



**Holding them down: the lived experience of  
mental health nurses when force feeding  
patients with eating disorders**

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## Introduction

Anorexia nervosa (AN) is a serious mental health issue with long-lasting consequences on the physical and mental health of those with the illness [1]. Rates of inpatient admissions, often reserved for patients considered most at risk, have risen steadily in the UK during recent years [2]. These units are typically set up to promote recovery from AN, and are designed to work with patients collaboratively towards this goal [3].

For some patients, sectioning, to compel a patient to receive treatment, may be used [4]. This is seen as a last resort, an intervention used when a patient denies the seriousness of their illness despite their AN becoming life threatening [5]. Once sectioning occurs, collaborative treatment is still strived for [6], although the use of forced interventions become clinical options if deemed absolutely necessary [7].

Forced interventions may involve feeding via naso-gastric tube (for calorific intake), including doing so against the patients' will and therefore under restraint; rapid tranquilisation via intramuscular injection (to prevent excessive exercise or deliberate harm to self or others); and physical restraint of the patient by clinicians (to prevent harm to self or others).

Development of a therapeutic alliance between clinician and patient in this setting plays an important role in treatment outcome [8], yet can be a hard thing for a clinician to foster [9]. The use of compulsory treatment compounds the problems of developing a workable therapeutic alliance, as a majority of patients who are placed under a legal restraining order originally entered treatment as an informal patient [10].

There have been but a handful of empirical studies regarding the impact of compelled treatment and forced interventions. The tentative consensus is that short-term outcomes are comparable between informal patients and those legally committed to treatment [10]. The aforementioned use of forced interventions is largely guided by clinical 'feel' and experience, rather than evidence [11].

The role of the eating disorder nurse is recognised to be difficult and challenging, even when working with patients who are in treatment voluntarily [9, 12]. No work to date has paid due attention to the experiences of healthcare professionals whose role it is, at times, to force-feed, restrain, or forcibly inject their patients.

It was the aim of this to examine the experiences of clinicians who are required to enforce treatment on their patients. How, for example, do people in a caring profession manage the feelings of having to force feed patients under restraint? How do these experiences shape their approach to their work, and their response to their patients?

These issues have until now, been neglected by researchers in this field, but are of great importance to understand: clinicians who perform these duties are in need of appropriate levels of training, support, and specialist supervision to enable them to process these experiences effectively. This is particularly salient when considering the risks of burnout, sick leave, or compassion fatigue, which may lead to poor standards of care if these needs are left unaddressed [13].

## Context Setting: The national picture of sectioning patients with anorexia

Prior to commencing this study, the project lead sent Freedom of Information (Fol) requests to all fifty-one specialist NHS Mental Health Trusts in England. Each Fol request asked if the Trust had a specialist in-patient eating disorder unit (SIEDU), and if so, requested year-by-year admission rates for 2008-2014, and year-by-year rates of eating disorder patients being involuntarily compelled to treatment for 2008-2014. Fol requests were utilised in anticipation of a high response rate and accurate data: once a Fol request has been received, the organisation contacted is required to provide data within twenty working days. As such, this was a timely, cost-effective and reliable method for retrieving such data on a national scale.

A one-hundred per-cent response rate from NHS Trusts was received. Of the 51 Trusts, 35 (69%) did not have SIEDU's. Of the 16 Trusts who did have inpatient eating disorder provision, 14 (87.5%) provided all of the information that the Fol applications requested, whilst 2 (12.5%) provided admission numbers but could not provide details on involuntary commitment due to lacking sufficient data in their records. These two Trusts have been excluded from subsequent analysis. Chart one illustrates the rise in number of ED patients across England who were treated under section between 2008 and 2014. Chart two shows the rise in the proportion (percentage) of patients being treated under section in this same time period.

Twelve of the SIEDU's (86%) reported sectioning more patients in 2014 than they did in 2008. On average, these units treated an additional five patients on section (range 1-13) in 2014 compared to 2008. One major national treatment unit was treating 4% of its patients under section in 2008, but by 2014 this figure had risen to 54%.

