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Transition experience in adults after hospitalisation for anorexia nervosa

Portfolio for Professional Doctorate in Counselling Psychology (DPsych)

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Preface

Clinician to researcher

Having qualified as a Counselling Psychologist, I spent ten years working in a clinical role in the NHS. I had worked in a variety of settings and then specialised in working with people with eating disorders. The ideas that brought together this research portfolio started from my clinical role and the portfolio has evolved over the last few years into its current form. It began with me as a clinician being curious to know what it was like for people who have had inpatient treatment for an eating disorder to transition out of hospital. My initial assumptions were that it might be problematic for them and, if correct, I wondered how the situation might be helped. This led me to conduct the research project, the details of which follow below. The second component of the portfolio outlined below is a clinical case study which provides an example of how I worked with a woman who transitioned out of hospital. The third component focuses on the dissemination of the findings from my research in the form of a publishable paper. The final section of this preface revisits the theme of my transition from clinician to researcher and contains some personal reflections on the process by which this came about.

The Research Project

The main part of the portfolio is concerned with the research project. In order to carry out the research, a sizable piece of work was done to obtain the necessary ethical approval to enable me to recruit and interview potentially very vulnerable people who might have suffered much and gone through difficult times. The project was therefore intensely scrutinised by an independent panel of assessors on the local NHS research committee.

The research investigates the experiences of adults transitioning out of a specialist eating disorder inpatient unit into the community. Six women, who were receiving on-going support in a specialist outpatient service unrelated to the inpatient service, were recruited to the project. The participants were interviewed using a semi-structured format. The aim was to find out what the lived experience of their transition was like by listening to their personal accounts. Analysis of the data generated from the interviews was conducted using Interpretative Phenomenological Analysis (IPA). The focus of the experience was then formulated through an interpretative process. Difficulties in the transition were highlighted and presented thematically. Factors that facilitated the transition were also observed and presented thematically. The content of the interviews included a focus on maintaining adequate nutritional intake in order to preserve physical health gains achieved as an inpatient. There was also attention paid to the environmental change but most of all the psychological challenges in the transition were a focus.

The findings of the study are discussed in relation to current trends in psychological interventions and service provision for people who are in the process of recovery from an eating disorder and anorexia nervosa in particular.

The case study: an example of clinical practice

This piece aims to demonstrate the way in which I work as a Counselling Psychologist. My style and approach have been developed over a number of years, having originally completed psychotherapy training in the Person-centred approach prior to undergoing my counselling psychology training. In the case study I aim to show how my approach of focusing on the therapeutic alliance as a vehicle for change is valuable and effective. However, I am also in support of the development of cognitive behavioural therapy and the emergence of Compassion Focused therapy for eating disorders (CFT-E) as described by Goss and Allan (2009).

The study describes the case of a 32-year-old woman with a long-standing history of anorexia nervosa dating back to childhood. She had experienced many different interventions from different clinicians and my work with her spanned four years. The study, as I have written it, acknowledges our past work as a precursor for the main work which came about after a transition out of a specialist in-patient service for the treatment of eating disorders. Thus, the focus of the study is the last year of therapy, meeting more or less weekly. The study demonstrates how we collaboratively used a Compassion Focused formulation to bring together her difficulties. It also demonstrates the use of a transition formulation to really focus on the difficulties at the point of transition.

The intervention, which focused on the acquisition of skills to promote self-compassion, was not without difficulties. Many of the blocks to change were played out within the therapeutic relationship. Thus, the study also demonstrates my use of supervision to help the client move away from some of her more destructive interpersonal and eating disordered behaviours. Furthermore, the case serves to demonstrate the need for on-going self-evaluation and self-reflection within the therapeutic process when working as a counselling psychologist. However, the case also importantly remains about my client, not about myself; this balance in favour of the client is evident in the reporting style of the case study.

The dissemination process: the publishable paper

The third and final part of the portfolio consists of the publishable paper. One of the most important things for me as a clinician wanting to engage in becoming a researcher was keeping in mind the purpose of the research. There was, on the one hand, the personal academic purpose, which will be described and reflected on in detail in the next section, but also the purpose of the work was not to keep the results hidden in a drawer of my desk. I started the research with the notion that dissemination of findings was very important and part of my transition to becoming a researcher. Ensuring that the findings were disseminated was also respectful to the participants who gave up their stories, time and energy to take part in the research. All of them were keen that the research make a difference to the lives of fellow sufferers.

The choice of journal was made after reading a variety of journals that specialised in eating disorders. However, what was also important was the focus of the journal in terms of methodology. From my research of relevant papers for the current study, particularly in the discussion section of the thesis, I could see that The European Eating Disorders Review journal often published qualitative studies, many of which had used IPA. My study raised many issues for service provision, especially in terms of psychological approach and interventions for people with anorexia nervosa. Thus, it seemed appropriate to write the paper with this journal in mind for publication after completion of my doctorate. The decision for which journal to choose was therefore made on pragmatic grounds.

The next decision involved determining what slant I wanted to take. I chose to present the findings of one of my themes and selected the one I felt had the most to contribute to how clinicians might think about their interventions. I also wanted to showcase how my research might fit with current research being carried out by others at the present time. This felt quite exciting with a sense that my research might be a small cog in the wheels of current ways of thinking of the dilemmas of treating anorexia nervosa.

Reflections on my transition to researcher

What follows are some personal reflections on my own personal transition from clinician to researcher and how, in the end, I was able to embrace both.

In terms of the publishable paper, I had never written a paper before and it took courage to think that I would be capable of doing so and that it would be something that others might want to read and take notice of or debate. I am grateful to discussions with fellow eating disorder psychologists with regard to the choice of journal. A very difficult challenge was deciding what slant I wanted to take in the paper. I had to accept that much of my study could not be included; I had the task of deciding what was essential to include and what to leave out. This was a dilemma in that I needed to present a logical argument in the paper but could not use all the examples I had used in the thesis itself.

As far as the case study was concerned, writing and talking about my clinical work was more familiar to me, and I felt more confident in expressing my thoughts and feelings. However, there were some anxieties as it had been many years since I had written a case study, even though I was familiar with the format. It was very different conducting therapy to stopping, writing about it and justifying my choices. What I noticed that surprised me was the effect writing about the client had on me. I had completed the work some two years before I wrote the study and I realised when I finished writing it up that in fact the client had still been open in my mind. It was only through finishing the write up of the case that I gained closure.

In terms of the research itself, conducting this from proposal, ethical permissions, conducting semi-structured interviews, understanding the methodology, analysing the data, writing up the results, discussing the findings and thinking about the impact of the research on people with eating disorders, were all new adventures for me. The process took many turns with trials and tribulations along the way, with break-through ideas and serious challenges to what I thought was appropriate. What I noticed eventually was that practice with my writing skills did reap benefits as gradually my performance improved and I became quicker and more fluent. Interestingly this transferred to other areas of my life as well in terms of fluency. So, on a personal note the transition to researcher left me feeling more educated and confident. In terms of being a counselling psychologist this preface has demonstrated the importance of being reflective. In addition, I have enjoyed the intellectual challenge of conquering my fears of writing. I am left feeling more balanced as both a scientist researcher and clinician practitioner which is at the heart of being a counselling psychologist.

Reference

Goss, K., & Allan, S. (2009). Shame, Pride and Eating Disorders. *Clinical Psychology and Psychotherapy, 16*, 303-316.

Part 1: The research

Specialist inpatient care to specialist outpatient care: experiences of this transition for adults with eating disorders.

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Supervised by Dr Elena Gil-Rodriguez

Abstract

Research into the experiences of hospitalization for people with eating disorders (ED) has previously focused on the inpatient stay itself and generally been limited to the adolescent experience. Very little is mentioned in terms of the experience of being discharged from specialist eating disorder units and concerns have been raised about the issue of this transition in terms of other psychiatric conditions. In view of the paucity of research into the discharge transition in ED, this study investigated the lived experiences of the transition from inpatient to outpatient care following hospitalization for anorexia nervosa. Participants were six women who were recruited from one specialist outpatient service. The study design was qualitative, using semi structured interview data, analysed using Interpretative Phenomenological Analysis (IPA). Two superordinate themes emerged: living with ambivalence to change and living in recovery. Participants' accounts highlighted psychological blocks that accompanied the environmental transition. Transition from hospital brought to mind the continued ambivalence that the women felt towards their eating disorder. Moreover, a focus on recovery was revealed: recovery involved letting go of inpatient relationships, harnessing support from others in the community and having a vision of the recovered self. Ambivalence was experienced in a complex manner with elements of conflict, confusion and shame attached to it. It is suggested that these findings may be useful for the psychological reformulation of current ambivalence at point of discharge and clinical implications are presented.

Introduction

Beginnings

In setting out to write this thesis I have several hopes. The first is that I can describe what it is like to come out of hospital and return to the community following inpatient care for an eating disorder. The second is that those that took part in the study and told their stories found the research experience helpful. Thirdly, that communicating my findings will impact on clinicians' thoughts and ideas about the transition and will influence their vision and practice.

Understanding Eating Disorders

For ease of understanding, eating disorders are often identified through specific diagnostic categories. It is helpful to start by acknowledging and being familiar with the existence of these groupings. Diagnostic groups exist in order to cluster similar types of symptoms together. This can then help services to better understand and plan effective treatment strategies (DSM-V; APA, 2013) Currently, in the United Kingdom, commissioning services devise treatment pathways for eating disorders based on diagnosis (Goss & Fox, 2012). The main classification system for mental health diagnosis is the recently updated Diagnostic and Statistical Manual-V (DSM-V, APA, 2013). In this system there are three main diagnoses for Eating Disorders that are important to know about for this study; these are anorexia nervosa, bulimia nervosa and other eating disorders. I summarize the diagnostic criteria for all three diagnoses below.

In the DSM-V criteria (APA, 2013, pp. 338-339), to be diagnosed as having anorexia nervosa, a person must display:

A. *Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.*
B. *Intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain, even though at a significantly low weight.*
C. *Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight and shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.*

There are also two subtypes within this diagnostic category. Firstly, there is the restricting type, which is where the problem is dietary restriction and/or excessive exercise. The second subtype is where there are episodes of binge eating, with purging-type behaviour.

Subtypes need to be used to describe the current presentation as over the course of the disorder there is often cross-over between subtypes. (DSM-V, APA, 2013 p. 339). Furthermore the symptoms are also classified in terms of severity. Anorexia can be:

Mild: BMI[1] *< 17 Kg/m²*

Moderate: *BMI 16-16.99 kg/m²*

Severe: *BMI 15-15.99 Kg/m²*

Extreme: *BMI < 15 Kg/m²*

(DSM-V, APA, 2013, p. 339)

As far as bulimia nervosa is concerned, according to DSM-V criteria (APA, 2013, pp. 345-347) a person must display:

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

1. *Eating, in a discrete period of time (e.g., within in any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.*
2. *A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).*

B. Recurrent inappropriate compensatory behaviours in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviours both occur, on average, at least once a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during periods of anorexia nervosa.

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[1] A healthy body weight is calculated using the Body Mass Index. Multiplying height in metres by itself and then dividing weight in kilograms by this number makes the calculation. The BMI has a healthy range of 20-25 (Goss, 2011).

Again the severity is also part of the classification. Thus bulimia nervosa can be:-
Mild: *An average of 1-3 episodes of inappropriate compensatory behaviours per week.*
Moderate: *An average of 4-7 episodes of inappropriate compensatory behaviours per week.*
Severe: *An average of 8-13 episodes of inappropriate compensatory behaviours per week.*
Extreme: *An average of 14 or more episodes of inappropriate compensatory behaviours per week.*
(DSM-V, APA, 2013, p. 347)

A third diagnosis is Other Specified Feeding or Eating Disorder (OSFED) (DSM-V, APA, 2013 p. 353). This category does not in itself have a set of criteria. It is a diagnosis given by clinicians when the eating disorder is clinically severe, causing high levels of distress, but the presentation does not meet the full criteria for any of the eating disorder diagnostic classifications. It was previously known as Eating Disorder Not Otherwise Specified (EDNOS) in a previous version of DSM-V, the DSM-IV (APA, 2013). Thus the diagnosis of OSFED is given accompanied by the reason why it does not fit a defined classification, (e.g., bulimia nervosa - low frequency).

Despite clear criteria, similarities between disorders and a high frequency of cross-over symptoms, in practice, makes specific diagnosis difficult. Many individuals move between these diagnoses over time. Those with bulimia nervosa, not always, but sometimes have a history of anorexia nervosa. Equally those with anorexia nervosa, not always, but sometimes move into bulimia nervosa en-route to recovery (Goss & Fox, 2012). This diagnostic instability gives support for the use of the general term eating disorders, as advocated by Milos, Spindler, Schnyder and Fairburn (2005), rather than separate diagnoses.

More recently clinicians and researchers alike have focused more on the ‘common features’, which tend to be seen in all the different disorders. Fairburn, Cooper and Shafran (2003) argued for a trans-diagnostic approach, which they related to what they termed a ‘shared psychopathology’ (p.519). They argued that it was helpful to see the pathology as being similar between diagnostic categories. Thus eating disorders could be viewed as something wrong within the individual that consisted of over valued ideas about eating weight and shape, purging behaviour all of which led to cognitive distortions that would necessitate treatment and likely respond to a course of cognitive behavioural therapy. The idea that eating disorders have common features is helpful as it removes the need try to try and link specific symptoms to specific disorders. However, what this approach omits or at least sidelines is the individual within the disorder; the emphasis is on a pathology that needs to be cured. Thus the focus is taken away from the individual themselves and how they have come to understand the multiple meanings and considerations that they experience with their eating disorder.

Specialist Treatment

The first treatment option for patients with an eating disorder is specialist outpatient care (NICE, 2004, 2017). Historically there have been wide variations in the provision of eating disorder services (Gowers et al., 2002). There has been 'generic' outpatient therapies provided by community mental health teams and backed up by admission to general psychiatric hospitals or, if need be, short admissions to general hospitals for medical care. More recently specialist multidisciplinary outpatient eating disorder services have been set up (Willinge, Thornton & Touyz, 2012, p.385) The aim of these services is to provide a comprehensive assessment of the patient's physical, psychological and social needs, and assessment of risk of harm to self. The areas of risk that can develop as a result of an eating disorder can be a risk to physical and mental health and have been summarised by Goss and Fox (2012). The physical health risk relates to severe food restriction which results in weight loss. The impact of continued and rapid weight loss can have acute medical complications related to the heart and circulation. With muscle loss around the heart there is potential for drops in blood pressure and heart beat irregularities. There can also be hair loss, poor intestinal function and loss of menses and more longterm disturbances to bone health. (Fairburn, 2008, p.42) The mental health risks include co morbidity of depression (Herzog, Rathner, & Vandereycken, 1992; Fairburn, 2008, p. 40). In terms of treatment, the guidelines recommend psychological therapy, accompanied by regular monitoring of a patient's physical state, including weight and specific indicators of increased physical risk (NICE, 2004, 2017).

Specialist inpatient service provision remains divided between private and NHS providers. NHS providers struggle to meet the demand for inpatient beds (Jarman, Smith &Walsh, 1997, p.138) The need for inpatient treatment may occur at first presentation of the problem where there is a significantly low Body Mass Index (BMI). People with a very low BMI usually fit into the diagnostic category of anorexia nervosa, however, there is often variation in whether people want or reject the diagnosis

(Vitousek, Watson & Wilson, 1998). Inpatient treatment may also be required if during a period of outpatient treatment there is significant deterioration, usually in terms of weight (NICE, 2017). Equally, inpatient treatment may be considered if there is little improvement following an adequate course of outpatient treatment, or if the completion of an adequate course of outpatient psychological treatment does not lead to any significant improvement (NICE, 2017). The important point is that the decision for what would be an appropriate intervention of care is one that comes through clinical experience (Jarman, Smith & Walsh, 1997). The decision for inpatient care is individualized and not based solely on weight and BMI (NICE, 2017). The focus and aim of inpatient care is weight restoration and, with this, psychological components are added to enable weight restoration to be accomplished (Bowers & Andersen, 1994, p.195)

Transition

The overall aim of the inpatient programme is weight restoration and enabling the sufferer to be discharged back into the community and this process was described by Vanderycken (2003). This process of transition has developed in the NHS over the last forty years.

Care in the Community

Following a major shift in the management of mental health patients at the end of the twentieth century, systems were devised to allow management of patients in the community. Previously, care had been focused on psychiatric institutions, but with these closing, patient management moved to the community (Fakhoury & Priebe, 2007). This new way of working led to the development of a care management system – the Care Programme Approach (CPA), which was introduced by the Department of Health in the UK in 1990 (Firth, 2004). The system grew mainly from fears about public safety in relation to mental health patients posing a risk to the wider public (Fakhoury & Priebe, 2007). In fact, this did not prove to the norm at all, with only a handful of notorious cases proving a danger to others (Warner, 2005). The CPA system has thus been more focused on the risk that patients pose to themselves, but it also focused on providing joined up care for patients with long-term conditions, when multiple agencies are involved (Goodwin & Lawton-Smith, 2010). One particular focus of CPA has been at points of transition in patient care, (Walker & Eagles, 2002).

Transition from hospital and the Care Programme Approach (CPA)

The need for aftercare following general psychiatric admission has been highlighted by Walker and Eagles (2002). They refer to the Scottish Executive study (Scottish Executive, 2001) which undertook a confidential enquiry into deaths of general psychiatric patients' post-discharge from hospital into the community. The findings suggested that patients were most at risk of death within the first week of discharge. Recommendations therefore emerged suggesting that all patients should routinely be followed up in the community within one week of discharge. Furthermore, that discharge should be preceded routinely by a joint case review between inpatient and community teams.

Service transition interventions in general psychiatric presentations

Steffen, Kosters, Becker and Puschner (2009) and Kalseth, Lassemo, Wahlbeck, Haaramo and Magnussen (2016) reviewed the literature regarding the transition out of hospital for general psychiatric patients, and in particular they focused on the association between readmission in relation to provided health care systems. In general, discharge planning and aftercare programmes most often had a positive effect on reducing the need for readmission. Other studies cited in Bennewith et al. (2014) have investigated how the risk of harm might be prevented post-discharge. These authors refer to reports by Meehan et al. (2006) and Appleby et al. (2006) that indicate the high risk of suicide in the first three months post-discharge from psychiatric inpatient care; this risk was also previously highlighted by Walker and Eagles (2002). Therefore, the focus of investigation for transition from hospital to community has often been at the service level, whereby interventions with the aim of promoting a satisfactory outcome are evaluated. This approach has looked at readmission rates and patient safety. Many of the interventions have been creative in their design and will be summarised here briefly.

The idea that peer support would be helpful on transitioning out of hospital has been investigated and Reynolds et al. (2004) designed a transitional discharge model. This quantitatively assessed intervention had two phases, the first was peer support and the second involved support from a transition nurse. The nurse provided a bridge of care between hospital inpatient care and outpatient care. Patients were randomly allocated to the model or treatment as usual. The results indicated no significant difference in terms of remaining in the community and reduction of symptoms between the two groups, however, those who were in the experimental group experienced improved psycho-social functioning.

Kidd et al., (2016) revisited the peer support approach in a feasibility study with people with severe mental illness. This intervention, called the 'welcome basket' (p.335), involved peers making contact with the patients before discharge, organising practical things to welcome them home and then meeting with them for support in the community post-discharge. They found that, as this group had severe mental health difficulties, the process of transition might take longer before gains emerged. In a further study, Wolf, Chung and Kordy (2010) designed an email aftercare intervention that had the intention of smoothing the process of transition to outpatient services for patients who had had inpatient psychotherapy treatment for psychosomatic conditions. Post-discharge patients were invited to email their inpatient therapist once a week, or more if they so wished, for twelve weeks. Themes were extracted from the emails. Results were hard to interpret due to methodological issues. The main problem it was suggested by the authors was that similar topics could be found in other contexts. The extrapolated themes might be found in email diaries written by a non-clinical population. It was therefore hard to link particular concerns specifically to people post discharge. The themes that Wolf, Chung and Kordy found related to concerns the patients had about work, socialising and relationships.

Finally, a New York based study by Tomita, Lukens and Herman (2014) designed a "Critical Time Intervention" (p.4). This intervention was focused on preventing the risk of homelessness for patients discharged from psychiatric hospitalization. The programme involved a social worker making contact with the patient before discharge and then giving intensive contact and support immediately post-discharge and working with the family to teach them to give support to the patient. Gradually the input from the social worker was withdrawn, such that the family and the patient learnt to work together in order to support the patient in the community. The conclusion was that family support during transition to the community is crucial alongside help to mobilize the support.

Discharge from General Psychiatric hospital: the patients' perspective

There are some studies from general psychiatric discharges that investigated the patients' perspective. Nolan, Bradley and Brimblecombe (2011) explored service users experience of discharge from an acute inpatient setting. The aim of the qualitative study was evaluative in nature; the authors sought to discover what might improve the experience for the participants and interviewed 44 patients face to face prior to discharge. Two follow up telephone interviews took place at two and four weeks post discharge and 18 of the 44 took part in this part of the research. Reasons for opting out including being lost to follow up, declining and being too ill to take part. Results led to an understanding of the participants' concerns, which included a need for reassurance, psychological support and companionship post-discharge.

In a qualitative patient experience study conducted in Japan by Niimara, Tanoue and Nakanishi, (2016), patients' experience of discharge was found to be one of a continued burden with residual symptoms of schizophrenic spectrum disorder. The patients experienced difficulty accessing help and a loneliness, all compounded by a difficulty in expressing themselves.

In summary, investigation of the transition from inpatient to outpatient care amongst general psychiatric populations has focused on two approaches. The first has been involved in the design of interventions to optimise relapse prevention and manage risk. The second has, in a limited way, asked service users about their experiences of discharge, but in a way that services might be adjusted to optimise the outcomes

Inpatient to Outpatient transition management

As a result of the above, the current management of the transition of patients from specialist inpatient care for eating disorders to specialist outpatient care is informed by general psychiatric recommendations, with some additional guidelines in relation to physical health monitoring (NICE, 2004, 2017).

The CPA Discharge meeting

In the NHS, discussions about discharge to outpatient services from inpatient care typically take place in multidisciplinary team meetings. Discharge planning involves the inpatient and outpatient team, the patient and usually the family. The aim is to have a discharge plan describing the specific responsibilities of everyone in the team so as to ensure a smooth transition of care for the patient in terms of managing potential risks after discharge. The focus is to maintain patient safety in terms of their mental health, monitoring any self-harm, suicidal ideation or suicidal intent. However, it is also important to ensure that the physical health of the patient is monitored, outlining who is responsible for weight monitoring, blood tests and other physical health check-ups. A written summary of the plan is then circulated. This approach to discharge is informed by the National Institute for Clinical Excellence guidelines (NICE, 2004, 2017) for managing patients with eating disorders.

The guidelines stress that inpatient to outpatient interfaces need to be managed effectively. Care planning for discharge, it is advised, should start at admission. There should be clear objectives and outcomes for the admission and these should be developed with the patient and their family members (as appropriate) and the community team. There also needs to be a plan on discharge setting out how they will be discharged and how they will move back to community-based care and also what this care should be. (NICE, 2017, p.33).

The transition from inpatient to outpatient care involves ensuring there is appropriate communication across services, with an emphasis on this being a smooth process, (Whittaker, Treasure & Todd, 2010) A handover is seen as important and the overall aim of this process is continuity of care for the patient. Continuity of care is important as it aims to keep the patient safe, manage any risk effectively and provide quality care for the patient (Walker & Eagles, 2002). Drawing up a plan of care as a team aims to address the concerns of everyone: the patient, the clinicians and the family. The idea is to build on the work that the patient has done in the inpatient setting and devise an individualised plan of care, (NICE, 2017, p.33). Post-discharge care includes a focus on physical health, particularly the management of physical risk to the patient. Best practice advocates that psychological care should also be offered, (Vandereycken, 2003, p. 417). A focus in therapy on eating behaviour, attitudes to weight and shape, alongside other psychological issues, is recommended. Psychological risks should also be monitored.

Management of risk and relapse

Two clinical issues have informed the practice outlined above. The first is the need for clinicians to manage any risks of harm that may occur after discharge. The second is the need for clinicians to prevent any relapse.

In terms of risk of harm, anorexia nervosa has been found to have the highest mortality of all mental illnesses with 5.8 percent dying from anorexia nervosa-related conditions (Herzog, Rathner, & Vandereycken, 1992). Although a more recent review by Keel and Brown (2010) more optimistically found that mortality rates for anorexia nervosa had lessened overall to 2.8 percent. What is important to note is that, with these figures in mind, it is unsurprising that clinicians are keen to plan effective care and especially at times of transition such as from inpatient to outpatient services.

In terms of relapse, Vandereycken (2003) has identified a serious risk of relapse and a “revolving door” (p. 416) pattern of readmission for patients being discharged following inpatient treatment for anorexia nervosa. Anorexia nervosa has been regarded as a complex condition that brings great challenges at each stage of treatment and relapse rates have been reported as high. Indeed, Treasure and Ward (1997) suggest that 50 percent of patients who receive multidisciplinary care recover, 20 percent have residual symptoms and 30 percent go on to a chronic course. More recently a systematic review of relapse rates in anorexia nervosa by Khalsa, Portnoff, McCurdy-Mckinnon and Feusner (2017) highlighted the problem of pinning down relapse rates due to the vast difference regarding definition of relapse. The authors reviewed 27 studies that had been published between 1975 and 2016 and they identified a range in relapse from as low as nine percent to a high of 52 percent with the majority of studies reporting more than 25 percent relapse. The most recent study cited in the review was by Carter, Mercer-Lynn, Norwood, Bewell-Weiss and Crosby (2012) where at 12 months follow up 41 percent of the patients with anorexia nervosa had relapsed.

Transition Literature

Concerns of risk and relapse have generated a number of different types of reviews, case reports and studies. What follows is a summary of the transition literature.

Relapse prevention literature based on research on outcomes

In a review by Bowers and Andersen (1994), concerns were raised about managing relapse rates after inpatient treatment for anorexia nervosa. The authors describe a lack of studies concerning what manner of effective treatment would prevent relapse. They focus on the idea that relapse would be prevented if the right combination of therapy for patients could be determined and that research needs to be in terms of measured outcomes, preferably using controlled trials of treatment. A study by Howard, Evans, Quintero-Howard, Bowers and Andersen (1999) also focused on outcomes. This study reviewed medical records to determine what could predict success or failure of the transition from inpatient care to day care. The authors reviewed the case charts of 59 female patients who had been transitioned to day care. The results identified that illness duration of more than six years, amenorrhea duration of more than two and a half years and BMI less than 16.5Kg/m^2 at inpatient admission were prognostic indicators for relapse and readmission to inpatient care. Furthermore, the low BMI indicated the greatest risk, followed by amenorrhea and finally duration of illness. With this in mind, they suggested that those with a low BMI and therefore the greatest risk indicator for relapse continue to be treated as an inpatient rather than transfer to day care. Prognosis was also discussed by Venderecken (2003); in this article, the optimum point of discharge was reviewed, considering the clinical and economical indicators for discharge as being central to decision making by the clinician and also alluding to the need for 'aftercare' (p. 417). Thus, the assumption is that effective treatment keeps patients from returning to hospital care; however, it may be that the transition process itself also has an impact on relapse. Outcome continued to be used to investigate the transition. For example, Herpertz-Dahlmann et al. (2014) found that day-patient care after short term inpatient care, in this case for adolescents, was no less effective than inpatient care for weight restoration and maintenance of gains over the following year. In economic terms they suggest the former made sense.

Furthermore a case report by Fennig, Fennig and Roe (2002) suggested that there was a need for in-depth understanding of the transition process from inpatient to outpatient care. The authors hypothesized that adolescents in recovery from anorexia nervosa, experienced a gap between the pace of physical and psychological recovery. Physical recovery could be much faster than psychological recovery, The authors described case vignettes of three adolescent girls and how they relapsed following specialist hospital treatment for anorexia nervosa in a unit in Israel. Three different outcomes post discharge were reported in each of the cases. This included transition from anorexia nervosa to bulimia, suicidal ideation and relapse back into anorexia nervosa. Based on these anecdotal reports they introduced a gradual transition from an inpatient to an outpatient package of care. This involved slow exposure to daily activities but returning to the inpatient unit at night. Patients had continuity of care by attending the same group therapy as an inpatient, then as a day patient and finally as an outpatient. In addition to this, discharged patients had individual psychotherapy. After three years of introducing this transition of care package, the authors' audit noted a trend of decreased readmission rates. They did acknowledge, however, that this change in approach was not based on research evidence, but rather on clinical experience and theoretical understandings. What was understood from this case report was that the transition process from inpatient to outpatient was sensitive to psychological input. What the experience of transition involved could only be surmised due to lack of qualitative research into this area. What was known, however, was that patients responded well to psychological input, but only in a very general way, so specific psychological interventions that might help this transition remained unknown.

Likewise, an outcome study by Gowers, Weetman, Shore, Hossain and Elvins (2000), using a combination of patients', relatives and General Practitioner views of the inpatient experience, suggested that discharge required a huge amount of adjustment and significant loss of support. Similarly, in a Canadian outcome study of which treatments patients seek after inpatient care, Grigoriadis, Kaplan, Allan, Carter and Woodside (2001) found that most treatment hours were spent with a psychiatrist in individual psychotherapy, which they put down to the severity of the eating disorder. This suggests a need for on-going psychological support post-discharge and in fact the authors point out that aftercare was required due to the heavy demands for services from patients post-discharge.

In the study by Gowers et al. (2000) they looked at the long-term impact of treatment for adolescent anorexia nervosa. Seventy-five cases with a diagnosis of anorexia nervosa were assessed for illness severity using a Global Assessment Score based on a standardised assessment instrument (Morgan & Hayward, 1988, as cited in Gower et al., 2000). The cases were followed up at two to seven years, the setting of the treatment was noted at follow up. The authors found that treatment received between assessment and follow up was predictive of outcome. Using statistical analysis (Anova and multiple regression analysis), it was found that those patients who had had inpatient treatment had a statistically significant poorer outcome than those patients who had just had outpatient treatment. Interestingly they did not find a statistically significant association between illness severity and a worse outcome at follow up as might have been expected This led the researchers to suggest that the effects of inpatient treatment might be further investigated and they suggested a randomised controlled trial as their study was based on naturally occurring data from the clinical population. This was primarily a quantitative study looking at what might predict outcomes. However, in order to try and explore outcomes further the authors drew on other sources and looked outside the study to gather data on patients' views. Other sources included interviewing patients, relatives and clinicians. They found that patients did not experience the inpatient stay as a negative experience as it was often a psychologically supportive time and it felt like a safe environment. In fact, the idea of being readmitted to hospital was a relief in that it provided an escape. Being discharged on the other hand, required adjustment, both in terms of having to eat and cope without the extra support of the inpatient service. The authors also acknowledged that this positive view of the inpatient experience was not found in other studies where being an inpatient was experienced more negatively with high levels of criticism towards the service. Thus, the authors suggest further research would be helpful and that a plurality of research methods may be useful, although they do not specify which methods. This study therefore introduces the concept of asking the patients about their experiences and the potential for utilising a qualitative approach.

Thus, transition from hospital has been of interest to researchers, but it has focused on the treatment outcomes, although these research studies did seem to lean towards the idea that the transition involved some psychological shifts. Focusing on outcomes alone limited research to a more 'top down' approach.

However, it is argued here that further research to investigate the psychological shifts would require a different approach. Rather than a focus on the measured outcomes, further studies could qualitatively investigate the transition process by focusing on the patient experience or journey through the services. This data might therefore contribute to our understanding of the psychological complexities of potential relapse, which might in turn influence psychological interventions and case management.

The patients' perspective in the literature

In a review by Bell (2003) of studies that described what was helpful and unhelpful regarding eating disorder treatment, many studies cited the usefulness of psychological input. Indeed Button and Warren, (2001) studied how treatment for anorexia nervosa was experienced 7.5 years after presentation to a specialist UK eating disorder service and identified that individual therapy was felt to be the most helpful aspect of treatment. Thus, the focus for transition research might be expected to consider looking at the patient experience. However, studying the patient experience of eating disorder treatment has been identified by Malson, Finn, Treasure, Clarke, and Anderson (2004) as being under-researched. They described how the focus of research on eating disorders has been more on outcomes and prognosis, as opposed to the lived experience of treatment.

More recently, the patient's experience of eating disorders in general, and specifically anorexia nervosa, has been researched using qualitative methods. Sternheim, Konstantellou, Startup and Schmidt (2010) used interpretative phenomenological analysis (IPA), to investigate the psychological construct of uncertainty and what that meant for people with anorexia nervosa. The authors conducted three focus groups from patient populations recruited from a UK specialist eating disorder service. The participants came from three different treatment options. There was an inpatient group, a rehabilitation group and a day care group. What emerged was that for people with anorexia nervosa there were external sources of uncertainty, which included the idea that the world was bad and dangerous; the authors suggest that this made thinking about the future very anxiety provoking. It is possible that this would include leaving hospital as a potentially feared future event in their lives. Thus, transition experiences have begun to emerge, albeit without direct links, when the participants have talked about their experiences of having anorexia nervosa.

A qualitative study by Colton and Pistrang (2004) involved interviewing 19 young women with a mean age of 15.4 years. Participants were recruited from two similar specialist eating disorder units in the UK. A semi-structured interview schedule was constructed specifically for the study and the topics covered ranged widely. Participants were asked what was helpful and unhelpful about their treatment, what is was like to be treated with other patients with anorexia nervosa, the experience of being away from their outside life, relationships with staff on the unit and feelings about having anorexia nervosa. The interview was conducted flexibly so as to explore aspects that the participants raised themselves and therefore viewed as central to their inpatient experience.

Interviews were analysed using Interpretative Phenomenological Analysis (IPA), a qualitative approach developed by Jonathan Smith in the 1990's and described in detail in J.A. Smith, Flowers and Larkin (2009). In the Colton and Pistrang (2004) study the aim was to systematically explore participants' experience of their personal situation and they found that participants experienced being with other patients with anorexia nervosa both distressing and supportive. They had the desire to get well, but also the desire to remain thin. In terms of their care, they wanted to have input and yet they also wanted to be managed. Thus, the experience was conceptualised by the authors as being one of conflict for the participants. What is interesting about these findings is that participants expressed views about what they felt was therapeutic for them and the authors suggest that this could be linked to the trans-theoretical Stages of Change model

(Prochaska & DiClemente, 1983) which they tentatively suggest might explain the conflict. Thus, the patients 'voice' would appear to be important to consider when planning therapy, treatment and management, and so could well be relevant to transition of care. This abovementioned study generated broad ideas about the inpatient experience, thus it was thought that by looking at specific areas of the inpatient experience further insights might emerge.

A further study by Offord, Turner and Cooper (2006) also investigated the adolescent inpatient experience using qualitative methods. Seven participants aged 16 to 23 years were interviewed in the UK. The aim was to explore retrospective views of their experience of treatment and discharge. All had been discharged from a general adolescent inpatient setting, from between two and five years prior to the study. Again, this was a study that used semi-structured interviews and was analysed using Interpretative Phenomenological Analysis (IPA). The difference with this study to that of Colton and Pistrang (2004) is the retrospective nature of the design and that participants' experience related to being on a general adolescent inpatient unit as opposed to being on a specialist eating disorders unit. They also found that participants talked about a broad range of areas in their inpatient experience, such as their perceived level of control whilst an inpatient and the importance of peer relationships. However, they were also asked specifically about their discharge experience, and they talked about a sense of their life being 'on hold' whilst an inpatient. Adjustment was reported as difficult once they had been discharged; for example, there was an impact on friendships after discharge. Participants described a sense of having to find a gradual reconnection with their community after discharge and there was a role for college courses in this process. It may be that because the Offord, Turner and Cooper (2006) study was retrospective this allowed the participants to focus on the discharge process in a way that perhaps was not possible for the participants in the previous study by Colton and Pistrang (2004). Thus, some of these reflections could be further developed, such as looking at the process by which discharge came about (e.g., planned or unplanned), liaison with community services and looking at the whole experience of transition from inpatient to outpatient care. This may give useful information to clinicians in planning such transitions of care.

These two studies are both limited to the adolescent experience, as is a further study by Spivack and Willig (2010). Eight females aged between 12 and 17 years who were inpatients on a Specialist Eating Disorder unit in the UK were interviewed at the time of their admission. The investigation used the same methodology and analysis as in the two previous studies. Interview topics covered daily life on the unit, best and worst experiences, perceptions of treatment and the meanings that participants attributed to their experiences. As in the study by Colton and Pistrang (2004), a sense of conflicting feelings in relation to the inpatient experience was identified. The authors suggested that this could be understood in terms of a "split sense of self" (Spivack & Willig, 2010, p. 10). For example, in relation to anticipated discharge, discharge was experienced as both scary, feared and to be avoided and yet there was also a sense of missing home. Furthermore, the clinic was experienced as both a place of safety and yet also a place of entrapment.

The findings of this study therefore suggest that understanding the confused thought processes experienced by participants may be helpful. The two 'voices' conceptualise the idea of two quite opposing thought processes; that is the drive to get well and the drive to stay thin. What is interesting to consider is how a split sense of self might impact on the transition process for patients. If there is a "battle within" (Spivack & Willig 2010, p.7), the question might be raised as to what the implications for psychological therapy would be at this stage in treatment. Thus, a deeper exploration of the transition is necessary and would be useful to generate rich data that could help understand the patient's perspective and in turn inform clinical practice and provision of services.

A further and more recent study by V. Smith et al. (2016) interviewed 21 adult women about their specialist inpatient experience in the UK. Using thematic analysis, the findings suggested that a perceived level of control was important for these women when it came to change and adjustment. The participants focused on difficulties they experienced between home and treatment environments and their fears about loss of support on discharge. Hence the inpatient experience focused on psychological matters with regards to change.

In summary, much of the previous literature has therefore focused on what professionals believe is appropriate for patients' continued recovery as they are transitioned from inpatient to outpatient care. Furthermore, qualitative studies such as Colton and Pistrang (2004), Offord, Turner and Cooper (2006) and Spivack and Willig (2010) have generated ideas about patients' inpatient experience. Moreover, studies that have looked at specialist eating disorder services and general psychiatric unit experience, have been mostly limited to the adolescent experience. As such, the experiences of adults is limited. Additionally, the studies described above have only explored the broad experience of being an inpatient. Data collected in these studies does however suggest a focus on the discharge experience. This was particularly so in the retrospective study of inpatient experience by Offord, Turner and Cooper (2006). It can therefore be seen that a gap in the literature exists as the meaning for patients of the experience of transition from inpatient to outpatient care has not been specifically explored. Consequently, it is proposed here that a contribution to patient care could be achieved by qualitatively exploring this transition of care for adults with an eating disorder. Firstly, by observing any conflicts in accounts about transition and then trying to understand the clinical implication of these conflicts. Secondly, by generating ideas for service provision as a result of these understandings.

In summary, over the last twenty years, researchers have been interested in investigating discharge from hospital following treatment for an eating disorder, and especially for anorexia nervosa. The focus of the investigations began with outcome research; clinical and economic. Following this, some qualitative accounts have emerged, alongside more measured approaches, and the discussion points have drawn attention to a psychological component to the transition. In more recent times, qualitative methodologies have been used to explore patient experience more directly. The outcome of these studies has drawn attention to the psychological components of eating disorders. The current study aimed to add to this last body of knowledge of patient experience but specifically it focused on the transition experience.

Aims of the research

This study therefore aims to fill the gap in the literature identified in the section above. The research aimed to explore the discharge experiences of adults (i.e., people over 18 years of age) who had had specialist inpatient treatment for an eating disorder and are currently receiving outpatient care. The focus was on retrospective experiences from discharge to two years post-discharge, which allowed participants to formulate meanings to their experiences.

This study also aimed to complement existing qualitative studies on the inpatient experience. Patients have previously identified the importance for them of discharge, but their psychological needs could only be assumed. Giving patients a voice to describe their experience could help clinicians further understand the psychological needs and processes related to this type of transition of care.

Research questions

With all the above points in mind the following research questions were devised:

What are the discharge experiences of patients who transition from specialist inpatient care to specialist outpatient care for an eating disorder?

And an associated sub-question:
What features of these experiences might we draw upon in order to inform clinical practice in the form of:

a) psychological interventions
b) service provision and the process by which this comes about?

Personal Reflexivity

What follows are some personal reflections on the research process.
I am a qualified Counselling Psychologist and I worked for many years in an outpatient eating disorder service. I retired from clinical practice when I reached retirement age and have since been on my own transition to researcher in the area of eating disorders. Many years before, prior to training as a psychologist, in the 1970's I trained as a general nurse. As part of the nurse training I spent a period of time working on a general psychiatric inpatient unit which had a special interest in treating anorexia nervosa. It was later to become well known due to the research and writings of the Consultant Psychiatrist, Arthur Crisp. The patients were all inpatients, as the move of treatment to the community was in its infancy and virtually non-existent for anorexia nervosa. With this background, some thirty years later, now as a Counselling Psychologist with several years of general psychology experience mostly within physical health, I was appointed to work on the outpatient eating disorder team.

People with anorexia nervosa made up a high proportion of my caseload. Quite often these patients had had inpatient treatment. Sometimes, whilst having outpatient psychological therapy after inpatient treatment, these patients had to go back into hospital. Other times, patients who started with outpatient therapy deteriorated and had to go into a specialist inpatient facility. I was curious about these different environments for treatment. When a patient went into hospital it seemed clinically appropriate to let the inpatient team take the helm and for me to step back. Equally though, it also seemed appropriate for me to keep in touch with both the patient and inpatient team. It was never clear to me what would really be appropriate in terms of how much input and when.

This thought led me to reflect on the purpose of keeping in touch. Inpatient teams were keen to update me at CPA review meetings with the patient and their family present. Patients never refused my attendance, but I began to realize that some appeared to need my attendance more than others at these reviews. Some needed to talk to me regularly and update me. Others were frostier, wondering why I had turned up. In line with the spirit and ethos of counselling psychology that advocates promoting a helping and therapeutic relationship (Woolf, 1996), I wanted to keep in touch in order to maintain a good quality relationship. The aim was to bridge the gap whilst the patient was in hospital in order to transfer smoothly to effective therapy post-discharge. I had chosen a rather standardized approach even though I was aware of the values that underpin counselling psychology, including a belief that the individual is separate and unique, with different needs and values (Woolfe, 1996, p.6) This belief is central to any work the counselling psychologist sets out to do with the client and something I find very attractive in our profession. In view of this, it seemed important for me to understand what patients experienced of the transition process out of hospital. It could also lead to changes and improvements in clinical practice and thus help the patients. Any findings I produced might be useful for other outpatient clinicians.

On reflection, I realise that my assumptions at the beginning of this study were rather fixed on expectations the patients had of the service. At the outset I seemed very focused on the impact of service interventions on the experience for the participants. As I shall show, it is only through my transition to researcher that I could stand back and allow the experiences to emerge and through interpretations of these experiences, see a different picture evolve, thus challenging my initial assumptions.

Methodology and Procedures

The rationale for adopting a qualitative paradigm

This study takes a qualitative approach (Forrester, 2010, p. 1). The predominance of a quantitative approach to psychological research in general has been documented by J.A. Smith (1996). Historically, in terms of eating disorder research a quantitative methodology was used in order to establish causal relationships between clinical approaches and outcomes so that interventions could be adjusted to improve outcomes. This approach needs to be taken seriously as a contribution to understanding (Parker, 1994b, p.14). However, this approach does appear to be somewhat limited (Hepworth, 1994). Previous quantitative research, was limited because it could not foreground or provide insight into the patients' side of the story. The idea of capturing the patients' perspective has gained a lot more support in recent times. Peterson et al., (2016) have highlighted the need for balance between clinical observation, research ideas and the patients perspective when devising best treatment options.

The aim in the present study was to listen to the participants' accounts of their transition out of hospital. It is because of the aims of the research that a qualitative approach to the research design was adopted (Silverman, 2000, p.100). It was also appropriate and suitable for two other reasons. Firstly, it allowed a wide and full investigation of a very specific part of the treatment journey for people with severe eating disorders (J.A. Smith et al. 2009). Secondly, previous qualitative research on the related area of inpatient experience had yielded new and interesting insights both at the clinical and theoretical level (see Spivack & Willig, 2010). Thus, it was hoped that a qualitative approach would reveal insights into the transition experience (J.A. Smith et al. 2009).

The Decision to use Interpretative Phenomenological Analysis

Having chosen a qualitative paradigm, the next step involved considering the choice of which qualitative analysis approach to use. Willig (2009) advises that it is important and necessary to select a data collection and analysis method that will answer the research question and that there are several approaches from which to choose. The choice of analytical method in this study is IPA. This approach has been initially established and described by J.A. Smith (1996) and subsequently developed further with his collaborators (J.A. Smith et al., 2009).

IPA is one particular method of data analysis which is concerned with what Smith originally called the 'insider's perspective' (J.A. Smith, 1996, p. 264); the aim being to capture the concerns of the participants, focusing on their experiences and understandings of a particular situation or phenomenon (J.A. Smith et al., 2009). In a study by Jarman, Smith and Walsh (1997) the researchers used IPA to investigate health care professionals' experiences of treating patients with anorexia nervosa. The aims of their study resonate with the aims of the current study as the authors sought to make a clinical contribution regarding anorexia nervosa. Using IPA meant a focus on individual personal experiences emerging from interview accounts and allowed the researchers to develop an interpretation of the particular phenomenon, in their case the impact on treatment of clinicians' experiences. IPA is therefore concerned with the idiographic, the individual's various responses. It is also concerned with phenomena and how people experience a specific phenomenon. In addition, in order to make sense of this data the researcher makes interpretations through close engagement with the data (J.A. Smith et al., 2009). The researcher's engagement is crucial and involves a high level of reflexivity in order to produce effective research outcomes (Finlay, 2011, p.113). IPA therefore seemed to resonate with the current study, in that it is concerned with the lived experiences of people in their world as they come out of hospital; additionally, it is a method of applied psychology (J.A. Smith et al., 2009, p.5).

IPA is not the only methodological approach that seeks to make sense of people's experiences (Willig, 2009). As advocated by J.A. Smith et al., (2009) it is necessary to position IPA in relation to other methods of data analysis in order to highlight the particular qualities of IPA and how it can be argued to be the best fit and most suitable choice for the current study. What follows is a presentation of two other methods and a consideration of why both may not be as suitable for the current study. In the final part of this section there will be a return to IPA, to further suggest the importance of using this approach.

The Grounded Theory approach to qualitative data gathering and analysis

Grounded Theory (GT) has been described as being the main alternative approach to IPA (J.A. Smith et al., 2009). GT was developed to understand social processes from the bottom up. It allowed researchers to make links between individual's interactions which could lead to an identifiable theory with potentially important implications for the world at large. The focus is therefore on process and change (Willig, 2009). Furthermore, GT has a clear-cut procedure to it in practical terms, allowing social researchers a way to gather data from the field and analyse it (J.A. Smith et al., 2009). Researchers can then generate a theoretical account of a particular phenomenon. The sampling is very particular and prescribed, data is gathered, reviewed with a theoretical openness, tentative interpretations are made through codes and categories and then there is a return to the field to gather more data. This involves a 360 degree approach to data gathering, bringing in different participants according to the research topic and emergent ideas (Willig, 2009). GT is long established, first described by Glaser and Strauss in 1967. Because of this it has gone through various revisions with a rift between these two sociologists in response to Strauss and Corbin's (1998) alternative interpretation of the approach. The description of the process of GT above fits more with a social constructionist version as described by Willig and Stainton Rogers (2008, p.241).

In terms of the current project, there are theoretical, practical and ethical problems with using a GT approach. Each will be considered in turn. Theoretically GT is not such a good fit as IPA on two counts. Firstly, GT aims to look at an unfolding social process in order to build a theory, whereas this study aims to look at the patients' experience; using GT for this study would risk reducing the research to a categorization of what happens on discharge, and this may or may not be the way that participants view discharge. Secondly GT suggests that information is 'out there' to be found and that objectively any researcher could elucidate it if they follow the prescribed method (Willig, 2009). IPA on the other hand can illuminate rich and varied meanings because there is a flexibility for the researcher to reflect on what is being revealed and allow the experience to emerge. The researcher is not seen as someone who can elucidate material that already exists, but rather is involved with the participant in co-constructing the results, through interpretation of the data (Willig, 2009, p. 65). Thus, from a theoretical perspective IPA fits better with the desired knowledge outcomes of the study, that is to say, a rich varied summary of the experience itself of coming out of hospital. In practical terms there are problems with the GT approach as it requires 360 degree sampling which would not be feasible. In the current study participant's inpatient stays would not necessarily be in the same geographical location; as such it would not be possible given time constraints, to travel all over the UK to interview clinicians or the participant's family members who also may be in a third location. Furthermore, because of the vulnerability of the participants, it would not be ethical to repeatedly interview them within a relatively small time-frame. By using a 360 degree method there is also the real risk that this would affect the data if participants knew one was talking to their family and clinicians. Thus, GT could potentially have been chosen, but the disadvantages of taking this approach have been pointed out.

The analysis of discourse; a route to understanding for the researcher

Discursive psychology is concerned with the role of language in helping researchers gain insights into their topic of investigation (Willig, 2009). The idea, simply stated, is that it seems reasonable to suggest that what people say in terms of their beliefs and attitudes would give researchers insight into what was in their mind. In response to this position, which Willig (2009, p. 94) refers to as ‘cognitivism’, two versions of discursive psychology emerged that challenged the primacy of the role of cognitions. The first is Foucauldian Discourse Analysis (FDA) where language is viewed as shaping our ways of understanding experiences. The second is Discourse Analysis (DA), where the construction of meaning is made through the context in which the speech is uttered, thus performance is seen as central to understanding data (Willig, 2009). From the point of view of the current study, using these discursive psychology approaches means the focus of enquiry would be too narrow, and opportunities for a wealth of other data would be missed (Eatough & Smith, 2006).

Nevertheless, the advantages of discursive approaches should not be ignored. It is important to consider how the context and cultural perspective impacts on how participants speak and make sense of their experience. What is important to recognise is that discursive approaches are only partial, and the recounting has another component (Eatough & Smith, 2006). As people recount they are working out, trying to make sense of events and situations which includes referring to past, present and future experiences.

IPA revisited

An IPA approach can include many aspects mentioned above in GT and discursive psychology. IPA is not purely a descriptive methodology, as Larkin, Watts and Clifton (2006) have pointed out. The IPA approach does not simply describe the phenomena under investigation. What IPA can do is to take into account individual context and situation (J.A. Smith et al., 2009, p. 3). This is possible through the researcher’s interpretations and these are made taking into consideration the context, the description of the situation and the way in which language is used to convey both context and description. Thus, IPA provides a broader approach to finding out about the discharge experience. (J.A. Smith et al. 2009, pp.84-88).

Overview of IPA methodology with reference to the philosophical underpinnnings.

IPA is a particular methodology that resides within the family of qualitative methods of psychological enquiry (Willig, 2009). What follows is an outline of the methodology with reference to the philosophical underpinnings of the approach. This starts with a brief history of its development, followed by a description of the key elements within the methodology.

History of IPA

IPA was developed and first described by Jonathan Smith in a 1996 position paper. Here he positioned the approach as being an attempt to confront the space between the underlying thoughts people had of a phenomenon and what they said about the phenomenon. There was a gap that discourse analysts had identified and they argued for the social construction of emotion rather than emotion being causally related to cognition (Eatough & Smith, 2006, p. 117). J.A.Smith (1996) accepted that societal accounts could provide valid information regarding phenomena, however maintained that the individual could contribute to our understanding of particular situations. What was informative was the variation that individuals displayed towards a phenomenon, such as in response to health issues. He went on to argue that this was particularly useful within Health Psychology research (J.A. Smith, 1996, p. 264). Thus, research using IPA has often (but not exclusively) been used to investigate illnesses, for example, Bramley and Eatough (2005) study on living with Parkinson's disease. It has also been used to explore long-term conditions that might disrupt life, such as chronic benign back pain, as investigated by J.A. Smith and Osborn, (2007). Studies have also been carried out at specific points in an illness such as the study of the inpatient experience for adolescents with anorexia nervosa (Spivack & Willig, 2010).

IPA Methodology: a phenomenological approach

IPA is an approach that is concerned with investigating how people make sense of important life experiences (J.A. Smith et al., 2009, p.1). The approach explores specific situations themselves, that is to say a specific phenomenon, and therefore the perspective is phenomenological (J.A. Smith, 2004, p. 40). Phenomenology is a philosophical approach to the study of experience (J.A. Smith et al., 2009) and there are various ways this has been understood. The philosopher Husserl argued that to understand a phenomenon it is important to 'go back to the things themselves' (J.A.Smith et al. 2009, p.12). Adding to this debate another philosopher Heidegger argued that what is central to understanding a phenomenon is relatedness to the world, we are caught up in some action and we find ourselves in a pre-existing world (J.A.Smith et al., 2009, p.17). Furthermore, our experience is always in relation to something and has a temporal element. The philosopher Merleau-Ponty pointed out that the nature of our relationship with the world is embodied, that is to say the body shapes our knowing about phenomena. What all phenomenology is concerned with is an interest in human experience and what it is like in situations that are important to us as human beings. This appeals to researchers and psychologists in particular because the method has the potential for producing interesting and rich data that is of use for understanding and perhaps helping to inform, improve and expand 'lifeworlds', (Finlay, 2011, p.126).

IPA Methodology: a hermeneutic approach

So far IPA has been described as having phenomenology at the heart of it with the idea that experiential claims of participants are central. The aim for the researcher is to attempt to understand the participants' world mostly through a focus on a specific experience (Larkin et al., 2006, p.104). However, as J.A. Smith (1996) points out, it is not possible to understand the participant's world completely. So, what this means for the research is that the analysis is co-constructed by the researcher and the participant. This takes IPA in to the realms of hermeneutics which is the theory of interpretation (J.A. Smith et al., 2009, p.21). The link between hermeneutics and phenomenology originates with Heidegger who argued that to understand a phenomenon, it is necessary to ask questions about it and form interpretations within relationships and particular circumstances (Larkin et al., 2006, p.107). The choice of questions must fit with what we already know about the phenomenon and what we already know about a phenomenon needs to be put to one side, so that outside theories are not imposed inadvertently on the phenomenon. This immediately acknowledges that the researcher cannot help but be brought into the research process (Finlay, 2011, p.113). This presence will also influence the research process (J.A. Smith et al., 2009, p.46). This involvement is managed through a reflexive stance so that any predilections on the part of the researcher can be known as far as possible and recognised for what they are (Willig, 2009, p.18). The aim in IPA is firstly to try and understand what the situation is like for the participant and produce an account of this. However, there is another aim which is to advance an interpretation beyond that which the participant is aware of themselves (Larkin et al., 2006, p.104). Meaning through interpretation has two further elements informed by hermeneutic philosophers. Gadamer draws attention to the historical perspective and that interpretation is a discussion between past and present and the meaning is affected by the stage at which the interpretation is made (J.A.Smith, Flowers & Larkin, 2009). Furthermore meaning is also affected by the approach of the interpreter, Ricoeur refers to the hermeneutics of recollection and the hermeneutics of suspicion. J.A.Smith explains that although IPA interpretations are concerned with the former, that is to say interpretations about recalling meaning, they also have elements of suspicion, in that the researcher can put forward questions that the participant may have been unable to consider themselves. Thus, the researcher is focused on what it means for the participant to feel the way they do in this particular situation at this point in their lives. The social, cultural and context of the situation is therefore brought to bear on the interpretation (Larkin et al., 2006).

Jonathan Smith has taken the hermeneutic circle concept from hermeneutic theory and developed the idea that in IPA there is a dynamic relationship between the part and the whole (J.A. Smith, 2006). In hermeneutic theory, in order to understand the whole, one needs to consider the part and vice versa. Thus in research terms the individual participants' experiences, with all their convergence and divergence, can inform the phenomenon as a whole. The process has been described as cyclical (J.A. Smith, 2006) with new ideas emerging each time the researcher goes round the hermeneutic circle. The dynamic is a process that J.A. Smith et al. (2009, p.3) refer to as a 'double hermeneutic'. This is the participant making sense of the situation and in turn the researcher making sense of the participant's sense making.

IPA Methodology: an inductive and idiographic approach

IPA has an interrogative characteristic towards phenomena, that is to say it seeks to establish and interpret findings and relate them to existing literature, thereby expanding what is known about a phenomenon (J.A. Smith, 2004). J.A. Smith (2004) described

IPA as inductive, although he does not deny there is a deductive element as well. The main point of being inductive is that the approach to research starts with a focus on an area of interest with an open attitude on the part of the researcher and without a planned hypothesis. The approach can involve a process orientation whereby the area of interest is explored. Thus, unanticipated ideas or themes can emerge during the analysis and the end product of the research may look different from what was believed to be the case; it is therefore a flexible approach (J.A. Smith, 2004, p.43). In practical terms IPA does not start with a hypothesis to be tested.

A further practicality involves IPA being idiographic. This is explained as being a specific approach to data analysis (J.A. Smith, 2004). The procedure for data collection is described in detail in J.A. Smith et al. (2009). It is idiographic in that it starts with a detailed examination of one case until there is some closure. Then the researcher moves on to the second case and repeats the examination but suspends any thoughts on similarities or differences as far as possible between the two cases. This idea stems from Heideggers ideas of bracketing forestructures in order to interpret the phenomenon (J.A Smith et al. 2009, p.25). It is only when all the cases have been examined in this way that a cross-case analysis can be performed and the final analysis is constructed during the writing up phase of the study. The net result is that shared and differing aspects of the phenomenon under investigation can be seen, yet at the same time an overarching theme can be seen to make sense of the individual experiences. For the wider research community, therefore, there can be analytic generalisation of findings, as noted and attributed to Yin by Bramley and Eatough (2007), as opposed to statistical generalisation. In effect the idiographic approach requires the researcher to engage with the data in an individual and intense way and then the findings are pulled together as the analysis progresses (Willig, 2009, p.57). J.A. Smith et al. (2009) have pointed out that focusing on the individual as being idiographic is problematic and suggest idiography can better be explained as a focus on the particular. This analytic method has roots in the writings of the Schleiermacher, another philosopher who argued for the importance of making interpretations through close reading of texts (J.A. Smith, 2006).

Epistemological Standpoint

I start from the position that the literature on the epistemological position taken by researchers is often quite difficult to comprehend and lacks clarity, thus when authors such as Henwood and Pidgeon (1994) categorize epistemologies, on the face of it, it is appealing. However, on further investigation there is complexity as epistemologies often cross over methodologies (Willig, 2009, p. 8). Furthermore, the epistemological position taken by the researcher, and the chosen methodologies, do limit which methods can be used. J.A. Smith (2004) does not link a particular epistemology to IPA, but rather takes a broader view arguing that it is possible to take different epistemological positions within an IPA methodology (J.A. Smith, 1996, p.264). In order to do justice to explaining my epistemological position, what follows is a summary of my position in relation to other epistemological positions. My aim is to explain how I understand what can be known and how it can be known. This explanation of epistemology is the one offered by Willig (2009, p.2) and allows a wide approach to working out my own position.

For completeness and to complement the following discussion I start with describing my ontological stance. By ontological stance I mean the assumptions I make about the world and my understanding of reality (Willig, 2009, p.13). My view rejects the realist idea that there is one universal definable truth that would be available to anyone to discover if they followed a particular recipe or route. I consider that reality is less orderly and relates to other structures in the world and that as individuals we navigate this world from different viewpoints, thus there are varied narratives that inform reality. It is from the basis of my belief that there are multiple narratives to explain reality that my epistemological position has emerged.

To begin this process of justifying my position, I need to clearly explain the knowledge goal that I seek to present as a result of this research. My aim for the research is to gather and analyse data to explore the discharge experience for the participants. This fits within an empiricist epistemology (Willig, 2009, p.3). Knowledge is grounded in data and this relates to the positivist view that the facts of the experience speak for themselves. Furthermore, this approach would be expected to lead to finding definitive knowledge, such that services could be altered in order to fit with the results. The results would be objectively evident with a direct relationship with the world and our understanding of it (Henwood & Pidgeon, 1994).

However, taking an empiricist position does not fit at all with other parts of the goal of this research. The research is not aimed at finding a definitive view of the discharge experience. Rather, it aims to understand how the participants understand their experiences, as per the double hermeneutic (J.A. Smith et al, 2009, p. 187). Furthermore, how they make sense of their experience alongside their objects of concern in relation to the phenomenon (J.A. Smith, 2004). An empiricist position would not answer these questions, so this epistemological position, although a valid one for certain research questions (J.A. Smith, 1996), is not appropriate or one that I take for this research. Furthermore, an empiricist approach is at odds with IPA because in IPA there is an acknowledgement that it is not possible to obtain direct access to a person's world, something that an empiricist would hope to achieve (Willig, 2009, p.69). Rather, my hope is to gain insight into the participants' beliefs, experiences and understandings. Also, to acknowledge that people with the same medical condition can experience treatment in very different ways.

With the above in mind, an alternative epistemological position that I consider here involves the use of language. It is reasonable to assume that what people say about their experiences reflects what they think and feel about a situation; this is known as cognitivism (Willig, 2009, p.93). An approach influenced by this idea of talk being related to experience is discursive psychology of which DA is one aspect (Parker, 1994a, pp.92-107). DA rejects the idea that there is a direct causal route from thoughts to talk, rather, they argue that discourse constructs meaning through interaction with others and it is performance and action orientated towards people (Willig, 2009, p.97). Eatough and Smith (2006) draw attention to these ideas, acknowledging in a social constructivist way that it is important to not neglect the social and discursive elements of people's explanations. This epistemological approach can be viewed as symbolic interactionism, where people's ideas are not loose, but tied up with social interactions and processes shared between people, as described by Willig (2009, p. 70). This position is described and linked to IPA also by J.A. Smith (1996, p.263).

