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ORIGINAL ARTICLE

The focus on weight in the inpatient care of anorexia nervosa: A qualitative investigation of consumer perspectives

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Abstract

Anorexia nervosa has a high mortality rate and is often treated in the inpatient setting, where close monitoring and medical support are available. Consistent with objective biomedical benchmarks, conventional inpatient treatment is often focussed on weight gain. Consumers report that clinicians provide care focussed on weight and physical restoration without adequate consideration of their full spectrum of needs. The aim of this study was to explore consumers' perspectives of the biomedical focus on weight gain in the inpatient care of anorexia nervosa. This study employed a qualitative approach, involving semistructured interviews, and participants were recruited from relevant social media communities. This study was ethically approved by a university ethics committee and the COREQ checklist ensured ethical reporting. Ten women participated in interviews. Participants reported that the biomedical imperative of weight gain is focussed on at the exclusion of other relevant determinants of well-being, and the narrow focus on weight gain does not suitably prepare consumers for discharge. The conflict between clinicians' biomedical focus and consumers' broader unmet needs leads to harmful interpersonal dynamics and feelings of invalidation. The inpatient care of anorexia nervosa needs to develop beyond biomedically driven objectives and incorporate the merits of an approach that substantively integrates person-centred care, therapeutic relationships and trauma-informed principles.

KEYWORDS
anorexia nervosa, inpatients, mental health, psychiatric nursing, therapeutic alliance

INTRODUCTION & BACKGROUND

Anorexia nervosa (AN) is a complex mental health issue that requires specialised care and attention. Expert consensus indicates that the combination of complex medical and psychiatric needs of people with AN are best managed through a multidisciplinary approach (O'Donnell & Meloncelli, 2023). Consumers with a high acuity of illness are often treated in the inpatient setting, where close monitoring, supervision and medical support are available (Rankin et al., 2023). Although hospital services for the care of people with AN are long established and amply utilised, research of consumer perspectives indicates considerable deficits and limitations of inpatient care. Consumers with AN report numerous negative appraisals of inpatient care, such as the restrictive and noncollaborative nature of the inpatient setting (Smith et al., 2016), the harsh demands of mealtimes (Long et al., 2011), stigmatization from healthcare professionals (Bezance & Holliday, 2013) and poor relationships with staff (Smith et al., 2016). Such dynamics during inpatient admissions are a likely antecedent to poor satisfaction with care, with reported satisfaction scores akin to those experiencing involuntary inpatient treatment (Zugai et al., 2018b). Consumers' poor satisfaction with

care must be addressed, as treatment dissatisfaction is liable to increase the risk of premature treatment termination and poor subsequent outcomes (Lindstedt et al., 2020). Notably, consumers' negative appraisals of care are largely related to the focus on physical restoration and outcomes. That is, consumers' negative experiences of care are generally related to aspects of treatment that are focussed on weight.

AN has a high mortality rate, and its life-threatening implications are primarily mediated by nutritional insufficiency and the starvation state (Gibson et al., 2019). Nutritional restoration is then a necessary aspect of recovery from AN (Treasure, 2016). Clinicians' focus on weight is consistent with objective biomedical benchmarks and is defensible to this extent. The biomedical model is the prevailing philosophical orientation for Westernised health services, laying emphasis on the biological and scientific basis of illness. The biomedical model reduces the concept of 'illness' to a condition mediated by physical causes and one resolved through physical measures (Deacon, 2013; Rocca & Anjum, 2020). Although scientifically valid, biomedically oriented mental healthcare fails to duly consider and address the social, psychological and behavioural dimensions of illness (Deacon, 2013).

Although consumers acknowledge the necessity of life-saving measures that involve nutritional intervention, they also report that clinicians exercise care focussed on weight and physical restoration without adequate consideration of their psychological needs (Bezance & Holliday, 2013; Rance et al., 2017; Sibeoni et al., 2017). Failure to integrate consumer perspectives is inconsistent with the principles of recovery-focussed mental healthcare, and consideration for consumer perspectives is essential for the development of ethically sound mental healthcare (Zugai, 2022). Consumers' views regarding the focus on weight in the inpatient setting remain underexamined. The implications of the focus on weight as it applies to the inpatient setting warrants focussed investigation, as the acuity of illness and the intensity of treatment are novel to this environment. This study addresses this specific concern with the aim of exploring consumers' perspectives of the biomedical focus on weight gain in the inpatient care of AN.