Paired t-tests examined if there were any statistically significant differences in the numbers of patients admitted to SIEDU's, the number of patients treated under section, and the percentage of patients treated under section across the course of the study's timescale (2008-2014). No differences were detected between the numbers of patients admitted in 2008 and 2014 ( $t = 0.13$ ,  $df = 13$ ,  $p = .990$ ). Significant differences were found both in the number of patients treated under section across time ( $t = -4.18$ ,  $df = 13$ ,  $p = .001$ ), and in the percentage of patients treated under section across time ( $t = -2.99$ ,  $df = 13$ ,  $p = .011$ ).

Data on this level has not been collected before, and makes for sobering reading. Significantly more patients are being legally compelled to treatment in 2014 compared to 2008. A rise in the number and proportion of patients treated this way has risen in the majority (86%) of national NHS units. The initial purpose of uncovering these figures was to provide some context to the stories the participants from this study told. It is not a given that forced interventions are utilised once a patient with AN is legally detained to treatment, yet forced treatment can only be used once detainment has occurred. It is not a stretch of the imagination to infer that a

nation-wide increase in legal detainment has led to similar increases in the use of forced interventions, but future research on this area is much needed to understand exactly what treatment is being provided to these patients.

## Design and Methods

Semi-structured in-depth interviews were employed, covering themes elicited from the literature review and refined in a focus group of eating disorder specialists. The following interview topics were covered: experiences of delivering forced care, feelings evoked around these experiences, and the coping mechanisms employed. Interviews lasted typically between 50 and 60 minutes, were recorded using a digital audio recorder, and subsequently transcribed in their entirety, available for external scrutiny within the bounds of confidentiality. Interviews covered the key topics as summarised above, but were also flexibly responsive to the participants' narratives. The principle research question was to uncover the core experiences of being a clinician who, at times, had to enact forced treatment on their patients.

### Participants and sampling methods

Inclusion criteria for the study included any clinical staff who were working, or had worked up to two years prior to the study, on specialist in-patient eating disorders units in the UK. All interviewees were required to provide signed informed consent to participation following a written briefing of the study aims and protocol. These staff were required to have been actively engaged in delivering forced treatment to patients with eating disorders. Excluded from the study were professionals who were part of the treatment team for patients who required forced care, but who did not directly deliver such care (psychiatrists or dieticians for example). Specifically, this involved interviewing mental health nurses (RMN) and healthcare assistants (HCA), who were the only two professions who actively engage in the direct delivery of these interventions. Twelve participants (aged 22 – 48, mean 31 years) of whom 7 (6 female, 1 male) were RMN, and 5 (2 female, 3 male) were HCA participated in the semi-structured interviews. A total of fifteen potential participants were approached to take part in the interviews, but 3 (2 RMN, 1 HCA) declined to take part, citing a lack of time or desire to engage with the study.

Sampling was purposive, and participants worked at one of three national eating disorders centres in the UK. Data saturation prior to cessation of data collection was not sought: under an IPA framework, data saturation is often not considered possible or indeed desirable [15]. Instead, this sample would provide rich data based upon their own personal lived experiences – which is the primary goal of employing IPA as a framework.

## Analysis

Interview transcripts were read and emerging themes were highlighted as primary topics of relation to the research question. The project lead, together with a research assistant re-read transcripts and codified primary topics throughout, and amalgamated data on the themes. Definitions of themes were subsequently agreed upon.

Half of the transcripts were recoded according to those definitions, and then all subsequent transcripts were recoded. Definitions were refined on discussion throughout this process. The project lead re-read a random sample of transcripts to assess the construct validity of theme definitions. Categories of inter-related themes were developed independently by the researchers, with flow charts employed to associate themes and categories.

Horizontal analyses were used to group clusters of text thematically, and the repetition of analyses ensured bias was minimised, and no major themes were overlooked. As themes emerged, evidence that was potentially contradictory was sought for, explored, and analysis was modified to take this into account.

## Findings from interviews conducted with nursing team members who deliver forced treatment

Four key categories emerged from the analysis, which will be separately discussed in the following sub-sections, which encompass areas such as: dangers of forced interventions ('it's unsafe for all of us'), professional duality ('I'm supposed to be caring for them and I'm fighting, literally fighting'), disassociation ('just switch off and grab a limb'), and burnout ('you just can't switch off from it'). In broad terms, dangers of forced interventions and issues of professional duality relate to the direct experiences of delivering forced care on eating disorders units, whilst disassociation and burnout relate to the responses to these experiences.

