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Working with Medical and Psychological Illness: A Phenomenological Exploration of Nurses' Experiences in Treating Eating Disorders

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WORKING WITH MEDICAL AND PSYCHOLOGICAL
ILLNESS: A PHENOMENOLOGICAL EXPLORATION
OF NURSES' EXPERIENCES IN TREATING
EATING DISORDERS

A Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy

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College of Education and Behavioral Sciences
Department of Counseling Psychology
Program of Counseling Psychology

December 2014

This Dissertation by: Diana Levas-Luckman

Entitled: *Working with Medical and Psychological Illness: A Phenomenological Exploration of Nurses' Experiences in Treating Eating Disorders*

has been approved as meeting the requirements for the Degree of Doctor of Philosophy in College of Education and Behavioral Sciences in Department of Counseling Psychology, Program of Counseling Psychology

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Date of Dissertation Defense _____March 24, 2014_____

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ABSTRACT

Levas-Luckman, Diana. *Working with Medical and Psychological Illness: A Phenomenological Exploration of Nurses' Experiences in Treating Eating Disorders*. Published Doctor of Philosophy dissertation, University of Northern Colorado, 2014.

Eating disorders (EDs) have become an epidemic within the United States, with medical and psychological consequences that can be lethal. Treatment for these diseases is complex and demanding, requiring an integrated treatment approach by a multidisciplinary team in which nurses play an integral role. Research has demonstrated a wide array of both positive and negative experiences among nurses in traditional medical and mental health settings. Though researchers have assessed nurses' subjective experiences in treating EDs, the literature neglects to focus upon the broader experiences of nurses, including perceived benefits and challenges, in treating both adult and adolescent ED patients.

The current study employed qualitative, phenomenological methodology to explore the experiences of nurses in treating EDs. Interviews were conducted with 12 nurse participants and were analyzed via a phenomenological method of analysis. The outcome was the development of textural–structural descriptions for participants and composite themes capturing the essence of their experiences. Three primary thematic categories emerged: initial attitudes, conditions of treatment, and emotional awareness and outcomes. Understanding of these nursing experiences may help mental health professionals to improve education/training for nurses entering the field, increase

support and communication with the treatment teams, mitigate negative emotional

experiences, and highlight the benefits that such ED nurses experience.

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CHAPTER I

INTRODUCTION

Both a psychological and medical illness, an eating disorder (ED) can manifest in a variety of ways and elicit increasing challenges for those professionals involved in its treatment (Mehler & Andersen, 2010; National Association of Anorexia Nervosa and Associated Eating Disorders [ANAD], 2014; National Institute of Mental Health [NIMH], 2014). This phenomenological study sought to examine the experiences of nurses treating patients diagnosed with EDs. My aim was to gain an in-depth understanding of the complexities of each nurse's experience, as well as a shared understanding of the common factors that pervade each nurse's work. Gaining a better understanding of the essence of these experiences increases awareness of their work and can enhance subsequent efforts of psychologists to train and support nurses in these intensive and high stress environments. Furthermore, it also helps psychologists to promote positive experiences and reduce potentially negative psychological consequences among nurses, such as sadness, frustration, and/or lost hope (King & Turner, 2000; Raveneau, Feinstein, Rosen, & Fisher, 2014).

In this chapter, I outline the background and context for the present study and provide a statement of the problem and purpose of the study, with accompanying research questions. I then outline my research approach, assumptions, and researcher stance.

Finally, I conclude this section by discussing the rationale and significance for the current study.

Background and Context

Collectively, EDs have become a societal epidemic within the United States. Though they affect only approximately 4% of the population (Hudson, Hiripi, Pope, & Kessler, 2007), the symptoms and ensuing consequences can be devastating. Dependent on whether a patient suffers from anorexia nervosa, bulimia nervosa, binge eating disorder, or avoidant/restrictive food intake disorder (American Psychiatric Association, 2013), there may be various accompanying psychological symptoms. He or she can experience depression, anxiety, avoidance, isolation, neuroticism, and an inability to develop trust with others (American Psychiatric Association, 2013; Budd, 2007; Mehler & Andersen, 2010; NIMH, 2014; Strober & Johnson, 2012). Furthermore, medical symptoms and other risk factors often arise, such as organ failure or possibly death (McBride, 2012; Mehler & Andersen, 2010). The etiology and maintenance of such illnesses are complex, with various forms of social influence, media, and biology all contributing to its sustained impact (Strober & Johnson, 2012).

Given their multifaceted nature, ED treatment in an inpatient facility typically includes an integrated approach, utilizing expertise from professionals in a variety of fields (Mehler & Andersen, 2010; Strober & Johnson, 2012). Nurses play an integral role in this treatment, managing the medical, social, and psychological needs of patients. They are vital to communication within the multidisciplinary treatment teams as well as from team to patient, given their round-the-clock presence (King & Turner, 2000; Mehler & Andersen, 2010; Ramjan, 2004).

To understand the experiences of nurses who specifically treat EDs, it is helpful to first assess common experiences among nurses in a broader context to identify potentially overlapping experiences. The literature includes a wide array of both positive and negative experiences among nurses in medical settings. These nurses endorse that having sufficient knowledge within their field, support from colleagues, and the ability to engage in regular self-care and positive coping strategies as integral in their success with patients and sense of personal competence and satisfaction (Allcock & Standen, 2001; Bassett, 2002; Feng & Tsai, 2012; Hilliard & O'Neill, 2010; Zammuner, Lotto, & Galli, 2003). Consequently, a global perspective and overarching sense of meaning and purpose further facilitate growth in the nursing profession (Hilliard & O'Neill, 2010; Johansson & Lindahl, 2011; Wallerstedt & Andershed, 2007) and enhance their experience of vicarious resilience, in which nurses experience emotional benefits upon witnessing a patient heal and grow (Grafton, Gillespie, & Henderson, 2010).

Medical nurses also experience immense challenges due to their increased job demands and subsequent high levels of stress. Such challenges can come in the form of organizational discomfort, including perceived unfair treatment and lack of encouragement, feedback, or effective communication (Bassett, 2002; Feng & Tsai, 2012; Lindahl & Norberg, 2002; Olofsson, Bengtsson, & Brink, 2003). Many nurses also express patient-specific challenges including difficulty establishing rapport and building trust with both patients and their families (Hilliard & O'Neill, 2010); guilt regarding the possibility of hurting patients, not effectively contributing to their healing (Maytum, Heiman, & Garwick, 2004); and/or wondering why they have been spared the pain that their patients experience (Hill, 1991). Finally, nurses report an array of negative, often

chaotic, emotions (Feng & Tsai, 2012) that cannot always be pinpointed, such as feelings of powerless and frustration (Allcock & Standen, 2001; Olofsson et al., 2003); sadness, anxiety, and fear (Johansson & Lindahl, 2011; Lindahl & Norberg, 2002; Wallerstedt & Andershed, 2007); trouble identifying and regulating emotions (Burnard, 1994; Hochschild, 1983); compassion fatigue (Bush, 2009; Maytum et al., 2004); and burnout (Maytum et al., 2004).

The literature of nurses' experiences in the mental health field has demonstrated similar findings, while also emphasizing additional factors specific to managing psychologically-based illnesses. There is an increased emphasis on the need for group supervision as a means to support one another and process emotional experiences more effectively (Maier, 2011; Winship, 1995). Mental health nurses also experience additional negative consequences. Some report struggling to establish strong patient relationships due to their own mistrust, often developed through perceived societal stigma of specific mental health concerns and expectations of manipulation on the part of patients (Bjorkman, Angelman, & Jonsson, 2008; Hem & Heggen, 2003, 2004). However, medical nurses report even higher rates of stigma towards patients with mental illnesses (Bjorkman et al., 2008; Harms, 2010; Zolnierek & Clingerman, 2012); this is important to consider because many mental health nurses have previous medical backgrounds and may enter the field with such views.

Interpersonal connectedness with mental health patients is essential in promoting nurses' satisfaction, health, and growth, as well as positive patient outcomes (Van Sant & Patterson, 2013). Given the nature of working with such patients, mental health nurses often find themselves experiencing role dilemmas, unsure about whether to act more as a

nurse or a therapist (Hem & Heggen, 2003). Many also experience distress and fear surrounding the emotional unpredictability of patients and potentially violent encounters (Carlsson, Dahlberg, Lutzen, & Nystrom, 2004; Winship, 1995). The term, vicarious trauma, is used among mental health nurses (referred to more commonly as compassion fatigue or secondary traumatic stress in the medical literature) (Bush, 2009; Maytum et al., 2004), acknowledging the potential for caretakers to take on their patients' traumatic symptoms when exposed repeatedly to their stories of trauma (Figley, 1995; Maier, 2011). Such symptoms further enhance the likelihood of subsequent burnout (Jenkins & Elliott, 2004; Kilfedder, Power, & Wells, 2001; Yousefy & Ghassemi, 2006).

Research has directly addressed the topic of nurses' experiences treating EDs. Thus, thoroughly examining this research is integral to identifying where gaps in the ED/nursing research lie and how to focus the research questions of the current study. For example, research has illustrated powerful conclusions regarding challenges that ED nurses experience. Many such nurses have endorsed knowing very little about mental health and EDs and how to manage such symptoms (e.g., nutrition management) (Cordery & Waller, 2006) when entering the field, thus decreasing their confidence (King & Turner, 2000; Reid, Williams, & Burr, 2010) and increasing already-existing anxiety and fear surrounding patient safety (Snell, Crowe, & Jordan, 2010). Given the resistance of many patients diagnosed with EDs (especially anorexia nervosa) and the power struggles that emerge, nurses often acknowledge the complexities and overall importance of making and maintaining relationships with patients (George, 1997; Irwin, 1993; King & Turner, 2000; Malson & Ryan, 2008; Micevski & McCann, 2005; Moulding, 2006; Ramjan, 2004), as well as the need for balance between maintaining boundaries and

fostering patient empowerment (Bakker et al., 2011; van Ommen, Meerwijk, Kars, van Elburg, & van Meijel, 2009).

Problem Statement

Research has demonstrated that nurses play an integral role in the treatment of EDs, especially at the inpatient level of care (King & Turner, 2000; Mehler & Andersen, 2010; Ramjan, 2004; Ryan, Malson, Clarke, Anderson, & Kohn, 2006; Snell et al., 2010; Turrell, Davis, Graham, & Weiss, 2005). The nursing literature illustrates and discusses important facets of effective ED nursing care, such as therapeutic factors, the need for boundaries, and nursing roles (George, 1997; Halek, 1997; King & Turner, 2000; Micevski & McCann, 2005; Ramjan, 2004; Ryan et al., 2006; Wright & Hacking, 2012) and the myriad challenges that ED nurses experience (King & Turner, 2000; Raveneau et al., 2014; Reid et al., 2010; Snell et al., 2010; Wolfe & Gimby, 2003). However, there is a paucity of information examining nurses' perspectives of both perceived benefits and challenges in treating adult and adolescent ED patients, in addition to examining how their training and employment have affected their experiences.

In addition to gaining a better understanding of their broad experiences, such specific foci are valuable. Nurses can provide insight into potential similarities and differences in treating adults compared to adolescents, given their different stages of cognitive and emotional development, and describe ways in which nurses training affects their interpretation experiences. Furthermore, given the high-stress conditions under which nurses work, they often experience increased negative symptoms themselves (AbuAlRub, 2004; King, Vidourek, & Schweibert, 2009; Wallerstedt & Andershed, 2007; Winship, 1995). This holds true for ED nurses as well (King & Turner, 2000;

Raveneau et al., 2014; Snell et al, 2010). Through gaining further insight into nurses'

shared experiences, psychologists can work to strengthen education and training and

increase support for nurses. Furthermore, gaining a better overall understanding of both

staff and patient issues in an ED treatment setting may also aid psychologists in

enhancing and promoting the use of evidence-based practices in ED treatment.

Subsequently, the overall understanding and connection between the medical and

psychological sides of ED treatment can be strengthened.

Statement of Purpose

The purpose of this phenomenological study was to explore the experiences of

nurses treating patients diagnosed with EDs. Through conducting interviews, making

observations, and collecting artifacts from participants, this study's aim was to

understand the individual and shared essence of their experiences. Direct knowledge of

their attributed meanings and perceived roles and obligations in the workplace

strengthens a deeper understanding of such nurses' lived experiences and enables

psychologists to promote growth for education, training efforts, and treatment modalities.

Rationale and Significance

Through in-depth exploration of ED nurses' lived experiences, a deeper

understanding of the value of their work, in both emotional and educational terms, is

acquired. Subsequently, this aids psychologists in the development of more effective and

inclusive educational and training efforts to help bridge the gap between the medical and

psychological facets of ED treatment. According to Haverkamp and Young (2007), the

rationale for a qualitative study in counseling psychology should emerge from the

literature in the field, field experience with the phenomenon or topic being studied, and

the research paradigm that most fits the beliefs, values, and experience of the researcher as well as the topic under investigation.

Given that approximately eight million Americans currently suffer from some type of an ED (NIMH, 2014), providing treatment for these patients has become commonplace in the mental health field. There is an increased awareness about the importance of the interactions between trained mental health workers (e.g., therapists, psychologists, psychiatrists, and social workers) and medical professionals who treat patients with EDs. Research illustrates that nursing staff experience significantly increased exposure to patients in any inpatient/residential treatment setting when compared with other professionals primarily due to their long work shifts and the need to work with patients face–to–face throughout the day (King & Turner, 2000; Mehler & Andersen, 2010). As perhaps the ED patients' primary caregivers, nurses want to implement the best patient care possible; however, at times they may not know exactly what to do (Bassett, 2002; Reid et al., 2010). This could be due to inexperience and lack of knowledge in the ED field (Cordery & Waller, 2006; King & Turner, 2000). Therefore, for those who are on the frontlines of ED treatment, ED nurses may be more susceptible to vicarious effects, both positive and negative.

From social constructionist and existential perspectives, the tendency for nurses to experience these vicarious effects makes sense. Social constructionism posits that people interpret and create personal meaning from both societal views/constructs as well as personal experiences (Crotty, 1998; Patton, 2002). Existentialism asserts that people have the same intrinsic ultimate concerns in life (e.g., freedom, isolation, meaninglessness, and death) that elicit anxiety and guide existence (Yalom & Josselson, 2011). (Both theories

are expanded upon in the Research Paradigm section of Chapter III). Thus, nurses' emotional experiences may be strongly impacted by both their pre-conceived societal expectations and need to address existential life concerns. However, their prolonged exposure to direct patient care is integral to shaping the subsequent meaning and value that they create from their work treating EDs.

Gap in the Research

Despite several studies examining the broad effects on nurses who work in the ED field (Bakker et al., 2011; Halek, 1997; Micevski & McCann, 2005; Pryde, 2009; Reid et al., 2010; Snell et al., 2010; Wolfe & Gimby, 2003), there is a paucity of research assessing both the subjective positive and negative emotional experiences of specifically nurses in treating adults and adolescents at the inpatient level of ED treatment. While research has examined such nurse–patient relationships (Micevski & McCann, 2005; Ramjan, 2004; Ryan et al., 2006; Snell et al., 2010; Zugai, Stein-Parbury, & Roche, 2013), further exploration is warranted with regard to their experiences of dealing with such intense patient resistance (e.g., patients denying the severity of symptoms and/or not wanting to weight restore) and issues of countertransference, typically explored solely among ED therapists, psychologists, and psychiatrists (Satir, Thompson-Brenner, Boisseau, & Crisafulli, 2009; Thompson-Brenner, Satir, Franko, & Herzog, 2012). Given that the potential for death is also a concern among all professionals treating EDs (ANAD, 2014; Crow et al., 2009; NIMH, 2014), research should expand beyond grief and loss issues among ED therapists (Warren, Schafer, Crowley, & Olivardio, 2012) and include the subjective experiences of these ED nurses as well. Furthermore, though there has been exploration of compassion fatigue, or vicarious trauma, among medical and

mental health nurses (Bush, 2009; Maier, 2011; Maytum et al., 2004), there has been little exploration of vicarious trauma specifically among nurses treating EDs. There has also been little research examining the ensuing positive experiences, including vicarious resilience. For example, research has examined vicarious trauma among therapists (Ben-Porat & Itzhaky, 2009; Devilly, Wright, & Varker, 2009; McCann & Pearlman, 1990) and nurses in medical and mental health settings (Adams & Riggs, 2008; Collins & Long, 2003; Van Sant & Patterson, 2013), as well as vicarious resilience among similar populations (Grafton et al., 2010; Hernández, Engstrom, & Gangsei, 2010). Though research has examined these experiences among ED treatment providers (Satir et al., 2009; Thompson-Brenner et al., 2012), minimal research has focused upon these experiences solely among ED nurses. This is important to examine because this information might add to the understanding of ED nurses' experiences and expand on the ways in which support and training could be augmented.

There are also several limitations in the existing research on nurses' experiences in treating EDs. Several studies focus on the experiences of ED healthcare professionals, aggregating the perspectives of various members of the treatment teams (Cordery & Waller, 2006; Fleming & Szmukler, 1992; Long, Wallis, Leung, Arcelus, & Meyer, 2012; Reid et al., 2010; Satir et al., 2009; Thompson-Brenner et al., 2012; Wright & Hacking, 2012), while others assess ED patient interactions from a caregiver perspective (e.g., parents, family, friends) (Coomber, 2010; Martin et al., 2013; McMaster, Beale, Hillege, & Nagy, 2004; Sepúlveda et al., 2012). Other research has focused on homogenic levels of care, such as focusing solely on the experience of treating adolescent ED patients (Bakker et al, 2011; King & Turner, 2000; Ramjan, 2004; Raveneau et al.,

2014; Ryan et al., 2006), neglecting to examine the collective experience, including potential similarities and differences, among nurses that may treat both adults and adolescents. Finally, several studies have examined nurse–patient relationships solely from a patient perspective (Berge, Loth, Hanson, Croll-Lampert, & Neumark-Sztainer, 2011; van Ommen et al., 2009; Westwood & Kendall, 2012; Zugai et al., 2013), neglecting to convey the nursing standpoint. Gaining a rich understanding of the experiences of nurses who treat EDs may provide a framework for psychologists to improving nursing training, support, and care.

Relevance to the Field of Psychology

Understanding more fully the role that nurses play in treating EDs, and more importantly their perceived experiences, is essential information for those who are creating and managing ED treatment facilities to become aware of to provide stronger and more effective care. Psychologists and other mental health professionals typically lead efforts in creating, structuring, and implementing effective treatment protocols at ED treatment centers. These professionals share the same concerns and ultimate goals in treatment, though they may interpret and socially construct their experiences in different ways (Crotty, 1998). Thus, increased knowledge of the shared meaning that nurses attribute to their work may lead to more effective training protocols for nurses and increased preparedness through enhanced supervision and education, which has been noted to improve overall experiences for nurses (Lindahl & Norberg, 2002).

Ultimately, increased awareness of nursing experiences helps to minimize potentially adverse outcomes that may arise due to feeling unprepared and uncertain and lacking support. Due to high rates of compassion fatigue and burnout among nurses as a

whole and among other professionals who also treat EDs, supervision and training should seek to address ways to manage and prevent such negative symptomatology (Warren et al., 2012). Nurses can then begin to feel more confident and competent in implementing appropriate care strategies. Subsequently, support for such nurses can also be enhanced. Furthermore, there has been a strongly demonstrated link between past trauma and the development of EDs (Mehler & Andersen, 2010) as well as vast body of research examining symptoms of vicarious trauma among therapists and nurses (Collins & Long, 2003; McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995); yet there has been little direct examination of such potentially harmful effects in nurses treating EDs.

Many nurses new to the field report a lack of connection and support among their colleagues as being one of the largest reasons for experiencing negative symptoms (AbuAlRub, 2004; Hilliard & O'Neill, 2010). From an existential perspective, it makes sense that fears of isolation are common experiences for nurses (Yalom & Josselson, 2011). Through increased training and support, nurses may become better prepared and attuned to what to expect when treating EDs, how to handle adverse situations, and learn ways in which they can emotionally and mentally prepare themselves and utilize support to improve both nursing and patient outcomes. Furthermore, communication and support across these multi-disciplinary teams, including between nurses and psychologists, become essential facets of ED treatment.

The Current Study

Given the methodological weaknesses and gaps within the existing literature, the current study aimed to (a) examine the broader context of nurses' experiences working with ED patients, and (b) focus on specific areas that have been collectively neglected in

the literature thus far, such as perceived meaning, challenges, preparedness, and support. Within each of the aforementioned domains, specific questions were asked to increase insight and gain a deeper understanding of these important facets of ED nursing care. Given that psychologists and nurses frequently work together to treat EDs, this study intended to bridge the gap between the two fields and promote an important area for further research.

Research Questions

The specific research questions addressed in this study were:

Q1　　How do nurses describe their experiences in treating patients with EDs?

Q2　　What do nurses perceive as meaningful and valuable in their work?

Q3　　What do nurses see as factors or challenges that impede their work with ED patients?

Q4　　How has their education, training, and preparedness impacted their experiences in working with those suffering from EDs?

Research Approach

This study utilized a phenomenological methodology to capture the essence of nurses' experiences in working with those suffering from EDs. Upon approval from my dissertation committee and the University of Northern Colorado's Institutional Review Board, data collection began. Twelve adult nurse participants were recruited and then interviewed on the inpatient units in which they currently worked (adult or adolescent) (Polkinghorne, 1989), the point of saturation determining this final number of participants included in the sample (Creswell, 2007; Lincoln & Guba, 1985; Merriam, 2009).

The primary data collection method was the use of detailed semi-structured interviews, directed by an interview guide (Merriam, 2009; Patton, 2002). In addition, participants were also asked to bring in artifacts in the form of written or artistic expressions symbolizing their work with EDs, which were reviewed at the time of the interview. To further enhance the richness of the data, the researcher conducted observations on the ED units to better understand the nurses' daily activities and interactions as well as the philosophy of the treatment center itself. Data were collected until saturation was reached (Lincoln & Guba, 1985).

After the data were collected and interviews were transcribed, all data were examined for statements, themes, and descriptions that conveyed the essence of nurses' experiences, using Moustakas' (1994) steps for analyzing phenomenological data. In summary, such steps included identifying participants' experiences (textural descriptions), explaining how they experienced it (structural descriptions), and combining these two descriptions to reveal the invariant structure, or essence, of the phenomenon. Furthermore, the objective of such an analysis was to uncover the idiographic and shared essence of nurses' experiences in treating EDs.

To enhance the overall rigor and trustworthiness of the current study, several methods were utilized during the research process. Triangulation, using multiple and different sources of data to better substantiate one's conclusions (Creswell, 2007), was attained through collecting data from multiple participants and perspectives (different types of nurses at different facilities), as well as through using peer checks or multiple researchers to analyze the data (another Ph.D. candidate in Counseling Psychology trained in the procedures and ethics of qualitative research and transcription) (Creswell,

2007). A thorough interview guide with detailed questions bolstered the rigor of the interview process. The interviews themselves as well as the use of multiple researchers to transcribe the data resulted in prolonged engagement in the field, further enhancing the study's dependability. I became further immersed in the data through reading and re-reading all the transcriptions (both those I transcribed myself and those transcribed by a research assistant). I subsequently provided rich, detailed verbatim descriptions of the participants' lived experiences through the use of quotes and obtained a thorough understanding of the data through which themes emerged. Finally, I engaged in member checks, asking each participant to review the interpretation and themes that emerged from the data to better ensure accuracy (Creswell, 2007; Merriam, 2009), as well as review the way in which her demographic information was presented to ensure confidentiality.

A reflexive journal was also maintained throughout the research process to explain the various methods of data collection and analysis, acting as an audit trail to remind myself and inform the reader of specific steps taken to enhance possible replication, as well as to authenticate the subsequent findings (Merriam, 2009). This was an integral step in the process, enhancing my ability to assess personal biases and ways in which I could potentially affect the data (Morrow, 2005).

Assumptions

Based on (a) a review of the literature, (b) my personal theoretical orientation, and (c) professional experience working with patients diagnosed with ED and the nurses involved in their treatment, this study aimed to address my own assumptions that otherwise might have affected the data. First, the study relied on the assumption that nurses had experienced and would be able to identify factors that impede and challenge

their work as well as those that they find meaningful. A second assumption was that

participants were willing to share such details of their experiences and would be honest

and genuine in describing their values, thoughts, and feelings surrounding their intensive

work environments. Third, there was an assumption that varying levels of training,

experience, and preparedness actually affect how nurses make meaning of and explain

their experiences in treating EDs. Finally, I held the assumption that participants'

perspectives and shared experiences were necessary to understand in order to improve

both their training and the overall efficacy of ED treatment programs. Given these

assumptions, a qualitative research approach was determined to be the most effective way

to capture such a phenomenon.

The Researcher

In qualitative research, the researcher becomes the primary instrument of data

collection and a central figure in the overall research study (Creswell, 2007). Therefore, I

must first identify my background and acknowledge any potential bias that could

influence the subsequent analysis of data. Known as reflexivity, this process not only

promotes an increased focus on the subjective experience of the participants, but also

contributes to the overall trustworthiness of the study (Creswell, 2007).

Personally, I have worked with nurses in various capacities as well as with

patients diagnosed with EDs. In 2006, I began working in hospital settings, starting as a

psychiatric technician in an inpatient psychiatric unit. Engaging in case management of

patients with severe mental illnesses including major mood disorders, thought

disorders/psychoses, and violent tendencies both towards oneself and others, I quickly

understood the importance of working with multidisciplinary teams. Medical staff,

psychologists, social workers, and case managers all worked together to stabilize and manage large groups of patients who often behaved in erratic and volatile manners. This experience shaped my professional career; I realized that I wanted to continue working with such teams of professionals, but in a more impactful capacity. Therefore, I decided to go back to school and work towards a graduate degree in psychology.

During my master's program, I wanted to learn more about EDs, an area with which I previously had limited exposure. In 2009 I began working in a behavioral health hospital specializing in treating adults and adolescents with EDs. As a milieu coordinator, I conducted group therapy, regularly ate meals with patients, and counseled patients at the acute ED unit at a neighboring hospital. Over my three-and-a-half years of employment there, I was exposed to a myriad of medical and psychological symptoms of EDs and, once again, worked with the nursing staff to provide social case management services for the patients.

Throughout my doctoral education, I have maintained my interest in EDs, participating in various research and educational opportunities on the topic. My work with both nurses and ED patients has driven my interest and pursuit of such a study for my doctoral dissertation research. Furthermore, I also hope to continue my professional career in working directly with nurses and multidisciplinary teams in a hospital setting

Definition of Terms

Burnout. Defined as decreased motivation, a sense of helplessness, exhaustion, detachment, an overall decline in sense of personal effectiveness, and extreme physical and mental exhaustion occurring after long periods of prolonged stress.

Compassion fatigue. The negative psychological and physical consequences (e.g., fear, anxiety, physical exhaustion) that one may experience from acute, prolonged care-giving to, or over-involvement with, those who have endured significant trauma or suffering.

Compassionate detachment, The ability to recognize another person's feelings and feel compassion for them while also being able to detach oneself enough from the issue in order to act effectively (similar to empathy*).*

Cooperativeness. One's relationships with others.

Emotional intelligence. The degree with which people understand and experience their emotions.

Emotional labor. The ability one has to regulate his or her emotions in the work context as well as to display emotions that remain congruent with his or her necessary duties or requirements.

Harm-avoidance. The degree to which one is easily inhibited in his or her behavior and anxiety prone (similar to neuroticism).

Mindsight. The attempt to try and understand another person from his or her perspective.

Novelty-seeking. The degree to which one is impulsive in thinking, anger prone, and easily excited to initiate activity (similar to extraversion).

Patients. Most often used in medical settings, used synonymously with the term client, which is most often used in counseling settings.

Persistence. The degree to which one views disappointments and failures as opportunities for growth and to overcome setbacks, a subscale including perfectionism.

Reward dependence. The degree to which one is sensitive to social cues, sympathetic towards and dependent upon responses of others.

Self-directness. One's relationship with oneself.

Self-transcendence. One's relationship with the universe.

Vicarious resilience. The vicarious (positive) impact that trauma survivors' stories and experiences have on those professionals who work with them.

Vicarious trauma. The negative effects that one can experience when working with traumatized patients and hearing their stories, which can often present similarly to those experienced directly by the traumatized individual (e.g., decrease in sense of safety, lack of trust, hypervigilance).

CHAPTER II

A REVIEW OF THE LITERATURE

Overview

The treatment of eating disorders (EDs) is a complex and intricate process. Medical and mental health professionals must work together to treat a multitude of medical and psychological factors (Mehler & Andersen, 2010). Though researchers have gained knowledge on the direct experiences of the ED nurses who play an integral role in ED patient care, there is little research assessing both the subjective positive and negative emotional experiences of nurses in treating adults and adolescents at the inpatient level of ED treatment, while also exploring the effects of their prior training. Therefore, the purpose of this qualitative phenomenological study was to explore and better understand the experiences of nurses who treat adult and adolescent patients diagnosed with EDs, specifically within inpatient settings. Understanding the positive and negative components of nurses' experiences will enhance further education and preparation for nurses in the ED field so they can best care for their patients and themselves. In examining this topic, the research exploring similar topics (e.g., nurses' abilities to connect with ED patients, their perceptions on effective interventions, and/or their emotional experiences) (Bakker et al., 2011; Halek, 1997; Irwin, 1993; Pryde, 2009; Ramjan, 2004; Ryan et al., 2006; Snell et al., 2010; Wolfe & Gimby, 2003) was explored in depth. There are also many additional facets of mental health and medical care that

were examined to obtain an integrated perspective and understanding by which to evaluate the aims of the current study.

In this chapter, I present research relevant to this current study, including (a) an overview of EDs; (b) a framework commonly used to treat EDs; (c) an exploration of nurses' interpersonal and emotional experiences in both the medical and psychiatric arenas; and (d) common experiences of those specifically treating patients diagnosed with EDs, including perspectives from nurses and other mental health workers (Mehler & Andersen, 2010).

Eating Disorders

The prevalence of EDs within the United States continues to raise concern within psychological and medical communities (ANAD, 2014; NIMH, 2014). The EDs result in dietary imbalances, in which those affected either restrict food intake or consume excessively large amounts of food. Such individuals also experience unrelenting concern and dissatisfaction with his or her body shape and size. Common EDs include anorexia nervosa, bulimia nervosa, and binge eating disorder, in addition to avoidant/restrictive food intake disorder and other specified or unspecified feeding or EDs (American Psychiatric Association, 2013).

A person with anorexia nervosa is defined by significantly low body weight, intense fear of gaining weight or becoming fat, and distorted body image (American Psychiatric Association, 2013). It typically involves the suddenness of onset (the average age being 19 years of age) and rapidly peaking intensity. Patients with anorexia nervosa typically eat very little, if any, food, yet many also use compensatory purging behaviors for their minimal food intake (anorexia nervosa, binge-purge type), such as vomiting,

over-exercising, laxative/diuretic use, or fasting (Hudson et al., 2007; NIMH; 2014;

Strober & Johnson, 2012).

  A person with bulimia nervosa is defined by frequent episodes of excessive food

consumption (binging) in which a patient feels a complete lack of control, followed by

recurrent compensatory behaviors to rid the body of the excess calories (e.g., purging,

over-exercising, use of laxatives or diuretics, etc.). Similar to anorexia nervosa, a patient

with bulimia nervosa self-evaluates based on his or her body shape and weight (American

Psychiatric Association, 2013). Though one suffering from bulimia nervosa also pursues

a thin body shape, he or she often falls within a normal weight range. Like anorexia

nervosa, bulimia nervosa typically develops in late adolescence or early adulthood

(NIMH, 2014). However, due to various socio-cultural and biological factors, the age of

onset of both anorexia nervosa and bulimia nervosa in younger generations is gradually

decreasing (Favaro, Caregaro, Tenconi, Bosello, & Santonastaso, 2009).

  Binge eating disorder is characterized by binge-eating behavior followed by

marked distress regarding the binging, without the compensatory behaviors (American

Psychiatric Association, 2013). Thus, the individual is often overweight. Though this

typically occurs in approximately 2% of the adult United States population, there is far

less research focusing on it specifically (NIMH, 2014). Finally, avoidant/restrictive food

intake disorder involves a persistent failure to meet nutritional/energy needs associated

with significant weight loss, nutritional deficiencies, dependence of enteral feeding or

nutritional supplements, and/or interference with psychosocial functioning. In patients

with this type of ED, there is not a psychological preoccupation with weight (American

Psychiatric Association, 2013). The first three EDs include significant dissatisfaction

with one's body shape and size and often an identity almost inseparable from the ED

(Budd, 2007; Hudson et al., 2007).

Prevalence of Eating Disorders

As of 2007, approximately 4% of the United States population reported struggling

with EDs (including anorexia nervosa, bulimia nervosa, and binge eating disorder) for

most of their adult lives; that statistic increases when just examining symptomatology

over a 12-month-span (Hudson et al., 2007). Though men, women, and children all suffer

from EDs, they are most common among females between the ages of 12 and 25 years of

age, with this subset accounting for approximately 90% of those who endorse EDs

(Hudson et al., 2007; Mehler & Andersen, 2010; NIMH, 2014). However, EDs have been

documented from ages 7 to 77 and up to 40% of those between the ages of 9 and 10

reported a preoccupation with being fat, even if they are not medically over or

underweight (Mehler & Andersen, 2010). In addition, the discrepancy in the ratios of

females to males diagnosed with EDs is smaller than commonly believed: 10:1 in clinical

referrals and between 2:1 and 3:1 when assessed in community samples, a large number

of these men identifying as gay (ANAD, 2014; Mehler & Andersen, 2010).

Many individuals not diagnosed with an ED also endorse patterns of disordered

eating, which can lead to the development of a diagnosable ED (Cave, 2010). Research

examining such patterns of disordered eating within the general population has found that

45% report feeling guilty after eating, 45% report thinking that they have a weight

problem, 22% report dieting within the past two months, and 8% endorse feeling as

though their lives are dominated by conflicts with eating (Langer, Warheit, &

Zimmerman, 1991). In a recent study, Reba-Harrelson et al. (2009) found that

approximately 75% of women without a history of an ED reported being so concerned about their weight and body shape that it affected their happiness. Furthermore, 31% of women without an ED had purged at some point in their lives to try to control their weight. It is important to keep in mind that these statistics merely represent those who report or seek treatment for such eating problems, as there remains a large portion of people with a diagnosable ED (over 50%) who keep their condition hidden or refuse to seek help (Hudson et al., 2007).

Culture also plays a role in the development of EDs. Though often misperceived as a disorder experienced solely by upper-middle class Caucasians, several studies have examined increased desires for thinness and ED behaviors among diverse populations. Research has not consistently demonstrated a strong correlation between anorexia nervosa and upper socioeconomic status and, in fact, has shown bulimia nervosa as occurring in various levels of economic status, often more common among those of lower socioeconomic status (Gard & Freeman, 1996). Though cultural beliefs may serve as a buffer for some minorities against the risk factors associated with EDs, acculturation into mainstream American culture has broken down some of those protective factors (Pumariega, Gustavson, Gustavson, Motes, & Ayers, 1994) and the rate of EDs among minority women are similar to those of Caucasian women (NIMH, 2014). In a 1994 survey of African American women, researchers found that over 50% were at risk for developing an ED and reported levels of abnormal eating attitudes and body dissatisfaction at least as high as those found in Caucasian women (Pumariega et al., 1994). Furthermore, 74% of Native American girls report engaging in some sort of an ED behavior (e.g., taking diet pills, purging) (NIMH, 2014), while similar issues are

considered to be of the most common psychological problems among girls in Japan (NIMH, 2014).

Etiology of Eating Disorders

There are many contributing factors to the development of EDs, all of which may be important to consider when treating ED patients. It has become clear that a "gene-by-environment interaction" (Strober & Johnson, 2012, p. 158), involving a complex interaction of genetic, biological, psychological, and environmental factors, underlies ED etiology, especially with regard to anorexia nervosa (NIMH, 2014; Strober & Johnson, 2012; Walsh & Devlin, 1998). Furthermore, characteristics associated with AN, such as anxiety and perfectionism, are biological vulnerabilities that typically appear before the onset of the ED (Strober & Johnson, 2012).

Various environmental factors influence the development of an ED. These include social comparison, mirroring/learned behaviors, peer pressure from the media and social networks, and intense dedication to athletics (Bakker et al., 2011; Strober & Johnson, 2012). Many male and female adolescents often perceive a significant lack of control in their lives and may seek to gain control through ED behaviors (Budd, 2007). Family dynamics also play an important role in the development and maintenance of EDs. Berge et al. (2011) discovered numerous themes connected to family life cycle transitions that can affect ED development, including school transitions; relationship changes; home and job transitions; illness/hospitalization; death of a family member; and physical abuse, sexual assault, or incest.

Parental attitudes also play a role. Parents of children diagnosed with anorexia nervosa are often worried, uncertain, and fearful about how to get their child to eat

(Strober & Johnson, 2012). Unintentionally, they may exert increased pressure on their children; become overprotective and overly critical; and make comments about their child's body shape, weight, and eating habits (Johnson, 2011; Strober & Johnson, 2012). Parents of children diagnosed with bulimia nervosa may be indifferent, exhibiting little affection, high expectations, similar levels of aforementioned criticism, and higher levels of familial discord of change in family structure (Johnson, 2011).

Psychological Symptoms

The EDs are accompanied by a myriad of mental health concerns, significantly impacting the treatment process. Persons suffering from EDs (specifically anorexia nervosa) often experience low feelings of self-worth and self-esteem, deficient self-concepts and personal identities, stress sensitivity, neuroticism, anxiety, fear, avoidance, and a lack of trust for both themselves and others (Garner, Garfinkel, & Bemis, 1982; Strober & Johnson, 2012). Patients tend to think dichotomously, in absolute terms (e.g., all or nothing type thinking), exhibit excessive levels of personalization, inappropriate cognitive schemas, and poor affective expression and regulation (Garner et al., 1982). Many symptoms experienced by patients (again, especially those diagnosed with anorexia nervosa) are egosyntonic by nature, in that there is little self-awareness regarding specificity and severity (Garner et al., 1982; Strober & Johnson, 2012).

