Submitted in partial fulfilment of the Lancaster University Doctorate in Clinical Psychology

May 2021

Doctoral Thesis

Healthcare Professionals' Capacity for Compassion and Interactions with People Diagnosed with Eating Disorders

Emily Retkiewicz

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:

Emily Retkiewicz

Doctorate in Clinical Psychology

Faculty of Health and Medicine

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster

LA1 4AT

e.retkiewicz@lancaster.ac.uk

Word Count

	Main Text	Appendices (including tables, figures, reference lists, etc.)	Total
Thesis abstract	(299)	-	
Literature review	7,999	15,035	23,034
Research paper	8,000	9,903	17,903
Critical appraisal	3,990	1,195	5,185
Ethics section	5,139	3,800	8,939
Total	25,128	29,933	55,061

Thesis Abstract

This thesis explored vital aspects of care offered to people diagnosed with eating disorders (EDs). Firstly, a systematic literature review was carried out to explore experiences of people diagnosed with EDs on their therapeutic relationships with healthcare professionals (HCPs) during an inpatient admission. Findings from 13 studies were synthesised using a meta-ethnography approach. Three themes emerged: treated as an 'anorexic'; us versus them; a good therapeutic relationship with inpatient staff is vital. These themes highlighted the benefits of a positive therapeutic relationship and the challenges of negative relationships with HCPs. Furthermore, an overarching theme of "a delicate balance" highlighted the challenges emerging from polarised expectations patients had regarding how HCPs should interact with them, along with dilemmas associated with distinct aspects of HCPs' roles in inpatient settings. Recommendations for improving HCPs' self-awareness and relationships with patients are identified.

Secondly, a cross-sectional study was carried out to explore the role of workplace stress factors and emotion regulation strategies in predicting levels of compassion fatigue and compassion satisfaction in HCPs working with people diagnosed with EDs in various settings. "High" levels of compassion fatigue were experienced by approximately 22% of HCPs in the sample, while "low" levels of compassion satisfaction were experienced by approximately 17% of HCPs. Workload demands and job insecurity were identified as the most influential variables in predicting compassion fatigue. Recommendations for addressing these factors at an organisational level are discussed. The expressive suppression strategy for emotion regulation was identified as the most influential variable in predicting compassion satisfaction. Recommendations for tackling workplace stress factors and expressive suppression at an individual and team level are offered.

Finally, a critical appraisal of the project discusses the author's reflections on the challenges associated with it. Recommendations for future research and clinical implications of the project are also identified.

Declaration

The research presented in this thesis has been undertaken for the degree of Doctor of Clinical Psychology at Lancaster University. The presented thesis is the author's own and has not been submitted elsewhere for the award of any other degree or academic award.

Acknowledgements

Firstly, I would like to extend my sincere thanks to every single healthcare professional who took time out of their busy day to participate in this study. I was very humbled by the response I received and the widespread interest in the topic of my thesis. Thank you also to all the healthcare professionals who responded to my enquires and supported me in setting up this study in their NHS Trusts. Your time and dedication were very much appreciated.

I am extremely grateful to my supervisors Dr Ian Fletcher and Dr Nicola Pilkington for their time and support throughout the development and write-up of this thesis. Thank you, Ian, for trusting my decision to focus this project on staff working in eating disorder services. Nicola, I am very grateful for all the insights and suggestions you provided on ensuring this thesis reflects the realities of eating disorder services. I would also like to thank Dr Ian Smith, Dr Emma Munks, and Dr Richard Slinger for assisting me with draft reads; I really appreciate you all stepping in. I am also deeply grateful to Professor Bill Sellwood for reading my research paper drafts and being a consistent and reassuring support during initial data analysis.

To all my friends and family – thank you for believing in me, especially at times when I didn't believe in myself. Special thanks to my 'One day a week colleagues' whose humour brightened my days and who have always been helpful whenever I struggled with anything. Also, thank you, Mel, for all your support and your friendship over the last three or so years. To my parents, sister, and my grandma (Buba), thank you for believing that I will get to this point one day. I hope I have made you proud. Massive thanks to Jon for being my rock, especially when times were tough. Finally, even though they won't be able to read this, thank you to my two cats who have shown me so much love through all the ups and downs of doctorate life.

Contents

Doctorate in Clinical Psychology | Lancaster University

Section 1: Literature Review

Interactions with Healthcare Professionals During Inpatient Care: What are the Experiences of People Diagnosed with an Eating Disorder? A Meta-synthesis

Emily Retkiewicz

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:

Emily Retkiewicz

Doctorate in Clinical Psychology

Faculty of Health and Medicine

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster

LA1 4AT

e.retkiewicz@lancaster.ac.uk

Prepared for: *International Journal of Eating Disorders*

Abstract

Objective: Qualitative studies have explored the therapeutic relationship between people diagnosed with eating disorders (EDs) and healthcare professionals (HCPs), yet none have specifically focused on the views of patients admitted for ED treatment. This meta-ethnography aimed to synthesize findings from qualitative studies to explore experiences of people diagnosed with EDs on their interactions and therapeutic relationships with HCPs during an inpatient admission. **Method:** Five online databases were systematically searched to identify relevant literature. Reference sections of identified papers were also reviewed. Papers identified through the search strategy were quality assessed using the Critical Appraisal Skills Programme checklist. The results were analysed following Noblit and Hare's (1988) seven phase process. **Results:** Thirteen studies were identified through the search strategy. The analysis resulted in three themes: treated as an 'anorexic'; us versus them; a good therapeutic relationship with inpatient staff is vital. An overarching theme of "a delicate balance" was also identified. **Discussion:** It was highlighted that HCPs working in inpatient ED services should receive supervision which allows them to reflect on how their interactions impact on patients. It is recommended clinical psychologists facilitate team formulation sessions to increase HCPs' empathy towards patients and support the growth of person-centred care. Psychologically oriented training and identification of evidence-based practical activities for developing therapeutic relationships are also recommended. Future research would benefit from exploring patients' relationships with specific HCP groups, focusing on men's experiences of inpatient therapeutic relationships, and investigating the impact of team formulation on inpatient therapeutic relationships.

Introduction

Eating disorders (EDs) are mental health conditions characterised by severe disturbances in eating behaviour, thoughts, and emotions, often associated with high levels of risk either from physical deterioration caused by medical complications, or from suicidal intent (Beat, N.D.; Forrest, Grilo, & Udo, 2020; Tabler & Utz, 2020; The Royal Colleges of Psychiatrists, Physicians and Pathologists, 2014). Compared to all other psychiatric diagnoses, EDs are associated with the highest mortality rates (Halmi, 2009; Joint Commissioning Panel for Mental Health, 2013; Smink, van Hoeken, & Hoek, 2012). Additionally, EDs are associated with high levels of psychological distress (Tabler & Utz, 2020). It is estimated there are approximately 1.25 million people in the UK affected by the following ED diagnoses: Anorexia Nervosa (AN), Bulimia Nervosa (BN), and Eating Disorder Not Otherwise Specified (EDNOS) (Beat, N.D.). It is estimated that 4.6% of people in America, 3.5% of people in Asia, and 2.2% of people in Europe have an ED diagnosis of AN, BN, Binge Eating Disorder or EDNOS (Galmiche, Déchelotte, Lambert, & Tavolacci, 2019). Prevalence of EDs is likely even higher due to issues of under-diagnosing sub-threshold symptoms and assumptions that only people with specific demographic characteristics develop EDs (Sonneville & Lipson, 2018). Furthermore, it has been established that many people diagnosed with EDs do not access adequate treatment for their condition (Morris, Simpson, & Voy, 2015; Sonneville & Lipson, 2018), increasing the risk of physical and mental health deterioration, and sometimes death. Consequently, there is a growing recognition of the need to improve both access to, and quality of, ED services in the UK (NHS, 2019; NHS England, 2019) and worldwide (Ward, Rodriguez, Wright, Austin, & Long, 2019) for patients across the lifespan to better support their physical and emotional wellbeing.

While treatments for EDs are offered in community healthcare settings, some people diagnosed with an ED will be admitted to a medical unit, mental health ward, or specialist

inpatient EDs unit, primarily when they present with acute distress and physical risk requiring intensive interventions (Conti, Joyce, Hay, & Meade, 2020; Johns, Taylor, John, & Tan, 2019; Joint Commissioning Panel for Mental Health, 2013; Morris et al., 2015; National Institute for Health and Care Excellence [NICE], 2020; NHS England, 2019; Tabler & Utz, 2020; The Royal Colleges of Psychiatrists, Physicians and Pathologists, 2014). People diagnosed with AN are at increased risk of requiring an inpatient admission due to the impact severe food restriction can have on their acute health (Tabler & Utz, 2020). Between the years 2016/2017 and 2018/2019, admission episodes in England increased from 3252 to 4233 for BN, 6436 to 8011 for AN, and 4587 to 6872 for "other" EDs (NHS Digital, 2018, 2019b), indicating heightened demand for specialist inpatient admissions. In 2018/2019 there were 4,540 admissions for EDs for people aged 18 or under (NHS Digital, 2019b), while there were 10,677 general mental health admissions for people aged 17 or under (NHS Digital, 2019a), suggesting that EDs constitute a considerable number of mental health admissions in children and young people. There is mixed evidence on the benefits of inpatient stay on weight gain and psychopathology (Danielsen et al., 2020; Goddard et al., 2013; Morris et al., 2015; Schlegl et al., 2016).

One important aspect of quality of healthcare services, including ED inpatient units, is the therapeutic relationship between patients and healthcare professionals (HCPs) involved in their care. The therapeutic relationship was traditionally conceptualised as the relationship between a patient and a therapist (Horvath, 2005), although it is recognised as an integral aspect of care provided by other HCPs too (O'Brien, 2001; Roter, 2000; Solman & Clouston, 2016; Wright, 2010). Research has consistently shown that the therapeutic relationship is the most important predictor of outcomes of psychological treatment for mental health difficulties (Gelso, Kivlighan Jr, & Markin, 2018; Lambert & Barley, 2001; Martin, Garske, & Davis, 2000) and has been recognised as a fundamental component of treatment in inpatient

psychiatric settings (Priebe & McCabe, 2006). Shame and stigma are identified as major barriers for people accessing professional support for a possible or diagnosed ED (Ali et al., 2017; Innes, Clough, & Casey, 2017; Joint Commissioning Panel for Mental Health, 2013; NICE, 2020) and a good therapeutic relationship with HCPs may be important in reducing such feelings. A recent meta-ethnography by Graham, Tierney, Chisholm, and Fox (2020) suggested HCPs may often experience their relationships with people diagnosed with EDs as challenging and that the nature of their interactions with them may have an impact on patients' recovery.

Quantitative systematic reviews on the role of the therapeutic relationship in predicting outcomes for people diagnosed with an ED provide interesting differentiation across ED diagnostic groups. Antoniou and Cooper (2013) reported a significant association between the therapeutic relationship and outcomes of psychological therapy for people diagnosed with AN, while there was no clear association for people diagnosed with BN. The authors noted that reasons for those differences across ED diagnoses were not clear. Similarly, Brauhardt, de Zwaan, and Hilbert (2014) reported no clear association between the therapeutic relationship and outcome of psychological therapy in various settings for patients diagnosed with BN. They noted that ratings of the therapeutic relationship were not related to outcomes for adults with AN, but there was an association for adolescents with AN and BN. Zaitsoff, Pullmer, Cyr, and Aime (2015) noted there was a lot of variability in the literature on the links between patients' relationships with HCPs and various indicators of recovery. Overall, the authors identified that some studies did show an association between the therapeutic relationship and patient outcomes, while others did not. It could be informative to supplement the findings of these reviews with qualitative opinions of people diagnosed with EDs and their experiences of their therapeutic relationships with HCPs.

Salzmann-Erikson and Dahlén's (2017) review identified key nurse attributes which aid the development of a positive therapeutic relationship in various settings. The authors

highlighted the importance of nurses seeing patients diagnosed with AN as individuals separate from their diagnosis. The review also acknowledged nurses' role in patient recovery, particularly in terms of maintaining motivation and hope, and establishing structure and normality. The authors recognised the benefits and challenges of nurses balancing how much control and autonomy they exert over patients. Studies from both nurses' and patients' perspectives were included in their analysis, therefore patients' unique views are still unclear. Furthermore, this review focused specifically on nursing staff, so it is unclear how the findings may apply to other HCPs, who have different roles and responsibilities within an individual's care. Sibeoni et al. (2017) conducted a meta-synthesis of the literature to explore views of adolescents diagnosed with AN, their parents, and HCPs on treatment for AN in outpatient and inpatient settings. The authors noted that all parties agreed on the importance of the therapeutic relationship on treatment outcomes for patients. Participants identified empathy, understanding, and reliability as important HCP attributes to developing a good therapeutic relationship, along with HCPs' availability and accessibility. This review offered a broader perspective on the therapeutic relationship with HCPs other than nurses but was limited by not separating patients' views consistently and not focusing the review aims specifically on the relationship.

There have been three reviews focused exclusively on patient experiences. These reviews included studies with participants from inpatient settings, but also incorporated articles with participants from outpatient settings. Bell (2003) reviewed qualitative studies to explore the views of participants diagnosed with a range of EDs on their treatment. The author found that empathic and understanding relationships with HCPs were important to recovery and positive experiences of treatment. Westwood and Kendal (2012) reviewed qualitative research pertaining to the views of adolescents diagnosed with AN on their treatment. The authors noted the adolescents found it difficult to establish a relationship with HCPs, particularly due to

HCPs' negative perceptions and attitudes about EDs. HCPs' knowledge and experience of working with EDs were also found to be important in adolescents feeling safe around them. The authors highlighted the importance of HCPs demonstrating empathy and an openness to understanding patients' experiences. Conti et al. (2020) conducted a similar review with a focus on the views of adults diagnosed with AN. The authors noted the importance of the therapeutic relationship with HCPs on patients' abilities to engage in change behaviour. A two-way trust process between patients and HCPs was identified as vital to patients' wellbeing. Given that inpatient treatment for EDs is often offered to people who are extremely physically unwell, and HCPs must focus on weight restoration and physical stabilisation as a priority, it can be potentially experienced differently from outpatient treatment in terms of patient relationships with HCPs. Therefore, the unique views and experiences of people who have been through an inpatient admission are still unclear.

Given the identified gaps in the literature, this review aims to understand patients' experiences of interactions and their therapeutic relationships with HCPs during an inpatient admission for EDs. This is important because it will inform ways of improving patients' relationships with HCPs and consequently their experience of inpatient ED treatment.

Method

A meta-ethnography approach was chosen to synthesise qualitative studies and gain new insights and understandings arising from author interpretations in individual studies (France et al., 2014). This review was conducted in line with eMERGe guidelines for meta-ethnography reporting (France et al., 2019) and was registered with Prospero (ID: CRD42020221781).

Search Strategy

The research question was identified using the PICoS (population, intervention, comparison and outcome/context, study type) framework. A comprehensive search strategy

was utilised to find all available studies that answered the research question. Studies were identified by systematically searching the following online databases: AMED, CINAHL, EMBASE, MEDLINE, and PsycINFO. These databases were chosen to ensure a wide range of research from different disciplines was found. For practical reasons, English language limits were applied. The final search was conducted on 2nd December 2020; no date limits were applied to the databases to ensure a comprehensive search. Search terms were a combination of synonyms and database thesaurus terms for: eating disorders, experience, healthcare professionals, therapeutic relationship, and qualitative research (see Appendix 1-B for full search strategy example). The terms for "healthcare professionals" and "therapeutic relationship" were combined with "OR" to ensure all relevant studies were identified, as scoping searches indicated that combining these terms with "AND" excluded some relevant articles. Furthermore, reference sections of included studies were reviewed to identify additional papers. An information specialist was consulted on the above strategy.

Inclusion and Exclusion Criteria

Studies identified through the initial search were screened against inclusion and exclusion criteria listed in Table 1. Specific ED diagnoses were included or excluded based on whether they were currently within referral criteria for ED services in the UK (Joint Commissioning Panel for Mental Health, 2013).

[Insert Table 1]

Screening and Selection

Studies identified through database searching were initially inputted into EndNote (The EndNote Team, 2013) where duplicates were removed. Study titles and abstracts were firstly screened against inclusion criteria, following which full-text screening took place. Studies included and excluded during the full-text screening stage and any borderline studies were discussed with the research team to reach consensus on their adherence to the criteria. The

selection process and decisions were recorded on EndNote. See Figure 1 for details of the search process.

[Insert Figure 1]

Quality Assessment

Critical appraisal of included studies is an important aspect of a systematic review, although there is debate around what constitutes good qualitative research and implications of quality assessment of such literature (Butler, Hall, & Copnell, 2016; Toye et al., 2014). Nevertheless, it has the potential to exclude poorer quality research from the final analysis (Atkins et al., 2008), or improve awareness of how such research may be contributing to the evidence base. As the search process identified only 13 papers, none were excluded based on quality appraisal. Instead, the quality assessment informed interpretation and discussion of the results.

An adapted version of the Critical Appraisal Skills Programme (CASP; Critical Appraisal Skills Programme, 2019) was used to assess the quality of studies identified in this systematic review. Based on Duggleby et al.'s (2010) method, papers were evaluated on eight out of 10 domains of the CASP and given a score of either 1 (little or no evidence), 2 (some evidence but lack of a full elaboration) or 3 (strong evidence and full justification), yielding a maximum score of 24. The identified papers scored between 13 and 22, although majority scored 19 or lower, with several scoring 14 (Table 2). A selection of three papers was assessed by a peer to establish reliability of scoring.

[Insert Table 2]

Methods of Synthesis and Analysis

Noblit and Hare's (1988) seven phase process was followed by the author while consulting the research team regularly. A full description of steps taken is in Table 3. Concepts and metaphors included in the analysis consisted of study author's descriptions and

interpretations of themes and subthemes, along with direct quotes reported in the articles. An example of the synthesis process is depicted in Table 4. To be included in the review, each paper had to have at least one theme or subtheme related to the research question, however entire results and discussion sections were reviewed to extract relevant author concepts and participant quotes.

[Insert Table 3]

[Insert Table 4]

Reflexivity

The author is a trainee clinical psychologist with experience of working with adolescents and adults presenting with various mental health difficulties, along with experience of working in acute mental health wards. Despite not having worked directly with people presenting with EDs, it was important to be aware of any pre-conceived ideas which may impact on the analysis and results (Palaganas, Sanchez, Molintas, & Caricativo, 2017). The author kept a reflective diary during the process of analysing and interpreting data to identify any instances of interpretations being coloured by previous experience.

Results

Thirteen studies were identified through the search process. Three studies explored participants' relationships with nursing staff (Sly et al., 2014; van Ommen, Meerwijk, Kars, van Elburg, & van Meijel, 2009; Zugai, Stein-Parbury, & Roche, 2013) and one with doctors (Boughtwood & Halse, 2010). Nilsen, Hage, Rø, Halvorsen, and Oddli (2019) detailed staff involved in the participants' care as consisting of a psychiatrist, clinical psychologist, nurses, and occasionally a clinical nutritionist. Olofsson et al.'s (2020) participants were selected from a randomized controlled trial comparing different therapeutic approaches for people diagnosed with EDs and a history of trauma, and consequently their findings were reported in relation to interactions participants had with their therapists; those consisted of clinical psychologists, a

psychiatrist, and clinical nurse. The remaining studies did not specify the HCPs involved in participants' care. Table 5 further summarises study characteristics.

[Insert Table 5]

The analysis resulted in three themes: treated as an 'anorexic'; us versus them; and a good therapeutic relationship with inpatient staff is vital. Table 6 demonstrates which studies contributed to these themes. An overarching theme of "a delicate balance" was also identified.

[Insert Table 6]

Treated as an 'Anorexic'

The title of this theme reflects the predominance of studies with participants diagnosed with AN, however this theme relates to other ED diagnoses too. Participants spoke about HCPs frequently making assumptions about their actions and words being an expression of their ED, as opposed to a reflection of their individual personality: "It is assumed that every single thing we say is an eating disorder. Yes sometimes it is but people genuinely do have likes and dislikes" (participant; Smith et al., 2016, p. 22). This seemed to particularly be the case if HCPs struggled to understand the reasons behind a participant's behaviour: "if [staff were] unable to understand why an emotion was being expressed … then the expression and emotion would be regarded as a symptom of the eating disorder" (Pemberton & Fox, 2013, p. 233). Participants felt their whole experience was reduced by HCPs to their diagnosis of an ED, which they felt resulted in their "voice" being ignored and in a negation of unique struggles each participant may have had with their ED and other experiences, such as trauma. Additionally, participants felt they were "treated as part of a collective rather than an individual" (Eli, 2014, p. 4) because of diagnostically informed assumptions.

These assumptions and seeing patients as "just another anorexic" (Colton & Pistrang, 2004, p. 311) also meant that participants considered they were being stereotyped, their experiences and actions generalised. Participants felt that HCPs expected them to act and think

in accordance with their ED. For example, one participant paraphrased what they felt HCPs thought as: “It was, you know ‘you’re anorexic, you’re just gonna say this to try and get out of this’” (participant; Offord, Turner, & Cooper, 2006, p. 382). Participants also felt HCPs were more likely to interact with them based predominantly on these assumptions: “the ways in which staff engaged with girls in the clinic was not necessarily shaped by any objective indicators or by what they did or said” (Boughtwood & Halse, 2010, p. 90). These assumptions and stereotypes were experienced by participants as dehumanising, leaving them feeling powerless: “especially if you get upset about anything, you’re treated as a walking, talking illness … You’re not a human being” (participant; Pemberton & Fox, 2013, p. 232).

Being treated as an “anorexic” by HCPs also resulted in participants feeling that their care and treatment were not tailored to their individual needs: “I didn’t trust any of his advice … because I felt he was telling me about what … your classic anorexic ought to do” (participant; Malson, Finn, Treasure, Clarke, & Anderson, 2004, p. 481). Participants felt that their difficulties being seen as predominantly an expression of an ED meant that HCPs focused more on their physical rather than emotional or psychological needs: “a perception [among participants] that staff simply wanted to ‘fatten them up’; their emotional and psychological needs not being viewed as important’ (Offord et al., 2006, p. 381). Additionally, in Fox and Diab’s (2015) study participants diagnosed with chronic AN felt HCPs “could be pessimistic in their recovery” (p. 33).

Consequently, participants stressed the importance of HCPs recognising them as individuals independently of their diagnosis: “participants valued individualised care, highlighting the need to be seen as an individual without the label of having an ED” (Smith et al., 2016, p. 22). Particularly, it was felt HCPs should pay more attention to participants’ psychological difficulties, rather than focusing primarily on their physical needs. Participants valued when HCPs recognised their unique strengths and helped them utilise these in treatment:

"the young women wanted their abilities to be seen again and wanted to be reassured that their pre-anorexia dreams and ideals could actually be pursued once more" (van Ommen et al., 2009, p. 2806).

Us Versus Them

Participants identified that the nature of their role as patients diagnosed with EDs in an inpatient setting inevitably resulted in power differentials between them and HCPs. This was often reflected in HCPs being strict in their interactions with participants: "'bad' initial sessions involved the key nurse taking an overly authoritarian stance" (Sly et al., 2014, p. 240). It could also be seen in HCPs giving inconsistent messages to participants: "they spend all their time telling you not to bottle things up and that you need to let it out but when you do you get told … you're causing trouble and making a scene" (participant; Pemberton & Fox, 2013, p. 234). It was noted that even HCPs' appearance could contribute to participants perceiving them as members of a dominant group: "according to participants, this [policy shift ensuring staff were dressed in smart clothes] only served to highlight a 'them and us' dynamic, creating a rather corporate, instead of therapeutic, atmosphere" (Sly et al., 2014, p. 241).

HCPs' power over patients was particularly evident in the enforcement of inpatient rules: "they all knew that it didn't apply to me, but they said 'well we've got to do this cos it's the rule'" (participant; Offord et al., 2006, p. 381). It was recognised that HCPs often failed to explain the rationale behind various rules: "sometimes it was felt that staff actively discouraged these friendships [with other patients] for reasons that were unclear" (Offord et al., 2006, p. 384). Rules which were not clearly explained were perceived as punitive and it was felt that "nurses should apply rules in a way that considers the intent of the rules, rather than an inflexible approach" (Zugai et al., 2013, p. 2024). Participants felt more able to accept and follow rules if their rationale was clear and consistent with the patients' goals: "quite a few

[participants] reflected on the difficulties of adhering to strict rules that did not seem to fit their perceived needs at the time" (Nilsen et al., 2019, p. 5).

Some participants felt that HCPs positioned in a powerful role did not pay adequate attention to creating a positive therapeutic relationship: "from the girls' perspectives, little attention is given to the therapeutic alliance" (Boughtwood & Halse, 2010, p. 92). Additionally, there was a sense that HCPs occupying the dominant position led participants to feeling stigmatised, judged, patronised, and powerless (Malson et al., 2004; Offord et al., 2006; Pemberton & Fox, 2013). For participants who accessed psychological therapy, this power differential resulted in reduced likelihood to experience positive outcomes: "less helpful therapeutic approaches involved those that drew on the use of psychodynamic interpretations, as this often led to a sense that the therapist was in a position of power relative to the patient's more vulnerable position" (Offord et al., 2006, p. 383).

Power differentials between patients and HCPs often resulted in a fight for control. HCPs attempted to assert their dominance through direct means: "staff would often disengage with the patient, using repetition or avoidance to regain authority and control" (Pemberton & Fox, 2013, p. 232). HCPs would also exert their dominance in implicit ways: "a patient was more likely to receive a validating response to an expression of emotion, for example, if they tried to leave a situation as opposed to staying in the situation and challenging staff" (Pemberton & Fox, 2013, p. 232).

However, participants noted more instances of their own fight for control in response to HCPs' position of power:

> [Nurses name], last admission, told me … in a way that gave me no choice, what I was going to do or needed to do. All I did from then was resist, fight her, even if she made sense … her manner of talking to me just made me dig my heels in. (participant; Sly et al., 2014, pp. 237-238)

Often, participants made conscious efforts to assert some control: “girls discussed the various techniques they used to resist gaining weight or to deceive the doctors into believing they had gained weight” (Boughtwood & Halse, 2010, p. 88). Participants also seemed to fight for control in indirect ways, such as refusing to see one’s identity as that of a “patient”: “a refusal to take up the position of ‘patient’ might be interpreted not so much as a denial of illness or problem than as a resistance to the particular power-relations implied in this construction of ‘the patient’” (Malson et al., 2004, p. 482).

It was recognised that occasionally those strategies resulted in the participant being given some form of a concession: “even when crying did not cause the clinicians to reverse a decision immediately, it usually provoked an explanation for the decision, which provided girls with a further opportunity for negotiation” (Boughtwood & Halse, 2010, p. 91). Power dynamics and struggles for control between patients and staff were inherently associated with mutual distrust: “I had a [gastrointestinal condition] and it was really painful … They didn’t believe me until they found me, fainted… That’s what annoys me, that they don’t trust you” (participant; Eli, 2014, p. 5).

Consequently, participants wanted to be treated with respect: “some emphasized that years of medical education and extensive clinical experience did not matter if staff did not treat the young person with respect and curiosity” (Nilsen et al., 2019, p. 5); as equals, rather than inferior to HCPs. Equality was achieved by collaboration on treatment and other aspects of inpatient stay: “several participants spoke of their wish to become more involved in treatment, perceiving limited opportunities to attend review meetings, which led to feelings of anxiety and frustration” (Smith et al., 2016, p. 21). Equality and respect were also evident when HCPs trusted participants and provided them with some autonomy in treatment: “the respondents highlighted the importance of being trusted by the nurses, since that made them aware of their own potential and increased their self-esteem” (van Ommen et al., 2009, p. 2806).

Equality was also maintained by HCPs being genuine in their interactions with participants: “the younger staff used to be really good … talk about what they did last night, and just hearing a bit of normal life … that really helped” (participant; Offord et al., 2006, p. 380). Being genuine about wanting to work with people diagnosed with EDs was also highlighted: “I get the impression they don’t want to be here it’s just … It’s a job, and I think that’s sad in this environment that you get staff like that” (participant; Pemberton & Fox, 2013, p. 232).

A Good Therapeutic Relationship with Inpatient Staff is Vital

This theme reflects the positive impact a strong therapeutic relationship with HCPs had on patients’ experiences of their inpatient stay and treatment: “good or bad, the relationship with key nurses was often described as a reflection of the treatment experience as a whole” (Sly et al., 2014, p. 236). I It was noted that the therapeutic relationship with HCPs was a key aspect in participants’ motivation for recovery: “when they’re more encouraging and supportive it makes me want to try harder and when they’re more forceful it makes me always want to pull against and try harder at doing the wrong things” (participant; Colton & Pistrang, 2004, p. 313). However, Pemberton and Fox (2013) highlighted how creating a positive therapeutic relationship in inpatient settings may be very challenging: “staff were described as being extremely good, or terribly (verging on morally) bad, with expectations of care being idealised and perfect” (p. 235).

A strong relationship impacted on participants’ adherence to and perseverance with treatment, engagement in help-seeking behaviours, such as opening up to HCPs about struggles with their ED, insight into the effects of the ED on them, and belief in their ability to tackle difficulties associated with EDs treatment (Fox & Diab, 2015; Pemberton & Fox, 2013; Sly et al., 2014; Smith et al., 2016; van Ommen et al., 2009; Zugai et al., 2013). Conversely, difficulties with the therapeutic relationship were associated with the presence of intolerable

emotions and self-beliefs, feelings of isolation, increased engagement in ED behaviours, difficulties being honest with HCPs about challenges, reduced motivation to recover, and lack of progress in treatment (Boughtwood & Halse, 2010; Colton & Pistrang, 2004; Fox & Diab, 2015; Olofsson et al., 2020; Pemberton & Fox, 2013; Sly et al., 2014; Smith et al., 2016).

Despite the predominantly negative experiences described in the previous themes, this theme highlights HCP qualities and skills valued by participants, particularly in terms of the development of a good therapeutic relationship. The nature of an inpatient environment means that some HCPs, specifically qualified and unqualified nursing staff, are always present. Presence, however, did not mean much to participants, as it did not guarantee that HCPs would develop a relationship with them: "some participants felt neglected [by HCPs] – unless they were in obvious distress on the unit, they were ignored" (Colton & Pistrang, 2004, p. 312). Instead, participants valued when HCPs took initiative to seek them out and interact with them: "it was only when staff sought out and were persistent in their attempts to engage with patients that the participants would engage and feel as though care was being received" (Pemberton & Fox, 2013, p. 234).

Such attempts by HCPs to get to know the participants could also result in participants being more amenable to HCPs' suggestions regarding treatment: "I said this man [a doctor] doesn't know me, he hasn't come up and said to me: what are your interests" (participant; Malson et al., 2004, p. 481). This links in with the "treated as an 'anorexic'" theme where recognising participants' individuality was seen as important. The current theme highlights participants' views of the need for HCPs to be proactive in getting to know patients for them to be able to be aware of patients' individual personalities. HCPs' availability was valued both during challenging times and later stages of recovery: "it's hard, you know? It's like, getting nearer and nearer to target [weight] you're feeling worse and worse about yourself … But she

[key nurse] … I always know she's there for me at those times" (participant; Sly et al., 2014, p. 237).

In addition to HCPs making the time to connect with patients, their emotional availability and attunement to participants' needs was also valued: "the patients indicated that the nursing staff's emotional availability was particularly vital: are you prepared to make time for me and do you notice when I have a hard time?" (van Ommen et al., 2009, p. 2804). Attunement was also manifested through HCPs being able to empathise with participants' experiences: "a key part of these interactions with staff was that they were sensitive to their needs of living with [chronic AN] and were able to set appropriate and meaningful goals" (Fox & Diab, 2015, p. 32). HCPs' ability to empathise impacted on how they interacted with participants: "an empathic connection meant that nurses were able to understand the feelings and needs of consumers, and respond accordingly" (Zugai et al., 2013, p. 2025). Finally, HCPs' ability to provide emotional support through listening in a non-judgmental manner and by validating participants' experiences was also felt to be important in developing a good therapeutic relationship: "in participants' views, a 'good' session at the start of treatment was characterised by how little talking the key nurse did during that session" (Sly et al., 2014, p. 239) and "staff were naming not only the emotional experience but also through their identification and acknowledgement of the emotion in an empathic manner, giving the message that these emotions were appropriate and valid" (Pemberton & Fox, 2013, pp. 230-231).

Overarching Theme: A Delicate Balance

This concept, which emerged within each theme, emphasizes how HCPs often struggled to balance between differing expectations from patients with EDs and between distinct aspects of their roles. Within the "treated as an 'anorexic'" theme, this was reflected in participants' views that, whilst they did not wish to be seen as an "eating disorder patient", HCPs' expertise on EDs and other mental health diagnoses was also of importance in creating

a positive therapeutic relationship: “a relationship of trust also grew because nurses showed expertise in the field of eating disorders” (van Ommen et al., 2009, p. 2805). Indeed, HCPs’ knowledge was seen as helpful for understanding participants as individuals: “in part, she said, the clinical staff’s understanding of her as an individual was informed by their understanding of her as a sufferer of anorexia nervosa and obsessive-compulsive disorder” (Eli, 2014, p. 4). Participants felt it was important for HCPs to use their expertise of EDs to support them through treatment. One aspect of that was HCPs’ ability to identify when patients were trying to conceal their ED behaviours or manipulate staff: “some warned staff to not be too naïve or inattentive to the evident self-destructive forces that can drive a young person with anorexia nervosa during hospitalisation” (Nilsen et al., 2019, p. 7). Another aspect was HCPs’ ability to share knowledge about EDs in a collaborative and constructive manner: “psychoeducation with an exploring, empathic stance increased self-understanding” (Olofsson et al., 2020, p. 60).

Within the “us versus them” theme, participants voiced the importance of HCPs finding a balance in how powerful or powerless they were in their relationships with patients:

> Approximately three quarters of participants talked about past experiences of key nurses with whom they had a relationship which was felt to be unbalanced. Some thought it was in terms of the key nurse being too domineering … or indeed, too passive. (Sly et al., 2014, pp. 237-238)

Despite calling for HCPs to treat them as equals, participants occasionally needed them to be stricter and more authoritative to feel safe: “I was able, or my AN was able, … to dominate them, just run the programme and nurse was really nice and friendly but couldn’t control it, me” (participant; Sly et al., 2014, p. 238).

Finally, within the “a therapeutic relationship with inpatient staff is vital” theme, it was identified that HCPs needed to recognise how much involvement participants required at any given time: “staff who were able to balance a relaxed approach with more professional support

when needed were the most helpful" (Offord et al., 2006, p. 380). The role of some HCPs spanned different activities to facilitate participants' engagement with social events outside of the inpatient environment: "they took us to the pictures … a normal thing to do" (participant; Smith et al., 2016, p. 21). This reflects the challenges of balancing provision of care and maintaining appropriate boundaries with patients.

Discussion

This review aimed to explore patients' views on their interactions and therapeutic relationships with HCPs during an inpatient admission for a diagnosis of an ED. Three themes were identified, with an overarching theme of "a delicate balance". The notion of balance was also identified in Graham et al.'s (2020) qualitative synthesis of HCPs' experiences of working with patients diagnosed with EDs; HCPs were aware of the benefits of being flexible in their interactions with patients, and of balancing between polarised roles.

The "treated as an 'anorexic'" theme highlighted how patients diagnosed with EDs did not want to be seen exclusively as a complete expression of their ED. Patients valued when HCPs were able to see the individual as opposed to the label. This review highlighted that being seen as an "anorexic" resulted in patients feeling dehumanised and in experiencing treatment as uniform instead of person-centred. This builds on Salzmann-Erikson and Dahlén's (2017) findings that being seen as an "anorexic" reinforced self-identification with the illness. Consequently, patients who perceive that they are seen as "anorexic" by HCPs may be more likely to engage in ED behaviours. Additionally, this review found that patients felt more attention needed to be paid to their psychological needs, as opposed to treatment being predominantly focused on their physical needs. Given the role of interpersonal issues, emotions and negative beliefs on the development and maintenance of ED behaviours (Fox & Froom, 2009; Goss & Allan, 2009; Hartmann, Zeeck, & Barrett, 2010; Jones, Leung, & Harris, 2007; Naylor, Mountford, & Brown, 2011) it could be argued that effective treatment for EDs should

address underlying psychological difficulties. Furthermore, this review highlighted that recognising patients' individuality enables HCPs to incorporate patients' existing strengths and skills into treatment. Therefore, being recognised as an individual separate from the ED is an important aspect of a positive inpatient experience and is significant to recovery.

Patients diagnosed with EDs valued staff expertise and knowledge regarding diagnoses and their various manifestations and impacts on people. Salzmann-Erikson and Dahlén (2017) noted that HCPs' lack of knowledge and experience of EDs resulted in reduced empathy for the challenges of recovering from EDs. Westwood and Kendal (2012) highlighted the challenges of developing a good therapeutic relationship with HCPs who had negative assumptions about EDs. There is some evidence that increased knowledge and expertise regarding EDs are related to lower levels of negative attitudes towards patients (Seah, Tham, Kamaruzaman, & Yobas, 2017; Thompson-Brenner, Satir, Franko, & Herzog, 2012). The findings of this review suggest a link between increased empathy of experienced HCPs and patients' positive responses to those HCPs. Consequently, it appears that HCPs working with patients diagnosed with EDs in an inpatient environment must tread a delicate line between using their expertise to better understand patients and help them with their recovery while also honouring their individual experiences and trying to empathise with their unique situations.

The "us versus them" theme acknowledged that inpatient environments may inevitably accentuate power differentials between patients and HCPs. This was particularly evident in the rigid enforcement of inpatient rules, which is something patients would not experience to the same degree in other environments. The benefits of HCPs taking control over aspects of inpatient stay and treatment related to EDs, such as mealtimes, was highlighted by Salzmann-Erikson and Dahlén (2017). This control and direction can help patients learn new skills and recover physically from the effects of EDs. Participants in some of the studies identified in this review also expressed their relief at having control taken away from them. Rules and

expectations of patients are typically put in place for the patients' benefit; however, this review highlights that patients respond better when the rationale behind rules is communicated to them and when that rationale is compatible with their changing needs and goals. However, adapting responses to patients at different points in their care may be challenging for HCPs, especially within the context of the overall inpatient organisational structure.

Power differentials between patients and HCPs were also seen as detrimental to developing a good therapeutic relationship and to progressing in treatment. There was some evidence that participants felt HCPs were fighting to retain their control over patients. This was mirrored in Graham et al. (2020) where HCPs in several studies viewed themselves as "waging battle with 'rebellious and dominating' service users" (p. 434). Patients themselves frequently sought to regain control in various ways; often these could result in the patient holding on to their ED behaviours. Interestingly, the notions of control and battling are often reported as an integral part of EDs, particularly AN (Ali et al., 2017; Reid, Burr, Williams, & Hammersley, 2008; Tan, Hope, Stewart, & Fitzpatrick, 2003; Túry, Szalai, & Szumska, 2019; Westwood & Kendal, 2012), which is also the diagnosis most represented in inpatient settings and in this review. Many patients diagnosed with EDs report lacking sufficient control in their lives and often the ED can function as helping patients feel more powerful or contained in relation to their emotions, bodies, and experiences. Therefore, it is not surprising some patients resist their control being taken away in inpatient settings, as, at that time, it could result in them feeling highly vulnerable with limited effective strategies to cope with their distress.

Being treated in a respectful manner and as equals of sorts by HCPs was shown to be important to patients. This supports Salzmann-Erikson and Dahlén's (2017) and Bell's (2003) findings. This review suggests HCPs can create a respectful and equal relationship with patients by facilitating collaboration, providing patients with some autonomy, and displaying a genuine interest in working with patients diagnosed with EDs. However, it appears HCPs must strike a

balance between allowing patients the freedom they desire and helping them feel psychologically safe and able to overcome their ED behaviours by being directive.

The theme "a good therapeutic relationship with inpatient staff is vital" highlighted the benefits of a positive therapeutic relationship between HCPs and participants on their inpatient experience and their recovery. It also noted the disadvantages of a "bad" therapeutic relationship. These findings add to the results of several quantitative systematic reviews which suggest there is to some degree an association between the therapeutic relationship and outcomes of psychological therapy or inpatient stay for EDs (Antoniou & Cooper, 2013; Graves et al., 2017; Zaitsoff et al., 2015), by providing a more in-depth explanation of the reasons behind this association. This review identified that patients valued HCPs being available, attuned, and empathic to their needs and experiences. Literature suggests these are qualities HCPs already endeavour to embody when working in inpatient EDs settings (Salzmann-Erikson & Dahlén, 2017; Snell, Crowe, & Jordan, 2010).

It was acknowledged patients diagnosed with EDs may have polarised views of the care they receive from staff, which makes it more challenging for HCPs to be seen as "good enough", as opposed to "bad" or "perfect". Compared to community staff, HCPs working in ED inpatient settings often occupy multiple additional roles, such as conducting patient observations or enforcing compulsory treatment (Graham et al., 2020; Túry et al., 2019). These roles may be perceived to be at odds with patients' understanding of empathic care, making it harder for HCPs to be seen as "good enough". As highlighted in the "us versus them" theme, explaining the rationale behind such activities and involving patients in discussions regarding their impact may allow the therapeutic relationship to be strengthened. This could assist HCPs in maintaining a balance in their interactions with patients by preventing them from occupying a polarised, powerful role.

Strengths and Limitations

The results of this review need to be considered in relation to the quality of the included studies. One of the strengths of this review is that four of the highest quality studies (i.e., those which scored between 18 and 22 on the CASP) contributed to each of the three themes, suggesting that all themes are built on strong evidence. Additionally, most of the studies included in this review scored lowest on the research-participant relationship and ethical issues; it may be that journal guidelines prevented studies from expanding on those aspects. Therefore, it is difficult to objectively comment on the overall quality of the studies which scored in the lower margin.

One of the limitations of this review is the homogeneity of the participants of the included studies, in terms of female gender, diagnosis of AN, and ethnicity being predominantly white. The findings of this study may therefore be limited to patients with these characteristics. However, it is also the case that patients with those characteristics are more likely to be admitted to inpatient environments (Calderon, Stoep, Collett, Garrison, & Toth, 2007; Goddard et al., 2013). Nevertheless, men, in particular, can experience EDs, services, and treatment for EDs differently from women (Richardson & Paslakis, 2021), which means that the findings of this review may not be generalisable to them.

Recommendations and Conclusion

This review identified that developing therapeutic relationships with patients in inpatient ED settings can be challenging and requires empathy and self-awareness to ensure a balanced approach is maintained. This highlights the importance of supervision for HCPs working in ED inpatient settings (Bell, 2003; Snell et al., 2010). For example, clinical psychologists embedded in ED services may be well positioned to support HCPs with supervision due to their training in different therapy models and skills in formulating from a variety of perspectives, including biological and social (Health and Care Professions Council, 2018). Supervision facilitated by clinical psychologists may allow HCPs to reflect on any

struggles with maintaining a balance between being strict and relaxed, powerful and powerless, and treating patients as individuals while ensuring their physical recovery. HCPs may also be supported by clinical psychologists to better understand patients through team formulation approaches. Team formulation in mental health settings not only helps HCPs gain an increased awareness of a patient's difficulties, but also allows to see the patient's relationship with the team from a different perspective and improves HCPs' empathy (Clarke, 2015; Short et al., 2019). By taking a relational approach, clinical psychologists may improve HCPs' understanding of how their interactions may be experienced by patients. Team formulation can facilitate problem-solving in relation to challenging dynamics between HCPs and patients, resulting in more person-centred care (Short et al., 2019).

Additionally, this review highlighted the benefits of HCPs' knowledge about EDs. It is therefore recommended that all HCPs involved in the care of people admitted to inpatient ED units are given specialist training on the physical and psychological impacts of EDs. Psychologically oriented training would benefit from a focus on sharing knowledge with patients in a collaborative and empathic manner, and on creating and maintaining a dialogue with patients with regards to their care and inpatient experience. Additionally, while recognising that patients diagnosed with EDs admitted to an inpatient setting are not always ready to engage in treatment or may be actively resistant to treatment, particularly if they have been sectioned under the Mental Health Act, it would be of benefit for HCPs to seek to involve patients in their care throughout their admission. Through consultation and service development, HCPs, especially nursing staff, could be supported to identify evidence-based practical activities which may aid the development of a therapeutic relationship on admission, and be given appropriate time to prioritise such activities. Regularly meeting with patients and encouraging them to voice their opinions may serve to strengthen the therapeutic relationship and enable patients to feel more in control of various aspects of their medical and psychological

treatment while admitted for management of ED symptoms. For patients who are actively resistant, this may involve discussions around aspects of their care which are not directly related to treatment, such as engagement in ward-based activities. Clinical psychologists' skills may be utilised to regularly evaluate services offered and identify barriers to engaging in regular meetings with patients.

This review highlighted areas for future research. Most studies included in this review did not specify which HCPs were involved in patients' care. It may be interesting for future qualitative studies to explore patients' interactions and therapeutic relationships with specific professionals, such as occupational therapists or dietitians. Given the disparities in frequency and duration of interactions various HCPs may have with inpatients, as well as the variations in roles and responsibilities, some noteworthy differences may emerge from such research. It would be of benefit to explore men's views on their inpatient admissions for EDs and their therapeutic relationships with HCPs, to identify similarities and differences to the views of women. Given the comparatively lower numbers of men admitted to ED inpatient settings, such research may need to be conducted retrospectively with former inpatients. In addition, it is vital future studies include a more ethnically diverse sample of participants. Furthermore, the benefits and challenges of team formulation in inpatient ED settings could be explored either qualitatively by interviewing HCPs, or quantitatively by comparing patient- and HCP-rated levels of the therapeutic relationship before and after a team formulation session. Other outcomes, such as HCPs' perceived level of knowledge and attitudes towards patients diagnosed with EDs, could be included in such studies.

In conclusion, this meta-ethnography adds to the current literature by specifically identifying views of people diagnosed with EDs on their interactions and therapeutic relationships with HCPs during an inpatient admission. The findings support previous quantitative literature exploring the association between the therapeutic relationship and

treatment outcomes. The results also support previous qualitative literature, which, to date, has not focused on the exclusive views of patients admitted to hospital.

