

**AN INTERPRETIVE PHENOMENOLOGICAL STUDY OF THE  
THERAPEUTIC RELATIONSHIP BETWEEN WOMEN  
ADMITTED TO EATING DISORDER SERVICES AND THEIR  
CARE WORKERS**

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## **STUDENT DECLARATION**

\*I declare that while registered for the research degree, I was with the University's specific permission, an enrolled student for the following award:

**Postgraduate Certificate in Research Methods in Health and Social Care**

I declare that no material contained in the thesis has been used in any other submission for an academic award and is solely my own work.

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**Type of Award** PhD

**School of Health**

## **ABSTRACT**

**Title:** AN INTERPRETIVE PHENOMENOLOGICAL STUDY OF THE THERAPEUTIC RELATIONSHIP BETWEEN WOMEN ADMITTED TO EATING DISORDER SERVICES AND THEIR CARE WORKERS.

**Aim:** To explore the lived experience of the relationship between women with anorexia and their care workers in the context of a specialist eating disorder unit.

### **Background**

The establishment of a positive therapeutic relationship (TR) has been widely acknowledged internationally as an intrinsic part of therapy and caring services; which is healing and restorative in its own right. A TR is crucial when working with patients who are difficult to engage and have high 'drop-out' rates such as those within eating disorder services who are considered to be '*high risk*', '*difficult*', '*defiant*', '*reluctant to engage in treatment*' and '*frustrating*' (Fairburn and Harrison, 2003; Pereira *et al*, 2006). To date there has not been any qualitative exploration of the therapeutic relationship involving women and their care workers.

### **Method/ Methodology**

This interpretive phenomenological study focuses on women with anorexia and their care workers in both day care and in-patient specialist eating disorder services in the UK. Van Manen's methodological and analytical approach was adopted for this study. Twelve women with anorexia and thirteen of their care workers (nurses, doctors, dieticians and therapists) participated in the study which was conducted in two phases. Phase one was conducted with care workers and women with anorexia in a day care service (between October - November 2009). Phase two was conducted with care workers and women with anorexia within an

inpatient care unit (between May – June, 2011). Semi-structured interviews were conducted with all participants to explore their experience of the therapeutic relationship. Phase one data were thematically analysed, following which the full data set (phases one and two) was analysed as a whole, using MAXQDA as a tool for the organisation of the emerging themes. The initial themes were subsequently re-organised into themes and sub-themes through the lens of Merleau-Ponty's existential themes and Heidegger's concept of 'authenticity'.

## **Findings**

The findings illustrate that the experience of the therapeutic relationship for women with anorexia and their workers cannot be viewed without fully acknowledging the impact of the anorexia, the anorexic identity, the context (the therapeutic landscape) in which this exists and the effect of time. Hence Merleau Ponty's existential lens provided a very suitable framework for the findings.

Corporeality, the bodily experience, is integral to the lifeworld of both women and workers and reflects the primary goal of eating disorder services. Its associated sub-themes of '*identity*', '*externalisation*' and '*recovery measured in kilos*' highlight how anorexia is integrated within the women's perception of their identity, as well as the care workers focus on weight restoration. 'Spatiality' reflects the significance of 'space' in the creation and experience of a TR; the sub-themes of '*lived space*', '*the therapeutic landscape*' and '*rules and regulations*' consider the contextual basis of care. The theme relationality focusses on the person-to-person encounters and included the sub-themes '*conflicting perspectives*' and '*maternalism*'. Finally, the time spent together was considered to be fundamental to the connection made between the women and the workers and so, within temporality, '*the gift of time*' and '*availability*' emerged as sub themes within the data. The fifth theme, '*authenticity*' is pivotal to both the therapeutic relationship and also phenomenology and reflects Heidegger's perception that authenticity is '*being one's self*', for which honesty and truthfulness are

essential components. Hence this last theme includes the sub-themes of *'the power and uniqueness of the individual'*, *'empathy for the worker'* and *'trust'*.

Both the women and the care workers valued the relationship but the externalisation of the disorder created difficulties in the authenticity of the relationship. A temporary, maternalistic, nurturing approach was highly valued and recognised as only transitory.

### **Contribution to knowledge of the subject**

This study offers new knowledge and understanding about the experience of the relationship that occurs between women with anorexia and their care workers. Overall, the findings suggest that whilst a relationship that has therapeutic effects existed between the women with anorexia and their care workers, some fundamental features of the therapeutic relationship that have been previously accepted as pre-requisites in other contexts (e.g. mutuality and reciprocity) were not identified as crucial to the instrumental nature of the relationship. Care workers should re-consider the assumptions of mutuality for this client group and thus construct their relationship differently. A meaningful connection can be made between the care workers and the women which is based upon a 'tear and repair' model, but it is only therapeutic if the patient perceives it to be therapeutic for them. A fractured relationship is inevitable when the woman's sense of self is split, that is, divided into the authentic ('real') self and the anorexic self. Hence, in order to gain an authentic connection, it is suggested that the care worker focus on the 'real' woman in order to establish a relationship with the part of the person that has the capacity for an authentic relationship. Thus, a two-fold intervention takes place; the relationship is potentiated and the woman's battle remains between her and her anorexia, rather than with her care workers.

# TABLE OF CONTENTS

STUDENT DECLARATION .....	1
ABSTRACT.....	2
LIST OF TABLES.....	14
PUBLICATIONS ARISING FROM THE PROJECT .....	15
ACKNOWLEDGEMENTS.....	16
A READER'S GUIDE TO THE TEXT AND TERMINOLOGY .....	18
ABBREVIATIONS .....	20
Chapter 1: Introduction .....	21
1.1. The history of the study .....	21
1.1.1 Professional motivations for the study .....	23
1.1.2 The professional and academic rationale for the study .....	24
1.2. A guide to the chapters.....	25
Chapter 2: Background .....	28
2.1. The therapeutic relationship.....	28
2.1.1 In search of a definition .....	28
2.1.2 Framing the therapeutic relationship.....	31
2.1.3 The therapeutic use of self within the relationship.....	33
2.2. Anorexia Nervosa:.....	35
2.2.1 'Eating distress' .....	37
2.2.2 Why women? .....	38
2.2.3 The association made between eating disorder and personality disorder. ....	38
2.3. Eating disorder services in the UK .....	40
2.3.1 Availability of services.....	40
2.3.2 Service provision .....	42

2.3.3	Admission and the reluctant patient .....	42
2.3.4	'Drop-out' from services, care and treatment .....	44
2.3.5	The social environment that hosts the relationship .....	46
2.4.	The therapeutic relationship with women with an eating disorder .....	48
2.4.1	Fundamental assumptions about the therapeutic relationship, the relevance to eating disorder services and the challenges .....	51
2.5.	Conclusion.....	53
Chapter 3:	The literature review.....	55
3.1.	Introduction .....	55
3.2.	The importance of the literature review .....	55
3.2.1	Search strategy.....	56
3.3.	Focus on the therapeutic relationship within eating disorder services.....	62
3.3.1	Summary of the key points .....	71
3.4.	Conclusion.....	72
Chapter 4:	Theoretical Positioning .....	74
4.1.	Introduction .....	74
4.2.	Positioning the theoretical approach .....	74
4.2.1	Aim of the study.....	74
4.3.	The research journey .....	75
4.3.1	Phenomenology .....	75
4.4.	The phenomenologists that have influenced van Manen's approach.....	76
4.4.1	Edmund Gustav Albrecht Husserl (1859-1938): 'Husserlian phenomenology' ...	77
4.4.2	Martin Heidegger (1889-1976): Heideggerian phenomenology .....	78
4.4.3	Hans-Georg Gadamer (1900-2002).....	79
4.4.4	Maurice Merleau-Ponty (1908- 1961) .....	80

4.5.	Max van Manen (1942-present) .....	81
4.5.1	The hermeneutic circle .....	82
4.6.	Conclusion.....	85
Chapter 5:	Study design and methods.....	86
5.1.	Introduction .....	86
5.2.	Study design: a phased approach .....	86
5.2.1	Phase one.....	87
5.2.2	Phase two.....	88
5.3.	Gaining access to the service and participants.....	88
5.3.1	Ethical approval.....	89
5.3.2	'A vulnerable population'.....	90
5.3.3	Confidentiality and storage of data .....	92
5.4.	Recruitment to the study .....	92
5.4.1	Purposive sampling .....	93
5.4.2	Gaining consent .....	93
5.5.	Van Manen's methodical structure of human science research .....	95
5.6.	Turning to a phenomenon which seriously interests us and commits us to the world. 96	
5.6.1	Bracketing .....	96
5.7.	Investigating experience as we live it, rather than as we conceptualize it. ....	98
5.7.1	The interviews.....	99
5.7.2	Use of the hermeneutic circle within the interviews.....	101
5.7.3	Transcription .....	103
5.8.	Reflecting on the essential themes which characterize the phenomenon. ....	104
5.8.1	Reading and writing .....	104

5.8.2	Organisation of the data .....	105
5.8.3	Development of the themes and sub-themes .....	106
5.8.4	MAXQDA .....	108
5.9.	Describing the phenomenon through the art of writing and re-writing. ....	109
5.9.1	The use of the 'anecdote' .....	110
5.10.	Maintaining a strong and oriented relation to the phenomenon. ....	112
5.11.	Balancing the research context by considering parts and whole. ....	113
5.12.	Organisation of the data utilising the structure of fundamental existential themes. 114	
5.13.	Addressing Rigour and Trustworthiness. ....	115
5.13.1	Dependability .....	115
5.13.2	Credibility .....	116
5.13.3	Confirmability.....	117
5.13.4	Transferability .....	118
5.14.	Conclusion.....	120
Chapter 6:	phase one of the research in a day care setting .....	121
6.1.	Introduction .....	121
6.2.	The context .....	121
6.3.	Participants: phase one.....	122
6.4.	The interviews.....	124
6.5.	Analysis of phase 1 data.....	125
6.5.1	Emergent Themes .....	125
6.5.2	Authenticity of the relationship. ....	126
6.5.3	The importance of safety .....	127
6.5.4	Externalisation of the eating disorder .....	128

6.5.5	Recovery measured in kilos .....	129
6.5.6	The power of hope and optimism.....	130
6.5.7	Maternalism.....	131
6.6.	Discussion of phase one findings .....	132
6.7.	The utility of a mid-point analysis.....	134
6.8.	Conclusion from phase one of the study .....	135
Chapter 7:	Phase two: the in-patient service. ....	137
7.1.	Introduction .....	137
7.2.	The transition from phase 1 to phase 2 of the study.....	137
7.3.	The context .....	139
7.4.	The participants, phase two: in-patient care.....	139
7.4.1	Demographics of participants phase two: in-patient care .....	141
7.5.	The interviews.....	142
7.6.	Organisation of the data utilising the structure of fundamental existential themes. 142	
7.6.1	Corporeality: lived body.....	143
7.6.2	Spatiality: lived space.....	144
7.6.3	Relationality: lived human relation, or communality .....	145
7.6.4	Temporality: lived time .....	145
7.6.5	Authenticity.....	146
7.7.	Analysis of the data using the existential themes .....	147
7.7.1	Emergent themes.....	147
7.8.	Conclusion.....	148
Chapter 8:	Guided existential reflection: Corporeal reflection .....	149
8.1.	Introduction .....	149

8.1.1	Lucy .....	150
8.2.	Identity .....	150
8.3.	Externalisation .....	157
8.4.	Recovery measured in kilos .....	164
8.5.	Conclusion.....	169
Chapter 9:	Guided existential reflection: Spatial reflection (lived space) .....	171
9.1.	Introduction .....	171
9.2.	Lived space (spatiality).....	172
9.3.	The therapeutic landscape.....	172
9.4.	Rules and regulations.....	180
9.5.	Conclusion.....	182
Chapter 10:	Guided existential reflection. Relationality: lived human relation, or communality 184	
10.1.	Introduction .....	184
10.2.	Conflicting perspectives .....	185
10.2.1	The battle .....	188
10.2.2	Surrender .....	191
10.2.3	'Tears and tantrums' .....	194
10.2.4	Peer support/peer effect .....	197
10.3.	Maternalism.....	199
10.3.1	Closeness.....	203
10.3.2	Attachment .....	205
10.3.3	Approval.....	208
10.4.	Conclusion.....	210
Chapter 11:	Guided existential reflection: Temporal reflection (lived time) .....	211

11.1.	Introduction .....	211
11.2.	The gift of time .....	211
11.2.1	Availability.....	215
11.3.	Conclusion.....	216
Chapter 12:	Authenticity.....	218
12.1.	Introduction .....	218
12.1.1	The power and uniqueness of the individual.....	218
12.1.2	Empathy for the worker.....	223
12.1.3	Trust .....	225
12.2.	Conclusion.....	228
Chapter 13:	Theorising the findings: Discussion.....	229
13.1.	Part one:.....	229
13.1.1	Introduction .....	229
13.2.	Guided existential reflection. Corporeality: Lived body .....	231
13.2.1	Identity.....	231
13.2.2	Externalisation .....	234
13.2.3	Recovery measured in kilos .....	237
13.3.	Guided existential reflection. Spatial reflection (lived space). .....	239
13.3.1	Therapeutic landscape .....	239
13.3.2	Rules and regulations.....	242
13.4.	Guided existential reflection. Relationality: lived human relation. ....	244
13.4.1	Conflicting perspectives .....	244
13.4.2	Maternalism.....	247
13.5.	Guided existential reflection. Temporality: lived time .....	250
13.6.	Authenticity.....	252

13.7.	Part Two:.....	256
13.8.	Contribution to knowledge.....	256
13.8.1	The fragmentation of identity created by externalisation of the disorder creates fragmentation in the relationship.....	257
13.8.2	Maternalism can be a tool for transition.....	258
13.8.3	A therapeutic relationship can exist with very tentative agreement around the tasks and the goals if the bond is strong enough. ....	259
13.9.	The therapeutic landscape is pivotal to the therapeutic relationship in specialist eating disorder units.....	260
13.10.	Implications for practice.....	260
13.10.1	Be authentic - communicate person to person. ....	260
13.10.2	Focus on the present.....	261
13.10.3	Make time every day to 'be' with the patient - not simply to 'do'.....	262
13.10.4	Create a therapeutic landscape.....	262
13.11.	Implications for policy.....	263
13.12.	Implications for further research.....	263
13.13.	Strengths and limitations of the study.....	264
13.13.1	Strengths.....	264
13.13.2	Limitations.....	264
13.14.	Conclusion.....	265
Chapter 14:	Reflexivity.....	266
14.1.	Introduction.....	266
14.2.	The use of self as a researcher.....	266
14.3.	The participants' awareness of me.....	269
14.4.	Researching women with anorexia and their care workers.....	270
14.5.	Conclusion.....	274

Chapter 15: Conclusion.....	276
REFERENCES:.....	281
APPENDICES .....	316
Appendix 1: NHS ethics committee letter .....	317
Appendix 2: University of Central Lancashire ethics permission letter .....	318
Appendix 3: Participant information sheets with consent forms.....	319
Appendix 4: Semi-structured interview schedule for patients .....	326
Appendix 5: Semi-structured interview schedule for workers .....	327
Appendix 6: the toast story.....	328
Appendix 7: Bracketing statement .....	330
Appendix 8: Reflexive journal example .....	335
Appendix 9. Published papers.....	339

## LIST OF TABLES

Table 1: Literature searching strategy .....	57
Table 2: Study Search terms .....	59
Table 3: Inclusion and Exclusion criteria.....	59
Table 4: Literature referring to the TR in ED services.....	62
Table 5: Phase 1 demographics—patients.....	123
Table 6: Phase 1 demographics - care workers .....	124
Table 7: Phase 1 themes .....	125
Table 8: Phase 2 demographics - patients .....	141
Table 9: Phase 2 demographics - Care workers.....	141
Table 10: Figurative illustration of the thematic analysis.....	148

## **PUBLICATIONS ARISING FROM THE PROJECT**

**(see appendix 9)**

Wright, K.M. and Hacking S. (2011) An angel on my shoulder- the lived experience of the therapeutic relationship between women with an eating disorder and their workers. Journal of Psychiatric and Mental Health Nursing. **19** (2):107-15

Wright, K.M. (2010) The therapeutic relationship– developing a new understanding for nurses and care workers within an eating disorder unit. International Journal of Mental Health Nursing. **19**, 154–161

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To my supervisors, Gill Thomson, Fiona Dykes and Sue Hacking. Thank you. You have believed in me and in this study; your commitment to both has been my motivation to complete it. In particular, Gill's forthright honesty and enthusiasm has kept me believing that it is possible to get through this journey even when I felt overwhelmed by the task; she has been an inspiration to me. Thanks to Mick McKeown for encouraging me to write about things that matter and who has been both challenging and inspiring in equal measure.

Phil, John and Caraline have all have been incredibly patient and supportive. I am eternally grateful for their patience with me over the last year. I promise you, I really will stop studying very soon.

Thank you to Jean, Nigel and Bernard for making it possible for me to write. Thank you for your encouragement and practical support.

In September 2011 I travelled to Toronto, Canada, where I met with Professor Marion Olmsted from Toronto General Hospital, Toronto University. Toronto General Hospital is where the first eating disorder in-patient service was established and where the first notable study into eating disorders and the therapeutic relationship was published. Whilst there, I also visited 'Sheena's Place', a community based support centre (in Toronto) offering support group programmes, outreach/education for individuals with eating disorders and their families. Sheena's Place had an extensive library which I was allowed to browse. This library included a

number of autobiographical accounts which provided insight and understanding into the plight of the women and their families.

I would like to acknowledge the continued support and guidance offered by Max van Manen. His two-day master class enabled me to grasp the essentials of his methodology and he has kindly responded to emails when I have had difficulty. He also has a web-site for continuing support which has been invaluable.

Finally, I thank *Millie* who will never know the impact that her death had on me. I promise that I will do my very best to help people to understand.

Thank you all.

## A READER'S GUIDE TO THE TEXT AND TERMINOLOGY

I would like to provide some clarity and explanation for the way this thesis is presented, grammatical matters and abbreviations.

I have written in the first person throughout this study. There are several reasons for this. Primarily, it conveys my position as author and creates transparency where I state something from my own perspective, without the awkwardness of framing this in the third person. The very nature of the study, interpretive phenomenology, requires the researcher to situate herself/himself within the research in order to illuminate the text (Smythe *et al*, 2008) and bring about understanding, derived through the lived experience of others. It is, therefore, necessarily reflexive throughout.

The therapeutic relationship has been examined comprehensively within many texts written for nurses, therapists and other care workers resulting in the use of several similar terms. For example '*therapeutic alliance*', '*working alliance*', '*helping alliance*', '*therapeutic relationship*', '*working relationship*' and '*helping relationship*'. A number of these terms are sometimes used interchangeably within the same article, as though they are synonymous. Here, I will use the term '*therapeutic relationship*' at all times, for consistency, except if I am referring to a specific author's work, where specific terms have been used. I have also chosen the term '*therapeutic relationship*' for this study since it is the term most frequently used in nursing, my own professional background.

Italics are used to demonstrate direct quotations from the literature and from the research participants. These quotations are identifiable by the use of *Century Schoolbook* italic font and single line spacing. Participants are identified by a pseudonym, whether they are a patient or care worker participant, the phase of the research, (P1 or P2), the number of their interview and the MAXQDA line reference, thus: Olivia, patient P2 iii: 19.

The use of an ellipsis i.e. ... means that some text is missing. The word 'participants' refers to the both care workers and patients. Sometimes I have referred to the patients as the 'women', depending on the context. As a number of the care workers who participated in this study were from various disciplines, I have mainly used the term '*care worker*' to refer to members of the care team. There are instances when the discipline or role of the worker is important, e.g. psychiatrist, or nurse manager. In these instances I have stated their professional role.

I generally use the term '*patients*'. However, the term '*service user*' is the term of choice for some writers, for e.g. Beresford (2000/2002). So, when referring to their work, I have used their terminology.

Anorexia Nervosa (AN), is usually shortened to '*anorexia*' within this study.

## ABBREVIATIONS

AN	Anorexia Nervosa
BMI	Body Mass Index
BN	Bulimia Nervosa
CBT	Cognitive Behavioural Therapy
DLA	Disability Living Allowance
EDNOS	Eating Disorder Not Otherwise Specified
ED	Eating disorder
EDU	Eating Disorder Unit
FBT	Family-based therapy
GP	General Practitioner
HCA	Health Care Assistant
MH	Mental Health
MHA	Mental Health Act
NMC	Nursing and Midwifery Council
NICE	National Institute of Clinical Excellence
NRES	National Research Ethics Service
PCT	Person Centred Therapy
PD	Personality Disorder
RCT	Randomised controlled trial
UCLan	University of Central Lancashire
TR	Therapeutic relationship
RGN	Registered General Nurse
RCP	Royal College of Psychiatrists
SEDU	Specialist Eating Disorder Unit
TA	Therapeutic Alliance
WA	Working alliance

## Chapter 1: INTRODUCTION

The purpose of this interpretive phenomenological study is to explore the experience of the therapeutic relationship between women with anorexia receiving care and treatment in specialist eating disorder services (SEDUs) and their care workers. Anorexia Nervosa (AN) is a serious disorder with both physical and psychological manifestations (RCP, 2012). This research is not a study of anorexia, rather, it aims to shed light, or 'illuminate' (Todres and Galvin, 2008; Smythe *et al*, 2008) the experience of the relationship between the women who suffer with this debilitating condition and those striving to help them recover, the care workers. Here, I provide an overview of the journey to establish the study focus and provide a rationale for the final research project before outlining the chapters to follow.

### 1.1. The history of the study

The impetus for this study falls loosely into three areas, personal, professional (clinical) and academic. I say 'loosely', because the personal and professional are difficult to separate as some of my personal responses occurred whilst conducting professional duties.

Firstly, I offer a personal recollection from thirty years ago:

When I was in the sixth form doing my 'A' levels, I sat next to a girl (who I shall call '*Millie*<sup>1</sup>') in my human biology class who was much brighter and cleverer than I. She was more conscientious with her homework and was quicker than me with her answers in class. I noticed that she was thin, but over time she became thinner and thinner. Somebody told me that she had anorexia. A year or so later, when I was a student nurse undergoing my 'general' training (Registered General Nurse [RGN] ), Millie was admitted to the hospital where I was training. At

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<sup>1</sup> *Millie* is a pseudonym. The Data Protection Act 1998 does not apply after death, but the NMC code of conduct does: *The duty of confidentiality does continue after death of an individual to whom that duty is owed.* <http://www.nmc-uk.org/Nurses-and-midwives/Regulation-in-practice/Regulation-in-Practice-Topics/Confidentiality/> [accessed 22nd October 2012].

this time, we were both about 19 or 20. I was called to assist with 'last offices'<sup>2</sup> on the adjacent ward in the still and quietness of the early hours of the morning. There, in a side ward, a tiny female body was laid out on the bed, covered with a white sheet. In those days, we were required to identify the body by writing the patient's name with indelible marker pen along the outside of the person's left leg. I picked up the file, read the name of my friend from school and then I dutifully wrote her name along her emaciated, grey, cold limb. I was shaking, but in 1982 and at 4am there was no room for emotion on the ward; there was a strict 'stiff upper lip' culture. I was consumed by thoughts of '*why did anybody let this happen?*' I (silently) blamed the people who were there to care, for not caring enough; not helping her to see how beautiful and special she was. Why did somebody not make her better? In my naivety, I thought that surely it could not be that hard, all she had to do was eat, all her carers had to do was to persuade her to eat, to talk to her, to be believable to her. Thirty years later I am only just beginning to understand. I'm sorry that it was not soon enough for Millie, but I may now be able to shed some light to help those working in ED services to better understand the experience of similar women.

It is not unusual for researchers to have a personal interest or reasons for wanting to explore the lived experience (Moustakas, 1994) or to seek to find a deeper level of meaning than is presented at the conscious level (Patton, 2002). Van Manen (1990) firmly advocates that we use personal experience as a starting point and that this is useful:

*'...to show that the author recognises both that one's own experiences are the possible experiences of others and also that the experiences of others are possibly the experiences of oneself.'*

(van Manen, 1990: 58).

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<sup>2</sup> 'Last offices' is the care given to a deceased patient which demonstrates our respect for the dead and is focused on fulfilling religious and cultural beliefs as well as health and safety and legal requirements (Dougherty and Lister 2004).

Hence my initial impetus was to attempt to make sense of, and disentangle, my observations in order to provide some clarity and meaning to what seemed to be an extremely complex relationship.

### **1.1.1 Professional motivations for the study**

Professionally, I qualified as a RGN in 1985 and then as a Registered Mental Health Nurse (RMN) in 1988. I have been trained in the notion that the 'therapeutic relationship' is pivotal to the care that I provide and fundamental to my practice. Many of the care plans that I wrote as a student nurse started with '*establish a rapport with the client*'. There is value, however, in recognising what we mean by this and whether the relationship needs to be different with different groups of patients or in differing settings. Establishing and maintaining a relationship with the patient which is professional, respectful and therapeutic and which promotes recovery is still assumed to be the '*cornerstone of psychiatric nursing*' (Welch, 2005:161).

Sometimes my attempts at creating a relationship have been welcomed and I have felt that a connection has occurred between the patient and me. On other occasions, I have felt dismissed or rejected by patients. I have always found a way to deal with this on the basis that I could (usually) understand why: for example, the person was unwell; it might have been that they just did not trust me, or the system; I reminded them of somebody; I was positioned in a role of authority; or that I did not know them well enough to know how best to conduct myself in their company to elicit engagement. I have come to realise that if an interaction is not going well, it is as likely to be as much about me as the other person (Benjamin, 2003). There have been patients who I have felt were 'easier' to care for. That is, notwithstanding the usual challenges of mental health nursing, there has been mutual respect and understanding of each other's perspective.

I left full time clinical practice in 2006 to take up an academic post, but retained links<sup>3</sup> with a small in-patient service caring for people with eating disorders (predominantly anorexia). I observed the challenges of caring for people with anorexia and this created a curiosity and inquisitiveness that inspired me to search for the unique characteristics of the relationship between the care workers and the patients. I saw care workers using caring and compassionate approaches but this was often set against a barrage of resistance and refusals to accept the care and treatment offered, accompanied by emphatic expressions of why not. These were some of the most oppositional encounters I have ever witnessed, where workers make daily attempts to persuade the women to eat and to be still<sup>4</sup> and the women seem to make every effort to eat as little as possible and exercise as much as possible.

My personal and professional experiences and interest inspired and motivated me towards this study. Now I discuss the rationale in terms of the existing knowledge and the importance of understanding this phenomenon.

### **1.1.2 The professional and academic rationale for the study**

Anorexia Nervosa<sup>5</sup> is a serious condition, in terms of its impact on quality of life and mortality. The Royal College of Psychiatrists reports that only about 40 per cent of those with anorexia will recover (RCP, 2013). About 30 per cent survive into adulthood accompanied by major long-term illness; some improve, but up to 21 per cent<sup>6</sup> will die (NICE, 2004). Therefore, for people suffering from this condition, recovery rates are poor and mortality rates are high (Steinhausen, 1997; Birmingham *et al*, 2005). To the observer, the women on an eating disorder ward look incredibly emaciated and, at times, close to death. However, they assertively deny the seriousness of their condition and flout attempts to 'save' them (George,

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<sup>3</sup> All nurse lecturers at UCLan assume the 'link lecturer role' whereby they connect with a clinical practice area used for student nurse placements.

<sup>4</sup> The usual care plan for somebody with a low body weight is to increase nutritional intake (calories) and to reduce physical exercise. Therefore remaining still, i.e. seated or lying down, is important to their care.

<sup>5</sup> See chapter 2 for more detail.

<sup>6</sup> Figures vary across databases: RCP (2013) state 15%, Steinhausen (1997) states 5%, NICE (2004) state 0-21%, from a combination of physical complications and suicide.

1997; Vandereycken, 2006). By adulthood, most are well versed as to their diagnosis, have a high level of knowledge regarding the diagnosis and treatment options and have learnt to control and maintain their condition (Bloks *et al*, 2004).

The therapeutic relationship has been considered many times within many contexts, both in nursing and other caring professions and this will be discussed in more depth in chapter two. This phenomenon has rarely been considered within the context of adults within an eating disorder service, however. Much of the literature under-pinning this study has therefore been drawn from other disciplines and studies across a range of settings and it is acknowledged that these may have limited transferability. Previous studies into the therapeutic relationship, considered within eating disorder services, have been conducted solely from the perspective of the worker, rather than the patient and the literature is predominantly focused on adolescents, not adults (Wright, 2010).

There is no doubt that the therapeutic relationship is important, but to date, there is a lack of research undertaken with this vulnerable population group and a lack of research that explores the perspectives of both the women and the care workers. Hence, there were personal, professional and academic factors that created a 'serious interest' in me and thus led to the decision to conduct this study.

An overview of the thesis has been presented as follows:-

## **1.2. A guide to the chapters**

In the second chapter, I present the background to the study. The therapeutic relationship within eating disorder services, the eating disorder (anorexia nervosa) condition, the specialist eating disorder units (SEDUs) and the therapeutic relationship have all been considered. The range of terminology used for both the relationship that occurs between the worker and the patient and the disorder (AN) is also discussed.

In chapter three a more focussed review of the literature on the therapeutic relationship between care workers and women with an eating disorder is presented. This section includes the search strategy adopted and details of the 11 papers identified to be most relevant to this study are discussed. A summary of the literature is provided together with the rationale as to why further research was required in order to understand the relationship that occurs between women with anorexia and their care workers in specialist units.

In the fourth chapter, the theoretical positioning of the study is presented. I review the major influences on phenomenology and my rationale for choosing interpretive phenomenology, guided by the work of van Manen.

In chapter five the study design and methods are described for both phases of the study. The rationale for the phased approach, gaining access to the participants and ethical issues are also discussed. In this chapter I demonstrate how the interpretive phenomenological approach was adopted, as well as how rigour was achieved. I also discuss the use of in-depth semi-structured interviews, their subsequent transcription and the organisation and analysis of the full data set.

In chapter six I report on the preliminary thematic findings from phase one of the study. Phase one informed the approach and conduct of phase two which is introduced in chapter seven, together with the proposed organisation of the whole data set (phase one and two) using Merleau-Ponty's existential framework.

Chapters eight to twelve present the interpretations across both phases of the study; illuminated through Merleau-Ponty's four existential themes and Heidegger's concept of 'authenticity'. Chapter eight relates to 'corporeal reflection', that is, the lived body. This was a significant part of the experience of the therapeutic relationship, given the nature of the suffering of women with anorexia and recognition that the goals of treatment focussed on

physical changes. In chapter nine, the data which revealed elements of 'spatial reflection', i.e. 'lived space' are presented. Here, the therapeutic landscape is revealed as an important consideration as are the rules and regulations of the services.

In chapter ten, the findings related to 'relationality' are discussed. Here, specific encounters between the worker and the women are considered. These are '*the battle*', '*tears and tantrums*', '*maternalism*' and '*approval*'.

In chapter eleven I present the data that related to the preciousness of time, or in the context of the existential framework, 'temporality'.

Chapter twelve considers the theme of 'authenticity', which is pivotal to both the therapeutic relationship and also to phenomenology.

In chapter thirteen I bring together the findings and discuss these in the light of what I have learned through the study, how these compare with existing knowledge and also identify the unique findings which are specific to this client group and service setting. Recommendations are made for practice, research and policy and a conclusion to the study is presented.

Chapter fourteen has a very personal flavour as I write reflexively about my journey through this study.

Chapter fifteen concludes the study.

## Chapter 2: **BACKGROUND**

In order to situate the study of the therapeutic relationship within eating disorder services there are three major areas of concern: the therapeutic relationship, the context in which this occurs and the way in which anorexia affects the individual. Hence, the construct of the therapeutic relationship, its definition within both nursing and therapy literature, the specialist eating disorder units (SEDUs) in which the relationship is played out and the eating disorder itself (anorexia nervosa) all require individual consideration. In this chapter, I consider these aspects and associated issues such as the therapeutic use of self, admission and the 'reluctant patient', drop-out from services and a consideration of the social environment that hosts the relationship. Lastly, I consider some of the fundamental assumptions about the therapeutic relationship, the relevance to eating disorder services and the challenges in this context. A more focussed literature review of existing research in this area follows in chapter three.

### **2.1. The therapeutic relationship**

Literature from both nursing and therapy contexts was reviewed to examine the defining characteristics of the therapeutic relationship and to enable consideration of whether these characteristics are applicable within the context of specialist services for adults with anorexia.

#### **2.1.1 *In search of a definition***

As Freud is often considered to be the founder of the idea of the centrality of the therapeutic relationship, I shall commence with definitions found within the therapy literature before moving to nursing definitions. Freud believed that deep and intense feelings emerged in the therapeutic relationship, albeit at an unconscious level and that these could distort the perspective of both the therapist and the relationship (Breuer and Freud, 1885; Freud, 1936).

Since Freud, many more attempts have been made to define the therapeutic relationship.

Carl Rogers, an American psychologist, developed a way to assist in understanding human relationships person-centred approach in the middle of the last century. Rogers defines a helping relationship as one in which promotes the growth, development, maturity, improved functioning and improved coping of the other:

*' a relationship in which one of the participants intends that there should come about , in one or both parties, more appreciation of, more expression of, more functional use of the latent inner resources of the individual'*

(Rogers, 1961: 39-40 )

He coined the phrase '*unconditional positive regard*' to describe the demonstration of complete support and acceptance of a person irrespective of who they are and what they have done (Rogers, 1961/ 1980).

Morgan (1996) views the 'professional' therapeutic relationship as unilateral, with the focus being on solving the problems of the patient; it is usually time limited and the duration is defined by the achievement of the agreed goal. Contractual agreements may also be in place to guide the behaviours within the boundaries of the one-to-one therapy relationship (Morgan, 1996).

Bordin<sup>7</sup> (1979), a psychotherapist, suggested that the therapeutic relationship (*alliance*) develops between therapist and patient within a reciprocal agreement and understanding of the therapy. Bordin used the terminology *therapist* and *therapy* as do writers informed by his work. It is believed, however, that he intended his theory to be applied to all manner of helping relationships and subsequent helping alliances. He identified three interdependent components, i.e. the goals, the tasks and the bond; each relying upon mutual agreement and

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<sup>7</sup> Edward S. Bordin (1913–1992) Bordin served as president of the Division of Counseling Psychology of the American Psychological Association in 1955, as chair of its Education and Training Board in 1956 and as a member of its Board of Professional Affairs in 1964

collaboration between the therapist and the patient (Bordin, 1979/ 1994). Bordin's model appears simplistic, but he argues that it is not that straightforward and proposes that we should anticipate a tearing and repairing of the relationship that ultimately makes it stronger and leads to client change (Bordin, 1979/ 1994).

A good therapeutic relationship is often considered to be a reliable predictor of outcome in all types of therapy, even being healing and restorative in its own right. Safran and Murran commence their book with the emphatic statement that the therapeutic alliance is '*the most robust predictor of treatment success*' (Safran and Murran, 2000: 1). Yalom, an existential psychotherapist, asserts that '*it's the relationship that heals*' (Yalom, 1989: 91), irrespective of the therapy. So, for Yalom, it could be said that the bond and the mutuality referred to in Bordin's model may be of greatest importance (Bordin, 1979). Other writers see the relationship as a catalyst to therapeutic practice, for example, Kirsh and Tate (2006) describe the therapeutic relationship as a '*key ingredient*' and Bale *et al* refer to the therapeutic relationship as '*central to mental health practice*' (Bale *et al*, 2006:257). Subsequent writers, such as Meissner (2006) have recognised the value of the relationship and see its role as '*operative*' within all therapies. Antoniou and Blom (2006) conclude that the therapeutic relationship itself is of greater value than any specific form of counselling and may be particularly pertinent to an in-patient service where no single model or paradigm is in place.

Despite the difficulty in establishing a shared definition, many writers acknowledge the pivotal nature of the relationship as a conduit for therapy (Androsyna, 2000; Antoniou and Blom, 2006; Green, 2006; Horvath and Symonds, 1991; Kraemer, 2006; McCabe and Priebe, 2004).

For me, the simplicity of Bordin's three factor model increases its utility, but the reliance upon the underpinning mutual agreement is a factor worthy of further consideration. The deconstruction of the relationship into component parts does, however, allow us to identify

features that can be used in the measurement of the therapeutic relationship. These will be considered next.

### **2.1.2 Framing the therapeutic relationship**

There are many examples of attempts to measure and frame the therapeutic relationship, particularly in the psychotherapy/counselling literature. Several scales and frameworks such as the 'Working Alliance Inventory' (Hatcher and Gillaspy, 2006) and the 'Kim Alliance Scale' (Kim *et al*, 2001) have been developed to measure the therapeutic alliance. Whilst ultimately these lead to delineation, segmentalising and identification of the components of the relationship, they do provide frameworks to measure and quantify the relationship and its perceived impact on the success of the therapy.

I will briefly outline two measurement scales to provide some insight into the components that are measured; the Working Alliance Inventory (WAI) (Horvath and Greenberg, 1989) and the Kim Alliance Scale (Kim *et al* 2001). Clarkson's five-relationship framework (Clarkson, 2003) and Peplau's theory of interpersonal relations model (Peplau, 1952/1988) are then presented as these provide a segmenting of the relationship, thus allowing for component parts to be identified, although no tool of measurement is provided for either of these.

Horvath and Greenberg's (1989) Working Alliance Inventory (WAI) assesses the three essential components of Bordin's model of the TR:

1. *Agreement between patient and therapist on the **goals** of the therapy,*
2. *The patient's agreement with the therapist that the **tasks** of the therapy will address the problems the patient brings to treatment ,  
and*
3. *The quality of the interpersonal **bond** between the patient and therapist.*

(Hatcher and Gillaspy, 2006: 12)

The Kim Alliance Scale (Kim *et al*, 2001) identifies four dimensions which they consider identify the effectiveness of the alliance. These are '*collaboration*', '*communication*', '*integration*' and '*empowerment*'. The term '*empowerment*' is a particularly interesting concept here since it is cognisant of the potential of the patient to take control and responsibility for their recovery whilst still inferring the worker's role in revealing this potential and initiating the recovery (Clark and Nayar, 2012).

Clarkson (2003) suggested that there are five types of relationship; these are: the '*working alliance*'; the '*transference/counter transference relationship*'; the '*developmentally needed/reparative relationship*'; '*person-to-person relationship*' and; '*transpersonal relationship*'. In Clarkson's five-relationship framework there is an implicit assumption that the responsibility for the therapy lies predominantly with the therapist (Clarkson, 2003).

In nursing, the person most renowned for work in this area is Hildegard Peplau<sup>8</sup> (Peplau, 1952/1988). One of the early pioneers of mental health nursing, Peplau developed the concept of the '*nurse-patient relationship*' in her book '*Interpersonal Relations in Nursing*', which is regarded as the first systematic theoretical framework of the therapeutic relationship in psychiatric nursing<sup>9</sup> (Forchuk, 1994). Peplau developed her psychodynamic framework for nursing and, although Peplau refers to the '*nurse-patient*' relationship, much of the terminology she uses is borrowed from psychotherapy.

Peplau (1952) identified that as human beings are unique, so are their experiences. She identified six '*sub-roles*' within the role of the nurse; the '*mother-surrogate*', the '*technician*', the '*manager*', the '*socialising agent*', the '*health teacher*' and the '*counsellor or psychotherapist*'. With this in mind, Peplau developed a nursing model for practice based upon the therapeutic interpersonal process (known as '*Peplau's theory of interpersonal relations*

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<sup>8</sup> Hildegard Peplau (1909-1999) was born in Pennsylvania and published *Interpersonal Relations in Nursing* in 1952. Her study was conducted within in-patient psychiatric care in the USA.

<sup>9</sup> Peplau uses the terms '*psychiatric nursing*' and '*psychiatric care*' however, in contemporary UK practice, we tend to use the terms '*mental health nursing*' and '*mental health care*'.

model') which is made up of four 'phases'. The four phases are first, 'orientation', followed by 'identification', 'exploitation' and then 'resolution' (Peplau, 1988). Peplau suggests that the patient engages with the therapeutic relationship by passing through the identified phases. For example, Peplau's 'orientation phase' is the 'getting to know you' stage when the nurse and patient first meet and roles and expectations are laid out (Peplau, 1952:19). The tasks of this phase are largely to establish trust and to explore ways of interaction that will connect both nurse and patient. Travelbee<sup>10</sup>, a nurse theorist, has stressed the goal orientated nature of the relationship, which is underpinned by mutuality and is pivotal to Bordin's psychotherapy model (Bordin, 1979; Travelbee, 1971). Welch, a nurse, described the interpersonal relationship as:

*'Central to the growth and development of the psychological, emotional, cognitive and behavioural skills and features that act towards forming and sustaining the complex of the self-system'* (Welch 2005: 161).

It is interesting that Welch sees the relationship as being so pivotal in the maintenance of the individual's sense of 'self', or 'self-system'. This statement stands outside the main body of literature which focuses predominantly on the activity that occurs in the interpersonal space between the care worker and the patient. Welch sees the relationship as important for revealing how the person regards him/her self and uses self within the relationship.

The therapeutic use of self within the relationship is now discussed in more depth.

### **2.1.3 The therapeutic use of self within the relationship**

Travelbee (1971) believed that the nurse should 'know thyself' and that the nurse's 'use of self' was a basic principle of nursing as the human-to human relationship is the means through which the purpose of nursing is fulfilled. Travelbee (1971) explains this as occurring within a conscious process which she refers to as the 'therapeutic use of self' and defines this as:

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<sup>10</sup> Joyce Travelbee (1926-1973) developed the human-to-human relationship model, which she presented in her book *Interpersonal Aspects of Nursing* (1966, 1971)

*'When a nurse uses self therapeutically she consciously makes use of her personality and knowledge in order to effect a change in the ill person. This change is considered therapeutic when it alleviates the individual's stress.'*  
(Travelbee 1971: 19)

Travelbee asserted that nursing needed a '*humanistic revolution*' and a return to compassion, which she believed was lacking, but could be restored through the human-to-human relationships that involved empathy and sympathy. For Rowan and Jacobs (2002), the therapist trains the self to become a '*therapeutic instrument*' which is turned on and off at will (Rowan and Jacobs, 2002: 10).

According to Freshwater, the goal of any therapeutic alliance is to '*facilitate the emergence of the authentic self*' and the '*therapeutic use of self*' which are integral to nursing, amongst other caring professions (Freshwater, 2002:4). Therefore, a care worker who has poor self-awareness and does not recognise the impact that their presence and manner may have on the patient is unlikely to develop a therapeutic relationship which is professional. Freshwater (2002) believes that nursing is a deep experience that occurs between two people and which is not only interpersonal, but intrapersonal. She notes that when a person is unwell, their self-concept is changed and that it is the nurse's role to assist the person to facilitate the (re)emergence of the self. Furthermore, this can only be achieved if the nurse is themselves self-aware and self-conscious. Freshwater draws on the work of Carl Rogers to demonstrate how his person centred approach under-pins a humanistic approach to nursing and a possible route to discovery of the authentic self via the therapeutic relationship (Freshwater, 2003).

Therapeutic relationships, therefore, seem to be more about a way of **being** rather than **doing**. Hence, it is crucial that we look not only at the experience of individuals, but the connection between them. As Hycner (1991) describes:

*'If we take seriously the concept of between there is a reality that is greater than the sum total of the experience of the therapist and client. Together they*

*form a totality that provides a context for the individual experience of both'. (Hycner, 1991: 134-5).*

It is clear that the relationship is fundamental to caring and therapeutic work. This study is specifically about the relationship between women with an eating disorder (anorexia) and their workers, so in order to understand the challenges of working with a specific client-group, we need to understand how their illness affects them and understand the use of the diagnostic term 'anorexia nervosa'.

## **2.2. Anorexia Nervosa:**

The World Health Organisation diagnostic guidelines for anorexia nervosa recommend that the diagnosis fulfils the following list of essential characteristics:

- A. Weight loss, or in children a lack of weight gain, leading to a body weight of at least 15% below the normal or expected weight for age and height ;
- B. The weight loss is self-induced by avoidance of 'fattening foods';
- C. A self-perception of being too fat, with an intrusive dread of fatness, which leads to a self-imposed low weight threshold;
- D. A widespread endocrine disorder involving the hypothalamic-pituitary-gonadal axis, manifested in the female as amenorrhoea and in the male as a loss of sexual interest and potency (an apparent exception is the persistence of vaginal bleeds in anorexic women who are on replacement hormonal therapy, most commonly taken as a contraceptive pill);
- E. Does not meet criteria A and B of Bulimia nervosa (F50.2).

**Anorexia Nervosa (AN): ICD-10<sup>11</sup> criteria [F50.0 Anorexia nervosa ] WHO (1992)**

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<sup>11</sup> ICD-10 is the 10th revision of the [International Statistical Classification of Diseases and Related Health Problems](#) (ICD), a [medical classification](#) list by the [World Health Organization](#) (WHO). It codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases

Eating disorders have the highest rates of mortality for any psychiatric condition; around 1.6 million people in the UK have an eating disorder at any one time (NICE, 2004). The teenage years are the most common age of onset (Fornari, 1994) with seven girls in every thousand affected by an eating disorder (RCP, 2010/2012/2013). The lifetime risk of anorexia nervosa (AN) in women is estimated to be 0.3% to 1% (Arcelus *et al*, 2011) and whilst 46% of patients with Anorexia Nervosa will recover, about 20% will continue to suffer chronically in the long term and the remainder will only partially recover (Steinhausen, 1997).

The media perception of anorexia is that of young people, vulnerable to an unrealistic portrayal of beauty who resist treatment and progress to an early death (Thompson and Heinberg, 1999). Externally, women with anorexia often have the physical appearance of a young person or adolescent due to their small frame and style of dress. Additionally, the behaviours described by Kaplan and Garfinkel have many similarities with the sorts of descriptions attributed to adolescence (Kaplan and Garfinkel, 1999).

Individuals suffering with eating disorders are not exempt from other mental health problems and it is common to observe co-occurrence with depression, personality disorder, obsessive compulsive behaviours and suicidality (Strober, 2010). Furthermore, physical problems such as osteoporosis, cardiovascular and gastrointestinal abnormalities are also common, particularly in adults who have struggled with anorexia from adolescence to adulthood (Fairburn and Harrison, 2003). It takes a skilled workforce to address the multifaceted nature of these patients' needs, develop empathic approaches and establish positive therapeutic relationships (Strober, 2010). The gravity of concern about the vulnerability and fragile nature of women with eating disorders is largely underpinned by the acute awareness of the many physical complications involved and elevated morbidity that exists, particularly with Anorexia Nervosa (Arcelus *et al*, 2011).

Whilst 'anorexia' is a clinical term, '*eating distress*' is a term used to detract from a medicalised model and is deemed preferable to some because of its non-medical emphasis (Jacob, 2001; Pembroke, 1994).

### **2.2.1 '*Eating distress*'**

Whilst it is not used within the context of this study, it is important to acknowledge that some sufferers prefer this term, which conforms to a social rather than clinical/medical model (Beresford, 2000). Beresford (2002) argues that service users have developed a different language in order to explore different conceptual frameworks and approaches. He cites a number of examples, such as '*madness*' and '*mental distress*' instead of '*mental illness*' and includes the term '*eating distress*' in this context (Beresford, 2002: 582).

As a UK nurse, I used the terms that were most familiar to my profession, that is, 'anorexia' or 'eating disorder', which are identified within the International Classification of Disease (WHO, 1992).

In order to acknowledge differing perspectives and respect the choice of the participants, however, I went back to the research site and asked some of the workers and current patients for their opinion. They said that their preferred terms were '*eating disorder*' or '*anorexia*' since they felt that this added validity to their experience. They felt that '*eating distress*' lessened the seriousness of the condition. Libby (patient participant, phase two), an ambassador for BEAT<sup>12</sup>, thought that the term '*eating distress*' made the focus on '*eating*' more pronounced and, for that reason, believed it to be less useful than '*eating disorder*' or '*anorexia*' in understanding the complexities of the disorder. Libby also thought that the term '*distress*' gave the impression that the problem was a temporary or transient emotional state rather than a longer term and disabling condition.

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<sup>12</sup> BEAT is the UK Eating Disorders Association and provides Information and help on all aspects of *eating disorders*, including *Anorexia Nervosa*, *Bulimia Nervosa*, binge eating disorder and related *eating disorders* <http://www.b-eat.co.uk/> [accessed 19th October 2012].

### **2.2.2 Why women?**

Of the 1.6m people affected by eating disorders in the UK, 91% are women (up from 88% in 2010-2011 (HSCIC, 2013)). In 1999, Dolan and Gitzinger attempted to provide some insight into why women suffer more than men from eating disorders and to explore whether women therapists could offer something more than their male colleagues. In their text, '*Why Women?*', Dolan and Gitzinger argued that '*normal*' women binge eat once a month and that the majority have been on slimming diets; they ask why eating disorders are not actually '*a disorder of our culture*' (Dolan and Gitzinger, 1999: 6).

Eating disorders are themselves considered to be socially produced, a way in which women express themselves in our Western society and hence a product of social and societal interactions (Heenan, 2005a). Susie Orbach (1978) suggested that anorexia is a woman's protest against her position in society and, whilst the current study is not a feminist study, the body of feminist literature around women and eating disorders deserves some recognition here. Heenan (2005b) discusses the role of European consumer culture in the promotion of insecurities in women, their diet and their body image. She argues that the woman with an eating disorder has a perceived need to transform herself that is accompanied by the much needed sense of control, enabling her to translate her insecurities into bodily concerns.

### **2.2.3 The association made between eating disorder and personality disorder.**

Personality type is often seen as a precipitating factor which influences the onset of an eating disorder (Schweigher and Sipos, 2007; Davies et al, 1997; Wonderlich and Mitchell, 2001).

Kaplan and Garfinkel refer to the eating disordered patients as '*ego-syntonic*'<sup>13</sup>, '*therapeutically nihilistic*', and refer to the patient's possible co-morbidity with personality disorder. They specifically state that '*characterologic disturbances in patients with EDs lead to*

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<sup>13</sup> *Ego-syntonic*: describing those elements of a person's behaviour, thoughts, impulses, drives and attitudes that are acceptable to him or her and are consistent with the total personality (Mosby's Medical Dictionary, 2009).

*difficulties in the psychotherapeutic relationship'* (Kaplan and Garfinkel, 1999: 3). This is a view which is reinforced by King and Turner (2000) when they refer to the '*repetitious and obstructive behaviours of the patients'* (King and Turner, 2000: 143).

George (1997) and Bryant Waugh (2006) highlight several other interpersonal features apparent in eating disordered patients such as perfectionism, sense of ineffectiveness, dichotomous thinking and difficulty in interpersonal trust. Additionally, care workers can often be heard making a connection with personality disorder (PD) and utilising the pejorative terminology that is regularly associated with PD, such as '*manipulating*', '*dependent*', '*clingy*', '*attention seeking*', '*difficult*', '*uncooperative*', '*saboteurs*' and '*unappreciative*' (Bowers, 2002; Wright *et al*, 2007). These interpersonal dynamics between patients and care workers have been considered in great depth when seen within the context of personality disorder as this is regarded as an interpersonal disorder, unlike an eating disorder (Smith Benjamin 2003). Hartmann *et al* (2010:619) speak of the '*interpersonal problems*' experienced by people with an eating disorder and, whilst identifying common personality characteristics of individuals with ED, they do not make any link with personality disorder.

There is an on-going debate about whether ED is secondary to PD or part of the PD spectrum. Sansone and Levitt (2006) report:

*'The juncture between personality disorders and eating disorders truly remains one of the challenging frontiers in the eating disorders field'.*

(Sansone and Levitt, 2006: xxiii.)

Schweiger and Sipos, (2007) provide a compelling argument for the co-occurrence of personality disorder with eating disorder, although others (Davies *et al*, 1997; Wonderlich and Mitchell, 2001) consider that the diagnostic spectrum of eating disorders could well be a

subcategory of personality disorder. The relationship of anorexia nervosa, perfectionism and obsessive-compulsive personality disorder (OCPD); and the relationship of bulimia nervosa, impulsivity and dramatic-erratic personality disorders have been compared in previous studies where a clear association is made between eating pathology and personality disorder (Bryant Waugh, 2006). Additionally, Vandereycken suggests that '*eating disorders belong to the broad category of self-harming behaviours*' (Vandereycken, 2011: 295), which are often considered within the context of borderline personality disorder (Koehne and Sands , 2008).

Although this 're-labelling' may be appropriate in terms of diagnosis and clinical guidelines, it only serves to provide another label and one which still carries pejorative and negative connotations.

Having considered the diagnosis of anorexia nervosa, I now discuss access to eating disorder services available in the UK for somebody with this disabling condition.

### **2.3. Eating disorder services in the UK**

In 2003, Hoek and Hoeken stated that the prevalence of eating disorders had been stable in Europe since the 1970s (Hoek and van Hoeken, 2003). This is no longer the case, in October 2011, hospitals recorded 2,290 eating disorder admissions in the 12 months to June 2012; a 16 per cent rise on the previous 12 month period (HSCIC, 2013). This is despite the assertion by Escobar-Koch *et al* (2010) who suggest that there is a general under-detection and under-treatment of eating disorders in the UK. Patients who do manage to access care and treatment often have to travel long distances from home to do so. Some parts of the UK have little or no NHS in-patient provision for eating disorders at all (RCP, 2012).

#### **2.3.1 Availability of services**

Clinicians struggle to find specialist care due to the poor availability and accessibility of specialist services, a situation which is referred to as the '*postcode lottery of UK eating disorder services*' (Escobar-Koch *et al*, 2010: 558). Clinicians then struggle, again, to gain

funding, as some of the UK specialist provision is in the private sector. London, host to the largest concentration of services in England and Scotland, now has thirteen specialist services, but Wales and Northern Ireland are very poorly served. In the North-West of England, where this study was conducted, there are six NHS and two independent services (RCP, 2012; Simon *et al*, 2005). Those services that do exist tend to use low body weight as a criteria for admission and general practitioners (GPs) act as the 'gatekeepers' to specialised treatment in the UK.

