Turning the Tables - The Vulnerability of Nurses Treating Anorexia Nervosa Patients

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Introduction

Vulnerability is part of the human condition. We are all born vulnerable to various harms, especially at the beginning and the end of our lives. Vulnerability is, thus, a very broad concept, broad in scope and possibly vague on substance[1] [2] [3] [4] . It "can be ascribed to objects such as ecosystems, computers, economic systems or entire countries: for instance, computers can be said to be vulnerable to viruses, and countries vulnerable to attack" [5].

By contrast, the concept of vulnerability is normally used for a very specific purpose in bioethics, namely the identification and protection of those at risk of being exploited in research[6]. Trying to steer a middle path between applying the concept to entire countries or restricting it to research participants, this article has two aims:

1. We want to show that a specific definition of vulnerability can be used in a real-life case that goes beyond the identification and protection of those at risk of being exploited in research.
2. In applying such a specific definition of vulnerability to nurses caring for *anorexia nervosa* (AN) sufferers, we want to show that concrete possible harms and ways to mitigate them can be identified.

The definition of vulnerability we have chosen to achieve our aims is the following:

> "To be vulnerable means to face a significant probability of incurring an identifiable harm, while substantially lacking the ability or means to protect oneself.[7]

We apply the definition in the context of caring for AN sufferers. It is quite obvious that those who are hospitalized with AN due to their extremely low body weight are indeed vulnerable. In many cases they face a significant probability of incurring an identifiable harm (mortality or morbidity due to starvation) while substantially lacking the ability to protect themselves against this manifestation of their illness. Given that the vulnerability of AN sufferers has been widely described in the literature, we are not going to provide further details here.[8] [9] [10] [11] [12] [13]

Instead of focusing on the AN patients' vulnerabilities, we consider whether the *nurses* caring for AN sufferers might face a significant probability of incurring an identifiable harm, while substantially lacking the ability or means to protect themselves. In addition the relevant literature, this article is based on a qualitative study undertaken in the UK which explored the lived experience of the relationship between women with AN and their care workers in the context of a specialist Eating Disorder Unit.[14]

We start with a case study.

Treating AN Patients - Caring for 'Anna'

Anna's clinical background

> *Anna is a voluntary patient in a specialist Eating Disorder Unit (in-patient). At 5'2" (1.55m) and weighing only 70lbs (31.7kg) her BMI is 12.8. She is visibly emaciated. She is 18 years old and was diagnosed at age 16 as having AN after she collapsed following an audition for a dance academy. She disputes the diagnosis but agreed to her admission informally because her psychiatrist became so concerned about her that he discussed possible detention in hospital under the UK Mental Health Act. At that time Anna's BMI was 11.2. She has been in hospital for three months, she is desperate to be discharged, but fears she will be detained against her will if she attempts to leave.*

Anna's perspective

> *Admission to hospital, enforced rest and re-feeding* (i.e. interventions aimed at both weight gain and also the normalisation of eating behaviours) *are absolutely unbearable to Anna; every meal is an ordeal for her. Being prevented from dancing is highly frustrating for Anna who believes that the care team are preventing her from realising her dream; dance is the most important thing in her life.*

The care team's perspective

> *The team (dietician, psychiatrist, nurses, therapists) have used their specialist skills to try to help Anna understand the relationship between eating and the realization of her aspirations, but she cannot accept that there is a problem. She does not come to the dining room voluntarily. Once at the table, she looks terrified. Staff will sit with her for 45 minutes, but usually end up giving her a meal replacement drink, which requires another 45 minutes. Anna cries and screams at the nurse who sits with her that she is ruining her life. The nurses take turns to assist Anna at the table because it is so stressful. When Anna has calmed down, she blames her behaviour on 'Anorexic Anna' and does not seem to take any responsibility for the disturbance to other patients nor the upset she causes the nurses.*

The Vulnerability of Nurses Caring for AN Sufferers

As the above case outline already indicates, caring for AN sufferers can be a highly complex and stressful task. In the following we ask, in which areas, if any, AN nurses face a significant probability of incurring an identifiable harm, while substantially lacking the means to protect themselves.

Inauthentic relationships

Authenticity within a relationship between patient and carer is not only personally satisfying, it is considered to be the catalyst for a therapeutic relationship[15]; a relationship that might create a bond between the AN patient and the nurse, possibly leading to the acceptance of

treatment. Authentic relationships are honest, open, transparent, trustworthy, genuine, faithful and reliable. Therapeutic relationships are relationships that contribute to the positive outcomes of health care and to the possible re-establishment of health and well-being.