References

Ali, K., Farrer, L., Fassnacht, D. B., Gulliver, A., Bauer, S., & Griffiths, K. M. (2017). Perceived barriers and facilitators towards help-seeking for eating disorders: A systematic review. *International Journal of Eating Disorders*, *50*(1), 9-21. doi:10.1002/eat.22598

Antoniou, P., & Cooper, M. (2013). Psychological treatments for eating disorders: What is the importance of the quality of the therapeutic alliance for outcomes? *Counselling Psychology Review*, *28*(4), 34-46. Retrieved from https://www.researchgate.net/profile/Pavlina-Antoniou/publication/265085572_Psychological_treatments_for_eating_disorders_What_is_the_importance_of_the_quality_of_the_therapeutic_alliance_for_outcomes/links/53fdf98b0cf2dca8000428ac/Psychological-treatments-for-eating-disorders-What-is-the-importance-of-the-quality-of-the-therapeutic-alliance-for-outcomes.pdf

Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A., & Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: Lessons learnt. *BMC Medical Research Methodology*, *8*, 21. doi:10.1186/1471-2288-8-21

Beat. (N.D.). Statistics for journalists. Retrieved February 4, 2021, from https://www.beateatingdisorders.org.uk/media-centre/eating-disorder-statistics

Bell, L. (2003). What can we learn from consumer studies and qualitative research in the treatment of eating disorders? *Eating and Weight Disorders*, *8*(3), 181-187. doi:10.1007/BF03325011

Boughtwood, D., & Halse, C. (2010). Other than obedient: Girls' constructions of doctors and treatment regimes for anorexia nervosa. *Journal of Community & Applied Social Psychology*, *20*(2), 83-94. doi:10.1002/casp.1016

Brauhardt, A., de Zwaan, M., & Hilbert, A. (2014). The therapeutic process in psychological treatments for eating disorders: A systematic review. *International Journal of Eating Disorders, 47*(6), 565-584. doi:10.1002/eat.22287

Butler, A., Hall, H., & Copnell, B. (2016). A guide to writing a qualitative systematic review protocol to enhance evidence-based practice in nursing and health care. *Worldviews on Evidence-Based Nursing, 13*(3), 241-249. doi:10.1111/wvn.12134

Calderon, R., Stoep, A. V., Collett, B., Garrison, M. M., & Toth, K. (2007). Inpatients with eating disorders: Demographic, diagnostic, and service characteristics from a nationwide pediatric sample. *International Journal of Eating Disorders, 40*(7), 622-628. doi:10.1002/eat.20411

Clarke, I. (2015). The emotion focused formulation approach: Bridging individual and team formulation. *Clinical Psychology Forum, 275*, 28-32. Retrieved from https://www.researchgate.net/profile/Lucy-Johnstone-3/publication/292305384_Integration_of_formulation_in_adult_multidisciplinary_services_across_a_large_NHS_foundation_trust_-_Phases_1_and_2_Training_and_integration/links/5778c4a908aeb9427e2bbf7a/Integration-of-formulation-in-adult-multidisciplinary-services-across-a-large-NHS-foundation-trust-Phases-1-and-2-Training-and-integration.pdf#page=30

Colton, A., & Pistrang, N. (2004). Adolescents' experiences of inpatient treatment for anorexia nervosa. *European Eating Disorders Review, 12*(5), 307-316. doi:10.1002/erv.587

Conti, J. E., Joyce, C., Hay, P., & Meade, T. (2020). "Finding my own identity": A qualitative metasynthesis of adult anorexia nervosa treatment experiences. *BMC Psychology, 8*, 110. doi:10.1186/s40359-020-00476-4

Critical Appraisal Skills Programme. (2019). CASP Qualitative Studies Checklist. Retrieved from https://casp-uk.net/wp-content/uploads/2018/03/CASP-Qualitative-Checklist-2018_fillable_form.pdf

Danielsen, M., Bjørnelv, S., Weider, S., Myklebust, T. Å., Lundh, H., & Rø, Ø. (2020). The outcome at follow-up after inpatient eating disorder treatment: A naturalistic study. *Journal of Eating Disorders, 8*, 67. doi:10.1186/s40337-020-00349-6

Duggleby, W., Holtslander, L., Kylma, J., Duncan, V., Hammond, C., & Williams, A. (2010). Metasynthesis of the hope experience of family caregivers of persons with chronic illness. *Qualitative Health Research, 20*(2), 148-158. doi:10.1177/1049732309358329

Eli, K. (2014). Between difference and belonging: Configuring self and others in inpatient treatment for eating disorders. *PLoS ONE, 9*(9), e105452. doi:10.1371/journal.pone.0105452

Forrest, L. N., Grilo, C. M., & Udo, T. (2020). Suicide attempts among people with eating disorders and adverse childhood experiences: Results from a nationally representative sample of adults. *International Journal of Eating Disorders, 54*(3), 326-335. doi:10.1002/eat.23457

Fox, J. R. E., & Diab, P. (2015). An exploration of the perceptions and experiences of living with chronic anorexia nervosa while an inpatient on an Eating Disorders Unit: An Interpretative Phenomenological Analysis (IPA) study. *Journal of Health Psychology, 20*(1), 27-36. doi:10.1177/1359105313497526

Fox, J. R. E., & Froom, K. (2009). Eating disorders: A basic emotion perspective. *Clinical Psychology & Psychotherapy, 16*(4), 328-335. doi:10.1002/cpp.622

France, E. F., Cunningham, M., Ring, N., Uny, I., Duncan, E. A. S., Jepson, R. G., . . . Noyes, J. (2019). Improving reporting of meta-ethnography: The eMERGe reporting guidance. *BMC Medical Research Methodology, 19*, 25. doi:10.1186/s12874-018-0600-0

France, E. F., Ring, N., Thomas, R., Noyes, J., Maxwell, M., & Jepson, R. (2014). A methodological systematic review of what's wrong with meta-ethnography reporting. *BMC Medical Research Methodology, 14*, 119. doi:10.1186/1471-2288-14-119

Galmiche, M., Déchelotte, P., Lambert, G., & Tavolacci, M. P. (2019). Prevalence of eating disorders over the 2000-2018 period: A systematic literature review. *The American Journal of Clinical Nutrition, 109*(5), 1402-1413. doi:10.1093/ajcn/nqy342

Gelso, C. J., Kivlighan Jr, D. M., & Markin, R. D. (2018). The real relationship and its role in psychotherapy outcome: A meta-analysis. *Psychotherapy, 55*(4), 434-444. doi:10.1037/pst0000183

Goddard, E., Hibbs, R., Raenker, S., Salerno, L., Arcelus, J., Boughton, N., . . . Treasure, J. (2013). A multi-centre cohort study of short term outcomes of hospital treatment for anorexia nervosa in the UK. *BMC Psychiatry, 13*, 287. doi:10.1186/1471-244X-13-287

Goss, K., & Allan, S. (2009). Shame, pride and eating disorders. *Clinical Psychology & Psychotherapy, 16*(4), 303-316. doi:10.1002/cpp.627

Graham, M. R., Tierney, S., Chisholm, A., & Fox, J. R. E. (2020). The lived experience of working with people with eating disorders: A meta-ethnography. *International Journal of Eating Disorders, 53*(3), 422-441. doi:10.1002/eat.23215

Graves, T. A., Tabri, N., Thompson-Brenner, H., Franko, D. L., Eddy, K. T., Bourion-Bedes, S., . . . Thomas, J. J. (2017). A meta-analysis of the relation between therapeutic alliance and treatment outcome in eating disorders. *International Journal of Eating Disorders, 50*(4), 323-340. doi:10.1002/eat.22672

Halmi, K. A. (2009). Salient components of a comprehensive service for eating disorders. *World Psychiatry, 8*(3), 150-155. doi:10.1002/j.2051-5545.2009.tb00235.x

Hartmann, A., Zeeck, A., & Barrett, M. S. (2010). Interpersonal problems in eating disorders. *International Journal of Eating Disorders, 43*(7), 619-627. doi:10.1002/eat.20747

Health and Care Professions Council. (2018). The standards of proficiency for practitioner psychologists. Retrieved from https://www.hcpc-uk.org/standards/standards-of-proficiency/practitioner-psychologists/

Horvath, A. O. (2005). The therapeutic relationship: Research and theory. *Psychotherapy Research, 15*(1-2), 3-7. doi:10.1080/10503300512331339143

Innes, N. T., Clough, B. A., & Casey, L. M. (2017). Assessing treatment barriers in eating disorders: A systematic review. *Eating Disorders, 25*(1), 1-21. doi:10.1080/10640266.2016.1207455

Johns, G., Taylor, B., John, A., & Tan, J. (2019). Current eating disorder healthcare services – the perspectives and experiences of individuals with eating disorders, their families and health professionals: Systematic review and thematic synthesis. *BJPsych Open, 5*(4), e59. doi:10.1192/bjo.2019.48

Joint Commissioning Panel for Mental Health. (2013). *Guidance for commissioners of eating disorder services*. Retrieved from https://www.jcpmh.info/wp-content/uploads/jcpmh-eatingdisorders-guide.pdf

Jones, C., Leung, N., & Harris, G. (2007). Dysfunctional core beliefs in eating disorders: A review. *Journal of Cognitive Psychotherapy: An International Quarterly, 21*(2), 156-171. doi:10.1891/088983907780851531

Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training, 38*(4), 357-361. doi:10.1037/0033-3204.38.4.357

Malson, H., Finn, D. M., Treasure, J., Clarke, S., & Anderson, G. (2004). Constructing 'the eating disordered patient': A discourse analysis of accounts of treatment experiences. *Journal of Community & Applied Social Psychology, 14*(6), 473-489. doi:10.1002/casp.804

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*(3), 438-450. doi:10.1037/0022-006X.68.3.438

Morris, J., Simpson, A. V., & Voy, S. J. (2015). Length of stay of inpatients with eating disorders. *Clinical Psychology & Psychotherapy, 22*(1), 45-53. doi:10.1002/cpp.1865

National Institute for Health and Care Excellence. (2020). *Eating disorders: recognition and treatment* (NICE guideline 69). Retrieved from https://www.nice.org.uk/guidance/ng69

Naylor, H., Mountford, V., & Brown, G. (2011). Beliefs about excessive exercise in eating disorders: The role of obsessions and compulsions. *European Eating Disorders Review, 19*(3), 226-236. doi:10.1002/erv.1110

NHS. (2019). *The NHS long term plan*. Retrieved from https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

NHS Digital. (2018). Finished Admission Episodes (FAEs) with a primary or secondary diagnosis of eating disorder. Retrieved from https://digital.nhs.uk/data-and-information/find-data-and-publications/supplementary-information/2018-supplementary-information-files/finished-admission-episodes-faes-with-a-primary-or-secondary-diagnosis-of-eating-disorder

NHS Digital (2019a) Admissions for mental health and self-harm. Retrieved from: https://digital.nhs.uk/data-and-information/find-data-and-publications/supplementary-information/2019-supplementary-information-files/admissions-for-mental-health-and-self-harm

NHS Digital. (2019b). Hospital admissions for eating disorders. Retrieved from https://digital.nhs.uk/data-and-information/find-data-and-publications/supplementary-information/2019-supplementary-information-files/hospital-admissions-for-eating-disorders

NHS England. (2019). *Adult eating disorders: Community, inpatient and intensive day patient care - Guidance for commissioners and providers*. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2019/08/aed-guidance.pdf

Nilsen, J.-V., Hage, T. W., Rø, Ø., Halvorsen, I., & Oddli, H. W. (2019). Minding the adolescent in family-based inpatient treatment for anorexia nervosa: A qualitative study of former inpatients' views on treatment collaboration and staff behaviors. *BMC Psychology, 7*, 72. doi:10.1186/s40359-019-0348-2

Noblit, G. W., & Hare, R. D. (1988). *Meta-ethnography: Synthesizing qualitative studies*. London: SAGE Publications.

O'Brien, A. J. (2001). The therapeutic relationship: Historical development and contemporary significance. *Journal of Psychiatric and Mental Health Nursing, 8*(2), 129-137. doi:10.1046/j.1365-2850.2001.00367.x

Offord, A., Turner, H., & Cooper, M. (2006). Adolescent inpatient treatment for anorexia nervosa: A qualitative study exploring young adults' retrospective views of treatment and discharge. *European Eating Disorders Review, 14*(6), 377-387. doi:10.1002/erv.687

Olofsson, M. E., Oddli, H. W., Hoffart, A., Eielsen, H. P., & Vrabel, K. R. (2020). Change processes related to long-term outcomes in eating disorders with childhood trauma: An explorative qualitative study. *Journal of Counseling Psychology, 67*(1), 51-65. doi:10.1037/cou0000375

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., . . . Moher, D. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ, 372*, n71. doi:10.1136/bmj.n71

Palaganas, E. C., Sanchez, M. C., Molintas, V. P., & Caricativo, R. D. (2017). Reflexivity in qualitative research: A journey of learning. *Qualitative Report, 22*(2), 426-438. doi:10.46743/2160-3715/2017.2552

Pemberton, K., & Fox, J. R. E. (2013). The experience and management of emotions on an inpatient setting for people with anorexia nervosa: A qualitative study. *Clinical Psychology & Psychotherapy, 20*(3), 226-238. doi:10.1002/cpp.794

Priebe, S., & McCabe, R. (2006). The therapeutic relationship in psychiatric settings. *Acta Psychiatrica Scandinavica*, *113*(s429), 69-72. doi:10.1111/j.1600-0447.2005.00721.x

Reid, M., Burr, J., Williams, S., & Hammersley, R. (2008). Eating disorders patients' views on their disorders and on an outpatient service: A qualitative study. *Journal of Health Psychology*, *13*(7), 956-960. doi:10.1177/1359105308095070

Richardson, C., & Paslakis, G. (2021). Men's experiences of eating disorder treatment: A qualitative systematic review of men-only studies. *Journal of Psychiatric and Mental Health Nursing, 28*(2), 237-250. doi:10.1111/jpm.12670

Roter, D. (2000). The enduring and evolving nature of the patient-physician relationship. *Patient Education and Counseling*, *39*(1), 5-15. doi:10.1016/S0738-3991(99)00086-5

Salzmann-Erikson, M., & Dahlén, J. (2017). Nurses' establishment of health promoting relationships: A descriptive synthesis of anorexia nervosa research. *Journal of Child and Family Studies, 26*(1), 1-13. doi:10.1007/s10826-016-0534-2

Schlegl, S., Diedrich, A., Neumayr, C., Fumi, M., Naab, S., & Voderholzer, U. (2016). Inpatient treatment for adolescents with anorexia nervosa: Clinical significance and predictors of treatment outcome. *European Eating Disorders Review, 24*(3), 214-222. doi:10.1002/erv.2416

Seah, X. Y., Tham, X. C., Kamaruzaman, N. R., & Yobas, P. (2017). Knowledge, attitudes and challenges of healthcare professionals managing people with eating disorders: A

literature review. *Archives of Psychiatric Nursing, 31*(1), 125-136. doi:10.1016/j.apnu.2016.09.002

Short, V., Covey, J. A., Webster, L. A., Wadman, R., Reilly, J., Hay-Gibson, N., & Stain, H. J. (2019). Considering the team in team formulation: A systematic review. *Mental Health Review Journal, 24*(1), 11-29. doi:10.1108/MHRJ-12-2017-0055

Sibeoni, J., Orri, M., Valentin, M., Podlipski, M.-A., Colin, S., Pradere, J., & Revah-Levy, A. (2017). Metasynthesis of the views about treatment of anorexia nervosa in adolescents: Perspectives of adolescents, parents, and professionals. *PLoS ONE, 12*(1), e0169493. doi:10.1371/journal.pone.0169493

Sly, R., Morgan, J. F., Mountford, V. A., Sawer, F., Evans, C., & Lacey, J. H. (2014). Rules of engagement: Qualitative experiences of therapeutic alliance when receiving in-patient treatment for anorexia nervosa. *Eating Disorders, 22*(3), 233-243. doi:10.1080/10640266.2013.867742

Smink, F. R. E., van Hoeken, D., & Hoek, H. W. (2012). Epidemiology of eating disorders: Incidence, prevalence and mortality rates. *Current Psychiatry Reports, 14*, 406-414. doi:10.1007/s11920-012-0282-y

Smith, V., Chouliara, Z., Morris, P. G., Collin, P., Power, K., Yellowlees, A., . . . Cook, M. (2016). The experience of specialist inpatient treatment for anorexia nervosa: A qualitative study from adult patients' perspectives. *Journal of Health Psychology, 21*(1), 16-27. doi:10.1177/1359105313520336

Snell, L., Crowe, M., & Jordan, J. (2010). Maintaining a therapeutic connection: Nursing in an inpatient eating disorder unit. *Journal of Clinical Nursing, 19*(3-4), 351-358. doi:10.1111/j.1365-2702.2009.03000.x

Solman, B., & Clouston, T. (2016). Occupational therapy and the therapeutic use of self. *British Journal of Occupational Therapy, 79*(8), 514-516. doi:10.1177/0308022616638675

Sonneville, K. R., & Lipson, S. K. (2018). Disparities in eating disorder diagnosis and treatment according to weight status, race/ethnicity, socioeconomic background, and sex among college students. *International Journal of Eating Disorders, 51*(6), 518-526. doi:10.1002/eat.22846

Tabler, J., & Utz, R. L. (2020). Hospitalization following eating disorder diagnosis: The buffering effect of marriage and childbearing events. *SSM - Population Health, 12*, 100672. doi:10.1016/j.ssmph.2020.100672

Tan, J. O. A., Hope, T., Stewart, A., & Fitzpatrick, R. (2003). Control and compulsory treatment in anorexia nervosa: The views of patients and parents. *International Journal of Law and Psychiatry, 26*(6), 627-645. doi:10.1016/j.ijlp.2003.09.009

The EndNote Team. (2013). EndNote (Version EndNoteX9) [64 bit]. Philadelphia, PA: Clarivate.

The Royal Colleges of Psychiatrists, Physicians and Pathologists. (2014). *MARSIPAN: Management of really sick patients with anorexia nervosa* (College Report 189). Retrieved from https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr189.pdf?sfvrsn=6c2e7ada_2

Thompson-Brenner, H., Satir, D. A., Franko, D. L., & Herzog, D. B. (2012). Clinician reactions to patients with eating disorders: A review of the literature. *Psychiatric Services, 63*(1), 73-78. doi:10.1176/appi.ps.201100050

Toye, F., Seers, K., Allcock, N., Briggs, M., Carr, E., & Barker, K. (2014). Meta-ethnography 25 years on: Challenges and insights for synthesising a large number of qualitative studies. *BMC Medical Research Methodology, 14*, 80. doi:10.1186/1471-2288-14-80

Túry, F., Szalai, T., & Szumska, I. (2019). Compulsory treatment in eating disorders: Control, provocation, and the coercion paradox. *Journal of Clinical Psychology*, *75*(8), 1444-1454. doi:10.1002/jclp.22783

van Ommen, J., Meerwijk, E. L., Kars, M., van Elburg, A., & van Meijel, B. (2009). Effective nursing care of adolescents diagnosed with anorexia nervosa: The patients' perspective. *Journal of Clinical Nursing, 18*(20), 2801-2808. doi:10.1111/j.1365-2702.2009.02821.x

Ward, Z. J., Rodriguez, P., Wright, D. R., Austin, S. B., & Long, M. W. (2019). Estimation of eating disorders prevalence by age and associations with mortality in a simulated nationally representative US cohort. *JAMA Network Open, 2*(10), e1912925. doi:10.1001/jamanetworkopen.2019.12925

Westwood, L. M., & Kendal, S. E. (2012). Adolescent client views towards the treatment of anorexia nervosa: A review of the literature. *Journal of Psychiatric and Mental Health Nursing, 19*(6), 500-508. doi:10.1111/j.1365-2850.2011.01819.x

Wright, K. M. (2010). Therapeutic relationship: Developing a new understanding for nurses and care workers within an eating disorder unit. *International Journal of Mental Health Nursing, 19*(3), 154-161. doi:10.1111/j.1447-0349.2009.00657.x

Zaitsoff, S., Pullmer, R., Cyr, M., & Aime, H. (2015). The role of the therapeutic alliance in eating disorder treatment outcomes: A systematic review. *Eating Disorders, 23*(2), 99-114. doi:10.1080/10640266.2014.964623

Zugai, J., Stein-Parbury, J., & Roche, M. (2013). Effective nursing care of adolescents with anorexia nervosa: A consumer perspective. *Journal of Clinical Nursing, 22*(13-14), 2020-2029. doi:10.1111/jocn.12182

Table 1

Inclusion and Exclusion Criteria

Inclusion criteria	Exclusion criteria
Study investigates or reports at least one theme/subtheme on: • Patients' experiences of the therapeutic relationship or interactions with HCPs while receiving inpatient treatment or care • Patients' perceptions of HCPs' contributions to a positive or negative experience of inpatient treatment or care • Patients' preferences for desired interactions with HCPs in inpatient settings • Patients' experiences of collaboration or emotional/psychological support provided by HCPs in inpatient settings	The study includes patients and other parties (e.g., HCPs or parents) in their sample and does not report separate results for patients only
Study participants/population: • Any age and any gender	Study participants/population: • Participants diagnosed (either formally or self-reported) with Pica,

• Participants who have an eating disorder (either formally diagnosed or self-reported), including Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, Atypical Eating Disorder, and Eating Disorder Not Otherwise Specified, or Other Specified Feeding or Eating Disorder, or Unspecified Feeding or Eating Disorder • Participants who are/were inpatients in either specialist or non-specialist (e.g., general mental health ward) services	Rumination Disorder, Selective Eating Disorder, Avoidant/Restrictive Food Intake Disorder, Orthorexia, or obesity
Qualitative or mixed methods design	Quantitative design
The study contains extractable qualitative data, i.e., participants quotes	Studies with limited extractable data (e.g., no quotes)
Peer-reviewed empirical studies	Unpublished dissertations, books or book chapters, book reviews, literature reviews, systematic reviews, editorials or commentaries
Written in English	

Note. HCPs = healthcare professionals

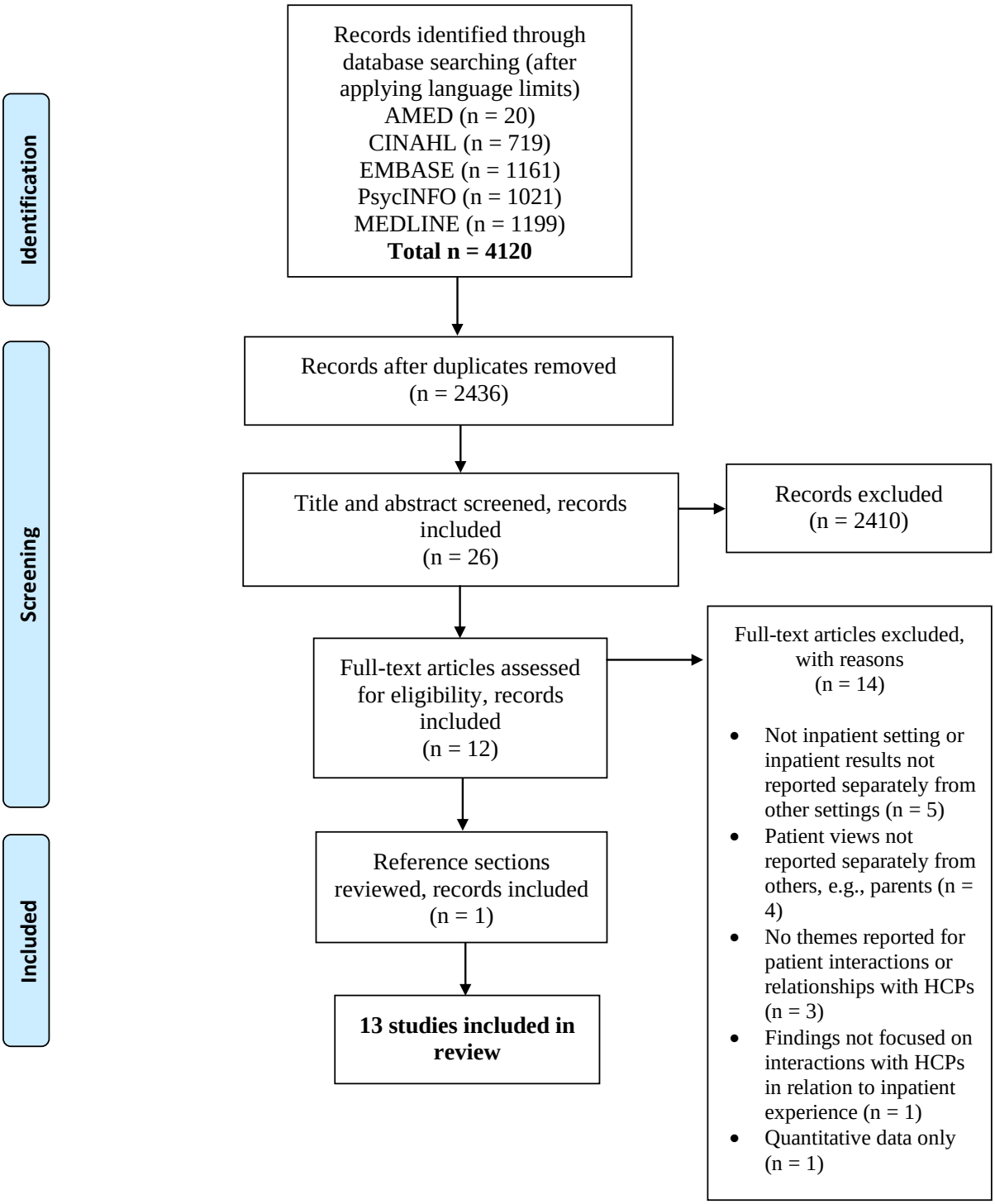


Figure 1. PRISMA Flow Diagram. This flow diagram presents the results of the search process. Template adapted from Page et al. (2021).

Table 2

CASP Ratings

Papers	Research design	Recruitment strategy	Data collection	Researcher-participant relationship	Ethical issues	Data analysis	Findings	Value of research	Total (out of 24)
Colton and Pistrang (2004)	3	2	2	1	1	2	3	3	17
Malson et al. (2004)	3	2	2	1	2	2	1	2	15
Offord et al. (2006)	3	2	2	1	1	2	2	3	16
van Ommen et al. (2009)	3	3	2	1	2	1	3	3	18

Boughtwood and Halse (2010)	3	2	1	2	1	1	2	2	14
Pemberton and Fox (2013)	3	2	3	2	3	2	2	1	18
Zugai et al. (2013)	2	2	1	1	2	1	2	2	13
Eli (2014)	2	2	3	1	2	3	2	2	17
Sly et al. (2014)	1	2	2	1	1	2	3	2	14
Fox and Diab (2015)	2	1	2	1	1	2	3	2	14

Smith et al. (2016)	1	3	2	2	3	3	3	2	19
Nilsen et al. (2019)	2	1	2	1	2	1	3	2	14
Olofsson et al. (2020)	3	2	3	2	3	3	3	3	22

Note. Eight out of the 10 domains of the CASP were given a score of either 1 (little or no evidence), 2 (some evidence but lack of a full elaboration) or 3 (strong evidence and full justification).

Table 3

The Seven-phase Meta-ethnography Approach

Phase	Description
Phases 1 (“Getting started”) and 2 (“Deciding what is relevant to the initial interest”)	Details on these phases are given in the “search strategy” and “inclusion and exclusion criteria” sub-sections of the method section.
Phase 3 (“Reading the studies”)	Each included study was re-read, and initial concepts and metaphors were extracted (and coded) on to post-it notes.
Phase 4 (“Determining how the studies are related”)	Concepts and codes on post-it notes from each article were compared in chronological order (France et al., 2014) to establish initial relationships between all the studies (presence or absence of the initially identified concepts). Studies were also compared based on whether their participants were admitted or discharged from inpatient settings at the time of data collection and based on the age group of participants (adolescents versus adults).
Phase 5 (“Translating the studies into one another”)	Based on the above step, the identified studies were subject to reciprocal translation to identify central metaphors or concepts which account for those in each individual study. This consisted of clustering

	together concepts written on post-it notes into theme piles starting with the earliest study. Throughout this process the author repeatedly checked that the emerging themes represented the original studies.
Phase 6 (“Synthesising translations”)	This phase involved establishing new interpretations (third-order constructs) of all studies and of the central metaphors/concepts.
Phase 7 (“Expressing the synthesis”)	New interpretations were discussed in relation to current literature in the discussion section of this review.

Table 4

Excerpt of the Process for Deriving the "Treated as an 'Anorexic'" Theme (Third-order Construct)

Reciprocal translation across studies	Codes	Initial concepts and metaphors					
		Malson et al. (2004)	Boughtwood and Halse (2010)	Pemberton and Fox (2013)	Eli (2014)	Offord et al. (2006)	Smith et al. (2016)
Assumptions about patient responses being a result of their ED or a manifestation of their ED symptoms, rather than an expression of	Seen as just an "anorexic" by HCPs	"Because everything you say [to a doctor] is part of the disease … I'm a person … I'm not just anorexic kind of thing"	Yet it appears that in hospitals, girls' words and actions are often interpreted in terms of a universal, generalised	Patients [felt] that they were defined by their eating disorder … staff had difficulty differentiating between behaviour which was	Danielle … felt her entire experience … had been subsumed under the umbrella of her eating disorder: having been told that her		

their individuality		notion of 'the anorexic' rather than of diverse individuals struggling with an illness …	directly related to the eating disorder … and the characteristics of the individual …	disorder was 'talking' … her own voice had been consistently ignored.	
	Assumptions that patients are going to act in accordance with their ED			"It was … 'You're anorexic, you're just gonna say this to try and get out of this'"	"It is assumed that every single thing we say is an eating disorder"

Note. Initial concepts and metaphors consist of participant quotes (in quotation marks) and original author interpretations.

Table 5

Summary of Characteristics of Included Studies

Authors and date	Location	Study aims	Design and methodology	Participant demographics						
				N	Age group	Gender	ED diagnosis	Ethnicity	Inpatient status at time of data collection	Type of inpatient environment
Colton and Pistrang (2004)	UK	To provide a detailed description of how adolescents on two inpatient specialist ED units view their treatment	IPA Semi-structured interviews	19	Adolescents	Female	AN	White British (n = 17) White Irish (n = 1) British with Afro-Caribbean origin (n = 1)	Inpatients	Two 10-bed ED units

Malson et al. (2004)	UK and Australia	To investigate ED treatments by analysing participants' accounts of their treatment experiences, and through explicating the ways in which "the eating disordered patient" is construed	Discourse Analysis Semi-structured interviews	39	Adolescents and adults	Female (n = 38) Male (n = 1)	AN and/or BN	Not stated	Inpatients (n = 31) Former inpatients (n = 8)	Specialist ED inpatient ward in a psychiatric hospital, UK (n = 16) Adolescent medicine ward of a general hospital specialising in EDs treatment, Australia (n = 16)

Offord et al. (2006)	UK	To explore views on the treatment patients received for AN whilst admitted to a general adolescent psychiatric unit	IPA Semi-structured interviews	7	Young adults (16-23)	Female	AN	White British	Discharged 2-5 years	General adolescent inpatient setting
van Ommen et al. (2009)	The Netherlands	To develop from the patients' perspective a tentative theoretical	Grounded Theory Semi-structured interviews	12	Adolescents	Female	AN	Not stated	Discharged within 3 months	ED inpatient unit

		model explaining the effectiveness of inpatient nursing care of adolescents diagnosed with AN									
Boughtwood and Halse (2010)	Australia	To contribute to knowledge about the therapeutic alliance in hospitalisation for AN by providing insights into the perspectives	Discourse Analysis Semi-structured interviews and field notes	25	Adolescents	Female	AN	Anglo-Australian (n = 22) First generation Australian of Chinese descent (n = 2)	Inpatients (n = 20) Former inpatients treated as outpatients (n = 5)	Two large, metropolitan hospitals

		of teenage girls about their doctors and treatment regimes						Second generation Australian of Italian descent (n = 1)		
Pemberton and Fox (2013)	UK	To understand factors that were important in the care and emotional management of people with EDs on an inpatient unit	Based on IPA Semi-structured interviews	8	Not stated; seven participants under the age of 25	Female (n = 7) Male (n = 1)	AN	Not stated	Inpatients	Two specialist ED units
Zugai et al (2013)	Australia	To establish how nurses	Thematic Analysis	8	Adolescents	Female	AN	Not stated	Discharged 0-2 years	General adolescent

		contribute to weight gain and to a positive inpatient experience	Semi-structured interviews							ward (with an ED program)
Eli (2014)	Israel	To identify ways in which inpatient ambivalence might be embedded in the special social institutional setting that an EDs ward presents	Modified form of IPA Semi-structured interviews	13 interviewed in 2005-2006 9 re-interviewed in 2011	Adults	Female (n = 12) Male (n = 1)	AN/EDNOS-AN (n = 12) BN (n = 1)	Not stated	Discharged several months or years (n = 11) Inpatients (n = 2)	ED ward for adults

Sly et al. (2014)	UK	To examine the service user experience of therapeutic alliance, to assess its perceived importance, and to explore what elements help contribute to building a stronger alliance with clinical staff	IPA Semi-structured interviews	8	Adults	Female	AN	Caucasian	Inpatients	Not stated

Fox and Diab (2015)	UK	To explore sufferers' perceived experiences of living with and being treated within an EDs unit for their chronic AN	IPA Interviews	6	Adults	Female	Chronic AN (defined as duration of 6+ years)	White British	Inpatients	Two ED units
Smith et al. (2016)	UK	To explore women's experiences of specialist inpatient treatment for AN during treatment admission	Thematic Analysis Semi-structured interviews	21	Adults	Female	AN	Not stated	Inpatients	27-bed specialist high-intensity ED unit

Nilsen et al. (2019)	Norway	To investigate post-treatment patient reflections following discharge from a family-based treatment program which emphasized parents	Thematic Analysis Semi-structured interviews	37	Young adults (15-25)	Female (n = 33) Male (n = 4)	AN	Not stated	Discharged 1-7 years	Adolescent family-based ED treatment unit
Olofsson et al. (2020)	Norway	To explore subjective experiences of change processes or a lack thereof	Combination of IPA and Grounded Theory	11	Adults	Female	BN (n = 5) OSFED-AN (n = 5) BED (n = 1)	White	Discharged on average 37 days	Tertiary care psychiatric hospital offering highly specialised

for patients who had good long-term outcome versus those who had poor long-term outcome	Semi-structured interviews	Participants additionally had experiences of childhood trauma	eating disorder treatment

Note. AN = Anorexia Nervosa, BED = Binge Eating Disorder, BN = Bulimia Nervosa, ED = Eating Disorder, IPA = Interpretative Phenomenological Analysis, OSFED = Otherwise Specified Feeding and Eating Disorder.

Table 6

Themes Across Studies

Theme	Studies																				
	Colton and Pistrang (2004)	Malson et al. (2004)	Offord et al. (2006)	van Ommen et al. (2009)	Boughtwood and Halse (2010)	Pemberton and Fox (2013)	Zugai et al (2013)	Eli (2014)	Sly et al. (2014)	Fox and Diab (2015)	Smith et al. (2016)	Nilsen et al. (2019)	Olofsson et al. (2020)								
Treated as an "Anorexic"	√	√	√	√	√	√		√		√	√	√	√								
Us versus Them		√	√	√	√	√	√	√	√		√	√	√								
A Good Relationship with Inpatient Staff is Vital	√	√	√	√	√	√	√		√	√	√		√								

Appendix 1-A

International Journal of Eating Disorders Author Guidelines

GUIDELINE SECTIONS

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium. If there is a related paper under consideration at another journal, a copy of that paper should be submitted with the primary manuscript as supporting information.

International Journal of Eating Disorders will consider submissions that have previously been made available online, either on a preprint server like arXiv, bioRxiv, or PeerJ PrePrints, or on the authors' own website. However, any such submissions must not have been published in a scientific journal, book or other venue that could be considered formal publication. Authors must inform the editorial office at submission if their paper has been made available as a preprint.

- Authors of accepted papers that were made available as preprints must be able to assign copyright to *International Journal of Eating Disorders*, or agree to the terms of the Wiley Open Access agreement and pay the associated fee
- Given that the measurable impact of the article is diminished when citations are split between the preprint and the published article, authors are required to:
    - Update the entry on the preprint server so that it links to and cites the DOI for the published version
    - Cite only the published article themselves

Authors should follow the guidelines carefully; failure to do so will delay the processing of the manuscript. **Once the submission has been prepared in accordance with the Author Guidelines, manuscripts should be submitted online at mc.manuscriptcentral.com/ijed**. Authors unfamiliar with ScholarOne can find details on how to use the system here: **www.wileyauthors.com/scholarone**.

The submission system will prompt the author to use an ORCID iD (a unique author identifier) to help distinguish their work from that of other researchers. Details can be found **elsewhere** in these guidelines.

By submitting a manuscript to or reviewing for this publication, an individual's name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at **authorservices.wiley.com/statements/data-protection-policy**.

Preprint policy:

Please find the Wiley preprint policy **here.**

This journal accepts articles previously published on preprint servers.

International Journal of Eating Disorders will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article.

For help with submissions, authors should contact the Editorial Office: **ijed@wiley.com**. When necessary, the Editorial Office staff may refer questions to the Editor-in-Chief or Associate Editors.

Return to Guideline Sections

2. AIMS AND SCOPE

The *International Journal of Eating Disorders*—A leading peer-reviewed journal in the fields of psychology, psychiatry, public health, and nutrition & dietetics.

Mission: With a mission to advance the scientific knowledge needed for understanding, treating, and preventing eating disorders, the *International Journal of Eating Disorders* publishes rigorously evaluated, high-quality contributions to an international readership of health professionals, clinicians, and scientists. The journal also draws the interest of patient groups and advocates focused on eating disorders, and many of the articles draw attention from mainstream media outlets.

Scope: Articles featured in the journal describe state-of-the-art scientific research on theory, methodology, etiology, clinical practice, and policy related to eating disorders, as well as contributions that facilitate scholarly critique and discussion of science and practice in the field. Theoretical and empirical work on obesity or healthy eating falls within the journal's scope inasmuch as it facilitates the advancement of efforts to describe and understand, prevent, or treat eating disorders. The *International Journal of Eating Disorders* welcomes submissions from all regions of the world and representing all levels of inquiry (including basic science, clinical trials, implementation research, and dissemination studies), and across a full range of scientific methods, disciplines, and approaches.

A complete **overview** of the journal is given elsewhere on the journal's homepage.

Return to Guideline Sections

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

The *International Journal of Eating Disorders* publishes the following contribution types:

1. Original Articles
2. Brief Reports
3. Intervention Studies

4. Reviews
5. Spotlight
6. Commentaries
7. Registered Reports
8. Forum
9. Perspective

When uploading their manuscript, authors will be asked to complete a checklist indicating that they have followed the Author Guidelines pertaining to the appropriate article type. For all manuscripts reporting statistical analyses, authors are advised to use the **Statistical Reporting Checklist.** For more detailed background information on statistical analyses and their rationale, authors are referred to the **IJED Statistical Reporting Guidelines.** Manuscript with incomplete reporting will be referred back to the author without review. All word limits relate to the body of the text (i.e., not including abstract, references, tables and figures) and represent maximum lengths. Authors are encouraged to keep their manuscript as short as possible while communicating clearly.

1) Original Articles

These contributions report substantive research that is novel, definitive, or complex enough to require a longer communication. Only a subset of research papers is expected to warrant full-length format.

- Word Limit: 4,500 (excluding abstract, references, tables or figures)
- Structured Abstract: 250 words.
- References: ≤60 are recommended; more are permissible, for cause.
- Figures/Tables: a maximum of 8 essential tables/figures, overall.

When preparing their manuscript, authors should follow the IMRaD guidelines (***I***ntroduction, ***M***ethods, ***R***esults, ***a***nd ***D***iscussion), which are recommended by the International Committee of Medical Journal Editors (ICMJE) (**J. Pharmacol. Pharmacother. 2010, 1, 42–58**).

2) Brief Reports

This contribution type is intended for manuscripts describing studies with straightforward research designs, pilot or "proof of concept" studies, and replications.

- Word Limit: 2,000 (excluding abstract, references, tables or figures).
- Structured Abstract: 200 words.
- References: ≤20 are recommended; more are permissible, for cause.
- Figures/Tables: a maximum of 2 essential tables/figures, overall.

As for **Original Articles**, when preparing their manuscript, authors should follow the IMRaD guidelines.

3) Intervention Studies

Unless noted otherwise, all interventions studies require that authors have preregistered their study in an online repository before the first participant has been enrolled. The preregistration number should be entered in the manuscript submission checklist and also be reported in the Methods section. Examples of repositories include https://cos.io/prereg/, https://www.clinicaltrials.gov/, etc.

Intervention studies will be accepted under one of two broad categories, reflecting the processes outlined in the literature for research into clinical interventions. They can include prevention, early intervention and treatment studies.

When submitting an intervention study manuscript, authors first should determine whether the study warrants a full-length report (**Original Articles** format) or whether it best fits the **Brief Reports** format.

Upon selecting the manuscript format, authors will then be able to select whether the manuscript describes a) an innovation or implementation study; b) a comparative treatment or prevention trial; or c) a non-intervention study (i.e. all other studies).

In all cases, ethical considerations should be addressed, including the obtaining of ethical permission where required. Statistical analysis and data presentation should be appropriate and follow the guidelines for statistical reporting provided for IJED contributors (including treatment of missing data). Any presentation of post-hoc findings needs to be clearly justified and contextualized. The inclusion of qualitative feedback on the experience of patients and clients is encouraged.

Innovation and Implementation

Such papers demonstrate the potential of new innovations in treatment for eating disorders, and the effectiveness of strongly evidenced therapies in routine clinical settings. Those papers are expected to meet the standards included for Template Intervention Description and Replication Checklist (TIDieR): **http://www.equator-network.org/wp-content/uploads/2014/03/TIDieR-Checklist-PDF.pdf**

Single case experimental designs, where one or more cases are presented using visual or statistical methods to demonstrate the clinical impact of an intervention, based on at least an A-B design and session-by-session data. Such case reports should have heuristic value, so need to be innovative and leading to stronger research. Such cases require a clear statement from the authors that the patient (or the patient's legal guardian) has given permission to publish the material anonymously. Case reports without such clinical outcome data and structured presentation of findings will not normally be considered. Preregistration encouraged but not required.

Innovative uncontrolled trials, using a case series to demonstrate the initial implementation of interventions, under uncontrolled conditions (e.g., a series of patients treated with a new therapy; a comparison of therapies for similar but not identical patients). Such case series should be placed in context (e.g., were the patients recruited as a true series, or were they selected from the available pool?) and supported with a CONSORT diagram or the appropriate procedural detail. Preregistration encouraged but not required.

Implementation studies, effectiveness studies, demonstrating the rolling out of evidence from controlled trials to routine practice, other populations, etc. Differences relative to the original intervention should be outlined.

For both study types, reporting of intent-to-treat results is preferred unless a strong rationale for a different approach is provided. Completer results can also be reported if this is considered to add important information. Results should include the mean and SD of pre- and post-scores, within-group effect sizes with 95% confidence intervals, and pre- and post-score correlations (allowing within-subject effect sizes to be verified). Appropriate follow-up data are desirable.

Comparative Trials

This category requires evidence that an intervention has been compared to either a control or active condition and has been conducted and reported appropriately in conformity to the appropriate CONSORT checklist (**http://www.consort-statement.org/**), particularly randomization of participants. CONSORT diagrams will usually be required, and such trials should be pre-registered to ensure that the core aims and hypotheses are openly addressed. Replication studies are welcomed but are more likely to be suited to Brief Reports.

Proof of concept and pilot studies are not required before an RCT can be published. However, each of these types of study is accepted by IJED, as they form key steps in the development of ideas, grant proposals, etc. Proof of concept and pilot studies can be combined into one submission, but both functions should be addressed adequately in that paper in such a case. The study description should conform to the CONSORT 2010 checklist of information to include when reporting a proof of concept or pilot study trial. Authors are advised to review the CONSORT extensions for additional information **http://www.consort-statement.org/extensions**.

Proof of concept studies answer the question: Does the RCT pose questions well worth asking? Data can be presented on effectiveness but should not be used to estimate effect sizes for the RCT as such estimates can be misleading. Preregistration encouraged but not required.

Pilot studies assess issues related to proposed sampling and measurement, design and analysis and answer the question: Is the RCT well-designed enough to address the hypotheses? Such studies should report feasibility as the primary outcome rather than clinical outcomes. This requires a focus on information that addresses hypotheses about recruitment, acceptability, attrition, cost, accessibility, e.g., Can you recruit as many participants in the time allowed as your study proposes? Will the participants accept randomization? Will they comply with treatment protocols? Is the protocol for delivery of treatment well and clearly enough defined to promote fidelity? Will the participants accept the testing procedures? Can the testing procedures be completed in the time allowed? If these data are included in any subsequent study (e.g., an RCT), that fact should be explained transparently.

Randomized controlled trials, where there needs to be an adequate sample size (demonstrated through the presentation of a power analysis), clear aims and hypotheses. Any blinding (e.g., of researchers) and problems of de-blinding should be clearly detailed. An appropriate follow-up period is required. Definitions of terms such as 'attrition', 'remission' and 'recovery' should be fully replicable, and intervention protocols should be readily available to the reader. The study description should conform to the CONSORT 2010 checklist of information to include when reporting a randomized trial.

4) Reviews

These articles critically review the status of a given research area and propose new directions for research and/or practice. Both systematic and meta-analytic review papers are welcomed if they review a literature that is advanced and/or developed to the point of warranting a review and synthesis of existing studies. Reviews of topics with a limited number of studies are unlikely to be deemed as substantive enough for a Review paper. The journal does not accept papers that merely describe or compile a list of previous studies without a critical synthesis of the literature that moves the field the forward.

- Word Limit: 7,500 (excluding abstract, references, tables or figures).

- Structured Abstract: 250 words.
- References: ≤100 are recommended; more are permissible, for cause.
- Figures/Tables: no maximum, but should be appropriate to the material covered.

All Review articles must follow the PRISMA Guidelines (**www.prisma-statement.org**), summarized in a 2009 *J. Clin. Epidemiol.* article by Moher et al. entitled *"Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement"* (DOI: **10.1016/j.jclinepi.2009.06.005**), freely available for download in both English and Spanish.

In addition to the required PRISMA review paper components, all review articles must also include a full description of the age, gender, race, ethnicity, and socioeconomic status of participants in the reviewed studies. This information will most often take the form of separate entries in tables describing the studies included in the review. Review papers must also explicitly discuss (in the text) the diversity of the samples and the ways in which this diversity may impact the generalizability and representativeness of the study results and conclusions.

Authors who choose this contribution type must complete the Review Checklist upon submission of the manuscript, an example of which can be found **here**). This example is for informational purposes only. During the submission process, authors will be prompted to complete the Review Checklist directly in ScholarOne. The rationale for any unchecked items on the Review Checklist must be explicitly described in the accompanying Cover Letter.

5) Spotlight

This is a contribution type where authors propose an idea that may not yet have adequate empirical support or be ready for full empirical testing, but holds great promise for advancing research of eating disorders. Authors are encouraged to write a piece that is bold, forward looking, and suggestive of new and exciting avenues for research and/or practice in the field. The manuscript should identify the specific knowledge gap and why filling the gap will advance research and practice in the field; it should delineate several concrete steps for addressing the gap.

- Word Limit: 2,000 (excluding abstract, references, tables or figures).
- Unstructured Abstract: 200 words.
- References: ≤20 are recommended; more are permissible, for cause.
- Figures/Tables: a maximum of 2 essential tables/figures, overall.

6) Commentaries

Commentaries are solicited by the Editors when multiple perspectives on or critical appraisal of an article would assist in placing that article in context. Unsolicited commentaries are not considered for publication.

- Word Limit: 2,000 (excluding abstract, references, tables or figures).
- Unstructured Abstract: 200 words.
- References: ≤5 are recommended, more are permissible for cause.
- Figures/Tables: none.

7) Registered Reports

This manuscript type is intended for publishing a detailed research protocol of original empirical studies prior to commencing data collection or of studies involving secondary data analyses of large public access data bases, prior to commencing analyses. The journal will not consider Registered Reports for analyses that may reasonably be expected to be conducted as part of a complex research study (e.g., moderator/mediator analyses in a treatment trial). The journal does not support Registered Reports for meta-analytic or systematic reviews.

Registered Reports manuscripts should use section headings under which authors provide the following information. Introduction: Study aim(s) and background literature, and statement of hypotheses. The introduction would provide a succinct and compelling rationale for the study. Methods: Experimental design and procedures, analysis plans, and statistical power analysis. The methods section should be written with the goal of facilitating study replication and describe in detail, where possible or applicable, recruitment target numbers, criteria and procedures; instruments or other materials; experimental stimuli and procedures; intervention protocols; analysis scripts or code; etc. Preliminary Data (if applicable): any pilot data. Conclusion: a concise statement regarding the expected knowledge to be gained.

Authors are advised of the following additional requirements:

1. By the time of submission of the registered report manuscript, authors will have completed a preregistration of their study in an online repository (e.g., cos.io/prereg/); authors report the preregistration number as part of the submission process (on the author checklist) and in the methods section. If the preregistration is embargoed at the time of submission, authors should attach for the editor a confidential file containing the preregistration information and date when the study was preregistered.
2. If the preregistration is embargoed, the embargo must be lifted at the of acceptance of the Registered Report.
3. Having received extramural funding is not a prerequisite to potential acceptance of the registered report. However, authors are required to indicate in their submission letter whether the research plan has been reviewed and approved for funding by an extramural funding organization.
4. While institutional review board (IRB) approval is not required at the time of submission, publication will be conditional on receipt of IRB approval for the research plan as described in the accepted manuscript.

Registered Reports are peer reviewed using the same review criteria and procedures as apply to the introduction and methods sections of empirical studies involving confirmatory hypothesis testing. Reviewers would evaluate whether the rationale for the study aims is well justified and whether the design and methods are appropriate for testing the hypotheses.

Registered Reports manuscripts meeting the rigorous and transparent requirements for conducting the research proposed will be accepted for publication.

In addition, authors of a published Registered Report manuscript will be offered an in-principle acceptance of a subsequently submitted (Stage 2) manuscript. Specifically, following data collection, authors may submit a Stage 2 manuscript that includes the introduction and methods from the original submission plus their obtained results and

discussion. All planned analyses and resulting findings should be reported. Authors choosing to include in their Stage 2 manuscript unplanned analyses will need to clearly distinguish them from planned analyses. Authors may select the Original Report format or, if indicated, the Brief Report format. In either case, authors should update their manuscript considering the literature that has become available since publication of the Registered Report.

The Stage 2 manuscript will undergo full review. Referees will consider whether the authors properly executed the study and adhered precisely to the registered research procedures and analysis plans. Referees will review any unregistered post hoc analyses added by the authors to confirm they are justified, methodologically sound and informative. Finally, the referees will evaluate the scholarly quality of the discussion.

Submission of the Stage 2 manuscript to IJED is optional; authors are free, therefore, to publish their completed study in any journal of their choosing. Authors who opt to submit their stage 2 manuscript to IJED should select the Original Studies or Brief Report format. Stage 2 manuscripts published in IJED will be eligible for the "Preregistered" Open Science badge: **https://cos.io/our-services/open-science-badges/**

Should the author choose to publish their Registered Research Report open access and should the article be accepted for publication, a 50% discount is applied on the Article Publication Fee at both stages of publication.

Throughout the process, the journal editor or associate editors retain the right to reject manuscripts where the quality of academic writing is deemed not to be of a publishable standard.

Registered Reports Stage 1 Details:

Word Limit: 3,000 (excluding abstract, references, tables or figures); much of the word count should be devoted to a detailed description of study methods and procedures.

- Title page: Include preregistration information.
- Unstructured abstract: 200 words.
- References: ≤30 recommended; more are permissible, for cause.
- Figures/Tables: a maximum of 4 essential tables/figures, overall. Authors are encouraged to summarize key methodological details in table or figure format.
- Supplemental information. For lengthy information that cannot be accommodated within the word limit of the Registered Report format, authors are encouraged to utilize publicly accessible repositories and report the relevant hyperlinks in their methods section.

Registered Reports Stage 2 Details

Authors should use instructions for Original Studies or Brief Report manuscripts, respectively.

8) Forum

A Forum manuscript introduces an important knowledge or practice gap in regards to preventive or clinical interventions, policies, or research methods in the field and proposes specific solutions to filling the gap. A Forum manuscript is grounded in expert review of the literature and presents novel ideas regarding prevention or clinical care (Clinical Forum), public health or health care policy (Policy Forum), or research methods (Research Forum). Unlike Systematic Reviews or Meta-Analytical Reviews ("Review manuscripts"), the literature

reviewed in a Forum manuscript may involve a smaller number of studies (i.e., the field may not yet have matured to the point where a systematic review is indicated); however, as in Review manuscripts, authors need to describe and critically discuss the relevant details of the prior literature. Unlike Idea manuscripts, Forum manuscripts need not necessarily pose a novel problem; the gap or problem being addressed may have plagued the field for some time. What is expected to be novel is (are) the solution(s) being proposed in the Forum manuscript. As with all journal content, authors should consider the relevance and implications of their work for a global audience.

When submitting the Forum, authors will be prompted to select whether their Forum manuscript primarily focuses on treatment or prevention (Clinical Forum), public health or health care policy (Policy Forum), or research methods (Research Forum).

Main text, excluding abstract, references, tables or figures: 5000 words

Structured abstract: 250 words

Tables, figures: up to 5

References: no restriction

9) Perspective

A Perspective manuscript comments on an Original Research, Brief Report, or Meta-Analysis Review manuscript published in the IJED. A Perspective expands upon the published research by offering additional context, interpretation, or suggestions regarding the potential application of the research for advancing science and practice in eating disorders. Perspective manuscripts may not merely summarize the published research nor are they intended to primarily discuss the author's own work. Because the Original Research, Brief Report, or Meta-Analysis paper has already been peer reviewed, the Perspective manuscript should be viewed as an opportunity to develop the ideas and potential of the work reported, rather than a critique of the paper. Indeed, only submissions that add a new dimension to the published research will be considered suitable for publication.

Perspective manuscripts should provide a personal viewpoint and, as such, authorship should be limited to one or two authors. We recognize various forms of expertise, including research expertise, clinical expertise, expertise by lived experience (e.g., individuals impacted by an eating disorder), policy expertise, or expertise in a scholarly field distinct from eating and weight disorders. When submitting a Perspective manuscript, authors are requested to specify their primary expertise as pertaining to the Perspective submission.

To be considered for publication, the Perspective should focus on an Original Research, Brief Report, or Meta-Analysis Review manuscript that has been published in early view no more than three months before submission of the Perspective manuscript. Submissions that do not meet these requirements are rejected without review.

Main text: up to 750 words.

No abstract, up to 10 references.

Return to Guideline Sections

4. PREPARING THE SUBMISSION

Parts of the Manuscript

The submission should be uploaded in separate files: 1) **manuscript file**; 2) tables; 3) **figures**; 4) if applicable, **supporting Information file(s)**.