The NICE guidance states that the main reasons for admission to in-patient care are to provide a structured, symptom focused treatment regimen with the expectation of weight gain, careful monitoring of the patient's physical status and psychological treatments that focus on eating behaviour and attitudes to weight and shape (NICE, 2004). Despite the NICE guidance recommendations that patients of low BMI should be prioritised for treatment (NICE, 2004), a study by Green *et al* (2008) showed that the weight of the patient at GP consultations did not make a significant difference to their decision to refer to specialist services. Despite these problems, there are some who recover without any care and treatment, seemingly spontaneously; they do not enter the health care system but can be considered to be clinically recovered (Vandereycken and Devidt, 2011).

Day services are limited, so when patients are admitted to a specialist ED unit, they tend to be those diagnosed with 'anorexia nervosa', as they are clinically underweight and initial concerns focus on weight restoration. In-patient specialist eating disorder services, such as the site accessed for phase two of the current study, provide twenty four hour, around the clock care for severely malnourished patients. Hence, re-feeding and the establishment of a healthy weight is usually the primary goal (NICE, 2004; Zeeck and Hartmann, 2005). Treatment is also offered for other medical problems and management of behaviours which may compromise

treatment, such as food avoidance and concealment, exercising, falsifying weight and excessive water drinking (RCP, 2010).

### **2.3.2 Service provision**

Services are generally multidisciplinary, including nurses, dieticians and some psychotherapy for those well enough. Eighty-two percent of all ED services in the UK (RCP, 2012) are led by a consultant psychiatrist. As recovery commences and both body weight and cognitive function improves, the patients may have the opportunity to leave the ward to attend sessional therapies such as cognitive behavioural therapy (CBT), group therapy including art therapy, or 'healthy eating' groups with a dietician. They may also go 'on leave' to home for time spans between a few hours and a few days. Therefore, whilst the patient's relationship with the ward-based staff, (mainly nurses and healthcare support workers) occurs in both day and in-patient care settings, it might be assumed that the relationship within the in-patient service might be the most complex, due to the diversity of interactions and possible situations within this environment.

An important factor in caring for people with anorexia are that few people choose care and treatment and their admission is often the result of a good deal of persuasion from family, friends and clinicians. Hence, although '*voluntary*'<sup>14</sup> in legal terms, they are '*reluctant*' patients. These issues are discussed in more depth below.

### **2.3.3 Admission and the reluctant patient**

The word '*reluctant*' is used frequently when referring to a patient's decline of services as well as in Nordbø *et al*'s use of the phrase, '*reluctance to recover*', referring to the enduring nature of the condition and the patients' wish to retain their anorexia (Nordbø *et al* 2012). The NICE guidance highlights the problem that '*patients with anorexia nervosa are notoriously reluctant*

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<sup>14</sup> Under the Mental Health Act (MHA, 1983/2007) the terms informal and voluntary patient, are both used for someone who is not detained for care and/or treatment under the Mental Health Act 1983 (MHA).

*to have treatment'* (NICE, 2004: 58), making these patients some of the most challenging and resistant to treatment because they are not ready for active change (Treasure, 2004). Kaplan and Garfinkel (1999: 665) use the word '*reluctant*' about both the patients and the clinicians; the patients are unwilling to give up the disorder and the clinicians may struggle to find sufficient motivation to treat them.

Serpell *et al* (1990) assert that the anorexia nervosa is highly valued by the sufferer and so acceptance of treatment threatens ownership of their anorexia. Paulson-Karlsson *et al* (2006) discuss the issue of treatment resistance, in relation to adolescents with anorexia, due to the patient's reluctance to admit the seriousness of their condition. Patients believe they are coerced, persuaded or threatened by family, friends and health workers which may cause an antagonistic relationship to develop with those who try to help them (Goldner, 1989).

MacSween (1996) argues that patients suffering from AN believe that thinness will provide a solution to their unhappiness so they strive to achieve food-control and to seek '*selfhood*' (MacSween, 1996: 38). Any attempts to feed and to promote weight gain are in direct conflict with these views and women with anorexia will go to extreme lengths to prevent their attempts to lose weight being thwarted (Cassell and Gleaves 2006). De La Rie (2008), whilst not disputing the value of a good relationship, suggests that this is not enough.

Many eating disorder sufferers have a long history of admissions, some of them involuntary (RCP, 2010/2012/2013) as women with anorexia will regularly refuse treatment, if they can. Once admitted a named nurse, or key-worker will be assigned to them who they are unlikely to know, have no choice about and they may '*resent the imposition*' (Hewitt *et al*, 2009: 68). An effort to treat very low BMI<sup>15</sup> clients who are steadily losing weight and becoming increasingly physically vulnerable often results in the use of the Mental Health Act (MHA, 1983/2007), thus

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<sup>15</sup> a BMI of less than 15.

imposing treatment on people who deny that they are unwell and so decline voluntary treatment. Although the Mental Health Act (1983/2007) allows for compulsory treatment of patients with eating disorders, all of the women with anorexia who participated in this study were 'informal', that is, voluntary patients.

Kim *et al* (2008:88) discuss '*empowerment*' as an important factor in the therapeutic alliance, adding:

*'...the patient develops confidence and becomes a partner in the decision-making process'*

Yet, the reality is often that the treatment plan requires that anorexic patient to surrender their goal to eat less and strive for thinness, in favour of compliance; thus, if not formally 'detained' they are still, effectively 'involuntary'. Whilst sufficient weight gain remains the primary goal of eating disorder services, the patients do not want to eat; they do not want to put on weight; they do not consider themselves to be ill and they may appear deceptively well, for example, they are often extremely energetic right up to a physical collapse (Cassell and Gleaves, 2006; RCP, 2010). Hence, persuading people to accept and engage in care is a challenge and many sufferers 'drop out' of care.

#### **2.3.4 'Drop-out' from services, care and treatment**

'Drop-out' rates from eating disorder services are high and patients report low satisfaction with treatments that are often lengthy, expensive and of limited efficacy (Ryan *et al*, 2006). Studies relating to treatment drop-out tend to focus on aspects such as weight at admission, diagnosis, characteristics of the patient, family environment, treatments offered and co-occurring conditions rather than the context of care (Campbell, 2009; Mahon, 2000 ; Wallier *et al*, 2009). But, as Wallier and colleagues report:

*'Future research should consider whether the therapeutic alliance of the patient and her family to clinicians predicts dropout, as we believe that a good therapeutic alliance will also relate to treatment completion.'*  
(Wallier *et al*, 2009: 646.)

Seidinger *et al* (2011) cite the patient's difficulty in interpersonal relationships and the therapeutic alliance as significant issues affecting the drop-out rates. These insights further reinforce the rationale for research into how relationships are played out within these services. We can speculate that high levels of ambivalence about treatment will influence a decision to opt-out of treatment, but there is very little high quality evidence about why (DeJong *et al*, 2012; Mahon, 2000; Zeeck and Hartmann, 2005). 'Drop-out' from a treatment programme is often associated with lack of engagement or motivation to engage with treatment. Patients who reluctantly engage with treatment that is in conflict with their own view of their health and well-being may take an early option to leave that treatment. However, this ultimately results in halted recovery and a poorer prognosis, as patients who leave treatment early ('drop-out'<sup>16</sup>) are unlikely to recover independently (Coldham *et al*, 2002; Dejong *et al*, 2012).

The high drop-out rate is somewhat predictable when we acknowledge the lack of agreement between the worker and the patient around the task and goals of the therapy (Fairburn and Harrison, 2003; Pereira *et al*, 2006). If we consider this from Szasz's perspective, that we all have a right to bodily and mental self-ownership (Szasz, 2007), then conflict can be seen as inevitable as the individual relinquishes their personal beliefs and choices in favour of adherence to the treatment goals. Goldner suggests that patients are coerced, persuaded or threatened by family, friends and care workers and consequently an antagonistic relationship develops due to the patient's intense fear of gaining weight (Goldner, 1989). The patients may have a strong need to be self-determining, a distrust of care workers and a reluctance to give

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<sup>16</sup> Although the term 'drop-out' is frequently used, some authors such as Sly (2009) and Vandereycken and Devidt (2010), view it as pejorative, and call for new, less pejorative terms for those who do not complete treatment

up control, but are ultimately compliant rather than concordant<sup>17</sup>. Their beliefs about themselves remain unchanged but are often dismissed as delusional, irrational and as such lacking in insight. As soon as the patient is discharged, Goldner says that the patient will revert to the behaviours that originally brought about their weight loss and admission thus becoming known as '*revolving door*' patients as re-admission occurs (Langdon *et al*, 2001). Ironically, slow progression may also be attributed to the care workers' reluctance to upset the patient by challenging their perspective (Goldner, 1989). The Maudsley method for eating disorder treatments adopted by Treasure (2000) is underpinned by a motivational style that is designed to encourage and stimulate patients to maintain their attendance and engagement with services and so thus reduce 'drop-out' (Prochaska and DiClemente, 1992).

Vandereycken and Devidt (2010) suggest that we need to actively engage and *listen* to our patients more and although it might not prevent drop-out from treatment, it may mean that prematurely stopping therapy can be a positive decision rather than a flight from it. Different settings influence the ways in which people communicate and behave, dependent upon social factors and how these occur within the built environment due to considerations such as available space and privacy (Bandura<sup>18</sup>, 1977) DeVito, 1991). This will be considered next to provide context to the study.

### **2.3.5 The social environment that hosts the relationship**

When an adult patient requires in-patient care the ward becomes their community. The nurses and care workers within that community provide structured care, treatments and every-day interactions. Social interactions that occur within this community (the ward), can

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<sup>17</sup> Compliance is defined as: 'The extent to which the patient's behaviour matches the prescriber's recommendations.' However, the use of this term is declining as it implies lack of patient involvement. 'Concordance' is predominantly used to describe the situation where the worker and the patient agree therapeutic decisions that incorporate their respective views.

<sup>18</sup> Bandura's social learning theory, more recently known as 'social cognitive theory', can be described as '*the impact of observing other people's behaviour on one's own behaviour*' (Odgen, 2003: 29) and is rooted in child development theory. Bandura claimed that people learn by observing others and adopt patterns of behaviour that are fitting within their group, particularly in institutional settings, such as a hospital or education establishments.

have a significant impact on the patient and the ward develops a culture of its own thus creating a *micro-society*. A micro society is a group of individuals within society bound together by a common thread, condition, location or goal; it refers to the patterns of relationships among people within a definite territory (Scupin, 1992).

The opportunities to establish and sustain positive, connected relationships are crucial to recovery, not merely when specific 'therapies' are being administered. Five essential aspects of care in such services were identified by both UK and US patients as: a good therapeutic relationship, a holistic approach, specialised treatment, client-centred care and support (Escobar Koch *et al*, 2010).

When we consider therapeutic relationships there is an assumption that the context of the relationship, (the setting), is also therapeutic; but Vandereycken and Devidt (2010) suggest the peer context of ED services may actually be unhelpful because of social learning and 'peer contagion' in group therapy and/or in-patient treatment. In the context of an eating disorder service this might be seen in the women's observation of each other and the acquisition of learned behaviours which increase weight loss and prevent weight gain or avoidance of food.

The interpersonal relationship exists within a situation, a context. For this study, the context is the service, day care or in-patient. Situationalists such as Scarr and McCartney (1983) suggest that individuals who situate themselves within a stable environment may subsequently present the illusion of stability. Conversely, an environment that is made unstable by the changing patient population and also the changing shift patterns of the staff may create instability in the individuals present within that situation. Furthermore, we recognise that the individual affects the situation and changes the environment by his/her very presence; care workers also share responsibility for the environment experienced by the client, for instance the context of the ward or community (Wright *et al*, 2007).

Inevitably, there are unique and pertinent features to these services which may have a bearing on the relationships that occur within. These, in turn, may affect the experience of all who work and receive care and treatment there and may impact on the experience of the relationship between them. Mischel (1968, 1969) suggested that behaviours seemed to be more controlled by the situations which people were in and the belief that people responded differently, or inconsistently, as situations changed. It is therefore possible that the prevailing social situation shapes the behaviour of the individual.

So far in this chapter I have considered the theory about the therapeutic relationship and our use of ourselves in that relationship. As this study focuses on the therapeutic relationship that occurs within women with anorexia and their workers in eating disorder services, I have then considered what is meant by 'anorexia' and also considered the services in which the care is delivered. I now consider how the therapeutic relationship occurs within ED services.

#### **2.4. The therapeutic relationship with women with an eating disorder**

Much of in-patient care is delivered by unqualified health care support workers who use themselves as the therapeutic tool using intuition and communication skills, often utilising nothing more than 'general conversation' as a tool for engagement (Hayes, 2012; Wright and Wright, 2011). These care workers develop the skills required to sustain a therapeutic relationship as an individual process based upon their own personality and moral development rather than via academic study (Green, 2006). Kwaitek and colleagues (2005) suggest that listening to the patient was an example of the 'therapeutic use of self' that occurs during '*presencing*', a term adopted from Benner (1984) meaning that the nurse uses themselves as a person within the relationship so that the client feels cared for and that this is part of the trusting, committed relationship encompassing the moral values of humanity. The healthcare support worker within an in-patient service does a good deal of this, particularly whilst they

conduct '*close observations*'<sup>19</sup> of patients who are felt to be '*at risk*' (Jones and Eales, 2009; Thomas and Hogg, 2011; Wright and Wright, 2011). But care-workers should not expect to be trusted by our patients, '*we must work to achieve it*' (Hewitt *et al*, 2009: 67).

Established practice is largely based upon intuitive responses or established custom and practice (Oakley, 2000). Oakley<sup>20</sup> (2000) discusses her observation that '*professionals do what they think is best, without necessarily having any evidence to support it*' (Oakley, 2000: 17). She expresses concern that practitioners decide what do in a very unscientific way based on guesswork, rather than because it has been shown to be safe or effective. Opinions about approaches to creating a good, therapeutic relationship may also be overlaid with social and parental experiences which cloud any scientific view or adopted modality (Oakley, 2000).

Kozart (1996) suggests that the therapeutic relationship should be considered in the absence of therapeutic goals, which, for the patient with anorexia is an important consideration, as their goals may be different from the goals of the worker. Although Kozart uses the phrase '*therapeutic goals*', this may be slightly misleading in eating disorder services where the goals are more treatment oriented than therapy oriented. More recently, Long *et al* (2012) refer to '*the illusion of therapeutic alliance*' and talk about the '*significant therapeutic challenge*' of caring for the patient with anorexia (Long *et al*, 2012: 1).

The SEDU nurses deliver clinical treatments as well as talking therapies and whilst these are clearly intended to be '*therapeutic*' it is a very different relationship from that which exists within one-to-one therapy. Additionally, a team of nurses are jointly responsible for the care,

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<sup>19</sup> '*Close observations*' aka '*supervision*' is when a patient is considered to be at risk or in need of additional support/nursing care and/or the monitoring of physical health vital signs; for example post-meal when patients in SEDUs often feel troubled and/ or tempted to vomit. In the services used for this study, the observer was usually a HCA or a student nurse.

<sup>20</sup> Ann Oakley, Professor of Sociology and Social Policy at the Institute of Education, University of London

thus also creating a significant difference between the nursing relationship and the psychotherapy-derived therapeutic relationship. If a therapeutic relationship is so crucial to success, (recovery<sup>21</sup>), then the markers of success, including the hopes and expectations of both patient and worker, must be paramount to this process too (Connan and Treasure, 2000).

Communication skills are vital to quality of treatment (Morrissey, 2009). Morrissey links communication skills with the TR when she says:

*'In the therapeutic relationship, communication is an interpersonal and interactive process that aims to affect a positive change...'*

(Morrissey, 2009: 56)

Few studies mention the common stance of many patients with anorexia nervosa (AN) in refusing intervention and their ambivalence towards staff. Interactions with AN patients can be strained, therefore one of the main tenets, that it is the interaction which is *'at the heart of most therapeutic practice'* (Brownie, 2004: 515) is questionable, as the interaction is effectively flawed by ambivalence and conflict.

Care workers often feel overwhelmed when providing an eating disorder service (Kaplan and Garfinkel, 1999; George, 1997; King and Turner, 2000; Palmer, 2000). Kirsh and Tate report on how care workers are:

*...left to rely on instinct and experience to work through these challenging and powerful relationships'* (Kirsh and Tate, 2006:1072).

The sufferers' absolute denial of the life-threatening nature of their condition is a significant obstruction to the workers, particularly when attempting to engage young people with anorexia in care and treatment. Lask (2000) report:

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<sup>21</sup> Recovery is a contested concept in this context. For many people, the concept of recovery is about staying in control of their life despite experiencing a mental health problem. In SEDUs a recovery goal may be attaining an identified body weight; but attaining that weight is insufficient to say that recovery has occurred, as cognitive changes are also required, which are less easily measured.

*'It is unusual to effect a therapeutic alliance with younger patients with anorexia as their fear and denial is too strong'. (Lask, 2000:168)*

Palmer (2000) infers that the apparently obstructive, subversive and manipulative young woman with an eating disorder is more likely to be feeling lonely, misunderstood and rather fragile; she seeks 'understanding' from therapy, but her attitude affects the worker who then feels unwanted and unvalued. Shipton (2004) proposes that attending to the underlying emotional issues can also be achieved through the medium of a good therapeutic relationship. She describes the patient's need for privacy, their fear of intrusion, their mistrust of others and suggests that patience, warmth and honesty are paramount to the care process.

Attempting to establish the mutuality and reciprocity that underpins the concept of shared goals and plans for care is therefore a huge challenge, particularly when coupled with the constant battle to re-establish the physical balance.

#### **2.4.1 *Fundamental assumptions about the therapeutic relationship, the relevance to eating disorder services and the challenges***

In many ways, the term '*therapeutic relationship*' has become such common-speak and taken-for-granted terminology that it is possible that we neglect its original meaning, or fail to realise that it may be unique for different people. The most significant and questionable assumption about the therapeutic relationship, is that that it is '*therapeutic*'. It is actually only therapeutic if the patient derives therapeutic benefit from it. Furthermore, it is important to recognise that, within the context of this study, eating disorder services offer '*therapy*', but they also offer clinical treatments which are aligned with medicalised, clinical care rather than talking therapies, which is where the difficulties tend to arise (Kaplan and Garfinkel, 1999).

Much of the available literature refers to the apparent difficulties of caring for people with an eating disorder and has predominantly been undertaken with adolescents. These difficulties are mainly attributed to interpersonal difficulties and differences in the perspectives of the

worker and the client. It therefore seems pertinent to consider how these two groups of people connect with each other. We rarely talk about a functional 'connection' made between workers and patients, but rather use terms such as 'engagement', 'alliance', 'rapport' and 'relationship' all of which seem to be used synonymously. Furthermore, Kim's study (Kim *et al*, 2008), which infers that 'empowerment' is bestowed upon the patient by the worker, could possibly reinforce a paternalistic regime.

Established theories about the therapeutic relationship provide insight and understanding about the way worker and patient co-exists during recovery. The therapeutic relationship can be facilitator of change between the care worker and the patient. It may occur in different guises, (Clarkson, 2003); it may have different component parts, (Bordin, 1979/ 1994) and it may be a 'struggle' (Ramjan, 2004). Current perspectives of the therapeutic relationship, however, focus on a shared understanding of the aims and expectations of both care worker and patient. The often reluctant stance of the patient and the difference in perspective of the care worker is problematic when applying established models of therapeutic relationship. Ramjan's work provides valuable insight into the development of therapeutic relationships in hospital settings, but is focussed on the experience of adolescent patients and paediatric nurses (Ramjan, 2004).

For me, the most useful theory for considering the relationship within an eating service is that of Bordin and his categorisation of the three tenets of the 'goal', the 'task' and the 'bond' occurring in therapy (Bordin, 1979), (as described in chapter 1). He suggests that all three must be mutually agreed and collaboratively addressed. The clinical treatments, including re-feeding and weighing can be seen as the tasks of the treatment. Weight gain is the goal of the treatment. His use of the word 'therapy', implying a one-to-one relationship and the apparent disagreement that occurs around both the task and the goal, might however appear to render the model inappropriate.

The divergence from Bordin's model in eating disorder units is indeed clear, as two of the three conditions are frequently absent. Neither the goals nor the tasks of the therapy are readily agreed upon. However, the significance of Bordin's tripartite model, in this context, is its apparent split between that which is clinical, (the goal and the task) and that which is relational, (the bond).

## **2.5. Conclusion**

In this chapter I have set out the context of the study and provided an overview of the condition of anorexia nervosa. The way we communicate with others is pivotal to the establishment of any relationship and our communication and behaviour are, inevitably, affected by the environment in which we exist. Hence, services for eating disorders in the UK have been reviewed as well as the high levels of 'drop-out' from these services. I have made reference to the predominantly female client-group and this is especially significant in this study where all the patient participants were women. I have also provided an overview of what is meant by '*therapeutic relationship*' from both a nursing and therapy perspective. The well documented challenges posed to staff working within these services are have also been discussed.

Whilst it is clear that 'something happens' between nurse and patient within eating disorders services, we cannot be sure that this is the same as the 'therapeutic relationship' that occurs within mental health services, as described by Peplau in her USA study in the 1940's, (published in 1952), nor if similarities exist within the work conducted in more recent studies. However, in summary, there are fundamental and distinctive features of the therapeutic relationship that have been accepted as commonalities and defining characteristics, such as mutuality and reciprocity.

Establishing and maintaining a relationship with the patient which is professional, respectful, therapeutic and which promotes recovery is still assumed to be the '*cornerstone of psychiatric*

*nursing'* (Welch, 2005:161). Clark and Nayar assert that for patients with eating disorders, recovery can only occur in the presence of certain elements, which are '*hope, healing, empowerment and connection*' (Clark and Nayar, 2012: 14). Treatment effectiveness, recovery rates and patient satisfaction are all considered within the context of the relationship and yet we know relatively little about how the relationship is actually played out in the adult eating disorder service.

The next chapter is a focussed literature review conducted to determine what is currently known about the subject and how this might inform the current study.

## Chapter 3: THE LITERATURE REVIEW

In the previous chapter I presented the background to the study, utilising a wide range of literature pertaining to the therapeutic relationship derived from both nursing and therapy literature. I also looked at other background information regarding anorexia and services for people with an eating disorder, in order to set the context for the study.

### 3.1. Introduction

My 2010 published review of the literature identified the lack of previous research considering the therapeutic relationship between women with anorexia and their workers (Wright, 2010), provided a clear rationale for the study and how such a study could make a unique contribution to the current body of knowledge, (see appendix 9). In this chapter I have identified the importance of undertaking a literature review within the context of phenomenology. I then re-present the review strategy and identified literature before focussing on a discussion of the papers most relevant to this study, that is, the therapeutic relationship between care workers and adults with eating disorders.

### 3.2. The importance of the literature review

In this section, I discuss the importance of the literature review and consider this within the context of phenomenology. Holloway and Walker (2000) advise that even for qualitative studies it is important to conduct a literature review at the beginning of the research to ensure that the planned research has not been done in a similar way before and to determine and define the topic and concepts on which to focus. Phillips and Pugh (1993) reinforce the need to conduct the literature review early in the process in order to demonstrate that the researcher has a '*fully professional grasp to the background of your subject*' (Phillips and Pugh, 1987: 53). In hermeneutic research, all knowledge and experience contributes to what is known and

understood by the reviewer and provides impetus and thinking that drives the momentum of the research (Smythe and Spence, 2012).

Smythe and Spence (2012) put forward a very common sense approach to literature reviewing whilst encompassing the essence of hermeneutic phenomenology in their model for reviewing the literature. They recognise that it is traditional to conduct a literature search first and that this is '*taken for granted*' (Smythe and Spence 2012: 13). They assert that:

*'The purpose of the literature review is therefore not simply to lay down pre-articulated knowledge simply to show a gap in the literature, or as a means to argue the catalyst of on-going research. The key purpose...in hermeneutic research is to provoke thinking.'*

(Smythe and Spence 2012: 14.)

Hence, the literature search was conducted to prepare the foundation of the study in terms of what is known, as well as to provoke thought. This is presented next.

### **3.2.1 Search strategy**

Higgins and Green (2011) highlighted the need to include as many sources of information as possible when conducting a literature search, in order to minimise selection bias. It is clear when researching a subject as broad as the therapeutic relationship, where thousands of texts exist, that it is important to reduce the material to that which directly relates to the study in question. Here, I present the way I approached the filtering of the papers until the most relevant papers were identified.

As the 'therapeutic relationship' is a term adopted from psychotherapy and is now used in a range of caring professions, the literature explored has been found largely within the therapy and counselling literature as well as the nursing literature. I employed a range of electronic data bases, (see table 1, below). Tracking the references from selected papers provided additional materials not otherwise discovered using the databases or e-journals. A diligent

search though a number of textbooks also provided further sources of information. No date restrictions were employed.

Databases (16)	'Discovery' (@UCLan), Science Direct, Academic Search Complete, CINAHL, EBSCO, EMBASE, PsycINFO, journals@Ovid, PsycARTICLES, Wiley Online Library, Medline, Google Scholar, British Library Electronic Thesis online Service (EThOS), Taylor and Francis online. BIOSIS.
Eating Disorder Journals (5)	Eating Disorders Review, International Journal of Eating Disorders, Eating Disorders: The Journal of Treatment and Prevention, European Eating Disorders Review
Conference Proceedings (3)	International Nursing Ethics Conference  National Psychiatric Nurses Research Conference (x2)

**Table 1: Literature searching strategy**

Searches were also conducted through the library catalogue, Amazon, Google and physical searches of the libraries and bookshelves of clinical eating disorder units, including a number of autobiographical accounts housed at 'Sheena's Place', Toronto, Canada. Colleagues were contacted through networks; conferences in the context of presentations, (national and international), led me to other literature sources. I have a large personal collection of nursing,

eating disorder and therapy books and I also searched the shelves of both clinical and academic colleagues.

A combination of search terms were used including 'therapeutic relationship', 'working relationship', 'working alliance', 'helping relationship', 'helping alliance' and I combined these with 'anorexia', 'eating disorder' and 'qualitative' (as seen in table 2,below) .

The filtering of the searches allowed me to focus in on the many thousands of publications relating to the therapeutic relationship in search of specific literature referring to the fundamental aspects of the therapeutic relationship, as well as identifying previous studies into the relationship within eating disorder services. The following table gives an indication of the literature search. Many of the 'hits' were not relevant, however, so inclusion/ exclusion criteria were established (see table 3).

<b>Key words searched</b>	<b>Results</b>
Therapeutic relationship	75,049
Therapeutic relationship + Anorexia	237
Therapeutic relationship + Eating disorder + women	79
Therapeutic alliance + Eating disorder + women	14
Working alliance + Anorexia	15
Working alliance + Eating disorder	39
Therapeutic relationship +	10

<b>Key words searched</b>	<b>Results</b>
Anorexia + Nursing	
Therapeutic alliance + Anorexia	11
Therapeutic alliance + Anorexia + Nursing	11
Working alliance + Anorexia	15
Therapeutic relationship + Eating disorder + qualitative research	8
Therapeutic alliance + Eating disorder + qualitative research	10
Therapeutic alliance + Anorexia + qualitative research	3
Therapeutic relationship + Anorexia + qualitative research	3

**Table 2: Study Search terms**

<b>Inclusion criteria</b>	<b>Exclusion criteria</b>
TR, TR, TA or WA in abstract Eating disorder or anorexia focus Qualitative and quantitative studies Studies reported in English Studies that reported on adult health or therapy services.	Studies where the main focus is on the evaluation or comparison of treatment or therapy interventions. Papers published by the author (KMW) Papers not published in English

**Table 3: Inclusion and Exclusion criteria.**

Overall, 11 academic papers were identified that specifically focussed on the therapeutic relationship with an eating disorder service. However, no qualitative based studies were found that considered the therapeutic relationship from the perspective of the patients suffering with an eating disorder.

Of these 11, three qualitative studies researched the perspective of the workers within eating disorder services (King and Turner, 2000; Ramjan, 2004; Snell *et al*, 2010). (Please refer to table 4. below for a breakdown of these studies in relation to their characteristics, results and key points).

As there were such a small numbers of relevant papers, a formal quality assessment tool was not used; rather an appraisal of the literature was undertaken. This was conducted to apply the principles of a theory-driven realist review approach (Pawson, Greenhalgh, *et al*, 2005) in terms of inclusion based on relevance (e.g. whether it addresses the theory under exploration) and rigour (whether insights made a credible contribution), rather than a means for exclusion.

As all identified literature was considered to provide some insights into the phenomenon, all papers were reviewed and reported.

<b>Literature referring to Therapeutic Relationship (TR) Therapeutic Alliance (TA) Working alliance (WA) Helping Alliance (HA), Helping relationship (HR) and Eating Disorder Services</b>					
<b>Citation of study</b>	<b>Where?</b>	<b>Who?</b>	<b>Study design and methods</b>	<b>Analysis (research papers only)</b>	<b>Key findings</b>
Gallop, R., Kennedy, S.H. & Stern, D. (1994)	Toronto, Canada	31 patients mixed AN , BN & 18 staff ( nurses, doctors, nutritionalists and occupational therapists).  <b>Adult</b> , in-patient ED ward	<b>Quantitative</b> Research paper using the Working Alliance Inventory (WAI)	Statistical analysis. Relationships between the various dyads' perceptions of the WAI Analysed using Pearson correlations.	The perception of the alliance strengthened over time for the patients while staff perceptions did not. Involvement in a structured programme is a particular challenge.

George, L.(1997)	Ipswich, England	Anorexia nervosa patients (no age specified)	<b>Discussion</b> paper re the psychological characteristics of patients suffering from anorexia nervosa and the therapeutic relationship	N/A	Nurses require adequate education and supervision for working with this client group.
Treasure, J. <i>et al</i> (1999)	London, England.	125 out-patients patients with Bulimia nervosa (mean age = 28)	<b>Quantitative</b> research examining the roles of readiness to change and therapeutic alliance in determining engagement and outcome in the first phase of a treatment programme. RCT	Statistical analysis	Readiness to change is more strongly related to improvement and the development of a therapeutic alliance than specific types of treatment
Kaplan, A.S. & Garfinkel, P.E. (1999)	Toronto, Canada	Specialist ED service. No age specified.	<b>Discussion</b> paper re the challenges of caring for in-patients with AN.	N/A	Improving understanding of the reasons for treatment refractoriness in patients with EDs is critical to improving their care.
King, S. & dS Turner (2000)	Australia	5 female registered nurses caring for <b>adolescent</b> , anorexic females in paediatric wards of general hospitals.	<b>Qualitative</b> Research paper- Husserlian phenomenology.	Colaizzi's (1978) procedural steps	Need for educational programmes New care regimes needed More nursing involvement in assessment
Toman, E.(2002)	Switzerland	18 female , <b>adult</b> patients <b>bulimia</b> All female therapists In-patient ED ward	<b>Quantitative</b> Research paper: Attempt to interrelate knowledge of the TR with knowledge re transference and counter-transference. Considered BMI and its impact on TR Hospitalisation Symptom-centred.	Statistical analysis:  SPSS for Windows	Transference/ Counter-transference phenomena in the work with ED patients show strong differences depending on BMI and age of patient.

Ramjan, L.M.(2004)	Australia	10 registered nurses caring for <b>Adolescents</b>  Acute ward in children's hospital ward	<b>Qualitative</b> Research paper Naturalistic inquiry.	Manual thematic analysis & NUD*IST computer programme.	Improvements suggested to establish genuinely therapeutic relationships Improvements suggested to establish genuinely therapeutic relationships
Pereira T., Lock J. & Oggins J. (2006)	California, USA	41 <b>adolescents</b> (ages 12–18 years) having family therapy for anorexia nervosa	<b>Quantitative</b> research paper  Working Alliance Inventory-Observer (WAIo) used.  Family therapy	Statistical analysis. Analyses of variance (ANOVAs). Two-tailed Pearson's correlations used.	Strong TA in both parents and patients. Early alliance linked with early weight gain. TA likely to contribute to treatment retention and outcome.
Surtees, R. (2007)	New Zealand.	Specialist ED service. No age specified.	<b>Discussion</b> paper	N/A	Stresses importance of TA
Snell, L., Crowe, M. & Jordan, J. (2010)	New Zealand	7 Nurses. Six -bedded, in-patient ED ward No ages specified (patients not included in study)	<b>Qualitative</b> research paper Grounded theory	Open & axial coding and the integration of theory.	Nurses play a crucial role in the smooth running of the unit and successful treatment. The central variable was 'connecting' .
Isserlin, L. & Couturier, J. (2012)	Ontario, Canada	14 female adolescents with AN and their families.	<b>Quantitative</b> research paper (pilot study). System for Observing Family Therapy Alliances Scale used.(SOFTA)	Statistical analysis.	TA important in family based treatment for AN.
<b>Key</b>	Shaded rows indicate the <b>qualitative studies</b> available that look specifically at the <b>therapeutic relationship in an eating disorder service</b> .				

**Table 4: Literature referring to the TR in ED services**

### **3.3. Focus on the therapeutic relationship within eating disorder services**

Each of the identified 11 published papers which related specifically to the therapeutic relationship and eating disorders are now reviewed in chronological order.

The first paper which considers the therapeutic relationship in eating disorder services was conducted in the first eating disorder service in the world, in Toronto, Canada. Gallop, Kennedy

and Stern (1994) conducted a quantitative study which measured the therapeutic alliance using the Working Alliance Inventory. They researched both the unit staff and the patients (n=33) over a two year period at admission and eight weeks later. This was a mixed group, which combined patients with anorexia and bulimia, as well as co-occurring conditions. Ten of the patients had left the programme before the second part of the study, which is not unusual in eating disorder services; engagement can be sporadic (Sly, 2009). Although they found that in-patients prematurely terminating their treatment reported a poorer therapeutic alliance within the first three weeks of treatment, they observed that there was little correlation between the staff and the patients' perception of the alliance. Furthermore, it was a purely quantitative study with no qualitative data to explore the nature of the relationships. Therefore this paper offered little insight as to why the correlation between staff and patients was poor. However, as patients with co-occurring AN and BN tend to be more impulsive and sensation seeking than patients with restricting type AN (Herpertz-Dahlmann, 2008), this may have contributed to the high drop-out rate. The paper also assumes that the staff and patients participating in the study were reporting on the relationship with each other, although this is not clearly stated.

Of the three authors of the second study reviewed, two (Gallop and Stern) are registered nurses, the third (Kennedy) is a psychiatrist and yet, of the seven referenced papers used in the preparation of their paper, no nursing literature was used and references to the therapeutic alliance are taken solely from the psychotherapy literature between 1979 and 1988. Whilst these have transferability, the transferability of the psychotherapy literature is assumed and 'treatment' is considered to be equivalent to 'therapy' throughout the paper. The conclusion of this paper includes the advice that staff should enquire as to the patient's subjective experiences of the programme, as '*perceptions of the therapeutic alliance are not objective*' (Gallop *et al*, 1997: 409).

In 1997, George, a community psychiatric nurse working in Ipswich, England, published a literature review drawing on a mix of sources to emphasise the importance of considering the psychological profile of the patient when nurses attempt to create a therapeutic relationship. One of the important features of this paper is the author's early recognition that the perception of anorexic patients as '*difficult patients with a self-induced illness*' (George 1997: 899) is unacceptable. George suggests that this might be addressed by providing insight into their psychological profile. The inference made by George is that if the patients are better understood, then the nurse-patient relationship will improve. George (1997) provides an overview of the psychological characteristics of the patients, followed by an overview of the therapeutic relationship which is then utilised in her description of the implications for practice. A number of issues are raised including the need for positive regard, the patients' phobia of gaining weight, their interpersonal mistrust and the possible presence of depression. Evidence based responses are recommended to support the nurse in caring for this client-group as well as a recommendation for improved education for nurses in eating disorder care settings.

Treasure *et al* (1999) studied engagement and outcomes in the treatment of bulimia nervosa and specifically examined the roles of readiness to change and therapeutic alliance in determining engagement and outcome. One hundred and twenty-five female patients who met the DSM-IV criteria for bulimia nervosa took part in a randomised control trial which considered the effectiveness of cognitive behavioural therapy (CBT) or motivational enhancement therapy (MET) in engaging patients in treatment. Although the paper focuses on bulimia, rather than anorexia, they concluded that readiness to change is more strongly related to improvement and the development of a therapeutic alliance than the type of therapy offered.

Kaplan and Garfinkel (1999), who are both doctors, relate their clinical experience and synthesise the literature which considers the treatment resistance of the patients in their care and the subsequent negative, non-therapeutic reactions. Kaplan and Garfinkel acknowledge that comments and conclusions in this paper are not based on rigorous clinical studies and they tend to refer to 'therapeutic approaches' throughout the paper, which could mean therapy rather than the relationship. They reported that care workers exhibited strong negative feelings of hostility, anger, hopelessness and stress because of the heavy demands on their time and energy from patients craving attention. They report that patients suffering from eating disorders seek high levels of human warmth from their care workers, but equally, may not trust the care workers.

There is some connection here between the expressed opinion of Kaplan and Garfinkel and that of George (1997). Both refer to the perception that anorexic patients are regarded as 'difficult', that they are sensitive and do not trust others easily. A notable difference is that Kaplan and Garfinkel consider co-morbidity in terms of describing co-existing conditions followed by a sub-heading for 'Strategies for working with difficult people' which lists therapeutic interventions with the patient (Kaplan and Garfinkel, 1999: 5); George takes an approach which offers support for the nurse and includes strategies for the nurse, such as staff meetings and supervision. George sees the need to support and educate the staff in order to improve their relationship with the patient with anorexia, whereas Kaplan and Garfinkel focus on the need to provide expert clinical skills in order to aid recovery.

In 1999 there was limited knowledge about specific therapies for eating disorders and the approaches within in-patient settings were heavily influenced by traditional hospital care. Kaplan and Garfinkel call for a *'trusting, genuine, honest relationship that is collaborative in*

*nature and where there is agreement on commonly shared goals'* is based on their observations about what would be helpful in this setting (Kaplan and Garfinkel, 1999: 4). Kaplan and Garfinkel's paper also refers to Prochaska and DiClemente's transtheoretical model<sup>22</sup> of change which Treasure *et al* (1999) speculated might be of relevance to eating disorders, at around the same period of time in the UK.

In the following year King and Turner (2000) published a paper that specifically focussed on in-patient services in Victoria, Australia. In this study, their research participants were five female registered nurses, without mental health training, caring for adolescents with anorexia within paediatric wards. Of the six themes that were explicated in this study, three referred to the personal impact of caring for this caring group. The first '*core values challenged*' discusses the deceitful and untruthful nature of the patients that caused the nurses to use derogatory labels to describe them and found that the '*sneaky*' and untrustworthiness of the patients challenged their core beliefs. Two other emergent themes are '*emotional turmoil*' and '*frustration*', emphasising how exhausting it can be in caring for such complex and vulnerable patients.

Although previous literature has emphasised Rogerian principles and the need to be empathic, this study emphasises how staff '*distance themselves to realise that anorexics are sick people*' (King and Turner 2000: 145). Although the study identifies turning points in the relationship, there is a sense of resolution that the reason their patients were not recovering was not because of the quality of the nurses' work. The resolution enabled them to merely continue with this difficult work in the same vein, rather than offering alternatives. Although they do not interview the patients nor provide any recommendations for changing the way the relationship is managed, they do create insight into the way the relationship changes over

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<sup>22</sup> Prochaska and DiClemente's (1992) well-known transtheoretical model for change can be usefully applied to anorexia nervosa. The model represents change as a process revolving through five stages: precontemplation, contemplation, determination, action and maintenance.

time. The registered nurses in this study were not mental health nurses and the patients were children, so there is limited transferability to adult patients with mental health care workers. However, King and Turner (2000) provide valuable insight into the challenge of this caring role and the emotional and tiring nature of this work, to the point of being overwhelmed at times. It is of concern that this exhaustion leads to a subsequent '*disenchantment*' with nursing which occurs as a consequence (King and Turner, 200: 145). They suggest that educational programmes and greater understanding of the patients' needs may help, as does George (1997) and Kaplan and Garfinkel (1999).

A further paper, Toman (2002), highlights the anxiety of the worker, the frustration manifesting itself in aggressive thoughts and the emotional dynamics that are generated within the relationship with the bulimic patient. This quantitative, Swiss study researched two therapists and their 18 patients on an in-patient eating disorder ward. They utilised current understandings of the relationship in order to research the relevance of the patient's BMI and its impact on the therapeutic relationship. They concluded that the thinner the patients are, the higher the probability that a '*close-protective*' pattern occurs within the therapeutic relationship. The heavier the patients are, the greater the probability of a '*distant-demanding*' pattern of therapeutic relationship.

Toman's study resonates with that of King and Turner (2000) to a degree, but, because she is referring to therapists within the discrete relationship of a specific therapy intervention (rather than a generalised caring role throughout the day), the similarities are limited. Although the patients are receiving in-patient treatment, they suffered from anorexia of the bulimic sub-type, or bulimia nervosa. In Toman's study, interviews were conducted, but the data is analysed in a quantitative way using the statistics programme SPSS for Windows. Transcriptions of the interviews were searched for items for a list of nine criteria relating to the feelings and attitudes of therapists toward the patients.

The Australian study conducted by Ramjan (2004) studied the difficulties of ten paediatric nurses (who were her colleagues) in establishing therapeutic relationships with adolescent patients with eating disorders. She identified three themes influencing the development of the therapeutic relationships in the acute care, hospital setting:

1. *Struggling for understanding- (with regard to the diagnosis;*
2. *Struggling for control- ( examining the power struggle and mutual distrust);*
3. *Struggling to develop therapeutic relationships.*

(Ramjan 2004: 495)

There are some similarities with the 'refractory' relationship as described by Kaplan and Garfinkel (1999) and also with the King and Turner (2000) study which emphasises the impact of the patients' resistance to treatment demonstrated by their 'sneakiness' and untrustworthiness. The similarities with the King and Turner (2000) paper have greater relevance because the care workers are not mental health trained and the patients are also adolescent. Ramjan concludes that the behavioural programmes promoted are not conducive to establishing therapeutic relationships at all, because of the conflict between behavioural programmes and the denial of the seriousness of their low body weight, a view shared by others (George, 1997; Vandereycken, 2006).

Ramjan's work is enlightening, but again, focuses only on adolescents, as does Pereira *et al's* (2006) study in California. Pereira *et al* (2006) considered the role of the therapeutic alliance and its role in predicting drop-out from treatment; the treatment in this case being family-based therapy (FBT) for adolescents with anorexia nervosa. Forty one adolescents (aged 12-18) were included in the randomised controlled trial study over a twelve month period of family therapy. No care worker or therapists were included in the study. The authors conclude that the therapeutic relationship is likely to contribute to treatment retention and particularly refer to the '*collaborative, non-blaming therapeutic style of the FBT that contributes to the*

*success of these families...*' (Pereira *et al*, 2006: 683). These findings do not, however, explore or describe the relationships between the patients and their workers; they merely provide a prediction of drop-out.

An expert, but not empirical paper, entitled '*Developing a Therapeutic Alliance in an Eating Disorders Unit*' was published by Ruth Surtees<sup>23</sup> in 2007. Surtees stresses how important the development of the relationship is, as well as the importance of defining shared goals.

This paper appears to promise insight and guidance into the therapeutic alliance/relationship. In reality, however, it provides a descriptive account of anorexia, an overview of New Zealand's limited service, the therapeutic approaches adopted for this client group, the dietary treatment plan and the recording of the patient's vital, physiological signs. She does, however, suggest that a lenient and flexible approach is required which should involve the whole family. She notes the importance of mutual and commonly understood goals and that cohesiveness across the team is vital. The remainder of the paper outlines the treatment plan. Although the title of this paper is directly relevant to this study (*Developing a therapeutic alliance in an eating disorders unit...*) the content does not reflect the title and the advice is based upon the recommendations of service guidance and the research of others, including Snell (2005), (see below).

Again in New Zealand, Snell, Crowe and Jordan (2010) reported on a grounded theory study into maintaining a therapeutic connection in an in-patient eating disorder unit. In this study they interviewed seven registered nurses about their experiences of establishing therapeutic relationships in the only dedicated (six bedded) specialist eating disorder unit in New Zealand. They do not mention the age of the patients within the service and no patients were included in the study. Although Snell *et al* (2010: 353) describe the anorexic patient as '*resistant and*

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<sup>23</sup> Ruth Surtees writes as a specialist mental health nurse and case manager in the eating disorders in-patient unit at Princess Margaret Hospital in Christchurch.

*oppositional'* and refer to patient interactions as '*negative and potentially destructive*' they have provided discussion of the data which is worthy of note. Their commentary centres on the concept of '*maintaining a therapeutic connection*' and lists three major categories stemming from this; '*developing the therapeutic connection*', '*negotiating the therapeutic connection*' and '*coordinating the connection*' (Snell *et al*,2010: 353).

A continued searching of the literature over the years of my study uncovered the 11th paper, published in 2012, by Isserlin and Couturier. This paper studies the therapeutic relationship occurring in the family based therapy of fourteen adolescents with anorexia. Given that it was a quantitative paper, utilising the System for Observing Family Therapy Alliances Scale (SOFTAS)<sup>24</sup>, the sample size of only 14 adolescents was very small, (pilot study). It concluded that those patients who had gained weight had more favourable SOFTAS scores demonstrating enhanced Engagement in the Therapeutic Process (ETP) but not in the Shared Sense of Purpose (SSP). The authors thus conclude that the therapeutic alliance is important in family based treatment for anorexia because their study demonstrates that it reduced drop-out from therapy. This resonates with the findings of Pereira *et al* (2006) who also used a scale to measure the relationship (WAlO<sup>25</sup>) for family therapy with an adolescent group of patients and their parents. They too found that a good therapeutic alliance in patients and parents predicted better retention, thus lower drop-out from therapy.

Having considered the papers individually I now summarise the key points.

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<sup>24</sup> The System for Observing Family Therapy Alliances (SOFTA-o) is a way of estimating the strength of the working alliance in conjoint family treatment. The SOFTA-o is designed to be completed while observing a videotaped family therapy session. Individual family members are rated separately on Engagement in the Therapeutic Process (ETP), Emotional Connection and Safety; the entire family unit is rated on Shared Sense of Purpose (SSP).

<sup>25</sup> WAlO = Working Alliance Inventory-Observer scale. This scale consists of 12 items, 10 positively worded and two negatively worded, rated on a seven-point Likert-type scale. The items are divided into three subscales of four items each. The subscales are based on Bordin's working alliance theory.

### **3.3.1 Summary of the key points**

Five papers of the 11 were quantitative in nature focussing on factors associated with the scale used, such as the Working Alliance Scale which was used in both Gallop's and Pereira's paper (Gallop *et al*, 1994; Isserlin and Couturier, 2012; Pereira *et al*, 2006; Toman, 2002; Treasure *et al*, 1999). The utility of measuring the relationship is clear; the relational factors occurring within a therapeutic encounter such as family therapy are made clear. Such scales are less relevant, however, when considering the on-going and more naturally occurring relationship within the context of a ward or day care facility.

Similarities across the papers include the observation that patients are not trustworthy, that they are deceitful and that they will defy all attempts to persuade them to eat thus creating frustration and exhaustion in the nurses (George, 1997; King and Turner, 2000; Toman, 2000). There is a clear consensus evident from the eating disorder and therapeutic relationship literature that the goals of patients with anorexia nervosa will frequently conflict with those of the worker and the service, even if these are not overtly expressed. Although these papers do not provide commentary on the characteristics of the care workers; they do provide insights into the personal characteristics of the patients which result in the treatment sabotage. These insights are highly reminiscent of Felicity's Stockwell research in the 1960's where she provided commentary on the 'unpopular patient', that is, one who is uncooperative, stubborn and lacks appreciation (Stockwell, 1972).

From the only three published qualitative studies that specifically focussed on the therapeutic relationship in an eating disorder service view; these studies only considered the relationship from a professional perspective (nurses). Furthermore two of the three papers concern the care of adolescents (King and Turner, 2000; Ramjan, 2004; Snell *et al*, 2010) (see table 4.) Only one phenomenological study (King and Turner, 2000) was found, which utilised a Husserlian

approach to explore the perceptions and experiences of five registered nurses caring for adolescent, anorexic females in paediatric wards.

Although environment is clearly important to interpersonal relationships, none of the 11 studies considered the impact of the context or environment on the relationship. Other studies concerned with eating disorder therapy, including that by Zeeck and Hartmann (2005), talk of the '*therapeutic process*' which can be described as having six central aspects: the '*therapeutic alliance*', the '*therapeutic contract*', '*interventions*', '*self-relatedness*', '*therapeutic realizations*' and the '*timeframe of events*' (Zeeck and Hartmann (2005: 246). Snell *et al* (2010:357), does however, speak of the '*therapeutic milieu*' and makes the observation that this was dependent on the '*nurse's ability to counter negative, potentially destructive patient interactions*'.

### **3.4. Conclusion**

In this chapter I have reported on the focussed literature review, explained the search strategy adopted and presented the key papers which are most informative about what is known already about this subject area. Whilst there are thousands of papers written about the therapeutic relationship, this chapter has focussed on published studies which have considered the therapeutic relationship within the context of eating disorder services, specifically for adults. Of the 11 papers identified, only three were qualitative based studies and all of them focussed exclusively on the workers' perspectives (no patient participants). It is therefore questionable whether the findings of the existing studies are generalisable or transferable, given Gallop *et al's* (1994) conclusion that the perspective of the patient appears to be different to that of the worker.

This review identified that there is no published qualitative based research into anorexic women's and their care workers' perspectives of the therapeutic relationship. Further

research into the relationship is necessary from a multi-professional perspective which includes the women who suffer with eating disorder as participants in the research. Indeed, it can be argued that to view a relationship from a single perspective neglects to recognise that any connection made is invested by both parties and, as such, tells only half the story.

In the following chapter I consider the theoretical positioning of this study.

## Chapter 4: **THEORETICAL POSITIONING**

In the previous chapter I discussed the research, currently available, that focuses on the therapeutic relationship within the context of care for people with an eating disorder and what we currently know about the challenges posed in establishing a therapeutic relationship within this setting.

### **4.1. Introduction**

In this chapter I set out my reasons for choosing van Manen's approach to phenomenological research as a means to address the aim of the study. The methodology is considered and a rationale provided for the suitability of an interpretive phenomenological research approach for the study. I outline the path taken before deciding upon van Manen's approach and describe the explorations into the various qualitative methodological approaches that were considered during this process. From there, I consider the approaches of the major contributors to phenomenology and their influence upon the methodology put forward by van Manen (van Manen, 1990). Finally, I present the eclectic nature of van Manen's approach including his adoption of bracketing and the hermeneutic circle.

### **4.2. Positioning the theoretical approach**

#### **4.2.1 *Aim of the study***

Bordage and Dawson (2003) consider that the '*the single most important component of a study is the research question. It is the keystone of the entire exercise*' (Bordage and Dawson, 2003:378).

The aim of this study is:

*'To explore the lived experience of the relationship between women with anorexia and their workers in the context of a specialist eating disorder unit'.*

### 4.3. The research journey

Both Crotty (2009) and Guba (1990) were influential in providing insight into the significance of what Crotty calls '*scaffolding*' (Crotty, 2009:16), in order to support and frame the research. Crotty suggests that a framework is established that requires us to 'unpack' our assumptions, explicate and explain ourselves to ensure that the research is underpinned by a robust approach which is made transparent to readers. In the following sections, I address the theoretical perspective and the methodology of the study. The methods adopted are presented and discussed within chapter 5.

#### 4.3.1 Phenomenology

Phenomenology is the philosophy that underpins phenomenological research and thus the research methodology (Crotty 2009). The two phenomenological approaches most commonly referred to fall broadly into two camps, which are descriptive/eidetic phenomenology (e.g. Husserl and Giorgi) and hermeneutic (interpretive) phenomenology (e.g. Heidegger, Gadamer and Merleau-Ponty).

Anderson states that the purpose of phenomenological research is to uncover, understand and illuminate the experience of everyday life (Anderson, 1993). Van Manen, although interpretive in his approach, utilises some features of both interpretive and descriptive phenomenology in order to sensitively evoke meaning from the text (Kockelmans, 1987; Levering and van Manen, 2002, van Manen 1997/2007). Phenomenological research differs from the more pragmatic and thematic approaches of qualitative research which focus on **what** is said rather than **how** the text conveys its meaning to the reader.

Despite a plethora of literature referring to the therapeutic relationship, Welch (2005) believes that, in psychiatric nursing, it is '*notoriously undefined*' (Welch, 2005: 161). I would argue that 'therapeutic relationship' has been defined many times in articulate and intelligent

ways, albeit predominantly within the psychotherapy literature and in quantitative studies. This phenomenological study aims to describe the therapeutic relationship as experienced by the partners in the relationship in ways that are meaningful to them. A phenomenological research approach is particularly suited to the study of the therapeutic relationship because, it is both a shared experience and a personal experience. Gendlin explains this as:

*'Phenomenology has no problem going beyond a single person's private experiencing, because experiencing is inherently an interaction process in a situation with other people and things. What appears is neither internal nor external, neither just private nor just interactional. My situation is not subjective since the others in it are more than I can experience, but neither is it "objective" since my situation does not exist apart from me.'*

(Geldin, 2004: 147-148)

Understanding the philosophy of the approach creates a further dimension in the researcher journey. With this in mind I have provided some background into the philosophers that influenced van Manen in the development of his approach (van Manen, 1990/1997); that is, the work of Husserl, Heidegger, Merleau-Ponty and Gadamer, before discussing my chosen approach, that of Max van Manen.