### "It's unsafe for all of us"

All interviewees touched upon their concerns about safety and the perceived dangers of implementing forced care. This lack of safety for some stems from a lack of specific training and guidance as to how to conduct the eating-disorder specific interventions such as tube feeding a patient under restraint. Some of the perceived danger stemmed from a lack of space in which to execute the intervention safely, whilst some concerns were about the patient themselves, and the dangers of being involved in a physical confrontation whilst severely physically unwell.

Participants spoke of the physical dangers of restraining and tube feeding patients. Some were concerned with the danger posed to staff who had to deliver forced feeds:

*"I have colleagues who've been bitten, we got spat at, scratched, kicked. They're just so terrified of the feed they'll do anything they can to us."* (HCA1)

Other interviewees were concerned with issues of patient safety, and whether such a physical intervention could do additional harm to patients:

*"How safe can it be? You have a patient who is so ill she needs to be tubed – maybe poor heart output, brittle bones, stuff like that too, you know, and you're wrestling with them, four or five on one, and you're wrestling to get the tube in and with all the effort you're just praying she doesn't have a heart attack or broken arm you know? Awful."* (RMN3)

A lack of clear space in which to carry out forced tube feeding are a source of concern and frustration amongst interviewees, who felt as if the lack of specific facilities placed all involved in the process at further risk:

*“You’ve got no space. So it’s done it their bedspace. There’s hardly any room once we’re all in – we’re talking one single bedspace with furniture and the like, and the patient, and up to five or six staff.” (RMN7)*

*“Our ward’s not designed for it. We have only their bedspace to do it in, there’s nowhere else. There’s been no thought of the practicalities.” (RMN1)*

It was felt that this situation exacerbated the risks posed by forced intervention procedures, and participants highlighted that to alleviate this, eating disorder units who tube feed patients against their will should invest in proper facilities to assist the process:

*“We need a space away from their room, somewhere with all the equipment, plus padding, cushions and all that, somewhere safe.” (HCA5)*

The above issues contributed to a feeling of a lack of safety in the procedure of delivering forced care. Perhaps the greatest issue regarding safety though, was that there is a lack of actual professional guidelines as to how to carry out forced interventions. This, participants felt, significantly compromised their professional standards. When discussing the issue of tube feeding under restraint, interviewees were quick to raise that even though they were expected to restrain and tube feed patients on a regular basis, there was no specific training on how to deliver this intervention:

*“At no point have we been trained what to do – no one knows the best way, safest way to do it, we all just find what works and do it, but it always feels so risky you know? If there was a specific ‘this is how you restrain and tube feed’ course, then great, we’re doing the right thing, but there’s not.” (RMN7)*

*“All staff have to complete a control and restraint course, and they think that then we can restrain patients when we tube them. But, the course is like set up for all disciplines, it’s about managing violent patients more than anything, so it’s great if you work on an acute ward, but useless for our purposes.” (HCA3)*

This lack of eating-disordered-specific training for restrain is evident when interviewees discussed the actual processes involved when feeding a patient under restraint:

*“The only training is on the job, in the room with a patient. It’s like ‘you grab a leg, you an arm, you the head and lets go’. When you first do it, it’s terrifying – what if I’m using the wrong hold and they end up breaking an arm or something you know? Then you find out there is no right hold because no one’s given it any thought.” (HCA1)*

Alongside the physical dangers of this, as outlined above, participants – notably the professionally qualified RMN’s – felt this added up to their professional standards being put at risk:

*“It leaves us terribly open, professionally. If you have to use five staff to hold down a patient, get a tube down, pass the feed down, and they’re fighting it, it’s violent. It’s tough. If someone gets hurt can we say we did it by the book, safely? Well - there is no book. It’s unsafe for all of us.” (RMN2)*

### **“I’m supposed to be caring for them, and I’m fighting. Literally fighting”**

A key theme that appeared throughout the interviews was the existence of a psychological balancing act being performed by staff who deliver forced interventions. Many interviewees spoke of a struggle between seeing oneself as a carer on one hand, and an enforcer on the other.