METHODS

The aim of this study could only be addressed with an in-depth investigation of consumers' perspectives. For this reason, this study utilised a qualitative descriptive design (Doyle et al., 2020). This approach facilitates the exploration of consumers' rich narratives with methodically sound analysis. The data analysed in this study are part of a larger dataset, with results reported elsewhere (*currently under review*).

Sample

All participants in this study were residing in Australia at the time of data collection. Participants in this study were > 18 years of age and had previously been hospitalised specifically for the treatment of AN. All participants were required to be able to speak and read English to ensure informed consent. Participants were either recovered or receiving outpatient support, as dependency on inpatient care warranted exclusion from the study.

Recruitment

Two social media community support pages for people with experience of eating disorders in Australia were the main platforms for recruitment. With permission from the administrators, a flyer was posted on these social media pages, which provided details of the study such as the aims and requirements of participation. Potential participants were provided with the principal investigator's (PI) contact information to express interest or to ask further questions. All participants were supplied with an information sheet detailing the study aims, investigators, requirements of participation and relevant support services. The information sheet also clearly outlined the voluntary nature of participation.

Data collection, analysis and management

Recruitment and data collection occurred from October to December 2022. Data were collected through in-depth semistructured interviews over a cloud-based conferencing service at a time that suited the participant. Upon commencement of the interview, participants were asked for their permission to record the interview, and screening questions confirmed that participants met the criteria for participation. Verbal consent to participate was then established. During the interview, participants were encouraged to explore themes they felt were significant. The PI conducted all interviews. The interviews were recorded and stored securely in Cloudstor hosted by AARNET. The audio recordings were deidentified and were then dispatched for transcription. The transcripts used in the analysis were then consequently deidentified. The transcription service was compliant with *Australian Privacy Act 1988* and the Guidelines on Privacy in the Private Health Sector issued by the Federal Privacy Commissioner under the *National Health Act 1953* (Pacific Transcription, 2023). This study was approved by a university human research ethics committee (EC00418: 2022-120S).

Data were analysed using thematic analysis (Braun & Clarke, 2006), and the process of data analysis is outlined in Table 1. JZ, KG, LM, TR and LR conducted the data analysis. The data were initially subject to an inductive

TABLE 1 Process of thematic analysis (adapted from Braun and Clarke (2006)).

Phase 1: Familiarization	Transcripts were read, and interview recordings were listened to multiple times to establish insight into the participants' general perspectives. From this phase, it became clear that clinicians were focussed on weight gain as a primary objective and that this salient focus had harmful implications
Phase 2: Initial code generation	With an understanding of the data, two codes were determined to categorize the data: (1) Salient focus on weight; and, (2) harmful outcome from the salient focus on weight.
Phase 3: Establishing themes	From the coding process, relevant extracts (quotes) were examined for establishing themes. Analysis of the data established four themes: (1) The salient focus on weight; (2) limited preparation for discharge; (3) harmful interpersonal dynamics resulting from the focus on weight; and, (4) dependence on weight as a biomedical benchmark to determine legitimacy of need
Phase 4: Reviewing themes	Themes were then compared with the entire dataset to determine whether or not they wholly represented the patterns in the data and duly addressed the aim of the study. This phase established the four themes reported
Phase 5: Defining and naming themes	The themes were then named and defined to accurately represent the dataset. A final analysis of transcripts confirmed the organization of data (represented in Table 2)
Phase 6: Producing the report	With an in-depth understanding of the themes, the study is comprehensively reported with supporting quotes and analysis

TABLE 2 Themes.