#### **4.4. The phenomenologists that have influenced van Manen's approach.**

There are many variants of phenomenological philosophy under the rubric of the broad movement (Moran, 2000). Van Manen (1990) asserts that his approach to interpretive<sup>26</sup> phenomenology reflects aspects and features of a number of the 'founding fathers' of phenomenology and his work is written with the assumption that the reader has some foundation knowledge of their work.

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<sup>26</sup> van Manen tends to use the terms 'hermeneutic' and 'interpretive' interchangeably within his text, '*Researching Lived Experience*' (van Manen, 1990).

#### **4.4.1 Edmund Gustav Albrecht Husserl (1859-1938): 'Husserlian phenomenology'**

Edmund Husserl was the principal founder of phenomenology in 1900-1901. He adapted Franz Brentano's descriptive psychology which was considered ground breaking at the time (Moran, 2000). Husserl defined phenomenology as the study of the intentional content remaining in the mind after the bracketing of the world. He argued that all philosophy should be a description of experience, the intellectual conception of a thing as it is in itself, not as it is known through perception. He instructed researchers to '*get down to what matters!*' (van Manen, 1997: 184). Husserl's call '*back to things themselves*' originally indicated a return to the:

*'...objective logical, ethical, legal and aesthetic laws and values which had been reduced to the sphere of mere subjectivity and thus falsified, by psychologism'.*

(Seifert, 1997: 8).

He went on to develop the concept of the '*lifeworld*', which he described as the '*world of immediate experience*', where we live in the natural, taken for granted attitude (Husserl, 1970: 103), each showing certain pervading structures or styles. Husserl argued that the '*lifeworld*' (*Lebenswelt*) is understood as what individuals experience pre-reflectively, without resorting to interpretations; they question what is 'real' and 'valid' about the experience of a phenomena and the relationship between the 'knower' and 'the known' (Husserl, 1970; Moran 2000). This is fundamental to his assertion that researchers should 'bracket', (a term borrowed from mathematics), or suspend, their own beliefs in the reality of the natural world, in order to study the essential structures of the world.

Sokolowski (2000) has explained phenomenology as stating both the obvious and the necessary, but for Husserl, the purpose of inquiry was to investigate phenomena and describe its essential structure in a manner that is free of interpretation without making assumptions or

judgements about the world (Koch, 1999). Hence, Husserl advocates 'bracketing' as a way to put aside previous knowledge and obtain objective and fundamental knowledge of the phenomena, (discussed further in chapter 5). Bracketing is a facet of Husserl's approach which has been adopted by van Manen (1990).

#### **4.4.2 Martin Heidegger (1889-1976): Heideggerian phenomenology**

Heidegger<sup>27</sup>, once a personal assistant to Husserl, was a German philosopher known for his existential and phenomenological explorations of the 'question of Being' (Heidegger, 1962). Heidegger's name is synonymous with interpretive phenomenology; his seminal text, *Being and Time* (1962), is considered to be one of the most important philosophical works of the 20th century, but was perceived by Husserl as a betrayal of the principles of phenomenology. Heidegger opposed Husserl's process of bracketing, asserting that it is not possible to separate out our previous knowledge or experience to establish an independent standpoint.

In *Being and Time*, Heidegger gives the idea of the lifeworld a more '*worldly, existential thrust*' (van Manen 1997: 183), and so, for Heidegger, phenomenology is ontology, his professed aim being to let things speak for themselves as we live our lives through experience of the world and not principally by knowing it (Thompson, 1990). He subsequently promoted the 'thoughtfulness' of phenomenology (Heidegger, 1962). This thoughtfulness was considered to be a mindful, caring wondering about life and personal experience and what this means to the individual.

Heidegger's focus on existence (being-in-world) as opposed to consciousness (something out there) was subsequently a significant turning point in the development of hermeneutic phenomenology (Thompson, 1990). The interpretive (or hermeneutic) phenomenologists are ontological and concerned with the meaning of 'being' and the interpretive endeavour that

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<sup>27</sup> When Husserl retired as Professor of Philosophy at the University of Freiburg in 1928, Heidegger was elected as his successor.

leads to understanding (Cohen and Omery, 1994). Hence the distinction between descriptive and interpretive phenomenology is largely defined by the differences between Husserl and Heidegger (Silverman, 2000).

Heidegger uses the expression *Dasein* to refer to the experience of 'Being' that is particular to human beings and literally means 'being there'. Heidegger's phenomenology is thus a method of access to this question of 'Being', not a descriptive, detached analysis of consciousness as it is for Husserl (Heidegger, 1962). For Heidegger, the question of *Being* (or 'self-hood') is the absolutely fundamental question of both philosophy and also of existence. He argues that we are practical agents, caring and concerned about our projects in the world and allowing it to reveal, or '*unconceal*' itself to us. Likewise, van Manen emphasises the importance of phenomenological writing as a route to '*let us see*', as it is '*through the words that the shining through becomes visible*' (van Manen , 1990: 130).

#### **4.4.3 Hans-Georg Gadamer (1900-2002)**

Hans Georg Gadamer was a German philosopher and student of Heidegger. In 1923 he met Husserl and Heidegger at Freiberg and once stated that he owed everything to Heidegger, his greatest influence. *Truth and Method* described his work on philosophical hermeneutics. Gadamer argues that the truths of history, society and culture are only revealed through dialogue and are inaccessible to scientific observation. He believed that science could not be free of subjectivity or human drives, since all scientific studies rely upon humans for their conduct. He argued that human beings continually interpret their world and are therefore not neutral, independent or objective observers, but rather existential finite interpreters, always expressing linguistically their relation to the world. Van Manen points to Gadamer's view that the essence of the question is the opening up and the keeping open of possibilities (Gadamer, 1975: 266), to the extent that van Manen states that to truly question something is to

*'interrogate something from the heart of our existence, from the centre of our being'* (van Manen, 1990: 43).

#### **4.4.4 Maurice Merleau-Ponty (1908- 1961)**

Merleau-Ponty was particularly interested in 'perception' and the part it plays in understanding the world as well as engaging with the world. In his book *'Phenomenology of Perception'* (1962) Merleau-Ponty states his position, derived from Husserl, that 'intentionality', one of the essential tenets of phenomenology, refers to the inseparable connectedness of beings to the world. Merleau-Ponty develops this further by reinforcing that we cannot accurately describe the world except in terms that express our personal experience and perception of that world; hence the world can never be seen in isolation from the observer. Hence, for Merleau-Ponty, all human existence acquires meaning through consciousness and thus our 'lived experience' refers to our human involvement with the world. He has been called both a phenomenologist and an existentialist<sup>28</sup>.

Merleau-Ponty explained that:

*'phenomenology ... puts essence back into existence, and does not expect to arrive at an understanding of man and the world from any starting point other than their facticity'*<sup>29</sup>

(Merleau-Ponty, 1962: vi).

Merleau-Ponty purported that four existential themes pervade the lifeworld of all human beings. These are *lived space* (spatiality), *lived body* (corporeality), *lived time* (temporality) and *lived human relation* (relationality or community) (van Manen, 1990: 101). These are discussed further in the context of the data organisation in chapter six as these are suggested by van

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<sup>28</sup> Existentialism refers to the philosophical and cultural movement which holds that the starting point of philosophical thinking must be the individual and the experiences of the individual.

<sup>29</sup> <sup>29</sup>'Facticity'- i.e. their actual, definite ways of being.

Manen as a platform on which to explore the findings of phenomenological studies and for the organisation of the data.

Having considered the four philosophers that have each made significant contributions to van Manen's methodology, I now turn to van Manen himself.

#### **4.5. Max van Manen (1942-present)**

Max van Manen is Professor Emeritus at the University of Alberta, in Canada. He developed his interest in the human sciences and phenomenology through his studies into pedagogy (*'Fenomenologische Pedagogiek'*) in the Netherlands before becoming a Canadian citizen in 1973. His approach to phenomenological research represents convergence of the German tradition (the Dilthey-Nohl School) and the Dutch movement (the Utrecht School) and so reflects characteristics of both descriptive and interpretive phenomenology (Cohen and Omery, 1994; van Manen, 1990).

According to van Manen (1990), phenomenology differs from almost every other science in that it attempts to gain insightful descriptions of the way we experience the world pre-reflectively, without taxonomizing, classifying or abstracting from it.

Both Heidegger, and subsequently Merleau-Ponty, had considerable influence upon van Manen (1990). Van Manen recognises the strengths of hermeneutic phenomenology, an interpretive approach that aims to understand lived experience by exposing our assumptions underpinning what we know, or our way of knowing. Van Manen asserts that the phenomenological text is interpretive in that it effectively *mediates*. Once these intentions and meaning are apparent they can be viewed alongside what is known already and the interpretation which is derived from the data.

Van Manen makes reference to the philosophers that underpin his methodology at frequent junctures within his works, (van Manen, 1984/1989/1997/2002/2007). For example, van

Manen refers to what Heidegger calls '*in-being*', by which he means '*our everyday being-involved-with the things of our world*' (van Manen, 2007: 13). This enables an engagement with the '*lifeworld*' that is sensitive and explores our everyday involvements with our world; thus leading to us to know what we know as well as be what/who we are. This, within the context of a research approach, seeks to bring forth the lived experience of the individual within their own context. For this study, it is the lived experience of the relationship; that exists both within the context of the service and the dynamics between those sharing the interpersonal relationship.

Van Manen also refers to Gadamer, both in his books and within his website, with particular reference to Gadamer's condensing and intensifying meaning of the word 'experience'; van Manen connects this with the significance that we attribute to experiences by giving memory to them. Van Manen's description of the hermeneutic interview also draws on the work of Gadamer from whom he quotes:

*'The art of questioning is that of being able to go on asking questions, i.e. the art of thinking'.*

(Gadamer, 1975: 330 cited by van Manen, 1990: 98.)

#### **4.5.1    *The hermeneutic circle***

Heidegger (1962) developed the concept of the Hermeneutic Circle so that interpretation of the text could be developed on the basis of the 'fore-structures' of understanding that allow external phenomena to be interpreted or in a preliminary way. Van Manen subsequently refers to the '*hermeneutic interview*' (van Manen, 1990: 98) where he refers to the interviewer keeping the question open and the interviewee orientated to the phenomenon.

Polt (1999) describes Heidegger's hermeneutic circle as his constant return to the previous descriptions and his re-conception of these in an attempt to make them more accurate and nuanced. Polt suggests that this is more of a 'spiral' than a 'cycle' as each turn of the cycle

'reaches a deeper level' (Polt, 1999: 31). The voiced experience needs to be heard, but it may need the researcher to expose the essence through interpretation. The understanding of the term *hermeneutics* is crucial to this process. Hermeneutics is described by Moustakas as:

*'...the art of reading a text so that the intentioned meaning behind appearances are fully understood'*. (Moustakas, 1994: 9).

The debates about the extent to which the philosophy of phenomenologists such as Heidegger and Husserl can realistically be utilised alongside the pragmatic concerns of qualitative research tend to spur controversy (Todres and Wheeler, 2001). Applebaum<sup>30</sup> (2007) criticises van Manen for creating confusion between hermeneutic and descriptive phenomenology because he draws on Husserl, Heidegger and Gadamer who provide the philosophical basis of his approach. Applebaum (2007) believes that this obscures the epistemology of van Manen's research approach. Van Manen (1997) asserts that all phenomenological descriptions have an interpretive element; Webb (2003) agrees but suggests that some kinds of phenomenology can be interpretive; whilst Jones (2001) disagrees and is of the opinion that phenomenology is not interpretive.

Van Manen describes his method for researching lived experience as:

*'A human science research approach, showing a semiotic employment of the methods of phenomenology and hermeneutics'*. (van Manen, 1990: 1).

Van Manen writes poetically and with passion about his endeavour to portray the lived experience of others in a way that illuminates it for his readers, for example:

*'But, phenomenology is also a project that is driven by fascination: being swept up in spell of wonder, a fascination with meaning.'*

(van Manen 2007: 12.).

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<sup>30</sup> The full-text of this paper was published only in Spanish. However, I have corresponded with Marc Applebaum by email in order to clarify my understanding of his paper which critiques Max van Manen's *Researching Lived Experience* (1990) and Clark Moustakas' *Phenomenological Research Methods* (1994), from the standpoint of Amedeo Giorgi's phenomenological psychological method. The abstract is available from: [http://saybrook.academia.edu/Departments/Department\\_of\\_Psychology\\_and\\_Interdisciplinary\\_Studies/Document\\_s](http://saybrook.academia.edu/Departments/Department_of_Psychology_and_Interdisciplinary_Studies/Document_s)

For me, van Manen's eclectic approach draws together a workable methodology that allows the philosophy of phenomenology to gain pragmatics and utility for human science research. Van Manen's methodical framework for conducting human science research provides researchers with guidance that has utility as well as philosophy and is described in detail in the next chapter (see chapter 5).

Van Manen makes many references to the process of 'phenomenological *reflection*' in order to '*grasp the essential meaning of something*' (van Manen 1990: 77), as Husserl suggests that we create meaning or essence of things every day (Husserl, 1980). Phenomenological reflection is '*both easy and difficult*' (van Manen, 1990: 77) and is one of van Manen's six research activities (see p.97). Reflection is considered to be fundamental to caring and compassionate nursing (Benner, 1994). In Benner's text, *From Novice to Expert*, she describes the skills required to reflect on practice in order to develop expert practice and increase self awareness (Benner, 1984). Benner, like Schön<sup>31</sup> (Schön, 1984), considered that nurses often act intuitively; consequently, she demanded that nurses looked at what they did, reflected upon why they did it, the impact or response of their actions and how they could do things differently, (better).

Todres and Wheeler suggested that the '*articulation of human experience*' is central to nursing and '*foundational to practice*' (Todres and Wheeler, 2001: 2). It is the humanness of van Manen's approach which makes it so relevant for this study:

*'[Methodology] includes the general orientation to life, the view of knowledge and the sense of what it means to be human...'* (van Manen, 1990 : 27).

For me, interpretive phenomenology and the application of this approach is one way of gaining insight into the relationship between the care workers and the women. If we can better

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<sup>31</sup> Donald A. Schön (1930-1997), a philosopher, was concerned with the development of reflective practice and learning systems within organizations and communities. He is cited often in nursing literature.

understand what is happening in the relationship we may be able to better utilise this catalyst for engagement, and thus recovery.

#### **4.6. Conclusion**

In this chapter, a thorough engagement with the methodology and the philosophy of the approach has been presented in order to provide the methodological context for the research.

I considered the aim of the study and have followed Crotty's lead in establishing the research journey, (Crotty, 2009), reviewing a range of epistemologies, theoretical perspectives and methodologies. Having decided upon phenomenological research I have presented the underpinning philosophy and my rationale for using the methodology of van Manen.

In the next chapter I describe the phased approach to the study and the design and methods employed.

## Chapter 5: **STUDY DESIGN AND METHODS**

In the previous chapter I considered the epistemological and theoretical approach proposed for this study and established that van Manen's approach would be adopted. Having decided upon the theoretical perspective (phenomenology), Crotty suggests that concerns around method should follow (Crotty, 2009).

### **5.1. Introduction**

It is in this chapter that I outline van Manen's methodological structure of human science research and demonstrate the utility of this approach for this study (van Manen, 1990). I consider the design of the study, including the justification of the two phases adopted. I then discuss the process of ethical approval for the study and the concerns regarding the vulnerable nature of the patient participants, recruitment and data collection. Van Manen's methodological structure for human science research is presented and data collection for both phases to avoid repetition later. However, description of the environmental context of the different services (e.g. day care – phase one and in-patient – phase two) have been included in chapters 6 and 7 respectively. Issues of rigour and transferability adopted within this study are also discussed.

### **5.2. Study design: a phased approach**

The study was undertaken in two phases. Patients and care workers from two different eating disorder services were interviewed regarding their experiences of the therapeutic relationship. Phase one was conducted in a day-care setting to pilot the interview and test the impact of the research on a stronger, but similar group of patient participants to the in-patient group who were interviewed in phase two. Whilst the numbers of participants in phenomenological studies are intentionally small due to its in-depth nature and methods I originally aimed to recruit between 12-20 participants as suggested by Smythe (2011). However, due to

conducting the research over two phases this resulted in a total of 25 participants (whilst there were 13 participants within phase one and 13 within phase two, one of the patients [Heather] took part in both phases due to her subsequent admission to the in-patient unit). As all the patients were female, the patient participants are sometimes referred to as the 'women' in this study. As the professionals were from a range of clinical backgrounds they are referred to as 'care workers'

### **5.2.1 Phase one**

In the day care setting, patients attended two or three days a week. They returned home at the end of each day and were living independently. All seven of the patients who participated in this study were considered to be 'well enough'<sup>32</sup> to take part. The seven staff participants were all female and included nurses, nurse-therapists, a CBT therapist and a dietician.

Demographic information about the participants can be found in chapter six, table 5.

As previously identified (chapter 2), patients with anorexia attend treatment reluctantly and sometimes only because the threat of using the legal system to obtain agreement to treatment could result in compulsory in-patient care rather than day care (Tan *et al*, 2010). Hence, day care patients tend to have higher BMIs, than in-patients, although Burket and Hodgkin (1993) state that individuals with more severe eating problems may be the most reluctant to seek treatment, so for many, their engagement with care is not necessarily help-seeking but may be with an intention to maintain their survival without admission to hospital.

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<sup>32</sup> I was given permission to approach all the patients, bar a few who were also visibly, physically frail. All the patients discussed their wish to take part in the study with their care-team and all were considered to be 'well enough' to take part. That is, they had the physical and mental capacity to participate. A copy of the consent form was given to the nurse in charge for filing in the patient participant's clinical notes.

### **5.2.2 Phase two**

The second phase of the research was conducted within an in-patient setting in a different location, albeit in the same city (see chapter 7). At the time of the study, the two services were unconnected, managed by different independent healthcare providers<sup>33</sup>, although one patient was admitted to both services<sup>34</sup> during the course of the research.

As in phase one, all seven patients who participated in phase two were considered to be 'well enough' to take part and were female. Four of the six care worker participants were female; the two psychiatrists involved were male. Psychiatrists, nurses, a dietician and a healthcare support worker participated. Demographic information about the participants is presented in chapter seven (Tables 5 and 6).

### **5.3. Gaining access to the service and participants**

There are limited eating disorder services in the UK, so the potential for the patients to become an 'over researched'<sup>35</sup> group, as well as a potentially vulnerable group, is high. Both service directors reiterated this concern to me when I met with them to seek permission to conduct the study. Hunt (2011) emphasised the need for improving the process of gate keeping<sup>36</sup> to enhance the experience for both participant and researcher and ultimately, to advance the field of eating disorders in general. Access was only allowed when ethical permission had been granted and the service was satisfied that the research would not be a burden to the participants (Roach *et al*, 2009; NRES).

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<sup>33</sup> These eating disorders services are now owned by the same healthcare provider which has combined the in-patient services, thus closing the unit where the research was conducted.

<sup>34</sup> Heather was a day patient during phase 1 and was admitted to hospital when phase 2 of the research was being conducted.

<sup>35</sup> Certain groups in the population can be 'over-researched' either because they easily defined, are accessible and convenient for researchers, or because they have characteristics that are distinctive and particularly interesting for researchers.

<sup>36</sup> The 'gatekeepers', in this context, are the people that allow access to the participants. Initially this was service governance and the ethics committees (NHS & UCLan). When on site, the gatekeepers were the care team and the service managers.

McCann and Clark (2005: 8) suggest that there are five main areas where research access can be particularly problematic, namely when:

1. *the research process poses an 'intrusive threat' to participants because it concentrates on topics that are private or evoke fear;*
2. *information is provided in the study that can be stigmatizing or incriminating;*
3. *participants are drawn from vulnerable groups who are open to exploitation;*
4. *there are political implications from the findings, which may lead to controversy;*
5. *there is an inherent risk to the researcher in carrying out the study.*

I wrote to the medical directors (both consultant psychiatrists) at both research sites to introduce the study; I offered to meet with them and sought their opinion on the study. Subsequently, I met with the hospital director for the day care service (phase one) and the consultant psychiatrist and the clinical services manager for the inpatient service (phase two). Portfolios of information were provided which included documentation such as the protocol, the participant information sheets and the interview schedule to enable scrutiny of the study proposed and to facilitate discussion. They were keen to know what questions I would be asking the participants and how I would ensure that taking part would not be a negative experience for anybody.

### **5.3.1 Ethical approval**

I applied to the Service Governance leads of both services for permission to conduct the study and was initially granted permission in principle, pending permission being granted from the NHS ethics committee. I adhered to the University of Central Lancashire's Ethical Procedures for Teaching, Research, Consultancy, Knowledge Transfer and Related Activities for the

preparation of the study protocol and documentation<sup>37</sup> as well as the guidance provided within the NHS ethics application process<sup>38</sup>. I also applied to a local NHS ethics committee for permission to conduct the study, (Cumbria and Lancashire 'A' NHS Research Ethics Committee) and I was sponsored by the University and the University's Director of Research. I also met with the NHS ethics committee and hence was able to discuss the project with them and answer their questions.

The NHS National Research Ethics Service provided a favourable opinion for the research in July 2009 and the University's Faculty of Health and Social Care Ethics Committee (FHEC) granted permission to conduct the study in August 2009 (see appendices 1 and 2).

The NHS Ethics Committee made it a condition that participants under the age of 18 could only be included if parental consent was given. Retrospectively, the decision not to include the 16-18 year olds was the right one because it set the study firmly outside the context of the 'adolescent' studies, such as those previously reviewed in chapter 3 (King and Turner, 2000; Pereira *et al*, 2006; Ramjan, 2003). In the event, the youngest patient receiving care in either service was eighteen, so nobody was formally excluded from the study on the basis of their age. The considerations raised by the ethics committee and senior staff are discussed in the following section.

### **5.3.2 'A vulnerable population'**

One of the biggest concerns of researching a group of individuals such as the patient participants within this study is their perceived vulnerability. Hence, I was aware that there was a fine line between obtaining information and the necessity of protecting the participants'

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<sup>37</sup>[http://www.uclan.ac.uk/research/graduate\\_research\\_school/files/Research\\_ethical\\_principles\\_june07.pdf](http://www.uclan.ac.uk/research/graduate_research_school/files/Research_ethical_principles_june07.pdf)

<sup>38</sup> National Research Ethics Service: <http://www.nres.nhs.uk/applications/>

well-being (Blegen *et al*, 2012; Liamputting, 2007). I therefore adopted a range of actions to safeguard the patient participants. These included seeing the nurse in charge prior to every appointment, discussing confidentiality issues at the beginning of every interview, offering to stop or defer the interview at any time and being sensitive to signs of tiredness or discomfort during the interviews. I thought it less likely that the care workers would be affected by the research interview, but I was reassured that all staff members received clinical supervision and would never be on shift alone during or after the interview.

The population being researched would fall under McCann and Clarke's third category of 'vulnerable' (McCann and Clarke, 2005: 8). Thus the patients considered to be most vulnerable, the in-patients, were not seen until phase two of the study. This also enabled me to refine the research interview and demonstrate my competence as a researcher in managing the sensitivities and ethical dimensions of the project, before moving on to the in-patient group.

Safeguards were put in place to limit any potential harm that might come about as a consequence of taking part in the study. Information sheets and consent forms providing comprehensive information were made available. These enabled an autonomous choice to be made about agreement to take part in the study. All participants were aware that they could withdraw from the study at any time (or withhold parts of their interview after the event) and that their contribution would be anonymised and classified as confidential (World Medical Association, 2008).

The support of senior staff at the hospital was important, because it ensured that care workers were available to participate and support any participant affected by the interview. The care team also agreed for the women who were being closely observed (one-to-one supervision, post meal) to be interviewed without the presence of a duty nurse. Only one patient who had

consented was withdrawn from the study by the care team due to concerns about his 'wellness' to take part. 'Gatekeepers' are an integral part of the negotiations for access and exist to ensure that potential participants are not exposed to excessive demands generated by research; nobody has a right to gain access to a research site or to participants (Barnes *et al*, 2009; DH, 2001; Hodgson, 2001; Mulhall, 2003; Payne *et al*, 2007).

### **5.3.3 Confidentiality and storage of data**

Bok (1988) describes the justifications for maintaining confidentiality; the first is the respect customarily given to personal information that is disclosed for a particular purpose. Bok further justified maintaining confidentiality because it helps to strengthen the relationship between the researcher and the research participant and because assurances given at the outset of a relationship should be maintained. Finally, Bok also reinforced that we have a professional obligation to maintain confidentiality (Bok, 1988).

Pseudonyms have been used to protect confidentiality. I chose names that I thought suited the individuals. One person asked to choose her own pseudonym ('Olivia') and so I agreed, on the condition that she promised not to tell anyone else because of my duty to protect her anonymity. The only places where both the real name and the pseudonym exist together are the consent forms which are stored according the University of Central Lancashire's academic regulations, in a locked filing cabinet at the University. The transcriber (phase two interviews only) was contracted to the University and was subject to a confidentiality agreement. The digital recordings of the interviews were stored with the transcribed interviews in a password protected, electronic file at the University.

### **5.4. Recruitment to the study**

This section describes the sampling strategy used and how participants were recruited to both phases of the study.

### **5.4.1 Purposive sampling**

A purposive (purposeful) sampling strategy was adopted in order to ensure that only care workers and patients currently within the eating disorder service were able to take part in the research (Holloway, 2005). Purposive sampling is defined as: '*Judgemental sampling that involves the conscious selection by the researcher of certain subjects or elements to include in the study*' (Crookes and Davis, 1998: 151). Typically, the basis of sampling in interpretive phenomenological studies is that participants are willing and able to recount their experiences (de Witt and Poley, 2006; van Manen, 1997).

As the therapeutic relationship is not a one-way process, it was important that both parties in the relationship were included in this study. The therapeutic settings meant that relationships occurred informally, in groups and on a one-to-one basis, so there were no 'pairings' as such. Previous studies into the relationship between patients and care workers have not included the patients as participants in the research (King and Turner, 2000; Ramjan, 2004; Snell *et al*, 2010). For this study it was important to me that both care workers and patients were recruited.

### **5.4.2 Gaining consent**

After taking advice from the care teams from both services in the study, I requested information about when it would be appropriate to meet with participants individually. For each phase, I left two folders containing all the information about the study, the information sheets, my contact details and consent forms; one in the communal lounge area, for the patients and one in the nursing office, for the care-workers (see appendix 3). Prospective participants were therefore able to take an information sheet and consent form and then I would meet them at least 24 hours later to provide further information, to clarify any issues regarding their consent to take part and offer them the option of withdrawal from the study at any time. In the two weeks before the data collection commenced, I attended the services

several times to make myself available to any potential participants as Roach *et al* (2009) stress the importance of the amount of time spent in the field prior to and during data collection, as planned interactions promote trust and provide more opportunity for informed consent to be obtained.

Although unplanned, a 'snowballing' effect evolved in the recruitment process during phase one which was subsequently repeated in phase two. 'Snowball sampling' is usually purposefully adopted and chosen because of its utility with hard to reach groups where the researcher needs to rely upon connections within the community to gain access to individuals. In simple terms it consists of identifying respondents who are then used to refer researchers on to other respondents (Atkinson and Flint, 2001). Vogt describes it as:

*'A technique for finding research subjects. One subject gives the researcher the name of another subject, who in turn provides the name of a third and so on'. (Vogt, 2005: 300)*

Each week I had appointments with women who then recommended other women within the service who could participate. These women would then leave me a note for when I next visited, sometimes including a number to call them on or ask that I could go on a different day to see them. I clarified that care team approval was required before booking an interview appointment and I also gave a copy of their consent form to the nurse-in-charge for inclusion in their case notes (see appendix 3). I was given an interview room to use for the entire day and participants informed me of the best time for me to meet with them. After a couple of the women booked in appointments with me that ran across 'snack times', (meaning that they would be in an interview with me, rather than in the dining room having a supervised snack), I

asked that all women checked with their key-workers<sup>39</sup> that the time-slot they chose was compatible with their care plan prior to confirmation of the appointment.

The care workers had been informed of the study by the service manager before my arrival and everybody that I met already knew about the study and had volunteered to take part. Virtually all the day care workers participated (phase one) as well as most of the full-time day-duty staff working in the in-patient service (phase two). Most of the day care worker interviews were conducted before the patients arrived (8am-9am) or at the end of the day (after 4.30pm), depending on how busy the unit was.

It has been suggested that volunteers may differ from non-volunteers, they may have a particular interest in the study, and they may have strong views, radical opinions, greater enthusiasm, a more progressive approach or a personal agenda that may affect research findings and consequently the validity of the study (Bowling, 1997; Slevin *et al*, 1995). In this case, because the research sought to discover an individual experience that would not be shared with the care team afterwards, the possibility of 'hidden agendas' was lessened.

In the following sections, I present the conduct of the research using van Manen's framework (1990). Information regarding the data collection, data organisation, interpretation and analysis has been discussed within the relevant stage of van Manen's methodical structure (van Manen, 1990).

### **5.5. Van Manen's methodical structure of human science research**

When undertaking an interpretive phenomenological study it is the task of the researcher to describe, develop and analyse the shared experiences of the participants by engaging in deep reflection upon the accounts (van Manen, 2007). The task was made easier by the framework proposed by van Manen who describes his approach as a '*dynamic interplay among six research activities of human science*' (van Manen, 1990: 30). The six research activities are not

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<sup>39</sup> The 'key worker' role was allocated to a nurse who coordinated the care and treatment of the patient whilst admitted to the service.

necessarily sequential and van Manen emphatically denies that a systematic or procedural approach can be followed; he insists that '*critical moments of inquiry are ultimately elusive to systematic explication*' (van Manen, 1990: 34), nonetheless, he lists his methodical structure as:

- 1. turning to a phenomenon which seriously interests us and commits us to the world;*
  - 2. investigating experience as we live it rather than as we conceptualise it;*
  - 3. reflecting on the essential themes which characterize the phenomenon;*
  - 4. describing the phenomenon through the art of writing and re-writing;*
  - 5. maintaining a strong and oriented relation to the phenomenon;*
  - 6. balancing the research context by considering parts and whole.*
- (van Manen, 1990: 31-34).*

These steps are considered individually as I explain how this framework was adopted for the study.

## **5.6. Turning to a phenomenon which seriously interests us and commits us to the world.**

In chapter one I provided an extensive discussion in terms of my stated interest in the study (*Turning to a phenomenon which seriously interests us and commits us to the world*) and I considered the literature currently available to us in chapter three. Van Manen's emphasis on researching areas which have special significance or interest to individuals means that, inevitably, the researcher is likely to have some experience and perceptions of the phenomenon before commencing the study, (van Manen, 1990). For this, and the reasons discussed below, he recommends that bracketing is conducted.

### **5.6.1 Bracketing**

Although most often assumed to be related to Husserlian phenomenology, van Manen makes use of bracketing, otherwise known as *'the reduction'* or *'the epoche'*, which is where van Manen (1997) differs significantly from other interpretive phenomenologists such as Heidegger and Gadamer. Bracketing refers to the act of suspending judgement about the phenomenon in question (Moustakas, 1994). Tufford and Newman (2012: 80) refer to the value of this being *'to mitigate the potentially deleterious effects of preconceptions that may taint the research process'*. Van Manen describes it thus:

*'Bracketing describes the act of suspending one's various beliefs in the reality of the natural world in order to study the essential structures of the world. The term "bracketing" was borrowed from mathematics by Husserl (1970), the father of phenomenology, who himself was a mathematician'. (van Manen 1990: 175)*

The following definition by Ihde acknowledges that we cannot ignore what we know already, but rather refers to the phenomenological researcher's responsibility to:

*'Suspend or step back from our ordinary ways of looking, to set aside our usual assumptions regarding things.'* (Ihde, 1986: 32).

Van Manen recognises that it is not possible to forget or neglect what you already know because we might find that the *'presupposition persistently creeps back into our reflection'* (van Manen, 1990: 47). My previous knowledge and exposure to the phenomena of the therapeutic relationship was my impetus and the inspiration for this study, but bracketing does not neglect nor minimise these influences, rather my pre-conceptions and pre-understandings are put to one side and I acknowledge their existence. Dowling (2007) suggests that the phenomena being investigated should be understood by its own essential features, *'as free as possible from cultural context'* (Dowling, 2007: 132). However, relationships are largely bound by cultural norms and values, making this appear unachievable. Furthermore, van Manen suggests that the researchers need to recognise their own thoughts and their autobiographical experience of the phenomena in order to collate what they know about the subject already, whether that be derived from texts or experience (van Manen,

1997). As the researcher is required to be an active participant in both data collection and interpretation in hermeneutic approaches, they cannot be entirely free of pre-existing knowledge and experience.

Ahern identifies a number of ways in which the researcher can participate in reflexive bracketing (Ahern, 1999). This includes the questioning of taken for granted assumptions such as age, gender, socio-economic status and ethnicity. She also suggests that the researcher should appraise their own position by identifying any power relationship between themselves and the research participants; recognition of any feelings which may indicate a bias, or lack of neutrality; and that reflection should be repeated during the analysis and the writing up of the data. I have written a bracketing statement (appendix 7.) and my account of 'Millie' at the commencement of this study (p.22) could also be considered to be a positional statement which required bracketing at the commencement of the study. Additionally, I kept an on-going reflective diary and discussions in the supervision team meetings were also facilitative of the process of reflexivity.

### **5.7. Investigating experience as we live it, rather than as we conceptualize it.**

The second research activity advocated by van Manen is related to establishing a '*renewed contact with the original experience*' (van Manen, 1990: 31), thus attempting to understand the nature of the lived experience itself and refers to the data collection strategy. I chose to investigate the phenomena (the TR) by conducting individual interviews using a semi-structured schedule with all participants (see appendices 4 and 5).

### **5.7.1 The interviews**

A semi-structured interview schedule was written for both patients and care-workers with only very slight differences between the two (see appendices 4 and 5) and both were subject to ethical approval.

In-depth interviews are the most common means of data collection in phenomenology and are designed to elicit rich narratives (Cohen *et al* 2007; Moustakas 1994; Ploeg, 1999). The in-depth nature of the interviewing for phenomenology indicates that a small sample is recommended (Crookes and Davis, 1998). For van Manen, interviews have a dual role in that they help develop conversational relationships about the meaning of an experience and they also allow the researcher to gather narrative material that will enrich understanding of human phenomena (van Manen, 1990). Van Manen warns against the effect of the intense conversations which may occur within the context of the interview and may result in either new levels of self-awareness, or conversely, '*if done badly these methods may instead lead to feelings of anger, disgust, defeat, intolerance insensitivity, etc.*' (van Manen, 1990: 163).

Hence, in order to pursue a personal authentic perspective of lived experience, it was appropriate to be guided by the individual. The decision to adjust the structure for each person is advocated by authors such as DiCicco-Bloom and Crabtree (2006). Interviews were allowed to stray from the aide memoire occasionally whilst remaining focussed on the unique experience of the therapeutic relationship. Some participants (both workers and patients) asked to see the questions first so that they could prepare, or be less nervous and this enabled them to focus on the parts of the interview that were meaningful to them. Clarification was sought throughout the interview to assist the interviewee to extend their descriptions and provide further insight into their world.

I hoped to hear the personal accounts and narratives, but I also needed to reflect back to the participant what I heard, to make sure that I understood what they meant and so that they

knew I had understood them accurately. It was important to me that they knew that they could trust me to tell their 'truth', as described by Pelias<sup>40</sup> (2004). For Heidegger, 'truth' is 'unconcealment' or 'uncovering', as the Dasein is the primary locus of truth (Heidegger, 1962). I am thus using the term 'truth' in this regard, in terms of the authentic meaning acquired by speaking from a personal perspective.

Participants were asked to consent to the audio-recording<sup>41</sup> of the interview, as recommended by Holloway and Wheeler (2002). This enabled me to give the participants my complete attention whilst their exact words were being captured on a tiny device that participants told me was barely noticeable after the first few minutes. I was able to listen, not merely record. Yardley (2000) asserts that both the verbal and the non-verbal communication that occurs within the interview can affect the interaction significantly so it was important for us both to be at ease with each other, as far as possible.

I was keen to persuade participants to talk about their experience rather than give me a theoretical description of the therapeutic relationship, so I explained that it was a '*phenomenological study*'.

The word '*phenomenology*' was a little intimidating to some. To make it understandable I told them the 'toast story' (appendix 6) which explored my experience of my breakfast. Not what I ate, when or how, but my experience of it<sup>42</sup>. This was a real turning point and it seemed to give licence for the use of a range of metaphors and story-telling which then opened up discussion

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<sup>40</sup> Also see chapter 4 re Pelias.

<sup>41</sup> One participant (a worker) found the audio recording to be stressful and had difficulty because of their raised awareness of the presence of the digital recorder. Consequently we did a practice interview, I sent this to her electronically in an email and then she re-booked an appointment for the research interview. I reassured her that the only people who would hear her recorded voice was me and (possibly) my supervision team and no names were used during the interview. I would have abandoned the digi-recorder if required and made written notes. However, she saw this as an opportunity to conquer her fear of voice recording.

<sup>42</sup> After the first time I did this, I momentarily panicked, because it was a food-related story and it occurred to me that (for the patients rather than the workers), it might have served to emphasise the difference between my pleasure in eating and their disgust at the same activity. But this was not the case at all. Afterwards, I asked the participant how it felt for me to tell the story. She said that it was a good help and that she didn't think the story was about the food, it was telling somebody about an experience of something.

and provided greater insight into their experiences than I could have hoped for. Rarely did I manage to ask all the questions in one interview, so further appointments were arranged at the end of the interview until each participant felt that they finished telling me about their experience of their therapeutic relationships, in accordance with methodological traditions in phenomenological enquiry (Holloway, 2005)

### **5.7.2 Use of the hermeneutic circle within the interviews**

Use of Heidegger's 'hermeneutic circle' is one way of staying close to the phenomenon, in that it funnels down into the exploration of the phenomenon, thus honing our understanding, rather than widening it (Derbyshire *et al*, 1999; Holloway 2005). Van Manen (1997: 131) draws on the work of Heidegger and asserts that the methodology of phenomenology requires a dialectical going back and forth during questioning and identifies a three stage process thus: *re-thinking - re-reflecting - re-cognizing*. The literature tells us that, as interpretive phenomenological researchers, we engage in the '*hermeneutic circle*', during both the data collection stage and during the interviews, as well as the stage of data analysis (Derbyshire *et al*, 1999; Holloway, 2005), thus returning to the spoken words in a recursive way, reflecting on these and revisiting what is meant by them. Debesey *et al* (2008) asks the researcher to bring the parts together into one whole, referring to what Gadamer (2004) considers to be proper understanding.

Thematic statements were isolated either during the interview, or in follow-up interviews as '*objects for our reflection*' (van Manen, 2007: 15). The participants were asked '*is this what the experience is really like?*', thus the interview became an interpretive conversation, which enabled the participant to develop the meaning of an experience through conversation (van Manen, 1997) and minimised researcher bias. Certainly at this stage of the research, at the

pre-reflective point, it seemed sensible to check with the participants that that the findings relate to their perspective and that they summarise the aspects '*worth paying attention to*' (Lincoln and Guba, 1985: 290).

I agree with Gadamer (1975), who saw the hermeneutic circle occurring linguistically rather than merely through the consideration of text; through conversations with others in which reality is explored and then agreement is reached that represent a new understanding. I engaged the participants as partners in the research rather than simply providers of data. Some of the interpretation was done by the participants themselves, by creating a co-construction of meaning with them which also assures the trustworthiness of the findings.

This sort of in-depth interview, utilising the hermeneutic circle, takes time and can be draining. It involves allowing the participant to story-tell, to reflect and to muse about their experience. I therefore made the decision to divide the interviews up into smaller conversations to prevent tiredness and so that it was not too intrusive in the participant's daily schedule. As I was determined not to make any assumptions about what a person meant, I would go over the same thing, teasing out meaning, until I was sure that the participant had not only told me about the experience (descriptively), but what the experience was like for them. This enabled saturation of the data to occur and it allowed for early interpretation of the participants' words to occur during the interview and re-affirmed to them that I would convey their story accurately.

In this study, a relationship between the participants and me inevitably developed. The majority of the participants were interviewed more than once and also I spent a great deal of time within the service, either waiting to see people or talking about the study. In between

appointments I would often sit and write up my reflective log, or chat with care workers and patients. They inevitably got to know me a little bit and an informal rapport developed. For Sorrell and Redmond (1995), the researcher is a key instrument in qualitative research; on more than one occasion I was asked what I was doing and I would talk about the nature and purpose of the research.

### **5.7.3 Transcription**

I transcribed all phase one interviews myself, verbatim. In the literature, there has been a great deal of debate about the verbatim transcription (Halcomb and Davidson, 2006) due to a high level of errors present when interviews were transcribed by somebody other than the researcher (up to 60%) and the significant cost in terms of time and human resources.

Silverman (2006) emphasises how important transcription of the interviews is as part of the research process, rather than merely a technical task prior to the analysis. Silverman stresses the value of the close, repetitive listening of the recordings during transcription; a process that resonates with the subsequent repetitive reading and writing of the future phenomenological interpretation.

For me, the transcription of phase one interviews facilitated a detailed review and allowed me to carefully examine what had been said. It also gave me a further opportunity to make notes about the emotive content of the interview and my personal intuitive response to the interviewee could be recorded. During the actual interview I was acutely aware of my need to remain impartial and focussed on the well-being of the participant. On listening back in such a slow and methodical way I could acknowledge the impact upon myself, review my own performance and reflect on every line of the conversation whilst hearing the voices and noting the intonation.

When phase two data was complete, the additional twenty seven interviews were transcribed by a professional transcriber<sup>43</sup> contracted by the University due to the size of the task and restricted time due to competing workload commitments. I contacted the transcriber at the time of engaging her services to explain the nature of the clinical site and that many of the interviews included personal disclosures that she might find distressing. I was required to read through all transcriptions to check for accuracy as there were times where the transcriber was unable to hear satisfactorily or when clinical terminology was used that was unfamiliar to her.

Once the all the transcriptions, from both phases were complete, I used these within the third stage of van Manen's methodology, (see below, 5.8) '*reflecting on the essential themes which characterise the phenomenon*' (van Manen, 1990: 30).

## **5.8. Reflecting on the essential themes which characterize the phenomenon.**

Although the full data set was treated as a whole once complete, phase one data was transcribed and a preliminary analysis applied before phase two commenced. Phase one data was manually coded, rather than using the MAXQDA software, as in phase two. I will firstly describe how I reflected upon phase one data (see chapter 6), which prepared me for phase two and then I will consider how I reflected on the essential themes that characterised the phenomenon across the full data set.

### **5.8.1 *Reading and writing***

Van Manen says that it is in the act of '*reading and writing that insights emerge*' (van Manen, 2006: 715). Therefore, I read the transcriptions and listened to the voice recordings repeatedly in order to immerse myself in the data (van Manen, 1997). Deys (1993) emphasises the active nature of reading and compares the reading of the text with the activity of digging the garden

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<sup>43</sup> The transcriber had committed to a confidentiality agreement when contracted by the university.

in preparation for planting, a process which is compared to the seeds of analysis growing roots and taking form.

Although I have not chosen to use descriptive phenomenology, I found the use of a method of perusing the data, taught to me by Amedeo Georgi<sup>44</sup> during my attendance at his master class, to be very useful. Georgi maintains Husserl's position that the object of phenomenological description is achieved solely from the direct grasping (*intuiting*) of the essential structure of phenomena. Georgi's method involves reading and re-reading transcribed interviews from which we would identify the 'meaning units'. The meaning units were then transformed into statements expressing either explicit or implicit meaning. For me, this process of returning to the interview transcripts repeatedly is a very active process; one that requires the reader/researcher to do something every time they read it. Although I have not adopted Georgi's method, I learnt essential and focussed reading skills from Georgi which enabled a methodical engagement with the text, allowing meaning to be revealed, thus lessening the chance that superficial reading might result in a distorted interpretation.

### **5.8.2 Organisation of the data**

Data is commonly understood to be a collection of information used in research such as in a data set or data bank (McLeod, 2001). For the purposes of this study, the data are the interview transcripts. Polit *et al* (2001) advises that concepts of importance and themes start to be identified by the researcher as soon as data collection begins and van Manen acknowledges the fluid nature of the six stages. Although I waited for all the interviews and transcripts to be complete before formally engaging with the analysis and uploading the data into MAXQDA, I was mulling over the words of the participants and making reflective notes about areas of note from the interviews.

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<sup>44</sup> Amedeo Georgi is a descriptive phenomenologist. He founded both the phenomenology program at Duquense University (Pennsylvania, USA) and the Journal of Phenomenological Psychology.

Van Manen (1990) expresses a concern that the word 'data' has quantitative overtones which recognises that the information gathered is, effectively, the data. He draws our attention to earlier understandings of the word '*datum*', meaning '*given*' or '*granted*', which he recognises as relevant to the experience being considered. This is especially important as van Manen asserts that the experience is already transformed by the very nature of its translation into language and thus is constrained by language. For me, the understanding of the word '*datum*' as '*given*' is a powerful and important way for me to conceptualise the contribution of the participants who gave of themselves when they disclosed their stories and life experiences through their accounts. It felt like a gift which I was very grateful to receive. By the same token, a gift should be cherished and respected and the giver thanked. Hence, I will continue to refer to the interviews as 'data' and treat them as 'given' accounts.

### **5.8.3    *Development of the themes and sub-themes***

Van Manen (1990: 92) suggests that there are three methods for isolating thematic statements and '*uncovering*' or isolating aspects of the phenomenon in the text. The first is a '*wholistic*' approach; the second a selective or highlighting approach and the third, a detailed line by line approach (van Manen, 1990: 93). The twin phased approach to this study meant that all three methods were utilised in varying degrees.

The decision was made to complete a preliminary thematic analysis on phase one data prior to the commencement of phase two of the research project for the following reasons:

- i.    it would provide insight into the effectiveness of the interview schedule in eliciting responses from the participants;
- ii.   to identify where the sensitivities lay in order to refine interview technique and schedule in a way that was protective of the participants;

- iii. to allay any concerns about the ethics of the project (e.g. re the vulnerability of the participants);
- iv. to gain insight into dominant themes thus enabling subsequent interviews to gain depth in the most meaningful areas, (for the participants) and;
- v. to provide a report that could be seen by the participants. They were able to reflect upon the findings and provide commentary to confirm accuracy of interpretation and consider any necessary changes of approach.

Phase one data was reviewed manually and a preliminary analysis conducted. Van Manen (1997) suggests that we should consider the parts and then the whole, so this was done interview by interview, marking the individual transcripts with coloured pen. Sections were then 'cut and pasted' into a Word document, which was a line by line approach; culminating in an over-arching view of the parts (thematic statements) that were then clustered into groupings. Consequently, this informed the rest of the study, as well as contributing to what van Manen describes as '*grasping the essential meaning*' of something. Although the themes were noted from phase one before the full data set was complete, these were revisited when all the interview transcripts from both phases were complete.

When both phases of the study were complete, the full data set was considered in light of Merleau-Ponty's existential themes, as advised by van Manen (1990) and uploaded into the MAXQDA software. The themes previously identified for phase one were re-listed for coding, as well as any new ones that emerged from phase two. It was felt that this would provide a second review of phase one data and the analysis which was viewed as a whole. It was planned that if discrepancies or disagreements were found then these would be taken up with those involved in the original thematic analysis (KMW and SH).

#### 5.8.4 MAXQDA<sup>45</sup>

In this technologically driven world it is inevitable that there will be computer programmes designed to analyse research data of all kinds. For qualitative studies these are generally referred to as Computer Assisted/Aided Qualitative Data Analysis (CAQDAS, the use of computer software to aid qualitative research).

A number of researchers have commented on the utility of using software such as MAXQDA in the analysis of qualitative data. St. John and Johnson (2000) found that it saved time and was particularly useful when there is a large amount of data. Such organisation and management of the data was applauded by Banner and Albarran (2009) who suggest that the analysis produced is '*rigorous*' (Banner and Albarran, 2009: 24).

I had a large body of data, all of it was important and I needed to find a way to sift through it, manage it into sections and organise this in a way that captured its diversity and uniqueness as well as its similarity. I looked at two options, NVivo and MAXQDA. I decided upon MAXQDA as it felt more intuitive and when Saillard<sup>46</sup> did a comparison between MAXQDA and NVivo she concluded that MAXQDA was preferable (Saillard, 2011). 'MAX' is a reference to Max Weber, the famous German sociologist and, "QDA" stands for qualitative data analysis (Humble, 2009).

MAXQDA allowed me to peruse each interview, moving sections into coded themes which were then compared against each other for similarity and difference; resulting in some areas being re-coded or classified as sub-codes. Some of the statements needed to be kept within the context of the paragraph since meaning was lost when the section was shortened. This enabled the utilisation of what van Manen's describes as an 'anecdote' (see p.110).

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<sup>45</sup> I was initially very sceptical about this. I had sat in class with two phenomenology masters, van Manen and Amedeo Georgi, whilst they spoke at length about the reading and re-reading of the text. Georgi guided us through the writing units of meaning using paper, text, a ruler and a pencil. Van Manen had set us homework to write our own anecdotes of significant experiences, which we then reflected upon, spoke to others about and then wrote about at length. We were encouraged to work intensely and to refine the art of writing in a way that felt both exposing and poetic at the same time. At no time did we look at a computer, nor discuss the possibility.

<sup>46</sup> Saillard also has a helpful website called '*methodspace*' with a blog enabling researchers to seek advice and guidance in the use of the software (<http://www.methodspace.com/profile/ElifKusSaillard>).

Once all transcripts from both phases of the study were uploaded into MAXQDA, each interview was read and re-read searching for sections that provided understanding of the world of the participants. These were highlighted and saved under temporary thematic headings initially. When all transcripts had been through this process I met with GT to review these, after which several were merged, or re-named and then subsequently grouped into Merleau-Ponty's existential themes. It was at this stage that it was clear that, as well as Merleau-Ponty's existential themes (Merleau-Ponty, 1962), Heidegger's concept of 'Authenticity', which had been identified as a theme within phase one, was essential to the experience of the TR and thus required recognition as a fifth major theme.

Van Manen emphasises<sup>47</sup> that the account of the lived experience is not merely presented by extracting pertinent data, but also through the art of writing to illuminate the experience (van Manen, 1984/1989/2002). His fourth stage focussed entirely on the art of writing and is considered next.

### **5.9. Describing the phenomenon through the art of writing and re-writing.**

Van Manen (1999) encourages the researcher '*to write and re-write*', returning to the text many times to interpret, understand and critique in order to '*be able to do justice to the fullness and ambiguity of the experience of the lifeworld*' (van Manen, 1999: 131).

I essentially searched for themes which shed light upon the meaning of the TR for the participant before entering into a further, deeper analysis of the interviews using van Manen's *writing and re-writing* approach to understanding the lived experience for each participant.

This started with the identification of emerging themes but then progressed to seek for

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<sup>47</sup> I attended a 2-day master class, led solely by van Manen in May 2009, at the University of Bournemouth. During this time we practiced writing, re-writing and again re-writing our accounts of experiences in a process of constantly refining the words to provide an evocative and meaningful account (some in class, but also homework).

'meaning', 'focus' and 'point' in order to provide a thematic analysis and uncover the experience as lived by them rather than as interpreted by others (van Manen, 1990). Van Manen describes this search for meaning thus:

*'Analyzing thematic meanings of a phenomenon (a lived experience) is a complex and creative process of insightful invention, discovery and disclosure. Grasping and formulating a thematic understanding is not a rule-bound process but a free act of "seeing meaning"'. (Van Manen website, 2012)*

The interpretive journey through the interview was a vital constituent for the analysis of this study. Van Manen (1997) speaks of the ability to 'see' something as a consequence of phenomenological writing, so that interpretive inquiry provides a deeper and more meaningful dimension to emancipate the experience, which is step five on his list of the six research activities of human science.

### **5.9.1 The use of the 'anecdote'**

For van Manen, (van Manen, 1989: 246-247/ 1997:119-120) an '*anecdote*' is a short passage of text to facilitate in-depth reflection and to tease out understanding of the experience for the person giving their account of their experience in an effort to '*bring to light*' the meaning of these words. Anecdotes were only used after the completion of phase two when a more in-depth analysis was completed across the whole data set.

Anecdotes allow a person to reflect about a specific time and experience in a very vivid way, aimed at clearly telling the story of an experience to another person. To anecdote is to reflect and recreate an experience in a way that is very focussed and concise, so is perfect as an exemplar when presenting research data. Van Manen attributes his interest in the anecdote to the philosopher Strasser (1963) on the phenomenological-pedagogical work by the human science proponents of the Utrecht School (van Manen, 1979a, 1979b, 1984).

The following suggestions are given by van Manen to provide a description of what an anecdote is and to enhance the narrative power of the anecdote (van Manen, 1989: 246-247/1997:119-120):

1. An anecdote is a very short and simple story;
2. an anecdote usually relates one incident;
3. an anecdote begins close to the central idea;
4. an anecdote includes important concrete detail;
5. an anecdote often contains several quotes;
6. an anecdote closes quickly after the climax; and
7. an anecdote requires punctum\* for the punch line.

Anecdotes are used periodically throughout the data presentation as exemplars of lived experience.