*“When it’s your patient, it’s particularly hard. You’ve just spent an hour working, talking with them about their past or whatever, how they feel and then later you’re clamping their head as someone passes the tube down” (HCA1)*

*“I’m supposed to be caring for them – and I’m fighting, literally fighting. And you know their history and it impacts on you. You feel abusive. Tainted.” (RMN7)*

This new duality to the nursing role also leads, according to one interviewee, to patients developing a similar dual vision of the nurse in this environment:

*“I think they [the patients] perceive you differently too – even the patients who are informal, there to recover. They know what you’re doing and it makes them wary of you too, I think. You’re no longer a nurse to them either – you’re also...I don’t know, a combatant, a...a guard. It just creates barriers, everywhere.” (RMN3)*

Alongside this professional duality, interviewees also spoke of a moral or ethical duality that they struggled with. Many spoke of feeling as if they were no longer caring for the patient, and were actually doing the wrong thing by tube-feeding under restraint:

*“You’re telling me that you’ve got a patient with a history of sexual abuse – lots of them do, at this point, yeah? – and then you get a load of strangers pile into their bedroom, hold her down and shove something in them against their will – it’s hard to feel like you’re doing a good job there, you know?” (RMN4)*

*“I definitely felt with some patients, just ship them out to palliative care or something you know? We could be helping others, but we were locked in this cycle of mutual abuse, them of us, us of them, and no one won. It just felt pointless.” (RMN1)*

At the same time, however, they also spoke of their hope of doing the right thing by the patient:

*“I tend to hope that it’s okay – that we’re taking on the anorexia rather than the patient, I hope in time they see that, that we do too.” (RMN1)*

*“You know, somewhere deep down, there’s no other way, really. We are saving a life. But in the moment, when that life doesn’t want saving, it doesn’t feel like it.” (RMN4)*

### **“Just switch off and grab a limb”**

Perhaps as a means to manage these conflicting emotions and experiences, interviewees reported using a series of techniques to divert their attention away from the experience of force-feeding. One such common approach was a form of dehumanisation of the patient that they were force feeding. Rather than approaching them as an individual person, interviewees spoke of seeing them as a non-sentient body part, of which they were to hold on to during the restraint:

*“Just switch off, grab a limb, keep hold and think of something else – songs, shopping lists I’ve done it all – anything to distract myself” (RMN3)*

*“Grab an arm, focus on it, just an arm you know? Its worse if you have to hold the head – a head’s got a face, its clearer it’s a person you know?” (HCA2)*

This tactic – to dehumanise the patient in order for the clinician to disassociate from the psychological difficulties of delivering forced care is mirrored in the way that interviewees felt that they were treated. They spoke of how they felt their difficulties in delivering forced care were not considered by those who they perceived to be higher in the chain of command – clinical managers, consultants, and other staff who did not engage in the delivery of forced treatment:

*“We’re left to it – do the consultants actually know what it’s like, what happens? Do they care? The rest of the team, other disciplines, do they? At the end of the day we’re left to it, and no one really wants to know” (RMN3)*

*“No-one really cares how many people we feed, how exhausting it is – we’re a part of the machine, not people about to break” (RMN2)*

Disassociation of the process of forced care was not just evident in participants’ accounts of what happens during the intervention, but also in the descriptions of their approach to treatment before and after the forced intervention takes place. The following are examples of this, in which escaping the reality of the process is a key coping mechanism:

*“It all gets a bit gun-ho. Trying to convince ourselves, gee ourselves up you know? We’re all like ‘yeah let’s just do it let’s go’ but so little thought goes into planning it, or talking about it after. We try and fool ourselves it’s all okay I guess.” (HCA4)*

*“Grim humour, gallows humour – not during the restraint, where we’re always business like, almost introverted – but before and after, we escape using humour.” (RMN1)*

Despite this process of disassociation, the experiences of delivering forced care are still felt deeply by protagonists, as the next theme to be discussed identifies.

### **“You just can’t switch off from it”**

The preceding themes from the interview data have dealt with the experiences (feelings of lack of safety, struggles of the carer-enforcer balancing act) and responses (disassociation and dehumanisation) to delivering forced care. The final core theme to emerge from the data was more related to the consequences of delivering this form of care, and indeed the consequences of the aforementioned experiences and responses of interviewees.

