier to put into words than that empty, desolate feeling.	the anxiety and fear is then projected into other members of staff. The subject reflects that this is easier to speak about than the vacuum, the feeling that nothing can be done.	7.3	
That kind of empty risk almost. It's a risk, but it feels like a non-verbal risk. A risk that someone is falling apart.	the subject tries to articulate the emptiness, the vacuum, the danger of this. She is thinking about internal disintegration and fragmentation	7.5	
(Pause) how do you survive it? Well, you just do. You just say it,	Pause indicates thinking…trying to understand. She cant say what it is for her…she knows it but cannot find words for	7.6	
that shitty feeling that you get when you're sitting and you're really in contact with a person and I recognise that that will pass.	the subject refers to an experience with a patient that is like excrement. A toilet feeling. She believes she can sit with these kinds of experience's with patients because she knows that they will pass.	7.7	
I need almost to get like a feel from them like a bit of pass the parcel or can you do someone take a bit of this off me so that I can hold it a bit more comfortably?	The subject is thinking about how much she can take and how much of the work can be shared…reflecting how hard it is to bring the internal fragmentation together.	7.8	
Laughter… I don't really know what I do, but it might be one of those times where I maybe just sit. If there's no one there I just stare into the vacant space.	the subject refers to being o her own after a session and still being in contact with a vacuum, empty space. She finds it hard to find words to describe some of the experience.	7.9	
I have to think oh my God it could exhaust you, could end up quite drained. It could suck the whole life out of you.	the subjects worry an=bout how tiring the work is…that she could be drained… everything good could be sucked out of her	7.9	

Experiential Statements. Subject 2			
I'm trying to bring it back to some logical words, even if it's not a soothing thing, but it is a recognition that this is part of the work.t's part of their illness, this is the pathology, and it's not mine.	Subject speaks about the struggle to find words. How this is calming and matters to her to be able to understand and name	8.2	
t's part of their illness, this is the pathology, and it's not mine. know I'm holding it for now, and I know how shit the young person must be feeling, and they must feel that a lot of the time, considering I think for half an hour, and it feels awful but, it's not mine to hold forever	She feels that something bad is given to her to hold and she thinks how it might feel for the patient to feel like that more of the time. She reflects on how awful these kinds of feelings are and how grateful she does not have to have them long term	8.2	
I'm not wanting to give it back to the young person, but it's not going to kill me.	subject thinks they would like to hold the awfulness for longer, that they can do that for a while	8.2	
I do feel I've got to give myself a little pep talk sometimes.	The subject reflect on how she deals with the awfulness internally by talking to herself.	8.2	
Sometimes you have to feed yourself a little bit.	the subject talks about liking after feeding herself.	8.4	
people come from other teams to eat in our office whenever they need a bit of something.	the subject and her team cope by eating in their office and other services come there to eat too. The feeding function	8.5	
sometimes there is a sense that the parents try and feed the team.	Some parents displace their need to feed food onto the team, or they feed their children indirectly…through feeding the	8.6	
I find myself feeling desperately sorry for a lot of the mums.	the subject feels saddened by the mums in the service.	8.7	
I'm a bit irritated by the dads.	And angered by the dads	8.8	
mothers who haven't been able to mother in the way that they wanted to. Whether it's due to a postnatal depression, or or an illness or a trauma. Ghosts from their own Nursery (coughing). The mums get to such a place where they're so defended. Well those ones that are so defended they are the really critical ones. I have had so many different mum's coming to shout at me that I am breaking their child.	suject reflects that something in the mothering function has not worked properly for the mums. She related this to things that have goe wrong for the mums. Coughing indicated discomfort.	8.9	
Or that I haven't fixed their child quickly enough really mad and ludicrous statements, but I never really feel angry with them, I don't really know why. I don't feel angry at the mother. I feel angry for them. I don't feel angry at the father either, but I just they are a bit more irritating. Because usually they're absent and then they turn up and give off.	The subjects understanding that this is a projection is helped by it being not the reality of the situation. The subject feels she doesn't understand this about herself. The fathers are not part of the treatment, but show up every so often to complain.	8.9	

Experiential Statements. Subject 2			
But there is a lot of maternal sorrow that has been masked in different ways or where it comes up in different ways, but it comes up really through their child so, so I feel desperate like I want to parent the mother as well.	subject feels the maternal sorrow in the mothers, it make her feel like the mums need to be mothered. The subject connects with how the mothers losses have created the losses for the patients.	9.1	
but it's just like a balanced voice is sometimes it's really missing in the whole family system.	the subject reflects on what seems to be a lack of balance in the families. Suggesting that perhaps people hold extreme positions and cant see the others perspectives.	9.2	
hey feel like families that haven't been able to stabilise.	Somethign has gotton in the way of the family function…is stablising containinig… there is poor containment in the family.	9.3	
t's becoming a team that bickers and disagrees and has bad feelings. A lot more than it used to.	subject reflects on the increase in splits with her team	10.3	
I think it seems to be more manageable when there are fewer people,	subject notes how the quality of team relationships was better when there was fewer team members.	10.4	
she was the mummy and the other person was the daddy and I was the baby. And we will look after you and I remember thinking that this was so lovely and I understood that I had a place and I knew where I was. I had a role and my role was valued	the subject used to feel that they knew there place in the team family system and felt secure in this.	10.5	
but I know that there's a lot of other insecurities within the service. They're in the near members of staff are people who only work part-time. And I see it being played out.	Part time working has increased the splits.	10.7	
I do want to keep working in the area., e even though I kind of expect to be hated for a while, but I guess that I'm kind of used to that, but I would like to have the scope to do a lot more parent work, which is interesting because this is the thing that I probably would have avoided at the start.	she wants to keep going, she understand this involves projections of hatred from the patent.	11.2	