1. Manuscript File

The text file should contain the manuscript text, references, and the figure legends. The text should be presented in the following order:

1. Title page
    1. Title. The title should be short and informative, containing major keywords related to the content. The title should not contain abbreviations (see Wiley's best practice SEO tips) and should not be phrased inform of a question.
    2. A short running title of less than 40 characters.
    3. The full names of all authors
    4. The authors' institutional affiliations where the work was conducted, with a footnote for an author's present address if different to where the work was carried out
    5. If applicable (required for clinical trials): Trial registration number.
    6. Word counts (abstract and main text, excl. tables and references)
2. Data Availability Statement
3. Acknowledgements and Conflicts of Interest
    1. If applicable: funding source
    2. If applicable: other acknowledgements
    3. Conflict of interest statement (if none, state "The authors have no conflict to declare")
4. Abstract and Keywords
5. Main text
6. References
7. Figure legends

Title Page

Authorship

For details on eligibility for author listing, please refer to the journal's **Authorship policy** outlined in Section 5 of these Author Guidelines.

Acknowledgments

Contributions from individuals who do not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Conflict of Interest Statement

Authors will be asked to provide a conflict of interest statement during the submission process. See the journal's policy on **Conflict of Interest** outlined in Section 5 of these

Author Guidelines. Authors should ensure they liaise with all co-authors to confirm agreement with the final statement.

Abstract

The abstract should be typed as a single paragraph. The word maximum and abstract format vary by contribution type (see above).

Structured abstracts should be organized as follows: **Objective**: briefly indicate the primary purpose of the article, or major question addressed in the study. **Method**: indicate the sources of data, give brief overview of methodology, or, if review article, how the literature was searched and articles selected for discussion. For research based articles, this section should briefly note study design, how participants were selected, and major study measures. **Results**: summarize the key findings. **Discussion**: indicate main clinical, theoretical, or research applications/implications.

Keywords

Please provide about 10 keywords. Keywords should be taken from those recommended by the US National Library of Medicine's Medical Subject Headings (MeSH) browser list at **www.nlm.nih.gov/mesh**.

Main Text

- Manuscripts reporting original research should follow the **IMRaD guidelines** (***I***ntroduction, (***M***ethods, ***R***esults, ***a***nd ***D***iscussion), which are recommended by the International Committee of Medical Journal Editors (ICMJE) (J. Pharmacol. Pharmacother. 2010, 1, 42–58).
- The Methods section should include a statement about sample selection, response rate, and other factors that would impact selection or response bias and, in turn, representativeness of the sample.
- Articles reporting data taken from or deposited elsewhere should refer to the journal policy on Data Storage and Documentation in Section 5 (below).
- If the study involves qualitative data, authors need to include a statement about sample size in relation to theme saturation. It is also important that the sampling strategy is driven by theory rather than convenience, the data analysis procedures are justified, and the advantage of a qualitative (vs. a simple quantitative) approach are well-described.
- For additional detail regarding statistical requirements for the manuscript see **IJED Statistical Reporting Guidelines** and please use the **Statistical Reporting Guidelines Checklist** as you prepare your manuscript.
- Authors should refrain from using terms that are stigmatizing or terms that are ambiguous. For further explanation and examples, see the 2016 IJED article by Weissman et al. entitled "*Speaking of that: Terms to avoid or reconsider in the eating disorders field*" (DOI: 10.1002/eat.22528.)
- To facilitate evaluation by the Editors and Reviewers, each manuscript page should be numbered; the text should be double-spaced; and line numbers should be applied (restarting from 1 on each page). Instructions on how to implement this feature in Microsoft Word are given here.
- The journal uses US spelling. Authors may submit using any form of English as the spelling of accepted papers is converted to US English during the production process.

- Footnotes to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.
- It is the primary responsibility of the authors to proofread thoroughly and ensure correct spelling and punctuation, completeness and accuracy of references, clarity of expression, thoughtful construction of sentences, and legible appearance prior to the manuscript's submission.
- Authors for whom English is not their first language are encouraged to seek assistance from a native or fluent English speaker to proof read the manuscript prior to submission. Wiley offers a paid service that provides expert help in English language editing—further details are given below.
- Articles reporting data taken from or deposited elsewhere should refer to the journal policy on Data Storage and Documentation in Section 5 (below).

References

References in all manuscripts should follow the style of the American Psychological Association (6th edition), except in regards to spelling. The APA website includes **a range of resources for authors learning to write in APA style**, including **An overview of the Publication Manual of the American Psychological Association, Sixth Edition**; includes **free tutorials on APA Style basics** and an **APA Style Blog**. Please note APA referencing style requires that a Digital Object Identifier (DOI) be provided for all references where available.

Tables

Each table must be numbered in order of appearance in the text with Arabic numerals and be cited at an appropriate point in the text. Tables should be self-contained and complement, not duplicate, information contained in the text. They should be editable (i.e., created in Microsoft Word or similar), not pasted as images. Legends should be concise but comprehensive—the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as standard deviation (SD) or standard error of the mean (SEM) should be identified in the headings.

Figure Legends/Captions

Each figure caption should have a brief title that describes the entire figure without citing specific panels, followed by a description of each panel. Captions should be concise but comprehensive—the figure and its caption must be understandable without reference to the text. Be sure to explain abbreviations in figures even if they have already been explained in-text. Axes for figures must be labeled with appropriate units of measurement and description. Include definitions of any symbols used and units of measurement.

2. Figures

Although authors are encouraged to send the highest quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted. **Click here** for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Helvetica typeface is preferred for lettering within figures. All letters, numbers and symbols must be at least 2 mm in height. Courier typeface should be used for sequence figures.

Figures should be numbered consecutively with Arabic numerals, and they should be numbered in the order in which they appear in the text.

Figures should be submitted as electronic images to fit either one (55 mm, 2 3/16", 13 picas), two (115 mm, 4 1/2", 27 picas), or three (175 mm, 6 7/8", 41 picas) columns. The length of an illustration cannot exceed 227 mm (9"). Journal quality reproduction requires grey scale and color files at resolutions of 300 dpi. Bitmapped line art should be submitted at resolutions of 600–1200 dpi.

Figures submitted in color will be reproduced in color online free of charge. Authors wishing to have figures printed in color in hard copies of the journal will be charged a fee by the Publisher; further details are given **elsewhere** in these Author Guidelines. Authors should note however, that it is preferable that line figures (e.g., graphs) are supplied in black and white so that they are legible if printed by a reader in black and white.

Graphical Table of Contents

International Journal of Eating Disorders incorporates graphics and a small piece of text from journal articles into the online table of contents (which are distributed to readers who have signed up to Table of Contents (ToC) alerts). The extra graphic and text, in addition to being eye-catching, gives the reader a much more immediate impression of what each article will cover.

If you would like a graphic to accompany your article in the Table of Contents, please specify one of your figures. You will be given the option to specify a figure during the submission process at the file upload stage.

3. Supporting Information Files(s)

Supporting Information is information that is supplementary and not essential to the article, but provides greater depth and background. Examples of such information include more detailed descriptions of therapeutic protocols, results related to exploratory or post-hoc analyses, and elements otherwise not suitable for inclusion in the main article, such as video clips, large sections of tabular data, program code, or large graphical files. It is *not* appropriate to include, in the Supporting Information, text that would normally go into a discussion section; all discussion-related material should be presented in the main article.

Because the Supporting Information is separate from the paper and supplementary in nature, the main article should be able to be read as a stand-alone document by readers. Reference to the Supporting Information should be made in the text of the main article to provide context for the reader and highlight where and how the supplemental material contributes to the article.

Should authors wish to provide supplementary file(s) along with their article, these materials *must* be included upon submission to the journal. If such materials are added to the submission as a result of peer review, i.e., during a revision, then the authors should bring this to the attention of the editor in their response letter. If accepted for publication, Supporting Information is hosted online together with the article and appears without editing or typesetting.

Wiley's FAQs on Supporting Information are available on the Wiley Author Services site: **www.wileyauthors.com**.

Note: Authors are encouraged to utilize publicly available data repository for data, scripts, or other artefacts used to generate the analyses presented in the paper; in such cases, authors should include a reference to the location of the material within their paper.

General Style Points

The following points provide general advice on formatting and style.

- **Terminology**: The journal rejects terminology that refers to individuals by their condition. Terms such as “anorexics," “bulimics," “obese,” or “diabetic," etc., as personal pronouns, referring to groups of individuals by their common diagnosis or condition, should be avoided. Terms like “individuals with anorexia nervosa," “people with bulimia nervosa," “participants with eating disorders," “patients with diabetes," or “participants with obesity," etc., should be used instead. Note, “participants” should be used in place of “subjects”.
- **Abbreviations**: In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement**: Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website at www.bipm.fr for more information about SI units.
- **Numbers** under 10 should be spelt out, except for: measurements with a unit (8 mmol/L); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).
- **The word “data”** is plural; therefore, text should follow accordingly (for example, “The data show…the data are … the data were…”).
- **Sex/Gender & Age**: When referring to sex/gender, “males" and “females” should be used only in cases where the study samples include both children (below age 18) and adults and only if word limit precludes using terms such as “male participants/female participants,” “female patients/male patients”; when the participants comprise adults only, the terms “men” and “women” should be used. In articles that refer to children, “boys” and “girls” should be used.
- **Trade Names**: Chemical substances should be referred to by the generic name only. Trade names should not be used. Drugs should be referred to by their generic names. If proprietary drugs have been used in the study, refer to these by their generic name, mentioning the proprietary name and the name and location of the manufacturer in parentheses.

Wiley Author Resources

Manuscript Preparation Tips: Wiley has a range of resources for authors preparing manuscripts for submission available **here**. In particular, authors may benefit from referring to Wiley’s best practice tips on **Writing for Search Engine Optimization**.

Article Preparation Support

Wiley Editing Services offers expert help with English Language Editing, as well as translation, manuscript formatting, figure illustration, figure formatting, and graphical abstract design – so you can submit your manuscript with confidence.

Also, check out our resources for **Preparing Your Article** for general guidance about writing and preparing your manuscript.

Return to Guideline Sections

5. EDITORIAL POLICIES AND ETHICAL CONSIDERATIONS

Editorial Review and Acceptance

Rigorous evaluation of submitted material by expert reviewers is essential to ensuring that the journal achieves its mission. To facilitate timely feedback to authors and to avoid burdening expert reviewers unduly, the journal utilizes a two-tiered review process for all contributions (whether invited or unsolicited). The first tier involves an initial editorial preview to be implemented within days of receipt of a submission. If the manuscript is considered to have potential for publication in the journal, the second tier involves peer review, typically by two to three experts. The Editor-in-Chief, at times, may delegate final decision making authority to one of the Associate Editors.

Editorial Pre-Screen. The Editor-in-Chief will pre-screen all submissions to determine the suitability based on fit with the journal's scope and scholarly merit. Manuscripts deemed to fall outside of the journal's scope or to be of limited merit (e.g., because of substantial methodological flaws or insufficiently novel contribution to the field) will not be sent out for peer review. Pre-screening of articles does not involve detailed evaluation. Authors receiving a negative decision at this stage may appeal by sending a concise rationale to the Editor-in-Chief.

Appeal of Rejection Decision. Requests for **appeal** will be considered only where the author makes a case that one or more reviewer, or the editor, has clearly made a substantive mistake. Submissions not sent out for external review are subject to the same grounds for appeal as submissions that have undergone full peer review. Please address appeal requests in writing to the Editor-in-Chief.

Peer Review. Submissions that, based on editorial pre-screening, are considered of potential suitability for the journal are forwarded to experts in the field—ad hoc reviewers or members of the journal's Editorial Board—for detailed evaluation and feedback. Expert reviewers are asked to evaluate the merit of a manuscript based on the quality of the methods applied, presentation, and overall contribution to the field. Reviewers are instructed to offer a thorough, constructive, and timely evaluation of all aspects of the submission and to enumerate strengths and weaknesses. Authors are invited to recommend expert reviewers.

Wiley's policy on confidentiality of the review process is available here: **www.wileypeerreview.com/reviewpolicy**.

Revision Submission. Authors are asked to upload two versions of the revised manuscript. One version should include all tracked changes and be labelled "Manuscript with revisions" when uploaded. The other version should contain no mark up and be labelled "Manuscript" when uploaded.

Transferable Peer Review. To enable rapid publication of good quality research that is unable to be accepted for publication by the *International Journal of Eating Disorders*, we work together with Wiley's Open Access journals through **Wiley's Manuscript Transfer Program**: *Brain and Behavior*, *Obesity Science and Practice*, *Clinical Case Reports*, and *Molecular Genetics and Genomic Medicine*. Authors may be offered the option of having their manuscript (inc. any Supporting Information), along with any related peer reviews, automatically transferred for consideration by the Editor of the recieving journal. Authors taking up the offer to transfer will not need to reformat or rewrite their manuscript at that stage, and a publication decision will be made a short time after the transfer has taken place. The Editors of the recieving journals will accept submissions that report well-conducted research that reaches the standard acceptable for publication. These journals are a part of the Wiley Open Access portfolio (**www.wileyopenaccess.com**), and thus Article Publication Fees apply.

Work Involving Cross-Cultural Studies

If the work involves cross-cultural assessment or assessment in a new language or study population, authors should provide information about local literacy in the language of assessment, the validity of (or process for validating) a translation of an assessment, and for inclusion of regional samples, a statement about the representativeness of the regional sample (or distinction from) the national sample. If statistical analyses are employed, effect size estimates should be reported in the Results section.

Guidelines for Genetic Studies

Authors of manuscripts describing association studies should note that the *International Journal of Eating Disorders* has adopted Methods guidelines developed and published by the *American Journal of Medical Genetics Part B: Neuropsychiatric Genetics*. These guidelines recommend minimum sample sizes; in the case of positive findings, an adequately powered independent replication sample; and adjustments for multiple comparisons. As is required for all papers, the guidelines also require that authors report effect size estimates. For a complete description, please refer to the AJMGB Editorial Policy on Association Studies described in their **Author Guidelines**.

Please note, when referring to genetic material, the names of genes should be spelled out in full the first time they appear in the text, after which an italicized abbreviation can be substituted. Sequence variants should be described in the text and tables using both DNA and designations whenever appropriate. Sequence variant nomenclature must follow the current Human Genome Variation Society (HGVS) guidelines; see **varnomen.hgvs.org**, where examples of acceptable nomenclature are provided.

Data Sharing and Data Accessibility

Please review Wiley's policy **here**. The *International Journal of Eating Disorders* expects but does not require data sharing.

All accepted manuscripts are required to publish a data availability statement to confirm the presence or absence of shared data.

The *International Journal of Eating Disorders* recognizes the many benefits of archiving research data. *IJED* expects you to archive all the data from which your published results are derived in a public repository. The repository that you choose should offer you guaranteed preservation (see the registry of research data repositories at **https://www.re3data.org/**) and should help you make it findable, accessible, interoperable, and re-useable, according to **FAIR Data Principles**.

The *International Journal of Eating Disorders* notes that FAIR data sharing allows for access to shared data under restrictions (e.g., to protect confidential or proprietary information) but notes that the FAIR principles encourage you to share data in ways that are as open as possible (but that can be as closed as necessary).

If you have shared data, this statement will describe how the data can be accessed, and include a persistent identifier (e.g., a DOI for the data, or an accession number) from the repository where you shared the data. If you cannot share the data described in your manuscript, for example for legal or ethical reasons, or do not intend to share the data then you must provide the appropriate data availability statement. Sample statements are available **here**. If published, all statements will be placed in the heading of your manuscript.

Human Studies and Subjects

For manuscripts reporting studies that involve human participants, a statement identifying the ethics committee that approved the study and confirmation that the study conforms to

recognized standards is required, for example: **Declaration of Helsinki**; **US Federal Policy for the Protection of Human Subjects** ; or **European Medicines Agency Guidelines for Good Clinical Practice**.

Every effort should be taken to ensure the anonymity of the patient concerned, and any clinicians not involved as authors. If there is any potentially identifiable information, then it is the responsibility of the authors to seek and obtain approval from the local Institutional Review Board (IRB) (or equivalent) for the case to be reported, and a copy of that approval should be made available to the Editor on request.

Images and information from individual participants will only be published where the authors have obtained the individual's free prior informed consent. Authors do not need to provide a copy of the consent form to the publisher; however, in signing the author license to publish, authors are required to confirm that consent has been obtained. Wiley has a **standard patient consent form available** for use.

Animal Studies

A statement indicating that the protocol and procedures employed were ethically reviewed and approved, as well as the name of the body giving approval (e.g., in the USA, the Institutional Review Board (IRB) or Institutional Animal Care and Use Committee (IACUC)), must be included in the Methods section of the manuscript. Authors are encouraged to adhere to animal research reporting standards, for example the **ARRIVE reporting guidelines** for reporting study design and statistical analysis; experimental procedures; experimental animals and housing and husbandry. Authors should also state whether experiments were performed in accordance with relevant institutional and national guidelines for the care and use of laboratory animals:

- US authors should cite compliance with the US National Research Council's Guide for the Care and Use of Laboratory Animals, the US Public Health Service's Policy on Humane Care and Use of Laboratory Animals, and Guide for the Care and Use of Laboratory Animals.
- UK authors should conform to UK legislation under the Animals (Scientific Procedures) Act 1986 Amendment Regulations (SI 2012/3039).
- European authors outside the UK should conform to Directive 2010/63/EU.

Clinical Trial Registration

The journal requires that clinical trials are prospectively registered in a publicly accessible database and clinical trial registration numbers are included in all papers that report their results. The name of the trial register and the clinical trial registration number should appear at the end of the abstract along with the URL for a hyperlink, if possible. A full list of registers can be found via the **WHO International Clinical Trials Registry Platform (ICTRP)**. Contributors should make clear when registration took place relative to the start or end of data gathering. Any discrepancies between the trial protocol and the study itself must be reported and justified in the methods section of the submitted paper. If the trial is not registered, or was registered retrospectively, the reasons for this should be explained.

Research Reporting Guidelines

Accurate and complete reporting enables readers to fully appraise research, replicate it, and use it. Authors are encouraged to adhere to any research reporting standards relevant to their study. A list of the most well-known guidelines is given here:

- Consolidated Standards of Reporting Trials (CONSORT)
- Standard Protocol Items: Recommendations for Interventional Trials (SPIRIT)
- Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA)
- PRISMA Protocols (PRISMA-P)
- STrengthening the Reporting of OBservational studies in Epidemiology (STROBE)
- CARE: Guidelines to increase the accuracy, transparency, and usefulness of case reports
- Consolidated criteria for reporting qualitative research (COREQ) by Tong et al. (*Int. J. Qual. Health Care* (**2007**) *19*(6): 349–357)
- STARD 2015: An Updated List of Essential Items for Reporting Diagnostic Accuracy Studies
- TRIPOD: Transparent Reporting of a multivariable prediction model for Individual Prognosis Or Diagnosis
- Consolidated Health Economic Evaluation Reporting Standards (CHEERS) by Husereau et al. (*BMC Medicine*(**2013**) *11*: 80; DOI: 10.1186/1741-7015-11-80)
- The EQUATOR Network: an author's one-stop-shop for writing and publishing high-impact health research
- FORCE11: Recommended reporting guidelines for life science resources
- ARRIVE (Animal Research: Reporting of In Vivo Experiments) guidelines
- Guidance for the Description of Animal Research in Scientific Publications from the US National Research Council's Institute for Laboratory Animal Research
- The Gold Standard Publication Checklist from Hooijmans et al. (ATLA (**2010**) *38*: 167–182)

Species Names

Upon its first use in the title, abstract, and text, the common name of a species should be followed by the scientific name (genus, species, and authority) in parentheses. For well-known species, however, scientific names may be omitted from article titles. If no common name exists in English, only the scientific name should be used.

Sequence Data

Nucleotide sequence data can be submitted in electronic form to any of the three major collaborative databases: DDBJ, EMBL, or GenBank. It is only necessary to submit to one database as data are exchanged between DDBJ, EMBL, and GenBank on a daily basis. The suggested wording for referring to accession-number information is: 'These sequence data have been submitted to the DDBJ/EMBL/GenBank databases under accession number U12345'. Addresses are as follows:

- DNA Data Bank of Japan (DDBJ): www.ddbj.nig.ac.jp
- EMBL Nucleotide Archive: ebi.ac.uk/ena
- GenBank: www.ncbi.nlm.nih.gov/genbank

Proteins sequence datashould be submitted to either of the following repositories.

- RCSB Protein Data Bank (PDB): www.rcsb.org/pdb.
- Protein Information Resource (PIR): pir.georgetown.edu
- SWISS-PROT: expasy.ch/sprot/sprot-top

Conflict of Interest

The journal requires that all authors disclose any potential sources of conflict of interest. Any interest or relationship, financial or otherwise that might be perceived as influencing an author's objectivity is considered a potential source of conflict of interest. These must be disclosed when directly relevant or directly related to the work that the authors describe in their manuscript.

Potential sources of conflict of interest include, but are not limited to: employment at a for-profit treatment center where data collection occurred, employment at a for-profit corporation if the corporation manufactures or sells products used in the research (e.g., medications; equipment used in a treatment tested as part of the research), patent or stock ownership, membership of a company board of directors, membership of an advisory board or committee for a company, and consultancy for or receipt of speaker's fees from a company.

The existence of a conflict of interest does not preclude publication. It is the responsibility of the corresponding author to review this policy with all authors and collectively to disclose with the submission ALL pertinent commercial and other relationships. These conflicts of interest should be disclosed in the relevant section of the submission questionnaire and in the manuscript. If the authors have no conflict(s) of interest to declare, they must also state this.

Funding

Authors should list all funding sources in the Acknowledgments section. Authors are responsible for the accuracy of their funder designation. If in doubt, please check the Open Funder Registry for the correct nomenclature: **www.crossref.org/services/funder-registry**.

Authorship

The list of authors should accurately illustrate who contributed to the work and how. All those listed as authors should qualify for authorship according to the following criteria:

1. Have made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data;
2. Been involved in drafting the manuscript or revising it critically for important intellectual content;
3. Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content; and
4. Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section (for example, to recognize contributions from people who provided technical help, collation of data, writing assistance, acquisition of funding, or a department chairperson who provided general support). Prior to submitting the article all authors should agree on the order in which their names will be listed in the manuscript.

Joint first or senior authorship: In the case of joint first authorship, a footnote should be added to the author listing, e.g. 'X and Y should be considered joint first author' or 'X and Y should be considered joint senior author.'

Authorship responsibilities: Eligibility for authorship requires that authors have made substantive contributions to the work described in the manuscript, have read and approved the manuscript in its current form, and have approved the ordering of authorship. All authors agree that, once a manuscript has been submitted, the subsequent addition, removal or change of authorship order requires the approval of all authors (including making such changes as part of a resubmission). Such changes in revised versions of a manuscript should be brought to the attention of the Editor in the response letter.

Correction to Authorship: In accordance with **Wiley's Best Practice Guidelines on Research Integrity and Publishing Ethics** and the **Committee on Publication Ethics' guidance**, [JOURNAL] will allow authors to correct authorship on a submitted, accepted, or published article if a valid reason exists to do so. All authors – including those to be added or removed – must agree to any proposed change. To request a change to the author list, please complete the **Request for Changes to a Journal Article Author List Form** and contact either the journal's editorial or production office, depending on the status of the article. Authorship changes will not be considered without a fully completed Author Change form. Correcting the authorship is different from changing an author's name; the relevant policy for that can be found in **Wiley's Best Practice Guidelines** under "Author name changes after publication."

Wiley's Author Name Change Policy: In cases where authors wish to change their name following publication, Wiley will update and republish the paper and redeliver the updated metadata to indexing services. Our editorial and production teams will use discretion in recognizing that name changes may be of a sensitive and private nature for various reasons including (but not limited to) alignment with gender identity, or as a result of marriage, divorce, or religious conversion. Accordingly, to protect the author's privacy, we will not publish a correction notice to the paper, and we will not notify co-authors of the change. Authors should contact the journal's Editorial Office with their name change request.

ORCID

As part of the journal's commitment to supporting authors at every step of the publishing process, the journal requires the submitting author (only) to provide an ORCID iD when submitting a manuscript. If the submitting author is not already registered with ORCID, they can do so here: **orcid.org/register**; this takes around 2 minutes to complete. For more information, visit **www.wileyauthors.com/orcid**.

Publication Ethics

The *International Journal of Eating Disorders* is a member of the **Committee on Publication Ethics (COPE)**. Note this journal uses iThenticate's CrossCheck software to detect instances of overlapping and similar text in submitted manuscripts. Read the *Top 10 Publishing Ethics Tips for Authors* at **www.wileyauthors.com/ethics** ; a link to **Wiley's Publication Ethics Guidelines** can also be found there.

Return to the Guideline Sections

6. AUTHOR LICENSING

If a paper is accepted for publication, the author identified as the formal corresponding author will receive an email prompting them to log in to Author Services, where via the Wiley Author Licensing Service (WALS) they will be required to complete a copyright license agreement on behalf of all authors of the paper.

Authors may choose to publish under the terms of the journal's standard copyright agreement, or **OnlineOpen** under the terms of a Creative Commons (CC) License.

General information regarding licensing and copyright is available **here**. To review the Creative Commons License options offered under OnlineOpen, please **click here**. (Note that certain funders mandate that a particular type of CC license has to be used; the Wiley Author Compliance Tool, available at **www.wileyauthors.com/compliancetool**, provides assistance to authors in checking for any open-access mandates from their funder(s).)

Self-Archiving Definitions and Policies

Note that the journal's standard copyright agreement allows for self-archiving of different versions of the article under specific conditions. For more detailed information about self-archiving definitions and policies, visit **www.wileyauthors.com/self-archiving**.

Open Access Fees

Authors choosing to publish using OnlineOpen will be charged a fee. A list of Article Publication Charges for Wiley journals is available at **www.wileyauthors.com/APCpricing**.

Funder Open Access

For more information on Wiley's compliance with the open-access policies of specific funders, visit **www.wileyauthors.com/funderagreements**.

Return to Guideline Sections

7. PUBLICATION PROCESS AFTER ACCEPTANCE

Accepted Articles Received in Production

Signing the License

When an accepted article is received by Wiley's production team, the corresponding author will receive an email asking them to login or register with **Wiley Author Services** . The author will be asked to sign a publication license at this point. Further details are given in **Section 6** of these Author Guidelines.

Proofs

Once the paper is typeset, the author will receive an email notification with the URL to download a PDF typeset page proof, as well as associated forms and full instructions on how to correct and return the file.

Please note that the author is responsible for all statements made in their work, including changes made during the editorial process—authors should check proofs carefully. Note that proofs should be returned within 48 hours from receipt.

Questions regarding the production of articles accepted for publication in the *International Journal of Eating Disorders* should be directed to the Production Editor: **eat@wiley.com**

Publication Charges

There are **no mandatory charges** to authors publishing in the *International Journal of Eating Disorders*.

Authors may choose to publish in an open access format through OnlineOpen, which carries a fee (see the section on Author Licensing).

Color figures may be published online free of charge; however, the journal charges for publishing figures in color in print. If the author supplies color figures at Early View publication, they will be invited to complete a color charge agreement in RightsLink for Author Services. The author will have the option of paying immediately with a credit or debit card, or they can request an invoice. If the author chooses not to purchase color printing, the figures will be converted to black and white for the print issue of the journal.

Early View

The journal offers rapid publication via Wiley's Early View service. **Early View** (online Version of Record) articles are published on Wiley Online Library before inclusion in an issue. Note there may be a delay after corrections are received before the article appears online, as the proofs need to be reviewed and processed. Once the article is published on Early View, no further changes are possible. The Early View article is fully citable and carries an online publication date and Digital Object Identifier (DOI) for citations.

Video Abstracts

A video abstract can be a quick way to make the message of your research accessible to a much larger audience. Wiley and its partner Research Square offer a service of professionally produced video abstracts, available to authors of articles accepted in this journal. You can learn more about it at **www.wileyauthors.com/videoabstracts**. If you have any questions, please direct them to **videoabstracts@wiley.com**.

Return to Guideline Sections

8. POST PUBLICATION

Access and Sharing

When the article is published online:

- The author receives an email alert (if requested).
- The link to the published article can be shared through social media.
- The author will have free access to the paper (after accepting the Terms & Conditions of use, they can view the article).
- The corresponding author and co-authors can nominate up to ten colleagues to receive a publication alert and free online access to the article.

Authors may order print copies of the article. Instructions are sent at proofing stage. Alternatively, authors may use the following link: **caesar.sheridan.com/reprints/redir.php?pub=10089&acro=eat** or email **chris.jones@sheridan.com**.

Promoting an Article

Wiley's Promotional Toolkit is a resource designed to help authors disseminate their work to the fullest extent through their networks and beyond. Authors can find the toolkit and other ideas on how to promote their research here: **www.wileyauthors.com/maximize**.

Wiley Editing Services offers professional video, design, and writing services to create shareable video abstracts, infographics, conference posters, lay summaries, and research news stories for your research – so you can help your research get the attention it deserves.

Cover Image Submissions

This journal accepts artwork submissions for Cover Images. This is an optional service you can use to help increase article exposure and showcase your research. For more information, including artwork guidelines, pricing, and submission details, please visit the **Journal Cover Image page.**

Authors intending to issue a press release through their institution or affiliation are kindly asked to inform the Editorial Office at their earliest convenience.

Measuring the Impact of an Article

Wiley also helps our authors **measure the impact** of their research through citation tracking, and specialist partnerships with Kudos (**www.wileyauthors.com/ kudos**) and Altmetric (**www.wileyauthors.com/altmetric**).

Return to Guideline Sections

9. JOURNAL CONTACT DETAILS

Author queries regarding submissions under review or accepted articles in production should be directed to the Editorial Office (**ijed@wiley.com**) or Production Editor (**IJEDprod@wiley.com**), respectively.

Author Guidelines updated May 31, 2019

Appendix 1-B

Example of Full Search Strategy for PsycINFO (EBSCOhost)

1. TI (“eating disorder*” OR “bulimia nervosa” OR bulim* OR “anorexia nervosa” OR anorex* OR “binge eating disorder*” OR “binge eating” OR “atypical eating disorder*” OR “eating disorder not otherwise specified” OR EDNOS OR “other specified feeding or eating disorder*” OR OSFED OR “unspecified feeding or eating disorder*” OR UFED OR “disorder* eating”) OR AB (“eating disorder*” OR “bulimia nervosa” OR bulim* OR “anorexia nervosa” OR anorex* OR “binge eating disorder*” OR “binge eating” OR “atypical eating disorder*” OR “eating disorder not otherwise specified” OR EDNOS OR “other specified feeding or eating disorder*” OR OSFED OR “unspecified feeding or eating disorder*” OR UFED OR “disorder* eating”)
2. DE "Eating Disorders" OR DE "Anorexia Nervosa" OR DE "Binge Eating Disorder" OR DE "Bulimia" OR DE "Purging (Eating Disorders)" OR DE "Binge Eating"
3. 1 OR 2
4. TI (perception* OR view* OR experience* OR opinion* OR understand* OR perspective* OR reflection* OR attitude* OR knowledge OR satisf* OR dissatisf*) OR AB (perception* OR view* OR experience* OR opinion* OR understand* OR perspective* OR reflection* OR attitude* OR knowledge OR satisf* OR dissatisf*)
5. DE "Consumer Attitudes" OR DE "Consumer Satisfaction" OR DE "Preferences" OR DE "Client Attitudes" OR DE "Client Satisfaction" OR DE "Dissatisfaction" OR DE "Satisfaction" OR DE "Health Attitudes"
6. 4 OR 5

7. TI (“healthcare profession*” OR “health care profession*” OR “health profession*” OR “healthcare personnel*” OR “health care personnel*” OR “healthcare provid*” OR “health care provid*” OR “healthcare service*” OR “health care service*” OR “health service*” OR “health personnel*” OR Clinician* OR Therapist* OR Psychologist* OR Counsel#or* OR Physician* OR Doctor* OR Psychiatrist* OR Nurs* OR “healthcare assistant*” OR “support worker*” OR Dieti?ian* OR “occupational therapist*” OR Physiotherapist* OR Staff*) OR AB (“healthcare profession*” OR “health care profession*” OR “health profession*” OR “healthcare personnel*” OR “health care personnel*” OR “healthcare provid*” OR “health care provid*” OR “healthcare service*” OR “health care service*” OR “health service*” OR “health personnel*” OR Clinician* OR Therapist* OR Psychologist* OR Counsel#or* OR Physician* OR Doctor* OR Psychiatrist* OR Nurs* OR “healthcare assistant*” OR “support worker*” OR Dietcian* OR “occupational therapist*” OR Physiotherapist* OR Staff*)
8. DE "Health Care Services" OR DE "Mental Health Services" OR DE "Community Services" OR DE "Community Mental Health Services" OR DE "Health Personnel" OR DE "Mental Health Personnel" OR DE "Clinicians" OR DE "Professional Personnel" OR DE "Counseling Psychologists" OR DE "Clinical Psychologists" OR DE "Psychiatric Nurses" OR DE "Psychiatrists" OR DE "Psychotherapists" OR DE "Counselors" OR DE "Occupational Therapists" OR DE "Psychologists" OR DE "Therapists" OR DE "Nurses" OR DE "Physicians" OR DE "Psychiatric Hospital Staff"
9. 7 OR 8
10. TI (“therapeutic relationship*” OR “working alliance*” OR “therapeutic alliance*” OR “therapeutic bond” OR “helping alliance*” OR “psychotherapeutic process*” OR

“psychotherapeutic transference*” OR “therap* process*” OR “therapeutic encounter*” OR “interpersonal relation*” OR ((patient OR client) N7 (nurse OR professional OR staff) AND relation*) OR interaction* OR communic* OR conversation* OR collaborat* OR rapport) OR AB (“therapeutic relationship*” OR “working alliance*” OR “therapeutic alliance*” OR “therapeutic bond” OR “helping alliance*” OR “psychotherapeutic process*” OR “psychotherapeutic transference*” OR “therap* process*” OR “therapeutic encounter*” OR “interpersonal relation*” OR ((patient OR client) N7 (nurse OR professional OR staff) AND relation*) OR interaction* OR communic* OR conversation* OR collaborat* OR rapport)

11. DE "Psychotherapeutic Transference" OR DE "Therapeutic Alliance" OR DE "Psychotherapeutic Processes" OR DE "Therapeutic Processes" OR DE "Interpersonal Interaction" OR DE "Collaboration" OR DE "Cooperation" OR DE "Interpersonal Communication"
12. 10 OR 11
13. 9 OR 12
14. TI (qualitative OR “qualitative research” OR “focus group*” OR interview* OR survey* OR “grounded theory” OR IPA OR “interpretative phenomenological analysis” OR “content analysis” OR “thematic analysis” OR “narrative analysis” OR “discourse analysis” OR “mixed method*”) OR AB (qualitative OR “qualitative research” OR “focus group*” OR interview* OR survey* OR “grounded theory” OR IPA OR “interpretative phenomenological analysis” OR “content analysis” OR “thematic analysis” OR “narrative analysis” OR “discourse analysis” OR “mixed method*”)
15. DE "Focus Group" OR DE "Grounded Theory" OR DE "Mixed Methods Research" OR DE "Focus Group Interview" OR DE "Interview Schedules" OR DE "Semi-

Structured Interview" OR DE "Interpretative Phenomenological Analysis" OR DE "Narrative Analysis" OR DE "Qualitative Methods" OR DE "Thematic Analysis" OR DE "Interviewing" OR DE "Interviews" OR DE "Surveys" OR DE "Mail Surveys" OR DE "Online Surveys" OR DE "Telephone Surveys" OR DE "Discourse Analysis" OR DE "Content Analysis"

16. 14 OR 15
17. 3 AND 6 AND 13 AND 16

Doctorate in Clinical Psychology | Lancaster University

Section 2: Research Paper

Compassion in Staff Working with People Diagnosed with Eating Disorders: Impact of Workplace Stress Factors and Emotion Regulation Strategies

Emily Retkiewicz

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:

Emily Retkiewicz

Doctorate in Clinical Psychology

Faculty of Health and Medicine

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster

LA1 4AT

e.retkiewicz@lancaster.ac.uk

Prepared for: *Journal of Advanced Nursing*

Abstract

Aim: Compassion fatigue (CF) and reduced compassion satisfaction (CS) are associated with decreased quality of healthcare. The role of workplace stress factors and emotion regulation strategies in predicting levels of CF and CS in healthcare professionals (HCPs) working with people diagnosed with eating disorders was investigated.

Design: Cross-sectional study.

Methods: 102 HCPs completed an online survey consisting of a demographic questionnaire, and measures of workplace stress, cognitive reappraisal (CR), expressive suppression (ES), CF and CS. A factor analysis of the workplace stress measure identified four factors: organisational facilitators, workload demands, job insecurity, and role demands. The role demands factor was dropped from further analysis due to low reliability.

Results: "High" levels of CF and "low" levels of CS were reported by approximately 22% and 17% of HCPs, respectively. Correlations revealed that CF was significantly associated with organisational facilitators, workload demands, job insecurity, and CR. Multiple regression indicated those variables accounted for 32.2% of the variance in CF. CS was significantly correlated with organisational facilitators, CR, and ES. Women scored significantly higher on CS than men. Multiple regression indicated that, together, these variables accounted for 16% of the variance in CS.

Conclusion: Workload demands and job insecurity were identified as the most influential variables in predicting CF. ES was found to be an influential variable in predicting CS.

Impact: A two-pronged strategy is outlined for enhancing CS and reducing CF in HCPs working with people diagnosed with eating disorders. First, workplace stress factors could be tackled at organisational levels. Second, at the individual and team level, both workplace stress and ES could be addressed through individual supervision or group reflective practice. These changes may positively affect HCPs' capacity for compassion and thus improve patient care.

Introduction

People diagnosed with eating disorders (EDs) may experience stigma or shame regarding their condition, which can, in turn, impact on their willingness to seek or engage with treatment (Ali et al., 2017; Innes et al., 2017; Joint Commissioning Panel for Mental Health, 2013; National Institute for Health and Care Excellence [NICE], 2020). Given the high mortality levels associated with EDs (Halmi, 2009; Joint Commissioning Panel for Mental Health, 2013; Smink et al., 2012), it is important to reduce barriers for people accessing support. Therefore, it is recommended that healthcare professionals (HCPs) working with people diagnosed with EDs show empathy, compassion, and respect in their interactions with them (NICE, 2020). Compassion is increasingly recognised as a key quality for various HCPs (Fotaki, 2015; Lee et al., 2012; Perez-Bret et al., 2016; van der Cingel, 2009). It is highly valued by patients in ED services and is reported in qualitative studies to lead to better treatment outcomes in patients accessing such services (Bell, 2003; Doran & Smith, 2004; Sinclair et al., 2016; Wright, 2015). Elements of compassionate care, such as empathy and effective communication, have been found to impact on various health outcomes (Lown et al., 2011). Consequently, this study explored the influence of several variables on capacity for compassion in HCPs. In turn, the findings can inform ways of improving capacity for compassion in HCPs and, therefore, their ability to create positive therapeutic relationships with people diagnosed with EDs. It is hoped this will have a positive impact on staff wellbeing and perceived effectiveness, as well as an indirect influence on the quality of patient care and on patient outcomes.

Background

The concept of compassion in healthcare can be defined as “an acknowledgement of suffering [which] gives us a choice of acting and behaving in such a way that it is evident we want the suffering to end” (van der Cingel, 2009, p. 133). Compassion is often acknowledged

as a motivation to recognise and prevent suffering (Gilbert, 2019). This motivation can be directed towards others or the self, or received from others, and involves learning how to best alleviate suffering (Gilbert, 2019, 2021; Roeser et al., 2018). Being open to receiving compassion has been shown to be a buffer against mental health difficulties (Gilbert, 2021). However, there are many barriers to the different flows of compassion, such as lack of trust in interpersonal relationships, and there are therefore different practices for developing the capacity to receive or offer compassion (Roeser et al., 2018).

It is recognised that HCPs can experience pleasure from working in an empathic way with people who are distressed and offering them compassion; this is referred to as compassion satisfaction (CS; Stamm, 2010). CS is a personal resource which can act as a buffer between job demands and job strain (Tremblay & Messervey, 2011) and was shown to be associated with self-compassion in student midwives (Beaumont et al., 2016). However, people can also experience compassion fatigue (CF), which refers to the negative aspects of repeatedly responding compassionately to high levels of distress and trauma (Sorenson et al., 2016; Thompson et al., 2014). According to Figley's (2002) model, empathy and emotional energy are key factors in creating an effective therapeutic relationship but these factors can also make people vulnerable to the development of CF. CF appears to develop when people become pre-occupied with the high levels of distress and trauma experienced by those they are supporting in a compassionate and empathic manner (Heritage et al., 2018), particularly when the distinction between the self and others is blurred (Neff et al., 2020).

The concept of CF is currently debated in the literature. Neuroimaging studies show that engaging empathically versus compassionately with people in distress activates different brain areas (Hofmeyer et al., 2020; Neff et al., 2020). The former activates areas associated with pain processing, while the latter activates areas associated with feelings of reward (Hofmeyer et al., 2020; Neff et al., 2020). It is argued that engaging with people

compassionately cannot result in fatigue and therefore the term "empathic distress fatigue", rather than CF, was proposed as a more accurate reflection of the phenomenon (Hofmeyer et al., 2020; Neff et al., 2020; Taylor et al., 2020). Nevertheless, compassion appears to be closely linked to empathy: Taylor et al. (2020) highlighted that empathic concern (i.e., act of compassion) is one of three distinct components of empathy, and Hofmeyer et al. (2020) noted that compassion is one of two distinct empathy-related responses. Furthermore, it appears that empathic distress fatigue can be reversed through compassion training (Hofmeyer et al., 2020). As there is no clear consensus, and CF has been extensively researched in the past, it was decided to explore this concept in the current study. In this study, the term CF is used as a descriptor of the emotional drain and pre-occupation with others' emotional pain, resulting from working with people experiencing high levels of distress.

Research suggests that HCPs with increased levels of CF can be less empathic towards patients and more likely to avoid working with certain patients (Lombardo & Eyre, 2011). Lower levels of CS and higher levels of CF were associated with reduced standards of care and increased irritability with patients (Dasan et al., 2015). HCPs with high levels of CF may experience physical symptoms, such as headaches or fatigue, along with emotional symptoms, such as anxiety or depression (Lombardo & Eyre, 2011; Sinclair et al., 2017). Additionally, HCPs, who feel they are not allowed to work compassionately, may experience emotions such as guilt (Barron et al., 2017). Consequently, CF and CS are important concepts which may impact on both patient care and staff wellbeing.

Several studies have shown that mental health nurses in various settings experience high levels of stress at work (Dickinson & Wright, 2008; Edwards et al., 2000; Foster et al., 2019; Mann & Cowburn, 2005; Richards et al., 2006). More specifically, working in ED services requires HCPs to manage emotionally charged situations, and deal with stress, conflict, and resistance (Davey et al., 2014; Devery et al., 2018; Graham et al., 2020; Warren et al.,

2008). HCPs working with people diagnosed with EDs may also experience moral injury, which is a phenomenon associated with engaging in acts that violate individuals' moral beliefs or failing to prevent such acts (Williamson et al., 2018). Acts such as weighing patients or subjecting them to coerced nasogastric tube feeding may go against many HCPs' values. Additionally, service limitations, which could prevent HCPs from providing appropriate levels of care, may also result in moral injury. Those might include ineffective pathways (Treasure et al., 2021) resulting in higher levels of acuity for patients who are accessing services and increased demands on HCPs. Moral injury has been shown to be associated with symptoms of burnout in HCPs (Mantri et al., 2021). Burnout can be defined as "physical and emotional exhaustion that occurs in practitioners working in stressful environments" (Beaumont et al., 2016, p. 240), suggesting that moral injury may also play a part in HCPs' stress levels.

Experiencing increased stress at work is associated with emotional exhaustion and with higher risk of developing mental health difficulties, such as depression (Colligan & Higgins, 2006; Mann & Cowburn, 2005; Williams & Lewis, 2020). Acute psychosocial stress has been shown to impact on people's appraisal of pain experienced by others, suggesting reduced feelings of empathy (Buruck et al., 2014). It has also been found that burnout can impact on empathy levels in staff (Warren et al., 2012). A qualitative study identified that working with people with complex mental health needs, along with increased work demands, can have a detrimental impact on compassion in HCPs working in community mental health teams (Barron et al., 2017).

A literature review identified that critical care nurses' feelings of powerlessness in relation to their ability to facilitate meaningful change for injured soldiers was a key cause of CF (Alharbi et al., 2019). Working with people diagnosed with EDs may bring up similar challenges for HCPs who may especially find it difficult to feel empathy or compassion towards patients if they perceive them to be deliberately preventing themselves from

recovering (Graham et al., 2020; Warren et al., 2012). Attribution theory suggests willingness to help is negatively associated with the perceived control people have over their difficulties (Weiner, 1980a, 1980b). Given that there is some evidence the general public and some HCPs perceive people diagnosed with EDs as being responsible for their symptoms (O'Connor et al., 2016; Reas, 2017; Thompson-Brenner et al., 2012), this could impact on HCPs working with people diagnosed with EDs. Chronic ED presentations or perceived slow progress towards recovery could also be challenging for HCPs (Warren et al., 2012).

Several workplace stress factors were found to be associated with CF in oncologists, and nurses working across critical care, neonatal intensive care, and emergency departments: lack of managerial support (Alharbi et al., 2019; Hunsaker et al., 2015), subjective time pressure (Kleiner & Wallace, 2017), role conflict and role overload (Barr, 2017). Job satisfaction was found to be negatively associated with CF (Kelly et al., 2015; Yu et al., 2021) in acute and emergency care nurses. Additionally, role ambiguity was found to be a predictor of reduced CS in nurses working in neonatal intensive care (Barr, 2017). Conversely, factors such as job satisfaction (Kelly et al., 2015; Yu et al., 2021), support from management (Cavanagh et al., 2020; Hunsaker et al., 2015), meaningful recognition (Kelly et al., 2015), and specialist training relevant to the healthcare setting (Frey et al., 2018; O'Callaghan et al., 2020; Yu et al., 2016) were associated with higher levels of CS in HCPs working in various medical settings. Given the parallels of the services in the above studies with ED services, in relation to working with acuity, risk, and complexity, it may be reasonable to presume that these workplace stress factors have some relevance to understanding CF and CS in HCPs working with people diagnosed with EDs. Currently, no such research exists.

Emotion regulation skills prove important in successfully managing stressful work situations. Emotion regulation is the ability to observe, appraise, and adjust emotional reactions, by influencing which emotions are experienced, along with how and when they are

experienced and expressed (Buruck et al., 2016; Gross, 2002). Gross (1998) proposed that emotion regulation skills can be divided into two major classes: antecedent-focused and response-focused. Cognitive reappraisal (CR) is an example of antecedent-focused emotion regulation, as it involves changing the input into the emotional system by re-evaluating the situation or one's ability to cope with the situation (Gross, 1998; Gross, 2002). CR may therefore prevent the triggering of certain emotions. Expressive suppression (ES), on the other hand, is an example of response-focused emotion regulation, as it entails changing the output from the emotional system, i.e., inhibiting a response to an emotion that has already been triggered (Gross, 1998, 2002).

CR can be successful in decreasing the subjective experience and expression of a negative emotion, while increasing the subjective experience and expression of positive emotions (Gross, 2002; Richardson, 2017). There is some evidence CR has a moderating effect on the association between life stress and depressive symptoms; when stress was high, people with increased levels of CR experienced fewer depressive symptoms than people with lower levels of that skill (Troy & Mauss, 2011). CR was positively associated with CS in physicians and nurses working across various medical settings (Măirean, 2016). CR may be an important strategy for improving CS. Given its impact on negative emotions, it may also be a crucial strategy for reducing CF.

Nurses working in mental health services often engage in emotional labour. That involves suppressing their emotions to help patients feel safe and reassured (Barron et al., 2017; Brown et al., 2014; Mann & Cowburn, 2005). ES has been shown to decrease behavioural responses to all emotions, while decreasing the subjective experience of positive emotions without impacting on the subjective experience of negative emotions (Gross, 2002; Richardson, 2017). Butler et al. (2003) found that increased use of ES led to disruptions in social communication in undergraduate participants, resulting in a reduction in perceived

rapport. Given that effective communication is a component of compassion (Lown et al., 2011), this suggests ES could have a detrimental impact on compassion. Additionally, the experience of daily stress was shown to have a moderating effect on the relationship between ES and positive affect, indicating that suppression had a larger impact on reducing positive affect on days of high stress, compared to less stressful days (Richardson, 2017). Given the impact of ES on positive and negative emotions, it may be assumed this skill also influences CS and CF. However, to the author's knowledge, no such research has been conducted so far.

To summarise, working in ED services could result in high stress levels. Workplace stress affects CF and CS in HCPs in various healthcare settings. However, the impact of workplace stress experienced by HCPs working with people diagnosed with EDs on their capacity for compassion has not yet been investigated.

It has been suggested that CR improves CS, but this has not been investigated in HCPs working with people diagnosed with EDs. Furthermore, it can be assumed that CR reduces CF, while ES may decrease CS. The impact of those two emotion regulation skills on capacity for compassion would benefit from further exploration.

Therefore, the research question addressed by this study is: what is the relationship between various workplace stress factors, emotion regulation skills, and capacity for compassion in HCPs working with people diagnosed with EDs?

The Study

Aims

This study aimed to investigate the impact of factors related to stress in the workplace and emotion regulation skills on CF and CS levels in HCPs who work with people diagnosed with EDs. The following hypotheses were tested: (1) higher levels of workplace stress risk factors will be associated with higher levels of CF and lower levels of CS, (2) higher levels of workplace stress protective factors will be associated with lower levels of CF and higher levels

of CS, (3) higher levels of CR will be associated with lower levels of CF and higher levels of CS, (4) CR will have a moderating effect on the association between workplace stress factors and CF and the relationship between workplace stress and CS, (5) higher levels of ES will be associated with lower levels of CS, with no significant relationship to CF, (6) ES will have a moderating effect on the association between workplace stress factors and CS.

Design

This study employed a correlational cross-sectional design utilising online surveys to collect data.

Participants

A convenience sample of HCPs working with people diagnosed with EDs was recruited. Inclusion criteria consisted of HCPs working in specialist ED services or wards, along with HCPs working in general mental health settings who have had contact with patients diagnosed with EDs. HCPs from the National Health Service (NHS), private and charitable sectors were included. To take part in the study, HCPs had to have a clinical or therapeutic relationship with patients. The exclusion criteria were staff who were not considered to have a clinical or therapeutic relationship with patients, such as administrative or domestic staff. Participants who were fully retired or those who had worked with people diagnosed with EDs for less than 3 months were also excluded.

ED services were identified using an online directory hosted by the UK's leading ED charity (BEAT; www.beateatingdisorders.org.uk) and by utilising a member of the research team's connections. Ten NHS trusts in North England were approached directly. From these, participants were recruited through contacting service managers or appropriate named contacts and requesting them to cascade the study information to their staff. Additionally, study information was shared on social media, such as Facebook, Twitter, and the British Eating Disorders Society (BrEDS) workplace forum.

The sample size was calculated using G*Power for regression analysis and six variables (Faul et al., 2009). To achieve a power of 0.8 and medium effect size ($f^2 = 0.15$), a minimum of 98 participants were required. To improve model stability, a minimum of 110 participants were required (Field, 2009).