> "Without exception, patients' experiences are influenced by how care is delivered. Through communication, a patient can: be reassured; be put at ease; be taken seriously; understand their illness more fully; voice their fears and concerns; feel empowered; be motivated to follow a medication regimen; express a desire to have treatment (or not); be given time and treated with respect... Communication is therapeutic. Building relationships is the cornerstone of nursing work"[16] .

If authentic relationships are the cornerstone of therapeutic relationships, what are the special difficulties for caring for AN sufferers? The overwhelming fear of weight-gain stands as an obstacle to entering into an authentic relationship for the AN sufferer. Schmidt and Treasure[17] describe the AN patients' constant fear of not pleasing others in that they crave validation and likability and so will appear agreeable and eager to conform but, in reality, cannot surrender to the care regimes of AN care facilities, which require open and honest communication. Hence, the sufferers appear, superficially, to agree to the treatment to avoid conflict, but it is only a veneer of acceptance; it is not genuine, authentic acceptance and communication. For instance, in the above case, Anna appeared to agree to the treatment plan as she was concerned that she might otherwise be detained in hospital under the UK Mental Health Act[18]. At the same time, when it came to the act of eating, the foods presented to her in the dining room terrified her and she refused to eat.

As a result, interactions between care workers and AN patients are often strained and frequently characterised by ambivalence and conflict [19 20 21 22] The care workers are torn between the high levels of supervision required, accusations that the care deprives the patients of autonomy, coupled with the patients' frequent, sometimes seemingly contradictory demands for physical closeness and soothing when they are distressed and upset. It is not unusual in this context for patients to be labelled as manipulative, attention-seeking, oppositional or difficult by the care team [23 24 25]

On the other hand, Palmer [26] infers that an apparently obstructive, subversive and manipulative young woman with an eating disorder is more likely to be feeling lonely, misunderstood and fragile. She wants to be understood by those providing care.

One response to the conflict between apparent acceptance and inward rejection of therapeutic options is for the patient *and* the care worker to talk about AN as though it was a separate entity. As soon as conflict and disagreement occurs, these features of the relationship tend to be attributed to an externalised entity which is the 'anorexic self', or the 'anorexic voice'[27]. Thus, responsibility for the conflict is given to 'anorexic Anna', for example, and thereby externalised.

What does this mean for the nurses' potential vulnerability? Authentic, therapeutic relationships are an important cornerstone of nursing care. Nurses are meant to be open, honest, and genuine communicators as part of their caring work. However, when dealing on

an ongoing basis with those unable or unwilling to enter into such a relationship, whilst maintaining that they do, the only option may seem to meet the patient on their own territory, to adopt their way of communicating in order to effect a therapeutic outcome. There are times when the professional caring role becomes skewed and there is an admission that the initial establishment of that relationship is almost coercive:

> *…I fish for them and reel them in…so that actually you can help them move on because you've got that hook into them.*
>
> Lizzie, nurse

Caring for people with AN is exhausting and the burn-out rates are high for staff [28]. Of the seven nurses/nurse therapists that were part of this study (see box after conclusion) all have left the service. One left to work in child and adolescent services; two are currently on long-term sick leave, one works exclusively as a therapist and the other three work in generic mental health services. Although it is not possible to say conclusively that all left because of the stressful nature of the job, all spoke about the difficult nature of their work in the interviews.

By trying to achieve their goals using inauthentic means, nurses may face a significant probability of incurring an identifiable harm without the means to protect themselves. They may suffer burn-out and other health and mental health problems due to an unresolvable conflict between two equally important nursing values, the value to maintain authentic relationships and the value to achieve a therapeutic outcome.

Non-reciprocal relationships

The "Standards of conduct, performance and ethics for nurses and midwives" published by the Nursing and Midwifery Council[29] is the highest ethical reference point for nurses and midwives in the UK. The first rule in these guidelines is that: "You must treat people as individuals and respect their dignity." Rule 3 reads, "You must treat people kindly and considerately." Whilst these obligations are placed on health care staff, patients have their own responsibilities. The UK National Health Service (NHS) Constitution summarises patient rights *and* patient obligations:

> "Please treat NHS staff and other patients with respect and recognise that violence, or the causing of nuisance or disturbance on NHS premises, could result in prosecution. You should recognise that abusive and violent behaviour could result in you being refused access to NHS services." [30]

Nevertheless, abusive and even violent behaviour does occur on AN wards and derogatory personal comments are frequently directed towards the AN nurses.