To illustrate, I have included here an '*anecdote*' from an interview conducted with Rachel as an exemplar. Rachel suffers from Anorexia Nervosa; her account was, for me, illuminating because it gave me insight into her experience. I will never know what it is like to have anorexia or to feel the fear that Rachel feels; but her anecdote gave me a glimpse into her world ['lifeworld']. This anecdote was part of a conversation that I had with her whilst she was in hospital. Her BMI was about 13 at the time, so she appeared visibly emaciated to me and she had been in hospital for about three weeks at this stage:

*'You don't want to go into hospital, you end up sort of either being forced into hospital or you're essentially at a point where, if you don't voluntarily go you're going to end up being forced into hospital. I mean you know it's not going to be nice but you sort of think, well I want it to be, when you're told you've got to go into hospital it feels so threatening I think, especially with an illness like this because, you know, people say, well all the control is going to*

*be taken away from you and all this sort of thing about food and what you can do. And to be fair, I think sometimes that's what I wanted, you know, I wanted that. But it still does feel really frightening and it's really threatening and you do just think, well, at least if there are people there who know me and who know how I am and who know that, I don't know, I might react in a certain way in a certain situation because they've experienced that from me in the past. **Yes, it just feels safer\*.***

Rachel, patient P2 i: 11.

The punctum\* is clearly: '*Yes, it just feels safer.*'

So, to van Manen's fifth activity for researching lived experience; this stresses the importance of staying close to the phenomenon.

#### **5.10. Maintaining a strong and oriented relation to the phenomenon.**

Van Manen speaks of the many temptations to stay orientated, in order to avoid getting side tracked; '*we will not settle for superficialities or falsities*' (van Manen, 1990: 33)

Thus reflection and explication of the meaning of the lived experience, for that person, occurs to make that explicit. Van Manen believes that meaning is both '*multi-dimensional*' and '*multi-layered*' (van Manen, 1990: 78). So my endeavours to draw out these layers within the interview process, using the hermeneutic circle, means that these multi-faceted meanings have been manifested in the language used and can be identified within the analysis of the transcripts.

Van Manen warns against getting too wrapped up in the '*what is this?*' question, to the extent that we lose sight of the meaning of what we have found. He describes this thus:

*'...one gets stuck in the underbush and fails to arrive at the clearings that give the text its revealing power'. (van Manen, 1997: 33).*

Explanations of the meaning of phenomenology at the commencement of the interviews further emphasised that I was searching for individual meaning rather than theorised or

descriptive definitions and facilitated a more personalised discussion which enabled me to identify accounts of lived experience.

Hence, van Manen advises us to '*balance the research context by considering parts and whole*', which is the sixth and final activity which he lists (van Manen, 1997: 33).

### **5.11. Balancing the research context by considering parts and whole.**

Van Manen (1990) is very clear that human science research cannot be easily captured by research plans and surveys due to the multi-staged approach required in conducting such research. This is where the nature of his methodical approach is clearly non-sequential. Van Manen lists a multi-staged approach required for human science research, commencing with the need to write a research proposal setting out the chosen method of data collection, review of the transcripts and how interpretation will be conducted. He suggests that this includes concrete statements such as :

*'I am planning conversational interviews with six elementary schoolchildren about their favorite play space...'* (van Manen, 1990: 161).

This study has been conducted utilising a robust research protocol which was reviewed at all stages of seeking permission for the study (e.g. ethical, service governance, University regulations). Van Manen (1990) suggests that the next step is to consider the effects and ethics of the research followed by the practicalities of conducting it, such as how to word the questions and the environment context. He then advises on how the research is presented and includes the suggestion that this is done '*thematically*', '*analytically*', '*exemplificatively*', '*exegetically*' and/or '*existentially*' (van Manen, 1990: 168-172). I have identified themes which have then been presented existentially; van Manen describes this as:

*'To weave one's phenomenological description against the existentials of temporality (lived time), spatiality (lived space), corporeality (lived body), sociality<sup>48</sup> (lived relation to others).*

(van Manen, 1990: 172)

Hence, the final stage of van Manen's methodology refers to the fundamental existential themes as a framework for the organisation of the findings.

### **5.12. Organisation of the data utilising the structure of fundamental existential themes.**

The four existential themes identified by Merleau-Ponty (1962) and subsequently recognised by van Manen (1990) provide an appropriate platform on which to explore the findings of the study and my subsequent reflection upon the words of the participants. Van Manen states that all '*phenomenological human research efforts are really explorations into the structure of the lifeworld*' (1990:101) and acknowledges the uniqueness of the individuals' experience of their own lifeworld. He refers to the four fundamental existential themes mentioned above which pervade the lifeworld of all human beings irrespective of their particular position in society, history or culture. The purpose of phenomenological analysis for Merleau-Ponty is not the intuition of essences, but rather it is '*concentrated upon re-achieving a direct and primitive contact with the world*' (Merleau-Ponty, 2002: vii).

However, these themes provide more than convenient groupings. The existential categories are not 'clusters' in the way that themes are clustered to further thematically label them. The 'reflection' refers to lenses through which these will be viewed. Realistically, participants do not restrict their accounts of lived experience to only one of the existential categories at once and so there are necessary overlaps. These are referred to again in more detail in chapter seven prior to the presentation of the findings.

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<sup>48</sup> Van Manen refers to '*relationality*' later (1990:101), using '*sociality*' and '*relationality*' inter-changeably. I have used the term relationality throughout this thesis, but use '*sociality*' in the context above to be true to van Manen's text.

### 5.13. Addressing Rigour and Trustworthiness.

*'Issues of rigor in interpretive inquiry are confusing to discuss, at times, as there is not an agreed upon language used to describe it or one universal set of criteria used to assess its presence.'* (Lafferty, 2003: 28)

Despite Lafferty's assertion above, Guba and Lincoln identify four criteria for judging the soundness of qualitative research: dependability, credibility, confirmability and transferability; explicitly suggesting these as an alternative to quantitatively-oriented criteria (Guba and Lincoln, 1994). The supervision process that occurs within a PhD study also supports a robust and ethical approach to the research and analysis (Holloway and Walker, 2000) and promotes the accurate and ongoing recording of all phases of the research process, thus promoting the dependability of the research.

Hence, I consider these individually in the context of this study.

#### 5.13.1 Dependability

Holloway states that *'the researcher must be able to account for the data whilst displaying process, procedure and outcome.'* (Holloway, 2005: 143).

The traditional view of dependability relates to the study's reliability. That is, the assumption that the study has replicability or repeatability. In quantitative research this would mean that we would obtain the same results if we could observe the same thing twice. In phenomenology, where the researcher seeks to discover the unique experience of a small number of individuals this is not possible. Rather, the researcher must account for the process and ensure that a robust protocol is in place and adhered to. Continuing supervision<sup>49</sup> facilitated a regular reporting back of my conduct during the research process. Additionally, the uploading of all interviews to MAXQDA provided some transparency in terms of how the

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<sup>49</sup> Regular supervision is an integral part of the PhD process and annual progression depends upon adequate supervisory record and reports.

data was handled during analysis, as the selected sections can be seen within the whole, thus enabling easy access for review of the context of a quotation within a whole interview.

Holloway (2005) suggests that a study diary is kept throughout the data collection time to make a note of responses and reactions, as well as reflective notes and a recording of the 'decision trail' (Holloway, 2005: 143). I carried a notebook with me at all times. I recorded my thoughts immediately after the interviews and my reflections upon the experiences of the interview process. There were a number of times when I felt that this was crucial to my ability to move on to the next participant interview with a clear head. Committing my thoughts to paper enabled me to free my mind and 'situate' myself with the different interviews. There were also occasions when I felt emotionally affected by the interviews. Being able to record this, so soon after the event, meant that I could record my thoughts, unchanged by time, and then take these to supervision. Van Manen promotes the use of reflexivity for the recognition of the connections between the researcher's interpretation and the participant's story (van Manen, 1989).

### **5.13.2 Credibility**

Credibility refers to the 'truth', 'value' or 'believability' of the findings (Morse, 1994).

Qualitative research tends to assume that each researcher brings a unique perspective to the study whilst still maintaining transparency in the research process. When quotations are presented they are taken out of the context of the original interview. So, the identifying pseudonyms, interview and line number enables inquiry, should there be any concern about misinterpretation. Rørtveit *et al* (2009) argue that this process of decontextualising quotations which are subsequently put into a dialogue with existential–ontological theory might increase coherence and reduce bias. However, Burns and Grove (1983) argue that the process of interpreting issues based on theoretical, experiential and practical knowledge gained from a

researchers' professional experience as a mental health nurse and researcher adds to the credibility of the research (Burns and Grove, 1983).

Beck (1993) argues that the credibility of qualitative research depended upon how vivid and how faithful the description is to the experience lived. In this study, I have used both quotations and anecdotes from the participants in order to be true to their words, discuss these sympathetically and to do this in an enlightening way for the reader. The constant reflecting back and clarification process throughout each interview helped me to understand their meaning, rather than ascribe mine (as well as increasing confirmability, see below). The involvement of the participants in the interpretation of the data created respondent validation. This, in turn, enabled me to discuss their words in the context of their lives and to do this in an honourable and respectful way, thus enabling authenticity. Both van Manen and Merleau-Ponty agree that that indubitable or certain knowledge is not unattainable through *phenomenological inquiry* (Merleau-Ponty 1945/1962; van Manen, 2012).

### **5.13.3 Confirmability**

Confirmability means '*obtaining direct and repeated affirmations of what the researcher has heard*' and refers to the degree to which the results could be confirmed or corroborated by others. (Morse, 1994: 105).

This was done during the interviews, by seeking clarification and researcher interpretations during the interview. Phase one data was subjected to a preliminary analysis prior to the conduct of phase two; then the entire interview data was re-analysed, which provided an additional level of scrutiny to the interpretations generated. Additionally, I found a few moments after each interview to capture my feelings at the time and write down anything that

seemed important in my reflective notes journal for use later when interpreting the data (see appendix 8 ).

When the publication of phase one research was complete (Wright, 2010), this was taken to the research site for their perusal. All but one participant ('Lynne', a patient) had access to the publication and all stated their acceptance of the data. Donna (patient) asked to see me individually to talk about it. She said that she felt proud to be part of the study and thanked me for my sensitivity to the data. She said that she was pleased to read a research paper that showed the perspective of the patient and was so empathic of their position. Van Manen refers to the participant as a '*co-investigator*' when this happens and reinforces the importance of this for confirmability (van Manen, 1997: 98).

Feedback and discussion with respondents about the trustworthiness of the thematic analysis of their experience therefore supports and validates its credibility, as Guba and Lincoln (1994) recommend in their prerequisites for soundness in qualitative research.

#### **5.13.4 Transferability**

Transferability refers to whether or not '*findings from one study can be transferred to another similar context or situation and still preserve the particularised meanings*' (Morse, 1994: 106).

In the main, phenomenology is not considered to be generalisable, nor does it strive to be.

Small sample groups tend to be used and interviews are in-depth, seeking the specific, personal and unique experience of the individual, rather than the group. MacRenato (1995) wrote:

*'Since the purpose of the phenomenological approach is to gain rich descriptions of individual experiences or of specific human phenomena, findings from such studies should not be considered generalizable'*.  
(MacRenato, 1995: 134).

In studies where little research has been conducted, however, it is inevitable that researchers will draw on work that precedes their study, even if there are only limited similarities. Examples exist at every level and can be seen in the studies reviewed for this project. The proposed research, looking at the therapeutic relationship in an eating disorder service, related to a very specific field. Currently, workers practising within the field of eating disorders draw on other, similar research and theories, assuming that findings are transferable to their setting. For example, Bordin's theory about the working alliance<sup>50</sup>, conducted in a psychotherapy setting was referred to in the Gallop *et al* study, conducted in an in-patient eating disorder service (Gallop *et al*, 1993). The Ramjan study (Ramjan, 2004) which considers the therapeutic relationship encountered between adolescents and their workers is referred to in the Snell *et al* (2010) study which considers an adult inpatient eating disorder service. This is inevitable and necessary in the absence of similar studies with greater similarity.

Whilst I do not aim for generalisability, the findings of this study may assist in revealing features of the therapeutic relationship, as experienced both by the women with anorexia and their care workers, which may shed light on this phenomenon and provide insight for those in similar care settings.

Utilising an interpretive phenomenological methodology and a relatively small sample has provided funnelled but rich accounts of their experiences but this may not be transferable to the experience of other groups or even other individuals. Yonge and Stewin (1988) claim that the question of reliability and validity is not wholly transferable to phenomenology, as the validity of the research lies in the power of the text to elicit recognition of the individual experience.

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<sup>50</sup> Bordin measured the working alliance using the Working Alliance Inventory (WAI).

#### **5.14. Conclusion**

This chapter has provided an overview of the design of the project. The ethical issues, access to the participants, recruitment and the decision to conduct the study in two phases have all been discussed. The research design and method for the study have been considered with a specific examination of van Manen's methodical structure of human science research, which was adopted for this study. Both bracketing and the hermeneutic circle have been considered within van Manen's approach and are examples of the derivative nature of his methodology. Each of the six parts of van Manen's methodical approach has been considered in light of this study. Finally, issues of rigour are considered.

In the following chapter I present the findings from phase one of the study, conducted in the day care setting.

## Chapter 6: PHASE ONE OF THE RESEARCH IN A DAY CARE SETTING

In the previous chapter I provided an overview of the design of the project and the decision to use Manen's methodical structure of human science research.

### 6.1. Introduction

In this chapter I present some of the findings from phase one of the study<sup>51</sup>. Additional details regarding the context of the day care service is provided followed by information about the participants. I discuss the interviews and present the themes that emerged from phase one of the study only, followed by a brief discussion of the findings and a preliminary conclusion. Phase one provided the foundation from which I could move forward to phase two of the study and subsequently this data was re-considered within the context of the whole study (combined phase one and two data), (see chapters 8-12). The subsequent discussion and conclusions from this part of the research informed phase two; the full data set is then reported on in chapters eight to twelve.

### 6.2. The context

Although the service contexts accessed during this study provided care for all types of eating disorders<sup>52</sup>, all the participants of the study had a diagnosis of Anorexia Nervosa (AN). The day care service was a small, modern building within a development of other identical semi-detached units close to a retail park. Most of the other units were company offices. The signage was very discreet, so it was not obvious from the outside that this was a clinical setting. Inside, the ground floor was very open plan. Apart from a small administration office and the toilets, the lounge, dining area and kitchen areas were, effectively, one room and

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<sup>51</sup> In addition to this chapter, which reports on phase one of the study, a paper entitled '*An angel on my shoulder- the lived experience of the therapeutic relationship between women with an eating disorder and their care workers*', was published in 2011 (Wright and Hacking, 2011), (see appendix 9).

<sup>52</sup> Eating disorders are generally divided into three diagnostic categories: anorexia nervosa, bulimia nervosa and the atypical eating disorders.

constituted the whole ground floor. One of the women who had been attending the unit intermittently for many months was an artist and she had produced a number of paintings that adorned the walls. Upstairs were some small therapy/interview rooms, a clinic room containing the weighing scales and examination equipment and the nursing office. There were few spaces that provided any privacy or isolation.

### **6.3. Participants: phase one**

Although anorexia does affect men, it is rare (RCP, 2010/2012/2013). At the time of the study there were only female patients available to take part. With the exception of the psychiatrists, all the care workers were also women. This is not unusual, but is an important factor in the study which is also considered in chapter 2 (*'Why women?'* p.38). One participant, Heather, was in the day care service during phase one, but had been admitted to the in-patient service during phase two and consented to being interviewed in both settings.

During phase one there were 13 participants in total; six women with anorexia and seven care workers. Typically, the patients interviewed for phase one of the study had also experienced in-patient hospital care prior to receiving day care services and were now recovering in the community. Three of the patients had been attending services since they were teenagers. One patient had self-managed her condition for twenty years before seeking help after a life-threatening event caused by chronic malnutrition. All the women were White British women aged between 21 to 44 years with a diagnosis of anorexia nervosa. They were mostly well educated; four of the six having university level qualifications, one was a student and another was employed in clerical work. The six women had been in contact with ED services for an average of 11 years and their current service use ranged from 2 to 28 months. Originally, seven patients had consented but one (male) was withdrawn on the advice of the care team before the interview. Demographic information about the participants was collected (Tables 5 and 6.) and all participants were given a pseudonym.

Of the seven care workers who participated all were aged between 33 and 51, all were female and White British; one was a cognitive behavioural therapist (CBT), one was a dietician and five were nurses. Of the five nurses, three had additional counselling qualifications and were working as nurse therapists. Three of the care workers also worked on an in-patient eating disorder ward (the dietician, the CBT and one of the nurse therapists). The remaining four care workers worked solely in day care. Demographic information about the participants was collected and is presented in **Error! Reference source not found.5** and **Error! Reference source not found.6** below:

<b>Pseudonym</b>	<i><b>Donna</b></i>	<i><b>Catherine</b></i>	<i><b>Chloe</b></i>	<i><b>Lynne</b></i>	<i><b>Lucy</b></i>	<i><b>Heather</b></i>
<b>Age</b>	32	29	22	42	21	44
<b>Time in current service</b>	2y 4m	4m	1m	2m	1y 8m	7m
<b>First contact with ED services (age)</b>	13	25	19	23	12	40
<b>Employment</b>	Ex art teacher	Ex phlebotomist	Psychology Student	Ex teacher	College student	School admin/tech assistant
<b>Number of interviews conducted</b>	2	2	1	3	1	3

**Table 5: Phase 1 demographics—patients**

<b>Pseudonym</b>	<i>Gina</i>	<i>Gail</i>	<i>Serena</i>	<i>Sharon</i>	<i>Nicky</i>	<i>Angela</i>	<i>Hannah</i>
<b>Age</b>	50	44	40	51	47	47	33
<b>Gender</b>	F	F	F	F	F	F	F
<b>Time in current Service</b>	2y	4y	3y	4y	3y 3m	11m	2y
<b>Role</b>	Nurse Therapist (groups)	Dietician	Nurse Therapist (PCT)	Nurse Manager	Therapist (CBT)	Staff Nurse	Nurse Therapist (PCT)
<b>Professional background</b>	MH Nurse	Dietician	Nurse Counsellor	MH Nurse	Counsellor	MH nurse	MH nurse Counsellor
<b>Number of interviews conducted</b>	2	3	2	1	1	1	2

**Table 6: Phase 1 demographics - care workers**

[Interviews were conducted between October- December, 2009]

#### **6.4. The interviews**

A total of 24 interviews were conducted for phase one (12 patient interviews and 12 worker interviews) ranging from 20 to 70 minutes. The semi-structures style of the interview utilising the hermeneutic circle was time consuming. I had anticipated that the interviews would last no longer than 45 minutes to ensure that neither therapy nor meals snacks were missed. In the event, I checked the time available with the nurse in charge prior to the commencement of the interview and also checked-out how the participants felt at the 40 minute point, with a view to closing the interview.

Participants were aware that they could move the conversation on or stop the interview at any time. We discussed that I would stop the interview if I was concerned about anything that was said so that we could discuss what action needed to be taken (for e.g. access support). Details of the interview topics were given prior to the interview. The number of interviews conducted

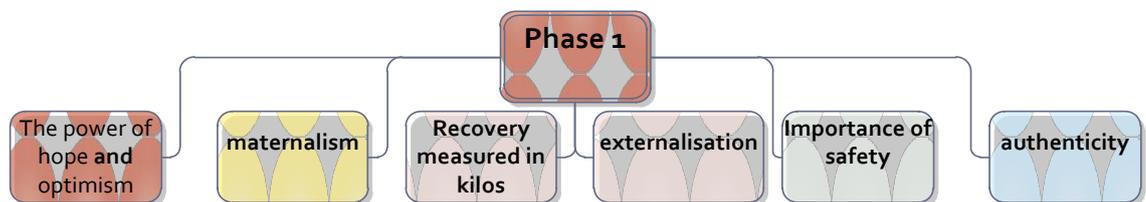
per participant are recorded on the table of demographics (Tables 5 and 6) and ranged from one to five. As soon as one interview was complete I would transcribe it and re-live the experience of interviewing that person. I made a number of notes and was aware of themes emerging from the text.

## 6.5. Analysis of phase 1 data

When phase 1 data collection was complete I conducted a preliminary analysis of the data. Here I employed stage three of van Manen's approach: *'Reflecting on the essential themes which characterize the phenomenon'* (van Manen, 1990: 31-34).

### 6.5.1 Emergent Themes

Here I employed stage three of van Manen's approach: *'Reflecting on the essential themes which characterize the phenomenon'* (van Manen, 1990: 31-34), in order to conduct a preliminary analysis of this first part of the data collection. Six themes arose from the interviews. The six themes were: the authenticity of the relationship; the importance of safety; externalisation of the eating disorder; recovery measured in kilos; the power of hope and optimism and the use and acceptance of 'maternalism' in the eating disorder care setting .



**Table 7: Phase 1 themes**

### **6.5.2 Authenticity of the relationship.**

Both staff members and patients expressed the need to be *'genuine'*, even *'transparent,'* in order to establish an authentic and therapeutic relationship. Several of the patients suggested that this did not come naturally to them, as though they usually hid their *'real'* selves behind a veneer of *'normality'*, but that this was not possible within the exposing environment of the care setting. Donna, a patient at the unit explained the impact that the environment had on her, in terms of being herself:

*'... whilst I'm here, I can't pretend.'*

Donna, patient. P1 i: 102

Serena, a worker, described the connection between her and a woman who had been raped some years before, who, when with her in a one-to-one setting, was able to be open up and share the experience with her:

*'I felt that we had sort of succeeded in something... in the fact that she had felt able to share that [a personal disclosure] ... it's a very private thing and a private behaviour; something that a lot of people feel quite guilty about and ashamed of ...'*

Serena, nurse therapist P1 i: 21

Donna believed that the genuineness, skill and dedication of the care workers enabled the women in the unit to feel able to be authentic and honest:

*'She's not confrontational, she doesn't judge, she listens. She is very genuine and ... sort of ... cares about people ... she always goes out of her way ... she'll do anything to try and get you to sort of, not get you to eat, but work around you - she's really good at everything.'*

Donna, patient P1 ii: 89

Donna tells us: *'she goes out of her way'*. She will *'not get you to eat, but work around you'*, reflecting her view that the staff member is not just performing a duty, but that they go beyond the common duty. She describes the nurse as someone who it is safe to be with

because she cares about people. It is not surprising that 'safety' was frequently mentioned, since such transparency might not be possible without a secure environment that facilitates such openness. This is discussed in more depth within the following theme, *safety*.

### **6.5.3 The importance of safety**

The women frequently mentioned the need to feel 'safe'. The care workers clearly appreciated this and talked about their responsibility to create a 'safe place'. Whilst safety<sup>53</sup> is one of the grounding principles of group therapy, (Bayne *et al*, 1994) the workers/workers were all versed in the terminology and topics of therapy and it was spontaneously discussed in virtually every interview in similar terms. Some of the women attempted to describe what this sense of security meant to them:

*'It's like having a life-raft there and knowing that you are not going to drown ... you can feel yourself drowning and you can feel your mood dipping and dipping and dipping and Gina has the ability to throw the life raft out. Sometimes you can't catch it - but you know it's there - and on the day she's strong enough to catch it and she can pull you through it and have you leaving in a better place than you were... Whilst we are in her care - that's her job; to keep us safe.'*

Catherine, patient P1 i: 183

Catherine described this visually. Her visualisation of Gina (a nurse therapist) reaching out to her and throwing '*the life raft out and pulling her through to a better place*' evokes a monumental strength that is enough for both of them. Gina throws the line out but Catherine herself is passive, awaiting the rescue, knowing the line is there but not helping; she sees this as Gina's '*job*'. Gina, confusingly perhaps, is also the catcher, pulling her through, not always able to do it but showing the way, in an over-arching protective role.

Catherine also refers to Gina as an *angel* in the same interview:

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<sup>53</sup> safety is also known as 'personal security' in counselling texts.

*'...she's like a little support angel on your shoulder<sup>54</sup>...she just makes you feel safe somehow. She makes you feel like she can hold you and the disorder and no matter what happens she's got hold of you and don't worry 'cos there is somebody there.'*

Catherine, patient P1 i: 62

However this process was not always seen in such a rescuing way. Serena, a nurse therapist, described the 'safe place' as somewhere where it was possible to go with the patient:

*'...but if you can develop true empathy with your clients then I think it's about going into that deeper place and saying that this is a safe place...'*

Serena, nurse therapist P1 ii: 18

Despite references to the process of sharing the experience of the disorder and the positive experience of being held in a 'safe place' there seemed to be some separation or division occurring. This had the effect of separating out, or externalising, the anorexia, thus attributing part of their personality and certain, undesirable behaviours, to the anorexia whilst maintaining the real person who is almost seen as a victim, partially possessed by the disorder.

#### **6.5.4 Externalisation of the eating disorder**

Referral to the eating disorder as a separate entity, as though it had a life of its own outside of the control of participants was a common phenomenon across both care workers and the women's interviews. This is also fairly common in narrated accounts of eating disorder (for example in Judith Fathallah's recollection of her own anorexia in adolescence (Fathallah, 2006). Catherine described her anorexia as a parasite; feeding off her:

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<sup>54</sup> This phrase was used for the title of the published paper: Wright, K.M. and Hacking S. (2011) An angel on my shoulder- the lived experience of the therapeutic relationship between women with an eating disorder and their workers. *Journal of Psychiatric and Mental Health Nursing*, **19** (2):107-15.

*'That's what the disorder uses; it uses your miserableness to keep itself going. The more miserable you are the more it can thrive.'*

Catherine, patient P1 i: 70

Heather, on the other hand, felt close to her disorder, describing it as reliable and always present in a way that was comforting, even if it also had a controlling voice:

*'I think that this is why I kind of rely on the eating disorder because it is always there for me - it gives me time, at the end of the day and I know that it is always there...'*

Heather, patient P1 iii: 78

The weekly weigh is one of the most anxiety-provoking events reported by the patients. This was discussed within the interviews as an internal conflict. The anorexic self is fighting against the recovering, real self and, at times, patients attributed blame to the '*anorexic voice*'; seen as a separate entity from the real self. Nevertheless, to the medical and nursing staff, an increased BMI was seen as a sure sign of recovery, as though recovery could be measured in kilos.

### **6.5.5 Recovery measured in kilos**

Evidence of weight gain represented steps towards recovery and this was heavily relied upon as an indicator of progress and recovery. Often, the interaction between the weigher and the weighed could be emotional as the women were frightened of weight gain, so were frightened of the process that caused them to see the evidence of their weight gain. Donna reflected on how she could only feel able to be weighed by a particular nurse.

*'I think that if she said to me, "I'm not going to weigh you, it's going to be Angela", then I would say, "Well sod off then, I'm not going to have anyone weigh me.'*

Donna, patient P1 ii: 37

Weight gain was such a difficult subject to broach that Serena felt that discussion was only possible to after a positive rapport had been established:

*'If I do have that relationship with them then I'll say, "come on then, I'm going to be honest, unless you get to this healthy weight, how on earth do you think you are going to be doing this, this and this... the only way you are going to be doing that is by trying different foods and you are going to have to increase your calories" and you can see people looking at me like... What?!'*

Serena, nurse therapist P1ii: 48

Despite clear differences in perspective and a sense that the staff members needed some resilience against the sometimes hostile or provoking behaviour of patients, there was a profound sense of kindness and patience. The message that no one was giving up on anyone was clear and there was a pervading belief that recovery was possible.

#### **6.5.6 The power of hope and optimism**

Catherine saw the growth of hope and optimism as stemming from a partnership with her nurse therapist, Gina. When Catherine spoke about Gina she was animated and up-beat, it was clear that she felt a sense of togetherness with Gina that gave her optimism:

*'Yeah - cos you're a unit and you can battle it together, if Gina says it will be ok- then it will be ok. You can battle together ... she always makes you feel like you are in it together.'*

Catherine, patient P1 i: 155

Gina, however, saw this hope as a gift from her; something borrowed rather than something inherent within her patient, so they could battle it together. However, at times the insights offered suggested, that Gina intended to stay with Catherine, rather than promoting her ability to act independently:

*'Sometimes and freely, with my permission, they borrow my hope. They borrow a belief when they just can't get a hold of that belief of their own; they actually borrow some of mine.'*

Gina, nurse therapist P1 i: 27

Therapy often required the patient to look forward, to visualise the future. However, the women spoke about this vision was 'blotted out' by the selfishness and self-centeredness of their disorder which created introspection and tunnel vision. In the following quote, Lynne refers to her therapist (Nicky) who is a cognitive behavioural therapist:

*'My vision is so tunneled I need them [the workers] to help me see the wider zone. I can't do that on my own cos I am too focused on me... me... me; they give me eyes.'*

Lynne, patient P1 iii: 58

Sometimes the connection between the care workers and the patients was seen in familial terms also. As this was primarily spoken about in parenting terms I have named this theme 'maternalism'.

### **6.5.7 Maternalism**

As previously identified, the vast majority of care workers in this setting are female, as are the patients. Peplau identified the nurse as a '*mother-surrogate*' (Peplau, 1952: 129) due to the dominance of females in the workforce at the time of her study and also the feeding and nurturing role of nurses (Peplau, 1952:51). Certainly patients overtly attributed a 'mothering' role to some of the nurses, perhaps as an idealistic substitute for a mother they missed out on earlier in life. They also cast other patients in sibling roles:

*'... maybe she's a bit of a 'mother figure'... I haven't had a mother in my life either and maybe that's what I want - that's why I gravitate [towards particular workers]'*

Donna, patient P1 i: 90

The care workers seemed to acknowledge and accept this role and regularly referred to the women as *'the girls'* and themselves as mother figures in the *'house'*:

*'I think that it is just my personality... there are times when I am an absolute grump and I huff around the house [day care centre] - but the girls know that.'*

Gina, nurse therapist P1 i: 81

It must be remembered that although many of the patients were quite physically small, some of the women patients were older than the care workers themselves. All the patients were adult females, however, some were inclined to behave and speak in a dependent, self-centred and oppositional way, as if they were adolescents<sup>55</sup>. This occurred most frequently when they were discussing their disorders, their meal plan and their weight with the care workers<sup>56</sup>.

In the following section, a brief discussion of the findings from phase one will be presented by, as van Manen suggests, *'describing the phenomenon through the art of writing and re-writing'* (van Manen, 1997:30).

A more in-depth discussion and theorising of the findings was conducted following the completion of the full data set (see chapter 13).

## **6.6. Discussion of phase one findings**

Many writers have theorised about how the therapeutic process is established through the relationship, providing general insight and understanding about the way care workers, carers and patients co-exist and co-relate during treatment and recovery (Larsen, 2010; Spandler and Stickley, 2011). This study, however, considers a context where therapeutic processes are implicit but where the traditional precursors to a reciprocal relationship that are central to recovery, such as the goals of treatment, the tasks agreed to achieve these and the common

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<sup>55</sup> This was reported by both care workers and patients in their interviews.

<sup>56</sup> Although it was talked about in the interviews, the patients' style of communication was insightful, articulate, mature and focussed, even when difficult subjects came up. They were prompt, well prepared for interviews, cognisant of time constraints and showed concern for my comfort.

bond between the worker and the client, are missing or partial (Bordin, 1979/1994; Welch, 2005).

Most literature around eating disorder services acknowledges the challenges and difficulty of working with a patient group who are not aligned to the goals of treatment (Ryan *et al.* 2006). Nevertheless, current perspectives of the therapeutic relationship focus predominantly on the shared understanding of, and commitment to, the aims and expectations of both worker and patients based on a model relating to a psychotherapeutic relationship with an individual therapist (Wright, 2010). The first phase of this study identifies no such agreement or understanding. It is unclear whether recovery outcomes can be achieved simply on the existence of the bond, without those central tenets of agreed tasks and goals within the context of mutual agreement and collaboration (Bordin, 1979).

I felt slightly uncomfortable about some of the things that one of the participants, a nurse therapist (Gina) said, even though I knew that the women in the service virtually idolised her. They felt safe with her; she was kind and nurturing with them. Later in this study (chapter 6) we hear about how Gina read bedtime stories to women, whom she refers to as '*girls*'. Here, when she said that the women '*borrow*' her hope, I got the impression that she still retained ownership of the hope, as though it belonged to her, she was neither giving it away, nor culturing hope so that they could grow their own. Therefore, she never lets go of the hope, nor inspires hope so that the women can feel independently hopeful; she retains the hope and thus the independence. She partnered them, to enable them to cope with the present. I felt as though Gina needed to be needed by the women.

Furthermore, the very concept of 'recovery' embodies a return of self-esteem, pride, choice and dignity and requires the worker to accept the whole person. The relationship is recognised as vital to recovery (Antonio and Blom, 2006) and in this sense, understanding the relationship as it develops, in its different stages, is crucial to understanding how progress is explained.

The challenges of working with this client group were accepted and rationalised by the care workers. Oppositional behaviour was ascribed to the *'battle'* with the parasitic condition that had possessed the patient, to the degree that they entered into a further *'battle'* with anybody challenging their eating behaviour. Externalising the anorexia had positive and negative consequences. The patient was seen as enabled to fight it and consequently there was an expectation that she would relinquish herself from its control. The externalisation could, however, extend to a tolerance of unpleasant behaviour attributed to a fantasy of the anorexic self.

The participant accounts of their experiences seemed often well-rehearsed, probably reflecting the patient's long involvement in services and the care-workers recurrent emphasis on trust and safety. It could be a concern that such accounts from retelling and elaboration can seem inauthentic and thus get overlooked or neglected. Recent research has suggested that such *'storytelling'* is often laid down as a basis for building relationships and shared understanding (Clarke, 2010; Holloway and Freshwater, 2007; Schwartz and Abbot, 2006), thus patients may have used these topics as an introductory experience, familiar to them but that *'set the scene'* for the researcher. Although issues of safety and trust are clearly important to the therapeutic relationship, the exchange and retelling of their *'stories'*, in itself, may have contributed to the trusting relationship established with the care workers.

Welch (2005) maintains that for the relationship to progress, all the elements of the therapeutic alliance need to be present. These findings suggest that bond (as described by Bordin, 1979/ 1994) may be present and even sufficient in isolation, to provide a conduit for positive outcomes in the absence of agreed task and goals.

## **6.7. The utility of a mid-point analysis**

The interpretation of phase 1 data and the preparation of a summary report, prior to the commencement of phase 2 was beneficial for a number of reasons:

*To reflect upon the themes emerging from the interviews:*

During the course of this process it was sensible to take a rigorous approach to the data; it was clear that themes were emerging and these were noted and discussed with my supervision team .

*To prepare a summary report which would enable transfer from MPhil to PhD*

I had enrolled on the MPhil/ PhD route of study. Hence, I was required to provide a report at the juncture at which a decision could be made as to my suitability to transfer to the PhD route. The presentation of some of phase 1 data, with a preliminary analysis and a discussion of the findings provided the resources required to demonstrate my capacity make the transition to PhD study.

*To present the findings to the participants*

I was keen to ensure that my interpretation of the women's words was accurate and reflected their meaning, not mine. Returning to the research site with my summary report enabled me to clarify my interpretations with the research participants, thus ensuring accuracy, reliability and giving the participants a further opportunity to provide comment. Thus, the participants became partners in the interpretation and added authenticity to the findings.

## **6.8. Conclusion from phase one of the study**

This chapter has reported on phase one of the study, the participants and the findings that have emerged from their interviews. Six themes were identified; *'the authenticity of the relationship'*, *'the importance of safety'*, *'externalisation of the disorder'*, *'recovery measured in kilos'*, *'the power of hope and optimism'* and *'maternalism'*.

It is clear that some kind of relationship that has therapeutic effects exists in eating disorder units but this may be more related to a 'maternalistic' nurturing and protecting approach

which seeks to 'save' the patient from dying of starvation. Patients are responding to the 'rescue' rather than the treatment goals.

It seemed that the recovery aim for many of these women was to remain 'safe' until such a point that they were ready to relinquish their disorder and reclaim their position in society, but some were using the service as respite rather than recovery. Some adult patients with anorexia have been accessing treatment for many years without making significant headway so there are indications that these patients may benefit from a longer term treatment goal. Patients focussed on the care workers to lead them out of their '*miserableness*', but common assumptions of mutuality and reciprocity are questionable in the sense of goals, even though they may arise within the shared relationship as trust indicators. They found the idea of gaining weight unbearable and, whilst being anxious about discharge, they found the treatment intolerable at times.

The findings of this study confirm that expectations of recovery are not aligned to the view that '*recovery is measured in kilos*', but that engagement with people who provide a nurturing and maternalistic context for safety and optimism is supportive. Although both patients and care workers recognise the temporary nature of the relationship and the unsustainability over the longer term, there seems to be a short-term value in this sort of relationship as it can develop the right conditions for a therapeutic outcome.

The literature has centred the relationship as vital to recovery and in this sense, understanding the relationship as it develops and at different stages, will be crucial to how the treatment delivery is both explained and for implications to change the process.

In the next chapter I discuss how the study moved forward into phase two.

## Chapter 7: PHASE TWO: THE IN-PATIENT SERVICE.

The previous chapter presented phase one of the study; the findings and how these prepared me for phase two in terms of knowledge and experience.

### 7.1. Introduction

In this chapter I present the transition to the next phase of the study, conducted in the in-patient SEDU setting. I then present the context, the participants and discuss the nature of the interviews. The analysis of phase 1 data and the dissemination of this to the participants had facilitated a shared and mutually agreed interpretation of the data. Here I discuss the organisation of the full data set<sup>57</sup> utilising the four existential themes and the concept of authenticity. All the interview transcripts from phase 1 were revisited and reconsidered within the context of the full data set.

### 7.2. The transition from phase 1 to phase 2 of the study

Having conducted phase 1 of the study in a day care service and conducted a preliminary analysis, it was useful to identify the lessons learnt from this process and how this would inform phase 2 data collection and analysis. A number of issues were raised and these are detailed below:

#### *I needed to be transparent about my role and professional identity*

I had identified myself solely as a PhD student, as advised by the ethics committee. Being a nurse and an academic had relevance to the participants for several reasons. They were disclosing in their interviews with me and it was important that I was transparent with them about who I was. Hence, for phase 2, I introduced myself a nurse lecturer who was completing PhD studies.

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<sup>57</sup> Phase two is not presented in isolation.

*To review my adherence to the ethical requirements of the study*

I had given assurances to the ethics committee (NRES) that I would remain sensitive to the research participants and thus approach a less vulnerable population prior to researching in-patients with anorexia. Hence, it was important to review the interview transcripts carefully; to consider how I phased the questions, the responses that were elicited as a consequence and any impact upon the participants

*To review the utility and suitability of the interview, prior to commencing phase 2 of the study*

When reflecting my interview technique during phase 1 interviews I realised that I was often too affirming, and sometimes insufficiently probing. I am more accustomed to conducting clinical interviews than research interviews and I had fallen into a default position of protectiveness towards the participant. This mid-point review enabled me to correct this for phase 2 .

I also realised that the last question about 'recovery' created some difficulty for the women with anorexia as it caused them to consider themselves at a 'normal' weight which was distressing for them. Hence, this question was removed.

*A reflective log is helpful*

After each interview I would consider what had been said and my responses to the participants. Sometimes I realised that I had not picked up on things they had said and so I made a note of this for a subsequent interview. Sometimes I was personally affected by the suffering of the women. It was helpful to write this down. I needed to acknowledge my own responses but not allow these to effect subsequent interviews or create emotional or intuitive helpful responses from me. Writing down my thoughts discharged these onto paper allowing me to treat the next participant with fresh eyes and renewed vigour.

*I would need to reconsider other ways of conducting the analysis for the full data set (phase 1 and phase 2 combined)*

Manual analysis, aimed at gaining an early understanding of the data was sufficient for phase 1 but would be inadequate for the full data set (see section 5.8).

### **7.3. The context**

The eating disorder ward is fairly unique within mental health services in that the primary goal is physical health restoration and is secondary to mental health well-being due to the seriousness of the health risks and high mortality rates (RCP, 2012). Some background information about in-patient eating disorder services has already been provided in chapter 6. Here, I will consider the unique features of the phase two research site. The environmental context is significant, because there were some unique aspects to the design and position of the building. This eating disorder hospital<sup>58</sup> was unlike a traditional hospital; it was a converted house in a cul-de-sac in a residential area. The adjacent properties remained residential and families came and went, dogs were walked, children taken to school and footballs were kicked across the road. An intercom at the door suggested that this was no ordinary house, but inside it was furnished in a homely way; there were scatter cushions and sewing baskets, shoes under the sofa and cuttings from plants on the window sills. The dining room, kitchen and consulting rooms were downstairs, but the patients went upstairs to bed and there was also a small lounge and nursing office upstairs. The corridors were narrow and decorated with drawings and encouraging words placed there by the patients and it had a cosy, homely feeling to it.

### **7.4. The participants, phase two: in-patient care**

There were also 13 participants in phase two; seven women with anorexia and six care workers, although one of the women with anorexia, Heather, had also participated in phase one. Five out of the seven women had had their first contact with ED services in the previous two years. Of the remaining three, a woman in her sixties had her first contact with services

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<sup>58</sup> Unfortunately this hospital has now closed.

only seven years previously and the other, in her twenties, had been treated for anorexia since her teenage years. Six of the women were White British aged between 18 and 63 years with a diagnosis of anorexia nervosa, one was White Irish who was unable to access treatment in her own country. Three were striving to attain University degrees, but had suspended their studies. One was a ballet teacher who was working up to the time of admission. The other three were either retired or unable to work because of their ill-health. The seven women had been in contact with ED services for an average of three years and their current service use ranged from four weeks to seven months.

Of the six care workers who participated, all were aged between 25 and 47 and were White British. The four female care workers all worked exclusively within the in-patient service and were made up of a dietician, a HCA and two nurses. The two male participants were both doctors, a staff psychiatrist and a consultant psychiatrists who worked in more than one hospital as well as offering out-patient appointments. Demographic information about the participants was collected and is presented in **Error! Reference source not found.**<sup>8</sup> and **Error! Reference source not found.** below.

### 7.4.1 Demographics of participants phase two: in-patient care

Pseudonym	<i>Petra</i>	<i>Debbie</i>	<i>Anna</i>	<i>Rachel</i>	<i>Christine</i>	<i>Libby</i>	<i>Olivia</i>
<b>Age</b>	37	18	36	26	63	24	25
<b>Time in current service</b>	18 wks	2 mths	3wks	4 wks	14wks	7+mths	4 weeks
<b>First contact with ED services (age)</b>	37	16	35	15	56	24	25
<b>Employment</b>	Ex-HCA	Student (studies suspended)	Ballet teacher	DLA	Retired head teacher	Student (studies suspended)	Student (studies suspended)
<b>Number of interviews conducted</b>	1	2	3	2	3	2	5

Table 8: Phase 2 demographics - patients

Pseudonym	<i>Lily</i>	<i>David</i>	<i>Lizzie</i>	<i>Jackie</i>	<i>Kelly</i>	<i>Tom</i>
<b>Age</b>	25	40	44	53	27	47
<b>Gender</b>	F	M	F	F	F	M
<b>Time working for service</b>	2 yrs	22mths	6yrs	2 yrs	3mths	7yrs
<b>Role</b>	Staff nurse	Staff psychiatrist	Ward manager	Dietician	HCA	Psychiatrist
<b>Professional background</b>	Nurse	Doctor	Nurse	Registered dietician	None (HCA)	Doctor
<b>Number of interviews conducted</b>	2	2	2	1	1	1

Table 9: Phase 2 demographics - Care workers

[Interviews were conducted between January and February 2011]

## 7.5. The interviews

A total of 27 interviews were conducted for the second phase. I saw the women more often than the care workers and usually for shorter periods due to their availability, their programme of care<sup>59</sup> on the unit and their stamina. I was acutely aware that the care workers were busy and had limited time and that I must not tire the patients; so if they appeared weary or distracted I would ask them if they wished to stop or take a break. This accounts for the number of times that some of the patients were interviewed; one woman saw me five times. All the interviews were conducted at the hospital in a private room and lasted from 30 to 60 minutes.

A number of issues were raised as a result of phase one of the research that resulted in reviews and amendments to the interview schedule prior to phase two. I took out the question that asked about recovery. I also became more experienced in interviewing in a phenomenological way, thus eliciting responses about the experience of the relationship rather than the relationship per sé.

## 7.6. Organisation of the data utilising the structure of fundamental existential themes.

Van Manen, influenced by Merleau-Ponty, states that all *'phenomenological human research efforts are really explorations into the structure of the lifeworld'* (1990:101). As discussed in chapter five. Van Manen promotes the use of Merleau-Ponty's existential themes as guides for reflection in the research process (Merleau-Ponty, 1945/1962); these are: *'lived body'* (corporeality), *'lived time'* (temporality), *'lived space'* (spatiality) and *'lived human relation'*, (relationality or communality). It became clear that a further fifth theme of *'authenticity'* was also required as it was apparent that this was pivotal to the lived experience of the therapeutic relationship.

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<sup>59</sup> Frequent snacks, meals and therapies were planned throughout the day and adherence to the timing of these was important to the care plan.

Merleau-Ponty (1945/1962) included the description and role of the lived-body in perception which is indicative of an existential position that asserts that certain phenomena are what they are because of the way they show themselves. So, for this study the phenomenon (the therapeutic relationship) shows itself through the words and expression of the participants. It is therefore their experience of this phenomenon that is captured. The existential reflection is as crucial to the interpretation in this study as it was to Merleau-Ponty's phenomenology which is existential, oriented to lived experience, the embodied human being in the concrete world (Merleau-Ponty, 1945/1962).

In the following sections I provide a brief synopsis of the four fundamental existentials as well as 'authenticity', with an explanation of why these are relevant for organisation of this study. Sub-themes were also attached; these can be seen identified within the theme diagram (see Table 10, p 150) and are discussed within the theme chapters.

### **7.6.1 Corporeality: lived body.**

Corporeality refers to our bodily existence in the world (Merleau-Ponty, 1962). The women in the SEDUs were pre-occupied with their bodily presence. Anorexia is characterized by excessive food restriction, the irrational fear of gaining weight and a distorted body self-perception (RCP, 2012). Furthermore, a person with anorexia is often identified by their low body weight and their bodily appearance; Skårderud suggests that '*there is a striking closeness between emotions and different bodily experiences*' (Skårderud, 2007:243). In the context of this study, corporeality was therefore perceived to be important in terms of its impact on the lived experience of the therapeutic relationship and also the individual's sense of self within that relationship. Atwood and Stolorow (1984) believe that the anorexic's sense of self is grounded in their corporeality and is thus pivotal to an understanding of their subsequent interpersonal encounters with others.

### **7.6.2    *Spatiality: lived space***

Merleau-Ponty (1962) also makes reference to the connection between the environmental space and the bodily space, when he speaks of spatiality; that is, the space between one's body and other similarly connected objects.

Merleau-Ponty talks of 'situated space' and uses the example of leaning against a desk. He says that the spatiality is not the positioning of the desk, but his experiencing of it in spatial terms. Therefore, it is a '*spatiality of situation*' (Merleau-Ponty 1945/1962: 115). He explains that when he leans against the desk with both hands he experiences the feeling of stress in his hands and he is not consciously aware of his back or his shoulders. He provides a thorough and comprehensive description of his bodily connection with the desk, but concludes that spatiality refers to our bodily connection with the space. Ultimately, Merleau-Ponty is interested in our connectedness, our lived experience of the space, rather than the space itself.

In this context, 'space' does not necessarily refer to the measured space, the dimension. We cannot escape spatiality: we are spatial beings, we live and meet each other in space and there are cultural and social conventions attached to space (Hornecker, 2005; van Manen, 1990). Hornecker explains this in terms of the space that we occupy, coupled with our perception of that space, the quality of it and the positioning of others or objects within that space. She suggests that spatial qualities have psychological meaning in that they can feel protectively enclosing or claustrophobic, for example. Thus, by inhabiting space, we appropriate it, interpret it and give it meaning. Van Manen emphasises the '*felt*' nature of the inhabited space, which is an important difference in terms of how the environment feels to the women with anorexia:

*'Lived space is felt space... It is largely pre-verbal; we do not ordinarily reflect on it. And yet we know that the space in which we find ourselves affects the way we feel'*

(van Manen, 1990, p. 102).

The therapeutic relationship has been described within the context of the '*therapeutic landscape*' of care by Gesler (1992) and it is clear that the experience or feeling of the 'situated space' which is occupied by both worker and patient has relevance. Repeated readings of the data identified similarities that could be illuminated using this framework of interpretation.

### **7.6.3      *Relationality: lived human relation, or communality***

Merleau-Ponty uses the term '*relationality*' in order to conceptualise the 'between space' (Merleau-Ponty, 1945/1962). He asserts that perception cannot occur without perceiving and being perceived by others. Van Manen refers to this as '*the lived relation we maintain with others in the interpersonal space that we share with them*' (van Manen, 1990: 104). In order to differentiate this from all other factors within the therapeutic relationship it is useful to consider van Manen's comparison with corporeal experiences such as a handshake or the physical presence of another person. In this study, this referred to the interpersonal space existing between the women with anorexia and their care workers.

### **7.6.4      *Temporality: lived time***

Temporality means subjective time, rather than actual clock, linear time; including past events that have impacted on present experiences as well as hopes for the future (van Manen, 1990: 105). Hence the dimensions of time, the past, present and future will have relevance when we attempt to consider the here and now of the relationship. Relationships can be momentary and yet the experience of that connection can have a lasting effect. In the context of this study, this relates to how the time spent with a therapist can feel precious or threatening if it means confronting uncomfortable issues.

Within Merleau-Ponty's '*Phenomenology of perception*', temporality is granted the least attention; placed at the end and only once referred to elsewhere within the text (Merleau-Ponty, 1945/1962). We are encouraged to consider our experience within the context of time:

*'We need ... to consider time itself it is by following through its internal dialect that we will be led to revise our idea of the subject'*

(Merleau-Ponty, 1962: 477).

Hence, the meaning and experience of the relationship is not simply defined by the present. Merleau-Ponty describes time as being like a river, never still and moving from the past (its source) towards the future. Thus the experience of the relationship has to combine all features of past and future to define the present. Many of the women interviewed alluded to previous relationships that had been damaging, unhealthy, traumatic and dismissive as well as those that were loving and nurturing. The concept of temporality brings these past experiences into the present experience where lived experience can be a web of past and present as well as hopes and dreams for the future.

Having presented the four existential themes of corporeality, spatiality, relationality and temporality, I will now discuss a fifth major theme, that of *authenticity*.

### **7.6.5 Authenticity**

The fifth theme is discreetly different to the existential themes, but is pivotal to both the therapeutic relationship and also to phenomenology. Firstly, phenomenology. It is useful here to go back to Heidegger<sup>60</sup> who talks of authenticity as '*being one's self*'; honesty and truthfulness are essential components he says that '*Dasien is in the truth*' (Heidegger, 1962: 263). Heidegger denies that we can be authentic all the time and that we control the way that we present ourselves to others. The self is therefore a way of existing and all our human possibilities are made available to us by our culture

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<sup>60</sup> van Manen makes no mention of authenticity and only briefly refers to the Dasein within his book *Researching Lived Experience*

## **7.7. Analysis of the data using the existential themes**

The purpose of phenomenological analysis for Merleau-Ponty is not the intuition of essences but rather it is '*concentrated upon re-achieving a direct and primitive contact with the world*' (Merleau-Ponty, 2002: vii). Corporeality, spatiality, relationality and temporality are therefore productive categories for the process of phenomenological question posing, reflecting and writing (van Manen, 1990: 102) and provide a perfect platform on which to explore the findings of the study and my subsequent reflection upon the words of the participants. However, these themes provide more than convenient groupings.

The existential categories are not 'clusters' in the way themes are clustered to further thematically label them. The 'reflection' refers to the lens through which these will be viewed. In reality, many of the participants said things that were akin to more than one of the emergent themes and more than one of the existential categories. This is human nature; we do not restrict our sentences to only one aspect of our experience at once. For example, Rachel talks about being within the service, the place where the relationship occurs and links this with the development of her individuality and personal identity:

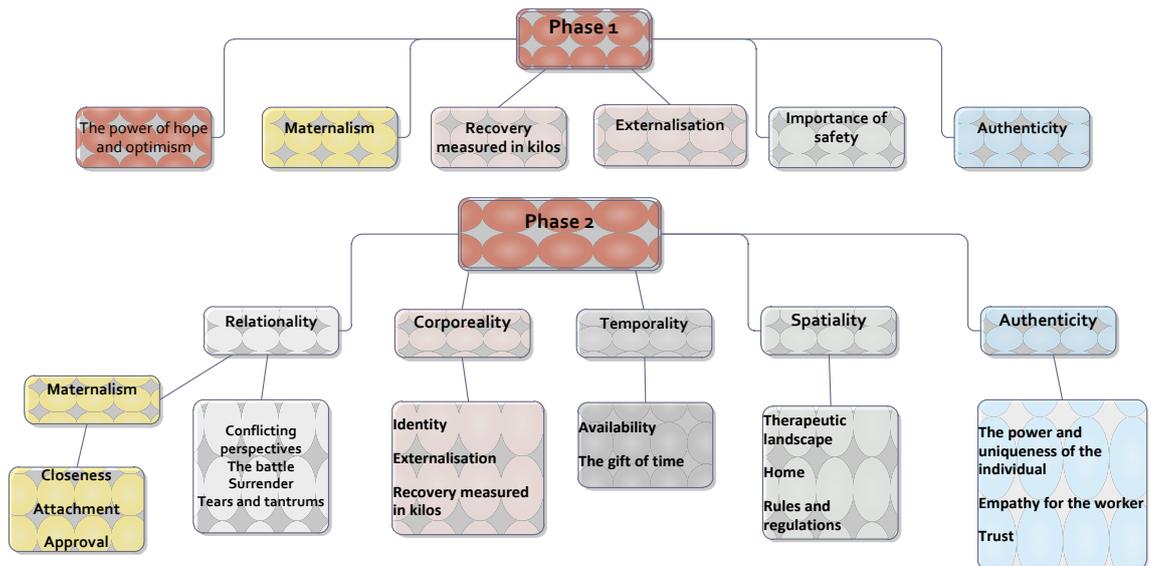
*'But I actually think that's really nice here because everyone sort of always, when you do that it like gives you permission to kind of develop your individual style, which I think isn't necessarily a massive part of your identity, but it's certainly part of your identity'*

Rachel, patient P2 i: 74

This statement of Rachel's could be included within discussions about 'Spatiality' or 'Corporality'. Hence, some direct quotations may be used to present one aspect. More shall be discussed about these in the following chapters that capture the data under the headings of 'corporeal reflection', 'relational reflection', 'spatial reflection' and 'temporal reflection'.