Data Collection

The study was conducted online using Qualtrics Survey Software (Qualtrics, 2020). After reading the study and consent information, participants consented to taking part in the study by proceeding to the next page. They were able to withdraw from the study at any point prior to the final submission of their results by leaving the website. Data collection was anonymous and consisted of four questionnaires. Data collection occurred between 29th June 2020 and 31st March 2021.

Demographic Questionnaire

This questionnaire captured demographic information about participants, including age, gender, and occupation. Additionally, data regarding length of time working with people diagnosed with EDs, workplace setting, age group of patients accessing the participant's service, mode of working (for example, individual direct work with patients or systemic indirect work), amount of face-to-face contact with people diagnosed with EDs, amount of supervision received, and completion of specialist training in EDs were collected.

Measure of Workplace Stress

A measure of workplace stress was created using items from the Copenhagen Psychosocial Questionnaire (COPSOQ) III (Burr et al., 2019). The COPSOQ III was chosen because it was originally designed for use within various industries and measures a range of organisational and social work conditions which have been explored in previous studies in relation to CF and CS, such as role conflict (Barr, 2017) or social support from managers (Alharbi et al., 2019; Cavanagh et al., 2020; Hunsaker et al., 2015). The COPSOQ III short

version requires that all ‘core’ items be included, with some additional items labelled ‘middle’ or ‘long’. However, stakeholders involved in study design expressed concern with regards to using lengthy measures. For this reason, only the ‘core’ items were selected for the version used in this study, as adding more items would have increased the amount of time participants would need to complete the questionnaire. Therefore, this measure consisted of 32 items.

Factor Analysis. Including only ‘core’ items from the COPSOQ III created a new scale, therefore an exploratory factor analysis was conducted. The items chosen for this measure were answered using a 5-point Likert scale. Item scores were transformed to values from 0 to 100 and positively worded items were reverse scored. A principal axis factor analysis was conducted on the 32 items with oblique rotation (direct oblimin). The Kaiser-Meyer-Olkin measure (KMO = .73) fell within the acceptable levels (Field, 2009). The initial analysis yielded nine factors with eigenvalues above 1, accounting for 69.56% of the variance. However, the scree plot (Appendix 2-B) indicated that four factors, accounting for 49.27% of the variance, would be more appropriate. Therefore, the analysis was conducted again and limited to four factors. Table 1 shows the factor loadings after rotation. Summed factor scores were used to retain the variability of the original data (DiStefano et al., 2009). This resulted in each item in a given factor having equal weight. Factor one was named Organisational Facilitators. It contains 15 items and reflects the presence of workplace elements which may inhibit the development of workplace stress. It contains questions about organisational justice and trust, quality of leadership, recognition, role clarity, predictability, job satisfaction, possibilities for development, sense of community at work, and social support from supervisor and colleagues. Scores were reversed again, so high scores reflected an increased presence of such facilitators. This factor yielded a maximum score of 1500. The remaining factors reflect the presence of workplace elements which may contribute to the development of workplace stress. Higher scores on these factors reflected an increased presence of these elements. Factor

two was named Workload Demands and yielded a maximum score of 600. It consists of six items which ask about the perception of falling behind with work, the emotional and physical impact of work, and the speed of work. Factor three was named Job Insecurity and consists of three items asking about fears of becoming transferred or unemployed. Factor four was named Role Demands and contains three items which ask about perception of working at a fast pace, having to deal with people's personal problems during work, and having to complete tasks which should be done in a different way. Both factor three and four yielded a maximum score of 300. The reliability of three of the factors was in the acceptable range, while the reliability of the Role Demands factor was in the unacceptable range (Table 2), therefore it was not incorporated in further analysis.

[Insert Table 1]

Emotion Regulation Questionnaire (ERQ)

This validated 10-item scale consists of two facets measuring different ways of regulating emotions: CR and ES (Gross & John, 2003). Items are answered using a Likert scale ranging from one (strongly disagree) to seven (strongly agree), yielding a maximum possible score of 42 for CR and 28 for ES. Higher scores on each facet indicate increased use of respective strategies. Reliability of the ERQ's two subscales has been reported as .79 for CR and .73 for ES (Gross & John, 2003). This study found similar reliability levels (Table 2).

Professional Quality of Life Scale (ProQOL-21)

This is a 21-item measure revised from the original ProQOL-5 (Stamm, 2009, 2010) in order to improve construct validity (Heritage et al., 2018). It consists of two subscales measuring CS and CF in helping professionals. Questions falling under the CS subscale explore positive feelings, such as satisfaction or invigoration, stemming from supporting patients. The CF subscale consists of questions about over-identification with patients' distress or trauma and questions relating to aspects of emotional drain resulting from working with patients. Items

are answered using a Likert scale ranging from one (never) to five (very often). Scores were coded according to a modified response approach suggested by Heritage et al. (2018), yielding a maximum score of 46 for CF and 36 for CS. Higher scores on each subscale indicate higher levels of CF and CS.

Stamm (2010) proposed using the 25th and 75th percentile as cut-off scores for CF and CS. Heritage et al.'s (2018) modified cut-off points for ProQOL-21 were used to establish the prevalence of CF and CS in participants of this study.

Reliability of the two ProQOL-21 subscales has been reported as .90 for CF and .92 for CS (Heritage et al., 2018). This study found reliability levels in the "good" range for both subscales (Table 2).

Ethical Considerations

This study was approved by Lancaster University's ethics committee and by the Health Research Authority. Approval from 10 NHS trusts' Research and Development departments was sought prior to direct recruitment from those sites.

The main ethical consideration was the exploration of potentially emotionally challenging factors, such as reduced capacity for compassion at work, high levels of workplace stress, and difficulties managing emotions. Consequently, participants may have become concerned when completing the online survey. To mitigate this, participants were informed about the nature of the questions before they consented to take part in the study. After completing the study, participants were also encouraged to contact an urgent care service (NHS 111), their general practitioner, or local workplace counselling services, if they felt they required support following any concerns raised by the questionnaires.

Data Analysis

All questions in the online survey were mandatory, therefore there were no missing data. Three questions from the workplace stress measure allowed participants to answer "I do

not have a supervisor/colleagues" and those responses were coded as missing. Item means were used to replace missing data for three participants. Data were tested for normality of distribution, linearity, outliers, and multicollinearity (Appendices 2-C and 2-D). All analyses were conducted using SPSS (version 27.0; IBM Corp, 2020).

Variables were correlated to identify relationships (workplace stress factors, ES, CR, CF, CS). Differences in demographic characteristics were tested using independent samples t-tests. Regression analyses were carried out to identify significant predictors of CF and CS. Variables significantly correlated with those dependent variables were entered into the respective analyses. Any demographic variables that yielded significant differences on those dependent variables were also entered into the respective regression analyses. A forced entry hierarchical multiple linear regression was carried out with workplace stress factors entered in step one and the remaining variables entered in step two (Field, 2009). Bootstrapping was applied to regression analyses. Moderation analyses were conducted using the PROCESS tool plug in for SPSS (version 3.5 by Andrew F. Hayes) to identify the impact of interactions between predictor variables on the outcome variables. Variables were centred and bootstrapping was applied.

Results

Participant Characteristics and Descriptive Statistics

A total of 123 HCPs began the online survey; 102 participants (82.93%) completed it and therefore comprised the sample (female, n = 92; male, n = 10). Participants' ages ranged from 23 to 62 years (M = 37.2, SD = 9.1). Participants had worked with patients diagnosed with EDs between 3 months and 31 years, with an approximate average of 6 years and 10 months (M = 81.9 months, SD = 78.7). They spent between 0 and 40 hours working directly with service users (M = 14.1, SD = 9.1) and received between 0 and 10 hours of formal clinical supervision per month (M = 2.0, SD = 1.6). Table 3 contains further details of participant

demographics. Table 2 details mean scores for all participants on the workplace stress, ERQ and ProQOL-21 measures. Scores for the job insecurity factor and the CR facet of the ERQ were not normally distributed, however this was accounted for with bootstrapping the analyses. One outlier was identified for workload demands and CR, while two outliers were identified for organisational facilitators and job insecurity. However, outliers were not removed from further analyses due to the sample size not reaching the desired target. Table 4 shows the prevalence of CF and CS in participants.

[Insert Table 2]

[Insert Table 3]

[Insert Table 4]

Bivariate Analyses

Table 5 summarises bivariate correlation analyses. There was a small negative relationship between organisational facilitators and CF. There was also a medium positive relationship between organisational facilitators and CS. Higher occurrence of organisational facilitators was associated with a decrease in CF and an increase in CS. There was a large positive relationship between workload demands and CF, and a medium positive relationship between job insecurity and CF. Increased levels of workload demands and job insecurity were associated with an increase in CF.

There was a small negative relationship between CR and CF. There was also a small positive relationship between CR and CS. Increased use of the CR strategy for managing emotions was associated with a decrease in CF and an increase in CS. Finally, there was a small negative relationship between ES and CS. Increased use of the ES strategy for managing emotions was associated with a decrease in CS.

[Insert Table 5]

Demographic Differences on Outcome Variables

There was a statistically significant difference between women and men on the ProQOL-21 CS subscale; $t(100) = 2.32$, $p = .022$, 95% CI [0.57, 7.22]. On average, women scored higher on CS ($M = 26.4$, $SD = 5.0$) than men ($M = 22.5$, $SD = 5.2$). This was a medium to large effect ($d = .77$, 95% CI [0.11, 1.43]). There were no significant differences on either of the variables between participants who worked in ED specialist services and those who worked in general mental health services, therefore both groups were included in final analyses.

Multiple Regression Analyses

Compassion Fatigue

A multiple linear regression model was carried out to examine the effect of organisational facilitators, workload demands, job insecurity, and CR on CF. The results show that the model was statistically significant with a large effect size; $F(4, 97) = 13.00$, $p < .001$, $f^2 = .47$ (Table 6). The adjusted R^2 revealed that 32.2% of the variance in CF can be explained by variances in the four predictor variables. The analysis indicated that workload demands was the most influential predictor in the model ($\beta = .45$, $t(97) = 5.30$, $p < .001$), with job insecurity being the next most influential predictor ($\beta = .18$, $t(97) = 2.09$, $p = .039$). Organisational facilitators ($\beta = -.16$, $t(97) = -1.89$, $p = .06$) and CR ($\beta = -.11$, $t(97) = -1.24$, $p = .22$) were not significant predictors of CF. A moderation analysis revealed that the interactions between CR and organisational facilitators ($b = .001$, $t = -.36$, $p = .97$), workload demands ($b = -.002$, $t = -1.98$, $p = .051$), and job insecurity ($b = -.001$, $t = -.10$, $p = .92$) were not significant predictors of CF.

[Insert Table 6]

Compassion Satisfaction

A multiple linear regression model was carried out to examine the effect of organisational facilitators, CR, ES, and gender on CS. The model was statistically significant with a medium effect size; $F(4, 97) = 5.82$, $p < .001$, $f^2 = .19$ (Table 7). The adjusted R^2

indicated that 16% of the variance in CS can be explained by variances in the four predictor variables. The analysis indicated that organisational facilitators was the most influential predictor in the model (β = .24, *t* (97) = 2.24, *p* = .027). ES (β = -.20, *t* (97) = -2.12, *p* = .036) and CR (β = .19, *t* (97) = 2.06, *p* = .043) were the next most influential predictors. Gender was not significant predictors of CS (β = -.13, *t* (97) = -1.36, *p* = .18). However, when bootstrapping was applied, only ES was a significant predictor of CS. A moderation analysis revealed that the interaction between organisational facilitators and ES was not a significant predictor of CS; *b* = .001, *t* = -.04, *p* = .97. The interaction between organisational facilitators and CR was also not a significant predictor of CS; *b* = .001, *t* = .01, *p* = .99.

[Insert Table 7]

Discussion

The main aim of this study was to examine known predictors of CF and CS in a new population – HCPs working with people diagnosed with EDs. In the current study, approximately one fifth of participants scored in the "high" level of CF, suggesting cause for concern. Additionally, approximately 17% of the participants scored in the "low" level of CS. However, Stamm (2010) highlighted the somewhat artificial nature of the ProQOL measure cut-off scores, including the possibility for false positives, and therefore suggested those be treated with caution. More reassuringly, most participants scored in the "low" and "average" levels of CF and about one fifth scored in the "high" level of CS.

Research on the prevalence of CF and CS in HCPs working in various settings is mixed and it is therefore difficult to draw direct comparisons (Alharbi et al., 2019; Dasan et al., 2015; Frey et al., 2018; Hunsaker et al., 2015; Kelly et al., 2015; O'Callaghan et al., 2020). The ProQOL-21 version has not yet been used widely and, given that it particularly differs in the construct of CF, compared to the original extensively used ProQOL-5 as well as other versions, it may not be appropriate to draw such comparisons. Heritage et al.'s (2018) sample of nurses

working in Australian hospitals completed the ProQOL-21 and their mean scores for CF and CS were comparable to those found in the current study. This study adds to the literature by noting the prevalence of CF and CS in HCPs working with people diagnosed with EDs.

An interesting finding from this study was that the regression model for CS did not predict the variable well, since it only accounted for 16% of the variance. This suggests that there are crucial variables predicting CS which have not been investigated in the current study.

Specialist Training

Despite evidence suggesting that receiving training relevant to the healthcare setting improves CS (Frey et al., 2018; O'Callaghan et al., 2020; Yu et al., 2016), the current study did not support those findings, as there were no significant differences between HCPs who received specialist ED training and those who did not. Previous research on the impact of specialist training on CS included nurses working predominantly with medical conditions, and the training explored in those studies appeared to focus on improving the psychological wellbeing of staff and their ability to support patients emotionally. It may be that those are skills HCPs working in ED services already possess, given that a great number of them would have gained prior qualifications in mental health. Additionally, in the current study, it was not made clear what "specialist training" may be, therefore participants may have used their own judgement as to what they considered to be specialist training. These factors may account for the results of this study differing from previous literature.

Organisational Facilitators

This concept reflects beneficial organisational aspects which could contribute to preventing the development of workplace stress. In this study it was associated with a reduction in CF and an increase in CS but was not a significant predictor of either in their respective regression models. Previous studies found similar associations between CS and workplace stress factors, such as job satisfaction, support from management, and meaningful recognition

(Cavanagh et al., 2020; Hunsaker et al, 2015; Kelly et al. 2015; Yu et al., 2021). Job satisfaction was the only positive concept associated with a reduction in CF in previous research (Kelly et al. 2015; Yu et al., 2021), although it has also been found that lack of managerial support was associated with an increase in CF (Alharbi et al, 2019; Hunsaker et al., 2015). Given the findings of this study, it appears that these organisational facilitators may play a part in influencing CF and CS, but they are not the main influences.

Workload Demands

In this study, workload demands were the most influential predictor of CF. This finding mirrors previous studies which found that similar concepts, such as subjective time pressure and role overload, were associated with CF in various medical settings (Barr, 2017; Kleiner & Wallace, 2017). The timing of this study is particularly interesting, as many HCPs who participated may have been faced with an increase in workload demands due to the COVID-19 pandemic (Kniffin et al., 2021). Given the large association between workload demands and CF, it appears that the former is a key concept influencing CF in HCPs working in ED services.

Job Insecurity

Job insecurity was the second most influential predictor of CF in this study, with a medium association. To the author's knowledge this concept has not been previously investigated with regards to CF. It is important to highlight that the challenges of the COVID-19 pandemic may have made job insecurity a more salient issue for HCPs working in ED services, particularly as the questions explored concerns about being transferred to another job, in addition to questions about becoming unemployed. Redeployment of mental health HCPs working for the NHS, specifically to support inpatient and medical environments, was a real prospect when this study was conducted (Royal College of Nursing, 2021). Consequently, it appears that job insecurity is another important aspect to take into account when considering

CF in HCPs working in ED services, particularly when the NHS is under pressure and redeployment is likely.

Cognitive Reappraisal

This study found that higher levels of CR were significantly associated with lower levels of CF and higher levels of CS. However, these relationships were small, and CR was not a significant predictor of either CF or CS in the respective regression models. Măirean (2016) found a relationship between higher levels of CR and increased CS. However, the association between CR and CF has not been explored before. Even though CF is not specifically conceptualised as an emotion, it appears to have emotional components in terms of its development and symptoms. The results of the current study reflect previous research in which CR was associated with a decrease of the subjective experience of negative emotions (Gross, 2002; Richardson, 2017). It appears that CR could be a helpful skill for managing CF and CS in HCPs working with people diagnosed with EDs, however it does not appear to be a key component.

CR did not have a moderating effect on the association between workplace stress factors and CF, nor on the relationship between workplace stress factors and CS. However, these analyses may have been underpowered, as discussed below. There is limited research examining the moderating effect of CR on CF and CS. Troy and Mauss (2011) proposed that CR was a moderator between stress and resilience, as measured by depressive symptoms. It may be that the concepts of CF and CS are related, but different from resilience and depression, which could explain why the current study did not find an interaction between workplace stress and CR on the dependent variables.

Expressive Suppression

As predicted, higher levels of ES were significantly associated with lower levels of CS while there was no significant relationship to CF. Additionally, ES was a significant predictor

of CS in the regression model. Even though the impact of ES on CF and CS has not been investigated before, the results of this study reflect previous research on its relationship with positive and negative emotions (Gross, 2002; Richardson, 2017). Although the relationship found in this study was small, ES may not be a beneficial personal resource for HCPs working with people diagnosed with EDs, as it has no impact on CF and is associated with a reduction in CS.

ES did not have a moderating effect on the relationship between workplace stress and CS. Again, this could be due to the analysis being underpowered. Similarly to CR, there is limited research exploring the moderating effect of ES on CS. Richardson (2017) found an interaction between stress and ES on levels of affect in undergraduate students. It may be that, despite having emotional components, CS differs sufficiently enough from the concept of affect to not yield similar results. Furthermore, Richardson (2017) measured daily stress over several days, whereas in the current study workplace stress was assessed at a single point in time. These differences in study design may explain why the current study did not find an interaction between workplace stress and ES on CS.

Limitations

One limitation of this study is in its development of a new measure of workplace stress. To reduce the time participants had to spend on the online survey, only items marked as 'core' on the COPSOQ III were included, however COPSOQ III guidelines state that the short version requires the addition of some items marked as 'middle' or 'long' (Llorens et al., 2019). A factor analysis was completed to mitigate any impact on the validity of the results. However, the findings need to be interpreted with caution as it is typically recommended that a "large" sample size is used for a reliable factor analysis (Beavers et al., 2013; Costello & Osborne, 2005; Field, 2009).

It is recognised that adapting the COPSOQ III into a new measure has implications on comparing the results of this study with existing research. However, various questionnaires were used in previous studies exploring this topic and therefore using the short version of the COPSOQ III would not have allowed for direct comparisons either. Using a different measure, such as the 22-item Workplace Stressors Assessment Questionnaire (WSAQ; Mahmood et al., 2010), could conceivably have produced a more accurate reflection of the levels of workplace stress experienced by participants in this study. However, the WSAQ was developed specifically for staff working at a US government high-tech worksite and was therefore not validated with a clinical healthcare staff population. Additionally, questions from the COPSOQ III were specifically chosen for this study as the various scales reflected aspects of workplace stress which had been identified in previous literature to be associated with CF and CS.

Additionally, while the ERQ is a widely used measure of CR and ES, it offers limited insight into the exact processes HCPs engage in when they attempt to cognitively reappraise their emotional reactions. It is likely some HCPs in the sample reappraised challenging situations by blaming patients or their families, which could have reduced the impact of such events on their emotional reactions but may not be a useful coping strategy to engage in long-term. Conducting a qualitative study which explores HCPs' ways of reappraising stressful situations could offer an increased insight into these processes and the usefulness of this coping strategy when working in ED services.

Another consideration is the possibility of a self-selecting bias. Due to the nature of recruitment, it may be that highly committed staff decided to take part. It is possible that HCPs experiencing higher levels of workplace stress and CF, and lower levels of CS, were not sufficiently motivated to participate in the study. It is also possible that some HCPs had taken a leave of absence due to the adverse impact of those experiences. Consequently, being less likely to become aware of this study through their organisation, they could have missed the

opportunity to participate in it. Therefore, the results of this study may not be reflective of the whole population of HCPs working with people diagnosed with EDs.

Moreover, most of the moderation analyses may have been underpowered. Effect sizes were estimated based on recommendations by Warner (2013) and varied between $R^2 = .1$ and $R^2 = .3$. Therefore, most analyses required a minimum of 135 participants to reach power of .80 (Warner, 2013). Additionally, there were large differences in the number of women and men in the sample, along with differences in the numbers of participants who completed specialist ED training and those who did not complete such training. Therefore, both significant and non-significant differences between those groups on the various variables should be treated with caution.

Furthermore, data collection started several months after the COVID-19 pandemic outbreak and UK's first lockdown began. Those events brought unique challenges to ED services, such as deterioration of patients' wellbeing, redeployment of staff, remote working with high-risk patients, reduced opportunities for support from colleagues and supervisors, or a requirement to adapt the workplace at short notice, for example to accommodate for social distancing (Branley-Bell & Talbot, 2020; Kniffin et al., 2021; Schlegl et al., 2020; Weissman et al., 2020). The current study did not specifically seek to explore the impact of COVID-19 on HCPs working with people diagnosed with EDs, and it may be that these unforeseen changes affected some or all variables. However, the results of this study may serve as an accurate reflection on HCPs' wellbeing during the pandemic.

Conclusion

The findings of this study showed that approximately 22% of HCPs working with people diagnosed with EDs experienced "high" CF and approximately 17% of them experienced "low" CS. Therefore, it may be beneficial for managers and supervisors in ED services to consider ways of reducing CF and increasing CS in their staff.

Implications

Organisational Change

The findings of this study suggest that workload demands and job insecurity are influential variables in predicting CF. Organisational change is required to address those factors (Bennett et al., 2001) and prevent HCPs from experiencing high levels of workplace stress and CF. Qureshi et al. (2020) suggested analysing possible drivers of an increased workload. For their sample of nurses, the authors identified nurse-patient ratio and patient acuity as the main reasons for an increase in demands. ED services may benefit from modelling the impact of such factors on workload demands, thus identifying avenues for reducing demands and CF. This type of data could inform staffing levels in ED services. ED services could consider practices such as analysing and clarifying work roles or offering flexible working patterns (Bennett et al., 2001; Elkin & Rosch, 1990). Furthermore, providing HCPs with sufficient information regarding redeployment, keeping open channels of communication between HCPs and management, and positive leadership strategies could impact on reducing a sense of job insecurity in ED services (Burke et al., 2015).

Clinical Support and Supervision

The results of this study also suggest that ES, as one way of regulating emotions, is an influential variable for CS. Given that ES is a response-focused strategy and therefore involves suppressing one's reactions to an already generated emotion, it may be that alternative strategies need to be considered for HCPs' management of emotions. Clinical psychologists embedded in ED services may be uniquely placed to support their colleagues in this. Gross and John (2003) highlighted that ES may result in feelings of inauthenticity due to the mismatch between the felt emotion and the behavioural reaction to it. The authors also found that individuals who utilised the ES strategy were more likely to avoid sharing any emotions. Therefore, it may be beneficial for clinical psychologists to enable expression of negative and

positive emotions in clinical supervision with individual HCPs. It may also be helpful for clinical psychologists to facilitate reflective groups with HCPs to normalise and model sharing of emotions, giving a safe space to process such experiences with another. Such groups may also allow HCPs to regularly monitor their overall levels of workplace stress and capacity for compassion, which could prompt discussions with managers and supervisors around changing particular stressors.

Future Research

Due to the CS regression model accounting for merely a small amount of the variation, it is recommended that future research includes measures of additional variables. Access to social support has been shown in previous studies to have an impact on CS in HCPs (Barr, 2017; Yu et al., 2016) and may therefore be an interesting variable to explore in ED services. The current study explored CR and ES as two ways of coping with difficult situations, however additional coping strategies to explore may be cognitive empathy, such as perspective taking (Yu et al., 2016), and self-compassion (Beaumont et al., 2016a; Yu et al., 2021). Exploring self-compassion would also be relevant for CF, due to emerging evidence (Beaumont et al., 2016a, 2016b). Such findings could inform ways of reducing CF and improving CS through training aimed at increasing self-compassion and reducing fear of compassion (Beaumont et al., 2017; McVicar et al., 2021; Raab, 2014; Wasson et al., 2020). Finally, previous research found that aspects of HCPs' personality, such as psychological hardiness (Frey et al, 2018) or conscientiousness (Yu et al., 2016), were associated with higher levels of CS. Exploring these additional variables may result in a better understanding of the predictors of CS in HCPs working in ED services. To avoid self-selecting bias, future research may benefit from following up on non-responders.

To conclude, tackling workplace stress factors at an organisational level, along with addressing workplace stress and ES at an individual level, are recommended to improve HCPs' capacity for compassion and consequently improve levels of patient care.

References

Alharbi, J., Jackson, D., & Usher, K. (2019). Compassion fatigue in critical care nurses. An integrative review of the literature. *Saudi Medical Journal, 40*(11), 1087-1097. http://hdl.handle.net/10453/137719

Ali, K., Farrer, L., Fassnacht, D. B., Gulliver, A., Bauer, S., & Griffiths, K. M. (2017). Perceived barriers and facilitators towards help-seeking for eating disorders: A systematic review. *International Journal of Eating Disorders*, *50*(1), 9-21. https://doi.org/10.1002/eat.22598

Barr, P. (2017). Compassion fatigue and compassion satisfaction in neonatal intensive care unit nurses: Relationships with work stress and perceived social support. *Traumatology, 23*(2), 214-222. https://doi.org/10.1037/trm0000115

Barron, K., Deery, R., & Sloan, G. (2017). Community mental health nurses' and compassion: An interpretative approach. *Journal of Psychiatric and Mental Health Nursing*, *24*(4), 211-220. https://doi.org/10.1111/jpm.12379

Beaumont, E., Durkin, M., Hollins Martin, C. J., & Carson, J. (2016a). Compassion for others, self-compassion, quality of life and mental well-being measures and their association with compassion fatigue and burnout in student midwives: A quantitative survey. *Midwifery*, *34*, 239-244. https://doi.org/j.midw.2015.11.002

Beaumont, E., Durkin, M., Hollins Martin, C. J., & Carson, J. (2016b). Measuring relationships between self-compassion, compassion fatigue, burnout and well-being in student

counsellors and student cognitive behavioural psychotherapists: A quantitative survey. *Counselling and Psychotherapy Research, 16*(1), 15-23. https://doi.org/10.1002/capr.12054

Beaumont, E., Rayner, G., Durkin, M., & Bowling, G. (2017). The effects of compassionate mind training on student psychotherapists. *The Journal of Mental Health Training, Education and Practice, 12*(5), 300-312. https://doi.org/10.1108/JMHTEP-06-2016-0030

Beavers, A. S., Lounsbury, J. W., Richards, J. K., Huck, S. W., Skolits, G. J., & Esquivel, S. L. (2013). Practical considerations for using exploratory factor analysis in educational research. *Practical Assessment, Research, and Evaluation, 18*, Article 6. https://doi.org/10.7275/qv2q-rk76

Bell, L. (2003). What can we learn from consumer studies and qualitative research in the treatment of eating disorders? *Eating and Weight Disorders, 8*(3), 181-187. https://doi.org/10.1007/BF03325011

Bennett, P., Lowe, R., Matthews, V., Dourali, M., & Tattersall, A. (2001). Stress in nurses: Coping, managerial support and work demand. *Stress & Health, 17*(1), 55-63. https://doi.org/10.1002/1532-2998(200101)17:1<55::AID-SMI879>3.0.CO;2-2

Branley-Bell, D., & Talbot, C. V. (2020). Exploring the impact of the COVID-19 pandemic and UK lockdown on individuals with experience of eating disorders. *Journal of Eating Disorders, 8*, 44. https://doi.org/10.1186/s40337-020-00319-y

Brown, B., Crawford, P., Gilbert, P., Gilbert, J., & Gale, C. (2014). Practical compassions: Repertoires of practice and compassion talk in acute mental healthcare. *Sociology of Health & Illness, 36*(3), 383-399. https://doi.org/10.1111/1467-9566.12065

Burke, R. J., Ng, E. S. W., & Wolpin, J. (2015). Economic austerity and healthcare restructuring: Correlates and consequences of nursing job insecurity. *The International Journal of Human Resource Management, 26*(5), 640-656. https://doi.org/10.1080/09585192.2014.921634

Burr, H., Berthelsen, H., Moncada, S., Nübling, M., Dupret, E., Demiral, Y., Oudyk, J., Kristensen, T. S., Llorens, C., Navarro, A., Lincke, H.-J., Bocéréan, C., Sahan, C., Smith, P., & Pohrt, A. (2019). The third version of the Copenhagen Psychosocial Questionnaire. *Safety and Health at Work, 10*(4), 482-503. https://doi.org/10.1016/j.shaw.2019.10.002

Buruck, G., Dörfel, D., Kugler, J., & Brom, S. S. (2016). Enhancing well-being at work: The role of emotion regulation skills as personal resources. *Journal of Occupational Health Psychology, 21*(4), 480-493. https://doi.org/10.1037/ocp0000023

Buruck, G., Wendsche, J., Melzer, M., Strobel, A., & Dörfel, D. (2014). Acute psychosocial stress and emotion regulation skills modulate empathic reactions to pain in others. *Frontiers in Psychology, 5*(517). https://doi.org/10.3389/fpsyg.2014.00517

Butler, E. A., Egloff, B., Wihelm, F. H., Smith, N. C., Erickson, E. A., & Gross, J. J. (2003). The social consequences of expressive suppression. *Emotion, 3*(1), 48-67. https://doi.org/10.1037/1528-3542.3.1.48

Cavanagh, N., Cockett, G., Heinrich, C., Doig, L., Fiest, K., Guichon, J. R., Page, S., Mitchell, I., & Doig, C. J. (2020). Compassion fatigue in healthcare providers: A systematic review and meta-analysis. *Nursing Ethics, 27*(3), 639-665. https://doi.org/10.1177/0969733019889400

Colligan, T. W., & Higgins, E. M. (2006). Workplace stress. *Journal of Workplace Behavioral Health, 21*(2), 89-97. https://doi.org/10.1300/J490v21n02_07

Costello, A. B., & Osborne, J. (2005). Best practices in exploratory factor analysis: Four recommendations for getting the most from your analysis. *Practical Assessment, Research, and Evaluation, 10,* Article 7. https://doi.org/10.7275/jyj1-4868

Dasan, S., Gohil, P., Cornelius, V., & Taylor, C. (2015). Prevalence, causes and consequences of compassion satisfaction and compassion fatigue in emergency care: A mixed-methods study of UK NHS consultants. *Emergency Medicine Journal, 32*(8), 588-594. https://doi.org/10.1136/emermed-2014-203671

Davey, A., Arcelus, J., & Munir, F. (2014). Work demands, social support, and job satisfaction in eating disorder inpatient settings: A qualitative study. *International Journal of Mental Health Nursing, 23*(1), 60-68. https://doi.org/10.1111/inm.12014

Devery, H., Scanlan, J. N., & Ross, J. (2018). Factors associated with professional identity, job satisfaction and burnout for occupational therapists working in eating disorders: A mixed methods study. *Australian Occupational Therapy Journal, 65*(6), 523-532. https://doi.org/10.1111/1440-1630.12503

Dickinson, T., & Wright, K. M. (2008). Stress and burnout in forensic mental health nursing: A literature review. *British Journal of Nursing, 17*(2), 82-87. https://doi.org/10.12968/bjon.2008.17.2.28133

Distefano, C., Zhu, M. & Mindrila, D. (2009) Understanding and using factor scores: Considerations for the applied researcher. *Practical Assessment, Research & Evaluation, 14*, Article 20. https://doi.org/10.7275/da8t-4g52

Doran, D., & Smith, P. (2004). Measuring service quality provision within an eating disorders context. *International Journal of Health Care Quality Assurance, 17*(7), 377-388. https://doi.org/10.1108/09526860410563186

Edwards, D., Burnard, P., Coyle, D., Fothergill, A., & Hannigan, B. (2000). Stress and burnout in community mental health nursing: A review of the literature. *Journal of Psychiatric and Mental Health Nursing, 7*(1), 7-14. https://doi.org/10.1046/j.1365-2850.2000.00258.x

Elkin, A. J., & Rosch, P. J. (1990). Promoting mental health at the workplace: The prevention side of stress management. *Occupational Medicine, 5*(4), 739-754. https://europepmc.org/article/med/2237702

Faul, F., Erdfelder, E., Buchner, A., & Lang, A.-G. (2009). Statistical power analyses using G*Power 3.1: Tests for correlation and regression analyses. *Behavior Research Methods, 41*, 1149-1160. https://doi.org/10.3758/BRM.41.4.1149

Field, A. (2009). *Discovering statistics using SPSS* (3rd ed.). SAGE Publications Ltd.

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *Journal of Clinical Psychology, 58*(11), 1433-1441. https://doi.org/10.1002/jclp.10090

Foster, K., Roche, M., Delgado, C., Cuzzillo, C., Giandinoto, J.-A., & Furness, T. (2019). Resilience and mental health nursing: An integrative review of international literature. *International Journal of Mental Health Nursing, 28*(1), 71-85. https://doi.org/10.1111/inm.12548

Fotaki, M. (2015). Why and how is compassion necessary to provide good quality healthcare? *International Journal of Health Policy and Management, 4*(4), 199-201. https://doi.org/10.15171/ijhpm.2015.66

Frey, R., Robinson, J., Wong, C., & Gott, M. (2018). Burnout, compassion fatigue and psychological capital: Findings from a survey of nurses delivering palliative care. *Applied Nursing Research, 43*, 1-9. https://doi.org/10.1016/j.apnr.2018.06.003

Gilbert, P. (2019). Explorations into the nature and function of compassion. *Current Opinion in Psychology, 28*, 108-114. https://doi.org/j.copsyc.2018.12.002

Gilbert, P. (2021). Creating a compassionate world: Addressing the conflicts between sharing and caring versus controlling and holding evolved strategies. *Frontiers in Psychology, 11*, 582090. https://doi.org/10.3389/fpsyg.2020.582090

Graham, M. R., Tierney, S., Chisholm, A., & Fox, J. R. E. (2020). The lived experience of working with people with eating disorders: A meta-ethnography. *International Journal of Eating Disorders, 53*(3), 422-441. https://doi.org/10.1002/eat.23215

Gross, J. J. (1998). Antecedent- and response-focused emotion regulation: Divergent consequences for experience, expression, and physiology. *Journal of Personality and Social Psychology, 74*(1), 224-237. https://doi.org/10.1037/0022-3514.74.1.224

Gross, J. J. (2002). Emotion regulation: Affective, cognitive, and social consequences. *Psychophysiology, 39*(3), 281-291. https://doi.org/10.1017/S0048577201393198

Gross, J. J., & John, O. P. (2003). Individual differences in two emotion regulation processes: Implications for affect, relationships, and well-being. *Journal of Personality and Social Psychology, 85*(2), 348-362. https://doi.org/10.1037/0022-3514.85.2.348

Halmi, K. A. (2009). Salient components of a comprehensive service for eating disorders. *World Psychiatry, 8*(3), 150-155. https://doi.org/10.1002/j.2051-5545.2009.tb00235.x

Heritage, B., Rees, C. S., & Hegney, D. G. (2018). The ProQOL-21: A revised version of the Professional Quality of Life (ProQOL) scale based on Rasch analysis. *PLoS ONE, 13*(2), e0193478. https://doi.org/10.1371/journal.pone.0193478

Hofmeyer, A., Kennedy, K., & Taylor, R. (2020). Contesting the term 'compassion fatigue': Integrating findings from social neuroscience and self-care research. *Collegian, 27*(2), 232-237. https://doi.org/j.colegn.2019.07.001

Hunsaker, S., Chen, H.-C., Maughan, D., & Heaston, S. (2015). Factors that influence the development of compassion fatigue, burnout, and compassion satisfaction in emergency department nurses. *Journal of Nursing Scholarship, 47*(2), 186-194. https://doi.org/10.1111/jnu.12122

IBM Corp. (2020). *IBM SPSS Statistics for Windows, Version 27.0*. In IBM Corp.

Innes, N. T., Clough, B. A., & Casey, L. M. (2017). Assessing treatment barriers in eating disorders: A systematic review. *Eating Disorders, 25*(1), 1-21. https://doi.org/10.1080/10640266.2016.1207455

Joint Commissioning Panel for Mental Health. (2013). *Guidance for commissioners of eating disorder services*. https://www.jcpmh.info/wp-content/uploads/jcpmh-eatingdisorders-guide.pdf

Kelly, L., Runge, J., & Spencer, C. (2015). Predictors of compassion fatigue and compassion satisfaction in acute care nurses. *Journal of Nursing Scholarship, 47*(6), 522-528. https://doi.org/10.1111/jnu.12162

Kleiner, S., & Wallace, J. E. (2017). Oncologist burnout and compassion fatigue: Investigating time pressure at work as a predictor and the mediating role of work-family conflict. *BMC Health Services Research, 17*, 639. https://doi.org/10.1186/s12913-017-2581-9

Kniffin, K. M., Narayanan, J., Anseel, F., Antonakis, J., Ashford, S. P., Bakker, A. B., Bamberger, P., Bapuji, H., Bhave, D. P., Choi, V. K., Creary, S. J., Demerouti, E., Flynn, F. J., Gelfand, M. J., Greer, L. L., Johns, G., Kesebir, S., Klein, P. G., Lee, S. Y., . . . van Vugt, M. (2021). COVID-19 and the workplace: Implications, issues, and insights for future research and action. *American Psychologist, 76*(1), 63-77. https://doi.org/10.1037/amp0000716

Lee, M., Laurenson, M., & Whitfield, C. (2012). Can compassion be taught to lessen the effects of compassion fatigue? *Journal of Care Services Management, 6*(3), 121-130. https://doi.org/10.1179/1750168713Y.0000000016

Llorens, C., Pérez-Franco, J., Oudyk, J., Berthelsen, H., Dupret, E., Nübling, M., Burr, H., & Moncada, S. (2019). *COPSOQ III. Guidelines and questionnaire*. https://www.copsoq-network.org/licence-guidelines-and-questionnaire/

Lombardo, B., & Eyre, C. (2011). Compassion fatigue: A nurse's primer. *The Online Journal of Issues in Nursing*, *16*(1), Manuscript 3. https://doi.org/10.3912/OJIN.Vol16No01Man03

Lown, B. A., Rosen, J., & Marttila, J. (2011). An agenda for improving compassionate care: A survey shows about half of patients say such care is missing. *Health Affairs*, *30*(9), 1772-1778. https://doi.org/10.1377/hlthaff.2011.0539

Mahmood, M. H., Coons, S. J., Guy, M. C., & Pelletier, K. R. (2010). Development and testing of the Workplace Stressors Assessment Questionnaire. *Journal of Occupational and Environmental Medicine*, *52*(12), 1192-1200. https://doi.org/10.1097/JOM.0b013e3181fb53dc

Măirean, C. (2016). Emotion regulation strategies, secondary traumatic stress, and compassion satisfaction in healthcare providers. *The Journal of Psychology*, *150*(8), 961-975. https://doi.org/10.1080/00223980.2016.1225659

Mann, S., & Cowburn, J. (2005). Emotional labour and stress within mental health nursing. *Journal of Psychiatric and Mental Health Nursing*, *12*(2), 154-162. https://doi.org/10.1111/j.1365-2850.2004.00807.x

Mantri, S., Lawson, J. M., Wang, Z., & Koenig, H. G. (2021). Prevalence and predictors of moral injury symptoms in health care professionals. *The Journal of Nervous and Mental Disease*, *209*(3), 174-180. https://doi.org/10.1097/nmd.0000000000001277

McVicar, A., Pettit, A., Knight-Davidson, P., & Shaw-Flach, A. (2021). Promotion of professional quality of life through reducing fears of compassion and compassion fatigue: Application of the compassionate mind model to specialist community public health nurses (health visiting) training. *Journal of Clinical Nursing, 30*(1-2), 101-112. https://doi.org/10.1111/jocn.15517

National Institute for Health and Care Excellence. (2020). *Eating disorders: recognition and treatment* (NICE guideline 69). https://www.nice.org.uk/guidance/ng69

Neff, K. D., Knox, M. C., Long, P., & Gregory, K. (2020). Caring for others without losing yourself: An adaptation of the Mindful Self-Compassion Program for Healthcare Communities. *Journal of Clinical Psychology, 76*(9), 1543-1562. https://doi.org/https://doi.org/10.1002/jclp.23007

O'Callaghan, E. L., Lam, L., Cant, R., & Moss, C. (2020). Compassion satisfaction and compassion fatigue in Australian emergency nurses: A descriptive cross-sectional study. *International Emergency Nursing, 48*, 100785. https://doi.org/10.1016/j.ienj.2019.06.008

O'Connor, C., McNamara, N., O'Hara, L., & McNicholas, F. (2016). Eating disorder literacy and stigmatising attitudes towards anorexia, bulimia and binge eating disorder among adolescents. *Advances in Eating Disorders, 4*(2), 125-140. https://doi.org/10.1080/21662630.2015.1129635

Perez-Bret, E., Altisent, R., & Rocafort, J. (2016). Definition of compassion in healthcare: A systematic literature review. *International Journal of Palliative Nursing, 22*(12), 599-606. https://doi.org/10.12968/ijpn.2016.22.12.599

Qualtrics. (2020). *Qualtrics*. https://www.qualtrics.com

Qureshi, S. M., Purdy, N., & Neumann, W. P. (2020). Development of a methodology for healthcare system simulations to quantify nurse workload and quality of care. *IISE Transactions on Occupational Ergonomics and Human Factors, 8*(1), 27-41. https://doi.org/10.1080/24725838.2020.1736692

Raab, K. (2014). Mindfulness, self-compassion, and empathy among health care professionals: A review of the literature. *Journal of Health Care Chaplaincy, 20*(3), 95-108. https://doi.org/10.1080/08854726.2014.913876

Reas, D. L. (2017). Public and healthcare professionals' knowledge and attitudes toward binge eating disorder: A narrative review. *Nutrients, 9*(11), 1267. https://doi.org/10.3390/nu9111267

Richards, D. A., Bee, P., Barkham, M., Gilbody, S. M., Cahill, J., & Glanville, J. (2006). The prevalence of nursing staff stress on adult acute psychiatric in-patient wards: A systematic review. *Social Psychiatry and Psychiatric Epidemiology, 41*, 34-43. https://doi.org/10.1007/s00127-005-0998-7

Richardson, C. M. E. (2017). Emotion regulation in the context of daily stress: Impact on daily affect. *Personality and Individual Differences, 112*, 150-156. https://doi.org/10.1016/j.paid.2017.02.058

Roeser, R. W., Colaianne, B. A., & Greenberg, M. A. (2018). Compassion and human development: Current approaches and future directions. *Research in Human Development, 15*(3-4), 238-251. https://doi.org/10.1080/15427609.2018.1495002

Royal College of Nursing. (2021). *COVID-19 and redeployment*. htpps://www.rcn.org.uk/get-help/rcn-advice/redeployment-and-covid-19

Schlegl, S., Maier, J., Meule, A., & Voderholzer, U. (2020). Eating disorders in times of the COVID-19 pandemic—Results from an online survey of patients with anorexia nervosa. *International Journal of Eating Disorders, 53*(11), 1791-1800. https://doi.org/10.1002/eat.23374

Sinclair, S., Norris, J. M., McConnell, S. J., Chochinov, H. M., Hack, T. F., Hagen, N. A., McClement, S., & Bouchal, S. R. (2016). Compassion: A scoping review of the healthcare literature. *BMC Palliative Care, 15*, 6. https://doi.org/10.1186/s12904-016-0080-0

Sinclair, S., Raffin-Bouchal, S., Venturato, L., Mijovic-Kondejewski, J., & Smith-MacDonald, L. (2017). Compassion fatigue: A meta-narrative review of the healthcare literature. *International Journal of Nursing Studies, 69*, 9-24. https://doi.org/10.1016/j.ijnurstu.2017.01.003

Smink, F. R. E., van Hoeken, D., & Hoek, H. W. (2012). Epidemiology of eating disorders: Incidence, prevalence and mortality rates. *Current Psychiatry Reports, 14*, 406-414. https://doi.org/10.1007/s11920-012-0282-y

Sorenson, C., Bolick, B., Wright, K., & Hamilton, R. (2016). Understanding compassion fatigue in healthcare providers: A review of current literature. *Journal of Nursing Scholarship, 48*(5), 456-465. https://doi.org/10.1111/jnu.12229

Stamm, B. H. (2009). *Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL)*. www.proqol.org

Stamm, B. H. (2010). *The Concise ProQOL Manual* (2nd ed.). ProQOL.org.

Taylor, R., Thomas-Gregory, A., & Hofmeyer, A. (2020). Teaching empathy and resilience to undergraduate nursing students: A call to action in the context of Covid-19. *Nurse Education Today, 94*, 104524. https://doi.org/10.1016/j.nedt.2020.104524

Thompson-Brenner, H., Satir, D. A., Franko, D. L., & Herzog, D. B. (2012). Clinician reactions to patients with eating disorders: A review of the literature. *Psychiatric Services, 63*(1), 73-78. https://doi.org/10.1176/appi.ps.201100050

Thompson, I. A., Amatea, E. S., & Thompson, E. S. (2014). Personal and contextual predictors of mental health counselors' compassion fatigue and burnout. *Journal of Mental Health Counseling, 36*(1), 58-77. https://doi.org/10.17744/mehc.36.1.p61m73373m4617r3

Treasure, J., Oyeleye, O., Bonin, E.-M., Zipfel, S., & Fernandez-Aranda, F. (2021). Optimising care pathways for adult anorexia nervosa. What is the evidence to guide the provision of high-quality, cost-effective services? *European Eating Disorders Review*, *29*(3), 306-315. https://doi.org/10.1002/erv.2821

Tremblay, M. A., & Messervey, D. (2011). The Job Demands-Resources model: Further evidence for the buffering effect of personal resources. *SA Journal of Industrial Psychology*, *37*(2), a876. https://doi.org/10.4102/sajip.v37i2.876

Troy, A. S., & Mauss, I. B. (2011). Resilience in the face of stress: Emotion regulation as a protective factor. In S. M. Southwick, B. T. Litz, D. Charney, & M. J. Friedman (Eds.), *Resilience and mental health: Challenges across the lifespan*. Cambridge University Press.

van der Cingel, M. (2009). Compassion and professional care: Exploring the domain. *Nursing Philosophy*, *10*(2), 124-136. https://doi.org/10.1111/j.1466-769X.2009.00397.x

Warner, R. M. (2013). Moderation: Tests for interaction in multiple regression. In *Applied statistics: From bivariate through multivariate techniques* (2nd edition, pp. 611-644). Sage.

Warren, C. S., Crowley, M. E., Olivardia, R., & Schoen, A. (2008). Treating patients with eating disorders: An examination of treatment providers' experiences. *Eating Disorders*, *17*(1), 27-45. https://doi.org/10.1080/10640260802570098

Warren, C. S., Schafer, K. J., Crowley, M. E., & Olivardia, R. (2012). A qualitative analysis of job burnout in eating disorder treatment providers. *Eating Disorders, 20*(3), 175-195. https://doi.org/10.1080/10640266.2012.668476

Wasson, R. S., Barratt, C., & O'Brien, W. H. (2020). Effects of mindfulness-based interventions on self-compassion in health care professionals: A meta-analysis. *Mindfulness, 11*(8), 1914-1934. https://doi.org/10.1007/s12671-020-01342-5

Weiner, B. (1980a). A cognitive (attribution)-emotion-action model of motivated behavior: An analysis of judgments of help-giving. *Journal of Personality and Social Psychology, 39*(2), 186-200. https://doi.org/10.1037/0022-3514.39.2.186

Weiner, B. (1980b). May I borrow your class notes? An attributional analysis of judgments of help giving in an achievement-related context. *Journal of Educational Psychology, 72*(5), 676-681. https://doi.org/10.1037/0022-0663.72.5.676

Weissman, R. S., Bauer, S., & Thomas, J. J. (2020). Access to evidence-based care for eating disorders during the COVID-19 crisis. *International Journal of Eating Disorders, 53*(5), 639-646. https://doi.org/10.1002/eat.23279

Williams, I. M., & Lewis, W. G. (2020). Stress in the workplace for healthcare professionals. *Physiological Reports, 8*(13), e14496. https://doi.org/10.14814/phy2.14496

Williamson, V., Stevelink, S. A. M., & Greenberg, N. (2018). Occupational moral injury and mental health: Systematic review and meta-analysis. *The British Journal of Psychiatry, 212*(6), 339-346. https://doi.org/10.1192/bjp.2018.55

Wright, K. M. (2015). Maternalism: A healthy alliance for recovery and transition in eating disorder services. *Journal of Psychiatric & Mental Health Nursing, 22*(6), 431-439. https://doi.org/10.1111/jpm.12198

Yu, H., Jiang, A., & Shen, J. (2016). Prevalence and predictors of compassion fatigue, burnout and compassion satisfaction among oncology nurses: A cross-sectional survey. *International Journal of Nursing Studies, 57*, 28-38. https://doi.org/10.1016/j.ijnurstu.2016.01.012

Yu, H., Qiao, A., & Gui, L. (2021). Predictors of compassion fatigue, burnout, and compassion satisfaction among emergency nurses: A cross-sectional survey. *International Emergency Nursing, 55*, 100961. https://doi.org/10.1016/j.ienj.2020.100961

Table 1

Summary of Exploratory Factor Analysis Results for Measure of Workplace Stress

Item	Rotated Factor Loadings			
	Organisational Facilitators	Workload Demands	Job Insecurity	Role Demands
Are conflicts resolved in a fair way?[a]	**.808**	.008	-.187	.067
Is your work recognised and appreciated by management?[a]	**.781**	-.136	.067	.190
Can the employees trust the information that comes from the management?[a]	**.720**	-.013	-.041	.347
Is the work distributed fairly?[a]	**.697**	.005	-.073	.045
Do you receive all the information you need in order to do your work well?[a]	**.694**	-.104	.090	.140
Does your work have clear objectives?[a]	**.679**	.064	.110	-.037
How often do you get help and support from your immediate superior, if needed?[a]	**.664**	.050	.005	-.121
To what extent would you say that your immediate superior is good at solving conflicts?[a]	**.652**	.220	-.132	-.345
To what extent would you say that your immediate superior is good at work planning?[a]	**.647**	.161	-.071	-.163
How often do you get help and support from your colleagues, if needed?[a]	**.586**	-.019	-.052	.054
How pleased are you with your job as a whole, everything taken into consideration?[a]	**.568**	.178	.107	.050

Do you have the possibility of learning new things through your work?[a]	**.516**	-.140	.003	-.286
Is there a good atmosphere between you and your colleagues?[a]	**.502**	.052	-.004	.164
Does the management trust the employees to do their work well?[a]	**.490**[b]	-.146	-.012	**.408**[b]
At your place of work, are you informed well in advance concerning for example important decisions, changes or plans for the future?[a]	**.428**	-.332	.273	.182
Can you use your skills or expertise in your work?[a]	.369	-.184	.134	-.288
Is your work meaningful?[a]	.335	.078	.084	-.179
In general, would you say your health is…[a]	.238	.202	.228	.064
Do you feel that your work takes so much of your time that it has a negative effect on your private life?	-.033	**.719**	.391	-.104
Do you get behind with your work?	.220	**.674**	-.023	.079
Do you feel that your work drains so much of your energy that it has a negative effect on your private life?	-.002	**.660**[c]	**.455**[c]	.040
How often do you not have time to complete all your work tasks?	.061	**.634**	-.334	.010
Is your work emotionally demanding?	-.077	**.475**	.159	.385
Do you have to work very fast?	.049	**.409**	-.095	.347

Are you worried about being transferred to another job against your will?	.040	.057	**.706**	.039
Are you worried about becoming unemployed?	-.023	-.008	**.672**	.022
Are you worried about it being difficult for you to find another job if you become unemployed?	-.168	.044	**.666**	.026
Do you have a large degree of influence on the decisions concerning your work?[a]	.207	-.140	.224	-.112
Do you work at a high pace throughout the day?	-.153	.128	-.062	**.570**
Do you have to deal with other people's personal problems as part of your work?	-.017	-.007	.098	**.422**
Do you sometimes have to do things which ought to have been done in a different way?	.211	.049	-.051	**.401**
Are contradictory demands placed on you at work?	.149	.078	.218	.397

Note. Factor loadings over .4 appear in bold.