My position takes these arguments into consideration, but like Eatough and Smith (2006), accords with their revised position that rejects linguistic performance and action alone in order to understand people. The reason for this is because when people talk about their experiences they also inject meaning which is full of thoughts about past, present and future lived experiences. As well as this, my approach is concerned with the lifeworld of the individual; to concentrate on linguistics alone would take the focus away from the individual which is so important in my approach. Thus we can see that interaction through language is important to attend to but it is not the only route to understanding. This accords with the IPA method described by J.A. Smith et al. (2009, p.88).

A similar argument applies to a more firmly social constructionist position explained by Willig (2009, p.70). This position takes a relativist perspective (Willig, 2009, p.13) whereby knowledge is only generated through language and the way it is constructed relates to the social, cultural and historical concerns that participants find themselves in. Knowledge would be likely to be generated from this position using FDA (Willig, 2009, p.112). However, an IPA approach does not deny these influences on participants, but the experience of the individual is of more central concern with my study, therefore I accord with this position taken by Eatough and Smith (2006).

So far two major epistemological positions have been discounted. Firstly the empiricist position because it has a focus on obtaining a definitive truth about a situation, this is at odds with the aims of the research which is to look at multiple truths that inform a phenomenon. Secondly the discursive psychology position because of the focus being limited to the linguistic and social construction of peoples' worlds. Now I will focus on what might be considered a middle ground which more closely resembles my position. My view is that knowledge about a situation or a phenomenon needs to be situated and grounded in individuals' experience and the meaning and understanding they bring to that particular experience. This is not to say that the way in which they talk about the experience is irrelevant, in fact it is important because there can be a sense of working things out through talking. Furthermore, the generation of meaning through talking does not take place in a void; it is connected as Heidegger (J.A. Smith et al., 2009, p.16) argues with a context, both the context of the phenomenon and the context within which the research interview takes place. This view is that context is central to knowledge production. The epistemological position of contextualism is described by Jaeger and Rosnow (1988) and further developed by Madill, Jordan and Shirley (2000). Eatough and Smith (2006) take up this position in their IPA study and this is the epistemological position I take in this research. What this means is that it is the context that contributes to what is able to be known. The aspects that are important are the individual's meaning making and the context in which that takes place. The linguistics as pointed out by Schleiermacher (J.A.Smith et al., 2009, p.22) and historical perspectives as pointed to by Gadamer (J.A.Smith et al., 2009, p.25) are not unimportant, but the focus must be on the participant's experience. The context of the interview is important and this also brings into sharp focus how important the researcher is in the research process, noted by Heidegger (J.A.Smith et al., 2009, p.25). This means that my thoughts, views and ideas will have an impact on what knowledge is produced and it is not possible or desirable to eradicate these impacts. This is where the epistemological position of contextualism serves to incorporate this view and set the middle ground for understanding and this is the position I take in this research.

Now it is important to turn to the ways in which the researcher's impact can be managed in the research process. This has been the focus of debate and Finlay (2011) has described reflexivity as an important component to be considered when managing the researcher's influences.

Reflexivity

Reflexivity is the acknowledgement by the researcher of thoughts, feelings and experiences that they bring to investigating a particular topic and how it shapes the research process and findings (Willig, 2009, p.6).

The reflexive position adopted for the current study

The position taken in this study in terms of reflexivity is influenced by the ideas described by Finlay (2002b; 2008) and Shaw (2010). My aim in being reflexive is to consider my own experiences in relation to the research topic and to disentangle my perceptions of the object of study (Finlay, 2002b). This allows me to view the participants' utterances with fresh eyes, and not to impose my own theories on the research at the initial stages (Finlay, 2002b). Furthermore, an open attitude is adopted (Finlay, 2008, p. 73). This openness is crucial so as not to miss important aspects being presented by the participants. It is an empathic approach that could also help manage the complicated power dynamics that can be at play in the research situation (Finlay, 2002a, p.220).

The reflexive approach is both in terms of personal reflexivity that is to say a personal reflection on one's own experience and how that might affect the research, findings and process (Willig, 2009, p. 10). However, there is also methodological reflexivity involves the researcher reflecting on what might have limited or influenced decisions made during the research, (Willig, 2009, p. 10). The whole process is neatly summarised by Finlay (2002, p. 531) as '"Outing" the Researcher'.

How reflexivity is to be achieved

Reflexivity is considered at all points in the research. Consequently, my reflexive summary began in the Introduction section to the thesis where I have set out my relationship to the topic. I have attempted to describe my interests (Finlay, 2002) and to clarify my position, experience and commitments to the research topic. The aim was that I continued to be reflexive at each stage of the research process. Thus, there are reflexive summaries at the end of the method, analysis and discussion sections.. However, reflexivity is not the goal of the research rather reflexivity is the means by which the goal of understanding and interpretation is achieved (Shaw, 2010, p.241).

Validity

Validity in broad terms, is the degree to which the study describes, explains or measures, what it aims to describe, explain or measure (Willig, 2009, p.16).

The choice of how to demonstrate validity

The approach I have chosen is that proposed by Yardley (2000) and endorsed by J.A. Smith et al. (2009) for use with IPA. The method is composed of four principles; sensitivity to context, commitment and rigour, coherence and transparency and impact and importance (Yardley, 2000). It has advantages because it helps demonstrate the utility of a piece of research for a defined purpose.

Sensitivity to context

Why and how the research study came into being was shown by a detailed literature search around eating disorders and the discharge experience from hospital. A gap in the literature was described and a specific research question formulated. Furthermore, how the question might be answered was considered in detail with reference to the relevant literature on qualitative methodology and IPA in particular. Details of the methodology were carefully described. Furthermore the perspective of the participants and the power dynamics involved were addressed by care being taken to ensure support for the participants through the research process was in place. Finally sensitivity was shown towards the participant in the research report of the analysis through the verbatim extracts that were used. The report makes interpretations with direct reference to the ‘voice’ of the participant. Thus, the use of the raw data respects and gives validation to the points made in the analysis.

Commitment and rigour

In terms of rigour the choices for recruitment were rigorously followed. The participants were selected according to eligibility criteria In the interview itself, the participants were interviewed starting with adherence to the same schedule. Deviations from the schedule only occurred in relation to the participants' responses. The schedule was reviewed by the research supervisor prior to use to check for appropriateness in relation to the study. The schedule was also checked by the independent NHS research ethics committee for ethical appropriateness. The interview was conducted in a thorough fashion. The data was meticulously analysed by the researcher who used an immersive process in relation to the data, going back and forth, deducing and interrogating ideas from different aspects of the data (J.A. Smith et al. 2009). Only when all individual cases had been analysed was a cross-case analysis performed. Thus, a clear systematic approach was undertaken (Meyrick, 2006).

In terms of commitment, participants were treated with empathy and respect throughout all the different stages of the research. At recruitment, contact from the researcher was only made when requested by the participant. During the data gathering, participants were invited to ask questions at any point and were seen in a room with no interruptions. The researcher, being an experienced clinician, was able to respond to any distress evident in the interview through reassurance and direction to an appropriate contact following the interview.

Transparency and coherence

Transparency was evident in the data gathering process, for example, being open about the loss of some data (please see procedures section). Transparency was also seen in the detailed report of how the data was analysed and how, on supervisory review of the analysis, the approach and therefore the quality was questioned which led to a complete re-analysis of the data. The re-write resulted in a far more coherent and in-depth analysis.

Impact and Importance

An important means by which the research can be assessed is whether it is able to tell us anything new and important about the phenomena under investigation. Most importantly is the degree to which the research makes sense to an audience. Supervisory input aimed to ensure that others might consider the research to be valid. This involved regular discussions throughout the research stages, from applying for independent NHS ethical approval, recruitment, data gathering and analysis, to discussion points when writing up. A further aim from supervision included advice on the level of academic rigour required for a doctoral research project in order to improve on the impact of the study.

Procedures

Sampling and Participants

Seven participants were purposively recruited from one outpatient eating disorder service, based in the United Kingdom. The idea of a purposive sample was in line with IPA (J.A. Smith et al., 2009, p.48). Initially it was thought that two outpatient services would be required, as there was uncertainty as to whether one outpatient service alone would yield sufficient participants. A decision to use one outpatient service only was made after the seven participants were recruited and no others were forthcoming. At supervisory review of recruitment, it was agreed that introducing another outpatient service would affect the homogeneity of the sample; homogeneity is advised for an IPA study (J.A. Smith et al., 2009, p. 50). The reason for choosing participants from the same or similar situation is that the research question will have some meaning for them (J.A. Smith et al., 2009, p.49). The aim was to be able to explore variability in terms of psychological similarities and differences within the sample (J.A. Smith et al., 2009, p. 50). In terms of sample size, this remained modest. The reason for this was to maintain the commitment to the IPA method. Using IPA involved exploring and looking for connections within participants' accounts of their experience. It also required reflections and dialogue with the data and this extensive and in-depth process might have been inhibited with a larger sample size (J.A. Smith et al., 2009, p.51).

The outpatient eating disorder service provided clinical interventions for people with eating disorders. In practice this included a range of care from psychological therapy, medical review, dietetics, occupational therapy and nursing care. The decision for which care was appropriate was taken at assessment and adjusted at regular review (NICE, 2017). It was therefore important to specify inclusion and exclusion criteria as not all patients receiving treatment at the outpatient clinic were suitable for the study.

Those people that were appropriate for the study were receiving regular on-going specialist outpatient treatment for an eating disorder. They had had an inpatient admission to a specialist adult eating disorder unit. They were English speaking; people who could not understand or speak English were excluded, because of anticipated difficulties with data analysis under these circumstances. IPA involved two stages of interpretation. In the first, the participant had to make sense of their experience and in the second, as the researcher, I had to make sense of the participant's sense making (J.A. Smith et al., 2009, p. 80). It was therefore important for the participant to be able to understand the questions, and be able to speak clearly, otherwise the meaning of the experience could have been lost. For ethical reasons, participants were also required to have the mental capacity to provide informed consent to take part in the study. The assessment of the participants' mental capacity was made by the clinician involved in their care, following guidance set out in the Mental Capacity Act 2007.

Recruitment procedure

The researcher worked as a psychologist in the specialist outpatient eating disorder service, thus the clinicians in this service were known to her. At a specially convened meeting, clinicians within the outpatient service were briefed about the research. They were invited to identify any patients that were currently on their caseload who were eligible to take part in the study. Clinicians were given two handouts, both were flow diagrams (see appendix M): the first assisted them in making the eligibility decision and the second outlined the recruitment procedure. Clinicians were given the opportunity to ask questions about the research.

Outpatient clinicians agreed to identify eligible participants. The clinician gave the eligible participants an information pack about the study. The patients were reassured that it was entirely their decision about whether or not they took part in the study and that their treatment in the outpatient service would not be affected in any way should they have decided not to take part. The aim of giving the patients the information pack was to allow them time to process and consider the information provided and, if need be, to talk to others about whether or not they would like to take part or to contact myself as the researcher for any further clarification.

The information pack consisted of a letter to the participant which invited them to take part in the research (see appendix C). The letter explained why they had been invited to take part in the research and included a brief introduction as to what would be involved if they chose to take part. Also included in the information pack was an information sheet about the research (see appendix B). The information sheet provided a more detailed explanation of the objectives of the study. In particular, it stated the purpose of the study, gave information about what taking part would involve, some information about myself as the researcher, what information would be collected and how it would be stored. It also stated that taking part was entirely voluntary and that declining would not affect their usual treatment. There was also an 'opt-in' slip for the people to complete if they so wished. They were asked to state their preferred method of contact (telephone, email or letter) and an appropriate time for me to contact them to discuss the study. In order to facilitate and simplify the response procedure, a stamped addressed envelope was also included in the pack. In practice the participants mostly gave the completed opt-in slip to their clinicians to pass on to me.

Following receipt of the opt-in slip by the researcher, contact with the participant was made using their preferred method. The aim of this initial contact was to provide further details of the study and give the participants the opportunity to ask questions with the aim of reducing any anxiety they might have had about taking part and clarify what participation might involve. Participants were given

the choice of where and when they wanted to be interviewed. All participants chose to be interviewed at their usual clinic location and an interview date and time was arranged.

Situating the sample

Out of the seven participants recruited, six were included in the study. One participant was withdrawn from the study. Although the interview was completed, the audio recording was unfortunately lost during the transcription process. This meant that the transcribed interview was incomplete and thus a decision at supervision and during consultation with the wider university research team was made to not include the incomplete data.

A brief narrative follows regarding the participants' demographic details and background in order to show how their details relate to the research. More information about the participants is included in appendix D. This information emerged during the interview process and has been included as it gives important contextual background. Contextualisation is viewed as central to understanding the emergent themes and is an important part of analysis in IPA (J.A. Smith et al. 2009, p.98).

The names of the participants have been changed to ensure that there was no identifiable material in the research. All the six participants were white, English speaking (first language), Caucasian women.

Alice was a 21-year-old university student who developed an eating disorder when she left her home to study some distance away at university. Living in halls of residence, she quickly lost weight, and had repeated medical admissions related to her eating disorder. Soon after referral to the outpatient service, and because of her rapid weight loss, she was referred for inpatient treatment at a specialist National Health Service (NHS) unit. She had had one inpatient stay that lasted five months. At the time of the interview she reported that the duration of her eating disorder was 2.5 years.

Nicola was a 22-year-old university student who was also living some distance away from home. At the time of her interview she reported having had an eating disorder for seven years. She had had two admissions, both as an adult (over 18yrs). Both these admissions had interrupted her university studies. The first admission lasted three months and the second admission lasted one month. She described the last admission as a ‘top up’. Both admissions were in a private mental healthcare unit that specialised in eating disorders.

Lara was a 27-year-old woman who described at the time of interview having had an eating disorder for the past nine years. It had dominated her life. Before the age of 18 she had one inpatient admission which lasted an unspecified time as she only recalled it during the interview and was unable to recollect the details. As an adult her memory was clearer and she described three admissions, the first lasted a month, the second lasted nine months and the third lasted eight months. She had attended university, studying English, and the second and third admissions were after finishing university; she was not able to work at the present time. All except the last admission were at NHS specialist inpatient units for eating disorders. The last admission was at a private facility.

Sally was a 25-year-old woman who had developed her eating disorder whilst living away from home with her boyfriend. Not eating regularly and an intense exercise regime had led to rapid weight loss such that by the time she was seen by services she required inpatient treatment. She reported that she had had an eating disorder for two years, with one inpatient stay and this was for six months.

Gail was a 37-year-old woman, it was unclear if she had attended university, but she had worked as an employment advisor and was uncertain if the stress of this job had caused her eating disorder; she currently felt unable to work. She described having had her eating disorder for six years, but also alluded to having problems with alcohol some years before that, but not currently. She had had one inpatient stay in an NHS facility which lasted for one year. On returning home she had continued to have psychotherapy provided by the inpatient service and this went on for at least one year post-discharge. Although allocated to the outpatient clinic she had not engaged in treatment with the service until her final discharge from her psychotherapist at the inpatient service.

Kay was a 32-year-old married lady with a young daughter of less than three years of age. Kay also worked part time in an office. It was unclear if she had been to university. She reported that she had had an eating disorder all her adult life, spanning some 15 years. She had had two inpatient admissions, one as a child and one as an adult; the last admission as an adult was to a specialist inpatient NHS unit and lasted one year.

In terms of services, all the participants had ongoing clinical input from the same outpatient service. Three (Gail, Kay and Alice) were hospitalised in the same inpatient facility, but it is believed not at the same time. Lara had had a previous, but not her most recent stay, in that same unit. The remaining three (Nicola, Lara, Sally) were all inpatients in different units. Two participants, Lara and Nicola, received inpatient care from a private eating disorder inpatient service.

Interview procedure

The day before the interview was due to take place, telephone contact was made with the participant, as previously agreed. The purpose of the telephone call was to confirm the arrangements for the interview and to check that the participant wished to continue to take part in the study. On arrival, the participant was shown to the interview room and allowed to settle before completing some pre-interview components. These included a consent form (see appendix G) which was signed by both the participant and the researcher. The participant was reminded that the interview would be recorded using audio taping equipment. The participant was also advised that they could stop the interview at any time and could request to take a break. The participant was given information about being allowed to withdraw from the study at any time, but that data obtained to that point (in aggregate form), might still be used for analysis and publication. No participant required a break during the interview and no participant withdrew from the study.

The participants were asked some demographic questions (see appendix A). The interview began and taping commenced, the questions followed the interview schedule (see appendix E). However, the interview progressed according to the concerns and experiences that each participant brought up in response to the scheduled interview questions. I responded to the participant with appropriate prompts to further facilitate their focus, the aim being to yield further information as advised by J.A. Smith et al. (2009, p.65). All participants were interviewed for approximately one hour. The interview was not intended to be part of therapy (Finlay, 2011, p. 201), nevertheless by talking, participants may have found that issues were raised for them. At the end of the interview during a debrief, participants were encouraged to take any issues back to their outpatient clinician if they would find this helpful. At the debrief, no participants exhibited any overwhelming distress, however they were aware that should they need support immediately after the interview, they could have contacted their clinician. The participant was offered the opportunity to ask any questions about the research and they were asked if they would like to receive a summary of the study when it was completed. Six out of the seven participants requested a summary and they provided details as to where this summary should be sent (see appendix H). A letter was sent to the outpatient service clinician to inform them that their patient was taking part in the study (see appendix I).

Ethical considerations

Ethical considerations were followed (J.A. Smith et al. 2009) and this included gaining ethical approval for conducting the study, confidentiality, record keeping and risk of distress to the participants. Each will be considered in turn.

Ethical approval was sought and approved from the National Health Service Trust Research and Ethics Committee (NRES: see Appendix F). Ethical approval was also sought and granted by City University ethics committee (see Appendix F).

In terms of confidentiality, each participant's interview was audiotaped and then transcribed verbatim. In the write up of the thesis participants were quoted, but in an anonymous way with the use of pseudonyms. Any other identifiable material such as names of institutions, clinicians, friends and family names were removed. No participants were recruited that the researcher had had any clinical contact with, or planned to have contact with, in order to avoid any duality of roles or relationships (British Psychological Society, 2018).

In terms of record keeping, care was taken with storage of identifiable material as agreed in the NHS ethical approval. Participant identity was only known to myself. All materials such as consent forms and contact details have been kept in a locked filing cabinet. This material will be destroyed when the research process has been fully completed. It was anticipated that talking about experiences of discharge from hospital had the potential for generating some distress for the participants. In order to minimise this distress the participants were prepared for the interview as much as possible with the information pack. The participants were reminded at the beginning of the interview about stopping at any point if they felt too upset.

Transcription

All interviews were transcribed from the audiotape to a laptop. During the transcription, all identifiable names and places mentioned in the interview were removed. All non-verbal sounds, pauses, silences and laughter, along with ummms and errs, were noted. The rationale for noting the non-verbal utterances was that they might contribute to the analysis (J.A. Smith et al. 2009, p.74). The transcripts had wide margins for note taking and each line was numbered for ease of reference.

A summary of each participants' concerns was written, this informed the summaries written in Appendix D, the aim of which was to further contextualise the study.

Analytic strategy

The analytic strategy followed that devised for IPA by J.A. Smith et al. (2009, pp.82-107). The transcribed data was first printed out on one side of A4 paper and stuck into a scrap book. Thus, each participant's data was contained separately in their own scrap book. Each page of data had space on the right for initial noting and on the left for notes on emergent themes. I began by reading Alice's transcript and listening to the tape. By doing this I was able to hear the tone and delivery of her interview. I re-read her interview transcript several times and on occasions went back to certain parts of the audio tape in order to clarify my thoughts on what was being said. At this point, as a novice researcher, I listened to parts of the tape with my supervisor to learn how to really understand the nuances of the interview. Following this I proceeded to make initial notes on the right hand side column of the transcript, making a note of descriptive, linguistic and conceptual comments (J.A. Smith et al. 2009, pp. 84-88). On re-reading the initial notes, I identified some emergent themes which I wrote on the left margin of the transcript. I typed up a list of these emergent themes on to an Excel spread sheet as they presented in the interview and then printed them out and cut them up to see where they overlapped and clustered themes into groups. Each theme had a reference to where in the transcript they emerged and some data to support the theme. A large list of themes was generated. This whole process was repeated for each participant, completing each individual analysis before moving on to the next case. The themes were not viewed in any definitive way at this stage.

The next stage in the analysis was a cross case analysis, where patterns were looked for across the participants. This was done by sorting themes into clusters and looking for similarities and differences across the themes. This process was initially done generating a number of themes and sub-themes and a draft analysis chapter was completed. However, on review and with supervisory support, this analysis was rejected on the grounds that it consisted of a set of themes that really represented solely a thematic analysis of the data. The thematic analysis was rejected for two main reasons: the first because it was not what I had set out to do. My intention, as has been stated, was to analyse the data using IPA and this requires an additional interpretative element. Secondly, by not using IPA, it would not be possible to answer the research question at the depth needed to make a contribution to this area. As such, the thematic analysis did not offer the level of interpretation that was considered to be an essential part of the research. I therefore repeated the cross case analysis.

This time I reviewed all the emergent themes and re-clustered them, trying to move beyond the descriptive to a more conceptual framework, looking for the ‘gem in experiential psychology’ (J.A. Smith, 2011, p. 6). Having repeated the cross case analysis, two superordinate themes with sub-themes emerged. The re-write up of the analysis chapter began and it was during this process that the analysis as a whole gained shape and, most importantly, the depth I sought. The second analytic process and procedure has been captured in the paper trail included in Appendix J, K and N. My thoughts about this extended process have been captured in the reflexive section following the analysis. Now I turn to reflexive thoughts concerning the methodology and the procedure.

Methodological and Procedural reflexivity

Using the outpatient clinic where I worked clinically for recruitment of participants, had an attraction for me. In practical terms as advised by J.A. Smith et al. 2009 p.49, the potential to access participants from a source with which I was familiar was an opportunity I thought was important for me to take. Having decided that I wanted to investigate the patient's experiences of the transition and having chosen IPA as the most appropriate methodology, I was at pains to suspend my thoughts and feelings as much as I could with regard to the topic, so as to facilitate my engagement in the recruitment process, (J.A. Smith et al. 2009 p. 35). However, the clinicians wanted to inform me about who they had selected to invite and why they had made the selection. Interestingly it became clear that the clinicians were keen for the research to have a direct influence on service provision. They wanted less inpatient treatment; they questioned the need to travel long distances to attend reviews and they wanted a day care service to be set up all on the back of this research. This felt a far cry from my concerns of finding out about the patient's experience of the transition and at the same time working on my own transition from clinician to researcher.

In terms of the interview procedure, the interview schedule was influenced by the notion of service development. So just as my colleagues had feelings about service provisions needing review, the content of my questions revealed that I also had made the same assumptions. Although I followed the interview schedule quite closely, especially at the start of the interview, as the participant talked and as I relaxed, I had the courage to take the clients lead and follow with spontaneous probing, (Smith et al., 2009 p. 65). The engagement with the participants during the interview was very hard to do. At the point of conducting the interviews I had been working therapeutically with clients for over 20 years and felt confident in using psychotherapeutic skills, especially using empathy to help clients work on aspects of their lives that were not in their immediate awareness, (Truax & Carkhuff, 1967). The dilemma for me was in knowing how far to use my skills as a therapist and when to hold back. This transition of myself from psychological therapist to researcher will be revisited later, since although transition was talked about by the participants, there was also the parallel process of my own transition.

A particular concern in terms of the ethics of the research was unintentionally causing harm or excessive distress. There were three circumstances during the interviews that required ‘in the moment decisions’ in relation to distress. The first situation was when Lara began to talk about being very depressed. I checked out with her at that point in the interview about talking with her therapist. This was a hard decision for me to make, as I did not want to distract her, but seeing her so stuck and entrenched in anorexia nervosa it seemed the most ethical thing to do as a researcher. As a therapist I would have managed the situation very differently. The second situation was with Gail, who was far more robust. During her interview she was recalling the help she had received and her eyes filled with tears. This distress felt very different. I didn’t comment in the interview itself, in fact to draw attention to it seemed inappropriate as Gail was clear that she had learnt to tolerate her emotions. The third and rather unexpected situation was with Kay who spoke about the difficulty she had had on transition, because of the loss of her outpatient clinician. During her inpatient admission the clinician who she knew well and saw regularly in the outpatient service had died. This was a complex situation for the whole department, patients and staff alike and which also impacted on me. I spoke to Kay after the interview in the debrief part of the session.

Following the interviews I chose to do all the transcription myself. The reason for this was to fully immerse myself in the data and to dwell with it for a time (Finlay, 2011 p. 229). What I learnt from this process was that the practicalities of managing data and technology have to be attended to in detail. It was a low point in the research process when I lost the complete audio recording of my first participant whilst transcribing the interview. This encapsulates the remainder of my learning in relation to undertaking this research. I did make mistakes or go down the wrong path, but I learnt more by doing this than not attempting the process in the first place.The methodology and method were a new adventure for me, (Willig, 2009 p. 1). In the next chapter I have reported on the analysis, following the analysis a reflexive review of the analytic process is presented.

Analysis

Overview

In this section, analysis of the data is presented, which will be limited to an interpretation of the phenomenon of the participants' experiences of discharge from hospital, following inpatient treatment in a specialist eating disorder unit. The following Discussion section will then critically consider the analysis in terms of the implications and contributions this study makes to existing research. All names and identifying details of the participants have been changed, in order to protect confidentiality.

Data was analysed from six transcripts a large number of emergent themes were evident. Final theme selection was made on the basis of their most relevance to the research question and the interpretation being presented. This meant that not all the themes have been included for discussion. Those that have been included, support the interpretation presented. Not all the examples for each theme are included, due to limitation of space; only those that provided the best evidence in support of the interpretation were used. A table is included in the appendix L listing the frequency of examples pertaining to each theme across all of the participants.

From the range of themes, two higher order themes were extrapolated, which encapsulated the participants' experience of discharge. The results were a mixture of the expected and the surprising. The second superordinate theme entitled 'Living in recovery' was more in line with what was expected in terms of the investigation into the meaning for patients of the experience of transition from inpatient to outpatient care. Whereas the first superordinate theme entitled 'Ambivalence to change' was more unexpected. This first higher order theme spoke to the residual deeper underlying psychological experiences of the transitioning from hospital.

Within the first superordinate theme of 'Ambivalence to change', three subthemes have been described. These were firstly: being ambivalent and being confused. Secondly, the shamefulness of being ambivalent and thirdly, the struggle with conflict and ambivalence. There was some overlap of these themes.

Within the second superordinate theme 'Living in recovery', three smaller more discreet subthemes, which embody living in recovery emerged from the data. Firstly, recovery involving a disconnection from services. Secondly, the harnessing of help from other people and thirdly, the importance of the vision of what living in recovery would be like in reality, during the transitional phase leading to discharge from hospital.

In the following section these superordinate themes and their subthemes are used as a basis for an interpretation of the experiences of transitioning out of hospital care back into the community.

Superordinate theme one: Living with ambivalence to change

The term ambivalence is taken here in the context of this research to be a state of being in two minds towards a phenomenon.

The first superordinate theme outlines how various emotional states accompanied ambivalence. Ambivalence was shown to generate feelings and states of confusion for the participants. Being in an ambivalent state led to participants being self-critical, a manifestation of intense shamefulness at not being able to fully commit to change. The consequence of being confused and ashamed was that when faced with change, ambivalence led to intense conflict.

Theme one: Being ambivalent and being confused

Ambivalence towards physical change meant being in two minds about eating regularly and maintaining a healthy weight whilst transitioning to live in the community away from hospital. In addition ambivalence was also focused on letting go of eating disordered thoughts and feelings as a way of coping with life in the outside world. Being ambivalent towards transitioning to a different state both physically and psychologically, ran alongside a sense of feeling confused. The links between the two concepts are explored below, evidenced with quotes from the participants' accounts. There did not appear to be a simple, single causative relationship between ambivalence and confusion, as might have been expected. Also, the ambivalence and confusion were not focused on the environmental change associated with discharge. What seemed to be more important to participants was ambivalence towards treatment regimes, weight gain and engaging with life in general. Thus, the focus of change involved psychological matters rather than practical concerns. The different experiences of ambivalence and confusion are described:

Lara said of her treatment:

> *it was quite up in the air a lot of the time no one genuinely knew what would be best for me and so that's why I felt like sometimes I'd persuade them of one thing that another month would be beneficial that that in reality no one was quite sure what was the best thing um or what would bring about the best results and that's really problematic because I really want to rely on want to think oh medical staff know what they are doing they can make these decisions for me but*

> *then I'm quite defensive if anyone would say you know inpatient treatment's just not for you full stop or if someone said tomorrow well I think it could work for you then I just think I wouldn't hesitate to go back to it that's the thing it's like I don't know whether or not it's got to get burnt fingers enough times to learn or if there's anything to learn or I don't know, it's so kind of confusing I suppose a lot of different views that changed every day.* Lara:9,4-16,10,1-3[1]

On the surface, Lara described the confusion that she experienced when relating to services. She seemed to have needed to rely on them to tell her what to do and yet by her own admission found it hard to follow what was advised. It could be said that this was at the heart of her ambivalence towards change. She presented as not being able to take responsibility for change herself; she had to rely on services to come up with the ideas: *'I really want to rely on…medical staff'*. She wanted to trust them, but could not bring herself to do so, possibly because she could not trust herself.

She described herself as *'defensive'*. Maybe this defensive position also made it difficult for her to own her ambivalence. She was more comfortable talking about her confusion over what to do, rather than owning directly how ambivalent she felt towards change.

However, ambivalence and confusion, it could be interpreted, were revealed at a deeper level of Lara's account. Lara appeared to also have a real mental struggle to make sense of change. She expressed this by using the image of *'burnt fingers'*, which it could be surmised was a way of her communicating that change might be painful. However, alongside this she questioned herself, wondering if *'there's anything to learn'* at all. On the one hand she seemed to have been able to predict the impact of change, but on the other she was unsure of what the learning might be. Herein seems to lie a deep confusion for Lara. Perhaps deep down Lara knew that she needed to learn something more about herself in order to transition to a new way of being, but she might have been fearful and avoidant of risking change, therefore presenting herself as ambivalent and confused. The confusion emerged from Lara not knowing what decisions to make for the best. In other words, her confusion was linked to ambivalence to change. She gave the impression that she knew that it would be good for her to accept treatment more fully. The outcome of this was intense rumination on what course of action she should take.

In summary, in her account, Lara overtly acknowledged her ambivalence and confusion with regard to engaging in treatment. However there was also evidence to suggest that

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[1] Key to notation: Participant pseudonym: transcript page number, line number – (page number,) line number

she experienced ambivalence more deeply perhaps, through a painful, confused, mental struggle with regards to change and transition.

Sally presented differently. She said:

> *Um I suppose you have a lot of expectation I suppose it's like they asked me to go back and do a recovery talk you know before I left and I was like well you know let me get to the New Year see how I'm doing because I've you you don't know what's going to happen you see so many people leave and go back that you kind of think well are people getting the right support that they need on the outside yeah well I've gone for full recovery and that but it doesn't mean in a couple of months' time I'm still going to be at that stage and I wasn't I'd gone back down again.* Sally: 28,4-13

There was no overt description of an ambivalent, confused self. Instead there appeared to be a sense of Sally really struggling to express herself. She moved from using the personal pronoun *'I'* to using *'you,'* all in the same sentence. She said *'you have a lot of expectation'* after discharge, yet then she said *'I was like…let me get to the New Year and see how I'm doing'*. The problem seems to do with owning her thoughts and feelings. We could surmise that she may be feeling ambivalent about maintaining the changes she has made. Sally then went on to make reference to what seemed to be the present situation *'I've gone for full recovery and that'* and it could be assumed from this statement that this might be her current state. In other words, that she has made a transition to a fully recovered place, maybe both physically and mentally. However, her ambivalence appears to creep in: *'but it doesn't mean in a couple of months' time I'm still going to be at that stage'*. So, there is a sense that weight loss was potentially still an on going threat to her. In her final comment, Sally discloses that in fact weight loss was not just a theoretical possibility, it had already happened.

This temporal shift could be said to be at the heart of Sally's ambivalence to recovery. Maybe her ambivalence was quite deep rooted and confusing for her. The confusion and also the ambivalence regarding responsibility made worse by the switching back and forth of the use of the pronouns *'I'* and *'you'*. More was developed from this when the question of doing a recovery talk was revisited later in her interview. The confusion could be said to have masked the shame she seemed to feel about doing a recovery talk when she was still struggling with ambivalence towards recovery. This shame will be explored further in the next sub theme.

In summary, in Sally's account she did not express overt confusion or ambivalence to change. What could be deduced from the way she expressed herself, sentence construction and temporal shifts, was some deep confusion within. On further interpretation this confusion was linked to her rather hidden ambivalence towards change.

Gail's account builds on this theme of ambivalence and confusion:

> *Yeah cause these places have saved my life I don't I did want to die I was on it of a suicide mission with my eating and I feel when I first came here [short pause] I feel that [outpatient therapist]*[2] *understood me and when I went to I just feel they've all saved my life and I've had a second chance in life [long pause] I can't think of any negative things it's all been a positive experience for me even though it's hard it's all been it worked well you know here and [inpatient unit] you know it's worked well.* Gail:24,6-14

It was as though Gail recalled her whole transition as having been without difficulties at all. On the surface, she expressed little ambivalence or confusion regarding change. It could be said that Gail's view of her discharge was presented with rosy coloured spectacles: *'I can't think of any negative things'*. Everything seemed to work well for Gail and possibly she was referring more to the environmental change from hospital to home, than psychological transitions. However, there appeared to be some intense mental shifts in order for Gail to get home.

Gail has had a *'second chance in life',* which she put down to the staff who *'saved [her] life'*. It might be said that it was the environment that saved her, thus seemingly a complex relationship emerged between the environment and Gail's psychological health. It was as if Gail had transitioned to a new psychological state, evidenced in her acknowledgement of her past ambivalence with living. This change is possibly communicated almost unintentionally in her slip of the tongue: *'I don't I did want to die'*. The change of tense seems to give the sense that change happened over time. It therefore seems that any ambivalence towards life and living has lessened over time. Gail could be said to have moved on from any ambivalence. However, maybe not all of the ambivalence has passed, as slightly earlier in her account Gail talks about going back to work and some residual concerns regarding change emerge:

> *I mean recently I've been talking about going back to work………..*[3]*[as] an employment advisor which was a high-pressured job and maybe that might have affected me getting ill as well [short pause] the thought of ever working before would just absolutely freaked me out but now I can think about yeah maybe I could now do some sort of work um but you know I want to get my life fully back to normal.* Gail:30,14-16,31,1-8

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[2] [Text] indicates explanatory text added by author

[3] ……indicates editorial omission of non-relevant material

On the face of it Gail appeared to describe a readiness to return to work, however on closer scrutiny perhaps this seemingly straightforward statement might indicate something deeper. She acknowledged her past fears in that work *'might have affected me getting ill'* and yet maybe some of the fear was unresolved. This could be potentially seen in the last phrase, where she expressed a desire to return to work, but the use of the word *'but'* appeared to powerfully suggest that she remained rather ambivalent about this. One interpretation of this might be that the decision to go back to work could not be made until everything was *'back to normal'*. An alternative interpretation might be that if Gail could get back to work, then her life would be normal. Gail had over time experienced a shift in her thinking with regards to work. In the past, just thinking about work would have *' absolutely freaked me out'* whereas now, she could *'think about'* it. However, immediately after this, she seemed to retract what she had said and pulled back with the idea that she could do *'some sort of work'*. This suggests that perhaps she would not be doing the work she did before, which she considered stressful and she reflected, may have been implicated in her getting ill. It could therefore be proposed that Gail remains slightly ambivalent about her return to work.

In summary there is in Gail's account, a further difference in how ambivalence and confusion are experienced. Gail appeared to have shifted in her thinking, which provides more evidence to suggest that she is less ambivalent. She does not seem altogether without ambivalence, but perhaps it relates to specific parts of her life, such as work, rather than for example, Lara's more global ambivalence. For Gail, the loosening of ambivalence seemed to have taken place gradually over time and with it Gail appears to have more clarity of thought, rather than confusion towards the advantages of change.

Three different ways in which the complex relationship between ambivalence and confusion coexist have been presented. It has been suggested that ambivalence and confusion appear to coexist in the participants' accounts, rather than having a causal relationship. This may reflect the struggle to make sense of change that the participants experienced. For some, the ambivalence was associated with confusion and for others feeling fearful and confused seemed to bring on ambivalence more poignantly. Some participants, Lara for example, were ambivalent about any change at all, whereas others could reflect on change and see that they themselves had changed. For Gail, some clarity seemed to have emerged and although the specific area of returning to work generated ambivalence, there was at least clarity of thought about this. Sometimes confusion was conveyed, not only by what was said, but also in how it was said, with confused syntax adding to the confusion.

The way in which the transition is experienced, is therefore complex. Living with ambivalence, also involves living with confusion.

Theme two: The shamefulness of being ambivalent

Being ambivalent seemed to be hard for the participants because at times it made them quite anxious. They appeared to fear the consequences of not being able to adhere to their treatment regime, or to maintain the gains they had made in inpatient treatment. There was a sense of fear of rejection and concern that treatment may be withdrawn, leading to them being censured. Many of the participants were self-critical because they were unable to attain their objectives to engage with the inpatient service. The goals of the inpatient team were to encourage eating and weight restoration using both dietary and psychological interventions. The self-criticism seemed to be what the participants shared, possibly because of being in two minds regarding the goals of the inpatient team. One interpretation of this could be that the criticism was an expression of their shame about their ambivalence. The ways in which the self-criticism was experienced varied between participants:

Lara's account frequently expressed self-blame at her difficulty to engage in treatment:

> *Um I think my parents have been very grateful to [inpatient service] for being so flexible with a difficult patient…….I think that's quite an objective way of putting it I mean I don't think anyone would deny that it's not been you know it has been a difficult course of treatment*
>
> JM *Do you think that is how your parents view it that you're a difficult case so to speak?*
>
> L *I think they do now and I think that's almost a way of us accepting it because I can't really I don't really know how to describe to them the reflex action to like resist help that comes when someone offers it I think I it's just it's me wanting to be independent and I can't stand um feeling that someone's trying to take control of things for me and if I could let them do that then I'm sure it wouldn't take long for me to get to a better stage in my life but it's just bringing down those barriers it's almost unbearably hard.*
>
> Lara:32,15-16,33,1-16,34,1-3

Lara seemed to be overtly self-critical of her ambivalence to engaging in treatment as she called herself '*a difficult patient'*. Further evidence of Lara's highly critical approach to herself was present throughout her interview. For example, she said she was: *'a complete failure'* [Lara:4,3-4] and *'I'm not a person that is able to be recovered'* [Lara:7,7-8] At first sight this could perhaps have been her style of relating to herself, but equally, it could be interpreted as her self-criticism serving a function. Lara referred to herself critically as a *'difficult patient';* she expanded on what this meant for her: she suggested that it was not just calling her difficult that helped her and her parents cope, but it seemed to be the manner of conceptualising herself as an object, that also helped them. Lara also referred to herself in the third person giving further weight to the interpretation of her need to distance herself from the criticism. One interpretation of this might be that she had a sense of both shame at being ambivalent to treatment and pride in her defence of herself and her *'independence',* which she indicated was central to her and could have underpinned her ambivalence. There appeared to be a strong defence of her position as well; it was a *'reflex action'* to *'resist help'* and we might wonder whether she could be covering up her shame at not being able to bring *'down those barriers'* which she explicitly described as being *'almost unbearably hard'*. The shameful process of this experience seemed to almost trip her up, seen here in the double negative: *'I don't think anyone would deny that it's not been you know it has been a difficult course of treatment'*. She carefully adjusted this to make sense, but with further distancing of herself. There is a sense that she finds it as easier to view herself as an object that received treatment. This attitude might have served to devolve some responsibility and therefore lessened the shame that she could not engage in what was required in order to recover.

At the opposite end of the spectrum in terms of self-criticism was Gail:

> G *I feel like a different it feels like I was a different person but um [slight pause] I know it sounds bad but it was a good year for me I really….. because being in hospital shouldn't really be a [slight pause] but really that just my life that was one of the best years of my life [laughing]*
> JM *I wonder what was what made it one of the best years of your life?*
> G *[laughs] well I mean it wasn't at first but I think afterwards I think I thought I'd never recover from anorexia I guess I never thought life living with that is the most miserable greyist, dullist cold life and I guess and I felt so weak physically and I just I could feel meself slipping away and I was already saying my goodbyes to people um [short pause] and I guess they made me feel it was ok to get better…….. I didn't want to get better and they [short pause] said it doesn't matter what your heads thinking we're telling you that this is what you should do you know well maybe not quite like that but.* Gail:34,13-16,35,1-16,36,1-2

Unlike Lara, Gail seemed to have taken the responsibility upon herself to engage in treatment and she reflected on the experience. Although she gently chided herself for viewing her inpatient stay as a good experience, there did not appear to be harshness to her observation and maybe there was a sense that she could make a critical comment about herself and could tolerate this now. However, it could also be said that there might have been some hidden self-judgement that related to her ambivalence towards life. Gail described having sunk to the very depths of her being, as she outlined *'saying goodbyes to people'*, and it's hard to see that her situation could have ever got worse than that. She implied that at the height of her illness there was ambivalence to life itself, *'saying goodbyes'* as if I may see you; I may not. It could be that the shamefulness of letting oneself get into such a state was hidden by her laughter and there were several episodes of laughter that broke up this account. In hindsight it was a good year because she survived, but at the time it was the *'greyist, dullest cold life'* and only now could she fully realize this; the poignant description conjured up an atmosphere of death.

Gail seemingly had to rely on others to manage her ambivalence and give her permission to recover: *'it doesn't matter what your head's thinking we're telling you that this is what you should do'*. Immediately however, Gail seemed to retract this, with a quip about how the challenge to her was said *'well maybe not quite like that'*. One interpretation could be that Gail's way of presenting herself here was hiding some thoughts of how shameful the whole experience had been for her. What makes her account different to Lara's, is that Gail's ambivalence was mostly, but not entirely, rooted in the past. There was a sense of before and after (now); that she had become changed through her inpatient experience, unlike Lara, who appeared to be stuck.

Alice shared some similarities to Gail's account when she talked about being honest with staff:

> *Yeah it is kind of saying if someone knows then they have to look out for it [over exercising] they're more conscious of it even if they bring me up on it even if it made me I don't know makes me seem worse like more ill than I am in relation to other people who keep stuff secret I would rather still have that and an outpatient a bit longer and have that transition a bit longer than hide it and go back to inpatient* Alice:40,2-10

The context for this section was that Alice had been describing how as an inpatient, she had learnt to seek help from staff with her problem of over exercising. She argued the case for continuing with this strategy, whatever the consequences. This was seen in Gail's account too, illustrating a sense of importance in engaging with staff, despite feeling very ambivalent. One interpretation of this could be that in both accounts there was a sense of their self-criticism being projected onto the staff, hence for Alice, being corrected by staff was expected. This could be part of their felt shame, whereby deeply shamed people expect to be punished and treated badly. This seemed more marked in Alice's account, as Alice seemed to say that even being shamed by staff; *'they bring me up on it'*, which in tone sounded school-like or parental, would be nothing in comparison to being shamed by needing to go back to inpatient treatment. This would perhaps have been a walk of shame for Alice, since it would have been indicative of failure.

Maybe Gail had changed a little over time. Alice, although attempting a similar transition approach, was it seemed, still enmeshed in her ambivalence and was dealing with critical and shameful feelings; there was rawness in Alice's account that could imply this. Alice appeared to be tackling her ambivalence in a confrontational way with staff. Her ambivalence could be a shameful experience, as it could have been exposing to be challenged by staff. However, she seemed to view the honesty and clarity of challenging her ambivalence as a way to not be as ashamed as those who, in contrast to her, *'keep stuff secret'*.

So far, the shamefulness of being ambivalent towards recovery has emerged as having different manifestations of self-criticism for different participants. For example, Lara seemed to exemplify the harshest form and Gail and Alice less so. There was a sense of Gail to some extent having transitioned to a new way of being, while Alice seemed to be on the road to change, as elsewhere she conceptualises her transition as a journey.

Sally was also self critical:

> *Um I said that I was happy to go and do a recovery talk um but um I said I'd rather leave it until the New Year..... they've contacted me a couple of times to do that but I've declined that because I don't feel that I've been in a position where I could like I've got any right to give advice um [short pause] because I was struggling myself because I'm not at my full recovery weight any more I've dropped a bit so I'm kind of thinking well it would be pretty hypocritical of me*

> *to go in there and give all this advice on you know recovery you know about people's daughters and sons and friends and stuff you know what help can they I just didn't feel like I was in place that I could I should go in and do that so I declined those I would like to eventually go and do recovery talk and hopefully when I'm better and you know months or a year down the line I'd hope to be able to do that.* Sally:38,12-17,39,1-15

This quote gives further insight into the ambivalence identified in the previous theme, around Sally being invited to give a recovery talk to patients currently in hospital. Sally seemed to be of the mind set that the recovery talk had to be *'declined'* because she had current struggles with weight maintenance. Not only this, she felt that it would have been morally wrong and deceitful to others, if she had put herself forward as an example of a recovered person, when in her eyes this was far from the truth and it would be *'pretty hypocritical*'. The interview also revealed the intensity of her experience, of having been in two minds towards recovery. Perhaps there was a feeling of pride at repeatedly being invited to give the talk: *'they've contacted me a couple of times, but I've declined'*. Another interpretation might be that the shame of her weight loss led her to decline the invitation. It could be suggested that it was her ambivalence to change that underpinned the whole episode and shame and pride were alongside this and fuelled her decisions.

The complexity of the participants' experience was quite hard to disentangle and this has been illustrated in the discussion of the theme. However, what can be said, was that many of the participants were self-critical regarding their ambivalence to the transition to health. The focus seemed to be on being critical of their ability to engage psychologically in treatment; some were overtly harsh and critical of themselves, e.g. Lara's highly critical global self-evaluation of being a *'difficult patient*', while others seemed to criticise themselves more subtly, e.g. Gail's criticism of herself in the past. The function of this self-criticism may have been to hide the shameful feelings participants felt in response to being unable to fully engage in treatment.

Theme three: the struggle with conflict and ambivalence

The ambivalence associated with making changes and transitioning to a healthier state, has been explored in the previous themes. It appeared firstly to be associated with some confused feelings and secondly it connected with shameful feelings. In both theme one and theme two no clear unidirectional causal relationship between ambivalence and these two separate phenomena was evident. What was suggested was that where ambivalence was seen in some extracts, confusion could also be seen. In other extracts shamefulness in relation to ambivalence also appeared to be evident. This next theme considers the role of conflict in relation to ambivalence. In some ways ambivalence and conflict may be one and the same thing, being in two minds could lead to a clash of ideas. However, in the context of this theme that emerged, conflict was more intense, it was being in two minds, but it was also a battle and struggle at a deep level. In this third theme, what is suggested is that the impact of being ambivalent, confused and ashamed could also mean that participants were living in a state of conflict and battle.

Lara talked about feelings generated immediately after she was discharged, when she spoke with her outpatient clinician:

> *Um I think I took a lot of I think I kind of took a lot of that plan to him and it was quite it's always a kick up the arse when you've either gone into hospital or when you've come out and it was very like ok these are the things that I need to do it's ridiculous that it's taking me so many years to do these like driving test moving into the house er getting involved in certain things which I had a list and it was sort of you know I'm fed up with myself um and given your age.* Lara:29,13-16, 30,1-5

Lara appeared to have had a metaphorical fight with herself, which she described quite graphically: transitions both in and out of hospital required a *'kick up the arse'*. This could be interpreted as an almost brutal experience, where Lara seemed to be bullying herself about her ambivalence to change. The sense of physical violence towards herself is conveyed in her account. What she appeared to be saying was that a change in environment was a "wake up call" to attend to her on-going ambivalence. Lara used the word *'ridiculous'*, which seemed to be an expression of her frustration of not being able to move on with her life. However, at the same time there was a conflict within her that made it difficult for her to own her frustration. This conflict in owning her frustrated feelings also appeared in her moving from the use of 'I' in *' I'm fed up with myself'* to the use of ‘you’ in *'given your age'.* This change of pronoun distanced Lara from her angry feelings and despite trying hard to acknowledge these, there also seemed to be part of her that did not want to own them. Her ambivalence towards being in touch with her feelings, therefore began to emerge. The overall impression was of Lara reprimanding herself, as if she were standing apart from herself; she was in that instant, in the role of a critical authority figure. This might give further insight into her experience that somehow she was to blame for being ambivalent and she might expect others to be cross with her. What seemed to emerge in Lara’s account was a mixed picture of owning and struggling to own conflict within herself, as a result of being ambivalent to change. However the account could be said to show that the owning of conflict was presented in quite a straightforward manner. Only some part of the conflict was a struggle to own.

Nicola’s account built on the more hidden aspects of ambivalence and conflict:

> *Apart from weekly appointments I just and I don’t know you see the problem is I don’t know what will help cause part of me says it’s my brain I’ve got to sort it well quite a lot of me says that and I’m a stubborn old* [does not say the word] *so you know it will always be my brain and it will always and it’s always my decision in the ultimate sense.* Nicola:22,6-12

In Nicola’s account her frustration and her ambivalence appear to be closely intertwined. Initially there was a hint of frustration expressed towards services being offered to support her. She was given *‘weekly appointments’,* but there was a sense that this was not enough as she searched her mind for what else might help. Ambivalence in terms of taking responsibility for change seemed to emerge, as she then began to own the fact it was not down to services alone, it was down to her *‘brain’*. There was therefore a shift from putting the responsibility for her change onto others, towards owning her own role in change. Maybe she knew she was ambivalent, but there was not really much she could do about it. Perhaps it was easier for Nicola to blame herself for her ambivalence and to rely on others, rather than for her to address her issues with change. This would make sense in the context of her long association with hospital services which had been part of her life since childhood; historically, she had relied on doctors to ‘save’ her. It could be said that she was somewhat stuck in childhood; illness having stopped her from maturing, so it was difficult for her to be grown up about taking responsibility.

It might be that recognition of this ambivalence led Nicola to be frustrated with herself. Yet it also appeared that Nicola was ambivalent about owning her frustrations. An example of this was when she stopped short of saying what she felt about herself. She said: *'I'm a stubborn old* [does not say the word]'. She seemed to have held back in terms of owning her frustrations. A complex relationship therefore appeared to emerge in Nicola's account, between being ambivalent to change and being ambivalent towards owning difficult emotions.

Alice's account gave further insights into the complex relationship between ambivalence and conflict. The context was Alice's observations on the limitation of talking therapy:

> A *I think just different [hesitation] sessions where I could practice my not just talking like practice something like I know when I was a day patient I had like I did cooking lessons or you know just something like at first like there was the occupational therapist who helped you some people had really big image problems [fast speech] and it would be just go shopping ..... which is very good for some people but I don't think [names city where outpatient service is located] has the facilities for that or has the staff..... and just having maybe if you have a problem something like a feared food that like when I was a [names city where day and inpatient service is located] and I know when you are a day patient you have more care it was like if you had a fear of eating chocolate you'd have someone there to eat your chocolate with and even just having you know a bar of chocolate or going out with someone for a doughnut is [slight pause] it kind of seems a bit like it would help you* ***a lot*** *[emphasis] but it isn't anything …….just having some kind of therapy that could help you that wasn't necessarily centred about you sitting down and (hesitation) talking all the time*
> JM *Talking?*
> A *Yeah well in therapy you talk discuss and you're working things out whereas if you're doing art therapy it's like a different way to express yourself but you don't necessarily have to go sit there and just talk and stuff*
> JM *Is it hard to do the talking?*
> A *For some people yes I think, for me I always went in thinking well this is your job to kind of hear me rant if I need to rant.*
>
> Alice: 32,17,33,1-17,34,1-14

Alice presents a long argument almost as an explanation as to why she might need to *'rant'*. The long passage might also be viewed as the way she made sense of her frustration, as if she was working it all out as she went along. There seemed to be a tension for Alice to own the frustrations for herself. She made a list of all the things that were lacking from outpatient care, but presented them as if relating to people in general rather than specifically to herself. This was seen when she used the pronoun ‘you’ rather than ‘I’ when describing her complaint and frustration with services. An example of this was *‘if you had a fear of eating chocolate you’d have someone there to eat your chocolate’* rather than saying what her fears were. The impact of this was to distance Alice from being critical of services. However, at the end of her long stream of consciousness, there appeared a window into her internal critical and angry feelings: I’ll *‘rant’* if I want to *‘rant’*. Finally she seemed able to own her frustration. The level of frustration also appeared to be quite intense, not just mild annoyance but ranting, as if her anger went to the very core of her being. The frustration for Alice seemed to be that talking therapy was not enough, or maybe this was at the centre of her ambivalence and she did not want to talk anymore; she didn’t want to be *‘working things out’*. It could also be that Alice’s anger might have been fuelled by the idea, that with the right help, her ambivalence with making helpful choices might itself have been helped, for example with a *‘feared food’*. A possible interpretation of this criticism of a lack of resources for outpatients, was a projection of Alice’s anger and frustration on to services; a getting rid of horrible feelings. Alice appeared to say if you want me to talk, I’ll talk and I’ll *‘rant’* and what’s more *‘ this is your job to kind of hear me rant if I need to rant’*. In this phrase there was a sense that Alice was addressing me directly and, in that moment, I became a place for her to project her anger.

Alice went on:

> *Yeah, but also I for me sometimes it is hard sometimes it is hard say to try and say what you’re thinking especially when it makes no sense to you when sometimes they ask how do you feel and I actually don’t know I don’t know how I feel and maybe sometimes I just want to be able to vent that frustration out some other way but if you don’t know the other way and you vent it out I know people vent it out doing all kinds of anorexic things like if they’re bulimic they’ll throw up or if they have an exercise problem they go running or jogging more exercising or cutting themselves or limiting food and maybe finding a way in a group to kind of channel their energy into something else helps.*
> Alice:34,16-17, 35,1-11

Alice appears more insightful now. She owns her frustration of it being *‘hard’* to talk when it *‘makes no sense’*. What’s more, she gives the impression of being able to acknowledge her own need to project out her frustration, *‘maybe sometimes I just want to be able to vent that frustration out’*. Alice is perhaps referring to a way of expressing herself that is more psychologically healthy. The implication is that she recognises that venting her anger verbally is an important transition to health; it is *‘some other way’* of being. She compares ranting as a favourable option to doing *‘anorexic things’*. She was also ambivalent about owning that anorexic things applied to her as she talked of it relating to other people: *'like if they're bulimic they'll throw up or if they have an exercise problem they go running'*.

A pattern seems to have emerged in relation to Alice's processing of her ambivalence and conflict. At first she struggled to own angry feelings for herself, preferring to talk about her frustrations in general terms. This might represent the ambivalence that she experienced in being true to herself. Then on owning her anger there were times when she projected it on to others and she had begun to recognise this in herself. Part of her transition was also learning how to manage conflict within and particularly not to resort to anorexic behaviours to manage her feelings

In summary, there emerged an intensity of feeling generated by the participants' ambivalence to change. The intensity arose as angry feelings. What seemed to differ between participants was the process by which the inner conflict was experienced. Three different presentations came to light. Firstly frustration was owned repeatedly and overtly with name-calling and evidence of vicious, verbal attacks on one's self. On closer inspection though, there was a struggle with the ambivalence of owning the frustration with one's self.

Secondly, the idea of being ambivalent about owning feelings, was on occasions more central to the presentation. On occasions feelings and particularly angry feelings, were avoided and yet on further interpretation what could be seen was an underlying fury with the self.

Finally, frustration was presented as something that needed to be understood and worked out before it could be owned. The outcome of this process was that ambivalence towards choices was exposed.

Ambivalence has emerged as an important aspect in the lives of the participants. It has a rather encompassing effect, which impedes psychological transition to health. Ambivalence can confuse, evoke shame and lead to conflict. The consequence of this was participants appearing to remain stuck in the process of transition.

The second superordinate theme describes different experiences and can be thought of as being at the opposite end of the spectrum in terms of the process of transition. As will be described, where ambivalence to change can be viewed as stationary, recovery and its lived experience, is more active. The components of this second superordinate theme will now be outlined.

Superordinate theme two: Living in recovery

The second superordinate theme considers specific aspects of living in recovery. Recovery involved disconnecting from services. However, it also involved harnessing some help and support. For the transition to be fully realized, there was also a need for a vision of recovery.

Theme one: Disconnecting from being an inpatient

This theme suggests that adjustment to being at home, can be viewed as a process that involves disconnecting from the inpatient service. The various aspects of separation will be considered. Participants referred to a graded discharge from hospital. This was where there was a gradual reduction in contact from a hospital setting, allowing some limited time back in the community, in order to adjust. The various ways graded discharge was experienced will be outlined. Participants were also concerned about the loss of support as they disconnected from the inpatient service. The different experiences of this loss will be considered.

For some participants a graded discharge involved being discharged from hospital and living at home, but also going back to the inpatient service where they attended a day care programme.

Alice said this about being a day patient as part of her transition:

> *Um good thing about becoming a day patient is that [slower] you still feel supported you still had that environment where you knew what was going on still had that safety net kind of like it was like being wrapped in your own little blanket all the outside world was you know if they're not happy you had your own little world nothing that was going on could affect you you had all the doctors there you had people to could talk to you had your therapist but also you had those people that made it well the other patients that didn't judge you so much in being ill..... and going back to a day patient you had people who did understand it you did have you could speak to your therapist speak to other patients and it was a safety net and that was the good thing about it* Alice:16,11-17,17,1-12

Alice described being in favour of day care, as a step down from inpatient care, rather than full discharge. Day care was a safe place, where you could retire into *'your own little world'* in order to be fully understood. The assumption seemed to be that the world outside did not understand. Day care was almost like another world, which was so safe, nothing horrible could happen. The image of *'being wrapped up in your own little blanket'* seemed to convey a sense of a return to babyhood; nestled in a comfort blanket.

Maybe the knowledge that this comfort blanket existed, facilitated better engagement with the world outside. Alice was clear that day care was a helpful service, although possibly she struggled to fully own the use of day care for herself, as part of her disconnection from inpatient services. Day care might be good for people in general, but not specifically for Alice. This struggle of owning the benefits of day care for herself was seen when she used the term *'you'* in her description of day care. The effect of this was to distance her from any personal involvement. It may be that to acknowledge this as being helpful for her, might also involve her owning some vulnerability in relation to her own discharge. This might have been a step too far for Alice as she transitioned out of hospital. Maybe she was not ready to accept this part of herself and so avoided thinking about it for herself during the disconnection process. Furthermore, what seemed crucial was that the transition needed to have safety built into it in some way. Day care seemed to fulfil the function of providing a safe place to retire to and to have this safe place in mind, was important as well. Therefore, the graded discharge provided a partial disconnection for participants, even if, like Alice, they acknowledged that it was a struggle.

For other participants graded discharge did not involve day care, but entailed repeated and extended home visits. This was the context for Sally's gradual discharge and she had a different view to Alice of the impact of this service provision on her. Sally said:

> *Um I think it's a much bigger step than I ever thought it would be I suppose I it had probably given me I was probably given a false sense of security because I went towards the end of my inpatient stay I did a lot I took a lot of home leave so I ended up probably being at home five days of the week and then just going back to hospital for two days but then being discharged and being at home fully and no knowing knowing that you're not for going back for that support and that structure routine is very difficult you literally going to one hour a week where you can actually talk about your problems with someone who can understand so it's a huge huge transition [short pause]* Sally:1,5-16

Sally talked of her increased home visits as being rather unhelpful; the process gave her *'a false sense of security'*. The suggestion was that extended home leave, might be a logical graded exposure to a potentially feared situation. However Sally did not accept this rationale and argued that it could have tricked her into thinking all would be fine when finally discharged. She gave the impression in her narrative that no graded discharge could ever be the solution to preparing for final discharge. When discharged, it was difficult for Sally to say what the experience was like, other than that it was big. It appeared to overwhelm her in some way and to have an element of loss, as she lost the understanding ear of the clinicians. She went on in her account to describe the support of her parents. It seemed that they tried to bridge the missing part of support post-discharge. However, later Sally said that there was a feeling that her parents couldn't '*fully appreciate what [she went] through*' (Sally:3,1-2) and were not able to offer the same therapeutic understanding as clinicians, reinforcing her sense of loss of support.

Sally's response to the loss was:

> *I think you feel you do feel like you're coming out and you you by yourself you're all alone kind of thing and it it's I think it's everyone kind of thinks you know that you put the weight on in the hospital you've got up to a healthier weight you've got to a healthy BMI you must be cured but I think it's it's when you leave hospital that the hard work actually really does start and um I don't think you're ever fully prepared for that big step.*
> Sally:3,6-13

She clearly identified that on discharge there was a sense of being on your own. There was a loss of contact with clinicians and the impact was of feeling completely isolated. However, it could be said that the isolation was a process that Sally had to go through, to understand what transitioning to health really involved. This was revealed by Sally's observation that 'cure' did not happen in hospital and that it was not entirely connected to weight restoration. Sally appeared to point out that there was other *'hard work'* that could in fact only be done alone, when back out in the community. Thus, her comments earlier about the inpatient stay being a *'false'* situation, rang true.