### **7.7.1 Emergent themes**

The figurative illustration below shows both phase one and phase two together. In combining the two phases and re-analysing the transcripts as a full data set, some of the themes identified within phase 1 became subsumed. The diagram below summarises the clustering of the themes and sub-themes which will be described in the following chapters:



**Table 10: Figurative illustration of the thematic analysis**

The following chapters consider the emergent themes in depth

## 7.8. Conclusion

Here, I have discussed the transition into phase two of the research and the additional methods used to manage the research and the data, including the organisation of the data utilising the structure of fundamental existential themes, after Merleau-Ponty (1962) and 'authenticity' after Heidegger (1962). In the next five chapters I will present the emergent themes from the entire data set.

## Chapter 8: GUIDED EXISTENTIAL REFLECTION: CORPOREAL REFLECTION

In the previous chapter I discussed the presentation of the findings of the study as a whole.

The following five chapters will each focus on the emergent themes, commencing with 'corporeality' (lived body).

### 8.1. Introduction

This chapter considers the data that can be seen through the lens of 'corporeal reflection'.

'Lived body' (corporeality) refers to the phenomenological position that we are always bodily in the world. The participant accounts were therefore searched for references to experiences of physical presence or awareness of their own body. Eating disorder services are predominantly focussed on physical restoration and recovery, whilst also attempting to address the cognitive distortions that create the physical manifestation of the condition. Hence there were many references which have been filtered down to the few that are included here, arranged thematically as '*identity*', '*externalisation*' and '*recovery in kilos*'.

*'So I said right ok- I'll go into hospital and I will stop this- not intending at all to completely recover. I would never ever have wanted to do that. It makes me who I am. I am not Lucy, the girl- I am Lucy the anorexic- that is what I do- I am not a student, I am not a daughter- I am anorexic and a bulimic- that is what I do- I make myself sick for a living – I starve myself for a living- that's what I do and that's what made me who I am. I was not getting rid of it. It's a life style- my identity- it WAS my identity. It's impossible- no matter how much you try you will not be able to do it- I can't do it and I don't want to do it.'*

Lucy, patient P1. i: 46.

### **8.1.1 Lucy**

I chose to present the anecdote from Lucy's interview (above) as it epitomises the view of many of the women that I spoke to. When I spoke to Lucy she was doing well, she was a 'normal' weight; she was attending college and preparing herself for an application to study nursing. She was buoyant and she spoke emphatically. Speaking from the 'recovery side' of anorexia, she was recounting her experience of her reluctant agreement to go into hospital. She spoke with clarity about her previous resolution not to engage in therapy although she was agreeable to go into hospital. Her fundamental belief was that, even if she ate and gained weight, it was merely a veneer. Underneath, she believed that her identity was her eating disorder. Hence, this could be veiled by her bodily appearance, her corporeality, but that the 'real' Lucy, the anorexic Lucy would not be changed. She spoke in short, emphatic statements. Nobody could help her, she would not allow it and she could not do it. There was real defiance in her voice.

Some of the features of this anecdote, in particular the defiant tone, the clear sense of identity and the resistance against change are seen in other accounts too, but none as emphatic as Lucy's retrospective account of that time in her life.

## **8.2. Identity**

*'It has become who I am'*

Lynne, patient P1 ii: 26

'Identity' was a prominent theme within the words of the women with anorexia who saw themselves as 'anorexic'; not just in terms of a diagnosis. Anorexia is not something that they **have** - it is **who they are** and is pivotal to their corporeality and their understanding of being in the world.

Our identity, who we are and who we are seen to be, is important to all relationships for different reasons. 'Identity' can refer to the person that one believes they are; one's culture, one's job or simply the person registered in one's passport. Our identity is whatever makes us definable and recognisable, it is how we relate to our world and impacts on how we relate to others.

The presence of the person within the relationship was often referred to in terms of how they saw themselves, or believed that they were perceived by others. I will consider extracts from the interviews from both the women and the care workers.

The first time that I met Anna she seemed to be observably self-consciousness. Her posture was closed and she sat with her legs crossed, hugging her top knee in a very self-protecting position. Her BMI cannot have been above 12 and her tiny frame looked fragile as she spoke to me. I introduced myself to her, a little more than previously in the lounge, and thanked her for agreeing to take part. Her response was:

*'And I'm Anna; I'm not the gibbering nervous wreck in the corner, which is what I am quite a lot of the time here. '*

Anna, patient P2 i: 171

I had never seen her as a '*gibbering wreck*'; objectively, it did not describe her presentation at the time that she was talking to me. She managed a great deal of composure during the time that I spent in the hospital and specifically during her interviews with me. She recognised this, which is why I think that she said '*I'm Anna...* Yet, it was her perspective of herself; her fear of eating caused her to degrade into a shaking and helpless individual in later interviews, she speaks about the fear and anxiety that she feels destroy her. She appeared physically frail and this added emphasis to her statement. I could imagine her tiny and lost in a corner, frightened and out of reach. It's an image that might give the impression that she was needy

and dependent, but this was not her perspective of herself outside of the service setting. She was in complete denial about the seriousness of her condition:

*'...I know I want to be able to look after my daughter ... well I'm perfectly capable of doing that now and I was doing fine before. ... I still can't see why I need to change to be able to do that, because I was doing fine'.*

Anna, patient P2 ii: 89

Anna refers to the perceived 'need to change' rather than 'gain weight'. She sees gaining weight (the goal of her admission), not simply as a physical attribute but as a change in her, as a person.

Most, like Rachel who had suffered since age 15, and Lynne who had suffered since age 11, had not experienced adulthood without anorexia:

*'I think this time I'm really learning that in order to recover I have to like, I have to find what my identity is without an eating disorder because I've had it for the majority of my life.'*

Rachel, patient P2 i: 58

There was recognition that being ill for so long creates an identity that included anorexia as a defining characteristic of the person that they are. For Rachel, who has suffered from severe anorexia since her teens, she has never experienced wellness during her adulthood, hence, reflection upon an earlier time in her life when she was well was not an option for her; she needed to re-invent herself. Only one of care workers discussed their self-consciousness about their weight in the presence of the women. Hannah was overtly aware of her weight and the observable difference between her and the women:

*'I am very aware of my weight and my body image ...I imagine that they do see me as overweight-teaching them about healthy body image... they probably are repulsed and disgusted about having a therapist who is a bit on the large size'.*

Hannah, nurse therapist P1 ii: 40

Paradoxically, the Hannah (nurse therapist) who wished to be seen only as a therapist and not in terms of her own physical presence, or her personal identity, experienced difficulty because of the '*nosiness*' of the women. She worried that they might struggle to form a relationship with her, not because of their pre-occupation with their own body, but with hers. Here Hannah is conscious of physical difference and is acutely aware of this, although none of the women commented on it. It was much less common for the care workers to consider their personal identity in the context of the therapeutic relationship. Usually it was related to their professional identity and role within the service, rather than their sense of self, as it was for the women.

The care workers were less personally disclosing and gave more 'professionalised' accounts, often shifting to a seemingly default position of talking in a theorised, descriptive way. It was much more difficult to guide the care workers into talking about their 'experience' of the relationship since they were less likely to talk about themselves. They were accustomed to their focus being on the patient, rather than themselves. Inevitably, 'identity' was barely spoken about since this would relate to a much personalised discussion.

Here, I use another anecdote; it is from Lily's first interview. Lily talked about a therapeutic exercise designed for helping the women to see themselves:

*'You won't be able to go travelling like you want to do, you won't be able to have a family like you want to do, you won't be able to do this, this and this.'*

Lily, nurse P2 i: 213

When Lily spoke, she listed things that the women will be unable to do if they stay '*ill*'. It was unusual for Lily to speak in negative terms, she tended to be encouraging and talk in positive terms. However, the reason for the negativity is made clear by her later statement '*we don't allow the eating disorder to be part of that plan*'. The plan is for the person, without the disorder.

David, one of the psychiatrists, talked about the role of the doctors in terms of how they are perceived in comparison to the nurses. He spoke of nurses being verbally abused by relatives:

*'We go to doctors for advice and they make you better ... So I wonder if I do have a slightly different outlook on things than the staff, who are more frontline than I am.'*

David, psychiatrist P2 i: 48

Here the identity of the professional might be seen in terms of authority and hierarchy. David suggested that it is because doctors are not on *'the front line'*, but also acknowledged that doctors are identified as people who are believed to have the power to make people better. So in terms of the relationship, their position may be considered to be a healing and restorative one.

Lucy was very protective of her identity. Lucy has now recovered from her anorexia, but visits the day care unit for a review every few months or so. She also offers encouragement and support to those still in the midst of their illness there, many of whom were her peers when she was in the acute stage of her illness. She had a wonderful, inspiring story of her recovery and spoke in a very up-beat and spontaneous way about her experience of the care and treatment she received:

*'I had no idea that people would actually start to like me and love me- for me. I didn't need my illness any more. I didn't need it [anorexia] to be loved- I didn't need it [anorexia] to be a person anymore- because I was perfect just the way I was. Cos they showed me that.'*

Lucy, patient P1 i: 76

For Lucy, the discovery of who she was could be made because her workers helped her to see herself differently. Previously, she had needed her anorexic body as a vehicle to attain the *'love'* that she needed. Lucy's body was her agent, in the sense that it made it necessary for health care professionals to engage with her; to care for her. She told me about the time that

she was in hospital and she felt angry that the staff wanted to change her. She could not see that they wanted her to be 'well', she felt that they were taking away who she was. She said:

*'I just thought that nobody is taking my illness away- it's mine- it makes me who I am- so nobody- I am not me without it.'*

Lucy, patient P1 i: 44

Rachel, an in-patient, spoke at length about her 'identity'. She came to the second interview with me with an intention to actually explore those thoughts in the interview and had made some notes. The exploratory nature of the phenomenological interview where the participant was encouraged to delve into their experience rather than their opinion was very facilitative of this. She told me after the first interview that she was going to think about what she was going to tell me when we next met, because she felt that she needed to tell me about her experience. It was the second interview with Rachel when she spoke about her resistance towards her treatment and those who tried to treat her because of the potential change in who she would be if she recovered:

*'I feel like this fear of who am I going to be when I don't have anorexia anymore.'*

Rachel, patient P2 ii: 7

Rachel's concerns about her identity were impacting on her capacity to allow others to help her. Anorexia was who she was; it was how she was known to others. She had suffered from anorexia since she was a child, coming to the attention of services when she was thirteen. When she spoke to me she was considered and articulate. She was a bright, intelligent young woman who was planning for her future and considering embarking upon a Master's degree. But she could not envisage her future without anorexia. Anything else was alien to her. When she tried to remember when she was last physically healthy it was in her childhood, which was not a happy time for her. As an adult, that was both inconceivable and also re-traumatising because of childhood memories; she was married now and in her twenties.

Rachel was not the only person that viewed themselves in this way. Olivia also spoke about herself in similar terms and spoke about her boyfriend and her hopes to be a mother and part of a family. She understood that in her present physical state, this was impossible; not least because of some of the physiological changes that occur such as amenorrhea<sup>61</sup>. Despite this and her intractable fear of eating, she seemed to be beginning to see that being anorexic might not be a permanent state or identity, but that there may be potential to be different in the future:

*'Because previous to that I thought that that was all I was and that that was my identity and that was who I was and who I was meant to be.'*

Olivia, patient P2 i: 17

There were references to the low self-esteem and negative sense of identity, inferred as a factor that contributed to their need for anorexia. Anna was very clear that she did not want to be in hospital, she did not think that she belonged there and she attributed this to her unworthiness. She truly believed that she was not worth bothering about.

*'I don't feel worthy of help, I feel I'm wasting everybody's time and I shouldn't be here.'*

Anna, patient P2 ii: 43

It seemed to me that they weren't always referring to bodily manifestations of who they were, but rather their sense of themselves and how they felt about themselves:

*'I think especially when you've been ill for a long time, you lose sight of who you are without the illness ...So you've got to sort of reinvent yourself ... learn about who you are, like fundamentally and then build on that.'*

Libby, patient P2 ii: 82

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<sup>61</sup> Amenorrhea, cessation of periods for six months or longer, is one of the cardinal features of anorexia nervosa.

Additionally, there was an identity that was adopted because of being in the community of the hospital. There were a number of references about being in hospital which will be considered in chapter 13, but there was also the effect that this had on the person's sense of self and their identity.

Despite this, there were times when the women could see that they had an almost dual identity and they could name the person that is the anorexic person who was different from the real, internal person.

### **8.3. Externalisation**

There were two distinct views about the apparent separating out of the anorexic person from the (assumed) 'real' person. Some people saw this as helpful, to the extent that some care workers encouraged some of the women to attribute some of their thoughts and behaviours to another identity which was part of that person but was, effectively, the illness. I now realise that this is very common within eating disorder services, but I did not realise that at the time. At first, I thought that this perspective appeared to be bordering on psychosis or the separation of the personality. In the early interviews I assumed that this experience was unique to the person telling me their story. The first person to mention it to me was Catherine (phase one) who was talking to me about the relationship with her nurse therapist in day care, Gina.

There was clearly a bond between Catherine and Gina; Catherine saw her as exclusively good and as a strong influence on her recovery. When she first told me about Gina she described her as an '*angel on her shoulder*', a force for good and a reminder of her desire to recover and thus her need to stay with the treatment plan. Even Gina, who was seen as an '*angel*' by Catherine, acknowledged that she found it difficult at times. I can understand why the women would be so fond of Gina; she was always smiling, always made allowances for people and projected an incredibly nurturing personality. When she spoke, she would talk illustratively, so

the image of the angel and the demon was very typical of her style. I wondered if she also found it self-protecting to believe that the women's resistance towards her was attributable to the anorexic self rather than any genuine feelings about her.

Catherine also mentioned a '*gremlin*', which I assumed initially was the antipathy of Gina, but later realised that Catherine saw the gremlin as the anorexia personified. Before I understood that this 'externalisation' was a recognised and recurring phenomena I labelled it as 'personalisation' of the disorder.

Gail, the dietician also used this same language when she was speaking to me, so it was clear that there was shared understanding of this experience within the service. More than that, Gail believed that it was therapeutic for Catherine to separate out the anorexia and allow it to become labelled as something evil. She uses the words '*anorexic demon*', stronger terminology than '*gremlin*', which was used in a playful sense:

*'I will try to help them get a grip and to externalise it and to talk about the 'anorexic demon' or this kind of gremlin that has its hold on them.'*

Gail, dietician P1 ii: 30

Later in Phase two in a totally unconnected hospital service Petra said to me:

*'It's like you're another person. It's like you've got somebody else there speaking. It's like having, say you've got an angel on one side and a devil on the other, it's like having the angel fighting with the devil all the time.'*

Petra, patient P2 i: 166

The similarity of the words were striking, I did not think that Petra and Catherine had ever met, but there must be common phraseology around this phenomenon because, after my paper was published with '*an angel on my shoulder*' in the title, three of the participants from phase one thought that they had said those words to me (Wright and Hacking, 2011). In fact, it was none of those three.

When Anna talked to me about this phenomenon she acknowledged how odd it might seem:

*'Yes, well people say there's two sides of the anorexia and there's you, I still haven't found the me bit... there must be some of me in there, but at the moment I can't find me, I am it or it is me. I'm a complete doolally now.'*

Anna, patient P2 ii: 81

It's interesting here that she does not say that she thinks this herself, she is telling me that other people used this description. I was really hoping that she might tell me who the real Anna was, or what the real Anna might be like, if she found it. For Anna, she could see only the person who was consumed by anorexia. When Anna talked about her relationship with the care workers she never attributed difficulties to the illness. She repeatedly spoke about herself in degrading and belittling terms, not believing that she was worthy of care, *'doolally'* is yet another example of that.

There were tensions created by the perceived duality of personality or identity, however. The anorexia could be blamed for behaviour and was there to take the blame in a way that, in part, admonished the 'real person' for their destructive behaviour towards themselves and the care workers. It was as though the disorder also took away some of the individual's agency. Some of the women admitted that they behaved in ways that they were ashamed of, particularly at mealtimes. Sometimes they said things to care workers that were unkind or obstructive; sometimes it was more covert behaviours such as dribbling liquids into their hair or clothes. Olivia described her experience of this as though it was another person:

*'I just don't feel like me when I'm engaged in those behaviours.'*

Olivia, patient P2. v: 54

The anorexic identity was always seen as the 'bad guy' who is oppositional and defiant. Olivia stated this categorically in her description of her objection to a calorie increase. Her calories had been increased because it seemed as though she was tolerating her current diet and had

gained a small amount of weight and the usual course of action in this scenario would be to gradually increase diet plan. For Olivia, this was irrational and inconceivable. The fact that she had gained weight was not good news to her, although it was the goal of her care plan. When the dietician progressed her care plan to move up to the next diet plan which included a more varied diet and more calories, Olivia was incensed. When Olivia was telling me about this she described it in very visual and emphatic terms and attributed this oppositional response to 'anorexic Olivia', as though that was not the authentic, real Olivia, but was her illness talking:

*'Anorexic Olivia rears its head up and says, no I'm not having that, I'm not having it, and cannot, cannot see the rationale behind having a calorie increase when I've put on weight.'*

Olivia, patient P2 i: 27

Olivia felt that the care was provided for the eating disorder and that she, as a person, was neglected. She noticed that when she complied with the treatment, ate her meals within the right time frame, did not attempt to rid herself of food after meals, rested when she needed to and accepted calorie increases in diet plans that she saw less of the nurses on the ward. However, when she behaved in a way which she identified as 'anorexic Olivia' she saw more of the nurses who spoke to her, cajoled her, encouraged her and praised her for small achievements. Yet when she behaved in a way that was not representative of what she called 'anorexic behaviours' the nurses focussed on the women who were struggling to eat and accept their care. Olivia found this intolerable, as though care was being withdrawn when she was compliant and that she no longer mattered if she was not manifesting the eating disorder. In this way, signs of recovery appear to be unhelpful to the relationship between her and her care workers:

*'And it's just been all about the eating disorder and nothing else, and it's just making me feel like I'm nothing else except the eating disorder, I'm not a person anymore.'*

Olivia, patient P2 v: 4

Libby, also an in-patient, disagreed with this. She felt that the amount of attention she received from the care workers was unaffected by how 'anorexic' she was. She said '*They don't ignore you when you're feeling OK.*' (Libby, patient P2 i: 61); but Olivia was feeling rejected when I saw her, for the fifth interview. Olivia was approaching transfer to another hospital, closer to home. She told me that she found it difficult to adapt to changes of environment; it had taken time to allow the weaker Olivia to be exposed and so, 'anorexic Olivia' would take control again. It was as though the connection made between the worker and Olivia eventually caused some erosion of the tough anorexic shell.

When Olivia talked about 'anorexic Olivia' she called herself 'it', evoking imagery of the evil demon sneaking up on her and viciously grabbing words from her mouth, replacing these words with lies and deceit that are attributed to the anorexia. She referred to this experience as '*It's like being possessed*', again attributing the behaviour to a secondary being or entity that takes her over and behaves in a way outside of her control. She spoke venomously about 'anorexic Olivia' as though she despises that person and is angry with her. In the third interview she expressed the desperation of trying to express herself before the power of the anorexia took over:

*'I'm like wrenching the words from my mouth before the anorexia gets a chance to steal them back and tell some other lie or other.'*

Olivia, patient P2 iii: 19

The anorexia is also externalised as a 'voice', as when Petra attributed her reluctance to go into the dining room to the anorexic voice:

*'...you don't want to go in there and eat that because your anorexia tells you, you don't want to eat that.'*

Petra, patient P2 i: 31

It seems that when the anorexia takes over and is in control there is no room for the host, the person, nor the worker. The relationship with the anorexia takes precedence:

*'...the anorexia just takes over and that's the part of you that's in control and that's telling you everything. It's really hard to rein it in and get perspective and think about the bigger picture, because the bigger picture doesn't exist when there's a plate of food in front of you. That's how anorexia works, it takes control.'*

Olivia, patient P2 iv: 25

Christine, a woman in her sixties who had held a responsible job and raised a family, despite suffering with anorexia on and off for more than 40 years, was clearly aware of the perceived separation of identity that caused an externalisation of the anorexia and viewed it with extreme scepticism. When I was speaking to her it was a real 'stuff and nonsense' sort of moment. Christine has accepted responsibility throughout her life and this attitude was enduring throughout her admission. The very suggestion that there might be an anorexic voice or persona was dismissed without question:

*'Well for me, personally, that's ridiculous, that's my anorexia, it doesn't manifest itself like that at all ... we aren't just an eating disorder, we are people.'*

Christine, patient P2 iii: 12

The experience of being host to the anorexic persona is clearly a distressing and miserable one. Many of the care workers acknowledged that they could see the torment in the women and the women, in turn, expressed this vividly. Olivia felt that it was not merely a voice that spoke to her, but one that screamed at her persistently and intrusively. She was aware that she was 'disclaiming the behaviours' and felt guilty for not taking responsibility or ownership for the destructiveness of her actions.

The anorexic persona seems to be a separate entity that is virtually parasitic, for Catherine:

*'Cos that's what the disorder uses it uses your miserableness to keep itself going. The more miserable you are the more it can thrive.'*

Catherine, patient P1 i: 70

Although many of the care workers could see the utility of this externalisation of the disorder, to the extent that some of them encouraged it, some care workers were irritated by it, as though relinquishing responsibility for behaviours which could be difficult to manage was an easy option. David, a psychiatrist was clear that the care workers explained the separation to the women in an educative way. Whilst there is the recognition that this might be an understanding and empathic way to respond, it was not always appreciated:

*'It's explained to them like that and I think that pisses some people off actually, you know. I think it certainly annoys some nursing staff, when you talk about; well it's the illness, the illness. And some nursing staff say, it's not the bloody illness, it's them.'*

David, psychiatrist P2 ii: 55

The 'demon' or demonic quality of the anorexia was resonant in Lizzie's thoughts about the disorder. Lizzie was the nurse manager at the hospital and had worked with people with eating disorders for many years and spoke with real compassion for the suffering of the women and their efforts to maintain their disorder despite the misery that it caused them. Again, she uses powerful terminology ('hell'), when she described their plight, further strengthening the demon vs. angel dichotomy:

*'You can see it, you know that maintaining their eating disorder will not improve their life, it can't, it never does, it doesn't for anybody. It can't because they just remain in hell, but until they see it.'*

Lizzie, nurse manager P2 ii: 94

Lily, in the in-patient unit, was of a similar perspective, but stressed the destructiveness of the illness:

*'We always just try and reinforce that the other, the anorexic side is not the right route, and the route of getting well, the other side of them is the right way to go ... but we just reinforce to them how destructive the illness is and how it ruins your life.'*

Lily, nurse P2 i: 211

There is no denying that the primary goal of an eating disorder service is weight gain, for good reason. This is one area where mutual agreement is rarely established and is a major road-block in the therapeutic relationship. In the next section I discuss how the weight restoration treatment plan impacts on the experience of both women and care workers.

#### **8.4. Recovery measured in kilos**

Every day, on eating disorder wards all over the world, patients are being weighed and care workers are monitoring changes in body weight; diet plans are being written and negotiations about calorie intake are taking place. Whilst the corporeality of this experience is immediately apparent, it is the interpersonal process that occurs during these interventions that are pivotal to acceptance, or otherwise, of these interventions. The women's accounts swung from an acceptance of the inevitable, to a defiant refusal, with fear and loathing in between. Rachel recognised that gaining weight equated to '*getting your life back*':

*'I know I'm here to eat, to gain weight, you know all that stuff ...  
you're here to get your life back as well'.*

Rachel, patient P2 i: 74

Some of the women, such as Libby, emphasised that the experience of an eating disorder amounts to more than their problems with the process of eating. Hannah, a nurse therapist thought that it was '*very much used as a smoke screen a lot of the time, sub-consciously*' (Hannah, nurse therapist P1 ii: 8). It is important to mention here that at no time did I pose questions about food, diet, eating or meal plans. I emphasised that the study was of the relationship between with the care workers and the women when I introduced the research; but the patient's experience of the disorder and their relationship with food pervaded every interview. Nonetheless, the interactions that occurred at pivotal times were important and included those that occurring in the dining room, in the clinic room where the weighing scales stand, or when discussing a change of care plan. It seems that these are the

times when they feel more anxious and insecure and when the relationship takes on heightened importance. Libby did not feel that her vision of recovery was fully understood:

*'So just saying like, being recovered is getting to this BMI and eating chocolate and crisps and eating all these things that are scary, eating all these scary foods, that's not necessarily what's recovered for everybody'.*

Libby, patient P2 ii: 72

But Lucy could not imagine what life would be like if she gained weight, it was something unfamiliar and alien to her:

*'I was having to eat all this food and gain all this weight- be this person that I didn't know how to be- they were trying to make me into a fat person that was ok with food- and I didn't want to be that'.*

Lucy, patient P1 i: 27

All the women, without exception spoke about the workers' role in helping and coaxing them to eat. Persuading somebody who cannot tolerate the thought of eating to eat is a challenging task. Most of the women spoke about the kind, but persistent and emphatic approach of the nurses in persuading them to get through their meals. If the women thought that there was the slightest chance that they could avoid eating they would do so. Ultimately this could result in alternative ways of re-feeding that were not in their best interest such as naso-gastric feeding<sup>62</sup>, thus Lizzie felt that realism and clarity were needed:

*'And that's what I say, I just say to them, look I have to do this, you know, if you have to have a nasal gastric tube, I have to do this, I have no choice in this, this is where we are, this is what we've got to do'*

Lizzie, nurse manager P2 ii:151

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<sup>62</sup> Nasogastric re-feeding is used in the short term to speed up weight gain in those patients who are critically ill. It involves passing a fine plastic tube through the patient's nose to their stomach. Liquid feed is then poured into the tube, by a nurse. It is a last resort and often referred to as 'force -feeding'.

Anna accepted that weight gain was her only exit strategy, although she was clearly unhappy about it:

*'I have to do this to get out; there is no other way out.'*

Anna, patient P2 i: 100

A gain in weight felt devastating and whilst the care workers would hope that the women had gained weight, they dreaded their response when they saw the scales. Angela described the moment when she told somebody that they have gained a very small amount of weight:

*'She had put weight on and she was absolutely devastated and it was a minimal amount- it was about .2 of a kilo- but she was really quite devastated and she hugged me and she cried and that was the most intense sort of closest I've felt with that lady'.*

Angela, nurse P1 i: 60

It is ironic that she felt 'closest' when she was consoling her rather than celebrating with her about a small step towards her recovery.

Christine accepted that this disorder would kill her if she did not conquer it. She knew that she had to gain weight; she knew that her life was at risk if she did not gain weight, and yet she knew that she needed the staff to maintain her awareness of that. The necessary repetitious nature of the interactions between care workers and patients were reinforced by Christine. They did not simply need to act or speak, their actions needed emphasis and repetition; she referred to them being 'tough'. The impending physical health risk was insufficient, the voice of the care workers needed to be heard firmly and regularly:

*'...the staff have to keep reminding, keep reminding you that ultimately if you don't do what you're required to do in here, it will kill you, you know, in the short term or the longer term, **you** will not win, **it** will win.'*

Christine, patient iii: 26

The need to be firm, or 'tough', as Christine said, was well recognised. Christine was not telling me this as if she was resigning herself to her fate; she sounded strong, her head was held up high. She had been reluctant to come into hospital and had visited another unit first. When she was there she decided that she would not be able to tolerate the environment. At 63, she was very aware that she was in the minority and establishing relationships might be hard for her. In the event, she adopted a position within the community which allowed her to draw on her previous skills before her retirement. She and some of the other women created art work that was mood lifting and encouraging. Often the art work included encouraging statements like '*do something small but scary today*', encouraging others to accept their treatment plan. It allowed her to be a patient, but continued to be useful and this was important to her.

The women that I spoke to did look physically frail and, for me, it would feel counter-intuitive to be firm with them. When they spoke about being forced to eat foods that they would never chose to eat or quantities that seemed intolerable for them; they often looked shaken by the prospect. But their defiant objection was far from frail; the driving force for their emphatic resistance was a terrifying fear of the one thing that would allow them to go home, weight-gain. Many of the women told me about being reduced to tears, or as Anna said before, '*a gibbering wreck*', a state that often drew the care workers towards them in a caring and comforting way. This would soften the blow, the upset would be soothed and the impending calorie increase or 'fear food'<sup>63</sup> might be briefly forgotten. This might be the most appropriate approach for some, but the lead psychiatrist saw it differently:

*'You see it all from the patient's point of view. You can't blame her for not wanting her calories because she had her calories increased. She had a row with her mum last week and you know how important that relationship is. And so we all agree and we're all being very, very kind and softly, softly and wrapping people, well they're not getting*

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<sup>63</sup> A 'fear food' is a type of food which, for that person causes them anxiety, usually because of the high calorific value. Examples that I saw were Macdonald's thick shakes, KFC and pizza.

*anywhere. We're not actually being firm enough to drive a patient through the emotional distress to gain weight.'*

Tom, psychiatrist P2 i: 35

Not all psychiatrists were like Tom. Catherine spoke about a psychiatrist whom she saw in another town who she believed '*bullied and frightened her*' into gaining weight:

*'I must put a pound a week on or else she is going to bring me into the in-patient unit- they couldn't do that now cos I know more about my eating disorder and cos I am just stronger with it- but no – the first time it was horrible- absolutely horrible- that feeling of – cos your doing it for yourself- you're not recovering for yourself- you're doing it to stop yourself going into hospital – into care basically.'*

Catherine, patient P1 ii: 22

When I was talking to Catherine in the day care centre her immense irritation with eating disorder services was almost tangible. Her attendance at the day service was only a day a week and her reluctance to be there was obvious, yet she was one of the first people who offered to see me and her agreement was decisive, immediate and spontaneous. I was slightly anxious about talking to her because she was hyper-vigilant throughout the interview, listening to noises outside and asking me to be sure that our voices could not be heard outside the interview room. I was worried that I would not be able to put her at her ease sufficiently for her to trust me enough with her account and to share her experiences with me. Catherine surprised me. She was forthright, angry with psychiatrists, but honest, open and not afraid to speak frankly about the reality of her experience. She was an intelligent, articulate young woman who was intolerant of being either dictated to or patronized and who wanted to be in control of her care and treatment. Catherine was tall and thin (BMI about 18) but she was not frail, she was strong and resilient. She recognised the importance of the relationship with her care workers, she adored Gina who was her '*angel*' and who offered her a '*life raft*', but was unequivocally clear that the purpose of the care was to bring about weight-gain to a level that she was uncomfortable with.

During an interview with Lizzie, the nurse manager, we spoke about the relationships' place in the weight gain therapy. We had been talking for a while and so I tried to summarise her words and check out that I had correctly interpreted these:

Karen: *So the relationship is like the vehicle for the journey?*

Lizzie: *Yes.*

Karen: *Could the patient get better without it?*

Lizzie: *No, no I don't think they could. In that sense, all that you would be doing would be feeding them and then sending them on their way.'*

Lizzie, nurse manager P2 i: 102

Despite the pivotal role of the relationship, many people struggled to articulate what the experience of the relationship was like, except when recounting stories of when they felt the value of a relationship. The care and treatment plans in the services were both robust and prescriptive. There was limited flexibility and the ritualised weekly weigh was completely unavoidable. Maintaining the physical care regimes was not open to debate, but creating a sense that care was individualised, and that individuals mattered, was pivotal to success. Tom, the lead psychiatrist for the service described it thus:

*'That you cannot treat people like pieces of meat and just tell them, they have to do this because they have to do that and that's the way it is. And that they can't walk here and they can't stand there and they have to lie in bed, you just do not treat patients like that. You have to build on the therapeutic relationship and explain why it's not healthy for them to go for a walk at that time. It's very, very different to get somebody's understanding of why you've made that rule for them, than to just tell them it's a rule and they can't do it.'*

Tom, psychiatrist P2 i:16

## **8.5. Conclusion**

In this chapter I have discussed the words of the women and care workers that link with their lived experience of the relationships that they have with each other, seen through the existential theme of 'corporeal reflection'. The apparent pre-occupation with the body and

thus the 'Lived body' (corporeality), is quite predictable given the nature of the service. I have discussed it first, since it is an inescapable feature of the participants' experience and all else sits against this back-drop. Discussions about the anorexic experience were unavoidable. When we consider that the therapeutic relationship is an interpersonal dynamic, it is inevitable that a condition which changes the perceived identity and persona of the individual will become an integral part of that relationship. Thus, corporeality was a significant part of the experience of the therapeutic relationship, given the nature of the suffering of the women in the service and the goals of treatment, that is, the establishment of a 'normal' weight and eating pattern. An anecdote from Lucy, who is currently in recovery, has been presented as well as the excerpts from the interviews. Key findings here are the process of externalisation experienced and concern that recovery is measured in kilos and the effect that these have on the experience of the therapeutic relationship.

In the next chapter, I consider the experience of lived space within the therapeutic relationship.

## Chapter 9: GUIDED EXISTENTIAL REFLECTION: SPATIAL REFLECTION (LIVED SPACE)

*'Because there's such, there is such a lovely, lovely atmosphere and relationship here. I mean we joke, we laugh, Des, the chef has a real knack of making the dining room a happy place to be, because it can be, you know, mega issues, mega issues and struggles for people. And they're still struggling there but then the atmosphere, I mean we have this joke about, this ongoing joke about the porridge because some people make it so it turns out thicker than others. But one of the meal coordinators, Ellen, who's lovely, she makes really good porridge and we have this banter going as to who makes the best porridge, Des the chef or Ellen the meal coordinator, **I mean it sounds almost childish doesn't it? But it's lovely.\*'***

Christine, patient P2 iii: 121

### 9.1. Introduction

The previous chapter considered the existential theme of corporeal reality and specifically, who the person is that is connecting with the relationship. This was revealed by the presentation of the themes that emerged from the data of *'identity'*, *'externalisation'* and the expectation that *'recovery is measured in kilos'*, that is weight gain. The context in which that connection occurs is also important. Hence this existential theme, spatiality, considers the emergent themes of *'the therapeutic landscape'* and *'rules and regulations'*. The service environment was also considered to feel like *'home'* and is considered here, although there are some overlaps between this theme and those that are presented later within the existential theme of *'relationality'*.

The anecdote above, from Christine, is an example of some of the discussions heard about the dining room. She talked about the atmosphere and the sense of community in that space, sometimes called the *'therapeutic landscape'* within the wider literature. She spoke of the banter and sense of fun that transcended the struggles and emotional turmoils that are experienced in that room. Here, the *'punctum'*\* is interesting; she says *'...it sounds almost childish doesn't it? But it's lovely'*.

## **9.2. Lived space (spatiality)**

Lived space (spatiality) is felt space. Lived space is a category for inquiring into the ways we experience spatial dimensions of our day-to-day existence. Merleau-Ponty referred to the existential structure of human beings as 'being-in-the world', borrowing the term from Heidegger (Heidegger, 1962; Merleau-Ponty, 1962). Merleau-Ponty aimed to re-discover '*the fundamental relations between the body and space*' (Merleau-Ponty, 1962: 117). For this study, I am also borrowing the term to discover the space in which the person exists, in which the therapeutic relationship occurs; this therefore also refers to the 'space' between the care workers and the women, as well the space inhabited by the community of women together. There are many contexts for the relationship however, including the shared architectural space which might be seen as the 'therapeutic landscape', as well as the created space between individuals which I have called '*Peer support/peer effect*' and is included in the theme '*relationality*' (chapter 10.)

## **9.3. The therapeutic landscape**

In both services, the day care and the in-patient service, the place in which care was provided was important. It was repeatedly mentioned in the discussions. Both services were very different (see chapter 3) and were unique in their own right.

The contexts for phase one and phase two of the study were quite different from each other in many ways, but one of the most significant challenges for the women was the availability of privacy and the forced sharing of space. In phase one, the day care setting, the women could go home after the day and were usually only required to be there 2-3 days a week, but when there, they shared an open plan area with others at various stages of their recovery. For new attendees, especially those who had never accessed at SEDU previously, this was where comparisons were made and struggles were observed. In phase two, all the women had individual bedrooms where some privacy could be sought if they were at a stage of recovery

when they were less supervised by the care workers. However, the hour post-meal time was the time when the majority of women had to stay in an observable place together, usually the lounge. It was the enforced time in the lounge when individual behaviour could have the greatest impact on others. One of the women on the in-patient unit (Olivia) sought comfort from a soft toy which she clung to, curled up in a foetal position, sucking the ear of the toy when particularly upset. Whilst we can observe that this is how she sought comfort, it is also important to recognise that this also contributed to the environment for the other patients on the ward, not least because there were two sofas (accounting for six seating positions) and she would lie across two of the seating places.

The in-patient service was a house in a residential area, it had a garden with rabbits in hutches, there were neighbours living with their families in the next door properties; the women went upstairs to bed and the dining room was downstairs. This homeliness was mentioned frequently as a factor which made the environment seem more acceptable, as Anna said:

*'It's the flexibility here, just the environment is more homely ... I wouldn't say more relaxed because they stick to their rules, but they don't feel like imposing, it's less dictatorial here. It's more of a collaboration I think.'*

Anna, patient P2 i: 145

Anna equates 'homeliness' with a more collaborative style of care, one that creates a more horizontal power base and gives her the illusion that she has more choice. When the above quotation is viewed adjacent to something she said in her second interview (below), it is clear that it is merely an illusion:

*'And yet the people, the healthcare professionals are saying to you, we completely disagree with you, we're keeping you here and if you don't comply we will find a way that will involve forcing treatment, which is what the gastric tube does.'*

Anna, patient P2 ii: 170

The first encounter with a service can create a lasting impression and entering an eating disorder service can be disorientating. Unlike visiting a general hospital, few will enter an eating disorder hospital during the course of their lives. When Christine was first admitted to the in-patient service she felt a warmth and friendliness that made her feel at ease; she seemed surprised by the welcome she received:

*'We walked in and immediately there was something, it's quite uncanny really, the warmth of the people, everybody, we came in, obviously, through the door. My daughter was with us with the two little ones, the grandchildren. Everybody that passed made a fuss of them..., everybody that passed said, hello, it was just a lovely welcoming atmosphere.'*

Christine, patient P2 iii: 34

The way Christine talks about her first impressions makes it sound like a family day out; three generations were present, they were made comfortable and the friendliness of the people there put her at ease. When Christine says 'everybody' she was referring to people who were there for different reasons, some receiving care, some giving care and some visiting others. It is interesting that the friendliness is a communal response. I felt it too, when I was there. I was offered drinks, until the point when I was shown how to operate the digi-lock on the kitchen door. People I had only met once before greeted me by name. Christine told me that she was not looking forward to being hospitalised, but the warmth of her reception and the welcome given to her whole family made a significant difference to her acceptance of admission.

The in-patient service had single bedroom accommodation on the first floor where patients could personalise their rooms with their own belongings and door plaques, for example. Libby's room was one of the biggest and was highly personalised. She had music, books, a laptop, clothes, toiletries and such like all around the room and had decorated some of the walls with her own artwork. For Libby, her room was her sanctuary, she would take herself away when she was struggling and close the door. It was during these times that she felt that

she needed privacy and quietness. She did not want to talk to anybody or share her feelings whilst she was experiencing any distress; she wanted to be alone; and would sometimes self-harm to cope with her distress. At these times the nurses would seek to comfort Libby. The staff were concerned about the risk of her being on her own, so would ask her to come to a communal area. They did this for several reasons; they wanted to be able to see that Libby was safe, but they also felt that it would be more therapeutic for her to be with others. Libby did not agree, she often did not want to be with others:

*'Yes, you can tell because if I am sort of obviously upset about something ... but some people they don't like you to be sat in your room. So they try and make you go into the lounge and I don't usually want to go to the lounge. But they won't want you to; they won't just stay in your room with you. They want to take you and make you sit in the office with them or something. Whereas some people will just sit on the end of your bed and I'm like, I don't want to talk about it.'*

Libby, patient P2 i: 11

Not all patients felt entirely at ease within the unit. Debbie was not sure of what she could and could not do and she found that the single rooms could be isolating:

*'Sometimes it's quite hard, like if on a weekend especially, because I'm sometimes here on my own, the fact that they're in the office and I'm in my bedroom, I don't know whether I can talk to them or not.'*

Debbie, patient P2 i: 23

Debbie was a young woman who from a distance looked tiny and child-like. Her eating disorder had disrupted her higher education meaning that she had to leave university, suspending her studies. Whilst she was away at university she felt that she achieved some recognition and had enjoyed some independence away from her family home. She related her experience of being in hospital to being in a learning environment. However, Debbie did not use terminology aligned to adult-style learning environments that tend to be very self-directing. She used terminology more aligned to a 'school' setting where teachers lead children in their learning, rather than lecturers who facilitate learning for their students, who take

responsibility for their own learning. Hence, for Debbie, being admitted to hospital was more than a relapse, it was a regression; and the relationship and her increased sense of dependency on others reinforced this view:

*'Well it's just, because I was on track for doing certain things, going to Uni and people did kind of look up to me in a way. And now I've come in here, they all treat me the same but because I'm with these people 24/7, like we went out for a walk the other day and I felt like I had to ask them to cross the road. I don't know, it seems like I've gone back a step, if you will, instead of being talked to like an adult and a human being, I'm talked to like I'm a child, they're the teacher and I'm a student kind of relationship.'*

Debbie, patient P2 ii: 21

Olivia also used the analogy of a school room environment, using similar school and pupil vocabulary. She makes the same comparison that the carers are the teachers. Olivia creates an added dimension here; she suggested that the teachers 'pick on' some pupils as though some of the actions of the carers might be personalised or unnecessarily cruel:

*'There are teachers and pupils and there are teachers who really just pick on students because they just cannot take to them. And there are pupils who just cannot take to teachers, it's exactly the same, it's the same sort of thing. '*

Olivia, patient P2 ii: 27

Neither the day care nor the in-patient unit had been purpose built, so many of the rooms were quite small, especially upstairs. Sometimes, this added to their 'homeliness', but also enforced proximity. Many positive terms were used to describe both services; these included the feeling of safety (e.g. Rachel and Catherine) and that the environments were 'nurturing' where the women were treated gently and with kindness (Gina and Lizzie). This 'homeliness' was a frequently referred to concept which overlapped with a number of themes, but is considered here, within the theme of 'spatiality'.

David, the staff psychiatrist, suggested that the creakiness of the building meant that patients could be heard exercising, but he also thought that the enforced proximity created a bonding environment and that the relative smallness of the unit was positive:

*'If you're exercising, the floors upstairs they rattle, you hear it. The lounge is like this one is, it's not big enough for eight people, the one upstairs is barely big enough, I don't think that's big enough for eight people. So you're right on top of each other, so you're forced to be with each other here. And I wonder if that just forces you into a bond, but it is a relaxed atmosphere'*

David, psychiatrist P2 ii: 36

This was not always comfortable for the staff and several of the care workers (for example, Hannah and Angela) expressed a concern that the small unit had very few private areas or 'hiding places' for them, so they felt that they were being watched all the time, creating a self-consciousness and slight anxiety.

There was a clear differential about the homeliness of the unit and actual 'home':

*'So I was allowed to get away from this environment, go home and I was able to see what I was missing. And I realise I'm not living my life in there; this is what I need to do. And I just feel like, as I went home I've taken a step forward, I was able to do it a bit on my own, it didn't go as well as planned, but it still happened.'*

Debbie, patient P2 ii : 183

Furthermore, the clinical nature of the service and the presence of the professions made it a safer place to be for the woman. This had been an important finding in phase one of the research. It was as though the day care service was seen as a temporary sanctuary for those attending:

*'Certainly when I first started coming here I didn't want to be at home, I wanted to be here because I felt safe.'*

Heather, participant P1<sup>64</sup> i: 56

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<sup>64</sup> Heather was a participant in both phases of the study - but this quote was taken from phase one data.

Christine really appreciated the banter and joviality that occurred in the dining room. The dining room was a bright room in the style of a conservatory looking out onto a large garden. An objective view of this room would be that it was pleasant and inviting, but it was often seen as the most stressful place in the building. For example, Anna said that there should be a sign on the door saying '*abandon all hope all who enter here*', but for me, that seemed to mean '*abandon your eating disorder*' since this was the place where the greatest challenges and most emotive interactions occurred. For the women who felt forced into eating, this was more of a torture chamber.

When I first spoke to Christine she asked me who I was going to interview for the study, so I went through the study information explaining that I had permission to interview the patients and the care workers. Christine was interested in who was included in the term 'worker' and wanted to know if the chef and the cleaners were to be interviewed. She said that Des made a significant difference to the women whilst they were eating and that the relationship that they had with him was certainly '*therapeutic*'. It had not occurred to me that I should interview ancillary staff; I had assumed that the people responsible for therapeutic relationships were those who were employed because of their caring and professional attributes and qualifications. Christine wanted to tell me about the chef, 'Des', whose humour and banter changed the atmosphere in the dining room to one that allowed the women to feel at ease:

*'But it was getting a little bit intense and Des just called across to me and he said, this is just a typical scenario that made everybody laugh, he just called across to me, because he knows I like to cook. He said, Christine, what do you think? And he pointed to the rabbits, [in the garden] Deidre had her back to him and said, carrots, onions, potato, a bit of rosemary, a bit of nice stock. And then he said, Deidre, Christine told me to stew the rabbits. But everybody laughed, Deidre laughed, the whole thing, I mean it sounds trivial doesn't it, but it's so important.'*

Christine, patient P2 iii: 126

The chef made quite an impact on both staff and patients. Clearly, Des cared. He was not paid to care, he was paid to cook. If the patient says she felt cared for, and that she felt a therapeutic connection with the chef, then that is indisputable. For me, this is important. I realised that if we share a therapeutic space with others then all those present are partners in the therapy. Lily also said:

*'He just sings and asks them if they're alright and he doesn't go too much into detail. And sometimes you just need that lighthearted relief.'*

Lily, nurse P2 ii:53

The phase two participants inevitably made more comments about the environment, as they were there 24 hours a day. There were also notable differences, such as eating together (considered under rules and regulations below), which did not occur at every meal in the day service and, crucially, the ability to go home at the end of the day. Despite this, Sharon, the day care manager, thought that some of the women became so comfortable in the environment that they were not fully cognisant of its clinical nature, confusing it with a 'home':

*'...some people might want to stay here forever, cos it's a nice place and they are comfortable here- it's a second home. '*

Sharon, nurse P1 i: 101

The use of the word 'contained' in Lynne's quote below is used in a way that infers the meaning '*to have, or hold*'. It was in contrast to how she felt in the previous weeks at her home where she had become so malnourished that she had experienced a cardiac arrest and was resuscitated by her husband prior to paramedics arriving. She had been very secretive about how she had felt prior to the physical emergency, so the provision of a safe place where she could share her thoughts was an important part of her recovery.

*'It's a contained environment where you do feel safe to talk- you feel able to do that'.*

Lynne, patient P1 ii: 44

Inevitably, with a contained environment come customs and practices that maintain its level of security and predictability. I have labelled this theme '*rules and regulations*', from the words of Donna.

#### **9.4. Rules and regulations**

When I spoke to Donna in the day care service she accepted that she needed help, but that help had to be on her own terms. She was married with a university degree and had held down a professional post until becoming too unwell to continue. Day care, for Donna, was voluntary; she chose to accept care, but was well aware that when she had previously disengaged from services she had to be admitted to hospital. Donna was observably sociable, she appeared to be popular with the other women, who were attentive to her; she drove herself to the day care service and was proud of her independence, making self-determined choices was important to her. Her choice of the word '*prison*' rather than any other place where there may be an authoritarian or dictatorial climate is interesting, since it suggests that despite her apparent choice to attend, she felt constrained and uncomfortable with the required compliance with the regime. The security that was interpreted by Lynne as providing safety was perceived as constraining, rather than 'containing' by Donna:

*'I thought 'scuse me, I am not in prison, so don't even think about telling me what to do'.*

Donna, patient P1 ii: 24

Many of the women adopted regimented ways of conducting themselves with regard to their daily activities, their exercise regimes, their diet plans and their sleep pattern. Donna's prison existed because of a formidable and robust mind-set that forbade her to move outside of the boundaries of anorexia; it also prevented her from letting the care-workers into her world, to release her.

Entering a service which had its own perspective on 'rules and regulations' could also be a positive experience because the staff were much less judgemental and more accepting of the women than they were of themselves:

*'I've had a lot of rules and regulations and I am really critical of myself so in some ways they pull me back and tell me not to beat myself up and they are very good at saying well that's ok it doesn't matter- you tried it- you'll do it again and don't worry about it- you are at where you are at- and they are very accepting.'*

Donna, patient 1 ii: 29

Christine, in the in-patient service, found the house rules to be very constraining. Individual choices were replaced with global regulations that affected everybody in a 'regimented' way:

*'...but it's quite easy at that stage to look at how the unit is run, how everything is taken away from you, decision making, in every way, when you eat, what you eat, how you eat, what sort of cutlery you use to eat, certain spoons for certain yoghurts, how much dried fruit you have to have on your porridge, everything is regimented. How long you can go out of the unit, how many times you can have a snack out, either with staff or on your own as you get better. Everything is strict, every decision making, you know, any responsibility.'*

Christine, patient P2 iii: 16

Lily described the situation where her professionalism facilitated an approach that was not necessarily intuitive for her. There are overlaps here with the theme 'authenticity' (see chapter 12). Lily might have relaxed the 'rules' or perhaps made individual adaptations if she was able to act from a personal perspective, but she knew that a cohesive team and a consistent approach was vital:

*'One of the roles is to be a good actor I think as well, because if we always said what we felt we'd get into trouble wouldn't we, if we're being honest. So you do, you have to stick to the rules and say what's appropriate basically to them.'*

Lily, nurse P2 ii: 120

The environment was frequently described in negative terms because of the women's reluctance to be there and the 'nasty' comments being made about staff members, despite the good intentions of the staff:

*'Well it's a negative environment to be in because actually, if you want to be trying to recover, when you've got everybody else, you know, like being really nasty about staff members and stuff like that, it's really difficult. But it does really feel like, yes, it's us and them and they are there to, I really feel like they want us to get better. They actually do and like they don't want us to leave because they all say, oh we'll miss you when you go or whatever.'*

Rachel, patient p2 i: 22

Eating together (staff and patients) is a practice adopted in many SEDUs. Many of the staff found it uncomfortable. Hannah, a nurse therapist who had previously worked as a nurse in another unit and now worked solely as therapist, described the practice of eating together as *excruciating* because the women watched her every move:

*'...they [the patients] didn't take their eyes off you- they are obsessed with how much butter you have put in your sandwich or how you cut your sandwich. Table manners- of which they don't really have any- and then they would literally stare and it's not a relaxing environment in which to eat your food in.'*

Hannah, nurse therapist P1 ii: 36

Petra had a different perspective about eating together:

*'But they're very good the staff here because they sit there and they're eating with us. I think if they weren't eating with us, you would feel more uncomfortable... Yes, I think definitely if they weren't eating you would feel uncomfortable'.*

Petra, patient P2 i: 84

## **9.5. Conclusion**

The many references to how homely the service felt is clearly important to the context of care. The non-clinical environment creates a more relaxed space, but both the women and the care workers are under no illusion that there is work to be done here; work that is anxiety provoking. The safety and comfort of the environment seemed to have an effect on the

management of the tasks of therapy and create a learning culture, recognising the development and changes that would be required to work towards recovery. The therapeutic landscape is seen as important to the relationship and the rules and regulations create predictability and security. The next chapter considers the relational experience.

## Chapter 10: **GUIDED EXISTENTIAL REFLECTION. RELATIONALITY: LIVED HUMAN RELATION, OR COMMUNALITY**

In the previous chapter I discussed the findings related to the experience of the therapeutic relationship through the lens of spatiality and the contextual space that surrounded the women and their workers when seeking a connectedness that would aid in the recovery process. I looked at the service in terms of its therapeutic landscape, its homeliness and the rules and regulations, aspects that have some interface with the community.

### **10.1. Introduction**

In this chapter I discuss relationality which is also referred to as 'community'. However, relationality, or 'lived other', refers to 'the lived relation we maintain with others in the interpersonal space that we share with them' (van Manen, 1990: 104). In many ways, this is the focus of the entire study and hence a substantial amount of the data refers to relationality. Here, I focus on the extracts from the data that focus on the lived relation and specifically the connection between people. Van Manen reports that it is not possible to separate the lived body (corporeality), lived space (spatiality), lived time (temporality), only to differentiate between them. This is certainly true within the context of the lived therapeutic relationship.

There was much talk about the connection between people and the importance of it. I will use an anecdote from Tom, the psychiatrist, to illustrate this:

*'But you have to have people holding you and around you, you have to have a great sense of belief within the team, because we all have so many bad days. We all get so many things wrong, over and over and over again, that you have to have each other around believing, you know, we believe in what we do, we all believe in what we do, you know, it's just a bad day, it doesn't mean you've lost it. It doesn't mean you can't do it, you know, those days that you really get down, they hold you up. And they also counterbalance you, so when you are drawn into collusive relationships they pull you out, **we pull each other out**'\* .*

Tom: psychiatrist P2 i: 141

Van Manen refers to the 'punctum'\* (see page 111), the sting in the tale of the anecdote.

Here, the punctum is the phrase '*we pull each other out*'. Tom is referring to the close-knit community of the service, the belief they have in each other and the inspiration that they gain from each other. But there is a warning against the seduction of getting drawn into collusive relationships which are damaging and unhealthy.