Themes: The focus on weight in the inpatient setting
The hyper-focus on weight Inpatient care is focussed on weight gain at the exclusion of other determinants of well-being. Psychological needs are not addressed limiting the efficacy of care
Inadequate discharge preparation Weight gain during hospitalization is of limited value as inpatient care does not duly prepare consumers for discharge. Poor discharge preparation was often preceded by regression and subsequent admissions
Malignment Whilst clinicians focussed on and facilitated weight gain, the quality of care was often undermined by clinicians' attitudes towards consumers with AN. This represented a focus on weight gain and a neglect of interpersonal needs
Invalidation Consumers' care needs were dismissed by clinicians that referred to weight as a sole metric of relevance. Consumers' weight, rather than the consumers' words, determined access to care

analysis, with the identification of excerpts in the data that addressed the research aim. Subsequently, a coding structure was developed that aided the methodical organization of the data into thematic categories. Coding ensures validity and reliability of qualitative research findings (Morse, 2015). In reporting the results, pseudonyms replace participant names. All listed authors are PhD qualified with extensive experience in qualitative research. The PI and two other investigators are male, and the remaining two are female. JZ, LM, TR and LR are full-time nursing academics, and KG is a consumer representative with an extensive track record of advocacy group leadership. The research team did not have a pre-existing relationship with any of the participants. There were no reported adverse events. The COREQ checklist was used to ensure methodological rigour and transparency.

FINDINGS

Ten women participated in a semistructured interview, which was on average 40 min in duration. Participants reported that inpatient AN care was primarily focussed on weight gain and that clinicians' focus on weight gain was at the exclusion of other relevant determinants of well-being. Participants reported that care did not address underlying psychological needs and that they were ill-prepared for discharge. Furthermore, the focus on weight gain led to harmful interpersonal dynamics, and the biomedical focus on weight also diminished access to care. The findings of this study are organised into four broad themes, as presented in Table 2.

The hyper-focus on weight: 'How many grams did you put on?'

Participants were critical of the narrow and short-sighted objective of weight gain, which was focussed on at the exclusion of other needs. That is, clinicians focussed on weight gain without due consideration for other relevant determinants of well-being.

> My actual treating psychiatrist I think was hopeless. I think he was terrible. I still think he's terrible. He's still treating people. I can't believe it. I don't think he was helpful at all. I think it was more the people that were a little more – less clinical, if I can use that word? That treated me

more like a human with feelings and were more interested in what the feelings were about, that's where I had the breakthrough moments. Not how many grams did you put on and have you eaten all your food? I didn't find that helpful at all. That was – yeah, that made me feel like I wasn't really getting anywhere.

(Grace)

I personally think, as I said, that there are underlying issues that cause anorexia, and it's different for each individual, and when you're focusing so much on the weight and you also are restricted to your bed basically like almost 24 hours of the day, I don't see that as healthy in any way shape or form.

(Fiona)

it's just it really traumatised me and I've been traumatised my whole life. I was not probably like a lot of the – I feel I was not like a lot of the other kids with eating disorders because I had such a severe anxiety and OCD [obsessive compulsive disorder] going on like even before it. Of course, that never got helped at all. Like I don't know if they do that now, but it's just they weren't interested in that. They were just interested in getting your weight up and getting you out and keeping you out. The way to stay out was just to put the weight on and get you out without really giving you any help with the other things.

(Melody)

Whilst acknowledging the necessity of weight gain, many of the participants felt that care should address underlying psychological needs, which would enhance the sustainability of therapeutic weight maintenance. For example, mindfulness could be employed as an adjuvant therapy to aid engagement in nutritional intake.

You don't really get much of a choice foodwise too, but I think also focusing a lot on the mental side of things and really getting them to practice mindfulness, especially around mindful eating, I think can really help. So, I think if they introduce more exercises and stuff like that, I think people are more likely to ease into it more gently and come to an understanding of their own situation and their own relationship to food and why it sort of happened.

(Fiona)

I think there could be more emphasis on emotional literacy and learning to feel safe in your body. I think a lot of – for me, in hindsight, anorexia was about I feel unsafe in the world. Helping people to build safety with their feelings. I know that's really hard to measure. Like measuring weight is easy, right? So it's like there's clear progress here. But you know, I demonstrated that the weight and the food really meant nothing if I didn't feel safe in my body, I didn't feel safe in the world.

(Grace)

Inadequate discharge preparation: 'I was discharged… I was forgotten'

As part of the overfocus on weight gain during hospitalization, participants reported that care did not sufficiently prepare them for discharge. Clinicians seemed to focus on weight gain during hospitalization and discharged consumers with limited consideration for strategies that would sustain well-being and enhance treatment outcomes.