Cloninger, Przybeck, and Svrakic's (1994) Temperament Character Inventory has provided valuable insight into the specific nature of EDs, through examining personality traits (factors that are more ingrained in personality and less in immediate control) and characteristics (results of interactions between personality traits and life experiences that are more malleable). Though not created solely for use with ED patients, the

Temperament Character Inventory is a commonly used instrument in ED assessment and

treatment (Diaz-Marsa, Carrasco, & Siaz, 2000; Dickie, Wilson, McDowall, & Surgenor,

2012; Klump et al., 2004). For Cloninger et al., personality trait dimensions include

novelty-seeking, the degree to which one thinks impulsively, is anger-prone, and easily

excited to initiate activity; harm-avoidance (similar to neuroticism), the degree to which

one is anxiety prone and inhibited in behavior; reward dependence, the degree to which

one is sensitive to social cues and is sympathetic towards/dependent upon responses of

others; and persistence, the degree to which one views disappointments and failures as

opportunities for growth, including the subscale of perfectionism, directly correlated in

the literature with a subsequent drive for thinness (Dickie et al., 2012). Character trait

dimensions include self-directness, one's relationship with oneself; cooperativeness,

one's relationships with others; and self-transcendence, one's relationship with the

universe (Cloninger et al., 1994),

     Other researchers have demonstrated similar findings when examining these

dimensions specifically among patients with EDs. Diaz-Marsa et al. (2000) used the

Temperament Character Inventory to compare persons diagnosed with anorexia nervosa

and bulimia nervosa ($n = 103$) across personality and character dimensions. They found

that patients with anorexia nervosa typically scored much higher on the persistence

domain and harm-avoidance when compared to a control group, while patients with

bulimia nervosa typically scored even higher on harm-avoidance and high on some

domains of novelty-seeking. Both groups typically scored high on levels of neuroticism

and low on self-directedness. Klump et al. (2004) examined these traits in women who

had an ED, had recovered from an ED, and those without a diagnosis ($n = 971$). They

found that women currently suffering from either anorexia nervosa or bulimia nervosa scored significantly higher on harm-avoidance, lower on novelty-seeking, and lower on self-directedness when compared with control groups. Women who had recovered from an ED reported significantly higher levels of harm-avoidance and significantly lower levels of cooperativeness and self-directedness than did the control groups. More recent research by Abbate-Daga, Gramaglia, Malfi, Piero, and Fassino (2007) further demonstrated how persons with EDs tend to score low on measures of self-directedness and reward dependence and high on persistence.

People suffering from EDs often have comorbid psychological diagnoses. Many struggle with depression, anxiety, substance abuse, personality diagnoses, and engage in self-harm (American Psychiatric Association, 2013; Bowers, Evans, & Andersen, 1997; Diaz-Marsa et al., 2000; NIMH, 2014). They also often display a wide array of psychosomatic symptoms, including complains of aches, pains, and other physical discomfort, often which has been hypothesized to be associated with effects of past sexual abuse (Mehler & Andersen, 2010; Zerbe, 1993). Furthermore, research has also demonstrated that those diagnosed with anorexia nervosa are 56 times more likely to die by suicide when compared with same-aged healthy peers (Keel et al., 2003). These issues add to its increasing complexity, which can both perplex physicians and detract from needed psychological care and treatment.

Medical Complications

Due to the physical stress placed on the body of a person with an ED, there are often medical complications, some of which are severe, long lasting, and potentially irreversible. With regard to anorexia nervosa, over 95% of women experience

amenorrhea, or loss of a menstrual cycle (McBride, 2012). They may also experience

thyroid disturbances, gastrointestinal problems (such as delayed emptying or prolonged

transit times), dry and itching skin, thinning hair, development of lanugo (fine hair

created to keep the body warm) on face and arms, osteopenia, osteoporosis, anemia,

leucopenia, cardiovascular problems, infertility, and multi-organ failure (e.g., liver and

kidneys) due to lack of use (McBride, 2012; Mehler & Andersen, 2010). Ultimately,

cognitive deficits typically occur as a result of malnourishment. For, as the body starves,

so does the brain (NIMH, 2014). Finally, refeeding syndrome can also occur when trying

to reintroduce food into a malnourished system. Caused by metabolic disturbances, this

syndrome can elicit extreme discomfort in patients. In worst case scenarios, dramatic

reduction of phosphate levels can lead to cardiac arrest and/or delirium (McBride, 2012;

Mehler & Andersen, 2010; NIMH, 2014).

A myriad of medical complications can result from binging and purging as well.

Many persons suffering from bulimia nervosa may experience gastrointestinal

complications (including esophageal problems, constipation, diarrhea); oral

complications (such as loss of tooth enamel, pharyngeal soreness from excessive acid

exposure, and parotid gland swelling); and electrolyte, fluid, and acid-based disorders and

imbalances. Finally, given the tendency for binge-eaters to be overweight, there are a

variety of medical complications that they may also experience, including cardiac

problems, high cholesterol, and high blood pressure (McBride, 2012; Mehler &

Andersen, 2010; NIMH, 2014).

Regardless of the type of ED, mortality among those with an ED is concerning.

Individuals with anorexia nervosa are 18 times more likely to die early when compared

with same-aged peers in the general population without anorexia nervosa (NIMH, 2014).

It is estimated that approximately 4% of those diagnosed with anorexia nervosa, 3.9% of

those with bulimia nervosa, and 5.2% of those with an ED not otherwise specified die

prematurely due to their diagnoses (ANAD, 2014; Crow et al., 2009), though the

American Psychiatric Association (2000) concluded the long-term mortality rate for those

diagnosed with anorexia nervosa as being over 10%.

However, there is large variability in such statistics between studies and

resources, as many of the deaths from EDs are documented as being due to other related

causes, such as heart failure, suicide, or other medical complications (ANAD, 2014).

Given the numerous and potentially life-threatening medical issues that persons with any

type of ED may experience, an essential component of treatment is having continual lab

workups performed to assess white and red blood cell counts, platelet counts, and

magnesium and phosphorous levels (McBride, 2012).

Treating Eating Disorders

Despite the severe psychological and medical consequences associated with EDs,

on average, less than half of those reporting ED symptoms ever seek treatment (Hudson

et al., 2007). Unfortunately, many individuals may minimize the issue, fear the intensive

environment that inpatient treatment involves, or outright resist treatment due to a lack of

desire to live without the ED (Reid et al., 2010; Zerbe, 1993). Thus, when mental health

professionals (e.g., psychologists, psychiatrists) are attempting to design and implement

effective treatment approaches, various factors must be taken into consideration to

provide the most effective care for patients and maximize treatment adherence.

Psychological, medical, and dietary elements must all be accounted for while also

creating an environment that is most conducive for ED treatment and accepted by patients (Mehler & Andersen, 2010), especially when treating patients suffering from anorexia nervosa, who may be even more at risk for immediate medical complications (Mehler & Andersen, 2010; Strober & Johnson, 2012).

Multidisciplinary Teams

Given the complexity of EDs, treatment typically involves a wide range of professionals in which nurses play an integral role. When evaluating treatment effectiveness, research has demonstrated that a combined approach of supportive medical attention and psychotherapy is much more effective than psychotherapy alone (Mehler & Andersen, 2010; NIMH, 2014). Therapy alone has typically not been sufficient, perhaps because therapists often must work outside of their clinical expertise. They may feel obligated to try and force their patients to eat. Weight restoration is considered an integral component of treatment of anorexia nervosa, most effectively approached by physicians, nurses, and dieticians (Mehler & Andersen, 2010). Strober and Johnson (2012) acknowledged, however, that despite such efforts, "Therapist complacency in addressing malnutrition remains" (p. 159), with therapists often placing too much trust in their patients' abilities to manage eating on their own. Due to the necessary cognitive functioning that therapy requires, successful interventions cannot even begin until the starved brain is physically healed through weight restoration (Mehler & Johnson, 2010; Strober & Johnson, 2012).

Thus, the most effective treatment involves multiple elements working together simultaneously to assess and treat each facet of the ED that has often become integrated into the patient's identity, including (a) therapy, at the individual, group, and familial

levels; (b) medical care and monitoring; and (c) nutritional counseling (Bowers et al., 1997; Mehler & Andersen, 2010; NIMH, 2014). The result is often an interwoven treatment system, involving nurses, physicians, master and doctoral level therapists, and dieticians, all working to treat each patient with a team approach.

Levels of Care

Treatments for EDs occur at various levels: inpatient, residential, partial hospitalization, intensive outpatient, and traditional outpatient settings. The decision about which level of care is most appropriate is determined by the severity, duration, and current level of risk associated with the current presentation of the illness (Mehler & Andersen, 2010); each level of ED treatment provides a unique set of challenges for ED nurses. At times, outpatient therapy may be the easiest avenue for treatment, often far more economical and conducive to typical lifestyles. With this treatment option, nurses play a less integral role. Outpatient therapists must adhere to benchmarks in determining the effectiveness of their work and remain attuned and cognizant to when a higher level of care is required, especially when treating patients with anorexia nervosa (Strober & Johnson, 2012); for example, they must assess if the patient is maintaining a healthy weight, able to maintain employment and/or educational efforts, and sustain social support (Strober & Johnson, 2012).

In cases in which the aforementioned domains are not sustained, inpatient treatment is viewed as the most successful alternative place to begin. Inpatient treatment often facilitates a greater reduction in psychopathology over the long-term, greater support for sustained weight gain, and decreased likelihood of relapse through integrating skills of both medical and mental health professionals (Bowers et al., 1997; NIMH,

2014). Such programs stress the importance of the interpersonal effects that each patient has on each other within a milieu environment. Thus, inpatient facilities hope to act as microcosms of their patients' own worlds in which they can engage in cooperative learning strategies to become more self-aware and self-reflective (Bowers et al., 1997). Patients not only can learn from their treatment team, but they can also hope to gain support and learn from each other.

Family Focus

The nature of living with and potentially caring for a child, spouse, or other close family member with an ED can elicit a wide array of emotional responses. Many can become increasingly overprotective, exerting an increasing amount of pressure and/or rigidity (which may have already existed to some extent), or alternatively become distant, avoidant, or in complete denial out of frustration or lack of certainty about how to respond (Atkins & Warner, 2000). Thus, given the significant familial component in both the development and maintenance of an ED (specifically anorexia nervosa), there has been an increasing emphasis on the importance of family-based therapy for both adolescent and adult ED patients. This focus is pertinent to nurses, as they tend to have the most patient interaction. Separation of the ED symptoms from the patient who has them is an integral focus of treatment for all providers (Wright & Hacking, 2012), in hopes to safeguard against increased family and personal strain (Atkins & Warner, 2000). However, this process of separation is a continual challenge (Fleming & Szmukler, 1992; Ramjan, 2004; Raveneau et al., 2014).

Familial involvement, especially for children and adolescents with EDs, is an essential part of inpatient ED treatment and continues into the outpatient treatment. The

Maudsley approach is widely endorsed and used in a many treatment facilities in the

United States and Europe (Lock et al., 2010). This approach is a three-phase intensive

evidence-based treatment for children and adolescents diagnosed with anorexia nervosa

in which the facilitation of emotional communication and parental re-empowerment are

essential elements to recovery (Lock et al., 2010). Used also to augment or sustain

treatment gains made at the inpatient level, this approach has been successful in helping

people improve moods, gain weight, and improve eating habits, specifically in patients

with anorexia nervosa (Johnson, 2011; NIMH, 2014).

Lock et al. (2010) conducted research demonstrating the efficacy of this approach.

Through a randomized controlled trial with adolescents diagnosed with anorexia nervosa

($n = 500$), the Maudsley approach, also referred to as family-based therapy, was

compared to other therapeutic interventions. Examining patients who had received and

completed family-based therapy at a one-year follow-up: 40% of patients were in full

remission, defined by recovering to 95% of their ideal body weight and significant

reduction in psychopathology associated with the ED measured via the eating disorder

examination interview; 89% were in partial remission, defined by recovering to 85% of

their ideal body weight; and 15% remained hospitalized at an inpatient level of care.

These proved to be significant advantages when compared with adolescents who had just

received adolescent-focused individual treatment (Lock et al., 2010). Given the integral

nature of both parents and treatment teams in working with children and adolescent ED

patients, nurses often need to increase their awareness and understanding of treatment

protocols involved in such a method in order to build stronger relationships and facilitate

the treatment process (McMaster et al., 2004; Turrell et al., 2005).

Importance of Nurses

Given the multi-disciplinary approach of ED treatment, nurses play an integral role at both inpatient and intensive outpatient levels and are often viewed as the linchpin of the treatment team, interacting and communicating with both the patients and the team as a whole often more than anyone else (King & Turner, 2000; Mehler & Andersen, 2010; Ryan et al., 2006). Though not responsible for actual therapy or the creation of treatment and nutrition plans (instead responsibilities of psychiatrists, therapists, and dieticians, respectively), nurses are the multi-taskers of patient treatment. They are responsible for the full-time, 24-hour-care of each individual patient, management of the milieu as a whole, often engaging in crisis management and the use of de-escalation techniques, and continual communication back to the treatment team (Mehler & Andersen, 2010; Turrell et al., 2005). They implement various protocols created by the treatment team (e.g., tube feedings, lab draws, physical assessments including daily weights and vitals, and exercise monitoring), assess and treat medical complications, distribute medication, engage in continual milieu management, and aid in the facilitation and integration of patients back into their communities through discharge planning—all such interventions integrating their own clinical judgment and ability to support patients on their respective roads to recovery (Halek, 1997; Mehler & Andersen, 2010; Pryde, 2009; Snell et al., 2010; Turrell et al., 2005).

Nurses often bridge the gap between the medical and psychiatric components of treatment through acknowledgment and utilization of the philosophy and theoretical underpinnings of ED treatment, potentially using techniques from cognitive behavioral therapy, dialectical behavioral therapy, or acceptance and commitment therapy (Bowers

et al., 1997). Essentially, nurses play an integral role in both the immediate care and evaluation of patients' medical and overall stability in helping them work towards their long-term treatment goals, acting and facilitating treatment at a variety of levels (Mehler & Andersen, 2010; Pryde, 2009), some of which (e.g., nutrition management and therapeutic interventions) may be outside the scope of their immediate expertise. This study aimed to uncover how ED nurses' actual and self-perceived knowledge of EDs affect their overall experiences in the workplace.

Responsibility and boundaries. Nurses are responsible for providing structure and firm boundaries for patients, while also helping to alleviate concerns and normalize their experiences (Halek, 1997; Pryde, 2009; Ramjan, 2004; van Ommen et al., 2009). Many nurses report that an integral part of effective care for ED patients is in taking over full responsibility and providing continual directional support (Bakker et al., 2011; Irwin, 1993; Wright, 2010). Nurses must not only care for patients with EDs as they would for any other type of patient, but they also often feel compelled to enforce even stricter boundaries, control, and direct supervision to combat poor nutrition and to monitor excessive exercise (Irwin, 1993; Ramjan, 2004; van Ommen et al., 2009).

Nurses must adhere to strict treatment protocols, despite attempts for negotiation by patients. Through consistent firmness and demonstration of boundaries, nurses serve as role models for patients by demonstrating healthy interpersonal skills, as well as eating behaviors, especially considering they often have the greatest amount of patient contact by anyone on the treatment team (Bakker et al., 2011; Irwin, 1993; Snell et al., 2010; van Ommen et al., 2009). Though researchers have examined caregivers' perceptions and feelings towards taking on such responsibilities (Coomber, 2010; Martin et al., 2013), the

current study aimed to more deeply understand nurses' feelings towards these

obligations. With such an understanding, psychologists can augment efforts to better

support nurses in cases when they may feel overwhelmed to increase their own self-care

as well as to enhance patient care.

   Communication. Aside from direct patient care, nurses are key in effective

communication between the patient and various members of the treatment team. Nurses

frequently shift between multiple roles of communication, acting as both team members

and patient advocates (Pryde, 2009; Snell et al., 2010). Thus, an increased level of trust is

placed in nurses' abilities to follow through with treatment protocols and to communicate

effectively with the patient on behalf of other treatment team members (Snell et al.,

2010). Nurses are also directly involved in extended aspects of patients' treatment, such

as in providing communication directly with patients' family members as well as other

outpatient providers (Halek, 1997; Pryde, 2009; Snell et al., 2010). Nurses want to form

strong relationships with parents and family members in hopes that they, too, can become

essential parts of the treatment team (Turrell et al., 2005). Research has also emphasized

the need for nurses to establish collaborative partnerships with other health professionals

to enhance patient health outcomes (McMaster et al., 2004). Though research has

addressed their multitude of communicatory roles, the Snell et al. (2010) study was one

of the few studies to directly emphasize the struggles of nurses and the need for

emotional distance when forming relationships with resistant and unwilling ED patients.

Thus, more research is needed directly examining nurses' emotional experiences of

vacillating between different roles and different levels of such challenging

communication, a facet that the current study aimed to explore. Subsequently, identifying

such factors is important to increase support and training for nurses who may

subsequently experience negative consequences.

Education. An important aspect of effective ED treatment is providing psycho-

education to patients and families, often by nursing staff. Research demonstrates the high

degree of importance that nurses place on such education and planning from the onset of

treatment concerning nutrition, exercise, and the importance/dangers of medication, as

well as relapse prevention for patients nearing discharge (Bakker et al., 2011; Irwin,

1993; Pryde, 2009; Snell et al., 2010). Education must be provided to patients, but must

also involve community resource planning and the education of family members (Bakker

et al., 2011; McMaster et al., 2004; Turrell et al., 2005), often referred to by many nurses

as extending to the level of "counseling parents" (Bakker et al., 2011, p. 20).

The Experiences of Medical Nurses

Understanding both the positive and negative experiences of nurses across

varying medical disciplines provides valuable insight into shared themes and

perspectives. Medical nursing remains the largest area of research in which experiences

(emotional) among nurses have been directly assessed and may provide some valuable

insight into some of their potentially similar experiences, given the medical nature of ED

treatment, and help to direct the inquiry of the current study. Exploring experiences

among ED nurses will help to further enhance specific training efforts as well as the

overall effectiveness of, and collaboration among, all groups of professionals working

within ED treatment programs.

Nurses have reported a wide array of experiences resulting from their work in the

medical field. Many argue that the notion of giving oneself fully is needed to adequately

care for others (Allcock & Standen, 2001; Bassett, 2002), for one must be immersed with the patient and aligned with the road to recovery to be most effective. Through deconstructing the many facets that affect such experiences, one can gain a richer understanding of what nurses endure, as well as gain awareness into how nurses are able to grow and sustain their own well-being, an important facet of nursing that is often neglected. Given the medical complications experienced among persons diagnosed with EDs, such perspectives of medical nurses may also provide valuable insight into the less examined emotional experiences of ED nurses.

Precursors for Caring

  Knowledge and support. Nurses commonly note that the more knowledge they have about the field of nursing in which they specialize, the more competent they feel. Obtaining the adequate knowledge and clinical skills to perform their expected duties is a process that takes time. Being new to the field of nursing is a time of growth and adjustment, often eliciting feelings of chaos and a strong need to increase one's understanding and find support (Wangensteen, Johansson, & Nordstrom, 2008). Thus, thorough and proper training is key. However, Benner (1982), a nursing researcher, discussed the ways in which nurses develop skills and understanding of patient care over time, integrating education with novel experiences. She believed that nurses could learn the practical knowledge and know-how/skills of nursing through clinical experience. Though theory is important, from her perspective, experience was the key.

  Feeling like an "insider" (Feng & Tsai, 2012, p. 2067) on a particular unit, confident in knowing the specific rules that must be followed, as well as how to manage more challenging situations, all enhance one's comfort and ability to work more

effectively (Feng & Tsai, 2012; Wangensteen et al., 2008). Subsequently, when there is

an increased level of awareness and understanding of the tasks at hand, nurses report

feeling more engaged, more emotionally congruent, and report higher employment

satisfaction (Feng & Tsai, 2012; Zammuner et al., 2003). Finally, feeling supported by

colleagues and supervisors through feedback and emotional processing increases a sense

of unity and confidence among nurses when working in a group setting (Lindahl &

Norberg, 2002; Wangensteen et al., 2008). As demonstrated in later sections, such

knowledge and support also become key components of nurses' experiences in

psychiatric, and subsequently, ED treatment settings.

      Emotional engagement and empathy. Emotional engagement and empathy are

discussed throughout the literature as integral elements of nursing care. Not only is being

emotionally available seen as a means to connect with and support patients, but it is also

a way to help encourage autonomy and empower those who may feel helpless. Such

factors of enabling patient strengths are seen as integral parts of caring for patients

(Bassett, 2002; Lindahl & Norberg, 2002).

      Schell and Kayser-Jones (2007) defined role-taking, the ability to view life from a

patient's perspective, as a core structure for developing interpersonal connections and

empathy in nursing. Research examining the emotional experiences of certified nursing

assistants (CNAs) when dealing with patients nearing death demonstrated role-taking as

being integral in both the cognitive and emotional domains of empathy—to understand

the thinking and feeling components related to death (Schell & Kayser-Jones, 2007). The

mortality associated with anorexia nervosa is 12 times higher than those associated with

any other cause of death for women between the ages of 15 and 24 (ANAD, 2014), in

addition to often-increased challenges in forming relationships with patients due to the severity of their symptoms (Snell et al., 2010); thus, this concept of role-taking and empathy becomes increasingly relevant for nurses working with ED patients and was specifically explored within the current study.

Trust. The nature of the relationship between nurse and patient is integral in providing effective care. Built over time through honest and genuine communication, gaining trust with patients becomes an essential step towards developing and maintaining growth within such a relationship (Hill, 1991; Hilliard & O'Neill, 2010); this is especially important to examine because issues of trust are important in the medical field and also in the psychiatric and ED arenas as well. Morse (1991) examined the quality of nursing relationships through qualitative interviews. She found that mutual, connected relationships between nurse and patient included elements of trust, involvement, and caring, also while providing the most positive outcomes for both parties. However, unilateral nursing relationships, defined by a commitment on the part of the nurse along with a lack of trust and commitment on the part of the patient, lead to far less effective outcomes. Other research has demonstrated that some nurses have felt that trust was broken when they have unintentionally inflicted pain on patients, eliciting feelings of distress and guilt in nurses when engaging in standard nursing protocols (e.g., changing wounds or dressings) (Hilliard & O'Neill, 2010).

Challenges Faced by Medical Nurses

Organizational discomfort. Nurses often report that structural deficits within their places of employment increase and perpetuate their own respective stress levels, especially when working with multi-faceted levels of care with various levels of required

communication (e.g., such as with ED treatment). Finding a niche and cultivating strong,

supportive relationships with other professionals and colleagues within a bureaucratic

system can be a challenge. One can face conflict when attempting to negotiate and fit in

one's personal values and concerns with those emphasized by the organization (Feng &

Tsai, 2012). Many nurses have also identified that breaking away from standard

conventions and doing whatever is needed to benefit the patient, which may include

asserting oneself with colleagues or against standard procedures, can be challenging and

risky. Such assertive behavior becomes increasingly important, though challenging, when

nurses believe that they have been treated unfairly, are underappreciated, and/or

underpaid (Bassett, 2002; Lindahl & Norberg, 2002).

Many nurses also report feeling a lack of professional support at times by

supervisors and colleagues. With increasing responsibilities and often strict time

constraints, some nurses are unaware of, or feel as though they do not have access to, the

immediate resources that could potentially help alleviate some of their stress; thus, they

may not give priority to their own professional needs. Lack of feedback from supervisors

exacerbates such feelings of neglect (Olofsson et al., 2003; Schell & Kayser-Jones, 2007;

Wallerstedt & Andershed, 2007; Wangensteen et al., 2008). Some nurses have reported

feeling afraid to speak up and ask for help or guidance when needed due to the fear of

being negatively evaluated by supervisors (Hilliard & O'Neill, 2010; Lindahl & Norberg,

2002; Maytum et al., 2004). Since such fear and feelings of isolation are common among

novice nurses, it is key that a culture of support is encouraged from the onset of

employment.

Stress. Research has consistently reported high levels of stress associated with nursing in all types of work environments. Negative stress, the imbalance between perceived external demands and one's ability to cope cognitively, physically, and behaviorally (La Rocco, House, & French, 1980) can manifest in various ways among nurses. Feeling chronic stress accompanied by significant emotional engagement, a common experience for many nurses, may decrease the body's ability to respond effectively, leading to emotional upset or even physical illness. One may become over-engaged, emotionally over-reactive, hyperactive, anxious, and ultimately lose her/his energy (Hill, 1991; McQueen, 2004).

Often related to lack of time and increased demands from multiple people (e.g., patients, supervisors, and themselves), nurses frequently endorse a perpetuating sense of internal and external pressure. Bombarded with a myriad of tasks, they may feel powerless and become increasingly frustrated, often noting feeling trapped within their own environments (Lindahl & Norberg, 2002; Olofsson et al., 2003). Many nurses have endorsed a lack of recognition and acknowledgment as being a primary source and maintaining factor of their high stress levels. Supervisors may lack attunement to their nurses emotional needs, may not appear to be available to listen to their concerns, and may neglect to provide both encouragement and feedback, both positive and negative (Olofsson et al., 2003). AbuAlRub (2004) examined stress among American, British, and Canadian nurses (*n* = 303) through the use of various self-report questionnaires. The findings demonstrated that certain factors (e.g., increased work efficiency) acted to maintain and perpetuate chronic stress levels. Chronic and consistent stress was also significantly more damaging than acute, fluctuating levels of stress. In general, nurses

who experienced moderate levels of stress perceived themselves as performing their jobs less well than those reporting low or high levels of stress. High social support from co-workers negatively correlated with perceived job stress and positively correlated with high job performance.

Problems with family members. With any type of nursing, though increasingly emphasized when working with ED patients, family members of patients may become over-involved in the entire process of patient care (Hilliard & O'Neill, 2010; Strober & Johnson, 2012). Subsequently, nurses often experience feelings of insecurity and anxiety when dealing with such family members. Anxiety often arises around perceived expectations by others and concern that their work will not be viewed positively, leading them to feel continually questioned and scrutinized (Lindahl & Norberg, 2002). Nurses working with child patients especially emphasize the importance of enhancing parental support, which could elicit both positive and negative consequences. Anxiety and discomfort could be alleviated for some children when parents are present and involved, while parental anxiety can also be ameliorated when children appear more at ease and supported by nursing staff. However, this also comes with increased pressure on nurses to feel compelled to now comfort both patient and parents. Nurses have reported feeling anger and guilt when blamed for a child's pain, especially when it reduces their own empathy for the situation (Hilliard & O'Neill, 2010; Maytum et al., 2004).

Trouble understanding and regulating emotions. The high level of intensity and the nature of a caretaking role elicit a variety of emotional responses among nurses. Emotional intelligence, or the degree with which people understand and experience their emotions, can be understood as a social process that affects the value of human

interactions and relationships. Such a concept has relevance to the nursing field in that the formation of nurse–patient relationships has often been viewed as the cornerstone of effective care (McQueen, 2004). Gardner's (1993) theories of both interpersonal and intrapersonal intelligence become extremely important to examine when assessing the work of nurses. Interpersonal intelligence refers to the ability for one to understand others and work well with them in cooperation. Intrapersonal intelligence refers to the ability for one to accurately understand oneself, incorporating self-awareness along with the respective abilities to recognize personal feelings and function effectively with others. Both become extremely important in nursing with regard to one's ability to empathize with patients and subsequently engage in self-reflection to identify and understand one's own values and potential judgments (Burnard, 1994).

The ability to effectively engage in emotional regulation, or the managing of emotions to elicit appropriate behavioral responses, is often a concern among nurses. As defined by Hochschild (1983), emotional labor refers to the ability one has to regulate one's emotions in the work context, as well as to display emotions that remain congruent with one's necessary duties or requirements. One may have to express job-congruent emotions or consciously mask job-incongruent emotions (e.g., happiness surrounding a sad event). Such an endeavor inevitably comes with both increased psycho-physical effort and potential cost and may ultimately lead to symptoms of burnout (discussed further with regard to negative emotional experiences) (Hochschild, 1983; McQueen, 2004; Zammuner et al., 2003).

Empathy is the ability to recognize another person's feelings and feel compassion for them while also being able to detach oneself enough from the issue in order to act

effectively, often referred to as compassionate detachment (Schell & Kayser-Jones,

2007). Such factors are integral in effective nursing care, yet often are challenging and

can contribute to negative emotional experiences. In a study that interviewed 27 CNAs at

three separate facilities in which patients were nearing death, Schell and Kayser-Jones

(2007) found that approximately 26% of participants expressed struggles with such

detachment when it came to conversations surrounding death. Several CNAs reported

changing the topic or providing positive affirmations, such as, "Don't say that, just pray"

(Schell & Kayser-Jones, 2007, p. 149), when approached with conversations about death,

perhaps as a means to alleviate their own discomfort. Approximately 45% of CNAs noted

that coming into contact with a dead body made such compassionate detachment

increasingly challenging. The CNAs who had an increased degree of awareness of their

emotions surrounding death reported feeling more comfortable and competent in dealing

with such an issue. Given that death is a pervasive concern when working with patients

diagnosed with EDs (ANAD, 2014; Crow et al., 2009; NIMH, 2014), understanding ways

in which such nurses react to death is an important factor in how they make meaning of

their experiences.

Negative Emotional Experiences

  Anxiety, fear, and uncertainty. Anxiety-eliciting feelings of inadequacy,

uncertainty, and self-doubt pervade the nursing field due to levels of high stress and lack

of time (Johansson & Lindahl, 2011; Lindahl & Noberg, 2002; Wallerstedt & Andershed,

2007). One may feel uncertain of how to approach or effectively deal with particular

types of patients or simply forget what to do when overly stressed. This may be

especially true when patients report feeling excessive pain, which can intensify insecurity

surrounding their own professional identity and potentially lead to feelings of chaos

and/or hopelessness (Allcock & Standen, 2001; Feng & Tsai, 2012; Johansson &

Lindahl, 2011; Olofsson et al., 2003). Many nurses experience a strong ambivalent

attachment to their work, experiencing conflict between their care for their patients and

insidious self-doubt (Hill, 1991). Personal comparison regarding one's own ability to care

can also become a detriment. For example, some nurses feel as though they did the best

job possible with one patient, yet when comparing such results with more disabled and

less healthy patients, are left feeling like failures (Allcock & Standen, 2001).

Unfortunately, though most nurses acknowledge the importance of listening to

patients' stories and concerns as part of being empathic, many nurses may struggle with

this. Through interviews with nurses on pediatric burn units, Hilliard and O'Neill (2010)

uncovered that many nurses experienced increased feelings of tension and discomfort

when they were unable to listen and empathize enough due to lack of time, heavy

workloads, or simply being uncertain of what to say or how to respond.

Nurses new to the specialty area in which they work may feel anxiety simply due

to lack of experience. Role ambiguity and lack of confidence often perpetuates a state of

inner chaos and frustration, which ultimately worsens negative symptomatology and

potentially leads to lower self-esteem (Feng & Tsai, 2012; Lindahl & Norberg, 2002). For

example, nurses new to a pediatric burn unit have often reported increased levels of self-

doubt regarding their inexperience and knowledge regarding working with such a

population. Such uncertainty negatively affected their clinical competence, which at

times exacerbated symptoms, such as physical pain, among their patients. When new to

the field, such nurses also reported a fear of judgment in seeking out guidance from

superiors (Hilliard & O'Neill, 2010). Overall, approximately 60% of nurses leave the profession after their first year, given the high levels of stress (Maytum et al., 2004).

Lack of experience and specific education is pertinent to nurses in the ED field given their variety of roles and responsibilities (Bakker et al., 2011; Mehler & Andersen, 2010; Reid et al., 2010). However, more research is needed to better understand and explore ED nurses' experiences and accompanying emotions. A specific examination of how the experiences of nurses (time in practice) may influence their perceptions of working with ED patients was another aim of the current study.

Sadness, grief, and guilt. Nurses frequently acknowledge the immense sadness they experience when working with certain patients who are in severe discomfort and/or pain. Allcock and Standen (2001) provided a profound quote from one student nurse's experience in caring for a patient who reported a significant level of pain: "It's difficult at times because some people are in terrible distress and when you've done all you can and there is nothing else you can do—that's when it becomes quite upsetting" (p. 289). Such feelings of distress can also further elicit feelings of helplessness and vulnerability, which in turn often leads to frustration and anger, often when one felt as though he or she did not do enough or had let a patient down (Allcock & Standen, 2001).

Various symptoms of sadness and grief often ensue when working with terminally ill patients. Nurses have reported feeling ambitious to provide the highest quality care for patients in the last days or months of their lives, though such dedication often perpetuated an internal pressure to assume excessive responsibility (Schell & Kayser-Jones, 2007; Wallerstedt & Andershed, 2007). In addition, excessive exposure to death as well as grief and loss symptomatology of family members can lead to emotional and physical

exhaustion (Wallerstedt & Andershed, 2007). Johansson and Lindahl (2011) illustrated experiences of Swedish nurses working with terminally ill patients. One nurse reported, "It feels a little more like, like life . . . it's like, death is in the midst of us" (p. 2038). Caring for such patients have caused many nurses to feel entirely drained of energy while simultaneously eliciting feelings of guilt in recognizing that there was never enough time to do enough (Johansson & Lindahl, 2011). Given the potential medical severity and terminal conditions of those living on inpatient ED units, further exploration is warranted among nurses working with such populations.

Not only may nurses feel such pain and sadness for their patients, but they may also experience existential confrontations with their own mortality. Many nurses have felt consumed by the uncomfortable and terrifying nature of death itself (Johansson & Lindahl, 2011). For those patients who survive, nurses can also experience a vicarious sense of survivor guilt. For example, one might wonder why he or she, as a caregiver, has been spared such pain and suffering—there may be an encompassing sense of luck regarding one's own life. This dilemma can subsequently become extremely confusing and tormenting for caregivers (Hill, 1991). Given that patients with anorexia nervosa are 18 times more likely to die earlier that those without (NIMH, 2014), such emotional experiences and confrontations about mortality may also be common for nurses working with patients with such EDs. However, such a topic has yet to be thoroughly explored in the research and is important to understand to provide enhanced social support among nurses and open avenues to process grief/loss if needed. Thus, this was also a point of examination within the current study.

Avoidance. Many nurses have reported feeling the need to address the "emotional labor . . . that can constitute an emotional assault" (Bassett, 2002, p. 38) through finding a balance between caring and becoming overly emotionally involved in their work. Promoted in the idea of compassionate detachment, an integral element of self-care is the compartmentalization of intense emotion and the ability to de-personalize certain emotions and events for the good of both nurse and patient. This process involves identifying emotions and managing them effectively, as opposed to ignoring them (Bassett, 2002; Evans & Allen, 2002; Schell & Kayser-Jones, 2007).

Many nurses are unable to find such a balance. Hiding and "shutting out" (Hilliard & O'Neill, 2010, p. 2911) emotions is a strategy employed by some nurses to avoid feeling distress and discomfort, as well as to avoid upsetting their patients. Many nurses report being unable to disconnect from such emotions when already feeling so empathically engaged with their patients (Hilliard & O'Neill, 2010; Schell & Kayser-Jones, 2007). Concealing emotions and avoiding such processes of self-reflection in order to maintain one's professionalism has often been encouraged in traditional nursing training programs; however, there has been a more recent shift to be more committed to, and involved with, one's patients, which necessitates both identifying and processing one's own feelings (Evans & Allen, 2002; Williams, 2000). Regardless of the intent, the tendency of some nurses to feel disconnected or mistrustful of their patients may increase their anger, annoyance, and/or ignorance of any deeper emotional responses. This becomes especially true when working with ED patients (Bakker et al., 2011; Snell et al., 2010).

Compassion fatigue. According to the American Psychological Association (2011), trauma is an emotional response to a significant, awful, often life-changing event, such as a rape or serious accident. Many patients with whom nurses come into contact experience such states, an especially high prevalence among those with EDs (Mehler & Andersen, 2010; Zerbe, 1993), though such symptomology has been minimally explored in nurses working with such populations. Due to high levels of empathetic involvement in nursing, nurses may subsequently experience emotional contagion, sharing emotions of their patients (Omdahl & O'Donnell, 1999), an important phenomenon to understand when examining their experiences as whole.

Figley (1983) first coined the term, secondary traumatic stress, as a construct describing the negative effects of close contact with trauma survivors such as friends and family. Figley (1983) defined secondary traumatic stress as "the natural consequent behaviors and emotions resulting from helping or wanting to help a traumatized or suffering person" (p. 7). Other terms, such as contact victimization, have also been used since to describe similar symptomology. Figley (1995) subsequently coined the term, compassion fatigue, referring to the negative psychological and physical consequences (e.g., fear, anxiety, physical exhaustion) that one may experience from acute, prolonged caregiving to, or over-involvement with, those who have endured significant trauma or suffering. This appears to be a normal reaction to an abnormal situation, particularly when boundaries have become blurred (Bush, 2009; Figley, 1995; Hill, 1991). Ultimately, those who demonstrate significant empathy, compassion, and vulnerability while also becoming exposed to increased levels of stress, grief, and loss are at an increased risk of experiencing such symptoms. Prior personal experience and exposure to

such issues additionally may increase the intensity of negative symptoms. Thus, nurses not only are key targets, but also frequently endorse such symptoms themselves (Bush, 2009; Hill, 1991; Maytum et al., 2004).

Nurses experience compassion fatigue in a variety of ways, with symptoms even potentially mimicking those of post-traumatic stress disorder. Typical symptoms may include a decrease in concentration and/or self-esteem, irritability, moodiness, apathy, grief, and guilt. Physically, people may report changes in appetite and sleep disturbances. Interpersonal problems may result due to issues of mistrust, withdrawal, or isolation and can permeate many outside relationships. Subsequently, all such aforementioned symptoms may lead to decreased work performance, exhaustion, and detachment (Bush, 2009; Figley, 1995; Hill, 1991; Maytum et al., 2004).

Researchers have examined vicarious effects experienced by nurses working with specific populations. Allan (2006) researched the specific impacts of infertility work among nurses at an assisted conception unit in England. During his two-year ethnographic study, Allan found that the anxiety and sadness associated with the experience of infertility were experienced and carried by both patients and nurses. In addition, Hilliard and O'Neill (2010) found that nurses relived vivid memories of caring for patients' wounds on pediatric burn units, increasing levels of anxiety, still four years after engaging in such work.

Unfortunately, when compared to that of counseling, there has been an alternative training focus in nursing that sometimes has neglected to address the potential effects of compassion fatigue. Hill (1991) acknowledged the continual struggle for caregivers to find a balance between human closeness and professional distance, requiring a strong

delineation between friendship and a caretaker–patient relationship. Though this is a common issue among both medical and mental health workers (Wallerstedt & Andershed, 2007), there appears to be a lack of focus on subsequent issues of transference and countertransference in the nursing field.

      Burnout. Burnout can be defined as exhaustion, depersonalization, and an overall decline in sense of personal effectiveness; essentially, it is a gap between what one is able to do versus what one is expected to do (Pearlman & Caringi, 2009; Phelps, Lloyd, Creamer, & Forbes, 2009). In most helping professions, this can result gradually after prolonged periods of job-related stress, especially when people are regularly faced with issues of emotional labor in which they may be unaware or unable to reflect and process their feelings (Hill, 1991; McQueen, 2004; Omdahl & O'Donnell, 1999). Length of time in the profession, length of time at a particular site, and the intensity of one's particular job duties are all contributing factors (Maytum et al., 2004). Nurses have reported various symptoms of burnout: emotional disengagement, blunted emotional responses, a decreased sense of personal accomplishment, feelings of helplessness or hopelessness, decreased motivation and job commitment, detachment, depression, and an overall lack of energy and emotional exhaustion. Typically, symptoms appear similar to that of compassion fatigue, though often more pronounced or severe. Some report symptoms as becoming more pervasive in their home life in addition to experiencing blurred roles at work (Maslach, Schaufeli, & Leiter, 2001; Maytum et al., 2004; Omdahl & O'Donnell, 1999). One nurse in a study conducted by Maytum et al. (2004) reported: "I would say that burnout is a more lasting thing . . . compassion fatigue is more transient" (p. 174).