Experiential Statements. Subject 2			

PATS sub 3		
19 to 21-year-olds that a lot of my colleagues were not going to work with…they didn't really know what to do with them. I'm really happy for you to see them, so I had to sort of a young adult caseload.	The subject felt happy to provide clinical care to the patients her colleagues did not want to work with	2.1
I really have an interest in young people and that you know, that whole real defence, You know..that I don't need anybody kind of armour that a lot of them have, or I don't care about anybody. I got to really work with something that really drew me, I'm not sure why.	The subject is aware of how young people can unconsciously act to protect themselves and that is interesting to her.	2.2
our coworking was sort of curtailed unless you were working in eating disorders. So in that way, we could see a lot of families and do a lot of cowork.	Working with children who didn't feed allowed her to co work, be part of a team.	2.3
work with families a lot that way, because I really missed it.	The subject had missed working with families.	2.4
Really asking what is the disorder, what really is the problem?	The subject thinks about how to understand and what to name the ailment they are dealing with.	2.4
I think that there's something about food that is so central, you know, like it's it's so central to family life, but there's no getting away from it. it's much harder for parents to say that it's nothing to do with me	the subject sees food and family, therefore relationships as being central	3.2
Whereas whenever it's food and you know you can't, parents can't really say ohh it's not my job to feed them. They are part of it.	she sees the parents as central when I child does not eat.	3.2

PATS sub 3		
I think it's something that for a lot of families who are very defended. It's much harder for them to defend that.	she thinks about the family defenses, she sees that it is hard for a parent to defend against	3.4
parents don't really have a clear role in some types of work..	Comparison to other presentations in kids…she thinks that parents don’t have such a central role in other kinds of clinical work.	3.4
Parents are not therapists or colleagues. It's also about the team of the family around the child too.	the subject reflects on how relationships are central. The clinical team surrounds the family team which surrounds the child.	3.4
from when you become a mother, you know parenthood, an infant s are completely dependent on you for survival. That's part of the core role, is it? If you don't feed them they will	the feeding relationship is core to survival in infancy.	3.5
That kinda stays, but will definitely be for me as a parent as well, it stayed with me as well	the subject reflects on how that early feeding relationship with her own children stayed with her	3.6
it feels like it's so central to you know for some parents so central to their success. If my child doesn't feed, then I have, you know….I have a feeling as a parent that is unbearable. You know to try and even deal with that..it is very difficult.	the subject feels empathy towards parent as getting a good feeding relationship is key to other types of parenting success.	3.7
never really had to be the parent of this child. This child could have bought themselves up from age 3 or 4that's a bit wrong. Thinking that you have, you don't have a say that your child is completely autonomous at that age and how scary that must be for them and, and you know how they….What that's done?What that like to you know, to them, feeling this sort of omnipotence, and that like the adult can't challenge me,I am all-powerful and then they hit adolescence or some other something and it all just becomes make or break.	Subject thinks of a case where the parents never acted in a fully parental way, so the child had to manage a lot of things by themselves before they were ready to.	4.2
relied on their ability to seem to just get on with things	the parents relied on the child to just get on with things.	4.2
but there was this really challenging case and it's one that actually, unfortunately, they disengaged and it was like I often wonder how	the subject remembers a case that she found challenging and still thinks about even though the child did not want the clinical work	5.2
that it is separate and that it feels very disjointed.	Refers to fragments and things about the case not working well together.	5.2

PATS sub 3		
I've a girl who was Dangerously low weight but had parents who really, couldn't really accept that there was an eating issue.	the subject refers to parent not being able to see how ill their child was…too painful for them	5.3
They thought that she just exercised too much. No, they thought that she's addicted to exercise.	They could not allow thoughts about how ill she was	5.3
hey just couldn't bear to think about it as a food thing. Because no, she just she's really healthy. She really health conscious. She's really fit, she's she likes to exercise a lot.	Parents had subverted it into something that might actually be good for her. Problem of not understanding what is good for their child.	5.4
We were concerned about her physical health because of how lower her weight was,	the subject held an anxiety that the parents did not seem to feel	6.2
She was very unwell, I suppose also because her brain was a bit starved.	Split and connection between physical and emotional	6.3
She just couldn't think about change. Couldn't see the point	the subject had hope, the patient did not…seemed hopeless	6.3
it felt like she was somebody who was on the verge of collapse, you know she was in a bad way…	Her physical state was very poor.	6.3
Her hair, and her periods had stopped, and she was. She had that hair you know that newborn babies get for extra warmth so she'd started to grow soft hair on all over her body.	Her physical state was very poor and there were obvious signs of this.	6.4
She was very small and I'm, you know, not growing	the patients development had stopped.	6.5
They would just go round in circles in sessions.	It was impossible to make progress	6.6
when Mum was mum was very, very fixed on the idea had been an exercise disorder rather than eating,	Lots of things were working against progress, parts of mum could not accept the danger	6.7
mum and dad were both asking well, why do we both need to be here	parents opnely stated that they did not now there place n the clinical work, or see why they were part of it.	6.7
he's so she's great daughter, you know we've never had to intervene. I was trying to get them to even think about how they cope	they had thought of themselves as having produced a great daughter…they did not seem to want to know about the not great parts of hr.	6.8
they seemed to have no kind of parental techniques of any kind.	her parents did not seem to know what they were doing.	7.2

PATS sub 3		
I'm we used to sort of laugh about it in a way because it was like this family make me so hungry…t was just anytime I thought about them I was just my stomach would rumble and I would just really think I need to feed my body. I need sustenance.	the patient felt hunger…dealt with this by laughing. The hunger got projected into her.	7.4
It is really, really hard.	it was very difficult…painful work	7.6
felt like I was just working so hard at trying to get some kind of inroad because they were so defended against everything	the subject left that all she was working against was a defense	7.7
but yet no, they were not really worried about her.	the subject could not understand the parents apparent lack of anxiety	7.8
I did manage to engage, like engage her very superficially, but it took a lot.	the subject had to work very hard to get even a superficial kind of relationship	8.1
trying to have you know, get them to have a bit of a curiosity about some things	the subject wanted to project her curiosity into the parents…to get them interested in the risky parts of their child	8.2
it was like anything that we tried didn't get anywhere and anything we tried to get an opening in almost felt like an attack.	A dynamic evolved that felt like attack and defense.	8.3
we would do some joint work, and we set up some broard guidelines and things for staff.	the subject worked with the network to set things up around the family	8.4
she was still very low weight and still, eating hadn't really improved.	As time went on the patient remained a low weight…did not gain	9.2
then they sort of disengaged and we started getting lost to care and that I think that was really hard.	the subject found it scary and difficult when the family stopped the clinical work with her	9.3
I felt kind of quite hopeless.	it made her sad, anxious and hopeless	9.4
She had so much….power…just too much…	she felt that it was an abuse of the power that the patient had gained too early.	9.5
she decided what she did and didn't do.	This is about the absence of external parents and depriving inner ones.	9.6
I just found that that I really sat uneasily with me.	the subject was really uncomforted	9.7
I wrote lots of letters, tried to phone, tried to get them in but just…	the subject worked hard to make connections	9.7