Sally's comments on loss of support suggest that the whole process of losing support was frightening. Being completely isolated might put her at risk of something as yet not known. Maybe it was fear of the unknown. However in her account, there was an impression of it being hard for her to get to grips with what she really felt about this loss. Evidence for this is seen in the manner of her speech where there is a hesitant tone, *'you you by yourself you're all alone kind of thing'*. She is vague on the precise impact of being alone. Furthermore, in terms of how she makes sense of being alone there appears a struggle, as she often repeats herself. *'It it's'* is repeated on more than one occasion as she tries to pin down what it is she experienced. Sally's transition conveys a sense of the unknown and the scary, resulting in an overwhelming experience that was almost indescribable for her.

She went on:

> *because I went to full recovery I was probably given a lot more support but then towards the end of my stay I think they they concentrate on understandably so*

> *they concentrate on the new patients that are coming in who are very severely ill but they'd forget about kind of helping you and getting you adapted to when you do leave um they almost just to get to a point where like just get you up to your weight and we'll send you home kind of thing that's kind of what I felt when I was there*
> Sally:4,2-15

Sally started off by being quite empathic towards the inpatient staff. She seemed to have an understanding that the sickest patients needed the most input. Then a critical response emerged, where Sally appeared to feel let down by the inpatient team in some way. They, it seemed, had failed to prepare her. They were fixated on weight restoration and when that was achieved, Sally seems to have experienced a crashing sense of rejection. Sally, however had little sense of clarity about what help she would have wanted the inpatient service to give her, in preparation for discharge. She appeared to have little understanding about what the disconnection process needed to involve. Evidence for this was shown in the rather tentative way she made her point *'but they'd forget about kind of helping you'*. It was rather ambiguous. A question remains unanswered: were the inpatient team helping or not helping her? It may be that she was tentative also because she was nervous about making these points about the quality of her care. Sally perhaps did not want to criticize the service that she experienced as getting her on the road to full recovery. Nevertheless, however good the inpatient care, the disconnection process was felt as a kind of rejection.

Gail experienced the loss of inpatient care in a different way to Sally:

> *you know and um yeah it's been it's not been a [stutter] bad experience coming out of hospital it's been quite it's been nice I'm glad I had this place in [city where we are currently located] though, I'm glad that they've both communicated well with each other, where I think I could have easily slipped and if I thought that, I kind of felt like I was being looked after by [inpatient service] and [outpatient service].* Gail:13,13-18,14,1-8

Here there was the sense of risk for Gail, which hypothetically could have led to slippage and although unsaid, it could be assumed this meant relapse in some way. However, Gail seemed able to relieve her distress about this by calling to mind the continuity that she experienced between the inpatient and outpatient services *'they've both communicated well'*. Possibly Gail had somehow kept in mind the idea that the two services working together meant that she could feel confident that relapse would be unlikely. Continuity, it seemed in her recollection, led her to feel looked after and "held". However, what also was important to note contextually was that maybe Gail was helped by the fact that (unusually) she had extended one to one therapy sessions with her inpatient therapist after full discharge. Gail seems to have experienced her disconnection from inpatient services as an easy process. Taking the contextual points into consideration, it therefore appears that the ease of disconnection was facilitated by the continuity of the therapist.

What can be discerned from the idea of disconnecting from hospital was that it involved a process for the participants. This process was often service-led and various graded discharge options were evident, including use of day care and the use of increasing home leave. Some found the gradual disconnection from services helpful psychologically, as it acted as a buffer zone and safety net. Having continuity between inpatient and outpatient services appeared to be the most helpful way of easing the transition to home life. The least helpful disconnection process was gradually increasing home leave, with longer periods away from the inpatient unit, making it hard to cope both at home and on return to hospital. The difficulty here was hard to extrapolate, but it seemed to relate to fears of being alone. As in a grief reaction, there appeared to be a feeling of rejection (from inpatient services), even when they had previously been very supportive.

The disconnection process seemingly was an essential part of the process of transition out of hospital for the participants. Undergoing this process, could possibly be the way in which they were able to actively engage in supporting themselves. It is this idea of harnessing support that will now be considered in the next theme.

Theme two: Harnessing support on discharge from hospital

Part of the transition process of living in recovery, involved getting support. Most of the participants who sought care, did so through engaging with other people, or activities, in their lives. However, not all participants were able, or perhaps ready, to seek help. How and what help was harnessed will be outlined, alongside the impact of the help-seeking behaviour:

Gail spoke of harnessing support from her peers. These were patients from the inpatient service that she continued to engage with post-discharge:

> *I need to stick with people that are doing well that helps me do well I think if you stick with people that are finding it hard then part of the illness make you sort of slip back into that way so I think it's even though it's a little bit harsh you have*

> *to sort of move away from certain people I think [whispered] that's how I've had to do it um not in a nasty way um and I think a few of us did say that we were in that we would stick with the healthy people this was what helped each other out* Gail:13,4-12

Gail gave the impression that her peers were a powerful influence on her during her transition out of hospital. On the one hand they could be really helpful, but on the other, they could be a bad influence. Gail did not to blame peers who were *'finding it hard'*. She had come to understand that *'part of the illness',* that she had experienced, could easily attach on to unhelpful influences. Gail did not specify what an unhelpful influence might entail. However it could be guessed that it related to unhelpful eating behaviours, such as restriction of food intake. Maybe Gail did not go into details of what might be unhelpful, because she had transitioned away from her illness. Evidence of this progress was seen in the way she took charge and was assertive. She said *'I need'* using the pronoun *'I'*, plus she did not appear fearful of knowing what her needs were and taking action to make sure that they were met. Furthermore she appeared to address the fact that sometimes being assertive could be judged as being *' a little bit harsh',* giving the example of moving away from those who struggled. This had the potential for Gail to feel uncomfortable, as it seemed counterintuitive to her to not support people with difficulties.

Gail therefore gives the impression that she has made a psychological transition towards knowing what is good for her in terms of recovery and also being able to tolerate potentially harsh decisions. There is however, a sense that she needs to keep working at this process. This is evident when she says *'I need to stick'* and repeats the need to stick to her plan and decisions regarding recovery. 'Sticking to plan' involved a collective effort with her peers and she says that as a group, they were clear that *'we would stick with the healthy people this was what helped'* Gail could therefore stay on track and maintain her changes towards recovery by having an agreement with her peers and in this way, Gail harnessed support for herself on discharge, which seemed crucial to her transition to health.

Unlike Gail, Nicola did not access support from peers in terms of fellow patients, but rather from student peers at university. Nicola's use of support however, raised some issues for her:

> *when I came out and I discovered I couldn't have it* [support at lunch time] *one of my friends before Christmas had said look if you want me to meet you for*

> *lunch or for doing anything just give me a push…. she's had issues with depression as well so I knew it would be a two way thing as well- which is which what made it possible for me to ask in a way cause I knew it wouldn't just be me relying on her…. I did feel it was genuinely two way which made me feel better about the whole situation so I suppose I almost implemented it myself …. I began to question this over Christmas is it normal is it not normal should I be relying on people and then Mum said to me for goodness sake you know when I'm at work I have a colleague who emails*
> *me at lunch time and says are you ready for lunch? So it's normal for people to have lunch together and it's ok and it's you know and it's just getting into a routine to do it so*
> Nicola:6,14-16,7,1-16,8,1-6

Earlier in her account, Nicola described an expectation that support from services at lunchtimes would help her on discharge from hospital. In the absence of this support, Nicola made her own arrangements to meet a friend for lunch. She acknowledged that it was something she did for herself and this was encouraging, as like Gail, Nicola had taken responsibility and set up her own support. This seemed an adaptive way of coping with discharge; harnessing the help of friends to meet up at lunchtimes. The function of the meeting was likely to be to remind Nicola to eat or to give her permission to eat. From Nicola's perspective it might be that she was responding, not out of her own volition, but rather as a result of services withholding the care she felt she needed. She *'discovered she couldn't have it'* [support at lunchtime], therefore, she had little choice but to accept the offer of help from a friend. There was a hint of resentfulness on Nicola's part over having to take matters into her own hands; she said *'I suppose I almost implemented it [the support] myself'*. There seemed to be a sense of being rather let down by services and having to draw on her own resources. The power of the institution might have backed her into her corner to take responsibility for herself. On top of this Nicola appeared to struggle with accepting help from her friend. She could not trust herself to have needs of her own. When her friend had needs, it created a balance that was acceptable to her *'I did feel it was genuinely two way which made me feel better about the whole situation'*. This was different to Gail who took responsibility for her own needs and believed that her own needs were important. Nevertheless Nicola did accept the help offered and so harnessed support for herself. However, the psychological outcome of her help-seeking, seemed problematic. Nicola questioned her actions *'should I be relying on people'*; she seemed less concerned with issues of dependency and rather more concerned with issues of behaving normally. In her anxiety, she seeks reassurance for her behaviour from her Mother, who whilst reassuring her, also seemed to convey a slight exasperation, saying *'for goodness sake'* in response to Nicola's questioning.

So in terms of harnessing support for herself on discharge, Nicola does so with some reservations; she finds it hard. There is also a sense that there were few psychological gains from harnessing support, which in turn impacted on her capacity to transition to a more recovered state.

Unlike Gail and Nicola, Kay struggled to harness support, she said:

> K *(short pause) I just felt sorry for [other patients] like that were in there I just wanted to help make them better but I couldn't (long pause)*
> JM *Did they help you at all?*
> K *Um (short pause) yeah well I think well they all they they would have done if I had let them…I just didn't talk to them about anything ….I talked to them a lot about everything other than my eating disorder* Kay:20,17,21,1-1

Kay spoke about her blocks to harnessing support from people she had met, also with an eating disorder. The main problem was that it was hard for her to communicate at all, never mind her particular needs. She says *'I just didn't talk to them'* [the other patients]. Her difficulty in communicating is conveyed throughout her interview. In this extract she struggled, repeatedly pausing before she said something, as if unable to put into words exactly what she wanted to convey. She also paused after she spoke, as if it were a great effort to find the words and perhaps her mind had to take time to adjust to what she has just said, or maybe she was unsure that she had communicateded the real essence of what she wanted to say. Looking at the whole of her interview, there is a repeated pattern of dialogue with multiple prompts from myself. Kay really struggled to communicate her experiences of discharge clearly. However, on further examination of her interview, Kay can be seen to have some awareness that harnessing support from her peers would be helpful, recognizing also that this was a block for her *'they would have done [helped her] if I had let them'*. She put the blame on herself for not being able to harness support, saying she talked to her peers but about *'everything other than [her]eating disorder'*. What seemed to be blocked, was Kay's ability to recognize that in fact she was harnessing relational support through talking to her peers *'a lot';* she was unable to see that it might be the relationship that was helpful, irrespective of the topic of conversation. She blamed herself for not talking about the eating disorder, assuming that was the only way she could gain benefit. In fact there seems to be a sense in which Kay was rather stuck with her life. She could not harness support from her peers and as well as this, felt unable to support others *'I just wanted to help make them better but I couldn't'*. Kay therefore had some awareness of the usefulness of harnessing support and possibly it being a two way process, however she presented with a block, leaving her progression towards a transition to recovery in limbo.

Sally also gathered support, but in her case it was from a new situation. She does not mention work colleagues, but they appear to be part of her support system:

> *work is the only place where no one knows anything and that was that was why that was so important to me it was so nice to go somewhere and people know me for Sally cause everywhere else probably just you know oh Sally she's go an Eating Disorder she's got you know but they don't know anything at work and that's my kind of safety it's like it's my escape I suppose ……. it's just no one treats me any differently because of I suppose you know my parents and that they kind of tip toe around* Sally:19,14-17,20,1-8

The context was that when Sally came out of hospital, she decided that she wanted to change her job. Previously she had worked for her parents. Starting a new job gave Sally the opportunity to mix with people who had no prior knowledge of her. This was therefore a new start and enabled her to build a new identity. She could move away from Sally with *'an eating disorder'*. She no longer felt the burden of being watched and being treated with 'kid gloves' as her parents *'tip toe [d] around'*. Through harnessing the support of a new job, Sally was able to transition to a new identity, although what this was is not expressed. Maybe Sally felt that any identity where she was accepted for who she was and where people *'know me for Sally'* was the way forward for her, for recovery. What happened is that she no longer felt judged or treated differently. There was an impression that what was supportive was the fact that this new place felt safe and was also an escape from the eyes of her parents, who were ever-watchful for signs of recurrence of her eating disorder. There was the risk that harnessing this new environment could give Sally the opportunity to move backwards, away from her recovery but there is little evidence to support this idea other than her parents' concerns and fears as they observed her. Sally has transitioned in the way she wants to think about herself, not as someone who is ill, but rather as someone who can be recovered and she has assertively sought a new environment in order to harness the support she needs for the on-going transition to recovery.

In summary, what appeared to be a helpful support for Sally, was engaging in a new venture with none of her personal history attached or known. This environment was supportive, because it meant that people accepted her for who she was and did not attribute any label to her. She contrasted this with her parents who were experienced in treating her with caution. The transition to health needed to involve feeling safe and having a new start, leaving all the difficulties behind so that she could live a new life in recovery.

Living in recovery for the participants meant needing some support, in order to be able to do so effectively. In the case of Kay, she did have some impression that support would help her, but her difficulty with communication blocked her making this happen. Other participants such as Gail, harnessed support from people, who had knowledge and experience of an eating disorder. She was careful to engage with those who would be helpful, recognising the dangers of mixing with some who were actively struggling with their own recovery. Nicola also obtained support from others, in her case other students, but her efforts were hampered by anxieties and views about service involvement. Sally gained support by changing her environment which had an impact on how she felt about herself.

The conclusion of this theme is a mixed picture of experiences. Gail and Sally seemed to experience the most impact towards recovery through the support they harnessed. Nicola had managed to obtain support, but struggled to move forward in a transition to recovery. Kay with little support remained rather stuck in her process towards any sense of recovery.

Theme three: Working towards a vision of the recovered self

Living in recovery for the study participants, in part involved having a visualization or image of a recovered self. The accounts of the participants spanned a spectrum of how living in recovery was experienced. At one end of the spectrum, there emerged an awareness of what recovery would be like. At the other end, the vision of recovery came over as less clear. The scope of the vision of recovery and blocks to this vision will be discussed.

Sally spoke of her vision for recovery from being low in weight:

> *Yeah I think it's a gap [between mental and physical recovery] for a lot of people or I think I think they concentrate more on getting your weight up and they don't fully deal with the mental side of it because the mental side of it is the paramount it's the it's the main problem I suppose it's all in the head* Sally:26,8-12

Sally acknowledged that there are two types of recovery, *'the getting your weight up'* and *'the mental side of it'*. It is recognising that the two sides are equally important, that determines Sally's view of what it would be like to recover. Furthermore, to recover what needs to happen, she implies is that the *'gap'* between the two aspects of the illness need to be addressed. The use of the word *'gap'* brings to mind a hole and a potential space, that if overlooked, could jeopardise recovery completely. Sally also infers that services think all will be well in recovery, with weight restoration alone. However, Sally is critical of this viewpoint, therefore another gap is seen between Sally's vision and the service's vision for recovery. This critical approach allows Sally to be clear about what she visualizes as a recovered self. She does not deny that weight gain is important, but what she also suggests is that the *'mental'* side is important. In fact, the mental side is not only important, it is supremely important; it is *'paramount',* it could be said, that this side was in charge of her difficulties and leading them in some way. Thus to recover, involved including the mental side. Sally was keen to emphasize the point as she repeats the word *'mental'* twice, as if she wanted to ensure that it was understood. Perhaps it was the lack of clarity of what the mental side really was, that meant she needed to hammer home her point of view. She tries to explain further by saying really *'the main problem I suppose it's all in the head'.* This phrase on the face of it was used in the widest sense of referring to the illness as not being a physical health problem, but rather a mental health problem. In addition, if illness is in your head, potentially it is hard to understand and therefore hard to treat. The implication therefore could be that services did not really understand the *'in the head'* bit, so left it alone. Sally's view of recovery seems to say that the mental side needs to be addressed as well, even if it is not fully understood immediately.

Alice explains in more detail aspects of the mental side of recovery; she says:

> *Yeah and I think that was good that I didn't want to be rigid I didn't want to be completely inflexible cause that I think would have caused more problems [slightly slower pace of speech] if I came out thinking I've got to have this or that um and this brand and that brand that I think it probably would set you back a bit because you would have to that's the mentality you would have to take when you're an outpatient [faster pace of speech] and I think that's er when I was in I saw day patients who had been there for months and years they'd been there for years and they still had to have the same brand and I thought I don't want to have the same brand all the time you kind of get bored [laughs] I was bored in there, oh what's for dinner oh we get that oh great you knew what was in there it's like whilst it is safe [fast paced speech]it's also becoming more institutionalized.*
>
> Alice:46,9-17,47,1-7

Alice described how living in recovery could be visualized as someone who was flexible. Conversely, being inflexible, she argued, had bad outcomes. In Alice's account it is as if the reader is taken back to the day care experience. It is easy to imagine the scenario; along with Alice who *'saw day patients'* insisting on having *'the same brand* *[of food] all the time'* the outcome was that they were there for *'years'*. They were stuck, not moving on with their lives or transitioning to a new way of being. This was a vision of no recovery and it had a striking effect on Alice. The effect was that she began slowly, as reflected in her slower pace of speech, to understand that to create a more helpful vision for recovery, meant developing a different mindset. In Alice's view she needed to *'come out [of hospital] thinking'* in a flexible way. If she did not, rigidity would not only halt transition to health, but risked causing a relapse in any psychological gains previously made. Inflexibility *'would set you back'* because of having to adopt a specifically rigid mindset over food decisions. Alice uses *'you'* rather than *'me'* to make this point and also there is a faster pace of speech. Maybe this was because it was difficult to fully own the need for flexibility for herself, even though she recognized the benefits. There is further evidence to suggest that her idea of flexibility is a struggle for her. Alice is rather critical of services blaming them for promoting rigidity; she gave an example of the sameness of meals in hospital *'oh what's for dinner oh we get that oh great'* conveyed in a slightly sarcastic tone. Yet at the same time she speaks quickly, maybe because she does not want to be overtly critical. Perhaps because she also liked the rigidity as it was *'safe'* and provided a safe yet rather limiting way of living.

What seemed important was that Alice needed to keep motivated to recover, seen through her challenging herself to fight the *'boredom'* of rigidity. Comparing herself with others and not wanting to be like them also sustained motivation. Alice presented a recovered view of herself as someone who was determined and motivated to take on the challenge of living life in a flexible manner.

Sally also had a vision of living in recovery:

> *it was just everything you take for granted like going out for coffee with your mum you know when you're out shopping just going ' do you want to go for a coffee'? it's still it's still tough but needing to do it now you know if me and [boyfriend] were out and he goes 'do you just want to go for a coffee and cake or something'? it's like yeah ok it's like normal just things that people take for granted that you want back and you try and get that normality back.* Sally:11,13-16,12,1-5

In order to transition to a new life Sally was in favour of engaging in doing what she called *'normal'* things such as going out for coffee with her family. It was not just the coffee and cake, it was the reengagement in living a sociable life without giving it a second thought. This is Sally's vision for being ordinary, natural and usual. She is hoping for a transition to this relaxed way of being amongst other people. She does not, however, give the impression of being relaxed; she presents in an anxious way, indicated by her repetition of the quote asking her for a coffee and not only this, but cake as well. Rather anxiously she seemed unsure, or a bit ambivalent about how to respond; yes she wanted the normality of going for a coffee and cake and wanted the food, but in her heart she knew *'it's still tough'.* She does not expand on what is tough, but it is likely it relates to the decision to eat or not and the dilemmas this poses. The repetition of the request to go for coffee, also gives the impression that Sally in her anxious state is over thinking the whole scenario. The whole episode is presented as extraordinary for Sally; something that she knows constitutes normality for others, but not for her. For others going for coffee is just taken *'for granted,'* happening naturally, without much thought at all. Yet for Sally it was central and specific to her recovery and furthermore it was a process to be worked on and certainly not put off *'but needing to do it now'.* In addition, this way of being is normal in Sally's point of view, because it has been previously experienced *'you try and get that normality back'.* However, Sally uses *'you'* instead of *'I',* which then conveys that she has little personal past experience of going out and feeling normal. So what is revealed is that Sally, if she is able to go for coffees, will be transitioning to a very new way of being for her. This way of being socially is a vision of the recovered self.

So far Sally and Alice have articulated a clear vision of what they strived for in order to live in recovery. Nicola's account illustrates the struggles that other participants experienced in expressing their vision.

Nicola spoke in this way:

> *Yeah I want to be normal um I think I've always felt abnormal through, through my childhood I had neurological problems*
> *um due to a brain tumour um and then hydrocephalus and so I have been in and out of hospital and it led up to year 7, 8 and 9 being off school due to serious headaches and that was hard* Nicola:8,9-14

At first sight, Nicola, like Sally, had the vision of recovery meaning being normal. However unlike Sally, Nicola struggled to express what being normal might entail. It was as if she was stuck in some way in her thinking of how normality might come about, or what it would look like, as she was not able to give an example, but reflected on her 'abnormal' childhood instead. One interpretation might be that Nicola's ideas about normality were less about social normality, the going out for coffee that Sally described and more about being free from illness. Nicola says *'I've always felt abnormal'* referring back to the *'brain tumour um and then hydrocephalus'* of childhood. There was a feeling that she was scarred by her childhood experiences they were *'hard'* and have left her with the view that she has no ordinary normal life and that this has been lifelong. Childhood experiences of school were interrupted by year long *'year 7, 8 and 9'* absences. Nicola had missed out it appeared on a normal childhood and thus to be normal, seemed a logical vision for recovery. The tone she uses here is rather thoughtful and sobering as she talks of *'serious headaches'*. It can only be imagined the impact on Nicola of this horrible history to say nothing of having survived such an experience. Although Nicola is clear that normality is the route out of illness, she holds back in describing what *'normality'* would involve for her or what specifically the impact would be. Nicola's difficulty in articulating her vision appeared to be a specific block. This block was linked to her past and she talked about the impact of her past meaning that normality was outside her own personal experience. Thus it was the past that blocked her, in being able to imagine and articulate a specific vision for her recovery.

This theme focuses on the complexities of the reality of living in recovery. For some participants there emerged a clarity in their vision of what recovery might be like. More importantly, there were some participants who were able to articulate this vision. This was evident in Alice's account of recovery, involving not only weight restoration, but also a mental transition. She was able to express how this might come about through mental flexibility with regard to choices, especially with food. Equally, Sally was able to articulate her vision of living life in a normal and socially relaxed way with her family. Sally's vision of her recovery was that she understood that it involved her full engagement in new behaviours, even if they were scary or tough.

There were, however, other participants who had significant difficulty in articulating an imagined recovered self. Nicola did have a vision, but was distracted by recounting her painful past history and therefore blocked in articulating it. The transition to recovery therefore was individual, and different for different participants, but what emerged was that a vision of recovery had a part to play, even when participants found it hard to talk about their vision.

Recovery and how to live life in recovery, emerged as crucial to the transition out of hospital. Some of the aspects of living in recovery appear to be quite practical, such as disconnecting from services and harnessing help and support from others. However, most of the experiences of disconnecting from services, taking up offers of help and visualizing recovery, also have a large psychological component.

Analysis Summary

In conclusion, what can be deduced from this interpretation of the data, is that the transition from hospital to home after treatment in an inpatient service, is complex. The transition involves environmental change, but surprisingly the participants mentioned little about this. The priorities for the participants were primarily psychological issues. What emerged, was a tension between two ways of being. The first way of being was an overwhelming ambivalence to change. The intensity of the experience led to difficulties in making sense of their inability to decide what choices to make, hence an outcome of confusion, self-criticism and conflict. This way of being led to halting their transition to recovery and participants presented as stuck within a process. In the second way of being, participants were actively engaged in the process of recovery through letting go of the past and taking on new horizons, alongside a vision for their future self. Therefore, these were two contrasting ways of conceptualising the discharge experiences. What emerged was that some participants favoured one way of being over the other and yet others presented as experiencing aspects of both ways of being. This all impacted on the progress of their transition and whether it meant they changed, remained stuck or a mixture. What seemed to be central, was that psychological processes impacted on the transition process of being discharged. How these findings relate to existing theories and might influence the choice of interventions to aid the transition, will be considered in the following Discussion section.

Analysis and analytic process reflexivity

The analysis has been a joint creation between the participants' accounts and myself as the researcher (J.A. Smith et al. 2009, p.80). What follows is a continuation of the reflexive process that I have undertaken throughout the research.

The process of the analysis was iterative (J.A. Smith et al. 2009, p. 79), a moving backward and forwards between data and interpretation, noting differences and similarities and looking for patterns and emergent themes. I struggled with this process because as a therapist I was used to helping clients move beyond their current thoughts and feelings. As a researcher at the analysis stage I needed to link my interpretations directly to the data. I found that I had to rework my ideas substantially to make direct links between emergent themes and the data.

It was also hard for me to move to a more interpretative stage in the cross-case analysis. This led me to being quite cautious in my interpretations, thus I inadvertently produced a thematic analysis, rather than an interpretative analysis of the phenomenon. I have since come to understand the revisiting of the data, plus the re-clustering and generation of two superordinate themes as being, in research terms, a continuation of the iterative process. In personal terms it was part of my learning to be a researcher using IPA.

One of the ways in which a deeper level of interpretation was achieved was by being adventurous as encouraged by Gee (2011). A way of doing this was by looking for 'gems' in the data that might deepen the analysis (J.A. Smith, 2011, p. 7). An example of a gem was seen in Sally's account, where temporal shifts lead to an understanding of the core ambivalence in her transition to recovery. Alongside the context, it was possible to make conceptual and linguistic interpretations to further illuminate the theme of ambivalence.

I have therefore considered reflexivity in relation to the analysis and analytic process. In terms of reflexivity in relation to the findings of the research, an account of this has been included after the discussion chapter.

Discussion

What follows is a discussion of the results in relation to the existing literature. The findings are related to research focused on anorexia nervosa and ambivalence and anorexia nervosa and the concept of recovery. Explanations for the conclusions are sought from the psychology literature and clinical approaches that have been found to be useful in the treatment of eating disorders. The results are presented as being useful for informing clinical practice. At the same time limitations and suggestions for other approaches to the topic are pointed out.

Transition experience

The transition experience for the participants in the current study focused on the psychological aspects of the transition to health. This complements the study by Offord, Turner and Cooper (2006), which was also a qualitative study that also used Interpretative Phenomenological Analysis (IPA). Seven adults were interviewed about their experience of being in a general psychiatric unit for treatment of their eating disorder when they were adolescents. The range of years since discharge was two to five years, and having been discharged the participants talked about the discharge experience. The authors concluded that the process of discharge required psychological adjustments, alongside the need for psychological support. This was also seen in the current study, furthermore there appears to be a similarity between adolescent and adult experience, such that the transition out of hospital may be related to the psychological aspects of an eating disorder itself, rather than peculiar to a point in the lifespan of the individual.

All the participants in the current study alluded to the transition experience being composed of three aspects. It involved transition in terms of an environmental change, from hospital to a community setting, be that home or university. It included change in nutritional intake, with the resultant change in weight and shape and thirdly, it emerged that the most important aspect of their experience was the psychological change required to facilitate the first two changes.

The current study has added to the body of knowledge of patient experience, but has specifically focused on the transition experience. What has emerged are the psychological components that appear to be involved as patients transfer out of hospital into the community. The emergent components will now be considered, alongside how they fit with existing research.

Ambivalence and blockage to transition

All the participants in the current study had a degree of ambivalence towards their eating disorder. Ambivalence amongst people with anorexia nervosa is not a new concept. As far back as 1873, Lasegue (as cited in Bray, 1997, p.495) asserted that he had observed that despite seeking treatment for what he referred to as “hysterical anorexia”, his patient was “not ill pleased with her condition”. This appears to be one of the earliest descriptions of the ambivalence seen in patients with anorexia nervosa.

More recently, clinically observed ambivalence has led to studies that specifically investigated ambivalence. Serpell, Treasure, Teasdale and Sullivan (1999), carried out such a study in a UK specialist eating disorder service. Patients were given a letter writing task as part of their treatment for anorexia nervosa. The task was to write two letters one to ‘anorexia as a friend’ and the second was to ‘anorexia as an enemy’ (p.178). The therapeutic aim was to assess their ambivalence to change. The authors used these letters to develop pro-anorexia themes and anti-anorexia themes. There were many pro-themes, such as feeling in control, helping to avoid difficulties, and several anti-themes which included preoccupation with food, worrying what to eat being unable to socialise because this often involved eating. The authors suggested that the fact that participants could identify both sides towards their condition gave support for the idea that they really were ambivalent and this fitted with clinical observations. Furthermore, as in the current study, they linked ambivalence with confusion. They described how participants being ambivalent could indicate confusion towards the function of their disorder. In the present study however, the link between ambivalence and confusion was not causative, but rather there was an association, such as with Lara’s ambivalence towards engaging with treatment and generating some confusion for her. Ambivalence emerged here as being important and having implications for clinical interventions.

In a study by Cockell, Geller and Linden (2002) ambivalence was linked to treatment. A decision-making tool (The Decisional Balance scale) was used to help the patients weigh up the pros and cons of changing. Eighty women were recruited for this study from an eating disorder clinic in Canada. The idea was that the scale would help sufferers understand their ambivalence and start a cognitive shift towards recovery through challenging the indecision. This differed from the focus that emerged in the present study. Findings were not so much on ambivalence needing to be challenged, but rather on the different aspects of the ambivalence, i.e., conflict, shame and confusion. Thus the current study found that ambivalence was more complex as it was not one element that could easily be addressed. The complexity suggested that ambivalence was multifaceted and could not be assumed to represent one thing.

Further investigations into the components of ambivalence have been conducted by Tierney and Fox (2010) who investigated what it was like to live with an 'anorexic voice' (p. 243). The study was a thematic analysis of written accounts from 21 participants recruited from an eating disorder self-help group based in the UK. The content of the 'voice' was found to have both negative and positive characteristics and the authors suggested that these opposing elements could account for the clinically seen ambivalence. In the present study, Alice spoke directly about her anorexic 'voice' and how hard that was for her. She too appeared ambivalent both in terms of recovery and also in terms of her discharge from hospital. Thus the current study is consistent with previous findings of people with anorexia nervosa conceptualising their ambivalence as a voice in their head in order to distinguish it from other thoughts.

In a continued effort to investigate ambivalence, similarities regarding conflict were found by Williams and Reid (2007; 2010; 2012). They creatively designed studies using online pro-anorexia websites. Their first study in 2007 investigated how people used the pro-anorexia websites. The authors employed grounded theory to analyse information expressed by 176 participants on two online pro-anorexia forums. Results suggested that even though people used the sites because they felt good about their anorexia, their eating disorder could at the same time also raise problems for them, hence indicating some ambivalence. This led to the two further studies that investigated ambivalence more directly; in the 2010 study, using an online focus group and a qualitative methodology, the authors described how participants experienced an underlying conflict. This conflict was with the need to have control through anorexia and yet feeling anorexia was in control of them. Conflict led to further ambivalence in that participants were uncertain if anorexia was a functional, controllable tool for their use and support, or whether it was a disease that was out of their control and therefore should be ended. The researchers therefore concluded that ambivalence involved a battle with conflicting emotions.

In a third study in 2012, which looked in contrast at the use of websites for recovery purposes rather than to maintain anorexia, the authors also found that recovery involved battling with an anorexic ‘voice’ (p. 798). Spivack and Willig (2010) also connected anorexia with a battle. These ideas of battle and conflict, with links to ambivalence, were also seen in the current study, for example ambivalence leading to frustration and conflict for Nicola, alongside battling difficulties for Sally and Alice. What emerged in the current study was that ambivalence was part of the phenomenon of living with anorexia nervosa, a finding that was also observed in the studies described above. As in the previous studies the current study found links between ambivalence and conflict. However, rather than using conflict and battle within as a theory of the self to explain ambivalence, the present study interpreted the ambivalence/conflict relationship finding differently. Ambivalence it is argued is a complex phenomenon and one element of it involves conflict. The conflict is experienced in different ways and as a result of this presents itself with significant complexities that may account for the difficulties with helping individuals with eating disorders.

The ambivalence in the present study seemed to evoke the idea of participants being stuck. The notion of being stuck was also seen previously in a study by Norbo et al. (2012) in Norway where they investigated reluctance to recover in anorexia nervosa. After qualitatively analysing 36 interviews using NVivo they identified seven core obstacles to recovery, one of which was feeling stuck. Thus, ambivalence has been associated with preventing transition to recovery. This had led to studies that have focused more on looking for evidence of ambivalence (Kolnes, 2016; Leung & Russell, 2013; Marzola, Abbate-Daga, Gramaglia, Amianto & Fassino, 2015; Williams & Reid, 2012). The present study, however, found that ambivalence emerged through investigating the sufferers’ own experience and featured during the experience of being discharged from hospital. Finding ambivalence was unexpected, the interpretative phenomenological method was advantageous as it allowed this unexpected finding to emerge.

In a similar fashion, other studies looking at the patients’ experience of phenomena associated with anorexia nervosa also found that ambivalence featured. These studies include Fox and Diab (2015) who qualitatively investigated how people with anorexia nervosa experienced living with chronic anorexia using a sample of six participants recruited from two eating disorder services in the UK. What was revealed was not so much conceptualising chronic anorexia in terms of duration of illness, but in terms of what being chronic meant for these people. Chronicity involved an ambivalence in general and being in conflict with real life, unable to live at home and needing on-going support, leading to isolation, but also a real desire to form and seek supportive relationships.

In another qualitative study, Mulkerrin, Bamford and Serpell (2016) interviewed eight people who were receiving treatment at two London based eating disorder services and explored how their personal values related to their anorexia nervosa. What emerged was that ambivalence was central to dilemmas experienced with living out their desired values. The authors described ambivalence as having three components: ambivalence towards their anorexia nervosa, ambivalence towards recovery and ambivalence towards change. The conclusion was that values could be a tool that could be used to address ambivalence. Thus, ambivalence emerged and therapeutic ideas developed, through investigating a specific psychological construct and its impact on the sufferer.

In a similar way, a qualitative study in Norway on the experience of exercise for six people with anorexia nervosa by Kolnes, (2016) found that during treatment they experienced internal conflict. The participants wanted to rest because of fatigue yet were compelled to exercise; there was a sense that exercising felt like being in control and resting was a powerless position. They describe the conflict in terms of ambivalence and a lack of readiness for treatment. In addition their ambivalence about giving up exercise led to shameful feelings. Participants described choosing exercise over socialising and then feeling ashamed of their disconnection from close relationships. Such was the powerful influence of their ambivalence.

These last three studies have focused on a qualitative exploration of the lived experience of specific phenomena associated with anorexia nervosa: chronicity, the role of exercise and personal values. Interestingly, what emerged in all these studies was the centrality of ambivalence. The present study is consistent with this and supports the notion that, when investigating anorexia nervosa, ambivalence is involved. In the current study the strength of ambivalence was experienced differently by each of the participants, nevertheless they all exhibited this tendency. Ambivalence, it appears, is an important complex experience which has the effect of blocking the process of recovery for some of the participants for some of the time.

Models to explain psychological blocks in transition.

The 'split sense of self'

Psychological blocks became apparent in this study through the participants talking about their experience of being discharged from hospital. Psychological blocks were also described in the study by Spivack and Willig (2010) referred to previously. Again, as in the study by Offord, Turner and Cooper (2006), Spivack and Willig focused on the inpatient experience of young people. However, in both these studies and the current study, the experiences that emerged were similar in terms of highlighting patient ambivalence. Again, it is suggested that these experiences may be related to the experience of anorexia nervosa itself and that ambivalence is not a specific concern in a particular treatment setting, or at a particular point in the lifespan. This idea was previously argued by Vitousek, Watson and Wilson, (1998) who suggested that a degree of ambivalence was probably universal at every stage of anorexia nervosa. Further support for this is that in the abovementioned studies the participants talked about their experiences of being inpatients and of discharge; the two are closely related in terms of patient experience.

In their study, Spivack and Willig (2010) found that anticipated discharge was scary, feared and avoided, and yet there was an intense sense of missing home. This conflict was explained as the young people having experienced themselves as having an anorectic side and a non-anorectic side. These two sides could vary in strength, one gaining over the other. However, when they were of equal strength, participants experienced strong ambivalence. The authors went on to suggest that the ambivalence and the ensuing 'battle', could be explained in terms of a 'split sense of self' (p. 10). Thus, their findings were related to a wider psychological explanation for the blocks to transition to health. The focus of ambivalence however, in the current study, was not just of sense of self, but in terms of transitioning to a new way of being, alongside a transition to a different treatment setting in the community. What is interesting in the current study is that participants related their transition to the community to their transition from away from anorexia nervosa. Thus, their focus was partly on ambivalence for change, but also on their route to recovery.

The Stages of Change model

A previous study by Colton and Pistrang (2004) qualitatively researched the inpatient experience with young women. They also found the sense of being in two minds over getting well and that participants experienced conflict over this state of being. Conflict also emerged in the current study, seen in relation to themselves (Lara) and others (Alice) and services (Nicola), and conflict was then interpreted as being part of being ambivalent to change. Colton and Pistrang focused on how conflict and dilemmas could be explained, using the framework of the transtheoretical model as described by Proschaska, DiClemente and Norcross (1992). This model suggests a process of how people change their behaviour. There are stages that people go through associated with change; these include precontemplation, contemplation, preparation, action and maintenance. The spiral model shows that this may be an on-going repeated process. What underpins the model is that people can only go to each stage when they are ready to do so. In the current study the women did not conceptualize themselves in terms of readiness for recovery, indeed what emerged was an overarching sense of feeling blocked by ambivalence on the one hand and experiencing recovery as a kind of movement on the other.

However, for researchers, this explanation has been regularly used to explain resistance to change. Ward, Troop, Todd and Treasure (1996) studied ambivalence to change using a quantitative method amongst a group of eating disordered patients using the Stages of Change questionnaire. All the participants were inpatients on a specialist eating disorder unit in London, UK. The aim of the study which consisted of 35 participants was to try and understand these patients and to incorporate this understanding into a clinical intervention. Results showed that self-re-evaluation was important in order to achieve change. The process in terms of the model, they argued, was that ambivalence in particular, needed to be addressed at the contemplation stage because there was still evidence of ambivalence at the action stage. This supports the evidence so far that suggests that ambivalence reigns along the whole of treatment. Although potentially useful to explain a theory for ambivalence, it was hard to allocate patients accurately to a particular stage in the model. Nevertheless, it has been a popular theory not only to explain blocks to recovery, but also to work out ways of releasing blocks. For example, Touyz and Thornton, (2003) reported on a day programme they had devised in Australia for patients with anorexia nervosa. Their rationale was that because patients were at different levels of readiness for change they required different therapeutic interventions that matched their stage of readiness. For patients who were contemplating change but had a pronounced ambivalence the programme of care included motivational enhancement therapy. If there was no matching, they argued this would lead to resistance to change and be counter therapeutic. They planned to collect audit data on this programme to further support their claims.

In summary, the Stages of Change model has been used to explain the psychological blocks, alongside pointing to interventions, but there was not a recognizable fit between this model of explanation and the findings of the current study.

A maintenance model for anorexia nervosa

For a better fit, another psychological theory could be considered. Schmidt and Treasure (2006) proposed a model to explain why patients maintained anorexia nervosa. They described a maintenance model composed of symptoms that made up the block to change. They called these maintenance factors which included many familiar components that people with anorexia display, such as avoidance, perfectionism, interpersonal difficulties and pro-anorectic beliefs. The rationale for the model was then linked to the work of Gilbert (1998), who described an evolutionary approach to psychological difficulties. Thus, the proposed model connected the symptoms of maintenance as they described them to defences that had evolved in response to social threats and important life goals. For example, the need to elicit care from others and to be acceptable to others, for fear of being ashamed. They therefore argued that this explained how maintaining anorexia nervosa could be adaptive and fulfil important functions. This adaptive notion has previously been outlined by Vitousek, Watson and Wilson (1998). Therefore, in the present study, the notion of ambivalence could be linked to this idea of it being a response to key threats in the lives of the participants. This could have importance clinically as will be suggested later. For instance, through psychological formulation taking into consideration individual histories and patterns of coping in order to challenge ambivalence, clinicians could work at the psychological level.

The compassionate mind model of psychological functioning

The idea of key threats was taken up further in the work of Fox and Goss (2012). They support the approach taken by Schmidt and Treasure (2006) in that they call for a broader theoretical perspective to explain the psychological underpinnings of difficulties that people with eating disorders experience. They highlight the importance of emotional experiences for people with eating disorders over the understandable past preoccupation by clinicians with difficulties people find with eating, weight and shape. An important finding in the current study was the shame that was associated with ambivalence. Goss and Allan (2009) explored the connection of shame and pride in maintaining eating disorders. Their theory again related to the evolutionary ideas put forward by Gilbert (2010). A brief summary is included here for completeness.

Compassionate Mind theory

Gilbert (2010) developed the compassionate mind model of understanding human psychological difficulties. The model developed firstly from his clinical observations. He worked within a Cognitive Behavioural framework in general mental health clinical settings. He observed that in therapy his patients learnt to understand their difficulties and how to challenge negative thinking. However, despite being good at spotting their negative thoughts and challenging them, they did not feel relief from distress. Thus, he became curious as to why this should be so, and he began to investigate this further. With an interest in evolutionary psychology, Gilbert developed his theory as to why this mismatch may exist. His ideas briefly comprised of describing human beings living over millions of years in what he termed the ‘flow of life’ (2010, p.16) which involves forming bonds and affiliations necessary for survival. He described this as the ‘old brain’ (2010, p.30), however, evolution also brought about a self-awareness that he described as a ‘new brain’ (2010, p.31) for the survival of humankind. With this new brain there was the capacity to reflect and mentalize and with this came the need to be able to pursue activities from the old brain. This old brain, new brain interaction required an emotional regulation system. This system was presented in a model form and described as interrelated circles. There was a circle that represented the drive of human need to pursue goals and get things done. Connected to this there was a circle that represented threats to the self and how these were experienced, for example through anger, anxiety and negative self-beliefs. Finally, there was a circle that represented a soothing system that served to dampen down the other two systems of drive and threat. Psychological difficulties could ensue if the balance of the three systems faltered; this of course could happen as a result of many factors, genes, personality or life events. The system was how emotions were regulated and had evolved through time, because of the evolutionary nature the blame for distress could therefore not be attributed to individuals. It was not their fault, they just had tricky evolved brains.

Imbalance of the emotional regulation system in anorexia nervosa

Mindful of the above theory of the development of psychological difficulties in general, Goss and Allan (2009) made some specific theoretical observations with regard to eating disorders. These are particularly useful to explain the emergence in the current study of shameful and conflicting feelings in relation to ambivalence and the resultant blocks to transition in terms of recovery. Goss and Allan (2009) describe shame as being a powerful emotion associated with people who have eating disorders. They define shame as having two aspects: firstly, it can be internal, meaning the self is experienced as somehow flawed. This was seen in the current study, for example Lara's report of being a complete failure. Secondly, shame can be viewed as external, meaning holding negative beliefs about how the self is viewed in the eyes of others.

Again, in the current study this is seen when Sally declined to do a recovery talk, for fear of being judged as being hypocritical where she possibly feared rejection. Taking the view that shame can develop through the eating disorder itself and that eating disorders can develop for many reasons relating to personal history, genetic makeup and other complex reasons, Goss and Allan described how shame can be seen to maintain the eating disorder through a shame/pride cycle. Anorexia nervosa involves food restriction which is an individual's attempt to avoid a negative evaluation by others, in terms of remaining socially attractive. If they succeed in this effort there is pride in the achievement, if not, they experience further shame, feeling a failure. This, the authors argue, leads to the shame/pride cycle; the drive part of the emotional regulation system is fuelled by pride and shame from the on-going threat located in the threat system. In terms of the current study, the link to ambivalence is that with pride and shame working together, the outcome is ambivalent behaviour. Thus, this model is useful in explaining the psychological underpinnings of the experience of ambivalence and shame.

Furthermore, the emotional regulation system can also explain why conflict and confusion link to ambivalence and block change. This is explained by understanding the conflict and the confusion as internal threats that require management through the drive system. If these threats are successfully managed, for example by avoiding thoughts through the numbing associated with severe restriction, or by avoiding people through the preoccupation of food and eating associated with being low in weight and restricting food, then we could also argue that a sense of pride will be present. Thus, the threat, drive, pride cycle will go on. In summary, what is proposed is that previous individual theories and the popular trans-theoretical model have shed some light on ambivalence associated with eating disorders and anorexia nervosa in particular. However, this discussion suggests that much has been understood from the present study when relating it to a major theory of psychological functioning such as the Compassionate Mind Approach (Gilbert, 2010). Later this will impact on ideas put forward to address the clinical implications of the findings of this present study.

Movement towards psychological recovery: Transition to living in recovery

Being discharged from hospital involved movement to a community environment. The transition for most participants involved attaining, or trying to attain and maintain a certain weight, although this was not the case for Lara. Alice described needing to be a BMI of 17.5 before being allowed to go on home leave in preparation for discharge. Movement therefore involved a physical increase in weight and a shift towards a healthier physical state. However, there was also a psychological transition to the situation of living in mental recovery from illness. Participants identified how mental recovery often lagged behind physical recovery and there were fears about this state as they came out of hospital.

The main problem when considering the notion of living in recovery, and how this contributes to knowledge on this topic, is how recovery from anorexia nervosa is conceptualised. Garrett (1997) interviewed and analysed the narratives of 32 participants who were recruited through a newspaper article. The participants contacted her as a result of an article that she had written in the Australian newspaper regarding her own personal recovery from anorexia nervosa. She maintained that recovery from anorexia nervosa could be conceptualised from a medical, psychological or a sociological perspective. Garrett chose the latter to explain the recovery experience. She conceptualised recovery as a transformation involving reconnection with one’s community in general, a point that is also supported in the current study.

In an IPA study conducted in the UK involving 15 women who had received a diagnosis of anorexia nervosa, Jenkins and Ogden (2012) suggested that recovery could be viewed as a subjective experience involving meaning-making and relational processes. However, recovery could also be understood in health outcome terms through predictions for outcomes following treatment. These two basic approaches seem to have heavily influenced how recovery from anorexia nervosa has been researched. The construct of recovery is therefore not very straightforward. What follows is a description of two differing conceptualisations of recovery. It is the second conceptualisation of recovery that focuses on the sufferer that has resonance with the current study.

Conceptualisations of recovery from anorexia nervosa: the outcome focus.

In view of the medical risks associated with anorexia nervosa, it is unsurprising and understandable that recovery has been investigated in terms of outcomes in response to treatment. Although that in itself is complicated, as Garrett (1997) points out, because it assumes that professional intervention is central to recovery. As seen previously, this is the position adopted by Bowers and Andersen (1994). Interestingly the outcome focus is very much concerned with the clinicians' experience, rather than in the current study, where the focus is from the sufferers' perspective.

Viewing recovery in terms of outcome frames it within the ideas of medical recovery and suggests that a clear end point is required, in other words recovery needs to be defined. Definition has been found to be problematic, however. For instance, Bulik, Sullivan, Fear and Pickering (2000) pointed out that even weight-recovered people still experience cognitive difficulties with regard to body shape and food restraint. Coutourier and Lock (2006) also argued that limited definitions of recovery, for example in terms of no longer meeting diagnostic criteria and complete symptom abatement, were too narrow a focus for defining recovery. They suggest avoiding a definition of recovery and replacing the concept with response to treatment. However, having recovery as an undefined entity makes it problematic to establish quantifiable outcomes. The current study supports the broader concept of recovery as it focuses on the sufferers' response, such as the response of disengaging from inpatient care and harnessing support in the community in its widest sense.

Another study by Darcy et al. (2010), based on the idea of this lack of consensus to defining recovery, interviewed 20 women in the USA who had a former diagnosis of anorexia nervosa. A qualitative analysis showed that goals for recovery were variable; weight restoration being the highest, followed by recovered cognitions and relief from body image concerns. However, there were also aspects of recovery that were less clearly defined in terms of personal and interpersonal concerns. The authors' suggestion was that alongside recovery having an end goal, there was also a process of recovery that the sufferers underwent. This was viewed as a rather under researched area and so the focus of research shifted towards personal experience. Thus, a change of focus for research led to researchers adopting qualitative methodologies in order to investigate the sufferers' experience.

Conceptualisation two: Focus on the sufferer

The sufferers' experience was the focus of the present study, indeed it was the participants themselves that linked transitioning out of hospital to recovery. This was not a predicted or expected finding at the outset of the research project. In a qualitative grounded theory study alongside a past literature review, Cockell, Zaitzoff and Geller (2004) created a model of what supported or hindered maintenance of change post-discharge from eating disorder treatment. They interviewed 32 people who had undergone the inpatient treatment programme in Canada six months after discharge. Then they designed a model that was composed of hindering factors and supportive factors to maintain change and they used this model to devise a plan to help with the transition from home to hospital. As in the current study, factors that were important to facilitate the change were social support, being active in coping, and engaging in new activities. The authors were focused on identifying recovery factors, rather than in the current study, where the focus was more on the recovery experience.

Other authors in earlier studies also investigated recovery influences from the patients' perspective, such as the case study report by Hsu, Crisp and Callender (1992). They identified interpersonal issues as having an important role in recovery. Again, Pettersen and Rosenvinge (2002) in a quantitative study aimed at identifying recovery features, also employed a qualitative arm of the research and the authors interviewed 48 patients recruited from patient organizations and a university eating disorder unit in Norway, about their experiences. Their results pointed to concepts such as empathic caring relationships as being essential for recovery.

Other studies have focused on the process of recovery from anorexia nervosa as opposed to just identifying elements involved in recovery. Beresin, Gordon and Herzog (1989) argue that what their participants experienced was recovery through sincere and supportive relationships and that these are vital for the recovery process. Other studies such as Lamoureaux and Bottorf (2005) and Jenkins and Ogden (2012) have conceptualised a process that leads patients to recovery through finding themselves and becoming a whole person. For Lamoureax and Bottorf (2005), this involved having a new mindset; the current study supports this finding in the concept of the transition to health requiring a future vision and a change in beliefs; for example, Alice's flexibility. For Jenkins and Ogden (2012) the recovery process was facilitated through therapy and close relationships.

Furthermore, regarding the sufferer, Federici and Kaplan (2008) have suggested that not only are the factors such as readiness to change, and processes such as developing supportive relationships, important for recovery, but what is also important is to recognise that the process is on going. There is continued movement in the process of recovery and thus recovery cannot be thought of as a static entity to be achieved once and for all. The current study adds to this idea in that recovery is not something that happens in hospital as an end goal. Rather the transition out of hospital is what appears to continue to facilitate the recovery process.

In the current study, transition from hospital mirrors ideas about transition to recovery from anorexia nervosa. However, the concept of recovery is complicated and multifaceted. Ideas about recovery emerge when being discharged from hospital. The study lends support for the notion that recovery is an on-going process, with ups and downs. Coming out of hospital is just one point in the recovery process, but it is an important point and potentially it could allow people to re-evaluate their recovery process.

Movement and Transitional processes: comparison with other psychiatric presentations.

For all the participants, the process of being discharged from hospital involved transition towards recovery. Just as the notion of recovery in relation to anorexia nervosa has been described as complex, this is also the case for other psychiatric conditions. The difficulty of defining recovery from mental illness in general has been highlighted and summarized by Slade, Adams and O'Hagan (2012), Slade et al. (2014) and Nowak, Waszkiewicz, Switaj, Sokol-Szawlowska and Anczewska (2017). Slade, Adams and O'Hagan (2012) refer to a "second understanding" (p.2) of recovery. The first understanding involved complete symptom reduction and the idea of being cured in order to pursue life without any need for the use of support services. The second understanding challenges these points as being unhelpful for those experiencing mental health problems in general, both acute or long term, and with various diagnostic labels. Thus, recovery has been reconceptualised as involving “living as well as possible” (South London and Maudsley NHS Trust, 2010). Recovery would therefore include a personal experience of change in terms of attitudes, feelings and skills in order to live a more satisfying life. Living optimally would not be an end point, but rather a process to be engaged in, such that meaning in life is developed alongside any limitations experienced by mental ill health. The current study supports this second understanding, because the participants engaged with living in recovery as they transferred to community services, despite having residual difficulties with ambivalence to change.

Service transition interventions in general psychiatric presentations revisited.

Previously in the Introduction chapter studies were identified that were concerned with the general psychiatric population and discharge from hospital. In the light of the findings of the current study these studies are revisited.

Reynolds et al. (2004) identified that peer support would be helpful in the general psychiatric population on discharge from hospital. They suggested that there are relational needs on transfer, the current study also found relationships to be important during and after transition from hospital. This was seen in the letting go and the reconnecting in relationships on discharge. This disconnection from inpatient services and connection with community services as part of the transition process was previously seen in the study by Tomita, Lukens and Herman (2014). However, the focus of this previous study had been clinician led and driven, whereas by contrast, the current study was focused on the patients’ perspective. The present study draws attention to how important family, friends and peer support was in the transition out of hospital.

In another study, Kidd et al. (2016) suggested that specific mental health difficulties need different interventions on transition out of hospital. What emerged from the current study was that participants experienced a very specific type of transition. The transition involved living with the process of being ambivalent and yet at the same time working towards living in recovery. The participants experience was very varied along this process.

The themes identified by Wolf, Chung and Kordy (2010) in their study on an email aftercare intervention post discharge, were that post discharge psychiatric patients struggled with work, socialising and relationships and this might be relevant to the discharge process. Although the present study also raised these issues it was concerned with interpreting what those concerns might mean, thus the present study appears to raise the level of understanding of the discharge process.

The points about interventions to aid the process of transition will be revisited in the section below when consideration will be given to the clinical implications of the findings of the current study.

Discharge from General Psychiatric hospital: the patients' perspective

As in the study by Nolan, Bradley and Brimblecombe (2011) which explored service user experiences of discharge from hospital, the current study also found that psychological support was needed on discharge. The current study found that not everyone was able to make full use of support, some showed how mixing with peers and changing jobs really helped, whilst others found that they felt bad about asking for help and some found that they could not ask or communicate their needs at all. Thus, a spectrum of capacity to harness support can be seen in the current study.

The present study identified residual struggles post-discharge this was also found in the study by Niimara, Tanoue and Nakanishi, (2016) which described on going difficulties for patients with schizophrenic spectrum disorder on transition from hospital. In the case of the current study the struggles emerged and manifested themselves through the participants' ambivalence. As part of their ambivalence they experienced psychological struggles with confusion, self-criticism and shame. The result often led to interpersonal difficulties that were difficult to cope with and prevented them transitioning to a recovered position.

The present study has drawn attention to the notion of recovery and the notion that recovery requires some sort of transformation. This idea has also been postulated in the addiction literature and therefore some of these studies will now be reviewed, to explore how they might relate to the current study.

Recovery as a transition

Literature from drug and alcohol studies has frequently described the concept of recovery as a transition process. Laudet (2007) quantitatively investigated how recovery could be understood. The findings echoed the new framework of recovery proposed by Slade (2012) and outlined previously. The authors found that recovery did not just relate to abstinence, but also to other areas of functioning for the participants, and this they argue was a paradigm shift from pathology focus to health focus. As seen previously, recovery was conceptualized as a process with no specific end point; furthermore, it takes time and may require more than one attempt to achieve. The net result is that recovery needs to be actively managed by the individual with the support of others, peers and family. The recovery process for drugs and alcohol is not the same as in anorexia nervosa but living in recovery in the current study had some close parallels. The similarities in the recovery process are that both conditions involve a recovery in terms of physical health. In drug and alcohol this relates to physical dependency, whereas in anorexia nervosa it relates to maintaining adequate nutritional status. In terms of psychological recovery there are parallels in the two conditions in terms of the fact that they are both susceptible to relapse, thus recovery can take many attempts. For both there is a sense of the recovery process not being rushed and a lifelong commitment to the process.

Gubi and Marsden-Hughes (2013) described the recovery processes in chronic alcohol addiction in more detail. This was a qualitative study which interviewed eight severely alcohol dependent people who were recruited from Alcoholics Anonymous meetings in Lancashire UK. Results showed that recovery started with cessation of alcohol intake, although some remained ambivalent about this. Support was required to maintain changes, usually through AA groups. At first this support was sought and then the person began to identify with the group and an understanding developed of the self as a result of the process. Again, the parallels with anorexia nervosa and the current study are apparent: cessation of starvation, albeit with ambivalence, harnessing support and understanding the self, manifesting itself in a vision for the future.

An IPA study by Watson and Parke (2011) with heroin addicts described factors relating to recovery as being psychological in nature. Five participants were recruited from non-clinical counselling services in the Lincolnshire area of the UK. The authors reported that heroin addiction had a psychological cycle (they do not mention the physical addiction) that needed to be broken in order to pursue recovery. What was fundamental to recovery were relational matters, particularly new relationships as motivators for recovery. Shinebourne and Smith (2009) investigated the experience of addiction, using Interpretative Phenomenological Analysis (IPA); they interpreted the experience of addiction to alcohol using a case study. This methodology enabled the authors to interpret deep psychological processes that underpinned the alcohol addiction. They asked about the experience of addiction, not recovery, and yet what emerged from the data was a deep ambivalence towards change. Interestingly in the current study using the same methodology (IPA), asking about transition also led to the emergence of psychological processes. It appears that the interpretative phenomenological analysis method of enquiry has enabled a snapshot of the deep processes at work in the transition out of hospital to be revealed.

Relations between discharge and recovery transition

Although the participants talked about the practical side of discharge from hospital this was not their whole story. Transition out of hospital involved much more than a change in environment or weight restoration. What emerged was that the participants' experience of discharge focused on change and the psychological blocks to change. Thus, there was a sense of living with ambivalence to change and all the accompanying distress and feeling stuck. A key finding was that the discharge experience linked in with the recovery experience. What was surprising was that the focus was not entirely on recovery with all its' daily struggles, rather living in recovery involved a more fundamental inner struggle over change. The two aspects of experience; recovery and ambivalence were found to be linked at discharge from hospital, this was not an expected finding.

The following section addresses the most important question of how these findings might relate, add to and perhaps influence clinical practice.

Clinical implications

What will now be explored is how the findings from the study contribute to clinical understanding and management. All the participants were motivated to take part in the study for clinicians to understand anorexia nervosa more fully. Fundamentally their hope was that this research would also improve services, probably in a ground-breaking way. It is entirely understandable that people suffering from an illness that has often confounded clinicians and patients alike, would have high aspirations for any research. However, the contributions need to be understood in a rather more modest way. Suggestions are now made as to how the findings might impact on current ideas regarding transition from hospital to community. In the first instance these points can be considered at the theoretical level, but it could be suggested that these ideas might be operationalized in real clinical terms.

Managing the transition

In the discussion so far, what has become evident is the idea that the transition from hospital to community needs to be managed. The Maudsley hospital has led the way in this area through their research programmes. These include: Experienced Carers Helping Others, ECHO (Treasure, Rhind, Macdonald & Todd, 2015), the Maudsley Model of Anorexia Nervosa Treatment for Adults, MANTRA (Schmidt, Wade & Treasure, 2014), and a cognitive interpersonal model of anorexia nervosa, (Schmidt & Treasure, 2006; Treasure & Schmidt, 2013). Through these studies, the case for the importance of harnessing the support of families, carers and friends in the recovery from anorexia nervosa has been robustly made. With this perspective in mind, Whitaker, Treasure and Todd (2010) described an intensive three-day programme with families that had the aim of helping the patients transition from inpatient to outpatient care. Two families participated in this programme and worked together. The clinicians facilitated the learning process which was aimed at sharing helpful information and skills. Feedback indicated that this programme was well received and improved the confidence of the patient and the families in managing themselves together. Various techniques were used to facilitate the learning process, but above all, the facilitators conducted the sessions in an empathic, understanding and non-judgemental manner with the aim of modelling the usefulness of this stance for the families.

From this work, there is currently in progress a multicentre randomised trial in the UK. Cardi et al. (2017) describe the study protocol which is an aftercare project for adults who have had intensive treatment for anorexia nervosa, usually in an inpatient facility, but some will have had intensive day care. The intervention is directed at connecting patients with their families and also peers, before, during and after transition from hospital. The aim is to strengthen relationships, and this is facilitated through different modalities, including online. The objective is to teach the carers ways of optimally managing situations so as not to inadvertently enable eating disordered behaviour. However, the idea is also to teach the patients skills to maximise their communication abilities. It is hoped that this will improve psychological functioning, which as has been suggested also in the current study, is argued to be at the heart of optimum transition out of hospital.