[a]Item was reverse scored for the factor analysis. [b]Item added to Organisational Facilitators factor. [c]Item added to Workload Demands factor.

Table 2

Mean, Standard Deviation, Minimum, Maximum, and Cronbach's Alpha for Workplace Stress Factors, ERQ Facets, and ProQOL-21 Subscales

Variables	Mean	SD	Minimum	Maximum	Cronbach's alpha
Workplace Stress					
Organisational Facilitators	1034.3	221.1	375	1500	.91
Workload Demands	370.1	100.6	75	575	.80
Job Insecurity	42.7	55.5	0	300	.74
Role Demands	184.1	48.2	25	275	.39
ERQ facets					
Cognitive Reappraisal	28.4	5.4	11	42	.80
Expressive Suppression	12.2	4.3	4	25	.73
ProQOL-21 subscales					
Compassion Fatigue	21.6	5.1	12	33	.84
Compassion Satisfaction	26.0	5.1	15	35	.89

Note. ERQ = Emotion Regulation Questionnaire; ProQOL-21 = Professional Quality of Life scale.

Table 3

Participant Demographics

Demographic variables	n	%
Occupation		
Psychologist	39	38.24
Nurse	23	22.55
Therapist	11	10.78
Dietician	9	8.82
Healthcare support worker	9	8.82
Doctor / psychiatrist	6	5.88
Occupational therapist	3	2.94
Assistant Psychologist	2	1.96
Work setting[a]		
Specialist ED community service	77	75.49
Specialist ED inpatient unit	23	22.55
General community mental health service	10	9.80
Specialist ED private practice	6	5.88
General mental health inpatient unit	3	2.94
Paediatric setting	2	1.96
University	1	0.98
Outpatient service (not specified)	1	0.98
Client age group		
Adults (18+)	24	23.53
0-18	20	19.61
All age	18	17.65

8-18	7	6.86
16+	5	4.90
12-18	4	3.92
13-18	4	3.92
0-19	3	2.94
18-65	3	2.94
13-19	2	1.96
13-25	2	1.96
0-25	1	0.98
5-18	1	0.98
10 and older	1	0.98
10-16	1	0.98
10-24	1	0.98
11-17	1	0.98
11+	1	0.98
16-65	1	0.98
18-30	1	0.98
Adults (17+)	1	0.98
Mode of working[b]		
Service users	101	99.02
Families or carers	66	64.71
Other staff (e.g., consultation, training)	47	46.08
Other systems (e.g., schools)	32	31.37
Specialist training in ED		
Yes	77	75.49

No	25	24.51

Note. ED = eating disorder.

[a]Several participants worked across more than one setting; only six participants indicated they did not work in specialist ED services; [b]Several participants worked across different modes simultaneously.

Table 4

Prevalence of Compassion Fatigue and Compassion Satisfaction in HCPs Working with People Diagnosed with EDs

Levels	Compassion fatigue			Compassion satisfaction		
	Score	n	%	Score	n	%
Low	15 and below	11	10.78	20 and below	17	16.67
Average	16-25	69	67.65	21-30	64	62.75
High	26 and above	22	21.57	31 and above	21	20.59

Note. Heritage et al.'s (2018) modified cut-off points of 25th and 75th percentile were used to establish low, average, and high levels of compassion fatigue and compassion satisfaction.

Table 5

Bivariate Correlations Between All Variables

	Organisational Facilitators	Workload Demands	Job Insecurity	Cognitive Reappraisal	Expressive Suppression	Compassion Fatigue
Workload Demands	-.11	--				
Job Insecurity	-.09	.20*	--			
Cognitive Reappraisal	.17	-.08	-.33**	--		
Expressive Suppression	-.11	.01	.16	-.10	--	
Compassion Fatigue	-.24*	.51**	.32**	-.24*	.05	--
Compassion Satisfaction	.30**	-.12	-.13	.26**	-.26**	-.48**

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

Table 6

Compassion Fatigue Regression Model

		Bootstrap[a]				
				Sig. (2-	95% Confidence Interval	
Model	B	Bias	Std. Error	tailed)	Lower	Upper
Step 1						
Constant	16.498	.071	2.603	.001	11.180	21.302
Organisational Facilitators	-.004	-6.861E-5	.002	.060	-.008	.000
Workload Demands	.022	1.256E-5	.005	.001	.014	.032
Job Insecurity	.020	.000	.007	.007	.004	.034
Step 2						
Constant	19.171	-.050	3.536	.001	11.621	25.525
Organisational Facilitators	-.004	-9.581E-5	.002	.069	-.007	.000
Workload Demands	.022	4.710E-5	.004	.001	.014	.032
Job Insecurity	.017	.000	.008	.031	.002	.033
Cognitive Reappraisal	-.102	-.005	.077	.186	-.259	.051

Note. This was a forced entry hierarchical multiple regression with bootstrapping.

[a]Unless otherwise noted, bootstrap results are based on 2000 bootstrap samples

Table 7

Compassion Satisfaction Regression Model

		Bootstrap[a]				
					95% Confidence Interval	
Model	B	Bias	Std. Error	Sig. (2-tailed)	Lower	Upper
Step 1						
Constant	18.833	.142	2.777	.001	13.658	24.542
Organisational Facilitators	.007	.000	.003	.007	.002	.012
Step 2						
Constant	18.766	-.054	4.499	.001	9.518	27.355
Organisational Facilitators	.005	.000	.003	.065	-.001	.010
Cognitive Reappraisal	.181	.004	.104	.079	-.001	.393
Expressive Suppression	-.233	.005	.112	.047	-.448	-.003
Gender	-2.209	-.058	1.672	.186	-5.614	.853

Note. This was a forced entry hierarchical multiple regression.

[a]Unless otherwise noted, bootstrap results are based on 2000 bootstrap samples

Appendix 2-A

Journal of Advanced Nursing Author Guidelines

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

We recommend using our title page and manuscript templates, which are provided on the relevant page for each manuscript type. Once the submission materials have been prepared in accordance with the Author Guidelines, manuscripts should be submitted online at https://mc.manuscriptcentral.com/jan

The submission system will prompt you to use an ORCID iD (a unique author identifier) to help distinguish your work from that of other researchers. **Click here** to find out more.

Click here for more details on how to use ScholarOne.

For help with submissions, please contact: **jan@wiley.com**

Data Protection

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more **here ...**

Preprint Policy

The Journal of Advanced Nursing (JAN) will consider for review articles previously available as preprints. Authors may also post the **submitted version** of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article.

Data Sharing and Data Availability

This journal expects data sharing. Review **Wiley's Data Sharing policy** where you will be able to see and select the data availability statement that is right for your submission.

Data Citation

Please review **Wiley's Data Citation policy**.

2. AIMS AND SCOPE

The *Journal of Advanced Nursing (JAN)* contributes to the advancement of evidence-based nursing, midwifery and healthcare by disseminating high quality research and scholarship of contemporary relevance and with potential to advance knowledge for practice, education, management or policy.

All *JAN* papers are required to have a sound scientific, evidential, theoretical or philosophical base and to be critical, questioning and scholarly in approach. As an international journal, *JAN* promotes diversity of research and scholarship in terms of culture, paradigm and healthcare context. For *JAN*'s worldwide readership, authors are expected to make clear the wider international relevance of their work and to demonstrate sensitivity to cultural considerations and differences.

The majority of papers in *JAN* are written by nurses and midwives but there are no constraints on authorship as long as papers fit with the expressed Aims and Scope.

JAN's intended readership includes practising nurses and midwives in all spheres and at all levels who are committed to advancing practice and professional development on the basis of new knowledge and evidence; managers and senior members of the nursing and midwifery professions; nurse educators and nursing students; and researchers in other disciplines with interest in common issues and inter-disciplinary collaboration. Papers published in *JAN* are increasingly cited in reviews of evidence and used by other healthcare professionals, policy-makers, commissioners and users of services to inform their decision-making and practice.

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

To ensure completeness of content there is a recommended structure and format for different types of manuscript - **templates for which can be found on the relevant manuscript page**. We also ask that you include all information required by the reporting guidelines relevant to your study. Please consult for details.

Please click below on the type of manuscript you are planning to submit, and follow the guidance provided.

JAN also welcomes other types of paper that do not fit into the below categories. If you are unsure whether your paper is suitable, please send a structured abstract to the editorial office in the first instance (**jan@wiley.com**).

Evidence Synthesis

- Systematic review or other type of review
- Guidelines and consensus statements

Research Papers

Original Research:

- Empirical Research - Quantitative
- Empirical Research - Qualitative
- Empirical Research - Mixed methods
- Clinical trial
- Pilot Study

Protocols:

- Protocols for a research study or systematic review

Research Methodology:

- Instrument Development
- Discussion Paper - Methodology
- Empirical Research - Methodology

Discursive Articles (published Online Only)

Word limit: 8,000 words maximum.
Main text structure: Aims; Background; Design (stating that it is a position paper or critical review, for example); Method (how the issues were approached); Conclusions, Impact to nursing science, practice, or disciplinary knowledge.
References: 25 maximum; Authors who anticipate that their paper requires more than 25 references should outline the reason for requiring additional references in the main text in the 'Relevant Information' submission question on ScholarOne. Additional flexibility will be considered by the Editor-in-Chief on a case by case basis.

Commentaries

The Journal accepts two types of commentaries, with the first being preferable:

- Written in response to a paper published in the Journal, offering expert opinion from one or more people (who may agree or disagree) on a current understanding/status of an area, or how practice should be undertaken. No abstract; limit references to 5 or less; 2,000 words maximum.
- Expert opinion from one or more people (who may agree or disagree) on a current understanding/status of an area, or how practice should be undertaken. No abstract; limit references to 5 or less; 2,000 words maximum.

Letter to the Editor

a. Reserved for discussion about published papers.
b. No abstract; four or less references.
c. The Editorial Board reserves the right to accept or reject, edit, and condense letters for publication and to publish an author or editor response to letters.
d. If a Letter to the Editor is accepted for publication, the authors of the article you are writing about will have an opportunity to review their Letter and respond with a Letter to the Editor of their own in response if they wish. You will not be given another opportunity to respond to the author's response to you.
e. Letters to the Editor undergo review, but they do need to have a full standard peer review. The Editor-in-Chief might choose to accept or reject the Letter themselves, or consult with board members, or send the letter out for full peer review.
f. Letters by article authors in response to Letters to the Editor disputing their articles are usually accepted for publication after the same type of review described above in e.
g. If a Letter to the Editor is accepted for publication, the Editor-in-Chief will decide when and how it will be published.

Editorial

To convey an opinion, or overview of an issue, by the Editor or someone invited by the editor. No abstract; limit references to 5 or less; 1,500 words maximum.

Case Reports

JAN does not accept case reports for publication. Authors of case reports are encouraged to submit to the Wiley Open Access journal, *Clinical Case Reports*, which aims to directly improve health outcomes by identifying and disseminating examples of best clinical practice.

4. PREPARING THE SUBMISSION

Cover Letter

If the study that is being submitted is similar in any way to another study previously submitted/published or is part of multiple studies on the same topic, a brief sentence explaining how the manuscript differs and that there is no identical material should be stated in the cover letter upon submission. Manuscripts undergo a similarity check when submitted and your article may be returned to you, if the above has not been adhered to.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures.

Title page

The title page should contain:

i. A short informative title (max. 20 words) containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips and Five Steps to a Great Title);
ii. A short running title of less than 40 characters;
iii. All authors' full names (please put the last names in CAPITALS);
iv. All authors' institutional affiliations (maximum of 3 pre author);
v. Acknowledgments.
vi. Conflict of Interest statement
vii. Funding Statement
viii. Clinical Trial Registration Number (if applicable)

Authorship

Please refer to the journal's authorship policy the **Editorial Policies and Ethical Considerations** section for details on eligibility for author listing.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Conflict of Interest Statement

Authors are required to provide a conflict of interest statement during the submission process. For details on what to include in this section, see the section 'Conflict of Interest' in the **Editorial Policies and Ethical Considerations** section below. Submitting authors should ensure they liaise with all co-authors to confirm agreement with the final statement.

Main Text File

Please see the guidelines specific to the type of manuscript you are submitting for details on preparing your main text file.

As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors.

Title

Titles are restricted to 20 words.

Abstract

Abstracts should be 300 words maximum, no abbreviations. Do not report p values, confidence intervals and other statistical parameters in the abstract. Additional abstract requirements vary by article type. Please see **Manuscript Categories and Requirements**.

Keywords

Please provide up to 10 keywords including nurses/midwives/nursing within your manuscript itself. When choosing keywords, authors should consider how their article will be easily discovered online. Authors may wish to consider using **MeSH keywords**.

References

References should be prepared according to the Publication Manual of the American Psychological Association (7th edition). This means in-text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page 1.

Reference examples follow:

Journal article

Beers, S. R. , & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry*, 159, 483–486. doi:**10.1176/appi.ajp.159.3.483**

Book

Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.

Internet Document

Norton, R. (2006, November 4). How to train a cat to operate a light switch [Video file]. Retrieved from **http://www.youtube.com/watch?v=Vja83KLQXZs**

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figure Legends

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted. **Click here** for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Figures submitted in colour may be reproduced in colour online free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white. If an author would prefer to have figures printed in colour in hard copies of the journal, a fee will be charged by the Publisher.

Statistical guidelines

Details on how to present statistical information in your manuscript can be found **here**.

Data Collection

Identify the period of data collection; usually this should be no more than 3 years before submission of the manuscript.

Guidelines for Cover Submissions

If you would like to send suggestions for artwork related to your manuscript to be considered to appear on the cover of the journal, please **follow these general guidelines**.

Additional Files

Appendices

Appendices will be published after the references. For submission they should be supplied as separate files but referred to in the text.

Supporting Information

Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

Click here for Wiley's FAQs on supporting information.

Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

Wiley Author Resources

Manuscript Preparation Tips: Wiley has a range of resources for authors preparing manuscripts for submission available **here**. In particular, authors may benefit from referring to Wiley's best practice tips on **Writing for Search Engine Optimization.**

Article Preparation Supports

Wiley Editing Services offers expert help with English Language Editing, as well as translation, manuscript formatting, figure illustration, figure formatting, and graphical abstract design – so you can submit your manuscript with confidence. Also, check out our resources for **Preparing Your Article** for general guidance about writing and preparing your manuscript.

5. EDITORIAL POLICIES AND ETHICAL CONSIDERATIONS

Editorial Review and Acceptance

The acceptance criteria for all papers are the quality and originality of the research and its significance to journal readership. Except where otherwise stated, manuscripts are double-blind peer reviewed. Papers will only be sent to review if the Editor-in-Chief determines that the paper meets the appropriate quality and relevance requirements.

Wiley's policy on the confidentiality of the review process is **available here.**

Appeals

Any appeal against a decision on a manuscript should be filed within 28 days of notification of the decision. The appeal should be in the form of a letter addressed to the Editor-in-Chief and submitted to the *JAN editorial office*. The letter should include clear and concise grounds for the appeal, including specific points of disagreement with the decision. The appeal will

then be assessed by the JAN management team, led by the Editor-in-Chief, and informed by the reviewer assessments and subsequent editorial communications.

You will be informed of the outcome of the appeal within 28 days. The decision will be final.

Data Storage and Documentation

JAN encourages authors to share the data and other artefacts supporting the results in the paper by archiving it in an appropriate public repository. Authors should include a data accessibility statement, including a link to the repository they have used, in order that this statement can be published alongside their paper.

Authors can consult the global registry of research data repositories **re3data.org** to help them identify registered and certified repositories relevant to their subject areas.

Data Citation In recognition of the significance of data as an output of research effort, Wiley has endorsed the **FORCE11 Data Citation Principles** and is implementing a mandatory data citation policy. Journal policies should require data to be cited in the same way as article, book, and web citations and authors are required to include data citations as part of their reference list. Data citation is appropriate for data held within institutional, subject focused, or more general data repositories. It is not intended to take the place of community standards such as in-line citation of GenBank accession codes. When citing or making claims based on data, authors must refer to the data at the relevant place in the manuscript text and in addition provide a formal citation in the reference list. We recommend the format proposed by the **Joint Declaration of Data Citation Principles**

Authors; Year; Dataset title; Data repository or archive; Version (if any); Persistent identifier (e.g. DOI)

Human Studies and Subjects

For manuscripts reporting studies that involve human participants, a statement identifying the ethics committee that approved the study and confirmation that the study conforms to recognized standards is required, for example: **Declaration of Helsinki**; **US Federal Policy for the Protection of Human Subjects**; or **European Medicines Agency Guidelines for Good Clinical Practice**.

Images and information from individual participants will only be published where the authors have obtained the individual's free prior informed consent. Authors do not need to provide a copy of the consent form to the publisher; however, in signing the author license to publish, authors are required to confirm that consent has been obtained. Wiley has a **standard patient consent form** available for use.

Clinical Trial Registration

The journal requires that clinical trials are prospectively registered in a publicly accessible database such as **http://clinicaltrials.gov/** and clinical trial registration numbers should be

included in all papers that report their results. Authors are asked to include the name of the trial register and the clinical trial registration number at the end of the title page. If the trial is not registered, or was registered retrospectively, the reasons for this should be explained.

The ICMJE defines a clinical trial as any research project that prospectively assigns people or a group of people to an intervention, with or without concurrent comparison or control groups, to study the relationship between a health-related intervention and a health outcome. Health-related interventions are those used to modify a biomedical or health-related outcome; examples include drugs, surgical procedures, devices, behavioural treatments, educational programs, dietary interventions, quality improvement interventions, and process-of-care changes. Health outcomes are any biomedical or health-related measures obtained in patients or participants, including pharmacokinetic measures and adverse events. The ICMJE does not define the timing of first participant enrollment, but best practice dictates registration by the time of first participant consent.

Conflict of Interest

The journal requires that all authors disclose any potential sources of conflict of interest. Any interest or relationship, financial or otherwise, or personal, religious or political beliefs that might be perceived as influencing an author's objectivity is considered a potential source of conflict of interest. These must be disclosed when directly relevant or directly related to the work that the authors describe in their manuscript. Potential sources of conflict of interest include, but are not limited to: patent or stock ownership, membership of a company board of directors, membership of an advisory board or committee for a company, and consultancy for or receipt of speaker's fees from a company. The existence of a conflict of interest does not preclude publication. If the authors have no conflict of interest to declare, they must also state this at submission. It is the responsibility of the corresponding author to review this policy with all authors and collectively to disclose with the submission ALL pertinent commercial and other relationships.

Funding

Authors should list all funding sources in the Acknowledgments section. Authors are responsible for the accuracy of their funder designation. If in doubt, please check the Open Funder Registry for the correct nomenclature: **https://www.crossref.org/services/funder-registry/**

Authorship

The list of authors should accurately illustrate who contributed to the work and how.

All those listed as authors should qualify for authorship by meeting *all four* of the following criteria:

1. Have made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data;
2. Been involved in drafting the manuscript or revising it critically for important intellectual content;

3. Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content; and
4. Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section (for example, to recognize contributions from people who provided technical help, collation of data, writing assistance, acquisition of funding, or a department chairperson who provided general support). Prior to submitting the article all authors should agree on the order in which their names will be listed in the manuscript.

Additional Authorship Options. Joint first or senior authorship: In the case of joint first authorship, a footnote should be added to the author listing, e.g. 'X and Y should be considered joint first author' or 'X and Y should be considered joint senior author.'

ORCID

As part of the journal's commitment to supporting authors at every step of the publishing process, the journal requires the submitting author (only) to provide an ORCID iD when submitting a manuscript. This takes around 2 minutes to complete. **Find more information here.**

Publication Ethics

This journal is a member of the **Committee on Publication Ethics (COPE).** Note this journal uses iThenticate's CrossCheck software to detect instances of overlapping and similar text in submitted manuscripts. Read Wiley'sTop 10 Publishing Ethics Tips for Authors **here**. Wiley's Publication Ethics Guidelines can be found **here**.

Transparent Peer Review

The Journal of Advanced Nursing is participating in a pilot on Peer Review Transparency, where the reviewer reports, author responses, and the editor's decision letters will be hosted on Publons and linked to from the published article in the case that the article is accepted. Authors have the opportunity to opt out during submission, and reviewers can choose to remain anonymous unless they would like to sign their report.

Pre-Registered Badge

The Preregistered badge recognizes researchers who preregister their research plans (research design and data analysis plan) prior to engaging in research and who closely follow the preregistered design and data analysis plan in reporting their research findings. The criteria for earning this badge thus include a date-stamped registration of a study plan in such venues as the Open Science Framework (**https://osf.io**) or Clinical Trials

(**https://clinicaltrials.gov**) and a close correspondence between the preregistered and the implemented data collection and analysis plans.

Authors will have an opportunity at the time of manuscript submission and at the time of acceptance to inform themselves of this initiative and to determine whether they wish to participate. Applying and qualifying for Open Science badges is not a requirement for publishing with Journal of Advanced Nursing, but these badges are further incentive for authors to participate in the open science movement and thus to increase the visibility and transparency of their research.

More information about the Open Practices badges is available from the Open Science Framework **wiki**.

6. AUTHOR LICENSING

If your paper is accepted, the author identified as the formal corresponding author will receive an email prompting them to log in to Author Services, where via the Wiley Author Licensing Service (WALS) they will be required to complete a copyright license agreement on behalf of all authors of the paper.

Authors may choose to publish under the terms of the journal's standard copyright agreement, or **Open Access** under the terms of a Creative Commons License.

General information regarding licensing and copyright is available **here**. To review the Creative Commons License options offered under Open Access, please **click here**. (Note that certain funders mandate that a particular type of CC license has to be used; to check this please click **here.**)

Self-Archiving definitions and policies. Note that the journal's standard copyright agreement allows for self-archiving of different versions of the article under specific conditions. Please **click here** for more detailed information about self-archiving definitions and policies.

Open Access fees: Authors who choose to publish open access will be charged a fee. You can **read more about APCs** and whether you may be eligible for waivers or discounts, through your institution, funder, or a country waiver.

Authors receive a 50% discount on the Article Publication Fee for Protocols and a 50% discount also on the full stage 2 follow up paper if accepted for publication in *JAN*.

Funder Open Access: Please click **here** for more information on Wiley's compliance with specific Funder Open Access Policies.

7. PUBLICATION PROCESS AFTER ACCEPTANCE

Accepted article received in production

When an accepted article is received by Wiley's production team, the corresponding author will receive an email asking them to login or register with **Wiley Author Services.** The author will be asked to sign a publication license at this point.

Proofs

Once the paper is typeset, the author will receive an email notification with the URL to download a PDF typeset page proof, as well as associated forms and full instructions on how to correct and return the file.

Please note that the author is responsible for all statements made in their work, including changes made during the editorial process – authors should check proofs carefully. Note that proofs should be returned within 48 hours from receipt of first proof.

Publication Charges

Colour figures. Colour figures may be published online free of charge; however, the journal charges for publishing figures in colour in print. If the author supplies colour figures at Early View publication, they will be invited to complete a colour charge agreement in RightsLink for Author Services. The author will have the option of paying immediately with a credit or debit card, or they can request an invoice. If the author chooses not to purchase color printing, the figures will be converted to black and white for the print issue of the journal.

Early View

The journal offers rapid speed to publication via Wiley's Early View service. **Early View** (Online Version of Record) articles are published on Wiley Online Library before inclusion in an issue. Note there may be a delay after corrections are received before the article appears online, as Editors also need to review proofs. Once the article is published on Early View, no further changes to the article are possible. The Early View article is fully citable and carries an online publication date and DOI for citations.

8. POST PUBLICATION

Access and sharing

When the article is published online:

- The author receives an email alert (if requested).
- The link to the published article can be shared through social media.
- The author will have free access to the paper (after accepting the Terms & Conditions of use, they can view the article).
- The corresponding author and co-authors can nominate up to ten colleagues to receive a publication alert and free online access to the article.

Print copies of the article can now be ordered at **www.sheridan.com/wiley/eoc**. For any queries, please email

erica.garrett@sheridan.com

Promoting the Article

To find out how to best promote an article, **click here.**

Article Promotion Support

Wiley Editing Services offers professional video, design, and writing services to create shareable video abstracts, infographics, conference posters, lay summaries, and research news stories for your research – so you can help your research get the attention it deserves.

Correction to Authorship

In accordance with **Wiley's Best Practice Guidelines on Research Integrity and Publishing Ethics** and the **Committee on Publication Ethics' guidance**, *Journal of Advanced Nursing* will allow authors to correct authorship on a submitted, accepted, or published article if a valid reason exists to do so. All authors – including those to be added or removed – must agree to any proposed change. To request a change to the author list, please complete the **Request for Changes to a Journal Article Author List Form** and contact either the journal's editorial or production office, depending on the status of the article. Authorship changes will not be considered without a fully completed Author Change form. [Correcting the authorship is different from changing an author's name; the relevant policy for that can be found in **Wiley's Best Practice Guidelines** under "Author name changes after publication."]

Author Name Changes After Publication

In cases where authors wish to change their name following publication, Wiley will update and republish the paper and redeliver the updated metadata to indexing services. Our editorial and production teams will use discretion in recognizing that name changes may be of a sensitive and private nature for various reasons including (but not limited to) alignment with gender identity, or as a result of marriage, divorce, or religious conversion. Accordingly, to protect the author's privacy, we will not publish a correction notice to the paper, and we will not notify co-authors of the change. Authors should contact the Editorial Office with their name change request.

Measuring the Impact of an Article

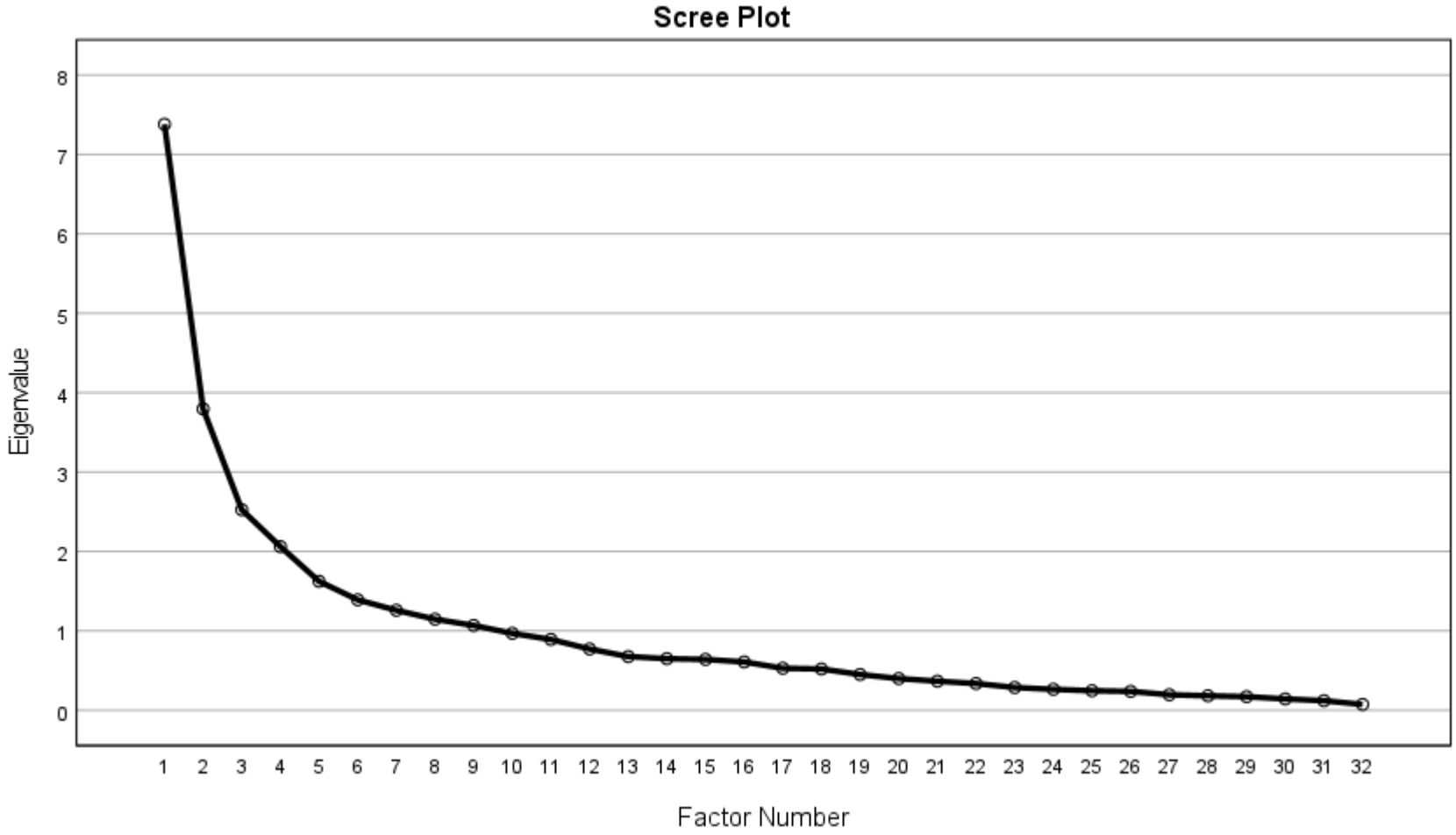
Wiley also helps authors measure the impact of their research through specialist partnerships with **Kudos** and **Altmetric.**

9. EDITORIAL OFFICE CONTACT DETAILS

Please email **JAN@wiley.com** .

Appendix 2-B

Factor Analysis Scree Plot

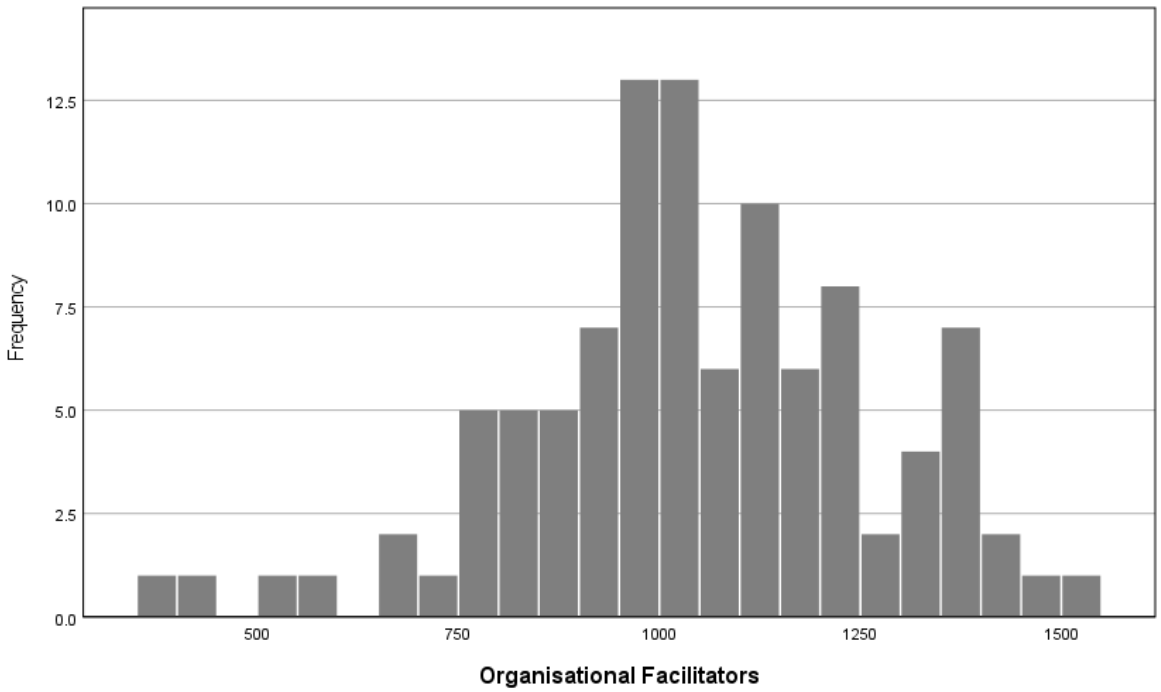


Appendix 2-C

Tests of Normality

Figure 1

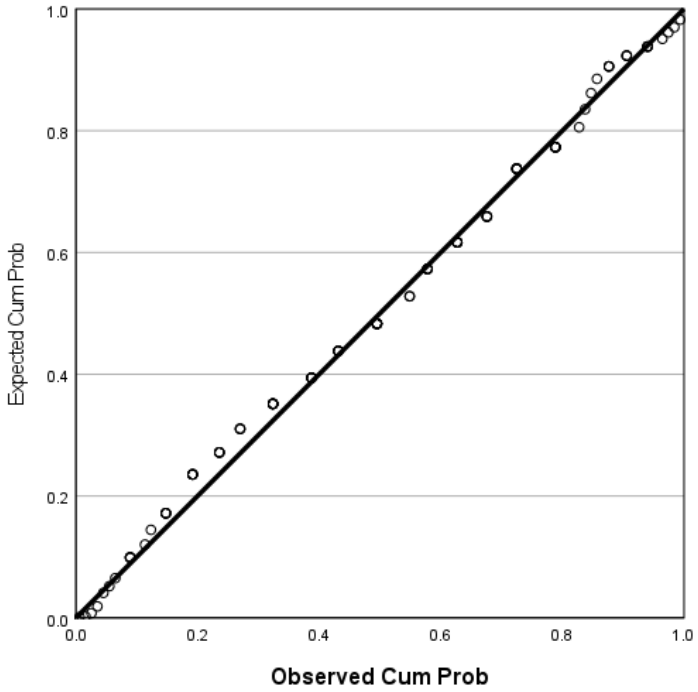
Histogram of Organisational Facilitators Scores



Note. Histogram depicting distribution of Organisational Facilitators subscale of the Workplace Stress measure scores.

Figure 2

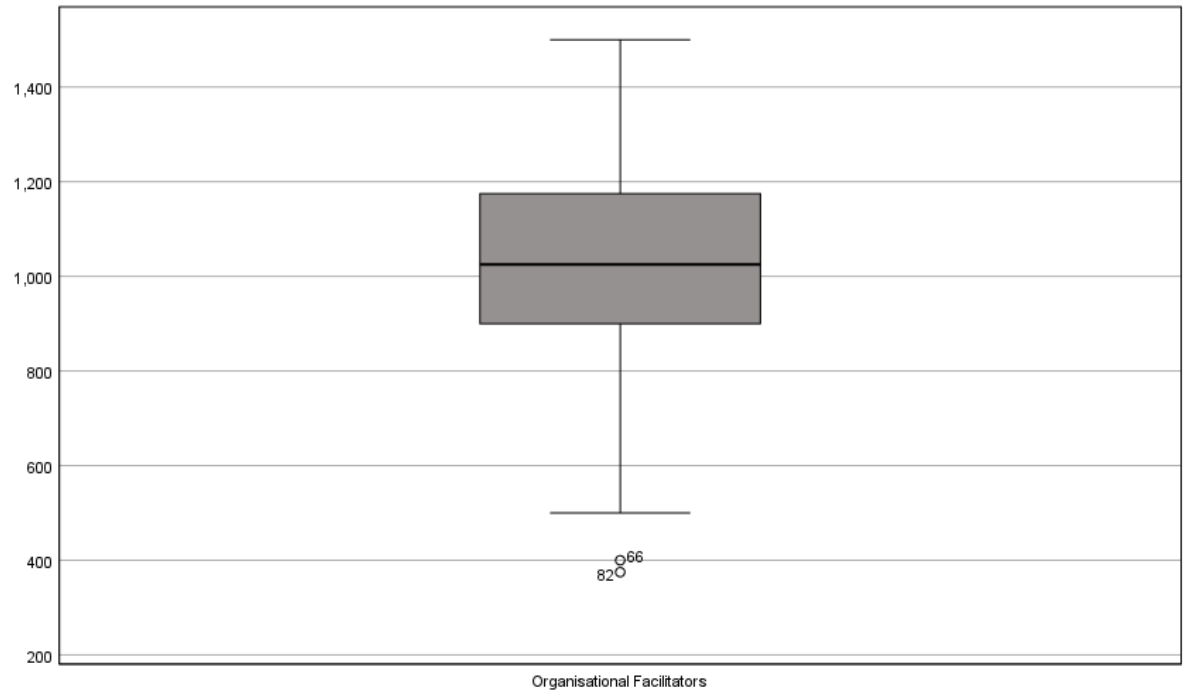
P-P Plot of Organisational Facilitators Scores



Note. P-P plot comparing observed Organisational Facilitators scores to expected scores.

Figure 3

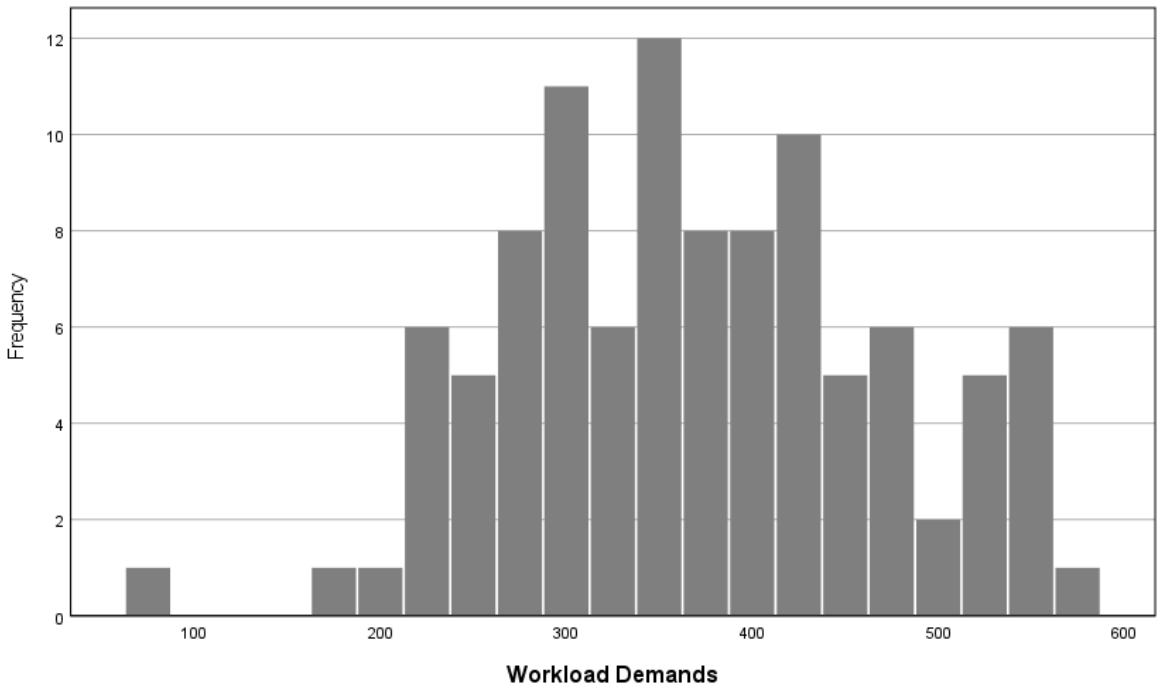
Box Plot of Organisational Facilitators Scores



Note. Box plot depicting shape of the distribution of Organisational Facilitators subscale scores, along with central value, variability, and outliers.

Figure 4

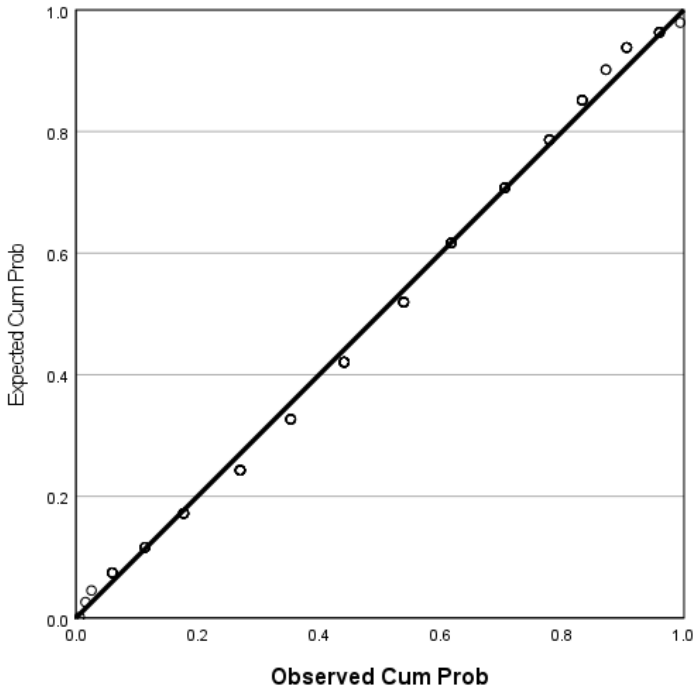
Histogram of Workload Demands Scores



Note. Histogram depicting distribution of Workload Demands subscale of the Workplace Stress measure scores.

Figure 5

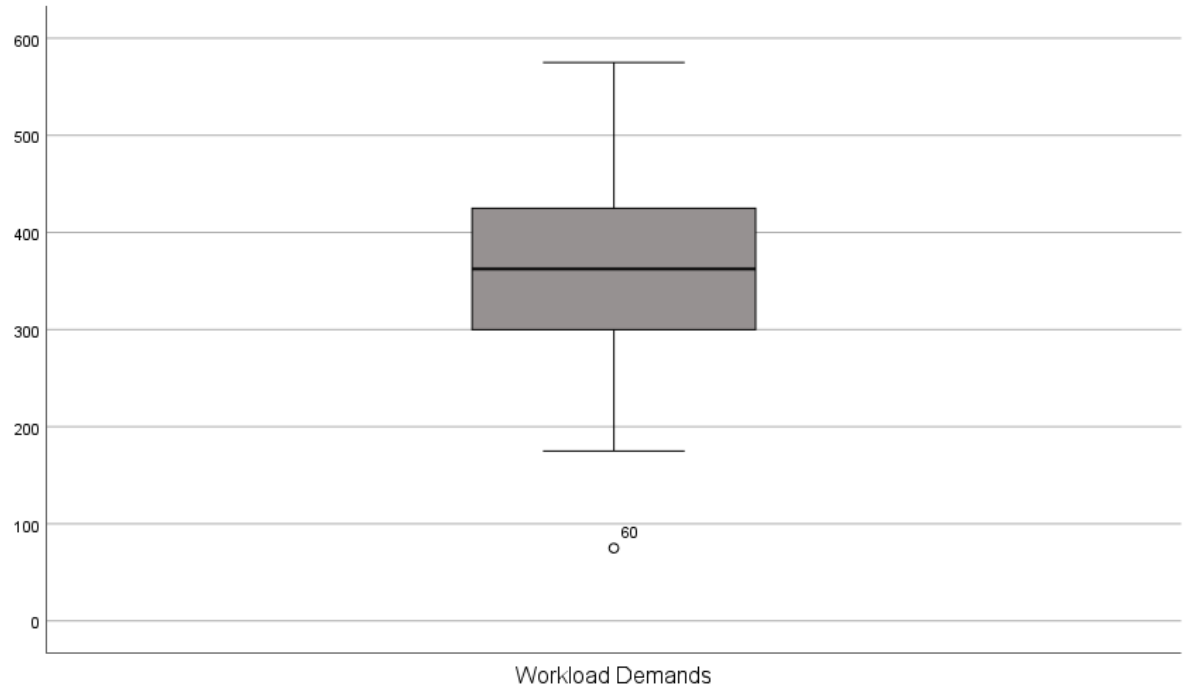
P-P Plot of Workload Demands Scores



Note. P-P plot comparing observed Workload Demands scores to expected scores.

Figure 6

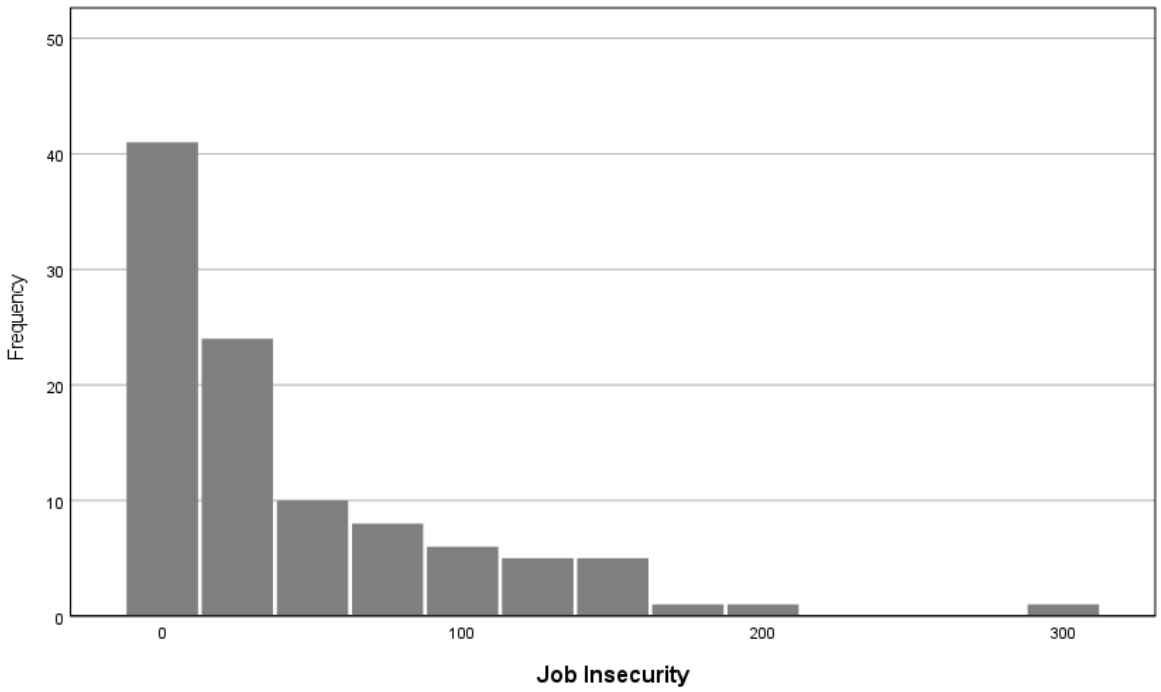
Box Plot of Workload Demands Scores



Note. Box plot depicting shape of the distribution of Workload Demands subscale scores, along with central value, variability, and outlier.

Figure 7

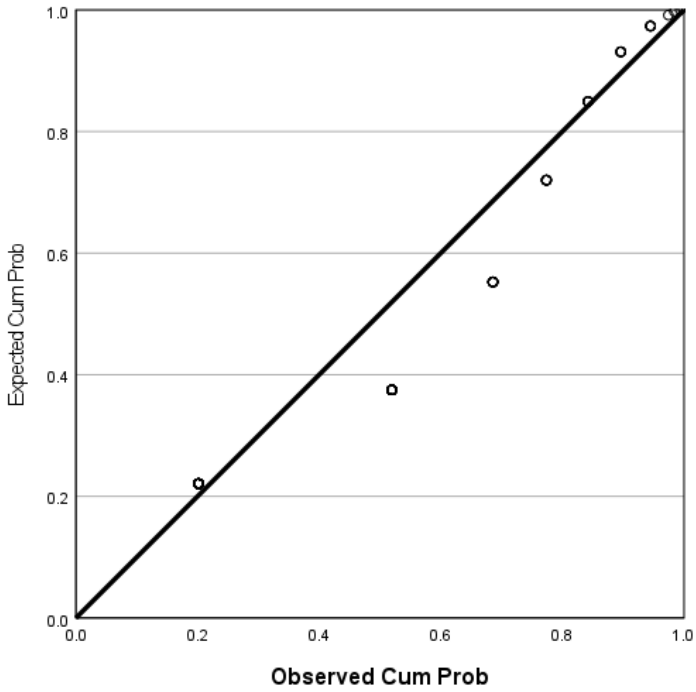
Histogram of Job Insecurity Scores



Note. Histogram depicting distribution of Job Insecurity subscale of the Workplace Stress measure scores.

Figure 8

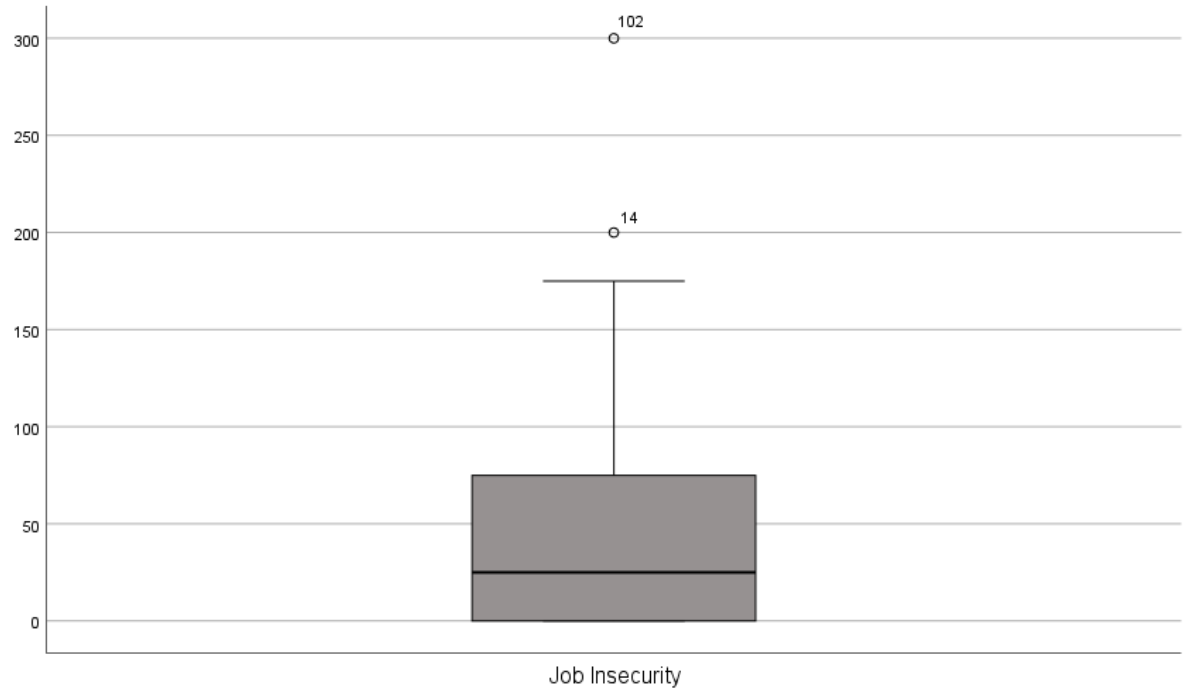
P-P Plot of Job Insecurity Scores



Note. P-P plot comparing observed Job Insecurity scores to expected scores.