Through interviewing nurses working with children with chronic medical conditions, Maytum et al. (2004) uncovered self-reported antecedents to both compassion fatigue and burnout. Most triggers were work-related, subdivided into categories such as (a) caring for children and families, including painful procedures, sadness, death, and angry/incompliant parents; (b) professional roles, including feeling alone without support; (c) work overload, including excessive workload and overtime shifts leading to an inability to provide good care; and (d) broader systems issues, including staffing shortages, unreasonable policies, excessive paperwork, and feeling the need to justify their positions. Participants also identified various personal triggers to compassion fatigue, such as becoming overly involved and having blurred boundaries, having unrealistic self-expectations, taking comments too personally, trying to get personal needs met through work, and having excessive alternative commitments or family crises.

Zammuner et al. (2003) analyzed compassion fatigue and burnout through examining various forms of emotional regulation techniques among hospital employees including nurses, doctors, and other technicians ($n = 180$). Through the use of a self-report questionnaire, researchers examined variables related to job involvement, life satisfaction, burnout, and emotional labor (Hochschild, 1983). These variables included surface acting, which refers to a more shallow form of emotional regulation in which people attempt to display the appropriate emotional repertoire, and deep acting, which refers to the intensification of one's emotions to feel what is required of them. Both may elicit emotional dissonance (Zammuner et al., 2003).

The Zammuner et al. (2003) research supported two (significantly correlated) factors that led to burnout, emotional exhaustion and depersonalization, a coping

mechanism used to protect against fatigue; such findings have also supported prior research (Omdahl & O'Donnell, 1999). Both emotional exhaustion and depersonalization were also significantly positively correlated with surface acting. In other words, nurses who tended to fake appropriate emotions tended to become exhausted more easily and ultimately have less control over their actions. Interestingly, emotional exhaustion and depersonalization were significantly negatively correlated with deactivated affect, indicating that, as opposed to becoming disconnected to emotions, such nurses tended to display more erratic emotional responses. As one might expect, emotional exhaustion was also significantly positively correlated with negative affect and negatively correlated with overall life satisfaction. Deep acting displayed an even greater significant positive correlation with depersonalization, presumably affected by the increased level of purpose and motivation needed to engage in such a façade, as well as social un-desirability. Consequently, all of such concerns further exacerbate symptoms of burnout (Zammuner et al., 2003).

Positive Experiences

Meaning and purpose. Caring for others while also witnessing treatment progress and recovery provides nurses with senses of accomplishment, pride, satisfaction, and gratitude. Nurses often endorse a sense of satisfaction, completeness, and personal growth in knowing that they have done all that they can to help their patients (Johansson & Lindahl, 2011; Wallerstedt & Andershed, 2007). Having patients who conveyed positivity and/or demonstrated progress (Hilliard & O'Neill, 2010), or being able to personally value one's impact upon patients' comfort (Johansson & Lindahl, 2011) further bolstered such positive feelings in nurses. Ultimately, feeling positively and

experiencing genuine job-congruent emotions, or emotional consonance (Hochschild, 1983) tends to increase overall level of job satisfaction and performance in nursing (Zammuner et al., 2003).

Despite the adverse side effects that nurses sometimes experience, many have also reported that, through learning techniques and successfully alleviating patients' pain, they gain an increased sense of competence that further enhances their work. After several months of employment, many nurses endorse feeling less stress and increased self-confidence (Feng & Tsai, 2012; Hilliard & O'Neill, 2010; Wangensteen et al., 2008). Even after prolonged exposure to terminally ill patients, many nurses report becoming better able to view life and death as natural parts of life, conceptualizing the hardships of their work from a more global perspective (Johansson & Lindahl, 2011). Interestingly, such positive perspectives have not been explored among nurses working with ED patients, a population that may experience drastic improvements in both emotional and physical health. Thus, meaning and value were a major focus of the current study.

Sustaining well-being. Both self-care and coping strategies and social support are components of sustaining well-being.

Self-care and coping strategies. As with any profession so prone to burnout, self-care is immensely important in nursing. To manage the myriad of negative effects that may ensue when working in such a high stress environment, nurses utilize various coping strategies. In the short term, nurses may implement various techniques at the workplace, including maintaining a certain amount of psychological distance from their patients, practicing assertion techniques, debriefing with colleagues, attending conferences, changing work assignments, and taking away from work when needed (Johansson &

Lindahl, 2011; Maytum et al., 2004). In addition, creating an open dialogue with patients and encouraging patient autonomy can also alleviate some of the emotional burden felt by nurses (Hilliard & O'Neill, 2010; Omdahl & O'Donnell, 1999). To better cope in the long term, nurses report developing strong professional relationships; developing a theoretical nursing philosophy from which to work; choosing a congruent professional environment; advancing in their education; fostering self-awareness around personal boundaries and triggers; and developing rituals for dealing with grief, loss, and death (Maytum et al., 2004). Nurses also report engaging in exercise, meditation, journaling, recreation, maintaining a sense of humor and positive thinking, and enjoying strong, interpersonal relationships outside of the work environment (Maytum et al., 2004).

Self-awareness and self-reflection are integral parts of combating negative effects from the stress of nursing. Becoming aware of vicarious symptomatology that can ensue from working with patients who have endured immense physical trauma and pain can help alleviate the emotional burden as well as helping to differentiate between empathic concern and symptoms of emotional contagion (Hill, 1991; Maytum et al., 2004). Looking explicitly at oncology care, Hill (1991) proposed that caring for patients dying of cancer can elicit intense, existential conflicts within the nurse and not just the patient. Understanding such shared processes and uncomfortable feelings that may be inappropriately expressed can be normalizing for both the patient's and caregiver's experiences. Further, continually seeking to identify hope and courage in both parties can also bolster one's inner strength.

Social support. Creating an environment of caring and support may be an integral element for sustaining one's personal well-being in a high stress nursing environment.

Key elements include sharing workloads; alternating care for the more acute/emotionally

draining patients; being able to openly discuss patient issues and nursing experiences; and

ultimately letting go of feelings of self-doubt, blame, and guilt (Allcock & Standen, 2001;

Bassett, 2002; Bush, 2009; Hilliard & O'Neill, 2010; Wallerstedt & Andershed, 2007).

Perceived social support in the workplace and feeling as though one is part of a team has

subsequently been noted to decrease levels of work-related stress and increase job

performance, alleviate some discomfort, and increase perceived level of experience

(Allcock & Standen, 2001; Feng & Tsai, 2012). Subsequently, nurses build relationships

in a variety of ways in order to elicit a sense of support, such as unifying through goals

and purposes via group supervision and sharing the same desire to learn and achieve

successful outcomes (Lindahl & Norberg, 2002). However, research also has

demonstrated a lack of social support among nurses that had led to increased stress in the

workplace (AbuAlRub, 2004).

Lindahl and Norberg (2002) demonstrated that obtaining regular supervision from

a nursing supervisor greatly enhanced positive professional outcomes among nurses (e.g.,

providing emotional relief and enhancing care for patients). Through tape-recording

nursing supervision sessions and interviewing nurses about their experiences, Lindahl

and Norberg identified several supportive elements in nursing supervision. First, nurses

reported that having positive role models enhanced their sense of support and ability to

self-reflect. Secondly, their ability to have time to reflect and discuss their experiences in

a group setting increased feelings of relaxation.

The Experiences of Mental Health Nurses

As demonstrated above, nurses experience a wide array of emotional responses in medical settings. Recognizing personal value as well as the positive benefits experienced by patients enhances the positive consequences of nursing; many nurses have reported a sense of appreciation from patients as helping to elicit personal senses of satisfaction and well-being (Johansson, Skarsater, & Danielson, 2007; Van Sant & Patterson, 2013). However, there are also many unpleasant or negative experiences that may ensue. Though experiences of medical and psychiatric nurses are often similar, there are additional complicating factors that can arise when treating mental illness. Such factors may also be directly related to ED nurses' experiences, given the large psychiatric component of such illnesses. However, such facets have typically not been specifically explored within that population. The following sections address specific experiences of mental health nurses, including building relationships with patients, challenges in working with mental health patients, emotional benefits, and personal coping strategies.

Building Relationships

Peplau (1952) developed an evolutionary theory by which to assess the interpersonal relationship between a psychiatric nurse, often referred to as a mental health nurse, and his or her patients. It states that an investment from both parties is needed to form an effective alliance. However, such a relationship is often unequal or can become strained in more challenging environments, specifically when dealing with chronic and acute mental illness. There has been a shift in the attitude of mental health nursing in recent years, embodying the primary tenets of caregiving and enhancing therapeutic factors while attempting to minimize the use of traditionally coercive tactics such as

restraints (Lakeman, 2012). The primary goal is to enhance strong interpersonal relationships with patients through use of active listening techniques, insight and respect, remaining present in the here and now, and having authenticity and a true will to implement change that value health care teams and interwoven members of treatment (e.g., family and friends) (Johansson et al., 2007; Lakeman, 2012). This supports Peplau's (1952) theory, advocating for increased investment on the part of nurses also likely while enhancing such efforts among patients. This theory further supports the existential perspective guiding all human interactions, in that all people seek out interpersonal relationships (whether it be friends, family, colleagues, or patients) to promote interpersonal connectedness and reduce fears of isolation (Yalom & Josselson, 2011).

Research has demonstrated mixed abilities among nurses to form effective, caring relationships with their patients. First, nurses who work with mostly medical patients find it challenging to work with mental health patients (Bjorkman et al., 2008; Zolnierek & Clingerman, 2012). They have noted their limited exposure and perception of mental illness to influence their initial clinical roles with patients (Harms, 2010). Many nurses note respect, flexibility, support, and patient-centered approaches as integral elements in forming strong relationships; strong value systems are viewed as the impetus in driving effective mental health nursing along with patient growth and change (Lakeman, 2012). Some nurses have also reported feeling a sense of physical and spiritual closeness as driving positive interpersonal interactions (Johansson et al., 2007). Furthermore, self-awareness and self-protective strategies play an integral role in fostering interpersonal connections with patients (Van Sant & Patterson, 2013). Overall, the "shared humanity"

(Walsh, 1999, p. 5) of all people existing together on the same earth allows many nurses to gain compassion and empathy for their patients and remain present when trying to understand their experiences. This mentality helps humanize patients, providing an equal and common ground upon which nurse and patient can interact (Walsh, 1999).

However, some mental health nurses have found it hard to develop a connection with psychiatric patients for various reasons. Lack of time and excessive patient load can play a huge role in that nurses may simply lack the means to develop a connection with each patient (Johansson et al., 2007). Societal stigma surrounding mental illness also can affect the ways in which nurses initially approach patients, conveying negative attitudes and skepticism, especially towards more highly acute patients (Bjorkman et al., 2008). Mistrust also can develop out of fears around potential manipulation and being taken advantage of; a need for emotional distance can drive this lack of connection and actually result in an unintentional rejection of the patient (Hem & Heggen, 2004). Many nurses have also reported not taking the symptoms of patients seriously, doubting the genuineness of their interactions. Finally, a lack of motivation due to minimal recognition for their hard work as well as exhaustion can affect the development of superficial nurse–patient relationships (Hem & Heggen, 2004; Johansson et al., 2007; Morse, 1991). A level of trust not only in one's patients but also in oneself and his or her employer becomes essential for the development of strong interpersonal relationships within this setting and in providing effective nursing care (Carlsson et al., 2004).

Other Challenges

Role confusion. As aforementioned, the role of the mental health nurse is comprised of both traditional elements of nursing and an increased focus on therapeutic

components. Though such contradictory demands can have immense benefits to patients,

it can also result in tension and confusion for the nurse. An ethical dilemma can arise in

seeking to find a balance between professionalism as a nurse, the ability to comfort

patients therapeutically (an area in which they not be trained or feel competent), and

personal vulnerability, which is often looked down upon. Demonstrating one's human

side, referred to by one nurse as "being sidelined" (Hem & Heggen, 2003, p. 104), causes

some nurses to criticize and negatively evaluate their performance in that it may fall short

of their perceived and desired professional standards. Continual evaluation by colleagues

perpetuates the notion that one must be strong-willed and unflappable. Given that

emotional states of patients are typically provided with the utmost consideration, nurses'

feelings about their roles and their own experiences often fall by the wayside (Hem &

Heggen, 2003, 2004). Though role confusion has been addressed in nurses working with

ED patients (Pryde, 2009; Snell et al., 2010), there continues to be a need for further

exploration.

     Distress, pain, and fear. Nurses working in mental health settings have

frequently reported experiencing varying levels of distress in the workplace (Johansson et

al., 2007; Kilfedder et al., 2001; Van Sant & Patterson, 2013; Winship, 1995). Issues of

transference become increasingly prevalent when working with patients who have mental

health concerns in which nurses, possibly seen by them as authority figures, may become

targets for hostility. They may experience such projections in a variety of negative ways:

feeling hurt, manipulated, or even abused. However, the emotional impact experienced

by nurses can be underestimated when there is a lack of overt, physical violence

(Winship, 1995).

Violence can occur as a result of hostility and anger among patients with acute

mental health issues, resulting in both positive and negative interpretations and

experiences for nurses (Carlsson et al., 2004). A positive violent encounter can arise

when nurses maintain a high level of insight into their fear and remain present and aware

within any given situation. With adequate support, a nurse can manage his or her

feelings, take responsibility, and demand respect. Thus, one can search for meaning

within the encounter and use elements of mindsight, or the attempt to try and understand

the patient from his or her perspective, in hopes of resolving the situation as best as

possible. A negative violent encounter is created from an often already-existing

uncontrolled fear of the patient or situation that causes a nurse to feel powerless and

appear disengaged. A nurse may subsequently view the patient simply as an object of fear

that must be controlled, potentially resulting in inappropriate and forceful actions that

reinforce dominance and negate the ability to effectively help guide the patient's future

actions (Carlsson et al., 2004).

In either type of violent encounter, there exists an internal battle characterized by

a fight or flight response. An inner dialogue debates the possibilities of what may ensue

as well as the possible pros and cons of one's decision to stay or flee. Nurses have

reported feeling the imminent need to assess violent situations for what is the most

necessary intervention in that moment, most often resulting in the need to stay put and

act. Stability and increased confidence is typically created from the decision to stay.

However, such persistent and uncontrolled fear can cause mental health nurses to feel

hesitant, insecure, and inauthentic in their actions, causing varying levels of self-doubt

(Carlsson et al., 2004). In addition, prolonged exposure to anger and violence may elicit

residual images of the events for undetermined periods of time, potentially resulting in experiences of vicarious trauma (as discussed below) (Whittington & Wykes, 1994). Given frequent resistance to treatment, the potential for aggressive and potentially violent encounters also exists among patients diagnosed with EDs. Though aggressive behavior has been researched, violence towards others has yet to be explored in the literature amongst the ED population.

Vicarious trauma. Over the last 15 years, there has been an increasing awareness and an increasing body of literature that suggests that mental health professionals who provide treatment to traumatized individuals may experience lasting negative effects (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995). As a result of the negative psychological consequences precipitating from childhood sexual abuse, domestic violence, violent crimes, or traumatic events caused by natural disasters, terrorist attacks, or wars, trauma impacts the lives of millions (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995). Thus, this has become an extremely pertinent concern among mental health professionals.

Similar to compassion fatigue, McCann and Pearlman (1990) introduced the term, vicarious traumatization, in an attempt to describe some of the negative effects that working with traumatized patients can have on therapists. A hallmark symptom can be a decreased sense of spirituality and overall loss of meaning and hope. The authors acknowledged that individuals working with traumatized persons may experience "profound psychological effects, effects that can be disruptive and painful for the helper and can persist for months or years after work with traumatized persons" (McCann & Pearlman, 1990, p. 133). This phenomenon of trauma has clearly affected the therapeutic

setting for years. Though it has often been examined among mental health professionals who provide crisis intervention and counseling (Ben-Porat & Itzhaky, 2009; Jenkins & Baird, 2002), there has also been an immense effect on mental health nurses (Maier, 2011; Pearson, 2012).

Rothschild and Rand (2006) stated: "All emotions are contagious—both the ones that are pleasant and the ones that are unpleasant" (p. 9). However, it is generally the unpleasant emotions that cause patients to utilize mental health services. Like other professionals in the mental health field, nurses are often drawn to such professions because of their desire to help those in need and their ability to empathize with others, empathy seen as a valuable asset enabling such professionals to be more effective. Therefore, they become increasingly at risk for symptoms of vicarious trauma or the internal change occurring as a result of empathetically engaging with the traumatic experiences of patients (Pearlman & Mac Ian, 1995). However, empathy can also act as a liability, placing nurses at greater risk to the negative effects of patient traumas. Merely being available and empathizing with another person's pain can elicit a sense of personal distress (Pearlman & Saakvitne, 1995).

Symptoms. Like other mental health workers, mental health nurses will be exposed to others' trauma at some point in their careers due to the sheer prevalence of traumatized patients. However, the likelihood, prevalence, and symptom severity of vicarious trauma can vary immensely (Maier, 2011). Thus, it is essential to be able to recognize the various potential manifestations of vicarious trauma both to better understand it and to aid those who may suffer from it. For counselors who experience vicarious trauma, distinctive symptoms can arise that often mimic those exhibited by the

individuals who directly experienced the trauma (Bober, Regehr, & Zhou, 2006). Similarly, nurses often report similar symptoms, in which they report to "get in their pain with them" (Van Sant & Patterson, 2013, p. 41). Thus, it is important to understand nurses' experiences in that the severity of such symptoms may warrant increased support and treatment.

One main effect of vicarious trauma is the overall decrease in a sense of well-being (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). This becomes evident through the disruption of individual cognitive schemas or important beliefs that people hold about themselves, others, and the world. Essentially, trauma can disrupt such schemas in one or more of the fundamental psychological need areas: safety, dependency/trust, power, esteem, intimacy, independence and control, and frame of reference. A key factor related to all of these is a sense of disrupted spirituality, shown through a decreased sense of meaning and hope (Ben-Porat & Itzhaky, 2009; McCann & Pearlman, 1990; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995).

Disruptions in cognitive schemas may also be accompanied by changes in one's affective states (Marriage & Marriage, 2005; McCann & Pearlman, 1990). Anxiety, fear, anger, sadness, aggression, and symptoms of post-traumatic stress disorder (e.g., numbing, avoidance, and hyper-arousal) are common responses to vicarious trauma (Pearlman & Mac Ian, 1995). Such symptoms may further intensify feelings of depression, helplessness, despair, distrust, as well as decreased feelings of both efficacy and self-esteem (Marriage & Marriage, 2005; McCann & Pearlman, 1990; Pearlman & Caringi, 2009).

Treating victims of rape, through both talking with victims as well as witnessing the physical consequences, can have an emotional impact on nurses. Maier (2011) discussed specific aspects of vicarious trauma experienced by mental health nurses working with patients experiencing post-traumatic stress disorder. Through interviewing Sexual Assault Nurse Examiners, the majority (approximately 67%) reported experiencing significant symptoms of vicarious trauma. They endorsed feeling chronic levels of worry regarding their patients' current states and their own futures upon leaving the emergency room in addition to frustration, helplessness, changed worldviews, preoccupation with events at work, detachment from victims, and problems sleeping. Approximately 46% of nurses also indicated symptoms of subsequent burnout. They reported that feeling overworked, obligated to work overtime and remain on-call, feeling trapped, and having to work with traumatized children as factors that intensified their symptoms. One nurse reported: "It is hard listening to the story they tell me. For them to describe what happened—sometimes it can get pretty graphic" (Maier, 2011, p. 166).

Ben-Porat and Itzhaky (2009) also found that attributes of personal growth, including increased sensitivity, maturation, openness, acceptance of others, compassion, and patience, were significantly lower for those who had worked directly with victims of family violence versus those who did not. Those who worked directly with violence also reported more negative changes with regard to their own spousal relationships. Similar to much of the research on vicarious trauma (e.g., Marriage & Marriage, 2005), Ben-Porat and Itzhaky focused on the experience of those trained in the psychological field (e.g., social workers). Given the importance of understanding this concept, one that may negatively impact both medical and mental health professionals, more research is needed

examining the unique experiences of vicarious trauma among mental health nurses. Such research, specifically with nurses working with patients with EDs, could aid in bridging the gap between the two fields through uncovering similarities and differences in experiences.

Risk factors. Various personal characteristics can influence one's vulnerability for developing vicarious trauma. Such factors can include one's own personal history of trauma (personal meaning attached to); specific traumatic events; level of professional development/experience; unclear roles in treating trauma; psychological and interpersonal style; current life stressors; workload; and level of support (Pearlman & Mac Ian, 1995; Phelps et al., 2009; Williams, 2010). According to Pearlman and Mac Ian (1995), work characteristics that may contribute to vicarious trauma include "the nature of the clientele and the material they present in therapy, stressful patient behaviors, work setting, and social-cultural context" (p. 558). Thus, it is a complex interaction of both internal and external factors that can influence whether a mental health professional may experience vicarious trauma.

Defense mechanism styles. Defense mechanisms (or coping styles) are "automatic psychological processes that protect the individual against anxiety and from the awareness of internal and external danger or stressors" (American Psychiatric Association, 2000, p. 807). Various defense mechanism styles have been implicated as risk factors for experiencing vicarious traumatization. For example, a self-sacrificing defensive style in which one aims to serve and help others and may neglect his or her own needs, has been thought to increase vicarious trauma risk, while an adaptive defense mechanism style may have less of a correlation with vicarious trauma symptoms (Adams

& Riggs, 2008). Furthermore, Adams and Riggs (2008) found that certain defensive styles may mitigate the effects that personal trauma history and experience level have on a nurse.

Personal trauma history. A personal history with trauma can have an impact on one's subsequent experience of vicarious trauma. Pearlman and Mac Ian (1995) examined vicarious trauma among self-identified trauma therapists ($n = 188$). Therapists with their own personal trauma histories showed significantly increased negative effects from their work when compared to those without such personal histories. According to the authors, increased trauma training, supervision, and support for both newer and experienced trauma therapists could help buffer the effects of prior exposure. Such an issue becomes especially pertinent to nurses working in mental health, who may have had such personal exposure to trauma in their past, yet due to their medical training, may have had minimal training in trauma. Thus, this study aimed to further explore how nurses' preparedness and levels of knowledge and support affect their experiences working with patients diagnosed with EDs.

Experience in the field. Unfortunately, it often occurs that those in training, having far less experience than those having practiced for decades, are exposed to patients who have experienced trauma. And, inexperience alone can increase one's chances of experiencing the negative effects of vicarious traumatization (Adams & Riggs, 2008). Thus, experience level becomes an extremely pertinent issue (though are rarely examined) among novice nurses to the ED field given their frequent lack of prior training in EDs. Studies that have utilized samples of practicing therapists have found that a shorter length of time in providing trauma treatment is associated with increased

difficulties related to trauma work (Pearlman & Mac Ian, 1995; Way, VanDeusen, & Cottrell, 2007). Thus, nurses who are newer to the field or merely less familiar with ED are at an increased risk of developing vicarious trauma symptoms. By gathering qualitative data from participants who have worked in the ED field for varying amounts of time, this study aimed to assess how such training and preparedness affects the idiographic nursing experience.

      Burnout. Research among social workers has shown that symptoms of burnout often blur with those of vicarious trauma (Adams, Matto, & Harrington, 2001). As with vicarious trauma, burnout tends to increase among those who are younger and less experienced in that they are often ill-prepared to deal with such intensity in the workplace (Randall & Scott, 1988). Such factors are important to acknowledge in that mental health nurses experience significant burnout as well. Much research has demonstrated the propensity for mental health nurses to experience increased negative symptomatology associated with burnout. Such symptoms include negative overall affect and psychological distress, increased emotional exhaustion, and depersonalization (Jenkins & Elliott, 2004; Kilfedder et al., 2001; Van Sant & Patterson, 2013; Yousefy & Ghassemi, 2006), all caused by a variety of issues such as role conflict/ambiguity, unpredictability in job events, lack of job security, and decreased social support (Kilfedder et al., 2001). Given the increased level of stress in working with both the medical and psychiatric components of EDs, far more research is needed to tap into such emotional experiences among such a specific population of nurses.

Emotional Benefits

Introduced by Hernández et al. (2010), vicarious resilience refers to the personal benefits experienced by caregivers upon witnessing their patients overcome adversity. It is an integral dimension of human experience that can often counteract the normally fatiguing processes that exposure to trauma may elicit (Hernández et al., 2010). It can also increase the potential for innate resilience tendencies, such as adaptability, coping, faith, optimism, hardiness, tolerance, patience, sense of humor, self-efficacy, self-esteem, and a perceived sense of growth and personal effectiveness (Grafton et al., 2010). However, this literature has focused on the examination of vicarious resilience among medical nurses and therapists. Researchers have yet to examine its effects among nurses working in mental health and with EDs. The current study sought to gain insight into such a construct among ED nurses by exploring meaning, value, and the more positive feelings that arise after patient recovery.

In recent years, researchers have engaged in more rigorous investigations of the ways in which positive patient outcomes can benefit mental health workers. Therapists have reported that positive changes can occur from being exposed to trauma and vicarious trauma. For example, family violence therapists have been able to acknowledge having increased control over their anger, an increased sense of assertiveness, and development of various constructive communication skills (Ben-Porat & Itzhaky, 2009). When examining the experiences of psychologists, social workers, and marriage and family therapists working with survivors of torture, Engstrom, Hernandez, and Gangsei (2008) demonstrated similar positive findings. First, many participants reported recognizing the human capacity to thrive and indentified immense strength, persistence,

courage, and resourcefulness among the survivors. Secondly, participants reported re-evaluating their own struggles and recognizing the existential theme of freedom, allowing them to increase their own positive thinking, emotional strength, motivation, and subsequent positive behavior. Finally, participants reflected upon their work with such survivors as reaffirming of the value of therapy, as well as of their motivation and desire to continue working to enhance others' post-traumatic growth.

Grafton et al. (2010) examined the experience of vicarious resilience among oncology nurses. They found that cognitive transformational practices, environmental support, and education could enhance innate resilience potential, often reducing the negative effects of workplace stress, compassion fatigue, and burnout. As evident with these nurses, it appears imperative to support the development of vicarious resilience among nurses through personal and organization stress-management and coping strategies. Such self-monitoring and self-care practices act to increase the potential positive outcomes when working with challenging populations who have experienced significant medical and psychological trauma. Given the prevalence of traumatic experiences among patients with EDs, it is first important to attain a deeper understanding of the positive outcomes that nurses who work with that population may already experience, and then seek to integrate their use of such skills into their daily practice.

Personal Coping Strategies

As in other nursing settings, mental health nurses employ various coping and self-care strategies to maintain their personal well-being. Reaching out for social support through talking to family, friends, and colleagues, as well as engaging in relaxing

personal activities, all can be sources of stress relief (Maier, 2011). Examining the experiences of mental health counselors, there appear to be many self-care strategies that one can utilize to defend against or cope with already-existing symptoms of vicarious trauma and promote well-being, such as self-monitoring of emotional responses, maintaining emotional boundaries, using humor, learning to accept one's limits, developing compartmentalization strategies, maintaining spiritual well-being, making meaning of the trauma, seeking continual professional education, and obtaining the social support of both peers through consultation networks as well as that of friends and family (Marriage & Marriage, 2005; Pearlman & Caringi, 2009; Phelps et al., 2009). Following the awareness, balance, and connection model of vicarious trauma prevention can also provide a concrete framework to support professionals dealing in the treatment of complex traumatic symptoms (Saakvitne, Pearlman, & Staff of the Traumatic Stress Institute, 1996).

   Group supervision. Due to the increasing emotional challenges brought about by mental health nursing, group supervision has become increasingly utilized (Winship, 1995). Being able to debrief and process one's emotional experience is integral in a profession where much emotional distress can be experienced. Supervision and group meetings can provide an outlet to debrief cases, make sense of complicated nurse–patient dynamics, and help unblock thinking that may have become blurred by such stressful emotional responses (Maier, 2011; Winship, 1995). Further research is warranted on the emotional benefits of group supervision not only with regard to mental health nurses, but also specifically with ED nurses.

The Experiences of Eating Disorder Nurses

Examination through the lens of Peplau's (1952) theory of interpersonal nursing

explains how the stressful environment of inpatient ED treatment, including how the

severity of patients' symptoms influence interpersonal dynamics, increase challenges for

nurses. Though little research has been done specifically with ED nurses, interviews with

mental health nurses, as well as with other professionals who treat EDs (e.g., therapists),

have revealed some common themes that may also be common to ED nurses' own

experiences. Furthermore, examining these issues from social constructionist and

existential perspectives further provides a framework for understanding the ways in

which nurses may interpret and construct meaning from their work experiences (Crotty,

1998; Yalom & Josselson, 2011) and how they may emotionally react when confronted

with concerns of freedom/responsibility, isolation, meaning, and/or death (Yalom &

Josselson, 2011).

**Developing Rapport and
Building Relationships**

In developing therapeutic alliances with patients on inpatient ED units, nurses

share many similar experiences to those of psychiatric nurses as well as to therapists and

other treatment team members involved in their recovery. Existentially, they all want to

socially connect with their patients (Yalom & Josselson, 2011). As with any type of

nursing, key values remain continually important to build relationships with patients and

provide the necessary medical support, such as conveying empathy for patients and their

life circumstances, remaining non-judgmental, and promoting patient rights (King &

Turner, 2000; Pryde, 2009; Ryan et al., 2006; Zugai et al., 2013). However, despite such

commonalities with medical and mental health nurses, several new themes also emerge specific to nurses working with ED patients.

Knowledge. Higher levels of education have to be shown to decrease anxiety among caregivers of ED patients (Sepúlveda et al., 2012). Not surprisingly, nurses' awareness of the psychological and medical symptoms of EDs contributes to their abilities to build relationships with patients in such settings (Fleming & Szmukler, 1992; Halek, 1997; Ramjan, 2004; Reid et al., 2010). Many nurses have reported that being able to understand the nature of the disease and how patients may tend to be anxious, angry, demonstrate a lack of awareness, or engage in manipulative behaviors allows them to separate the EDs from the patients themselves and individualize treatment (Micevski & McCann, 2005; Reid et al., 2010). Examining each patient in this way, through an individual lens, enhances nurses' abilities to strengthen interpersonal relationships and ultimately become more effective in working with ED patients (Irwin, 1993; Micevski & McCann, 2005; Snell et al., 2010).

Lacking an understanding of the complexity of ED recovery may leave nurses uncertain and skeptical about their roles in treatment, elicit potential feelings of inadequacy, and cause them to feel responsible for their patients' recoveries (Ramjan, 2004; Reid et al., 2010). Cordery and Waller (2006) noted that ED nurses were no more knowledgeable about the specific nutritional needs of this population when compared with lay people within the community. This is concerning in that nutrition is a central facet in treatment in which nurses are responsible for administering nutritional tube feedings or supplements. Even after working in the ED field for longer than other team members, both nurses and psychologists reported knowing minimal information about

such dietary procedures, increasing their own frustration. Many ED nurses have

emphasized the need for increased education to support their practice (King & Turner,

2000; Pryde, 2009; Reid et al., 2010). The specific clinical experience, training, and

exposure to EDs that is so integral for effective psychotherapy (Strober & Johnson, 2012)

is also extremely helpful from a nursing perspective. More recently, training programs

have been created to provide education and certification for all professionals in the ED

field. To become a Certified Eating Disorder Specialist, a nurse can gain expertise in the

history, therapy, dietary needs, and medical issues involved in ED treatment. However,

little research has directly examined the degree to which nurses' overall level of

education (e.g., Bachelor of Science in Nursing, Master of Science in Nursing, Doctor of

Philosophy) as well as specific ED education and preparedness affects their subsequent

experiences in the workplace (International Association of Eating Disorder Professionals,

2014). This is an important component of their perspectives that the current study sought

to access, important to understand to both increase support and training efforts for

nursing staff.

Challenges in establishing the relationship. The ability to develop strong

relationships with ED patients and experience positive interactions reduces symptoms of

anxiety and depression among their primary caregivers (Sepúlveda et al., 2012).

However, the development of such strong relationships between nurse and patient can be

complex and challenging given nurses' roles in patient care. Ramjan (2004) conducted a

qualitative study examining nurses' experiences in developing therapeutic relationships

with adolescents on an inpatient ED unit. She identified various factors that contributed

to nurses' struggles in building relationships with their patients. Some nurses reported

feeling unable to understand the complexities and recovery process of such a complicated diagnosis as anorexia nervosa, having often felt as though patients should just change their faulted actions. Some nurses reported feeling a lack of control between themselves and the patients, illustrating ways in which power struggles and mistrust further damaged the potential for stronger bonds. Many nurses also described ways in which they struggled to form therapeutic alliances, often blaming the victims, defining them as inflexible. Furthermore, Davidson (1999) conveyed how connectedness amongst the ED treatment team is "perhaps founded on a kind of oppressive suspicion and antagonism towards patients" (p.114). Building upon such research, the current study more deeply explored factors that affect the therapeutic relationship as well as examined other challenges and benefits that affect the way in which ED nurses make meaning of their experiences.

Snell et al. (2010) conducted qualitative research examining nurses' ($n = 7$) experiences in establishing and maintaining therapeutic relationships with adult patients on an inpatient ED unit. Participants treated patients admitted for long-term weight restoration (approximately 6 to 12 months of treatment) and were registered psychiatric or comprehensive nurses, having also engaged in additional case management activities. Various factors played a role in nurses' abilities to build relationships with their patients, including gaining trust, having a negative outlook, managing their own difficult emotions, pacing within the relationship, dealing with resistance, maintaining hope, maintaining dual roles, and high levels of burnout. Though this study provided valuable information with which to further understand such nurses' experiences and what factors affected nurses' relationships with patients, it did not examine their experiences in a

broader context. In addition, it focused solely on challenges, neglecting to examine the positive experiences that such nurses may have had. Thus, there appears to be a need for more in-depth research examining nurses' emotional experiences in a more general sense, while also increasing inquiry on their positive experiences.

The difficulty in developing trust. The development of trust between the patient and nurse is a key component for a strong therapeutic alliance and treatment compliance. However, trust is often a controversial issue when it comes to treating patients with EDs, especially challenging due to issues of secrecy, shame, deceit, issues of control, and potential power struggles (Irwin, 1993; King & Turner, 2000; Ramjan, 2004; Snell et al., 2010; Thompson-Brenner et al., 2012). Managing patients' physical well-being can be an issue in itself. Given the psychosomatic components of EDs (Mehler & Andersen, 2010; Zerbe, 1993), forming a trusting relationship can become increasingly complex in that patients may feel as though nurses are not being sensitive to their medical needs, often increasing patient resistance and potential nursing staff frustration (Irwin, 1993; Micevski & McCann, 2005; Snell et al., 2010).

In addition, the pre-conceived notions of EDs held by some professionals in the field of patients being manipulative, aggressive, and resistant, along with potentially similar initial experiences, can taint the lens through which nurses approach treatment with such patients (Davidson, 1999). Many have negative impressions of some patients even before forming relationships, making the establishment of trust on either side increasingly difficult (Malson & Ryan, 2008; Ramjan, 2004; Sansone, Fine, & Chew, 1988). Though developing trust in such a capacity can be extremely challenging, we know little about how such struggles directly affect such nurses on a personal emotional

level. This study also hoped to explore how such an integral process to the course of treatment directly impacts the ED nurse.

Dealing with resistance. Depending on the level of treatment and the severity of the illness, there are varying levels of resistance that nurses may face when working with patients with EDs (Halek, 1997; King & Turner, 2000; Reid et al., 2010; Snell et al., 2010; Zerbe, 1993). Though firm boundaries are integral to nurses' roles, excessively controlling environments can often elicit higher levels of resistance in ED patients and result in power struggles (Moulding, 2006; Ramjan, 2004). Nurses often feel overly invested and act as if in a mothering role, especially when working with female ED patients, a dynamic that can increase patient resistance (Malson & Ryan, 2008). Mistrust can become mutual in which nurses seek to exert excess control over patients while patients grow increasingly skeptical of their intentions (King & Turner, 2000; Ramjan, 2004). Furthermore, the presence of comorbid psychological diagnoses, such as depression, can act simply by virtue of its symptomatology to increase levels of resistance (Irwin, 1993). Thus, finding a balance between control and empowerment continues to be an integral treatment issue for nurses. Yet, as with many of the aforementioned challenges that such nurses may experience, there is a lack of research directly examining the connections between managing resistance and nurses' experiences. This study aimed to explore such a relationship.

Pacing. Recent research has examined the way in which pacing affects nurses' experiences. Nurses have reported pacing as a strategy to help them to manage patient symptomatology while strengthening rapport. This process of "being alongside the patient while they move towards recovery" (Snell et al., 2010, p. 354) involves working

with the patient to maintain a hopeful presence while striking a personal balance between both acknowledging and challenging the disorder. Nurses feel obligated to work together with patients to aid in both their understanding and ability to let go of their EDs (Micevski & McCann, 2005; Pryde, 2009; Snell et al., 2010). Yet, specific factors contributing to nurses' abilities to define and understand how to pace effectively have been minimally explored. The current study aimed to examine pacing through assessing the broader context of maintaining therapeutic relationships.

Empowering the patient. Despite the need to maintain control, a level of empowerment has also been identified an integral component to effective ED interventions. Such empowerment involves supporting the facilitation of patients' recovery in a variety of ways. Nurses must, when patients are deemed fit and ready, begin to relinquish some responsibility back to them and promote their abilities to make their own choices (Bakker et al., 2011; van Ommen et al., 2009). Such space can increase patients' sense of support and aid them in fostering their own recoveries through healthy eating, exercise, and developing their own social relationships (van Ommen et al., 2009). However, nurses have also elucidated gender role and identity issues that have made it increasingly challenging in working to empower women with EDs. Some women appear to lack strong personal identities, veering away from the norm in their over-identification with traditional feminine ideals, such as social restraint and the need to be liked (Malson & Ryan, 2008). Ultimately, in addition to strengthening overt behaviors within the patient, such empowerment can also provide increased self-esteem and strengthen values within the nurse (Irwin, 1993; van Ommen et al., 2009). Yet, the inevitable emotional

challenges that may ensue from such patient empowerment have yet to be examined. Once again, this was an aim that this study sought to explore.

Other Emotional Challenges

Dual roles. One major challenge for many ED nurses is that of dual roles. Most, if not all, nursing staff at inpatient and residential ED treatment facilities are members of multi-disciplinary treatment teams (Mehler & Andersen, 2010). Thus, nurses are not only responsible for direct patient care, but also for regular and direct communication with other treatment team members. Though such teams offer immense support for both patients and staff, such roles can be confusing. Many nurses find themselves uncertain of the exact nature of their duties (Long et al., 2012), especially with regard to how to effectively communicate with both patients and other staff (Davidson, 1999; Reid et al., 2010) or are simply required to take on too many roles at once (Pryde, 2009). Such dual roles require nurses to constantly transition from directly communicating with their patients to passing information back to the team at large. When dealing with patients, they often find themselves feeling like central figures in the treatment decision process. Yet, they must maintain a firm balance between implementing strict decisions made by the treatment team and maintaining and negotiating a personal therapeutic relationship with each patient (Mehler & Andersen, 2010; Snell et al., 2010), which is often felt as a more nurturant or mothering role (Halek, 1997; Malson & Ryan, 2008; Wright, 2010). Though such roles involve a multitude of duties, the literature has neglected to examine how such responsibilities affect nurses' experiences. This study sought to gain a deeper understanding of the ways in which such challenges affect the demeanor and overall experience of the ED nurse.