Once I was discharged, it was just – I was forgotten. That's when you need a lot of support. Yeah, there was lots of – and like I said, wasted time where I think more therapy can be given during that time which wasn't used. So every time I was discharged, I really just only had that same coping mechanism I used before. Nothing changed. Then I think that's why I was re-hospitalised so many times. It's like the pattern just kept repeating itself because I hadn't learnt anything new.

(Grace)

If you've got anorexia and you're underweight, clearly you have to eat, to put on weight and then you can cope better with things. But it's not enough just to force weight on and then discard and leave to [your] own devices, because all that does is just send you straight back down and over time it gets worse.

(Melody)

The absence of psychological care and the primary focus on weight gain did not adequately prepare participants for the challenges outside the structure and support of the inpatient setting. Participants recognised the importance of early, intensive psychological therapy once medically stable.

> The whole time I've been in, I've seen a psychologist once and I've seen the eating disorder nurse once. Out of eight to nine months of admissions, I've had one therapy session. Where I think, a lot of the time when we're in hospital - I understand the first week, we're probably too malnourished to properly work with the psychologist, but I think after that initial refeeding and getting a bit of nutrition, I think that's probably the best time to start trying to do some therapies with us to give us other skills. Because when we get out, I'm sure a lot of - for me personally, I know that the time that I'm going to get the most nutrition is in hospital. So, it's probably the best time to work with my cognitions because when I get out, I try and stay on track but you still don't really have the skills.
>
> (Mary)

> The thing is, with the medical system, they don't really take into consideration why that person has got to this place to start with. So, for me, I had a lot of childhood trauma and I know that the whole time I was in hospital nobody had really focused on the trauma behind my anorexia. So, yes, like every time I got, you know, released or discharged, I would be out of hospital maybe for a week max [laughs], and like next weigh-in at outpatients they were like, 'okay, we need to send you back in'.
>
> (Fiona)

Malignment: 'You're wasting our time'

Clinicians' hyper-focus on weight gain led to harmful interpersonal dynamics. Participants reported being routinely maligned and stigmatised, as they were made to feel as though they themselves were culpable for their illness, rather than a person in need of care. That is, clinicians failed to make a distinction between AN as an illness and the person with AN; the very personhood of participants was replaced by a stereotyped identity of pathology. Interactions with clinicians demonstrated an absence of consideration for interpersonal needs. Participants also reported that some clinicians would attempt to lever guilt against them out of frustration and misunderstanding.

> A nurse had said to me, 'you're wasting our time. Someone else could be getting well if you don't want to get well'. So there was that kind of guilt around that.
>
> (Grace)

> Sometimes you get the vibe it's like, 'if you didn't want to be here - which you literally got told numerous times- if you don't want to be here, you can go home' sort of thing. Which isn't really cool … I don't think that's really helpful to be honest.
>
> (Rebecca)

> Not much has changed. Not only are they forceful with things such as like food and nasogastric tubes but I think just the way they treat patients verbally as well. I know in my experiences you kind of kept getting told that you were the problem and a lot of them kept telling me, or kept saying, 'why should we bother helping you when you don't want to live' because really, at that time, I didn't want to be alive. I really did want to end my life…I had to get rushed to emergency and the nurse in there – I had my mother and my boyfriend at that time standing right outside the curtain thing, and she had just been yelling at me saying, 'why should we help you when you don't want to help yourself? Like, why should we just let you die? This is all your fault'.
>
> (Fiona)

Conversely, participants reported an appreciation for staff who maintained a distinction between AN as an illness and the individual in need of care. Such an approach was an acknowledgement of the importance of a focus beyond weight gain and was a reportedly more effective approach to combatting the disorder as a team.

> I was more willing to oblige because I didn't feel it was me against them. It was us against a problem. I felt like they were on my side.
>
> (Rebecca)

> I really notice that the clinicians who separate me from the eating disorder, I find that very helpful because I'm a very caring, trustworthy person and sometimes your eating disorder will cause you to do things you wouldn't usually do. So, I think just really being able to separate the person from the

illness, you notice it in the clinician when they do that.

(Mary)

Invalidation: 'You can't be that sick if your BMI is not that low'

Several participants reported frustration that clinicians determined the needs of consumers based on weight. To be determined 'atypical' or not sufficiently underweight gave clinicians licence to dismiss the needs of consumers. Rather than consult consumers about their needs, clinicians made unilateral determinations based solely on reference to weight as a biomedical benchmark. This led to greater difficulty in accessing care.