Psychological therapy

What has emerged from the study is that transition from hospital is experienced as part of an on-going psychological recovery process for sufferers. As they come out of hospital they also work towards transitioning towards recovery. What was seen was that all the participants varied greatly in the extent to which they had moved towards recovery. All participants in the current study remained in outpatient services, although it was not clear what this involved. The psychological difficulties and the processes that appeared to be involved in moving towards recovery would indicate that psychological therapy might be helpful in facilitating this. Psychological therapy is recommended as treatment for anorexia nervosa (NICE, 2004; 2017). Cognitive Behavioural Therapy (CBT) has been the approach most widely viewed as helpful for patients with anorexia nervosa (Fairburn, Shafran & Cooper, 1998). However, as described previously, Goss and Allan (2012), informed by Gilbert (2010), have developed the idea that an intervention needs to be felt to be helpful, in order for clients to change their behaviour. Knowing and learning that there are alternative ways of thinking, as in CBT, is necessary, but arguably not sufficient for lasting change. Goss and Allan (2012) propose Compassion-Focused Therapy for Eating Disorders, to address this insufficiency. The shame/pride cycle, as described earlier in the psychological model section of this discussion, can be addressed by therapy that targets breaking the cycle. The interventions include exploring how the soothing system can be brought in to moderate the drive and the threat system. The therapy addresses blocks to harnessing the soothing system through compassionate mind exercises. The aim is that patients develop compassion for themselves, others, and their eating disorder. Feeling less distressed, and due to the therapeutic element involved in showing compassion towards others, sufferers experience an increase in social connectedness. In the current study participants showed little self compassion or compassion to others. Indeed, there were high levels of self-criticism which appeared to relate to their shame at being ambivalent. Yet also for some participants there appeared to be a kind of pride also at being ambivalent. There were other internal threats evident in the participants accounts, but all could be helped by introducing some compassionate mind training. An aim of psychological therapy therefore at this transition point could involve some skills training in self compassion in order to re-balance the emotional regulation system and break the drive threat cycle.

Psychological therapy and transition management: a joint venture.

The participants in this study experienced intense ambivalence in relation to having an eating disorder. This ambivalence was associated with shame, confusion and conflict. These can be viewed as key threats that could be addressed with Compassion Focused Therapy (CFT). Furthermore, these threats emerged as being closely linked to transition out of hospital, following intensive specialist inpatient care. It would therefore seem appropriate that at the transition point, clinicians might help the patients with a reformulation of their psychological state to assess current threats and the extent to which they concern the patient. This could then inform the therapy needs and the approach.

The contributors to this study also experienced a sense of loss on discharge that involved them disconnecting from services and clinicians, whilst at the same time daring to harness support from those around them. It would therefore seem appropriate that an intervention aimed at promoting this process would be fitting, alongside a forward-looking focus. The aftercare project (Cardi et al., 2017), it would be hoped, would fulfil this need. What is suggested in terms of clinical implication, is that the current study seems to provide the missing piece of a jigsaw in relation to transition out of inpatient care. It links the notion of transition to recovery with the notion of transition out of hospital. It also links theory and approach, and this arguably is the heart of the clinical implication. What might help these patients is a joint approach. Such an approach might be through service management to help access support, although in order to achieve this, psychological therapy to assist in moving towards recovery might also be indicated. The two approaches described above might in practical terms be a way forward with this idea.

Limitations of the study and suggestions for further research

The clinical contributions described, however hopeful in nature, need also to be treated with some caution. As with any qualitative investigation, the methodology is based on an assumption of the usefulness of drawing conclusions from a small number of participants. The study design, interviewing six participants and interpreting their lived experiences of discharge, is not expected to produce results that would be applicable to all patients who are discharged from a specialist eating disorder unit. However, this weakness can also be viewed as a strength, because the data generated has been used to get to the detailed depth of experience and in particular discover the underlying psychological processes at work under the guise of an environmental change. At the same time though, this study may be criticised for being rather weak because it would not be possible to generalize the findings from such a small number of participants. The intention of this study and the qualitative approach was never to generalize findings. The strength of this approach is in the detail and richness of the data which can then be interpreted at the theoretical level. Thus, there is theoretical transferability (J.A. Smith et al. 2009). What this means in practice is that this study has been able to be linked to clinical experience and current research interests. The point is that the findings have theoretically shed some light on the transition.

The study initially involved seven participants and the idiographic nature of the methodology allows for individual experience to be captured, with all its convergence and divergence (J.A. Smith et al 2009, p.3). The unfortunate loss of data from one participant, will therefore have had an impact on the similarities and differences in experience and the interpretations drawn.

Participants were recruited from one specialist outpatient eating disorder service in the UK; perhaps different experiences would have been elicited if participants had come from different outpatient services. A strength of the research was that not all participants were inpatients in the same hospital and the environmental change process was not the same for any of the participants. Even amongst the three participants who were discharged from the same hospital, the discharge process and arrangements were different for all of them. These differences contributed to the richness of the data, whilst maintaining a homogenous group.

In the recruitment interestingly no males were invited to take part, hence the findings are limited to the experience of transition for women. Consequently, it is unknown what the experience of males might have added to the findings. The clinicians may have selected people who were rather reticent in speaking, with the idea that the interview might help them to express themselves and engage in therapy. Conversely, they may have selected rather vocal people in order that they contribute in a helpful manner. The content of the interviews may also have been influenced by the agenda set by the participants themselves, such as wanting to help services, either by criticising or by praising. Also, the content of the interview may have been influenced by the stage of therapy; all participants were receiving some sort of psychological support. Equally the participants past experiences and duration of illness could have affected the content.

Further impact on the interpretations comes from myself as the researcher and the dynamic between myself and the participants. The participants were aware that I was a clinician within the outpatient department, but they understood that my relationship with them was as a researcher. Being a clinician helped the research process as I was able to be empathic and sensitive to the context within which the interview took place; this was a distinct strength to the research, and facilitated a relatively quick alliance, such that the participants were able to trust me and so reveal more of their feelings. However, it could also be said that my closeness to the outpatient service could have influenced what the participants said. For instance, their feedback on the service; overly critical and conversely overly complimentary. My closeness to the process of discharge from hospital may also have impacted on what questions I chose for the semi structured interview. Despite aiming to put to one side my fore-understandings maybe there were aspects of my clinical experience that I could not reach into via my reflective awareness.

One question that would have been useful to know at the time of the interview, was the length of time since discharge. Unfortunately, this was not asked directly, although a broad sense of how much time had passed was conveyed during the interview. Even if this was accurately known, it would not have been possible with this study to link the psychological transition to passage of time, because the study depended on a single interview. To investigate the impact of the transition over time would necessitate a longitudinal design where participants were interviewed at key calendar points post-discharge. This could be an interesting way to further investigate the transition process. It would be necessary, however, to decide on what constituted discharge, as this was not entirely clear in the current study. For example, when interviewed, Gail had been out of hospital for two years, was still receiving psychotherapy from the inpatient unit, and still felt connected with that service. Of all the participants, she appeared to have made the most psychological movement.

In summary, further studies might consider different ways of recruiting participants, such as self-selection. Using outpatient services where the researcher had no previous contact. Purposely seeking out participants who were from ethnic minorities. Seeking participants who were less educated. Finally, changing the research to a longitudinal design with multiple interviews, to get a sense of change over time in relation to discharge.

Methodological and personal reflexivity

J.A. Smith et al. (2009, p. 55) warned that the process of getting to research findings is often messy, chaotic and unpredictable. In the reflexive sections of the introduction, methodology and analysis chapters I have drawn attention to this uncertainty being in line with my own experience. What emerged from this process were surprises and unexpected findings.

When I allowed the participants to talk freely about their transition experience I had quite a surprise. I did not realise that their experience of the transition would link in with their experiences of having an eating disorder. Although, from the position of being at the end of the process now, this finding seems reasonable. It surprised me that the participants focused on being stuck with their difficulties and yet fighting to move on through to some sort of recovery. The main unexpected finding was that it appeared that this state of affairs for them came into sharp focus as they were discharged. Thus, what came together was a sense of recovery as an on-going process, and that different people were at different stages of transition to recovery as they were discharged from hospital. J.A. Smith et al. (2009) warn researchers of being prepared to be surprised and this was indeed something that I have experienced during the research process.

The openness of the qualitative research process was something I found rather disconcerting as a novice researcher. I wanted certainty and had to tolerate holding things lightly in my mind, even though I was desperate to pin them down and file them neatly away. On a personal level, I therefore learnt a lot about being courageous with data, as Gee (2011) described in her own personal reflections of doing IPA for the first time. I was aware of my own tendency to be unable to tolerate not getting things absolutely right. J.A. Smith et al. (2009, p. 81) acknowledge that it is not possible to create the perfect interpretation; it simply needs to be good enough. I was reminded of how people with eating disorders have been found to be perfectionists with a fear of not being good enough and making mistakes and this has been described as a trait that has held them back in their lives (Schmidt & Treasure, 2006). A parallel process could therefore be seen with regard to the transition process: the participants' different struggles with change as they transitioned out of hospital and me risking being different in my learning process to transition to a researcher.

Conclusions

The main findings in this study were that the transition out of hospital for patients with anorexia nervosa involved fundamental psychological change for the participants. The participants linked transition to the community, with their transition away from anorexia nervosa. What emerged was that this was a process of recovery from anorexia nervosa and was experienced very differently for each participant. The advantage of using IPA methodology (J.A. Smith et al. 2009) was that interpretations of the data produced from individual interviews, could go under a process of abstraction in the analysis, such that an overarching understanding of the transition out of hospital could be described. Thus what emerged was two superordinate themes, firstly, living with ambivalence to change and secondly, living in recovery.

The outcome of the analysis showed that in the transition to recovery there was a process. This process involved an ambivalence towards change. Anorexia nervosa and ambivalence have been linked in previous research, for instance Serpell et al. (1998). However, what was different in the current study, was that ambivalence was shown (for all the participants), to be a complex process often being connected to confusion, conflict and shame.

Ambivalence emerged as being experienced as a psychological block to recovery. Recovery involved a letting go of hospital support and a harnessing of community support and this was possible with a vision or goal in mind for recovery.

These research findings can be seen to have had a twofold impact. The first is that it has been possible to consider the findings in the light of existing psychological theory. Ambivalence can be viewed as a response to key threats in the lives of individuals with anorexia nervosa (Goss & Allan, 2009). The link of shame to ambivalence being the central threat, thus the shame/ambivalence link described in the current study can be viewed as a part of what maintains anorexia nervosa during transition out of hospital.

Therefore, at this theoretical level the study adds to the existing psychological knowledge.

The second impact is on how the findings might help clinically with the transition out of hospital. In view of the participants experiencing a sense of being stuck because of their ambivalence, it could be helpful to assess any ambivalence at the point of transition from hospital. This might be a psychological reformulation at the point of discharge which could then inform a psychological intervention. It would make sense that an intervention that particularly focused on shame-based difficulties would be appropriate. Thus Compassion Focused Therapy as described for eating disorders (Goss & Allan, 2009), could be considered. Furthermore, the study may also make a contribution to existing projects that are currently being developed (Cardi et al. 2017), around the more service-based interventions for people with anorexia nervosa as they transition out of hospital.

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Appendix A

Demographic Information

Specialist inpatient care to specialist outpatient care: experiences of this transition for adults with Eating Disorders.

Participant number: ________________________

Date of birth ________________________

Gender: M / F

How long since discharge from inpatient service ________________________

How long engaged with outpatient service ________________________

Length of inpatient stay ________________________

Previous inpatient stay after 18 years of age and length of that stay. ________________________

Previous inpatient stay up to 18 years of age and length of that stay. ________________________

Duration of time with an eating disorder ________________________

eating disorder diagnosis ________________________

Appendix B
Participant Information Sheet

Specialist inpatient care to specialist outpatient care: experiences of this transition for adults with Eating Disorders.

Researchers: Johanna Mitchell (Principal Investigator), Dr Paula Corcoran (internal academic supervisor) and Dr Elena Gil-Rodriguez (external academic supervisor).

You are invited to take part in a research study. This information sheet is designed to give you the information you need so that you can understand what the project involves and what your role would be. Do take time to read this information and feel free to discuss this research with others if that would be helpful for you. Please do contact me if you would like to ask questions or if you would like more information or clarification.

What is the purpose of this study?

This is an exploration into the experiences of adults with eating disorders as they discharge from specialist inpatient care to outpatient care.
It will give patients an opportunity to discuss their experience in detail. The aim of the research is to look at what features of the experience could help inform the management of other patients in the future.
Additionally, the research could provide more information with regard to the role of psychological input, both before, during and after discharge from hospital. It is hoped that the information will therefore improve the support given to patients. The research will also be part of my Doctoral Thesis.

Do I have to take part?

You do not have to take part. If you decide not to take part your usual care will not be affected in any way.

What will be involved if I agree to take part?

If you would like take part in the study, you will be invited to meet with me at the clinic, the hospital or your home at a time that is mutually convenient in order to talk about your experience of this transition. The interview will last approximately one hour and will be audio recorded.

By taping the interview I will be able to write up the interview word by word and use this to complete the analysis. The interview will be stored on a Nottinghamshire Healthcare Trust computer and a City University, London computer both of which will be password protected. I will be the only person who can access the data. All data files on the computer will be stored anonymously using pseudonyms and by altering any other identifiable information, your name will not be used. The data obtained from the interview will only be viewed in full by myself and my external academic supervisor. The thesis will use quotes from the interview, but I will ensure that you cannot be identified from the quotes.

What are the potential disadvantages and risks of taking part?

The research is keen to find out your experience of transferring your care to the outpatient service, therefore there are a set of questions in the interview, but not a defined interview plan. There will be some questions that will be asked as a result of how you answer develops. The interview may therefore potentially bring in sensitive topics of conversation. If during the interview you feel you need to stop to take a break or stop recording this can be done.

What would be the benefit of taking part?
Following the interview you may find there are aspects that were raised in the interview that you would be keen to work on with your therapist. Furthermore it is to be hoped that by discussing your experiences, this will benefit other patients as they are discharged and also provide information for clinicians.

Can I withdraw from taking part in the research?
You are free to withdraw from the study at any time without giving any reason and your recordings will be erased. However data that has been collated and analysed cannot be erased and will still be used in the project.

If I have any concerns about the research, what should I do?
If you have a concern about the research, please do feel free to contact me on 0115-9606666, and I will try to answer any questions you may have. Alternatively, you can contact my internal academic supervisor at City University **Paula Corcoran on 020 7040 3307.**

Will all information be kept confidential?
Yes. If you choose to take part there is an ethical and legal responsibility for me to ensure that information about you is kept safe and secure. Your data such as anything with your name on it (consent form and information matching your name with a pseudonym) will be stored in a locked filing cabinet on Nottinghamshire Healthcare premises. All other data, such as demographic information, recording and write up of the interview, will be made anonymous using an identification number so that you are not recognisable. The Clinician involved in your care at the outpatient service will be informed by letter that you are taking part in the research, but will not have access to the research data.

Will I find out about the results of the research?
The aim is for this research to be written up by me as part of my Doctoral thesis. It is anticipated that this will lead to me writing up parts of the thesis for publication in academic journals. There may also be the opportunity to discuss and present the research at workshops and conferences. There will be no identifiable data presented.
You will be asked if you would like to receive a summary of the research study.

Who is supporting this study?
This research is being sponsored by City University, London. It is supported and partially funded by Nottinghamshire Healthcare NHS Trust.

Who has reviewed this proposed study?
All research conducted in the NHS is closely looked at by an independent Research Ethics Committee in order to protect you. This study has been
reviewed by Nottinghamshire and Derbyshire Research Ethics Committees and passed as a suitable project.

Who do I contact if I have further questions?

For further information regarding ethical practice regarding research, please refer to the Code of Human Research Ethics published by the British Psychological Society and available on their website www.bps.org.uk.

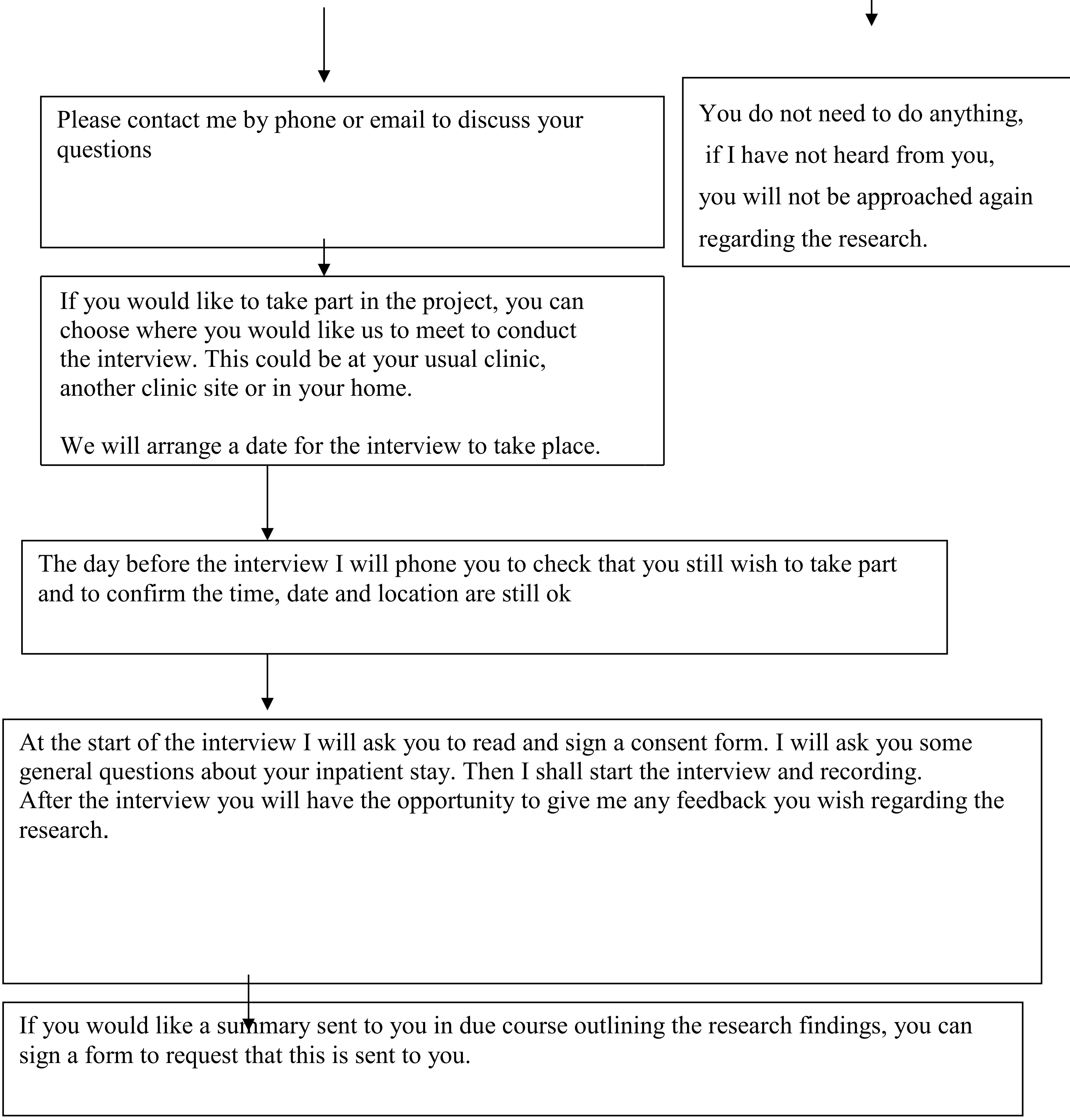
For more information regarding this study please contact me via the Eating Disorder Service

Principal Investigator
Johanna Mitchell
Name, address, phone number and email details

Academic Supervisor (external)
Dr Elena Gil-Rodriguez
Address, phone number and email details

Academic Supervisor (internal)
Dr Paula Corcoran
Address, phone number and email details

Diagram to show what can happen now



Option 1: I would be keen to find out more

Please contact me by phone or email to discuss your questions

If you would like to take part in the project, you can choose where you would like us to meet to conduct the interview. This could be at your usual clinic, another clinic site or in your home.

We will arrange a date for the interview to take place.

The day before the interview I will phone you to check that you still wish to take part and to confirm the time, date and location are still ok

At the start of the interview I will ask you to read and sign a consent form. I will ask you some general questions about your inpatient stay. Then I shall start the interview and recording.
After the interview you will have the opportunity to give me any feedback you wish regarding the research.

If you would like a summary sent to you in due course outlining the research findings, you can sign a form to request that this is sent to you.

Option 2: I do not wish to take part

You do not need to do anything, if I have not heard from you, you will not be approached again regarding the research.

Appendix C
Participant invitation letter

Specialist inpatient care to specialist outpatient care: experiences of this transition for adults with eating disorders.

Dear

Patients in contact with outpatient eating disorder services who have had experience of discharge from a specialist adult inpatient eating disorder service are being invited to take part in a research study on their experiences of this transfer of care.

The purpose of the study is to explore your experience of transfer from inpatient to outpatient care. The aim is to enhance care for patients in the future by looking in detail at the patient experience.

The study involves being interviewed about this experience by a Chartered Psychologist and Health and Care Professions Council (HCPC) Registered Counselling Psychologist who has experience of working with people with Eating Disorders. The interview will take approximately one hour.

Please do have a look at the enclosed information sheet about the study and if you are interested in taking part or would like further information please do phone me.

Phone number and email contact details

Alternatively you can let your therapist know if you would like me to contact you.

I look forward to hearing from you.

Best wishes

Johanna Mitchell
Chartered Psychologist
Registered Counselling Psychologist
Eating disorder service

Appendix D
Participant thumbnail sketches

Below are included thumbnail sketches for each of the participants. These are included to give further contextualisation to their accounts. Also it demonstrates how each participants' experiences were very different and individual.

Alice

Alice grew up in a big family, she lived with her parents and five other siblings. Having an eating disorder was something the family, especially her siblings did not understand and this had led to some estrangement with them that emerged once she returned home from hospital. Her parents were very concerned that by going for inpatient treatment Alice would become institutionalised. Alice's eating disorder only fully emerged once she went to University and she lost a lot of weight very quickly. On coming out of hospital she went back to University which was a really hard experience for her and she seemed to be very lost at times, her life in general lacked direction. She socialised regularly with people she had met whilst being an inpatient.

Sally

Sally had had a rather protected life, she had worked in the family business and been looked after and cared for by her parents. Her eating disorder emerged when she left home to live with her boyfriend in his flat. She spent days eating very little and over exercising, she lost a lot of weight. Eventually she was admitted for inpatient treatment and the family and her boyfriend became very concerned about her. On discharge her boyfriend started University and so her parents and Sally all relocated to the University city in another part of the UK in order for them to be together. Sally recognised that she needed to become more independent and part of her recovery involved obtaining work outside the family business.

Lara

Lara lived alone and seemingly had little support outside of hospital services. She recognised that at times she could get quite low and hopeless. Nevertheless she tried to help herself in terms of getting her house in good order. She also had the yearning to become a writer and was hopeful that she would be able to supplement this with some library work. She presented as lonely and alone. She had had the most number of admissions for an eating disorder and she had been unable to engage in weight restoration, so this had repeatedly led to being discharged because of being unable to engage in eating.

Gail

Gail had had a hard past life, it was not clear what had happened to her as a child, but she acknowledged that there had been severe problems as she was growing up. She lived alone and was fearful of starting any paid employment. Now she understood that things had not been right in childhood because she had started drinking alcohol from around the age of 8. Having had treatment for her alcohol difficulties she went on to develop anorexia nervosa and became very low weight. Gail was very grateful for all the help she had received as an inpatient. She had had continued psychotherapy from her inpatient therapist for at least one year post discharge, rather than being transitioned back to outpatient therapy. The impact of this was beneficial in her eyes, however she was aware that this was unusual and that she had had a different transition to others.

Kay

Kay hinted that she had had a difficult past as a child and her eating disorder was connected to these difficulties. It was unclear what had happened to her, but she was clear that she was very frightened of men. Her eating disorder had gradually taken hold of her and she lost a lot of weight. She was married with a young daughter who she worried about throughout her admission. Her husband had cystic fibrosis and Kay was concerned about his prognosis. Kay tried to hide her difficulties from her husband as she felt he did not understand mental health, she felt that he thought she could recover if she put her mind to it. This was not the case for him, he was stuck with cystic fibrosis. All this appeared to make a strain within the marriage.

Nicola

Nicola had spent her childhood going in and out of hospital for treatment relating to a brain tumour which left her with hydrocephalus. The hospitalisations involved management of her shunt, changing the shunt and sorting out blockages. Nicola was quite anxious about hospitals and medical care and the family even at the time of interview were always searching for her to have better care. Over the years there had been times when Nicola did not really trust clinicians. She was sceptical that outpatient eating disorder services could help her. She lived with university friends during term time. Her eating disorder had interrupted her studies at university twice because of two hospital admissions, she struggled to allow herself to maintain her weight gains from inpatient care.

Appendix E
Interview Schedule

Specialist inpatient care to specialist outpatient care: experiences of this transition for adults with eating disorders.

1 Outline what will happen in the interview

There has been some research done on patients' experiences of discharge from inpatient to outpatient care. Research so far has been limited to looking at adolescent experiences. Little work has been done on looking at the experiences of adults when they are discharged from specialist inpatient eating disorder services. I would like to spend some time today talking about your experiences around discharge.

2 Check that participant has read the information leaflet and ask if they have any further questions.

3 Interview Schedule

i) Please could you tell me about your experience of being discharged from hospital?

ii) What was your experience of the stages involved in the process of being discharged from hospital? *Prompt: home leave, purpose, feelings.*

iii) Can you describe your experience of any contact that you may have had with community services whilst in hospital? *Prompt: who, what was their input, thoughts and feelings about this.*

iv) Can you tell me about any discussions you had about being discharged? *Prompt: when raised, who by, how?*

v) What opinions were expressed about what you required on discharge from hospital? *Prompt: who, when?*

vi) How do you think others might view your discharge from hospital? *Prompts: such as inpatient / outpatient health professionals. Friends, family, other patients, career contacts, workplace.*

vii) Can you describe your experience of contact from the inpatient service after you were discharged?

viii) Thinking back, could you tell me how you saw yourself in the future when you were an inpatient?

ix) What happened to you when you came out of hospital?

Appendix F

Ethics forms

Health Research Authority

24 October 2013

Mrs Johanna Mitchell Chartered Psychologist and Registered Counselling
Psychologist at ….shire Eating Disorder Service ….shire Healthcare Trust

Dear Mrs Mitchell,

Thank you for your letter of 18th October 2013. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 03 October 2013

Documents received

The documents received were as follows:

NRES Committee 2

Address and telephone of NRES

Study title:	Specialist inpatient care to specialist outpatient care:exp
REC reference:	13/EM/0321
Protocol number:	N/A
IRAS project ID:	118646

Document	Version	Date
Covering Letter		17 October 2013
GP/Consultant Information Sheets	2	17 October 2013
Interview Schedules/Topic Guides	2	17 October 2013
Letter of invitation to participant	2	17 October 2013
Other: OPT-In Slip	1	17 October 2013
Other: Lone Working Policy	Issue 8	01 May 2013

Other: Demographic Information	2	17 October 2013
Participant Consent Form	2	17 October 2013
Participant Information Sheet: Clean	2	17 October 2013
Summary/Synopsis	2	17 October 2013

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	Version	Date
Covering Letter		25 Jul
Covering Letter		17 Oc
Evidence of insurance or indemnity		
GP/Consultant Information Sheets	2	17 Oc
Interview Schedules/Topic Guides	2	17 Oc
Investigator CV	Johanna Mitchell	10 Jul
Letter from Sponsor		25 Jun
Letter of invitation to participant	2	17 Oc
Other: CV	DR Elena Gil-Rodriguez	05 Ap
Other: CV	Dr Paula Corcoran	04 Jul
Other: Study Summary request letter	1	24 Jun
Other: OPT-In Slip	1	17 Oc
Other: Lone Working Policy	Issue 8	01 Ma
Other: Demorgraphic Information	2	17 Oc
Participant Consent Form	2	17 Oc
Participant Information Sheet: Clean	2	17 Oc
Protocol	1	24 Jun
REC application	118646/474694/1/50 7	10 Jul

Summary/Synopsis	2	17 Oc

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

Yours sincerely

Liza Selway Committee Co-ordinator

13/EM/0321 Please quote this number on all correspondence

[redacted]

E-mail: NRESCommittee.

Copy to: Paula Corcoran, City University London, Programme Director MSc in Health Psychology

Ms Shirley Mitchell...........Health Care NHS Trust

NHS
Health Research Authority

03 October 2013

NRES Committee

Mrs Johanna Mitchell Chartered Psychologist and Registered Counselling Psychologist

Dear Mrs Mitchell,

The Research Ethics Committee reviewed the above application at the meeting held on 23 September 2013.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager Liza Selway.

Ethical opinion

The committee noted that this is a qualitative study that is part of a doctorate in Counselling Psychology

The committee noted that the study will involve adult participants who have been admitted to inpatient care with Anorexia, Bulimia or an un-specified eating disorders and are now receiving outpatient care from specialist outpatients services

The committee noted that previous studies have involved adolescents rather than adults and adolescents have provided feedback in the patients discharge and general hospital support that has been received

Study title:	**Specialist inpatient care to specialist outpatient care: experiences of this transition for adults with eating disorders**
REC reference:	**13/EM/0321**
Protocol number:	**N/A**
IRAS project ID:	**118646**

The committee noted that there will be a sample size of 12 patients throughout …..shire and …..shire.

The committee discussed that the participants recruited to the study will have an interview with a trained researcher which will give the participants the opportunity to discuss their experiences of the transition from being an inpatient to an outpatient

The committee noted that interviews will be conducted either at clinic, hospital or the participant's home

The committee noted that the participant will be sent an Interview

Schedule and Patient Information Sheet to review. If the participant does not respond then the chief investigator would follow up with a telephone call to the participant. If there has been no response after a two week period then the researcher will assume that the participant does not want to take part in the research

The committee noted that if a participant is interested in taking part in the research, the chief investigator will contact the participant the day before to check that they are happy to go ahead

The committee noted the questionnaire and processes may be distressing for some participants as the topics which are being discussed may include sensitive information or safeguarding concerns. The committee agreed that the chief investigator is a chartered psychologist and is able to manage distress which participants may show and will encourage the participant to talk to their own therapist or social worker following the interview

The committee noted that the interview will take one hour to complete and the participant will be debriefed after the interview

The committee suggested that the section “What will happen to me if I agree to take part” in the Patient Information Sheet should include the nature of the questions being asked

The committee noted that the participants data and personal details will be stored for a period of 6-12 months, so the researcher can contact the participant during this period for feedback and to discuss the participants current support needs

The committee noted that participants would not receive any payment for taking part in the study

The committee noted that PALS contact details are not included within the Patient Information Sheet

The committee noted that within the Consent Form there is not a section to advise that the GP will be informed, but a letter to the GP is being sent separately

The committee noted that the Opt-in slip was not submitted with the application

The committee agreed that the flowchart that is within the protocol is an interesting and helpful document. It was suggested that this be included within the Patient Information Sheet

The committee asked if the researchers had a lone working policy in place as the researchers may be conducting interviews within the participants' homes

The committee noted that the academic supervisor has signed as being the study sponsor, this can be seen as a conflict of interests, the committee were advised by the Ethics Officer and REC manger that the correct signatures had been requested prior to the study being presented at the REC meeting

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

NHS Sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

1. Please reassure committee that a recognised Lone Worker Policy is being used.

2. Insert PALS contact details within the Patient Information Sheet

3. Insert a section on the Consent Form advising that the GP will be informed

4. Include information on the nature of the questions being asked to the participants in the section "What will be involved if I agreed to take part" in the Patient Information Sheet

5. Provide a copy of the opt-in slip for participants

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining

permissions.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations

involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett [redacted] the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved at the meeting were:

[redacted]	[redacted]	[redacted]
Covering Letter		25 July 2013
Evidence of insurance or indemnity		
GP/Consultant Information Sheets	1	24 June 2013
Interview Schedules/Topic Guides	1	24 June 2013
Investigator CV	Johanna Mitchell	10 July 2013
Letter from Sponsor		25 June 2013
Letter of invitation to participant	1	24 June 2013
Other: CV	DR Elena Gil-Rodriguez	05 April 2013
Other: CV	Dr Paula Corcoran	04 July 2013
Other: Demographic Information	1	24 June 2013
Other: Study Summary request letter	1	24 June 2013
Participant Consent Form	1	24 June 2013
Participant Information Sheet	1	24 June 2013
Protocol	1	24 June 2013
REC application	118646/474694/1/507	10 July 2013

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

Notifying substantial amendments

Adding new sites and investigators

Notification of serious breaches of the protocol

Progress and safety reports

Notifying the end of the study The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures. Feedback You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website. Further information is available at National Research Ethics Service website > After Review We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/ With the Committee's best wishes for the success of this project. Yours sincerely **Dr Martin Hewitt Chair**

13/EM/0321 Please quote this number on all correspondence

[redacted]

Email: NRESCommittee.

Enclosures:

Copy to:

List of names and professions of members who were present at the meeting and those who submitted written comments "After ethical review – guidance for researchers" SL-AR2

Paula Corcoran, City University London, Programme Director MSc in Health Psychology Ms Shirley Mitchell, Nottinghamshire Health Care NHS Trust

NRES Committee Attendance at Committee meeting on 23 September 2013

Committee Members:

[redacted]	[redacted]	[redacted]
Ms Gill Bumphrey	Clinical Trials Pharmacist	Yes
Miss Shamim Byrne	Gynaecologist/Obstetrici an	Yes
Mr David Carpenter	Social Scientist	Yes
Dr Frances Game	Consultant Physician	Yes
Dr Martin Hewitt (Chair)	Consultant Paediatric Oncologist	Yes
Dr Asam Latif	Research Pharmacist	Yes
Mrs Veronica Lyon	Lay member	Yes
Dr Simon Roe	Consultant Nephrologist	Yes
Dr John Shaw	Lay Member	Yes
Miss Catherine Shenton	Lay Member	Yes
Mrs Sally Ann Smith	Retired Audit Manager	Yes
Dr Alison Thorpe	Research and Governance Facilitator	Yes
Ms Margret Vince	Translator	Yes

Also in attendance:

[redacted]	[redacted]
Miss Liza Selway	REC Manager

From: Pestell, Carmai [mailto[redacted]

Sent: 04 November 2013 16:16
To: Mitchell Johanna
Cc: 'Elena Gil-Rodriguez'; Corcoran, Paula; Sykes, Catherine
Subject: RE: ethical approval from City University
Dear Johanna

Thanks for sending these on. I confirm that the Ethics Committee is now happy for you to start your research
Thanks
Carmai

Carmai Pestell
Assistant Registrar (Arts and Social Sciences)
Student and Academic Services
Ext. 8529
From: Mitchell Johanna [mailto:Johanna.Mitchell
Sent: 01 November 2013 14:58
To: Pestell, Carmai
Cc: 'Elena Gil-Rodriguez'; Corcoran, Paula; Sykes, Catherine
Subject: ethical approval from City Universi

Appendix G

CONSENT FORM

Specialist inpatient care to specialist outpatient care: experiences of this transition for adults with Eating Disorders.

Name of Researcher: Johanna Mitchell

Name of Participant: _______________ **Please initial box**

1. I confirm that I have read and understood the information sheet for the above research. I have had the opportunity to think about this information and I have received satisfactory answers to my questions.

   ☐

2. I understand that my participation in this study is entirely voluntary. I am aware that I may withdraw from the study at any time, without giving any reason and without my medical care being affected. I understand that should I withdraw information that has been collated from my participation cannot be erased.

   ☐

3. I understand that relevant sections of my audio recorded and transcribed interview may be looked at by authorized individuals from City University, London, and the research group. I give permission for the research group to have access to data and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential and all data will be anonymised.

   ☐

4. I understand the interview will be audio recorded and that anonymous direct quotes from the interview may be used in the research reports.

   ☐

5. I agree to take part in the above research.

   ☐

__________________________ ______________ ____________________

Name of Participant Date Signature

__________________________ ______________ ____________________

Name of Principal Investigator Date Signature

(Three copies will be produced, one for the participant, one for the research notes and one for the medical notes)

Appendix H

STUDY SUMMARY REQUEST

Specialist inpatient care to specialist outpatient care: experiences of this transition for adults with Eating Disorders.

I____(NAME)

would like to receive a summary of the research when it has been completed.

Please send this to me by:

Post to the following address:

____

____

____

Email: ____

Appendix I
Letter to outpatient service clinician

Dear *Name of outpatient clinician*______________

RE: *Name of participant* ___________________________

I write to let you know that the above patient has agreed to take part in the following study regarding transition of care.
‘Specialist inpatient care to specialist outpatient care: experiences of this transition for adults with eating disorders’

A copy of their consent form for this study is enclosed and I write to request if this could be filed in their notes.

Please do not hesitate to contact me if you have any queries regarding this matter.

Thank you for your help

Yours sincerely,

Johanna Mitchell
Chartered Psychologist & Registered Counselling Psychologist

Name and address of service with contact phone number

Appendix J

Emergent themes from transcript five –Sally

1 **Battle of the illness - hugeness, toughness, challenges** **Sally**

1 **Lack of preparation for the massive change on discharge**

L1-14
P1 T5

Um I think it's a much bigger step than I ever thought it would be I suppose I had probably given me I was probably given a false sense of security because I went towards the end of my inpatient stay I did a lot I took a lot of home leave so I ended up probably being at home five days of the week and then just going back to hospital for two days but then being discharged and being at home fully and no knowing knowing that you're not for going back for that support and that structure is very difficult

2 Limitedness of aftercare

L14 -16
P1 T5

literally going to one hour a week where you can actually talk about your problems with someone who can understand so it's a huge huge transition (short pause)

4 The tough relentless battle

L10-16
P2 T5

I mean talking to someone once a week is you know you can take your problems to them but it's your still at home battling a lot of it by yourself which is pretty tough (whispered)……..just facing challenges every day facing battles every day I suppose

9 Life is obviously very tough with an eating disorder during transition

L1-5
P5 T5

towards the end um I mean cause it was really tough I always found it really tough to go back to the hospital being surrounded by very ill people obviously doing a lot of behaviours obviously you feel (hesitation) very big compared to all the other people coming in um

20 Transition meeting: an effort for nothing **?waste of time**

L1-8

we travelled down it took us two and a half three hours to there and to the hospital

P9 T5 *…….no one was prepared for my CPA they were literally just rushing around and they managed to get two people into it it lasted ten minutes and then we had to travel three hours back and I just felt there was no importance to it*

26 Hard to return to the outside world from hospital

L1-5
P12 T5 *It's still, it's still tough but needing to do it now you know if me and XXX were out and he goes do you just want to go for a coffee and cake or something'/* *thing'? It's like normal just things that people take for granted that you want back and you try and get normality back*

30 Warfare: the battle with others and battle within

L12-15
P16 T5 *I get defensive I get argumentative um I kind of question what gives them the right to question me you know they don't know what I'm battling with everyday kind of thing*

31 The battle is won when challenges and goals are achieved

L17 P16
T5 *It's just little decisions feels like today I kind of set*

L1-5 P17 T5 *myself I try and set myself little challenges um so kind of like little challenges at the moment was have a latte a day because they used to be really scary for me so I do that every day before work and that's become really easy I look forward to that*

32 The battle of AN is an ongoing internal debate **bate and denying oneself**

L6-17
P17 T5 *that's still a battle in my head what do I want to do I have the safe option I know what my safe option is I'm not pushing myself enough and I need to gain weight so I should have something nice that I really really want or would really enjoy and so those* *are the kind of*

things and it's down either way it's kind of calories are the big one for me it's kind of not to be swayed by or influenced by calories in some things so I face battles with that every day um going out for meals is quite hard um challenging myself to go and sit down that's a huge one for me I feel lazy if I sit down so I kind of always on the go exercising was a thing for me so that's still a battle

33 Battle with others over AN is neverending and inescapable

L1-6 *just it does seem never ending I suppose in your head and even now it's kind of there's one*

P18 T5

thing you knid of never you don't feel that you ever get away from it I think when you do have day when you just you know go out shopping and not even think about it you know no one brings it up everyone just kind of treats you like normal

42 The challenge of being alone with food choices

L2 - 8
P22 T5

thinking what what do I do there was a section of five hundred calories or less and I was so tempted because no one was there to stop me but I didn't do that I just went for something else I kind of went for something that was probably more of a safe option because obviously it was a petrifying time for me but it was still challenging enough someone else had the same thing

45 Graded activities towards discharge were hard

L1-17
P24 T5

you'd go out like for snacks with the staff you'd go out for group snack um and towards the end I was going out to town for a snack by myself……they did it all very graded…I was given the opportunity to do cooking so I would cook my own meal with the support of someone and then you'd eat that kind of the unit that was a huge challenge because I suppose you're again everyone else is eating the same thing you're sitting there with something different so you're comparing what you've got to them and then it was never easy when someone drew attention to what you were eating oh look what's that like I just want to eat it just don't draw attention to me having something different

2 Journey from illness to recovery - back and forth

8 Experience of staff through treatment journey

L4-15
P4 T5

they don't encourage people to they pretty much ask people what they want to do and that's that and I mean I felt like I suppose because I went to full recovery I was probably given a lot more support but then towards the end of my stay I think they concentrate on the new patients that are coming in who are very severely ill but they'd forget about kind of helping you and getting you adapted to when you do leave um they almost just to get to a point where like just get you up to your weight and we'll send you home kind of thing that's kind of what I felt when I was there

19 Time passing impacts on care

L8 P8 T5		*towards the end* (repeated phrase through transcript)		
	24	**Critique of previous life choices: goals and new life choices**	**?survivor**	
L16 -17 P10 T5		*it was just to get a new job cause I'd always I'd worked for my parents and I was never happy…*		
L1-8 P11 T5		*there um it was kind of just the easiest option for me I'd always gone for the easiest option and never put myself out there never taken a risk I was kind of wrapped up in cotton wool by my parents I never had to do anything I didn't want to do and I think it was to literally just push myself to take some risks and challenge myself and as I say just try and find a new job that I liked um just the simple things really that you kind of take for granted*		
	27	**Making sense of the treatment journey the history of the transition of**	**going in**	**?concept of dis**
L2 - 8 P13 T5		*it wasn't like I'd kind of known her but so it was they didn't really say much to be honest because they hadn't I hadn't been on their books for long so they didn't really too much it literally that I signed up with them and they knew I was in a bad enough state that I needed inpatient so that was what they sorted out for me straight away so I didn't have too much contact with them (first outpatient team)*		
L11 -13 P13 T5		*where I went for inpatient was completely there was no where near my home*		
L15 -17		*…I think it was just south of X (town) and then obviously we moved up here really quite far away from each other*		*re so they all ki*
L8 -10 P14 T5		*they had a few (hospitals) that they worked with but that was the first one that came up with a bed so that's why I went in there*		
	28	**Making sense of the treatment journey the history of coming out of hospital**	**out of hospital**	**satisfaction**
L16 P14 T5		*they (first outpatient team) knew that my parents*		
L1-3 P15 T5		*were moving up here and that I would be moving up here this was going to be where I needed outpatients so they kind of knew they were going to be handing me over*		
L7		*they did everything they said they would do*		

P15 T5 L11-14 P15 T5	*I didn't expect them to do much all they were kind of they they got the bed for me and that was essentially what I needed and then sorted out um as I say for me to come here when I was discharged so that was all I needed I suppose*	
	37 Identity is often defined through the illness and this follows you	
L14- 17 P19 T5 L1 -2 P20 T5	*I suppose work is the only place whre no one knows anything an that was that was why that was so important to me it was so nice to go somewhere and people know me for Sally everywhere else probably just you know oh Sally she's got an Eating Disorder she's go you know but they don't know*	
	51 Being put on a pedestol by inpatient service raises fear of failing	**ng; self criticism and criticism of service**
L4-13 P28 T5	*I suppose you had a lot of expectation I suppose it's like they asked me to go back and do a recovery talk you know before I left and I was like well you know let me get to the New Year see how I'm doing because I've you you don't know what's going to happen you see so many people leave and go back that you kind of think well are people getting the right support that they need on the outside yeah well I've gone for full recovery and that but it doesn't mean in a a couple of months time I'm still going to be at a that stage and I wasn't I'd gone back down again*	
L16 +17 P28 T5	*oh you'd gone to full recovery you weight everything was fine*	
	52 Coming full circle through the recovery talks	
L2-3	*Just me going in and talking to all the inpatients about my experience*	(me)
L16 P29 T5	*they were doing it they were proof that recovery is possible*	(others)
	53 Experiencing motivational talks as an aid to recovery	
L5-7	*well she can do it why you well we can too I think cause I I saw*	*a couple of recovery talks*
L9	*and they were really helpful*	
P29 T5	*just seeing that actually it is possible*	
L12	*they had come out the other end*	

	54	**The essence of recovery**
L10-15 P29 T5		*seeing how happy these people are …the kind of battles they'd gone through some worse than what I had……they are not fixated by food…they're living a happy healthy life …they can have a take away and not too much about it*
	57	**Sense of self in the past**
L4-5 P31 T5		*I would joke about I would (slight hesitation) I would always be up for a laugh*
L16 -17 P31 T5		*I would just I would take things with a pinch of salt rather than immediately thinking it's an attack*
	58	**Sense of self in the present**
L8-10 P31 T5		*I'm a lot more irritated at the moment I get a lot more snappy a lot more defensive um and it is noticeable*
	59	**Plan for future sense of self**
L2 -3 P31 T5		*I wanted to be more ambitious and take more risks and be a bit more spontaneous*
	68	**Transition to health generates an internal pressure to find a route whilst lost (a maze?)**
L1 -6 P37 T5		*it's quite anxiety provoking I suppose because you just well you just feel lost …I know what I need to do but only I can do it and that's a lot of pressure to put on yourself it's quite overwhelming to think that only I can make the changes that I need to od to get better do to get better*
L8-15 P37 T5		*(feeling lost is) no sense of direction no concrete answers …I like to have the to know exactly what's happening, like to have the structure I like to have the to know what's going on and to (short pause) to be asked a question that I don n't know the answer to even like I could say well I'll about it I just I don't know where to start to try and come up an answer*
3		**Sense of self- ashamed, proud, critical of self and others**
	7	**Pride in being different to others with an eating disorder**
L1-4 P4 T5		*but then I don't feel I think a lot of patients that especially when I was there I think I think I was the only one to go to full recovery a lot of people just go to maintainance*
	11	**comparison of self with others ?taking up a bed**

P5 L5 T5 *obviously you feel very big compared to all these new people coming in*
P5 L17-18 *it felt like towards the end like they're kind of just trying to get you out because they've*
T5 *got people that want that they want need to come in*

13 sense of having an incurable relapsing illness

L11 -15 *I suppose you can cover things in those sessions but I don't think it's ever going to fully um*
P6 T5 *(short pause) cure what the problem problems are or you known I had always had problems*
with communication and you know we'd talk about that but as soon as I was properly discharged
L1 -3 *and everything it's because it's so overwhelming you kind of go back down to your your usual*
P7 T5 *manners of coping and that's not*

17 Questioning of entitlement for inpatient care: sense of self worth

L6 12 *someone else needs that room more important than me and I think you kind towards the end*
P8 T5 *you was question you just think well I'm using up a bed that could be used for someone else*
but essentially kind of still think well actually I need as much help as probably the new patient
coming in so I'm worthy of that bed

29 Dissatisfaction with current care

L5-10 *I think my family even now feel that one hour a week isn't enough* *gh…..*
P16 T5 *I think when they see me slipping into bad ways again they don't know how to handle it um*
they don't like to challenge me on it because I don't like to be challenged

40 Self critical of own defensiveness

L5-9 *I know in my head when I am challenging myself or when I'm taking the easy route I think*
P21 T5 *I am aware of um of that it just again I get defensive just thinking you know you've chosen*
what you want just leave me to choose what I want

43 Contrast of experience: a sense of achievement in trusting self

L8 - 16 *I was ok this seemed quite normal but it was just and then after that I just didn't even think*
P22 T5 *about it you know cause laughter jokes and conversation everything going on but it was just*
there was no no focus on oh what's Sally having you know kind is she challenging herself is she
cause I suppose that's what I just everyone I just always feel like people are looking at my plate
thinking has she got enough there and it's just it's probably my paranoia more than anything

47 Identification of a mental barrier to transition to health

L9 -14 P25 T5 *Yeah yeah I think it's all in my head I heard a little only battle kind of thinking I know what I should be doing and what I need to be doing it's just doing that and getting there just seems to sometimes just be a barrier in the way I know I want to get better I know I want to the weight on but there is something that's stopping me it's still a fear that's stopping me from doing that*

48 Transition to health is weight focused and mental side is left

L8-13 P26 T5 *I think I think they concentrate more on getting your weight up and they don't fully deal with the mental side of it because the mental side of it is the paramount it's the it's the main problem I suppose it's all in the head and I don't think they do do enough support for that*

49 Pride in own achievement compared to other patients

L4 - 11 P27 T5 *I was the one that went to full recovery and they didn't know and as I say no one else at the time they had had a few people that just discharged themselves too early because they can't stick it there any more er people that they don't want to get better that they kind of give up on so the fact that it was my first admission I d gone in there I'd literally taken on everything they had thrown at me*

56 Motivation to get well is finding self

L7-8 P30 T5 *I could remember my personality before (Eating Disorder) and that's what I wanted back …*

L14 -16 P30 T5 *I want to kind of get back to you know being the bubbly person who was always up for a laugh kind of thing*

67 Self critical re block to change

L8-12 P36 T5 *Ultimately only I can make myself better only I can eat what do I what I need to do to get there no one else can do anything in in that sense you know I need to want to to have to get better to get better*

69 Self critical ?shame

L3-7 P38 T5 *but to say …what kind of care I got maybe wasn't the best (short pause) but then I don't know what what suggestions I would have made to improve that which doesn't seem very helpful I suppose (laughs)*

L8 -11 P38 T5 *you want to help others you want to give answers to be able to improve on things so that other people get better help and the things but I just wouldn't know what to suggest (quietly spoken)*

70 Shame at not transitioning to full health

L3-10 P39 T5	*I don't feel that I've been in a position where I could like I've got any right to give advice um (short pause) because I was struggling myself because I am not at my full recovery weight any more I've dropped a bit so I'm kind of thinking well it would be pretty hypocritical of me to go in there and give all this advice on you know recovery you know about people's daughters and sons and friends and stuff*
4	**<u>Experience of loss rejection and abandonment</u>**
3	**Loss of care practical and emotional**
L5 - 9 P2 T5	*they pretty much discharge you and wipe their hands of you I think they they don't really even take an interest as I suppose to what care you're going to um I think I don't think I was given a true indication of how different it was going to be*
5	**Terrified, alone and not fully understood inspite of family support**
L16-17 P2 -T5	*I've got a lot of support around me with my parents and boyfriend family and that*
L8 -13 P3 T5	*they don't know the true they can't fully appreciate what I go through so I think sometimes I challenged by them they don't understand what what is actually going on in my head just the small things that probably seem completely insignificant to them are petrifying to me but um so you're literally I think you feel you do feel like you're coming out and you you by yourself you're all alone kind of thing*
10	**Rumination on best place to be: inpatient or outpatient** **? Loss of illness**
L9-16 P5 T5	*I did get to a point where I was I could try and block it out um and I knew that I still needed to go back there um but it did get to a point where you kind of just think well what am I doing here yeah like there not I'm not I wasn't participating in any groups because I didn't find them useful towards the end um I was put on low support so I didn't even need to be eating with any with any members of staff um so it did get to a point where I was just thinking what am I doing here*
12	**withdrawal of inpatient care by staff**
L5-10 P6 T5	*I think you kind of start to resent them so I think it was you know you go you start it was like the therapist I saw you know I had a lot of sessions when I was there and then towards the end she was just like well I think we've covered everything so you know there's probably just about*

time that you were discharged

14 Feeling of abandonment on discharge

L5 -9
P7 T5

probably just more (short pause) truthful information about what it's going to be like when you leave um maybe a bit of reassurance that ok if if things do start to go wrong you can still call us for you know problems or support or advice but um

15 Feeling of messy rejection on discharge

L12 -18
P7 T5

No well I kind of went back I had my last CPA um probably the week after I was discharged because I was meant to be discharged on my CPA day but they were going to I was going home for home leave and they were going to move me rooms and I said I've been in same room for six months I said well it's pointless moving all my stuff into another room to leave so that's kind of where I felt like I was being chucked

L1-2
P8 T5

out so I was like I might as well discharge now they were kind of like oh ok then without any question

16 Feeling passed over / passed on at discharge

L4 -6
P8 T5

as if they well they've done their job with me now so it you know they can just get rid of me you know send me off for someone else to look after

18 Hurt by being abandoned

L12-14
P8 T5

but it just felt like I was you know I was I was close enough to my full recovery weight that I could get there by myself when I was discharged so it did it did hurt me I think

21 Experience of inpatient staff on discharge : when out of their sight out of their mind

L7-13
P9 T5

I just felt like it was there was no importance behind it (CPA) it it was just pretty much saying well done you've got to full recovery good luck and that was it and it just felt like ok you know I had put in all this hard work I had travelled down three hours and for what you know you did feel as if you kind of just you get forgotten about I suppose as soon as you're gone that's it

22 Mixture of feelings on transition meeting

L1-4
P10 T5

I was frustrated I was angry annoyed um again I was upset….I think it worried me again

46 Graded activities didn't fully prepare for discharge

L1-6 *I suppose that is the preparation for it (discharge) but then it doesn't fully prepare you for it*
P25 T5 *when you're kind of out on your own for the whole time like you can't go back there and ask*
for support or go back there and say actually I did struggle with this I worried about this and
things like that you don't have that reassurance to know that you are going back to that

63 Belief that being kept an eye on post discharge would prevent any relapse

L7 -9 *I would be coming to see someone here um I would be living with my parents so I would have*
P34 T5 *someone around all the time um*
L14-17 *when I was ill and that's where it got a lot worse cause I was at home by myself so I was just*
P34 T5 *exercising the whole time and not really eating cause no one was there to keep an eye on me*

64 The benefits of structure at home post discharge

L4-10 *I moved back in with them (parents) cause they work from home so sos there was always going to*
P35 T5 *be someone around um all the meals they would always have the same meals as me um at the same*
time and that really helped at first that was kind of good to have that structure it was nice to know that
they were doing that for me

65 Expectations from services: the unknown

L11 -12 *I wasn't really sure what I was going to get I suppose*
L15-17 *I don't know I don't know what I almost expected or what I even now would think would be helpful,*
P35 T5 *yeah I don't actually know (short pause)*

66 Uncertainty about what could help

L5-7 P36 T5 *I don't know my parents say how can we help you I don't know I don't know what it is that's going to*
help me (swallows) I don't know
L14 P36 T5 *what could have been done differently I don't know*

71 Post discharge contact from service is restricted

L8-10 *I don't feel like an hour a week just to talk through problems is enough (quietly said) especially at the*
P40 T5 *beginning*
L4 P41 T5 *I think a lot can happen in a week that you can't cover in an hour*
L1 -2 P42 T5 *so much has happened you kind of just feel like a bit more contact would help*

72 daily variability of mood immediately post discharge

L13 -17
P40 T5
I can go home and then and have an argument with my parents or face a different struggle and then the next day can be the worst of the week and then after that can be an alright day so when you come back after a week there's so much to cover so

L1-5
P41 T5
so many different things that that on that day when go back in like you might feel good again you know so you don't really want to go over all the crap days that you've

L14-17
P41 T5
you can have a really crap day you know say I come in on a Monday I can have a really crap day Wednesday good day Thursday Friday crap day Saturday

5 Support is an internal and external experience

6 Facing responsibilities

L8 - 13
P3 T5
everyone kind of thinks you know that you put the weight on you've go to a healthy BMI you must be cured but I it's when you leave hospital that the hard work actually really does start and I don't think you're ever fully prepared for that big step

23 A full on effort: staying on track versus slippage

L5 -14
P10 T5
I was alone I was out here and I was having to face all these things by myself and try and get back on my feet um again I did have the support and I've always had the family around and I think moving back in with my parents was good but then it became comfort and so I'd start slipping into bad ways um (short pause) so it was very much um (slight stutter) you know I've had all these ambitions when I was in hospital sort of what I wanted to do but coming out and having to try and recover try and stay on track and try and do all these things just seemed impossible I suppose…

25 Craving and valueing the simple taken for granted life of the world outside hospital

L10 16
P11 T5
I suppose when I was in hospital it was just like when I did start coming home at weekends just spending time with my parents going out shopping for my mum doing little things with XXX (boyfriend) um it was just everything you take for granted like going out for coffee with your mum you know when you're out shopping just going 'do you want to go for coffee?'

me *at the weekends*

34 Avoidance of friendships as a means of protection against intrusive comments

L14-16 *I never really had that closer friendships when I was at X (County) anyway I kind of just keep*
P18 T5 *in touch with one person um who is my best friend*

35 Care in choosing helpful friendships from the inpatient group: a deliberate decision

L17 -18 *I do keep in contact with quite a few people I did meet in hospital um but you do get to know*
P18 T5 *when you're in there*
L1 -4 *who's going to be a positive influence and who's not* *so you you do you're very wary and you kin*
P19 T5 *of you build friendships based on those that you know are going to be helpful to you and not*
kind of push you the other way um

36 Supportive nature of some of the other patients from hospital

L5-12 *but having those friendships are key for me cause if I do have any struggles you can talk to*
P19 T5 *them and you know they fully understand what you're going through (slight laugh) so that's*
really nice like have one girl who I speak to literally every day um so that means a lot to me
but that there is still someone I can talk to if I need it that that can still give you the push and
go come on you know you need to do it just have what you want have what you like you
can do it um so that's that's important for me

38 Hiding Eating Disorder feels safe

L3-4+7 *they don't know anything a work and that's my kind of safety it's like it's my escape I*
P20 T5 *suppose*
it's just no one treats me any differently

39 Eating Disorder affects the behaviour of the family

L8-14 *you know my parents and that they kind of tip toe around we'll go out for a meal you know*
P20 T5 *they're they know that I'm probably struggling in my head and trying to help me make a*
decision and things like that um and I challenge myself……….they're kind of saying 'what do you
want um
L1-3 *could go for this or is that an easy route out or is that challenging yourself' and it's all those*
P21 T5 *little questions*

41 The challenge of going out with non family

L9 - 17 *I did face a huge challenge last weekend um where one of the girls from work was leaving they*

P21 T5 *were going out for a meal and that was the first time that I've been out for a mealwith girls*
in I don't even know how longum and to know that I still struggle when I go out with family
and that it was a big huge huge test so nice just to go out and kind of attention wasn't on me
there was no focus on me
it was just ok you

44 The Experience of watching others and being watched in both inpatient and outpatient

L6-13 *Yeah yeah cause they're always keeping an eye on whether you're doing any behaviours whether*
P23 T5 *you've cleared your plate um I suppose when I was inpatient you do you kind of start to you know*
maybe go out for lunchand go out for dinner and go out for snack you're always almost
comparing well I know what they're having on the unit I'm having way more than what they're
having in the unit you do start to compare in that sense

55 Eating Disorder has led to change in personality: hurtful when pointed out, challenging the comments

L9-13 *it's my parents always say we've lost you um whish we had the old Sally back it really hurts*
P30 T5 *me everytime they say it it was only recently that I've actually just said please*
don't say that to me because I know that I'm fully aware that I am not the same person

60 Longing to be rid of the Eating Disorder colouring identity in the eyes of others

L1-10 *at the moment.....I just think you know am I ever going to able to do something that people*
P32 T5 *don't equate to being Eating Disorder relatedyou know I'd do things before I was ill and yet*
why are you doing that?' well that's got to be down to the
if I do that now *Eating* *that's got to be*
down to the Eating Disorder that' that's what I feel with everything I do is Eating Disorder
related and I can't have that I'm not Sally I'm Sally with an Eating Disorder and I think that's
what I struggle with

61 Feeling judged negatively at home in the family

L14-17 *it does feel to me sometimes you know other people can eat you know my brother eats round*
P32 T5 *his plate no one will question it if I eat round my plate well why are doing that it's like well it's*
kind of like I
L1-4 P33 T5 *can understand it but then you just think is there ever going come a time where you don't*

kind of relate it to that or just let it go and know that ok maybe that's (short pause) fine

62 Push and Pull effect of comments by others on eating behaviour

L7-17 *me and XXX (boyfriend) have had many an argument because he's he's mainly the one that*
P33 T5 *will challenge me he will go 'well have you got enough h there maybe you should have a bit more of this that's not a main meal……..a lot of times when he says it I will get defensive and I will snap back but then upon reflection I'll think Mm yeah he was right but it's just in that moment I just think what gives you the right…I think it's more the way he says it sometimes I think .. just just leave it just can I not just eat things without having you pick holes in it*

Appendix K

Cross case analysis – Sally

Ambivalence

towards the end um I mean cause it was really tough I always found it really tough to go back to the hospital being surrounded by very ill people obviously doing a lot of behaviours obviously you feel (hesitation) very big compared to all the other people coming in um

Sally: 5, 1-5

I think it it worried me that again I felt I was alone I was out here and I was having to face all these things by myself and try and get back on my feet um again I did have to the support and I've always had the family around and I think moving back in with my parents was good but then it became comfort and so I'd start slipping into bad ways um (short pause) so it was it was very much um (slight stutter) you know I've had all these ambitions when I was in hospital sort of what I wanted to do but coming out and having to try and recover try and stay on track and try and do all those things just seemed impossible I suppose (quietly spoken) (shame)

Sally:10, 4-14

S It's just little decisions feels like today I kind of I set

1. *myself I try and set myself little challenges um so kind of like*
2. *little challenges at the moment was have a latte a day*
3. *because they used to be really scary for me so I do that every*
4. *day before work and that's become really easy I look*
5. *forward to that but I can of then challenge myself to have a*
6. *cake everyday and that's still a battle in my head what do*
7. *I want do I have the safe option I know what my safe*
8. *option is I'm not pushing myself enough and I need to gain*
9. *weight so I should have something nice that I really really*
10. *want or would really enjoy and so those are the kind of*
11. *things and then it's down either way it's kind of calories are*
12. *the big one for me it's kind of trying not to be swayed by or*
13. *influenced by calories in some things so I face battles with*
14. *that every day um going out for meals is quite hard um*
15. *challenging myself to go and sit down that's a huge one for*
16. *me I feel lazy if I sit down so I kind of always on the go*

exercising was a thing for me so that's still a battle um it's

(conflict with self)
(conflict and
ambivalence)
Sally:16,17,17,1-17

1. *Yeah yeah it's all in my head I heard a little old battle kind*
2. *of thinking I know what I should be doing and what I need to*
3. *be doing it's just doing that and getting there just seems to*
4. *sometimes just be a barrier in the way I know I want to get*

5. *better I know I want to put the weight on but there is*
6. *something that's still stopping me it's still a fear that's stopping me from doing that* (anxiety)

Sally:25,9-14

I suppose you had a lot of expectation I suppose it's like they asked me to go back and do a recovery talk you know before I left and I was like well you know let me get to the New Year see how I'm doing because I've you you don't know what's going to happen you see so many people leave and go back that you kind of think well are people getting the right support that they need on the outside yeah well I've gone for full recovery and that but it doesn't mean in a a couple of months time I'm still going to be at a that stage and I wasn't I'd gone back down Again (confusion)

Sally: 28, 4-13

1. S *(quickly) Yeah yeah I think I do find it hard to pin point*
2. *things as well you know it's like X (nurse) asked me the*
3. *other day 'what can I do what help do you want from me?'*
4. *I don't know my parents say 'how can we help you?' I*
5. *don't know I don't know what it is that's going to help me*
6. *(swallows) I don't know what help to ask for what could*
7. *make this any easier because ultimately only I can make*
8. *myself better only I can eat what do what I need to do to*
9. *get there no one else can can do anything in in that sense*
10. *you know I need to want to to have to get better to get*
11. *better so that's why I find it hard when people say well*
12. *what how can we help what could have been done*
13. *differently or I don't don't know*

JM *I wonder what feeling that generates when you don't know when someone is asking you what can we do*

S *(slight interruption)Yeah it's frustration it's really frustrating um (short pause) it's quite anxiety provoking I suppose because you just well you just feel lost I suppose it's like well I kind of as I say well I know what I need to do but only I can do it and that's a lot of pressure to put on yourself it's quite overwhelming to think that only I can make the changes that I need to do to get better*

JM Can you say a little bit more about feeling lost?