Anxiety and fear. Though perhaps not the initial research questions or overarching intent of many studies, some research has indirectly uncovered ED nurses' emotional experiences. King and Turner (2000) conducted a phenomenological exploration of five nurses' overall perspectives in caring for adolescents with EDs. However, these nurses working in general hospital units not specifically geared towards ED treatment had no prior mental health experience. Findings demonstrated that such nurses, often due to lack of experience, knowledge, and/or prior bad experiences with patients, became skeptical toward their patients as well as their own nursing abilities. Similarly, in a qualitative case study examining one nurse's experience on an inpatient ED unit, Davidson (1999) demonstrated that role confusion and an overall fear of mental illness when having minimal professional psychiatric experience can perpetuate anxiety in a nurse's job performance and increase the lack of empathy for a patient.

Due to the nature of EDs, concerns and fear surrounding the safety of their patients is quite often a legitimate concern. Many nurses report that their patients may have become accidentally injured. Rose et al. (2010) illustrated the specific safety concerns around nurses working with morbidly obese patients. Nurses most commonly reported three major concerns, some of which often overlapped: adverse events, near misses, and out-of-control situations. Adverse events referred to specific situations in which patients hurt themselves due to falls or equipment malfunctions. Near misses referred to adverse events that were avoided due to intervention by nurses, such as almost falling. Finally, out-of-control situations referred to situations that required an immense amount of nursing effort in which resolution often seemed near impossible. Examples of such situations included trying to transport extremely heavy patients to areas that were

not conducive to their own sizes or weight. Though such aforementioned examples specifically refer to the morbidly obese, a group that is far less common on inpatient ED units, such struggles can be easily translated to situations involving extremely malnourished or underweight patients.

Malnutrition, over-exercising, purging, and misuse of medication, diuretics, and laxatives are all imminent health concerns with potentially grave medical complications (McBride, 2012; Mehler & Andersen, 2010). Thus, research has identified an inherent level of worry over ED patients' health that is common among therapists in the field (Warren et al., 2012). Such chronic levels of worry can elicit an increased negative affect among them, primarily sadness and anxiety (Warren et al., 2012). Given the reality of such fears among all professionals working with EDs, this study sought to further examine such chronic worry from a nursing perspective to further understand their experiences.

Grief and loss. The ED nurses may be confronted with death, especially given that anorexia nervosa has continued to be one of the deadliest of all mental illnesses (ANAD, 2014; Crow et al., 2009). Experiencing a patient death can elicit negative emotional responses such as sadness, grief, and helplessness. Though the literature has yet to explore this experience among ED nurses specifically, researchers have examined such effects on therapists. Therapists have reported feeling partially responsible, endorsing heightened feelings of self-doubt in their own abilities and/or guilt, as well as increased awareness of the need to accept to the limits of treatment and the severity of the illnesses themselves (Warren et al., 2012). In a qualitative study by Warren et al. (2012), one therapist conveyed a profound statement with regard to experiencing death in this

capacity: "Very sad. Humbling. I was confronted with the limits of my power" (p. 184).

However, despite the harsh reality of death among those with EDs, there remains a

paucity of research directly examining the emotional experiences of nurses who have

worked with an ED patient who is near death or who has died. Increased research in this

area could not only increase awareness among nurses, but enhance support efforts and

self-care strategies.

Burnout. As in most psychiatric settings, there is an increased level of burnout

amongst ED nurses. Though burnout may present in a similar fashion as in many of the

aforementioned scenarios, it can include an increased level of complexity, given both the

medical and psychiatric nature of EDs. Snell et al. (2010) identified burnout among ED

nurses as resulting from the complexities and struggles inherent in developing therapeutic

relationships with these patients. However, burnout in the ED field is most often

examined through the perspective of the therapist or psychologist (Warren et al., 2012),

neglecting to tap into the specific experiences of nurses. This study sought to examine

such burnout solely from a nursing perspective to gain insight into such potentially

unique experiences.

Warren et al. (2012) conducted a qualitative study examining job burnout in

psychotherapists, psychologists, and psychiatrists ($n = 298$) who directly worked with ED

patients. The researchers identified various emerging themes. First, the nature of the

disorder was reported as being extremely challenging, especially with regard to its slow

progress and complexity of treatment, symptom severity, and likelihood of relapse.

Second, patient characteristics (e.g., the ego-syntonic nature of the disease, ambivalence

towards treatment, and comorbidity of disorders) increased perceived challenges in

treatment. Work-related factors such as time commitments, work demands, lack of organizational support, and problems in dealing with the treatment teams also contributed to burnout. Finally, personal factors such as negative affect (e.g., frustration, worry), countertransference, and one's own personal problems also increased levels of burnout.

Given that the typical frequency of direct interaction between nurses and ED patients far surpasses that of therapists (Mehler & Andersen, 2010), it may be that nurses are more prone to experiencing burnout; yet, this remains mostly unexamined. Through more concretely understanding ED nurses' experiences with burnout, efforts to more effectively treat patients can not only be improved, but those managing treatment facilities (e.g., medical doctors and psychologists) can also increase support for nurses and hopefully decrease such burnout by proxy.

Unhealthy behaviors. Increased stress in such a work environment can cause ED professionals to engage in a variety of unhealthy compensatory behaviors or coping strategies. Though much of this research has examined these behaviors among mental health therapists, such individuals have reported drinking alcohol, smoking cigarettes, and even engaging in self-injury in order to cope (Warren et al., 2012). Disordered eating of various types (e.g., excessive dieting, certain food restrictions, etc.) is also a relatively common phenomenon among many people in the general population, placing one at increased risk of subsequently developing an ED (Langer et al., 1991; Warren et al., 2012). People who report such problematic eating patterns tend to also endorse higher levels of perceived stress, placing nurses at potentially elevated risk for experiencing such symptoms (King et al., 2009).

King et al. (2009) researched levels of job stress and disordered eating among various types of nurses ($n = 435$), not just specifically those working with ED patients. Results from their study illustrated that both perceived job stress and perceived body image dissatisfaction were significantly correlated with disordered eating behaviors, defined solely as the tendency to diet and restrict food intake. The most commonly reported factors leading to increased job stress included heavy workload, large amounts of paperwork, and numerous interruptions in one's job tasks throughout the day. Given the high levels of stress that ED nurses experience (Bakker et al., 2011; Davidson, 1999; Irwin, 1993; Ramjan, 2004; Snell et al., 2010), combined with the fact that repeated exposure to those who are extremely thin or obsessive about one's body shape can lead to increased body image dissatisfaction (NIMH, 2014), such factors may be extremely pertinent to the experiences of ED nurses. Though not a major focus here, this study sought to examine the potential ways in which ED nurses' own perceived body image and eating behaviors were impacted by their high stress work environments and how such factors may have affected their overall experiences.

Maintaining Positivity

It is also important to examine the benefits that ED nurses may experience. Though there has been some indirect exploration of this topic (Bakker et al., 2011; Snell et al., 2010), there unfortunately has been little research addressing such topics specifically and examining positivity in-depth and a lack of research entirely on subjects such as vicarious resilience. This study sought to further examine perceived positivity through identifying the meaning and value expressed in ED nurses' experiences.

Managing emotions. Self-awareness and self-reflection are integral pieces reported by nurses with regard to their ability to maintain positive attitudes when working in such psychologically-stressful environments (Davidson, 1999; Snell et al., 2010). For example, many ED nurses have reported being treated with hostility by patients (Irwin, 1993; Snell et al., 2010). Though this can be a pervasive challenge among this population, those who are able to accept patient responses as valid and compartmentalize symptoms of anger and resentment (as part of the ED and not a direct personal attack) are typically able to function more effectively (Snell et al., 2010). Confidence in one's abilities has also been noted as another way in which nurses work to combat feeling personally attacked and instead enhance their effectiveness in the workplace (Snell et al., 2010). Overall, during the process of treatment, a healthy level of emotional distance remains essential in allowing nurses to reassess their own values and involvement, as well as to help them provide the most optimal degree of care (King & Turner, 2000).

Social support. Surprisingly, social support amongst staff at ED treatment centers can have positive and negative effects on both nurses' experiences and patient care. Typically, social support can provide greater senses of cohesiveness and security that are necessary for this stressful line of work (Davidson, 1999; Reid et al., 2010; Snell et al., 2010; Warren et al., 2012). As with most group environments, increased positivity, self-esteem, and openness enhances cohesion among members and increases effectiveness (Davidson, 1999). Yalom's (1985) definition captures such a sentiment beautifully, referring to cohesion as "the attractiveness of a group for its members" (p. 49). Research conducted by Sansone et al. (1988) demonstrated that frequent meetings among multidisciplinary team members helped to buffer against negative emotional experiences.

Subsequently, many of these nurses reported having positive overall experiences while working on inpatient ED units. In one recent study, Davey, Arcelus, and Munir (2014) illustrated how communication, support, and teamwork among members of multidisciplinary teams, especially nurses, all are integral in buffering the potentially negative consequences of such a high stress job.

However, support from colleagues can also elicit negative consequences. Dealing with negativity toward patients on the part of treatment team members affects nurses' mental health and effectiveness in their work (Davidson, 1999; Snell et al., 2010). Though many report feeling a sense of security and warmth among colleagues, it is often "founded on a kind of oppressive suspicion and antagonism towards the patients" (Davidson, 1999, p. 114). Team members may emit a sense of anger regarding the patients causing some nurses to feel a lack of strong emotional support. This can be even more pertinent to nurses new to the field in which they may become easily susceptible or angered (Davidson, 1999). Thus, such research solidifies the importance for increased social support among ED nurses. This study also sought to examine how such nurses experience support and how such support subsequently affects their experiences working with ED patients.

Self-care. As with any stressful nursing position, self-care is an integral part to maintaining positivity within both one's employment and one's outlook on life as a whole. Many ED professionals have identified several self-care strategies, such as exercise, hobbies and leisure activities, taking vacations/personal time, spirituality, eating well, detaching from work, sleeping, meditating, humor, and attempting to create an overall balance between life and work (including having a social life separate from work)

(Warren et al., 2012). Given the necessity of self-care strategies to combat the negative consequences experienced by such stressful work, this study also sought to examine the frequency and likelihood of ED nurses to engage in such strategies as well as potential factors obstructing their self-care.

Summary of the Current Study

There has been minimal research exploring the broader, subjective experiences of nurses, including perceived benefits and challenges, who treat adolescents and adults with EDs at the inpatient level. Yet, there is a substantial amount of literature that is relevant and indirectly linked to the aims of the current study. Several researchers have examined nurses' perspectives on effective therapeutic interventions and the nurse–patient relationship (Bakker et al., 2011; George, 1997; King & Turner, 2000; Micevski & McCann, 2005; Ramjan, 2004; Ryan et al., 2006; Wright & Hacking, 2012), while some have examined the myriad of challenges that ED nurses experience (King & Turner, 2000; Reid et al., 2010; Snell et al., 2010). These both tap into different parts of their experiences, though perhaps not as broadly. Case study research has also aided in the understanding of such nurses' experiences (Davidson, 1999), though on a smaller scale. Furthermore, research examining the emotional experiences among ED treatment providers, primarily therapists (Satir et al., 2009; Thompson-Brenner et al., 2012; Warren et al., 2012), provides valuable insight into what nurses may experience. Finally, research examining nurses' work treating adolescents diagnosed with EDs in general hospital settings, when having no prior experience working with such populations (King & Turner, 2000), has also demonstrated certain emotional experiences that may be somewhat relevant.

The current study explicitly examined the experiences of nurses working to treat patients diagnosed with EDs among two inpatient hospital settings. It sought to examine such nurses' experiences both broadly and in-depth, to gain a general picture as well as a deeper, more detailed understanding. Exploration of positivity (meaning and value); challenging and impeding factors; and prior education, training, and preparedness lends to a richer understanding of their experiences as a whole. Furthermore, nurses' experiences with both the treatment teams and adult and adolescent patients were examined. In examining such experiences through a psychological lens as opposed to a medical one, I sought to utilize theories and principles of existentialism and social constructionism to guide my interpretation. Such a conceptual framework can help to join the fields of nursing with psychology through acknowledging the ways in which all people inherently struggle with similar concerns and interpret their environment/ experiences to create greater personal meaning.

Furthermore, the detailed questioning in the interviews sought to explore more specifically the gaps in the prior research, such as how nurses strengthen relationships with their patients, deal with resistance, experience multiple roles, manage their own emotional responses, develop and maintain relationships among their colleagues, engage in personal self-care strategies, experience social support, and experience their own potential body image dissatisfaction and disordered eating. In Chapter III, I present the methodology of the study that guides the subsequent interpretation. This includes an introductory framework, research paradigm, methodology, research methods, procedures, ethical considerations, and methods for enhancing the rigor of the study

CHAPTER III

METHODOLOGY

Introduction

In accord with the foundational tenets of qualitative research (Crotty, 1998), this chapter outlines the overall purpose of the study and research questions; examines the research paradigm, methodology, and methods used; and introduces myself as the researcher. Ethical considerations as well as methods to increase the study's rigor and trustworthiness are also examined in depth.

As described in Chapter I, the goal of this study was to explore nurses' experiences treating patients diagnosed with eating disorders (EDs). Through deriving a holistic view and shared meaning of this social phenomenon, my aim was to understand the essence of what it is like for nurses to treat ED patients in inpatient settings. I studied participants through naturalistic inquiry (Lincoln & Guba, 1985) in their natural setting and examined multiple perspectives in detail (Creswell, 2007). Essential to all qualitative research, I remained a key instrument of data collection throughout the research process as the researcher, paying careful attention to documenting procedures and the emergent design of the study (Creswell, 2007; Merriam, 2009). Guided interview questions enabled a richer exploration of issues more specifically and in greater depth. Subsequently, the rich, descriptive data obtained from interviews allow both myself and readers to gain a deeper understanding of the lived experiences of the participants (Merriam, 2009).

The specific research questions addressed were:

Q1   How do nurses describe their experiences in treating patients with EDs?

Q2   What do nurses perceive as meaningful and valuable in their work?

Q3   What do nurses see as factors or challenges that impede their work with ED patients?

Q4   How has their education, training, and preparedness impacted their experiences in working with those suffering from EDs?

Research Paradigm

A research paradigm is the integration of an overarching system of ideas and beliefs working together with subsequent methodology (Lincoln & Guba, 1985). This section covers the four main elements that comprise paradigms and how they were applied to this study specifically. The elements examined are epistemology, theoretical perspective, methodology, and methods (Crotty, 1998).

Epistemology

Epistemology, defined by Lincoln and Guba (1985) as "the relationship of the knower to the known" (p. 37), consists of the theory of knowledge that forms the way in which one understands his or her own reality, further influencing the theoretical perspective and the methodology of the research. Crotty (1998) further argued that certain philosophical assumptions and ways of "understanding and explaining how we know what we know" (p. 3) guide one's research and provide the grounding for deciding what types of knowledge are even possible, worthwhile, and justifiable. Though Crotty defined three main epistemological views—objectivism, subjectivism, and constructionism—the latter describes how I view the world and is the paradigmatic framework from which this study was guided.

From a constructionist framework, people create meaning in different ways, through the merging of subject and object (Crotty, 1998). There is no single, objective truth or reality, and no object alone has any intrinsic meaning. Meaning is created, or constructed, subjectively by each individual through his or her interaction with the world and everything with which he or she comes in contact (Crotty, 1998; Patton, 2002). Constructionists observe how individuals make sense of their worlds and how historical, societal, and cultural influences further guide the ways in which such worlds are interpreted (Crotty, 1998). This current study sought to examine the individual experiences of, and meaning attributed by, nurses working with ED patients. Such idiographic examination may further contribute to a collective examination to understand the shared essence of their experiences (Crotty, 1998).

My own understanding of the world brought me closer to the study of nurses' experiences and guided the subsequent research (Crotty, 1998). Therefore, it becomes essential to examine the ways in which the researcher's perspective may obscure those of the participants to assure that the meaning does not become confused. Therefore, I maintained a continual balance between the integration and compartmentalization of my own perspectives throughout the research process.

Theoretical Perspective

The theoretical framework is the philosophical stance that informs the methodology, providing context for the process and grounding the logic and criteria (Crotty, 1998; Ponteretto & Grieger, 2007). As aforementioned with regard to the epistemology, constructivism essentially guides the way in which reality is interpreted, forming a stance that further guides the research.

Social constructionism. Like the epistemology, social constructionism posits that meaning is individually interpreted through both social constructions and symbolic interactions, differently by all humans. Based on the premise of ontological relativity, in which one's worldview shapes any rational statement or understanding (Patton, 2002), such a theory allows for unique interpretations in a world where societal conventions dominate collective thinking and understanding. Subsequently, meaning and ideals are best understood through examination of individual perspectives. Because both the fields of nursing and psychology value and posit that effective treatment must take into account and value individual characteristics, culture, values, and preferences (American Psychological Association, 2003), this framework fits well in guiding the research. These socially constructed professional views help to inform and further shape individual perspectives, the examination of which is the crux of this study.

Existentialism. Coinciding with my own values, the main tenets of existentialism also shape my theoretical perspective. Not an independent school but a philosophical framework, existentialist influence is seen in, and can be used concordantly with, constructivist theory given the shared focus on subjectively created meaning and purpose. Existentialism is a humanistic theory promoting a phenomenological view of people who are viewed as meaning-making creatures in a meaningless universe (Yalom & Josselson, 2011). The universe is neutral, yet infinitely complex, and life is finite. All people are confronted with the same ultimate concerns (givens) with regard to human suffering: freedom, isolation, meaninglessness, and death (Yalom & Josselson, 2011).

Similar to the tenets of constructivism, existentialism posits that there is essentially no fundamental meaning in life, no objective right or wrong, and no genuine

good or evil. Therefore, meaning can be created and recreated by each person, the subjective phenomenological experience being the only one of importance. People are creatures of free will, and though terrifying at times, responsibility must be accepted to live a purposeful and meaningful life (Yalom & Josselson, 2011). Jean Paul Sartre stated, "Man is *condemned* to be free; because once thrown into the world, he is responsible for everything he does" (Hoffman, 2009, p. 29). This existential perspective helps to explain the concerns that ED nurses face and the essence of their experiences, given that all nurses face ultimate life concerns and search for ways to confront such concerns to alleviate their inevitable anxiety; they do this despite the fact that they may not be solely responsible for their patients but to other parties (e.g., insurance, fellow treatment team members, patients' families). Furthermore, such ultimate life concerns can seem far more real for those treating patients whose freedom has been restricted (as in the case of being held on an inpatient unit) and for whom the potential of death is a reality.

Researcher Stance

My clinical experience over the past several years has been in working on adult and adolescent ED units as well as on an inpatient psychiatric unit. Working alongside medical professionals in hospital settings, specifically with nurses, has contributed to my strong commitment and dedication to uncovering more about nurses' experiences and to better understanding how we in the general field of psychology can work to further enhance their positive experiences. Not only have I been provided with direct exposure to the current study's topic, but I have also begun to recognize the importance of capturing the essence of nurses' experiences through their words and ideas. They experience both the typical challenges that any type of nursing evokes in addition to struggling with

managing comorbid psychological and medical issues. Entering the field of counseling psychology, I highly value gaining empathy for others through learning about their ideographic experiences via their own words and stories. To be an effective clinician in working with multidisciplinary treatment teams in my future career, I sought to understand nurses' subjective experiences, perspectives, and life values.

Given the axiological nature of qualitative research, my personal experience, biases, and values are not only integral to this entire process but also bound to present in the research (Creswell, 2007; Lincoln & Guba, 1985; Morrow, 2005). Thus, it is important to acknowledge my own perspectives throughout, while also compartmentalizing them to the best of my abilities, in an effort to separate them from those of the participants. Suspending my own knowledge and past experiences aided me in understanding the data more deeply from the participants' perspectives (Creswell, 2007; Merriam, 2009).

Methodology

Informed by the theoretical perspective, research methodology involves a process, strategy, or plan of action that guides the subsequent methods used, linking the use of such methods to a desired outcome (Crotty, 1998), in this case, understanding the essence of nurses' experiences in treating EDs.

In this study, I used a phenomenological approach as a method of analysis. Such an approach draws upon psychology, education, and strong philosophical origins in an effort to ultimately understand the shared structure, meaning, or essence of, an identified phenomenon or experience (Creswell, 2007; Merriam, 2009; Patton, 2002), in this case, the subjective experiences of ED nurses on inpatient treatment units. To obtain such data,

those who had directly experienced the phenomenon with "lived experiences" (Patton,

2002, p. 104) were interviewed. Through examining the thick, detailed descriptions from

each participant, one can then reduce the meaning to a central essence of the experience

(Moustakas, 1994).

Phenomenology first came into use as a social science methodology in the 1800s.

Philosopher Edmund Husserl used it as a precise scientific method to explain how people

understood and explained their sensory experiences (Patton, 2002). Emanating from his

work, psychologist Clark Moustakas refined the method to what is now known as

transcendental phenomenology (Moustakas, 1994), in which a greater value is placed on

participants' descriptions of phenomena when compared with the researcher's

interpretations (Creswell, 2007). Through interviewing nurses working on an inpatient

ED unit, I aimed to gain an understanding of both the idiographic and common

experiences of being a nurse in such an environment, identifying both challenges and

benefits to gain a better understanding of the essence of this phenomenon. Knowledge of

such common perceptions and meaning could contribute immensely to the development

of services and future training of nurses working with ED. Clinicians could subsequently

work to better prepare nurses for such challenging roles, making sure to address the

fundamental concerns and needs surrounding ED treatment as well as ways to identify

and manage often unexpected and uncomfortable reactions.

The opinions, values, and experiences of the researcher naturally affect the data

obtained. However, in utilizing phenomenology, the focus must remain on participants'

perspectives (Creswell, 2007). The researcher must bracket his or her own experiences,

known as an epoche, abstaining from traditional ways of viewing events and stories and

attempting to put aside preconceived ideas and judgments (Moustakas, 1994). This became an integral part of this data collection; although I did not live in the same circumstances as each participant, I anticipated being affected and moved by their stories and perhaps relating to some of their experiences given my experience working with ED nurses and patients. The epoche, along with other procedures of phenomenological research, such as analyzing the data and comparing it to identify common themes and experiences, are further discussed in subsequent sections.

Research Methods

This section covers several components that comprise the overall research methods, including the process of attaining approval by the Institutional Review Board, a description of the research participants, setting, and the procedures, including the data collection and analysis methods.

Institutional Review Board Approval

Upon approval of this research proposal from my dissertation committee, an application was submitted to my university's Institutional Review Board. Given that this study dealt with human subjects and potentially sensitive personal information from participants considered to be no more than a minimal risk, an expedited approval was sought (Merriam, 2009). Once the Institutional Review Board approved the study (see Appendix A), consent from the ED hospital was obtained and subsequent recruitment of participants began.

Research Participants and Setting

Research was conducted on two separate inpatient units (adult and adolescent) within one private behavioral health ED hospital in a metropolitan area in the United

States that serves clientele worldwide. The adult and adolescent inpatient units both serve inpatient and residential patients, while this hospital as a whole treats patients at all levels of care, including inpatient, residential, partial hospitalization, intensive outpatient, and outpatient levels. Having grown since its creation only a few years ago, this company continues to modify its services and expand its treatment capacity to fit the needs of its clientele. First, consent from the site itself was obtained. The nursing manager was specifically contacted via e-mail and provided with a detailed description of the proposed study via informed consent documents. She reviewed such information with other members of the hospital's management team, including the medical director and clinical director. Upon receipt of her approved consent, participants were then recruited.

Participants. A sampling method, selection criteria, and participant recruitment were used to obtain the final sample of participants

Sampling method. In order to obtain a broad range of perspectives from nurses treating EDs on inpatient units, I employed a purposeful sampling strategy, choosing participants from both the adult and adolescent units in hopes to provide in-depth insight and understanding to the emotional experiences of nurses (Bloomberg & Volpe, 2012; Merriam, 2009). As recommended for use when conducting phenomenological research, this was done via a criterion approach, trying to obtain a sample representative of the experienced phenomenon being examined through assuring that all participants met an inclusion criterion (Creswell, 2007; Merriam, 2009). The specific sampling of information sources used (e.g., which participants to interview, which documents to examine, which particular settings to observe) were ideally based on a maximum variation sampling method, individually selecting participants who represented different

populations and samples of nurses. This method utilizes a large variation of participants in an attempt to find as much diversity as possible and aids in maximizing the variety of perspectives to identify patterns of congruency and disparity amongst the different sources of information (Creswell, 2007; Merriam, 2009). The intent was to gain a largely diverse sample of nurses according to age, culture, ethnicity, level of experience, and specific role on the units (Creswell, 2007; Merriam, 2009).

Selection criteria. Specific participant inclusion criteria included adults over the age of 18 with degrees in nursing (at least an Associate Degree in Nursing) who worked as nurses at one of the two selected inpatient units at this ED hospital. Fortunately all nurses working at this hospital must be at least 18 and have at least an Associate Degree in Nursing; thus, all nurses employed at this facility met such selection criteria. All such participants came from various nursing backgrounds and varied with regard to both their time working at this facility and their overall experiences in working with ED patients.

There were also inherent selection criteria based upon the stipulations required for nurses to work at this hospital. All nurses must have completed a background check and attended employee training upon their hiring, which included training in crisis prevention intervention, a therapeutic training tool designed to teach ways to both verbally and physically de-escalate patients in situations where they may be a danger to themselves or others. They also all must have been attending bi-monthly supervision sessions with a nursing supervisor to discuss challenging patient issues and any changes to treatment protocol. With these requirements in place, it was my expectation that participants were at least somewhat knowledgeable about EDs and some therapeutic tools involved in their treatment, as well as being committed to working as a team.

Participant recruitment. The nursing manager and medical directors of the company were initially sent a letter of intent (see Appendix B) via e-mail. They then reviewed and signed the informed consent document for the site (see Appendix C), including a detailed explanation of the study that contained potential benefits, risks, the right for participants to drop out at any time, their ability to follow up with the researcher and ask questions, and the extent to which all information would remain confidential and private.

Upon their approval, nurse participants were then recruited via e-mail through the company's listserv with the same letter of intent (see Appendix B). Those who were interested in participating were asked to contact me directly, and times were then arranged with each participant to meet. Upon meeting, each participant signed informed consent paperwork (see Appendix D) with the same detailed explanation of the study to ensure that each person understood the purpose of the study and that his or her identity and other names mentioned remained confidential. (All signed paper consent documentation was kept in a locked filing cabinet in the researcher advisor's office.) At this point, each participant also chose her own pseudonym in order to protect confidentiality (Creswell, 2007). After all such consents were signed, interviews began. Ten to 20 nurses are the number of participants necessary to gain a clear sense of the essence of the phenomenon of nurses treating ED patients and hopefully reach saturation (Polkinghorne, 1989). In this study, 12 participants in total were recruited.

Final sample of participants. Twelve participants were interviewed, all of whom met the aforementioned selection criteria. This final number of participants was determined by the saturation of the data, in that data collection ceased after a point of

redundancy had been reached. Essentially, new themes no longer emerged from the data

(Creswell, 2007; Lincoln & Guba, 1985). After these interviews were completed,

transcribed, and initially reviewed for themes, another advanced doctoral qualitative

researcher analyzed the data independently. My primary research advisor also read the

transcripts and reviewed the textural–structural and composite descriptions as another

means of expert review or check. After thorough comparison and discussion of our

separate analyses, we concluded that the data were rich, themes had begun to repeat, and

the data, therefore, had been saturated.

Overall, nurse participants had varied ranges of experience as nurses in general

and in the ED field. Though maximum variation of the final sample was desired, a typical

case sample was obtained in that most nurses working on these units are Caucasian,

female, and in their 30s (Creswell, 2007; Merriam, 2009). In Chapter IV, I thoroughly

discuss and examine the demographic information for the participants.

Setting. Both inpatient units have a comfortable and nicely decorated feel. They

contain artwork, warm colors, and mantras/quotes on the walls within the facility to

enhance relaxation and promote recovery. The adult unit is located in the downtown

section of this metropolitan area on the top floor of a hospital complex, while the

adolescent unit is located about a 15-minute drive away in its own one-level building in a

more suburban location. Both the adult and adolescent units require badge access to enter

the facility, otherwise one must ring a doorbell and wait for a staff person to open the

door. Ideally, a quiet, secluded conference room within each facility was used for my

interviews in order to minimize any outside noise and distractions and to increase both

participants' and my focus and attention towards the interview goals and processes.

However, if such a space was not available or participants wanted to meet me during days in which they were not at the facility, another quiet space was used for interviews (e.g., private room at a public library or the living room at my home as a last resort). Such a space also allowed for minimal distractions, in that the only people in the room were myself and the participant.

Researcher's role. The researcher remains the key instrument of data collection in all qualitative research. In this phenomenological study, the researcher took an observer–participant role, primarily observing while on site at the ED unit, but also interviewing and otherwise interacting with various nurses at the hospital (Merriam, 2009). Such interactions likely affected, at least to some degree, the normal functioning of the unit, and this was taken into account when analyzing the results (Merriam, 2009). The fact that the researcher had worked previously at both units in this hospital must also be acknowledged. That said, it was imperative that the researcher engaged in a process of continual reflexivity, by which she self-reflected on the ways in which her role and potential biases may have impacted the research (Creswell, 2007).

Procedures

Data collection methods. In using a phenomenological approach, it is first essential that the researcher engage in an introspective process to identify personal viewpoints, fears, experiences, and assumptions about the phenomenon in question (Creswell, 2007; Merriam, 2009). I was initially very self-reflective in trying to uncover the ways in which my own experiences working with EDs may affect my expectations of the themes that I might uncover. Such a process of bracketing experiences (Creswell, 2007) helped me to better understand my own biases and ways in which it affected the

research. Such efforts to self-reflect continued throughout the research process in each step of both data collection and analysis through my regular examination of my own ability to remain objective and hear the participant's words and ideas and not my own.

There were several steps within the subsequent data collection process, each described in greater detail in the ensuing sections. Such steps included the following: (a) participants completed a background and demographic information form to gather information regarding the inclusion criteria (see Appendix E); (b) audio-recorded, semi-structured interviews were conducted (each lasting approximately 60 minutes) in which participants were verbally asked to answer several broad questions (see Appendix F); (c) to ensure the emotional and mental well-being of all participants and to alleviate any potential discomfort from feelings that may have arisen during the interviews, referrals to local counselors were provided (see Appendix G); (d) I engaged in a thorough review of the documents before initiating data analysis; and (e) I kept a detailed journal throughout each step of the process, an audit trail, including my own experiences and viewpoints (Creswell, 2007). Any paper trail involved in the current study, including signed consent forms (kept for three years), printed transcripts, field notes, copies of documents, and reflexive journals were stored in a locked filing cabinet in my office. In addition, the research supervisors also obtained copies of informed consent, also stored in locked filing cabinets in their own offices.

Interviews. After participants completed a basic demographic self-report questionnaire to locate each participant in comparison to the others (Patton, 2002), I began my primary method of data collection through conducting interviews. This process enabled me to gain a more thorough understanding of nurses' experiences working with

ED patients, attaining breadth and depth of information that could not be directly inferred from participant observation (Patton, 2002). My overall interviewing strategy determined the quality of information that I subsequently obtained; therefore, it was important for me to be both comprehensive and refined in my skills (Patton, 2002).

I used semi-structured interviews, described by Moustakas (1994) as being an interactive, informal process in which open-ended questions and comments are used to obtain direct reports of an individual's lived experience. An interview guide containing a variable list of more and less structured interview questions was used and tailored accordingly with each participant and specific context (see Appendix F) (Merriam, 2009). After each interview, referrals were provided (see Appendix G), and participants were notified that they may be contacted to participate in optional follow-up interviews. In the case that questions were left unanswered (Creswell, 2007; Merriam, 2009), I then contacted participants by phone to ask if they could clarify certain data or answer a few follow-up questions. Overall, data were collected until it was saturated, which occurred after 12 participants were interviewed. Participants were also contacted again at the end of the study to verify accuracy and discuss the emergent findings.

Each interview was recorded on two digital audio recording devices. Interview files were password-protected, stored on the researcher's password-protected computer, and then placed on password-protected flash drives. Three potential research assistants were initially recruited via a university listserv for master- and doctoral-level students in counseling or psychology; only one volunteer research assistant ultimately participated, as the other two later declined. I reviewed with her proper methods of transcription, including the need to record both verbatim responses in addition to non-verbal cues (e.g.,

sighs, laughs, crying, or long pauses) and issues of confidentiality in order to maintain the

professional rigor of the study and account for ethical considerations. She transcribed five

of the interviews verbatim from the audio-recorded materials on a flash drive. I

transcribed the remaining seven interviews verbatim from the audio-recorder materials on

another flash drive. I then listened to each audio recording while reviewing the

transcriptions, checking for accuracy and removing any identifying information. All

interview audio files were deleted once transcribed and checked to further enhance

security and confidentiality.

 Document review. I engaged in a visual elicitation technique in which participants

were contacted before the interview and encouraged to bring an artifact or any other

meaningful personal document with which they felt comfortable sharing that symbolized

their time treating ED patients. In addition to interviews, such documents were reliable

sources of data that were meant to enhance the richness and meaning of the study;

conveying individual views, beliefs, and attitudes; and helped to bolster the study's

trustworthiness as a source of triangulation (Creswell, 2007; Lincoln & Guba, 1985;

Merriam, 2009). They included written works and visual documents (which did not

contain any patient information), such as artistic expressions, including one drawing and

one letter (Merriam, 2009). At the end of each interview, I asked participants to describe

the objects that they brought with them and explain how they represented their

experiences working with patients with EDs, adding this onto their audio recording.

Given that this visual elicitation technique was encouraged and not required, only two

participants brought an artifact to the interview. I e-mailed the other 10 participants a few

weeks after their interviews and encouraged them to contact me if they thought of a

relevant artifact that they wanted to share. Three more participants responded and provided artifacts. Thus, a total of five artifacts were used for this visual elicitation technique.

  Audit trail. Based on steps proposed by Moustakas (1994), I kept a detailed reflexive journal throughout the entire data collection process, continually working to identify struggles and bracket my personal biases and experiences, an epoche (Creswell, 2007). I also created a record of my research processes through an audit trail. Playing an essential role in determining when to stop collecting data, once I was able to identify common themes and reach saturation, data collection stopped (Creswell, 2007; Merriam, 2009).

  Data analysis. This step of the research process involved interpretation of the data, in which I reduced the data into a story that provides meaning to the reader. It emerged as an inductive process, in which codes and categories were created based on the words of the participants after the audio-recorded interviews were conducted and carefully transcribed into verbatim script (Merriam, 2009).

  According to Moustakas (1994), interview data from a phenomenological approach should adhere to a specific data analysis process. The first step in this process was the epoche, similarly referred to as bracketing, in which I looked within and set aside personal biases and involvement with subject material, to try and best understand the experiences of participants from their points of view (Creswell, 2007; Patton, 2002). Through engaging in such an attitudinal shift, one attempts to view the investigated experience from a fresh perspective. However, such a process is far easier said than done in that it is virtually impossible for one to completely separate oneself from the data or

phenomenon of interest. One way to enhance this process is to attempt to at least set aside

all judgments until all the evidence has been uncovered. One may reflect on his or her

own opinions, yet trying to be as objective as possible at first. Thus, it becomes an

ongoing analytical process, as opposed to a single occurrence (Patton, 2002). In the

current study, I tried to remind myself before all interviews that, although I have worked

with ED patients, my experience most likely was much different in that I was never a

nurse providing care. Thus, I must always be attuned to nurses' idiographic experiences

and continue questioning based on their comments rather than my own assertions.

However, completely setting aside my biases, as bracketing asserts (Creswell,

2007; Moustakas, 1994), was challenging despite my continual attempts. Though

perfection in this respect is not the goal, even trying to completely set aside my biases did

not fit with my philosophical ideologies. Constructionism, in itself, acknowledges the

ways in which societal views shape those of the individual (Creswell, 2007). Thus, my

views are bound to shape some component of the emerging research, at least

inadvertently. Given this viewpoint, I adhered to a term coined by Dahlberg (2006),

known as bridling. This notion posits that, instead of cutting off personal biases from the

research, researchers can become even more reflective by examining the precise ways in

which such personal biases influence the data. One is not to exclude these biases, but

instead loosen the grip by which they might hold one captive to a narrowed viewpoint.

Through removing such restraints, one may gain a more equitable sense of the

phenomenon of inquiry.

Therefore, to bridle my own biases, I thoroughly described my interest in the

research topic and discussed my previous work with ED patients and the nurses who

provided their care. I attended to such experiences throughout the data collection and analysis process through writing in a reflexive journal. I not only continually self-reflected on such experiences, but I was also able to share such experiences with my peer debriefing colleague in order to gain a more objective point of view.

Following epoche, there are several remaining steps in a phenomenological approach. Adhering to Moustakas' (1994) description, I first engaged in a horizontalization process, a preliminary grouping procedure that involved listing every significant statement relevant to the experience, giving each equal value. I then determined the invariant constituents of the experience through reducing and eliminating data. This was done through testing each aforementioned statement to assure they (a) contained moments of experience sufficient for understanding, and (b) were capable of being extracted and labeled. If such requirements were not met, statements were eliminated. If statements were repetitive or vague, they were either eliminated or refined. Those remaining were considered the invariant constituents of the experience. Next, I clustered the invariant constituents, in which clusters of meaning were extracted through organizing statements into themes or meaning units while removing repetitive and overlapping statements to further enhance the richness of the data (Creswell, 2007; Merriam, 2009). These became the core themes of the overall experience. I then engaged in an application validation, checking the invariant constituents and themes against complete transcriptions of each participant. I assessed if participants had expressed each statement explicitly and if statements were compatible. If not, they were not considered relevant and were deleted.

Subsequently, I created descriptions through scrutinizing more evident content as well as underlying meanings. Continuing with Moustakas' (1994) steps, I then created textural and structural descriptions, two integral components to phenomenological research. Textural descriptions explain participants' experiences, including their attributed meaning. These included verbatim examples from transcriptions when they explained what they actually experienced. Following, I constructed structural descriptions from these textural descriptions, also known as imaginative variation, describing how participants experienced the phenomenon. Such descriptions involved seeking divergent perspectives, finding all possible meanings (including more deeply-imbedded characteristics such as feelings and thoughts), and varying the frames of reference about the phenomenon (Creswell, 2007). Finally, I constructed a textural–structural description of the essence for each participant, incorporating invariant constituents and themes. Through further reducing such descriptions, I gained a comprehensive understanding and created a composite description, tapping into the overall, shared essence, or invariant structure, of nurses' experiences treating ED patients, viewing the group as a whole (Creswell, 2007; Merriam, 2009; Patton, 2002).