In this chapter I consider aspects drawn from the anecdote above and the interviews of the women and their care workers, dividing these into two major sub-themes, '*conflicting perspectives*' and '*maternalism*'. Both of these sub-themes include more minor subthemes; '*the battle*', '*surrender*', '*tears and tantrums*' are each minor sub-themes of '*conflicting perspectives*', while '*closeness*', '*attachment*' and '*approval*' are minor sub-themes of '*maternalism*'

## **10.2. Conflicting perspectives**

As already described, the anorexic patient does not want to gain weight but the primary goal of treatment is weight gain. Hence all care and treatment is offered within the context of conflict. As the conflicting perspective is likely to impact on the therapeutic relationship, it is important to consider the experience of this.

An additional conflict, considered earlier in chapter 8, is that which occurs internally between the woman and her anorexic self. This is a parallel conflict but one that affects the way the women behave towards the care workers. An example of this is when Olivia was asked to increase her diet plan. She agreed to the increase, but internally, her anorexic voice was saying:

*'You should have been, you should have cried, you should have kicked and screamed and refused it and blar de blar de blar'.*

Olivia, patient P2 iii: 21

When this is considered within the practical context of the ward, it would appear that a diet plan was established and presented to Olivia; Olivia said that she would accept the diet; but then, when the diet was offered to her, it was likely that she would be unable to eat it. It is at times like this that care workers feel that the women are being dishonest or uncooperative. When I asked the psychiatrist about this he demonstrated both understanding and a non-judgemental attitude. He said that he did not believe that they 'told lies', as many suggest; he believed that at the time of the discussion the women do believe that they will adhere to the care plan, but that when it comes to the meal, they cannot go through with it.

Anna was almost apologetic when she explained her experience. She was aware that her refusal to eat was making the worker's job more difficult:

*'And I don't mean to make anybody's life difficult, it just happens naturally.'*

Anna, patient P2 ii: 47

Lizzie described how futile the job was at times, not only because of the inability to persuade the women to eat, but because she felt the impact of the hatred of the women as a consequence:

*'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 manager. P2 i: 147

Many of the women had experienced poor relationships in the past, not necessarily professional relationships, but nonetheless, they had had an impact. Some, like Lynne, found it difficult to believe that people cared about her:

*'I just feel like they are ridiculing me even though I know that they are not- but that comes back to the way I have felt all the way through my life.'*

Lynne, patient P1 ii: 52

Despite the apparent disagreement and conflict which was described by all participants, there was a sense of calm in both services. I was present at all times of day and observed a calm resolution and acceptance that conflict was inevitable. Only once did a staff nurse reveal an underlying frustration; she was smiling as she said:

*'You just feel like saying to them, don't be stupid, you know.'*

Lily, nurse P2 i: 112

Sometimes the reality of their fragile mortality was discussed by the care workers who worried that discussions around the life-threatening nature of the illness could be perceived as threats.

The women repeatedly denied how unwell they were and their continued survival merely reinforced their perspective. When the care workers tried to educate the women about the physiological changes that were threatening their continuing existence they were met with continued resistance and denial. It was clear that any ambiguity or perceived element of choice created conflict and disagreement because the women then attempted to negotiate.

The worker-to-worker relationships were also important. Tom acknowledged the extremes of working with such a client-group, where bad days felt like having *'lost it'*; which were construed in terms of personal incompetence (*'you can't do it'*). Thus it appeared that the peer-support between team members was a mediator for the worker's thinking and provided some balance and protection against potentially dichotomous positions. There were times when the workers needed rescuing from unprofessional relationships. It was also clear that it was not only the relationship between the women and their workers that were important, it was the relationships between the workers that were pivotal to creating a community that could nurture recovery.

### 10.2.1 *The battle*

Most of the participants mentioned the inevitability of the *battle*, the disagreement, and the dichotomy of the care workers' position against the women's position. David acknowledged that it '*can get tough in the relationship*' (psychiatrist P2 ii: 3), with an acceptance that the work is tough but that he did not expect his work to be easy:

*'Yes, that's right, that's what they're doing, being strong for us and fighting it.'*

Heather, patient P1 ii: 70

Heather was appreciative of the resilience of the care workers who tolerated a great deal of opposition whilst fighting the battle '*for us*' (rather than '*with us*'). There is an inference here that the care workers are doing the fighting rather than Heather. It is interesting that Heather, as a day care patient, referred to the staff as fighting '*it*', as the anorexia is being referred to in terms of an entity. Robust staff, working hard for the women is commendable, but it requires a unique skill-set and creativity:

*'...you have to do whatever you can, you have to cajole, bully, anything just to get them to eat and get that initial re-feeding, get their brain working a bit better.'*

Lizzie, nurse manager P2 i: 149

The interface between the battle against anorexia and the battle with the staff, who are the '*feeders*' was sometimes a grey area. It was as though there were two simultaneous battles going on at once; one between the care workers and the women and one between the women and their anorexic self. The care workers were only able to relate to the women, but, the women hid behind their anorexic selves, particularly when under stress. This made the creation of robust relationships very difficult and also created fractures in developing relationships. If a nurse had well developed skills and demonstrated that they could '*get through*' to the women, this made them more threatening to the anorexia. Anna would shy

away from the best nurses, for fear they may develop a relationship with her that would cause her to give up her anorexia and persuade her to work towards recovery:

*Yes, so the best nurses I'm more likely to run away from because I know they'll get through.*

Anna patient P2 ii: 155

In the following quote it could be said that Lizzie entered the battle fighting with kindness and patience in a way that engages the woman in the fight against the anorexia, rather than against them. She described resilience against oppositional responses, no matter how personal they are, she described the *faith* and belief that she has in them in order to raise their self-esteem to the point where they have the confidence to fight. Lizzie firmly believed that the relationship that she has with the patients is strong enough to weather the storm. She does not explain here how she developed the relationship to this point, but in a previous interview she told me that she takes a very personal interest in the uniqueness of the person, focussing on them and seeing them as individual and special:

*'And I'll just be constantly, right we're going to do it this, we're going to do it, you know. I've got faith in you, we're going to do this, we're going to get better, you know, you're a wonderful, fantastic, lovely person; you deserve a better life than this. So me and you together, we're going to fight this illness. And you can shout at me, you can fall out with me, but we're not, we're not giving in, this time round we're doing it.'*

Lizzie, nurse P2 i: 55

Tom described '*the battle*' in very physical terms, disclosing that he sometimes felt frustrated with patients who do not comply with the proposed interventions. He admitted that sometimes it is time to call it a day. His position as psychiatrist and medical director of the service meant that a conflict with him is especially significant as it tended to relate to acceptance of the treatment plan per se, rather than a specific interaction or intervention:

*'Because I'm not sure I'm helping you, I say to them. I'm not sure I'm getting this anymore, I'm getting frustrated, you're getting frustrated, we're just in danger here of just bumping heads and is it time to, you know.'*

Tom, psychiatrist P2 i: 94

It is apparent that different people fight their battles with different weapons. Des, used humour, Lizzie used kindness and Tom used straight-talking:

*'I was feeling sorry for myself this particular night, I can't do it, I can't do it, I really de, de, de. And he just looked at me and he smiled and he went, 'tough', but it was exactly the right thing because if he'd sympathised with me, I would have gone even further down. When he said, 'tough' like that, he knew me well enough to know that that sort of thing can lift my mood like that and make me laugh.'*

Christine, patient P2 iii: 62

Such straight talking worked well for Christine, on that occasion; but that approach would not have been appropriate for Rachel, who struggled with being told 'no':

*'If someone just says no to me, I feel like I'm being punished, I feel like they're being spiteful. I just feel like they're out to get me and out to hurt me, so I'm going to lose trust instantly and my trust just goes like that.'*

Rachel, patient P2 ii:50

Rachel had had several admissions; she had been anorexic since aged 11<sup>65</sup> and did not find it easy to accept care and treatment. She battled with the staff and she battled with herself; her arms were badly scarred from years of cutting herself in a self-punishing and self-blaming response to earlier rejection. She had found an identity that provided her with an element of recognition, the identity was that of an 'anorexic' and so the battle was not simply with the staff about care and treatment, she was protecting her identity from harm.

Olivia told me that she had been continuing to vomit at every opportunity and had been taking as many showers a day as she could, where she kept the water cool to burn more calories. It

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<sup>65</sup> Rachel did not gain access to ED services until she was 15.

was difficult for the staff to refuse her a shower because she often wiped Clinutrin<sup>66</sup> in her hair, clothes and over her skin, rather than drinking it. She hated the Clinutrin and was disgusted by having to drink it. The smearing of the Clinutrin over her body and clothes reminded me of seeing patients in conditions of high security engage in 'dirty protests'<sup>67</sup>. She was completely aware of how oppositional her behaviour was, but attributed these behaviours to 'anorexic Olivia'. She thought that this behaviour made her unlovable however, thus disabling the staff from offering her their approval, something she really needed.

With every battle there is a winner and a loser, or somebody surrenders. Surrender usually suggests an admission of defeat. Here surrender means defeating the anorexia and surrendering, thus allowing the care workers to help.

### **10.2.2 Surrender**

We often view 'surrender' in terms of 'giving up', but here I use it to describe the surrender in battle, the giving up of the anorexic self and the relinquishing of damaging behaviours that kept the women in a state of malnutrition, controlled by their anorexia. There was a cross-over between 'trust' and 'surrender' in the analysis of the data. I have considered surrender to mean more than merely trust. That the person has trusted and given in to the care of the worker to the degree that they relinquish previous positions, or, as Olivia stated:

*'So you're literally putting your life in their hands and you have to trust them and that's not easy.'*

Olivia, patient P2 ii: 31

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<sup>66</sup> Clinutrin is a meal replacement drink.

<sup>67</sup> A 'dirty protest' is most commonly associated with forensic/prison environments and occurs when the adult prisoner/ patients smears their own faeces around the walls, floor, ceiling or themselves.

There was awareness amongst both women and care workers that engaging with the care and treatment meant giving up established beliefs and lifestyles and that the anorexia directing these beliefs and lifestyles was very much in control:

*'You have to put your trust in them and you have to hand your responsibility over to them because an eating disorder is a very, very strong entity and it doesn't allow anybody to get in the way of it, it's too strong. You have to trust them.'*

Olivia, patient P2 i: 59

Trust was also identified many times in phase one as being pivotal to the relationship and for creating a sense of safety. Hannah spoke about how difficult it was to create a trusting relationship amidst a testing and hostile environment:

*'So yes, you get the explicit questions, but also you can just tell from people's body language that they're quite closed, almost quite hostile sometimes when they don't know you. Almost like you've got to prove yourself to them, you've got to earn their respect. Yes, it can be very, very difficult if you're not prepared for it. And even if you are prepared for it and you can't really describe it, it's just an atmosphere in the room of hostility. They're not welcoming to new people, in my experience anyway.'*

Hannah, nurse therapist P1 i: 14

Olivia, prior to her transfer to another hospital, was clearly feeling weak and worn-out. She had not gained weight during her stay in hospital and had continued to vomit and exercise at every opportunity. She knew that she was difficult to look after and was not trustworthy in terms of how she would behave when not being observed, but attributed these behaviours to 'anorexic Olivia'. The hospital that she was being transferred to was unfamiliar to her and she was frightened because the treatment regime would probably include naso-gastric feeding. It was difficult for her to accept this decision and blamed the care workers:

*'I just feel like they've given up on me and they don't think I can do it.'*

Olivia, patient P2 v: 4.

The feelings of insecurity were created by the care team's decision to transfer her care and, even though this was rationalised in terms of locality and clinical need, it still felt like a rejection to Olivia who felt alone and abandoned. Yet, the recognition that she could not do it on her own was, ironically, a step forward for her as she had previously insisted that she was fine and did not need help. Christine actually used the word '*ill*' to justify the medical intervention that she has agreed to when a realisation occurs to her about the dangerousness of her increasing weight-loss. She talked as though she has to assume the role of a passive recipient, by having the care '*done to*' her:

*'Yes, and accepting the fact that you really are ill and this has got to be done to you, otherwise, you know, ultimately it could kill you.'*

Christine, patient P2 ii: 68

Sadly, Olivia had got to a point where she could not tolerate her current experience, but she could not tolerate the treatment either. She had spoken repeatedly about her need to exercise and her abhorrence of food and eating. She wanted to be better, but she wanted that to happen without her engagement with the treatment plan. Anna had also told me that she wanted to be better, on her own terms, and of course, that did not mean gaining weight. For me, it was a contradiction in terms for them to be 'better' but not gain any weight, but their life-world allowed that for them. Olivia wanted an escape from her present position, even if that escape was her own death:

*'Now I really, really, really do not want to be like this. If that means dying, OK I don't really care to be honest, but it's either get better or die, I don't want to be like this anymore, I hate this illness, I hate it. '*

Olivia, patient P2 iii: 37

Lizzie, who always saw the best in everybody, all of the time, saw that to surrender the eating disorder and accept treatment created vulnerability in the women. She realised that when this happened that it was like opening a door to let the care workers into to their world, so she had to tread carefully:

*'...they're frightened of letting their guard down and letting you in and letting you start to picking out their behaviours because they feel very, very vulnerable.'*

Lizzie, nurse manager P2 i: 99

Christine found the prospect of 'surrender' easier because she was aware that she was not thinking clearly anymore. Anorexia affects cognitive functions and Christine acknowledged this, but she was unusual in this regard:

*'... you have to surrender everything because you can't make decisions, you're just not, in any shape or form, in control of your life when you come through those doors, somebody else is.'*

Christine, patient P2 ii: 70

Fortunately Lucy also arrived at the point where she was ready to be helped:

*'Because I did decide that something had to change and they were the ones that I needed to help me- little did I know that they would completely change me! '*

Lucy, patient P1 i: 50

Recovery from anorexia is a difficult journey and one that evokes emotional expression from women who feel coerced and manipulated by the care workers. I have used the phrase '*tears and tantrums*' with some reservation as I am aware that it is terminology more familiar to a dialogue which refers to children, however, it is taken directly from an interview with Gina.

### **10.2.3 'Tears and tantrums'**

*'...we've had tears and tantrums and all sorts of things. '*

Gina, Nurse therapist P1 ii: 106

Both women and care workers referred to how emotionally charged the atmosphere was sometimes. The emotional nature of the communication seemed to be occurring because of the nature of the relationship between the individuals rather than because of any

environmental aspects. Anna got to a point where she could no longer contain her distress at the proposed meal waiting for her in the dining room. She spoke graphically about her expression of this, when rational debate was not making any difference, she became upset and tearful. She stated:

*'I can't do it, I'm really sorry I can't do it today, no, no, no, cried and snot everywhere. And she said, come on, come on, it's time, you have to come now, come on, you're coming, come on, like she didn't have time for any messing about.'*

Anna, patient P2 i: 82

The child-like quality of her outburst is contrasted by the emphatic and reinforcing response by the worker, which is persuasive and repetitive; but as Anna rightly says, intolerant of '*messing about*'. If a worker had used the phrase '*messing about*' to describe the actions of one of the women I might have thought that it was rather critical and showed intolerance and impatience. As Anna described her own behaviour in this way, it seemed as though she was reflecting her belief that the worker was not trivialising her distress as '*messing about*', she had adopted a more disciplinarian style approach. Anna was not critical of the care workers at all, in fact she was highly critical of herself, wondering why they cared about her so much; she did not feel worthy of their time. Her tone here was that she was behaving in a childlike way and the worker was responding in a caring, but disciplined way.

It was Gina that first used the term '*tears and tantrums*'. Gina, a nurse therapist in day care accepted the emotional expressions and saw them as evidence that the service functioned like a family unit would:

*'Yeah. It's there and we've had tears and tantrums and all sorts of things- like you do in a family.'*

Gina, nurse therapist P1 ii: 106

Serena, again in the day care service added emphasis to Gina's comment; again using the word '*tantrum*', but suggested that behaviour of that nature was not tolerated by the care workers:

*'They don't really get away with that ... actually having little tantrums- you know that advert where that lady throws herself on the floor?'*

Serena, nurse therapist P1 ii: 58

Anna accepted that her tears and her outburst stemmed from her own inability to conform to the expectation of her, but Catherine attributed her upset to the psychiatrist who told her that she had to gain a pound a week or be admitted to hospital. She saw her as threatening; not that what she **did** was unpleasant for her, but that she, as a woman was '*horrible*', attributing blame for her upset to the psychiatrist:

*'Yeah- horrible woman- I hope I never come across her again- I hope not- I doubt it- I can't see me doing. But she made me cry every time I saw her.'*

Catherine, patient P1 ii: 30

Tears were mentioned many times. Care workers disclosed that they went home and cried, wondering how long they could do this work for, but they managed to maintain a professional composure when at work. One of the reasons given for their need to stay composed and resilient at work was the daily exposure to the distress of the patients. Serena, at the day care service, described a time when she sat with one of the women who cried for some time. She uses the term '*sobbing*', giving the impression that it was a not a quiet tear but a heart-felt, bodily expression. Serena did not interrupt. She told me that one of her roles was to provide a safe place where patients could safely express themselves fully, if emotionally, without being judged or stifled:

*'So when she was ready- she was sobbing for a good ten minutes or so and saying random things that must have meant something to her- and she said – 'you are the only person that I have let see me like this- apart from my mum'*

Serena, nurse therapist P1 ii: 28

For Serena, the woman's statement about her mum was a sign that she felt trusted and safe and that the women felt a secure connection with her. However, emotional expressions or outbursts were frequently directed towards the care workers, rather than with them and were derogatory and personal; for example, Rachel told me about a recent event when she said:

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

Rachel, patient P2 ii: 65

Hence the connection between women and worker could be emotional and threatening as well as comforting and familiar. 'Therapeutic relationship' is a term usually given to the relationship that occurs between nurse and patient, or perhaps therapist and client. Many of the participants in this study however, referred to the therapeutic nature of relationships occurring across other groups of individuals. Christine's account of Des, the chef, was an example of a time when a member of staff made a therapeutic connection or engagement that did not involve professionalised therapy or clinical activity and would be categorised as social interaction if it had occurred in any other environment.

#### **10.2.4 Peer support/peer effect**

There were many examples of women who formed connections with other women in the SEDU, which were therapeutic in terms of their mood, activity and motivation. Lily described this as:

*'...we can end up working as one big team trying to get everybody better, and that includes the other patients helping the other patients. I think that's why this unit is successful...*

*You see that's another example of them helping each other, all the artwork they've done. '*

Lily, nurse P2 ii: 79

Artwork was a feature of both settings, in different ways. The day care service had framed paintings on the walls that had been provided by Donna. However, the walls of the in-patient service were covered in work that had been created by the women to enhance their environment and to spur each other on. Much of it was intended to be motivational and was pinned up on the walls. I had noticed a similar tendency when I visited 'Sheena's place' in Toronto, which was also an adapted house in a residential area. Christine had taken a lead on a big project that covered a whole wall and the bond created between her and Petra, a fellow patient, was clearly observable.

The staff psychiatrist also observed the close-knit nature of the client-group:

*'... this unit feels to me like a group, it feels like they knit together as a group here. And they support each other as a group and usually in a very positive way.'*

David, psychiatrist P2 ii: 26

So, it is not just the care workers that promote recovery, the women help each other:

*'Yes, they're a prime example of camaraderie, they spur each other on, they go out for snack together and they make each other have what they need to have. And they go out together and they talk about their feelings, they really, really are helping each other.'*

Lily, nurse P2 ii: 97

*'They have a bit of a laugh about it actually- but they have done it and that is quite powerful- it gives them power. It gives the group a positive spin. They are getting a lot of benefit from the group and the peer support.'*

Gail, dietician ii: 49

Unfortunately, however, the close-knit nature of the group work affected individuals in both positive and negative ways. Kelly told me about one of the women who was having a difficult

time because she was intolerant of the treatment regime so was becoming depressed and tearful as a consequence. The small lounge area was where women were supervised (observed) after meals and it was here that the women shared their feelings with each other, sometimes to the detriment of the group:

*'One by one I kind of saw patient's moods drop, after that discussion she'd had with them. And I've seen it so many times.'*

Kelly, HCA P2 i:155

### **10.3. Maternalism**

I have presented a number of accounts which have referred to the family dynamic that was apparent within the services between the women and their care workers, but the most prominent and repeated family dynamic noted was that of the mother-daughter relationship. Some care workers admitted to falling into the mothering role, some patients searched for mother figures and felt protected by them whereas others ran from them. Some of the women spoke of behaviour more usually attributed to children or adolescents, for example, Anna's *'messing about'*. Debbie on the other hand appreciated the sense of normality and familiarity created by the presence of somebody who was like a mum towards her. Her description created the image of a reciprocated relationship where Debbie feels that she matters and normality is established, even in hospital:

*'Well she's a similar age to my mum, so it's kind of like a mum kind of figure. She's really funny, just open, just treats me like a normal person. She chats to me about anything; she comes to my room and reassures me that everything's going to be alright. She tries not to make a big emphasis on the food and all around as normal everyday life, she's really caring and sensitive to like any of my needs and anything that I need. She's just always there. '*

Debbie, patient P2 i: 100

Lucy was studying health studies and psychology at college when I saw her and so she explained to me what she thought had happened, including her own analysis of the dynamics

occurring with mature female nurses on the adolescent wards (initially). She even said that she had '*her head in the psychology books*' for her studies, but also because it enabled her to analyse her own experience, a process she felt helpful. Lucy believed that her fractured relationship with her mother and her sense of separation after the birth of her little sister had caused her '*mother seeking*' responses that could be attributed to feeling abandoned by her own mother. She told me that on each admission, the realisation that it was a professional relationship that would have to end when she was discharged would leave her devastated. She told me that this rejection on discharge replicated the sense of abandonment that she felt from her own mother.

So, Lucy made a conscious decision that when she accessed eating disorder services as a young adult she would be more self-protecting and not allow her child-like vulnerability to be revealed:

*'I let no one in- nobody- I would not talk- in fact if it was a mother figure I would stay well away. Because as far as I was concerned- mother figures left me. Past experiences told me that all mother figures do the same- there was a massive pattern of that. '*

Lucy, patient P1 i: 39

'Motherliness' meant a protecting, comforting person for Libby. She felt that she needed the maternal-style approach because she was feeling vulnerable and child-like. Hence, when the nurses behaved in that way an association was made:

*'And they were like motherly, like I don't know, just the way they acted with you, it's like they were wrapping you in cotton wool almost, which was good because I was very sort of in a fragile state at the time. I don't know how to describe it; it just felt like you were a little child being cared for.'*

Libby, patient P2 i: 107

There are many examples of the way the care workers behaved in a caring and nurturing way, but equally there were a number of examples of the women disclosing that they either felt

child-like, or that an interaction that occurred resonated with a child-adult transaction. When Lizzie sat down on the floor with Anna, Anna felt much less intimidated. However, Anna also recognised that the incident of Lizzie sitting down next to her is a caring one, because she sat with her, but also because Lizzie entered her bedroom, her safe place to be with her:

*'Yes because when I'm upset I go and sit on the floor in a corner somewhere. I don't know why, it just feels safer. And she'll always come and sit on the floor, whereas somebody else would just stand at the door and say, come on, are you coming and stand in front of you so you have to look at them, then that's a bit more intimidating I think. Whereas she'll come down, like you do with a child I guess.'*

Anna, patient P2 i: 85

The physical closeness and the worker's presence was seen as important to Debbie, who enjoyed the sense of somebody simply 'being there', or putting their arm around her (Debbie P2 ii: 47) and Donna appreciated the '*gently nurturing relationship*' (Donna P1 i: 179); but Lizzie was aware that it was important to reinforce that the relationship is a professional one, despite the cathartic or emotional nature of the interaction:

*'Yes and then you have to start to let them go, because at the end you have to start to withdraw, otherwise your boundaries, because you have to be constantly aware don't you, that this relationship, even though it can be very, very intense at times, it can only ever be what it is, it is a nurse : patient relationship.'*

Lizzie, nurse manager P2 ii: 9

Gina, also spoke to me about when she worked in a different in-patient service for people with eating disorders, (not one used for this study). She shared accounts of times that she spent with patients:

*'these lovely human beings... she made sure that the work that I did was lovely and gentle and not challenging at all- in any shape or form- we used to colour in and things to catch the nature and the sunshine'.*

Gina, nurse therapist P1 i: 30.

I include an excerpt of an interview that I did with Gina when she told me about working in the evenings on the eating disorder service:

*Gina: I used to read to them as well- I used to tell them stories and I'd read to the girls.*

*Karen: Really? Like a bedtime story?*

*Gina: Exactly like a bedtime story. And they used to get their cushions off the chairs cos it was a big room with cushions and bean bags- and they used to cover themselves up with a blanket- and quite often the girls used to carry their own cushions about and cuddle them in front of their tummies. There was a rage going around for squishy cushions- do you know the sort I mean?'*

Gina, nurse therapist P1 ii: 52

I was a little surprised by this; it seemed unusual for a nurse therapist to be using colouring books and bedtime stories with adult women. But there was no doubt at all that the connection between Gina and the women in the day care service was quite special. As a consequence they would often agree to do things that they were frightened about, knowing that Gina would keep them safe, that she would not let them do anything that she did not think that they were capable of, and, if they were struggling, that she would ease their suffering. She was a perfect example of the 'therapeutic use of self', where the self was a 'mother figure'.

Lily was less comfortable with a maternal style of relationship with the women, but realised that if she had not responded reciprocally to a 'hug' it would have hurt the relationship:

*Karen: So when she flung her arms round you, was that a bit of a surprise?*

*Lily: Yes, it really was because she'd never been that personable with anybody before really on the unit.*

*Karen: So it took you a bit by surprise really?*

*Lily: It did.*

*Karen: So what did you do?*

*Lily: I just, I hugged her back obviously, because what can you do? '*

Lily, nurse P2 i: 101

So, for Lily, she did not intuitively offer the physical closeness and comforting style that was typically adopted by some of the care workers, but fell into that response because that was what was expected of her. Anything else might have been interpreted as dismissive or uncaring or as a rejection. It seemed as though a family style of relating to each other had become a dominant culture and included many of the fundamental features of a family unit. One such feature is the 'closeness' that is felt between family members but might not, ordinarily be expected in a hospital environment.

### **10.3.1 Closeness**

The examples of physical closeness seem to be initiated primarily by the women, rather than the care workers, except in times of distress when physical closeness is offered to provide comfort. Debbie provided such an example:

*'I've always felt at ease with her, she's always been really funny. But it was when I opened up to her and started crying that she just came and talked to me and gave me a cuddle and reassured me that it was going to be alright.'*

Debbie, patient P2 i: 120

I spoke to Debbie about the value of finding the 'somebody' (a worker) who she could trust and who she believed understood her; she called it '*enlightenment*' (Debbie, patient P2 i: 168). For her, it was more than the words and professionalised actions of the workers, it was the way they were, their comforting presence and a much needed hug when she was struggling. The physical contact offered to Debbie was confirmatory of the connection between them. The need for physical and emotional closeness was also associated with the relationship in terms of the availability of the care workers as well as the need for comfort. As Lily discusses below, it made the women feel valued, but it did seem as though there was a pacifying feature

of the 'hugging' in that assuring them that 'everything would be alright' might be an over generalisation about the future that they were not able to assure:

*'But I mean this client group is like that, they do want to be hugged and, you know, be told that everything's going to be OK and for somebody to just be there to talk to and to feel like they're valued.'*

Lily, nurse P2 i: 106

Sometimes it was to facilitate catharsis:

*'...and you sometimes feel like you just want to hug and let her just release it all'*

Angela, nurse P1 i: 60

Sometimes, the small touch of a hand created a connection that was gentle and seemed to suggest that there was a common understanding and mutual appreciation between worker and patient that minimised the need for words. Kelly, a health care assistant, understood this:

*'And then she just like, put her hand on mine and just said, I'm struggling'*

Kelly, HCA P2: 9

Whilst there was recognition of the value of physical closeness there was also a little concern that it might appear unusual or be perceived as unprofessional. Lily rationalised this by talking about the nature of the clients, emphasising that the client group was 'different' to, for example, and people with personality disorder.

*'Yes because, you know, it doesn't really happen, you have to be careful, on other units and stuff like that, like if you're working with a client group of maybe a personality disorder or anything like that, you have to be really careful I think with them sort of physical relationships like hugging your clients and stuff like that. But I think this client group is different in a way.'*

Lily, nurse P2 ii: 108

There were many references to the attachments made between the care workers and the women, some of them purposeful, as in anecdote from Lizzie below. Catherine believed some of them are both unhelpful for the patient experiencing attachment as well as those observing the attachment.

### **10.3.2 Attachment**

*'I suppose I was just in her face all the time, all the time. And I do, instead of doing like long therapeutic sessions, I will be there every day and I will be there for twenty minutes, half an hour every day, twice, three times a day. And I'll just be constantly, right we're going to do it this, we're going to do it, you know. I've got faith in you, we're going to do this, we're going to get better, you know, you're a wonderful, fantastic, lovely person; you deserve a better life than this. So me and you together, we're going to fight this illness. And you can shout at me, you can fall out with me, but we're not, we're not giving in, this time round we're doing it. And that's how I do it and I do that with several of them. And I'll do that constantly and that's how **I sort of hook them, so that they know\***.'*

Lizzie, nurse manager P2 i: 55

This anecdote from Lizzie is an announcement of her determination to fight for the women in a way that is both connective and appreciative. She frequently expressed her need to help the women see their potential and she always saw the good in everybody. This anecdote builds up a crescendo to reach the climax with the words ...'*we're not giving in; this time round we're doing it*'. She sees herself and the patient as 'we', it is a partnership, but also a togetherness, an attachment which is notable by the 'punctum'\*...'*I sort of hook them, so they know*'.

Many of the women attending SEDUs have done so off and on for much of their adult life and this was the case for some of the participants in this study (e.g. Rachel, Libby, Donna). During this time some close attachments were made with the staff and these were clearly evident to other patients, for example Catherine, who was quite intolerant of the impact this had on her and other people's care. On this occasion (below) Catherine was tired of hearing the altercations between another patient and the staff on duty because she had refused to be weighed by anybody except **her** worker. Both Catherine and Gina suggested that they believed that there was jealousy shown when some women got more attention from particular workers. This level of attachment is not simply linear between woman and worker but impacted on other patients:

*Cos obviously some girls have been here quite a while and have got close to the workers and sometimes they find it a real struggle when that worker is not there- when they need to be weighed by somebody else- or they are just not here- or that worker is paying more attention to somebody else and not them- that has an impact, because it's all inter-related and we can see what is going on- that definitely has an impact.*

Catherine, patient P1 ii: 114

Unfortunately, this was not always perceived as helpful to recovery as it added to their difficulties:

*'I have done it- the problem wasn't weight-wise; food-wise or illness-wise it was emotional attachment-wise.'*

Lucy, patient P1 i: 92

Lizzie spoke about the need to create an attachment in order to 'hook' the women, thus engaging them so that they will trust her:

*'...it sounds horrible doesn't it? It sounds like I fish for them and reel them in. But it is, it's about making the relationship between you and them something important, so that actually you can help them move on because you've got that hook into them. '*

Lizzie, nurse manager P2 ii: 7

*So I hook them, so I get them, I get them to trust me.*

Lizzie, nurse manager P2 1: 39

*'And that's how I do it and I do that with several of them. And I'll do that constantly and that's how I sort of hook them, so that they know.'*

Lizzie, nurse manager P2 i: 55

Lizzie conveys a sense that she truly cares and sees beyond the physical manifestations of the women. It is as though she sees right through to their inner selves, their self-hood and is therefore both physically and existentially with them. It is as though Lizzie is herself, the embodiment of compassion. She uses herself, not just her therapeutic skills, but her physical self.

On the other hand, Hannah, a person-centred nurse therapist in day-care, felt quite uncomfortable about the women's attempts to form attachments with her on a personal, rather than professional level:

*'But they're almost quite nosy sometimes; they want to know every detail of your life. I don't know what that's about, perhaps it's about taking the focus and attention off them, again perhaps it's about sussing you out, wanting to know who you are. So yes, I think it's important to have that sort of relationship with them, because we've got long term relationships with them, but I have seen many professionals over the years getting sucked into that, it can be quite seductive.'*

Hannah, nurse therapist P1 i: 26

Hannah had spoken to me about how she maintained a professional self when at work. She chose not to disclose personal details about herself or her life and she would keep the number of personal items she brought into work with her to a minimum. She thought that it was important to be considered and controlled in her interactions at work. Gina disagreed and saw her connections with the women as much more intuitive:

*'I think that you just get a sense of when you are relating really well with somebody and I do think that it is all about that. It's hard to describe- it's a kind of chemistry- you sort of 'warm' to somebody. You are always aware that it is a personal relationship- it's not a friendship but within that it feels positive- it's a good connection- I don't know if it is something about that that helps the process.'*

Gail, dietician P1 ii: 20

### **10.3.3 Approval**

Approval was also wrapped up with the need for support and validation. For example, Olivia said:

*'Because it's so bloody hard and it's like, I just need somebody to, I don't know, because I have this desperate need to be approved of and I can't do it because I can't do it myself. I don't approve of myself, therefore nobody is going to. That's the way life works, if you don't help yourself, then you project lack of love and therefore that's what you get in return isn't it?'*

Olivia, patient P2 iv: 59

Here Olivia associates approval with collaboration, partnership and support in the first two lines. This is associated with a subjective need and dependency upon them. In a previous interview with Olivia, she acknowledged that she had '*a desperate, desperate need for approval and recognition and to be good enough*' (Olivia patient P2 iii: 111) that caused her to need praise and encouragement at every stage.

Subsequently, she uses the word 'approval' to suggest that she does not like herself or her behaviour; but also, there is a hint that she feels she is unlikeable and therefore this is projected outward to others, also disabling them from offering 'approval'. Olivia seems to believe that her own dislike or disapproval of herself is reciprocated. Further on (line 4), she progresses this significantly to '*love*' rather than 'approve'.

Lucy, on the other hand, felt able to comply with aspects of the treatment programme, simply to gain approval from particular workers. She associated approval with 'pride', she wanted the person who she had personally identified as her 'mother figure' to be proud of her, as a mother would be proud of her daughter:

*'I would think that was going to eat it cos she would be so proud of me. I was doing it for **her** – for this particular person- or knowing that if I get through this then she will come in at the end of the week and be really proud of me- so it wasn't for myself.'*

Lucy, patient P1 i: 21

Lucy attributed her success to another person, Eva who was a health care assistant on the ward. Despite Eva being a care worker Lucy referred to her as a '*good friend*'. She had explained to me that she no longer searched for '*mother figures*', but established a '*friendship*' with a healthcare assistant. In reality, this was still a professionalised friendship as it occurred only in the clinical setting. Lucy told me that Eva was a similar age and spurred her on with encouragement and by doing normal things together like watching films, painting nails and reading glossy magazines during the times that she was being closely supervised. Eva had had no formal training, she did what came naturally whilst in the company of another person who needed her; she befriended her and helped her to feel 'worthy' and thus 'brought her out':

*'I no longer look for that anymore to prove that I am worthy of being a daughter. She has proved it to me- and the whole friendship thing- being a good friend- Eva has proved that to me- she was there for me constantly and proved that- she brought me out- she saw it before I did.'*

Lucy, patient P1: 90

The examples of 'approval' often coincided with examples of physical closeness, as would be case in a family unit were approval is granted, as opposed to professional approval relationships.

#### **10.4. Conclusion**

'Relationality' featured heavily within the analysis of the findings and Merleau-Ponty's use of the term '*relationality*' to mean the 'between space' has been useful in the consideration of the data (Merleau-Ponty, 1962). Both care workers and patients referred to elements of the connectedness and the disconnectedness, the battle as well as the attachment; the conflict as well as the closeness. The two main themes of '*conflicting perspectives*' and '*maternalism*' are evidence of the diversity of experience of relationality.

The next chapter is related to 'temporality' within the participants' experience of the relationship.

## Chapter 11: GUIDED EXISTENTIAL REFLECTION: TEMPORAL REFLECTION (LIVED TIME)

### 11.1. Introduction

In the previous chapter I discussed the findings that were viewed within Merleau-Ponty's theme of 'Relationality' (Merleau-Ponty, 1962). In this chapter I consider the findings that related to temporality. By temporal reflection, Merleau-Ponty means subjective time, including past events that have impacted on present experiences, as well as hopes for the future (Merleau-Ponty, 1962). Hence the dimensions of time, the past, present and future, will have relevance when we attempt to consider the here and now of the relationship.

Relationships can be momentary experiences and yet the impact of that connection can be lasting. The time spent with a therapist can feel precious or threatening if it means confronting uncomfortable issues. There are only two subthemes within the themes of temporality; *'the gift of time'* and *'availability'*.

### 11.2. The gift of time

*'Yeah- for people to feel valuable... I think the most important thing is if they can give you the time'*

Heather, patient P1 iii: 38

In the current climate where 'time is money' and money is tight, it was clear that both the women and the workers valued time together. Here, the emphasis is on how one-to-one time is seen as precious time, rather than simple availability. This was to the extent that workers were judged in terms of how much time they had for the women and how prepared they were to stop doing something else in order to choose to be with them. The patients requiring more time were either the newer, more acutely ill patients, or the ones who were struggling.

Both Heather and Catherine viewed time with workers as precious. Heather was acutely aware of *'taking up their [the workers'] valuable time'* and Catherine found that the pressure to use therapy time was anxiety provoking for her:

*'You have to get a lot into the hour and you feel very on-edge and bit under pressure cos you know about the time and you're watching the clock and thinking oohh look at the time, look at the time I'm going over your time and get a bit falling over yourself- which isn't good, at all. When you are not in the right frame of mind to be rushed and you don't want to be rushed.'*

Catherine, patient P1 i: 29

Kelly was cognisant of the timing of interactions, she knew that initial encounters required a slow incremental building of understanding gained through *getting to know* each other ; she realised that they needed to know her as well:

*'The patients seem to respond more if you take the time to get to know them, instead of just going, my name's Kelly, blar, blar blar, do this, do that. It doesn't seem to work at all in my experience. So just taking the time to get to know them, let them get to know you as well, professionally speaking and then taking it from there, building it up block by block.'*

Kelly, HCA P2 i: 5

Heather spoke to me about how important it was to her own self-esteem that workers made time to be with her; she measured her own value in terms of how much time the day care services workers allowed her:

*'Yeah, but they have lots of other people to sort out as well and I think that's going back to what happened- people didn't have the time for me – when this trauma happened- and I think that they still haven't got the time for me.'*

Heather, patient P1 iii: 30

Heather, who was a participant in both phases of the study found some comfort in the presence of the anorexia which she said was *'always there for [her]'*. Heather's experience was in the minority; her anorexia is almost always seen as a destructive force, even parasitic. Kelly and Lizzie, on the other hand, felt that time is freely available if the person asks for it, either directly, or because they are distressed:

*'But if someone's particularly struggling, then we'll offer all the time in the world for them because we know how distressing it is for them.'*

Kelly, HCA P2 i: 111

*'And the other thing I always do is if they ask for me, I go. I very, very rarely say that I can't, I won't be there. If somebody comes to the door, if I had to deal with something I'll say, I'll be there in ten minutes and I will be there in ten minutes, I don't fob them off.'*

Lizzie, nurse manager P2 ii: 107

How the time was spent with the women was also important:

*'The use of the time, as well as the length, is seen as important to establishing trust.'*

Kelly, HCA P2 i: 23

Libby, in the in-patient service, liked workers to go to her, in her room and make time to be with her there. It was not about the 'qualifications' of the person, it was the quality of the time that was important:

*'I think if someone made the time, not to just come in and say, are you OK, yes and then go. If at some point during the day, not necessarily a qualified, but one of the nursing assistants or something came in.'*

Libby, patient P2 ii: 53

Moreover, once a good relationship was established, it was perceived by Libby that the workers were more generous with their time:

*'...people who you have a good relationship with are sort of more generous with their time.'*

Libby, patient P2 ii: 19

There were mixed views about how the psychiatrists connected with the women. As in most services, the doctors spent less time with the patients than the other workers, such as the nurses, for example. Catherine felt it was very difficult, because of the limited time that she

was with the psychiatrist (out-patient) to provide a personal account of her needs in order to assist the psychiatrist to understand her:

*'The psychiatrists are the harshest of people to try to get to understand you. They don't- they never seem as though they have got enough time for you at all.'*

Catherine, patient P1 i: 37

*'Cos you think that they're not listening properly and they are trying to rush you through cos time is ticking on and you don't feel like you're connecting properly at all.'*

Catherine, participant P1 i 129

In the following quote, Nicky refers to how during therapy she created 'space', space that enabled Lucy to 'be'. Whilst Nicky spoke very little, this enabled Lucy time (space):

*'I guess that she's just had that space to be...but whilst I did just give her that space to be, probably for fifty minutes of the hour- there were probably 5 mins when I spoke'*

Nicky, CBT therapist i: 9

Whereas Lily looked to the future and attempted the use the relationship to get to know the women well enough to know what they wanted from life:

*'Well that's when you have to get to know them individually and then you say, well you can't let yourself stay ill like this forever because you won't be able to do x, y and z ... So you get to know personally what their goals are for the future, aside from anorexia and then you can work with that. So we do these timeline things sometimes. Where are you now, where do you see yourself in five years, where do you see yourself in ten years? And we don't allow the eating disorder to be part of that plan'*

Lily, nurse P2 i: 213.

### **11.2.1 Availability**

Many of the women felt that there were people who they could connect with, but they were not always there when they needed them. This was most noticeable in the in-patient service where a shift pattern existed.

This was an important issue for Heather as she had engaged in a professional relationship with a community nurse which came to an abrupt end because it was identified as '*an unhealthy relationship*'. Heather trusted this worker implicitly, she felt that she was the first person to ever understand her and have time for her. When the worker spoke about Heather to her supervisor, however, she was advised to terminate their relationship and a replacement worker was put in place immediately, without any notice or opportunity for closure. Heather felt that she had been abandoned, her trust flouted and that she was being punished for her disclosures and openness. This significantly affected her current experiences of relationships with her care workers. She felt that nobody had enough time for her and that the workers made time for other patients in preference to her:

*'And I am not important enough for people to want to spend the time with me- even though they do- I don't like... I feel guilty that I am taking up their time.'*

Heather, patient P1 iii: 30

Connections made with workers were not sustainable overtime and both Olivia and Lucy recognised this.

Olivia found it difficult when staff were not available when she was struggling although she admitted that her need for both support and recognition changed from hour to hour:

*'Yes, I'm going to because I need the time when I'm feeling, I don't feel as strong as I was an hour or two ago. I feel very vulnerable right now and I need the recognition<sup>68</sup>, I need the support.'*

Olivia, patient P1 iv: 57

Care workers were always available at mealtimes<sup>69</sup> and often sat beside the women as they were eating. Following meals, the women with the lowest BMIs sat in the lounge for an hour with a worker who supervised them for 60 minutes; so some care workers were with the patients virtually all day. Ironically, this time was not appreciated as it was considered to be surveillance rather than therapeutic time. When Olivia's weight began to rise and she no longer needed to be supervised after meals, she felt isolated and as though she was being deprived of the workers' time as a result of complying with her care plan. She was envious of the time that the nurses spent with the women who were struggling and she felt abandoned; it was as though she was being punished because she was recovering. This is further reinforced by Kelly who reported that she has '*all the time in the world*' for those who are distressed. Olivia felt that, although she needed more of the worker's time to sustain her recovery, it was not being recognised which is evident by her words, above: '*I need the recognition, I need the support*'.

### **11.3. Conclusion**

Most references to temporal reflection were made with regard to current experience, although the existential view is that experience is made up of past, present and future. It is clear that time is seen as precious commodity, both in terms of the therapeutic relationship, but also in the value that the individual places on themselves; as though the amount of time awarded them is proportionate to their own personal value. The two sub-themes 'the gift of time' and 'availability' captured the essence of the participants' experience of temporality within the context of the therapeutic relationship.

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<sup>68</sup> By *recognition*, Olivia was referring to the recognition of her struggle, as opposed to personal recognition.

The next chapter considers '*authenticity*' as a discreet theme within the findings. The '*authenticity*' of the relationship was of such importance that it is worthy of separate consideration. There are, inevitably, overlaps with other themes within the findings.

## Chapter 12: AUTHENTICITY

### 12.1. Introduction

The previous four chapters focussed on the four areas which are known as Merleau-Ponty's existential framework (Merleau-Ponty, 1962). Reference to the genuineness of the relationship between the workers and the women, the honesty, and the trust placed upon individuals aligned itself to Heidegger's concept of 'authenticity'. Due to the large body of data that made reference to this concept special attention has been paid to these issues in a separate theme, rather than including it with 'relationality'.

Within this theme of 'authenticity', three sub-themes emerged; the 'power and uniqueness of the individuals', 'empathy for the worker' and 'trust'. Whilst 'authenticity' was identified as a sub-theme within the data set from phase one of the study (see chapter 6 ); the combination of findings from phase one and two enabled a more in-depth exploration of this concept. It was clear that the impact of the uniqueness of the individual care worker in creating a relationship was both meaningful and therapeutic.

#### 12.1.1 *The power and uniqueness of the individual*

The theme 'the power of hope and optimism' was identified in phase one. However, when viewing the whole data set it was clear that this could not be separated from the individual who instils that hope and optimism.

The following anecdote, from Lucy, describes the feeling of safety instilled by one nurse in particular:

*I wanted to be wrapped up in a blanket in a little cocoon and be looked after by this particular nurse and just the safety- it was just safety- pure safety- not having to live up anything for her. I would eat and would talk and I would try to get through therapy and stuff cos I know she would be proud of me - but there was no sort of worry about any conflict with her- no worry about whether she was going to go- because at the time I thought that- well this is it- I am going to stay*

*with her forever- I didn't contemplate that fact that I would be discharged one day and that **there were boundaries**\**.

Lucy, patient P1: 27

Lucy describes a warm, safe place, sheltered from others where she was prepared to comply with interventions that whilst difficult, enabled her to gain the recognition of a certain nurse. Now, recovered, she acknowledges the irrational nature of her perspective and the punctum\*, that there were professional boundaries and that she would be discharged one day; it was a parallel existence to reality.

The power of and uniqueness of the individual is manifested by their hope and optimism, as well as other characteristics that I will not repeat from phase one data (see chapter 6.)

*'Yes, there used to be someone who worked here the last time I was here, who used to be able to pull me out, he was absolutely brilliant.'*

Olivia, patient P2 v: 60

Olivia, in phase two, who spoke earlier about how bad things were for her, primarily when she was 'anorexic Olivia', found that the right approach from the right person who inspired her could facilitate a personal shift out of the control of the anorexia. The phrase '*pull me out*' refers to her externalisation of the disorder (see p.235), as though she is being pulled out from the clutches of her anorexic self. This is also alluded to by Debbie (below), who does not see herself as a '*normal person*'. However, the staff contact and availability is important to her and connected to her belief that they are caring. We know that the worker is not physically '*always there*', because Debbie spoke to me from the in-patient service where the workers change two or three times a day, but the perception is of an active response and a continued presence, which is important to her:

*'She's really funny, just open, just treats me like a normal person. She chats to me about anything; she comes to my room and reassures me that everything's going to be alright. She tries not to make a big emphasis on the food and all around as normal everyday life, she's*

*really caring and sensitive to anything that I need. She's just always there. '*

Debbie, patient P2 i: 100

As mentioned previously, time and availability is important. However, Debbie was a patient on the in-patient service, a 24 hour/7 day a week service. The nurses work about forty hours a week. Clearly, '*she*' (Lizzie) is not '*always there*', but it must feel that way to Debbie. It seemed as though the women saw the workers who helped them most as being the most available.

Different workers were seen as special in different ways. There are many references to this, for example, Des, the chef, was praised by Christine for his humour and the way he transformed the scariest room in the house (the dining room) into a place of fun. Lynne said of Nicky: '*she just makes me feel great*' (Lynne, patient P1: 62). Gina was seen as a '*life-raft*' by Catherine, for pulling her to safety. According to Kelly, '*you will never hear one bad word spoken about him [Tom]*', the psychiatrist, who was referred to as '*magical*' and even as a '*wizard*' for his instant connection with the patients:

*'I don't know exactly what it is that he does to make them think so straight away, not straight away but within a few seconds of meeting him, they trust him 101%.'*

Kelly, HCA, P2 ii: 33

*'Dr Tom, because he knows me so well, I do feel like almost that sometimes he knows what I'm going to say to a question before I've even said it. '*

Rachel, patient P2 i: 57

Anna marvelled at the way a worker could de-escalate her fears in such a discreet way that she barely realised it was happening:

*'She just has a way that, it's like if you're standing on top of a building about to jump and she'll sort of talk you down sort of thing, without you realising she's done it. So before you know it, you're sat*

*down having a cup of tea and a chat, rather than standing at the top of the building about to jump'.*

Anna, patient P2 ii: 57

Other workers were seen as special, or 'lovely', in that the women felt unable to disagree with them:

*'Yes because she's such a lovely person, you just can't say, you can't dig your heels in with her, you've got to do it because she's just, you know, she's just so nice and really very understanding and diplomatic. Yes, she is, she's just lovely'*

Heather, patient P1: ii: 96

Anna found it difficult to be in the presence of a worker who was so influential and would avoid being in her company as she knew that she would comply with the care plan if she were there:

*'Yes and I used to hate it if she was there because I knew I'd be more likely to finish it [the meal] but I didn't want to'.*

Anna, patient P2 ii: 153

Lucy was excited when she said, of one particular worker:

*'You will have seen her buzzing about probably. [laughing] she's fantastic- she's absolutely fantastic.'*

Lucy, patient P1 ii: 62

Christine attributed the 'specialness' (of Dr Tom) to how knowledgeable he was about the condition, rather than her, as a patient:

*'He's got such a deep, deep understanding of the condition'.*

Christine, patient P2 ii: 46

An unintended consequence of this was that as some of the workers were considered more special than others, it could lead to jealousy amongst the women:

*Gina: '...there has been a little bit of jealousy in the past.*

*Karen: between group members?*

*Gina: Yes, because – not that it often occurs- but on the odd occasion that I have a one-to-one and then they are in the group they kind of see me as theirs- and other group members might think – ‘well if I can’t have her as my therapist, why can you have her as yours?’*

Gina, nurse therapist P1 ii: 102

The workers demonstrated an awareness of the value of the team, knowing that they, as individuals, cannot always be there and the strength was often in the team. Tom says:

*'It's not about one person, somebody has to stand at the top of it and I suppose that I do and Lizzie stands at the top of it. But, you know, what happens, and this is very close to me, I mean we're close emotionally, what happens is, when you have days when you're not magical, which is like 30 days out of 31 actually in reality'.*

Tom, psychiatrist P2 i: 139

I was surprised that he used the words '*close emotionally*', rather than more professionalised terminology such as '*collaborative*' or '*cohesive*'. For me this reflected the intuitive nature of the work and of the team working where the staff seemed to be in tune with each other and where it was not unusual for emotions to be expressed verbally or physically.

Moreover, the 'team' was not just seen as the clinical team. Individuality was valued and the 'team' was regarded as workers and the women, pulling together:

*'And everybody is treated as an individual, there's no sort of hierarchy of patients or staff. It doesn't matter whether you're Dr Tom or whether, I don't know who would be considered at the other end, everybody is valued as being part of the team and that's what makes it such a strong unit.'*

Christine, patient P2 iii: 51

None of the workers spoke of patients with whom they had special connections; although they did speak of patients who they felt had recovered well because of a good connection/relationship between them.

### **12.1.2 Empathy for the worker**

Despite the highly positive statements made about the workers, many of the women acknowledged how difficult their job was. Some of the difficulties were attributed to the various tasks they had to complete, but also as a direct result of the women's behaviour towards them:

*'Yeah, I do and I think that that's one of the reasons why I sort of changed my attitude and I do need to get weighed because I can't see her stressed about people who are ill and I just don't think that it's worth it, it's like, I don't like seeing her stressed or worried about- anxious about different things- and I don't want to be a part of that.'*

Donna, patient P1 i: 145

It is interesting that Donna agreed to do something that causes her an immense amount of anxiety (being weighed) because she did not want to feel responsible for a care worker's stress and felt some empathy towards her.

Anna struggled to see herself positively and wondered why others cared about her:

*'It's just hard to accept help'*

Anna, patient P2 ii: 51

But she also thought that what she did, as well as who she was, must have been unpleasant for the workers:

*'Well I can't imagine anybody enjoying sitting in somebody else's bathroom where they've got snot and tears and red eyes and hiccupping and unable to breathe, I can't imagine anybody would find that enjoyable.'*

Anna, patient P2 i: 118

Despite this, she was able to express herself to the workers to assist them to take the approach that worked best for her:

*'I used to really struggle with breakfasts, and there was one nurse, come on get on with this, stop being silly, you've got to do it, we've been here two hours now, stop being so stupid. And then I actually said to her, I'm really sorry, if you're confrontational with me it makes it worse. So she came back ten minutes later and just completely changed her attitude and I finished it.'*

Anna, patient P2 ii: 109

Many of the women acknowledged a degree of insight into how challenging they could be to care for and the women's active refusal of the treatment regimes. Christine was almost apologetic, knowing that the workers have a 'difficult' time:

*'And until you realise that actually it's got to happen and they're just applying the necessary rules and regulations, and doing it because they want you to get better, it can be quite difficult. Whether it's in your own head or whether you actively refuse or, you know, be difficult for the staff'.*

Christine, patient P2 iii: 60

Hannah had been a ward nurse previously and recounted episodes that brought nurses to tears. She herself had felt abused and required to buffer a great deal of 'vicious' hostility whilst remaining professional. Hannah felt that, as professionals, it was their responsibility to reflect this back to the women, rather than simply 'soak it all up'. Many workers do not respond with the usual intolerance that they would display outside of work because of their professionalism, because they have a great deal of empathy for the women and understand that they are struggling. Nonetheless, Hannah (below) felt that it might be more helpful to respond with greater honesty and transparency to promote a sense of responsibility for their actions:

*'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 rooms- with the nurse in tears- and say look – what's going on. I actually think there was something in that because 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 therapist P1 ii: 30

### **12.1.3 Trust**

Trust is well accepted as an important component in relationships (1952/1988, Travelbee, 1971). I have included this concept with 'authenticity', due to how participants emphasised the importance of trust in terms of its place in the perception of a person's authenticity. That is, the women trusted the workers; not because they trusted their judgement, their clinical skills, or their knowledge in terms of treatment and care. They trusted **them**, as individuals, they had faith in them, they believed in them and they believed that their care was authentic and compassionate.