S (short pause) Um just no sense of direction no concrete answers I think and I don't like it if I don't I like to kind of know exactly what's happening, like to have the structure I like to have the to know what's going on and to (short pause) to be asked a question that I don't know the answer to even like I could say well I'll go and think about it I just don't I wouldn't even know where to start to try and come up with an answer (confusion)

JM So maybe it was quite uncomfortable when I asked you

S Yeah

Sally: 36, 2-17, 37, 1-17

but it did get to a point where you kind of just think well what am I doing here yeah like there not I'm not I wasn't participating in any of the groups because I didn't find them useful towards the end um I was put on low support so I didn't

5. *even need to be eating with any members of staff um so it did*
6. *get to a point where I was just thinking what am I doing here*
7. *and then it felt towards the end like they're kind of just trying*
to get you out because they've got people that want that they
1. *need to come in um*
2. JM *Did that sound like a bit of an unsaid message, like they didn't actually say it?*
3. S *Yeah it was (speaking over)*
4. JM *It was sort of covered up, but you sensed it?*
5. S *Yeah absolutely and I think you kind of start to resent them*
6. *so I think it was you know you go you start it was like the*
7. *therapist that I saw you know I had a lot of sessions when I*
8. *was there and then towards the end she was just like well I*
9. *think we've covered everything so you know there's probably*
10. *just about time that you were discharged it's kind of ended on* (conflict)
11. *the right thing but you know I suppose you can cover*
things in
12. *those sessions but I don't think it's ever going to fully um*
13. *(short pause) cure what the problem problems are or you*
14. *know I'd always had problems with communication and you*
know we'd talk about that but as soon as I was properly
1. *discharged and everything it's because it's so overwhelming*
2. *you kind of go back down into your your usual manners of*
coping (overwhelming)

Sally: 5, 11-18, 6, 1-17, 7, 1-3

1. JM *And I'm just rewinding thinking about the talk they*
2. *asked you to do I'm wondering if you did accept that*
3. *challenge or you declined it?*
4. S *Um I said that I was happy to go and do a recovery talk*
5. *um but um I said I'd rather leave it until the New Year and*

they con contacted me cause they have family and friends

1. *meetings every once every month I think and they've*
2. *contacted me a couple of times to do that but I've declined*
3. *that because I don't feel that I've been in a position where*
4. *I could like I've got any right to give advice um (short*
5. *pause) because I was struggling myself because I'm not at*
6. *my full recovery weight any more I've dropped a bit so*
7. *I'm kind of thinking well it would be pretty hypocritical of*
8. *me to go in there and give all this advice on you know*
9. *recovery you know about people's daughters and sons and*
10. *friends and stuff you know what help can they I just didn't*
11. *feel like I was in place that I could I should go in and do*
12. *that so I declined thoseI would like to eventually go and do*
13. *recovery talk and hopefully when I'm better and you*
14. *know months or a year down the line I'd hope to be able to*
15. *do that* (shame)

Sally:38, 17, 39,1-15 Sally:38,12-17,39,1-15

Conflict

I mean from the hospital that I stayed in they pretty much discharge you and wipe their hands of you I think they they don't really even take an interest as I suppose to what care you're going to um I think yeah I don't think I was given a true indication of how different it was going to be um what help I would I would get um I mean talking to someone once a week is you know you can take your problems to them but it's your still at home battling a lot of it by yourself which is pretty tough (whispered)

S *Um (hesitation) as if they well they've done their job with me now so it you know they can just get rid of me you know send me off for someone else to look after someone else needs that room more important than me and I think you kind of towards the end you was question you just think well I'm using up a bed that could be used for someone else but essentially kind of still think well actually I need as much help as probably the new patient coming in so I'm worthy of that bed but it just felt like I was you know I was I was close enough to myfull recovery weight that I could get there by* *myself when I was discharged so it did it did hurt me I think*

JM *Your feelings were hurt?*

S *Yeah because then I went back for as I say my CPA a week later and had to travel down my boyfriend came with me we travelled down it took us two and a half three hours to get there and to the hospital (speaking over)*

JM *From here to the inpatient service?*

S *Yeah yeah and no one was prepared for my CPA they were literally just rushing around and they managed to get two people into it it lasted ten minutes and then we had to travel three hours back and I just felt like it was there was no importance behind it it was just pretty much saying well done you've got to full recovery good luck and that was it and it just felt like ok you know I had put in all this hard work I had travelled down three hours and for what you know you did feel as if you kind of just you get forgotten about I suppose as soon as you're gone that's it*

JM *And the feeling as you came back from that as you came away?*

I was frustrated I was angry annoyed um again I was upset um

S *I think my family even now feel that one hour a week isn't enough um*

JM *They are concerned?*

4. S *Yeah I think when they can see me slipping into bad ways*
5. *again they don’t know how to handle it um they don’t like to*
6. *challenge me on it because I don’t like to be challenged.*
7. JM *What happens if you are challenged?*
8. S *I get defensive I get argumentative um I kind of question*
13. *what gives them the right to question me you know they*
14. *don’t know what I’m battling with everyday kind of thing*

just it does seem never ending I suppose in your head and even now it's kind of there's one thing you knid of never you don't feel that you ever get away from it I think when you do have day when you just you know go out shopping and not even think about it you know no one brings it up everyone just kind of treats you like normal

1. um I know in my head
2. when I’m challenging myself or when I’m taking the easy
3. route I think I I am fully aware of um of that it just again I
4. get defensive just thinking you know you’ve chosen what
5. you want just leave me to choose what I want um but I did
6. face a huge challenge last weekend um where one of the
7. girls from work was leaving they were going out for a meal
8. and that was the first time that I’ve been out for a meal
9. with girls in I don’t even know how long um and to know
10. that I still struggle when I go out with family and that it
11. was a big huge huge test but it was just so nice just to go

out and kind of the attention wasn’t on me there was no focus on me it was just ok you know I could I still struggled in my head thinking what what do I do there was a section of five hundred calories and less and I was so tempted because no one was there to stop me but I didn’t do that I just went for something else I kind of I went for something that was probably more of a safe option because obviously it was a petrifying time for me but it was still challenging enough someone else had the same thing so it wasn’t I was ok this seemed quite normal but it was just and then after that I just didn’t even think about it you know cause laughter jokes and conversation and everything going on but it was just there was no focus on oh what’s Sally having you know kind of is she challenging herself is she cause I suppose that’s what I just everyone I just always feel like people are looking at my plate thinking has she got enough there and it’s just it’s probably in my paranoia more than anything but I do like a lot of the attention is always on me.

you'd go out like for snacks with the staff you'd go out for group snack um and towards the end I was going out to town for a snack by myself and things like that so yeah they kind of

JM *It was graded?*

1. S *Yeah it they did it all very graded and then you kind of*
2. *um*

I was given the
opportunity to do cooking so I would cook my own meal with the support of someone and then you'd eat that kind of the unit that was a huge challenge because I suppose you're again everyone else is eating the same thing you're sitting there with something different so you're comparing what you've got to them and then it was never easy when someone drew attention to what you were eating oh look what's that like I just want to eat it just don't draw attention to me having something different

1. *so you're comparing what you've got*
2. *to them and then it was never easy when someone drew*
3. *attention to what you were eating oh look what's that like*
4. *I just want to eat it just don't draw attention to me having*

something different to you

1. JM *Tough, can you say a little bit more about that?*
2. S *Um just facing challenges every day facing battles every*
3. *day I suppose um even though I've got a lot of support*

around me with my parents my boyfriend family and that

1. *they don't know the true they can't fully appreciate what*
2. *I go through so I think sometimes I challenged by them*
3. *they don't understand what what is actually going on in my*
4. *head just the small things that probably seem completely*
5. *insignificant to them are petrifying to me but um so you're*
6. *literally I think you feel you do feel like you're coming out*
7. *and you you by yourself you're all alone kind of thing and*

8. it it’s I think it’s everyone kind of thinks you know that you
9. put the weight on in the hospital you’ve got up to a
10. healthier weight you’ve got to a healthy BMI you must be
11. cured but I think it’s it’s when you leave hospital that the
12. hard work actually really does start and um I don’t think
13. you’re ever fully prepared for that big step

1. I was lucky enough that because I hadn’t had the
2. Eating Disorder for long I could remember what how
3. happy I was before I could remember my personality
4. before and that’s what I wanted back you know I suppose
5. it’s my parents always say we’ve lost you um wish we had
6. the old Sally back it really really hurts me everytime they
7. say it it was only recently that I’ve just actually just said
8. look please don’t say that to me because I know that I’m
9. fully aware that I’m not the same person it’s not
10. intentionally obviously I want to kind of get back to you
11. know being the bubbly person who was always up for a
12. laugh kind of thing but
JM I was hearing that you wanted to be slightly different
1. from the old Sally?
2. S Um in a way yeah I wanted to be more ambitious and
3. take more risks and be a bit more spontaneous but I
4. wanted just the I didn’t want my you know I would joke
5. about I would um (slight hesitation) I would always be up

for a laugh.
JM Your mood was different?
S Yeah yeah I’m lot more irritated at the moment I get a lot more snappy a lot more defensive um and it is it is

Noticeable

Institution

Um I think it's a much bigger step than I ever thought it would be I suppose I had probably given me I was probably given a false sense of security because I went towards the end of my inpatient stay I did a lot I took a lot of home leave so I ended up probably being at home five days of the week and then just going back to hospital for two days but then being discharged and being at home fully and no knowing knowing that you're not for going back for that support and that structure is very difficult

1. y
2. c
can ur

it doesn’t it doesn’t fully prepare you for it when you’re kind of out on your own for the whole time like you can’t go back there and ask for support or go back there and say actually I did struggle with this I worried about this and things like that you don’t have that reassurance to know that you are going back to that *a lot of patients that especially when I was there I think I was the only one to go to full recovery a lot of people just go to maintenance um and they don't encourage people to they pretty much ask people what they want to do and that's that and I mean I felt like I suppose because I went to full recovery I was probably given a lot more support but then towards the end of my stay I think they they concentrate on understandably so they concentrate on the new patients that are coming in who are very severely ill but they'd forget about kind of helping you and getting you adapted to when you do leave um they almost just to get to a point where like just get you up to your weight and we'll send you home kind of thing that's kind of what I felt when I was there*

Sal

but it did get to a point where you kind of just think well what am I doing here yeah like there not I'm not I wasn't participating in any of the groups because I didn't find them useful towards the end um I was put on low support so I didn't even need to be eating with any members of staff um so it did get to a point where I was just thinking what am I doing here and then it felt towards the end like they're kind of just trying *to get you out because they’ve got people that want that they need to come in um*

JM *Did that sound like a bit of an unsaid message, like they didn’t actually say it?*

S *Yeah it was (speaking over)*

JM *It was sort of covered up, but you sensed it?*

S *Yeah absolutely and I think you kind of start to resent them so I think it was you know you go you start it was like the therapist that I saw you know I had a lot of sessions when I was there and then towards the end she was just like well I think we’ve covered everything so you know there’s probably just about time that you were discharged it’s kind of ended on the right thing but you know I suppose you can cover things in those sessions but I don’t think it’s ever going to fully um (short pause) cure what the problem problems are or you know I’d always had problems with communication and you know we’d talk about that but as soon as I was properly discharged and everything it’s because it’s so overwhelming you kind of go back down into your your usual manners of coping*

Sal

JM *What would you have liked?*

S *Um (short pause) probably just more (short pause) truthful information about what it’s going to be like when you leave um maybe a bit of reassurance that ok if if things do start to go wrong you can still call us for you know problems or*

6. *support or advice but um*

Sal

1. *I think I think it's maybe just the*
2. *fact that I don't I don't feel like an hour a week just to talk*
3. *through problems is enough (quietly said), especially at*
4. *the beginning you know because you can what I found is*
5. *you know that I can leave here after seeing X (nurse) and*
6. *feel great you know she'll make me feel like ok it's not the*
7. *end of the world you can do this and then I can go home*
8. *and then and have an argument with my parents or face a*
9. *different struggle and then the next day can be the worst*
10. *day of the week and then after that can be an alright day so*

when you come back in after a week there's so much to

1. *cover so many different things that that on that day when*
2. *go back in like you might feel good again you know so you*
3. *don't really want to go over all the crap days that you've*
4. *had I think a lot can happen in a week that you can't cover*
5. *in an hour*

Sal

Family/carers/peers

1. S *Um I never really had that closer friendships when I was*
2. *at X (County) anyway I kind of just keep in touch with*
3. *probably one person um who is my best friend um but I do*
4. *keep in contact with quite a few people I did meet in*

hospital um but you do get to know when you're in there

1. *who's going to be a positive influence and who's not*
2. *so you you do you're very wary and you kind of you build*
3. *friendship based on those that you know are going to be*
4. *helpful to you and not kind of push you in the other way um so*
5. *but but having those friendships are key for me cause if I do*
6. *have any struggles you can talk to them and you know they*
7. *fully understand what you're going through (slight laugh) so*
8. *that's really nice like have one girl who I speak to literally*
9. *every day um so that means a lot to me but that there is still*
10. *someone that I can talk to if I need it that that can still give*
11. *you the push and go come on you know you need to do it just*
12. *have what you want have what you like you can do it um so*
13. *that's that's important for me but it still doesn't give you that*

that break

Sally:18,14-18, 19,1-14

1. just I would take things
with a pinch of salt rather than immediately thinking it's
an attack I think that's at the moment I suppose it's
2 more so cause I just think you know am I ever going to be
able to do something that people don't equate um to it being

eating disorder related you know I'd do things before I was
ill and yet if I do that now 'why are you doing that?' 'Well
that's got be down to that's got to be down to the eating
disorder that' that's what I feel with everything
I do is eating disorder related and I can't have that I'm
not Sally I'm Sally with an eating disorder and I think
that's what I struggle
with

JM *And is that your perception or is it your family's*
perception or other people's perception

S *Um [slight stutter] it is probably my perception but that*
is how it does feel to me sometimes you know other people
can eat you know my brother eats round his plate no
one will question it, if I eat round my plate well
why are you doing that, it's like well it's kind of like I
can understand it but then you just think is there
*2.ever going come a time where you **don't** kind of relate it*
3. to that or just let it go and know that ok maybe that's
4. (short pause) fine

Sally: 31, 16-17, 32,1-17, 33,1-4

1. so my parents decided that they would move up here
2. um to kind of help me out um and so I moved back in with
3. them um cause they work from home so so there was
4. always going to be someone around um all the meals they

5. *would always have the same meals as me um at the same*
6. *time and that really helped at first that was kind of that*
7. *was good to have that structure it was nice to know that*
8. *they were doing that for me um but in terms of kind of*
9. *support elsewhere it was it wasn't I wasn't really sure*

what I was going to get I suppose (short pause

Sally: 35, 3-12

1. JM *Can you say a little bit about that 'escape' sense sounds*
2. *like it's very powerful*
3. S *Yeah it's just no one treats me any differently because of I*
4. *suppose you know my parents and that they kind of tip toe*

around

Sally:20,5-9

Recovery

S Um I suppose when I was in hospital it was just like when I
11 did start coming home at the weekend just spending time with
my parents going out shopping for my mum doing little things
with [boyfriend] um it was just everything you take for
granted like going out for coffee with your mum you know when

you're out shopping just going 'do you want to for a coffee? *it's*

1. *still it's still tough but needing to do it now you know if me*

and [boyfriend] were out and he goes do you just want to go for

3. *a coffee and cake or something'? it's like yeah ok it's like*
4. *normal just things that people take for granted that you want*
5. *back and you try and get that normality back.*

Sally:11, 10-16, 12, 1-5

it was just to get a new job cause I'd always I'd worked for my parents and I was never Happy
there um it was kind of just the easiest option for me I'd always gone for the easiest option and never put myself out there never taken a risk I was kind of wrapped up in cotton wool by my parents I never had to do anything I didn't want to do and I think it was to literally just push myself to take some risks and challenge myself and as I say just try and find a new job that I liked um just the simple things really that you kind of take for granted

Sally:10,16-17, 11,1-8

1. *I (hesitation)suppose work is the only place where*
2. *no one knows anything and that was that was why that was so*
3. *important to me it was so nice to go somewhere and people*

support f
people

know me for Sally cause

1. *everywhere else probably just you know oh Sally she's go an*
2. *Eating Disorder she's got you know but they don't know*
3. *anything at work and that's my kind of safety it's like it's my*

used

escape I suppose

Sally:19,14-17, 20,1-4

the experience of a recovery talk allowed a sense of possibility

1. S *Um just seeing that actually it is possible you know*
2. *seeing how happy these people were um the kind of battles*
3. *that they'd gone through some worse than what I had and*
4. *they had come out the other end and they are not fixated*
5. *by food they obviously they're living happy healthy life*
6. *where they can just go and have a take away and not think*
7. *too much about it or just just the normal things that I want*
8. *to do and they were doing it they were proof that recovery is possible*

vision for

used

Sally:29,9-17

context Sally is talking about the two types of recovery, mental and weight restoration

1. S *Yeah I think it's a gap for a lot of people or I think I*
2. *think they concentrate more on getting your weight up and*
3. *they don't fully deal with the mental side of it because the*
4. *mental side of it is the paramount it's the it's the main*
5. *problem I suppose it's all in the head and I don't think they*
6. *do do enough support for that.*
7. JM *Is there something else psychologically you would have*
8. *wanted to do whilst an inpatient or do you think it needed*
9. *to be done as an outpatient?*

S *Um (Long pause) I don't know really probably a bit of* *both*

1. JM *I was wondering if in their terms inpatient service*
2. *terms actually you were a model patient?*
3. S *Probably because I was the one that went to full*
4. *recovery and they didn't know and as I say no one else at*
5. *that time they had had a few people that*

were

6. *readmissions and a lot of people that just discharged*
7. *themselves too early because they can't stick it there any*
8. *more er people that they don't want to get better that they*
9. *kind of give up on so the fact that it was my first admission*
10. *I'd gone in there I'd literally taken on everything that they*
11. *thrown at me they knew I wanted to get better um they*
12. *knew I wanted to get to full recovery um and that I was*
13. *willing to do stay there for as long as I need to to make*
14. *sure that you know I always said that I didn't want to leave*
15. *too early cause I didn't want to go back there um so yeah*

yes in a way I was you know they did praise me for those
kind of things. (slight laugh

Sally:26, 8-17, 27, 1-17, 28,1

Appendix L

Theme frequency table

This table shows the themes and the frequency in which the themes were observed across the participants.

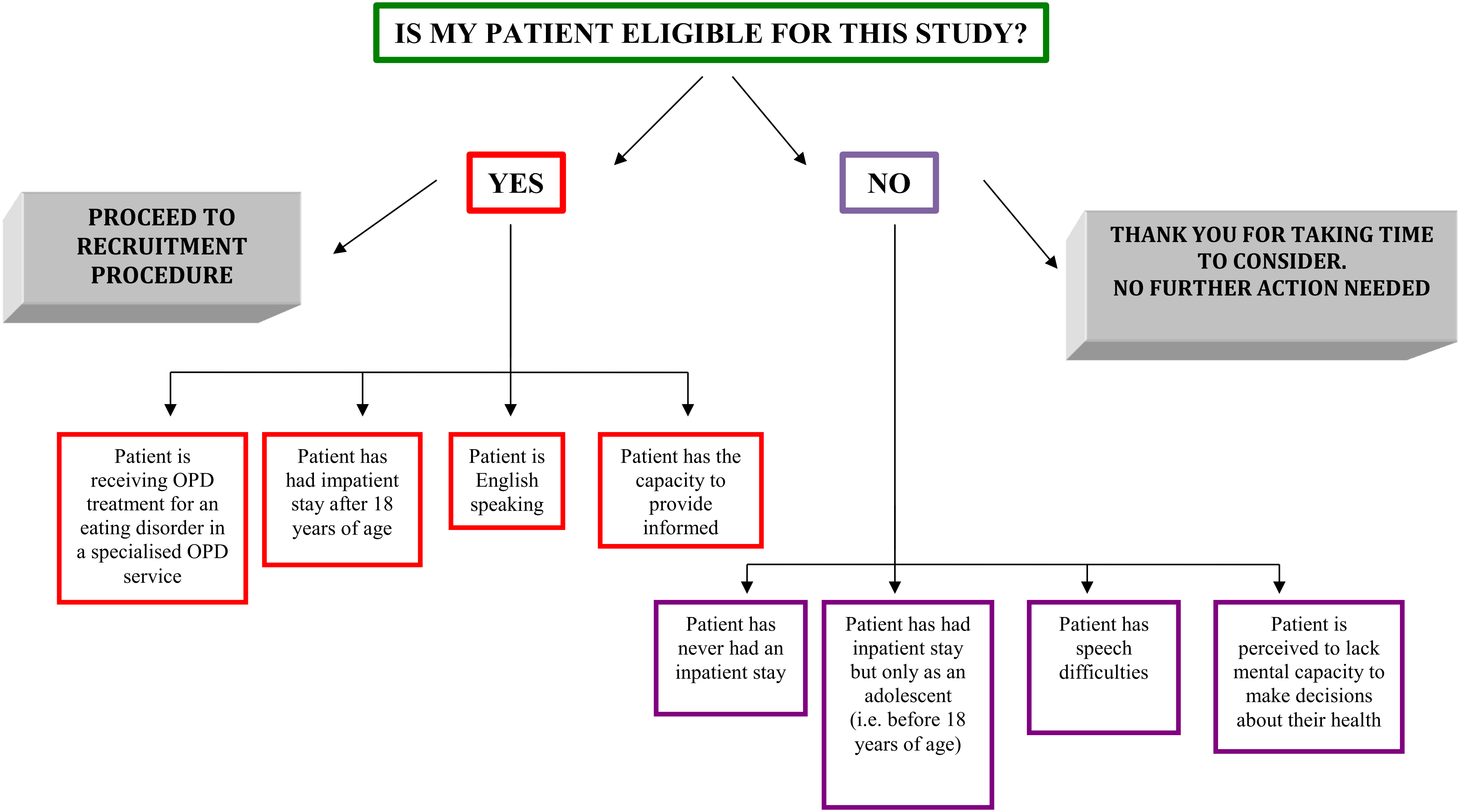
Living with ambivalence and conflict	**Ambivalence and confusion**		
Sally	Confusion	28,4-13 36,2-17,1-17	
Nicola	Confusion	22,13-17, 23,1-8	
Kay	Confusion	6,8-18, 7,1-8 7,12-17, 8,1-14 34,5-16, 35,1-10	
Alice	Confusion	6,12-17, 7,1-17, 8,1-17 40,12-17,41,1-17, 42,1-5 24,4-17, 25,1-2 29,8-17, 31,1-9 38,17, 39,1-17	
Gail	Confusion	5,14-18 24,6-14 30,14-16, 31,1-8	
Lara	Confusion	9,4-11 9,12-16, 10,1-3 36,12-16,	
Lara	Confusion	37,1-4 11,10-16 12,3-8	
	Shamefulness of ambivalence		
Sally	Shame	10,4-14 38,12-17 39,1-15	
Nicola	Shame	31,8-17 32, 1 and 6-9 4,6-15 5,1-6	
Kay	Shame	8,16-17	

		9,1-10 10,12-17 11,1-17 12,1-17 13,1-14 20,4-16 28,6-18 29,1-9	
Alice	Shame	40,2-10	
Gail	Shame	27,17 28,1-15 41,15-16 42,1-3 42,12-17 43,1-5 34,13-16 35,1-16 36,1-2	
Lara	Shame	32,15-16 33,1-16 34,1-3 6,10-16 7,1-9	
Lara	Shame	23,6-16 24,1-12 20,4-12 4,3-15 7,13-17 8,1-3	
	Struggle with conflict and the struggle with ambivalence		
Alice	Conflict with others	32,17 33,1-17 34,1-14	
Lara	Conflict with others	11,5-10 8,8-12 2,13-17 3,1-16 21,1-18	
Nicola	Conflict with others	32,16 33,1-17 27,14-16 28,1-8 21,6-16 22,1-5	
Sally	Conflict with	5,10-18	

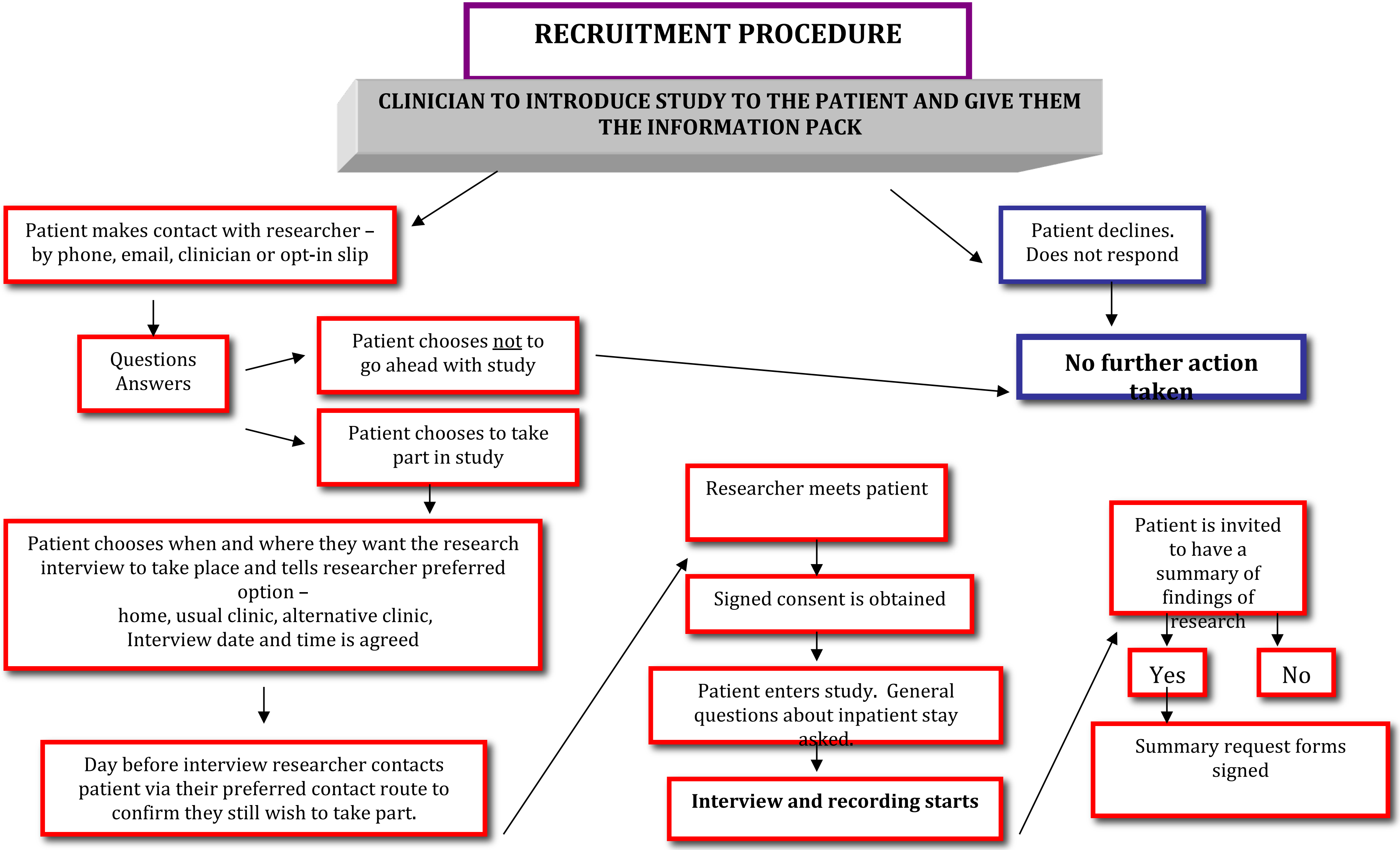
	others	6,1-17 7,1-3	
Kay	Conflict with others	29,15-17 30,1-17 31,1-9	
	Conflict with the self		
Lara		29,13-16 30,1-5 15,1-15 16,2-11	
Lara	Conflict with the self	28,1-16 29,1-7 13,8-16 14,1-13 18,15-18 19,1-5	
Nicola	Conflict with the self	22,6,6-12 43,3-17 44,1-8 2,16 3,1-17 4,1-3	
Sally	Conflict with the self	16,17 17,1-17	
Kay	Conflict with the self	26,9-17 27,1-17 28,1-5	
Living in Recovery			
	Disconnecting from inpatient treatment and help		
Alice	Disconnecting	1,3-17 2,1-7 16,11-17 17,1-17 20,9-17 21,1-8 21,9-18 22,1-3	
Kay	Disconnecting	33,4-17 34,1-4 31,11-17,32,1-6, 22,1-15	

Sally	Disconnecting	2,14-17 3,1-13 1,5-16 25,1-6 4,2-15 7,4-9	
Gail	Disconnecting	13,13-18 14,1-8 24,15-17 25,1-11 7,15-17 8,1-7	
Nicola	Disconnecting	13,14-17 14,1-8 2,3-12	
Lara	Disconnecting	5,11-18 6,1-7 10,15-16 11,1-2	
	Harnessing support on discharge from hospital		
Alice	Harnessing support	35,17 36,1-17 38,6-17 10,1-17 11,1-17 37,2-15	
Gail	Harnessing support	11,2-14 11,12-17 12,1-11 13,1-12 39,13-17	
Gail	Harnessing support	40,1-5 30,4-12	
Nicola	Harnessing support	6,14-16 7,1-16 8,1-6 26,2-17 27,1-7 36,7-16 37,1-16 38,1-17	
Sally	Harnessing support	19,14-17 20,1-4	

		20,5-9 18,14-18 19,1-12 35,3-12 10,16-17 11,1-8 29,9-17	
Kay	Harnessing support	20,17 21,1-13	
	Working towards a vision of the recovered self		
Nicola	Vision of self	8,9-17 9,1-16 5,10-16 6,1-10	
Lara	Vision of self	34,9-14	
Alice	Vision of self	5,12-18 6,1-9 46,9-17 47,1-7 42,16-17 43,1-17	
Alice	Vision of self	44,1-17	
Sally	Vision of self	11,10-16 12,1-5 26,8-17 27,1-17 28,1	
Gail	Vision of self	5,2-11 20,10-17 21,1-10	
Kay	Vision of self	35,16-17 36,1-15	


IS MY PATIENT ELIGIBLE FOR THIS STUDY?
YES
NO
PROCEED TO RECRUITMENT PROCEDURE
THANK YOU FOR TAKING TIME TO CONSIDER.
NO FURTHER ACTION NEEDED
Patient is receiving OPD treatment for an eating disorder in a specialised OPD service
Patient has had impatient stay after 18 years of age
Patient is English speaking
Patient has the capacity to provide informed
Patient has never had an inpatient stay
Patient has had inpatient stay but only as an adolescent (i.e. before 18 years of age)
Patient has speech difficulties
Patient is perceived to lack mental capacity to make decisions about their health

RECRUITMENT PROCEDURE



CLINICIAN TO INTRODUCE STUDY TO THE PATIENT AND GIVE THEM THE INFORMATION PACK

Patient makes contact with researcher – by phone, email, clinician or opt-in slip

Questions
Answers

Patient chooses not to go ahead with study

Patient chooses to take part in study

Patient chooses when and where they want the research interview to take place and tells researcher preferred option –
home, usual clinic, alternative clinic,
Interview date and time is agreed

Day before interview researcher contacts patient via their preferred contact route to confirm they still wish to take part.

Researcher meets patient

Signed consent is obtained

Patient enters study. General questions about inpatient stay asked.

Interview and recording starts

Patient is invited to have a summary of findings of research

Yes

No

Summary request forms signed

Patient declines.
Does not respond

No further action taken

Appendix N

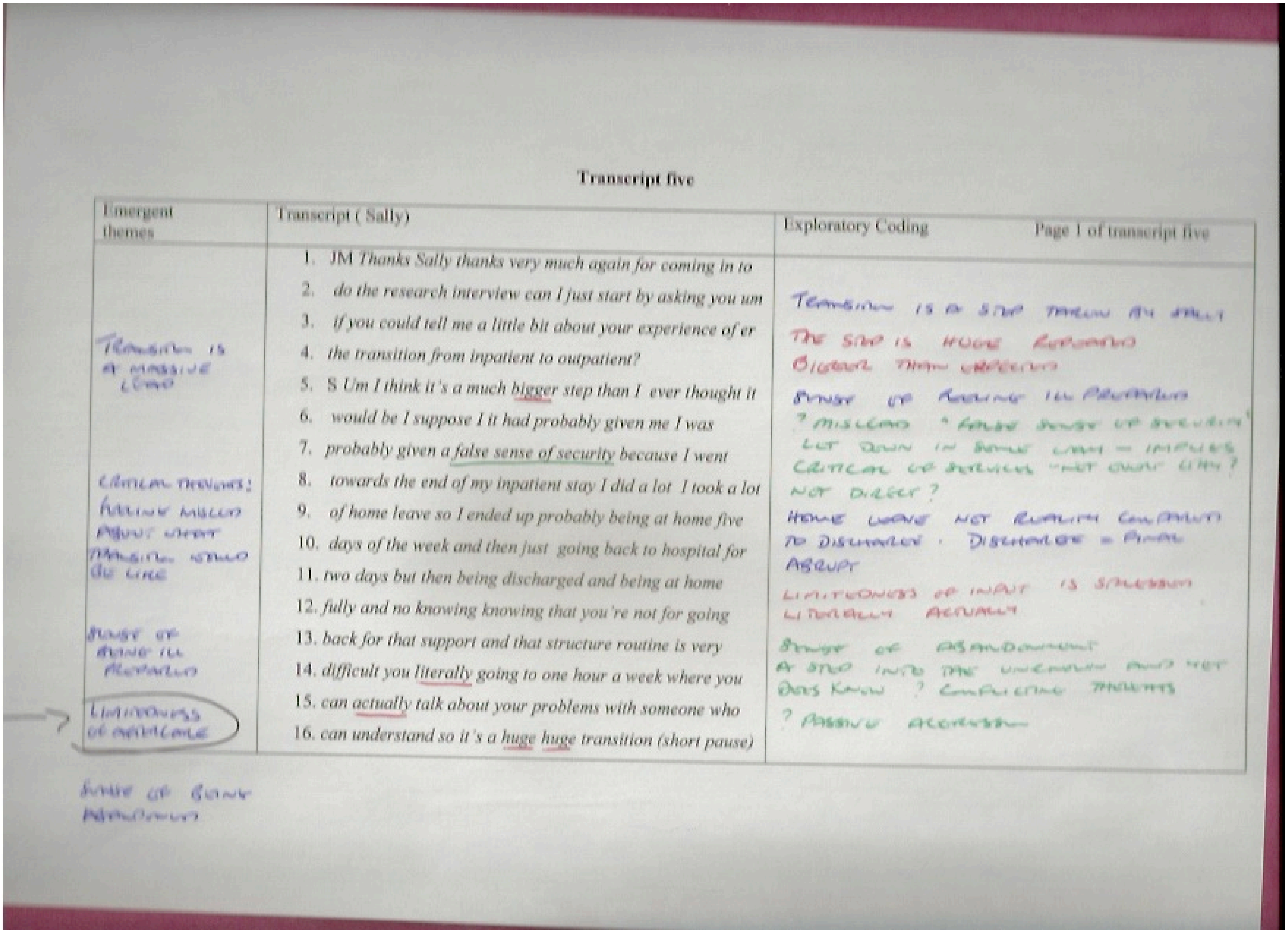
Annotated Transcript for Sally

Colour code

Blue – descriptive comments

Red – linguistic comments

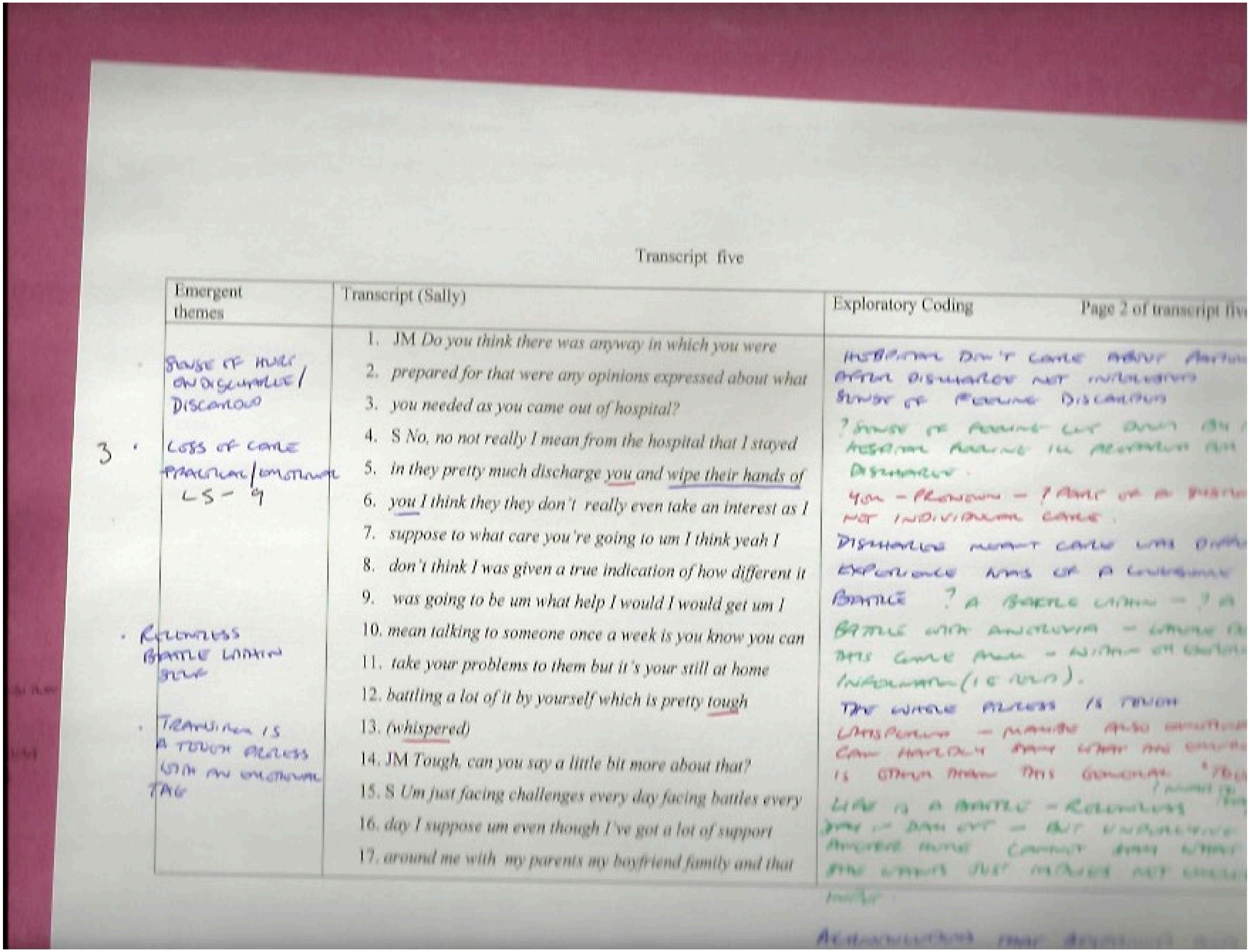
Green – conceptual comments



Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 1 of transcript five
	1. JM *Thanks Sally thanks very much again for coming in to*	
	2. *do the research interview can I just start by asking you um*	TRANSITION IS A STEP TAKEN BY SALLY
TRANSITION IS A MASSIVE LEAP	3. *if you could tell me a little bit about your experience of er*	THE STEP IS HUGE REGARDED
	4. *the transition from inpatient to outpatient?*	BIGGER THAN EXPECTED
	5. S *Um I think it's a much bigger step than I ever thought it*	SENSE OF FEELING ILL PREPARED
	6. *would be I suppose I it had probably given me I was*	? MISLEAD 'FALSE SENSE OF SECURITY'
	7. *probably given a false sense of security because I went*	LET DOWN IN SOME WAY – IMPLIES CRITICAL OF SERVICES "NOT OWN" WAY?
CRITICAL THOUGHTS: FEELING MISLED ABOUT WHAT TRANSITION WOULD BE LIKE	8. *towards the end of my inpatient stay I did a lot I took a lot*	NOT DIRECT?
	9. *of home leave so I ended up probably being at home five*	HOME LEAVE NOT REALISTIC COMPARED
	10. *days of the week and then just going back to hospital for*	TO DISCHARGE. DISCHARGE = FINAL ABRUPT
	11. *two days but then being discharged and being at home*	LIMITEDNESS OF INPUT IS STRESSED
	12. *fully and no knowing knowing that you're not for going*	LITERALLY ACTUALLY
SENSE OF BEING ILL PREPARED	13. *back for that support and that structure routine is very*	SENSE OF ABANDONMENT
	14. *difficult you literally going to one hour a week where you*	A STEP INTO THE UNKNOWN AND YET DOES KNOW ? CONFLICTING THOUGHTS
LIMITEDNESS OF AFTERCARE	15. *can actually talk about your problems with someone who*	? PASSIVE ACCEPTANCE
	16. *can understand so it's a huge huge transition (short pause)*	

SENSE OF BEING ABANDONED

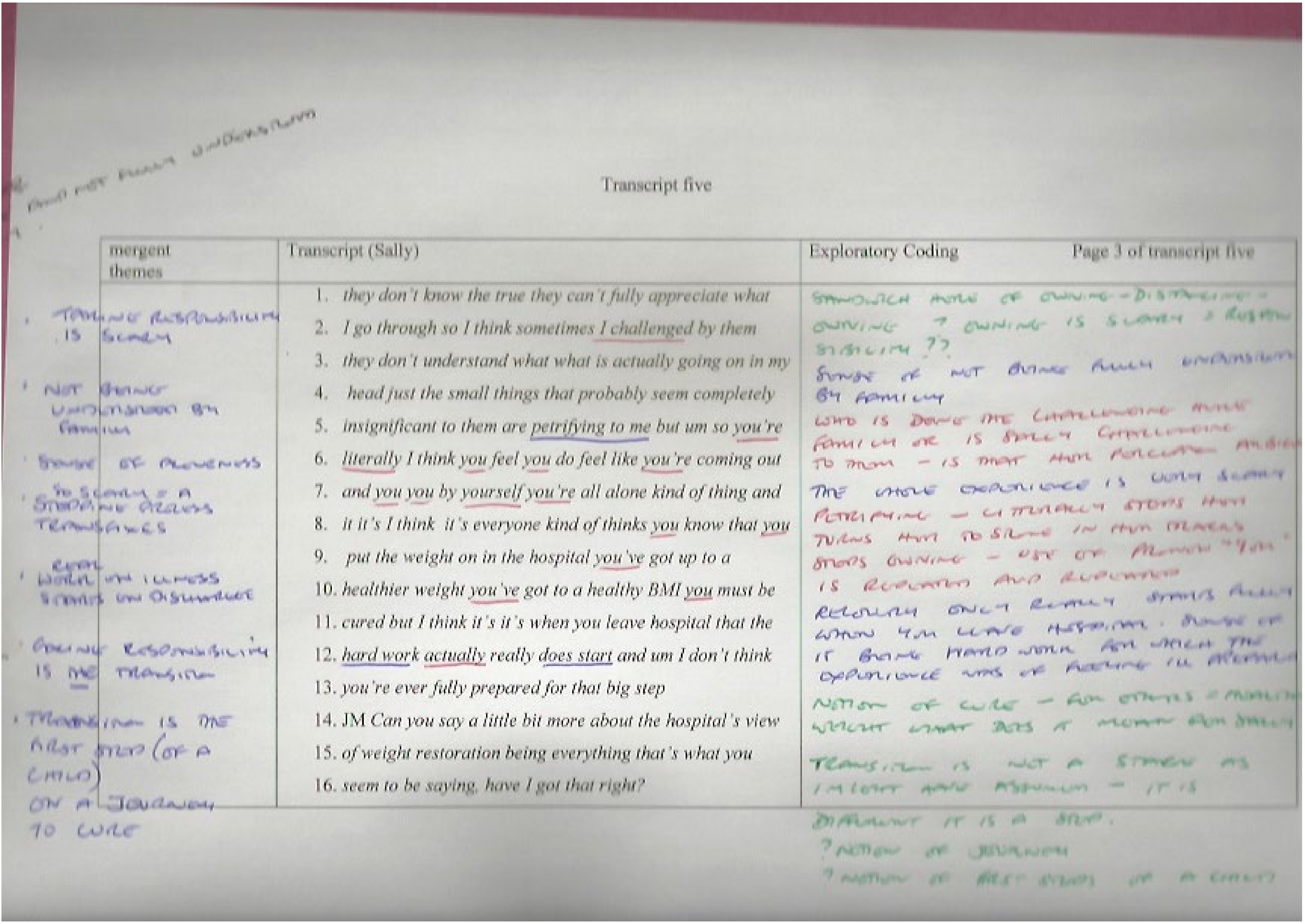


Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 2 of transcript five
	1. JM *Do you think there was anyway in which you were*	Hospital don't care about [illegible]
Sense of hurt on discharge /	2. *prepared for that were any opinions expressed about what*	after discharge not interested
Discarded	3. *you needed as you came out of hospital?*	Sense of feeling discarded
3 · Loss of care	4. S *No, no not really I mean from the hospital that I stayed*	? Sense of feeling cut down by [illegible] hospital feeling ill prepared for
practical/emotional	5. *in they pretty much discharge you and wipe their hands of*	discharge.
L5 – 9	6. *you I think they they don't really even take an interest as I*	You – pronoun – ? part of a system not individual care.
	7. *suppose to what care you're going to um I think yeah I*	Discharge meant care was [illegible]
	8. *don't think I was given a true indication of how different it*	experience was of a challenge
	9. *was going to be um what help I would I would get um I*	Battle ? a battle within – ? a
· Relentless battle within self	10. *mean talking to someone once a week is you know you can*	battle with anorexia – [illegible]
	11. *take your problems to them but it's your still at home*	this care and – within oneself information (i.e. [illegible]).
	12. *battling a lot of it by yourself which is pretty tough*	The whole process is tough
· Transition is a tough process	13. *(whispered)*	Whispered – maybe also emotional
with an emotional tag	14. JM *Tough, can you say a little bit more about that?*	can hardly say what [illegible] is other than this general [illegible]
	15. S *Um just facing challenges every day facing battles every*	Life is a battle – relentless
	16. *day I suppose um even though I've got a lot of support*	day in day out – but [illegible]
	17. *around me with my parents my boyfriend family and that*	[illegible] [illegible] cannot say what she wants just [illegible] [illegible]

[illegible]

Acknowledges that [illegible]



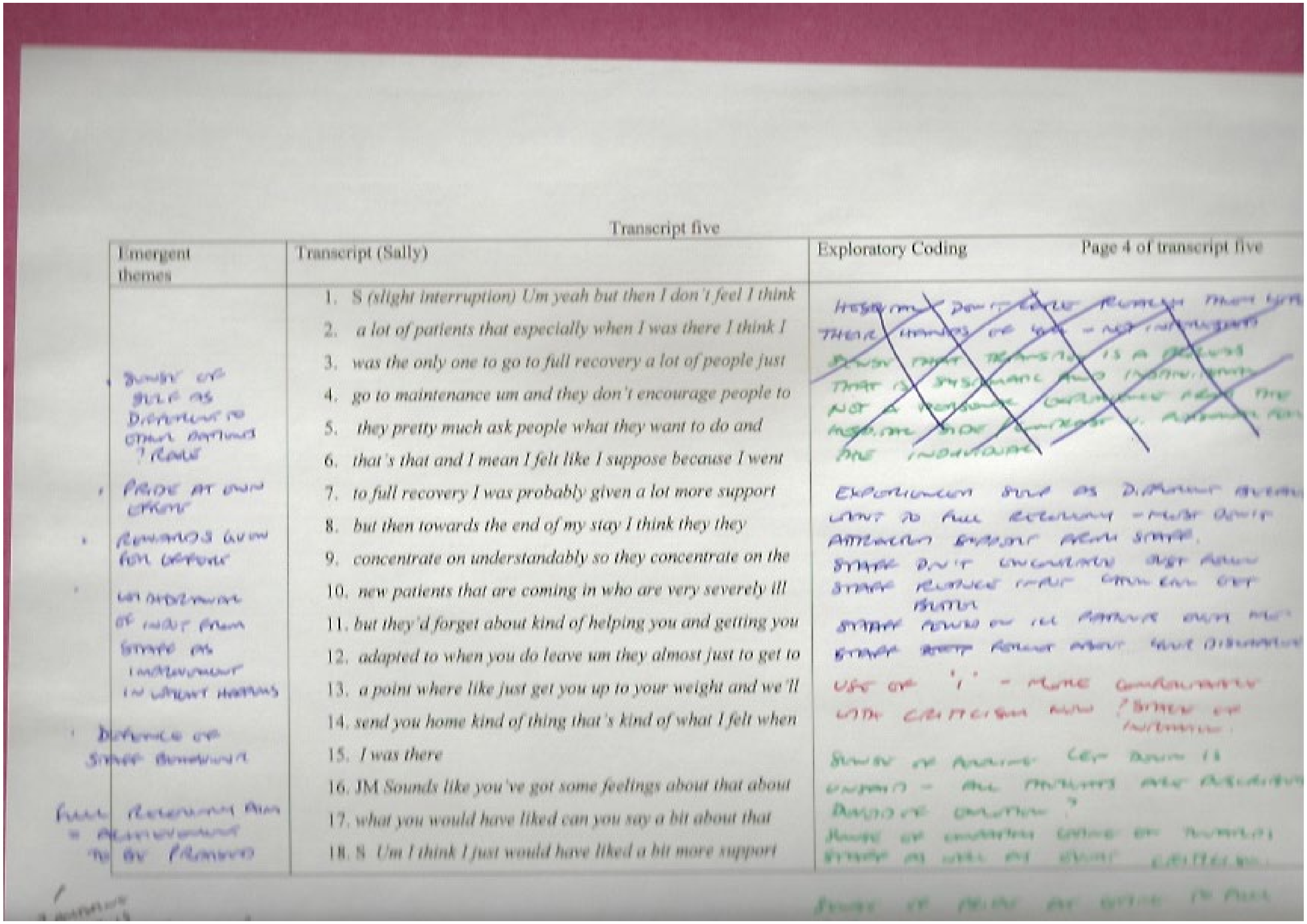
AND NOT FULLY UNDERSTOOD

Transcript five

mergent themes	Transcript (Sally)	Exploratory Coding Page 3 of transcript five
· TAKING RESPONSIBILITY IS SCARY	1. *they don't know the true they can't fully appreciate what* 2. *I go through so I think sometimes I challenged by them*	SANDWICH ROLE OF OWNING – DISTANCING – OWNING → OWNING IS SCARY → PUSHING SIBLING ??
· NOT BEING UNDERSTOOD BY FAMILY	3. *they don't understand what what is actually going on in my* 4. *head just the small things that probably seem completely* 5. *insignificant to them are petrifying to me but um so you're*	SENSE OF NOT BEING FULLY UNDERSTOOD BY FAMILY WHO IS DOING THE CHALLENGING HERE FAMILY OR IS SALLY CHALLENGING TO THEM – IS THAT HER PERCEPTION AMBIG
· SENSE OF ALONENESS	6. *literally I think you feel you do feel like you're coming out*	THE WHOLE EXPERIENCE IS VERY SCARY
· SO SCARY = A STEPPING ACROSS TRANSITIONS	7. *and you you by yourself you're all alone kind of thing and* 8. *it it's I think it's everyone kind of thinks you know that you*	PETRIFYING – LITERALLY STOPS HER TURNS HER TO STONE IN HER TRACKS STOPS OWNING – USE OF PRONOUN "YOU" IS REPEATED AND REPEATED
· EVEN WORK IN ILLNESS STARTS ON DISCHARGE	9. *put the weight on in the hospital you've got up to a* 10. *healthier weight you've got to a healthy BMI you must be* 11. *cured but I think it's it's when you leave hospital that the*	RECOVERY ONLY REALLY STARTS FULLY WHEN YOU LEAVE HOSPITAL. SENSE OF IT BEING HARD WORK FOR WHICH THE EXPERIENCE WAS OF FEELING ILL PREPARED
· OWNING RESPONSIBILITY IS THE TRANSITION	12. *hard work actually really does start and um I don't think* 13. *you're ever fully prepared for that big step*	NOTION OF CURE – FOR OTHERS = HEALTHY WEIGHT WHAT DOES IT MEAN FOR SALLY
· TRANSITION IS THE FIRST STEP (OF A CHILD) ON A JOURNEY TO CURE	14. JM *Can you say a little bit more about the hospital's view* 15. *of weight restoration being everything that's what you* 16. *seem to be saying, have I got that right?*	TRANSITION IS NOT A STAGE AS I MIGHT HAVE ASSUMED – IT IS DIFFERENT IT IS A STEP.