Upon completion of theme development, I engaged in two processes to enhance the trustworthiness of this study. I first engaged in peer debriefing, in which I consulted with one colleague in order to discuss/solidify emerging themes and address questions that may have arose during the data analysis process. He read each transcription and developed thematic categories, which were then compared to those I had already created. We subsequently discussed and resolved any discrepancies as well as discussing any biases from my reflexive journal that may have affected the data. Finally, I engaged in

participant checks in which I e-mailed the 12 participants with their textural–structural descriptions and requested that they check for the accuracy of the interpretations and extracted themes, as well as provide any necessary feedback. I also provided them with the description I created regarding their demographic information to verify that I had kept their identities as confidential as possible. I followed up and conferred with six participants via e-mail to confirm themes. Furthermore, upon their request, participants had the option to review their transcripts, though none requested to do so.

Ethical Considerations

There are numerous ethical considerations to keep in mind when conducting any research study, especially when interviewing human subjects and discussing potentially sensitive material, as in this case. Furthermore, the ethics of the researchers affect the reliability and validity of the study (Merriam, 2009); thus, it is imperative to examine potential ethical dilemmas thoroughly. Institutional Review Board approval acted as the initial means of assessing and promoting the ethical nature of the study in which potential risks were evaluated. Completion of consent by both the site and participants acted as a yet another way to promote their individual rights (Creswell, 2007; Merriam, 2009). The study sought to benefit participants by keeping promises (e.g., their rights to view their records, ability to review transcriptions, etc.) and by striving to avoid any potential harm through being respectful of the participants during questioning and providing of referrals (American Psychological Association, 2003). Additionally, efforts to engage in member checks preserved the dignity of participants, ensuring that information was accurate and I, indeed, understood the participants correctly (Merriam, 2009).

Patton (2002) demonstrated how the credibility of the researcher affects its ethics. For example, the process of observation or interviewing affects what is observed and what is heard. The personality of and the procedures chosen by the researcher have an undeniable effect on the data that ensues. Thus, there are many factors that I acknowledged regarding my own role when conducting this study. I remained reflexive throughout the entire research process, attempting to bridle my own experiences (Creswell, 2007; Dahlberg, 2006; Merriam, 2009) and hear data through the participants' perspectives. Though I did not want to bias the research, it was still important that I acknowledged my own values and how they might play out in the research.

Various dynamics may have ensued between researcher and participants, for which I remained aware and cautious. There was the inherent potential for dynamics of age, gender, culture, race, ethnicity, and socioeconomic status to emerge. I was also aware of potential power dynamics that may have arisen given my being in control of the interview, in addition to my now being a member of the mental health side of treatment, as a psychologist in training, as opposed to my previous role as a psychiatric technician on the nursing team. Participants may have simply told me what they thought I wanted to hear and censored certain information. Though I pursued certain themes with more specific follow-up questions, it was also important that I respected and remained sensitive to participants' rights to privacy and remained sensitive, even if I thought that they were not disclosing all relevant information. Furthermore, having worked at this hospital before elicited an ethical dilemma in my knowing some of the participants. This perhaps affected what information some participants disclosed to me; they may have been more open or more guarded, depending on their respective comfort levels in talking to me.

Given my training in counseling psychology, it was also continually important, especially if a participant divulged sensitive information, that I remained in the role of the researcher and did not fall into the role of the therapist. All such potential dynamics were also considered based upon the possibility that I had prior work relationships with some participants, in that I formerly worked at both the adult and adolescent ED units. This could compromise the validity of the study, making it increasingly important that I maintained the rigor of the study and addressed any potential concerns.

A qualitative study founded on rigorous data collection and analysis has the increased propensity for ethical soundness, yet there are certain such factors that may also elicit concerns. The nature of the interview itself can affect a study's ethics (Merriam, 2009) in that participants may feel embarrassed or potentially reveal more than intended, increasing their embarrassment or guilt. Potential long-term consequences affecting participants' employment could also result, in that nurses may have reported unpleasant parts of their jobs that they had previously kept to themselves or, perhaps, uncovered positive experiences that they had not yet realized (Merriam, 2009). Participant observation could also have elicited discomfort from patients on the unit and concerns over informed consent in that they inevitably were viewed since the facility has open spaces in which staff and patients interact.

Rigor in Qualitative Research

There are specific factors that affect the ultimate quality and rigor of phenomenological qualitative research, similar to the terms, reliability and validity, that are used in quantitative research. Such terms as trustworthiness, credibility,

dependability, confirmability, and transferability are utilized instead (Creswell, 2007; Lincoln & Guba, 1985; Merriam, 2009) and discussed in further detail in this section.

An integral concept to enhancing rigor in qualitative research, trustworthiness refers to the ability of research findings to not only be believable, but to also be seen as worthwhile in explaining the phenomenon of investigation (Lincoln & Guba, 1985). Williams and Morrow (2009) outlined several strategies that act to enhance a study's trustworthiness: maintaining integrity of the data, including documenting and justifying the rationale and purpose of the study throughout and paying precise attention to and conveying all the steps of the research process in qualitative terms, including the data collection and analysis procedures; maintaining a balance between reflexivity and subjectivity; and providing a clear description and interpretation of the findings that makes sense to readers**.**

Credibility

Credibility refers to how congruent the research findings are with reality and what the study initially intended to examine via the research questions. It enhances one's ability to believe the research findings, viewing them as a useful means of explaining the phenomenon at hand (Merriam, 1995, 2009). Thus, if the current study is credible, the researcher and readers will view the findings as a viable means of explaining and conveying nurses' experiences in treating ED patients. Demonstrating dependability, confirmability, and transferability, are all ways of enhancing this study's overall credibility (Merriam, 2009).

Dependability

Dependability refers to the extent to which the research remains consistent across time, researchers and various analysis techniques accounting for the continually evolving nature of research (Merriam, 2009); in other words, it refers to the overall integrity of the data (Williams & Morrow, 2009). I implemented various techniques to enhance the dependability of this study.

To maintain my own consistency, I first engaged in a semi-structured interview protocol. Asking each participant virtually identical interview questions—the same general wording though the order changed slightly as the process progressed—was a form of standardizing the questioning strategy. Audio recordings provided another firm check on the data, in that verbatim transcription did not permit participants' words or ideas to be taken out of context or skewed. Triangulation methods also utilized multiple sources of data to confirm the findings that emerged, such as multiple methods of data collection (e.g., interviews and observations); multiple sources of data (e.g., using participants from both the adult and adolescent units, as well as various types of nurses); multiple methods of data analysis; and various theoretical lenses from which the data were interpreted (e.g., constructivist with existential underpinnings), acknowledging the pluralism that exists through multiple ways of knowing and understanding (Creswell, 2007; Merriam, 2009).

I engaged in my own emerging process of awareness, reflexivity, in which I reflected on my own opinions and tried to bracket any biases throughout the research process as best as possible (Merriam, 2009). Unable to entirely put subjective opinions aside, I became aware of my own thoughts and brought them to the forefront when

collecting, checking, and re-checking data, attaining an overall balance between reflexivity and subjectivity (Williams & Morrow, 2009). I completed a researcher journal, audit trail, to account for events and changes throughout the research process and maintained a system of checks and balances (Creswell, 2007). I then used member checks, soliciting feedback on the emerging findings from the participants through showing them the transcribed interviews in which they partook (Creswell, 2007; Merriam, 2009). Finally, I engaged in an external check of the research process through a peer debriefing, having an advanced doctoral colleague trained in qualitative methods review my transcripts and assess my methods, meaning, and subsequent interpretations (Creswell, 2007; Merriam, 2009).

Confirmability

Confirmability refers to the degree to which the findings make sense, are consistent with the data, and represent the situation being research, instead of the personal agenda (e.g., biases, beliefs, and theories) of the researcher (Creswell, 2007; Merriam, 2009). As aforementioned, I engaged in a process of reflexivity, created audit trails, and engaged in both peer and member checks to enhance confirmability (Merriam, 2009).

Transferability

Transferability refers to how well the findings are interpreted as true for readers and can be subsequently generalized to their own lives (Lincoln & Guba, 1985; Merriam, 2009). The nature of thick descriptions, rich, detailed, and providing context within the data, enables readers to "compare the 'fit' with their situation" (Merriam, 2009, p. 226) and determine whether or not such findings are transferable (Merriam, 2009). In this

regard, I asked a variety of detailed questions within the interviews, frequently asking for follow-up or elaboration when needed.

The findings of this study may reflect situation-specific conditions at these specific ED units, given that these were the only sites accessed. Thus, any ensuing generalizations are viewed as a working hypothesis, not a conclusion. The themes and essence extracted from this study could act as concrete universals, translating into other similar situations, such as nurses' experiences at inpatient ED units similar to this one across the country, since the general often lies in the particular (Merriam, 2009). However, my utilization of a multi-site design (Merriam, 2009), using participants from two units within the larger umbrella company, was another method to increase transferability.

Summary

In this chapter, I outlined the methodological components that provided the framework and structure for interpreting the data collected in this study. After providing some initial context, I outlined the research paradigm, including the epistemology, theoretical perspective, and researcher stance that guided the study. I then outlined the methodology, research methods, and procedures, including an overview of the Institutional Review Board process, participants, setting, and data collection and analysis methods. Finally, I concluded by outlining ethical considerations and methods for enhancing the rigor of the study. In Chapter IV, I present the findings of this study, including background information about each participant, rich descriptions of their experiences, and individual and composite themes that capture the essence of their experiences with treating ED patients.

CHAPTER IV

FINDINGS

In this study, I examined nurses' experiences in treating patients diagnosed with eating disorders (EDs). I sought to understand their overall experiences; perceptions of meaning and value in their work; challenges impeding their work; ways in which their education, training, and preparedness may affect their experiences; and the overall essence of this phenomenon. I collected data through semi-structured interviews with 12 nurses who worked primarily with adult or adolescent patients, in addition to collecting artifacts from those who provided them that symbolized their experiences in treating patients diagnosed with EDs. I used a phenomenological qualitative methodology to guide the research process. Such a methodology allows one to extract both individualized interpretations in addition to creating a composite meaning, or essence, to better understand a particular phenomenon, in this case nurses' experiences in treating patients diagnosed with EDs.

According to Moustakas' (1994) phenomenological approach to analyzing qualitative data, it is essential that one first examine and understand each participant's individual experience. Combining individual textural and structural descriptions into textural–structural descriptions is essential before attempting to interpret shared meanings, or the composite description. Therefore in this chapter, I first provide information about each participant, including demographic information as well as

thorough descriptions of their experiences (e.g., general descriptions and themes), or the textural–structural descriptions. Following this individualized analysis, I then examine the overarching themes that comprise the composite experience of all 12 participants, or the essence of the phenomenon. Pseudonyms that were chosen by participants are used throughout, and all identifying information has been omitted to protect the confidentiality of participants.

Furthermore, to enhance the trustworthiness of these findings, I utilized two key methods in creating these themes. I first engaged in peer debriefing, reviewing thematic conclusions with a fellow doctoral candidate familiar with qualitative research. I then engaged in member checks, in which I contacted participants during the data analysis process several months after their respective interviews. I sent each one an outline of the individual themes extracted from their respective interview transcripts as well as the composite description, asking them to review the themes and note whether or not they agreed with the conclusions reached through my analysis and to provide any other information that I may have missed. Six of the participants responded with feedback, while the other six did not.

In the next section, I focus on describing each nurse's background and personal experiences treating EDs, separated by three main thematic categories: initial attitudes, conditions of treatment, and emotional outcomes and awareness. Individualized themes within these categories emerge for each participant. All nurses, regardless of which type of patients they treated and the level of degree they had attained, were licensed in the state where they practiced and had treated hundreds of patients diagnosed with EDs (unless otherwise specified).

Individual Nurse's Experiences

Jackie

Background. Jackie is a Hispanic female in her 20s. She earned a Bachelor of Science in Nursing and has been a nurse for approximately eight years. Jackie has been treating adult patients diagnosed with EDs for the past two-and-a-half years. Previously, Jackie had primarily medical experience in acute care hospital settings, in addition to some psychiatric experience as a float nurse, in which she filled in covering various nursing duties on a psychiatric floor when an extra nurse was needed. Jackie reported having no experience with, and minimal knowledge of, EDs prior to her working at this facility.

Jackie and I met at the hospital and interviewed in her office, which contained a desk, two chairs, and a bookshelf filled with paperwork and reference books. There was minimal décor or artwork in the office; it looked as though she possibly had just moved in. Jackie did not provide any feedback regarding the accuracy of her themes.

General description of the experience. In describing her work treating patients diagnosed with EDs, Jackie began by explaining the inherent uniqueness of her work. She noted that such patients are more complex than others with whom she has worked, having simultaneous medical and (often multiple) psychiatric diagnoses. Jackie further described various components and underlying factors that contributed to her experience as whole. The following sections outline the themes that Jackie conveyed, all of which are illustrated in Table 1.

Table 1

Individual Themes: Jackie

Core themes	Descriptions & sub-themes
Initial attitudes	Initial attitudes that impacted her work were comprised of a focus on: – Lack of preparedness and training – Challenges of combining medical and psychiatric skills
Conditions of treatment	Several components comprised her ability to treat patients and manage her duties: – Managing time and multiple roles – Finding balance – Positive attitude – Importance of support
Emotional awareness and outcomes	Her overall emotional experience and sense of awareness was impacted by: – Powerful emotions – Increased compassion – Feeling grateful – Increased focus on body image

Initial attitudes. Two themes emerged:

Lack of preparedness and training. Having worked primarily in medical settings, Jackie reported having no understanding of, or prior training in, EDs before working at her current job. Modeling other nurses' behaviors and skills initially, she stated, "I feel so easily moldable when I am new to something. I just want to absorb it and learn it." Given

that minimal training was provided by the facility, she felt that much of her learning was self-initiated. She gained a new "passion" and felt "sucked in" by the field. Therefore, Jackie prompted herself to go above and beyond and attained additional training in EDs. Jackie also learned information and taught herself new skills through reading books and watching videos on EDs. Despite the fact that she was "living and breathing EDs," Jackie still felt uncertain about all the "therapies" involved in ED treatment (e.g., dialectical behavioral therapy, acceptance and commitment therapy, trauma-informed models) given her lack of mental health training.

Challenges of combining medical and psychiatric skills. Given the unique nature of ED patients and their symptoms, Jackie was challenged by the combination of a medical and psychiatric skill set that she needed to utilize. Working with complex medical issues, while also having to manage emotional and behavioral issues common to patients diagnosed with EDs (e.g., manipulation, somatic concerns, etc.), increasingly complicated her role as a nurse.

Conditions of treatment. Four themes emerged:

Managing time and multiple roles. Jackie felt challenged in her ability to adequately balance her time. Not only did she have to tend to her own duties and manage other nurses, but also had to maintain the medical stability of all patients. She noted that "making sure people do their job" was often quite frustrating. Identifying herself as "detail oriented," witnessing other nurses cut corners made them seem incompetent.

Finding balance. Several factors impacted Jackie's ability to foster and maintain healthy relationships with patients; while some of which seemed natural and easy, others provided new avenues for learning. Jackie identified the need to build rapport, validate

feelings, remain calm, and support and advocate for patient needs. However, she stressed the importance of finding and maintaining balance between being empathic and compassionate with fostering independence. For her, this felt different from her previous work. Patients with EDs needed encouragement to practice skills on their own to promote their future success outside of the hospital. The need to be stern and feel respected has also been integral in her success with patients. Furthermore, she also noted the need for balance within her life. Though work was extremely important to her, she still needed time for self-care, to relax and to spend time at home.

Maintaining a positive attitude. Given how sick patients were throughout inpatient hospitalization, Jackie often felt challenged to identify the "rewards" in her work. She compared it to her previous work in labor and delivery in which she could see a tangible positive outcome (e.g., a baby). On an inpatient ED unit, patients were often at their worst and got visibly better after they transitioned to a less restrictive level of care, such as partial hospitalization or outpatient services. Furthermore, Jackie also noted that it became hard for her to maintain compassion at times when dealing with purposeful, negative patient behaviors, such as manipulation or self-harm. It was often challenging for her to separate the patients from the ED and attribute their symptoms as part of their disease and not as part of an inherent personality characteristic. She could also lose a sense of hope when seeing how long certain patients had lived with their EDs and how many times they had returned to inpatient treatment.

Importance of support. Despite the multifaceted nature of the nurse's role on an inpatient ED unit, Jackie acknowledged feeling supported by her colleagues and supervisors as well as respected and integrated within the treatment team. Having

recently transitioned into a new position, she also reported enjoying improving hospital wide systems and providing education (though still enjoying direct patient care). Despite this, Jackie still identified some struggles in her position, such as having to "work for trust in my role because I am so new and young."

Emotional awareness and outcomes. Four themes emerged:

Powerful emotions. Jackie described a mixture of emotions that arose within her when working with the ED population. First and foremost, she acknowledged her initial experience of feeling shocked, primarily by the physical appearance of some patients, having never seen such malnourishment before. This made it quite challenging for her to maintain a "professional face" when she first started. A novice to the field, she reported that most of her initial experiences were eye opening, constantly exposed to new medical and, especially, psychiatric issues.

Jackie described several negative emotions that often exacerbated already existing challenges in the work. Feelings of exhaustion and being overwhelmed pervaded the work in that patients constantly needed care and attention. Furthermore, Jackie endorsed feeling worried (from a medical standpoint) regarding her patients' physical health. She experienced concern when she would "leave from work and wonder if she [her patient] was going to die in her sleep." Jackie also worried about the future, stating: "I am definitely fearful now about what kind of experiences I might have someday when I have kids . . . There are always the 'what ifs.' . . . What if one of these girls was my daughter?"

Increased compassion. Prior to working with EDs, Jackie reported not having much compassion for such diseases. She found it challenging to see someone self-harm or refuse treatment and did not understand why anyone would purposely act in such a

way. However, upon exposure to EDs and the training that she received since working at her current hospital, Jackie became able to gain more compassion and to decrease judgment regarding EDs, mental illness, and accompanying symptoms.

Feeling grateful. Seeing the physical pain and psychological hardship that patients endured through fighting their EDs, Jackie felt thankful that she did not suffer from an ED herself. Her work increased her appreciation for her own life circumstances, as well as her ability to feel successful and to make a difference, in addition to her since-increased compassion for ED patients.

Increased focus on body image. Jackie described an increased awareness of, and focus on, body image among her colleagues. She acknowledged that this perspective sometimes made treating EDs increasingly challenging and uncomfortable in that such a focus on a body image was often what she needed to escape.

Evangeline

Background. Evangeline is a Caucasian female in her 40s. She earned a Bachelor of Science in Nursing and has been a nurse for approximately 10 years, with much psychiatric experience, specifically in community mental health settings. Though she had no prior professional ED experience, Evangeline reported that both her personal experience having had bulimia nervosa as well as her extensive experience working in mental health had peaked her interest in the field. Dealing with bulimia nervosa firsthand had also helped her understand the illness, symptoms, and how to relate to patients diagnosed with EDs better than other nurses. Evangeline treated adults diagnosed with EDs for approximately two-and-a-half years. However, she recently quit the ED field.

Given the timing of our interview and the fact that she was no longer employed in the ED field, Evangeline agreed to meet at my house for our interview. Conducting the interview in my living room, we sat on opposite couches near a window. The room was quiet and well lit, free from distractions. I later e-mailed Evangeline for feedback regarding some unclear descriptions that she had provided during the interview. She offered additional information that was then integrated into the already-created themes. Finally, Evangeline provided feedback regarding the accuracy of the themes, stating that I had accurately captured what she had been trying to convey through her interview.

General description of the experience. Evangeline reported many mixed feelings about her time treating patients diagnosed EDs. However, she repeatedly asserted that because she had been so immersed in her work, it was challenging for her to recognize and understand how she felt about it at the time. It took retrospective reflection for her to be able to convey and understand her thoughts and feelings about her experience.

I also asked Evangeline to think about an artifact or object that had represented her experience treating patients diagnosed with EDs. Following the interview, she contacted me and referenced a poem:

> You sent out beyond your recall . . . go to the limits of your longing.
> Flare up like flame and make big shadows.
> Let everything happen to you: beauty and terror.
> Just keep going. No feeling is final.
> (Rainer Maria Rilke, 1875 – 1926)

In explaining the personal meaning of these words, Evangeline described her use of this poem with patients, specifically referencing the last sentence: "No feeling is final." Writing this down and giving it to patients had helped her in reminding both them and

herself that no feeling is permanent. With regard to her own life, Evangeline noted, "It has also helped me move through my own burnout and overwhelm with my work." The following sections outline the themes that Evangeline conveyed, all of which are illustrated in Table 2.

Table 2

Individual Themes: Evangeline

Core themes	Descriptions & sub-themes
Initial attitudes	Struggles with the steep learning curve involved in ED treatment comprised the focus of her initial attitude towards ED treatment.
Conditions of treatment	Several components comprised her ability to treat patients and manage her duties: – Forming relationships – Separating patients from their EDs and maintaining compassion – Lack of time – Disrespect and lack of appreciation – Sense of community
Emotional awareness and outcomes	Her overall emotional experience and sense of awareness was impacted by: – Powerful emotions, including anger, stress, vicarious trauma, and burnout – Witnessing transformation – Growth

Note. ED = eating disorder.

Initial attitudes. Having minimal professional exposure to EDs previously,
Evangeline experienced a steep learning curve at the onset of her work at the hospital; "I
had to teach myself a lot of things." Though she had extensive professional psychiatric
experience and viewed her therapeutic skill set as an important asset, the uniqueness of
symptoms and need to integrate medical and psychiatric skills when providing care for
ED patients elicited new challenges. In addition to the inherent complexity, the newness
of the hospital presented further challenges for her in that there were minimal policies,
procedures, and guidelines.

Conditions of treatment. Five themes emerged:

Forming relationships. Making a connection with a patient, especially one who
was previously "closed off" or isolative, was meaningful for Evangeline. Given that
inpatient hospitalization can be lonely, it was important for her to let patients know that
they were cared for. She stated, "It's like a parent with a child. That's often what it felt
like." Her gentle and compassionate nature and constant motivation to understand and be
a part of the "bigger picture" of their treatment enabled Evangeline to create a safe,
therapeutic space for patients to heal.

Separating patients from eating disorders and maintaining compassion.
Evangeline initially struggled to see patients separately from their symptoms. Patients'
tendencies to become "consumed in their EDs," unable to recognize the reality of what
occurred outside in a healthy frame of mind was challenging. Patients sometimes became
"manipulative," "gamey," and/or "psychosomatic," which inhibited the ease with which
Evangeline was able to recognize their humanness in the moment and maintain
compassion. She stated, "It was her [patient's] ED but that doesn't mean that she wasn't

responsible for her behavior." Evangeline did note that as she gained experience with the ED population, she was better able to distinguish the person from the disease; a malnourished and "starved" brain often inhibited someone from reacting to a nurse or initially benefitting from care in a way that she had hoped.

Evangeline noted that despite her having previously engaged in the "typical" behaviors associated with bulimia nervosa (e.g., binging, purging, and using laxatives) when she was "in [her] ED," she did not think about her personal experiences much in the moment when working with patients. She felt it was still a challenge to relate to some patients in that "my life and behaviors were so different." Furthermore, Evangeline tried to be both nurturing and firm when interacting with patients. She later recognized that being firm with patients and maintaining boundaries was also a form of compassion.

Lack of time. Given the sheer number of duties and the inadequate nurse–to–patient ratio, Evangeline felt as though there was never enough time to complete all her tasks or to at least be as thorough as she would have liked. The unit was often so chaotic and the nurses were so busy that they did not get a break. Even if she was able to take 30 minutes for lunch, Evangeline was "attached" to a pager and often had to return to the floor.

Disrespect and lack of appreciation. To compound the issue of lacking time, the demanding nature of some patients left Evangeline feeling as though the minimal time she had to engage with each patient was not even respected. When the nature of the treatment team approach began to change as the facility expanded, Evangeline also felt less appreciated by members of the treatment team. People were less likely to ask for her input or value her opinion, and she perceived this to hold true for nurses as a whole.

Evangeline recognized that other members of the nursing team, such as the "people

working in the trenches" (the psychiatric technicians), were also disrespected. She was

astounded by this reality; those who spent the most time with the patients and often saw

the most difficult parts of their EDs were often the ones who were the least appreciated.

Sense of community. Despite the need to re-learn and/or teach herself various

medical procedures needed to aid in the care of this patient population, Evangeline

initially had felt much support and comfort from her colleagues. She had been part of

training and team-building activities designed to promote cohesion, camaraderie, and

knowledge amongst all staff within the hospital. She "loved it and thrived in it." She was

also able to utilize these skills when training newly-hired nurses. However, Evangeline

conveyed disappointment at the decreased cohesion that later ensued among the treatment

team as the hospital became larger. Such a distancing led many staff to become

increasingly negative and often mean (e.g., nurses complained about therapists and

dieticians, and vice-versa). She stated, "This is hard work. We need each other." When

such needs were not met, Evangeline felt lonely.

Emotional awareness and outcomes. Three themes emerged:

Powerful emotions. Anger, frustration, sadness, stress, and feeling overwhelmed

—Evangeline frequently experienced these emotions at various levels.

Anger. Feeling angry towards defiant patients often made it challenging for

Evangeline to provide quality care, which led to uncertainty in her own abilities and a

decreased sense of confidence. Evangeline reflected on one time when a patient with

whom she had worked with for many months ripped out a central intravenous line (placed

for nutrition), an act that could have had lethal consequences. She stated, "I'm thinking that I'm responsible and she might die, and I was so angry with her."

Stress. Though Evangeline recognized her passion for her work and a love for aiding in patient recovery and success, her negative emotions often seemed to outweigh the positive ones. She felt as though "the joy was just zapped out of me." Feeling as though she needed to be available for patients at all times, she felt increasingly stressed. Evangeline stated,

> I wanted to hide out where we gave medicine because I didn't want to be available all the time . . . There were constant emergencies . . . So when I started moving away from the floor and doing more administrative stuff, it was like a breath of fresh air.

Furthermore, Evangeline noted that the intensity of the work led to a high turnover of nurses, which further increased her stress level.

Vicarious trauma. Working with patients who were physically and often psychologically traumatized was difficult for Evangeline. She acknowledged her tendency to get "overwhelmed when I see people suffer." She stated: "I always want to fix the pain that my patients suffer and/or carry their burden so they don't have to." The incessant exposure to negativity and hardship became too much and affected Evangeline both mentally and physically. She became unable to recognize or engage in regular self-care and began drinking alcohol more frequently, eating more, and gaining weight.

Burnout. Not only was Evangeline overwhelmed at work, but she also spent most of her time outside of work with nursing colleagues further discussing and re-hashing the stresses of their work. When discussing her inability to "let work go," Evangeline became tearful. Evangeline felt unable to carry the "awful stories of trauma and pain" and bear witness to suffering any longer. Ultimately, she quit her job. However, she did not

recognize her feelings clearly in the moment, stating, "I don't think I knew what burnout actually looked like." After having learned more about the signs and symptoms of burnout, Evangeline recognized that many of the negative emotions she had felt so regularly were probably indicative of her burnout and that she had needed more professional support at the time.

Evangeline also attributed some of her burnout symptoms to her own nurturing and compassionate personality/nursing style. "I feel like a raw nerve sometimes, unable to tolerate even the slightest hint of stress." She thought that if she had been a different person, her situation may have turned out differently. She acknowledged, "Maybe if I had been a little closed down and not so nurturing, who knows, maybe I wouldn't feel as burnt out as I do. But I couldn't do less than that. I couldn't."

Witnessing the physical transformation. Evangeline had equated patients' malnourished bodies with sickness. This inadvertently helped her gain an appreciation and sense of peace with her own body, which she had associated with shame for many years, because she did not want to be sick. Seeing the physical changes in patients' bodies and the improved lab values that accompanied their recovery had an immensely positive impact on Evangeline. Once they gained weight, color often came back to their skin, sheen to their hair, and brightness to their eyes. Their personalities began to present themselves and Evangeline realized, "There is a human being in there. It does exist."

Growth. Given her lack of medical experience at the onset of her work with EDs, Evangeline felt as though she grew "by leaps and bounds" in her medical knowledge. She was able to practice skills and gain a sense of confidence, some of which she did not even

realize until after the fact. In addition, she also acknowledged that witnessing sickness amongst so many women helped her come to peace with her own body.

Emily

      Background. Emily is a multiracial female in her 20s. She earned a Master of Science in Nursing and has been a nurse for approximately eight years, with mixed medical and psychiatric experience. Though she had worked as a medical nurse prior to this job, primarily treating patients with terminal illnesses, Emily also has a Bachelor of Arts in Social Work and has worked with homeless youth. She has been treating adults diagnosed with EDs for the past three-and-a-half years. She reported having no experience with and minimal knowledge of EDs prior.

      Emily and I met at a public library, and given there were no private rooms available, we interviewed at a table in a private area in the back corner. We were surrounded by bookshelves and occasionally there were some loud noises in adjacent aisles. Emily did not provide feedback regarding the accuracy of the themes. The following sections outline the themes that Emily conveyed, all of which are illustrated in Table 3.

Table 3

Individual Themes: Emily

Core themes	Descriptions & sub-themes
Initial attitudes	A focus on the uniqueness of EDs comprised her initial attitude regarding ED treatment.
Conditions of treatment	Several components comprised her ability to treat patients and manage her duties: – Importance of balance – Building relationships and increasing support – Participating in the recovery process – Lack of time – Inability to see the positive – Maintaining compassion – Entitlement and disrespect
Emotional awareness and outcomes	Her overall emotional experience and sense of awareness was impacted by a myriad of powerful emotions, including: – Frustration and exhaustion – Anxiety, fear, and surprise – Sadness, grief, and loss

Note. ED = eating disorder.

Initial attitudes. Emily reflected on her work with patients diagnosed with EDs

as unique and interesting, vastly different from any other type of work (nursing or social

work) that she had experienced previously. She stated, "It was all new and foreign to

me." It exposed her to a new demographic, mainly females, who were often of middle or

upper socioeconomic status. She equated each day to an "adventure," in that she never

knew what to expect. Emily's previous work with homeless populations prepared her in how to manage crises, which was something that she enjoyed. However, ED treatment presented to her a new set of crises to manage: self-injurious behaviors, patients needing to be rushed to the emergency room for an array of medical emergencies, patients running away, etc. Lacking training and experience in the field, in addition to a lack of "formal orientation" when she began the job, Emily subsequently lacked any expectations. She learned on the go, "figuring out things together" (with other nurses), and researching on her own.

Conditions of treatment. Seven themes emerged:

Importance of finding balance. Emily recognized the importance of enjoying work and being able to have fun both on and off the job. She identified self-care as immensely important in maintaining balance. Reflecting upon her frustration when other nurses came to work sick or worked 80 hours in a week, she stated, "I know my limits. I think that's the only reason that I've been there three-and-a-half years. . . . If I don't take care of myself, I'm useless as a nurse." Not only did not taking the time to care for oneself have personal repercussions, but it also set a bad example for patients. To teach and model health for patients, Emily believed that she must practice what she preached.

Building relationships and increasing support. When Emily was able to "connect" with patients and know that they felt supported, she felt fulfilled with a sense of accomplishment. Despite the inevitable "personality clashes" that could arise when interacting with patients, Emily recognized the ability of at least one nurse to be able to build a relationship and gain trust with every patient. She emphasized the importance of being non-judgmental and trying not to take things personally. This concept translated

into her work with her colleagues as well, in which she identified satisfaction from supporting other nursing staff and feeling like a cohesive team. Emily also identified the value in feeling supported herself by her colleagues and supervisors and the need to maintain regular communication with everyone. She noted, "That's what makes it possible to stay here."

Participating in the recovery process. Emily identified the value in simply "being a part of [her patients'] journey." She recognized the importance of being present and conveying care and emotional availability for patients. She was sometimes even surprised in that some patients, those with whom she did not think that she had formed a relationship or had made an impact, conveyed to her the importance of her care on their recovery.

Lack of time. "I don't have enough time to give the care that I would like to give." Emily struggled with the lack of time given the high demand of her role. Given the poor nurse–to–patient ratio, Emily constantly felt spread thin, as if she had to minimize her time with each patient. She lacked the time and resources to provide the best patient care and often felt worried that she would not be able to keep patients safe, which is a nurse's primary goal and concern. Stating, "There isn't enough time for anything to go wrong," Emily conveyed a sense of anxiety regarding feeling incapable of managing all the potential scenarios that could ensue.

Inability to see the positive. The nature of working on an inpatient unit is seeing patients when they are often at their worst. Emily was challenged in not being able to see patients after their discharge, when they were able to actually maintain their recovery and health. She stated, "I see the people who come back again and again and aren't doing

well . . . I think the perspective is a bit jaded because I'm impatient." Furthermore, sometimes it became easy for Emily to lose hope for patients or for the disease itself, especially when working with older patients who had struggled with EDs for most of their lives.

Maintaining compassion. Given the aforementioned attitudes of some patients and her overall lack of understanding of EDs at the onset of her work, Emily felt challenged to maintain compassion. She initially did not recognize that patients who were severely medically compromised had brains that were often as starved as their bodies, which could contribute to various negative attitudes and behaviors. Upon this realization, Emily was able to develop greater compassion, though doing so remained a struggle at times. Such compassion was also affected by her ability to recognize the developmental level of a patient. She stated, "Developmentally, I might have people that are in their late 20s or early 30s who are like 20." Emily believed that though a patient might be an adult, a lifelong struggle with an ED could leave him or her feeling and acting more like an adolescent.

Entitlement and disrespect. Emily felt as though she could handle "acting out" behaviors. Certain personality characteristics and ways in which certain patients treated her often were hard to bear. She felt that "some think of me as their personal slave and everything should be on their time." Feeling as though someone was disrespecting her, either verbally or by not valuing her time, was "triggering" for Emily. This type of attitude was a new experience for her, something that she had not seen in the homeless or cancer patient population with whom she had worked previously.

Emotional awareness and outcomes. Emily endorsed a myriad of powerful emotional experiences that pervaded her work.

Frustration and exhaustion. Emily commented on the overwhelming, frustrating, and exhausting nature of her work. Primarily related to the high patient–to–nurse ratio, she felt as though the increasing number of patients made it difficult to provide the best level of care that she desired (e.g., having time to check in thoroughly with each patient). In addition to the numbers, Emily also witnessed a generalized increase in patient severity, increasing challenges for nurses in that symptoms were often more severe. Sometimes she felt as if she was so emotionally drained that she had "nothing left." She compared this to her previous work in oncology. In contrast, she never had to care for more than six patients at a time previously and felt capable of spending quality time and providing good emotional and spiritual care for each individual.

Anxiety, fear, and surprise. Raised with Eastern cultural influences in which her Chinese father emphasized the importance of physical health, the mere concept of EDs initially seemed foreign to Emily. She experienced fear in simply seeing the fragile state in which many patients with anorexia nervosa were living and reading lab values that were "quite frightening." Emily described having to tube feed such patients at night as a "horror," in that they were often so weak yet still maintained a strong aversion of nutrition. She also worried that when caring for fragile patients at night that she might lose the ability to keep everyone safe if a crisis occurred.

Emily conveyed a level of shock by the massive quantity of food that some patients needed to consume to gain weight, wondering how they could want to eat anything after being forced to eat such large amounts. She also reported feeling

self-conscious at times, mainly as a result of the excessive focus on weight and body image at the hospital. Given her thin frame, fast metabolism, and small bladder (frequently having to use the restroom), Emily worried that other staff and patients might think she had an ED herself, which she stated was far from the truth.

Sadness, grief, and loss. Emily reflected on the sadness, grief, and loss that accompanied her work treating EDs. She conveyed a level of sadness even in her tone, quieting her voice when discussing the experience of witnessing patient death. Though she believed that she had the skills necessary to work through trauma and cope with loss (learned during her previous role as a social worker), Emily still acknowledged the difficulty in losing a patient, especially when the patient had appeared to be doing well previously.

Willow

Background. Willow is a Caucasian female in her 30s who earned a Bachelor of Science in Nursing. Willow has been treating adult patients diagnosed with EDs for the past two years. A relatively new nurse, her only prior experience as a nurse was working for one year in a rehabilitation facility/nursing home. Willow reported having no experience with or knowledge of EDs previously. Willow and I met at a public library and interviewed in a private room. It was quiet and free from distractions. When asked to do so later on, Willow also provided feedback regarding the accuracy of the themes. She stated that she agreed with the themes that I had identified and did not feel that any had been left out.

General description of the experience. Willow identified many conflicting factors of her experience, some meaningful and some challenging. Primarily, she

identified her work as beneficial, stating, "I mean, sometimes I leave and never want to go back, and sometimes I leave and it's so rewarding and so positive and so amazing. I'd say overall it's more positive."

I asked Willow to think about an artifact or object that represented her experience treating patients diagnosed with EDs. Following the interview, she contacted me and described a smooth, gray stone, flat on both sides with an indentation on one side, the size of her thumb. Found on a beach in Barcelona, Spain, Willow carried this stone it in her pocket through all of her international travels. She stated:

> I have used the tactile sensation of its smoothness to give me confidence and ground me during stressful or challenging events. When patients are struggling with anxiety, self-harm, etc. and I am trying to help them identify grounding tools, I use my stone as an example of something that is so simple, but for me personally so powerful.

The following sections outline the themes that Willow conveyed, all of which are illustrated in Table 4.

Initial attitudes. Willow was struck from the onset of her work by the complexity of ED treatment. Not only was the work new to her, but such complexity elicited significant uncertainty within Willow. She was a new nurse who had never worked with mental health issues and felt unsure of what her role might look like and if she was capable of fulfilling it.

Unpredictability. The lack of predictability and concreteness in the course of an ED makes the nursing role increasingly challenging. Willow felt as though it took a lot of time to "figure out" each patient and each illness, which was somewhat unsettling for her. She stated, "I don't like emergencies . . . I like to know what's coming and be able to plan for it." Such uncertainty of what would happen while at work or when she left for

the day made it hard at times for Willow to leave her work at work, instead worrying about what might happen during her off hours.

Table 4

Individual Themes: Willow

Core themes	Descriptions & sub-themes
Initial attitudes	Her amazement regarding the complexity of EDs comprised much of her initial attitude towards treatment. This complexity consisted of: – Unpredictability – Illusions of health – Comorbid mental health and medical symptoms
Conditions of treatment	Several components comprised her ability to treat patients and manage her duties: – Building relationships – Feeling supported – Managing resistance – Uncertainty of her role, including feeling like a therapist, lack of hierarchy, and policing – Divide between mental health and nursing.
Emotional awareness and outcomes	Her overall emotional experience and sense of awareness was impacted by: – Emotional rollercoaster – Increased confidence

Note. ED = eating disorder.

Illusions of health. Willow was struck by the way in which patients often appeared healthy to the naked eye, walking and talking and carrying on seemingly normal conversations. This was vastly different from her prior experience in a rehabilitation facility/nursing home in which such aforementioned abilities were often indicative of health and recovery. In the case of patients diagnosed with EDs, appearing to function normally was often the standard (unless severely underweight), in which their symptoms were often more easily hidden and harder to identify.

Comorbid mental health and medical symptoms. In addition to the myriad medical issues that a nurse must manage, there were also various psychiatric and personality factors that affected treatment. Such issues appeared different from patient to patient. That, in addition to Willow's lack of knowledge in managing psychiatric symptoms, exacerbated her lack of confidence.