Rachel viewed trust in terms of individuality:

*'Yes, I did feel then that she's, and she is now someone that I feel like I can trust because she cares about me as an individual, and I think that's kind of, yes I think that's like what I mean with that'.*

Rachel, patient P2 i: 32

Gina understood that trust is an interpersonal, two-way process and that she too needed to trust her patients:

*'Trust, trust, trust. My belief in them'*

Gina, nurse therapist P1 i: 77

Trust is viewed by Tom as the '*key*'. He discussed the need for truth and honesty on the part of the workers, thus creating a level of transparency that, in turn, enabled the women to trust them. He painted a grim picture of the level of discomfort that treatment brings, but in doing so how it created an acknowledgement that the staff are empathic to their suffering. Tom as Lizzie who reported '*we're going to do this, we're going to get better*' (Lizzie, nurse P2 i: 55),

used the term 'we' to acknowledge the shared journey to recovery. In turn, this led the women to have faith in the staff:

*'Yes, which going back to where we originally started with this, gives them faith. They trust, and trust is the key to that scariest thing you're ever going to do, plus the fact I don't paint it in any other way than it is. It's going to be terrible, I will say to them, I hope this is the hardest thing you ever have to do in your life, because it is appallingly difficult. But we can do it, you know, and also you've got to do it, you don't have any choice.'*

Tom, psychiatrist P2 i: 73

Trusting somebody, a worker, for Donna, was also seen as 'scary' because she was aware that it could mean surrendering her anorexia and making the transition from anorexia to recovery.

Donna had suffered since she was a teenager and now, in her twenties, this would be a significant loss, creating the need to re-invent herself;

*'I do. That's what feels really weird, because it feels really frightening, scary, because I do really trust her- and that scares me. Because I think well, soon, or you know, at a certain stage I am going to go on and get on with my life.'*

Donna, patient P1 i: 42

This modelling of authentic relating is a powerful tool in the battle against the anorexic self that creates trustworthiness and the capacity for recovery, or, as Donna reported:

*'I think that the art of recovery is that you have to trust people'.*

Donna, patient P1 i: 47

It was strange for me to hear people saying that the concept of trust was *scary*. My most usual connotation of the word trust would be that of security and connection. Here, trust was a revealing concept that engendered agreement and acceptance of people and therapies outside of the comfort zone of the women with anorexia. Trusting a worker meant agreeing to engage in therapy that would cause weight gain and re-align their sense of identity from

'anorexic' to 'recovered anorexic'. Hence this was unfamiliar and frightening territory, which required that they trusted somebody to keep them safe. Christine emphasised the enormity of trusting somebody so implicitly:

*'But such is the man and such is my respect and trust of him, that I didn't like it, I'd be a liar if I said I did, but I knew it was for my own good and I knew it would mean that he would get me back on track, I trusted him implicitly and I don't say that lightly.'*

Christine, patient P2 iii: 60

Another valuable characteristic, thought to be aligned to trust, was 'consistency'. In the following quote, Donna is referring to Sharon, the worker who had been involved in her care since her first admission to day care service. Again, consistency and predictability were aligned to authenticity due to the genuineness of her actions:

*'She [Sharon] is the most consistent person who has been through it all with me and the person that I would trust the most'*

Donna, patient P1 i: 78

It seemed to me that Olivia was also aware of her need to be authentic with the workers. She speaks of trusting them. She was aware that the 'anorexic Olivia' was not the authentic Olivia, the *real* Olivia needed to engage with the workers without her alter ego, in a trusting way, even though this level of transparency was difficult for her, she knew it was a pre-requisite for her recovery:

*'You have to trust them, that's the thing, that you have to trust that they're right and not trust them by trial and error and like sort of engage in anorexic behaviours and then say, oh right, yes OK, you were right. But actually trust them from day one because they do know what they're doing, despite it being very difficult'*

Olivia, patient P2 i: 59

## 12.2. Conclusion

This chapter, outlining elements of authenticity within the experience of the therapeutic relationship has '*brought to the light*' or '*illuminated*' a number of excerpts from the interviews that demonstrate how powerful some of the relationships are; what a unique contribution the workers make and the shared understanding of suffering (Anderson, 1993; Smythe *et al*, 2008; van Manen, 1997). Although the word '*authenticity*' was mentioned only a few times, the elements that make up an authentic relationship, such as power and uniqueness of the individual, empathy for the worker and trust, are clearly evident within the data.

In the following chapter I discuss the findings from chapters 8-12 and present my interpretation of them, drawing what is known already, what I have found out and I draw on the data to provide new insights into the lived experience of the therapeutic relationship.

## Chapter 13: **THEORISING THE FINDINGS: DISCUSSION**

In the previous five chapters (chapter 8-12) I presented five broad themes which described the lived experience of the therapeutic relationship between women with anorexia and their care workers.

In part one of this chapter I present an interpretation and discussion of the accounts of the women and their care workers within the context of the two eating disorder services. Part two provides a number of recommendations for practice, policy and research which have been made on the basis of what has been learnt and the unique contribution that this study makes to our current knowledge. Lastly, I have discussed the limitations of the study as well as the strengths.

### **13.1. Part one:**

#### **13.1.1 Introduction**

The aim of this study was to explore the experience of the therapeutic relationship between women with anorexia receiving care and treatment in specialist eating disorder services (SEDUs) and their care workers; this has been achieved using an interpretive phenomenological methodology guided by the work of van Manen (1990).

Phenomenological research seeks to illuminate the lived experience (Anderson, 1993; Smythe *et al*, 2008; van Manen, 1997), The study has 'illuminated' the experience of both the care workers and patients enabling a better understand the connection that occurs between these individuals in the reach for recovery within specialist eating disorder units. Within the findings, I have emphasised the disabling and pervasive nature of the illness (anorexia) on the individual's sense of self and created insight into the uniqueness of the experience for both

patient and care worker in attempting to establish a relationship which is therapeutic in this context<sup>70</sup>.

The initial literature review identified that there was a gap in knowledge around the therapeutic relationship with adults with an eating disorder; that the available research and interventions had a primary focus on the care of adolescents and that it is aligned to counselling or psychotherapy models.

Van Manen (1990) stresses that all phenomenological human science research studies are explorations of everyday situations and relations but may also be organised to reflect a '*fundamental thematic structure*' (p.101). Consequently, I have discussed the findings through the lens of Merleau-Ponty's existential themes of corporeality, relationality, spatiality, temporality and Heidegger's authenticity.

Van Manen draws on the work of Gadamer to distinguish between two kinds of interpreting, that of '*pointing out*' something and also, that of '*pointing to*' the meaning of something (Gadamer, 1986: 68). In terms of this study, the participants were partners in the interpretation within the interviews which '*pointed out*' their experiences and these have been presented in the previous chapters. Here I consider the emergent themes once more in order to consider these as a '*meaningful whole*' (van Manen, 1990: 90) and to '*point to*' the meaning of these.

First, I return to corporeality, which in phenomenological terms refers to our bodily presence in the world. Preoccupation with the body is a facet of anorexia (Palmer, 2000), hence, existentially, corporeality (the lived body), is undeniably pivotal to the lifeworld of women with anorexia. Here I consider the lived body in terms of its relation to the experience of the therapeutic relationship between the care workers and the patients.

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<sup>70</sup> The context is both the anorexia and the service setting.

## **13.2. Guided existential reflection. Corporeality: Lived body**

There were three subthemes that emerged within the theme '*corporeality*'; these were '*identity*', '*externalisation*' and '*recovery measured in kilos*'. The findings connect with information known already about the TR and the experience of anorexia. Here I consider the interface with what is known already and what has been discovered during the course of this study.

### **13.2.1 Identity**

The most powerful, observable feature of anorexia is the bodily appearance of thinness; it is the deciding factor in the referral to services; it is the most easily recognised by others and it is the most highly valued feature for the anorexic (Granek, 2007). Hence, for care workers within SEDUs, their primary goal is the patient's weight restoration, albeit in the context of additional therapeutic interventions (RCP, 2013; Treasure *et al*, 2007). Therefore, the relationship exists against the backdrop of hyper-vigilance about the bodily existence of those receiving care and the constant physical monitoring conducted by those administering care.

For many of the in-patient participants in this study '*identity*' was a major factor in their relationships with others. '*Identity*' can be defined as that which is '*Used to convey the relatively stable and enduring sense that a person has of himself [or herself]*' (Bullock and Trombley, 1999: 413). Williams and Reid (2012) recognise the importance of '*identity*' in the development and maintenance of anorexia. They refer to adolescence as the time when identity formation takes place and as the most common time for the onset of anorexia; thus the need to establish control and an individual sense of self is hugely important at this time (Williams and Reid, 2012). It is important to note that, although many of the women in this study first experienced their eating disorder in adolescence, the average age of the patients across both phases was 32 years at the time of the interviews.

The *anorexic identity* was all consuming, and, as many of the women had suffered since adolescence, they had not constructed alternative, healthy adult identities. The care workers felt that they had a responsibility to 'model' a *non-anorexic identity* within their interactions. Such openness can be demanding for the care workers who may also be self-conscious about their own bodies, but Cash (2002) sees this as important in addressing body image discomfort and interpersonal reactions to one's body.

The participants (patients and workers) recognised that anorexia is seen as both part of the person and also as identifying the person. If the anorexic identity is eroded by weight-gain then this creates doubt in the person's sense of self, their 'Dasein'. Dasein is a Heideggerian term which translates as 'being there' (Polt, 1999); a concept to refer to our connectedness to our lifeworlds. The service focus on the flesh and the constant battle to re-establish the physical balance could also be a replication of what Susie Orbach (1978) has suggested is a protest against hierarchy. Consequently, both psychological and social factors may be as relevant as the pathologisation of eating disorders, where the clinician becomes part of the problem, not the solution (Orbach, 1978).

Findings from the current study concur with previous literature in terms of how the emaciated body of a person with advanced anorexia creates alarm in care workers and frantic efforts to save the person from starvation, which inevitably forces a connection between care worker and patient because of the perceived vulnerability of the patient (Ramjan, 2004; Vandereycken and van Deth, 1994). Daniel (1998) suggests that there are reciprocal gains for both the health care worker and the vulnerable patient when this happens:

*'Vulnerable individuals seek nursing care and nurses seek those who are vulnerable'. (Daniel, 1998: 191.)*

Vulnerability, in the context of anorexia, tends to be seen in terms of the physical self.

However, it was clear that the women in this study also had a vulnerable self-organisation as

has previously been identified by identified by Atwood and Stolorow (1984). Oppositional behaviour, such as that occurring at mealtimes, was ascribed to the 'battle' with the parasitic condition that had possessed the patient, to the degree that they entered into a further 'battle' with anybody challenging their eating behaviour. The challenges of working with this client group were both accepted and rationalised by the care workers; but externalising the anorexia had both positive and negative consequences. Externalising the anorexia (see below) was offered as a strategy to enable the women to fight the anorexia so that, ultimately, they could relinquish themselves from its control; a finding also identified by Treasure *et al*, (2007). The workers' acceptance of the externalisation process, however, tended to extend to a tolerance of the unpleasant behaviour which was attributed to the fantasy of the anorexic self and therefore not owned by the women.

Further reading on the subject of recovery reveals the importance of 'identity' and re-discovering one's self. Achieving a greater confidence in one's identity is seen as an important part of recovery (Bonney and Stickley, 2008; Larsen, 2007; Repper and Perkins, 2003). Brown and Kandirikirira (2007) write:

*'Re-finding and re-defining one's sense of self was as important to recovery as symptom alleviation'.*

(Brown and Kandirikirira, 2007: 7).

For the women in the study, the *re-defining* of themselves would be a necessary part of recovery and would challenge their '*anorexic mindset*'. This links with Lamoureux and Bottorff's study into the recovery of women with anorexia (rather than their relationship with care workers) who describe their recovery as '*becoming the real me*' (Lamoureux and Bottorff, 2005: 170). Additionally, it is suggested that there are a number of losses and unfamiliar territory associated with recovery from anorexia such as: relinquishing the companionship of the '*anorexic voice*'; the experience of being in control; being unique and the feeling of

predictability that represents both comfort and protection (Serpell *et al*, 1999; Skårderud, 2000; Williams and Reid, 2012).

### **13.2.2 Externalisation**

The findings that illuminate the externalisation<sup>71</sup> of the disorder, where the disorder is seen as separate and having a separate identity to the patient, is not uncommon. It is widely written about in both clinical and therapy texts as well as autobiographical literature and on internet sites (Bowman, 2007; de Rossi, 2010; Fathallah, 2006; Hope *et al*, 2012; Lock *et al*, 2001). The externalisation technique, utilised in the Maudsley Method (family-based approach), was developed with the aim of breaking the cycle of parental guilt and criticism of the young person with anorexia (Lock *et al*, 2001). In this study many patients found this helpful and the workers found it useful to describe the anorexic voice as a separate entity; thus enabling them to create a partnership in the battle against the 'enemy' of the 'evil'<sup>72</sup> anorexic entity that is seen to be destructive.

It was identified that meal times were frequently the trigger for many explosive and emotive outbursts when the women could no longer tolerate the pressure of being persuaded to eat. It is at this time that '*externalisation*', the duality of personal identity, was manifested by previously polite and friendly individuals who became distressed to the point of anguish or hostility, often in the dining room. Malson (1998) describes this in Cartesian<sup>73</sup> terms (referring

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<sup>71</sup> '*Externalising anorexia is a two stage process. The first stage requires being able to 'see' it as separate from you. By giving anorexia a separate identity outside of yourself, it is then possible to engage in the characteristic anti-anorexic/anorexic dialogue in which anorexia can, at long last, be confronted. Without such a separation, anorexia can well become so entwined with yourself that for all intents and purposes, you consider it to be an integral part of your being. Thereby, its voice becomes yours and you become its voice. Anorexia would have the person believe that it is their own voice speaking. This can have tragic consequences*'. (Lobovits *et al*, accessed 24.10.2013)

<sup>72</sup> 'Evil' was the word used by the participants. Arguably, the concept of 'evil', is a theological construct which, in itself, has an externalising function, for instance serving to explain human behaviour which would otherwise be incomprehensible.

<sup>73</sup> Reference to René Descartes- a French philosopher, sometimes call the 'Father of Modern Philosophy.

to *Cartesian dualism*), inferring that the experience is because of the conflict between the mind and the body; the body agreeable, but the mind in opposition.

When the women spoke of the anorexic voice or the anorexic identity it was often with some regret or shame about that persona. Hence, there is obvious utility for the patient as this enables them to separate themselves from the shame and guilt that could lower their self-esteem. The Maudsley method, which is aimed at adolescents, aims to discharge parental guilt and shame. Clearly, working with adults rather than adolescents is different, but nonetheless, the complexities of worker-patient relationships may continue to have some of these features. In the main, the care workers were tolerant of the behaviours attributed to the anorexia, on the pretext that it was the anorexia rather than the individual that was treating them badly, thus creating a permissible setting where oppositional behaviour was attributed to an elusive entity.

It is at the re-feeding stage that conflict between the care worker and the patient is at its highest and the anorexic voice is at its loudest (Fathallah, 2006; Hope *et al*, 2011; Williams and Reid, 2011). The attribution of anorexic behaviours to the disorder creates periods of time when the women are, effectively, possessed by this separate, externalised identity. This in turn causes difficulty for the worker who is attempting to engage with the woman. The genuineness that is stated as a requirement of the therapeutic relationship (Forchuk *et al*, 1998; Rogers *et al*, 1967; Welch, 2005) is difficult to achieve when the worker is uncertain about the identity of the other party in the relationship, that is, the person or the disorder. The anorexic identity is incapable of reciprocity, mutual agreement and respect of the worker and thus stands as an obstacle to mutuality and agreement. The therapeutic utility of externalisation is therefore in question as it creates fragmentation when we are in search of the self, the Dasein. Williams and Reid suggest that the anorexic voice/entity might be '*better regarded as a different position within the self*' (Williams and Reid, 2012: 808).

This duality of personhood resonates with Laing's '*divided self*' (Laing, 1969) and relates to the experience of psychosis. Associations have been made between anorexia and psychosis because of the fixed and unshifting belief system, lack of insight, denial of illness and the effectiveness of anti-psychotic medication (Jensen and Mejlhede, 2000; Powers *et al*, 2005). There may be some similarities between Laing's presentation of the divided self and that of the created '*anorexic self*' in terms of the description of duality of identity. The most significant difference is that the '*false self*' discussed by Laing is invented to provide a veneer behind which the schizophrenic patient can confront the world; whereas the participants of this study recognised the anorexic self as something created to embody the obsession with striving for thinness and maintenance of the anorexia which is largely hidden from the world. The 'false self' (the anorexic self) is the hidden self which shows itself only when under pressure to conform to the care plan, for example when in a treatment or dining environment. Interestingly, the person who seemed to speak the most about their worthlessness was Anna who, untypically, spoke in the first person throughout her interview. She did not attribute her anorexic behaviours to another entity, she took responsibility for them. The resulting sense of worthlessness conveyed in such statements as '*I'm slug slime*' was a profoundly devastating insight into her self-esteem.

Overall, therefore, belief in the '*anorexic self*' serves a dual purpose as it protects both worker and patient. It provided some minimising, or even relinquishing, of the guilt the women felt; and the workers could attribute hostility to a demonic entity rather than people they know are ill. Ultimately, fractures in the relationship are attributed to the '*anorexic self*', thus discharging responsibility for destructive or counter-productive behaviours and increasing tolerance of such hostility by the workers.

Corporeality in space and time is pivotal to the understanding of our 'being' (Heidegger, 1962) and so too is concretisation, which emphasises what is perceived to be real and specific.

Different forms of stress may threaten the integrity of the self and through concretisation the individual can bolster their sense of self by strengthening their experience of being. Atwood and Stolorow (1984) discuss the process of 'concretisation' as a possible way forward for people with a vulnerable self-organisation. For the person with anorexia, Skårderud suggests that this can be described thus:

*... 'immediate connection between physical and psychological realities; the bodily concretised feelings here-and-now... [they] attempt to bolster their sense of self by trying to strengthen the experience of being grounded in their own bodies'.*

(Skårderud, 2007: 244).

Concretisation is about us, our past, our future and our human setting. Moreover, Merleau-Ponty talks of the body-in-this-world as being a collection of bodily experiences rather than merely the flesh (Merleau-Ponty, 1996). When Merleau-Ponty (1962) describes the body subject (*corps sujet*), however, he does so in terms of the access it provides to the world of the individual, rather than the societal context.

### **13.2.3 Recovery measured in kilos**

Given that the primary treatment goal of weight restoration was, at the very least, challenging to the women as an immediate goal of admission, so treatment became a '*cruel to be kind*' act; calling attention to issues of power and conflict in the relationships between the women and the care workers (Melia, 1987). Some of the behaviour of the care workers is informed and underpinned by professional bodies such as the NMC. Nurses have a duty of care (NMC, 2008), so the failure to save a person from an avoidable death could be viewed as misconduct in the eyes of the Nursing and Midwifery Council, in the sense that the nurse has failed to administer life-saving treatment.

There were fewer references to oppositional behaviours within the day care setting, possibly because there is less emphasis on weight restoration, re-feeding and clinical treatment and more emphasis on talking therapies. It seems that increased emphasis on dietary issues results in increased conflict. Kaplan and Garfinkel also found that there was most opposition to the clinical treatments in Canada in 1999. Indeed, Walker and Lloyd (2011) report a lack of empathy and understanding by friends and healthcare staff; they tire of the emotional burden of caring for somebody who is so oppositional and some view recovery as simply weight-gain.

The physical frailty of the women in this study serves to emphasise their vulnerability and the potential for what McAllister (2004) suggests is the over-use of power with passive patients. When the women spoke about being forced to eat foods that they would never chose to eat quantities that felt intolerable to them, they often looked shaken by the prospect. But their defiant objection was far from frail, the driving force for their emphatic resistance was a terrifying fear of the one thing that would allow them to go home, weight-gain, hence the theme '*recovery measured in kilos*'. Additionally, unlike many frail and vulnerable patients they remained assertive and articulate, providing rationalised arguments to resist encouragement to eat, however irrational they may seem to the care workers. Touyz and Carney (2010) discuss this in the context of patients with anorexia who are being treated compulsorily, suggesting that coercion occurs to persuade the patients to accept treatment.

Ultimately, in eating disorder services, the anorexic body is a vehicle to attain care and '*love*' (Lucy's word). For such women the body is the agent, in the sense that it makes it necessary for health care professionals to engage. Also, conversely, when the bodily manifestations of the disorder become less apparent, connections with care workers become attenuated as the workers divert their attentions to the seemingly more needy. Less time is given (supervision is reduced) and this was perceived by Olivia and Heather, for example, as lack of care worker understanding of their suffering. In terms of the TR, the connections made between the

women and the workers at the re-feeding stage revolved around the tasks and goals of the treatment plan and align with Bordin's model (Bordin, 1979/ 1994). Whilst being central to the alliance, both the goal and the task are aligned with the clinical and re-feeding aspects of the care plan.

### **13.3. Guided existential reflection. Spatial reflection (lived space).**

Spatiality, '*the fundamental relations between the body and space*' (Merleau-Ponty, 1962: 117), refers here to a human science consideration of the lifeworld and the experience of '*being-in-the-world*' (Polt, 1999). The space in which the participants existed and in which therapeutic relationship occurred is seen here in terms of the *therapeutic landscape* and its facilitation (or not) of the relationship. The impact of architectural issues, like the lack of *hiding places* as well as the homeliness of the services, contributed to the therapeutic landscape. Additionally, *rules and regulations* that were specific to the services in the study added a further dimension to the concept of spatiality that occurs around us and between us.

#### **13.3.1 Therapeutic landscape**

Proximity, social ease and opportunity for interaction affect the establishment and maintenance of relationship and yet, whilst recognising the impact that Goffman's '*Asylums*' had in the 1960s and 70s, the effect of the environment is rarely mentioned in contemporary studies into the therapeutic relationship (Goffman, 1961, Thomas *et al*, 2002). Authors such as Spandler and Parr have emphasised the way in which different types of social space may support or impede patient agency and wellbeing (Parr, 2008; Spandler, 2009). Gesler says that places of healing can be known as therapeutic landscapes and described them as:

*'...physical and built environments, social conditions and human perceptions combine to produce an atmosphere which is conducive to healing'*.  
(Gesler, 1996: 96)

Rolph (1976) talks of the therapeutic landscape and refers to '*insiderness*' and '*outsiderness*', asserting that if a person feels '*inside*' a place then he feels that he belongs and feels safe, enclosed and at ease rather than stressed. Both services in the current study provided approaches considered facilitative of the positive therapeutic milieu recommended in the eating disorder literature (Garner and Garfinkel, 1997; Geller and Luby, 1997; Duker and Slade, 2003). The therapeutic milieu is dependent on the nurse's ability to counter negative, potentially destructive patient interactions by providing a transparent process for implementing treatment interventions (Snell *et al*, 2011).

In this study, there were many references to the homeliness and comfort of both the day care and the in-patient services and this seemed to be important for easing tension and reducing awareness of the clinical nature of the environment. There was some shared investment in the appearance of the premises and thus a sense of shared experience. Albert Schütz<sup>74</sup> (1967) described this in terms of lived corporeality, in that bodies share the same space. In terms of spatiality, it is the existence of the bodies within the space that creates the simultaneous growth of the individuals within it:

*'I immediately perceive another man only when he shares a sector of the lifeworld's space and of world time in common with me. Only under those conditions does the Other appear to me in his live corporeality: his body is for me a perceivable and explicable field of expression which makes his conscious life accessible to me. It is possible only then for my stream of consciousness and his to flow in true simultaneity: he and I grow older together.'* (Schütz 1974: 62)

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<sup>74</sup> Alfred Schütz (1899 – 1959) was an Austrian social scientist who attempted to relate the thought of Edmund Husserl to the social world and the social sciences thus bridging sociological and phenomenological traditions to form a social phenomenology.

In the UK, eating disorder service settings are intentionally homely and care workers wear their own clothes. The dining room is most commonly seen as the most stressful room, which contains the most emotional interactions and this has been recognised in other studies (Long *et al*, 2012). Although descriptions of the dining room were cloaked in negative connotations there were other spaces that were seen as safe, such as the bedrooms and the small interview rooms where ring-fenced time between worker and patient occurred. Both services had very few '*hiding places*' and the day service's communal areas, including the kitchen and dining room, were all open plan.

Stickley and Freshwater (2009) also refer to the space that occurs between people, the '*interpersonal space*'. They talk about the conceptions of space thus:

*'We believe, however, that conceptions of space, while seemingly nebulous and invisible, are vital to therapeutic working. Without an appreciation not only of the need for space but also of the qualities of space, we have the potential to be iatrogenic in our care as opposed to facilitative and enabling.'*

(Stickley and Freshwater, 2009: 28.)

The importance of providing a safe and nurturing environment in which the patients thrive and recover was mentioned often by both care workers and patients, but the dining room and the clinic (where weighing occurred) were places of fear and dread because of their association with eating and weight.

It is also possible that Vandereycken and Devidt's description of '*peer contagion*' occurs in the dining room, where the emotions expressed by one person will become the emotional environment of another (Vandereycken and Devidt, 2010). Attending a dining room en masse, at a specified time, has many similarities with institutions such as schools, asylums and prisons, possibly due to the '*rules and regulations*' ascribed to them. Furthermore, this collective eating brings these key moments out into the open where their anorexic selves are rendered public.

### **13.3.2 Rules and regulations**

In this study, rules and regulations tended to create a number of responses; some rejection and defiance, some a sense of predictability, discipline, control and security. There were very clear timings for activities, especially meal and snack times, but also therapy sessions and time allowed for walks or cigarette breaks. Many women with anorexia have their own rules and regulations, or '*controls*' that they set for themselves and are mechanisms of self-control (Palmer, 2000: 7). If they step outside of their rule-set it is anxiety-provoking and unsafe, as identified through the fear expressed during many of the interviews in this study. This fear then creates a denial of their need for treatment and resistance which are attempts to '*bargain their way out*' (Keel and McCormick, 2010:15).

Christine had declined admission previously since she believed the service offered to be stifling and constraining and had chosen this particular hospital for its inclusivity and welcoming nature. Daniel's (1998) words are reflective of the relationship that Christine established with her care workers in the in-patient service that was facilitating her recovery:

*'Nurses can choose to have "power with" or "power over" relationships. "Power with" relationships preserve the integrity of power, the capability of accomplishing something, while maintaining an equality of authority and advantage'.*

(Daniel, 1998: 191-192)

Patients with eating disorders are often seen as uncooperative, deceitful and untruthful in an attempt to gain power and control over their surroundings (King and Turner, 2000; Ramjan 2004). Olivia wiped Clinutrin over herself in a way that appeared to be similar to a 'dirty protest' and has similarities with resistive responses within the prison environment. Donna said that it felt like a '*prison*'. Bearing in mind that Donna was a day patient, where the space had few walls and one room merged into another; this could not have meant that it was physically like a prison. Prisons contain people, in the interests of public safety, against their will. However, many of the women in this study felt that they were not there by choice, even

although they were voluntarily patients in legal terms. Although Donna may have felt that the care workers held the power, she was not rendered passive as suggested by McAllister (2004); she was defiant and might have been described as a '*difficult patient*' by Koekkoek *et al* (2006).

Again, the absence of mutually agreed tasks or goals is to be noted as patients attempt to re-negotiate these; and yet the bond is observable (Bordin, 1979) and '*unconditional positive regard*' was evident within the care worker accounts, irrespective of the behaviour of the patients towards them (Rogers, 1961: 283).

Tyrer and Bajaj (2005) speak of '*nidotherapy*'<sup>75</sup>, which they say has come about due to the

*'...frustrations of exercising evidence-based treatment options in a minority of patients who despise them all with equal fervour.'* (Tyrer and Bajaj 2005: 232.)

By '*nidotherapy*' they mean that the environment adjusts to suit the needs of the patient, rather than the therapy and they see it as particularly useful for people with long term mental health conditions. Although there are five essential principles of nidotherapy, it is the first that has particular relevance here: '*collateral collocation*' (Tyrer and Bajaj 2005: 232). Collateral collocation refers to the workers adopting the patients' perception of their environment by '*standing side by side*' and '*standing in each other's shoes*'. Hence the worker recognises what impact the environment has on the sense of safety and well-being experienced by the patient. With this in mind, the dining room's association with fear and dread requires a re-thinking of how this space can be transformed to enable the worker to maintain a therapeutic association therein. It seemed to me that the community of the services was a collective effort, on the part of all the staff, including cleaners and cooks, for example.

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<sup>75</sup> The name is derived from the Latin *nidus*, or nest, as a nest, particularly a bird's nest, represents one of the best natural examples of an environment adjusted to an organism.

Many of the women expressed a sense of safety within the therapeutic relationship and I realised that they were taking sanctuary, both within the physical landscape of the service, and within the interpersonal space that occurred between them and others (workers and co-patients). In many ways, the service settings could be seen as *micro-societies*, in that the group of individuals within are bound together by a common thread, common language, location and goal; it is a community with its own rules and routines. Hence, gaining an understanding of relationality, a further existential reflection discussed by Merleau-Ponty, is pivotal to this study.

#### **13.4. Guided existential reflection. Relationality: lived human relation.**

Relationality, or 'lived other', refers to '*the lived relation we maintain with others in the interpersonal space that we share with them*' (van Manen, 1990: 104). Inevitably, in a study about the therapeutic relationship, this existential theme was almost over-arching. Within this theme there were two major sub-themes; '*conflicting perspectives*' and '*maternalism*'. Both of these sub-themes included minor subthemes; '*the battle*', '*surrender*', '*tears and tantrums*' were each sub-themes of '*conflicting perspectives*'; while '*closeness*', '*attachment*' and '*approval*' were sub-themes of '*maternalism*'. The participants recognised that engagement was possible within the context of safety and security in both environmental and relational terms. In particular a secure, nurturing and maternalistic context was seen as important.

##### **13.4.1 *Conflicting perspectives***

Many of the participants spoke about the difficulty in reaching agreement about the care plan and the therapeutic bond was frequently described in terms that were indicative of its

temporary nature. Bordin proposed however, that the tear and repair of the relationship was normal and could ultimately lead to a strengthening of the relationship (Bordin, 1979/ 1994).

There was an acceptance that the workers wanted different things to the patients, so there was an expectation of conflict; conflict that could not be resolved without one party acquiescing. Frequently, neither patient nor care worker would back down; thus creating an impasse that prevented resolution and thus stood in the way of progress and recovery. A number of the workers expressed how they accepted these stalemate situations because they merely 'held' the patients until they were ready to surrender the eating disorder, as the potential for alienating patients by interventions which are overly assertive is high (Strober, 2010). Strober's view regarding the psychotherapist's relationship with the patient resonates with the experience of care workers, suggesting that an altruistic position be adopted:

*... 'the relationship between the therapist and patient requires a fundamentally different paradigm, one in which the therapist must expect little, seek nothing and define the objectives carefully'.*

(Strober, 2010: 232).

Assumptions of mutuality and reciprocity are also questionable when working with individuals with anorexia since the recidivism rates reinforce the view that patients do not recover fully, but rather control their condition and hospital readmission occurs when this control lapses (Strober, 2010). Patients with anorexia tend to have a distorted view of their relationships and are intolerant of help. Care workers describe the relationship as like walking on eggshells, or as Strober writes:

*'...even the slightest misstep can provoke angry tirades, deepening resistance, or abrupt termination of a treatment scarcely begun'.*

(Strober, 2010: 226)

It is therefore important that staff accept this as part of their experience rather than make judgements about the individual. Although staff can expect to be treated with respect, the

care workers are the ones who have a duty of care and core responsibilities. It is the workers' duty to assist them in the recovery journey (Aston and Coffey, 2012) and whilst some reciprocal elements to the therapeutic relationship are required to secure a working partnership, it is clear that the patients have no duty to care about workers, or as Happell suggests '*go easy on us*' (2009:381).

The long, all-day shifts (phase two) took their toll, however there was a sense that patience and kindness could only be maintained for so long and workers can find themselves alienated in the relationship, making it harder to maintain resilience. In many ways this was an '*emotional labour*' (Hochschild<sup>76</sup>, 2009: 244; Smith, 1992: 17); i.e. nurses need to present a smiling, emotionally caring presence, even when they feel the burden of nursing challenging individuals. Furthermore, finding oneself in conflictual relations can unsettle nursing identities, especially if nurses prefer to see themselves as caring and kind rather than authoritarian (Smith, 2012).

The physical elements of anorexia such as the cycles of dysfunctional eating and purging which cause feelings of shame, guilt, disgust, negativity and dysfunctional relationships were played out within the environment of the SEDUs. It is not unusual in situations such as these for patients to then be labelled as manipulative, attention-seeking, oppositional or difficult (Connan, Dhokia, Haslam *et al*, 2009; Kaplan and Garfinkel, 1999; Ramjan, 2004).

The patients were fairly candid in their need for human concern from the care workers, often negotiating their food consumption or compliance depending on a particular worker's involvement; for example, Lucy described a conscious process of '*mother-seeking*' when in hospital and Donna refused to be weighed by anybody except Sharon.

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<sup>76</sup> Arlie Russell Hochschild is an American sociologist who first devised the term '*emotional labour*' to describe the way in which two contrasting occupational groups in the USA service sector - flight attendants and debt collectors - managed their emotions in their daily work.

### **13.4.2 Maternalism**

When I provided thematic titles for phase one data I used the term '*maternalism*' as an alternative to '*mothering*' or '*motherliness*' and certainly there were indications that patients identified staff as parent figures. In this study, like that of Dolan and Gitzinger (1991), patients are seen as child-like and their physical and emotional care is provided by a woman. This is not, however, meant as a female equivalent of paternalism. Paternalism is an institutional construction that overrules the preferences, decisions, or actions of a patient in support of their overall treatment and evokes an oppressive fostering of dependence (Breier-Mackie, 2006). The *maternalistic* approach is personal and individual, used to describe a person who cares **about** the patient as well as **for** them. *Maternalism* here also better reflects the protective, feeding and nurturing role that is adopted by the care workers (Christensen and Hewitt-Taylor, 2006), rather than Peplau's '*mother-surrogate*' therapeutic role (Peplau, 1952:129), where the patient's casting of the nurse into a mothering role occurs '*outside of his awareness*' (Peplau, 1952: 51). Maternalism thus occurs purposefully within the eating disorder service, out of necessity, negotiating the nutritional elements, but always individual and related to the concern expressed for the vulnerability of the patient.

*'Maternalism'* might be considered to be a fairly predictable position for women workers, but one that many nurses seek to disguise in an effort to maintain professional boundaries.

Clarkson, talking from a therapist's perspective, says that we respond in the same supportive way that a mother does in calming the anxious and reassuring the frightened, but without the personal feelings for the patient that a mother has for their child (Clarkson, 2003). Yalom, also speaking about therapists as opposed to nurses, challenges this notion of professional boundaries, exhorting:

*'Let your patients matter to you, let them enter your mind, influence you- and not conceal this from them'.*

(Yalom, 2010: 26).

The patients interviewed in this study clearly appreciated aspects of what felt like a mothering role in terms of its focus on comfort, nurture and care. They did not however, unlike younger people, confuse the boundaries of the professional maternal role. Although there were attachments formed that may be relatively unique to the service, these appear to be productive and assist in the journey to recovery rather than the regression to a child-like status that may be otherwise assumed. The participants (both workers and patients) were candid in their disclosure of their need for emotional expressions of distress to be met with physical comfort that may be provided by one woman (e.g. a nurse) to another (the patient) and saw this as helpful.

Bowlby provided some insight into why some adult relationships are determined by early experiences of parental attachment (Bowlby, 1980). The sense of attachment and being cared for by a *'mother figure'* (Lucy's words) resonates with Gilbert's reference to *'safe others'* (Gilbert, 1989), that is, people (male or female) who foster a sense of safety and protection. Oakley (2000) suggests that the way a person constructs the therapeutic relationship may be affected by their own parenting experiences. Gina told me about literally holding a woman in an embrace whilst she calmed down, the sort of hold that mothers give sobbing children to help them feel safe and contained.

The care workers in both services made many references to the need to *'be with'* or *'hold'* the women whilst in their care. Indeed, both Benner (1984) and Shipton (2004) agree that the therapeutic relationship is more about **being** than **doing**. Benner refers to *'presencing'* as to mean *'being with'* the person rather than *'doing to'* (Benner, 1984: 57). Yalom agrees that it is the *'therapeutic act, not the therapeutic word'* that is pivotal to the relationship (Yalom,

2002:38); thus the care worker participates in the patient's experience (Benner and Wrubel, 1989) and ultimately uses themselves as a therapeutic agent (Freshwater,2002). Bordin, who emphasises the essential presence of a bond for an alliance to be established, argues that it needs to be a reciprocal relationship (Bordin, 1979). So it could then be argued that that a therapeutic relationship is about the 'being with', or, 'being there' which has been suggested is the literal translation of 'Dasein' (Solomon, 1972).

Benner's talk of '*presencing*' in terms of the sense of security created by simply being with another (Benner, 1984) is further reinforced by May (1983) who when talking about the therapist's role, says:

*'The therapists' role is to be there'.* (May, 1983: 163.)

May (1983) also makes the link between the Dasein and self-awareness and suggests that when a person is accepted, then this frees the person to be their own being. Acceptance is a complex process in a SEDU since acceptance of the person with you might infer acceptance of their altered image of themselves and thus create collusion. The person's recognition that they can be accepted by another person is therefore liberating. Acceptance has to be of the person and their potential, rather than merely their current physicality. May asserts that Being is not merely the person you are currently, but also the person that you have the potential to be (May, 1983).

For Lucy, the relationship with Eva was the key to her recovery, because through this professional companionship she realised that she was '*perfect just the way I was*'. This realisation occurred because somebody (Eva) believed in her enough to help her to believe in herself and so for Lucy, Yalom's premise that '*it is the relationship that heals*' was true (Yalom 1980: 5). Lucy yearned for somebody to 'love' her, a term that we rarely use openly in mental health care. Campbell's 1984 text, '*Moderated love: a theology of professional care,*'

suggests that nurses should indeed love their patients within the concept of companionship, personal involvement and giving to the patient, which transcends skill or technique to create a truly loving care. Stickley and Freshwater (2002: 253) propose that we '*...foster a therapeutic alliance that is founded within love*' in order to realise its healing potential.

There are differing reasons for the women's acceptance of the care workers, their skill in therapy, level of knowledge, their genuineness, listening skills, patience and their continued presence.

Spending time with the patient was necessary for gaining an understanding of each other and creating a bond, but was also tiring. Merleau-Ponty refers to the lived time as 'temporality'.

### **13.5. Guided existential reflection. Temporality: lived time**

Polt says that temporality is the key to understanding ourselves as we truly are (Polt, 1999). He says that:

*'Time is the key to understanding, not only our being, but being in general'.*

(Polt, 1999:36.)

If we consider temporality through the lens of phenomenology then we accept that the person's experiences are affected by their past as well as their future (Merleau-Ponty, 1962). So when considering the lived time with respect to the therapeutic relationship, it is important that past relationships are considered in terms of their impact upon the current experience of relationship. For the care workers, the past is out of their control, but the emphasis here is on accounting for past experiences and, where possible, assisting the patient to recognise that current relationships do not need to replicate relationships of the past, many of which were traumatic.

This raises concerns for those putting their trust in workers and establishing a connection that will be therapeutic. It is the workers who have the responsibility for the professionalism of the encounter, even though it is a shared relationship. When Yalom advises us to '*turn towards another with one's whole being*' (Yalom, 1980: 410) initial thoughts are of precious time spent in a trusting and transparent relationship. It is a sensitive worker who can maintain trust and openness whilst remaining cognisant of the potential vulnerability to hurt and loss when the relationship comes to an end.

Kirsch and Tate (2006) suggest that it is important that workers spend time doing everyday things as a '*means of connecting*' in order to forge connections on a person-to-person level (Kirsch and Tate, 2006: 1061). This reinforces the need for the patient to feel that the worker is on their side. They use 'being there' as the terminology for being accessible and making a connection attainable. Surtees (2007) recognised this, referring to times of weight gain or when menstruation resumes as signalling the need for workers to make themselves available.

The women in this study spoke about doing 'normal' things which felt like being treated like a 'normal' person in healthy, friendly relationship. Campbell would argue that this is '*skilled companionship*', the '*epitome of nursing care*' (Campbell, 1984: 49), which is not directed by ill-health, distress or suffering. It is a mutual sharing of an activity that is shared; the focus is not on the 'problem' and success is attainable very quickly and with ease, for example, when a game is won or a painting is finished. In many ways, this enables the woman to be a whole person and the 'anorexic self' is not required. Miller *et al* (2003) suggest that it also influences positive outcomes. There are many references to the time required to form a relationship, time to feel familiar with the other person, to get to know them, to listen and to develop trust (Jenny and Logan, 1992; Kirsh and Tate, 2006; Kwaitek *et al*, 2005; Shattell *et al*, 2007; Stickley and Freshwater, 2006; Surtees, 2007; Vandereycken and Devidt, 2010; Wright and Jones, 2012). As identified within the current study, time is clearly a key ingredient of the therapeutic

relationship. Furthermore, many texts, similar to previous literature cite the lack of time that workers have to spend with their patients, largely as a result of non-nursing duties concerned with administrative tasks and documentation (Shattell *et al*, 2007; Stickley and Freshwater, 2006).

In the same way as past experiences are important to temporality, so are future experiences and with this in mind, it is suggested that we are clear about the temporary nature of the therapeutic relationship. This is also important in terms of being honest about the care and the relationship, being realistic, genuine and ultimately, authentic.

### **13.6. Authenticity**

*To thine own self be true, and it must follow, as the night the day,  
thou cans't not be false to any man.                      Shakespeare, Hamlet*

Authenticity is pivotal to both the therapeutic relationship and also phenomenology. First, in relation to phenomenology, it is useful to reflect on Heidegger's insights who talks of authenticity as '*being one's self*'; honesty and truthfulness are essential components. He says that '*Dasien is in the truth*' (Heidegger, 1962: 263), (see p.148) James Bugental (1987), a therapist, teacher and writer from the existential-humanist psychology movement, states categorically that strict honesty is required at all times to maintain the therapeutic relationship. He emphatically calls for no distortion of the information given to patients in order to maintain '*authenticity*' in the relationship. Truth telling, or as expressed within the ethics literature, '*Veracity*' (meaning to be truthful and honest at all times), is one of four principle rules<sup>77</sup> for ethical practice (Beauchamp and Childress, 1994). Indeed, Armstrong (2007) views honesty and kindness together in his discussion of both as '*virtue ethics*'; he suggests that the honest person will '*successfully form and maintain mutually beneficial*

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<sup>77</sup> The four rules are *Veracity, Privacy, Confidentiality* and *Fidelity*.

*relationships'* (35). Armstrong also links honesty with trust, an essential component of the therapeutic relationship according to both Forchuk (1994) and Peplau (1952).

Heidegger denies that we can be authentic all the time and that we control the way that we present ourselves to others. The self is therefore a way of existing and all our human possibilities are made available to us by our culture. Polt discusses Heidegger's use of the word '*truth*' meaning '*self showing*' and '*unconcealment*' (Polt, 1999: 149). Polt (1999) says that Heidegger acknowledges that complete authenticity is rarely achievable as we present an image related to other people's expectations of us and is responsive to the cultural norms in which we exist.

It could be assumed that the workers and women within the eating disorder services might have also adopted a culturally determined 'self', thus presenting themselves as the person that they need to be within this context. Although authenticity is considered desirable, it is also complex, and on occasions, discounted for instrumental reasons. For example, one could argue that the presentation of self in therapy, or conflicted encounters, is purposely inauthentic to prevent the revealing of personal irritations or frustrations with a reluctant patient which would be destructive. The emotional labour is therefore apparent for the workers in the study (Smith, 1992).

Polt (1999) suggests that we engage in '*leaping in*', a Heideggarian concept meaning that we take up the other person's burden hence helping them by relieving them of their trouble. He suggests that '*leaping ahead*' is more authentic, however, because it is not merely a direct helping act, but it also gives the other person the means to bear that burden on his own. Polt uses the example of a teacher who does not merely show the student the answers but teaches them how to discover their own answers for themselves. There are several examples of this within the interviews, particularly in the day-care group of participants.

Árnason (1994) analysed the concept of authenticity by examining its implications for the patient-professional relationship and for ethical decision-making in medical situations. Authenticity is seen as valuable in creating a therapeutic dialogue in which the subjectivity of both partners is respected. Such practice, based on mutual trust and responsibility, is thought to enhance common decision-making and overcome alienation between patients and professionals. Within this study, authenticity tended to relate to the specialness of the worker, the empathy they showed towards the patients and the level of trust elicited by them; the link with decision making was aligned to acting in the patient's best interests, having respect for them and reinforces Árnason's perspective with regard to the creation of a therapeutic dialogue.

Participants' accounts of their experiences often seemed to be well rehearsed, probably reflecting long involvement or employment. This was particularly apparent when discussing 'safety' and trust issues. It could be a concern that such accounts from retelling and elaboration can seem inauthentic and thus get overlooked or neglected. Recent research however, has suggested that such 'storytelling' is often laid down as a basis for building relationships and shared understanding (Clarke, 2010; Holloway and Freshwater, 2007; Schwartz and Abbot, 2006). Participants may have used these topics as an introductory experience, familiar to them, that set the scene. Although issues of safety and trust are clearly important to the therapeutic relationship, the exchange and retelling of their stories, in itself, may have contributed to the trusting relationship established between the women and the care workers.

Many writers emphasise the importance of listening and note this as the key to understanding (Kwaitek *et al*, 2005; Stickley and Freshwater, 2006; Vandereycken and Devidt, 2010); if the patient feels understood then George says that the relationship will improve (George, 1997). Person centred therapists take this one step further by referring to '*genuineness*', a

characteristic highly valued in this study, as being inextricably linked to the workers' way of being and see it as the same as '*congruence*' (Mearns and Thorne, 2000). Essentially, authentic positions are believable, but this still has to be individualised and focussed on the person you are with:

*'It is not enough to "be yourself" when caring for patients; one has to be able to use one's personality in a flexible way that is adapted to each individual patient and each situation.'* (Christiansen, 2009: 429).

Within the participant's accounts there were many references to '*trust*' and '*genuineness*' and, whilst this is clearly a different concept to '*authenticity*', I would like to make the association here. Dickinson (2011) suggests that trust, integrity and heritage are constructs related to authenticity and that authenticity is never finished, it always being made and re-made. Additionally, most people agree that integrity, authenticity, dependability and honesty are basic human strengths (Peterson and Seligman, 2004), which I would suggest provide the foundation for a trusting relationship.

'*Trust*' was mentioned in every single interview in phase one and most of the phase two interviews. The care workers used it in terms of their own trustworthiness but also with regard to trusting the women. They were aware that their patients would agree with a proposed care plan when it was written, but that in the event, they would not be able to meet this commitment when they were sat at the table, or at home. Trust is also referred to in virtually all texts referring to the fundamentals of the therapeutic relationship, (Clarkeson, 2003; Forchuk, 1994; Peplau, 1952/1988; Travelbee, 1971 ) A literature search using only the words '*therapeutic relationship*' (in the abstract) and '*trust*' (in the text) revealed 2,446 hits. . Trust is therefore clearly seen as important for effective therapeutic and working relationships (Calnan and Rowe, 2008), and is required for disclosure to take place (Bond, 1994). The client's capacity for trust in the therapeutic relationship, however, is thought to be affected by their early experiences (Laughton-Brown, 2010).

The dual identity of the participants is concerning. The existence of the '*real self*' (so-called by the participants in this study and also by Lamoureux and Bottorff, 2005:170) and the '*anorexic self*', creates some doubt about the authentic self within the therapeutic relationship.

Aubuchon and Maltesta (1978) theorised that the self that develops in adolescence is affected by the development of anorexia and thus creates difficulties for the individual expression of an authentic, independent sense of self with appropriate emotions. Paradoxically, the vulnerability created by childhood trauma and disordered eating is identified by Daniel (1998) as the '*key to authenticity*'. Daniel suggests that nurses work to ameliorate vulnerability, but that vulnerability is a human trait and cannot be eradicated as it is inherent, not inflicted.

Furthermore, Daniel suggests that nurses need to also recognise their own vulnerability so that they can recognise vulnerability in others, share in the human condition and enter into mutual vulnerability. She concludes that '*Vulnerability gives nurses the opportunity to be authentic*' (Daniel, 1998: 192). I would argue that, in this study, it is the humanness, compassion, dependability and the continued hope and optimism of the workers that assists them to present their authenticity and permits the women to trust them.

### **13.7. Part Two:**

Having discussed the findings of the study in part one of this chapter, I now present the contribution that this study makes to current knowledge; the implications for practice, research and policy and the strengths and limitations of the study.

### **13.8. Contribution to knowledge**

Although this is a small study, a number of contributions to knowledge have been made, largely because of the absence of any previous similar study and the challenging of assumptions about the transferability of other studies and theories about the therapeutic

relationship. Previous studies have focussed on the difficulty of caring for people with an eating disorder, but have tended to focus on adolescents and have not included adults with an eating disorder as participants in the study. Whilst there is some transferability from existing studies, this cannot be taken for granted without specific studies, such as the present one.

There are four main areas which appear to be new knowledge that could provide greater understanding for those working and recovering in specialist eating disorder units.

### ***13.8.1 The fragmentation of identity created by externalisation of the disorder creates fragmentation in the relationship.***

This study has revealed that the externalisation of the disorder creates a fractured sense of self in women with anorexia. The externalisation of the disorder is considered to be a therapeutic strategy to cope with the 'anorexic voice' (Serpell *et al*, 1999; Williams and Reid, 2012). The construction of the anorexic voice/identity has some utility as it provides an entity on which to attribute the anorexic behaviours and the angst. This identity separation however, creates a fracture in the self-hood of the person and thus a fracture in the relationship. Workers are unsure about whom they are relating to, and the 'bad' behaviours, such as emotional and expletive communication around mealtimes or weigh times, are attributed to the anorexic identity and not owned by the 'real' person. This creates a divided self and the attribution of responsibility and blame to an elusive entity that is unresponsive.

This study has revealed that, for these participants, the anorexic self became a scapegoat for the oppositional, disrespectful and difficult behaviours. That works for the women, but not for the care workers. The care workers do not want to blame or criticise, they want to be compassionate and caring, but they are met with a barrage of opposition and, although they are empathic enough to understand that they are at the receiving end of the woman's battle with a demonic anorexic self, they (the worker) is still the same person. The worker cannot separate out a part of them that does not feel hurt, worn-out or attacked. Whilst they do not

expect the patients to 'go easy' on them (Happell, 2008), it is difficult for them to relate to the 'real self' when the anorexic self is on the front-line and preventing the worker from reaching the patient in an authentic way.

Additionally, the duality of identity creates problems in terms of authenticity. The need for honesty, genuineness and warmth has been mentioned many times. Whilst the real/ authentic person may have the capacity for that, it would seem that the anorexic identity does not. This creates inauthenticity which is a barrier to authentic communication and thus a barrier to a trusting relationship.

### **13.8.2 *Maternalism can be a tool for transition***

The framing of the relationship within a '*maternalistic*' context can be helpful provided that it is viewed as temporary and intended to promote eventual maturation, independence and separation from the mother-figure. It is clear that some kind of relationship that has therapeutic effects exists in eating disorder units, but this may be more related to a 'maternalistic' nurturing and protecting approach which seeks to 'save' the patient from dying of starvation.

Anorexia is a highly complex disorder, mentally and physically. The women in this study suffered immensely and needed the sensitive and nurturing touch of people who showed them unconditional care and compassion. 'Mothering' is indeed unconditional, as in Rogers' statement, that we might provide unconditional positive regard in our interactions with our patients (Rogers *et al*, 1967).

Furthermore, when we consider the nature of the women's responses that are attributed to the 'anorexic self' we can see that they are behaviours often closely associated with children and adolescents. Gina referred to these as '*tears and tantrums*'. Although seemingly simplistic, the comforting, soothing and containing techniques that are used by the workers to diffuse

some of the distress and help the person feel cared for, have many similarities to 'mothering'. Hence a maternalistic approach which provides a sense of security and nurturing can be a compassionate way to facilitate a route out of their anorexia into recovery.

### **13.8.3 *A therapeutic relationship can exist with very tentative agreement around the tasks and the goals if the bond is strong enough.***

This study highlights the importance of the social space within which care and treatment occurs. An important element in my findings is the optimistic position that a strong therapeutic relationship can be established from relatively weak or even conflictual circumstances. In the early stages of the relationship, when treatment is most concerned with re-establishing body weight and the acceptance of diet, gaining mutual agreement about the tasks and the goals of treatment is most difficult. When we consider the literature that discusses the refractory relationship within SEDUs, it can be seen that focus is given to the tasks and goals that are couched within the clinical treatment plan (for e.g. Kaplan and Garfinkel, 1999; Surtees, 2007). It is clear that, in SEDUs, the task and the goal relate to clinical endeavours, whilst the tearing and repairing of the bond is wholly relational and, according to Bordin (1979/ 1994) can enhance the therapeutic relationship.