PATS sub 3		
I often think about her and wonder if she ever came back in to CAMHS, you know, at a later date.	this patient is still on the subjects mind… got inside her.	9.8
it was very sporadic and also cause we would try and get parents to come as well, so rather than see her individually we were trying to see them as as a family,	the clinical work was inconsistent, the subject made a lot of effort to change this to no avail.	10.1
I would see her, you know, for little bits on her own, just to sort of check in with her, she was quite hostile for a lot of the time	There was hostility in the work	10.2
But every now and again, you know she, you'd sort of felt like maybe it made a bit of connection and she did agree to increase it to her eating so that her weight went up a little bit.	But when things were consistent for a while and the subject felt that a bit of connection had happened in the relationship, the patient would do better for a while.	10.3
ut I think that was mainly, it wasn't really to nourish her, it was more to get people off her back. It was …kind of …well if I do this, can I stop coming here?	she recognizes that the patient did things to make th subject leave her alone. The patient wanted to reject her….stp her having any meaning.	10.4
So it was rejection….yeah	it was very difficult…painful work, the subject felt pushed away	10.6
Sure, trying to think because it was a while ago.	Things are not clear about the case in the subjects mind.	10.7
I think there was a glimmer of something, something resonated with her sometimes. You know. Whenever I had said things about, you know, like I sort of feel like you are trapped. (Pause)	When the subject could reflect some of the patients inner reality, the was a moment of connection	11.1
feels like now you're it's almost trapped, you can't really change it for fear of the fallout from it, the criticism or whatever.	the patient was trapped by her own thoughts	11.2
sometimes she would look as if she knew what I was talking about.	At times there were moments of real connection.	11.3
part of her might have been a little bit curious that to what I had to say	The patient could be interested, part of her anyway	11.5

PATS sub 3		
how we can become more rigid, you know the brain starved,	the subject tried to help the patient understand what was happening to their body in reality	11.6
I think there was a part of her that was just desperate for connection, but also some part of her just didn't know how to do that…I think I think there was a part of her that knew that this is not healthy	the patient was lonely and trapped inside herself and did not know what to do.	11.7
This is a road to nowhere kind of thing, but there was a part of it that felt helpless to stop it.	it was hard to feel hopeful	11.8
I think she was looking for someone to take control and stop it and it was really hard	There was a feeling that the patient wanted someone to be in charge but also could not let that happen	11.8
little changes like that and mum and Dad agreed or we managed to get them all to agree on some kind of small change. And she you know, managed to do that, but I just I felt like there was a bit of hope.	in the times when there was hope, it was very slight and over very small things.	12.1
I'm trying to remember what it was about that that it just got to a point where it just felt too much to expect her to make these changes.	it was hard for the subject to believe that things could ever change for the patient	12.2
We really needed to activate the parents and their parenting role and it just, that just where it all sort of got stuck.	the parents were unable to become active. The subject tried but it was too hard and it feel apart.	12.3
I call the lead therapist just to talk regularly about the case and sort of reflect on it	the subject need to talk about how she felt about the case regularly	13.1
I suppose because I have different modality training and you know, bits of lots of different things, then I often pull some of those.	she uses different parts of herself to help.	13.1
If I feel that fits or not, or that might be useful think about it. You know, to think about it in a certain way or maybe try to strengthen that relationship. (Pause)	she tried to make the therapeutic relationship stronger	13.1
we're also thinking a lot about the whole of it, you know what we were left with sitting with. What kind of feelings were evoked within the team? It wasn't always clear.	she observed the ripples of the case and how it affected the whole team	13.2

PATS sub 3		
She was so hostile, but I never really saw it as like well to begin with. Well, I did. Used to dread the sessions and think ohh she's so angry… she's just gonna start shouting.	the patient directed her angry hostile feelings towards the clinical staff	13.4
I started seeing it more than as you know, this is just terrifying for her. She is just, she's sort of from that kind of attack as a defence way of being.	she understood that behind the aggression there was fear. The patient was very scared and coped with her fear by being aggressive	13.4
sometimes just getting the anger out with her in session	it was better that she was angry in a session than cut off	13.5
As you know Mum had been getting so angry at her. There was a lot of anger.	the patient felt that her parents were really angry at her	13.6
I'd be thinking, they really have been, you know, useless to you.	she could see that they had not given her the kind of parental car she needed	13.6
talking about that in supervision because it was like ohh, I like these are very scathing words and thoughts I'm having about somebody	the subject wa angry with the parents…it was circular	13.7
I know she can't be completely useless, that she will have done good things too.	it is hard to be balanced in the face of aggression and fear. The subject had to remind herself to see the good things in the parents as well	13.8
but actually, I was thinking about the wrong things.	The doubts herself at times…not thinking the right things	14.3
Mum's doing nothing, thinking of those opposing parts, that the daughter was having to do everything…. but actually when you say that, they were kind of paralysed.	the patient was trapped and parlysed	14.4
I really want a mum to give her, you know, that nourishment, what she needed.	she was willing mum to be more maternal. To give more of what her child needed fro her	15.1
mum. Was like she was, you know, she wasn't particularly affectionate parent either.	there was a lack of affection and warmth anyway	15.2
wanted mum and Dad to sort of step up and you know embrace her and also b tougher off with.	she wanted the parents to be more parental	15.3
challenging was hard,	it was hard to stick up for this view. They did not like hearing about it	15.5