Figure 9

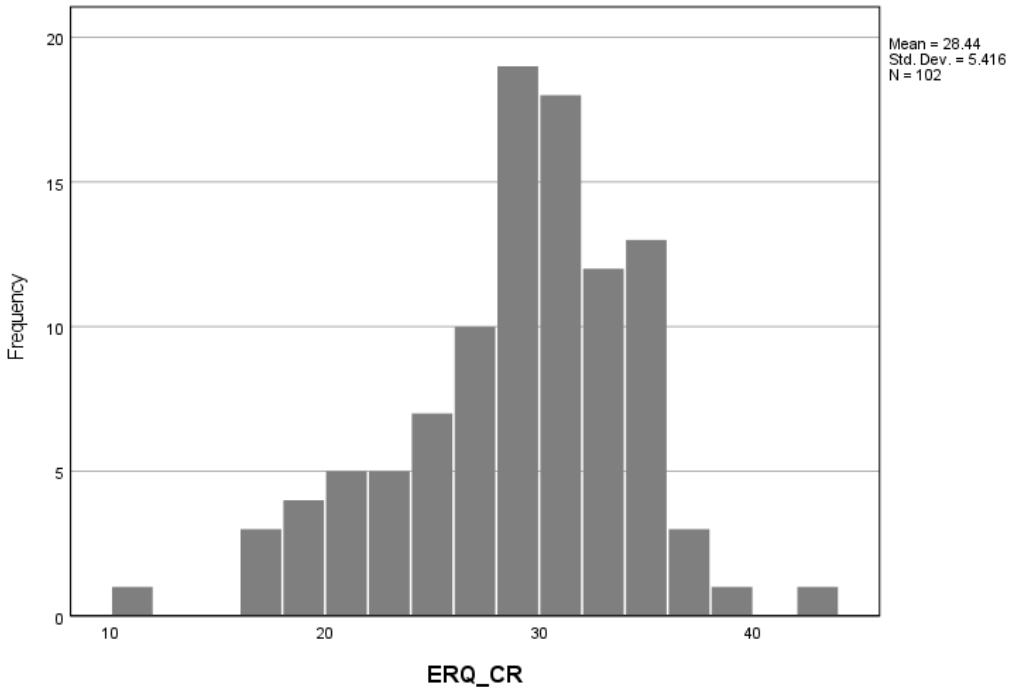
Box Plot of Job Insecurity Scores



Note. Box plot depicting shape of the distribution of the Job Insecurity subscale scores, along with central value, variability, and outliers.

Figure 10

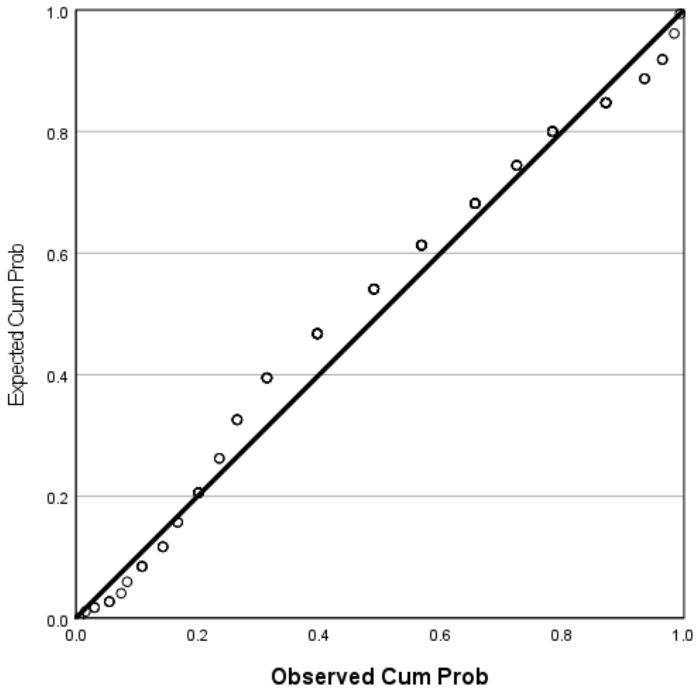
Histogram of ERQ Cognitive Reappraisal Scores



Note. Histogram depicting distribution of cognitive reappraisal facet of the Emotion Regulation Questionnaire scores.

Figure 11

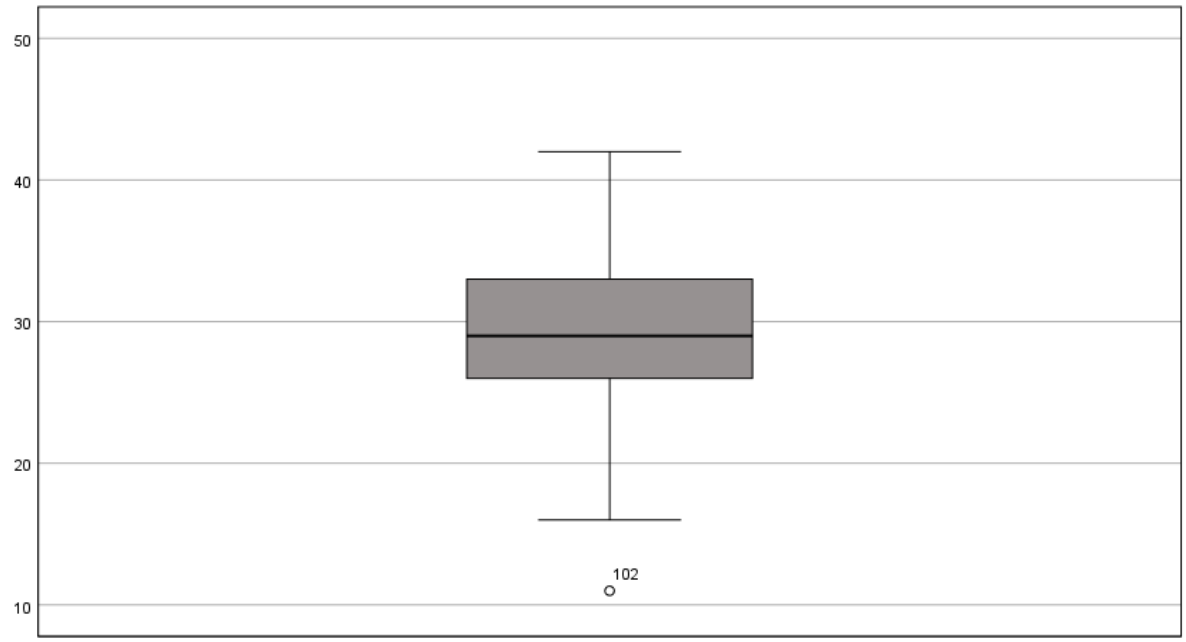
P-P Plot of ERQ Cognitive Reappraisal Scores



Note. P-P plot comparing observed Emotion Regulation Questionnaire cognitive reappraisal scores to expected scores.

Figure 12

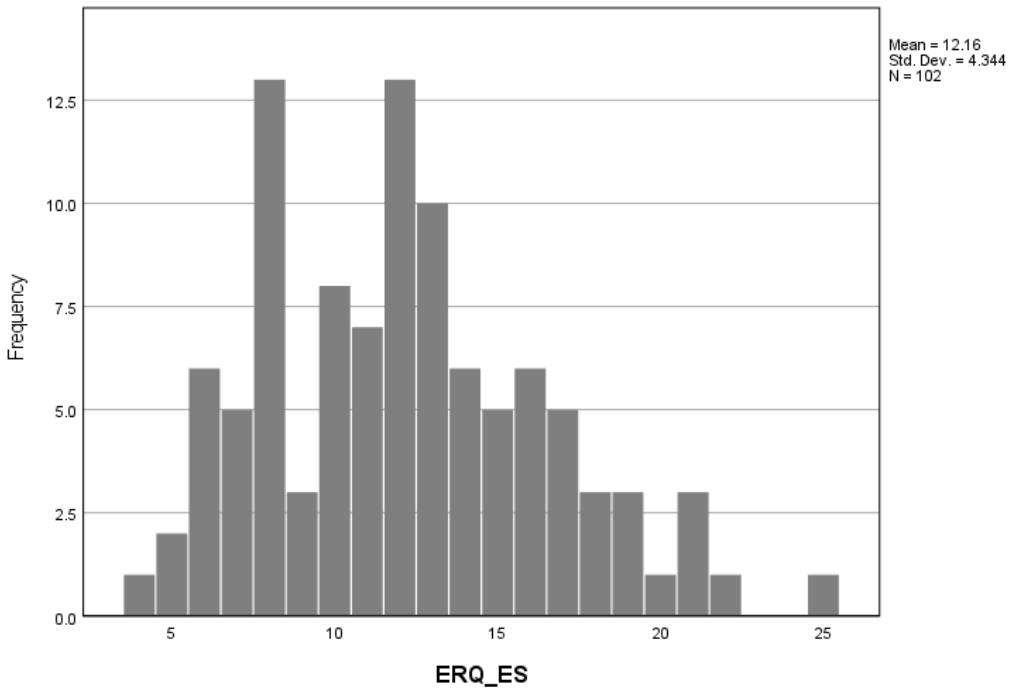
Box Plot of ERQ Cognitive Reappraisal Scores



Note. Box plot depicting shape of the distribution of cognitive reappraisal scores, along with central value, variability, and outlier.

Figure 13

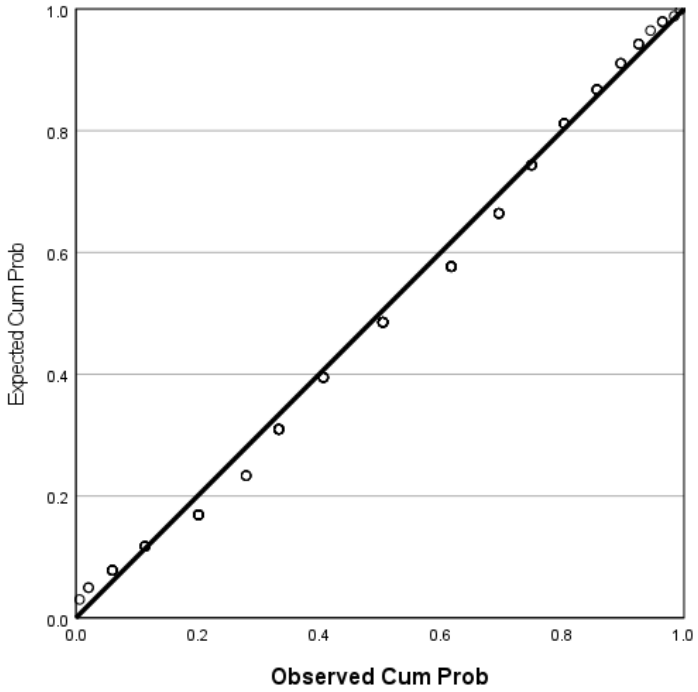
Histogram of ERQ Expressive Suppression Scores



Note. Histogram depicting distribution of expressive suppression facet of the Emotion Regulation Questionnaire scores.

Figure 14

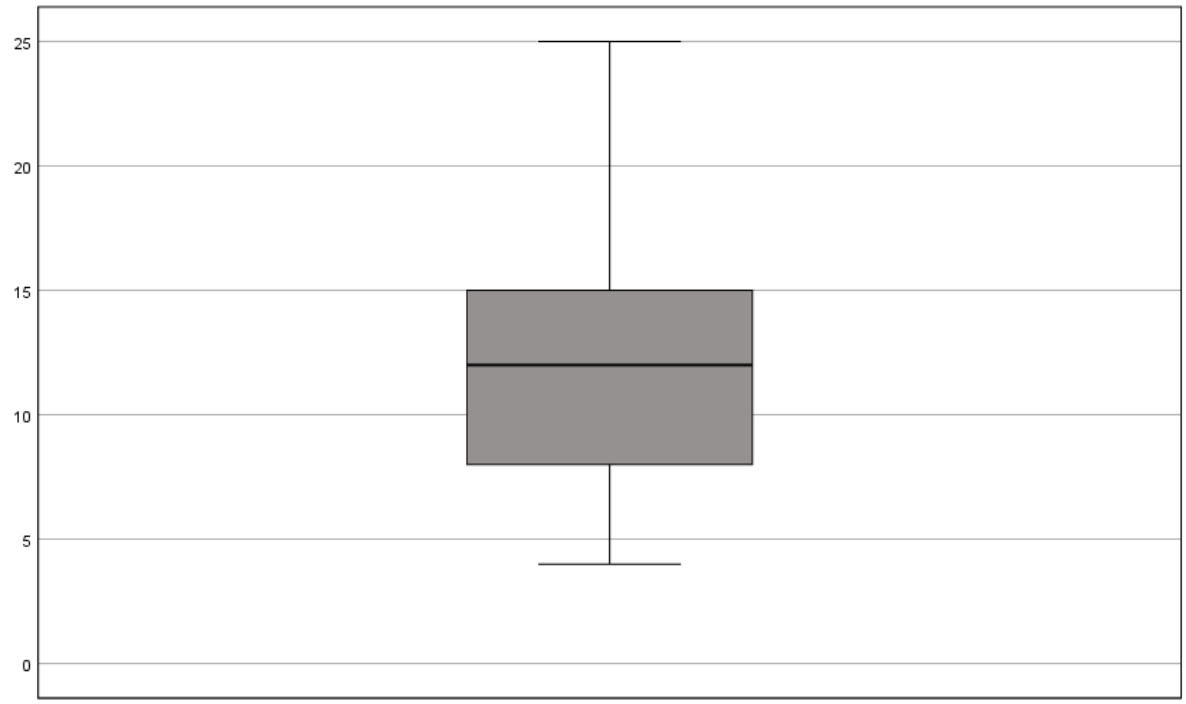
P-P Plot of ERQ Expressive Suppression Scores



Note. P-P plot comparing observed Emotion Regulation Questionnaire expressive suppression scores to expected scores.

Figure 15

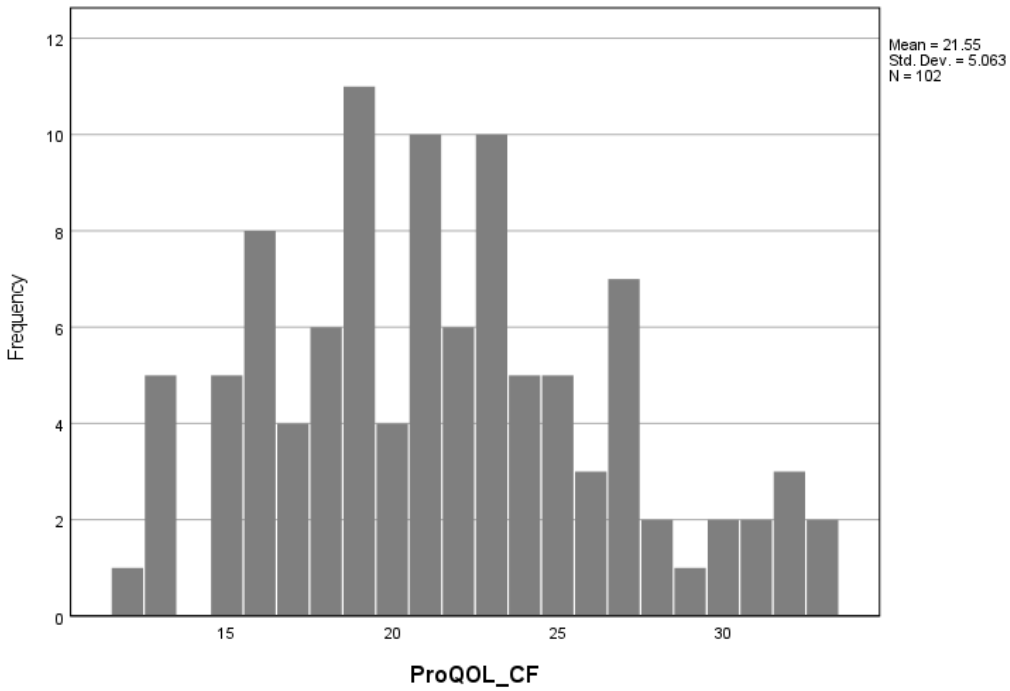
Box Plot of ERQ Expressive Suppression Scores



Note. Box plot depicting shape of the distribution of expressive suppression scores, along with central value and variability.

Figure 16

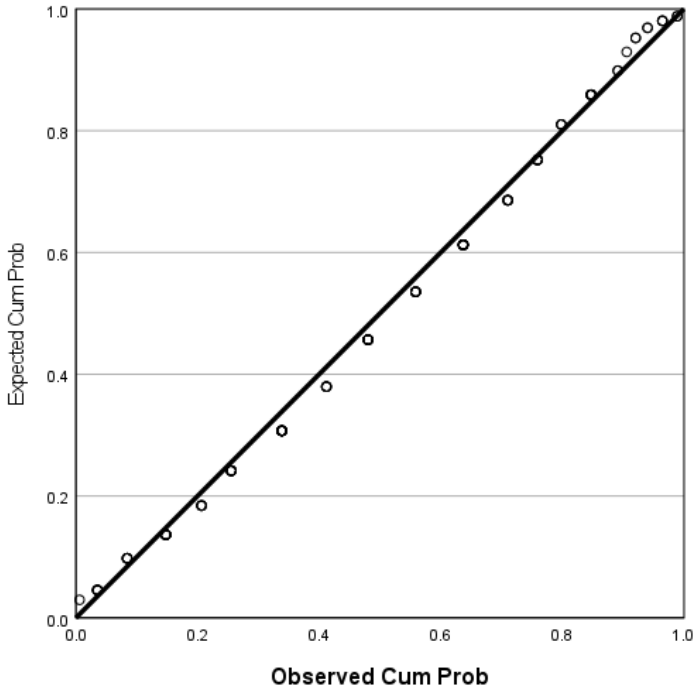
Histogram of ProQOL-21 Compassion Fatigue Scores



Note. Histogram depicting distribution of compassion fatigue subscale of the Professional Quality of Life scale scores.

Figure 17

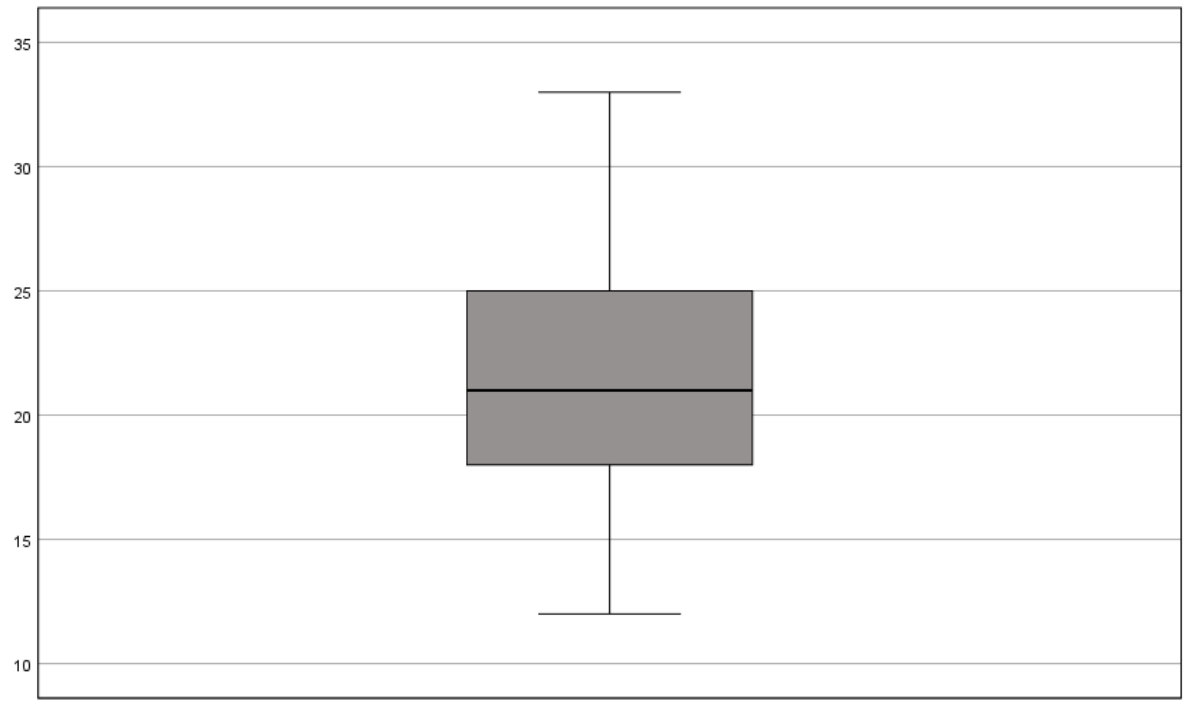
P-P Plot of ProQOL-21 Compassion Fatigue Scores



Note. P-P plot comparing observed compassion fatigue subscale of the Professional Quality of Life scale scores to expected scores.

Figure 18

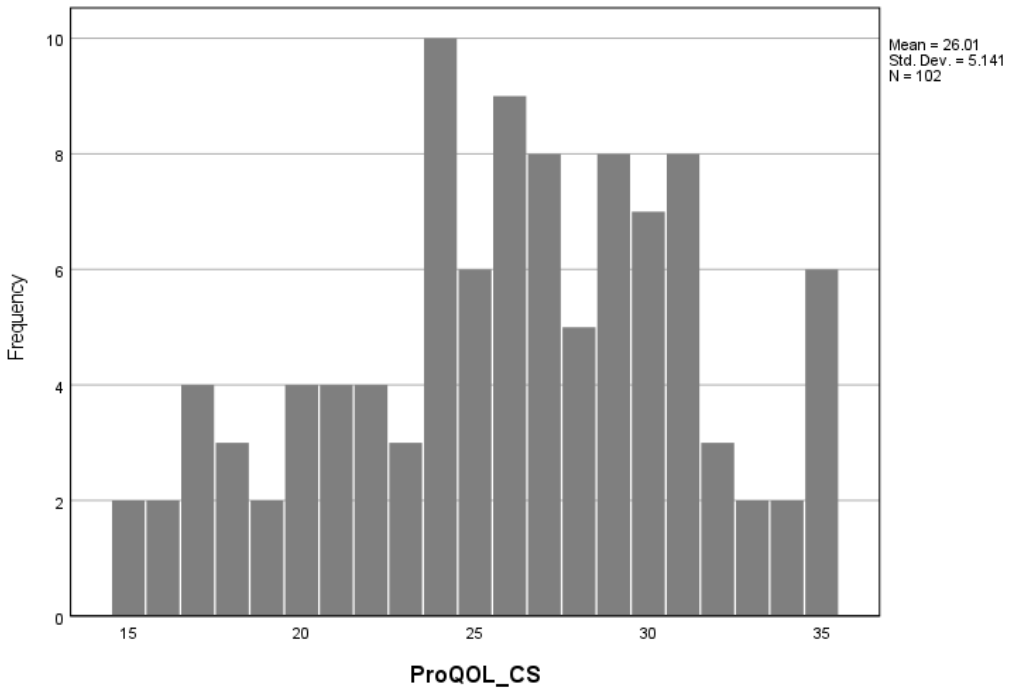
Box Plot of ProQOL-21 Compassion Fatigue Scores



Note. Box plot depicting shape of the distribution of compassion fatigue scores, along with central value and variability.

Figure 19

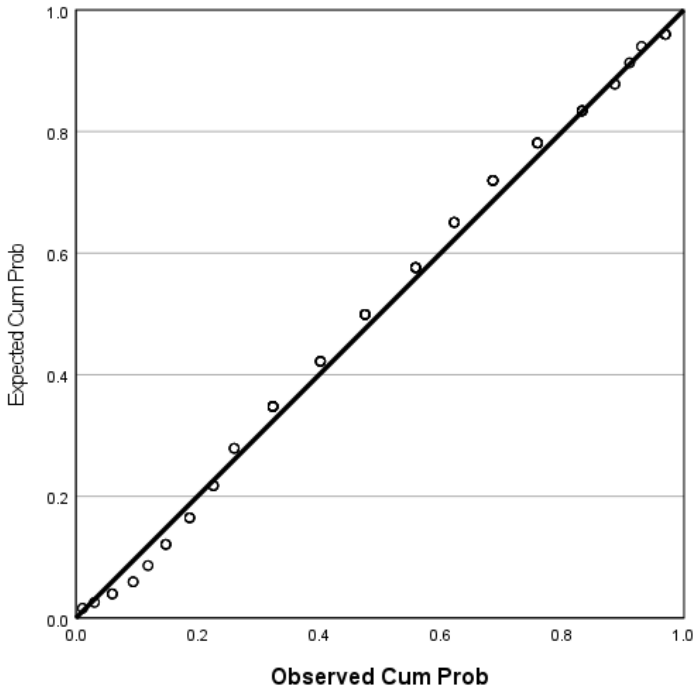
Histogram of ProQOL-21 Compassion Satisfaction Scores



Note. Histogram depicting distribution of compassion satisfaction subscale of the Professional Quality of Life scale scores.

Figure 20

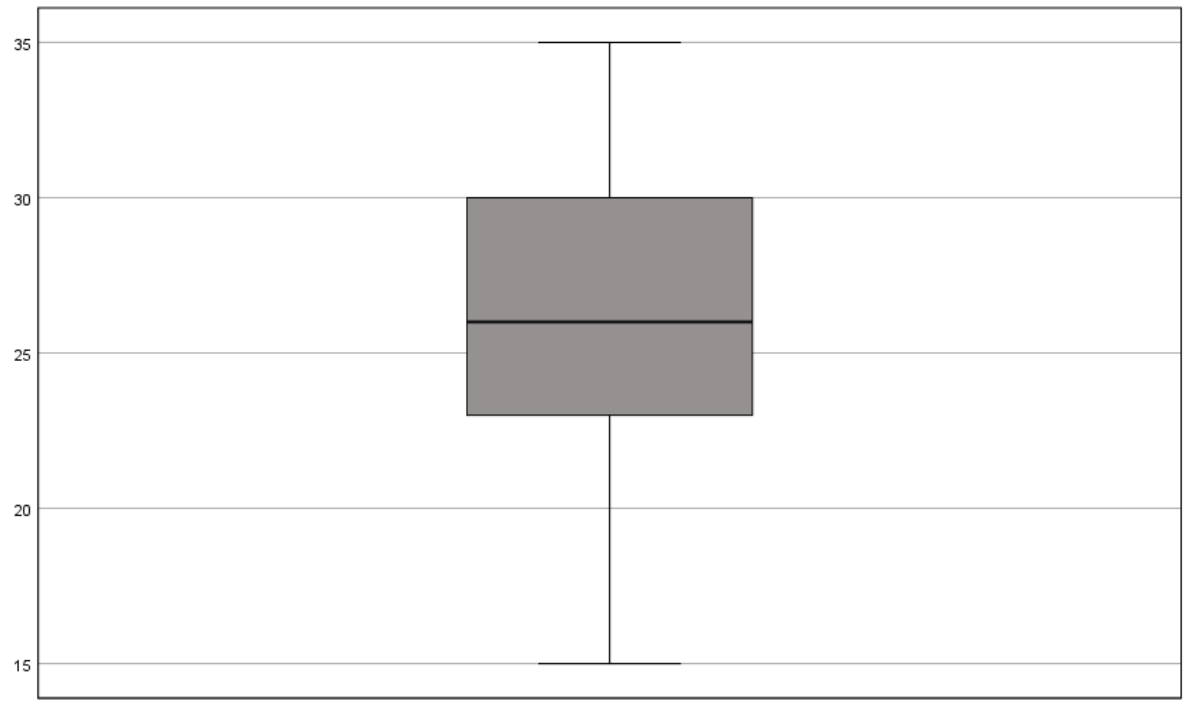
P-P Plot of ProQOL-21 Compassion Satisfaction Scores



Note. P-P plot comparing observed compassion satisfaction subscale of the Professional Quality of Life scale scores to expected scores.

Figure 21

Box Plot of ProQOL-21 Compassion Satisfaction Scores



Note. Box plot depicting shape of the distribution of compassion satisfaction scores, along with central value and variability.

Table 1

Distribution of Scores

Measure	Skewness		Kurtosis	
	Statistic	Std. Error	Statistic	Std. Error
Organisational Facilitators	-.392	.239	.502	.474
Workload Demands	.015	.239	-.313	.474
Job Insecurity	1.795	.239	4.027	.474
ERQ cognitive reappraisal	-.641	.239	.481	.474
ERQ expressive suppression	.465	.239	-.155	.474
ProQOL-21 compassion fatigue	.340	.239	-.435	.474
ProQOL-21 compassion satisfaction	-.239	.239	-.599	.474

Note. ERQ = Emotion Regulation Questionnaire; ProQOL-21 = Professional Quality of Life scale.

Table 2

Results of Statistical Tests of Normality

Measure	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Organisational Facilitators	.069	102	.200*	.979	102	.106
Workload Demands	.081	102	.099	.979	102	.105
Job Insecurity	.262	102	.000	.768	102	.000
ERQ cognitive reappraisal	.124	102	.001	.963	102	.006
ERQ expressive suppression	.095	102	.023	.973	102	.035
ProQOL-21 compassion fatigue	.085	102	.068	.975	102	.046
ProQOL-21 compassion satisfaction	.073	102	.200*	.974	102	.040

Note. ERQ = Emotion Regulation Questionnaire; ProQOL-21 = Professional Quality of Life scale.

a. Lilliefors Significance Correction.

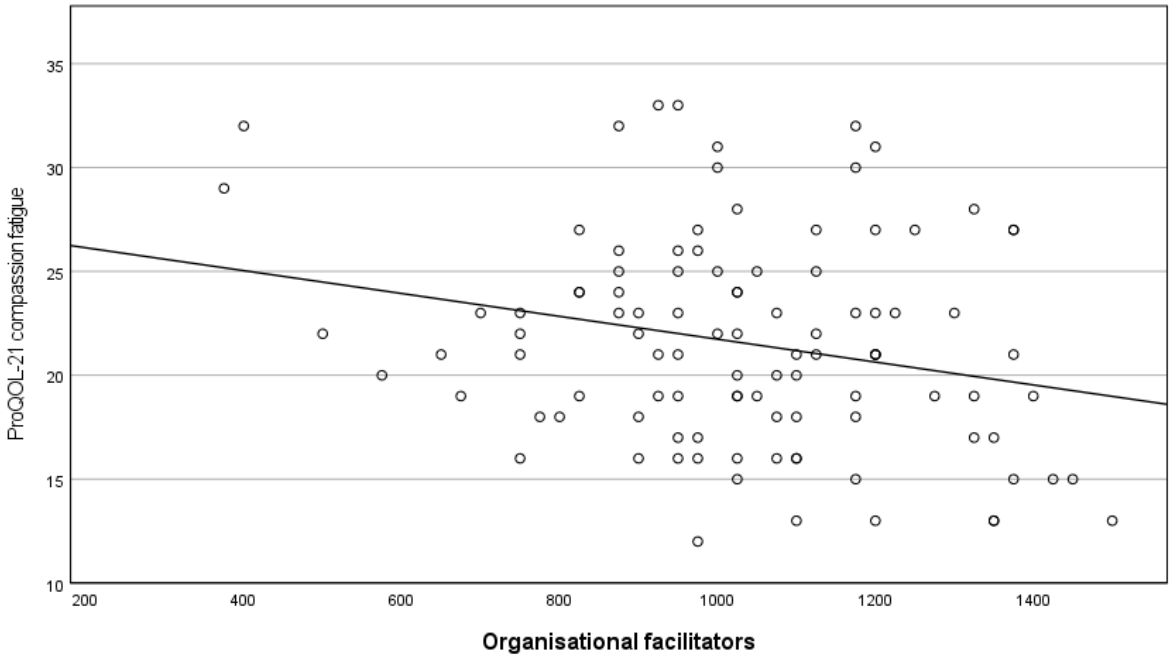
*. This is a lower bound of the true significance.

Appendix 2-D

Scatterplots of Significant Correlations

Figure 1

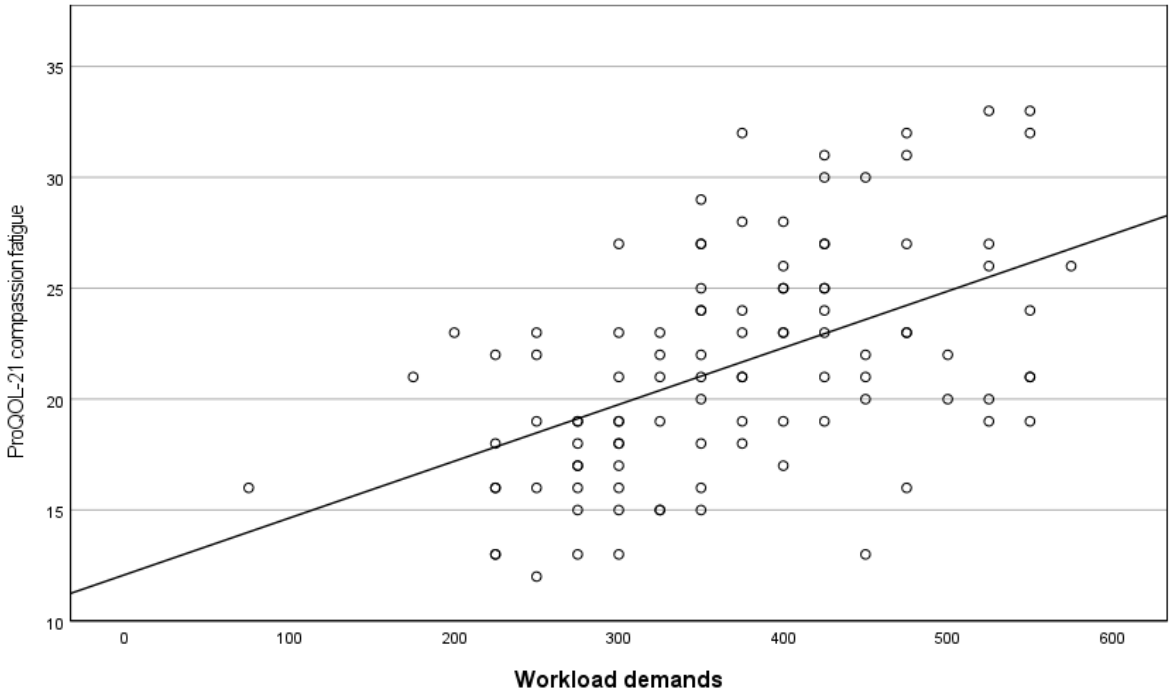
Scatterplot of the Relationship Between Organisational Facilitators and Compassion Fatigue



Note. This scatterplot depicts a significant negative association between scores on the organisational facilitators facet of workplace stress and scores on the compassion fatigue subscale of the Professional Quality of Life scale (ProQOL-21).

Figure 2

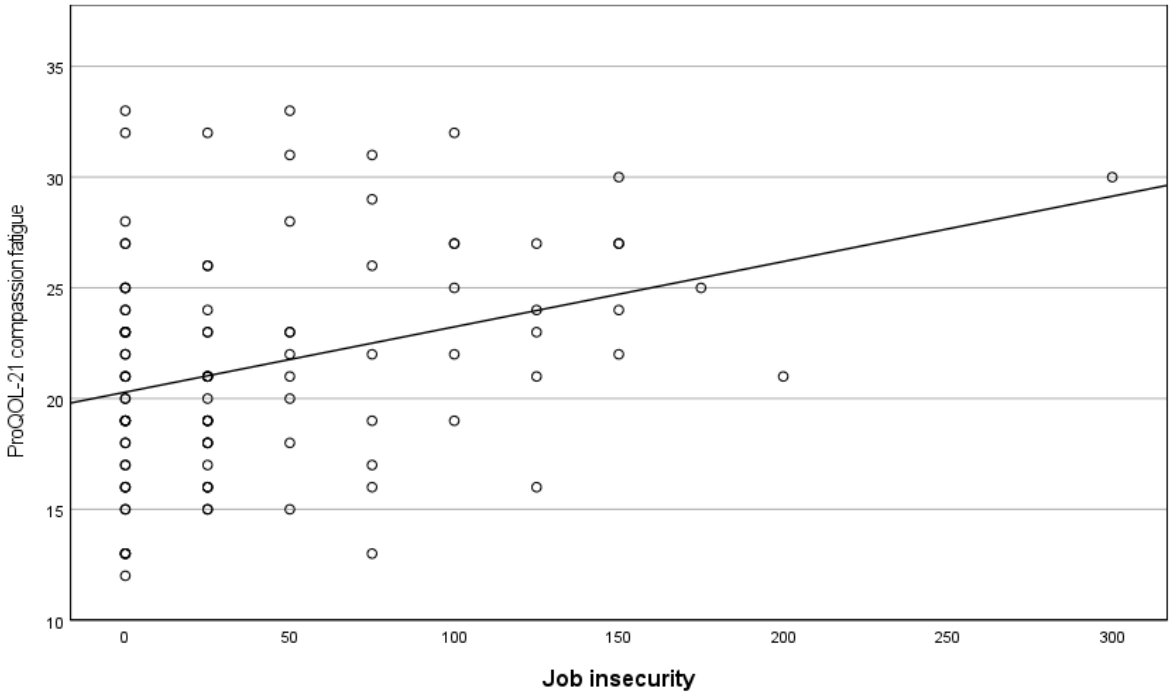
Scatterplot of the Relationship Between Workload Demands and Compassion Fatigue



Note. This scatterplot depicts a significant positive association between scores on the workload demands facet of workplace stress and scores on the compassion fatigue subscale of the Professional Quality of Life scale (ProQOL-21).

Figure 3

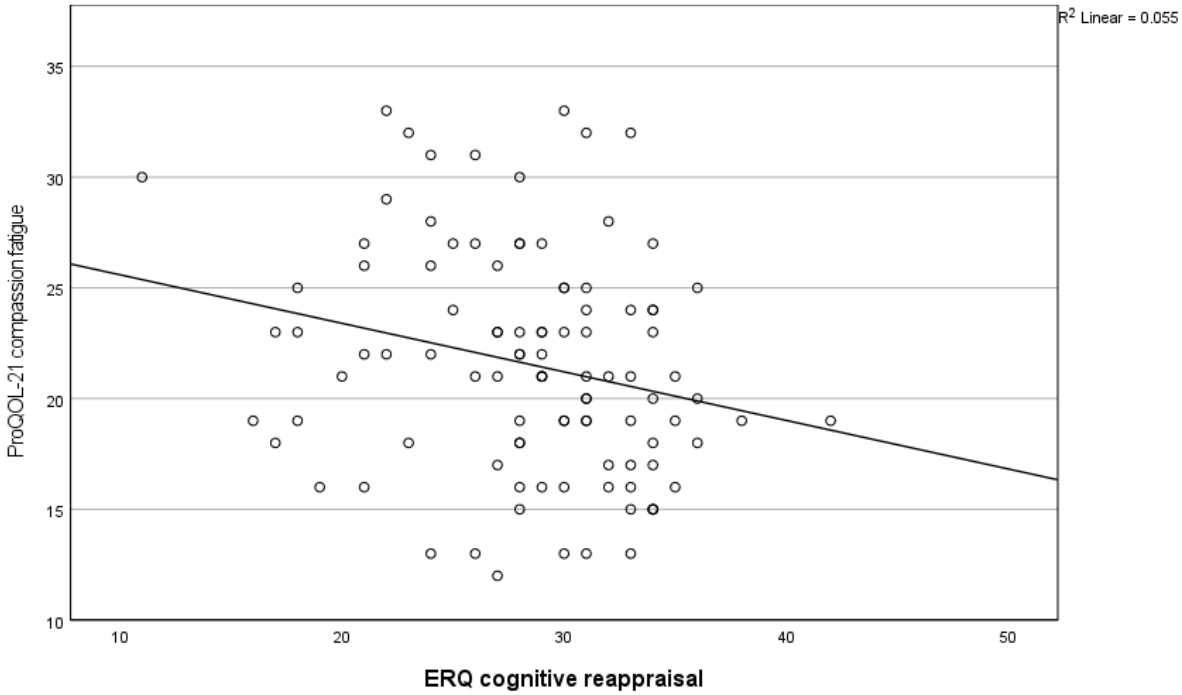
Scatterplot of the Relationship Between Job Insecurity and Compassion Fatigue



Note. This scatterplot depicts a significant positive association between scores on the job insecurity facet of workplace stress and scores on the compassion fatigue subscale of the Professional Quality of Life scale (ProQOL-21).

Figure 4

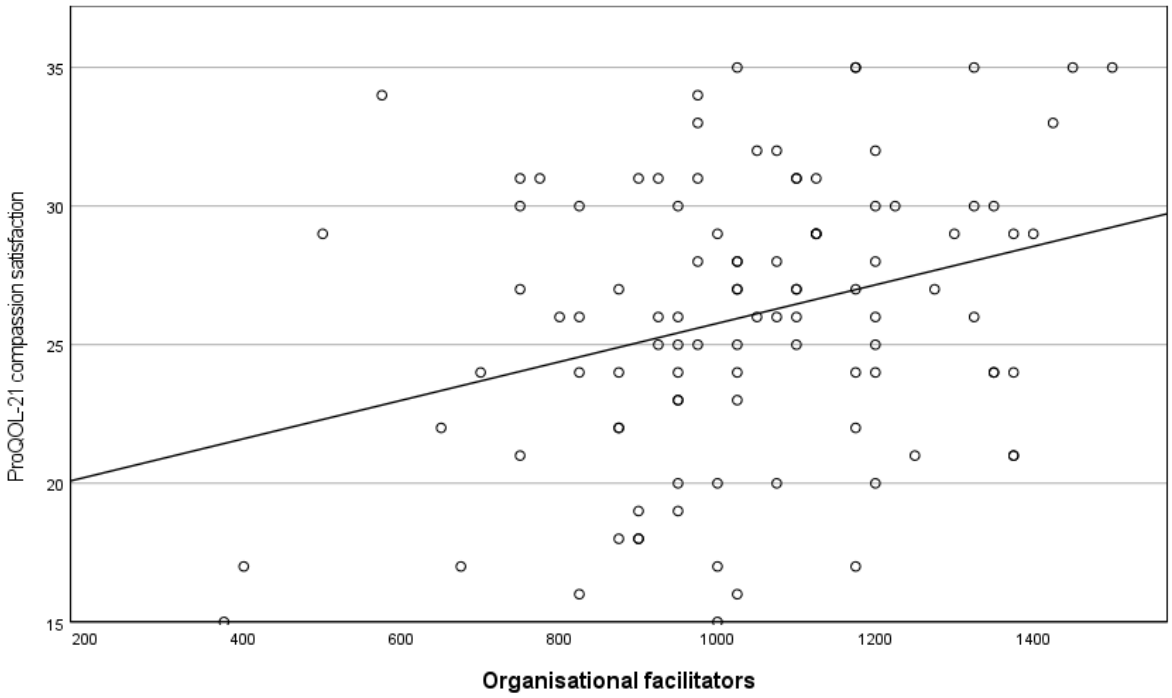
Scatterplot of the Relationship Between Cognitive Reappraisal and Compassion Fatigue



Note. This scatterplot depicts a significant negative association between scores on the cognitive reappraisal facet of the Emotion Regulation Questionnaire (ERQ) and scores on the compassion fatigue subscale of the Professional Quality of Life scale (ProQOL-21).

Figure 5

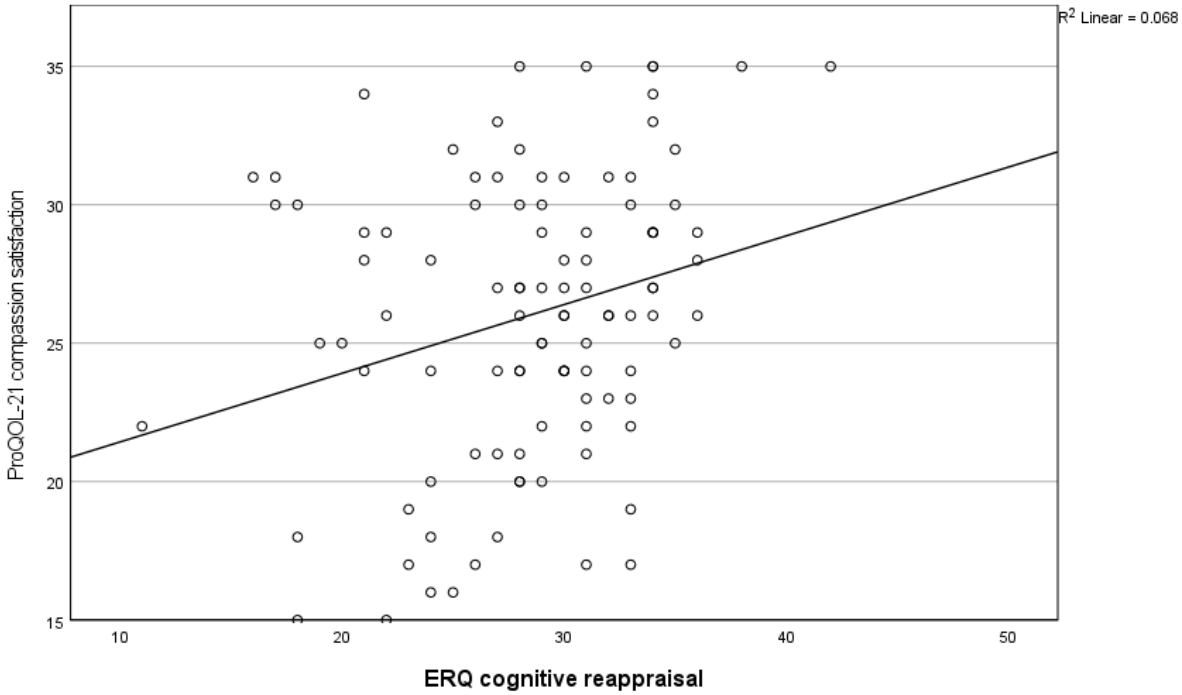
Scatterplot of the Relationship Between Organisational Facilitators and Compassion Satisfaction



Note. This scatterplot depicts a significant positive association between scores on the organisational facilitators facet of workplace stress and scores on the compassion satisfaction subscale of the Professional Quality of Life scale (ProQOL-21).

Figure 6

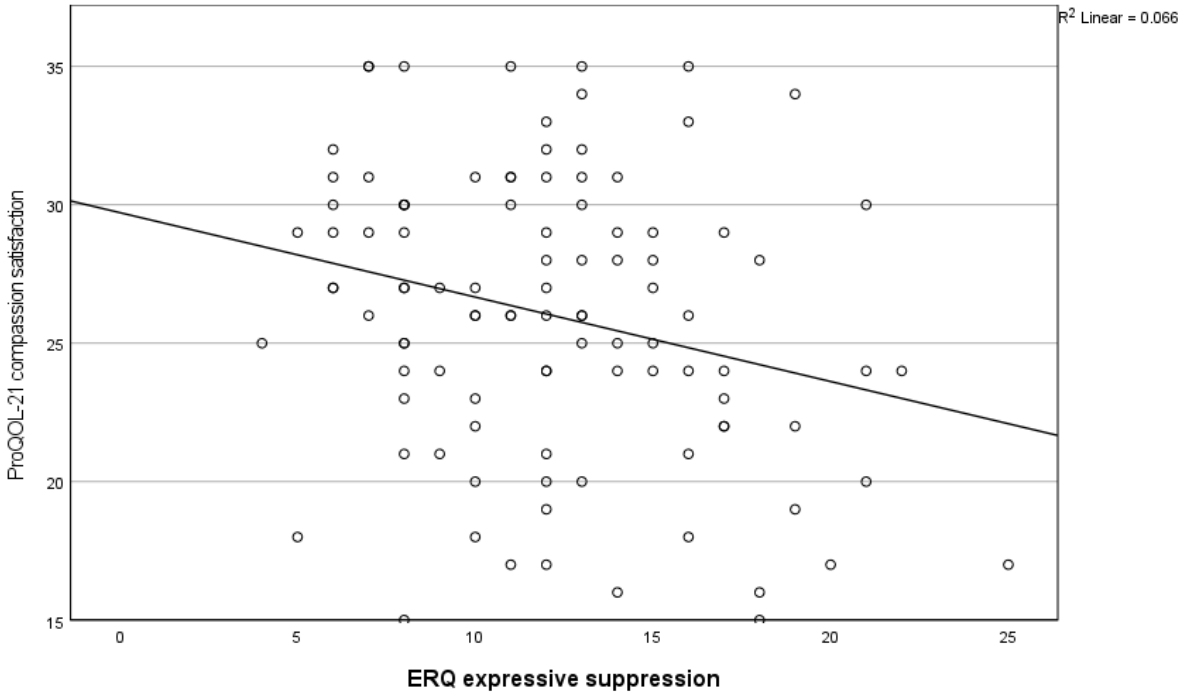
Scatterplot of the Relationship Between Cognitive Reappraisal and Compassion Satisfaction



Note. This scatterplot depicts a significant positive association between scores on the cognitive reappraisal facet of the Emotion Regulation Questionnaire (ERQ) and scores on the compassion satisfaction subscale of the Professional Quality of Life scale (ProQOL-21).

Figure 7

Scatterplot of the Relationship Between Expressive Suppression and Compassion Satisfaction



Note. This scatterplot depicts a significant negative association between scores on the expressive suppression facet of the Emotion Regulation Questionnaire (ERQ) and scores on the compassion satisfaction subscale of the Professional Quality of Life scale (ProQOL-21).