Conditions of treatment. Five themes emerged:

Building relationships. Willow found meaning in spending time with patients. Whether just being present and breathing with them or providing them with education of symptoms and recovery strategies, Willow truly valued quality time spent with each individual. Furthermore, patients diagnosed with EDs often spent long periods of time in treatment given their need to heal both medical and psychiatric symptoms. Thus, the ability to build trust and respect with patients was enhanced by the longevity of their treatment.

Willow recognized how her own experience with an ED helped her better relate to patients, especially those with anorexia nervosa. "I interact very well with anorexics because I think I have a lot of those [perfectionistic] traits myself." Since having

struggled many years with dieting and over-exercising, Willow felt as though she knew

the words to use when talking to patients. However, feeling as though she had

experienced more of a "disordered eating" as opposed to a full-blown ED, having never

experienced formalized treatment or hospitalization, Willow still struggled to understand

how the ED became a "complete part" of a person.

　　　　Feeling supported. Having had no professional ED experience prior, Willow

reflected not only on her engagement in training and personal research since being hired,

but also on the importance of learning from those around her. Support was integral to this

process. Among her nursing team (both supervisors and colleagues), Willow greatly

appreciated those with whom she worked. She identified a strong sense of support,

cohesion, and consistent communication. Such feelings allowed her to work more

efficiently while increasing her self-confidence. Acknowledging how challenging it was

for those outside of the ED field to understand her struggles and their subsequent inability

to provide support, she stressed the importance of utilizing her colleagues for such

support. However, it is important to note that Willow did convey disappointment in the

lack of support that she felt from the mental health side of the treatment team, primarily

the therapists.

　　　　Managing resistance. Resistance was challenging for Willow to manage. Patients

often opposed treatment procedures in that they were not willing or ready to "let go" of

their illnesses. Aside from many patients' inherent resistance to treatment, Willow also

reported having increased difficulties with patients who also were diagnosed with

borderline personality disorder. Seeing her as "either friend or enemy," she struggled to

manage such patients' vacillating extremes in moods and quickly-changing attitudes

towards her. Patient resistance was most challenging for Willow when she felt conflict, reporting that she just wanted to be liked by patients and had a hard time dealing with patients who acted as though they did not like or appreciate her. Furthermore, Willow's role as a nurse in this setting in which she felt like "the enforcer" elicited even more patient resistance.

Uncertainty of role. Willow endorsed having had no idea how a nurse "fit into EDs" when she began her work in the field, a sentiment that remained as she became more familiar and comfortable with the work. In terms of traditional medical nursing work, Willow felt confident: "I know A, B, C, D, and E. I know the steps to get me where I need to be." However, treating EDs proved to be much less concrete and far more ambiguous.

Feeling like a therapist. Engaging in a lot of "therapy" and crisis intervention, Willow often struggled to see the nursing part of her role. There constantly were circumstances in which patients would engage in self-harming behaviors or act out in other ways; nurses were needed to de-escalate and encourage them to express and manage their anxiety in alternate ways. These types of interpersonal interactions were new and unfamiliar to Willow.

Lack of hierarchy. Willow recognized a lack of hierarchy in ED treatment, when compared to other nursing settings in which she had been exposed. In traditional hospital settings, the nurse is often viewed as the main provider of, and most integral component in, patient care, and therefore she/he is viewed more respectfully. For example, a nurse may clean a patient's wound, and thus be met with appreciation by both the patient and family. However, in ED nursing, Willow felt that the nurse was viewed differently.

Though the nurse was still providing the care, patients often viewed this negatively, while the therapist was often the one more strongly valued by the patients. Thus, she felt as though she had less leverage with the patients.

Policing. At times, Willow equated her role to that of the police. She stated, "We enforce the policies. We enforce the rules. So you are inherently the enemy or Big Brother." This became even more frustrating for Willow because she felt as though the focus of being the "enforcer" often was on nursing staff alone. Therapists not only left it up to the nurses to do the "dirty work," but also often blatantly disagreed with them after the fact, siding with patients. Subsequently, Willow felt as though she was not only met with resistance by patients, but by clinical staff as well.

Divide between mental health and nursing. Willow identified a strong dichotomy between the mental health and nursing staff. There often was a lack of agreement regarding treatment issues as well as lack of acknowledgment for nurses by therapists (and sometimes medical doctors), decreasing her sense of support from amongst the treatment team as a whole. Stressing her desire for therapists to have to work the floor at some point to gain empathy for nurses' struggles, she stated, "It is easy to look at things from the rose bubble of your office and think the patient is doing great and high functioning."

Emotional awareness and outcomes. Two themes emerged:

Emotional rollercoaster. Willow equated her professional experiences to an emotional rollercoaster. She reported feeling overwhelmed and "drained" much of the time. Managing patients feeling anxious at a "10 out of 10" and various other crises, Willow spent a lot of her time having to de-escalate patients. She also reported sadness

and frustration. Not only were patients' battles difficult, but they were also hard to watch. "You get them outside of their ED, and they're pretty amazing people. It's really frustrating to be on the other side and watch this person not eat! . . . It's just like, 'Do it!' It's frustrating and hard to comprehend." She noted feeling especially saddened when treating older patients, who had been dealing with their EDs for decades, fighting an increasingly challenging battle. She stated, "There is almost less fight . . . they seem more beaten down." Finally, acknowledging the high recidivism rate, Willow also conveyed sadness when discussing patient successes: "Even the positives can be draining because you know that they'll probably be back, which is sad."

Increased confidence. Dealing with psychiatric issues and implementing therapeutic skills was foreign for Willow and initially "very, very hard." She stated, "This is not how my family operates. It's very different." Integral to an ED treatment and a recovery model, working in an environment in which healthy communication skills were stressed and valued, Willow was able to learn through her own exposure and practice. "The patients have demanded that from me." She benefitted from stepping outside of her comfort zone and identified improvement in her own communication skills and ability to be respectful of others. Never having seen herself as a "supporter" or "therapist" before, viewing herself in such a manner helped Willow identify what she was capable of as a professional and a person.

Little Girl

Background. Little Girl is a Caucasian female in her 50s. She earned a Bachelor of Science in Nursing, in addition to having a Master of Arts in Counseling and accompanying licensure. She has approximately 35 years of professional experience as a

nurse between the emergency room, inpatient, and outpatient settings, most of which focused on treating mental health populations. Little Girl has treated adult patients diagnosed with EDs for approximately eight years as a nurse, though she recently quit the nursing field. Aside from her years treating patients diagnosed with EDs, Little Girl personally struggled with anorexia nervosa for many years. She reports this as the primary reason why she began working with this population. Little Girl and I interviewed in her office. Though small, it was warmly decorated with artwork and other colorful décor. Little Girl did not provide feedback with regard to the accuracy of her themes.

General description of the experience. "Challenging" was the first word that Little Girl thought of when describing her experience. Uniquely having acted as both a therapist and nurse in the ED field, Little Girl reflected on how much harder it was to be a nurse with this population (ultimately leading to her recent decision to transition back to therapy). A nurse must constantly focus on the needs of the milieu, often comprised of numerous patients, while a therapist can focus her attention individually. Trying to maintain the safety of the milieu while meeting individual patient needs was incredibly challenging. Little Girl emphasized the importance of knowing and using one's voice, with the expectation that it often may not be heard. The following sections outline the themes that Little Girl conveyed, all of which are illustrated in Table 5.

Table 5

Individual Themes: Little Girl

Core themes	Descriptions & sub-themes
Initial attitudes	Her initial attitudes towards ED treatment involved: – Impact of her own personal and professional experience – Her unique role
Conditions of treatment	Several components comprised her ability to treat patients and manage her duties: – Complexity of EDs, including comorbidity and acuity, concreteness of therapy, and quantifying change – Providing education – Overload of responsibilities – Dealing with resistance and ambivalence – Disrespect
Emotional awareness and outcomes	Her overall emotional experience and sense of awareness was impacted by: – Powerful emotions – Witnessing success

Note. ED = eating disorder.

Initial attitudes. Two themes emerged:

Impact of personal and professional experience. Little Girl discussed the

importance of her personal background as it had affected her role as a nurse treating EDs.

Having personally struggled with anorexia nervosa for many years (including being

hospitalized three times), Little Girl felt more equipped to understand and relate to her

patients' experiences. She was able to reflect on the course of her own recovery process and recognize the important components of treatment that were integral to her patients' recovery. For Little Girl, being able to relate in this way was a positive experience; her vision when she had been immersed in her own ED was to "get over this and do something productive with it." However, she also recognized the danger of others with ED histories working in the field in that they may not have sustained as long of a recovery. Given the lack of discussion of EDs in nursing school, attaining a Master of Science in Counseling further aided Little Girl in her ability to effectively work with and treat patients with EDs.

Unique role. Little Girl felt as though the ability to provide both medical and psychiatric care was an opportunity that most nurses did not have. Further strengthened by her dual degrees, she valued the skill set required to care for ED patients in this unique way. Moreover, being able to help a patient to acknowledge her/his illness or to comply with treatment in some small way was immensely meaningful to her.

Conditions of treatment. Five themes emerged:

Complexity of eating disorders. Three sub-themes emerged.

Comorbidity and severity. To compound the inherent complexity of ED treatment, many patients also presented at a developmental age far lower than their chronological age due to having lived for years with their EDs, being physically malnourished and potentially having missed many important developmental milestones. Despite having personal experience with anorexia nervosa, Little Girl still was still surprised when seeing a patient who was at about 50% of her ideal body weight. In addition to the complexity of each diagnosis or combination thereof, one also had to account for

numerous external factors (e.g., social support, values, etc.) when treating EDs, making it difficult to categorize or predict success in treatment.

Since she began working in the field, Little Girl also saw an increase in both comorbidity of diagnoses and severity. The myriad of emotional and physical symptoms that comprise an ED made it increasingly difficult to treat. She stated that upon opening the hospital, they dealt with "mostly the ED aspect of things." In more recent years, the patient population had become more comparable to that of a "general psychiatric floor where you may have to restrain, put in tubes, etc."

Concreteness of therapy. Given the lower cognitive functioning of many patients due to their starved brains, treatment often focused on behavioral interventions. Little Girl often found herself disappointed, wanting to treat patients with deeper, more meaningful interventions to improve their symptoms. However, their level of functioning often would not support such insight-oriented approaches.

Quantifying change. Little Girl often found it difficult to quantify change or success with ED patients in an inpatient setting. The nurse is unable to follow their recovery to fruition, and thus must be able to identify and appreciate the small changes. These may include getting a patient to stop exercising for a few moments, taking a few bites of food, or using coping skills to help self-soothe and de-escalate. Little Girl noted, "It's a marathon, not a sprint, so you really have to look at the positives with the small and be a cheerleader."

Providing education. Little Girl strongly valued her ability to teach other nurses and help bridge the gap between nursing and mental health staff. She not only helped educate staff about various medical symptoms and procedures, but she also provided

therapeutic education, such as dialectical behavioral therapy and acceptance and commitment therapy skills. Witnessing nurses implement such skills in small ways with patients was immensely meaningful to her.

Overload of responsibilities. Little Girl felt overworked by the nature of her role and responsibilities. Helping to develop systems and strategies for training, she reported "loving" educating other nurses, though she sometimes struggled to manage this effectively or to do it without becoming too "therapeutic." Little Girl disliked the expectation of nurses to work weekends, holidays, and even 24-hour shifts if another nurse did not show up. As the hospital expanded, her role as a nurse became too complicated and lost its appeal to her; there were simply too many nurses and patients to manage. She continuously struggled to guide and "shape" employees, a challenging task in that "not everybody is shapeable." Furthermore, her excessive responsibilities and increased stress level provided her with less time to commit to self-care, which she so strongly valued.

Dealing with resistance/ambivalence. Little Girl identified challenges in dealing with resistance, ambivalence, and an overall unwillingness of patients to change. Not only did trying to guide patients to a place of acceptance consume so much time during the course of their treatment, but it was often extremely frustrating for her as a nurse. Little Girl wanted to feel as though she was helping patients and struggled when a patient did not want the help. Thus, she believed that nurses needed to look beneath this resistance to underlying issues; this was a skill that took time and practice. Little Girl also emphasized the importance of self-awareness, believing that nurses should work through their own personal issues. This process could enable them to stop taking negative patient

attitudes so personally, to improve relationships with patients, and to improve subsequent treatment outcomes.

Disrespect. Little Girl noted how feeling disrespected by other members of the treatment team (primarily mental health staff and upper management) negatively affected her sense of confidence and satisfaction as a nurse. The ED hospital was the first environment in which she had worked in which nurses were not "running the show" and in charge. She stated, "Nurses do not get the respect they need in this situation. They just do not! I think we pretty much had more respect when I worked in the emergency room." Given the nature of nursing training and professional experiences that most nurses had prior to working with EDs (medical, not psychiatric), Little Girl felt as though the mental health staff often did not hear the "nursing voice." Furthermore, the inability for other members of the treatment team to work "down in the trenches" and view safety as their priority made them unable to understand nursing perspectives and empathize with their struggles.

Emotional awareness and outcomes. Two themes emerged:

Powerful emotions. Little Girl experienced many (often conflicting) emotions during her time treating EDs. Despite the immense challenge, she relished the excitement she felt from seeing a patient recover. Conversely, Little Girl also felt deep sadness at times, especially when seeing or hearing of patient death. At the onset of her career, Little Girl had simultaneously harbored profound feelings of guilt, unable to accept that she had done all she could have for a patient and that such a death was not her fault. She has since transitioned to a healthier outlook in which she has tried to learn from her experiences to dismiss potential guilt and work to improve patient success in the future. Finally, Little

Girl often felt frustrated, at times helpless, and ultimately burnt out due to the complexity

of her job duties and the various instances of resistance with which she was often met.

Witnessing success. "When a patient succeeds, oh my gosh, it's so exciting!"

Little Girl conveyed that being able to see a patient succeed and be a part of that recovery

process was the motivation behind her desire to work in the field. Just as she had

personally experienced, Little Girl valued the moments in which she witnessed a patient

break free from the ED constraints and celebrate "the freedom to actually live."

Paige

Background. Paige is a Caucasian female in her 20s. She earned an Associate of

Science in Nursing and is currently pursuing her Bachelor of Science in Nursing. Paige

has been treating adult and adolescent patients with EDs for the past two years. Paige has

been a nurse for a total of five years, previously having worked as a medical nurse on

inpatient and outpatient units, as well as having mental health experience with geriatric

populations. Though she had no previous professional ED experience, Paige reported

gaining an interest in treating EDs after both her mother and sister were diagnosed with

EDs. She had never fully understood their EDs and wanted to learn more.

Paige and I met at a public library and interviewed in a private room. It was quiet

and free from distractions. Later on, Paige also provided feedback regarding the accuracy

of the themes. She stated that I had accurately captured the points that she had tried to

convey during her interview and that I had not missed any important themes.

General description of the experience. Paige reported that her work with EDs

had been extremely interesting. With a family history of anorexia nervosa, she was

intrigued to understand how and why some people developed EDs and others did not. She

wanted to better understand the predisposition and biological factors that played a role in their development. Given her lack of previous training or experience in treating EDs, Paige experienced a steep learning curve. Yet through her years working at the hospital, she had learned a lot about both psychiatric medications and therapy, two things that she previously knew little about, and had been able to integrate such knowledge into her work with patients.

I had also asked Paige to think about an artifact or object that represented her experience treating patients diagnosed with EDs. Following the interview, she contacted me and described a yellow star. To her, this was a symbol of vitality and the benefit of helping others. She stated, "I feel that my work is nothing short of rewarding. To be able to help others is truly a blessing, and I learn more about eating disorders every day that I work." The following sections outline the themes that Paige conveyed, all of which are illustrated in Table 6.

Initial attitudes. Two themes emerged:

Importance of helping others. As with any type of nursing, Paige identified the act of helping others as one that was incredibly meaningful and powerful to her. She stated, "I think that is why I'm a nurse." The complication of trying to figure out a patient's symptoms and integrate the medical and psychological components (as mentioned above) was part of the reward, in that solving the problem is what would ultimately help the patient.

Table 6

Individual Themes: Paige

Core themes	Descriptions & sub-themes
Initial attitudes	Her initial attitudes towards ED treatment involved focusing on: – Importance of helping others – Psychological focus
Conditions of treatment	Several components comprised her ability to treat patients and manage her duties: – Time invested – Finding balance in patient relationships – Communication and collaboration – Using humor – Lack of a clear nursing role – Lack of control, specifically examining defiance and disrespect and family dynamics
Emotional awareness and outcomes	Her overall emotional experience and sense of awareness was impacted by: – Emotional rollercoaster, including feeling shocked and uncertain, frustration, exhaustion, joy, and sadness – Witnessing success – Increased awareness of body image and eating habits – Importance of self-care

Note. ED = eating disorder.

Psychological focus. Coming from her background working as a medical nurse,

Paige saw ED treatment as more psychological than medical, sometimes feeling as

though her role was more on the "therapy side" of treatment. She had previous

experience with mental illness, having worked in a geriatric psychiatric setting as well as other mental health settings prior to becoming a nurse. During that time, she had refined her skills of how to calm patients in times of crisis. However, exposed to new types of mental illnesses comorbid to EDs, Paige learned more about "humanness," which she viewed positively. She enjoyed being able to integrate the medical and psychological components of an ED to best serve the patient population.

Conditions of treatment. Six themes emerged:

Time invested. Paige viewed the amount of time invested in ED patients' recovery as different from other nursing environments in which she had previously worked. Given the sheer amount of time patients may spend in treatment, more energy and effort was naturally expended towards their success. With this also came much responsibility. In reference to patient discharges, Paige noted, "It's almost like letting your baby walk out into the world."

Finding balance in patient relationships. Paige referenced her role as a nurse as similar to that within an authoritative relationship, one in which she needed to balance her ability to maintain structure versus being supportive and almost like a "friend." Building trust and safety within the relationship, mutual respect, listening and being non-judgmental, and using humor to lighten the mood were all important parts of this balance. Paige repeatedly asserted the need to "be human and real with them." She conveyed and made light of her own imperfections to patients to illustrate the point that no one is perfect.

Communication and collaboration. Paige felt increasingly empowered and satisfied with her work as a result of the strong sense of cohesion and support among the

nursing team. She reported that "loving" the people with whom she worked enabled her to have remained working there so long. Furthermore, she valued the good communication across disciplines within the treatment team (especially with the psychiatrists and dieticians), which helped her to feel more competent at her job. This was an improvement when compared to previous nursing positions that she had held in that she felt more like a part of the treatment team and less like a nurse just following orders.

Using humor. As aforementioned as a key role in building healthy relationships with patients, humor was an integral component of treatment for Paige. "Laughter is the best medicine in the whole wide world," Paige said. Helping to put a smile on someone's face experiencing such mental and physical hardship was extremely valuable.

Lack of a clear nursing role. Paige reported feeling as though other members of the treatment team often misunderstood what it was that she did. Being mistaken for a floor nurse when acting as a medication nurse, for example, increased confusion among both staff and patients in that messages were not getting clearly communicated to the right people. Thus, having to find the appropriate nurse and pass messages along inevitably increased the time necessary to accomplish tasks (of which there were already many).

Lack of control. Many components of nursing are out of one's immediate control, whether it be patient personality characteristics or unclear expectations from one's supervisor. Paige recognized such types of challenges as the most difficult parts of her job.

Defiance and disrespect. Paige discussed the tendency of many patients diagnosed with EDs to act defiantly. Whether consciously or unconsciously, engaging in such power struggles were challenging for her. She stated: "I do not like arguing. I think it's really hard because you really are fighting against people who can't see what you are talking about." Often their negative attitude towards treatment also came across as rude and disrespectful or might result in a patient lying or being deceitful to try and get his or her way. Though challenging, it was important in these moments for Paige to try and differentiate between the person and the ED and not take things personally. Paige noted that defiance and disrespect were even more pervasive when working with adolescent patients, which was an even bigger challenge for her. These patients were experiencing hormonal changes and existential dilemmas, making such issues less about their ED and potentially more about identity crises.

Family dynamics. Paige was challenged by the negative attitudes pervasive within some family dynamics, which often came across as a lack of support or tendency to be argumentative. She noted, "It's very tangled and difficult. Sometimes we release people back to where they're from, and where they're from is not a good environment to be in and unfortunately that's their home." Paige often worried that despite all she had done to help a patient, that patient may not succeed merely because of external familial factors that Paige could not control.

Emotional awareness and outcomes. Four themes emerged:

Emotional rollercoaster. Paige reflected upon various, often conflicting, emotions that she had experienced during her time treating EDs. She identified both positive and negative feelings that resonated with her: "You don't know what it is going

to look like—a lot of success with a lot of failure and a lot of failure with a lot of success. You have to take the good with the bad."

Feeling shocked and uncertain. Paige felt "shocked" by the physical appearance of many ED patients with whom she worked, their bodies often mirroring those of cancer patients. There was an inevitable uncertainty accompanying such feelings, in which Paige often felt unsure of how to even approach a patient who looked so frail. Furthermore, she never knew what to expect from any patient day–to–day, even the ones who appeared to be healthier. She stated, "You are often walking over a tripwire, never knowing what you are walking into that day with that person."

Frustration. There were often power struggles when treating patients with EDs given their frequent resistance to treatment. Thus, Paige could become quite frustrated. She felt this to be especially true when working with adolescent patients, in that the nurse was often seen as the "evil" parental figure and negative adolescent–parent dynamics would therefore ensue. For example, patients often seemed to blame nursing staff for enforcing their treatment and acted defiantly towards them as a means of rebellion.

Exhaustion. Having to listen to such difficult struggles and sad stories as well as having to remain constantly available to validate and provide support became exhausting for Paige. She also felt a sense of personal responsibility for her patients, which was exhausting in itself. Furthermore, she noted that being around primarily women all day (both patients and staff) had its own "exhausting" components, in that she felt the need to constantly "listen and talk and validate." Paige stated, "By Saturday night I often feel like I have been run over by a train multiple times."

Joy. Paige gained immense satisfaction from learning each patient's story and subsequently building meaningful relationships. She enjoyed understanding patients' symptoms and uncovering ways to work with and treat each patient. Finally, witnessing success (as further discussed below) became the most rewarding part of the job for her.

Sadness. Paige also felt that treating patients diagnosed with EDs was very sad and depressing at times. Their physical and psychological state alone was hard enough to deal with, in addition to the fact that many patients would fail in their attempted recovery. Paige noted that, as a nurse, she had prepared to lose patients along the way. However, though she had experienced patient death before, she felt that experiencing ED patient deaths were more challenging since she was typically more emotionally invested in their (often long-term) care.

Witnessing success. Paige reported feeling grateful to see patients recover. She stated, "I remember the first time I saw someone recover. It was amazing!" Paige had felt joyful in seeing patients heal, while such healing also reinforced her own pride in knowing that she had helped that person and been a part of his or her journey.

Increased awareness of body image and eating habits. The environment of an inpatient ED hospital naturally revolved around discussions of food and weight. Subsequently, this becomes a focus of not just patients, but of staff as well, who became more aware of their own eating habits and body image. Paige noted that many staff could not handle this sort of incessant talk; "I can see why people who come to work with this population either don't make it or they leave and realize they have much of their own issues." However, through her work, Paige was able to let such messages reinforce her own desire to stay healthy and strive to "best person I can be."

Importance of self-care. "It is really important to connect yourself physically, mentally, and spiritually." Paige acknowledged the importance of modeling positive behavior for the patients and "practicing what you preach." However, Paige reflected on her having almost quit within her first year. The highly demanding nature of the job and strong emotional investment in her patients made it challenging for her to refrain from thinking about work once home. It was at this point that she recognized the need to "check in with yourself" to avoid burnout.

Pat

Background. Pat is a Caucasian female in her 20s. She earned an Associate of Science in Nursing and has been treating adult and adolescent patients with EDs at this hospital for the past two years. Previously, she worked as a medical nurse with adults in long-term care for approximately one-and-a-half years. Pat reported having no previous professional experience with mental health or EDs previously. Pat and I met at a public library and interviewed in a private room that was quiet and free from distractions. Pat did not provide feedback regarding the accuracy of her themes.

General description of the experience. Pat described her experience in working with ED patients as "eye-opening" and still "shocking" at times. Despite the immense challenges that she continued to experience, she viewed her work as a positive experience overall, one that she valued and "loved." The following sections outline the themes that Pat conveyed, all of which are illustrated in Table 7.

Initial attitudes. Initially unprepared for and uncertain of her role, Pat often struggled with feeling incompetent and inadequate. Pat had no prior training or experience treating patients diagnosed with EDs, let alone with mental illness of any

type, and did not feel as though such needed training was provided at the onset of her

work at the hospital. Feeling "not very good with psychology at all," she tried to learn the

necessary therapeutic skills on the job.

Table 7

Individual Themes: Pat

Core themes	Descriptions & sub-themes
Initial attitudes	Focusing on her lack of preparedness and training comprised much of her initial attitude towards ED treatment.
Conditions of treatment	Several components comprised her ability to treat patients and manage her duties: – Contributing to recovery – Feeling appreciated and supported – Difficulty managing negative emotions – Lack of support across disciplines
Emotional awareness and outcomes	Her overall emotional experience and sense of awareness was impacted by powerful emotions, including: – Frustration and anger – Disappointment – Feeling stressed and overwhelmed – Countertransference and vicarious trauma – Emotional distance

Note. ED = eating disorder.

Conditions of treatment. Four themes emerged:

Contributing to recovery. Pat felt able to make a difference and to contribute to patient recovery through building relationships and providing support. Though meaningful for her, she also found an inherent challenge in maintaining balance within these relationships. Over the course of her time at the hospital, Pat personally transitioned from wanting to be viewed as the "cool nurse that everybody liked," essentially their friend, to upholding a stance more focused on enforcing the rules while still maintaining empathy and support. She noted, "It's okay if someone doesn't like me if I am doing my job."

Feeling appreciated and supported. Receiving appreciation was important to Pat. Receiving thank you cards from patients upon their discharge has helped her to feel valued and to "love my job even more than I already do." Getting supportive feedback from colleagues and supervisors also has increased her sense of appreciation and support and promoted her feeling like a "happy family" with the rest of the nursing team. Furthermore, this support has enabled Pat to feel comfortable in "releasing" (venting) negative emotions with her colleagues to alleviate potentially chronic feelings of anger or annoyance. By doing this, she fostered her own mental health while becoming a better caregiver for her patients.

Difficulty managing negative emotions. Pat often felt as though patients deliberately acted out or were purposefully deceitful, whether through engaging in self-harm or purging behaviors, lying about taking their medication, being manipulative, or just being rude. This was challenging for Pat in that such dishonesty and negativity

makes it challenging to build a relationship (or strains already-existing relationships) and subsequently makes her role more challenging.

Lack of support across disciplines. Pat acknowledged her tendency to feel undermined and unsupported by other members of the treatment team, specifically the therapists. Perceiving a divide between the therapists, doctors, dieticians, and nursing staff, she stated, "The treatment team doesn't always have the back of the nursing staff." Pat felt as though her "biggest enemy is the therapists," in that they were interested in building relationships with their patients, while not at all interested in doing the same with nursing staff. She felt that the therapists often undermined her authority as a nurse and provided patients with conflicting information from what the nurses had told them, which sometimes made the nurses seem stricter and less flexible.

Emotional awareness and outcomes. Powerful emotions highlighted this theme:

Frustration and anger. Given many patients' resistance to treatment, Pat often felt as though she was "forcing" recovery upon them. She noted, "I've had days where I'm almost in tears because I'm so frustrated." Alternatively, when she felt as though patients were being manipulative or deliberately acting out, she found herself becoming angry and struggled to provide the best nursing care.

Disappointment. Having solely prior medical experience, Pat missed using these "essential" nursing skills. Worrying that her abilities were diminished due to lack of practice, she wished that she could be more engaged in such types of duties in which she had been trained and used to performing (e.g., starting intravenous therapies). Instead, Pat often felt like a "babysitter," especially when working with the adolescents, focusing on

managing the milieu and being far less involved in the medical interventions that had peaked her interest in nursing in the first place.

Feeling stressed and overwhelmed. Pat often felt "overloaded" in her role as a nurse. Not only was the work itself stressful, but she felt expected to take on multiple roles. Acting as both nurse and therapist, Pat was required to complete tasks that were outside of her realm of training and experience, eliciting feelings of discomfort. Subsequently, Pat often felt incompetent. This was especially challenging for her in that she had never felt this way before in a nursing role.

Pat also took on too much as a nurse and worked a lot of overtime. She stated, "Like when people work to live, I live to work." Given such tendencies, Pat emphasized the importance of being able to engage in some type of self-care, which for her, was refusing to pick up extra shifts so that she could be with her family. Furthermore, it was important for her to be able to decompress after work (often during her long car ride on the way home) so she could be emotionally present for her family.

Countertransference and vicarious trauma. Being exposed to certain attitudes and events reminded Pat of previous personal experiences, with accompanying feelings often becoming difficult to manage. Her recent experience working with a pregnant woman with anorexia nervosa was triggering in that Pat had an infant at home. Pat struggled to work with this woman who had the opportunity to deliver a healthy baby, but instead was choosing not to. Pat experienced an inner conflict in that her discomfort and anger made her not want to give the top nursing care that she knew she had to. In addition, patients' self-loathing, their inability to emotionally care for themselves, and

their tendency to "give up," also coupled with her hearing of patient suicides, saddened Pat when reflecting on her own mother's suicide.

Emotional distance. Pat acknowledged the importance of keeping an emotional distance from her job and her patients in order to prevent herself from becoming engulfed in such aforementioned negative emotions; "I have gotten very good at separating the two, so I don't let it . . . try not to let it affect me." Pat also noted her hesitancy to share much about herself with this patient population given they were "mentally ill," illustrating her preconceived stigma of psychiatric patients.

Sarah

Background. Sarah is a Caucasian female in her 20s. She earned a Bachelor of Science in Nursing, in addition to having a Master of Science in Child Development. Sarah has been treating adolescents diagnosed with EDs for the past year, her only professional experience as a nurse. Given her relative newness to the field, she estimates to have worked with at least 50 patients diagnosed with EDs. She reported having no professional experience with EDs previously, though she did note having known a family friend who struggled with anorexia nervosa for years.

Sarah and I met in a private conference room at the hospital. The room was quiet and free from distraction; we sat at a large conference table. Later on at my request, Sarah provided feedback regarding the accuracy of the themes, stating that I had accurately captured the message that she had been trying to convey.

General description of the experience. Sarah viewed her experience in treating EDs as "eye-opening," noticing many nuances and differences with both patients and the overall structure of the hospital when compared to her previous experiences in nursing

school. Many components felt more challenging, often because they were so new. The

following sections outline the themes that Sarah conveyed, all of which are illustrated in

Table 8.

Table 8

Individual Themes: Sarah

Core themes	Descriptions & sub-themes
Initial attitudes	Her initial attitude towards ED treatment were focused upon: – Lack of preparedness and training – New type of nursing role
Conditions of treatment	Several components comprised her ability to treat patients and manage her duties: – Maintaining boundaries and conveying authority – Cohesive team – Longevity of care – Constant ambiguity – Remaining objective – Lack of nursing voice – Losing hope – Letting go of work
Emotional awareness and outcomes	Her overall emotional experience and sense of awareness was impacted by: – Emotional rollercoaster – Witnessing success

Note. ED = eating disorder.

Initial attitudes. Two themes emerged:

Lack of preparedness and training. Sarah reported feeling at a disadvantage when she began her work treating EDs in that she had no prior professional training or experience with them. Though she had some professional mental health experience prior to entering the field of nursing and life exposure to EDs, she had little, if any, understanding of such diseases, lacking confidence in her ability to treat patients diagnosed with EDs. Sarah felt thrown into a field about which she knew virtually nothing and subsequently had no expectations; thus, she had to ask a lot of questions and learn on the go. Though she did a lot of research on her own, Sarah reported wishing that there had been more extensive training upon getting hired to alleviate such lack of confidence.

New type of nursing role. Different from her previous nursing experiences, Sarah felt as though ED nursing was more communicative and therapeutic in nature and far "less hands on." Compared to her prior experiences on psychiatric units, Sarah felt as though ED psychiatric symptomatology consisted of more "drawn out" emotional experiences, less intense in the moment though often more complex to manage long-term. She also noticed a shift in hierarchy, feeling stifled at times, as if she had less control than she did as a nurse in a hospital setting. Her role in the ED hospital seemed to lack the autonomy that she had held in her clinical hospital rotations, feeling less in charge and more under the direct orders from those above (e.g., physicians). She emphasized the need to be more proactive and assertive than perhaps in other nursing environments.

Conditions of treatment. Eight themes emerged:

Maintaining boundaries/conveying authority. Though strongly valuing the need to remain open, honest, and flexible, Sarah emphasized the importance of maintaining strong boundaries with patients. Building trust and conveying support through active listening and empathy was essential to building healthy relationships with them. However, Sarah made sure not to get too friendly. She valued being explicit with patients and conveyed her role as that of the "one in charge." This demeanor was important to maintain, especially with adolescents. Sarah noted that this often became challenging when patients would gossip and try to side against nursing staff. Furthermore, she also noted that the ability to maintain authority and enforce rules was much more challenging when working with adults, in that the natural power dynamic that ensues from large age differences no longer existed.

Cohesive team. Having a cohesive, multi-disciplinary treatment team enabled healthy and more effective communication and, subsequently, better treatment. Sarah felt as though she was able to learn more about each patient through team meetings and discussions amongst the various disciplines involved in patient care.

Longevity of care. Sarah found spending time and talking with patients to be one of the most enjoyable parts of her job. Longevity of care was a strong asset of an ED hospital, in that treatment was often more comprehensive. Working alongside patients for more extended periods of time (in a smaller hospital setting) enabled Sarah to get to know each patient better and thus build stronger relationships and provide better patient care.

Constant ambiguity. As with most psychiatric settings, Sarah acknowledged the uncertainty of what each day brought. Unlike a medical setting in which there were often strict protocols, one had to always be ready to work "on the fly" at an ED hospital. Each patient not only had a complex combination of medical and psychiatric issues, but each responded differently to nurses and treatment as a whole. This made a nurse's role more complex and uncertain.

Remaining objective. Sarah reflected on the challenges of separating the patient from the ED. She noted that when someone was behaviorally acting out, it became difficult not to get angry and to maintain an objective perspective. She sometimes struggled to not let her values or personal opinions get in the way of treatment. Though this remained a continuous struggle, Sarah recognized the importance of keeping an open mind and remembering to try and distinguish the patient from his or her ED when she was becoming angry or frustrated.

Lack of nursing voice. Though Sarah noted feeling supported by her colleagues much of the time, she also acknowledged several challenges of working on a treatment team. First and foremost, it was extremely challenging to work with primarily females given the intensity of various personalities and the propensity for tension. However, with regard to other disciplines within the treatment team, Sarah often felt that her feelings were dismissed and her opinions were not always appreciated: "The nursing voice isn't valued as much in this field as I've seen it be in other fields." Sometimes she felt as though she was being instructed as opposed to having the opportunity to thoroughly consult with other members of the treatment team.

Losing hope. Though Sarah tried to remain positive, it was often a challenge. Many patients were so "stuck" in their EDs that recovery often seemed unattainable. Sarah also struggled to think about the environment from which many patients came and where they had "learned" maladaptive values, such as "being thin is better." It was hard to fathom that these were the homes to which these adolescents would return. In addition, the recidivism of patients was disheartening. Though in the case of return patients there was a slight advantage in that she had already built rapport with them and had an existing understanding of their specific disease, it became easier to lose faith in their ability to succeed and maintain recovery since they were back in treatment.

Letting go of work. Given the stressful nature of nurses' roles in this environment and the longevity with which they worked with patients, Sarah often found it difficult to leave her work at work. She stressed the importance of self-care and need to decompress. However, it was a constant challenge not to think about the intensity of what she had just experienced despite her desire to leave it all behind.

Emotional awareness and outcomes. Two themes emerged:

Emotional rollercoaster. Overall, Sarah felt that treating patients diagnosed with EDs was far more emotionally challenging than her prior experiences. She acknowledged a pervasive level of nervousness and worry that accompanied her work with some patients, given their compromised medical and psychological state. She often felt highly stressed, given the varying duties that nurses were responsible for, in addition to the high severity of many patients' symptoms. Conflicting feelings of sadness and joy pervaded her work, dependent upon the severity of symptoms of patients and their ability to recover. Finally, though not viewed as positive or negative, a unique focus on body

image and eating in ED treatment added to the complexity of her experience. Sarah became consistently more aware and conscious of how she physically portrayed herself at work (e.g., what she wore, what she ate) and how her image affected patients and colleagues.

Witnessing success. Sarah noted that being able to witness success and differentiate a healthy mind from one engulfed in an ED was extremely meaningful. She spoke of one patient in particular who had three admissions on the unit and had struggled each time. This patient often became defiant, pulling out her nasogastric tube, and nurses "battled" with her to gain treatment adherence. This process often seemed endless. However, upon finally transitioning to partial hospitalization, Sarah witnessed the immense transition towards recovery that this patient had made. The patient's words were quite meaningful for Sarah: "I didn't realize in the moment that these people were actually trying to help me. They weren't being mean to me. They weren't doing this as a form of punishment. Everyone was there to help me."

Morgan

Background. Morgan is a Caucasian female in her 20s, who earned a Bachelor of Science in Nursing. She has been treating adolescent patients diagnosed with EDs for the past two years. Previously, Morgan worked treating children at an outpatient facility for one-and-a-half years. She reported having no prior professional experience with EDs. Morgan and I met in a private conference room at the hospital. The room was quiet and free from distraction, and we sat at a large conference table. Later on, Morgan did not provide feedback regarding the accuracy of the themes.

General description of the experience. Though challenging in many ways, Morgan described her overall experience with ED patients as one that was quite positive. She initially viewed the lack of structure as a challenge, yet Morgan learned to appreciate the ambiguity and constantly evolving nature of ED treatment. Unlike a lot of medical nursing in which there is a specific protocol and process to follow, Morgan noted that when treating EDs, "No day is the same and every patient is different." The following sections outline the themes that Morgan conveyed, all of which are illustrated in Table 9.

Table 9

Individual Themes: Morgan

Core themes	Descriptions & sub-themes
Initial attitudes	Feeling challenged comprised her initial attitude towards ED treatment.
Conditions of treatment	Several components comprised her ability to treat patients and manage her duties: – Importance of balance – Cohesive multidisciplinary team – Longevity of care – Struggle to maintain empathy – Unrealistic expectations
Emotional awareness and outcomes	Her overall emotional experience and sense of awareness was impacted by mixed emotions, including: – Uncertainty – Responsibility – Emotional distance

Note. ED = eating disorder.

Initial attitudes. Morgan initially viewed working with ED patients as an opportunity to feel challenged, something that she viewed as beneficial. Learning how to work more collaboratively on a multidisciplinary team was both new and rewarding for her. She enjoyed figuring out how to work with and treat complex symptoms and challenging patients, learning how to separate the inherent components of an ED versus volitional behaviors. Disliking monotony, Morgan appreciated the need for her to "think on the fly," "step outside the box," and take initiative when treating EDs.