PATS sub 3		
'm trying to think of how I felt at this point. I definitely was quite attached and cause I remember the team lead was just going to say You're a glutton for punishment. Still trying to engage that family.	Something made the subject not want to give up. Colleagues saw the work as punishing	15.5
but I just didn't want to give up. I just there was, you know.	she didn't want to give up	15.5
I can't remember clearly, but I must have felt like there was enough of a connection there that there's maybe, There was a glimmer of connection, or there was a glimmer of something that maybe	she had made a very small connection, a relationship with the patient and wanted there to be hope for her	15.6
I really wanna help you or that I you know that. I think that you could be helped. Kind of. You know that I was supposed to show her that I still had hope.	she wanted to share this hope with the patient	15.7
felt like they were all going well….this is just how it is now….no point in doing anything.	there was a feeling of hopelessness	16.1
Yeah, there was definitely still risk there. There was definitely at hadn't gone away completely,	it was dangerous at times…the danger to the patients physical health had not gone away.	16.3
Ohh, it always felt like really hard work. It was, you know, it felt tiring.	she felt tired by the hoping and trying	17.1
there were so many unanswered questions.	So much was never understood in the work	17.2
so much that you were left holding and you didn't know quite what was about or where it came from or whose it was.	Some of this case got inside the subject, and stayed there	17.3
I didn't feel like you've really got that much of a sense of family…you know who they were and we could have had endless discussions about possibilities and Hypothesise and allsorts as a team about them but not with them.	the family was closed…the team tried to do some of the work for them	17.4
I think more when something is not really resolved… resolved or understood. I don't like it	The subject wanted to understand what had happened, she did not like that she didn't understand this family	17.5

PATS sub 3		
really feel for people who don't get enjoyment out of sustenance.	she felt that she could be a source of nourishment…but this wa not taken up	18.1
but maybe that is why I sort of want to try and help them enjoy it.	she wanted to. Help them enjoy life	18.2
I just think you've got it wrong, You're going about food all wrong. You know what should be there to be enjoyed.	They had made a mistake but she could help them	18.3
it's got nutrient sustenance, but maybe an awful lot of people their diet doesn't reflect that at all.	the subject thinks about the quality of what is taken in.	18.4
It's it's yes we all food is necessary for living but also it's good food that's good for you not. Not just any food, you know what I mean? If you know what I mean.	it is important to choose to eat wisely	18.5
Awful lot of food out there that's lacking and nutrition.	Not all food is equal	19.1
You are human and you have…you're meant to eat multiple times a day. So to have that you know where it causes a brings up huge, you know, negative emotions or causes such turmoil to people you know multiple times a day for the rest of your life is not like you'll grow out of it.	when an issues manifests in food it is a problem as humans need to eat a lot of Times in a day	19.2
if I can help, Make a difference here. This is going to make a difference for you until you die kind of thing. It's not just to get you through this small portion of your life or or whatever. It can have a lasting impact.	Food and relationships are lifelong needs	19.3
as soon as they leave they do not think about it until they come in the door next week. There's no nothing kept in mind.	when nothing can be taken in nothing can be kept in mind..	20.2

PATS sub 4		
t was used to working. With a lot of chaos, I suppose, and a lot of systems and um, a lot of that work was about containing the anxiety in the systems.	The subject understand that anxiety is present in professional systems	
I think back then, I thought that my job was to fix people, and so I dd the postgraduate diploma in Cognitive behavioural psychotherapy.	She sought CBT training s she thought it would help her in her work. She used to believe that she could fix people.	
it comes back to what your expectations are of what it is that you're doing or what you're expected today	she see that expectations are very important	
It was kind of to get them well enough that we could justify not failing	she does not believe that she can fix anyone now. Its about getting patients well enough	
the families with big expectations, big expectations of their kids, big expectations of services and lots of complaining about services not being	There is a weigh of expectations on clinicians from the patients, their families and the system.	2.4
as a team, most of us have only been there for the last few years. And you know, two to three years. We're all women will know.I think that we as a team support each other quite well when we're dealing with.	the subject works in a team were people have not worked a long time.	2.6
I think that we as a team support each other quite well when we're dealing with.	the subject thinks there is a lot of clinician to clinical support.	
here's a clear objective with eating disorders, you know you're objective is to get, you know, patients to a place where they're re-fed,	The subject thinks the goal of her clinical work is clearly understood	

Then you can address some of the underlying psychological, issues that led to the fact that they were restricted on and not eating in the 1st place, and also that parent and family work is accepted as part of the treatment.	the subject sees that there are reasons underneath the patients restriction of food. For her parent/family work is essential.	
it's like ice skating uphill, basically, to think that you're going to work with an adolescent or a child and independent of their family, and that you're going to affect any sort of change	"Ice skating uphill". It feels like hard, difficult energy intense work	
A cohesive approach is needed and because of that too, you're not on your own with cases,	She sees that the whole family system is part of the difficulty and the whole professional system is part of the solution…all have to work together.	4.1
I just like the way I'm working. I think that's mostly why I like it.	The subject likes being in a team of clinicians how understand similar things about the work	4.5
I found it quite frustrating in the beginning.	It was frustrating at the start.	4.5
That usually you know, the issues are anxiety based issues. It is an anxiety based issue.	the patients are all very anxious	5.2
And my experience thoughts linked to the person's self esteem, their sense of themselves, and usually that's to do with their attachment	the patients have low self esteem, poor sense of self and issues in their relationships.	5.3
an eating disorder being different to other kind of anxiety based disorders because there is that physical impact.	But the not eating makes the anxiety different…the physical risk increases.	5.3
You know that when you restrict and you starve your body that your brain will then only think about food. So your brain actually won't let you think about all of the other issues in your life.	she describes the Lin between the physical and the emotional…starved brain	5.3
it becomes all about food and weight and shape and controlling those things. And I can understand how if there's loads and loads of other chaos in your life that you don't know what to do about that.	A lot of things come down to one…control.	5.3
I find bits of it really hard to understand	the subject feels personally confused by the will to restrict.	6.1

it takes an incredible amount of determination to not to, not to resist, you know, like an natural drive that your body has.	The subject has respect for the unhealthy and damaging parts of the patient	6.2
I find that fascinating and and probably quite hard to understand I would find it really hard to deny myself food that I	she is compelled by what she sees even if she thinks she does not understand it	6.3
I make sense of it in that way that it's self punishment, that it's punitive, that it's a form of self harm.	the subject sees that the patient is punishing themselves. (For what?)	6.5
In some cases it like a slow suicide. (Pause)	the reality of potential death sits uneasily…she pauses to process.	6.5
But I think the risks are much easier to manage, to know what to do about, you know, if someone comes in and they've got low potassium, they go to the hospital and they get a bag of fluid to correct their potassium.	the subject is matter of fact about the physical side of the risk…perhaps distancing herself…it the business of the hospital, not her. Whose business is it?	7.2
you send them to the hospital and there will be a medical intervention. So I think in that way, the risks are much easier. But we don't have cohesion between physical and mental health.	The subject see the role of the medical intervention as easier…there not emotional connection	7.2
o it becomes this bunfight between is this a mental health crisis or is it a a, a physical crisis? And then once the physical crisis is over, there is no mental health crisis.	there are splits and different parts of the system are at war	7.3
it's really hard to get families to you know, recognise that there are part of the recovery, know I think parents are really resistant at times. have to accept that that maybe something that, you know happened in the family or something had some bearing on why their child's not eating.	the subject needs the parents to get in touch with the reality of what has happened, but finds them resistant.	8.4
he said, you knew we beat ourselves up for years and thinking as our fault, you know, it's not your fault. And I felt like standing up and going well, it is a bit, you know.	Parents want to avoid the very difficult feelings that come with a child who does not eat.	8.5