> *...right I hate you all, I hate all the staff here, they're all rubbish, they're all trying to kill me.*
> Rachel, patient

You just don't get anywhere because you're in this constant loop of, you're trying to force them to eat, they don't want to, they hate you for it.

Lizzie, nurse

As noted above AN sufferers can be perceived as manipulative, attention-seeking, oppositional, difficult, obstructive or subversive on the one hand, or as lonely, misunderstood and fragile on the other. As a general rule, one would not want to refuse access to health care services (as foreseen in the NHS Constitution) to young, lonely, misunderstood and fragile patients even if they are outwardly abusive, manipulative and violent as part of their condition. In any case, patients may be receiving compulsory treatment under the UK Mental Health Act, in which case refusion of service is not an option.

As a result, aggressive and violent behaviour is often tolerated. Nurses tend to pretend a calm acceptance of the patients' rejection of their care. However, the following quote gives an insight into a nurse's perspective, which shows that outward calm may not be mirrored by inner calm [31].

They need to see what they have done - what their behaviour has caused and they need to be accountable for that - so we should go back in to the patient's room - with the nurse in tears - and say look – what's going on. ... We do make a lot of allowances for these clients and sometimes they do need to be held accountable for their actions - they can be very vicious and they can be very hostile and it's not ok - why should we soak it all up - just 'cos they are throwing it at us - and yes we are professionals and yes we do have to contain all their shit - for want of a better word - but we also have to feed back to them when they cross the line - and sometimes they do cross the line.

Hannah, nurse

Whilst nurses in the study expressed their exhaustion through comments such as the above, none thought it appropriate – on reflection - to confront AN sufferers with highly upset staff. Instead, it was accepted that nurses and AN sufferers cannot have reciprocal relationships, characterized by mutual respect, nor can the NHS constitution and its option of refusal of treatment be evoked even though the organisation promises that:

"NHS employees have the right to expect a safe and secure environment in which to work, and NHS employers have a legal and ethical responsibility to ensure their employees are protected from violence and abuse at all times in the course of their duties." [32].

Nurses prefer to see themselves as caring and kind, but the conflictual relations and the argumentative nature of the AN patients is again likely to lead to poor staff retention, burn-out, and sick leave [33 34 35 36].

One could therefore maintain that the usual protection mechanisms for health care staff (exclusion from service) are not available to AN nurses. This means that they cannot protect themselves from mental and physical abuse, as this is likely to worsen the starvation and the already high risk of morbidity and mortality of the AN sufferers. As a result, they face a

significant probability of incurring an identifiable harm, while substantially lacking the means to protect themselves.

Vulnerability or Health and Safety Failures?

The above discussion certainly suggests that nurses in an AN facility have a very difficult job, but the following two questions pose themselves:

1. Are the nurses really vulnerable? Wouldn't it be better to say that they have a stressful job, much like fire fighters, military personnel or nurses on a palliative care ward? Why call them vulnerable?
2. Should one apply the concept of vulnerability to staff in the same way as one does to research participants?

In response to question 1, comparing AN nurses with fire-fighters is enlightening. Fire fighters certainly have a dangerous job, but they do not face a significant probability of occurring an identifiable harm, *while simultaneously* substantially lacking the means to protect themselves (or to be protected). In the UK, health and safety regulations are an essential and substantial part of fire fighters working lives. A National Officer at the Fire Brigades Union (FBU) said :

> "Firefighters face dangerous situations on a routine basis. No one wants to see them injured or killed while carrying out their work. In our profession Health and Safety is literally a matter of life or death. ... There is a balance between placing unacceptable expectations on firefighters and making sure they are trained and equipped to safely carry out the job they are expected to do - save lives."[37]

Thus, Health and Safety regulations together with adequate training are the protection mechanisms provided to fire fighters to overcome the otherwise significant probability of them incurring an identifiable harm. Protection adequate to the risks they face is therefore generally available. In our discussion we have argued that this does not always apply to AN nurses, where the NHS constitution, one important means of protecting staff, is not generally evoked. Below, we suggest possible mitigation strategies that would provide better protection to AN nurses, in line with the protection offered to fire fighters.