The relationship that exists during ED treatment does not fit, however, with either the psychotherapy or clinical models of the therapeutic relationship that currently exist, but is instead largely based upon the women's 'surrender' of their anorexic ways. Hence the potential for the patient to feel coerced into care is high and distress is inevitable. It is at this time that the women seem to appreciate the maternalistic approach that offers some level of discipline but is also sensitive, compassionate and nurturing and is aligned to Bordin's model that proposes that the bond is central to the relationship (Bordin, 1979/ 1994). Effectively, Yalom's assertion that *'it is the relationship that heals'* could be true in the eating disorder

setting (Yalom, 1980:5). It may be more appropriate to refer to the connection between patient and care worker as simply the 'relationship', rather than the 'therapeutic relationship'.

### **13.9. The therapeutic landscape is pivotal to the therapeutic relationship in specialist eating disorder units.**

Despite efforts made with the appearance of the building, it was still perceived in institutional terms, largely due to the disciplined approach to care which involved high levels of supervision (or perceived surveillance). Despite the apparent homeliness of the services used for this study, elements of institutionalism were identified which created feelings of imprisonment, protest, the promotion of compliance and surrender to the service model. The dining room and the clinic room, in particular, are places of fear and dread. Elements that indicated a transition away from an institutionalised model included the acceptance that 'house-keeping' workers, such as the cook and cleaner were part of the caring community and that doing 'normal things' with workers who were interested in being there could be as therapeutic as organised therapy .

### **13.10. Implications for practice**

There are number of recommendations that I consider worthy of note that have come to light as a result of this study which may assist workers to establish a relationship that is therapeutic and which promotes recovery. These are in addition to the contributions to knowledge, above, which also provide insight into possible ways forward.

#### ***13.10.1 Be authentic - communicate person to person.***

Authenticity is crucial for the worker to attempt to connect to the authentic self of the patient. Attribution of anorexic behaviours to a separate identity has its place in the battle with the anorexia, but also tend to create a battle with the worker. Whilst the anorexic identity needs to be acknowledged, the worker cannot create an authentic relationship with a dual identity. The value of the anorexic voice in terms of the Maudsley method for adolescents is well

established, but in terms of the therapeutic relationship with adults with an eating disorder it can be a barrier to reaching the real, authentic person.

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 example also demonstrates ownership of the response, by using the word 'me' rather than 'the team' or 'us'.

The anorexic self is no respecter of persons and so a resilient but caring response is needed to model consistency and cohesion within the care team. Done well, the 'broken record technique' is a response can be respectful to their distress but reinforces the non-negotiable position. Care workers who tried to cajole the women and seemed open to negotiation or to make minor changes were seen as less robust than other workers and became tired and stressed in their attempt to make things better for the patient.

### ***13.10.2 Focus on the present***

Many of the women had had traumatic pasts, some of which were disclosed to me during the interviews. In many cases these have impacted on their self-esteem and subsequent body-image, as well as their current striving for perfectionism. Most of the participants (workers and patients) made reference to possible triggers for the anorexia, many stating what the traumatic experience was, or alluded to previous abuse, exploitation or trauma. Additionally, the future was difficult or impossible for the women to envisage. It was either too awful for them to think of themselves within the 'normal' weight range, or they were too pre-occupied with current issues.

Hence, given that the therapeutic relationship is about making positive connections that will engender trust and create a culture of sharing, developing and progressing in order to move towards recovery, the immediacy of that relationship is crucial. When goals are established in

specialist eating disorder units they are short term, small steps towards recovery. Longer term goals are inconceivable.

Both distress and elation can occur in the same hour, for example when faced by 'thick and creamy yoghurt' at lunch time and then being allowed afternoon leave. So it is important to create short terms goals and provide the comfort or congratulations required at that time.

### ***13.10.3 Make time every day to 'be' with the patient - not simply to 'do'***

There are many activities that assist in the formation of the relationship and align with two of Bordin's central tenets for the creation of an alliance (the **task** and the **goal**) which are chiefly seen as 'clinical ' roles within a SEDU. Nursing roles and responsibilities are an important part of Peplau's model of the nurse-patient relationship. The patients in this study, however, found that the time they had with workers that focussed on them and thus established a **bond** with their workers, rather than achieving a task, was particularly meaningful. This is particularly true for recovering patients who are 'supervised' less; patients who have made small steps towards recovery require staff to maintain their level of engagement by offering positive and encouraging support. In phenomenological terms, this enables the person to discover their being, their self and thus enables the workers, by their presencing, to be authentic. The Rogerian non-judgemental, unconditional positive regard promotes acceptance and goes some way to helping those who, like Olivia and Anna, thought they were unlovable.

### ***13.10.4 Create a therapeutic landscape***

The creation of nurturing spaces is crucial to the establishment of the therapeutic relationship. There are some aspects in the homely environment of the SEDU that have the potential to create a 'nidotherapy' environment. That is, that the environment adjusts to the needs of the patient. There may be some value in seeing the dining room as a repository for the most

distressing reaction, for these to be contained in one place. The patients are often so closely observed by workers during their meals, however, that it might be possible to offer some choice about the place and time to eat as this would provide some limited autonomy to people who have many of their choices removed when they agree to admission.

### **13.11. Implications for policy**

Currently the NICE guidance suggests that most people with anorexia are managed within out-patient services (NICE, 2004) where drop-out from treatment is high and few workers have specialist knowledge and qualifications. Currently, there is a dearth of training or supervision available to assist the ED care-worker to enhance their practice. Although it is usually (minimally) included within undergraduate programmes, specialist training courses are scarce. It is clear that the patients that require these services have complex needs which are physical, social and psychological. One way forward would be to enhance funding for specialist education and supervision for people working with ED patients to enable the most relevant care and supervision to be provided.

### **13.12. Implications for further research**

A study which was inclusive of the observed behavioural and contextual factors would provide a broader understanding of the therapeutic relationship than that which could be captured utilising only interviews, as in this phenomenological study. An ethnographical study incorporating observation in the research design, as well as in-depth interviews would be a key recommendation for future research.

This study found that there is utility in the **bond** that is created between the care workers and the patients, even in the absence of agreement around the tasks and the goals of the therapy/treatment. Further research, conducted in areas where there are similar tensions surrounding goals and tasks, could progress this further by providing greater insight into relationships that are therapeutic solely because of the existence of the bond.

As this study involved only female patients and White European participants, further research in more culturally diverse settings and including males would further enhance our understanding of the phenomenon.

### **13.13. Strengths and limitations of the study**

#### **13.13.1 Strengths**

One of the benefits of conducting the study in two parts was that limitations discovered during the first phase could be addressed in the second phase. One example of this was, when presenting my findings from phase one, I was asked '*where is all the negative stuff?*'. There was very little negativity expressed by the participants throughout the whole of phase one. I returned to the questions, I listened to the recordings; I questioned my own possible biases and discussed this with the unit manager at the research site (Sharon). She was pleased; of course, her unit had been very positively described throughout the interviews. She did, however, say: '*They are people pleasers, Karen, they want you to like them*'. This was a term I was unsure of, but now realise is commonly used (Harrison *et al*, 2011).

The methodological approaches have been rigorous and I have adhered to the approach recommended by van Manen in a systematic way. Ethical concerns were attended to at an early stage in this study to the extent that the participants actually stated that they derived some benefit in taking part. Providing repeated opportunities for interviews and returning to the participants for their perusal of the proposed paper (phase one) was good practice and ensured that the intended meanings were captured.

#### **13.13.2 Limitations**

I realised that, in phase two, I needed to seek clarity and detail throughout the interviews, be less affirming and also to ask for exceptions when accounts seemed overly positive in nature.

Although the participants were few, the data obtained for this phenomenological study was in-depth and meaningful over multiple sessions. Initially, the study was planned only for in-patient care. Extending it to day care to meet ethical considerations doubled the study, creating a data set which was unusually large for a phenomenological study, so only a fraction of the data could be presented in this thesis.

This study is local to the North West of England and took place in only two services, although in my experience the treatment model and expectations of patients and staff are similar to other specialist eating disorder units. The participant group was exclusively made up of all European individuals; hence the findings can only reflect the experiences of this cultural group.

This study reports on a 'snap shot' of time, captured in the moment and reflects the temporal nature of our being. The same study conducted now might produce different findings because the effect of temporality. It is also inevitable, despite every effort to avoid biases and prejudices entering into the interpretive analysis, but the use of the reflexive diary and regular supervision will have minimised these as far as possible.

### **13.14. Conclusion**

This chapter has provided a theorising of the findings, presented as an interpretation and a discussion. Recommendations for practice, policy and research have been made and both the research findings and the subsequent recommendations will be discussed with the research sites in order to promote learning and development as a result of the study. Comment has also been made about the strengths and limitations of the study.

The next chapter contains my personal reflections upon the research journey and provides a reflexive account of the experience of the study, prior to the final chapter which concludes the study.

## Chapter 14: REFLEXIVITY

The completion of a PhD takes its toll on the student, no matter how experienced that person is. This PhD has been no different and so here I will consider my journey through the process of conducting this study. I will also discuss the use of myself as a researcher.

### 14.1. Introduction

Morse (1994) and Holloway (2005) both assert that the qualitative researcher must observe themselves reflexively to encourage self-exploration and promote self-awareness. Earlier, the '*use of self*' was considered within the context of the therapeutic relationship. Here, I would like to consider the use of self as a researcher, as the relationship between the researcher and the researched is pivotal to the process. I must also acknowledge that when I position myself in the role of researcher it is much less familiar to me than that of the role of mental health nurse. Hence, I am required to distance myself from that professional caring role when researching, but I cannot separate myself from my personal characteristics that drew me to nursing in the first place and that have been nurtured over the course of the last thirty years.

### 14.2. The use of self as a researcher

I had performed the researcher role for a number of other studies prior to this one, but none affected me like this one did; there could be many reasons for this, including the personal investment of studying for a PhD. The maintenance of a reflective journal throughout the study has been invaluable, since it captured my thoughts whilst they were fresh, allowed me to sleep at night and then provided a basis for some of my personal development through the research journey.

It is useful to mention the utility of the bracketing exercise again here (see appendix 7). At the beginning of the study I did this to be honest with myself, to be genuine and to provide an early position statement. I do not claim to have entirely put the bracketed thoughts away from

my consciousness whilst conducting the research. This process allowed me to shine an internal light on my personal sense of the phenomena, before I put the spotlight on the participants' sense of their experience. It was a process that felt very indulgent. I have been conditioned to be objective and non-judgemental; to work in evidence based way. I was slightly uncomfortable with some my presumptive thoughts; but this discomfort felt almost therapeutic, as though I needed to peel back the layers to work towards a position of authenticity (Heidegger, 1962). Indeed, Bernstein suggests that hermeneutic understanding can only be achieved in the presence of a '*profound experience of what is alien, different, and other*' (Bernstein, 2002: 278).

The bracketing exercise was particularly important during the time that I was conducting the interviews as it was one of the mechanisms that enabled me to separate out the data emerging from the interviews from my personal responses. Some of these personal responses will be interpretations, but I also need to acknowledge information that came to me from other sources. Sources that were not specified as data collecting mechanisms; for example conversations overheard whilst on site, personal observation made on site and also my own, subjective gut-reactions to being there in that environment that were recorded separately ensuring that I could focus on the interview data in isolation. I have included an example of some of my journal notes in the appendix (appendix 8).

In nursing, it could be argued that the articulation and description of human experience as an ongoing endeavour is foundational to practice. Freshwater, who provided insight into the utility of the nurse's therapeutic use of self, also argues for the value of writing reflectively in research as a:

*'Mode of monitoring research, a research method in itself and a product of research'*  
(Freshwater, 2005: 314).

For me, this is important, because I recognise that I too may use terminology and experience derived from many years in the nursing profession and the ingrained characteristics that I have acquired. I could easily fall into making assumptions about the meaning of participants' words, thus wrongly attributing my own interpretation of their words. Hence, in putting aside my assumptions and in using an interview style that searches for their meaning, I can promote the authenticity required in phenomenological enquiry. I am a nurse; I do not merely 'do' nursing. I cannot apologise nor subtract who I am or how this may tint my view of the world, but I can own it, which is what I aimed to do by 'bracketing' prior to commencing the data collection (appendix 7).

Although I am a nurse and a professional carer, I believe that I am also a caring person. Separating myself from the caring role, whilst being a researcher, was going to be tough. When talking to the women, I struggled to separate out the professionalised need for me to care about the patients and a sense of duty towards them in terms of their wellbeing and recovery; whilst realising an important responsibility to protect them from any negative impact of the research. When talking to the workers I had to stop myself making assumptions about what they said due to identification with their roles.

For me, I was constantly aware of my role as researcher rather than nurse. Ramos (1989) suggests that there is a fine balance between the nurturing concern of the nurse and the need to conduct the research and therefore the roles must be constantly re-defined in order to prevent the boundaries from becoming blurred. Every interview felt like a balancing act, drawing on well-rehearsed listening and interviewing skills such as probing, clarifying and summarising, as well as being encouraging. Early play-backs of the phase one recordings in supervision identified that I was being too affirming at times, as I would be if I were in the role

of nurse rather than researcher. I learnt that I needed to keep unpicking, probing and utilising the hermeneutic circle, constantly seeking clarity but never allowing myself to be seen as anything other than a researcher. Only once did I need to suggest that we stopped the tape and the participant (Anna) immediately jumped in to reassure me that she was fine and had discussed all of the issues with Lizzie (nurse manager).

### **14.3. The participants' awareness of me**

I was advised by the NHS ethics committee that I should only inform the participants that I was a research student and to take all references to my job title out of the documentation. They felt that it was important for the participants to be aware that they were being researched by a student. In the event, my professional background and also my academic post at the University became known. This occurred in different ways; Lynne, a forty-two year old woman with anorexia, said to me after two or three interviews *'you are such a good listener you would make a good nurse, you know'*. When I explained that I was actually a nurse, she could not understand why I had kept this information from her. I explained that in that setting my role was not to nurse, but to research. I apologised if she felt that I had deceived her in any way and, although she laughed about it, it troubled me.

In reality, I felt a constant sense of discomfort with this since it did not feel genuine or authentic and it felt as though I was keeping a secret from people who were being incredibly open and transparent with me. When Pelias describes his need to *'write from the heart'* he makes no apology for his subjectivity and talks of *'a scholarship that fosters connections'* (Pelias 2004: 2). In attempting to discover the lived experience of the therapeutic relationship in these settings and authenticity in the words of the participants, I attempted to enter their lifeworld so that I could better understand their experience. That meant trying to be with them in the sense that I felt their feelings and empathised with these. That was both painful and emotive and, paradoxically, felt like an 'emotional labour' of its own (Hochschild, 2003). I was

concerned that I could lose objectivity and become biased, but realised, after reading Pelias's '*Methodology of the Heart*' that there was value in attaining closeness with the participants of the research (Pelias, 2004) and it reinforced van Manen's perspective that the study should matter, personally, to the researcher (van Manen, 1990).

I am tasked in this study to reveal the subjective position of others. I have a responsibility to do this in a way that ensures that their voice is heard, not mine. I have endeavoured to treat their accounts with the same respect that I have for them as individuals. I have a sense that I have been entrusted with words that occurred in that moment, about those connections, by people who trusted me to look after their stories and treat them with sensitivity. So, I intend to care for the data and, for me, the interpretation that emerges is a result of both the academic, intellectualised responses that are expected from me, but also a heart-felt and intuitive understanding of the participants' words.

#### **14.4. Researching women with anorexia and their care workers**

At the commencement of this study I observed a patient who had a BMI of 13 who had lost a further 0.1kg in the previous 24 hours. She was attending a Mental Health Act review tribunal. She was fully expecting that she would be allowed to go home, to the extent that she was planning her gym membership, even though she had fainted the day before after vomiting through the window. I felt a sense that the women with anorexia were in a profoundly fragile position, mentally and physically. Yet, despite their apparent resistance to treatment and the lack of trust or agreement between the women on the ward and the staff, there were some observable connections made and evidence of recovery, for some. I could not tell what held the connection together, nor what it was based on but I wanted to understand this

phenomenon, in the terms used by the women and the workers and so I sought to reveal their perspectives.

It was a pleasure, a privilege and a painful experience to be with them whilst they shared their experiences with me. There were times when I felt helpless because my usual helping role was out-of-bounds for me and I was devastated to hear the words of Olivia, for example, who no longer cared whether she lived or died because the struggle was too much and when Anna referred to herself as '*slug-slime*'. When Hannah, a truly gentle and kind natured therapist, was self-conscious of her own body when conducting therapy I held back from my intuitive need to offer her reassurance.

The women seemed to enjoy talking to me and did so in quite a leisurely way; they had few other demands upon their time and were they were very illustrative in the manner in which they spoke, thus taking longer to express their thoughts. Unlike a clinical interview, I had no assessment or clinical notes to complete. The recorder was switched on and then I was able to talk to the person sat with me, listen to them recount their experience, unpick it with them, try to understand their world and be led into an understanding of that world to gain a sense of their being-in-their-world.

The participants spoke very calmly about the anguish within the relationship that occurred, particularly at mealtimes. Whilst away from the dining room and in the interview room with me, it was as though they could literally shut themselves away from those experiences. Given the concerns of the service regarding allowing me access to the client group, I was reluctant to prompt the women to talk about the difficulties in the relationship, but I was aware that the interviews seemed to be disproportionately positive. When not conducting interviews I often sat in the lounge, the office or the dining room. I saw women who usually made good eye contact with me, now staring down at their plate, not communicating with workers who were trying to distract them or cajole them. Later, when being interviewed they made no mention of this.

One of the women with anorexia spoke to me in a passionate and enthusiastic way, smiling constantly; but then later, when in the corridor, she was screaming in the face of a worker, saying that '*it wasn't fair*' and that she was misunderstood. She was consumed by angst and rebellion against the people that she had spoken about so positively in her interview with me. I felt incredibly privileged that the participants engaged with my study so willingly and were so generous with their time. Some stated that they were hoping that their experiences could potentially help others and so this contributed to their motivation to contribute. Hence, I have a responsibility to tell their stories authentically, accurately and respectfully so that it is their meaning which is made clear. Van Manen warns against '*the temptation to stab at meaning here and then there...*' (van Manen 1990: 168) since human science is the systematic study of human experience and thus requires the meaning to be extrapolated clearly and this can only be done if the interpretation is accurate.

Sometimes people made sweeping statements which created interpretative difficulties. For example, a participant said to be that '*it was like a roller coaster*' which could mean a host of different things to different people. I love roller coasters, I queue up for ages to get on and let people go before me in the queue so that I will be positioned for the front seat when the next carriage comes along. I find it exhilarating and exciting, I want to do it again straight afterwards. But some people are terrified and dread the very thought of a roller coaster. The beauty of an in-depth interview is that enables enquiry into unique experience so that the unique meaning of the individual can be captured with regard to any sweeping and illustrative statements. This subsequently encouraged the participant to provide personal examples and detail.

There were times when capturing the reality of their life, their sometime fragility, their sometime feistiness and the realisation of the importance of the web of interpersonal

connections formed with their workers felt like too great a responsibility. Many told me that they found the experience of talking to me to be enjoyable, even therapeutic. I was initially concerned about this as I was worried that I had fallen into a default caring position, so I sought clarification and felt reassured that it was their own exploration of their relationship with their workers that they found useful, rather than any therapeutic input from myself. They adapted quickly to speaking about the 'experience' of the therapeutic relationship rather than a theoretical description of the relationship and thus their interviews tended to be closer to the phenomenological approach.

Moreover, Tom, the consultant psychiatrist, said that the women had spoken about their participation in the research during their consultations with him. The overarching perception was that it had been therapeutic for the women to talk to somebody who was interested in them and their experience as opposed to their treatment or their weight gain. We discussed the initial concerns about the potential vulnerability of the women and concluded that this had never been a concern throughout the study and that both he and the team had felt that it was a positive experience for the women which, if anything, had bolstered their self-esteem.

All the participants (workers and women) spoke freely to me, without any reward, except the hope that the sharing of their experience might aid the understanding of caring for and being cared for within an eating disorder unit. Many of the women had not considered their experience of their relationships with their workers in such detail previously, but the workers considered their relationship with their patients as pivotal to their role and utilised clinical supervision to discuss it.

The workers were clearly more constrained by time. In the main, they were less relaxed in the interview and they tended to talk faster, more theoretically and less personally; thus moving more quickly through the questions. I generated more interview data from the interviews with the women and worried that I should have equal amounts from the workers; but the workers

either had nothing more to say, or no more time to say it in. There were several appointment cancellations by the workers because of the acuity of the ward or because of shift changes. Nonetheless, once they overcame concerns that the interview would test their knowledge about the therapeutic relationship, they were very open and disclosing about their experiences and quickly moved into a reflective and seemingly very honest discussion of their relationships with the patients in their care. Throughout the interviews there was a shared understanding that this was not an easy job; those workers who entered the profession with a mission to care for others with a vision of recovery and healing were both praised and rejected in equal quantities on a daily basis.

At the beginning of this study I was very sure about my position, that is, this is not a study about 'anorexia'. I am still certain about that. I have introduced this study many times, for example, to participants, to conference attendees and to colleagues. I always say that this study is NOT about 'anorexia'; I am not studying the illness/disorder and I am not seeking to find out about treatments or therapeutic interventions for anorexia. I always stress that this study is about the relationship that occurs between the workers and the women who suffer. This study has revealed however, that it has not been possible to consider the therapeutic relationship in this context, without recognising the impact that '*being anorexic*' has on the relationship.

I have included a section from my journal within the appendix (appendix 11)

#### **14.5. Conclusion**

This final piece of reflexivity looks back on my personal journey of conducting this research and what I have learnt as a consequence. There are, inevitably, findings to every research project; these are my own introspective findings that shed light on the experience of my personal, professional and academic journey. I have learned a great deal about eating disorders, the

therapeutic relationship and phenomenology since January 2008. I did not expect to learn quite so much about myself.

## Chapter 15: **CONCLUSION**

My impetus for this study, to better understand the experience of the relationship within adult eating disorder services, has driven me to complete this thesis. Conducting this study over two sites, in two phases, has resulted in an immense amount of rich data which has been presented in earlier chapters.

The utilisation of van Manen's methodological approach provided a structure and a guide to the phenomenological inquiry into the lifeworlds of the participants, both care workers and women with anorexia. Interpretive phenomenological studies do not intend to produce generalisable findings for practice (Holloway, 2005). Taking a phenomenological approach for this study has helped me to understand the lifeworld of the participants, and in doing so, to gain new understandings about the impact of current practice and consider this in the light of what else is known.

In total, 13 care workers and 12 women were interviewed, each giving very personal accounts. MAXQDA was used as a tool for the organisation of the emerging themes. The initial themes were subsequently re-organised into themes and sub-themes before being presented through the lens of Merleau-Ponty's existential themes of corporeality, relationality, spatiality and temporality and a fifth theme, 'authenticity' by drawing on Heideggerian insights. The existential reflections provided order and clustering of the emergent themes and enabled the data to be viewed in terms of the lived experience of the participants. This in turn illuminated their experience in such a way that we now know more about what it is to experience the therapeutic relationship within these settings.

Much of the literature around eating disorder services acknowledges the challenges and difficulty of working with a patient group who are not aligned to the goals of treatment (Ryan *et al*, 2006). When considering such a vulnerable client group who have deep rooted

difficulties and fixed beliefs about themselves we need to accept that agreement will be difficult to achieve and that, ultimately, the responsibility for making the relationship work is ours, the workers (Clarkeson, 2003). Snell *et al* (2010) are right in their suggestion that patients will be resistant and oppositional, but it remains the workers responsibility to create a positive environment and interactions that can build towards a relationship that is therapeutic and enhances the potential for recovery. Whilst it could be seen that a relationship that has therapeutic effects existed between the women with anorexia and their care workers, some fundamental features of the therapeutic relationship that have been previously accepted as pre-requisites in other contexts (e.g. mutuality and reciprocity) were not identified as crucial to the instrumental nature of this relationship.

Current perspectives of the therapeutic relationship focus predominantly on the shared understanding of the aims and expectations of both worker and patients which could be aligned to a model relating to a psychotherapeutic relationship with an individual therapist (Wright, 2010). It may be that, over time, we have developed an idealised view of the therapeutic relationship which is viewed as an 'ideal type'<sup>78</sup> and that there is an assumption that for a relationship to be therapeutic, it will fit into this model (Nafissi, 2005).

Bordin (1979) talks of reciprocity within the alliance but the findings of this study would suggest that the workers are the ones taking responsibility for the relationship, although they do attempt to share decision making about the treatment. There are many accounts of the patients treating the workers badly despite an often close and nurturing relationship, such that, if this were a personal relationship rather than a professional one, the relationship would fail. It is the professionalism and the empathy of the workers that ensures that they do not give up on the patients; rather, they are generally patient and forgiving. Additionally, when considering the three major tenets of Bordin's model, that of mutuality and agreement around

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<sup>78</sup> An analytical construct that identifies similarities as well as deviances, developed by the sociologist Max Weber (1864-1920).

the goal, the task and the bond, it is clear that, in SEDUs, the task and the goal relate to clinical endeavours, whilst the tearing and repairing of the bond is wholly relational and hence creates greater opportunities for success during the course of the care and treatment.

The space in which care took place has a bearing on recovery and how the women and workers related to each other. This was largely in terms of the perceived features of the institution than the actual space provided, which appeared homely and comfortable. The rules and regulations and the spaces that created fear (clinical room/ dining room) promoted responses that were similar to being imprisoned and thus created protest and conflict.

Recommendations are for the principles of 'nidotherapy' to be considered (Tyrer and Bajaj, 2005), where the environment conforms to the needs of the patient.

Being in the presence of someone who cares has been recognised as pivotal to a therapeutic relationship, both in terms of Benner's 'presencing' (Benner, 1984), but also in terms the preciousness attributed to time. The familiar saying '*time is a great healer*' has real meaning for the participants of this study.

Both the women and the care workers valued the relationship but the externalisation of the disorder, which was adopted to assist the adolescent and their family through the treatment process, created difficulties in the authenticity of the relationship between women (adults) with anorexia and their workers.

Whilst acknowledging the adult nature of the women in this study, it has been found that a temporary, maternalistic, nurturing approach was highly valued and recognised as only transitory. In the same way that a parent leads a child to a state of independence, so does the care worker, by establishing a trusting and parental style of relationship which eases their transition from vulnerable and frail anorexic to a state of recovery and independence. Thus, maternalism becomes a tool for transition.

A fractured relationship is inevitable when the woman's sense of self is split, that is, divided into the authentic ('real') self and the anorexic self. Hence, in order to gain an authentic and complete connection, it is suggested that the care worker focuses on the 'real' woman to establish a relationship with the part of the person that has the capacity for an authentic relationship. Thus, a two-fold intervention takes place, the relationship is potentiated and the woman's battle remains between them and their anorexia, rather than with their care workers.

Van Manen (1997) emphasised the importance of researching areas which have special significance or interest to individuals; to recognise their own thoughts and their autobiographical experience of the phenomena. In theorising the findings I have stayed true to the participants' accounts of their experience of the therapeutic relationship. From a personal perspective, 'Millie'<sup>79</sup> inspired me to gain a better understanding of how we, as care workers, can better connect with women with anorexia to assist in their journey to recovery and a positive view of themselves. Back in 1982 I questioned why care workers had not been able to help Millie to see how special she was, in this study, Lucy attributed her recovery to care-workers who created a connection with her which was initially maternalistic, then based on companionship. They gave her time and space, until she realised that:

*I was perfect just the way I was. Cos they showed me that.'*

Lucy, patient P1 i: 76

This study offers new knowledge and understanding about the experience of the relationship that occurs between women with anorexia and their care workers as no previous qualitative study of the therapeutic relationship involving both parties has been available, to date. The findings suggest that care workers should re-consider the assumptions of mutuality for this client group and thus construct their relationship differently. A meaningful connection can be

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<sup>79</sup> See chapter 1. Millie, a college friend, died of anorexia.

made between the care workers and the women which is based upon a 'tear and repair' model, but it is only therapeutic if the patient says that it is.

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## **APPENDICES**

## **Appendix 1: NHS ethics committee letter**

**Appendix 2: University of Central Lancashire ethics permission letter**

## Appendix 3: Participant information sheets with consent forms

### PATIENT INFORMATION SHEET

**Study title:** The study of therapeutic relationships and recovery within an eating disorder service.

#### **Invitation paragraph**

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

#### ***What is the purpose of the study?***

The study is about how care workers and patients build and maintain a relationship and how this might help or not help recovery from eating disorder. Not many research studies relate to adults who have an eating disorder, they concentrate on younger people. The purpose of this study is to gain some understanding of your experience of a relationship with your care workers and your understanding of recovery. I am also interviewing staff who will tell me about their understanding of the relationship and their understanding of recovery from eating disorder.

#### **Why have I been chosen?**

You have been chosen because you are a patient of an eating disorder service. I want to know about your views on your own personal experience because only you can tell me how your relationship with your carer impacted on you and what you think about your recovery.

#### **Do I have to take part?**

No. It is up to you to decide whether or not to take part. If you do decide to take part you can keep this information sheet to refer to and you will sign a consent form before you are interviewed. Even if you decide to take part and then later change your mind, or you do not feel well enough, you can withdraw at any time and without giving a reason. If you withdraw or decide not take part, the decision will not affect the standard of care you receive and you can still choose to take part later.

#### **What will happen to me if I take part?**

I will interview you for a period of up to 45 minutes and ask you about your experience of the ward and your understanding of how staff can help patients recover. I will not enquire into personal conflicts you may have with individuals and the emphasis will be positive. I will tell you before the interview what the topics are, and at any time, you can move the conversation on or stop. I will use a tape recorder so that I do not have to write notes and it will be like a conversation. You may ask me at any time to erase parts of the conversation even afterwards. This will be at the service that you are attending in a private room that I will arrange and at a time convenient for you. Usually I will finish on time, but if there are lots of issues that need more time, you can choose to extend the interview, or I may ask if I can interview you again. You can tell me if you feel you have given enough time to the study.

The interview is not expected to disturb you emotionally, but if I feel that emotional issues have arisen I will stop the recording to check this out with you, and may finish at that point and help you to access support.

**What are the possible benefits of taking part?**

The information from this study may help health professionals to better understand how relationships can be therapeutic in eating disorder settings for patients. There are no particular, immediate benefits to you, but the way we approach the care of others in your situation may be affected by the findings of this study.

**What happens when the research study stops?**

The information collected from all the participants in the study will be gathered together. All the issues discussed will be written in a report that describes the experience of being a patient or a care worker in an eating disorder unit and I expect to produce articles in journals that health professionals read.

The report will be submitted as part of an educational qualification.

**Will my taking part in this study be kept confidential?**

Any information which is collected about you during the course of the research will be kept strictly confidential to my research only. No-one at the hospital will be able to access these records and I will not reveal any information that occurs during a research interview to anyone at the hospital UNLESS you reveal to me that you are at serious risk of harm and in that case, I will talk to you about the need to talk to one of your workers and will negotiate a path to help you. Any information about you which leaves the hospital will have your name and address removed so that you cannot be identified from it. All information I collect will be stored securely at the University of Central Lancashire in accordance with the Data Protection Act.

Direct quotations from our conversations may be used in my report and publications, with pseudonyms attached. I will not use any information that might identify you inadvertently.

**What will happen to the results of the research study?**

The results of the research will be fed back in a number of ways. I will write a short report for the hospital directly but no individual will be mentioned by name and will endeavour to publish findings in a key nursing and/or healthcare journal. Copies of the results once presented can be obtained from the research team. You will not be identified in any report/publication.

**Who is organising and funding the research?**

This project is self funded by the researcher as part of a higher degree.

**Who has reviewed the study?**

The University Research Ethics Committee and approved by the Cumbria and Lancashire Local Research Ethics Committee through the national IRAS procedure. (LREC 11<sup>th</sup> June 2009)

**Contact for Further Information**

Karen Wright

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Victoria Street

PRESTON

PR1 2HE

Tel: 01772 893637

Email: [kmwright1@uclan.ac.uk](mailto:kmwright1@uclan.ac.uk)

Thank you very much for considering taking part in this study. You can have a copy of this and your signed consent form to keep should you wish to take part.



Centre Number:

Study Number:

Participant Identification Number for this project:

**PARTICIPANT CONSENT FORM**

**Title of Project:**

The study of the therapeutic relationship and recovery within an eating disorder unit

**Name of Researcher: Karen Wright**

**Please initial box**

- 1.I confirm that I have read and understand the information sheet dated .....
- (version 2) for the above study and have had the opportunity to ask questions.
- 2.I understand that my participation is voluntary and that I am free to withdraw
- at any time, without giving any reason.
- 3.I agree to the audio-tape recording of the interviews
- 4.I agree to take part in the above study.
- 5. I agree to (anonymised) quotes to be used in presentations and publications.

\_\_\_\_\_  
 Name of Participant                      Date                      Signature

\_\_\_\_\_  
 Name of Person taking consent Date                      Signature  
 (If different from researcher)

\_\_\_\_\_  
 Researcher                      Date                      Signature

1 for participant; 1 for researcher; 1 to be kept with hospital notes

## **CARE WORKER INFORMATION SHEET**

**Study title:** The study of therapeutic relationships and recovery within an eating disorder unit

### **Invitation paragraph**

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

*Thank you for reading this.*

### ***What is the purpose of the study?***

There is widespread agreement that a therapeutic relationship between care worker and patient is important and is central to recovery but there has been little work specifically relating to adults with serious eating disorder. The purpose of this study is to explore the views of patients and staff on how relations with staff help patients with eating disorder recover in the hospital setting. I am also interviewing patients who will tell me about their understanding of the relationship and their understanding of recovery from eating disorder.

### ***Why me?***

You are currently working in an eating disorder service and are involved in the care of people with eating disorders. As such, your views are important to this study.

### ***Do I have to take part?***

No, it is up to you to decide whether or not to take part. This information sheet is yours to keep so that you have time to decide. You need to sign a consent form and send it back to me, the researcher, if you decide to take part and I will arrange a convenient time and place for an interview, this can be at your place of work or at the University of Central Lancashire. You are free to cancel or withdraw at any time without giving a reason. If you withdraw or do not want to take part, this will not affect your role and no-one else in the hospital setting will have any access to information about who takes part and who doesn't.

### ***What will happen to me if I take part?***

I will interview you for a period of up to 45 minutes and ask you about your experience of the ward and your understanding of how staff can help patients recover. I will not enquire into personal conflicts you may have with any individual. I will tell you before the interview what the topics are and at any time, you can move the conversation on or stop. I will use a tape recorder so that I do not have to write notes and it will be like a conversation. You may ask me at any time to erase parts of the conversation even afterwards. Usually I will finish on time, but if there are lots of issues that need more time, I will ask you if you are able to extend the interview, or I may ask to come back. You can tell me at that time or later if you feel you have given enough time to the study.

The interview is not expected to disturb you emotionally, but if I feel that emotional issues have arisen I will finish at that point and help you to access support.

### ***What are the possible benefits of taking part?***

The information from this study will help to gain new knowledge about how relationships between staff and patients work in eating disorder settings, how these are experienced and effect recovery. New knowledge can help to share and change practice. Hence it may be that there are no particular, immediate benefits to yourself, but that your views may ultimately affect the way we approach the care of patients in eating disorder settings.

***What happens when the research study stops?***

When the research study stops, a report will be written that puts together all the information collected. Parts of the report may be published and feedback to your own setting as well as settings in other organisations that help patients with eating disorder will help to inform healthcare workers, researchers, patients and educators.

***Will my taking part in this study be kept confidential?***

No one but the researcher will have any access to information or data about individuals participating in this research, this includes recordings of conversations. At that time any identifiable information about you or your patients or colleagues will be anonymised, that is any names or ward details you mention will be removed and you will be identified by a pseudonym. I may quote parts of the conversation that we had, but I will not include anything that could be identified as coming from a particular individual. During the course of the research will be kept strictly confidential. Any information about you which leaves the service will have your name and address removed so that you cannot be recognised from it.

***Who is organising and funding the research?***

This project is self funded by the researcher as part of a higher degree.

***Who has reviewed the study?***

The University Research Ethics Committee and approved by the Cumbria and Lancashire Local Research Ethics Committee through the national IRAS procedure. LREC 11<sup>th</sup> June 2009

**Contact for Further Information**

Karen Wright

School of Nursing and Caring Sciences

Brook Building

Victoria Street

PRESTON

PR1 2HE

Tel: 01772 893637 Email: kmwright1@uclan.ac.uk

Thank you very much for considering taking part in this study. You can have a copy of this and your signed consent form to keep should you wish to take part.



Centre Number:

Study Number:

Participant Identification Number for this project:

### CARE WORKER CONSENT FORM

**Title of Project: The study of therapeutic relationships and recovery within an eating disorder unit**

**Name of Researcher: Karen Wright**

**Please initial box**

1. I confirm that I have read and understand the information sheet dated .....   
(version 2) for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw   
at any time, without giving any reason.
3. I agree to the audio-tape recording of the interviews
4. I agree to take part in the above study.
5. I agree to (anonymised) quotes to be used in presentations and publications.

\_\_\_\_\_  
Name of Participant                      Date                      Signature

\_\_\_\_\_  
Name of Person taking consent      Date                      Signature  
(If different from researcher)

\_\_\_\_\_  
Researcher                                  Date                      Signature

1 for participant; 1 for researcher

#### **Appendix 4: Semi-structured interview schedule for patients**

- Ice-breaker
- Introduction to interview
- Please can you tell me about the relationship that you have with the workers?
  - do you get much chance to talk ?
  - Do you have somebody in particular that you talk to and feel is there to help you – you as an individual?
- What is a good relationship like?
  - how does it feel? How do you know it is good? Who is in control? Is there anything in particular that encourages you to stay with the care plan?
  - Think about a specific incident...
  - Was there any time when you think you might not have got through if it wasn't for somebody in particular.
  - Think of a time when you made a connection- when you felt somebody made a difference? What was that like? What effect did it have within your recovery?
- How important is it that you have a therapeutic relationship with the workers here?
  - is it an individual thing? Could the patient get better without? Different with different workers? specific experiences? What would happen in an ideal world?
- Do you think that there is agreement between the workers and the patients about the goals of admission?
  - When you were first admitted did you sit down with a worker and talk about what you wanted. How similar was this to as what they seemed to want? (Common understanding?).
  - Did you ever feel like you didn't want to stay? what made you carry on?
- What happens when a relationship is struggling?
  - How did it affect the way you were with each other? did it get better? How? Who helped? Think back to a time...fix the moment- what happened there?
- What does recovery look like? (this question taken out)
- Anything else? Is there anything else that you think I should know and that could help me understand your experience of the therapeutic relationship?

## Appendix 5: Semi-structured interview schedule for workers

- Ice-breaker
- Introduction to interview
- Please can you tell me about the relationship that you have with the patients?
- What is a good relationship like?
- How important is it that the worker has a relationship with the patient?
  - is it an individual thing? Could the patient get better without? Different with different workers? specific experiences? What would happen in an ideal world?
- Tell me about the relationship that you have with the patients?
  - how does it feel? How do you know it is good? Who is in control?
  - Think about a specific incident
  - Think of a time when you made a connection- when you felt you made a difference? What was that like? What effect did it have?
- Do you think that there is agreement between the workers and the patients about the goals of admission?
  - tell me how the goals are established at admission? do you sit down with a patient and talk about what they want? Was there similarity/ Common understanding about the reasons for admission?
- What happens when a relationship is struggling?
  - How did it affect the way you were with each other? did it get better? How? Who helped? Think back to a time... fix the moment...what happened there?
- What does recovery look like? (this question taken out)
- Anything else? Is there anything else that you think I should know and that could help me understand your experience of the therapeutic relationship ?

## Appendix 6: the toast story

Throughout phase one of the data collection I was acutely aware of the participant's tendency to tell me about the therapeutic relationships they had in a very descriptive way. This was especially true of the care workers who had a tendency to tell me what they knew about the TR and what it should look like, rather than their experience of the TR. I struggled with how I might persuade them to speak from their own perspective, telling me what they experienced within the relationship rather than what they knew about it.

Finally I came up with an idea that I thought that I would try with phase two participants- it worked, so I kept doing it.

I said something like this:

*'I am going to ask you about your relationships with your workers/ patients. Now because this is a study of the **lived experience** of the TR I would like you to tell me about your relationships as you experience them. Sometimes it is hard to find those words, and we often default to telling people things that we **know** rather than things we experience on a personal level. Everybody's experience is different, your story is unique, so, there are no right or wrong answers. Let me give you an example:*

*Let me tell you about my breakfast this morning:*

*'This morning, I had toast and marmalade for breakfast.'*

*Now, the lived experience account (or phenomenological account of my breakfast):*

*'As usual, I am doing a million things at once, as I stick the bread into the toaster I am also rooting in the dishwasher for a plate and shouting out to my son as he leaves with his lunch box still on the kitchen table. The toaster is full of crumbs so I smell burning and throw the back door wide open to avoid the smoke detector going off. Typically, the little imp has used*

*the last of the butter so I root in the fridge for another pack. The toast pops up, the nuttiness of the seeded bread is lovely and makes me remember how miss this sort of bread that we haven't had for ages because it's a bit expensive. I scrape away at the cold, hard butter and then, as I put the first scraping on the hot toast I see it melting. Now, for the marmalade...not that orange one with the sticky top that the kids have, I am searching for the 'grown up' marmalade that my mum used to buy. It's Roses Lime marmalade, and reserved for mums! On goes the marmalade and as I lean back against the kitchen work top with a steaming cup of tea in one hand and my yummy toast in the other I take a sigh of relief that I am the only one left in the house and I can just have a moment or two's peace before I too fly out that door to work.*

It seemed to make a difference. It was apparent that I was interested in them, their world, their experience.

## Appendix 7: Bracketing statement<sup>80</sup>

### **My pre-conceived ideas and putting them aside: acknowledging what is known already.**

In all types of research it is important to acknowledge what we know at the start; we identify what we want to find out and then we seek to clarify what is new knowledge, or an extension of previous knowledge. Hence, what is known in the literature and what is known to us from personal or professional contexts will impact on the question 'what do we know already?'. In phenomenology there are two broad perspectives. The first, descriptive phenomenological studies, which are derived from Husserlian philosophy, suggest that the literature review should be conducted last to ensure that it does not *cloud* the mind of the researcher.

The researcher is also advised to 'bracket' (see below) current understandings of the phenomena, eliciting a view that all information is seen in the context in which it is found, where it can be seen for its own worth without the biases which may be brought about by prior thoughts or expectations (Husserl, 1970). Streubert and Carpenter (1999) are quite clear that a detailed literature review should not be conducted prior to initiating the study. The Husserlian tradition for descriptive phenomenology is also favoured by Giorgi who maintains that the object of phenomenological description is achieved through an intuiting of the phenomena and that any preconceived ideas, gained by reviewing literature already published in the area, for example, can inhibit the process of discovery (Giorgi, 1985). The whole ethos of Husserlian phenomenology is that we go '*back to the things themselves*', which Moran describes as phenomenology's '*clarion cry*' (Moran, 2000: 9). This means that we should approach our study of a particular phenomenon by studying it in its every day context, emphasising the importance of *intuition*. The meaning of *intuition* requires some consideration here; Henri Bergson describes it as:

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<sup>80</sup> This is a conglomerate of minor bracketing statements made at regular intervals throughout the process of the study.

*'By intuition is meant the kind of intellectual sympathy by which one places oneself within the object to coincide with that which is unique in it and consequently inexpressible.'* (Bergson H. 1913, cited by Moran, 2000: 10)

Hence, I wish to reflect upon my starting position not to set aside my pre-conceived ideas and understandings, in order to formally 'bracket' and separate. I do not believe that, for me, that is possible. I would like, however, to identify what is 'mine' in terms of my thoughts, understandings and assumptions about the therapeutic relationship within the eating disorder setting. Then, I can enter into the research with an open mind and one that values the contributions of the participants for themselves and not for any connection that they have with my thoughts. I appreciate the futility of attempting to 'bracket' my own thoughts, so my rationale is simply to label these thoughts as mine. My journey through the accounts of others may change the way I think about the therapeutic relationship and I hope that, by acknowledging my thoughts at this stage, that I can see the distance travelled when I reflect back later.

I was well aware of the theories about the therapeutic relationship or nurse-patient relationship; I had both studied and taught them. Some of my knowledge and/or assumptions were challenged by my supervision team prior to commencing the research, requiring me to explain and deconstruct my perspective within supervision. The first was the very title of the phenomena being investigated, the *therapeutic relationship*. I was asked *how do we know that it is therapeutic? Surely, it is simply 'the relationship?'*

Also on a personal level, and as a woman with a teenage daughter, I saw young women in hospital wasting away and defiantly refusing to be helped, repeatedly denying the need for help and asserting their belief that they did not need treatment. It took me back to my days as a student nurse when 'Millie' died and I was called to conduct her last offices. At that time I felt despair and frustration with the people paid to care for her. I never felt frustration towards her.

Additionally, I can see that the current staff on the SEDU were causing the women a huge amount of distress by forcing them to eat. Eating was seen as “disgusting”, “uncomfortable” and “frightening” to them, but the staff just kept on trying to persuade them to eat. I struggled with the possibility that any positive relationship could be developed under these conditions where perspectives were so dichotomous and conflicting. Yet, despite this, I witnessed some compassionate and caring connection between staff and patients. Patients sought comfort and cuddles from the staff who were imposing the feeding regimes, but then on other occasions screamed expletives at them and would even throw or spit food out. Some people do recover and I wondered what happened to create a connection that allowed therapeutic work to progress. For me, the relationship is the conduit for all interventions to occur. Hence it seemed pivotal to gain an understanding of the experience of the relationship, from both parties.

I readily admit to feeling a sense of helplessness and impotence when witnessing these scenes.

My second and most important assumption was that the relationship between the worker and the patients was a difficult one. By difficult, I mean strained, that perspectives were incompatible and that there was an uneasy tension that existed between the healthcare professionals, particularly the nurses and the women. When I reflect upon why I thought this, it is largely based upon nursing office conversations that I overheard where (mainly) nurses would 'let off steam' about the frustrations of caring for this client group.

If I am really honest, this upset me on a number of levels. Firstly, because a school friend of mine died of anorexia and because I do not think that it is any of our business to be making pejorative and unhelpful statements about the women. We are paid to care, we are supposed to have unconditional positive regard - and whilst I am no angel - personal and negative comments do not help anybody and have a tendency to create bias towards individuals. We are not paid to do that, we are paid to be compassionate. Also, I believe that we can say that somebody's behaviour is challenging or difficult - but to call the person 'difficult' creates their

identity. It does not matter whether we like the patient or not. Patients who are likeable might seem easier to care for, so maybe calling the patients by names that register them as unlikeable might be a justification for the hardship experienced in caring for them. Personally, I think that we can learn ways of caring for people in a way that is compassionate, even if we struggle with that intuitively, or go to work somewhere else.

Literature is heavily laden with such references and there are many similarities between the recorded responses to people with an eating disorder to people with a personality disorder. I have spent many more hours caring for people with PD rather than ED and I am aware that although many authors claim that the interface between the two creates the possibility that EDs are PDs anyway, I am troubled by the professional negativity and exclusion that people with these diagnoses experience.

### **Observations on the ward**

The women's behaviour observed was more akin to that of teenage girls.

- adult women often in night attire which looked appropriate for teenage girls, such as Winnie the Pooh pyjamas and big fluffy slippers that looked like animal heads
- elaborately painting each other's finger nails and sharing make-up tips
- piles of glossy magazines
- ribbons in hair/ plaits
- colouring books and games
- 'cuddles' from nurses
- 'little' voices
- teddies and blankets

Accounts from workers in the service, heard whilst on unit, not as part of the research study

- 'attention seeking' attributed to patients
- patients frequently referred to as 'PD'
- the upset and frustration experienced in trying to care and seeing no progress month after month

My observations of the interpersonal relationships between staff and patients

- kindness, patience and cuddles seen
- some staff certainly seemed more disciplined in their approaches whilst others seemed 'soft and warm'.

- the nurses were very accessible and available
- I worried that the pressure applied to the women at meal times might be construed as coercive
- a sense of the futility of the constant battle.
- the environment seemed to be a rationalised, but controlled one.

I made many more notes throughout the journey of this research, some of which caused me to return to my subjectivity and reflection on my 'gut feelings' and intuitions and then reflexively. The reflection upon my 'bracketed' thoughts then became a little mingled. It is important for me to recognise the cloudiness of that experience and acknowledge that those moments tended to be following interviews with the women that had high emotional content or were very disclosing. When I search myself for insights into what was happening for me then, it was in those times that I felt most human and least academic. It was as though I had been invited into the lifeworld of the participant during the course of the interview. I could hold myself together in terms of my professionalism and demeanour during the interview, but then, away from the hospital, listening to the recording afterwards, that veneer was stripped away. There were times, alone in my study, when the words of the women brought me to tears. Each time I sought additional supervision and wrote it down. Then, positioning it on paper I felt as though I could 'let it go'. I knew that these women were in safe hands, they trusted me with their accounts and I knew how precious their words were. Only once did I need to pause the recording to seek permission to share something with a worker and that was with Anna.

## Appendix 8: Reflexive journal example

### Example of reflective notes:

Today I want to write down my thoughts after seeing 'Anna' a nurse 'Lily' who I also saw yesterday. Both have made me feel as though I need to write down how I feel and what will, inevitably keep me awake tonight, if I don't off-load it onto the paper. At the moment there are lots of thoughts that will be easier to disentangle if I can take myself to each interview and reflect upon them separately.

'Lily'

Lily is a young staff nurse. She is uber confident and looks like she has walked out of the pages of a glossy magazine. Yesterday, she disclosed to me, during the interview, that she had had an eating disorder herself when she was younger. She became quite tearful. I wasn't expecting this. I have interviewed quite a few workers and I have found it much harder to persuade them to talk from a personal perspective, about their experience. They tend to talk on a much more intellectualised level, as though they fall into a default theory telling position. I guess they teach the theory of the TR to student nurses etc all the time. Even after the 'toast' illustration, they will often say 'we', instead of 'I' and relate their accounts to policies and the units ways of doing things. Not always, but there is a definite inclination to do that. Maybe also because they know I am a nurse lecturer. I always say that there are no wrong answers' and that it is about their experience of the relationship- not description etc etc.

One of the things that Lily said was:

*We always just try and reinforce that the other, the anorexic side is not the right route and the route of getting well, the other side of them is the right way to go. And we try and stress how destructive anorexia is or bulimia. That's the angle we work from in this particular unit,*

*I don't know what anybody else does, but we just reinforce to them how destructive the illness is and how it ruins your life.*

Then she just broke down, she told me about her own past experience of ED and became unable to compose herself for some time, (about 15 minutes). But it isn't that incident that has troubled me. We dealt with it, she had tissues, we were quiet, I asked her if she would like to be on her own, she said no. It was how she behaved today when I went to the unit to conduct other interviews that has troubled me. I went to the office, as usual, to check that the people I was due to interview were ok to go ahead and to organise a room and 'Lily' was there. I said hello and asked her if she was 'alright' and she seemed quite cool, diverted her eyes and was reluctant to engage in any conversation at all. I really needed her to consider the needs of the women I was going to see and if they were well enough to be interviewed but she just said 'oh hiya, you're in the downstairs lounge' and went out of the office. I assumed that she was just busy and carried on.

Being a researcher is an unusual role- it's neither inside nor outside the organisation. I am not there as a nurse and I even though I am there for days on end, nobody really gets to know me because I am locked away listening to others. Lily is not my responsibility but I felt responsible for creating the environment that caused her to become upset. I knew what do if one of the women got upset, there were strategies in place for that, but I didn't expect the staff to get upset. Was that narrow-minded of me? Also, if the women got upset there were support strategies there and people to care for them.

I need to come back to this, after thinking about 'Anna'

'Anna' is a thirty six year old ballet dancer. From a distance she looks about twelve years old. She is graceful and delicate. She is tiny, her skin is like bone china and her huge eyes make unshifting contact with mine. Nobody needed to tell me that Anna had anorexia, she is skeletal. But she is in complete and utter denial about how poorly she is, although, she is a brilliant story teller. She has told me all about an amazing relationship that she has with one of the nurses here and she really knows how to talk from the heart, with absolute genuineness. However, she said some things that really worried me, that made me think that I should stop the tape and get help for her. I asked her if I should stop the tape, if the workers knew; she said they did and that she was going to be moved to a unit where she would be detained under the MHA and she would be tube fed, if she didn't eat her tea tonight. I asked her if she wanted to continue and she said that she certainly did, she was enjoying being able to talk and she thought that the staff would be pleased that she was sat down for so long. She has a little girl who she says just sees her as 'mummy' not as anorexic. I felt impotent, I did not like the fact that I was causing her to talk to me, but I was going to do nothing for her. I know that the researcher's role is not to help people, but for me it is innate. I was holding myself back. I was saying 'go on..' and 'tell me what that was like' allowing her to go deeper and deeper into her experience.

Afterwards, I worried that it wasn't helpful for her to dig herself deeper into her experience. I tried to speak to Lily, but she said, 'yes we know'. I was glad that they knew, it was their job to care, not mine. But I did care.

I am home now. I have checked the recordings, they are clear and so I will download to the university network tomorrow. I hear Anna's little voice and I cry. I cry for Anna but also because I feel pathetic, useless.

Now I feel a little frustrated and mixed up because of Lily. I am guessing that she was a little stand offish today because she opened up too much for her own comfort yesterday.

The hospital feels like a house, it feels homely. But when it comes down to it, it is not a house, it is not a home and the staff are definitely not members of the family. It is as clinical as if it had disinfectant smelling lino on the floor and clipboards at the ends of metal framed beds. Neither am I a guest? I am a jobbing researcher and none of this fits together very well for me. I will see somebody tomorrow and work through this.

## Appendix 9. Published papers