it can be frustrating when you're right there, so there is a lot of, yeah, fighting and work around the actual patient.	the subject recognizes the splits and parts of the patient and the system that are in conflict.	8.6
Fault as fault has negative connotations.	Fault is to hard to think about.	9.2
It about understanding, you know, how do we understand what happened in your family? How do we make sense of what happened in your family?	the subject speaks about how hard it is for families to really know each other and be close with the painful parts.	9.3
I do believe that most parents do the best job. They know how to do sometimes.	the subject is optimistic about most parents	9.4
It's true sometimes that things weren't good enough and it has, and it has, you know, consequences.	but some parents don't get enough right and this has consequences for their children	10.1
But it's not about blame. It's about kind of understanding that that's just the way it was.	Blame is not a helpful word…its more about understanding, but it can be hard to have a shared understanding.	10.1
Ohh, I think I've had times where I've had hardly any parents and then times when I've had mostly parents.	The patient thinks about the balance of her caseload	10.3
You know the impact of the family and parenting is they can still be absent for the child. That's actually quite common with eating disorders and it makes it quite difficult to talk about. It has a big impact.	she sees that some patients feel an emotional absence from their parents.	11.3
who appear to be successful in the sense of how we most of a society judges a successful family general so that you know that the children are getting good grades at school and they're excelling in sports and they're excelling and musical instruments. And the parents have good jobs and they live in nice areas and they live in nice houses. And I think that that's part of what makes it really difficult.	What is on the surface does not always reflect what is underneath. Financial success does not mean emotional success.	12.2
So how could this happen in our perfect lives, you know?	the parents feel persecuted by their Childs illness.	12.4

we have given this child everything, you know, they haven't wanted for anything they don't want for anything.	the parents have given what they had…they find it hard ot hear that they have not given what was needed.	12.5
And I can't remember what mistaken point that I was gonna make was. (Pause)	the subject doubts herself. Pauses.	12.6
I like about working in the sort of team is that there's an acceptance from the outset that this works going to take a long time.	the subject appreciates the acceptance in her team that these kinds of issues can't be death with in haste	12.7
there's something really nice about that in terms of the pace that you and the expectations that you have of yourself as the as the clinician of them as a patient of them as a family	the subject appreciates the teams understanding that the process takes time.	13.2
And sitting in silence. I think part of there's a luxury in that in the sense that there's an acceptance that. It's going to take time for people to recover.	the subject appreciates the teams understanding that the process takes time.	13.3
That part of it is just sitting with people. (Pause)…And not knowing and… um.	she reflects on the depth and duration of the work	14.1
Some of the parents struggle with that concept more than the patients and some of them definitely come in you after a couple of months and kind of demand to know why their child's not cured	This parents are hopeful that it will g away quickly and feel angry when it does not.	14.3
I'm thinking of 1 family in particular that I've been working with for over a year, and it's really interesting because so high achieving family, both parents are medics and they the girls been coming for over a year and she's just stuck, you know, in terms of her weight, she's stuck.	Subject thinks of a patient who has been refusing food for a long time…her parents are high achievers in their own careers.	14.5
her eating sort of stays on the level sort of flies under the radar, doesn't cause too much havoc, you know, in terms of like physical things and like.	this patient keeps herself just physically safe enough but her inner world is very depriving.	15.1
er eating disorder maintains itself is by constantly trying to convince her and others that it doesn't exist, that it's not really a problem	this part of her keeps her away from healthy relationships, including a therapeutic one with the subject.	15.2

And it's very easy to do that because of our culture and round thinness and, you know.	the subject thinks about the external cultural context	15.3
physical exercise was important for her mental health, so they didn't follow the advice to take her out of, and the sports that she played.	Her parent were worried that stopping her exercising would be bad for her body	15.4
But I suppose they've never prioritised this child and her recovery, you know, and they've never prioritised tackling the eating disorder. there was always an excuse as to why they couldn't do those things	the parents appear to want her well enough without having to be involved in a different way	15.5
dad will be wheeled in and he's very aggressive and very arrogant and he'll come in and kind of, you know, demand to know why she's not better.	Dad stays away but comes in when the family want to complain.	16.2
I started working with the mum and then the mum asked that would I go back and work with the girl.	the subject has worked with the child and parents at separate times.	16.2
I I didn't really understand it because I didn't think the girl I had a particularly good alliance. She definitely came in, paid lip service…didn’t want to recover.	she did not feel that they had a close relationship	16.2
he wanted me to go and work with the girl because it meant she didn't have to talk to me anymore.	the subject felt the mum really did not want to change.	16.2
I went to work with the girl again and actually, my experience this time is that the girl is really engaged	the girl has starred to work. She is ready for something different.	16.3
accepting that she has an eating disorder, talking about the behaviours that her eating disorder makes her engaged in, you know.	the patient has more clarity about her own mind.	16.4
She is talking about not feeling good enough	the patient feels worthless	16.4
talking about always having had anxiety always haven't had worry about absolutely everything	the patient has always felt incredible burdened by anxiety and worry.	16.4