Section 3: Critical Appraisal

Emily Retkiewicz

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:

Emily Retkiewicz

Doctorate in Clinical Psychology

Faculty of Health and Medicine

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster

LA1 4AT

e.retkiewicz@lancaster.ac.uk

Introduction

This section of the thesis will offer a critical appraisal of the project. Firstly, a summary of the results of the literature review and empirical study will be presented to ground the remainder of this section. Next, I will explore my epistemological position and offer insights on how it affected the choice of methodologies employed in the literature review and empirical study. Following on from that discussion, I will offer some reflections on my motivations behind the choice of research area, along with a section on reflexivity. I will also discuss some considerations behind terminology used in both the literature review and empirical study. I will then move on to discuss the main challenges and limitations of the empirical study and will offer suggestions for areas of future research and clinical implications.

Summary of Findings

Findings from the literature review highlighted challenges healthcare professionals (HCPs) faced when working therapeutically with people diagnosed with eating disorders (EDs) during an inpatient admission. The overarching theme of "a delicate balance" showed that often HCPs faced polarised expectations from patients regarding how they should interact with them. The "treated as an anorexic" theme highlighted that patients preferred for HCPs to see them as individuals, instead of stereotyping them according to their diagnosis, while at the same time appreciating when HCPs used their knowledge and expertise of EDs to better understand patients' presentations and needs. The "us versus them" theme showed that patients were aware of the impact power differentials between them and HCPs had on their experience of, and recovery during their inpatient stay. Patients called for HCPs to engage in ways of reducing that power differential, while some expressed that having control taken away from them during their inpatient stay was beneficial. Finally, the theme "a good therapeutic relationship with inpatient staff is vital" highlighted the importance of HCPs continually monitoring and balancing the amount of professional support they offered patients. Furthermore, it was shown

that, due to the nature of an inpatient environment and HCPs' roles within it, it may be difficult for HCPs to be seen as "good enough" by patients and for HCPs to know how best to achieve this objective.

The results of the empirical study highlighted that some HCPs working with people diagnosed with EDs experienced "high" levels of compassion fatigue and "low" levels of compassion satisfaction. It was found that workload demands and job insecurity had the biggest influence on compassion fatigue. Expressive suppression was the only significant predictor of compassion satisfaction. Given that higher levels of compassion fatigue and lower levels of compassion satisfaction may lead to HCPs being less empathic and more irritable, or perhaps unintentionally dismissive towards patients, and can result in HCPs reducing their standards of care, it was considered important for services and managers to address factors influencing those concepts.

The overall project aimed to improve understanding of two aspects important to the care offered to people diagnosed with EDs: the therapeutic relationship and compassion. Together, the results of the literature review and empirical study highlighted facilitators and barriers to efficient care for people diagnosed with EDs. Good self-awareness, high levels of empathy, knowledge about EDs, and collaborative engagement with patients were shown to be beneficial to compassionate care in inpatient settings. Workload demands, job insecurity, and an increased use of the expressive suppression emotion regulation strategy had been shown to have an impact on compassionate care in HCPs working with people diagnosed with EDs across a variety of settings.

Epistemological Position

My experiences of clinical training and of conducting this thesis shaped my current epistemological position. During my undergraduate degree, research teaching was predominantly focused on quantitative methods and I had very little exposure to qualitative

approaches. Based on that, I developed an understanding that research in the area of psychology aimed to measure an objective "truth" (Park et al., 2020) and that only quantitative approaches allowed to objectively measure that "truth". Additionally, my clinical experience prior to the doctorate was largely in services that followed a medical model approach. Again, this prompted me to consider concepts such as diagnoses, as objective "realities" of people's experiences. Therefore, when I first started the doctorate, I would have described myself as leaning towards realism and positivism; that is, I would have broadly felt there is a "true reality" that can be discovered through theory-testing research (Park et al., 2020).

Throughout clinical training, I was frequently encouraged to consider relativist views. Furthermore, when I considered conducting a qualitative systematic review and a quantitative empirical study, this prompted me to re-evaluate my epistemological position. Even though qualitative research can align with positivism, quantitative methodology is more frequently associated with a positivist position (Park et al., 2020). I would now broadly describe myself as a critical realist. Critical realism offers an alternative to positivism and constructivism, but it also contains elements of both of those epistemological positions (Fletcher, 2017). Critical realism postulates there is a reality which is "real", but it is inevitably affected by our individual experiences and interpretations as researchers (Fletcher, 2017; Pilgrim, 2014; Roberts, 2014). This approach allows for the observation of causal relationships at an "empirical level" by utilising either an extensive or intensive type of data (Fletcher, 2017; Roberts, 2014). Extensive data can be statistical, as its purpose is to show trends, while intensive data is in-depth and interpretative (Fletcher, 2017). The literature review I conducted was an example of a critical realism approach to intensive data, while the empirical study utilised a methodology that aimed to explore extensive data. My personal views are that both approaches produced results that were affected by our experiences as human beings (i.e., at the "empirical level"). Completing questionnaires for the quantitative empirical study could have been affected by individual

participants' experiences and interpretations of the questions. Furthermore, my interpretations of the findings of the empirical study would have also been affected by my context and experiences and may have been interpreted slightly differently by another researcher.

Deciding on the Research Area

Since the inception of this project, one of the questions I was most frequently asked concerned my personal and professional motivations to conduct research in the areas of EDs and staff wellbeing. Therefore, it seems to be a pertinent topic to address in the critical appraisal section of the thesis. I have never worked in ED services or with people diagnosed with EDs, however someone close to me has struggled with their body image since adolescence. Research consistently shows that body dissatisfaction is a risk factor for the development of EDs (Beato-Fernández et al., 2004; Cooley & Toray, 2001; Gardner et al., 2000; Parkinson et al., 2012). Consequently, even though that person was never diagnosed with an ED, I became interested in the symptomatology and treatment of EDs. Through this interest, I learnt of the various barriers to recovery for people diagnosed with EDs, such as comorbid mental health diagnoses (Blinder et al., 2006; Grilo et al., 2009; Swinbourne et al., 2012) or ambivalence towards recovery (Eaton, 2020; Malson et al., 2011; Williams & Reid, 2010), which can be part of the illness trajectory itself. I also became aware of the impact these challenges may have on HCPs working with people diagnosed with EDs (Davey et al., 2014; Devery et al., 2018; Graham et al., 2020).

During my career in various mental health services, I became increasingly aware of additional challenges faced by HCPs of various professions, such as high workloads, complex client presentations, staffing issues, increasing amount of paperwork, or lack of resources (Barron et al., 2017; Brown et al., 2014; Edwards et al., 2000). These experiences piqued my interest in exploring staff wellbeing, particularly in relation to working with people diagnosed with EDs, due to the additional challenges reported in working with that client group. During

my job as a nursing assistant on an acute mental health ward I also observed how burnout and subsequent reduced capacity for compassion impacted on HCPs' interactions with patients. These experiences showed me the circularity of how complex client presentations and service-related challenges impact on staff wellbeing, which in turn can reinforce these factors. I hoped this project would shed some light on these processes and help identify strategies which could improve both staff wellbeing and client outcomes.

Reflexivity

Coming from a critical realism position, as this project addressed an area of interest, it was important for me to be aware of how any preconceived ideas could impact on the results (Palaganas et al., 2017; Pilgrim, 2014). This was particularly relevant for the literature review, which synthesised findings of qualitative studies. Given my experience of working on an acute mental health ward, my two predominant preconceptions were that patients would report more negative experiences of inpatient environments and of interactions with HCPs, with minimal mention of positive experiences or interactions. It was important I be aware of this while synthesising the results, to ensure notions of positive interactions were accurately reflected in the findings. As I started reading the 13 studies included in the literature review, I found myself drawn to the detailed descriptions of negative experiences. Having the awareness that my previous experience may be influencing what I tended to focus was helpful in enabling me to take a step back and consciously seek out counterarguments. This allowed for the development of a theme which focuses predominantly on the benefits of a good therapeutic relationship with HCPs and on positive experiences of patients' interactions with HCPs.

Reflections on Terminology

Through the development of this project and the process of writing it up, I started pondering on the use of the term "patients" to describe people diagnosed with EDs. Personally, I have had a fluctuating relationship with this term throughout my career. Having worked in

services with a medical model approach prior to clinical training, I rarely questioned the use of the term “patient”, as it was widely used by most HCPs in those services. Once I commenced my clinical training, and completed placements in various services, I became exposed to the debate around terminology in mental health services. I learnt that the term “patient” originally referred to people receiving medical care and has more recently been viewed by researchers and clients as implying a passive approach to receiving healthcare (Christmas & Sweeney, 2016; Flores-Sandoval et al., 2021; Lyon & Mortimer-Jones, 2020).

Coming from a critical realism position, I started criticising the idea of diagnoses as “real” constructs. Issues with validity and reliability of the diagnostic approach to mental health difficulties are widely recognised (Johnstone, 2018; Kinderman et al., 2013; Pilgrim, 2014). Furthermore, it is argued diagnostic approaches ignore or minimise the impact of psychosocial factors, such as poverty or unemployment, on understandable levels of distress (Kinderman et al., 2013). Nonetheless, I recognised diagnoses may have real implications for people with regard to observable “symptoms”, the type of treatment offered, the manner in which treatment is offered (in terms of it being voluntary or compulsory), and the impact of these factors on people (Pilgrim, 2014).

Having criticised the truth behind diagnoses as “real” concepts, I personally started to avoid the use of the term “patient” to describe people using mental health services. Instead, I started using the term “client”. However, as I started developing this project, it struck me how I may be alienating potential participants from non-psychology backgrounds who may not use the term “client” to describe people using their services. To improve the chances of recruiting participants from various professions, I made the decision to use the term “patients” in my recruitment poster. Furthermore, as I started writing up this thesis, I felt that using the term “clients”, particularly in relation to people admitted to inpatient settings, had the potential to sound incongruous with the dominant discourse in ED settings. Furthermore, using the term

"client" would have the potential to overlook real power dynamics in relationships with HCPs, especially in inpatient settings.

Some research indicates the term "patients" is preferred by people, over any other alternatives (Flores-Sandoval et al., 2021; Ritchie et al., 2000; Simmons et al., 2010). It is suggested that the term "patient" validates a person's mental health crisis (Lyon & Mortimer-Jones, 2020). A systematic review by Dickens and Picchioni (2012) noted that "patient" was identified as the preferred term in UK studies, while "client" was found to be the preferred term in studies conducted in the USA. This was replicated by Christmas and Sweeney (2016). McGuire-Snieckus et al. (2003) found that their participants had no preference between the terms "patient" and "client" when used by psychologists. Lyon and Mortimer-Jones (2020) found that the terms "individual" and "person with a mental illness" were most preferred by their participants, with the term "client" being considered acceptable by some. Given the evidence and the views of participants I decided to use the term "patients" when specifically referring to people using ED services, while I retained the term "client" in my own narrative. I also decided to use the term "people diagnosed with EDs" when referring to this group as a whole, as I feel it acknowledges individuality.

Reflections on the Research Paper

Recruitment of Participants

One of the main challenges of the empirical study was the recruitment of participants. This was particularly pertinent given that the research project explored factors such as workplace stress. It seemed somewhat paradoxical to ask participants to consider factors such as work demands and work pace, while potentially adding to those stressors by giving HCPs an additional task to complete. An a-priori power analysis identified that a minimum of 110 participants were required and the final sample fell short on that with 102 participants. It may be that higher levels of work demands and work pace prevented certain HCPs from being able

to participate in the study. Consequently, it may be that the levels of workplace stress identified in this study were not completely reflective of the experiences of all HCPs working with people diagnosed with EDs. Additionally, the recruitment for this study took place during the COVID-19 pandemic, and it may be that the additional challenges faced by HCPs working in ED services (discussed in more detail in the research paper section of this thesis; Branley-Bell & Talbot, 2020; Kniffin et al., 2021; Schlegl et al., 2020; Weissman et al., 2020) impacted both on HCPs' capacity to take part in the study and on the levels of workplace stress reported by those HCPs who were able to participate. Consequently, the results of this study may not be generalisable in the long-term once the impact of COVID-19 diminishes.

Additionally, the COVID-19 pandemic impacted on my ability to attend team meetings in person. Through prior discussions with my research supervisors, it was agreed that by going to team meetings I would be able to leave physical copies of the questionnaires for staff to complete and return later. This could have encouraged more HCPs to take part, as completing the study online involved the additional step of accessing the website. However, the pandemic also gave rise to increased virtual working (Kniffin et al., 2021), which allowed me to attend team meetings remotely in services that may not have been easily accessible to me in person. By speaking to certain teams through remote access, I was able to encourage potential participants to take part in the study. Having spoken to many service managers and teams, I consistently received the message that this research project was well-timed and relevant to HCPs working in ED services. On a personal level, this was heartening to hear and gave me hope that my study could have real-world implications. However, it was also saddening, as it highlighted that service managers and HCPs had real concerns about levels of workplace stress and capacity for compassion.

Another unexpected challenge involved in the recruitment of participants were the processes each National Health Service (NHS) trust had for approval of the study with their

Research and Development (R&D) departments. In the case of several R&D departments, these processes were straightforward. However, some R&D departments included additional procedures which were beyond my control, such as the local collaborator needing to complete training or the requirement for the study to be approved by other groups within the trust. Consequently, ED services from two NHS trusts that had expressed an interest in taking part in the study were unable to do so due to the processes not being completed before the end of recruitment. This impacted on recruitment and was also personally disappointing, as I had spent a lot of time on contacting these ED services, gaining their consent to take part in the study, and on commencing R&D procedures. In addition, it was disappointing to have to communicate to these services that they would not be able to participate in the study, after they had expressed significant interest.

The above challenge prompted me to reflect on qualified clinical psychologists' ability to partake in research as part of their clinical job roles. There is concern clinical psychologists face high levels of service demands, which leaves them with limited capacity to engage in research activity (Eke et al., 2012; Elphinston & Pager, 2015; Holttum & Goble, 2006; Ndukwe, 2011; Smith & Thew, 2017; Thomas et al., 2002). In this project, I devoted a significant amount of time on identifying ED services and their contact details, communicating with service managers and teams, and completing R&D processes, which could have been difficult for a clinical psychologist without dedicated research time. Despite the challenges associated with this project, I enjoyed completing the literature review and empirical study and would hope to continue being involved in research as a qualified clinical psychologist. The literature suggests that research activity being recognised as an integral part of the role of a clinical psychologist has an impact on the likelihood for psychologists to engage in conducting research (Holttum & Goble, 2006; Smith & Thew, 2017). Therefore, I was heartened to discover some services actively encourage clinicians to dedicate protected time to research

processes, such as preparing a doctoral thesis for publication (Ndukwe, 2011). It was also encouraging to learn there are factors within my control, such as finding a mentor, that increase the likelihood of engaging in research activity as a qualified clinical psychologist (Holttum & Goble, 2006).

Sample Characteristics

A limitation associated with the recruitment of participants were the characteristics of the final sample of participants. Given that the project was carried out as part of clinical psychology training and the field supervisor was a qualified clinical psychologist, it was perhaps unsurprising psychologists comprised nearly 40% of the sample. This is possibly not reflective of the staffing levels of typical ED services, which impacts on the generalisability of the findings. I attempted to employ a recruitment strategy that was inclusive of all HCPs working with people diagnosed with EDs. However, some of the recruitment strategies were specifically aimed at clinical psychologists. This limitation prompted me to reflect on the constraints of doctoral research. Smith and Thew (2017) highlighted that conducting research as a trainee clinical psychologist can often involve limited collaboration with other HCPs. Through this project, I recognised potential benefits of collaborating with other HCPs, such as improved knowledge and access to resources and recruitment avenues I had been unaware of.

Another noteworthy aspect of the sample characteristics was the inclusion of HCPs working in general mental health services. It may be that those HCPs had varied caseloads consisting of different presentations and that people with EDs were not highly represented in their caseloads. Furthermore, it may be that general mental health services did not experience some challenges common in ED services, or that they faced additional challenges that were not prevalent in ED services. Therefore, the inclusion of participants who only worked in general mental health services may have affected the results. However, it is important to note these HCPs accounted for approximately 6% of the sample. Furthermore, I ran t-test analyses which

revealed there were no significant differences on any of the variables between HCPs working in specialist ED services and those who worked in general mental health services, although these findings should be approached with caution due to the uneven sample sizes. Nevertheless, a possible solution may have been to exclude participants who did not work in specialist ED services, but I chose not to do so due to not having reached the minimum number of participants, as indicated by a-priori power analyses.

Directions for Future Research

Given the findings of this project, an interesting area of research may be to explore whether levels of compassion fatigue and compassion satisfaction in HCPs working with people diagnosed with EDs have an impact on their therapeutic relationship with patients. Such a study could involve utilising a measure of the therapeutic relationship, such as the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) and administering it to both HCPs and patients. Correlational analyses and multiple regressions could be applied to explore whether compassion fatigue and compassion satisfaction are predictors of a weak or strong therapeutic relationship. This would also allow for comparisons between HCPs' and patients' ratings of the therapeutic relationship.

It may also be interesting to explore HCPs' views on different strategies for managing workplace stress and compassion fatigue when working with people diagnosed with EDs. Individual interviews or focus groups could be held and participants could be asked questions with regard to their understanding of workplace stress and compassion fatigue, along with questions concerning the perceived impact of those phenomena, and staffs' strategies for managing them. An Interpretative Phenomenological Analysis (IPA; Smith et al., 2009) could be used to analyse the data. This would potentially generate a more in-depth understanding of the impact of workplace stress and compassion fatigue specifically on HCPs working in ED

services. Furthermore, such a study may generate additional variables, which could enhance our understanding of predictors of compassion fatigue.

Clinical Implications

The results of this project highlighted multiple challenges HCPs working in ED services faced in creating positive therapeutic relationships with their clients and in maintaining their emotional wellbeing at work. Given the influence of workload demands and job insecurity on compassion fatigue in HCPs, it is vital service managers and supervisors explore what contributed to these factors and attempt to mitigate them. This project noted the benefits of HCPs engaging in activities such as clinical supervision, reflective groups, team formulation, and psychologically oriented training. Therefore, it is recommended service managers and supervisors prioritise these activities and ensure HCPs have protected time to engage in them.

On a more personal level, as I am approaching entering the workforce as a qualified clinical psychologist, the outcomes of this project encouraged me to consider how I can support future colleagues. Self-awareness and the ability to safely express emotions were highlighted as important factors to HCPs' wellbeing and their relationships with clients. I intend to model these qualities in my interactions with future colleagues and work with them to ensure they have protected avenues to nurture and develop them.

Conclusion

To conclude, this critical appraisal explored some challenges and considerations that arose through the completion and write up of my thesis. Overall, this project contributed to the evidence base by highlighting the views of people diagnosed with EDs on their experiences of interactions with HCPs while admitted for inpatient treatment and emphasising the impact of workplace stress factors and expressive suppression on compassion fatigue and compassion satisfaction in HCPs working with people diagnosed with EDs. Completing this project allowed me to explore and strengthen my epistemological position. This in turn encouraged me to

approach concepts, such as terminology used in mental health services and research, with a critical perspective. Furthermore, the challenges that arose from this project prompted me to reflect on clinical psychologists' capacity to engage in research once qualified. I am aiming to continue engaging in research in the future and I hope I can keep a focus on staff wellbeing, which is important in itself, but also impacts on our clients.

References

Barron, K., Deery, R., & Sloan, G. (2017). Community mental health nurses' and compassion: An interpretative approach. *Journal of Psychiatric and Mental Health Nursing*, *24*(4), 211-220. https://doi.org/10.1111/jpm.12379

Beato-Fernández, L., Rodríguez-Cano, T., Belmonte-Llario, A., & Martínez-Delgado, C. (2004). Risk factors for eating disorders in adolescents. *European Child & Adolescent Psychiatry*, *13*(5), 287-294. https://doi.org/10.1007/s00787-004-0407-x

Blinder, B. J., Cumella, E. J., & Sanathara, V. A. (2006). Psychiatric comorbidities of female inpatients with eating disorders. *Psychosomatic Medicine*, *68*(3), 454-462. https://doi.org/10.1097/01.psy.0000221254.77675.f5

Branley-Bell, D., & Talbot, C. V. (2020). Exploring the impact of the COVID-19 pandemic and UK lockdown on individuals with experience of eating disorders. *Journal of Eating Disorders, 8*, 44. https://doi.org/10.1186/s40337-020-00319-y

Brown, B., Crawford, P., Gilbert, P., Gilbert, J., & Gale, C. (2014). Practical compassions: Repertoires of practice and compassion talk in acute mental healthcare. *Sociology of Health & Illness, 36*(3), 383-399. https://doi.org/10.1111/1467-9566.12065

Christmas, D. M. B., & Sweeney, A. (2016). Service user, patient, survivor or client … has the time come to return to 'patient'? *British Journal of Psychiatry*, *209*(1), 9-13. https://doi.org/10.1192/bjp.bp.115.167221

Cooley, E., & Toray, T. (2001). Body image and personality predictors of eating disorder symptoms during the college years. *International Journal of Eating Disorders*, *30*(1), 28-36. https://doi.org/10.1002/eat.1051

Davey, A., Arcelus, J., & Munir, F. (2014). Work demands, social support, and job satisfaction in eating disorder inpatient settings: A qualitative study. *International Journal of Mental Health Nursing*, *23*(1), 60-68. https://doi.org/10.1111/inm.12014

Devery, H., Scanlan, J. N., & Ross, J. (2018). Factors associated with professional identity, job satisfaction and burnout for occupational therapists working in eating disorders: A mixed methods study. *Australian Occupational Therapy Journal*, *65*(6), 523-532. https://doi.org/10.1111/1440-1630.12503

Dickens, G., & Picchioni, M. (2012). A systematic review of the terms used to refer to people who use mental health services: User perspectives. *International Journal of Social Psychiatry*, *58*(2), 115-122. https://doi.org/10.1177/0020764010392066

Eaton, C. M. (2020). Eating disorder recovery: A metaethnography. *Journal of the American Psychiatric Nurses Association*, *26*(4), 373-388. https://doi.org/10.1177/1078390319849106

Edwards, D., Burnard, P., Coyle, D., Fothergill, A., & Hannigan, B. (2000). Stress and burnout in community mental health nursing: A review of the literature. *Journal of Psychiatric and Mental Health Nursing*, *7*(1), 7-14. https://doi.org/10.1046/j.1365-2850.2000.00258.x

Eke, G., Holttum, S., & Hayward, M. (2012). Testing a model of research intention among U.K. clinical psychologists: A logistic regression analysis. *Journal of Clinical Psychology*, *68*(3), 263-278. https://doi.org/10.1002/jclp.20860

Elphinston, R. A., & Pager, S. (2015). Untapped potential: Psychologists leading research in clinical practice. *Australian Psychologist*, *50*(2), 115-121. https://doi.org/10.1111/ap.12102

Fletcher, A. J. (2017). Applying critical realism in qualitative research: Methodology meets method. *International Journal of Social Research Methodology*, *20*(2), 181-194. https://doi.org/10.1080/13645579.2016.1144401

Flores-Sandoval, C., Sibbald, S., Ryan, B. L., & Orange, J. B. (2021). Healthcare teams and patient-related terminology: A review of concepts and uses. *Scandinavian Journal of Caring Sciences*, *35*(1), 55-66. https://doi.org/10.1111/scs.12843

Gardner, R. M., Stark, K., Friedman, B. N., & Jackson, N. A. (2000). Predictors of eating disorder scores in children ages 6 through 14: A longitudinal study. *Journal of Psychosomatic Research*, *49*(3), 199-205. https://doi.org/10.1016/S0022-3999(00)00172-0

Graham, M. R., Tierney, S., Chisholm, A., & Fox, J. R. E. (2020). The lived experience of working with people with eating disorders: A meta-ethnography. *International Journal of Eating Disorders*, *53*(3), 422-441. https://doi.org/10.1002/eat.23215

Grilo, C. M., White, M. A., & Masheb, R. M. (2009). DSM-IV psychiatric disorder comorbidity and its correlates in binge eating disorder. *International Journal of Eating Disorders, 42*(3), 228-234. https://doi.org/10.1002/eat.20599

Holttum, S., & Goble, L. (2006). Factors influencing levels of research activity in clinical psychologists: A new model. *Clinical Psychology & Psychotherapy*, *13*(5), 339-351. https://doi.org/10.1002/cpp.501

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology*, *36*(2), 223-233. https://doi.org/10.1037/0022-0167.36.2.223

Johnstone, L. (2018). Psychological formulation as an alternative to psychiatric diagnosis. *Journal of Humanistic Psychology*, *58*(1), 30-46. https://doi.org/10.1177/0022167817722230

Kinderman, P., Read, J., Moncrieff, J., & Bentall, R. P. (2013). Drop the language of disorder. *Evidence-Based Mental Health*, *16*(1), 2-3. https://doi.org/10.1136/eb-2012-100987

Kniffin, K. M., Narayanan, J., Anseel, F., Antonakis, J., Ashford, S. P., Bakker, A. B., Bamberger, P., Bapuji, H., Bhave, D. P., Choi, V. K., Creary, S. J., Demerouti, E., Flynn, F. J., Gelfand, M. J., Greer, L. L., Johns, G., Kesebir, S., Klein, P. G., Lee, S. Y., . . . van Vugt, M. (2021). COVID-19 and the workplace: Implications, issues, and

insights for future research and action. *American Psychologist, 76*(1), 63-77. https://doi.org/10.1037/amp0000716

Lyon, A. S., & Mortimer-Jones, S. M. (2020). Terminology preferences in mental health. *Issues in Mental Health Nursing, 41*(6), 515-524. https://doi.org/10.1080/01612840.2020.1719248

Malson, H., Bailey, L., Clarke, S., Treasure, J., Anderson, G., & Kohn, M. (2011). Un/imaginable future selves: A discourse analysis of in-patients' talk about recovery from an 'eating disorder'. *European Eating Disorders Review, 19*(1), 25-36. https://doi.org/10.1002/erv.1011

McGuire-Snieckus, R., McCabe, R., & Priebe, S. (2003). Patient, client or service user? A survey of patient preferences of dress and address of six mental health professions. *Psychiatric Bulletin, 27*(8), 305-308. https://doi.org/10.1192/pb.27.8.305

Ndukwe, N. (2011). Research and publication: Reflections on the research writing process during clinical psychology training and on writing for publication once qualified. *Reflective Practice, 12*(1), 139-143. https://doi.org/10.1080/14623943.2011.541101

Palaganas, E. C., Sanchez, M. C., Molintas, V. P., & Caricativo, R. D. (2017). Reflexivity in qualitative research: A journey of learning. *Qualitative Report, 22*(2), 426-438. https://doi.org/10.46743/2160-3715/2017.2552

Park, Y. S., Konge, L., & Artino, A. R. (2020). The positivism paradigm of research. *Academic Medicine, 95*(5), 690-694. https://doi.org/10.1097/ACM.0000000000003093

Parkinson, K. N., Drewett, R. F., Le Couteur, A. S., & Adamson, A. J. (2012). Earlier predictors of eating disorder symptoms in 9-year-old children. A longitudinal study. *Appetite, 59*(1), 161-167. https://doi.org/10.1016/j.appet.2012.03.022

Pilgrim, D. (2014). Some implications of critical realism for mental health research. *Social Theory & Health, 12*(1), 1-21. https://doi.org/10.1057/sth.2013.17

Ritchie, C. W., Hayes, D., & Ames, D. J. (2000). Patient or client? The opinions of people attending a psychiatric clinic. *Psychiatric Bulletin, 24*(12), 447-450. https://doi.org/10.1192/pb.24.12.447

Roberts, J. M. (2014). Critical realism, dialectics, and qualitative research methods. *Journal for the Theory of Social Behaviour, 44*(1), 1-23. https://doi.org/10.1111/jtsb.12056

Schlegl, S., Maier, J., Meule, A., & Voderholzer, U. (2020). Eating disorders in times of the COVID-19 pandemic—Results from an online survey of patients with anorexia nervosa. *International Journal of Eating Disorders, 53*(11), 1791-1800. https://doi.org/10.1002/eat.23374

Simmons, P., Hawley, C. J., Gale, T. M., & Sivakumaran, T. (2010). Service user, patient, client, user or survivor: Describing recipients of mental health services. *The Psychiatrist, 34*(1), 20-23. https://doi.org/10.1192/pb.bp.109.025247

Smith, J. A., Flowers, P., & Larkin, M. H. (2009). *Interpretative phenomenological analysis: Theory, method and research*. Sage.

Smith, K. V., & Thew, G. R. (2017). Conducting research in clinical psychology practice: Barriers, facilitators, and recommendations. *British Journal of Clinical Psychology, 56*(3), 347-356. https://doi.org/10.1111/bjc.12142

Swinbourne, J., Hunt, C., Abbott, M., Russell, J., St Clare, T., & Touyz, S. (2012). The comorbidity between eating disorders and anxiety disorders: Prevalence in an eating disorder sample and anxiety disorder sample. *Australian & New Zealand Journal of Psychiatry, 46*(2), 118-131. https://doi.org/10.1177/0004867411432071

Thomas, G. V., Turpin, G., & Meyer, C. (2002). Clinical research under threat. *Psychologist, 15*(6), 286-289. https://www.researchgate.net/profile/Graham-Turpin/publication/232587568_Clinical_research_under_threat/links/0deec5294bf56d4339000000/Clinical-research-under-threat.pdf

Weissman, R. S., Bauer, S., & Thomas, J. J. (2020). Access to evidence-based care for eating disorders during the COVID-19 crisis. *International Journal of Eating Disorders, 53*(5), 639-646. https://doi.org/10.1002/eat.23279

Williams, S., & Reid, M. (2010). Understanding the experience of ambivalence in anorexia nervosa: The maintainer's perspective. *Psychology & Health, 25*(5), 551-567. https://doi.org/10.1080/08870440802617629

Section 4: Ethics Form

Emily Retkiewicz

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:

Emily Retkiewicz

Doctorate in Clinical Psychology

Faculty of Health and Medicine

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster

LA1 4AT

e.retkiewicz@lancaster.ac.uk

NHS Integrated Research Application Form (IRAS)

IRAS Form | Reference: 20/HRA/1802 | IRAS Version 5.15

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please complete the questions in order. If you change the response to a question, please select 'Save' and review all the questions as your change may have affected subsequent questions.

Please enter a short title for this project (maximum 70 characters)
Compassion in staff working in eating disorder services

1. Is your project research?

◉ Yes ○ No

2. Select one category from the list below:

○ Clinical trial of an investigational medicinal product
○ Clinical investigation or other study of a medical device
○ Combined trial of an investigational medicinal product and an investigational medical device
○ Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
○ Basic science study involving procedures with human participants
◉ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
○ Study involving qualitative methods only
○ Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
○ Study limited to working with data (specific project only)
○ Research tissue bank
○ Research database

If your work does not fit any of these categories, select the option below:

○ Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?	○ Yes	◉ No
b) Will you be taking new human tissue samples (or other human biological samples)?	○ Yes	◉ No
c) Will you be using existing human tissue samples (or other human biological samples)?	○ Yes	◉ No

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

☑ England
☐ Scotland

☐ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

◉ England
○ Scotland
○ Wales
○ Northern Ireland
○ This study does not involve the NHS

4. Which applications do you require?

☑ IRAS Form
☐ Confidentiality Advisory Group (CAG)
☐ Her Majesty's Prison and Probation Service (HMPPS)

Most research projects require review by a REC within the UK Health Departments' Research Ethics Service. Is your study exempt from REC review?

◉ Yes ○ No

4b. Please confirm the reason(s) why the project does not require review by a REC within the UK Health Departments Research Ethics Service:

☐ Projects limited to the use of samples/data samples provided by a Research Tissue Bank (RTB) with generic ethical approval from a REC, in accordance with the conditions of approval.
☐ Projects limited to the use of data provided by a Research Database with generic ethical approval from a REC, in accordance with the conditions of approval.
☐ Research limited to use of previously collected, non-identifiable information
☐ Research limited to use of previously collected, non-identifiable tissue samples within terms of donor consent
☐ Research limited to use of acellular material
☐ Research limited to use of the premises or facilities of care organisations (no involvement of patients/service users as participants)
☑ Research limited to involvement of staff as participants (no involvement of patients/service users as participants)

5. Will any research sites in this study be NHS organisations?

◉ Yes ○ No

5a. Are all the research costs and infrastructure costs (funding for the support and facilities needed to carry out research e.g. NHS Support costs) for this study provided by a NIHR Biomedical Research Centre, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC), NIHR Patient Safety Translational Research Centre or Medtech and In Vitro Diagnostic Cooperative in all study sites?

Please see information button for further details.

○ Yes ◉ No

Please see information button for further details.

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) Support and inclusion in the NIHR Clinical Research Network Portfolio?

Please see information button for further details.

○ Yes ◉ No

The NIHR Clinical Research Network provides researchers with the practical support they need to make clinical studies happen in the NHS e.g. by providing access to the people and facilities needed to carry out research "on the ground".

If you select yes to this question, you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form (PAF) immediately after completing this project filter question and before submitting other applications. Failing to complete the PAF ahead of other applications e.g. HRA Approval, may mean that you will be unable to access NIHR CRN Support for your study.

6. Do you plan to include any participants who are children?

○ Yes ◉ No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

○ Yes ◉ No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the Confidentiality Advisory Group to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes ◉ No

9. Is the study or any part of it being undertaken as an educational project?

◉ Yes ○ No

Please describe briefly the involvement of the student(s):
The student is the lead researcher and therefore all aspects of the project will be carried out by the student with support from research supervisors. This project will be completed as part of the Doctorate in Clinical Psychology.

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

◉ Yes ○ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ◉ No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes ◉ No

IRAS Form | Reference: 20/HRA/1802 | IRAS Version 5.15

Integrated Research Application System
Application Form for Research administering questionnaires/interviews for quantitative analysis or mixed methodology study

IRAS Form (project information)

Please refer to the E-Submission and Checklist tabs for instructions on submitting this application.

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting Help.

Please define any terms or acronyms that might not be familar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
Compassion in staff working in eating disorder services

Please complete these details after you have booked the REC application for review.

REC Name:

REC Reference Number:
20/HRA/1802

Submission date:

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

Compassion in staff working in eating disorder services: Impact of stress and emotion regulation

A2-1. Educational projects

Name and contact details of student(s):

Student 1

	Title	Forename/Initials	Surname
	Miss	Emily	Retkiewicz
Address	Division of Health Research		
	Lancaster University		
	Lancaster		
Post Code	LA1 4YG		
E-mail	e.retkiewicz@lancaster.ac.uk		
Telephone	[redacted]		
Fax			

Give details of the educational course or degree for which this research is being undertaken:
Name and level of course/ degree:

Doctorate in Clinical Psychology (DClinPsy)

Name of educational establishment:
Lancaster University

Name and contact details of academic supervisor(s):

Academic supervisor 1

	Title	Forename/Initials	Surname
	Dr	Ian	Fletcher
Address	Division of Health Research Lancaster University Lancaster		
Post Code	LA1 4YG		
E-mail	i.j.fletcher@lancs.ac.uk		
Telephone	01524 593301		
Fax			

Please state which academic supervisor(s) has responsibility for which student(s):
Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)	Academic supervisor(s)
Student 1 Miss Emily Retkiewicz	☑ Dr Ian Fletcher

A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

- ○ Student
- ◉ Academic supervisor
- ○ Other

A3-1. Chief Investigator:

	Title	Forename/Initials	Surname
	Dr	Ian	Fletcher
Post	Senior Lecturer		
Qualifications	PhD		
ORCID ID	0000 0002 1000 9581		
Employer	Lancaster University		
Work Address	Division of Health Research Lancaster University Lancaster		
Post Code	LA1 4YG		
Work E-mail	i.j.fletcher@lancs.ac.uk		
* Personal E-mail			

Work Telephone	01524 593301
* Personal Telephone/Mobile	
Fax	

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*
A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and HRA/R&D reviewers that is sent to the CI.

	Title	Forename/Initials	Surname
	Mrs	Becky	Gordon
Address	Lancaster University		
	N/A		
	Lancaster		
Post Code	N/A		
E-mail	sponsorship@lancaster.ac.uk		
Telephone	01524592981		
Fax			

A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available):	N/A
Sponsor's/protocol number:	N/A
Protocol Version:	1.0
Protocol Date:	09/12/2019
Funder's reference number (enter the reference number or state not applicable):	N/A
Project website:	https://lancasteruni.eu.qualtrics.com/jfe/form/SV_cNINz553odRozAx

Additional reference number(s):

Ref.Number Description	Reference Number

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.

A5-2. Is this application linked to a previous study or another current application?

○ Yes ◉ No

Please give brief details and reference numbers.
N/A

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. *Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments' Research Ethics Service, this summary will be published on the Health Research Authority (HRA) website following the ethical review. Please refer to the question specific guidance for this question.*

Staff working in mental health settings are at an increased risk of experiencing workplace stress and associated negative emotions, such as feelings of emotional exhaustion, which could lead to a reduction in compassion. Additionally, it has been shown that working in mental health settings requires skills in managing emotions, although it is currently unclear if those skills improve or reduce compassion. Compassion, or the desire to help others, is recognised as an important aspect of caring for people with eating disorders, particularly due to the risk of patients experiencing feelings of shame. Staff experiencing reduced compassion for patients with eating disorders can result in limitations in their job performance and can impact negatively on patients.
The following study will be a Lancaster University Doctorate in Clinical Psychology thesis project. It will investigate the impact of stress in the workplace and difficulties managing emotions on the ability of staff working in eating disorder services to be compassionate. The project will aim to collect information from a minimum of 110 staff working in eating disorder services and recruitment will be nation-wide over an approximately 9-month period. Online surveys and questionnaires will be utilised to collect anonymised information. The study will involve any staff who create clinical or therapeutic relationships with patients who have an eating disorder, in order to facilitate beneficial change. This study will investigate relationships between different factors and will identify any predictors of levels of compassion. By identifying what impacts on staff wellbeing, there could be an opportunity to improve staff compassion and therefore their relationships with patients.

A6-2. Summary of main issues. *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, HRA, or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

The main management issue arising from this study may be difficulties recruiting participants. This would be addressed through the lead researcher actively promoting the study online, utilising relevant professional contacts, and attending regional and national meetings. There are no major legal issues arising from this study.
There is a minor ethical issue arising from this study. This study will be exploring potentially emotionally challenging factors, such as reduced capacity for compassion, high levels of workplace stress, and difficulties managing emotions. Consequently, participants may become concerned when completing the online survey. In order to address this, participants will be informed about the sensitive nature of the questions before they consent to take part in the study. Participants will also be given support information. Participants will be reminded that they can access workplace support/counselling services, should their organisation have one. As this study will recruit nationally, it would not be feasible to supply specific organisational support services.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. *Please tick all that apply:*

- ☐ Case series/ case note review
- ☐ Case control
- ☐ Cohort observation
- ☐ Controlled trial without randomisation
- ☐ Cross-sectional study
- ☐ Database analysis
- ☐ Epidemiology
- ☐ Feasibility/ pilot study
- ☐ Laboratory study
- ☐ Metanalysis

- ☐ Qualitative research
- ☑ Questionnaire, interview or observation study
- ☐ Randomised controlled trial
- ☐ Other (please specify)

N/A

A10. What is the principal research question/objective? *Please put this in language comprehensible to a lay person.*

What is the impact of stress in the workplace and difficulties managing emotions on the capacity for compassion in staff working in eating disorder services?

A11. What are the secondary research questions/objectives if applicable? *Please put this in language comprehensible to a lay person.*

N/A

A12. What is the scientific justification for the research? *Please put this in language comprehensible to a lay person.*

Compassion is currently a fast-growing area of research, particularly when looking at compassion in staff working in mental health settings. Compassion is an important aspect of working in eating disorder services, as patients can experience a lot of stigma or feelings of shame regarding their condition. Compassion-focused therapy is also an increasingly used approach when working psychologically with patients with an eating disorder. It has been found that reduced capacity for compassion in staff could lead to reduced productivity at work and a decline in staffs relationship with patients.

It is recognised that working in eating disorder services can be very stressful, due to increased risk of patient physical and mental decline or death. Patients with an eating disorder may also have limited insight into their condition or may be resistant to treatment, which can also add to staff stress levels. It has been shown by previous research that stress has an impact on levels of empathy. Consequently, it is important to investigate the impact of workplace stress on staff capacity for compassion. This has not been previously investigated in staff working in eating disorder services.

Furthermore, working in eating disorder services requires good emotion regulation skills, in order for staff to be able to competently manage difficult situations, such as conflict and resistance. There is some evidence to suggest that difficulties regulating emotions can lead to an increased risk of developing mental health difficulties, such as depression. Consequently, it can be argued that such difficulties could impact on staff capacity for compassion. On the other hand, some research suggests that an improved ability to regulate emotions can lead to reduced compassion for a group of victims. Therefore, it is important to investigate the impact of emotion regulation skills on staff capacity for compassion. This has also not been previously explored in staff working in eating disorder services.

This study would allow a better understanding of factors influencing staff capacity for compassion in eating disorder services. This could then inform ways of improving staff compassion, which could have a beneficial impact on staffs relationship with patients.

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

Participants will be expected to fill out an online survey. This has been discussed with stakeholders (eating disorder services managers and staff) and was agreed that this approach would be more appropriate than paper questionnaires.

Emails with a flyer and a link to the online survey will be sent to managers or other contacts from eating disorder services, with a request to cascade them to staff members. Inclusion criteria will be detailed in the email to ensure that the link will not be unnecessarily sent to staff who cannot take part in the project – participants will consist of staff working in eating disorder services or wards (NHS, private or 3rd sector; outpatient or inpatient) who are considered to have a clinical or therapeutic relationship with patients. Therefore, the staff groups will include nurses, healthcare assistants, psychologists, assistant psychologists, therapists, counsellors, occupational therapists, physiotherapists, medical doctors, and dieticians.

Once participants click on the link in the email, they will be taken to the online survey which will start off by detailing participant information. Participants will be informed that entering the survey (following the participant information) and submitting their results will equate to informed consent.

The survey will consist of three questionnaires (Professional Quality of Life 21, Emotion Regulation Questionnaire, and Copenhagen Psychosocial Questionnaire III) – this will be a total of 63 items. The survey will also ask 12 demographic questions. The whole survey (including reading the participant information and debrief) should take

approximately 15-20 minutes. After participants finish answering questions, they will be presented online with debrief information.
Data collection will proceed for approximately eight to nine months to allow a high number of participants to take part – the minimum sample size aimed for is 110 participants.
A quantitative study design was chosen to allow an exploration of relationships between variables (levels of workplace stress and levels of emotion regulation) and the influence of individual differences in those variables on levels of staff compassion.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

- [x] Design of the research
- [ ] Management of the research
- [ ] Undertaking the research
- [ ] Analysis of results
- [ ] Dissemination of findings
- [ ] None of the above

Give details of involvement, or if none please justify the absence of involvement.
Managers and staff working in eating disorder services (both NHS and private sector) have been approached to invite them to be involved in the design of the project. Staff and managers were given an opportunity to look over the proposed questionnaires (ProQOL-21, ERQ, COPSOQ III) and proposed demographic information questionnaire and comment on: appropriateness of the validated questionnaires and the feasibility of completing the questionnaires given service constraints. They were also given the opportunity to suggest additional key demographic questions.

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A15. What is the sample group or cohort to be studied in this research?

Select all that apply:

- [ ] Blood
- [ ] Cancer
- [ ] Cardiovascular
- [ ] Congenital Disorders
- [ ] Dementias and Neurodegenerative Diseases
- [ ] Diabetes
- [ ] Ear
- [ ] Eye
- [x] Generic Health Relevance
- [ ] Infection
- [ ] Inflammatory and Immune System
- [ ] Injuries and Accidents
- [ ] Mental Health
- [ ] Metabolic and Endocrine
- [ ] Musculoskeletal
- [ ] Neurological

- ☐ Oral and Gastrointestinal
- ☐ Paediatrics
- ☐ Renal and Urogenital
- ☐ Reproductive Health and Childbirth
- ☐ Respiratory
- ☐ Skin
- ☐ Stroke

Gender:	Male and female participants
Lower age limit: 18	Years
Upper age limit: 100	Years

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

Participants will consist of staff working in eating disorder services or wards (NHS, private or 3rd sector; outpatient or inpatient) who are considered to have a clinical or therapeutic relationship with patients (i.e. staff who create a positive relationship with patients to facilitate beneficial change in patients). Therefore, the staff groups will include nurses, healthcare assistants, psychologists, assistant psychologists, therapists, counsellors, occupational therapists, physiotherapists, medical doctors, and dieticians. Participants will have to be 18 years or older and will have to have worked with patients diagnosed with an eating disorder for a minimum of three months. There is no upper age limit, as long as participants are not retired.

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

Staff working in eating disorder services who are not considered to have a clinical or therapeutic relationship with patients (i.e. staff who do not create a positive relationship with patients to facilitate beneficial change in patients; e.g. administrative staff, domestic staff, etc.). Participants who are fully retired and those who have worked in an eating disorder service for less than three months will also be excluded.

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Reading email and flyer with study information	1	N/A	5 minutes	Main researcher will send emails with flyers attached to service/ward managers, and request for those to be cascaded to staff
Reading information about the research and consent pages online	1	N/A	3 minutes	N/A - this will be completed online
Completing the online questionnaires	1	N/A	11-16 minutes	N/A - this will be completed online
Reading the debrief page online	1	N/A	1 minute	N/A - this will be completed online

A21. How long do you expect each participant to be in the study in total?

It is expected that completing the online survey (including reading the information about the study, the consent and debrief pages) will take approximately 15-20 minutes. There will be no further contact with the study once responses are submitted.

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

One potential inconvenience may be that participants complete the survey within their work time, which could have some impact on their workload. This will be addressed by contacting service/ward managers first and asking them to cascade the study information - this will allow them to decide if their staff are in a position to take 15-20 minutes out of their work time to complete the study.
Some participants may have concerns due to the nature of the questions asked. This will be minimised by listing resources in the debrief page, namely GP, NHS111, and workplace support/counselling service.

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

○ Yes ◉ No

A24. What is the potential for benefit to research participants?

Participants may find taking part in the study interesting, but there will be no direct benefit to them.

A26. What are the potential risks for the researchers themselves? *(if any)*

There will be no risks to the researcher as this is an online study and there will be no direct contact with participants.

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used? *For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).*

Due to the required number of participants, recruitment is going to be on a national scale. Eating disorder services in the UK will be identified using the website www.beateatingdisorders.org.uk, and by utilising a field supervisor's connections. Participants will be recruited through contacting ward/service managers and asking them to cascade the study information to their staff. Additionally, study information and surveys will be cascaded via online websites accessed by professionals, e.g. the Clinical Psychology Forum (www.clinpsy.org.uk/forum) or UK based Clinical Psychology Facebook Group to recruit clinical psychologists working in ED services. Appropriate online websites and organisations will be identified for other professionals (e.g. nurses, OTs) through discussion with field supervisor or service managers.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

○ Yes ◉ No

Please give details below:
N/A

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

◉ Yes ○ No

If Yes, please give details of how and where publicity will be conducted, and enclose copy of all advertising material (with version numbers and dates).

Study information and surveys will be cascaded via online websites accessed by professionals, e.g. the Clinical Psychology Forum (www.clinpsy.org.uk/forum) or UK based Clinical Psychology Facebook Group to recruit clinical psychologists working in ED services. Appropriate online websites and organisations will be identified for other professionals (e.g. nurses, OTs) through discussion with field supervisor or service managers.

A29. How and by whom will potential participants first be approached?

Participants will not be approached directly by the researcher. Study information will be emailed to service/ward managers who will then be requested to cascade the information to their staff. Study information will also be posted on online websites/forums accessed by professionals - no direct contact will be made with participants.

A30-1. Will you obtain informed consent from or on behalf of research participants?

◉ Yes ○ No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

The online survey will start with information about the research, which will allow potential participants to decide if they would like to take part in the study. Participants will then be presented with a consent page, which will explain to them that proceeding with the survey and submitting their responses will equate to consent.

If you are not obtaining consent, please explain why not.
N/A

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

○ Yes ◉ No

If No, how will it be recorded?

Participants will be informed that completing the survey and submitting their responses will equate to informed consent.

A31. How long will you allow potential participants to decide whether or not to take part?

Participants will not be approached directly by the researcher. They will be invited to take part by receiving an email with study information from their service/ward manager, or through online advertisements on professional websites/forums. Participants will be told when data collection is expected to cease and will have until then to decide.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs? *(e.g. translation, use of interpreters)*

It is expected that staff employed in eating disorder services who work in a clinical or therapeutic capacity will have adequate English language skills to take part in the study.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? *Tick one option only.*

- ○ The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.
- ○ The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.
- ○ The participant would continue to be included in the study.
- ○ Not applicable – informed consent will not be sought from any participants in this research.
- ◉ Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:
This will be an online survey study and therefore it will not be practicable to monitor capacity.

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)? *(Tick as appropriate)*

- ☐ Access to medical records by those outside the direct healthcare team
- ☐ Access to social care records by those outside the direct social care team
- ☐ Electronic transfer by magnetic or optical media, email or computer networks
- ☐ Sharing of personal data with other organisations
- ☐ Export of personal data outside the EEA
- ☐ Use of personal addresses, postcodes, faxes, emails or telephone numbers
- ☐ Publication of direct quotations from respondents
- ☐ Publication of data that might allow identification of individuals
- ☐ Use of audio/visual recording devices
- ☐ Storage of personal data on any of the following:
  - ☐ Manual files (includes paper or film)
  - ☐ NHS computers
  - ☐ Social Care Service computers
  - ☐ Home or other personal computers
  - ☐ University computers
  - ☐ Private company computers
  - ☐ Laptop computers

Further details:

None of the above will be undertaken - participants will submit anonymous information via Qualtrics.

A37. Please describe the physical security arrangements for storage of personal data during the study?

No personal data will be collected or stored.

A38. How will you ensure the confidentiality of personal data? *Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

No personal data will be collected or stored.

A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

No personal data will be collected or stored.

Storage and use of data after the end of the study

A41. Where will the data generated by the study be analysed and by whom?

Data will be stored in a password protected and encrypted Lancaster University network folder and will be analysed online via a VPN connection. Analysis will mainly be performed by the main researcher, Emily Retkiewicz, with support from research supervisor Dr Ian Fletcher.

A42. Who will have control of and act as the custodian for the data generated by the study?

	Title	Forename/Initials	Surname
	Dr	Ian	Fletcher
Post	Senior Lecturer		
Qualifications	PhD		
Work Address	Division of Health Research		
	Lancaster University		
	Lancaster		
Post Code	LA1 4YG		
Work Email	i.j.fletcher@lancs.ac.uk		
Work Telephone	01524593301		
Fax			

A43. How long will personal data be stored or accessed after the study has ended?

- (●) Less than 3 months
- ( ) 3 – 6 months
- ( ) 6 – 12 months
- ( ) 12 months – 3 years
- ( ) Over 3 years

A44. For how long will you store research data generated by the study?

Years: 10
Months: 0

A45. Please give details of the long term arrangements for storage of research data after the study has ended. *Say where data will be stored, who will have access and the arrangements to ensure security.*

The proposed retention period and storage arrangements are subject to Lancaster University guidance. Long-term, data will be stored in a password protected Lancaster University network folder. Members of the Doctorate in Clinical Psychology research team and the research coordinator (Sarah Heard) will have access to it. The research coordinator will destroy the data by deleting it.