Conditions of treatment. Five themes emerged:

Importance of balance. Balance was important to Morgan for many reasons. In building relationships with patients, she strived to maintain a sense of authority and enforce boundaries while also retaining the ability to relate to them as a friend. It was important to be candid in conversation and work to attain a mutual respect so that neither patients nor nurses would take things personally when said parties did not agree. While at the same time, finding humor and being able to joke with her patients was essential. Morgan stated, "It's kind of like you either laugh or cry," and she preferred the former.

Cohesive multidisciplinary team. Morgan valued the cohesion and strong communication among the treatment team as well as the importance of being a team player. Compared to her brief experience as a floating nurse on the adult unit (which was much larger), Morgan identified the sense of community that she felt when working with a smaller, more unified team. She also noted that nurses in this environment seemed to have stronger roles and more say in the treatment process.

Longevity of care. The lengthy nature of ED treatment was valuable to Morgan. It enabled her get to know her patients better, learning more about their diagnoses and

symptoms as well as about them as individuals. Having this better understanding

increased her ability to build rapport and provide effective interventions as a nurse.

Struggle to maintain empathy. Morgan found empathizing with patients very

challenging at times. This became especially difficult when she was able to identify what

seemed like an easy solution in her mind, thinking, "Just eat the freaking food already!"

Morgan also struggled to maintain empathy when dealing with certain patient

characteristics. When she thought patients were being manipulative, deliberately seeking

attention (e.g., purging in the dayroom), or being outwardly rude, she often became

angry. It was upsetting to see how one patient's actions could elicit profound negativity

upon the milieu or among the nursing staff as a whole.

Unrealistic expectations. Morgan reflected on the overworked culture among ED

nurses. She disliked the expectation and sense of obligation that nurses must work

overtime, recognizing the subsequent tendency for people to become irritable and

unhappy. She reflected on her own experience: "Hearing myself complain every night

when I would go home to my husband," was a realization to engage in more self-care.

However, though self-care was strongly emphasized (discussed) as integral to nursing

health, it was not actually promoted as a part of nursing culture.

Morgan also felt as though nurses, even those like herself with no prior ED or

mental health experience, were expected to know how to implement therapeutic

techniques at the onset of their hire. She saw this as unrealistic as well, "not because

we're not competent, but maybe you just don't know what you're doing because you've

never done it before." Morgan noted that she would have appreciated more training at the

onset to help alleviate some such concerns.

Emotional awareness and outcomes. Mixed emotions highlighted this theme.

Uncertainty. Morgan spoke to the huge learning curve in treating EDs. Initially completely unfamiliar with psychiatric and ED issues (having learned nothing about either in nursing school), Morgan lacked an awareness of how to approach and behaviorally manage patients. Thus, she felt unsure of herself. She also held negative, preconceived notions about psychiatric conditions, initially viewing mental health nursing as "scary" and unappealing. Morgan had to learn many skills on the job, watching and modeling other nurses, in addition to completing additional training in EDs. She had since gained confidence in her skills and an appreciation for mental illness and EDs.

Feeling responsible. Morgan saw her role as that of a parental figure, trying to increase a sense of support while modeling positive behavior for her patients. However, such feelings of responsibility often elicited a sense of internal pressure to make patients succeed. She often thought, "If only I could make them see. If only they could just get better." Subsequently, Morgan often felt exhausted, both emotionally and physically.

Emotional distance. Despite being empathetic and compassionate towards patients (which was still challenging at times), Morgan felt the need to keep an emotional distance from them as well. Providing such space was important in that it enabled her to avoid feeling sad and from taking her work home. She could subsequently care for patients without becoming too emotionally invested. She stated, "It's really important to keep work and my personal life separate, because, if not, I could be thinking about these kids or the adults all the time because there is always something sad." This attitude also proved useful in fostering Morgan's ability to avoid tension among her co-workers,

which she felt was vital to her work environment in that staff tension would inevitably negatively affect the milieu.

Jane

Background. Jane is a Caucasian female in her 30s. She earned a Bachelor of Science in Nursing and is currently working on her Nurse Practitioner degree. Jane has been treating adolescent patients diagnosed with EDs for the past two-and-a-half years and has been a nurse for almost seven years. Previously, she worked treating children in various inpatient medical settings for a total of four years. Though she had no formal ED experience, Jane reported having worked with several patients in pediatric cardiology who had EDs, in addition to having several athlete friends with EDs in college.

Jane and I met to interview in a private conference room at the hospital. The room was quiet and free from distractions; we sat at a large conference table with ample room. When requested to do so later on, Jane provided feedback regarding the accuracy of her the themes, stating that they "looked good;" she provided no additional information to add.

General description of the experience. Jane had a broad range of experiences in treating EDs. Though she viewed her overall experience positively, many challenging elements often made it seem otherwise. Despite the difficult emotions that she felt day–to–day, she emphasized the importance of maintaining self-care to promote balance and to calm her mental state in order to keep her coming back to work.

I had also asked Jane to think about an artifact or object that represented her experience in treating patients diagnosed with EDs. She described items (e.g., cards, drawings, etc.) that patients had made for her over the years, often near the time of their

discharge from the hospital. Such items were meaningful to her in that they represented

the patients' positive, appreciative, and overall happy mindset by the end of treatment—

the drastic shift from living with an ED to successfully growing beyond illness. The

following sections outline the themes that Jane conveyed, all of which are later illustrated

in Table 10.

Table 10

Individual Themes: Jane

Core themes	Descriptions & sub-themes
Initial attitudes	Uncertainty in managing psychiatric symptoms comprised her initial attitude towards ED treatment.
Conditions of treatment	Several components comprised her ability to treat patients and manage her duties: – Value in working with children and adolescents – Patients stuck in EDs – Pessimism – Lack of support – Uncertainty of role
Emotional awareness and outcomes	Her overall emotional experience and sense of awareness was impacted by: – Powerful emotions, including hope and happiness, anxiety and fear, sadness, and vicarious trauma – Witnessing transformation – Positive body image

Note. ED = eating disorder.

Initial attitudes. Uncertainty in managing psychiatric symptoms highlighted this theme. As a nurse treating ED patients, Jane was exposed to a broader range of emotional experiences than she had been in other settings. She worked with patients experiencing depression, anxiety, and impulsivity, in addition to a myriad of other psychological symptoms. Given her previous medical experience and tendency to want to immediately "fix the problem," Jane struggled to manage these symptoms. She found herself primarily involved in milieu management and often struggled to set limits, given her "softer" side and her desire to be liked by patients. Thus, she felt the need to maintain consistent communication with the therapists for advice regarding how to manage various situations.

Conditions of treatment. Five themes emerged:

Value in working with children/adolescents. Jane identified much value in working with youth. Aside from her increased sense of hope given the young age of many of her patients, she saw differences in the EDs of children and adolescents when compared to adults, which made it easier for her to empathize with them. Perhaps because such younger patients were more focused on getting attention and/or gaining control, Jane saw their treatment as less centered on deeply embedded body image issues. Not only was it somewhat easier in that regard, but Jane also valued this type of patient–nurse relationship. Taking on a more parental role, she was able to feel nurturing and caring while also connecting with patients through joking and humor. Furthermore, Jane often felt appreciated by these young patients upon their discharge (as evidenced in the cards and drawings that she previously described), which increased her own sense of worth and value as a nurse treating EDs.

Patients stuck in eating disorders. Though less common in youth when compared to the adult population, adolescent patients still often became "stuck" in their EDs. Seeing patients so embedded in their EDs and unable to identify their own positive qualities was challenging for Jane. She struggled to understand their inability to see their own value, in addition to her own frustration in that she could not convince them otherwise. Furthermore, Jane also struggled to manage the "sneaky" and "dishonest" ED behaviors that often ensued, such as hiding food and/or binging and purging.

Pessimism. Negative attitudes amongst staff played out in many ways. Perhaps due to expansion of the facility leading to an increase in patients and staff, high stress levels across disciplines became obvious. Jane noted that working with a primarily female staff could also have added to this. At times, Jane felt as though everyone was "out to get each other" and gossip about virtually anything. She commented, "It's kind of cliquey almost, like I feel like sometimes we mirror the kids." Furthermore, Jane noticed that patient failure or relapse often elicited a loss of hope amongst staff, which could exacerbate already-existing pessimism.

Lack of support. Though generally comfortable with the treatment team, Jane felt less supported than she had initially with the decrease in emphasis placed on individual staff support. Though feeling valued was important for Jane (and she frequently felt this from patients), Jane often felt unappreciated by staff. Pessimism and conflict with staff and/or supervisors also increased her sense of feeling alone. Jane emphasized her desire to have more team building activities to improve staff morale.

Uncertainty of role. Similarly, Jane noted that as time had passed, she became less certain of her role as a nurse on the unit. Potentially for similar reasons as were

mentioned above, she had lost certain responsibilities as a nurse and became confused at times as to what she was supposed to be doing. Such confusion was not only sensed among both staff and patients, but also led to wasted time and decreased productivity. Unfortunately, this potentially impacted treatment outcomes in a negative way.

Emotional outcomes and awareness. Three themes emerged:

Powerful emotions. Four sub-themes emerged:

Hope and happiness. Coming from previously treating children with cancer and other imminently life-threatening illnesses, Jane saw an increase of hope and personal energy when working with patients diagnosed with EDs. Witnessing death was not as common and she generally had more time to spend with each patient, given the length of inpatient ED treatment. Jane felt happy about being able to build relationships with each patient and to feel like a part of their respective recoveries.

Anxiety and fear. Jane had no prior professional experience treating EDs or mental illness; however, she had some personal experiences, having had athlete friends in college who struggled with EDs. Though she could relate a bit to her patients' struggles, Jane initially felt a strong sense of uncertainty and lack of confidence with regard to how to treat their symptoms. Combined with the need to "fly by the seat of your pants" in this position and given the medical and psychological frailty of many patients, Jane sometimes felt anxious and fearful. She reported that her job felt "terrifying" at times due to the uncertainty of how to help a patient or about what to do next.

Sadness. Witnessing patients continuously struggle, both physically and emotionally, living deeply embedded within their EDs, was extremely challenging for Jane. Some patients harbored a level of self-loathing that seemed impossible for anyone,

especially adolescents, to bear. Jane stated, "Seeing how she [a patient] struggled and how much she hated herself, and anyone that could see her from the outside could see what a cool kid she was . . . it just breaks your heart."

Vicarious trauma. Jane became tearful when discussing having to physically hold and/or give injections to patients who were a danger to themselves or others. She reported having a hard time letting such experiences go, often leaving work in tears. She stated:

> When I first started doing CPI [crisis prevention intervention] holds it felt wrong, almost abusive to the patient. Having had no psych experience prior to this job I wasn't used to doing holds. I think that especially holding people in order to place feeding tubes was horrible, because I felt like it was doing more harm than good. I remember one patient who started to have nightmares about being held. As a nurse we want to do things to help people and I felt very guilty that I was causing someone so much psychological distress, when my main goal as a nurse is to help people feel better!

Despite having initially felt this way, Jane stated that the hospital has since supported nurses in changing the culture of "forcing" patients to comply to a more collaborative approach, which has become less traumatizing for both patients and staff.

Witnessing transformation. Jane valued seeing patients succeed and maintain recovery. However, for Jane, it went beyond just recovery from the ED. Witnessing the emotional transformation of patients was equally as meaningful. She saw patients learn and retain tools to cope with and manage their anxiety, which was so impressive given the level at which they had struggled. Many patients were able to leave treatment seeming truly happy and positive. Jane acknowledged that these were not only joyful experiences, but also ones in which she felt was able to learn from the patients (e.g., how to be strong and resilient).

Positive body image. When she began working at the facility, Jane briefly convinced herself that she had an ED as well. She began noticing all the foods that she

did not eat as a vegetarian and focused on this elimination of food groups as being a typical ED behavior. Recognizing and reflecting that she, in fact, did not have an ED and had a healthy body image, Jane was still committed to changing her diet. She wanted to become more flexible with her eating and move away from negative food talk, just as was asked of patients receiving ED treatment. Subsequently, she valued her body and physical health more than before. Jane noted, "I have a better body image just because I see what they go through and you almost want to rebel against that and be like, 'No, I love myself and I would never do that.'"

Cassandra

Background. Cassandra is a Caucasian female in her 20s. She earned a Bachelor of Science in Nursing and has been a nurse for almost five years. She has been treating adolescent patients with EDs for the past two-and-a-half years. Previously, she worked as a medical nurse with older adults and treated terminal illnesses. Though she had no formal ED experience or previous exposure to patients diagnosed with EDs, Cassandra reported having always wanted to work with this population.

Cassandra and I met to interview in a private conference room at the hospital. The room was quiet and free from distractions; we sat at a large conference table with plenty of room. Later on, Cassandra did not provide feedback regarding the accuracy of the themes. The following sections outline the themes that Cassandra conveyed, all of which are illustrated in Table 11.

Table 11

Individual Themes: Cassandra

Core themes	Descriptions & sub-themes
Initial attitudes	Uncertainty comprised her initial attitude towards ED treatment.
Conditions of treatment	Several components comprised her ability to treat patients and manage her duties: – Complexity – Psychiatric focus – Need for balance – Sense of community – Lack of communication – Lack of appreciation
Emotional awareness and outcomes	Her overall emotional experience and sense of awareness was impacted by: – Emotional rollercoaster – Being part of success – Increased appreciation

Note. ED = eating disorder.

Initial attitudes. Uncertainty highlighted this theme. There was an inevitable uncertainty with regard to the progression and course of EDs for each patient. Cassandra never knew whether or not a patient would become a safety risk (with regard to their medical health or self-injurious/combative nature) and/or have the skills and support to maintain their recovery upon discharge. Cassandra noted that such factors exacerbated her already existing uncertainty in her role as a nurse in that she never knew what the next day might look like.

Conditions of treatment. Six themes emerged:

Complexity. In explaining her experience, Cassandra referenced elements of complexity that defined the nature of ED treatment. Given the lack of Cassandra's prior ED experience, she began her role as a nurse learning "on the go," which was a challenge in itself. An ED treatment was "much broader" in that there were a wider net of factors further complicating nursing care. The team approach was constantly evolving to reassess patient needs and develop new tactics to approach situations. This required attention and flexibility. Furthermore, nurses had a multi-faceted role, expected not only to manage working with a multidisciplinary treatment team, but also to integrate different members of the family in treatment and subsequently provide education to both patient and families. They also had to manage multiple diagnoses and symptoms, particularly given the specific physical changes and emotional symptoms that required constant monitoring (e.g., lab work, suicidal ideation, etc.).

Psychiatric focus. As was the case for many nurses, Cassandra was challenged by the lack of medical work and increased psychiatric focus in ED treatment when compared to her previous roles as a medical nurse. There was a large focus on the therapeutic skills needed to provide milieu management and the accompanying psychological and physical de-escalation techniques. In addition, though there were various medications involved in ED treatment, Cassandra struggled with the fact that the majority of these were psychiatric medications with which she was far less familiar. She noted that "even in nursing school, they could have done a better job of pinpointing certain psychiatric disorders because they really didn't do that."

Need for balance. Cassandra conveyed the need for balance throughout her interview, especially pervasive throughout her discussion of the patient relationship. A nurse must strive for balance between acting as a friend or "big sister" and setting boundaries, while also knowing "how to pick battles." Cassandra tried to always remain honest and present to build trust in the relationship, while also engaging in a "harder approach" if that was in the best interest of the patient. Having neglected it at first due to an excessive focus on work duties, Cassandra also acknowledged the importance of leaving work at work and engaging in self-care whenever possible. In order to maintain such balance, she stressed the importance of being able to "check out and go back to normal life."

Sense of community. Working in an environment treating children and adolescents contributed to an increased sense of community for Cassandra in which both staff and patients actively worked to support each other.

Lack of communication. Despite her fondness for working on a multidisciplinary treatment team, Cassandra felt that there was an overall lack of communication between nursing staff and other members of the team. Specifically referencing the dietary team, she noted that her job as a nurse became more challenging when she was unaware of why certain changes had been made in patients' treatment plans that affected her role. For example, often dieticians made changes to patients' diets that could affect their medications or had ordered other types of nutrition (e.g., total parenteral nutrition) that nursing also had to administer without informing them in advance.

Lack of appreciation. When working as hard as Cassandra did as an ED nurse, the job became increasingly difficult at times when she did not feel appreciated.

Cassandra noted that the need for nurses to enforce rules and be the "bad guys" often

elicited feelings of resentment and a lack of appreciation among the patients towards

nursing staff. Such sentiments became even more apparent when patients were already

outwardly resistant to treatment, in that taking away control (especially from a patient

with anorexia nervosa) could increase negative feelings towards those enforcing the rules

(i.e., the nurses). Furthermore, Cassandra saw the nurse as a "background member"

within the treatment team, which made it increasingly challenging for her to speak up and

to assert herself.

Emotional awareness and outcomes. Three themes emerged:

Emotional rollercoaster. Cassandra identified various, often conflicting, emotions

when describing her experience, or "emotional rollercoaster." Having lacked any prior

ED knowledge training, she stated, "I didn't even know this type of facility existed until I

kind of stumbled upon it." Such feelings of uncertainty regarding ED treatment increased

already-existing fears for her surrounding the course that one's ED might entail.

Cassandra repeatedly acknowledged the stress and exhaustion encompassed in caring for

ED patients, often with simultaneous feelings of reward and satisfaction. She also often

felt frustrated, primarily regarding patients' non-compliance with treatment. She also

frequently experienced sadness when patients did not succeed in their treatment and/or

returned after being discharged. To the contrary, witnessing a patient recover from an ED

was a joyful experience.

Finally, Cassandra discussed the ways in which the emotional undertone among

patients drastically affected the emotional stability of nurses (and vice-versa). For

example, an anxious group of patients often increased anxiety amongst nurses, just as

anxiety among nurses often increased anxiety among patients. Regardless of how she felt at any particular time (even in times of crisis), she felt the need to maintain stability and a calm appearance in order to preserve stability among patients and the milieu as a whole.

Being part of success. Cassandra emphasized the joy that came from witnessing or hearing of patient success. This provided the most meaning and value in her work. Quite often patients entered treatment feeling anxious, resistant, and angry toward the mere thought of giving up their ED. Watching them discharge and believing in their ability to succeed was such a positive experience for her. Cassandra specifically referenced one challenging patient with whom she had made a strong connection. Despite the patient being "out of control" at times, she was able to build a supportive relationship that ultimately contributed to her success.

Increased appreciation. The longer that she has been in the field, the more Cassandra had felt able to identify a personal sense of competence, accomplishment, and confidence in utilizing her previous and newly-attained skills. She also gained an increased awareness of, and empathy for, the struggles that people had with food and weight, both in and out of treatment facilities.

Amy

Background. Amy is a Caucasian female in her 30s. She earned a Bachelor of Science in Nursing and has been a nurse for almost seven years. Amy has been treating adolescents and adults diagnosed with EDs for the past three-and-a-half years. Previously, she worked as a nurse on an inpatient psychiatric unit. She reported having no prior professional ED experience. Amy and I met to interview in her office. It was quiet and free from distraction and nicely decorated with artwork and other decor. When

requested to do so later on, Amy provided feedback with regard to the themes. She stated

that the themes that I provided fit with what she had been trying to convey and "summed

it all up."

General description of the experience. Truly caring about the facility and the

patients' success, Amy endorsed having a positive work experience overall. Her role

allowed her to create systems and "make things fit together . . . like a big puzzle," which

was satisfying for her. Compared to her previous roles as a nurse, Amy also

acknowledged many differences unique to ED treatment. Working with the ED

population seemed less stressful than her previous work with psychiatric patients (many

of whom had suffered from acute psychosis) in that patients with EDs were often "people

pleasers," more docile, and "a little more predictable." She found herself less worried

about her safety around them.

I had asked Amy to think about an artifact or object that represented her

experiences treating patients diagnosed with EDs. She e-mailed me after the interview

and described a picture of a tree:

> The tree is a symbol of life, growing and hope. It changes throughout the season
> much like people change throughout their lives. In order to survive it has a system
> of roots to help get what it needs, much like people need systems of friendship,
> family and positive outlets. It can be barren and plain and yet can come back to
> life and be beautiful and full. Trees grow for many years to become sturdy and
> massive and I think it represents a person going through an ED because they can
> take a long time to grow into their own and realize that they too are strong and in
> the end can be beautiful and happy by just being themselves, in a sense growing
> through and into life.

The following sections outline the themes that Amy conveyed, all of which are illustrated

in Table 12.

Table 12

Individual Themes: Amy

Core themes	Descriptions & sub-themes
Initial attitudes	The need to educate herself was her initial focus when commencing ED treatment.
Conditions of treatment	Several components comprised her ability to treat patients and manage her duties: – Balancing roles, including being firm and compassionate and maintaining professional boundaries while retaining support – Importance of support – Benefits of treating youth, including the familial nature – Building relationships – Differentiating the person from the ED – Need to disconnect from work – Recidivism
Emotional awareness and outcomes	Her overall emotional experience and sense of awareness was impacted by: – Mixed emotions, including stress, sadness, happiness, and feeling responsible – Witnessing recovery – Skewed view of body image

Note. ED = eating disorder.

Initial attitudes. The need to educate oneself highlighted this theme. Despite her extensive formal mental health experience, Amy lacked specific training or experience with EDs at the onset of her work at the hospital. However, Amy had already understood the importance of educating oneself given the lack of education on mental health issues

that she had received in nursing school. She subsequently sought knowledge from her colleagues and engaged in her own research, learning the nuances of ED presentations and ways in which to manage such symptoms as a nurse, as well as obtaining additional training in EDs.

Conditions of treatment. Seven themes emerged:

Balancing roles. Amy emphasized the importance of maintaining awareness surrounding balancing roles in both patient and staff interactions.

Being firm and compassionate. Amy believed that setting boundaries with patients and being straightforward were integral skills for nurses to possess. Though she disliked it, Amy often had to enter "principal mode," in which her being firm and strict was necessary for patient safety and/or success. She stated, "That is something I wish I could have—more of a regular interaction. Instead of them [the patients] being like, 'Oh, there's that mean lady that only shows up when we are doing bad things.'" However, no matter what type of approach one needed to take with a patient in the moment, it remained essential to maintain compassion, empathy, and to remain non-judgmental.

Maintaining professional boundaries while retaining support. Amy identified the importance of maintaining boundaries with other nursing staff in order to maintain a professional relationship. She could be friendly, but not be friends. However, this was sometimes challenging given the unique nature of treating EDs. Those outside of the field did not understand the struggles of treating EDs and subsequently were unable to provide the outlet for emotional support that she needed. Thus, Amy recognized her own need for support in the workplace.

Importance of support. Feeling supported was integral to Amy's role as nurse

and to success in her job. She also felt a strong sense of support from her colleagues

across disciplines. Amy had the opportunity to exchange ideas, have her own experiences

validated, and both give and receive help when needed. She had felt as though there was

always someone there to back her up.

Despite typically feeling supported, Amy sometimes felt alone. For example, she

had felt unable to rely upon or receive support from a supervisor. Never following

through or fixing the problems that she had identified, Amy felt increasingly stressed

and/or sad when working with this supervisor. During times of collegial conflict, Amy

felt as though she was left entirely to fend for herself. She stated:

> I can come to work and deal with kids being out of control and making a mess.
> But when that's happening and I'm also having issues with staff, it's really hard
> for me and . . . it makes me not want to come to work. It's stressful and my
> feelings are hurt.

Benefits of treating youth. For Amy, the very nature of working with children

and adolescents elicited positivity and enhanced an atmosphere of teamwork. Amy felt

that she was more hopeful in kids' future success, not only because they are less

immersed in their EDs and less biased, but also because nurses have increased leverage

(in being the adults) to reinforce their treatment. Identifying similarities to her previous

job with children, Amy reflected upon the strong sense of cohesion and consultation

amongst the entire multidisciplinary team when structuring patient care.

Amy felt that one plays a unique role in treating youth, acting as a "mother or

sister figure," which elicits a strong sense of personal responsibility and thus a stronger

bond. Amy stated, "When you work with kids, this is like their home and you become

their family. And when you are their family, you have to get along. I think that's what we are all role modeling here is positive, healthy family relationships."

 Building relationships. Amy identified getting to know patients and becoming part of their recovery journey as the most valuable part of her work. One cannot just "come to work and do your job." Amy felt that nursing in general was much more than that; one has to truly care about what he or she does and take time to build relationships. This was one of her favorite aspects of treating EDs.

 Differentiating the person from the eating disorder. Given the complex nature of ED symptoms, Amy was challenged to separate the person from his or her ED. Patients often tested and pushed limits and it subsequently became challenging to not attribute such negative attitudes to their inherent personalities. Amy witnessed many new nurses struggle with this, unable to identify the "two parts" of the patient. Though she once struggled in a similar way, Amy's experience in the field enabled her to break through this barrier. She reported, "They're all just normal people, I guess, and they just need someone to help them get through a tough time."

 Need to disconnect from work. Amy had neglected her own self-care initially. She stated, "There was a year I worked there and I only took one vacation and by the time I got to that vacation I was about ready to pull my hair out." Despite loving to travel, go to the pool, and spend time with friends outside of work, she often felt attached to the job. When not at work, Amy was on call and felt obligated to still respond to e-mails. Though this was inherently part of her position at times, Amy learned the importance of periodically detaching from work completely (e.g., finding someone to temporarily cover her position) in order to maintain her own emotional balance.

Recidivism. "I think the biggest challenge is working so hard with certain people and seeing them come back and be sicker than when they left." Negative feelings associated with responsibility were also compounded when patients returned. Amy often felt hard on herself, questioning if she had not done enough to help the patient recover the first time.

Emotional awareness and outcomes. Three themes emerged:

Mixed emotions. Four sub-themes emerged:

Stress. There was an inherent level of stress that accompanied treating patients with EDs. Conflicts among co-workers, perceived lack of support, and dealing specifically with patients who tried to test her limits all were stressful for Amy and often led to her feeling emotionally exhausted. Amy also acknowledged the stress of working primarily with females, quite common in ED treatment facilities. Given the emotional nature of some women in general, Amy perceived that this dynamic could exacerbate existing negative emotions and increase her stress level.

Sadness. Amy recognized a general sadness in treating patients who struggled or those who ended up returning to treatment. Such experiences decreased her sense of hope for their (and other patients) future success and increased general feelings of negativity. Amy also acknowledged her deep sadness in learning of patients' deaths or suicides, which seemed to be happening more frequently since she had initially entered the field.

Happiness. The joy experienced from building relationships with patients and witnessing their success was the driving force in Amy's desire to keep working with EDs. It was these moments of joy that kept Amy motivated, hopeful, and continually striving to improve patient outcomes.

Feeling responsible. Similar to that of a parent, with positive feelings of responsibility also came negative ones. Amy acknowledged her distress when she was unable to help a patient or when they did not recover. She stated, "We do have some patients come in here that don't do well and don't get better and we end up sending them somewhere else because we can't do anything with them. And that's a horrible feeling." Such feelings felt unique to her experience working with youth, having had less personal investment during her prior work at the adult unit.

Witnessing recovery. With positive interactions and effective treatment comes patient success. Amy identified a strong sense of pride and happiness associated with seeing a patient recover, or at least being on the road to recovery. She provided an example of one patient with whom she had built a strong relationship, having spent extra time with her trying to understand her life goals and desires. Amy continued to hear about her progress from both her and her family after her discharge. Despite her continued struggles, the patient continued to move forward and search for help in her recovery through treatment. Amy was able to identify the positive impact that she had on this patient's life: "There is someone out there that supports her and wants her to do better and believes in her. So that makes me feel awesome."

Skewed view of body image. Amy thought that working in the ED field would provide one with a stronger and more realistic foundation of body image issues. While she did gain immense knowledge on the topic, Amy recognized that being constantly exposed and focused on body image and weight led to a skewed view of it in society. She stated that, though satisfied with her own body image, she was more attuned to issues within society, now noticing obesity and anorexia nervosa more often. However, she had

come to realize that she was often wrong. Though societal pressures often elicit disordered eating and body image concerns among most women in Western cultures, Amy stressed the importance of recognizing these concerns as different from those of an ED. Someone being thin did not automatically mean that he or she suffered from anorexia nervosa. Furthermore, Amy also noticed how colleagues often became far more food conscious and aware of each other's bodies once working with EDs, which was often unhealthy.

The Composite Experience

In this section, I outline the overarching themes that were present among all 12 participants, in addition to comparison of some viewpoints that did not align. I first provide the combined demographic information. Then I review the similarities described by participants with regard to their general descriptions, including descriptions of the artifacts as well as themes that encapsulated what they found to be meaningful and challenging in their work.

Demographic Information

All participants interviewed in this study resided in the United States and currently worked as nurses at this ED hospital (with the exception of two—one who had recently quit her position). Seven participants primarily worked with adults, while five primarily worked with adolescents. The number of years the participants worked treating patients diagnosed with EDs ranged from one year to over 20 years. Two participants earned Associate of Science in Nursing degrees, nine had Bachelor of Science in Nursing degrees, and one had earned a Master of Science in Nursing. All participants were female. The ages of the 12 nurse participants in the study ranged from 20 to 50, with an

average age of 33.9 years and a median age of 30.5 years. The majority were Caucasian, with one participant identifying as Hispanic and another participant identifying as multiracial. Additionally, three participants reported having had an ED or some type of disordered eating in the past and noted this as a salient reason behind their interest in the field. The demographics are reported in Table 13.

General Description of the Experience

All participants were encouraged beforehand to choose an artifact that symbolized their experiences treating EDs. Since most participants stated during their interviews that they could not think of a relevant artifact, they were encouraged to contact me after the interview if anything came to mind. I also followed up with all participants via e-mail after the interviews and inquired about potential artifacts if they respectively had not yet provided one. A total of five out of the 12 participants did share an artifact (see Table 14). Among the artifact descriptions, two primary themes emerged: (a) stability/ grounding, and (b) hope.

Stability and grounding. Two participants conveyed themes of stability and grounding through describing their artifacts. Willow described a stone that, though simple in its appearance, possessed an immense amount of power for her. She used it as a grounding force during her world travels and now gave it to patients for the same support when they were feeling anxious or overwhelmed. Amy also conveyed a sense of stability and grounding through her description of a tree. She described a deeply grounded root system that symbolized patients' ability to attain stability in their lives and ultimately heal. She compared this to other important support systems in her own life, such as friends and family.

Table 13

Participant Demographics

Participant	Age	Gender	Race	Education	Yrs. in nursing	Yrs. treating EDs
Jackie	20s	Female	Hispanic	BSN	7	2.5
Evangeline	40s	Female	Caucasian	BSN	10	2.5
Emily	20s	Female	Multiracial	MSN/BSW	8.5	3.5
Willow	30s	Female	Caucasian	BSN	3	2
Little Girl	50s	Female	Caucasian	BSN/MA (Counseling)	35	8
Paige	20s	Female	Caucasian	ASN	5	2
Pat	20s	Female	Caucasian	ASN	3.5	2
Sarah	20s	Female	Caucasian	BSN/MA (Child Develop.)	1	1
Morgan	20s	Female	Caucasian	BSN	3.5	2
Jane	30s	Female	Caucasian	BSN	6.5	2.5
Cassandra	20s	Female	Caucasian	BSN	7	2.5
Amy	30s	Female	Caucasian	BSN	6.5	3.5

Note. ED = eating disorder; BSN = Bachelor of Science in Nursing; MA = Master of Arts; ASN = Associate of Science in Nursing.

Table 14

Participant Artifacts

Participant	Artifact
Evangeline	Poem
Willow	Small gray rock
Paige	Yellow star
Jane	Cards/drawings from patients
Amy	Tree

Hope. Four participants conveyed themes of hope through their artifact descriptions. Evangeline discussed her use of a poem to emphasize the ability of all patients to transcend illness and become hopeful for the future. She read the poem to patients to provide inspiration, as well as to herself to enhance her own ability to "work through" feelings of hopelessness in her work. Amy conveyed hope through the description of the tree. Despite living a "barren" existence for years and feeling as though all hope is lost, patients could grow into something beautiful. Paige described a yellow star representing the rewards she had experienced from witnessing patient recovery, eliciting hope for future patient success. Finally, Jane conveyed hope through the cards and drawings that she kept from previous patients. Despite their illnesses becoming severe enough to necessitate inpatient hospitalization, patients since had taken steps to promote their recovery and healing and felt appreciative for life. This provided inspiration for future patients as well as the nurses who cared for them.

Core Themes

Initial attitudes. Participants conveyed two main themes when describing their

initial attitudes towards ED treatment, including (a) lack of preparedness and training,

and (b) complexity of ED treatment. These themes are all reported in Table 15.

Table 15

Initial Attitudes

Sub-themes	Description
Lack of preparedness and training	A lack of preparedness and training specific to ED treatment led to feelings of uncertainty, experienced differently dependent on the comfort level of the nurse.
Complexity of ED treatment	The ED treatment was complex and challenging for several reasons: – Ambiguity – Comorbidity – Challenges in separating the patient from the ED

Note. ED = eating disorder.

Lack of preparedness and training. Every participant mentioned feeling

somewhat uncertain about what to expect upon starting, given their lack of specific

training in EDs. However, five participants emphasized this as central to their

experiences, with varying perspectives as to whether it felt exciting or to be more of a

challenge. Jackie described her initial lack of knowing "nothing" about EDs. She did not

interpret this as stressful because her love of learning quickly allowed her to adapt and grow. Amy also emphasized her lack of understanding of EDs at the onset of her work. She discussed her pre-existing understanding that much learning is self-taught and was happy to teach herself. Both Jackie and Amy sought additional ED training.

Some participants viewed the lack of training and preparedness as more of a negative experience. Though Evangeline conveyed her love of learning, she reported feeling stressed when having to "teach [her]self" certain medical procedures. Given the physical fragility of many patients, this became unnerving at times. Pat described her level of "shock" at the onset of her employment at the hospital in that she had never seen such clinical presentations before and felt incompetent in her ability to intervene. Sarah described feeling "nervous" given the fragile state of the patients, this being her first job out of nursing school and that she had no training in EDs.

Complexity of ED treatment. Nine participants explicitly acknowledged ways in which the complexity of ED treatment created further challenges in their work.

Ambiguity. Willow and Sarah disliked the ambiguity of treating patients diagnosed with EDs. They both emphasized liking predictability and straightforward protocols, common to medical nursing settings. Willow noted that dealing with "crises" and never knowing what to expect was stressful and decreased her confidence. She stated, "That's when it's hard for me to leave everything at the door—when there's the possibility that someone could have gotten really hurt and I could have done something wrong." Sarah reported that having less opportunity to prepare when dealing with psychiatric issues was "really tough."

Comorbidity. Comorbidity is common among patients diagnosed with EDs. This includes the combination of medical and psychiatric symptoms of the ED, itself, as well as potentially multiple psychiatric diagnoses among any patient (e.g., depression, anxiety, etc.). Willow, Jackie, Cassandra, and Little Girl identified challenges related to treating comorbid issues. Jackie and Cassandra acknowledged that this was the first job in which they had to integrate both medical and psychological skills, and being uncertain of how to approach situations made it more challenging. Cassandra illustrated a specific challenge with a patient who had significant medical and psychiatric concerns in addition to resistance towards her treatment. She stated, "I think she got a little stir crazy from being here too long and just started pulling out her [nasogastric] tube any chance. I mean I was putting in probably two to three tubes a day for a while." Willow identified her struggle with illusions of health in that ED patients often appeared healthy to the naked eye, while in fact they struggled with many psychiatric concerns or perhaps less evident medical problems. Little Girl commented on the increase in both comorbidity and patient severity that she had witnessed over the last five years. She further stated that despite many patients needing insight-oriented psychotherapy and skill building, such goals were often unattainable in that their acute medical issues (e.g., starved brain) prevented them from being able to concentrate and retain information.

Separating the person from the eating disorder. Many participants struggled at times to differentiate patients from their EDs given they were often so intertwined. Behavioral acting out or rude attitudes made this especially challenging, as many nurses' natural instincts were to become angry. Evangeline and Morgan sometimes had difficulty maintaining compassion for patients, forgetting that their negative attitude or resistance

was often a result of their starved brains. Sarah also struggled to remain objective at

times, stating, "I think it's about keeping an open mind and not just looking at a patient

who's screaming at you or trying to hit you and just getting angry with them, because it's

not them; it's their ED." Having now worked in the field for several years, Amy had

become better at reminding herself of these two sides to every patient when she would

notice herself getting frustrated. She stated:

> You have to realize it's part of their disease and part of their illness; it's not
> actually them. Even here that's something that I constantly tell myself and I tell
> staff, "They are sick." If you can't realize that there are two different parts of
> them at that point in time, then you are going to have a hard time working with
> this population.

Conditions of treatment. Participants collectively expressed six main themes

with regard to components of treatment: building relationships, finding and maintaining

balance, importance of communication and support, fragmented roles, pessimism, and

managing resistance. These themes are reported in Table 16.

Building relationships. Nine participants identified building relationships with

patients as providing meaning to their work, many reflecting upon this factor as being the

most valuable part of being a nurse treating EDs. Amy acknowledged, "Developing those

relationships and wanting the best outcomes for the patients here is what I find the most

meaningful." Evangeline and Paige noted that building relationships and "helping others"

was the primary reason for being a nurse, and Emily noted that "just being there for part

of their journey" was what was important. Though she had previously doubted her own

communication skills and ability to build rapport, Willow noted that supporting patients

during their recovery process was a "pretty amazing gift." Sarah and Morgan appreciated

the longevity of ED treatment. Having the ability to build rapport over an extended

period of time and witness a broader range of patients' journeys towards recovery

enabled them to build stronger relationships. Pat and Cassandra further identified the

value in being a part of the recovery process.

Table 16

Conditions of Treatment

Sub-themes	Description
Building relationships	Building relationships was important to most nurses, if not the central most important part of their job.
Finding and maintaining balance	The importance of finding and maintaining balance took several forms: (a) finding balance in patient relationships, (b) balance within nursing roles, and (c) balance within their lives as a whole.
Importance of communication and support	Communication and support were essential to efficient work and successful patient outcomes. Nurses experienced this both positively and negatively.
Fragmented roles	Nurses struggled with fragmented roles for two reasons, including (a) unrealistic expectations and (b) split between the treatment team.
Pessimism	Nurses experienced pessimism in the workplace from colleagues and patients' family members in the form of (a) negative attitudes and (b) overall loss of hope.
Managing resistance	Managing patient resistance increased negative experiences for many nurses.

Finding and maintaining balance. Seven participants identified the need to find and maintain balance as integral parts of their experience treating EDs. This balance took many forms, such as finding balance in patient relationships, balance within nursing roles, and balance within their lives as a whole (e.g., between work and personal issues). Jackie acknowledged the importance of maintaining compassionate and firm boundaries/structure as important facets of fostering balance in patient relationships. Paige, Sarah, Cassandra, and Amy all agreed that nurses needed to foster balance when interacting with patients to both promote effective nursing and foster patient success. In referencing the vacillating sides of her role, Paige stated, "Sometimes they may see me as being mean and sometimes I may look like their best friend because I am giving them what they want." Both Paige and Morgan identified that, through this balance, the use of humor also became important in attempting to alleviate the perceived severity of many situations (for both patients and nurses).