But she's not gaining weight at the minute, but the parents find that really hard to get their heads around.	the patients inner world is become better understood and yet she continues to restrict food.	16.4
hese kids have a diagnosis, have a diagnosis to which actually doesn't really happen very often	the subject finds the external diagnosis helpful.	17.3
But when you have a diagnosis, then you have nice guidelines and you have evidence, you know, you have a theoretical framework, the backup, what it is that you're doing and you know, you have all of that to back up what you're	the diagnosis means that bad news about change can be given to parents in form of an evidence base about treatment.	17.4
you have to be really careful about labelling things, I think.	Whilst the diagnosis is helpful it has to be sued with caution	17.5
Nice guidelines are clearly saying that a family-based approach is what works for these young people.	NICe guidelines can validate and support the work.	17.6
in the team we are probably more cohesive and our manager, you know our senior manager is not afraid of complaints.She's not afraid of and um, you know, there is a sense that you are backed up.	it helps her feel brave in the face of risky patients and complaining parents.	17.7
when people ask for different therapists and change clinicians, it's because of something that's going on in them rather than something that's going on in the service.	Clinicians are not interchangeable therapy vending machines.	18.2
ou know, she's not scared of having those conversations with people	the subject is helped by her managers bravery.	18.3
here is an understanding too that you know the relationship is really important	the subject really values the therapeutic relationship	18.3
Not every patient is not going to click with the first therapist that they are	Not all therapeutic relationships are the same.	18.4
the discernment to tell the difference with those things	the subject does not always like her patients	18.5

tend to talk more about the ones that aren't going well, we're we're stuck or there's, you know, complexity. So, you know, I think there's a sense of trying to understand and figure out, you know like we've got. (Pause)m I think for me it's just like the sense of how hard I feel that I have to work in the session.	she speaks more about her difficult cases in the service	19.1
when things have shifted with somebody that they come into the session that they, they contribute more…It seems less of me trying to drag information out…. more than bringing stuff and us making sense of it.they're coming with their stuff and they're trying to make sense of it. And the structure of what we are doing together rather than, you know it being me against them.	the subjects welcomes the point with a patient where they begin to think and work more themselves. the subject sees a shift in the splitting…the patient no longer has her identified as an enemy.	20.1
So if you're still engaged and eating disorder behaviours you're it's not possible to change how you think about eating disorders. (Pause)	The subject reflects on hard it is to e starved and get emotionally better. She thinks deeply about his.	20.4
if someone's been restricted and they've been underweight for a period of time that they're quite shut down, you know their emotions are shut down,	the impoverished malnourished body reflects an impoverished and malnourished mind	21.1
whenever they start to regain and weight restore, you know, I mean they start to feel again and sometimes they feel very intensely and it's kind of, you know, and part of that is they also start to develop again	it can be painful to recover and be back in touch with all the emotions that were shut off.	21.2
They start their adolescent development again	the pause in adolescent development is ended.	22.1
that's actually just a teenager	the ordinary challenges of adolescence come back.	22.2
An eating disorder in adolescence or early adolescence is about trying not to grow up. that the patient that wants to stay a child or is it the parent that wants them to stay a	the family are not equipped to cope with an adolescent or adult child.	22.4

Ohh, none of our children went through the terrible twos and it was like a brag.	some parents think that compliant children is a sign of success.	23.3
well, they're going. She's gone through it now.	the subject feels pride that the ordinary challenges are back	23.4
Does it mean that, you know, she wasn't permitted to individuate it from them then? And if she didn't individually it from them. Then what she meant to do today as an adolescent and you know?	the subject sees how the patients need to be separate from their famili8es but it hard to move away when some devolvement seems incomplete	23.5
I would say it, incompatible with normal adolescent development.	Restriction of food does not work with ordinary adolescent development.	23.4
I think a lot of what's restricted in their religion is would make it really hard to actually develop as an adolescent.	Link between restriction in term of religion and illness	
hey're just so kind of not allowed for	some religions encourage restriction as devotion	24.2
It's too much..fear	Patients are scared	24.2
it's normal for adolescence is actually important for adolescents to push the boundaries and to kick back and resist. And the reason they do that is so that they can grow up and move out of your house	the subject sees adolescent/parental discord as helpful to propel the patient to an independent life	24.5
that if that hasn't happened in early childhood is much more difficult	If earlier stages are missed, adolescence becomes complicated	25.1
That can be one of the challenges of the work, but also one of the good things depending on the kind of where the patients are, because I always talk to patients about you know, the importance of the first seven years of life.	Early stages of life are always discussed with parents to hlep them make the links.	25.3
I would experience mothers with high levels of anxiety that have no idea that they're anxious. If you asked them or would you ever be anxious? They say No, no, no. And you can kind of see from their behaviour from their demeanour, from what their child describes that they're highly anxious.	Mothers anxiety is obvious to everyone but them	26.1

there's the task there is to help the child understand that about their mum, even if their mum can't understand it about herself an when there's an unconscious issue with the parent that they're not able to access. it's really frustrating.	the subject feels she can help the patient see their parents more objectively Sometimes the parents can be helped. Frustration/anger	26.2
Then that brings a sense of hopelessness and the sense of holding and waiting	sometimes the subject feels that there is no point in hoping for change with parents	26.5
ell, you just have to sit this out until you get to the point where you can go off and have your own life and. try to be okay.	sometimes the work is about helping the patients survive in their families until they are old enough to leave	27.1
I like the idea of like, you know, getting really knowledgeable and really experienced and a small area and kind of, you know, having a lot of you know confidence and and and your ability to kind of help people	the subject likes her sense of growing expertise in this area.	27.2
the other side of it where there's something really there is something really frustrating about working with eating disorders and especially the ones that don't shift on that don't reflect on	the work is very hard when the patient wont take in the clinical offering.	27.3
that are really resistant and you know, um and because the markers for recovery frequency order are so obvious to know, it's like with it's the weight on the scales.	the work is really hard when the patient is resistant to change, resistant to physical markers of good health.	27.4
you can't really reframe things if you know what I mean.	subject expresses doubt, worry that she wont be understood…linked to the difficulty of giving in the clinical work.	27.5
I suppose a sense of like hopelessness about it too.	the subject qualifies er occasional hopelessness with the term "like". Puts distance between herself and her feelings of hopelessness about the work.	27.6
Or, you know, as opposed to another feeling I have is a bit exasperated	the subject feels that she knows what can help but it cant be taken in by the patient or the family, leading to feelings of frustration and exasperation.	28.1
I think there's a lot of expectations,	there is a lot of pressure	28.9
everybody has expectations of calms that CAMHS just takes it doesn't really that we don't really push back on.	the subject wants to make patient take I that clinicians can only do so much…that they have to work to	29.1