> After my weight had gone up because they put me on a specific medication and they didn't tell me that it had a weight gain property, then it's been like oh well you're not underweight enough to have an eating disorder, you're not underweight enough to need treatment, you can't be that sick if your BMI is not that low. So, it's been the other way around, they seem to only treat you if your BMI is critically low, then if it's not they couldn't really care less.
>
> (Veronica)

> There was a misconception around people who were not underweight and the severity of their illness. So generally the private system, I found the nurses to be pretty crappy, to be honest, because they had that warped view of the people who should be in here and those who are significantly underweight. People who don't fit the mould don't kind of belong here… When I was admitted, they didn't anticipate me not being significantly underweight and I had questions asked of me by the nurses around like, 'are you sure you have a diagnosis of anorexia, because you don't look it?'. Like, to that extent, you'd get nurses asking those type of questions, which at the time was really not – it was really dismissive and really not helpful when you're trying to seek assistance.
>
> (Jill)

> Because when I first got admitted, I was still within a healthy weight range. I had lost a lot of weight but I was still within a healthy weight and one of the nurses, I overheard her at handover saying, 'oh, you wouldn't even know she has an eating disorder' and things like that are so unhelpful.
>
> (Mary)

DISCUSSION

The findings of this study correspond with other investigations of consumer perspectives. Participants reported that weight was focussed on at the exclusion of relevant determinants of well-being and that care did not address the underlying causes of illness (Bezance & Holliday, 2013; Rance et al., 2017; Sibeoni et al., 2017). The focus on weight gain in the inpatient setting led to transient progress, with limited long-term benefit. Furthermore, the participants reported experiences that diminished their confidence in the therapeutic value of inpatient care. The focus on weight in the inpatient setting did not secure long-term good outcomes and ironically discouraged engagement with care. Consumers with AN are often wary of seeking care owing to the threat of losing control and weight gain (Ali et al., 2020).

Consistent with the findings of this study, it has been previously reported that clinicians determine consumers' clinical needs based on weight rather than by deferring to consumers' own judgement; body mass index (BMI) was relied on to determine the validity of consumers' appeals for care (Rance et al., 2017). Clinicians' dependence on biomedical criteria for vetting the needs of consumers led to consumers feeling dismissed and invalidated. Compounding this, previous research has demonstrated that lower BMI on admission is associated with lower weight at discharge and significantly higher risk of readmission within a year (Sly & Bamford, 2011). This suggests that BMI is not suitably relied on for evaluating the needs of consumers and that care should not be withheld until the point of crisis.

It has been previously established that the very personhood of consumers in the inpatient setting is dependent on interactions with clinicians that convey equality, respect and autonomy (Cutler et al., 2021). Correspondingly, the narratives examined in this study demonstrated the harms attributable to stereotyping and stigmatizing attitudes and the importance of interactions that acknowledge consumers as individuals distinct from AN as an illness (Rance et al., 2017; Smith et al., 2016; Voswinkel et al., 2021; Zugai et al., 2018a). Clinicians' stigmatizing attitudes and behaviours reported in this study may be a consequence of the frustrations of the inadequacies of the biomedical approach. The biomedical approach lays emphasis on weight gain as the explicit goal of care and does not readily acknowledge the necessity of establishing person-centred care. The conflict between biomedical objectives and consumers' needs leads to irreconcilable

tension, leading to harmful interpersonal dynamics. The overall implication of these findings is that the care of AN is determined with reference to consumers' weight, excluding adequate focus on other relevant determinants and needs.

The findings of this study demonstrate the need to reconceptualize care in a way that integrates principles beyond the biomedical approach. Gunasekara et al. (2014) identified the need for renewed attention to the fundamentals of relationships between consumers and staff in inpatient settings. This engagement provides a foundation for recovery-oriented care (Polacek et al., 2015). Trusting relationships between healthcare professionals and consumers with AN have been identified as important factors in maintaining motivation for treatment and are commonly cited by consumers with AN as necessary for recovery (Duncan et al., 2015; Salzmann-Erikson & Dahlén, 2017). Despite the established merit of therapeutic relationships, participants in this study described a practice culture that privileged biomedical focus on weight gain. Paradoxically, the biomedical focus on weight may reduce the effectiveness of inpatient treatment for achieving weight gain and ultimately impact treatment outcomes (Werz et al., 2022). Research highlights that therapeutic alliances can increase the effectiveness of treatment outcomes (Salzmann-Erikson & Dahlén, 2017; Werz et al., 2022). For example, Bourion-Bedes et al. (2013) identified a correlation between consumers with AN and their perceptions of therapeutic alliances with health professionals and shorter times in achieving weight targets. Therapeutic alliances should therefore be prioritised as part of ongoing psychological support for consumers with eating disorders.