? NOTION OF JOURNEY

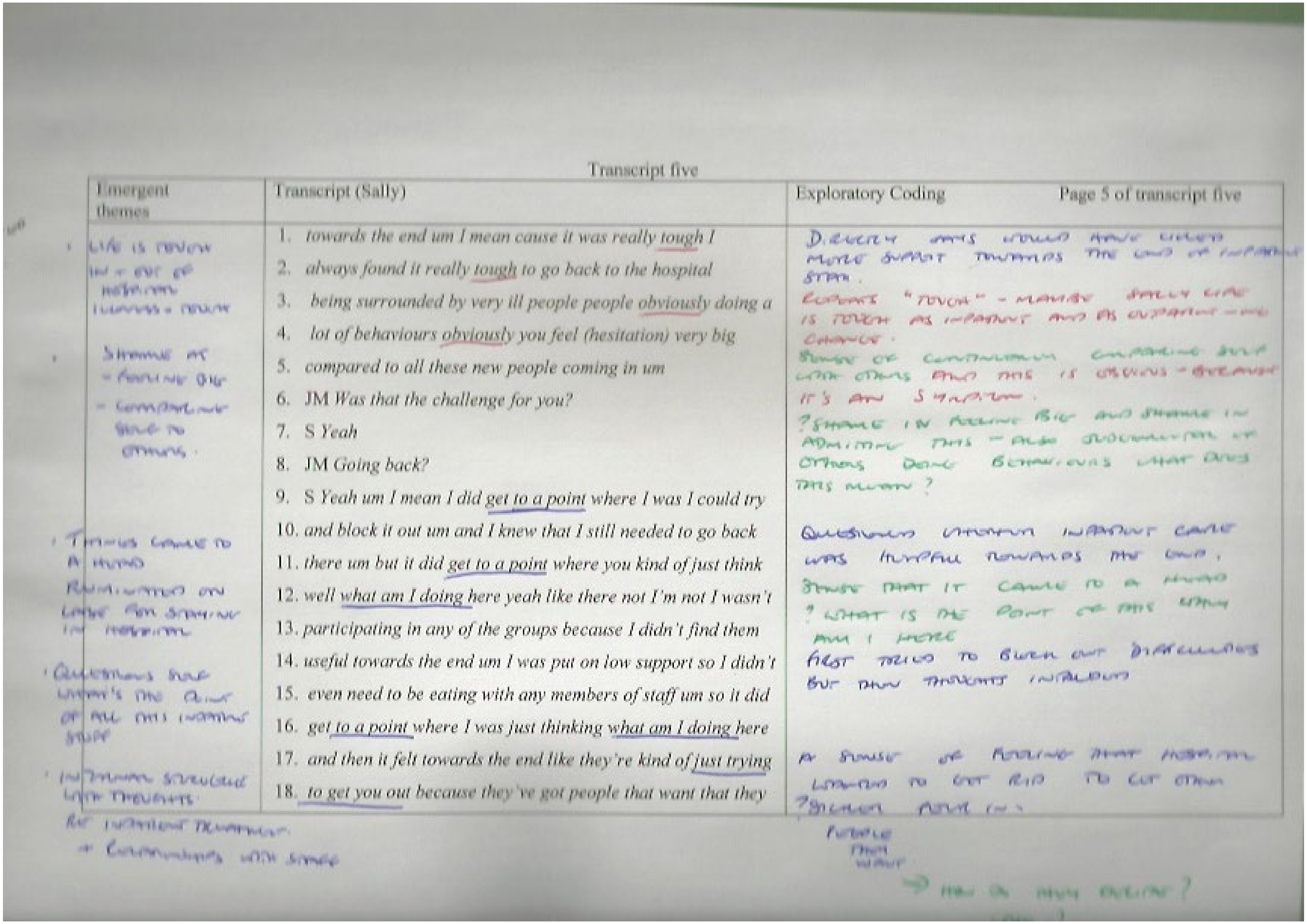
? NOTION OF FIRST STEPS OF A CHILD



Transcript five

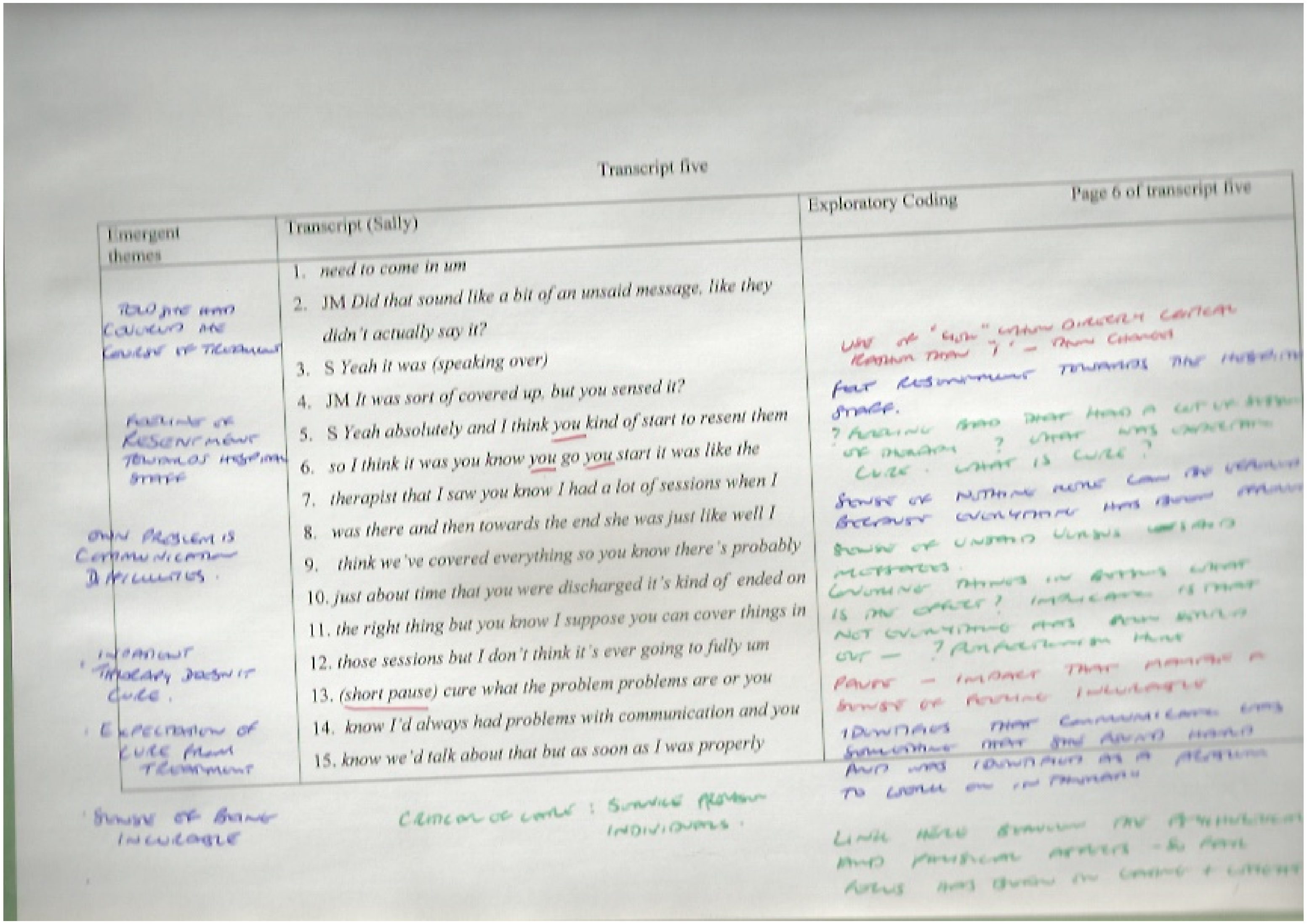
Emergent themes	Transcript (Sally)	Exploratory Coding Page 4 of transcript five
	1. S *(slight interruption) Um yeah but then I don't feel I think*	~~Hesitancy? Don't [illegible] [illegible] their [illegible] hands of [illegible] - not [illegible]~~
	2. *a lot of patients that especially when I was there I think I*	~~Shows that transition is a process that is [illegible] and [illegible] not a [illegible] [illegible] from the [illegible] [illegible] [illegible] the individual~~
· Sense of self as different to other patients ? Role	3. *was the only one to go to full recovery a lot of people just*	
	4. *go to maintenance um and they don't encourage people to*	
	5. *they pretty much ask people what they want to do and*	
	6. *that's that and I mean I felt like I suppose because I went*	
· Pride at own effort	7. *to full recovery I was probably given a lot more support*	Experience seen as different because went to full recovery - must have attracted support from staff.
· Rewards given for effort	8. *but then towards the end of my stay I think they they*	Staff don't encourage but allow staff [illegible] [illegible] [illegible] [illegible] better
	9. *concentrate on understandably so they concentrate on the*	
· Unawareness of input from staff as involvement in weight [illegible]	10. *new patients that are coming in who are very severely ill*	Staff focus on ill patients even though staff forget about their discharge
	11. *but they'd forget about kind of helping you and getting you*	
	12. *adapted to when you do leave um they almost just to get to*	
	13. *a point where like just get you up to your weight and we'll*	Use of 'I' - more comfortable with criticism now ? sense of independence.
· Defence of staff behaviour	14. *send you home kind of thing that's kind of what I felt when*	
	15. *I was there*	Sense of feeling let down is evident - all patients are [illegible] [illegible] of [illegible]?
Full recovery aim = achievement to be praised	16. JM *Sounds like you've got some feelings about that about*	[illegible] of [illegible] [illegible] of [illegible] staff as well as [illegible] criticism.
	17. *what you would have liked can you say a bit about that*	
	18. S *Um I think I just would have liked a bit more support*	

Sense of pride at being in full



Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 5 of transcript five
Life is tough in + out of hospital illness = tough	1. *towards the end um I mean cause it was really tough I*	Directly says would have liked more support towards the end of inpatient stay.
	2. *always found it really tough to go back to the hospital*	Repeats "tough" - maybe Sally life is tough as inpatient and as outpatient - no change.
	3. *being surrounded by very ill people people obviously doing a*	
	4. *lot of behaviours obviously you feel (hesitation) very big*	
Shame at - feeling big - comparing self to others.	5. *compared to all these new people coming in um*	Sense of comparison comparing self with others and this is obvious - because it's an symptom.
	6. JM *Was that the challenge for you?*	?Shame in feeling big and shame in admitting this - also judgemental of others doing behaviours what does this mean?
	7. S *Yeah*	
	8. JM *Going back?*	
	9. S *Yeah um I mean I did get to a point where I was I could try*	
Things came to a head	10. *and block it out um and I knew that I still needed to go back*	Questions whether inpatient care was helpful towards the end.
Ruminated on life for staying in hospital	11. *there um but it did get to a point where you kind of just think*	Sense that it came to a head ? what is the point of this why am I here
	12. *well what am I doing here yeah like there not I'm not I wasn't*	First tried to block out difficulties but then thoughts intruded
	13. *participating in any of the groups because I didn't find them*	
Questions self what's the point of all this inpatient stuff	14. *useful towards the end um I was put on low support so I didn't*	
	15. *even need to be eating with any members of staff um so it did*	
	16. *get to a point where I was just thinking what am I doing here*	
Internal struggle with thoughts re inpatient treatment + relationships with staff	17. *and then it felt towards the end like they're kind of just trying*	A sense of feeling that hospital wanted to get rid to get them ?quicker move in people than want
	18. *to get you out because they've got people that want that they*	→ How do they decide? [illegible]



Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding — Page 6 of transcript five
TOLD SHE HAD COVERED THE COURSE OF TREATMENT	1. *need to come in um* 2. JM *Did that sound like a bit of an unsaid message, like they didn't actually say it?* 3. S *Yeah it was (speaking over)* 4. JM *It was sort of covered up, but you sensed it?*	USE OF 'YOU' WHEN DIRECTLY CRITICAL RATHER THAN 'I' – THEN CHANGES
FEELING OF RESENTMENT TOWARDS HOSPITAL STAFF	5. S *Yeah absolutely and I think you kind of start to resent them* 6. *so I think it was you know you go you start it was like the* 7. *therapist that I saw you know I had a lot of sessions when I*	FELT RESENTMENT TOWARDS THE HOSPITAL STAFF. ? FEELING BAD THAT HAD A LOT OF SESSIONS OF THERAPY ? WHAT WAS CONCEPTION OF CURE. WHAT IS CURE ?
OWN PROBLEM IS COMMUNICATION DIFFICULTIES.	8. *was there and then towards the end she was just like well I* 9. *think we've covered everything so you know there's probably* 10. *just about time that you were discharged it's kind of ended on* 11. *the right thing but you know I suppose you can cover things in*	SENSE OF NOTHING MORE CAN BE VERBALISED BECAUSE EVERYTHING HAS BEEN COVERED SENSE OF UNSAID WORDS UNSAID METAPHORS. COVERING THINGS IN SESSIONS WHAT IS THE OFFER? IMPLICATION IS THAT NOT EVERYTHING HAS BEEN SORTED OUT — ? AMBIVALENCE HERE
· INPATIENT THERAPY DOESN'T CURE. · EXPECTATION OF CURE FROM TREATMENT	12. *those sessions but I don't think it's ever going to fully um* 13. *(short pause) cure what the problem problems are or you* 14. *know I'd always had problems with communication and you* 15. *know we'd talk about that but as soon as I was properly*	PAUSE — IMPACT THAT MAKING A SENSE OF FEELING INCURABLE IDENTIFIES THAT COMMUNICATION WAS SOMETHING THAT SHE AVOIDED HAVING AND WAS IDENTIFIED AS A PROBLEM TO WORK ON IN THERAPY

· SENSE OF BEING INCURABLE

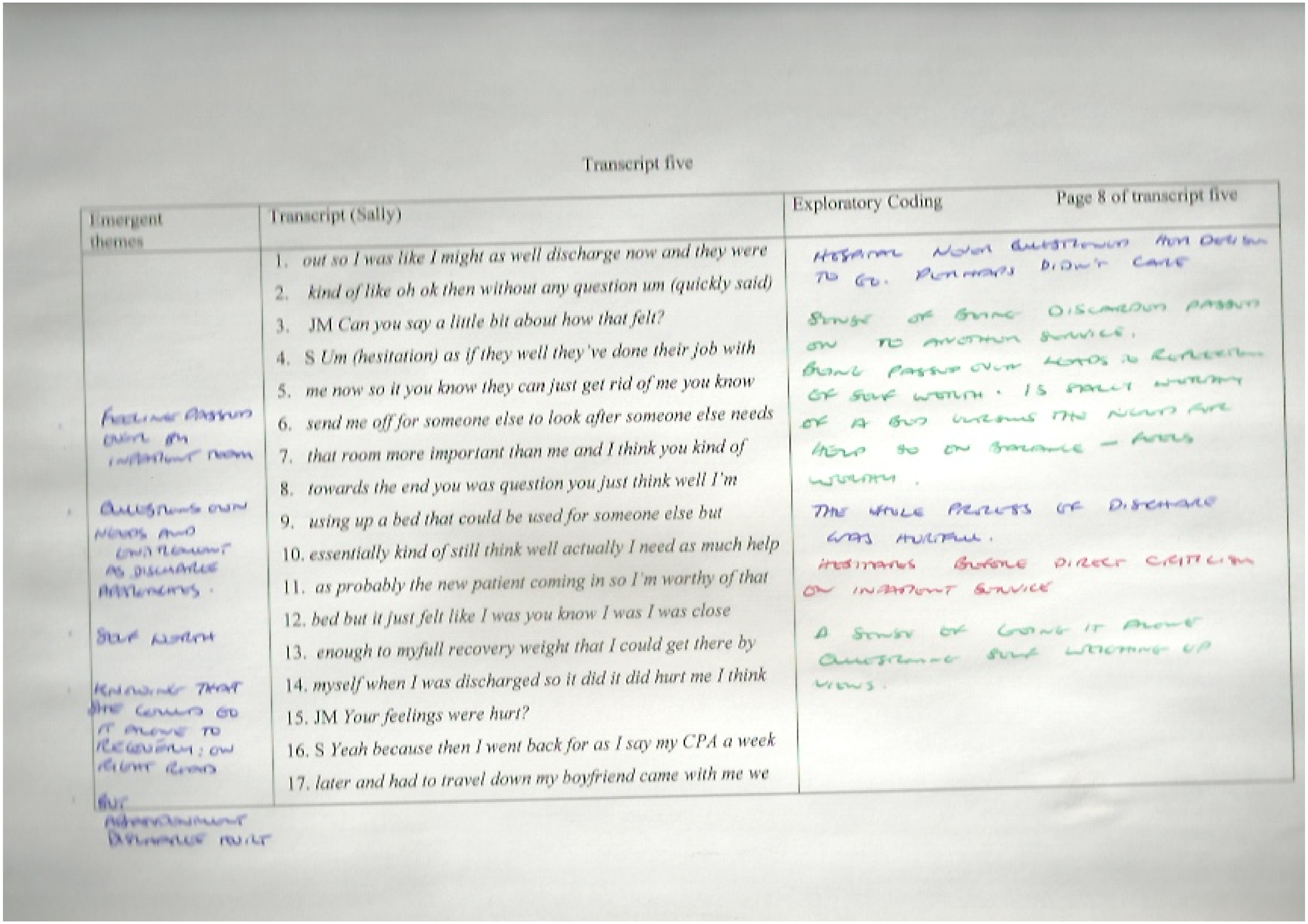
CRITICAL OF CARE : SERVICE FAILS INDIVIDUALS.

LINK HERE BETWEEN THE PSYCHOLOGICAL AND PHYSICAL ASPECTS - SO FAR FOCUS HAS BEEN ON EATING + WEIGHT

Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 7 of transcript five
OVERWHELMING FEELING LEADS TO OLD WAYS CREEPING BACK.	1. *discharged and everything it's because it's so overwhelming*	OLD WAYS CAN COME BACK AS A WAY OF COPING BECAUSE THE FEELING ON DISCHARGE IS OF BEING OVERWHELMED.
	2. *you kind of go back down into your your usual manners of*	
	3. *coping and that's not*	PERSONAL PRONOUN "YOU" – CANNOT OWN INTENSE FEELINGS FOR HERSELF – SO [illegible]
	4. JM *What would you have liked?*	PAUSES ? BECAUSE IT'S DIFFICULT TO SAY WHAT WOULD HAVE LIKED.
INPATIENT TEAM NOT ENTIRELY TRUTHFUL RE DISCHARGE CRITICAL OF SERVICES	5. S *Um (short pause) probably just more (short pause) truthful*	WOULD HAVE LIKED A PROGRAMME FOR DISCHARGE IN FORM OF INFO PLUS REASSURANCE + CONTACT POTENTIAL AS BACKUP.
	6. *information about what it's going to be like when you leave*	
	7. *um maybe a bit of reassurance that ok if if things do start to*	
	8. *go wrong you can still call us for you know problems or*	?SUSTAINABILITY OF CHANGES IS HARD ON DISCHARGE.
	9. *support or advice but um*	TRUTHFULNESS – IMPLICATION THAT HOSPITAL DID NOT TELL THE TRUTH ?LIARS – IMPLICIT HINTED AT
	10. JM *Was there any contact between you and the inpatient*	
	11. *service after you were discharged?*	
	12. S *No well I kind of went back I had my last CPA um probably*	DISCHARGE DID NOT GO AS PLANNED AND LEFT SALLY FEELING AS IF SHE WAS BEING CHUCKED OUT.
	13. *I think the week after I was discharged because I was meant*	
MESSY DISCHARGE NOT FOLLOWING THE PLAN	14. *to be discharged on my CPA day but they were going to I was*	SOUNDS DRAMATIC – ALMOST A STAND OFF WHERE SALLY FELT CHEATED AND LOST AND HOSPITAL ?RELIEVED PROBLEM
	15. *going home for home leave and they were going to move me*	
	16. *rooms and I said I've been in same room for six months I said*	
	17. *well it's pointless moving all my stuff into another room to*	
	18. *leave so that's kind of where I felt like I was being chucked*	

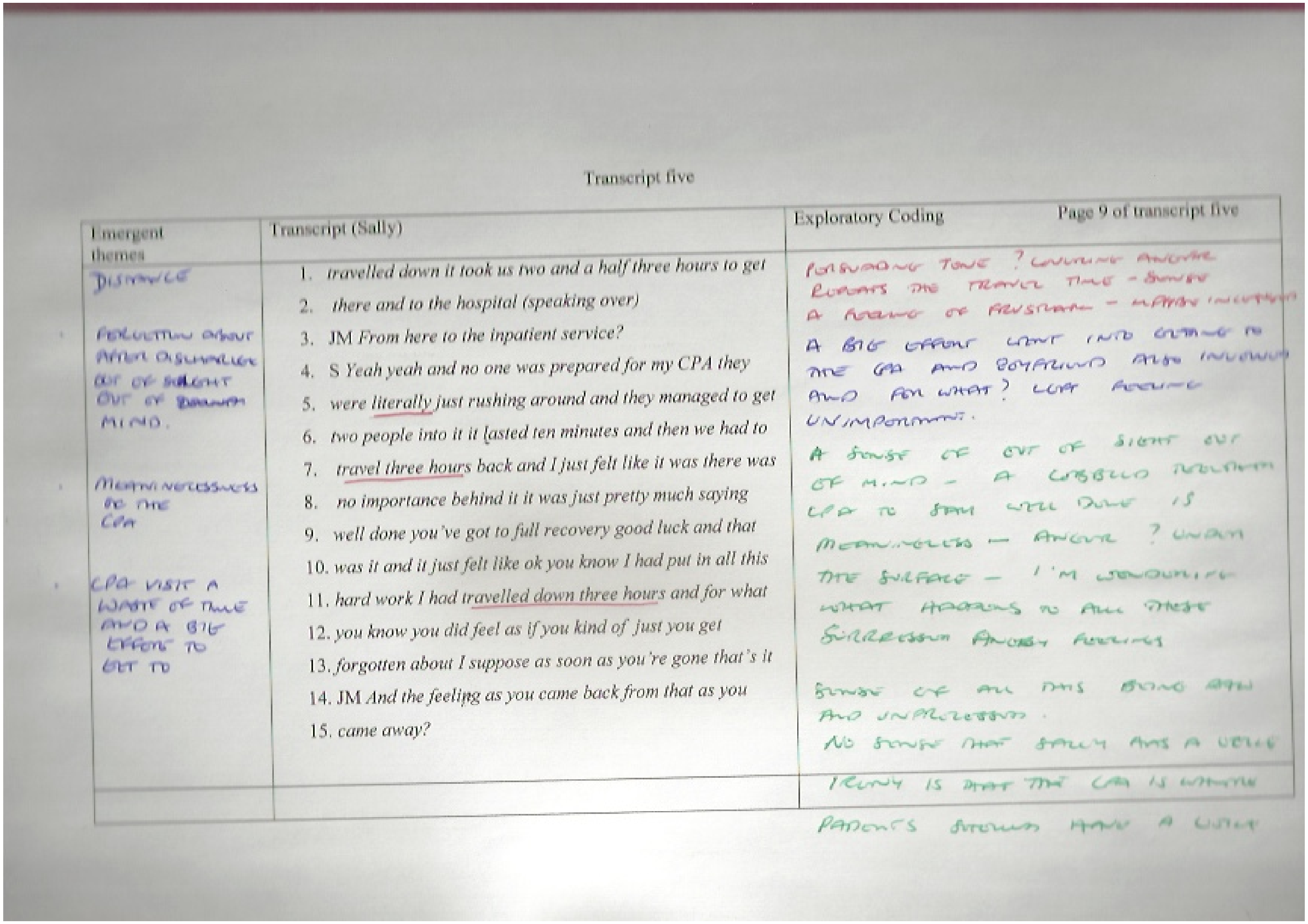
FEELING OF REJECTION AND ABANDONMENT ON DISCHARGE.



Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 8 of transcript five
	1. *out so I was like I might as well discharge now and they were*	HOSPITAL NEVER QUESTIONED HER DECISION TO GO. PERHAPS DIDN'T CARE
	2. *kind of like oh ok then without any question um (quickly said)*	
	3. JM *Can you say a little bit about how that felt?*	SENSE OF BEING DISCARDED PASSED ON TO ANOTHER SERVICE.
	4. S *Um (hesitation) as if they well they've done their job with*	BEING PASSED OVER LEADS TO REFLECTION OF SELF WORTH. IS PATIENT WORTHY
	5. *me now so it you know they can just get rid of me you know*	OF A BED VERSUS THE NEEDS ARE
FEELING PASSED OVER BY INPATIENT TEAM	6. *send me off for someone else to look after someone else needs*	HELD TO ON BALANCE – ASSESS
	7. *that room more important than me and I think you kind of*	WORTH.
	8. *towards the end you was question you just think well I'm*	
QUESTIONS OWN NEEDS AND ENTITLEMENT AS DISCHARGE APPROACHES.	9. *using up a bed that could be used for someone else but*	THE WHOLE PROCESS OF DISCHARGE WAS HURTFUL.
	10. *essentially kind of still think well actually I need as much help*	HESITATES BEFORE DIRECT CRITICISM
	11. *as probably the new patient coming in so I'm worthy of that*	OF INPATIENT SERVICE
SELF WORTH	12. *bed but it just felt like I was you know I was I was close*	A SENSE OF LOSING IT ABOUT
	13. *enough to myfull recovery weight that I could get there by*	QUESTIONING SELF STICKING UP
KNOWING THAT SHE COULD DO IT ALONE TO RECOVERY; ON RIGHT ROAD	14. *myself when I was discharged so it did it did hurt me I think*	VIEWS.
	15. JM *Your feelings were hurt?*	
	16. S *Yeah because then I went back for as I say my CPA a week*	
BUT	17. *later and had to travel down my boyfriend came with me we*	

ABANDONMENT
DISCHARGE HURT



Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 9 of transcript five
DISTANCE REFLECTION ABOUT AFTER DISCHARGE OUT OF SIGHT OUT OF [illegible] MIND. MEANINGLESSNESS OF THE CPA CPA VISIT A WASTE OF TIME AND A BIG EFFORT TO GET TO	1. *travelled down it took us two and a half three hours to get* 2. *there and to the hospital (speaking over)* 3. JM *From here to the inpatient service?* 4. S *Yeah yeah and no one was prepared for my CPA they* 5. *were literally just rushing around and they managed to get* 6. *two people into it it lasted ten minutes and then we had to* 7. *travel three hours back and I just felt like it was there was* 8. *no importance behind it it was just pretty much saying* 9. *well done you've got to full recovery good luck and that* 10. *was it and it just felt like ok you know I had put in all this* 11. *hard work I had travelled down three hours and for what* 12. *you know you did feel as if you kind of just you get* 13. *forgotten about I suppose as soon as you're gone that's it* 14. JM *And the feeling as you came back from that as you* 15. *came away?*	PERSUADING TONE ? CONVEYING ANGER REPEATS THE TRAVEL TIME - SENSE A FEELING OF FRUSTRATION – [illegible] A BIG EFFORT WENT INTO GETTING TO THE CPA AND BOYFRIEND ALSO INVOLVED AND FOR WHAT? LEFT FEELING UNIMPORTANT. A SENSE OF OUT OF SIGHT OUT OF MIND – A [illegible] [illegible] CPA TO SAY WELL DONE IS MEANINGLESS – ANGER ? UNDER THE SURFACE – I'M WONDERING WHAT HAPPENS TO ALL THESE SUPPRESSED ANGRY FEELINGS SENSE OF ALL THIS BEING [illegible] AND [illegible]. NO SENSE THAT SALLY HAS A VOICE
		IRONY IS THAT THE CPA IS WHERE

PATIENTS SHOULD HAVE A VOICE

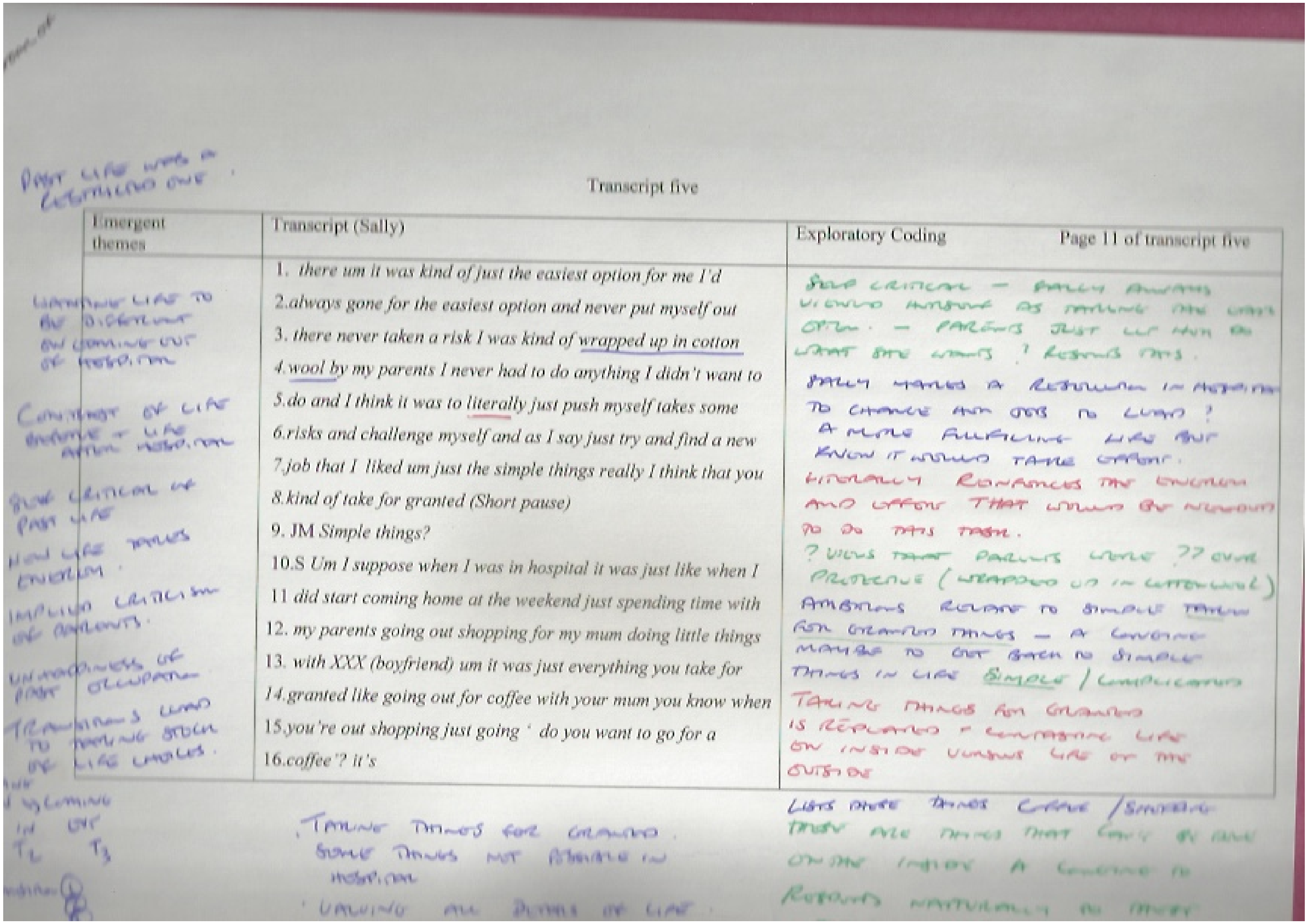
Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 10 of transcript five
	1. S *I was frustrated I was angry annoyed um again I was*	CPA LED TO FRUSTRATION ANGER ANNOYANCE AND FEARS ~~OF~~ BEING ALONE AND COPING ALONE.
	2. *upset um*	
FEELINGS OF TRAUMA: ANXIETY AND ALONENESS FRUSTRATION	3. JM *What impact did that have on you?*	
	4. S *Um (hesitation) I think it it worried me that again I felt I*	FEELING ALONE EVEN THOUGH WITH FAMILY
	5. *was alone I was out here and I was having to face all these*	STAYING WITH FAMILY WAS GOOD BUT LED TO SLIPPAGE OF OLD WAYS CREEPING BACK IN.
ALONE VS WITH OTHERS.	6. *things by myself and try and get back on my feet um again I*	
OVERWHELMING FEELINGS.	7. *did have to the support and I've always had the family around*	THE TASK OF BEING IN THE COMMUNITY IS ALWAYS HAVING TO WORK AT KEEPING ON TRACK WHICH FELT IMPOSSIBLE
	8. *and I think moving back in with my parents was good but then*	
MULTIPLE TASKS	9. *it became comfort and so I'd start slipping into bad ways um*	
SLIPPAGE CAN HAPPEN	10. *(short pause) so it was it was very much um (slight stutter)*	SENSE OF MULTIPLE BALLS BEING JUGGLED IN THE AIR
	11. *you know I've had all these ambitions when I was in hospital*	
THE IMPOSSIBLE FEELING OF HAVING TO WORK SO HARD TO STAY ON TRACK	12. *sort of what I wanted to do but coming out and having to try*	IMPOSSIBILITY (WHISPERED) MAY BE SHAMEFUL ?? CAN'T REALISE THE PLANS SHE HAD MADE
	13. *and recover try and stay on track and try and do all those*	
	14. *things just seemed impossible I suppose (quietly spoken)*	
	15. JM *Can you say a little bit about the ambitions?*	
THE SHAME OF THE PROCESS	16. S *Um (hesitation) I think it was just to to get a new job cause*	HESITATION BEFORE GIVING A DIRECT ANSWER
	17. *I'd always I'd worked for my parents and I was never happy*	

GOAL IS CLEAR + EASY ?
VS HARD TO MAKE HAPPEN.

CLEAR PLAN = CHANGE JOB = PREVIOUSLY
WORKED FOR PARENTS = NEVER HAPPY

MAKES IT SOUND EASY TO TACKLE
? THE PLAN — SALLY LIKES [illegible]



Transcript five

PAST LIFE WAS A RESTRICTED ONE.

Emergent themes	Transcript (Sally)	Exploratory Coding Page 11 of transcript five
WANTING LIFE TO BE DIFFERENT ON COMING OUT OF HOSPITAL CONTRAST OF LIFE BEFORE + LIFE AFTER HOSPITAL SELF CRITICAL OF PAST LIFE NEW LIFE TAKES EFFORT. IMPLIED CRITICISM OF PARENTS. UNHAPPINESS OF PAST OCCUPATION TRANSITIONS LEAD TO TAKING STOCK OF LIFE CHOICES.	1. *there um it was kind of just the easiest option for me I'd* 2.*always gone for the easiest option and never put myself out* 3. *there never taken a risk I was kind of wrapped up in cotton* 4.*wool by my parents I never had to do anything I didn't want to* 5.*do and I think it was to literally just push myself takes some* 6.*risks and challenge myself and as I say just try and find a new* 7.*job that I liked um just the simple things really I think that you* 8.*kind of take for granted (Short pause)* 9. JM *Simple things?* 10.S *Um I suppose when I was in hospital it was just like when I* 11 *did start coming home at the weekend just spending time with* 12. *my parents going out shopping for my mum doing little things* 13. *with XXX (boyfriend) um it was just everything you take for* 14.*granted like going out for coffee with your mum you know when* 15.*you're out shopping just going ' do you want to go for a* 16.*coffee'? it's*	SELF CRITICAL — SALLY ALWAYS VIEWED HERSELF AS TAKING THE EASY OPTION. — PARENTS JUST LET HER DO WHAT SHE WANTS ? RESENTS THIS. SALLY MAKES A RESOLUTION IN HOSPITAL TO CHANGE HER JOB TO LEARN ? A MORE FULFILLING LIFE BUT KNOW IT WOULD TAKE EFFORT. LITERALLY ROMANCES THE CHALLENGE AND EFFORT THAT WOULD BE NEEDED TO DO THIS TASK. ? VIEWS THAT PARENTS WERE ?? OVER PROTECTIVE (WRAPPED UP IN COTTONWOOL) AMBITIONS RELATE TO SIMPLE THINGS FOR GRANTED THINGS — A LONGING MAYBE TO GET BACK TO SIMPLE THINGS IN LIFE SIMPLE / COMPLICATED TAKING THINGS FOR GRANTED IS REPLACED = CONTRASTING LIFE ON INSIDE VERSUS LIFE ON THE OUTSIDE

UE
UPCOMING IN [illegible]
T_2 T_3

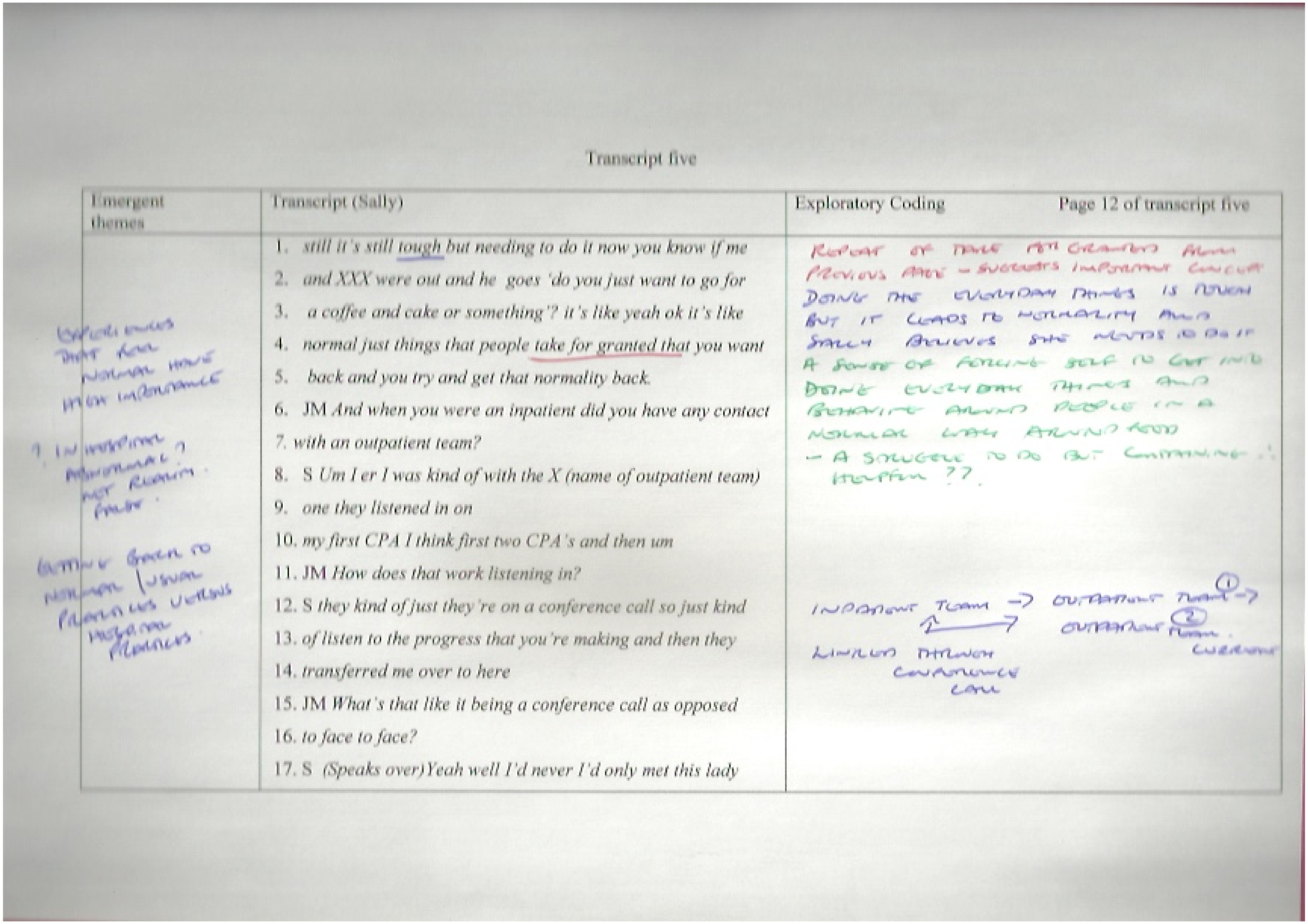
ITION ①②

'TAKING THINGS FOR GRANTED'. SOME THINGS NOT POSSIBLE IN HOSPITAL

'VALUING ALL DETAILS OF LIFE'.

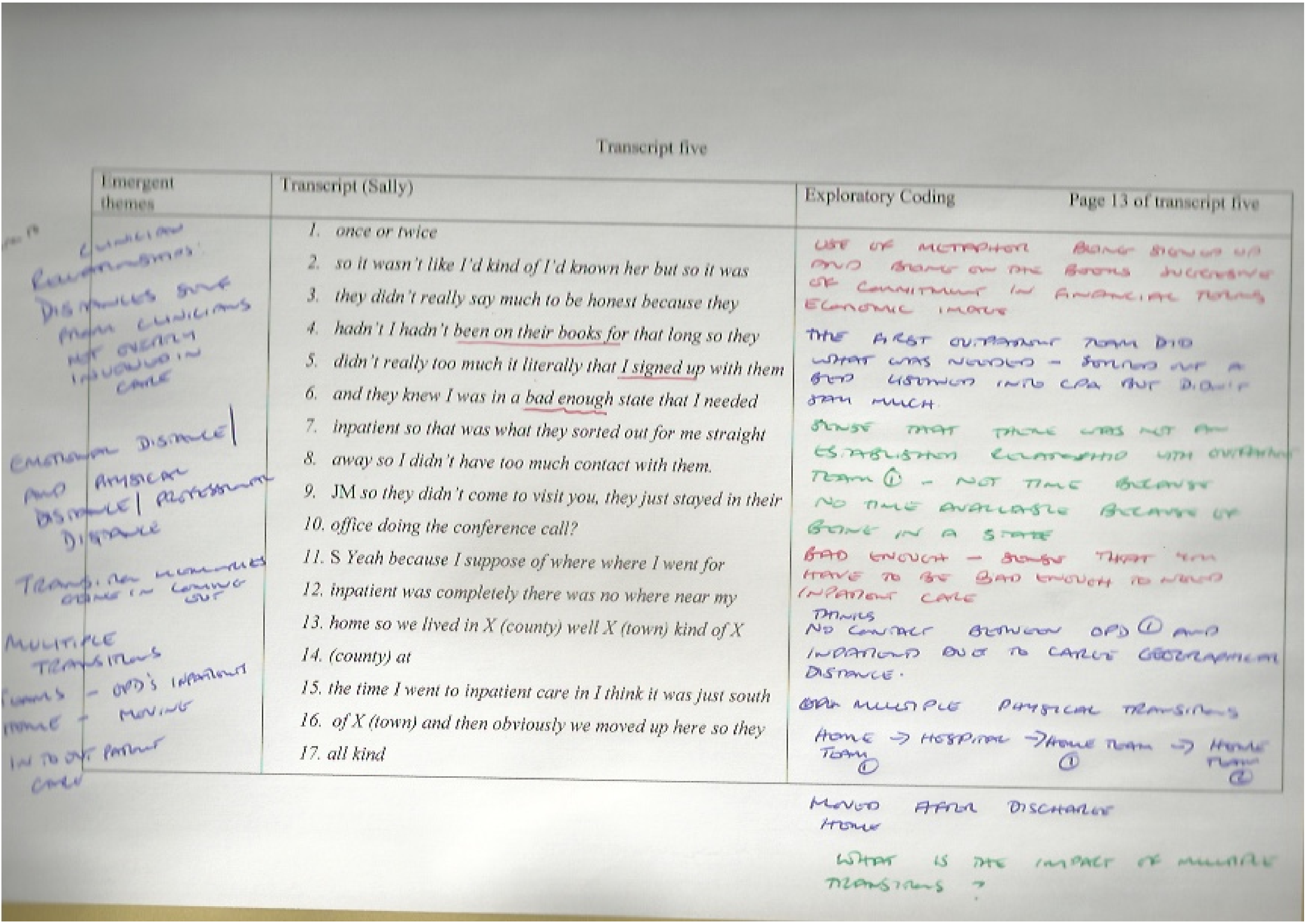
LISTS MORE THINGS COFFEE / SHOPPING

THESE ARE THINGS THAT CAN'T BE DONE ON THE INSIDE A LONGING TO RETURN NATURALLY TO THESE



Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 12 of transcript five
	1. *still it's still tough but needing to do it now you know if me*	REPEAT OF TAKE FOR GRANTED FROM PREVIOUS PAGE – SUGGESTS IMPORTANT CONCEPT DOING THE EVERYDAY THINGS IS TOUGH BUT IT LEADS TO NORMALITY AND SALLY BELIEVES SHE NEEDS TO DO IT A SENSE OF FORCING SELF TO GET INTO DOING EVERYDAY THINGS AND BEHAVING AROUND PEOPLE IN A NORMAL WAY AROUND FOOD – A STRUGGLE TO DO BUT CONTINUING ∴ HELPFUL ??.
	2. *and XXX were out and he goes 'do you just want to go for*	
EXPERIENCES THAT FEEL NORMAL HAVE HIGH IMPORTANCE	3. *a coffee and cake or something'? it's like yeah ok it's like*	
	4. *normal just things that people take for granted that you want*	
	5. *back and you try and get that normality back.*	
	6. JM *And when you were an inpatient did you have any contact*	
? IN HOSPITAL ABNORMAL ? NOT REALLY FREE.	7. *with an outpatient team?*	
	8. S *Um I er I was kind of with the X (name of outpatient team)*	
	9. *one they listened in on*	
GETTING BACK TO NORMAL | USUAL PRACTICES VERSUS HOSPITAL PRACTICES.	10. *my first CPA I think first two CPA's and then um*	
	11. JM *How does that work listening in?*	
	12. S *they kind of just they're on a conference call so just kind*	INPATIENT TEAM → OUTPATIENT TEAM ① → OUTPATIENT ② TEAM. CURRENT LINKED THROUGH CONFERENCE CALL
	13. *of listen to the progress that you're making and then they*	
	14. *transferred me over to here*	
	15. JM *What's that like it being a conference call as opposed*	
	16. *to face to face?*	
	17. S *(Speaks over)Yeah well I'd never I'd only met this lady*	

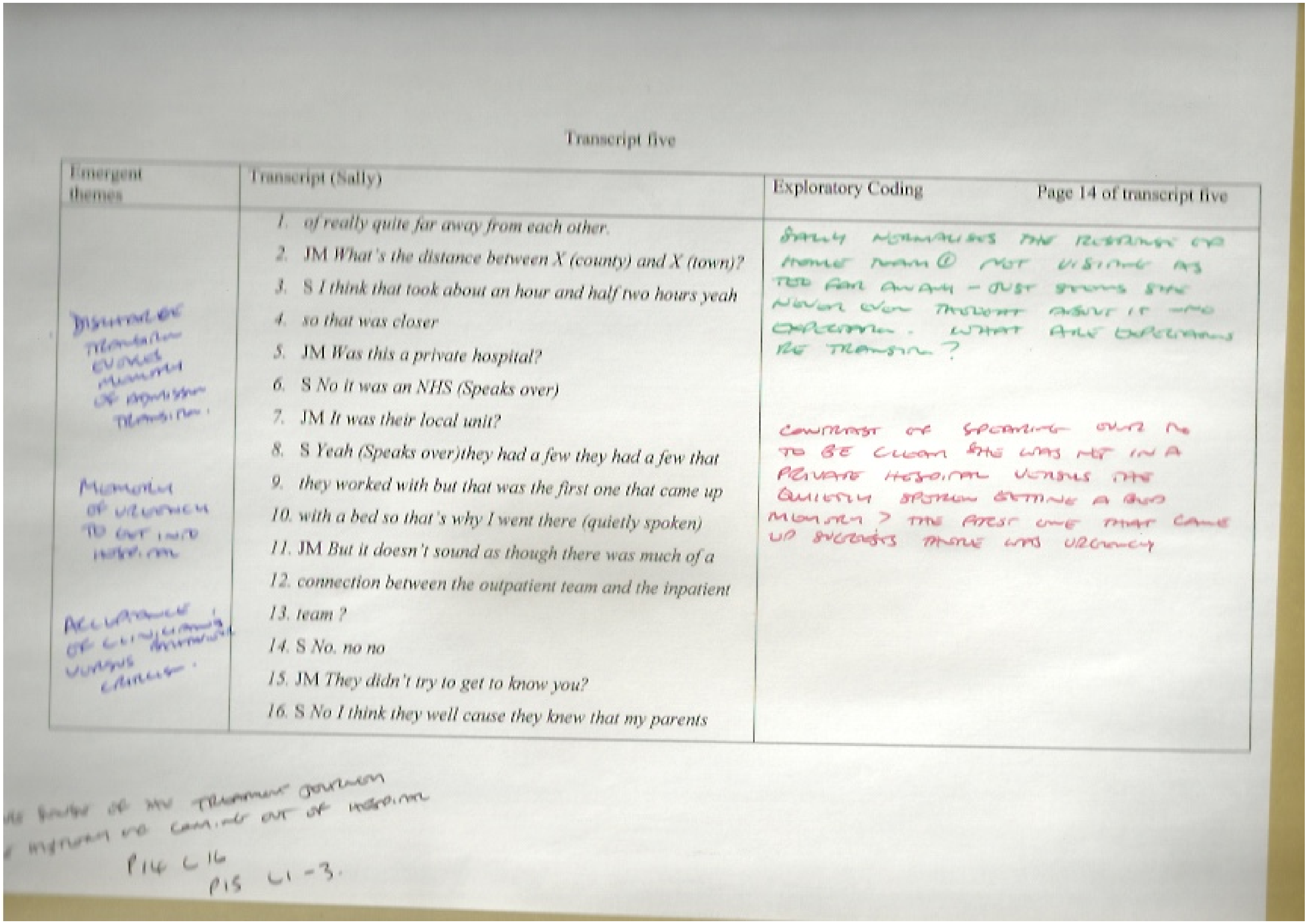


Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 13 of transcript five
CLINICIAN RELATIONSHIPS: DISTANCES SAVE FROM CLINICIANS NOT OVERLY INVOLVED IN CARE EMOTIONAL DISTANCE | AND PHYSICAL DISTANCE | PROFESSIONAL DISTANCE TRANSITIONAL MILESTONES GOING IN COMING OUT MULTIPLE TRANSITIONS TEAMS – OPD'S INPATIENT HOME – MOVING IN TO OUT PATIENT CARE	1. *once or twice* 2. *so it wasn't like I'd kind of I'd known her but so it was* 3. *they didn't really say much to be honest because they* 4. *hadn't I hadn't been on their books for that long so they* 5. *didn't really too much it literally that I signed up with them* 6. *and they knew I was in a bad enough state that I needed* 7. *inpatient so that was what they sorted out for me straight* 8. *away so I didn't have too much contact with them.* 9. JM *so they didn't come to visit you, they just stayed in their* 10. *office doing the conference call?* 11. S *Yeah because I suppose of where where I went for* 12. *inpatient was completely there was no where near my* 13. *home so we lived in X (county) well X (town) kind of X* 14. *(county) at* 15. *the time I went to inpatient care in I think it was just south* 16. *of X (town) and then obviously we moved up here so they* 17. *all kind*	USE OF METAPHOR BEING SIGNED UP AND BEING ON THE BOOKS INDICATIVE OF COMMITMENT IN FINANCIAL TERMS ECONOMIC IMAGE THE FIRST OUTPATIENT TEAM DID WHAT WAS NEEDED – SORTED OUT A BED ADMITTED INTO CPA BUT DIDN'T SEE MUCH. SENSE THAT THERE WAS NOT AN ESTABLISHED RELATIONSHIP WITH OUTPATIENT TEAM ① – NOT TIME BECAUSE NO TIME AVAILABLE BECAUSE OF BEING IN A STATE BAD ENOUGH – SENSE THAT YOU HAVE TO BE BAD ENOUGH TO NEED INPATIENT CARE TEAMS NO CONTACT BETWEEN OPD ① AND INPATIENT DUE TO LARGE GEOGRAPHICAL DISTANCE. MULTIPLE PHYSICAL TRANSITIONS HOME TEAM ① → HOSPITAL → HOME TEAM ① → HOME TEAM ②

MOVED AFTER DISCHARGE HOME

WHAT IS THE IMPACT OF MULTIPLE TRANSITIONS ?



Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 14 of transcript five
	1. *of really quite far away from each other.*	SALLY NORMALISES THE RESPONSE OF HOME TEAM ② NOT VISITING AS TOO FAR AWAY – JUST SEEMS SHE NEVER EVEN THOUGHT ABOUT IT – NO EXPECTATION. WHAT ARE EXPECTATIONS RE TRANSITION?
	2. JM *What's the distance between X (county) and X (town)?*	
	3. S *I think that took about an hour and half two hours yeah*	
DISTANCE OF TRANSITION EVOKES MEMORY OF ADMISSION TRANSITION.	4. *so that was closer*	
	5. JM *Was this a private hospital?*	
	6. S *No it was an NHS (Speaks over)*	
	7. JM *It was their local unit?*	
	8. S *Yeah (Speaks over)they had a few they had a few that*	CONTRAST OF SPEAKING OVER ME TO BE CLEAR SHE WAS NOT IN A PRIVATE HOSPITAL VERSUS THE QUIETLY SPOKEN GETTING A BED MOMENT > THE FIRST ONE THAT CAME UP SUGGESTS THERE WAS URGENCY
MEMORY OF URGENCY TO GET INTO HOSPITAL	9. *they worked with but that was the first one that came up*	
	10. *with a bed so that's why I went there (quietly spoken)*	
	11. JM *But it doesn't sound as though there was much of a*	
	12. *connection between the outpatient team and the inpatient*	
ACCEPTANCE OF CLINICIANS' BEHAVIOUR VERSUS CARING.	13. *team ?*	
	14. S *No. no no*	
	15. JM *They didn't try to get to know you?*	
	16. S *No I think they well cause they knew that my parents*	

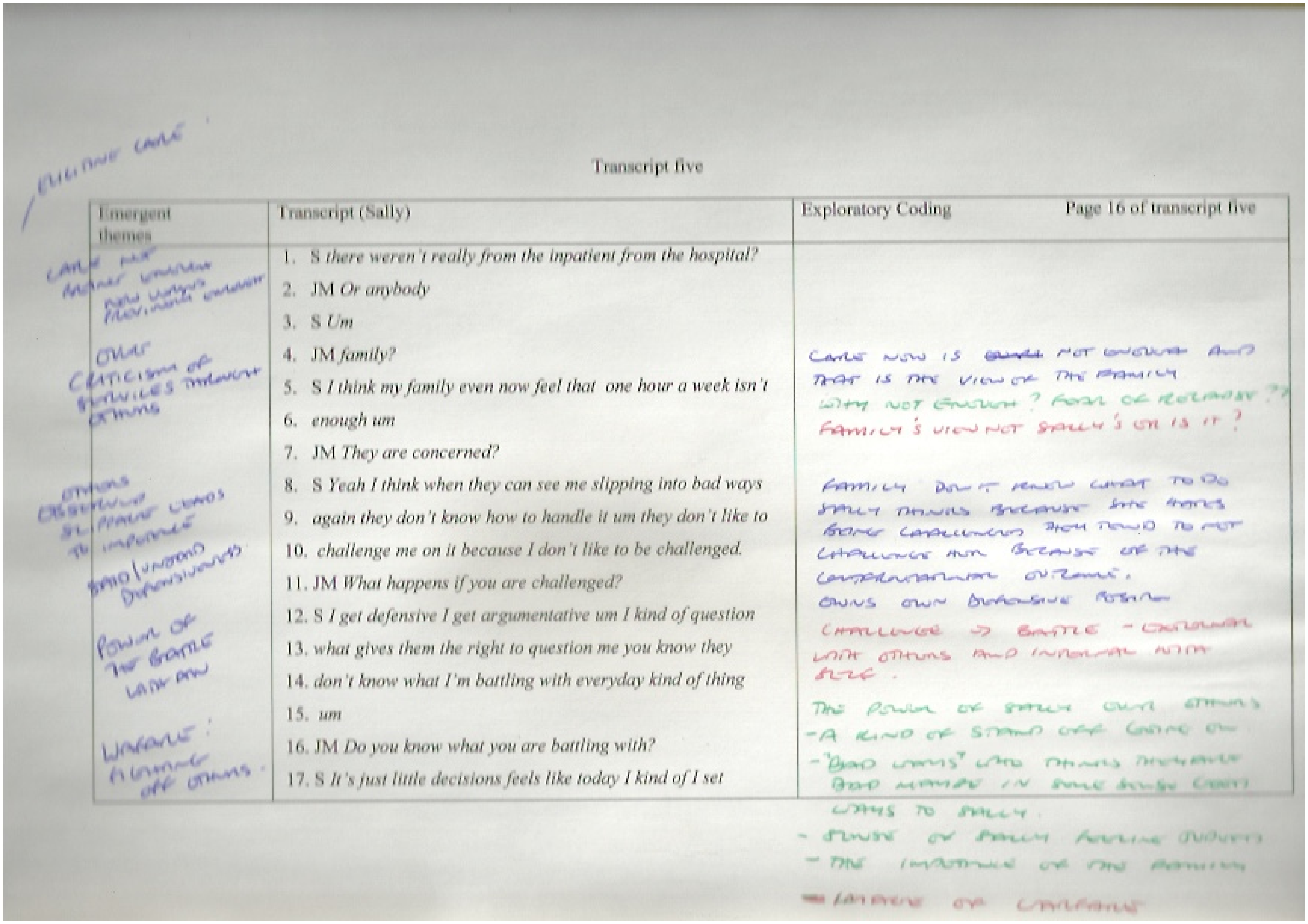
LE ROUTE OF THE TREATMENT JOURNEY
HISTORY RE COMING OUT OF HOSPITAL
P14 L16
P15 L1-3.

Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 15 of transcript five
RELIABILITY OF OUTPATIENT TEAM. ② IN → OUT ① OUT → IN. EXPECTATIONS OF CLINICIANS NON-CRITICAL VERSUS CRITICAL.	*1. were moving up here and that I would be moving up here* *2. this was going to be where I needed outpatients so they* *3. kind of knew they were going to be handing me over.* 4. JM *So they made the referral to here?* 5. S *Yeah they sorted all that out (speaking over)* 6. JM *So they were quite clerical?* 7. S *Yeah yeah but I think it did work out they did everything* *8. they said they would do* 9. JM *But there was something missing you were thinking* *10. they didn't do much* *11.* S *Um I didn't expect them to do much all they were kind of* *12. they they got the bed for me and that was essentially what I* 13. *needed and then they sorted out um as I say for me to come* 14. *here when I was discharged so that was all I needed I suppose* 15. JM *So thinking back about when you were an inpatient what* 16. *opinions were expressed about your needs on discharge?*	THE FIRST OPD TEAM DID NOT GET TO KNOW SALLY – RATIONALE FROM SALLY IS THAT THEY KNEW THEY WOULD BE HANDING HER CARE ON TO ANOTHER OPD TEAM. SPEAKS OUT – KEEN TO SHOW THAT THE FIRST OPD TEAM DID ALL THAT WAS REQUIRED OF THEM. SALLY HAD NO EXPECTATIONS FROM THE OPD TEAM ?WHY CAUSE THEY SAVED HER LIFE? CONTRAST THIS DEFENCE WITH HER EXPECTATIONS OF THE ① INPATIENT TEAM AND ② 2nd OPD TEAM SALLY HIGHLY CRITICAL OF THE LAST TWO. AS I SAY – LIKE SALLY HAD TOLD ME BEFORE

SALLY'S A SENSE OF A NARROW FOCUS ON DISCHARGE. / A RESTRICTED / REDUNDANT.

— A SENSE OF BEING FED UP WITH THIS LINE OF QUESTIONING

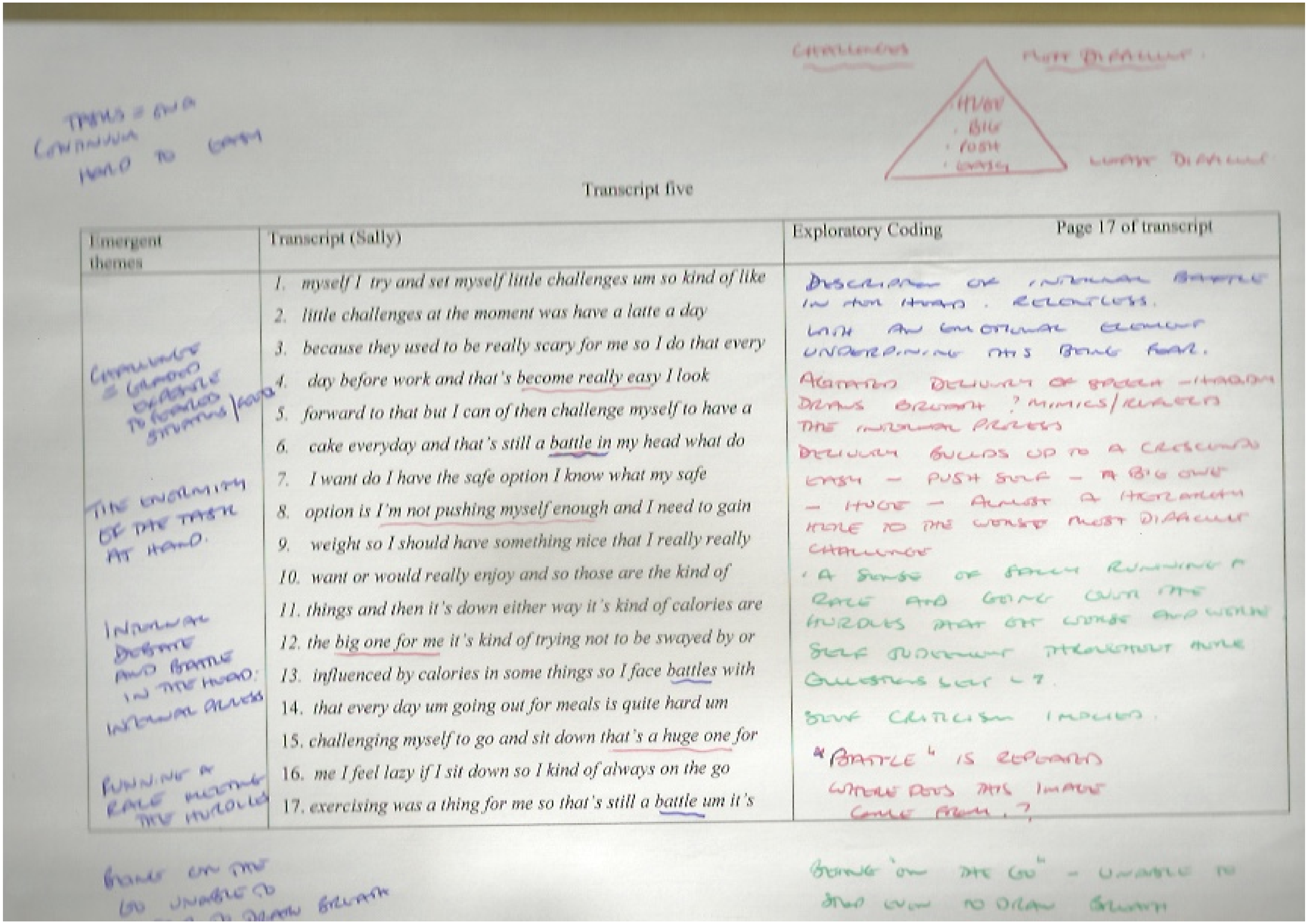


/ EVOLVING CARE

Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 16 of transcript five
CARE NOT [illegible] ENOUGH NEW WAYS PROVIDING [illegible]	1. S *there weren't really from the inpatient from the hospital?*	
	2. JM *Or anybody*	
	3. S *Um*	
OVERT CRITICISM OF SERVICES THROUGH OTHERS	4. JM *family?*	CARE NOW IS ~~[illegible]~~ NOT ENOUGH AND THAT IS THE VIEW OF THE FAMILY
	5. S *I think my family even now feel that one hour a week isn't*	WHY NOT ENOUGH? FEAR OF RELAPSE ??
	6. *enough um*	FAMILY'S VIEW NOT SALLY'S OR IS IT ?
	7. JM *They are concerned?*	
OTHERS OBSERVING SLIPPING LEADS TO INTERVENE	8. S *Yeah I think when they can see me slipping into bad ways*	FAMILY DON'T KNOW WHAT TO DO
	9. *again they don't know how to handle it um they don't like to*	SALLY THINKS BECAUSE SHE HATES
SAID / UNSAID DEFENSIVENESS	10. *challenge me on it because I don't like to be challenged.*	BEING CHALLENGED THEY TEND TO NOT CHALLENGE HER BECAUSE OF THE
	11. JM *What happens if you are challenged?*	CONFRONTATIONAL OUTCOME.
POWER OF THE BATTLE WITHIN	12. S *I get defensive I get argumentative um I kind of question*	OWNS OWN DEFENSIVE POSITION CHALLENGE → BATTLE – EXTERNAL
	13. *what gives them the right to question me you know they*	WITH OTHERS AND INTERNAL WITH SELF.
	14. *don't know what I'm battling with everyday kind of thing*	
	15. *um*	THE POWER OF SALLY OVER OTHERS
WARFARE: FENDING OFF OTHERS.	16. JM *Do you know what you are battling with?*	– A KIND OF STAND OFF GOING ON
	17. S *It's just little decisions feels like today I kind of I set*	– "BAD WAYS" WHO THINKS THESE ARE BAD MAYBE IN SOME SENSE [illegible]

WAYS TO SALLY.
- SENSE OF FAMILY FEELING GUILTY
- THE IMPORTANCE OF THE FAMILY
- LANGUAGE OF CHALLENGE



THINGS = ON A CONTINUUM
HARD TO EASY

CHALLENGES

MOST DIFFICULT

HUGE
· BIG
· PUSH
· EASY

LEAST DIFFICULT

Transcript five

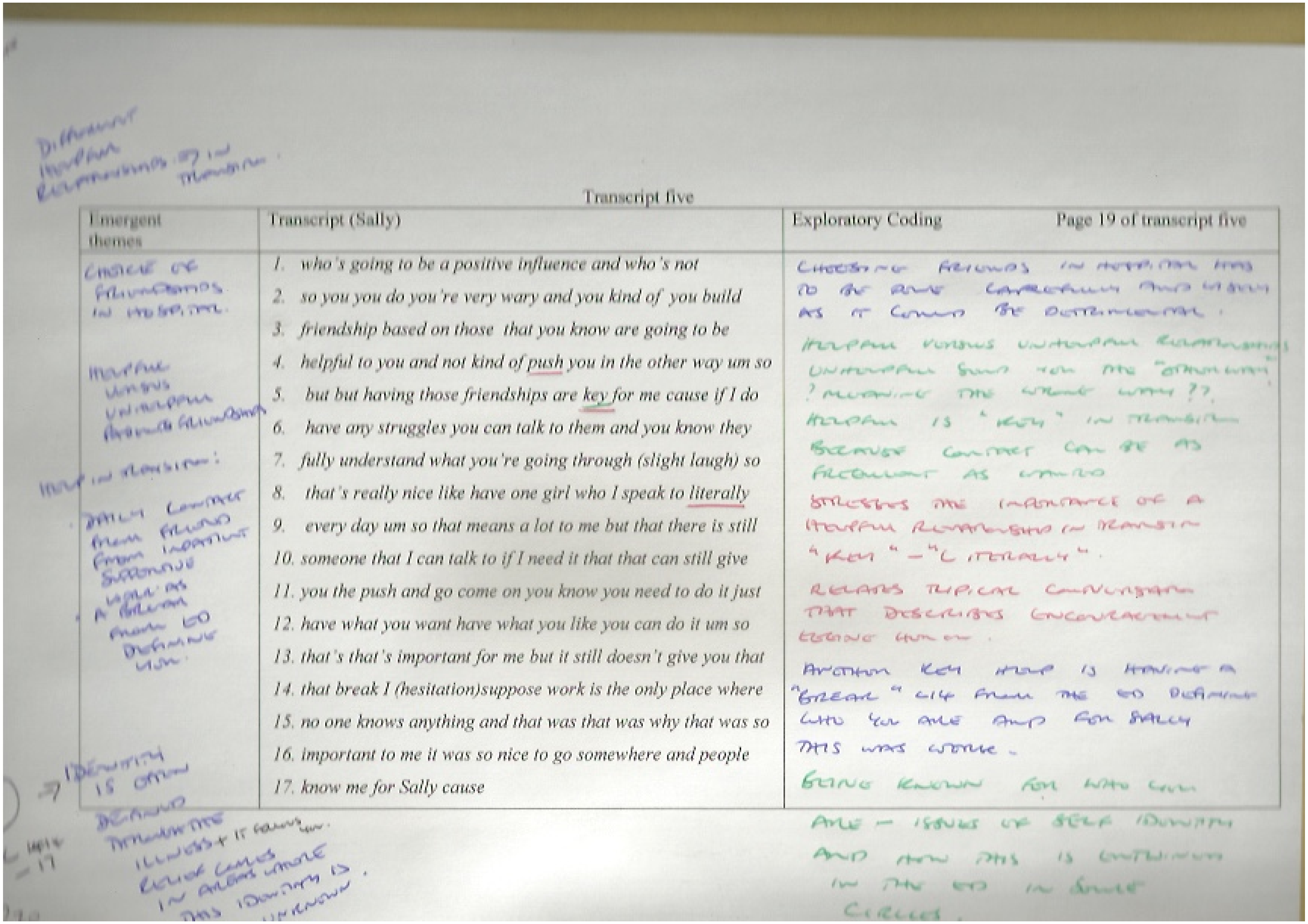
Emergent themes	Transcript (Sally)	Exploratory Coding Page 17 of transcript
CHALLENGES = GRADED DEGREES TO FORWARD STRATEGY | FOOD THE ENORMITY OF THE TASK AT HAND. INTERNAL DEBATE AND BATTLE IN THE HEAD: INTERNAL RULES RUNNING A RACE MEETING THE HURDLES	1. *myself I try and set myself little challenges um so kind of like* 2. *little challenges at the moment was have a latte a day* 3. *because they used to be really scary for me so I do that every* 4. *day before work and that's become really easy I look* 5. *forward to that but I can of then challenge myself to have a* 6. *cake everyday and that's still a battle in my head what do* 7. *I want do I have the safe option I know what my safe* 8. *option is I'm not pushing myself enough and I need to gain* 9. *weight so I should have something nice that I really really* 10. *want or would really enjoy and so those are the kind of* 11. *things and then it's down either way it's kind of calories are* 12. *the big one for me it's kind of trying not to be swayed by or* 13. *influenced by calories in some things so I face battles with* 14. *that every day um going out for meals is quite hard um* 15. *challenging myself to go and sit down that's a huge one for* 16. *me I feel lazy if I sit down so I kind of always on the go* 17. *exercising was a thing for me so that's still a battle um it's*	DESCRIPTION OF INTERNAL BATTLE IN HER HEAD. RELENTLESS. WITH AN EMOTIONAL ELEMENT UNDERPINNING THIS BEING FEAR. AGITATED DELIVERY OF SPEECH – HARDLY DRAWS BREATH ? MIMICS/REFLECTS THE INTERNAL PROCESS DELIVERY BUILDS UP TO A CRESCENDO EASY – PUSH SELF – A BIG ONE – HUGE – ALMOST A HIERARCHY [illegible] TO THE WORST MOST DIFFICULT CHALLENGE ' A SENSE OF FRENZY RUNNING A RACE AND GOING OVER THE HURDLES THAT GET WORSE AND WORSE SELF JUDGEMENT THROUGHOUT THE QUESTIONS SELF – ?. SELF CRITICISM IMPLIED. * 'BATTLE' IS REPEATED WHERE DOES THIS IMAGE COME FROM.?