In the context of question 2, would one not indeed want to restrict the concept of vulnerability to protect research participants rather than health care workers? We believe that this restriction is unnecessary. According to Rogers, Mackenzie and Dodds [38]a context-sensitive analysis of specific kinds and sources of vulnerability can avoid unnecessary harm. Avoidance of unnecessary harm is an ethical prerogative [39]. If the application of a definition of vulnerability can help identify and address harms, it is important to do so in any context.

In the following, we provide recommendations on how to improve the situation of AN nurses based on the interviews from the qualitative study.

Protecting AN Nurses from Harm - Some recommendations for practice

Applying a definition of vulnerability to AN nurses has led to the identification of two possible harms in the areas of inauthentic and non-reciprocal relationships. Recommendations 1-2 are tailored towards the mitigation of inauthentic relationships. Recommendations 3-4 are focused on mitigating non-reciprocal relationships. Recommendations 5-6 apply to both.

1. Being authentic – communicating person to person
   Whilst it may appear that manipulation might be successful in, for instance, making AN patients eat, consistent authenticity is crucial for the nurse to attempt to connect to the patient. Attribution of anorexic behaviours to a separate identity creates a battle with the nurse and should be avoided.

2. Being a catalyst for therapy
   Nurses should try to focus on creating a change in the patient without being altered themselves. Hence, *'don't take it personally'* is an extremely important message as staff must be cogniscant that the patient's battle is not with them as a person.

3. Establishing professional boundaries which promote mutual respect
   Attempts to remain professional, caring and kind with patients who declare their hatred for staff is difficult. Nurses should establish professional boundaries and adhere to these, but in order for these to be effective, both parties in the professional relationship (i.e patients and nurses) need to know where the limits of the professional relationship are set. It is recommended that these discussions with patients take place at admission and that all team members create consistent ways of creating a safe and professional clinical environment by upholding these boundaries.

4. Labelling the behaviour not the person
   To achieve consistency and cohesion within the care team and set boundaries in a caring manner, it will help to label the behaviour not the person. For example, not *'Olivia is a difficult patient'*, but rather *'Olivia is doing something that is difficult for me to deal with.'* This response also demonstrates ownership by using the word 'me' rather than 'the team' or 'us'.

5. Taking regular supervision
   To cope with the demands of working in an Eating Disorder Unit, clinical supervision is highly important. It can create insight and resilience. Nurses are put under significant strain by the highly emotional environment and the hostility and oppositional behaviours of the patients, directed at them. To be able to discuss this problem with a supervisor on a regular basis can increase resilience. This also requires that supervision sessions are built into the work plans and the personnel budgets.

6. Creating a connection that is professional and therapeutic

The following describes the approach of a nurse who was cited by many patients in the study as having the qualities of a caring and compassionate nurse.

- She would notice 'little things', such as a new piece of jewellery or a change of hair style. The patients believed that she was interested in them, as a person and an individual and these observations reinforced that view.
- She reached out to the patient. If the patient was sitting on the floor, she would sit on the floor.
- Her voice was always gentle and quiet. She never shouted at patients, even when she was directive, her intonation suggested empathy.
- A physical connection was sometimes made, such as holding a hand, or hugging a woman in tears until she was calm. Then she would return to the issue that had caused the distress. This was important so that the distress was not successful as a diversion. She would return to the issue when the patient was calm, in order to find a resolution.
- The 'broken record' technique was used regularly by her. It meant that she calmly repeated her directions in an identical manner without losing patience. This emphasized that the treatment plan was non-negotiable. Care workers who tried to cajole the women and seemed open to negotiation or to make minor changes were seen as less robust than her and more easily manipulated.

Conclusion

Nurses respond to the human condition, they are trained to care for the vulnerable in existential situations. We started the article with the statement that vulnerability is a feature of the human condition. We are all vulnerable. However, vulnerability comes in important degrees. AN sufferers *and* AN care workers are vulnerable to the possibility of identifiable harms without being able to protect themselves. However, in the case of AN nurses, *means* to protect themselves (e.g. regular supervision) could be readily provided with increased awareness of their situation. This is much more difficult to achieve for AN sufferers.

As such applying a definition of vulnerability to a real life case in a specialised Eating Disorder Unit has identified the possibility of concrete harms for AN nurses, which need to be mitigated against. At the same time, recommendations on how possible harms could be avoided could be generated.

According to Hurst [40] the purpose of a definition of vulnerability should be to draw attention to those who need protection, in whichever situation they find themselves in regarding health care. We hope to have drawn some attention to the situation of nurses in AN care facilities.

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