It's a complex area and I think I feel like talking about it and my head's been all that over the place and I don't know, maybe what that says about how it feels	the subject brings doubt in…anxiety about what she has said and whether it is acceptable and understood. Theme about having accetable feelings in the work.	29.2
And I think that's it, that is that it's so complex, you know and (pause)	Pause t show doubt and anxiety, worry about er own acceptance.	29.3
But really, it's not about eating, you know.the things that I usually spend time talking about are, you know, self-esteem, perfectionism, emotional regulation, relationship to other people and usually making sense of that.	she repeats that the issues is not eating…	29.4
Moving towards.Trying to bring a bit of flexibility.	the subject reintroduces optimism…has hope for moving forward, making things more flexible	29.6
people develop around those things. And so I usually that's what I'm talking about and I don't really talk about Eating or body image. Which is interesting.	subject is doubtful at the end, suggesting underlying confidence anxiety about her work.	29.7

Appendix 4

Personal Experiential Themes

Sub 1. (8)

TIME
WHERE ARE THE RESOURCES
ANXIETY AND NOT KNOWING
INADEQUATE AND WORTHLESSNESS
SPLITTING
CONFUSION ABOUT WHO HOLDS WHAT?
TAKING PARENTAL PROJECTIONS
SPACE AND PLACE

Sub 2. (7)

TIMING
SUBJECTS FEELING ABOUT THEMSELVES IN THE WORK
HOW DOES SHE KNOW WHAT SHE KNOWS
KEEPING THINGS APART…SPLITTING
SUBJECTS FEELING ABOUT THE PATIENT IN THE WORK
THE TEAM AROUND THE SUBJECT
MANAGING PARENTAL PAIN AND PROJECTIONS

Sub 3. (9)

PERTAINING TO WORKING, BEING IN A TEAM, NOT BEING ALONE WITH IT,
THE PATIENT INSIDE THE CLINICIAN
FEELING THE DIFFICULTY
PARENTS WHO COULD NOT/WOULD NOT DO IT
THE PARENT IN THE CLINICIAN
FEELINGS OF ANXIETY AND DOUBT
SPLITTING
THE PHYSICAL RISKS
TIME

A dynamic evolved that felt like attack and defence.
This is about the absence of external parents and depriving inner ones.
Not all food is equal
when nothing can be taken in nothing can be kept in mind.

Sub 4 (7)

THE TEAM WITHIN AND THE TEAM WITHOUT.
THE MEANING OF THE CLINICAL ROLE
THE CLINICIAN'S UNDERSTANDING OF THEMSELVES IN THE WORK
CYCLE OF SPLITTING AND LINKING
PARENTAL SUFFERING AND AVOIDANCE
CLINICIAN ANXIETY AND DOUBT
TIME. (DOES TIME LINK TO TEAM AND EXTERNAL REALITY)

The link between restriction in terms of religion and illness
some religions encourage restriction as devotion

Appendix 5

Public facing documents

The Tavistock and Portman NHS
NHS Foundation Trust

What are clinicians' experiences of therapeutic work with children and young people when the patient won't feed?

You have been given this information sheet to invite you to take part in a research project. This information sheet describes the study and explains what will be involved if you decide to take part.

What is the purpose of this study?

The origins of this study came after year of social restrictions due to the covid 19 pandemic. Large numbers of children and young people have been isolated without access to the ordinary things that would have helped them manage anxiety and stress precisely at the time when they have needed them most. There has been a rise in the numbers of young people presenting to services with restricted eating which means that more clinicians are working directly with children and young people with this particular presentation.

Aims
To better understand the impact on the clinician when the patient (child or young person) is restricting or refusing food and is unable to fully take the therapeutic feed.
To explore the effect of this on the clinicians' thinking during the therapeutic process.

Who is conducting the study?

My name is Deborah Hanna

I'm a researcher working for The Tavistock and Portman NHS Foundation Trust where I am training to be a Child and Adolescent Psychotherapist. This project is being sponsored and supported by The Tavistock and Portman Centre and has been through all relevant ethics approval (TREC). This course is overseen and certified by The University of Essex.

What will participating in this project involve?

You will be invited to take part in an individual interview. This will mainly be for you to talk freely about the topic with some prompts from myself. During the discussion I would be interested to hear about your professional experience of working clinically with this group of young people.

All interviews will last approximately 60 minutes and will be audio recorded. These interviews will be aimed to be conducted face to face, however, if this is not possible due to COVID-19 they will take place via telephone or video link. If it is possible to complete the interview face to face it will take place at your usual place of work at a time of your convenience and with respect to covid 19 safety measures. No extension to your usual working hours will be necessary.

Do I have to take part?

No, it is completely your choice whether or not you take part in the study. If you agree to take part, you can withdraw without giving any reason at any time up to three weeks after the interview. This timescale has been decided as the data will then be being processed and analysed. If you decide to withdraw all data collected or about you it will be destroyed immediately.

Criteria to take part in the study:

- Currently working for the******* CAMHS network
- At least three years' experience assessing and/or providing treatment within a CAMHS team
- Have experience of working with children and young people who restrict or refuse to feed.

What will happen to any information I give?

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 10 years after the study has finished. The interview will be audio recorded and transcribed by myself.

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.

Quotes from the transcript will be used in the write up of the project but these will be de-identified. However, please note, it is possible that other colleagues who know you well may recognise you in some of the quotes used, although every effort will be made to prevent this. Any extracts from what you have said that are quoted in the research report will be entirely anonymous.

All electronic data will be stored on a password protected computer. Any paper copies will be kept in a locked filing cabinet. All audio recordings will be destroyed after completion of the project. Other data from the study will be retained, in a secure location, for 10 years.

If you would like more information on the Tavistock and Portman and GHC privacy policies please follow these links:
https://tavistockandportman.nhs.uk/about-us/contact-us/about-this-website/your-privacy/
https://www.ghc.nhs.uk/privacy-notice/

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.uk

There will be limitations to the confidentiality of information provided if it is deemed yourself or someone else is at risk.

What will happen to the results of the project?

The results of this study will be used in my Research Dissertation Project and Doctorate qualification. It may also be used in future academic presentations and publications.

I would be happy to send you a summary of the results if you wish. Please contact me to request this if it of interest to you.

What are the possible benefits of taking part?