BEING ON THE GO UNABLE TO [illegible] DRAW BREATH

BEING 'ON THE GO' – UNABLE TO STOP EVEN TO DRAW BREATH

Transcript five

Emergent themes	Transcript (sally)	Exploratory Coding Page 18 of transcript five
	1. *just it does seems never ending I suppose in your head and*	INESCAPABLE NEVER ENDING PROCESS OF THOUGHTS LONGING FOR NORMALITY – TO HAVE A BREAK WHERE NO ONE MENTIONS THE ED.
INESCAPABLE STREAM OF NEVERENDING THOUGHTS.	2. *even even now it's kind of there's one thing you kind of*	
	3. *never you don't feel that you ever get away from it I think*	
	4. *when you do have that day when you just you know go out*	
	5. *shopping and not even think about it you know no one*	SENSE THAT OTHERS BRING THE ED CONTINUALLY – FAMILY AND FRIENDS.
BEING TREATED DIFFERENTLY BY OTHERS	6. *brings it up everyone just kind of treats you like normal*	
	7. *um*	FRIENDS ARE GIVEN RESTRICTED INFO AND HAVING FRIENDS IS RESTRICTED.
	8. JM *Is there a sense that people bring it up?*	
	9. S *Yeah*	
	10. JM *Who brings it up?*	
	11. S *My family XXX (boyfriend) um friends that know about it*	FRIENDS RESTRICTED TO ONE BEST FRIEND AND A FEW PEOPLE IN HOSPITAL
	12. *um*	
	13. JM *Has it impacted on your friendships?*	
CHOICE OF RESTRICTING FRIENDSHIPS.	14. S *Um I never really had that closer friendships when I was*	
	15. *at X (County) anyway I kind of just keep in touch with*	
	16. *probably one person um who is my best friend um but I do*	
	17. *keep in contact with quite a few people I did meet in*	
	18. *hospital um but you do get to know when you're in there*	



DIFFERENT HELPFUL RELATIONSHIPS ?? IN TRANSITION.

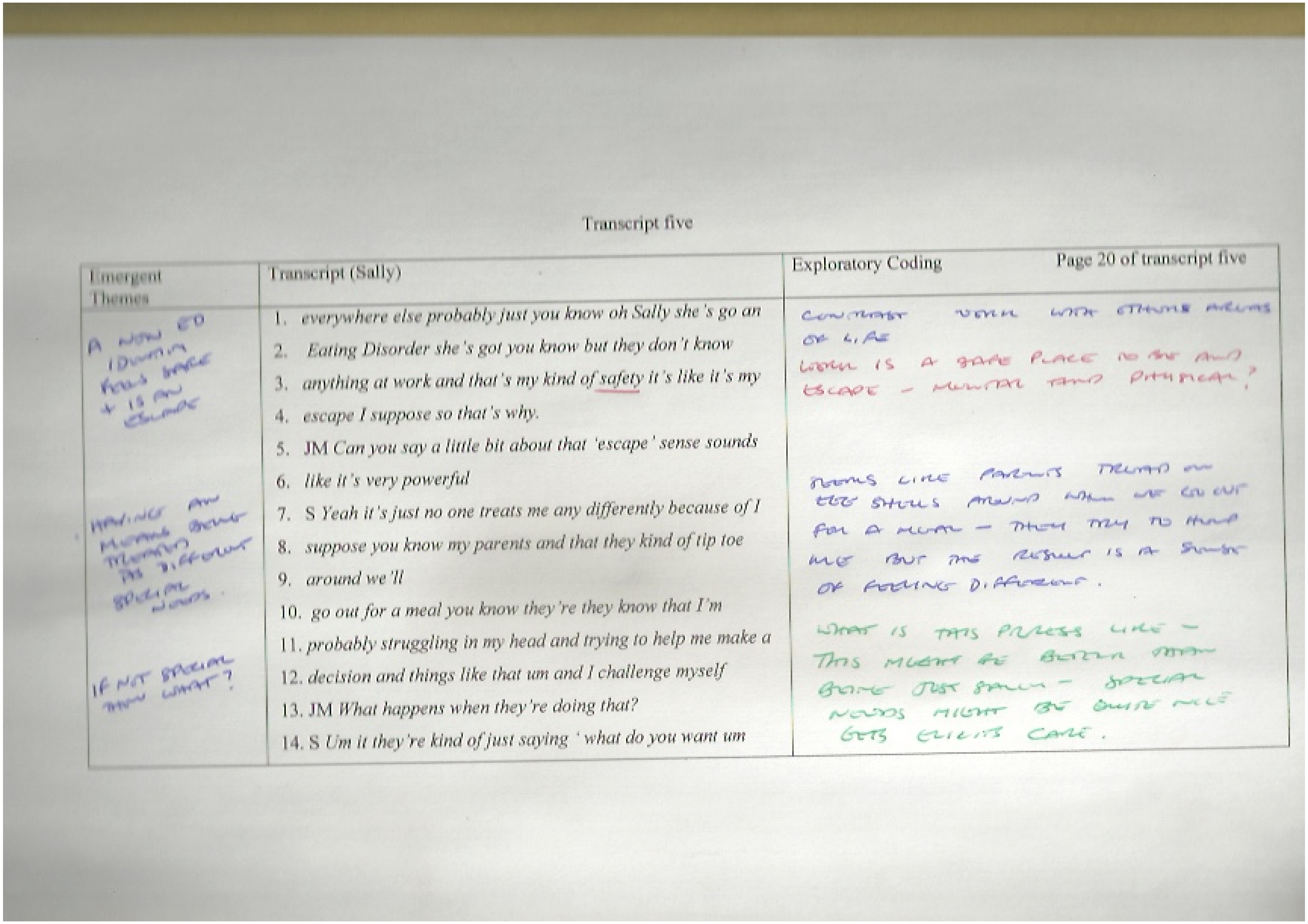
Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 19 of transcript five
CHOICE OF FRIENDSHIPS IN HOSPITAL.	1. who's going to be a positive influence and who's not	CHOOSING FRIENDS IN HOSPITAL HAS TO BE DONE CAREFULLY AND WISELY AS IT COULD BE DETRIMENTAL.
	2. so you you do you're very wary and you kind of you build	
	3. friendship based on those that you know are going to be	
HELPFUL VERSUS UNHELPFUL FRIENDSHIPS	4. helpful to you and not kind of push you in the other way um so	HELPFUL VERSUS UNHELPFUL RELATIONSHIPS UNHELPFUL SEND YOU THE "OTHER WAY" ? MEANING THE WRONG WAY ?? HELPFUL IS "KEY" IN TRANSITION BECAUSE CONTACT CAN BE AS FREQUENT AS WANTED
	5. but but having those friendships are key for me cause if I do	
	6. have any struggles you can talk to them and you know they	
HELP IN TRANSITION:	7. fully understand what you're going through (slight laugh) so	
· DAILY CONTACT FROM FRIEND FROM INPATIENT SUPPORTIVE	8. that's really nice like have one girl who I speak to literally	STRESSES THE IMPORTANCE OF A HELPFUL RELATIONSHIP IN TRANSITION "KEY" – "LITERALLY".
	9. every day um so that means a lot to me but that there is still	
	10. someone that I can talk to if I need it that that can still give	
· WORK AS A BREAK FROM ED DEFINING HER.	11. you the push and go come on you know you need to do it just	RELATES TYPICAL CONVERSATION THAT DESCRIBES ENCOURAGEMENT EGGING HER ON.
	12. have what you want have what you like you can do it um so	
	13. that's that's important for me but it still doesn't give you that	ANOTHER KEY HELP IS HAVING A "BREAK" LIFE FROM THE ED DEFINING WHO YOU ARE AND FOR SALLY THIS WAS WORK.
	14. that break I (hesitation)suppose work is the only place where	
	15. no one knows anything and that was that was why that was so	
→ IDENTITY IS OFTEN	16. important to me it was so nice to go somewhere and people	
	17. know me for Sally cause	BEING KNOWN FOR WHO YOU

DEFINED THROUGH THE ILLNESS + IT FOLLOWS HER. RELIEF COMES IN AREAS WHERE THIS IDENTITY IS UNKNOWN.

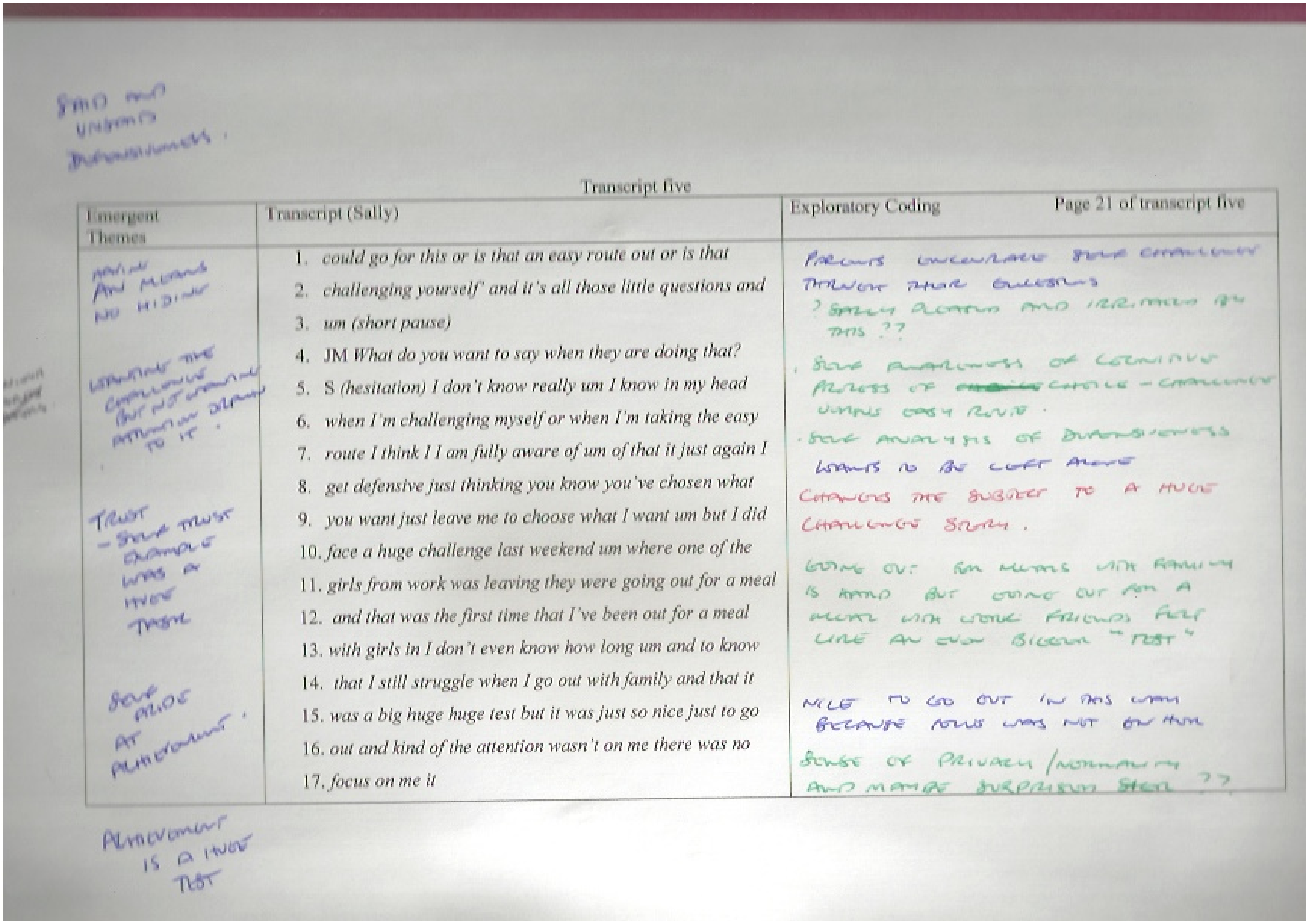
Ll 14 – 17

ARE – ISSUES OF SELF IDENTITY AND HOW THIS IS CONTINUOUS IN THE ED IN SOME CIRCLES.



Transcript five

Emergent Themes	Transcript (Sally)	Exploratory Coding Page 20 of transcript five
A NON ED IDENTITY FEELS SAFE + IS AN ESCAPE	1. *everywhere else probably just you know oh Sally she's go an* 2. *Eating Disorder she's got you know but they don't know* 3. *anything at work and that's my kind of safety it's like it's my* 4. *escape I suppose so that's why.*	CONTRAST WORK WITH OTHER AREAS OF LIFE WORK IS A SAFE PLACE TO BE AND ESCAPE – MENTAL AND PHYSICAL?
	5. JM *Can you say a little bit about that 'escape' sense sounds* 6. *like it's very powerful*	
HAVING AN MEANS BEING TREATED AS DIFFERENT SPECIAL NEEDS.	7. S *Yeah it's just no one treats me any differently because of I* 8. *suppose you know my parents and that they kind of tip toe* 9. *around we'll* 10. *go out for a meal you know they're they know that I'm*	SEEMS LIKE PARENTS TREAD ON EGG SHELLS AROUND HER WHEN WE GO OUT FOR A MEAL – THEY TRY TO HELP ME BUT THE RESULT IS A SENSE OF FEELING DIFFERENT.
IF NOT SPECIAL THEN WHAT?	11. *probably struggling in my head and trying to help me make a* 12. *decision and things like that um and I challenge myself* 13. JM *What happens when they're doing that?* 14. S *Um it they're kind of just saying ' what do you want um*	WHAT IS THIS PROCESS LIKE – THIS MIGHT BE BETTER THAN BEING JUST SALLY – SPECIAL NEEDS MIGHT BE QUITE NICE GETS ELICITS CARE.

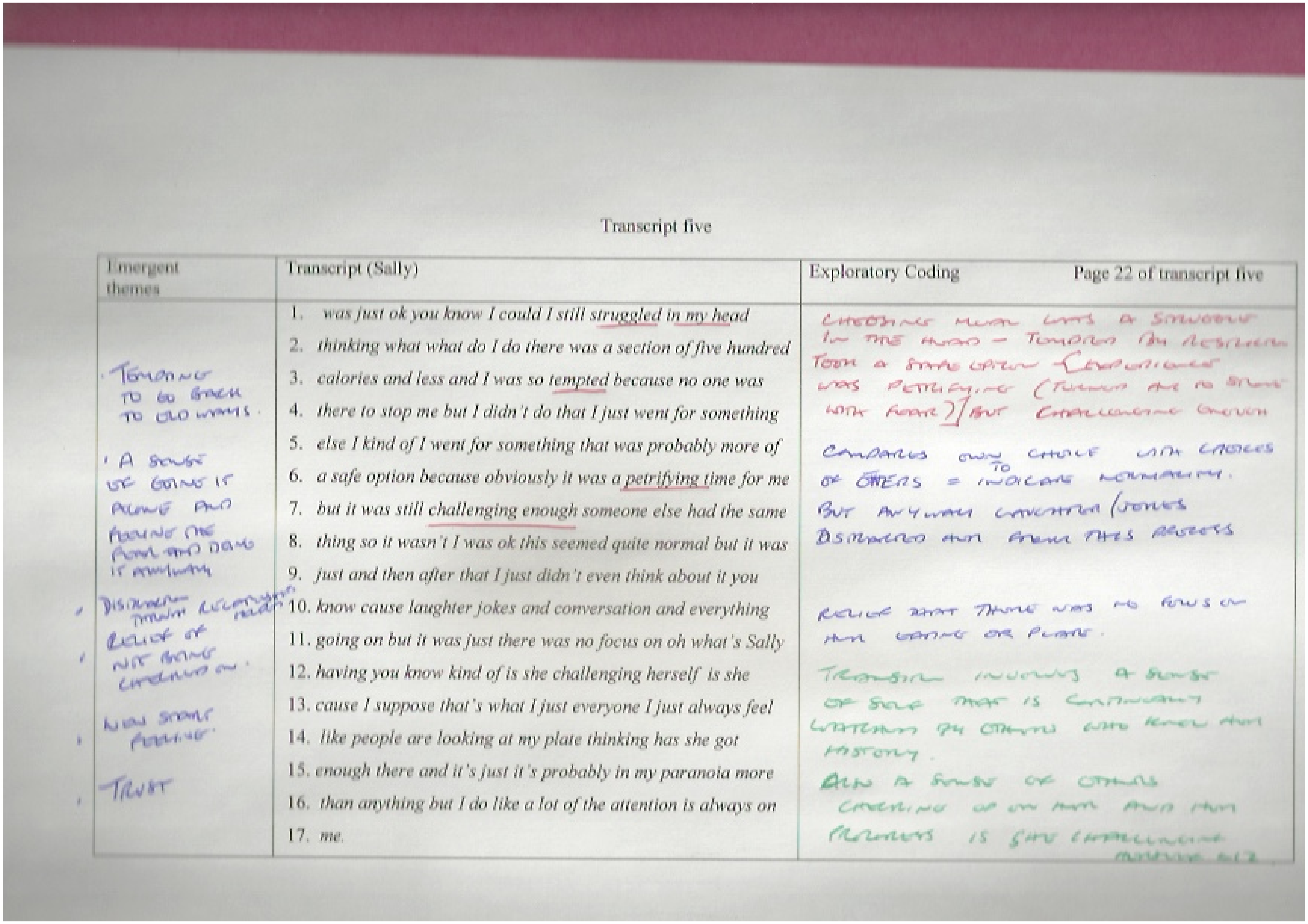


SAID AND UNDERSTANDS DEFENSIVENESS.

Transcript five

Emergent Themes	Transcript (Sally)	Exploratory Coding Page 21 of transcript five
HAVING AN MEANS NO HIDING	1. could go for this or is that an easy route out or is that	PARENTS ENCOURAGE SELF CHALLENGING THROUGH THEIR QUESTIONS
	2. challenging yourself' and it's all those little questions and	? SALLY FLATTERED AND IRRITATED BY THIS ??
	3. um (short pause)	
WANTING THE CHALLENGE BUT NOT WANTING ATTENTION DRAWN TO IT.	4. JM What do you want to say when they are doing that?	. SELF AWARENESS OF COGNITIVE PROCESS OF ~~[illegible]~~ CHOICE - CHALLENGE VERSUS EASY ROUTE.
	5. S (hesitation) I don't know really um I know in my head	
	6. when I'm challenging myself or when I'm taking the easy	
	7. route I think I I am fully aware of um of that it just again I	. SELF ANALYSIS OF DEFENSIVENESS
	8. get defensive just thinking you know you've chosen what	WANTS TO BE LEFT ALONE
TRUST - SELF TRUST EXAMPLE WAS A HUGE TASK	9. you want just leave me to choose what I want um but I did	CHANGES THE SUBJECT TO A HUGE CHALLENGE STORY.
	10. face a huge challenge last weekend um where one of the	
	11. girls from work was leaving they were going out for a meal	GOING OUT FOR MEALS WITH FAMILY IS HARD BUT GOING OUT FOR A MEAL WITH WORK FRIENDS FELT LIKE AN EVEN BIGGER "TEST"
	12. and that was the first time that I've been out for a meal	
	13. with girls in I don't even know how long um and to know	
SELF PRIDE AT ACHIEVEMENT.	14. that I still struggle when I go out with family and that it	
	15. was a big huge huge test but it was just so nice just to go	NICE TO GO OUT IN THIS WAY BECAUSE FOCUS WAS NOT ON HER
	16. out and kind of the attention wasn't on me there was no	SENSE OF PRIVACY / NORMALITY AND MAYBE SURPRISED SELF ??
	17. focus on me it	

ACHIEVEMENT IS A HUGE TEST

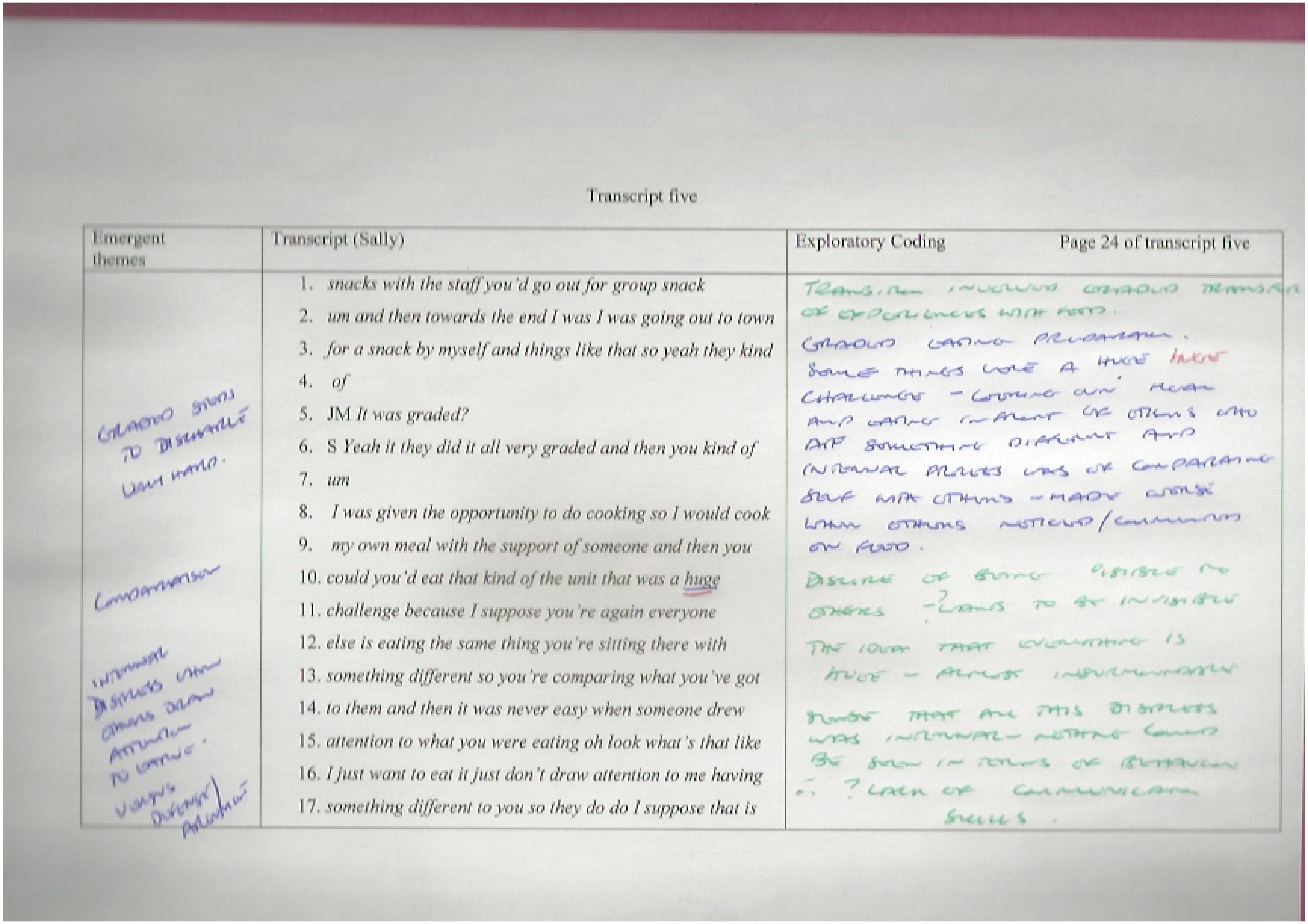


Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 22 of transcript five
	1. *was just ok you know I could I still struggled in my head*	CHECKING MENU WAS A STRUGGLE IN THE HEAD – TEMPTED BY RESTRICTION TOOK A SAFE OPTION {EXPERIENCE WAS PETRIFYING (THROWN [illegible] WITH FOOD)} BUT CHALLENGING ENOUGH
	2. *thinking what what do I do there was a section of five hundred*	
· TEMPTING TO GO BACK TO OLD WAYS.	3. *calories and less and I was so tempted because no one was*	
	4. *there to stop me but I didn't do that I just went for something*	
· A SENSE OF GOING IT ALONE AND FACING THE FOOD AND DOING IT ANYWAY	5. *else I kind of I went for something that was probably more of*	COMPARES OWN CHOICE WITH CHOICES OF OTHERS = TO INDICATE NORMALITY. BUT ANYWAY LAUGHTER/JOKES DISTRACTED HER FROM THESE ASPECTS
	6. *a safe option because obviously it was a petrifying time for me*	
	7. *but it was still challenging enough someone else had the same*	
	8. *thing so it wasn't I was ok this seemed quite normal but it was*	
	9. *just and then after that I just didn't even think about it you*	
· DISTRACTION THROUGH LAUGHTER RELIEF	10. *know cause laughter jokes and conversation and everything*	RELIEF THAT THERE WAS NO FOCUS ON HER EATING OR PLATE.
· RELIEF OF NOT BEING CHECKED UP ON.	11. *going on but it was just there was no focus on oh what's Sally*	
	12. *having you know kind of is she challenging herself is she*	TRANSITION INVOLVES A SENSE OF SELF THAT IS CONTINUALLY WATCHED BY OTHERS WHO KNOW HER HISTORY.
· NEW SENSE FEELING.	13. *cause I suppose that's what I just everyone I just always feel*	
	14. *like people are looking at my plate thinking has she got*	
· TRUST	15. *enough there and it's just it's probably in my paranoia more*	ALSO A SENSE OF OTHERS CHECKING UP ON HER AND HER PROGRESS IS SHE CHALLENGING HERSELF ETC
	16. *than anything but I do like a lot of the attention is always on*	
	17. *me.*	

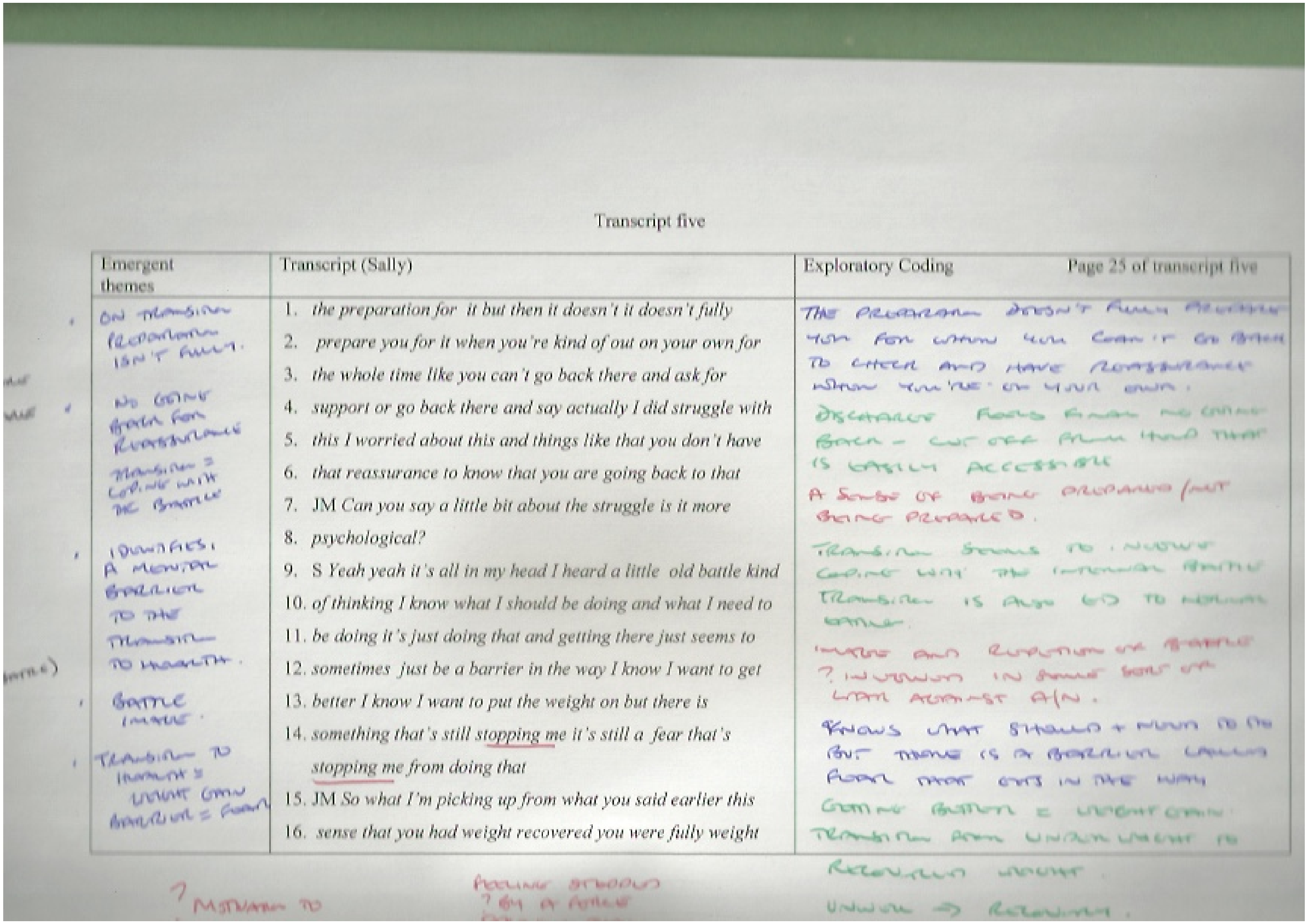
Transcript five

rgent es	Transcript (Sally)	Exploratory Coding Page 23 of transcript five
ING CHECKED UP ON : ENTIFYING OWN [illegible] : CONTINUE COMPARING SELF WITH OTHERS AS INPATIENT AND AS OUTPATIENT EPS TO DISCHARGE	1. JM *I'm wondering if it relates to the inpatient stay where* 2. *maybe there was a preoccupation on others by others on* 3. *what you were eating?* 4. S *Um possibly* 5. JM *By the staff?* 6. S *Yeah yeah cause they're always keeping an eye on* 7. *whether you're doing any behaviours whether you've* 8. *cleared your plate um I suppose when I was inpatient you* 9. *do you kind of start to you know maybe go out for lunch* 10. *and go out for dinner and go out for snack you're always* 11. *almost comparing well I know what they're having on the* 12. *unit I'm having way more than what they're having in the* 13. *unit you do start to compare in that sense um* 14. JM *So this was a stage really in your transition to* 15. *outpatient to go out for meals, was it with the staff?* 16. S *Um I didn't actually go out for a meal with the staff I um* 17. *went out for lunch with the staff and you'd go out for like*	AS AN INPATIENT THERE IS CHECKING BY STAFF – BUT AN INTERNAL CHECKING DEVELOPS COMPARING WHAT YOU EAT WITH WHAT OTHERS ARE EATING AND THIS HAPPENS WHEN YOU START TO HAVE MEALS/ FOOD OFF THE UNIT OTHERS JUDGE / SELF JUDGEMENT WHAT DOES IT MEAN TO HAVE "WAY MORE" LIZ – IS IT NICE AND HORRIBLE. PRIDE AND SHAME ??



Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 24 of transcript five
GRADED STEPS TO DISMANTLE [illegible]. COMPARISON INTERNAL DISTRESS WHEN OTHERS DRAW ATTENTION TO EATING. VISIBLE DIFFERENCE | ATTENTION	1. *snacks with the staff you'd go out for group snack* 2. *um and then towards the end I was I was going out to town* 3. *for a snack by myself and things like that so yeah they kind* 4. *of* 5. JM *It was graded?* 6. S *Yeah it they did it all very graded and then you kind of* 7. *um* 8. *I was given the opportunity to do cooking so I would cook* 9. *my own meal with the support of someone and then you* 10. *could you'd eat that kind of the unit that was a huge* 11. *challenge because I suppose you're again everyone* 12. *else is eating the same thing you're sitting there with* 13. *something different so you're comparing what you've got* 14. *to them and then it was never easy when someone drew* 15. *attention to what you were eating oh look what's that like* 16. *I just want to eat it just don't draw attention to me having* 17. *something different to you so they do do I suppose that is*	TRANSITION INVOLVED GRADED TRANSFER OF EXPERIENCES WITH FOOD. GRADED EATING PROGRAMME. SOME THINGS WERE A HUGE HUGE CHALLENGE – 'COOKING OWN' MEAL AND EATING IN FRONT OF OTHERS WHO ATE SOMETHING DIFFERENT AND INTERNAL PROCESS WAS OF COMPARING SELF WITH OTHERS – MADE WORSE WHEN OTHERS NOTICED/COMMENTED ON FOOD. DESIRE OF BEING INVISIBLE TO OTHERS – ? WANTS TO BE INVISIBLE THE IDEA THAT EVERYTHING IS HUGE – ALMOST INSURMOUNTABLE SENSE THAT ALL THIS DISTRESS WAS INTERNAL – NOTHING COULD BE SEEN IN TERMS OF BEHAVIOUR ∴ ? LACK OF COMMUNICATION SKILLS.



Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 25 of transcript five
ON TRANSITION PREPARATION ISN'T FULLY.	1. *the preparation for it but then it doesn't it doesn't fully*	THE PREPARATION DOESN'T FULLY PREPARE YOU FOR WHEN YOU CAN'T GO BACK TO CHECK AND HAVE REASSURANCE WHEN YOU'RE ON YOUR OWN.
	2. *prepare you for it when you're kind of out on your own for*	
	3. *the whole time like you can't go back there and ask for*	
NO GOING BACK FOR REASSURANCE	4. *support or go back there and say actually I did struggle with*	DISCHARGE FEELS FINAL NO GOING BACK – CUT OFF FROM HELP THAT IS EASILY ACCESSIBLE
	5. *this I worried about this and things like that you don't have*	
TRANSITION = COPING WITH THE BATTLE	6. *that reassurance to know that you are going back to that*	
	7. JM *Can you say a little bit about the struggle is it more*	A SENSE OF BEING PREPARED/NOT BEING PREPARED.
	8. *psychological?*	
IDENTIFIES A MENTAL BARRIER TO THE TRANSITION TO HEALTH.	9. S *Yeah yeah it's all in my head I heard a little old battle kind*	TRANSITION SEEMS TO INVOLVE COPING WITH THE INTERNAL BATTLE
	10. *of thinking I know what I should be doing and what I need to*	TRANSITION IS ALSO LED TO INTERNAL BATTLE.
	11. *be doing it's just doing that and getting there just seems to*	
	12. *sometimes just be a barrier in the way I know I want to get*	IMAGE AND RECEPTION OF BATTLE ? INVOLVED IN SOME SORT OF WAR AGAINST A/N.
BATTLE IMAGE.	13. *better I know I want to put the weight on but there is*	
TRANSITION TO HEALTH = WEIGHT GAIN BARRIER = FEAR	14. *something that's still stopping me it's still a fear that's stopping me from doing that*	KNOWS WHAT SHOULD + NEEDS TO DO BUT THERE IS A BARRIER CALLED FEAR THAT GETS IN THE WAY
	15. JM *So what I'm picking up from what you said earlier this*	GETTING BETTER = WEIGHT GAIN.
	16. *sense that you had weight recovered you were fully weight*	TRANSITION FROM UNDERWEIGHT TO RECOVERED WEIGHT.

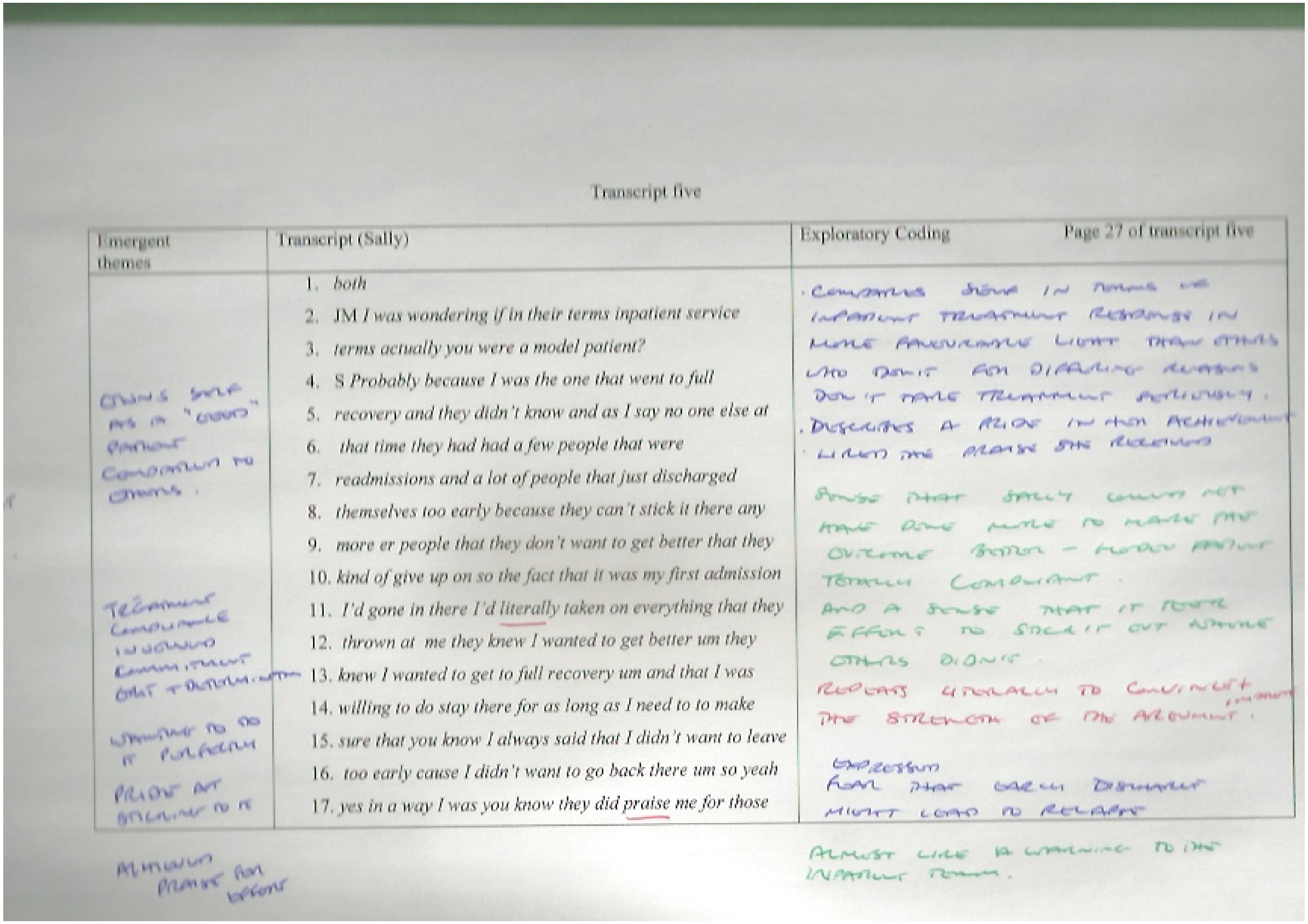
UNWELL → RECOVERY.

? MOTIVATION TO

FEELING STRONG ? BY A FEELING

Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 26 of transcript five
48 TRANSITION TO [illegible] FOCUS IS ON THE PHYSICAL SIDE AND MENTAL SIDE IS LEFT L8 – 13	1. *recovered* 2. S *(slight interruption) I'd got to the weight that I'd* 3. *specified that I would like to be discharged at* 4. JM *but there was a sense for you from what you just said* 5. *that psychologically there was still work to be done* 6. S *Yeah* 7. JM *and that was a bit of a gap for you?* 8. S *Yeah I think it's a gap for a lot of people or I think I* 9. *think they concentrate more on getting your weight up and* 10. *they don't fully deal with the mental side of it because the* 11. *mental side of it is the paramount it's the it's the main* 12. *problem I suppose it's all in the head and I don't think they* 13. *do do enough support for that.* 14. JM *Is there something else psychologically you would have* 15. *wanted to do whilst an inpatient or do you think it needed* 16. *to be done as an outpatient?* S *Um (Long pause) I don't know really probably a bit of*	INTERRUPTS TO BE SURE I'M TOLD ALL SHE HAD ACHIEVED HER WEIGHT GOAL IN TERMS OF THE PSYCHOLOGICAL MENTAL SIDE OF THE ILLNESS IT'S NOT FULLY DEALT WITH – FOCUS IS ON WEIGHT RESTORATION. MENTAL SIDE – REPEATS STRESS THE IMPORTANCE "PARAMOUNT" – SUGGESTS MORE IMPORTANT THAN ANYTHING. MATTER OF FACT WAY OF SAYING IT'S ALL IN YOUR HEAD – MAYBE A SENSE THAT WEIGHT RESTORATION IS EASY / OR EASIER THAN THE MENTAL SIDE

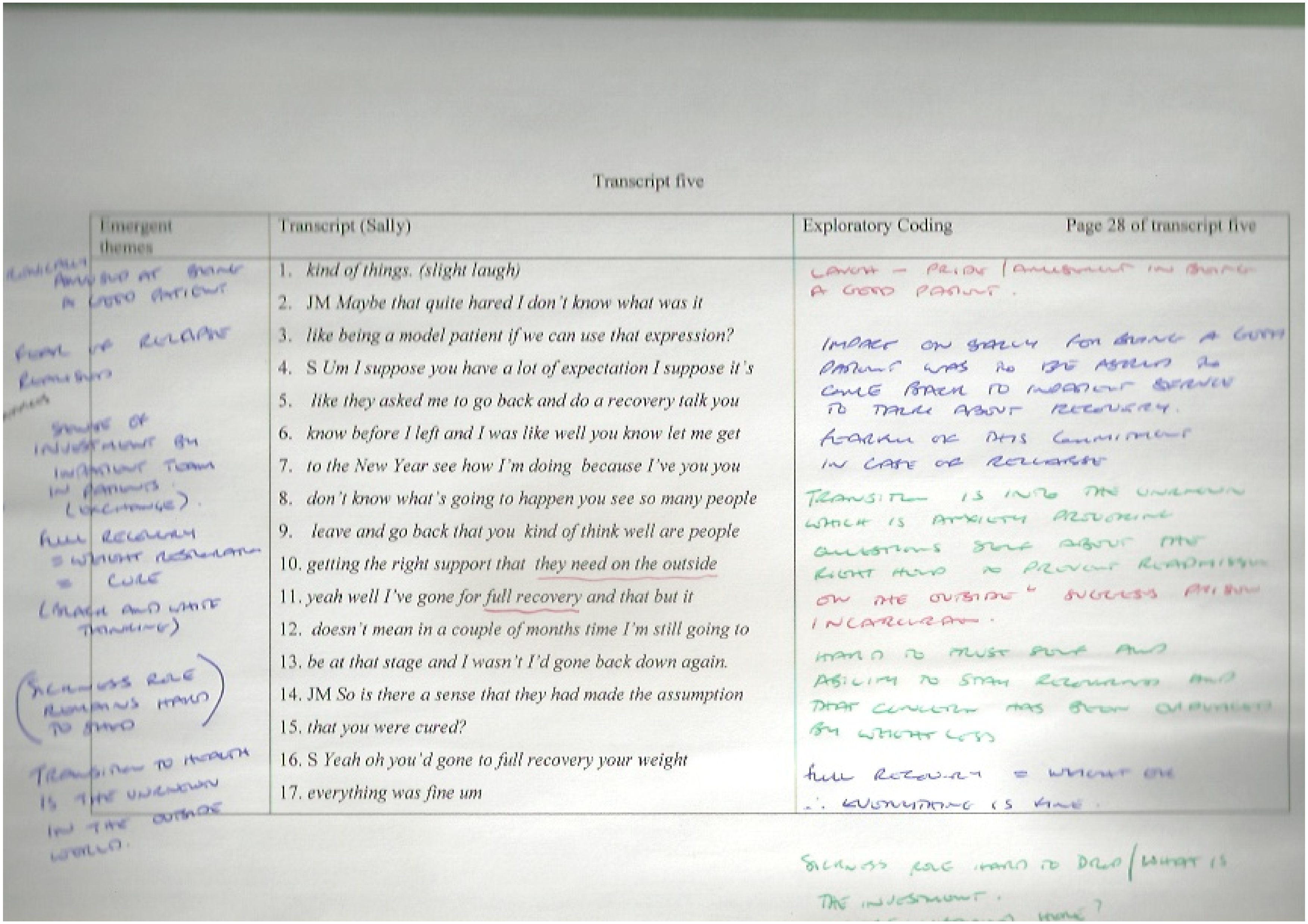


Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 27 of transcript five
OWNS SELF AS A "GOOD" PATIENT COMPARED TO OTHERS. TREATMENT COMPLIANCE INVOLVED COMMITMENT AND DETERMINATION WANTING TO DO IT PERFECTLY PRIDE AT STICKING TO IT	1. *both* 2. JM *I was wondering if in their terms inpatient service* 3. *terms actually you were a model patient?* 4. S *Probably because I was the one that went to full* 5. *recovery and they didn't know and as I say no one else at* 6. *that time they had had a few people that were* 7. *readmissions and a lot of people that just discharged* 8. *themselves too early because they can't stick it there any* 9. *more er people that they don't want to get better that they* 10. *kind of give up on so the fact that it was my first admission* 11. *I'd gone in there I'd literally taken on everything that they* 12. *thrown at me they knew I wanted to get better um they* 13. *knew I wanted to get to full recovery um and that I was* 14. *willing to do stay there for as long as I need to to make* 15. *sure that you know I always said that I didn't want to leave* 16. *too early cause I didn't want to go back there um so yeah* 17. *yes in a way I was you know they did praise me for those*	· COMPARES SELF IN TERMS OF INPATIENT TREATMENT RESPONSE IN MORE FAVOURABLE LIGHT THAN OTHERS WHO DON'T FOR DIFFERING REASONS DON'T TAKE TREATMENT SERIOUSLY. . DESCRIBES A PRIDE IN HER ACHIEVEMENT WHEN THE PRAISE SHE RECEIVED SENSE THAT SALLY COULD NOT HAVE DONE MORE TO MAKE THE OUTCOME BETTER – MODEL PATIENT TOTALLY COMPLIANT. AND A SENSE THAT IT TOOK EFFORT TO STICK IT OUT WHERE OTHERS DIDN'T. REPEATS 'TOTALLY' TO CONVINCE + INCREASE THE STRENGTH OF THE ARGUMENT. EXPRESSION FEAR THAT EARLY DISCHARGE MIGHT LEAD TO RELAPSE

ATTENTION PRAISE FOR EFFORTS

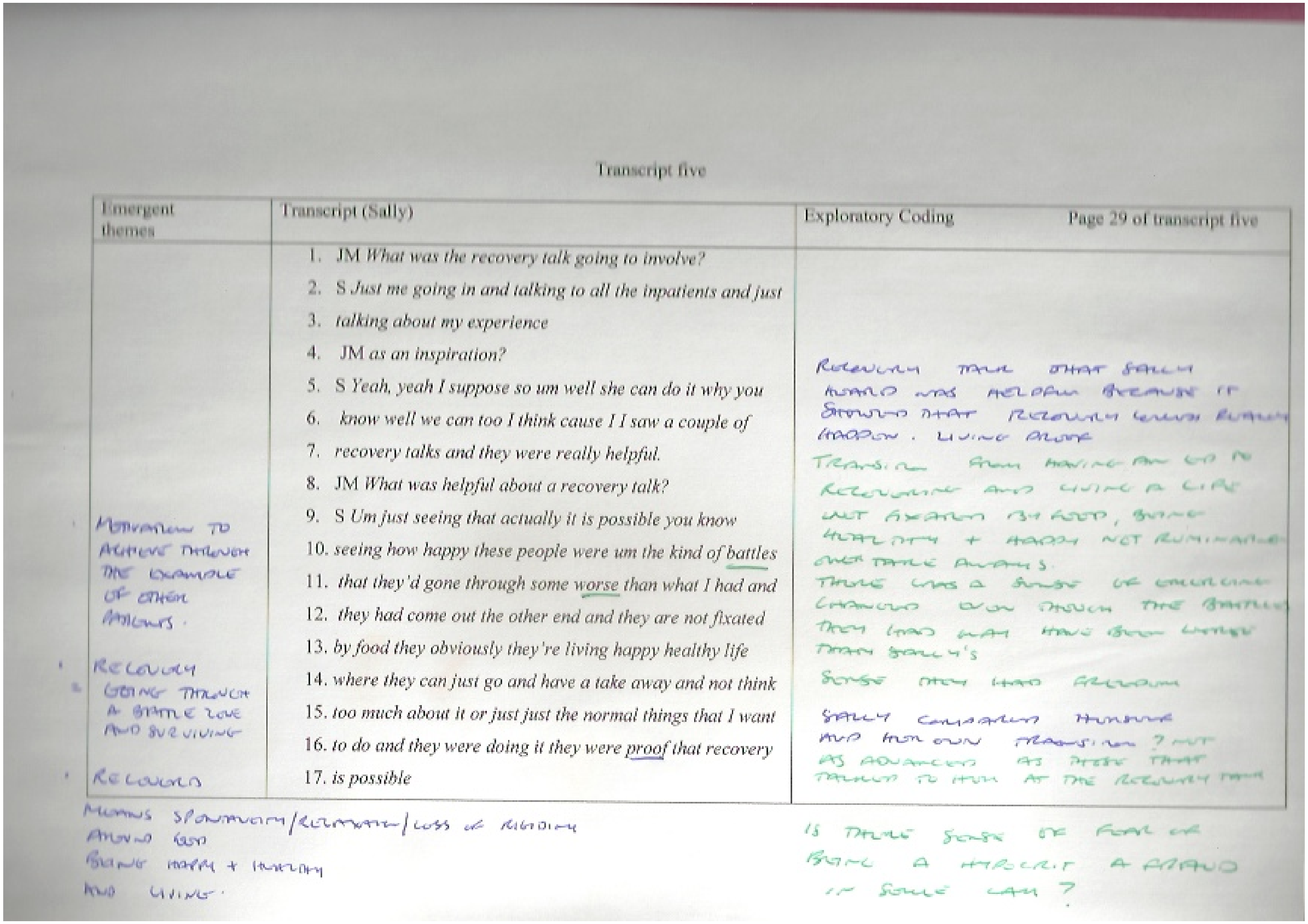
ALMOST LIKE A WARNING TO THE INPATIENT TEAM.



Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 28 of transcript five
IRONICALLY ANXIOUS AT BEING A GOOD PATIENT	1. *kind of things. (slight laugh)*	LAUGH – PRIDE / AMBIVALENT IN BEING A GOOD PATIENT.
	2. JM *Maybe that quite hared I don't know what was it*	
FEAR OF RELAPSE REMAINS	3. *like being a model patient if we can use that expression?*	IMPACT ON SALLY FOR BEING A GOOD PATIENT WAS TO BE ASKED TO COME BACK TO INPATIENT SERVICE TO TALK ABOUT RECOVERY.
	4. S *Um I suppose you have a lot of expectation I suppose it's*	
	5. *like they asked me to go back and do a recovery talk you*	
SENSE OF INVESTMENT BY INPATIENT TEAM IN PATIENTS (EXCHANGE).	6. *know before I left and I was like well you know let me get*	AWARE OF THIS COMMITMENT IN CASE OF RELAPSE
	7. *to the New Year see how I'm doing because I've you you*	
	8. *don't know what's going to happen you see so many people*	TRANSITION IS INTO THE UNKNOWN WHICH IS ANXIETY PROVOKING
FULL RECOVERY = WEIGHT RESTORATION = CURE	9. *leave and go back that you kind of think well are people*	QUESTIONS SELF ABOUT THE RIGHT HELP TO PREVENT READMISSION
	10. *getting the right support that they need on the outside*	"ON THE OUTSIDE" SUCCESS AFTER INCARCERATION.
(BLACK AND WHITE THINKING)	11. *yeah well I've gone for full recovery and that but it*	
	12. *doesn't mean in a couple of months time I'm still going to*	HARD TO TRUST SELF AND ABILITY TO STAY RECOVERED AND THAT CONCERN HAS BEEN COMPOUNDED BY WEIGHT LOSS
(SICKNESS ROLE REMAINS HARD TO SHED)	13. *be at that stage and I wasn't I'd gone back down again.*	
	14. JM *So is there a sense that they had made the assumption*	
	15. *that you were cured?*	
TRANSITION TO HEALTH IS THE UNKNOWN IN THE OUTSIDE WORLD.	16. S *Yeah oh you'd gone to full recovery your weight*	FULL RECOVERY = WEIGHT GAIN
	17. *everything was fine um*	∴ EVERYTHING IS FINE.

SICKNESS ROLE HARD TO DROP / WHAT IS THE INVESTMENT.
[illegible] HOME?

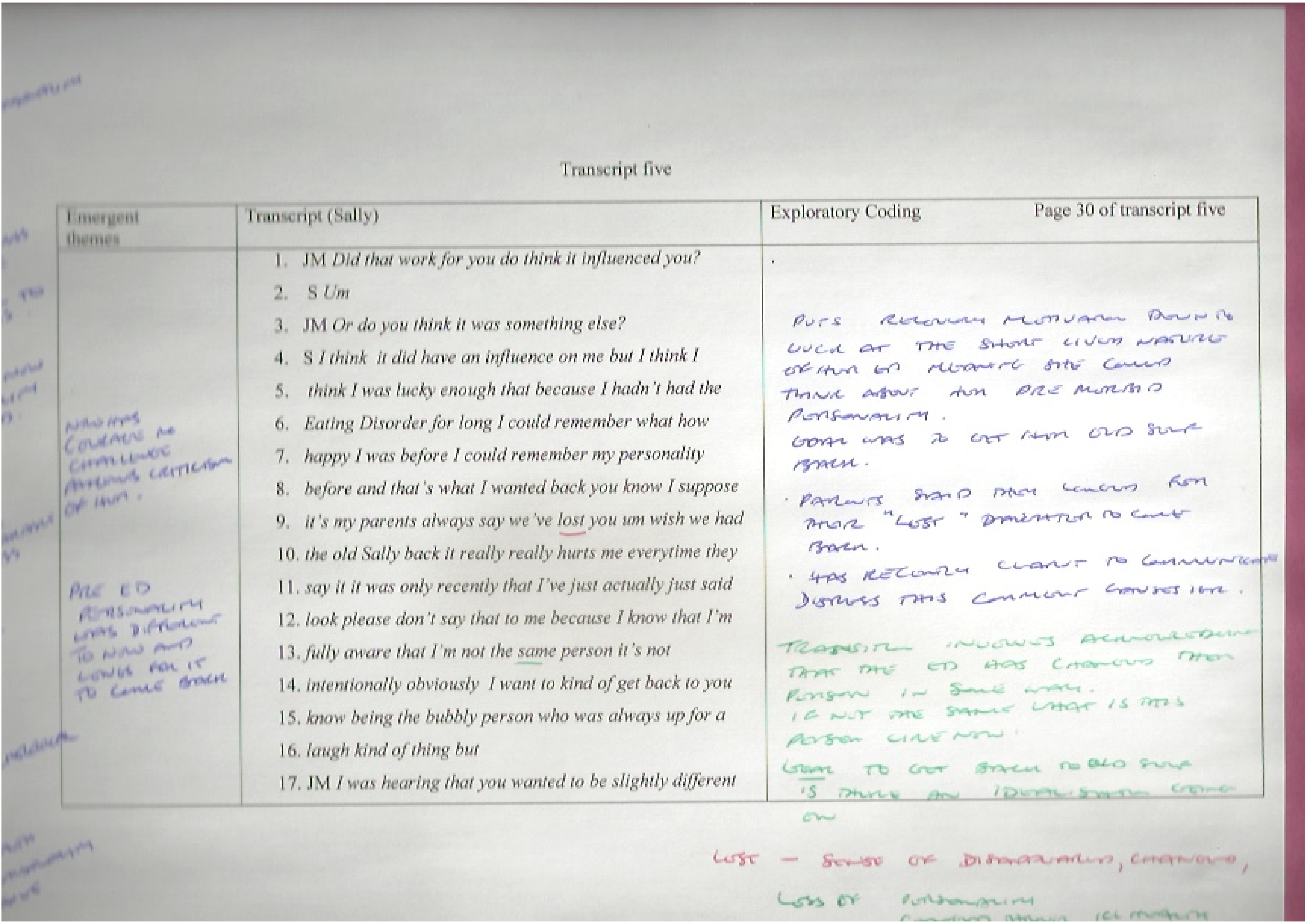


Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 29 of transcript five
MOTIVATION TO ACHIEVE THROUGH THE EXAMPLE OF OTHER PATIENTS. RECOVERY GOING THROUGH A BATTLE ZONE AND SURVIVING RECOVERED	1. JM *What was the recovery talk going to involve?* 2. S *Just me going in and talking to all the inpatients and just* 3. *talking about my experience* 4. JM *as an inspiration?* 5. S *Yeah, yeah I suppose so um well she can do it why you* 6. *know well we can too I think cause I I saw a couple of* 7. *recovery talks and they were really helpful.* 8. JM *What was helpful about a recovery talk?* 9. S *Um just seeing that actually it is possible you know* 10. *seeing how happy these people were um the kind of battles* 11. *that they'd gone through some worse than what I had and* 12. *they had come out the other end and they are not fixated* 13. *by food they obviously they're living happy healthy life* 14. *where they can just go and have a take away and not think* 15. *too much about it or just just the normal things that I want* 16. *to do and they were doing it they were proof that recovery* 17. *is possible*	RECOVERY TALK THAT SALLY HEARD WAS HELPFUL BECAUSE IT SHOWED THAT RECOVERY LEADS BEING HAPPY. LIVING ALONE TRANSITION FROM HAVING AN ED TO RECOVERING AND LIVING A LIFE NOT FIXATED BY FOOD, BEING HEALTHY + HAPPY NOT RUMINATING OVER THESE ALWAYS. THERE WAS A SENSE OF CHALLENGE CHANGED EVEN THOUGH THE BATTLES THEY HAD MAY HAVE BEEN WORSE THAN SALLY'S SENSE THEY HAD FREEDOM SALLY COMPARING HERSELF AND HER OWN TRANSITION ? NOT AS ADVANCED AS THOSE THAT TALKED TO HER AT THE RECOVERY TALK

MEANS SPONTANEITY/RELAXATION/LOSS OF RIGIDITY AROUND FOOD
BEING HAPPY + HEALTHY
AND LIVING.

IS THERE SENSE OF FEAR OF
BEING A HYPOCRIT A FRAUD
IN SOME WAY ?