In addition to the integration of therapeutic alliances, inpatient AN care should espouse the principles of trauma-informed care (TIC). TIC acknowledges the prevalence of trauma in the lives of people with mental illness (Goddard et al., 2022) and acknowledges that conventional mental healthcare practices can be traumatic or retraumatizing (Jina-Pettersen, 2022; Muskett, 2014). Consistent with the narratives in this study, early trauma is implicated in the development of AN (Malecki et al., 2022), and commonplace practices in inpatient AN care can be traumatic in nature, such as the manual restraint involved in the insertion of a nasogastric tube (Kodua et al., 2020). Furthermore, trauma experiences and PTSD are likely to have negative implications for the outcomes of AN care (Day et al., 2023). The integration of TIC in the context of AN care is not well established, and future research must address this.

This study also highlights the need to incorporate models of care that ensure ongoing well-being beyond the point of discharge. The participants of this study reported that inpatient treatment secured weight gain up to the point of discharge and that support was not offered beyond this. Consistent with previous research, the participants of this study viewed discharge with apprehension as the safety and containment of the inpatient setting was suddenly lost without adequate preparation for transition back into the community (Smith et al., 2016). Greater accessibility to transition programmes will enhance consumers' capacity for sustained recovery. Residential programmes provide a demonstrably effective means of transition from intensive care settings (Brewerton & Costin, 2011a, 2011b; Hiney-Saunders et al., 2021).

Limitations

This study investigated the focus on weight in the inpatient setting, and the analysis of data established criticism of the biomedical model. The authors acknowledge that the aim and methods of the study potentially portended a harsh appraisal of the biomedical model, and the credibility of the findings should be considerate of the highly specific aim of this study and appraised accordingly. The findings of this study were also limited by a small sample size, and the results do not represent male perspectives. The absence of a male perspective limits the generalizability of findings, as males may perceive the experience of inpatient care differently. This study also focussed on the inpatient care of AN in a single country, thus limiting generalizability, and is not representative of consumers with other mental health issues. Implications of the biomedical focus in mental healthcare should be examined across other contexts, such as the outpatient setting.

CONCLUSION

The focus on weight characteristic of inpatient AN care is representative of the biomedical imperative embedded within conventional mental healthcare. Weight is an objective metric and readily measurable lending itself to biomedical focus. Whilst scientifically valid, the biomedical model is limited by a narrow focus on objective and measurable factors and outcomes; the model does not duly address consumers' needs beyond this. The practice culture of mental healthcare needs reorientation to the extent that is required to integrate consumers' needs holistically, in a recovery-oriented and trauma-informed way. The focus of care cannot be limited to addressing the needs of consumers as determined by clinicians. Instead, care must be determined with consideration for consumers' stated needs and a person-centred approach.

Relevance for clinical practice

The findings of this study demonstrate the imperative of integrating principles of care beyond the biomedical orientation. The current focus on weight as a sole

metric of consideration does not secure long-term well-being, compromises the safety of discharge and leads to harmful interpersonal dynamics. Whilst a focus on weight is defensible, the development of therapeutic relationships and trauma-informed practices are also necessary.

AUTHOR CONTRIBUTIONS

All authors listed meet the authorship criteria according to the latest guidelines of the International Committee of Medical Journal Editors and are in agreement with the manuscript. The authors' contributions were as follows: JZ, KG and LR designed the study. JZ, KG, LM, TR and LR contributed to data collection and analysis and drafting and commenting on the paper.

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CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest to report.

DATA AVAILABILITY STATEMENT

Research data are not shared.

ETHICS STATEMENT

Approval to conduct this study was obtained from a university human research ethics committee (EC00418: 2022-120S).

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