There will be no direct benefits for you. However, by taking part you will be given the opportunity to consider this growing area of practice. It is hoped that it will provide a space for you to consider and reflect on your experience in a way that may be helpful for future work.

Are there any risks?

No, there are no direct risks. However, I am aware that it may be a challenging topic that involves possible unconscious beliefs which some may find uncomfortable. If needed details of a confidential service you can access will be provided.

Contact details

I am the main contact for the study. If you have any questions about the project or would like to discuss this further please don't hesitate to contact me. My contact details are:

Deborah Hanna
****

Debbiea.hanna@belfasttrust.hscni.net

Alternatively, any concerns or further questions can be directed to my supervisor:
Dr Rachel Abedi
Email: rabedi@tavi-port.nhs.uk

If you have any concerns about the conduct of this research, the researcher or any other aspect of this research project please contact Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk).

Thank you for considering taking part in this study and taking the time to read this information. If you are willing to take part in the research please complete the consent form provided

NHS
The Tavistock and Portman
NHS Foundation Trust

Dear All,

My name is Deborah Hanna, I am a Child and Adolescent Psychotherapist in Doctoral training in the ********** CAMHS team. I am about to embark on the Doctoral Research Project part of my Child and Adolescent Psychotherapy training. I am contacting you to see if you would be interested in taking part.

The project title is: **What are clinicians' experiences of therapeutic work with children and young people when the patient won't feed?**

I am interested in hearing from clinicians from all professional backgrounds working in a CAMHS setting. In relation to the young people the clinicians have worked with, there is no requirement for a formal diagnosis of an eating disorder to have been made regarding the child or young person, however there must be some elements of eating disordered behaviour, with food restriction or food refusal being significant causes for concern for over 6 months in the last 2 years.

I would like to invite anyone who works within the********CAMHS network, who has at least three years' experience working with this children or young people who don't feed to take part in an interview to discuss their experiences. These interviews will be guided by me and last around 60 minutes. They would take place within clinician's usual place of work wherever possible.

If you would be interested and willing to take part please find attached a participant information sheet for your information.

Best wishes,

Deborah Hanna

Debbiea.hanna@belfasttrust.hscni.net

Consent Form

Project title: What are clinicians' experiences of therapeutic work with children and young people when the patient won't feed?

Name of researcher: Deborah Hanna

- I______________________________________voluntarily agree to participate in this research project. ☐
- I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
- I understand that my participation in this study is voluntary and that I am free to withdraw, without giving a reason, at any time up to three weeks after the completion of the interview. ☐
- I understand that the interview will be digitally recorded and transcribed as described in the participant information sheet. ☐
- I understand that the information I provide will be kept confidential, unless I or someone else is deemed to be at risk. ☐
- I understand that direct quotes from the audio recording may be used in this research study but will be made anonymous to the reader and held securely by the researcher. ☐
- I understand that it is my responsibility to anonymise any examples referring to cases I chose to discuss during the interview. ☐
- I understand that the results of this research will be published in the form of a Doctoral research thesis and that they may also be used in future academic presentations and publications. ☐

Contact details:

Researcher: Deborah Hanna Email: debbiea.hanna@belfasttrust.hscni.net
Supervisor: Dr Rachel Abedi Email: rabedi@tavi-port.nhs.uk

Participant's Name (Printed):______________________________________

Participant's signature: ______________________________ Date: _____________

Thank you for agreeing to take part in this study.

Your contribution is very much appreciated.

The Tavistock and Portman NHS
NHS Foundation Trust

Dear….

I am writing to thank you for your contribution to my Doctoral Research Project. I hope you found it as interesting as I did.

If following taking part there are any issues that are concerning you I hope that you can access the support network around you (colleagues, supervisor and managers). However, if this isn’t possible or you feel there is a need for some additional support there is a free confidential counselling service provided by BHSCT for employees.

****

******** is the leading provider of counselling and Employee Assistance Programmes in Ireland and throughout the British Isles. Owned******** operates as an independent business that supports employers, managers and staff by providing a confidential service that is accessible on a 24/7 basis.

How to access the service

The service is normally accessed on a self-referral basis. There is also available a 24/7 helpline. ********* for more information visit

http://www.**********.****.net/?page_id=1681

Occupational Health

Occupational health is concerned with the interaction of work and health including: How work and the working environment can affect an employee's health and how the health of an employee may affect his/her ability to do their job.
The principle role of the Occupational Health Service (OHS) is to provide advice to employees, managers and the Trust on issues relating to health at work and fitness for work. The service is:

- Confidential
- Advisory
- Impartial

Occupational Health Service is based **********

If you have any questions or would like further information here are my contact details:
Email**********
Phone: ***********

If you have any concerns about how the study has been conducted please contact myself, my supervisor Dr Rachel Abedi, RAbedi@Tavi-Port.nhs.uk or Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk).

Kind regards,

Deborah

The Tavistock and Portman NHS
NHS Foundation Trust

Draft semi-structured interview schedule

Title: What are clinicians‘ experiences of therapeutic work with children and young people when the patient won't feed?

Welcome

I will explain that this is a semi-structured interview that will last approximately 60 minutes. Check that they feel comfortable and make adjustments necessary. Remind participants that they are welcome to talk freely about their experience of therapeutic work with children and young people who refuse or restrict food.

General information gathering

What is their professional experience to date to include professional background, previous positions, current position, and relevant cases?

Ask about what cases come to mind when they think about the research topic.

Lots of cases?
A particular case, if so what is/was it about the case that come to mind?
How long was the length of treatment, how frequently where the appointments?
How long ago?
What feelings come up about the work?

What was the treatment modality?

Did they work to a model?
If so, was there drift?
Was it patient lead?

What can be remembered about how it felt to work with the patient/patients?

Before, during and after appointments?
What seemed to go well?
What seemed to be difficult?

What comes to mind about supervision of these cases/this case?

What feelings come to mind about the patient/patients?

What feelings about the families and networks?

What comes to mind about risk?

Was medical intervention a factor?
Was co working available?

How do you feel about continuing to work with these patients?

Anything not asked but would like to mention?

Ending of interview

Thank you for taking part. Any questions or want any further information to contact me. Signpost them to colleagues, supervisors and senior staff who are within the clinic at that time if they need support following the interview discussion. Send debrief out to them.