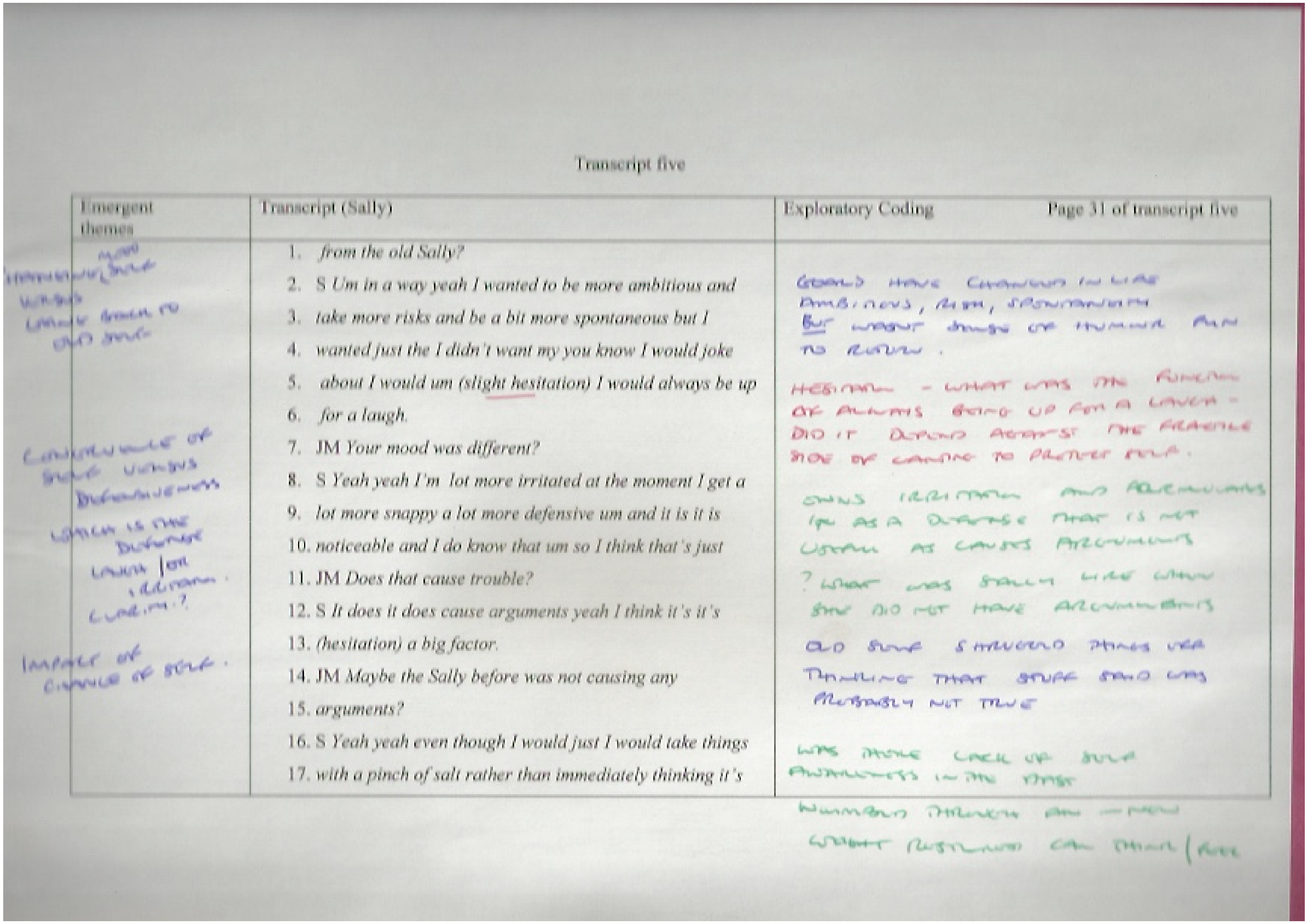


Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 30 of transcript five
NOW HAS COURAGE TO CHALLENGE PARENTS CRITICISM OF HIM. PRE ED PERSONALITY WAS DIFFERENT TO NOW AND LONGS FOR IT TO COME BACK	1. JM *Did that work for you do think it influenced you?* 2. S *Um* 3. JM *Or do you think it was something else?* 4. S *I think it did have an influence on me but I think I* 5. *think I was lucky enough that because I hadn't had the* 6. *Eating Disorder for long I could remember what how* 7. *happy I was before I could remember my personality* 8. *before and that's what I wanted back you know I suppose* 9. *it's my parents always say we've lost you um wish we had* 10. *the old Sally back it really really hurts me everytime they* 11. *say it it was only recently that I've just actually just said* 12. *look please don't say that to me because I know that I'm* 13. *fully aware that I'm not the same person it's not* 14. *intentionally obviously I want to kind of get back to you* 15. *know being the bubbly person who was always up for a* 16. *laugh kind of thing but* 17. JM *I was hearing that you wanted to be slightly different*	. PUTS RECOVERY MOTIVATION DOWN TO LUCK AT THE SHORT LIVED NATURE OF HIS ED ALLOWING HIM COULD THINK ABOUT HIS PRE MORBID PERSONALITY. GOAL WAS TO GET HIS OLD SELF BACK. · PARENTS SAID THEY LONGED FOR THEIR "LOST" DAUGHTER TO COME BACK. · HAS RECENTLY CHOSEN TO COMMUNICATE DISTRESS THIS COMMENT CAUSES HIM. TRANSITION – NOW ACKNOWLEDGING THAT THE ED HAS CHANGED THEM PERSON IN SOME WAY. IF NOT THE SAME WHAT IS THIS PERSON LIKE NOW. GOAL TO GET BACK TO OLD SELF IS THERE AN IDEALISATION GOING ON

LOST – SENSE OF DISAPPEARANCE, CHANGING,

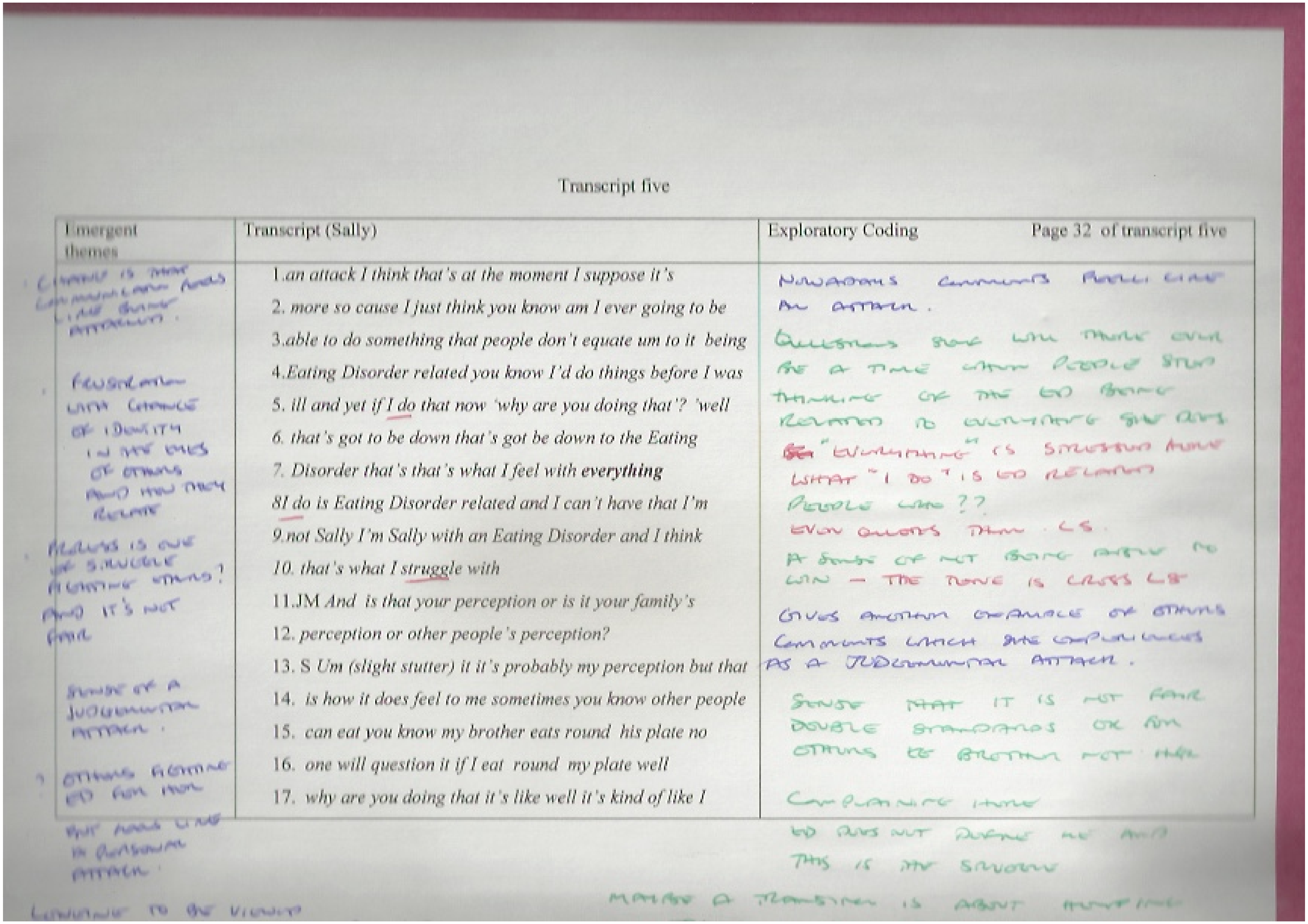
LOSS OF PERSONALITY



Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 31 of transcript five
[illegible] NEW SELF VERSUS LONGING BACK TO OLD SELF CONSEQUENCE OF SELF VERSUS DEFENSIVENESS WHICH IS THE DEFENCE LAUGH / OR IRRITATION. [illegible]? IMPACT OF CHANGE OF SELF.	1. *from the old Sally?* 2. S *Um in a way yeah I wanted to be more ambitious and* 3. *take more risks and be a bit more spontaneous but I* 4. *wanted just the I didn't want my you know I would joke* 5. *about I would um (slight hesitation) I would always be up* 6. *for a laugh.* 7. JM *Your mood was different?* 8. S *Yeah yeah I'm lot more irritated at the moment I get a* 9. *lot more snappy a lot more defensive um and it is it is* 10. *noticeable and I do know that um so I think that's just* 11. JM *Does that cause trouble?* 12. S *It does it does cause arguments yeah I think it's it's* 13. *(hesitation) a big factor.* 14. JM *Maybe the Sally before was not causing any* 15. *arguments?* 16. S *Yeah yeah even though I would just I would take things* 17. *with a pinch of salt rather than immediately thinking it's*	GOALS HAVE CHANGED IN LIFE AMBITIOUS, RISK, SPONTANEITY BUT WANT SENSE OF HUMOUR AND TO RETURN. HESITATION – WHAT WAS THE FUNCTION OF ALWAYS BEING UP FOR A LAUGH – DID IT DEFEND AGAINST THE FRAGILE SIDE OF CARING TO PROTECT SELF. OWNS IRRITATION AND ACKNOWLEDGES IT AS A DEFENCE THAT IS NOT USEFUL AS CAUSES ARGUMENTS ? WHAT WAS SALLY LIKE WHEN SHE DID NOT HAVE ARGUMENTS OLD SELF S HANDLED THINGS VIA THINKING THAT STUFF SAID WAS PROBABLY NOT TRUE WAS THERE LACK OF SELF AWARENESS IN THE PAST

WONDER THROUGH [illegible] – NEW
WITHOUT RESTRAINT CAN THINK / FEEL



Transcript five

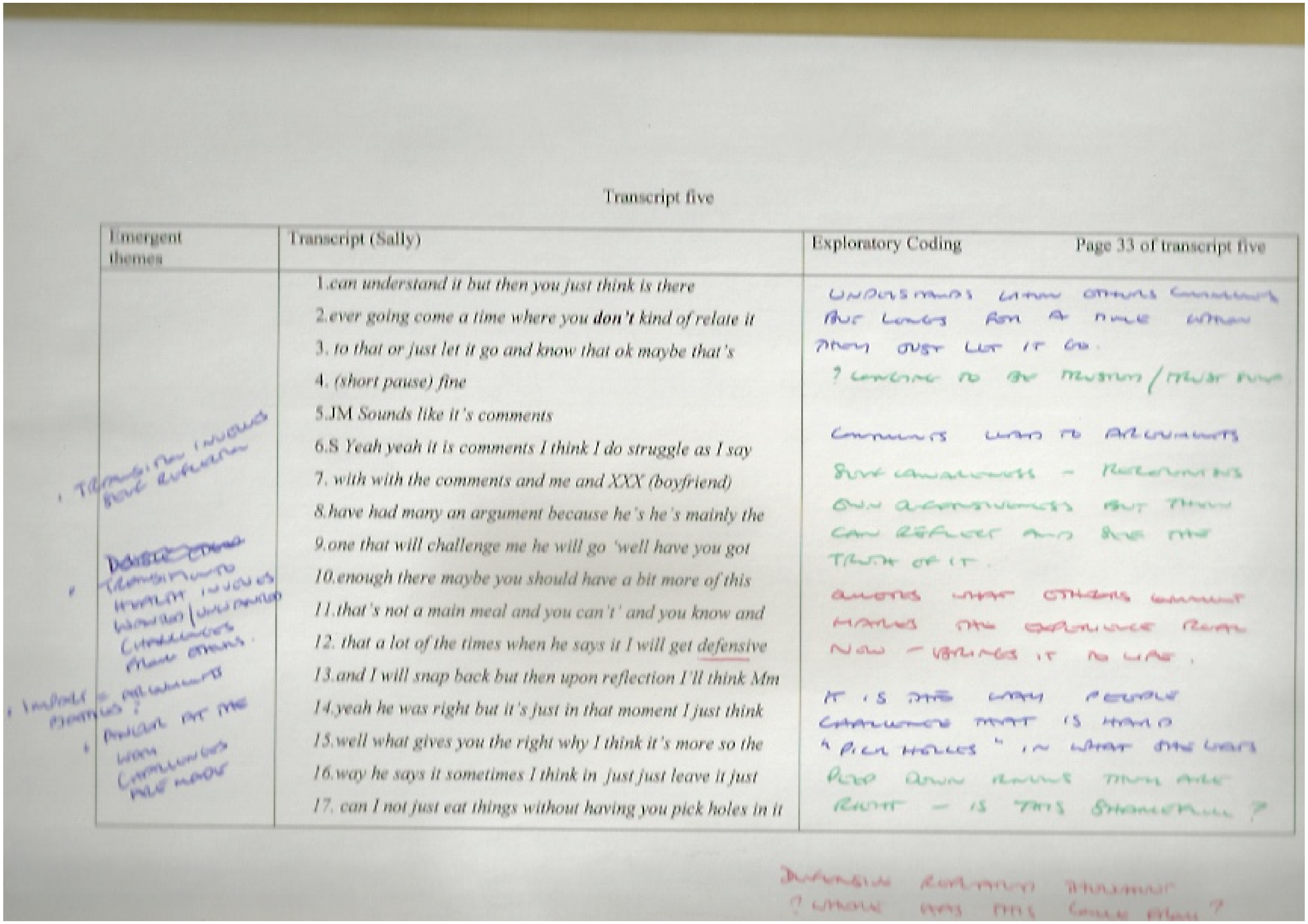
Emergent themes	Transcript (Sally)	Exploratory Coding Page 32 of transcript five
CHANGE IS THAT COMMUNICATION FEELS LIKE BEING ATTACKED.	1.*an attack I think that's at the moment I suppose it's*	NOWADAYS COMMENTS FEEL LIKE AN ATTACK.
	2. *more so cause I just think you know am I ever going to be*	
	3.*able to do something that people don't equate um to it being*	QUESTIONS SHE WILL THINK OVER ARE A TIME WHEN PEOPLE STOP THINKING OF THE ED BEING RELATED TO EVERYTHING SHE DOES
FRUSTRATION WITH CHANGE OF IDENTITY IN THE EYES OF OTHERS AND HOW THEY RELATE	4.*Eating Disorder related you know I'd do things before I was*	
	5. *ill and yet if I do that now 'why are you doing that'? 'well*	
	6. *that's got to be down that's got be down to the Eating*	
	7. *Disorder that's that's what I feel with* ***everything***	~~[illegible]~~ "EVERYTHING" IS STRESSED HOW WHAT "I DO" IS ED RELATED
	8*I do is Eating Disorder related and I can't have that I'm*	PEOPLE LIKE??
FEELINGS IS ONE OF STRUGGLE FIGHTING OTHERS? AND IT'S NOT FAIR	9.*not Sally I'm Sally with an Eating Disorder and I think*	EVEN QUOTES THEM. LS.
	10. *that's what I struggle with*	A SENSE OF NOT BEING ABLE TO WIN — THE TONE IS CROSS LS
	11.JM *And is that your perception or is it your family's*	GIVES ANOTHER EXAMPLE OF OTHERS COMMENTS WHICH SHE EXPERIENCES AS A JUDGEMENTAL ATTACK.
	12. *perception or other people's perception?*	
	13. S *Um (slight stutter) it it's probably my perception but that*	
SENSE OF A JUDGEMENTAL ATTACK.	14. *is how it does feel to me sometimes you know other people*	SENSE THAT IT IS NOT FAIR DOUBLE STANDARDS OK FOR OTHERS EG BROTHER NOT HER
	15. *can eat you know my brother eats round his plate no*	
OTHERS FIGHTING ED FOR HER	16. *one will question it if I eat round my plate well*	
	17. *why are you doing that it's like well it's kind of like I*	COMPLAINING HERE

BUT FEELS LIKE A PERSONAL ATTACK.

ED DOES NOT DEFINE ME AND THIS IS MY STRUGGLE

LONGING TO BE VIEWED

MAYBE A TRANSITION IS ABOUT ACCEPTING



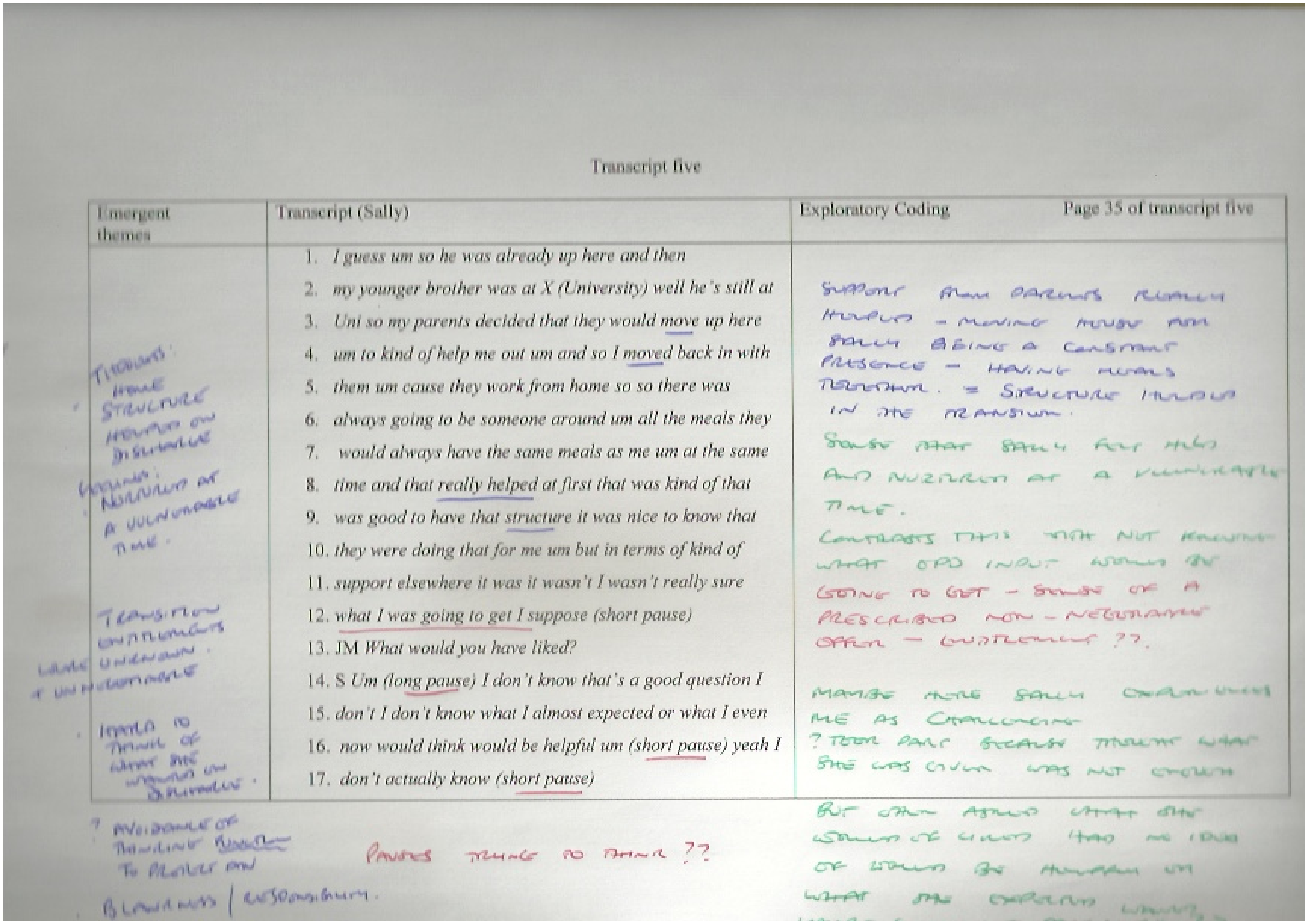
Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 33 of transcript five
• TRANSITION INVOLVES SELF REFLECTION ~~DOUBLE EDGED~~ • TRANSITION TO HEALTH INVOLVES WANTED/UNWANTED CHALLENGES FROM OTHERS. • IMPACT = ARGUMENTS PROBLEMS ? • ANGER AT THE WAY CHALLENGES ARE MADE	*1.can understand it but then you just think is there* *2.ever going come a time where you* ***don't*** *kind of relate it* *3. to that or just let it go and know that ok maybe that's* *4. (short pause) fine* *5.JM Sounds like it's comments* *6.S Yeah yeah it is comments I think I do struggle as I say* *7. with with the comments and me and XXX (boyfriend)* *8.have had many an argument because he's he's mainly the* *9.one that will challenge me he will go 'well have you got* *10.enough there maybe you should have a bit more of this* *11.that's not a main meal and you can't' and you know and* *12. that a lot of the times when he says it I will get defensive* *13.and I will snap back but then upon reflection I'll think Mm* *14.yeah he was right but it's just in that moment I just think* *15.well what gives you the right why I think it's more so the* *16.way he says it sometimes I think in just just leave it just* *17. can I not just eat things without having you pick holes in it*	UNDERSTANDS WHEN OTHERS COMMENT BUT LONGS FOR A TIME WHEN THEY JUST LET IT GO. ? LONGING TO BE TRUSTED / TRUST [illegible] COMMENTS LEAD TO ARGUMENTS SELF AWARENESS – RECOGNISES OWN DEFENSIVENESS BUT THEN CAN REFLECT AND SEE THE TRUTH OF IT. QUOTES WHAT OTHERS COMMENT MAKES THE EXPERIENCE REAL NOW – BRINGS IT TO LIFE. IT IS THE WAY PEOPLE CHALLENGE THAT IS HARD "PICK HOLES" IN WHAT SHE EATS PUT DOWN RULES THAT ARE RIGHT – IS THIS SHAMEFUL ?

DEFENSIVE REACTION TRIGGER
? WHERE HAS THIS COME FROM ?

Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 34 of transcript five
· TRANSITION MOVES TO INVOLVING BEING CHECKED ON BY OTHERS SUPPORT TRANSFERS · FORMAL CLINICAL SUPPORT. AND INFORMAL FAMILY SUPPORT. EXPERIENCE SAYS DANGEROUS TO BE ALONE! [illegible]	1. JM *A running commentary?* 2. S *Yeah I think that's what I do struggle with now (short* 3. *pause)* 4. JM *And looking back when you were a inpatient what was* 5. *your view when you were discharged? what was your* 6. S *Um I didn't really know I suppose it was just that* 7. *I would be coming to see someone here um I would* 8. *be living with my parents so I would have someone around* 9. *all the time um* 10. JM *So everybody your whole family including* 11. *your boyfriend moved here?* 12. S *No XXX (boyfriend) XXX is studying he is doing a* 13. *PHD in X (University) so I was actually living with* 14. *him (short pause) kind of when I was ill and that's where* 15. *it got a lot worse cause I was at home by myself so I was* 16. *just exercising the whole time and not really eating cause* 17. *no one was there to keep an eye on me (slight hesitation*	PRACTICALLY THE TRANSITION WAS SEEING SOMEONE IN AN ED SERVICE, LIVING WITH PARENTS, SOMEONE AROUND ALL THE TIME CONTRAST THIS WITH PRE INPATIENT LIVING – LIVING WITH BOYFRIEND BEING HOME ALONE WAS NO GETTING ILL = NOT WATCHING NO ONE CHECKING BEING "KEEP AN EYE ON" WHAT DOES THAT MEAN ? ENSURE SAFETY. ? LIKES BEING CHECKED ON ? HATES BEING CHECKED ON. TRANSITION INVOLVES KEEPING SAFE.



Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 35 of transcript five
	1. *I guess um so he was already up here and then*	
	2. *my younger brother was at X (University) well he's still at*	SUPPORT FROM PARENTS REALLY HELPED – MOVING HOUSE FOR SALLY BEING A CONSTANT PRESENCE – HAVING MEALS TOGETHER. = STRUCTURE HELPED IN THE TRANSITION.
	3. *Uni so my parents decided that they would move up here*	
THOUGHTS: · HOME STRUCTURE HELPED ON DISCHARGE	4. *um to kind of help me out um and so I moved back in with*	
	5. *them um cause they work from home so so there was*	
	6. *always going to be someone around um all the meals they*	
	7. *would always have the same meals as me um at the same*	SENSE THAT SALLY FELT HELD AND NURTURED AT A VULNERABLE TIME.
FEELINGS: · NURTURED AT A VULNERABLE TIME.	8. *time and that really helped at first that was kind of that*	
	9. *was good to have that structure it was nice to know that*	
	10. *they were doing that for me um but in terms of kind of*	CONTRASTS THIS WITH NOT KNOWING WHAT OPD INPUT WOULD BE GOING TO GET – SENSE OF A PRESCRIBED NON-NEGOTIABLE OFFER – CONTROLLING ??.
	11. *support elsewhere it was it wasn't I wasn't really sure*	
TRANSITION ENTITLEMENTS LEAVE UNKNOWN. & UNMANAGEABLE	12. *what I was going to get I suppose (short pause)*	
	13. JM *What would you have liked?*	
	14. S *Um (long pause) I don't know that's a good question I*	MAYBE HERE SALLY CHALLENGES ME AS CHALLENGING ? TOOK PART BECAUSE THOUGHT WHAT SHE WAS GIVEN WAS NOT ENOUGH
· UNABLE TO THINK OF WHAT SHE WANTED ON DISCHARGE.	15. *don't I don't know what I almost expected or what I even*	
	16. *now would think would be helpful um (short pause) yeah I*	
	17. *don't actually know (short pause)*	

? AVOIDANCE OF THINKING BECAUSE TO REFLECT ON
· BLAMING \| RESPONSIBILITY.

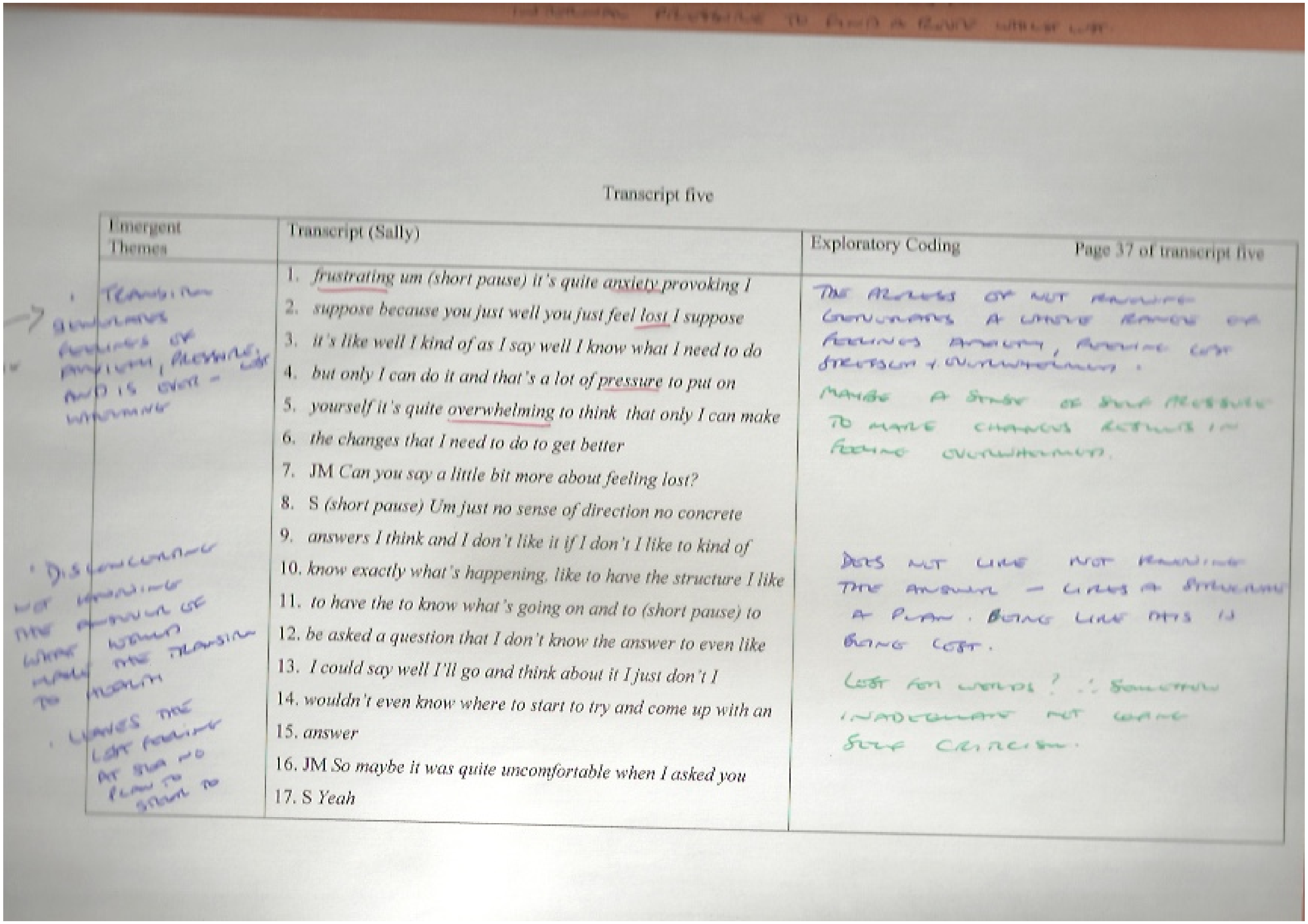
PAUSES TRYING TO THINK ??

BUT WHEN ASKED WHAT SHE WOULD OF LIKED HAD NO IDEA OF WHAT BE HELPFUL UM WHAT SHE EXPECTED WANT?

Transcript five

Emergent Themes	Transcript (Sally)	Exploratory Coding Page 36 of transcript five
· Frustration at not knowing what would help make the switch (transition to health). · Self critical of the block being entirely down to her. · Easier not to know as it keeps people away from helping in transition (is the avoidance is coping mechanism)	1. JM *Does that feel strange not knowing* 2. S *(quickly) Yeah yeah I think I do find it hard to pin point* 3. *things as well you know it's like X (nurse) asked me the* 4. *other day 'what can I do what help do you want from me?'* 5. *I don't know my parents say 'how can we help you?' I* 6. *don't know I don't know what it is that's going to help me* 7. *(swallows) I don't know what help to ask for what could* 8. *make this any easier because ultimately only I can make* 9. *myself better only I can eat what do what I need to do to* 10. *get there no one else can can do anything in in that sense* 11. *you know I need to want to to have to get better to get* 12. *better so that's why I find it hard when people say well* 13. *what how can we help what could have been done* 14. *differently or I don't don't know* 15. JM *I wonder what feeling that generates when you don't* 16. *know when someone is asking you what can we do* 17. S *(slight interruption)Yeah it's frustration it's really*	Reports didn't know maybe feels frustration at not being able to verbalize what she feels would help her. In the end ~~[illegible]~~ it is down to me to make changes so ? no one else can do it for me. Would it be nice if others could do it for her Self blame at not knowing and not doing the change Owns frustration of this process lit. ? Hard to get people in to help her ? Not knowing as a way of keeping an avoidance

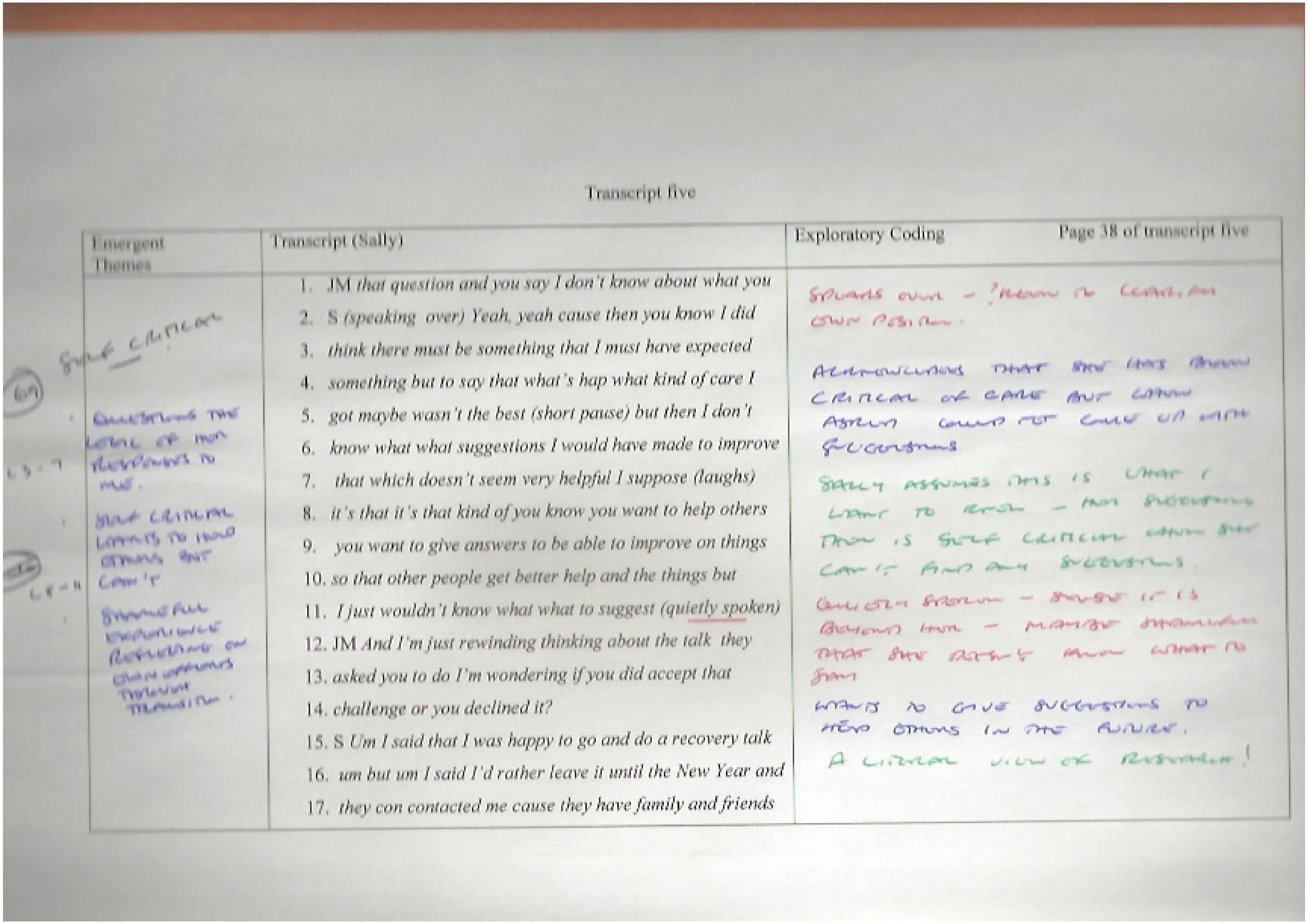
Same – carried down in box.



[illegible] PRESSURE TO FIND A [illegible] [illegible] [illegible]

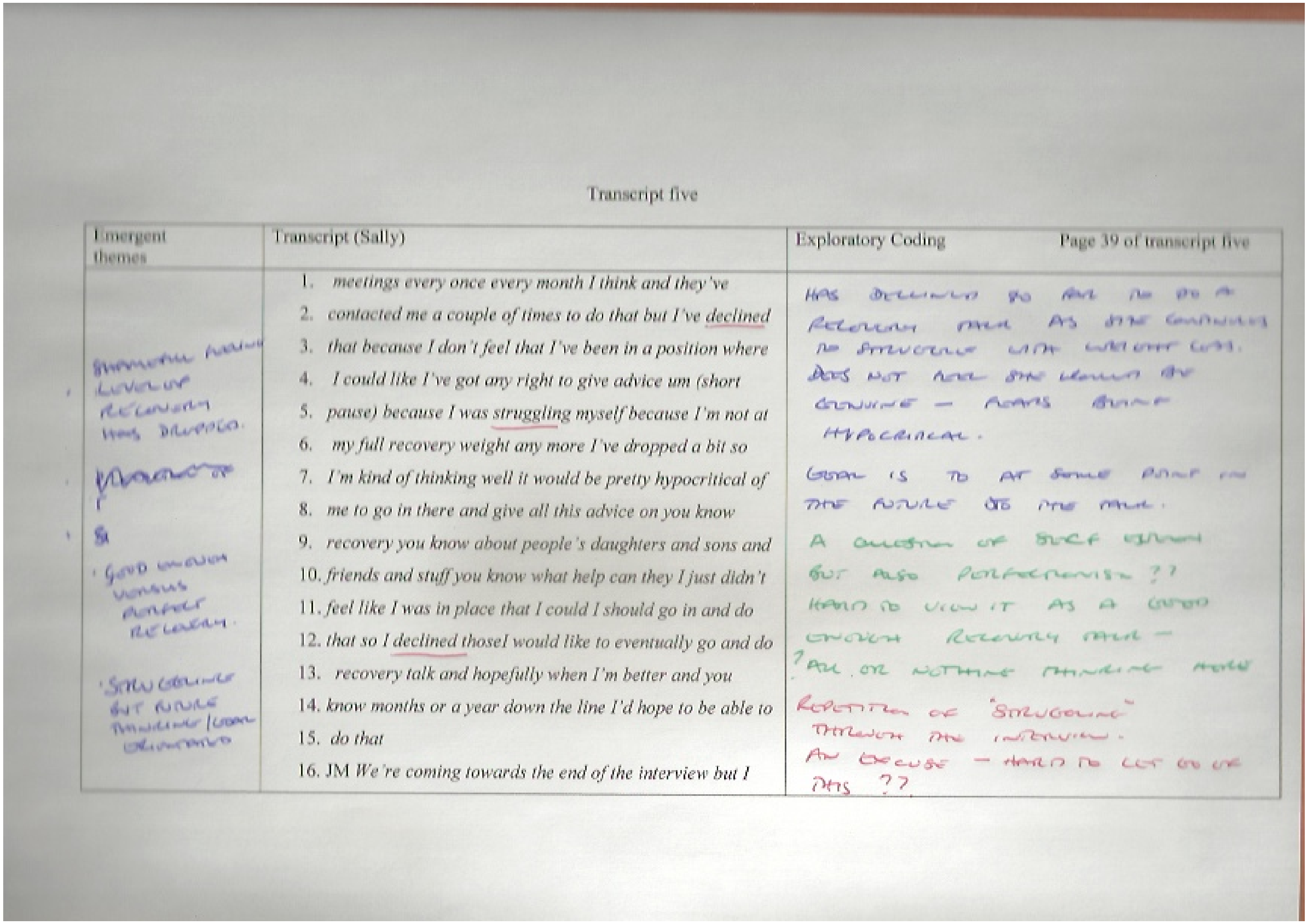
Transcript five

Emergent Themes	Transcript (Sally)	Exploratory Coding Page 37 of transcript five
• TRANSITION STIMULATES FEELINGS OF ANXIETY, PRESSURE, AND IS OVER-WHELMING	1. *frustrating um (short pause) it's quite anxiety provoking I* 2. *suppose because you just well you just feel lost I suppose* 3. *it's like well I kind of as I say well I know what I need to do* 4. *but only I can do it and that's a lot of pressure to put on* 5. *yourself it's quite overwhelming to think that only I can make* 6. *the changes that I need to do to get better* 7. JM *Can you say a little bit more about feeling lost?* 8. S *(short pause) Um just no sense of direction no concrete* 9. *answers I think and I don't like it if I don't I like to kind of*	THE PROCESS OF NOT KNOWING GENERATES A WHOLE RANGE OF FEELINGS ANXIETY, FEELING LOST FRUSTRATION + OVERWHELMING. MAYBE A SENSE OF SELF PRESSURE TO MAKE CHANGES RESULTS IN FEELING OVERWHELMED.
• DISCONCERTING NOT KNOWING THE ANSWER OF WHAT WOULD MAKE THE TRANSITION TO HEALTH • LEAVES THE [illegible] FEELING AT SEA NO PLAN TO START TO	10. *know exactly what's happening, like to have the structure I like* 11. *to have the to know what's going on and to (short pause) to* 12. *be asked a question that I don't know the answer to even like* 13. *I could say well I'll go and think about it I just don't I* 14. *wouldn't even know where to start to try and come up with an* 15. *answer* 16. JM *So maybe it was quite uncomfortable when I asked you* 17. S *Yeah*	DOES NOT LIKE NOT KNOWING THE ANSWER – LIKES A STRUCTURE A PLAN. BEING LIKE THIS IS BEING LOST. LOST FOR WORDS? ∴ SOMETHING INADEQUATE NOT KNOWING SELF CRITICISM.



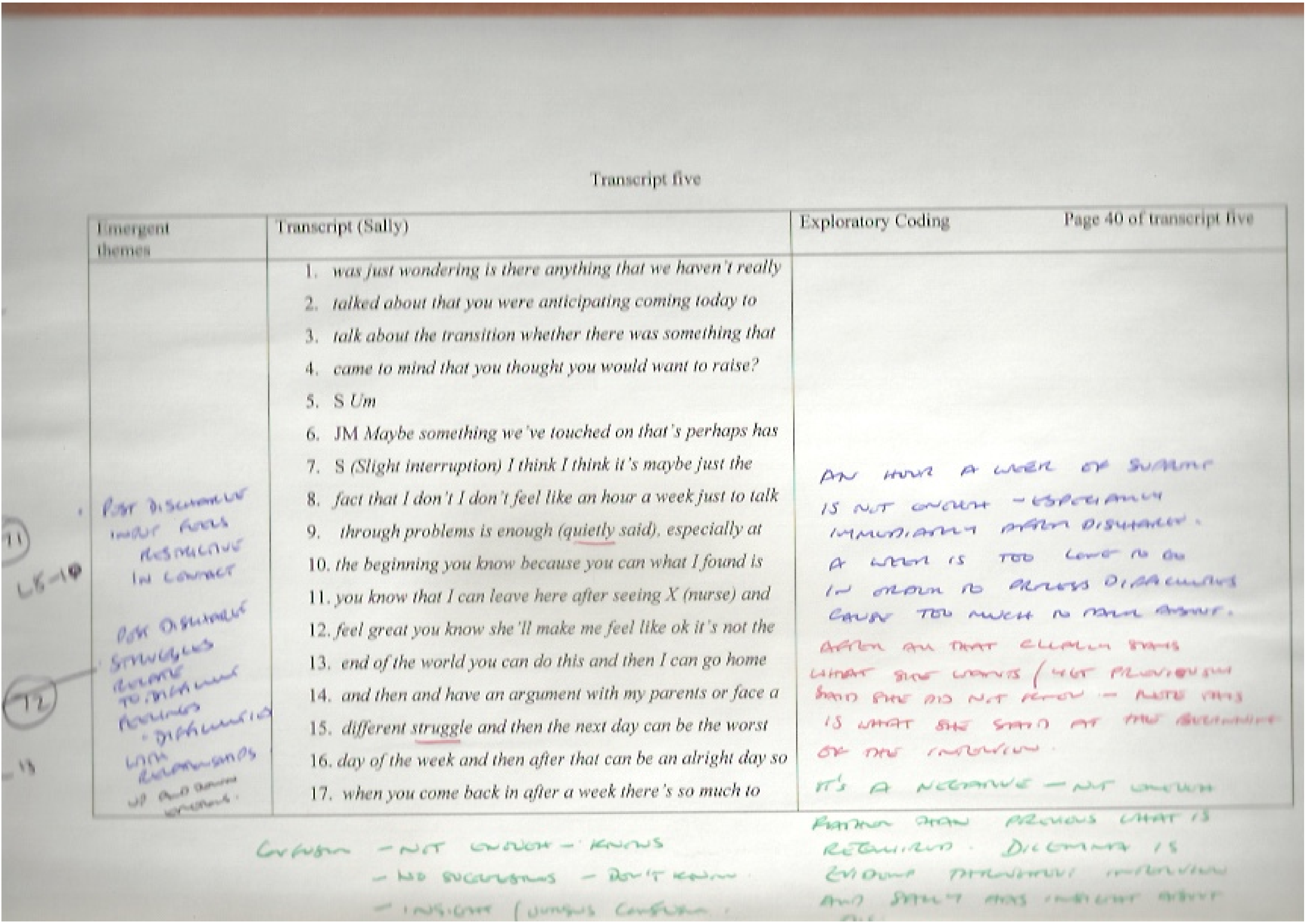
Transcript five

Emergent Themes	Transcript (Sally)	Exploratory Coding / Page 38 of transcript five
SELF CRITICAL (69) · QUESTIONING THE LEVEL OF HER RESPONSES TO ME. L3-7 · SELF CRITICAL WANTS TO HELP OTHERS BUT CAN'T L8-11 · SHAMEFUL EXPERIENCE REFLECTING ON OWN ACTIONS THROUGH TRANSITION.	1. JM *that question and you say I don't know about what you* 2. S *(speaking over) Yeah, yeah cause then you know I did* 3. *think there must be something that I must have expected* 4. *something but to say that what's hap what kind of care I* 5. *got maybe wasn't the best (short pause) but then I don't* 6. *know what what suggestions I would have made to improve* 7. *that which doesn't seem very helpful I suppose (laughs)* 8. *it's that it's that kind of you know you want to help others* 9. *you want to give answers to be able to improve on things* 10. *so that other people get better help and the things but* 11. *I just wouldn't know what what to suggest (quietly spoken)* 12. JM *And I'm just rewinding thinking about the talk they* 13. *asked you to do I'm wondering if you did accept that* 14. *challenge or you declined it?* 15. S *Um I said that I was happy to go and do a recovery talk* 16. *um but um I said I'd rather leave it until the New Year and* 17. *they con contacted me cause they have family and friends*	SPEAKS OWN – ?REASON TO LEAVE, AN OWN POSITION. ACKNOWLEDGES THAT SHE HAS BEEN CRITICAL OF CARE BUT CANNOT AGAIN COULD NOT COME UP WITH SUGGESTIONS SALLY ASSUMES THIS IS WHAT I WANT TO KNOW – HER SUGGESTIONS THEN IS SELF CRITICAL WHEN SHE CAN'T FIND ANY SUGGESTIONS. QUIETLY SPOKEN – SUGGEST IT IS BEYOND HER – MAYBE [illegible] THAT SHE DOESN'T KNOW WHAT TO SAY WANTS TO GIVE SUGGESTIONS TO HELP OTHERS IN THE FUTURE. A CRITICAL VIEW OF RESEARCH!



Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 39 of transcript five
SHAMEFUL FEELING LEVEL OF RECOVERY HAS DROPPED. HYPOCRITE · GOOD ENOUGH VERSUS PERFECT RECOVERY. · STRUGGLING BUT FUTURE THINKING / GOAL ORIENTATED	1. *meetings every once every month I think and they've* 2. *contacted me a couple of times to do that but I've declined* 3. *that because I don't feel that I've been in a position where* 4. *I could like I've got any right to give advice um (short* 5. *pause) because I was struggling myself because I'm not at* 6. *my full recovery weight any more I've dropped a bit so* 7. *I'm kind of thinking well it would be pretty hypocritical of* 8. *me to go in there and give all this advice on you know* 9. *recovery you know about people's daughters and sons and* 10. *friends and stuff you know what help can they I just didn't* 11. *feel like I was in place that I could I should go in and do* 12. *that so I declined thoseI would like to eventually go and do* 13. *recovery talk and hopefully when I'm better and you* 14. *know months or a year down the line I'd hope to be able to* 15. *do that* 16. JM *We're coming towards the end of the interview but I*	HAS DECLINED SO FAR TO DO A RECOVERY TALK AS SHE CONTINUES TO STRUGGLE WITH WEIGHT LOSS. DOES NOT FEEL SHE WOULD BE GENUINE — FEARS BEING HYPOCRITICAL. GOAL IS TO AT SOME POINT IN THE FUTURE DO THE TALK. A QUESTION OF SELF ESTEEM BUT ALSO PERFECTIONISM ?? HARD TO VIEW IT AS A GOOD ENOUGH RECOVERY TALK — ? ALL OR NOTHING THINKING HERE REPETITION OF "STRUGGLING" THROUGH THE INTERVIEW. AN EXCUSE — HARD TO LET GO OF THIS ??



Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 40 of transcript five
POST DISCHARGE INPUT FEELS RESTRICTIVE IN CONTACT POST DISCHARGE STRUGGLES RELATE TO DIFFICULT FEELINGS · DIFFICULTIES WITH RELATIONSHIPS UP AND DOWN EMOTIONS.	1. *was just wondering is there anything that we haven't really* 2. *talked about that you were anticipating coming today to* 3. *talk about the transition whether there was something that* 4. *came to mind that you thought you would want to raise?* 5. S *Um* 6. JM *Maybe something we've touched on that's perhaps has* 7. S *(Slight interruption) I think I think it's maybe just the* 8. *fact that I don't I don't feel like an hour a week just to talk* 9. *through problems is enough (quietly said), especially at* 10. *the beginning you know because you can what I found is* 11. *you know that I can leave here after seeing X (nurse) and* 12. *feel great you know she'll make me feel like ok it's not the* 13. *end of the world you can do this and then I can go home* 14. *and then and have an argument with my parents or face a* 15. *different struggle and then the next day can be the worst* 16. *day of the week and then after that can be an alright day so* 17. *when you come back in after a week there's so much to*	AN HOUR A WEEK OF SUPPORT IS NOT ENOUGH – ESPECIALLY IMMEDIATELY AFTER DISCHARGE. A WEEK IS TOO LONG TO GO IN ORDER TO PROCESS DIFFICULTIES CAUSE TOO MUCH TO TALK ABOUT. AFTER ALL THAT CLEARLY STATES WHAT SHE WANTS / YET PREVIOUSLY SAID SHE DID NOT KNOW – NOTE THIS IS WHAT SHE SAID AT THE BEGINNING OF THE INTERVIEW. IT'S A NEGATIVE – NOT ENOUGH

11

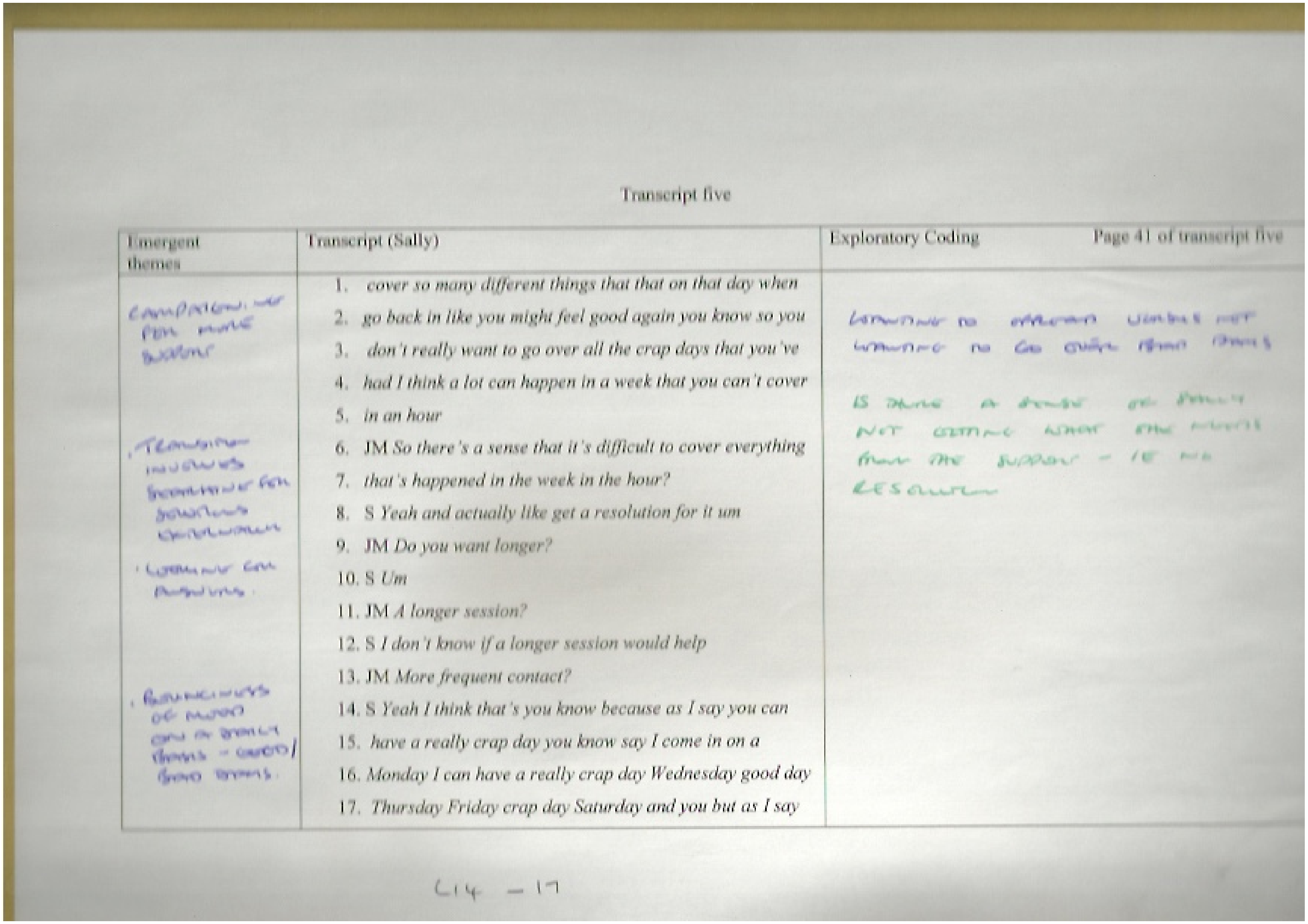
L8-10

12

– 13

CONFUSION – NOT ENOUGH – KNOWS
– NO SUGGESTIONS – DON'T KNOW.
– INSIGHT (UNSURE CONFUSION.

RATHER THAN PREVIOUS WHAT IS
REQUIRED. DICHOTOMY IS
EVIDENT THROUGHOUT INTERVIEW
AND SALLY HAS INSIGHT ABOUT



Transcript five

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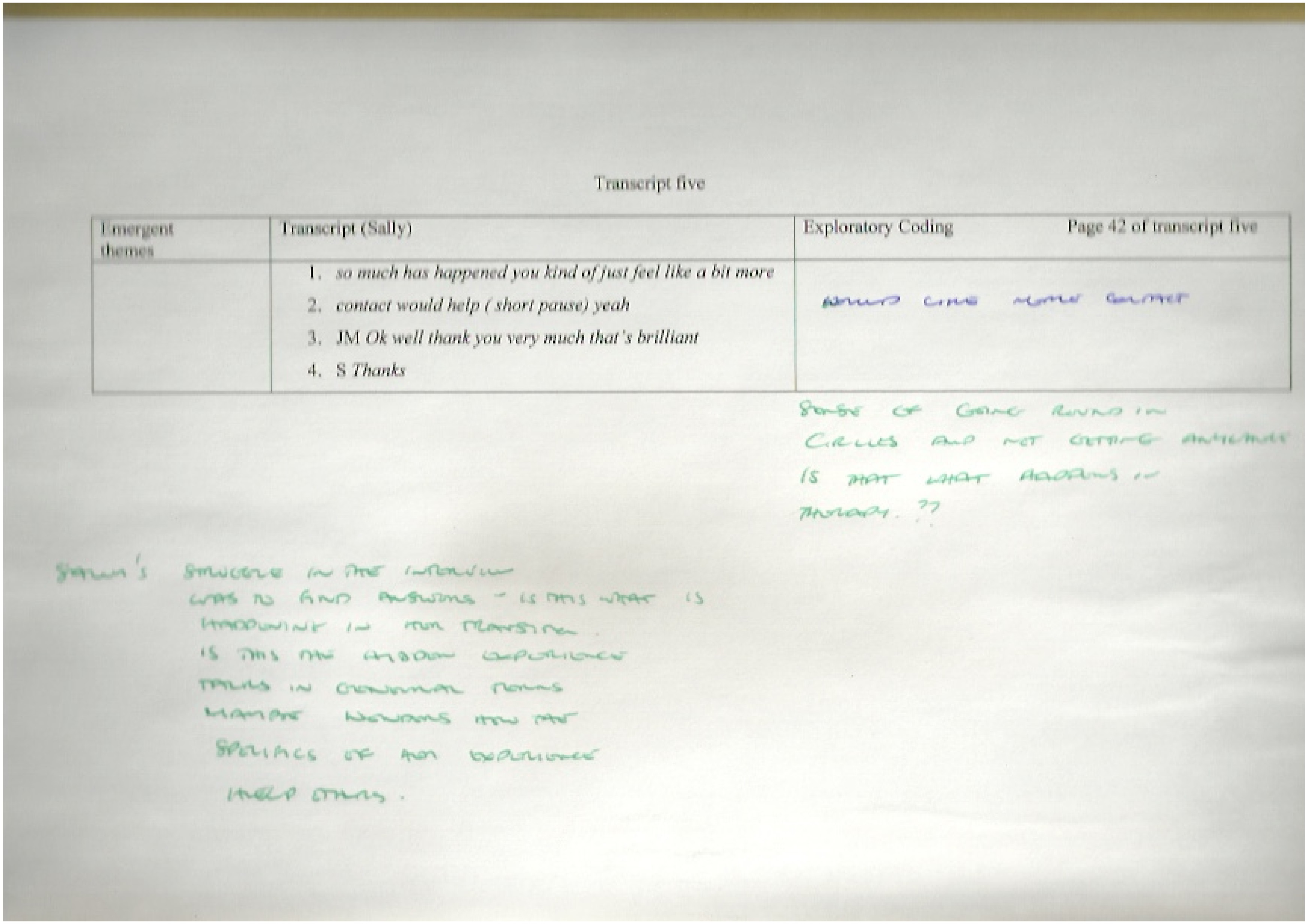
Emergent themes	Transcript (Sally)	Exploratory Coding
	1. *cover so many different things that that on that day when*	
CAMPAIGNING FOR MORE SUPPORT	2. *go back in like you might feel good again you know so you*	WANTING TO [illegible] [illegible] NOT WANTING TO GO OVER BAD DAYS
	3. *don't really want to go over all the crap days that you've*	
	4. *had I think a lot can happen in a week that you can't cover*	IS THERE A SENSE OF SALLY NOT GETTING WHAT SHE WANTS FROM THE SUPPORT - IE NO RESOLUTION
	5. *in an hour*	
· TRANSITION INVOLVES [illegible] FOR [illegible] [illegible]	6. JM *So there's a sense that it's difficult to cover everything*	
	7. *that's happened in the week in the hour?*	
	8. S *Yeah and actually like get a resolution for it um*	
· WORKING ON [illegible]	9. JM *Do you want longer?*	
	10. S *Um*	
	11. JM *A longer session?*	
	12. S *I don't know if a longer session would help*	
	13. JM *More frequent contact?*	
· FLUCTUATIONS OF MOOD ON A DAILY BASIS - GOOD/ BAD DAYS.	14. S *Yeah I think that's you know because as I say you can*	
	15. *have a really crap day you know say I come in on a*	
	16. *Monday I can have a really crap day Wednesday good day*	
	17. *Thursday Friday crap day Saturday and you but as I say*	

L14 - 17



Transcript five

Emergent themes	Transcript (Sally)	Exploratory Coding Page 42 of transcript five
	1. *so much has happened you kind of just feel like a bit more* 2. *contact would help (short pause) yeah* 3. JM *Ok well thank you very much that's brilliant* 4. S *Thanks*	AROUND LIKE MERRY GOROUND

SENSE OF GOING ROUND IN
CIRCLES AND NOT GETTING ANYWHERE
IS THAT WHAT HAPPENS IN
THERAPY. ??

SALLY'S STRUGGLE IN THE INTERVIEW
WAS TO FIND ANSWERS - IS THIS WHAT IS
HAPPENING IN HER TRANSITION.
IS THIS THE HIDDEN EXPERIENCE
TALKS IN GENERAL TERMS
MAYBE WONDERS HOW THE
SPECIFICS OF HER EXPERIENCE
HELP OTHERS.

Part 2

Professional practice: Case study

[redacted]

[redacted]

[redacted]

[redacted]

Part 3

Publishable paper

[redacted]

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