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

○ Yes ◉ No

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

○ Yes ◉ No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes ◉ No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

○ Yes ◉ No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

PUBLICATION AND DISSEMINATION

A50. Will the research be registered on a public database?

◉ Yes ○ No

Please give details, or justify if not registering the research.
The study will be registered through the host NHS organisation.

Registration of research studies is encouraged wherever possible.
You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study? *Tick as appropriate:*

- [x] Peer reviewed scientific journals
- [ ] Internal report
- [x] Conference presentation
- [ ] Publication on website
- [ ] Other publication
- [ ] Submission to regulatory authorities
- [ ] Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
- [ ] No plans to report or disseminate the results
- [x] Other (please specify)

Doctoral thesis, presentations to Lancaster University staff and trainees, and a summary of results will be available on request for participants and services.

A52. If you will be using identifiable personal data, how will you ensure that anonymity will be maintained when publishing the results?

No identifiable personal data will be collected. Data will be pooled for results and no individual data will be presented when publishing results.

A53. Will you inform participants of the results?

(•) Yes ( ) No

Please give details of how you will inform participants or justify if not doing so.
Participants and services will have the opportunity to request a summary of the results.

5. Scientific and Statistical Review

A54. How has the scientific quality of the research been assessed? *Tick as appropriate:*

- [ ] Independent external review
- [ ] Review within a company
- [ ] Review within a multi-centre research group
- [ ] Review within the Chief Investigator's institution or host organisation
- [x] Review within the research team
- [x] Review by educational supervisor
- [ ] Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:
A thesis proposal form was completed and reviewed by the academic supervisor and research team on two occasions - feedback was given on both occasions and the project was approved after the second submission.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A56. How have the statistical aspects of the research been reviewed? *Tick as appropriate:*

☐ Review by independent statistician commissioned by funder or sponsor

☐ Other review by independent statistician

☐ Review by company statistician

☐ Review by a statistician within the Chief Investigator's institution

☑ Review by a statistician within the research team or multi-centre group

☑ Review by educational supervisor

☐ Other review by individual with relevant statistical expertise

☐ No review necessary as only frequencies and associations will be assessed – details of statistical input not required

In all cases please give details below of the individual responsible for reviewing the statistical aspects. If advice has been provided in confidence, give details of the department and institution concerned.

	Title	Forename/Initials	Surname
	Dr	Ian	Fletcher
Department	Division of Health Research		
Institution	Lancaster University		
Work Address	Division of Health Research Lancaster University Lancaster		
Post Code	LA1 4YG		
Telephone	01524593301		
Fax			
Mobile			
E-mail	i.j.fletcher@lancs.ac.uk		

Please enclose a copy of any available comments or reports from a statistician.

A57. What is the primary outcome measure for the study?

The primary outcome measure will be scores on the two scales of the Professional Quality of Life (ProQOL-21) measure. The two scales are compassion fatigue and compassion satisfaction.

A58. What are the secondary outcome measures? *(if any)*

N/A

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size:	110
Total international sample size (including UK):	110
Total in European Economic Area:	110

Further details:
This study will require a minimum of 98 participants to achieve power of 0.8, and medium effect size f2 = 0.15 (calculated using G*Power for regression analysis and 6 variables). To improve stability, a minimum of 110 participants will be required (Field, 2009).

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

This study will require a minimum of 98 participants to achieve power of 0.8, and medium effect size f2 = 0.15 (calculated using G*Power for regression analysis and 6 variables). To improve stability, a minimum of 110 participants will be required (Field, 2009).

A61. Will participants be allocated to groups at random?

○ Yes ◉ No

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

The online survey will be designed to not allow missing data (i.e. all questions will be mandatory). Data will be tested for normality of distribution, linearity, outliers, and multicollinearity. Data will then be examined using correlational analysis to identify relationships between variables (workplace stress, expressive suppression, cognitive reappraisal, CF, CS and demographic information, such as occupation). Significant correlations will be considered for regression analysis to identify predictors of compassion in staff. A multiple linear regression will be carried out in order to examine moderation. The independent variables of the regression will be workplace stress, expressive suppression, cognitive reappraisal, and the interactions between workplace stress and expressive suppression, and workplace stress and cognitive reappraisal. The dependent variables of the regression will be CF and CS.

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. *Please include all grant co-applicants, protocol co-authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

	Title	Forename/Initials	Surname
	Dr	Nicola	Pilkington
Post	Principal Clinical Psychologist		
Qualifications	Doctorate in Clinical Psychology		
Employer	Lancashire and South Cumbria NHS Foundation Trust		
Work Address	The Gateway, Blackpool Football Club (South Stand)		
	Seasiders Way		
	Blackpool		
Post Code	FY1 6JX		
Telephone	01253951640		
Fax			
Mobile			
Work Email	nicola.pilkington@lancashirecare.nhs.uk		

A64. Details of research sponsor(s)

A64-1. Sponsor

Lead Sponsor

Status: ○ NHS or HSC care organisation ◉ Academic ○ Pharmaceutical industry

Commercial status: Non-Commercial

- ◯ Medical device industry
- ◯ Local Authority
- ◯ Other social care provider (including voluntary sector or private organisation)
- ◯ Other

If Other, please specify:

Contact person

Name of organisation	Lancaster University
Given name	Becky
Family name	Gordon
Address	Lancaster University
Town/city	Lancaster
Post code	N/A
Country	UNITED KINGDOM
Telephone	01524592981
Fax	
E-mail	sponsorship@lancaster.ac.uk

A65. Has external funding for the research been secured?

Please tick at least one check box.

- ☐ Funding secured from one or more funders
- ☐ External funding application to one or more funders in progress
- ☑ No application for external funding will be made

What type of research project is this?

- ◉ Standalone project
- ◯ Project that is part of a programme grant
- ◯ Project that is part of a Centre grant
- ◯ Project that is part of a fellowship/ personal award/ research training award
- ◯ Other

Other – please state:
N/A

A66. Has responsibility for any specific research activities or procedures been delegated to a subcontractor (other than a co-sponsor listed in A64-1) ? *Please give details of subcontractors if applicable.*

◯ Yes ◉ No

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?

○ Yes ◉ No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68-1. Give details of the lead NHS R&D contact for this research:

	Title	Forename/Initials	Surname
	Ms	Beverley	Lowe
Organisation	Lancashire and South Cumbria NHS Foundation Trust		
Address	Research & Development		
	Lantern Centre, Vicarage Lane Fulwood		
	Preston		
Post Code	PR2 8DW		
Work Email	beverley.lowe@lancashirecare.nhs.uk		
Telephone	01772773498		
Fax			
Mobile			

Details can be obtained from the NHS R&D Forum website: http://www.rdforum.nhs.uk

A69-1. How long do you expect the study to last in the UK?

Planned start date: 06/04/2020
Planned end date: 30/09/2020
Total duration:
Years: 0 Months: 5 Days: 25

A71-1. Is this study?

○ Single centre
◉ Multicentre

A71-2. Where will the research take place? *(Tick as appropriate)*

☑ England
☐ Scotland
☐ Wales
☐ Northern Ireland
☐ Other countries in European Economic Area

Total UK sites in study unknown

Does this trial involve countries outside the EU?
○ Yes ◉ No

A72. Which organisations in the UK will host the research? *Please indicate the type of organisation by ticking the box and give approximate numbers if known:*

☑ NHS organisations in England	2
☐ NHS organisations in Wales	
☐ NHS organisations in Scotland	
☐ HSC organisations in Northern Ireland	
☐ GP practices in England	
☐ GP practices in Wales	
☐ GP practices in Scotland	
☐ GP practices in Northern Ireland	
☐ Joint health and social care agencies (eg community mental health teams)	
☐ Local authorities	
☐ Phase 1 trial units	
☐ Prison establishments	
☐ Probation areas	
☑ Independent (private or voluntary sector) organisations	2
☐ Educational establishments	
☐ Independent research units	
☑ Other (give details)	

Staff, and not patients, will be recruited from those sites

Total UK sites in study: 4

A73-1. Will potential participants be identified through any organisations other than the research sites listed above?

◉ Yes ○ No

A73-2. If yes, will any of these organisations be NHS organisations?

◉ Yes ○ No

If yes, details should be given in Part C.

A73-3. Approximately how much time will these organisations expect to spend on screening records and/or provision of information to potential participants, and how will the costs of these activities be funded?

It is expected that minimal time will be required. Organisations will be asked to email clinical and therapeutic staff with study information, and no further screening is expected. It is expected that most organisations will have mailing lists which they will be able to utilise.

A74. What arrangements are in place for monitoring and auditing the conduct of the research?

All aspects of the research are supervised and monitored by the academic supervisor.

A76. Insurance/ indemnity to meet potential legal liabilities

Note: In this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (NHS sponsors only)

☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)

☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

☐ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)

☑ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.

A78. Could the research lead to the development of a new product/process or the generation of intellectual property?

○ Yes ◉ No ○ Not sure

IRAS Form | Reference: 20/HRA/1802 | IRAS Version 5.15

PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. *For further information please refer to guidance.*

Investigator identifier: IN1

Research site:
- (●) NHS/HSC Site
- ( ) Non-NHS/HSC Site

Organisation name: [redacted] NHS FOUNDATION TRUST
Address: [redacted]
Post Code: [redacted]
Country: [redacted]

Investigator Name:
Forename: Emily
Middle name: N/A
Family name: Retkiewicz
Email: e.retkiewicz@lancaster.ac.uk
Qualification (MD...): MA (Hons), MSc
Country: UNITED KINGDOM

Participant Identification Centres

PIC Type	Centre	Individual(s)
(●) NHS (England)		
( ) NHS (outside England)		E-mail:
( ) Non-NHS		

Investigator identifier: IN2

Research site:
- ( ) NHS/HSC Site
- (●) Non-NHS/HSC Site

Institution name: [redacted]
Department name: N/A
Street address: [redacted]
Town/city: [redacted]
Post Code: [redacted]
Country: [redacted]

Investigator Name:
Forename: Emily
Middle name:
Family name: Retkiewicz
Email: e.retkiewicz@lancaster.ac.uk
Qualification (MD...): MA (Hons), MSc
Country: UNITED KINGDOM

Participant Identification Centres

PIC Type	Centre	Individual(s)
( ) NHS (England)		
( ) NHS (outside England)		E-mail:

Non-NHS

IN3

NHS/HSC Site
Non-NHS/HSC Site

Forename Emily
Middle name N/A
Family name Retkiewicz
Email e.retkiewicz@lancaster.ac.uk
Qualification (MD...) MA (Hons), MSc
Country UNITED KINGDOM

Institution name [redacted]
Department name N/A
Street address [redacted]
Town/city [redacted]
Post Code [redacted]
Country [redacted]

Participant Identification Centres

PIC Type	Centre	Individual(s)
NHS (England)		
NHS (outside England)		E-mail:
Non-NHS		

IN4

NHS/HSC Site
Non-NHS/HSC Site

Forename Emily
Middle name N/A
Family name Retkiewicz
Email e.retkiewicz@lancaster.ac.uk
Qualification (MD...) MA (Hons), MSc
Country UNITED KINGDOM

Organisation name [redacted] NHS FOUNDATION TRUST
Address [redacted]
Post Code [redacted]
Country [redacted]

Participant Identification Centres

PIC Type	Centre	Individual(s)
NHS (England)		
NHS (outside England)		E-mail:
Non-NHS		

PART D: Declarations

D1. Declaration by Chief Investigator

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
2. I undertake to fulfil the responsibilities of the chief investigator for this study as set out in the UK Policy Framework for Health and Social Care Research.
3. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.
4. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.
5. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.
6. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.
7. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.
8. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.
9. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 2018.
10. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:
    - Will be held by the REC (where applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
    - May be disclosed to the operational managers of review bodies, or the appointing authority for the REC (where applicable), in order to check that the application has been processed correctly or to investigate any complaint.
    - May be seen by auditors appointed to undertake accreditation of RECs (where applicable).
    - Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
    - May be sent by email to REC members.
11. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 2018.
12. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the Health Research Authority (HRA) together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after the issue of the ethics committee's final opinion or the withdrawal of the application.

Contact point for publication *(Not applicable for R&D Forms)*

HRA would like to include a contact point with the published summary of the study for those wishing to seek further

information. We would be grateful if you would indicate one of the contact points below.

- ◯ Chief Investigator
- ◯ Sponsor
- ◯ Study co-ordinator
- ◯ Student
- ◯ Other – please give details
- ◯ None

Access to application for training purposes *(Not applicable for R&D Forms)*

Optional – please tick as appropriate:

☐ I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

This section was signed electronically by Dr Ian Fletcher on 07/04/2020 12:05.

Job Title/Post:	Senior Lecturer
Organisation:	Lancaster University
Email:	i.j.fletcher@lancs.ac.uk

D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co-sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.
2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.
3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.
4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.
5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.
6. The responsibilities of sponsors set out in the UK Policy Framework for Health and Social Care Research will be fulfilled in relation to this research.

   Please note: *The declarations below do not form part of the application for approval above. They will not be considered by the Research Ethics Committee.*
7. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.
8. Specifically, for submissions to the Research Ethics Committees (RECs) I declare that any and all clinical trials approved by the HRA since 30th September 2013 (as defined on IRAS categories as clinical trials of medicines, devices, combination of medicines and devices or other clinical trials) have been registered on a publically accessible register in compliance with the HRA registration requirements for the UK, or that any deferral granted by the HRA still applies.

This section was signed electronically by An authorised approver at sponsorship@lancaster.ac.uk on 07/04/2020 12:46.

Job Title/Post:	Head of Research Quality and Policy
Organisation:	Lancaster University
Email:	b.gordon@lancaster.ac.uk

D3. Declaration for student projects by academic supervisor(s)

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.

2. I undertake to fulfil the responsibilities of the supervisor for this study as set out in the UK Policy Framework for Health and Social Care Research.

3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.

4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Academic supervisor 1

This section was signed electronically by Dr Ian Fletcher on 07/04/2020 12:06.

Job Title/Post:	Senior Lecturer
Organisation:	Lancaster University
Email:	i.j.fletcher@lancs.ac.uk

Research Protocol

Title: Compassion in staff working in eating disorder services: Impact of stress and emotion regulation

Applicant: Emily Retkiewicz, Trainee Clinical Psychologist, Lancaster University

Supervisors: Dr Ian Fletcher, Senior Lecturer, Lancaster University

Dr Nicola Pilkington, Principal Clinical Psychologist, All-Age Eating Disorder Service – North Lancashire, Lancashire and South Cumbria NHS Foundation Trust

Version number: 2.0

Introduction

Compassion fatigue (CF), which is the negative aspect of caring for distressed people, can impact on staff's ability to be productive at work, and could impact negatively on patients. Staff with increased CF are more likely to avoid working with certain patients, or to reduce their standards of care (Dasan, Gohil, Cornelius, & Taylor, 2015; Lombardo & Eyre, 2011). It has also been found that compassion satisfaction (CS), which is the pleasure people derive from their job, can be a buffer between job demands and job strain (Tremblay & Messervey, 2011).

Eating disorders (EDs) are considered difficult to treat, and there is a high mortality rate for people experiencing disordered eating, compared to other mental health difficulties (Smink, van Hoeken, & Hoek, 2012). The National Institute for Health and Care Excellence (NICE; 2017) recognises that people with EDs may experience stigma or shame and recommends health professionals show compassion. Research demonstrates compassion is highly valued in ED services, and leads to better treatment outcomes in patients accessing them (Bell, 2003; Doran & Smith, 2004). There is growing evidence of the benefits of Compassion-

Focused Therapy in ED services (Gale, Gilbert, Read, & Goss, 2014). Compassion appears to be an important factor for investigation in ED services.

Nurses working in mental health services engage in emotional labour by suppressing their own emotions to help patients feel safe and reassured (Barron, Deery, & Sloan, 2017; Brown, Crawford, Gilbert, Gilbert, & Gale, 2014; Mann & Cowburn, 2005). Several studies have shown that mental health nurses experience high levels of stress at work (Foster et al., 2019; Mann & Cowburn, 2005; Richards et al., 2006; Tully, 2004). Increased stress at work can lead to negative emotions and higher risk of developing mental health difficulties (Mann & Cowburn, 2005). It has also been found that burnout can impact on empathy levels in staff (Warren, Schafer, Crowley, & Olivardia, 2012). However, the impact of stress on capacity for compassion in staff working in ED services has not been previously addressed.

ED services require staff to manage emotionally charged situations, and deal with stress, conflict and resistance (Davey, Arcelus, & Munir, 2014). Consequently, emotion regulation skills prove important in managing stressful situations involving other staff, patients, and their family members. Difficulties in emotion regulation, or the ability to observe, appraise and adjust emotional reactions, can lead to an increased risk of developing mental health difficulties, such as depression (Buruck, Dörfel, Kugler, & Brom, 2016), which could lead to a decrease in compassion. However, there is also evidence that improved emotion regulation leads to reduced compassion for a group of victims (Cameron & Payne, 2011). There is also some evidence in the literature that emotion regulation is a mediator between stress and resilience (Richardson, 2017; Troy & Mauss, 2011). Therefore, it is important to ascertain the impact of emotion regulation on compassion in staff working in ED services. This is another variable that has not been previously explored.

As has been shown, high levels of stress and difficulties managing emotions can have a negative impact on compassion levels in staff working in mental health services. Although it

has been found that working in ED services could result in higher stress levels, the impact of that on capacity for compassion has not been investigated. Evidence on the impact of emotion regulation on compassion is unclear and would benefit from exploring it further. This study would add to the existing literature by creating a more coherent picture of the factors that influence compassion in staff working in ED services. Given the importance of compassion in ED services, this could inform ways of improving staff compassion and therefore their relationships with patients.

Consequently, this study will look to use validated questionnaires for CF and CS, along with workplace stress, and emotion regulation. Previous research did not include staff working in ED services, therefore this study will specifically recruit a minimum of 110 staff working with patients diagnosed with an ED.

The research question addressed by this study is: what is the impact of stress in the workplace and difficulties managing emotions on the capacity for compassion in staff working in eating disorder services? Based on previous findings, the hypothesis is that higher levels of stress in the workplace will be associated with higher levels of CF and lower levels of CS. Additionally, it is hypothesized that expressive suppression of emotions will have a positive moderating effect on CF and a negative moderating effect on CS, while cognitive reappraisal of emotions will have a negative moderating effect on CF and a positive moderating effect on CS.

Method

Participants

Participants will consist of staff working in eating disorder services or wards (NHS, private or 3rd sector; outpatient or inpatient) who are considered to have a clinical or therapeutic relationship with patients (i.e. staff who create a positive relationship with patients to facilitate beneficial change in patients). Therefore, the staff groups will include nurses,

healthcare assistants, psychologists, assistant psychologists, therapists, counsellors, occupational therapists, physiotherapists, medical doctors, and dieticians. Participants will have to be 18 years or older and will have to have worked with patients diagnosed with an eating disorder for a minimum of three months.

This study will require a minimum of 98 participants to achieve power of 0.8, and medium effect size f^2 = 0.15 (calculated using G*Power for regression analysis and 6 variables). To improve stability, a minimum of 110 participants will be required (Field, 2009).

Due to the required number of participants, recruitment is going to be on a national scale. Eating disorder services in the UK will be identified using the website www.beateatingdisorders.org.uk, and by utilising a field supervisor's connections. Participants will be recruited through contacting ward/service managers and asking them to cascade the study information to their staff. Additionally, study information and surveys will be cascaded via online websites accessed by professionals, e.g., the Clinical Psychology Forum (www.clinpsy.org.uk/forum) or UK based Clinical Psychology Facebook Group to recruit clinical psychologists working in ED services. Appropriate online websites and organisations will be identified for other professionals (e.g., nurses, OTs) through discussion with field supervisor or service managers.

Design

The study will be quantitative with a correlational cross-sectional design. It will consist of three validated and reliable questionnaires which measure compassion (CF and CS), emotion regulation (cognitive reappraisal and expressive suppression), and workplace stress. It will also consist of a demographic questionnaire. The predictor variables will be: cognitive reappraisal, expressive suppression, and workplace stress. The outcome variables will be: CF and CS.

Materials

Professional Quality of Life Scale (ProQOL-21; Appendix G). This is a 21-item measure, which has been revised from the original ProQOL-5 (Stamm, 2009, 2010) in order to improve construct validity (Heritage, Rees, & Hegney, 2018). It consists of two subscales measuring facets of compassion satisfaction and compassion fatigue. It has been validated with a nursing population in Australia.

Emotion Regulation Questionnaire (ERQ; Appendix F). This is a 10-item measure, which consists of two subscales measuring facets of cognitive reappraisal and expressive suppression (Gross & John, 2003). Items are answered using a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree). Higher scores on each subscale indicate increased use of those strategies. Reliability of the two subscales has been reported as .79 and .73 respectively, and both have a test-retest reliability of .69.

Copenhagen Psychosocial Questionnaire (COPSOQ III), Short Version (Appendix E). This is a 32-item measure of risk factors for job strain (Kristensen, Hannerz, Høgh, & Borg, 2005). It contains several scales with various response options; most items are answered using a 5-point Likert scale. Higher scores indicate higher risk of workplace stress. Reliability of the scales ranges from .64 to .87.

Demographic Questionnaire (Appendix D). This is a questionnaire created by the researcher to capture the following information: age, gender, occupation, length of time working in an ED service, workplace setting, age group of service users accessing the service, mode of working (such as individual/direct, systemic/indirect, consultation), amount of face-to-face contact with service users, amount of supervision received, and completion of specialist training in ED.

Procedure

Participants will be referred to the study through contacting ward/service managers and asking them to cascade study information via email or in team meetings (see Appendix C for

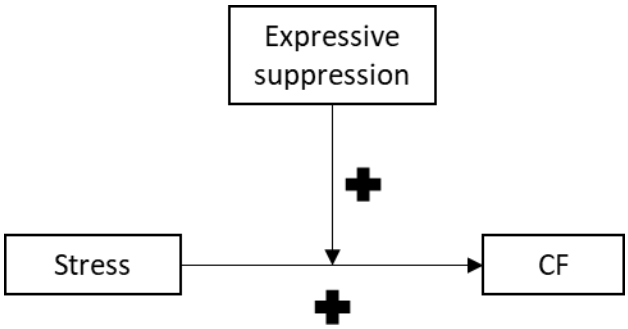
recruitment flyer). Study information will also be shared on several professional online forums. Participants will be able to decide if they would like to take part in the study by clicking on a link (https://lancasteruni.eu.qualtrics.com/jfe/form/SV_cNINz553odRozAx) which will bring them to further information about the study (Appendix A). Once participants read that information, they will be able to proceed to the next page which will detail what they are consenting to once they continue to the actual survey (Appendix B).

When participants consent to take part in the study, they will be redirected to the demographic questionnaire. Once they complete that, they will be redirected to the validated questionnaires in the following order: COPSOQ III short version, ERQ, and ProQOL-21. Once participants complete those questionnaires, they will be able to submit their answers to the study and will be redirected to the debrief page. Completing the whole study is expected to take between 15 and 20 minutes.

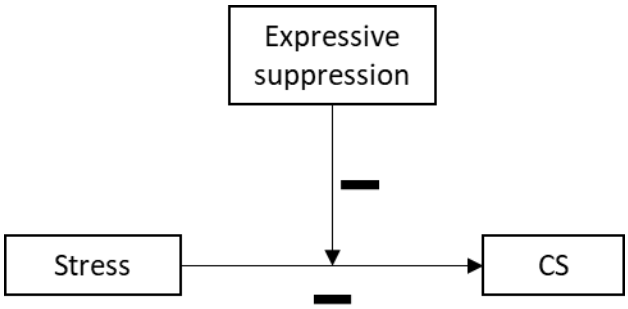
Proposed Analysis

The online survey will be designed to not allow missing data (i.e., all questions will be mandatory). Data will be tested for normality of distribution, linearity, outliers, and multicollinearity.

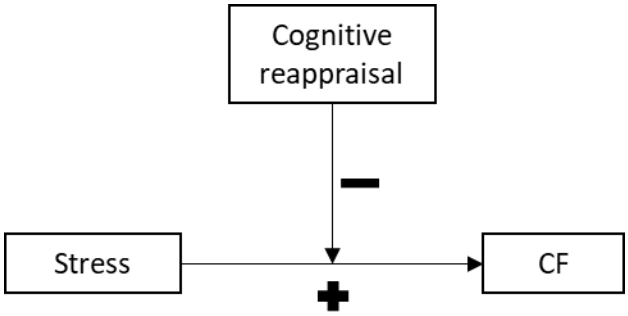
Data will be examined using correlational analysis to identify relationships between variables (workplace stress, expressive suppression, cognitive reappraisal, CF, CS and demographic information, such as occupation). Significant correlations will be considered for regression analysis to identify predictors of compassion in staff. A multiple linear regression will be carried out in order to examine moderation. The independent variables of the regression will be workplace stress, expressive suppression, cognitive reappraisal, and the interactions between workplace stress and expressive suppression, and workplace stress and cognitive reappraisal. The dependent variables of the regression will be CF and CS.



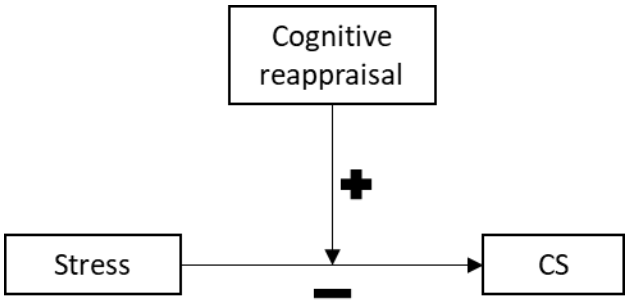
Model 1. It is hypothesised that higher levels of stress and expressive suppression will lead to higher levels of CF.



Model 2. It is hypothesised that higher levels of stress and expressive suppression will lead to lower levels of CS.



Model 3. It is hypothesised that higher levels of stress will lead to higher levels of CF, but levels of CF will be reduced by the interaction of higher levels of cognitive reappraisal.



Model 4. It is hypothesised that higher levels of stress will lead to lower levels of CS, but levels of CS will be increased by the interaction of higher levels of cognitive reappraisal.

Practical Issues

Data Storage

Data will be initially collected online through the Qualtrics website (www.qualtrics.com) and will then be stored securely on a password protected network folder. Only the researchers conducting this study will have access to it. The data controllers will be Dr Ian Fletcher and Ms Sarah Heard. Data will be destroyed after 10 years. Lancaster University will be the data controller for any personal information collected as part of this study.

Site Visits

The main researcher will occasionally visit local sites to present the study and recruit participants. In such situations, participants will be encouraged to complete the study online. Travel expenses will be covered by Lancaster University.

Dissemination of Findings

Findings from this study will be disseminated as a Lancaster University doctoral thesis and through presentations to the Doctorate in Clinical Psychology staff and peers at the university. The study will be submitted for publishing to a relevant academic journal, e.g. “Journal of Advanced Nursing”.

Recruitment sites, which took part in the study, will be able to request a brief report of the findings. Additionally, when possible, the main researcher will present findings verbally to interested recruitment sites.

Participant data will be pooled for results and no individual data will be presented when publishing findings.

Monitoring of Study

All aspects of the research will be supervised and monitored by the academic supervisor, Dr Ian Fletcher.

Ethical Concerns

There are no major ethical or legal issues arising from this study. This study will be exploring potentially emotionally challenging factors, such as reduced capacity for compassion, high levels of workplace stress, and difficulties managing emotions. Consequently, participants may become concerned when completing the online survey. In order to address this, participants will be informed about the nature of the questions before they consent to take part in the study. Participants will also be given support information after completing the survey. Participants will be reminded that they can access workplace support/counselling services, should their organisation have one. As this study will recruit nationally, it would not be feasible to supply specific organisational support services.

Timescale

The study is expected to start recruiting participants in April 2020 and is expected to complete recruitment by the end of September 2020. The data collection period would only be extended should the minimum number of participants not be reached by the proposed end time. Should participants and recruitment sites request a summary of the study, this would be expected to be provided by March 2021.

References

Barron, K., Deery, R., & Sloan, G. (2017). Community mental health nurses' and compassion: An interpretative approach. *Journal Of Psychiatric And Mental Health Nursing, 24*(4), 211-220. doi:10.1111/jpm.12379

Bell, L. (2003). What can we learn from consumer studies and qualitative research in the treatment of eating disorders? *Eating and Weight Disorders, 8*(3), 181-187. doi:10.1007/bf03325011

Brown, B., Crawford, P., Gilbert, P., Gilbert, J., & Gale, C. (2014). Practical compassions: Repertoires of practice and compassion talk in acute mental healthcare. *Sociology of Health & Illness, 36*(3), 383-399. doi:10.1111/1467-9566.12065

Buruck, G., Dörfel, D., Kugler, J., & Brom, S. S. (2016). Enhancing well-being at work: The role of emotion regulation skills as personal resources. *Journal of Occupational Health Psychology, 21*(4), 480-493. doi:10.1037/ocp0000023

Cameron, C. D., & Payne, B. K. (2011). Escaping affect: How motivated emotion regulation creates insensitivity to mass suffering. *Journal of Personality and Social Psychology, 100*(1), 1-15. doi:10.1037/a0021643

Dasan, S., Gohil, P., Cornelius, V., & Taylor, C. (2015). Prevalence, causes and consequences of compassion satisfaction and compassion fatigue in emergency care: a mixed-methods study of UK NHS Consultants. *Emergency Medicine Journal, 32*(8), 588-594. doi:10.1136/emermed-2014-203671

Davey, A., Arcelus, J., & Munir, F. (2014). Work demands, social support, and job satisfaction in eating disorder inpatient settings: A qualitative study. *23*(1), 60-68. doi:10.1111/inm.12014

Doran, D., & Smith, P. (2004). Measuring service quality provision within an eating disorders context. *International Journal of Health Care Quality Assurance, 17*(7), 377-388. doi:10.1108/09526860410563186

Field, A. (2009). *Discovering statistics using SPSS* (3rd edition), London: SAGE Publications Ltd.

Foster, K., Roche, M., Delgado, C., Cuzzillo, C., Giandinoto, J. A., & Furness, T. (2019). Resilience and mental health nursing: An integrative review of international literature. *International Journal of Mental Health Nursing, 28*, 71-85. doi:10.1111/inm.12548

Gale, C., Gilbert, P., Read, N., & Goss, K. (2014). An Evaluation of the Impact of Introducing Compassion Focused Therapy to a Standard Treatment Programme for People with Eating Disorders. *Clinical Psychology & Psychotherapy, 21*(1), 1-12. doi:10.1002/cpp.1806

Gross, J. J., & John, O. P. (2003). Individual differences in two emotion regulation processes: Implications for affect, relationships, and well-being. *Journal of Personality and Social Psychology, 85*(2), 348-362. doi:10.1037/0022-3514.85.2.348

Heritage, B., Rees, C. S., & Hegney, D. G. (2018). The ProQOL-21: A revised version of the Professional Quality of Life (ProQOL) scale based of Rasch analysis. *PLoS One, 13*(2), e0193478. doi:10.1371/journal.pone.0193478

Kristensen, T. S., Hannerz, H., Høgh, A., & Borg, V. (2005). The Copenhagen Psychosocial Questionnaire--a tool for the assessment and improvement of the psychosocial work environment. *Scandinavian Journal of Work, Environment & Health, 31*(6), 438-449.

Lombardo, B., & Eyre, C. (2011). Compassion fatigue: A nurse's primer. *The Online Journal of Issues in Nursing, 16*(1), Manuscript 3. doi:10.3912/OJIN.Vol16No01Man03

Mann, S., & Cowburn, J. (2005). Emotional labour and stress within mental health nursing. *Journal of Psychiatric and Mental Health Nursing, 12*(2), 154-162. doi:10.1111/j.1365-2850.2004.00807.x

National Institute for Health and Care Excellence (NICE). (2017). *Eating disorders: Recognition and treatment* (NICE Guideline No. 69). Retrieved from https://www.nice.org.uk/guidance/ng69

Richards, D. A., Bee, P., Barkham, M., Gilbody, S. M., Cahill, J., & Glanville, J. (2006). The prevalence of nursing staff stress on adult acute psychiatric in-patient wards: A systematic review. *Social Psychiatry and Psychiatric Epidemiology: The International Journal for Research in Social and Genetic Epidemiology and Mental Health Services, 41*(1), 34-43. doi:10.1007/s00127-005-0998-7

Richardson, C. M. E. (2017). Emotion regulation in the context of daily stress: Impact on daily affect. *Personality and Individual Differences, 112*, 150-156. doi:10.1016/j.paid.2017.02.058

Smink, F. R. E., van Hoeken, D., & Hoek, H. W. (2012). Epidemiology of Eating Disorders: Incidence, Prevalence and Mortality Rates. *Current Psychiatry Reports, 14*(4), 406-414. doi:10.1007/s11920-012-0282-y

Stamm, B. H. (2009). Professional Quality of Life: Compassion Satisfaction and Farigue Version 5 (ProQOL). Retrieved from www.proqol.org

Stamm, B. H. (2010). *The Concise ProQOL Manual* (2nd ed.). Pocatello, ID: ProQOL.org.

Tremblay, M. A., & Messervey, D. (2011). The Job Demands-Resources model: Further evidence for the buffering effect of personal resources. *SA Journal of Industrial Psychology, 37*(2), 1-10. doi:10.4102/sajip.v37i2.876

Troy, A. S., & Mauss, I. B. (2011). Resilience in the face of stress: Emotion regulation as a protective factor. In S. M. Southwick, B. T. Litz, D. Charney, & M. J. Friedman (Eds.), *Resilience and mental health: Challenges across the lifespan*. Cambridge: Cambridge University Press.

Tully, A. (2004). Stress, sources of stress and ways of coping among psychiatric nursing students. *Journal Of Psychiatric And Mental Health Nursing, 11*(1), 43-47. doi:10.1111/j.1365-2850.2004.00682.x

Warren, C. S., Schafer, K. J., Crowley, M. E., & Olivardia, R. (2012). A Qualitative Analysis of Job Burnout in Eating Disorder Treatment Providers. *Eating Disorders, 20*(3), 175-195. doi:10.1080/10640266.2012.668476

Appendix 4-A

Information About the Research

Information about the research

Compassion in staff working in eating disorder services: Impact of stress and emotion regulation

My name is Emily Retkiewicz and I am conducting this research as a trainee on the Doctorate in Clinical Psychology course at Lancaster University.

You are invited to take part in a research study.

Before you decide whether to take part, it is important for you to understand why this research is being done and what taking part would involve for you. Please take time to read the following information carefully. Your participation is entirely voluntary – you are under no obligation to take part.

What is the purpose of this study?
I am conducting this research to explore if workplace stress and difficulties managing emotions have an impact on capacity for compassion in staff working in eating disorder services. It is hoped that the findings from this study will help inform how to best support staff in those services.

Why am I being asked to take part in this study?
You have been approached because you are currently working in an eating disorder service and have a clinical or therapeutic relationship with service users.

Do I have to take part?
No. It's completely up to you to decide whether or not you take part. If you decide at any point, up until submitting your responses, that you would like to withdraw, you can leave the survey without saving. Once you submit your responses you will not be able to withdraw, as they will be anonymised.

What will I be asked to do if I take part?
If you decide you would like to take part, you would be asked to complete a series of questionnaires online. One asks about demographic information, such as your age, gender, role and your experiences of working in an eating disorder service. The other questionnaires look at compassion, managing emotions, and workplace stress. Completing the questionnaires is expected to take between 15-20 minutes and you would only be asked to complete them once.

Will my data be identifiable?

The information you provide is anonymous as no identifiable information will be collected. The information you provide will not be shared with your place of employment. Your information will be stored safely and securely on a password protected network folder and only the researchers conducting this study will have access to it. Data will be destroyed after 10 years.

Lancaster University will be the data controller for any personal information collected as part of this study. Under the GDPR you have certain rights when personal data is collected about you. You have the right to access any personal data held about you, to object to the processing of your personal information, to rectify personal data if it is inaccurate, the right to have data about you erased and, depending on the circumstances, the right to data portability. Please be aware that many of these rights are not absolute and only apply in certain circumstances. If you would like to know more about your rights in relation to your personal data, please speak to the researcher on your particular study by sending an e-mail to e.retkiewicz@lancaster.ac.uk.

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit the webpage: www.lancaster.ac.uk/research/data-protection.

What will happen to the results?
The results will be summarised and reported in a doctoral thesis. They will also be submitted for publication in an academic or professional journal. It is expected that the results will also be presented to the Lancaster University Doctorate in Clinical Psychology staff and trainees, and potentially presented at conferences. A summary of the findings will be available on request by emailing the main researcher: Emily Retkiewicz (e.retkiewicz@lancaster.ac.uk). All reports and presentations will be written in a way that no-one can work out that you took part in the study.

Are there any risks?
There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to contact the resources provided on the last page of the online survey.

Are there any benefits to taking part?
Although you may find participating interesting, there are no direct benefits in taking part. It is hoped that the results from this study will inform how to better support staff working in eating disorder services to maintain their capacity for compassion.

Who has reviewed the project?
This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University and the Health Research Authority.

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact the main researcher: Emily Retkiewicz (e.retkiewicz@lancaster.ac.uk). You can also contact the research supervisor Dr Ian Fletcher (i.j.fletcher@lancaster.ac.uk).

Complaints
If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Dr Ian Smith
Senior Clinical Tutor & Senior Clinical Lecturer in Research Methods
Email: i.smith@lancaster.ac.uk
Tel: (01524) 592282
Clinical Psychology Training Programme
Lancaster University
Lancaster
LA1 4YW

If you wish to speak to someone outside of the Clinical Psychology Training Programme, you may also contact:

Professor Roger Pickup
Associate Dean for Research
Email: r.pickup@lancaster.ac.uk
Tel: (01524) 593746
Faculty of Health and Medicine
(Division of Biomedical and Life Sciences)
Lancaster University
Lancaster
LA1 4YG

Thank you for taking the time to read this information.

Appendix 4-B

Consent Form

By proceeding to the survey, you confirm that:

- You have read the information about this study and understand what is expected of you;
- You understand that you can withdraw by leaving the survey, and that once you submit your responses you will be unable to withdraw;
- You understand that any responses you give will remain anonymous; and
- Your participation is entirely voluntary.

By clicking the button below, you consent to taking part in this study.

Appendix 4-C

Recruitment Flyer

Lancaster University Doctorate in Clinical Psychology Research Project

Capacity for compassion in staff working in eating disorder services

Would you like to take part in this research?

- Are you currently working with patients diagnosed with an eating disorder in a caring, therapeutic or clinical capacity?
- Would you like to take part in a research project which aims to inform factors impacting on staff capacity for compassion?

If so, I would like to hear from you!

What would be involved?

- Completing a short (15-20 minutes) online survey which consists of series of questionnaires;
- The questionnaires ask about your experiences of working in an eating disorder service, and look at compassion, managing emotions, and workplace stress.

When and where will the project take place?

- I am currently recruiting, so you can complete the online survey now!
- You can complete the online survey on any device which has access to the internet.
- Recruitment is expected to stop by the end of September 2020.

If you would like to participate in the study, please go to https://lancasteruni.eu.qualtrics.com/jfe/form/SV_cNINz553odRozAx which will bring you to the online survey. You can find out more information about the study by clicking the link too. If you would like to contact me directly, you can do so by email: Emily Retkiewicz, e.retkiewicz@lancaster.ac.uk.

Appendix 4-D

Demographic Information Questionnaire

How old are you? (please type your answer)

What is your gender? (please type your answer)

What is your occupation? (please select from the following options)

- Nurse
- Healthcare assistant / support worker / nursing assistant
- Psychologist
- Assistant psychologist
- Therapist
- Counsellor
- Occupational Therapist
- Physiotherapist
- Medical doctor
- Dietician

How long have you been working with service users with an eating disorder / in an eating disorder service (overall)? (please type your answer)

years months

What setting are you currently working in? (please choose all applicable)

- Specialist eating disorder inpatient unit
- Specialist eating disorder community service
- Specialist eating disorder private practice
- Mental health inpatient unit
- Community mental health service
- Other (please specify)

What is the age group of eating disorder service users you are currently working with? (please type your answer, e.g. 0-18, adults, etc.)

Who do you mainly work with? (please choose all applicable)

- Service users
- Families (e.g. parents, siblings, partners) or carers

- ☐ Other systems (e.g. schools)
- ☐ Other staff (e.g. indirect work / training / consultation)

On average, how much face-to-face contact do you have with service users with an eating disorder (on a <u>weekly</u> basis)? (please type the number of hours)

On average, how much formal clinical supervision do you receive? (please type the <u>number of hours per month</u>; please type N/A if you don't receive clinical supervision)

Have you received specialist training in eating disorders? (please choose one option)

- ☐ Yes
- ☐ No

Appendix 4-E

COPSOQ III Short Version

Please choose answers that best reflect your current work situation.

	Always	Often	Sometimes	Seldom	Never / hardly ever
How often do you not have time to complete all your work tasks?	○	○	○	○	○
Do you get behind with your work?	○	○	○	○	○
Do you have to work very fast?	○	○	○	○	○
Do you have to deal with other people's personal problems as part of your work?	○	○	○	○	○
Do you have a large degree of influence on the decisions concerning your work?	○	○	○	○	○
How often do you get help and support from your colleagues, if needed?	○	○	○	○	○
Is there a good atmosphere between you and your colleagues?	○	○	○	○	○

	To a very large extent	To a large extent	Somewhat	To a small extent	To a very small extent
Do you work at a high pace throughout the day?	○	○	○	○	○

Is your work emotionally demanding?	O	O	O	O	O
Do you have the possibility of learning new things through your work?	O	O	O	O	O
Can you use your skills or expertise in your work?	O	O	O	O	O
Is your work meaningful?	O	O	O	O	O
At your place of work, are you informed well in advance concerning for example important decisions, changes or plans for the future?	O	O	O	O	O
Do you receive all the information you need in order to do your work well?	O	O	O	O	O
Is your work recognized and appreciated by the management?	O	O	O	O	O
Does your work have clear objectives?	O	O	O	O	O
Are contradictory demands placed on you at work?	O	O	O	O	O
Do you sometimes have to do things which ought to have been done in a different way?	O	O	O	O	O
Are you worried about becoming unemployed?	O	O	O	O	O
Are you worried about it being difficult for you to find another job if	O	O	O	O	O

you became unemployed?					
Are you worried about being transferred to another job against your will?	○	○	○	○	○

The next questions are not about your own job but <u>about the workplace as a whole</u>.

	To a very large extent	**To a large extent**	**Somewhat**	**To a small extent**	**To a very small extent**
Does the management trust the employees to do their work well?	○	○	○	○	○
Can the employees trust the information that comes from the management?	○	○	○	○	○
Are conflicts resolved in a fair way?	○	○	○	○	○
Is the work distributed fairly?	○	○	○	○	○

The next two questions concern the ways in which your <u>work affects your private life</u>:

	To a very large extent	**To a large extent**	**Somewhat**	**To a small extent**	**To a very small extent**
Do you feel that your work drains so much of your energy that it has a negative effect on your private life?	○	○	○	○	○
Do you feel that your work takes so much of your time that it has a negative effect on your private life?	○	○	○	○	○

Regarding your work in general…

	Very satisfied	Satisfied	Neither / Nor	Unsatisfied	Very unsatisfied
How pleased are you with your job as a whole, everything taken into consideration?	O	O	O	O	O

The following question is about <u>your own health</u>. Please do not try to distinguish between symptoms that are caused by work and symptoms that are due to other causes. The task is to describe <u>how you are in general</u>.
The questions are about your health during the <u>last four weeks</u>:

	Excellent	Very Good	Good	Fair	Poor
In general, would you say your health is…	O	O	O	O	O

To what extent would you say that your <u>immediate supervisor</u> ...

	To a very large extent	To a large extent	Somewhat	To a small extent	To a very small extent	I do not have a supervisor
is good at work planning?	O	O	O	O	O	O
is good at solving conflicts?	O	O	O	O	O	O

	Always	Often	Sometimes	Seldom	Never / hardly ever	I do not have a supervisor
How often do you get help and support from your immediate supervisor, if needed?	O	O	O	O	O	O

Appendix 4-F

ERQ Questionnaire

We would like to ask you some questions about your emotional life, in particular, how you control (that is, regulate and manage) your emotions. The questions below involve two distinct aspects of your emotional life. One is your emotional experience, or what you feel like inside. The other is your emotional expression, or how you show your emotions in the way you talk, gesture, or behave. Although some of the following questions may seem similar to one another, they differ in important ways. For each item, please answer using the following scale:

	1 Strongly disagree	**2**	**3**	**4 Neutral**	**5**	**6**	**7 Strongly agree**
When I want to feel more *positive* emotion (such as joy or amusement), I *change what I'm thinking about.*	O	O	O	O	O	O	O
I keep my emotions to myself.	O	O	O	O	O	O	O
When I want to feel less *negative* emotion (such as sadness or anger), I *change what I'm thinking about.*	O	O	O	O	O	O	O
When I am feeling *positive* emotions, I am careful not to express them.	O	O	O	O	O	O	O

When I'm faced with a stressful situation, I make myself *think about it* in a way that helps me stay calm.	O	O	O	O	O	O	O
I control my emotions by *not expressing them.*	O	O	O	O	O	O	O
When I want to feel more *positive* emotion, I *change the way I'm thinking* about the situation.	O	O	O	O	O	O	O
I control my emotions by *changing the way I think* about the situation I'm in.	O	O	O	O	O	O	O
When I am feeling *negative* emotions, I make sure not to express them.	O	O	O	O	O	O	O
When I want to feel less *negative* emotion, I *change the way I'm thinking* about the situation.	O	O	O	O	O	O	O

Appendix 4-G

ProQOL-21 Questionnaire

When you support/help people you have a direct contact with their lives. As you may have found, your compassion for those you support can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a clinician/worker. Consider each of the following questions about you and your current work situation. Select the option that honestly reflects how frequently you experienced these things in the last 30 days.

	Never	Rarely	Sometimes	Often	Very often
I get satisfaction from being able to support people.	O	O	O	O	O
I feel invigorated after working with those I support.	O	O	O	O	O
I am not as productive at work because I am losing sleep over traumatic experiences of a person I support.	O	O	O	O	O
I think that I might have been affected by the traumatic stress of those I support.	O	O	O	O	O
I feel trapped by my job as a clinician / worker.	O	O	O	O	O
Because of my helping, I have felt “on edge” about various things.	O	O	O	O	O

I like my work as a helper / clinician.	O	O	O	O	O
I feel depressed because of the traumatic experiences of the people I support.	O	O	O	O	O
I feel as though I am experiencing the trauma of someone I have supported.	O	O	O	O	O
I am pleased with how I am able to keep up with my supporting / helping techniques and protocols.	O	O	O	O	O
My work makes me feel satisfied.	O	O	O	O	O
I feel worn out because of my work as a helper / clinician.	O	O	O	O	O
I have happy thoughts and feelings about those I support and how I could help them.	O	O	O	O	O
I feel overwhelmed because my case/work load seems endless.	O	O	O	O	O
I believe I can make a difference through my work.	O	O	O	O	O

I avoid certain activities or situations because they remind me of frightening experiences of the people I support.	O	O	O	O	O
I am proud of what I can do to help.	O	O	O	O	O
As a result of my helping, I have intrusive, frightening thoughts.	O	O	O	O	O
I feel “bogged down” by the system.	O	O	O	O	O
I have thoughts that I am a “success” as a helper / clinician.	O	O	O	O	O
I am happy that I chose to do this work.	O	O	O	O	O

Appendix 4-H

Debrief Information

Thank you for your time and cooperation in taking part in this study. **Please click the button below to submit your answers.**

If any of the questions have raised any concerns for you and you would like further support, please visit www.111.nhs.uk or contact your GP. You can also access your local workplace support or counselling services.

Appendix 4-I

Ethical Approval Confirmation Letter

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Dr Ian Fletcher
Division of Health Research
Lancaster University
Lancaster
LA1 4YG

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

22 June 2020

Dear Dr Fletcher

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

Study title:	**Compassion in staff working in eating disorder services: Impact of stress and emotion regulation**
IRAS project ID:	**271377**
Protocol number:	**N/A**
REC reference:	**20/HRA/1802**
Sponsor	**Lancaster University**

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

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

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

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

What are my notification responsibilities during the study?

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

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

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

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

Your IRAS project ID is **271377**. Please quote this on all correspondence.

Yours sincerely,
Nicole Curtis

Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Mrs Becky Gordon*

List of Documents

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

Document	*Version*	*Date*
Copies of advertisement materials for research participants [Recruitment flyer]	1.0	29 November 2019
Covering letter on headed paper [Cover letter]	1.0	11 December 2019
Covering letter on headed paper [Cover letter]	2.0	12 June 2020
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Lancaster University insurance certificate]		18 July 2019
IRAS Application Form [IRAS_Form_07042020]		07 April 2020
MHRA Notice of No Objection Letter (Medical Devices) and relevant correspondence [NHS trust assurance in principle]	1.0	25 March 2020
Non-validated questionnaire [Demographic information questionnaire]	1.0	08 November 2019
Organisation Information Document [OID]	1.0	11 December 2019
Other [Lancaster University Professional Negligence Insurance]		04 September 2019
Other [Letter of invitation to managers (email)]	1.0	16 December 2019
Other [Debrief page]	1.0	22 November 2019
Participant consent form [Consent page]	1.0	22 November 2019
Participant information sheet (PIS) [Information about the research]	2.0	04 June 2020
Referee's report or other scientific critique report [Thesis proposal approval]	1.0	26 July 2019
Research protocol or project proposal [Research protocol]	2.0	04 June 2020
Schedule of Events or SoECAT [Schedule of Events (HRA Assessed)]	2	22 June 2020
Summary CV for Chief Investigator (CI) [Summary CV for CI]	1.0	17 February 2020
Summary CV for student [Student CV]	1.0	16 December 2019
Summary CV for supervisor (student research) [Academic supervisor summary CV]	1.0	17 February 2020
Validated questionnaire [COPSOQ III short version questionnaire]	1.0	22 November 2019
Validated questionnaire [ERQ questionnaire]	1.0	22 November 2019
Validated questionnaire [ProQOL-21 questionnaire]	1.0	22 November 2019

IRAS project ID	271377

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
All sites will perform the same research activities therefore there is only one site type.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study.	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.	No external study funding has been sought.	A Local Collaborator should be appointed at study sites.	No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to obtain a Letter of Access based on standard DBS checks and occupational health clearance.

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio. The applicant has clarified that this study will be completed by participants online and recruitment will be nation-wide. Not all sites have been identified in Part C of the IRAS Form as they are not all known, and some participants will be recruited via word of mouth and professional online webstes/forums.

The applicant has explained that no costs are anticipated for any of the research activities which is why the Schedule of Events does not have any research cost types selected.