Interviewees noted that these consequences often manifested themselves as feeling ‘burnt out’, and analysis showed there were two broad types of burn out – described hereon as micro and macro. On the micro level, participants spoke of a type of short-term burnout in which, on an individual level, they felt exhausted prior to the end of their shift:

*“I’ve had patients come and ask for help, but although I see them, they get crap care – my heads still in that room, either stressed or exhausted or whatever, but I’ve got nothing positive to give at times like that” (RMN5)*

*“Definitely, by midway through a shift where you’ve done it a couple of times, you’re out on your feet, you’re praying for the next shift to take over” (HCA3)*

At times too, this micro-level burnout encroached beyond the ward environment and into the interviewees’ non-work life, which in turn impacts on their ability to return to work suitably refreshed:

*“I’ve had nightmares about tubing, really intense dreams, you just can’t switch off from it” (HCA1)*

*“I’ve taken days, phoned sick as I just can’t face any more, not so many days in a row you know, so many feeds. We all do.” (RMN7)*

The above experiences are a progression from the micro, or short term feelings of burnout. Indeed, many participants spoke of a team-wide, long-term sense of burnout that in this study was termed macro-level burnout:

*“I definitely think the number of [serious, or adverse] incidents has risen as this has gone on you know – the team’s exhausted, loses vigilance, doesn’t have time for patients’needs” (HCA5)*

*“We can’t do the work we’re trained to do...we’re broken, burnt out. We go on, just not very well, the team’s not like it was, we’re spent.” (RMN3)*

This, ultimately leads to the situation whereby many specialised clinicians choose to take their skills to a different setting in which the difficulties presented by delivering forced treatment are no longer present:

*“Lots leave – some of the best nurses I’ve worked with have gone elsewhere you know, community work, because the strain’s too much.” (RMN6)*

## Conclusions from this report

The core of this study is the collective stories and experiences of specialist staff who have delivered forced treatment to their patients. These experiences have been ignored in the literature until now – and the experiences of these staff are unsettling. Undoubtedly, this data stems from a small sample of professionals, yet the analytic framework used – IPA – has no requirements of ‘data saturation’ or large sample numbers: the experiences are enough in themselves.

Undoubtedly, these experiences make for uncomfortable reading. To hear staff describe carrying out a complex, potentially dangerous intervention without the assistance of any recognised guidelines or procedures is a core concern. The participants in this study described the impact of a lack of professional guidelines for force feeding: fears regarding safety, a lack of appropriate facilities to carry out the procedure, and high levels of stress and burnout. They also spoke of their responses when delivering forced care. Worryingly – although understandably – participants spoke of ‘switching off’ from the process, to an extent that they were no longer treating a person *per se*, but a body part. This speaks volumes for the psychological pressures that delivering such an intervention places upon staff; from what participants spoke of, it is clear that these professionals need additional support to enable them to function to a high professional standard, and to prevent the responses to this aspect of their roles from encroaching on their personal lives.

This study for the first time shines a light onto the murky practices of forced treatment for patients with AN. It suggests that much needs to be done to further understand what is going on in practice – when and why, for example, are forced treatments first utilised, delivered, and curtailed? Much needs to be done to support the staff who deliver this form of treatment, and there is a clear need for policies and guidelines to be put in place and appropriate, applicable training in forced care to be developed and delivered to staff. This study placed its focus on the staff who deliver forced care, and future work, as a priority, will need to examine experiences of the patients who receive these interventions. There is much work in this area to be done, but the results of this study – the figures demonstrating a significant rise in the use of legally coerced treatment in the UK, and the experiences of those who deliver forced treatment – should act as a catalyst for those who wish to improve our understanding and delivery of this often unpleasant yet necessary aspect of treatment for patients with AN.

## Report Recommendations

Considering the implications of the interviews carried out for this study, the following is a number of suggestions to address core issues raised. These are as follows:

- a) For more research to be carried out – particularly to understand what interventions are currently used in UK SIEDU's, how often, and in what circumstances.
- b) For the development of clear guidelines as to when to commence and cease using forced interventions.
- c) For SIEDU's to have designated specialist space to carry out forced interventions, and for the use of forced interventions in patient's bedrooms to be stopped.
- d) For staff who deliver forced interventions to be offered increased levels of psychological support and supervision.
- e) For structured debriefs to happen following each forced intervention.
- f) For there to be a maximum number of occasions a staff member can deliver forced interventions per shift.
- g) For there to be clear guidelines and specific training given into how to force feed patients under restraint. For there to be a clear, evidence based protocol to do this, to protect staff and patients alike.

### Post script on impact

This research has been picked up by B-eat, the national eating disorders charity, to form part of an awareness campaign in this area. It has also been picked up by national broadcast media and is being used to influence policy and guidelines in this area.

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