Several participants emphasized the importance of balancing life with self-care. Paige and Emily discussed the importance of "practicing what you preach." They recognized the hypocritical nature of promoting health among patients if nurses were not also being healthy themselves. Amy and Cassandra reiterated the need to take time to decompress and let go of work.

Importance of communication and support. Jackie, Evangeline, Paige, and Amy discussed the general importance of communication and support within an inpatient ED environment. They all stressed the value of communication within the nursing team (and among the treatment team as a whole) as integral to the maintenance of an efficient hospital and successful patient outcomes. Furthermore, feeling supported among

colleagues and supervisors was necessary for maintaining their own mental health and desire to return to work.

Some participants also noted experiencing positive outcomes as a result of feeling supported. Willow endorsed that strong feelings of support had enabled her to continue working at the hospital despite her initial hesitations. Pat appreciated the positive feedback she had recently received from her supervisor. Morgan felt as though she experienced good communication among the treatment team, which helped her to provide better patient care; however, she felt hesitant at times to report problems because she did not want to be the person always needing her supervisor. Sarah felt supported by her supervisor, stating: "My [supervisor] is great at speaking up for the nursing department as a whole, especially to other members of the treatment team, saying that nursing has a voice." In addition, Amy, Cassandra, and Jane identified feeling as though they were part of a family working on an adolescent team. Unfortunately, not all participants felt supported. Evangeline noted that as her time with the hospital progressed, she felt less supported by all members of the treatment team, including her fellow nursing staff.

However, four participants viewed communication and their perceived support at work more negatively, many also stressing that their (nursing) voices were not heard. Cassandra noted a lack of communication with members of the treatment team, especially between the nursing and the dietary teams. She stated, "We don't necessarily butt heads. We are just on two separate sides." Sarah noted that she often felt discord with colleagues, which sometimes led to her feeling unsupported and/or unable to effectively communicate. Jane and Pat endorsed an overall lack of support at work at times, either by

other nurses or by other disciplines within the treatment team. Pat believed that nurses in general were often dismissed by the therapists, referring to them as her "biggest enemy."

Fragmented roles. Eleven participants noted feeling some form of fragmentation in their roles as nurses. These nurses often felt a general uncertainty at the onset of their hire, given their typical lack of understanding ED treatment and the multifaceted nature of their role. Paige felt that her role lacked clarity amongst the treatment team, in that both patients and staff often mistook her role for that of another nurse on duty. Jane reported that as the hospital expanded, duties that she had once performed were split amongst other staff and she was left wondering what she was meant to do. Willow also identified the challenges that arose from a lack of hierarchy in the ED nursing role. To her, nurses seemed more respected and valued in traditional hospital settings in that in such settings, they were often in charge of patients' treatment.

Unrealistic expectations. Seven participants felt as though there were unrealistic expectations placed upon them as nurses in this hospital. Little Girl and Morgan commented on the general tendency of nurses to be overworked and having to work holidays, weekends, and overtime. Another significant problem for some nurses was the emphasis placed on therapeutic (counseling) skills. Willow and Pat noted that their lack of mental health experience, including rapport building and de-escalation skills, caused them to feel as though they were at a disadvantage. They believed that what was expected of them was unfair, such as having to "act like a therapist." Furthermore, Willow noted that feeling like she had to be the "enforcer" of rules when other disciplines often did not support her made her role increasingly challenging. Jackie, Evangeline, and Emily also acknowledged that a lack of time to complete all the necessary tasks during a shift played

a huge role. There had become such an uneven nurse–to–patient ratio that it often felt

almost impossible to get all of one's work completed during a shift. Emily stated,

> I started to get crabby and I realized that I was not able to keep these people safe
> and was not able to provide any type of decent care. We are just going on a wing
> and prayer that nothing serious goes wrong and that's, emotionally, that's just
> scary.

Split within the treatment team. Five participants felt a lack of integration between

the nursing and mental health teams, in which they felt unappreciated, dismissed, and/or

disrespected. Sarah noted the lack of appreciation of the "nursing voice" among the

mental health team, often feeling as though therapists or dieticians implemented new

additions to patients' treatment plans without having consulted with the nursing team.

Sarah and Cassandra often felt dismissed, while Willow and Pat sometimes felt as though

they were deliberately treated poorly by therapists who often disregarded the value of the

nursing role of setting boundaries. Furthermore, Little Girl compared her own

experiences of being both a nurse and a therapist. She stated that nursing was far more

challenging in that as a nurse, one has to manage the entire milieu at once. She felt as

though the mental health staff often did not understand this.

Pessimism. Given the fragile state of many ED patients, eight participants

discussed the inherent pessimism in their work. This took the form of generally negative

attitudes or a loss of hope for recovery.

Negative attitudes. Sarah discussed how such negative experiences, especially

regarding patients' struggles, made it challenging for her to let go of work issues when

leaving for the day. Paige acknowledged her struggle to manage negative family

dynamics. Jackie discussed the shocking and upsetting nature of some patients' medical

states. This often elicited feelings of excess worry, which could further provoke

negativity or hopelessness in more severe circumstances. An interesting theme contributing to negative attitudes was working with a predominantly female staff. Amy, Sarah, Jane, and Cassandra all acknowledged that working with almost all women often increased tension and pessimism. Sarah commented that intense female personalities often contributed to discord at work. Jane discussed the stressful environment in which she worked, referring to the "gossipy" nature of the workplace in which "everyone tells each other everything."

Loss of hope. Sarah and Jackie both identified challenges in maintaining hope. Jackie thought about the older adults who were so medically compromised, wondering if they could possibly sustain recovery. Sarah witnessed adolescents so "stuck" in their EDs that she sometimes felt unsure about their ability to change. Though not a personal struggle, Little Girl discussed the difficulty for many nurses to quantify change, given successes that ED patients achieved were often so small and potentially hard to see. Thus, nurses continuously struggled to identify the positive, even when it may have existed, subsequently losing hope. Jackie added to this in stating that there typically was not a concrete reward (no tangible outcome), while Emily acknowledged that the nature of inpatient treatment did not allow nurses to witness patients living in a recovery-focused, healthy state. Amy further noted that the high recidivism rate of patients diagnosed with EDs made it challenging to believe at times that recovery was possible.

Hope was more common among nurses working with adolescents, given the length that many such patients had dealt with their EDs. For example, Jane acknowledged the fact that children and adolescents were less "entrenched" in their EDs, which in fact made it easier to maintain hope in their recoveries. Kids often just wanted attention from

their families or friends or wanted to gain some control at a developmental point in their lives when they often had little. Amy recognized this as well, stating, "They [adolescents] are not as biased as adults."

Managing resistance. Seven participants identified struggles with managing resistance from ED patients, which often presented as rude attitudes or defiance. Little Girl emphasized that despite her developed clinical skills, she still struggled to manage resistance at times. Paige commented on her inability to tolerate "snotty" attitudes or outright lying, stating, "Defiance makes it harder." Willow identified her struggles in dealing with labile moods that seemed "extreme." Both Willow and Pat wanted to be liked by their patients and were challenged and surprised when treated disrespectfully. Evangeline and Emily noted that being treated like a "servant," in that their time was entirely de-valued, was triggering and they often became annoyed or angry. Finally, Sarah acknowledged that experiencing such negative feelings often made it challenging to remain objective and/or maintain empathy for patients.

Emotional awareness and outcomes. Participants conveyed four main themes with regard to emotional outcomes and awareness: emotional rollercoaster, witnessing recovery, body image awareness, and growth. These themes are all reported in Table 17.

Table 17

Emotional Awareness and Outcomes

Sub-themes	Description
Emotional rollercoaster	Nurses described various emotions that they experienced through their work, such as: Stress Exhaustion and burnout Sadness Anxiety Frustration and anger Emotional distance versus vicarious trauma Happiness and excitement Uncertainty
Witnessing recovery	Witnessing patient recovery had positive impacts on nurses. They reported feeling happy, satisfied, and excited.
Body image awareness	Treating EDs elicited an increased awareness of body image issues. This had both positive and negative outcomes for nurses.
Growth	Growth as a nurse included an increased sense of competence and gaining compassion for patients and their EDs.

Note. ED = eating disorder.

Emotional rollercoaster. Every participant described a myriad of intense

emotional experiences. Common themes among participants consisted of stress,

exhaustion/burnout, sadness, anxiety, frustration and anger, emotional distance versus

vicarious trauma, and happiness/excitement. There was also general consensus among

participants that working with EDs was unique. This uniqueness sometimes further exacerbated existing positive or negative emotions, such as excitement or uncertainty. All participants, except for Jane, Little Girl, and Morgan, explicitly stated feeling "stressed," "exhausted," or "drained" as integral to their emotional experiences in treating EDs. However, two of those participants still conveyed these emotional undertones in other parts of their descriptions. For example, Jane discussed her lack of confidence in her abilities at times and her struggle in setting limits with patients as challenges for her. Little Girl discussed the ways in which her role was often "too much." This level of stress led to burnout in Evangeline, which she had not even recognized in the moment.

Sadness was also a common emotional experience, as endorsed by seven participants. Jane and Sarah were saddened to watch children and adolescents struggle with deeply embedded depression, self-loathing, and physical symptoms of their EDs. Amy, Cassandra, Willow, and Paige were saddened by the perceived inability of some patients to recover as well as recidivism. Amy stated, "The biggest challenge is . . . working so hard with certain people and seeing them come back sicker than when they left." Finally, Emily, Little Girl, and Paige reported feeling sad (as well as grief and loss) surrounding hearing of patients' deaths. Little Girl was the only participant who endorsed an accompanying sense of guilt.

Four participants conveyed anxiety. Jackie, Sarah, and Emily worried constantly about their patients' health and safety, while Jackie also worried about her future potential encounters with EDs. Could she have a child with an ED? Cassandra discussed the ways in which not only her uncertainty around treating EDs elicited some anxiety, but also the ways in which the emotional undertones on the unit increased anxiety. For

example, an overall anxious milieu of patients often elicited increased anxiety among the nursing staff. She stated, "I think it can just get everyone a little on edge when things are chaotic."

Five participants reported feeling frustrated, which often led to anger. Willow felt frustrated by the ED behaviors and she struggled sometimes to understand why patients would not just eat. Paige became frustrated by the inherent power struggles of treating patients with EDs, acknowledging that it was difficult "fighting against the ED and knowing that you might not win." Evangeline, Pat, and Emily were frustrated and angered by patient defiance and disrespect. Evangeline and Emily were also frustrated by the lack of time to complete nursing duties and the poor nurse–to–patient ratios.

Three participants endorsed feeling some vicarious trauma. Jane became tearful when discussing her experiences of having to physically hold children and administer injections when they became unsafe towards themselves or others. This experience was quite traumatic for her. Pat described her struggles with hearing of patient suicide as especially traumatic (and personal) in that she had experienced suicide within her own family. Evangeline reported a general sense of vicarious trauma after years of exposure to patients' physical malnourishment and own traumatic experiences. Conversely, Morgan and Pat reported feeling emotionally distant. They stressed the importance of trying to not get too emotionally "connected" with their patients and their struggles. This prevented them from becoming engulfed in negative emotions, feeling sad and overwhelmed, and enabled them to keep working treating EDs. Pat also stated that she did not want "people [patients] to get too attached" since she had a difficult time trusting some people with mental illness.

Six nurses endorsed feeling happy and/or excited. Amy, Jane, and Paige discussed the happiness they each experienced from building relationships with patients. Cassandra, Sarah, Little Girl, and Jane emphasized the joy that they each experienced when witnessing a patient succeed. Jane stated,

> We have a patient that really struggled like every single day. She would get anxious and throw up, anxious, throw up, anxious, throw up and she thought there was nothing she could do to stop it. And she worked, worked, worked, and now she is doing amazing. She had such a flat affect and now she's so bright.

Little Girl referenced the excitement in witnessing the "small" steps and successes in recovery. She stated, "Any time you are able to work with a patient and get them to comply with something they need for their recovery is a meaningful situation . . . It may have only worked for an hour, but it worked!"

Many nurses experienced conflicting feelings, often simultaneously. Amy reflected on her experience witnessing patients struggle: "There are some people that you really connect with so it can be hard and stressful." Jane had a similar experience that was quite upsetting for her. She stated,

> We just heard she's not doing well at all and it sucks because the few moments you would see her outside of her ED, she was the funniest kid you've ever met. She's the one that makes me kind of cry.

On the positive side, Little Girl noted that witnessing patient success was the most "exciting" and rewarding part of the job. Jackie also reported "feeling grateful" that she, or no one close to her, suffered from an ED.

Witnessing recovery. Six participants reported witnessing recovery as a valuable component in their work. Little Girl acknowledged her "excitement" over the years in seeing patients recover, reminding her of her own recovery from anorexia nervosa (the reason behind her wanting to help other ED patients). Paige stated, "Success stories are

super cool." She relished in the ability to witness a patient's recovery, especially when

working with the adults in that they had been living "in their EDs" for so long.

Evangeline added her delight in witnessing the physical transformation of patients,

gaining brightness back to their eyes. Sarah and Amy identified their satisfaction after

hearing of patients who had maintained recovery after discharge. Cassandra also

acknowledged the happiness she experienced from witnessing recovery. She stated,

> I find that when a patient does go home and you really think they're going to be successful, at least in the short term, that's probably the biggest success. And then they'll write us a year later and they are still doing great. That is probably the biggest joy I get out of the job.

Body image awareness. Though not a central themes to all of their interviews,

many participants stressed the way in which working with EDs had increased their

general sense of awareness about body image. Paige, Amy, and Jackie discussed their

increased awareness of body image issues and EDs in general, becoming more attuned to

issues within society. Amy further discussed how nurses working with EDs often became

overly attuned to body image concerns in that they misattributed certain body types as

having EDs simply because of their size (e.g., a thin woman out in the community was

now perceived as having anorexia nervosa). The amount that staff focused on food and

weight while at work, discussing foods they were avoiding or what diet they were trying,

often bothered Jackie. She stated, "I'm not absorbed in it, which I'm thankful for." Emily

and Sarah noted that they had become more self-conscious at work. Emily worried what

others might think of her small frame and fast metabolism. Sarah made a consistent effort

to always ensure she was dressed appropriately so as to not trigger any patients. She

made sure not to wear clothing that was too revealing or too tight, as this might draw an

unnecessary focus to her body.

Two participants conveyed their positive experiences related to body image. Jane shared that becoming more aware of body image issues actually enhanced her own body image for the better. This increased focus amplified her desire to "learn to be happy and not focus on stuff [dieting] like that." Evangeline finally learned to come to peace with her own body after years of struggles with bulimia nervosa. She stated, "I never equated their bodies with mine. I just saw the sickness of it."

Growth. Four participants identified experiencing professional growth as nurses, including increasing competence and skills and gaining compassion for patients. Evangeline and Willow reported gaining a better handle on concrete nursing skills. Evangeline vastly increased her medical knowledge, while Willow learned how to better communicate and interact with patients on a personal level. Morgan noted that she thrived when feeling challenged. For her, not knowing what to do or having prior experience to reflect upon was a positive learning experience. She was able to quickly create solutions as she encountered problems and subsequently learned how to improve outcomes in the future. With regard to gaining compassion, Jackie and Morgan discussed their initial struggles in being empathetic towards ED patients. Not understanding that much of their negative symptoms came from the EDs themselves took time for them to learn and understand.

Summary

In this chapter, I examined the ways in which the participants described their experiences in treating patients diagnosed with EDs. Participants conveyed general themes through their artifacts, including stability/grounding and hope for recovery. Several core themes were identified under three main categories: initial attitudes,

components of treatment, and emotional awareness and outcomes. While each participant held a unique perspective and contributed her own rich descriptions and themes to the study, an aggregation of participant experiences resulted in composite themes. These encapsulate the essence of nurses' experiences treating EDs.

There were many core composite themes. I first examined themes regarding their initial attitudes towards treating EDs. All participants acknowledged their lack of preparedness and training in EDs prior to entering the field, and many discussed the various complexities of ED treatment. There were several composite themes that specifically addressed components of treatment. Building relationships, finding and maintaining balance, communication, and support were viewed as important facets among several participants. Also, many participants struggled with fragmented roles and the various types of negativity that can accompany such work, such as pessimism and managing resistance. Finally, with regard to emotional awareness and outcomes, all participants reported having mixed, conflicted emotions (an emotional rollercoaster). Many reported that witnessing recovery and experiencing personal growth as meaningful components of their work. Many participants also reported an increase in body image awareness.

In the next chapter, I further elaborate on these individual and composite themes through a discussion of overall assertions and interpretations from findings of this study, limitations, and areas for future research

CHAPTER V

DISCUSSION

The purpose of this study was to explore the experiences of nurses treating patients diagnosed with eating disorders (EDs) in order to better understand both their individual experiences and the essence of their shared experiences. The findings derived from this study help to bridge the gap between medical and mental health perspectives of ED treatment, specifically working to enhance the connection between the fields of nursing and counseling psychology. Such insight into nurses' experiences advances the field of psychology in several ways. By providing a richer understanding of the medical perspective of ED treatment, counseling psychologists can improve educational efforts and training for nurses, as well as help to increase nursing support. Further, through learning more about ED staff and patients, counseling psychologists can work to improve treatment modalities and evidence-based practices for treating EDs. In this chapter, I provide an overview of the study and discussion of the results including themes and their relationship to previous research. I then conclude with implications for, and limitations of, the current study and directions for future research.

Summary of the Study

Cases of EDs have become an epidemic within the United States. Though symptom presentation can vary dependent upon the specific type of ED (e.g., anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant/restrictive food intake disorder,

or other specified/unspecified eating disorders) (American Psychiatric Association,

2013), the medical and psychological consequences can be lethal. Furthermore, ED

patients may experience a myriad of comorbid mental health issues as well as struggle to

develop and maintain interpersonal relationships and socially connect with others

(Mehler & Andersen, 2010; NIMH, 2014).

The ED treatment is complex and demanding and typically requires a unified,

integrated, holistic treatment approach by a multidisciplinary team (Mehler & Andersen,

2010; Reid et al., 2010). Nurses play an integral role in ED treatment at the inpatient

level of care. Managing the various needs of patients, nurses provide 24-hour-care,

manage the milieu as a whole, and are integral in maintaining effective communication

among the team (King & Turner, 2000; Mehler & Andersen, 2010; Ramjan, 2004; Ryan

et al., 2006; Snell et al., 2010).

Research has demonstrated a wide array of both positive and negative experiences

among nurses in traditional medical settings. Having sufficient knowledge within their

field, support from colleagues, a sense of meaning, and engaging in regular self-care

often result in positive outcomes such as patient success, increased confidence,

happiness, and/or personal and professional growth among nurses (Bush, 2009; Feng &

Tsai, 2012; Hilliard & O'Neill, 2010; Johansson & Lindahl, 2011; Wangensteen et al.,

2008; Zammuner et al., 2003). Furthermore, nurses can experience emotional benefits

upon witnessing a patient heal and grow, known as vicarious resilience (Grafton et al.,

2010).

However, medical nurses also experience challenges due to their job demands and

subsequent high levels of stress. Such challenges may include feeling a lack of support,

poor communication among the treatment team, and difficulty building relationships with patients and their families (Feng & Tsai, 2012; Lindahl & Norberg, 2002; Olofsson et al., 2003). Furthermore, these nurses encounter many, often negative, emotional experiences, including sadness, fear, anxiety, powerlessness, guilt, compassion fatigue, and burnout (Allcock & Standen, 2001; Bassett, 2002; Hill, 1991; Hilliard & O'Neill, 2010; Maytum et al., 2004; Olofsson et al., 2003).

The literature on mental health nurses' experiences illustrates similar findings, emphasizing additional factors specific to managing psychologically-based illnesses. First of all, the importance of group supervision (Maier, 2011; Winship, 1995) has been specifically emphasized. Mental health nurses, including those who treat EDs, may also experience additional negative consequences, including increased challenges in building patient relationships as a result of societal stigmas towards patients with mental health diagnoses (Bjorkman et al., 2008; Harms, 2010; Hem & Heggen, 2003, 2004; Van Sant & Patterson, 2013); struggling with role dilemmas, that is, uncertainty about whether to act more as a nurse or a mental health therapist (Hem & Heggen, 2003); distress and fear surrounding the emotional unpredictability of patients (Carlsson et al., 2004; Winship, 1995); and vicarious trauma, that is, the potential for caretakers to take on their patients' traumatic symptoms when exposed repeatedly to their stories of trauma (Figley, 1995; Maier, 2011).

Despite extensive literature on nursing and EDs (Bakker et al., 2011; Halek, 1997; King & Turner, 2000; Pryde, 2009; Ramjan, 2004; Ryan et al., 2006; Wright, 2010), few researchers have focused their examinations upon nurses' subjective experiences of perceived benefits and challenges in treating both adult and adolescent ED patients at the

inpatient level of care. The research examining similar experiences among nurses does highlight the challenges that they do encounter. Such challenges may include having a lack of prior knowledge and understanding of EDs or specific facets related to their treatment, which increases anxiety and decreases confidence (Cordery & Waller, 2006; King & Turner, 2000; Reid et al., 2010; Snell et al., 2010); difficulty in and the importance of building relationships with patients (George, 1997; Halek, 1997; Irwin, 1993; King & Turner, 2000; Malson & Ryan, 2008; Micevski & McCann, 2005; Moulding, 2006; Ramjan, 2004); and the struggle to find balance between maintaining boundaries and fostering patient empowerment (Bakker et al., 2011; van Ommen et al., 2009). However, such research has yet to examine the subjective experiences of nurses in managing resistance, grief and loss, vicarious trauma, and positive experiences, such as vicarious resilience, in treating EDs.

This study aimed to gain a richer understanding of nurses' broader, subjective experiences in treating EDs, including perceived benefits and challenges. Specifically, the research questions addressed were:

Q1 How do nurses describe their experiences in treating patients with EDs?

Q2 What do nurses perceive as meaningful and valuable in their work?

Q3 What do nurses see as factors or challenges that impede their work with ED patients?

Q4 How has their education, training, and preparedness impacted their experiences in working with those suffering from EDs?

After Institutional Review Board approval was obtained from my university, I e-mailed a letter of intent to relevant personnel at an ED hospital that treated both adult and adolescent patients and obtained site consent. To recruit participants, I e-mailed the

letter of intent to nurses via the hospital's e-mail listserv. Interested nurses e-mailed me

directly, and we scheduled times to conduct the interview. Twelve female nurses

participated in this study. Data were collected through in-person semi-structured

interviews, although additional information was collected via e-mail in follow-up

conversations after the interviews. Interviewing was conducted privately in secluded

areas/rooms of public libraries and private conference rooms at the ED hospital, in

addition to one interview that was conducted in my home due to lack of alternative sites.

All interviews were audio recorded on two digital recording devices and subsequently

transcribed.

I utilized Moustakas' (1994) phenomenological method to analyze the data. From

the interviews and documents, I highlighted statements that encapsulated participants'

experiences in treating EDs, specifically general descriptions of information regarding

their experiences, what about their experiences that they found meaningful/valuable and

challenging, and their level of preparedness. Through grouping and labeling these

statements, I created textural–structural descriptions for each participant. From these

individual themes, I created the composite experience, the invariant structure, to describe

the essence of these nurses' experiences with treating EDs, or how they interpreted their

roles in ED nursing (Patton, 2002).

I utilized several methods to enhance the overall rigor and trustworthiness of this

study. These included collecting data until reaching saturation; obtaining thick

descriptions from participants; engaging in researcher reflexivity throughout the process,

including documenting in a reflexive journal later reviewed to aid in brindling of my

personal biases (Dahlberg, 2006); and maintaining an audit trail, in which I documented

the entire research process, including slight changes in the interview guide structure, contact with participants, and ways in which ultimate textural–structural and composite themes were created and evolved (Creswell, 2007; Lincoln & Guba, 1985; Merriam, 2009; Patton, 2002).

I employed triangulation methods through using multiple participants and multiple researchers. I used peer debriefing by having another doctoral candidate in Counseling Psychology who also has training in qualitative methodology review my transcripts. After independently analyzing the transcripts, we each identified textural–structural and composite descriptions. In comparing these themes, we discussed ways in which they were similar and/or different and concluded together which themes best represented the data. My primary research advisor also read the transcripts and reviewed the textural–structural and composite descriptions as another means of expert review or check. Finally, I conducted member checks with several participants. I provided individual textural–structural descriptions and the composite description via e-mail, asking them to review such themes for accuracy and provide additional information if desired. Six participants responded. None changed the meaning of the themes; rather, they all stated that the themes accurately portrayed the experiences that they had tried to convey. A summary of the research findings is provided in the following section.

Discussion of the Findings

I provided in Chapter IV detailed explanations of individual textural–structural descriptions. I derived common themes across participants to create the overall composite description, or essence of their experiences. In this section, I provide a discussion of these research findings, examining (a) interpretations of the findings, (b) how the findings are

related and interconnected, and (c) similarities and differences across participants.

Initial Attitudes

Similar to the experiences of many ED nurses (Ramjan, 2004), each of the 12 participants began their positions at the ED hospital with initial attitudes, or preconceived notions, about what their ensuing experiences would entail. Such attitudes subsequently affected their work. As posited by social constructionist and existential theories, these initial attitudes were molded from socially constructed views/constructs (Crotty, 1998; Patton, 2002) and intrinsic ultimate life concerns (Yalom & Josselson, 2011) and are further modified and/or changed based upon their unique experiences with ED patients.

Lack of preparedness. Each participant endorsed knowing little, if anything, about EDs at the onset of their employment, feeling uncertain about what to expect. Five participants noted this as being central to their initial attitudes towards ED treatment. Research supports that treating EDs with little knowledge of or training in EDs, or mental health issues in general, can be stressful for nurses (Cordery & Waller, 2006; Ramjan, 2004; Reid et al., 2010) and often result in negative attitudes towards patients (Thompson-Brenner et al., 2012). Initial uncertainty can lead ED nurses to feeling uncomfortable emotions and/or believe that they are unable to meet patients' needs (Reid et al., 2010; Snell et al., 2010). Often, nurses treating EDs report that their lack of both knowledge and experience specifically in treating persons with these disorders increases skepticism and uncertainty when treating such patients (King & Turner, 2000; Reid et al., 2010). Similar to other medical providers (Linville, Brown, & O'Neil, 2012), several participants reported wishing that they had more training at the onset of their employment in the form of one-on-one guidance, didactic training, and/or dissemination of literature

on relevant issues. Thus, these findings support the need to expand training efforts for nurses new to the ED field.

Though not all participants reported their initial lack of preparedness as stressful, finding ways to increase their knowledgebase through additional training, some reported initially feeling overwhelmed and nervous regarding such new roles. One explanation for this period of increased stress and "intense, emotional difficulties" (Bassett, 2002, p. 37) is that nurses generally need time to adjust to new lines of work, taking time to increase their knowledge and clinical skills (Feng & Tsai, 2012; Wangensteen et al., 2008). Feeling competent in treating EDs, knowing how to build relationships and approach certain conditions, ultimately increase effectiveness in nursing care (Halek, 1997; Irwin, 1993; Pryde, 2009).

Several participants reported experiencing biases towards EDs and/or hesitance towards treating ED patients, often due to an initial lack of awareness and understanding of ED treatment and the patient population. Some reflected upon past experiences with psychiatric issues in nursing school as "scary," while others did not disclose too much personal information to ED patients because they perceived patients as "crazy." These novel findings are important to recognize and address and suggest additional training and support is needed with nurses who are new to the ED field. Furthermore, this is also consistent with prior findings, in which nurses entering the ED field often hold negative impressions of ED patients before starting their work (Malson & Ryan, 2008; Ramjan, 2004; Sansone et al., 1988). Ramjan (2004) noted, "Blaming the victim, labeling, and stigmatizing adolescents as 'anorexic' made the establishment of therapeutic relationships arduous" (p. 500).

Nurses having solely medical experience, similar to the backgrounds of many of the participants in this study prior to commencing their work with EDs, often report feeling increased stigma in general towards mental illness (e.g., perceived dangerousness and unpredictability) when compared with nurses who have mental health training (Bjorkman et al., 2008; Harms, 2010; Zolnierek & Clingerman, 2012). Some medical nurses report hesitance in working with patients diagnosed with severe depression in that they are challenging to engage in conversation; depression is a common comorbid diagnosis among ED patients (Mehler & Andersen, 2010). These attitudes towards mental health patients mimic public opinions and biases, conveying a lack of awareness and understanding of mental health issues (Bjorkman et al., 2008; Harms, 2010; Zolnierek & Clingerman, 2012). This research also suggests that such negative attitudes decreased when treating patients with significant anxiety and/or eating disorders (Bjorkman et al., 2008), perhaps due to increased empathy. However, this conflicts with the findings in the current study. Several participants maintained their biases, often due to fear and uncertainty. Furthermore, research demonstrates that these biased attitudes may subsequently elicit a lack of trust and resistance by patients (Bakker et al., 2011; Morse, 1991; Snell et al., 2010). Thus, participants who relied on such biases in this study may have experienced an increase in negative treatment outcomes as a result.

Time and experience may mitigate biases among nurses (Bjorkman et al., 2008). For example, nursing research illustrates that initial knowledge and understanding of theory is often less important than experience in the field with regard to improving nurses' experiences and treatment outcomes for patients (Benner, 1982; Feng & Tsai, 2012; Wangensteen et al., 2008). Therefore, many of the participants may have

experienced such biases less frequently as they gained more experience in the field. For example, the older, more experienced nurses who had gained more exposure to mental health and ED symptoms tended to endorse biases and hesitance towards their patients less frequently. This perhaps could be a result of their having less bias, engaging in efforts to bridle their biases (Dahlberg, 2006), or neglecting to endorse biases to a therapist researcher due to discomfort or fear of judgment.

Research demonstrates that medical providers (e.g., physicians, nurse practitioners, nurses, etc.) in general medical settings have reported similar perspectives of uncertainty. For example, in a recent national survey, 59% of such providers reported lacking appropriate knowledge and skills to treat EDs; 23% reported feeling unsure about what types of questions to ask ED patients and their families when assessing their treatment needs; and most reported wishing that they could attend some type of specific training on EDs, such as shadowing an expert or attending didactic training (Linville et al., 2012). Such findings are applicable to participants in this study; most reported having solely medical training as nurses before entering the ED field.

Complexity of eating disorder treatment. Nine participants discussed the complexity of ED treatment related to ambiguity, comorbidity, challenges in often separating the patient from the ED, and how such complexity increased challenges in their work. Two participants discussed challenges associated with ambiguity in ED treatment. They reported that the lack of predictability, straightforward protocols, and time to prepare a plan of action oftentimes decreased their confidence. Research shows that such uncertainty and misunderstanding of ED symptoms and treatment may further

elicit feelings of inadequacy, incompetence, or a perceived inability to help patients among ED nurses (Ramjan, 2004; Reid et al., 2010).

Four participants in this study discussed challenges in managing comorbid diagnoses and increases in symptom severity. For most, it was challenging to simultaneously approach medical and psychiatric symptoms and to know how to best approach treatment in that they had never done so before. Comorbidity of patient symptoms may increase resistance, especially due to the ego-syntonic nature of EDs, eliciting greater challenges for ED providers (Irwin, 1993; Satir et al., 2009; Warren et al., 2012). However, one of these participants had years of nursing experience; she voiced challenges specifically in the apparent increase in symptom comorbidity and severity over the years with which she had treated EDs. In addition, many patients often conveyed illusions of health, in which their seemingly healthy physical functioning masked the significant internal physical problems and/or detrimental psychiatric issues (Mehler & Andersen, 2010; NIMH, 2014). This was especially challenging for newer nurses who were not yet adept in identifying such underlying symptoms. Identifying and managing comorbid and severe medical and psychiatric symptoms among their patients was challenging for nurses, especially when new to the field. These findings are imperative to consider when assessing the effectiveness of inpatient ED treatment in that the potential inability for nurses to recognize the significance and/or severity of ED symptoms may have significant consequences towards patient care.

Conversely, the severely malnourished state of many patients made nursing education virtually impossible at times; subsequent cognitive impairments often inhibited patients from retaining information. It is at this point of symptom severity that nurses

often have to take full responsibility over the treatment for the patient, stepping into the primary role of fighting against the ED temporarily for a patient who may be too weak to do so yet (Bakker et al., 2011; Ryan et al., 2006).

Many participants struggled at times to separate the patient from the ED, a challenge seemingly exacerbated by patient defiance. The subsequent frustration and anger of nurses appeared to decrease their ability to maintain compassion and remain objective. Time and experience in the field helped these nurses to build skills and awareness in differentiating patients from their symptoms. However, this was a work in progress, needing continual reminding. Literature examining nurses' abilities to view patients independently of their EDs quite often demonstrates that nurses may initially view ED symptomatology as volitional in nature (Fleming & Szmukler, 1992; Ramjan, 2004). Nurses may become frustrated, lacking understanding about why patients will not fix the problem and assert control. Once again, these issues are connected to a lack of knowledge and inexperience in ED treatment (Ramjan, 2004), a common experience among these participants.

Conditions of Treatment

As part of the inpatient ED treatment environment, participants encountered a variety of interpersonal and structural/systemic issues. These contributed to their personalized understanding of ED treatment and to the meaning that they subsequently created from their experiences (Crotty, 1998; Yalom & Josselson, 2011).

Building relationships. Building relationships with patients in any nursing environment involves various components. Nine participants noted that helping and supporting their patients provided meaning to their work, perhaps the most valuable part

of being an ED nurse. Mutual, connected, and cooperative relationships between nurse

and patient often include elements of trust, involvement, and caring. Such positive

interactions are important in effective nursing (Johansson et al., 2007; Morse, 1991;

Wallerstedt & Andershed, 2007) and especially in ED nursing (Halek, 1997; Pryde, 2009;

Wright, 2010). The value of being part of the journey towards recovery was often

indescribable for some participants, existentially providing meaning and a sense of

purpose to their work (Yalom & Josselson, 2011). Participants also appreciated the

longevity of ED treatment; having such an extended period of time with their patients

enabled them to increase rapport, build stronger relationships, and become a bigger part

of their recovery journey. Research illustrates that a strong therapeutic relationship is key

to successful interventions and outcomes in ED treatment (George, 1997; King & Turner,

2000; Ramjan, 2004; Zugai et al., 2013) and is established and strengthened over time

(Bakker et al., 2011; Snell et al., 2010).

Through their artifacts, two participants endorsed sub-themes of stability and

grounding, important facets to building/maintaining relationships and promoting

recovery. These themes were evident in the nurses' work with patients, in which they

tried to soothe and calm distressed patients by bringing them back to the present moment.

Therapists treating EDs commonly use these mindfulness techniques, often employed

through dialectical behavioral therapy practices (Bowers et al., 1997; Mehler &

Andersen, 2010). Participants' ultimate hope is that such stability could later translate in

these patients' lives outside of treatment.

Though strongly valued by nine participants, several also endorsed significant

struggles in their ability to build relationships with patients, often due to a lack of mutual

trust, patient resistance, personality conflicts, and/or a lack of time to engage with patients given the abundance of nursing duties. Research demonstrates that sometimes there is only commitment by the nurse while the patient remains untrusting and/or non-compliant, which may lead to increased stress for nurses and less effective outcomes for patients (Ramjan, 2004; Reid et al., 2010). Power struggles and uncertainty about how to respond to negative behaviors can further complicate the relationship (Bakker et al., 2011; Irwin, 1993; King & Turner, 2000; Ramjan, 2004).

The concept of emotional labor, or the regulation of emotions during interpersonal interactions (Cheng, Bartram, Karimi, & Leggat, 2013; Hochschild, 1983; Zammuner et al., 2003), is important in nurses' ability to establish patient relationships. To mitigate potentially negative effects, nurses may engage in surface acting, controlling or modifying emotional responses by hiding or faking (Cheng et al., 2013; Hochschild, 1983), or deep acting, actually attempting to alter their feelings to create an appropriate emotional response (Hochschild, 1983). Furthermore, struggling to regulate one's emotions by engaging in hiding and faking behaviors can lead to stress and burnout and a reduction in quality of patient care (Cheng et al., 2013; McQueen, 2004; Zammuner et al., 2003).

Finding and maintaining balance. Though varied in its focus, the theme of finding and maintaining balance was integral to participants' experiences in treating EDs. Five participants discussed the importance of maintaining balance within their relationships with their patients, through maintaining compassionate and firm boundaries/structure. Research demonstrates the importance of balancing control with empowerment when treating patients diagnosed with EDs. Nurses must provide firm

boundaries and guidance while also relinquishing some responsibility, returning decision-making back to patients, and maintaining a caring demeanor (Bakker et al., 2011; Irwin, 1993; Pryde, 2009; Ramjan, 2004; Wright, 2010).

Participants also identified finding balance within their nursing roles as important. There was an important middle-ground between building a relationship and, at times, seeming like a patient's friend versus being the strict nurse who enforces rules (Bakker et al., 2011; Snell et al., 2010; van Ommen et al., 2009). Humor was often important for participants as a means of forming social connections and alleviating the severity of patient illnesses/negative life circumstances (e.g., damaged relationships) when appropriate. Research illustrates that both using humor (Tremayne, 2014) and "maintaining a hopeful presence" (Snell et al., 2010, p. 354) are integral to nurses' ability to develop therapeutic connections with ED patients (Snell et al., 2010). Furthermore, ED patients have reported that nurses' abilities to "have fun like a regular person" helps to promote recovery and transform the treatment environment into one that is positive (Zugai et al., 2013, p. 2024). However, in balancing professionalism with humanness, nurses often become wary of becoming too close to patients out of fear of vulnerability and as a way of protecting themselves (Hem & Heggen, 2004; Johansson & Lindahl, 2011).

Four participants emphasized the importance of balancing life with self-care. It became vastly important to "practice what you preach," promoting personal health along with patient health. Nursing research supports this connection between regular self-care and positive emotional outcomes for nurses (McQueen, 2004). McQueen (2004) illustrated the importance for nurses to develop protective health strategies (e.g., coping

skills) as a means of combating stress and other negative emotional experiences. Insight, self-reflection, and experience are key factors in developing positive coping strategies to combat these negative emotional experiences and to prevent further burnout (Davidson, 1999; Maytum et al., 2004). Refining emotional intelligence can aid in this process (McQueen, 2004). Furthermore, compassionate detachment can be utilized when building relationships with patients as a means of protecting against potential negative outcomes, though it often may be challenging to detach from them (Schell & Kayser-Jones, 2007). Two participants in this study engaged in this type of emotional distancing as a means of promoting their own self-care. (This is expanded upon further under Emotional Outcomes and Awareness).

Other coping strategies demonstrated in the research to improve long term outcomes for nurses include developing a nursing theory or philosophy; advancing education; fostering self-awareness and self-reflection; developing strong professional relationships; developing rituals for dealing with grief, loss, and death; maintaining effective coping strategies outside of work, such as exercise, meditation, journaling, and recreation; having a sense of humor and positive thinking; and enjoying strong, interpersonal relationships (Hilliard & O'Neill, 2010; Maytum et al., 2004). Participants in this study noted using humor, exercise, and time with friends as self-care strategies, in addition to advancing their education and obtaining additional ED training. Five participants noted that they did not engage in self-care at the onset of their work with EDs, during which time they found themselves increasingly stressed and/or struggling to find time to balance their work with self-care. This was a result of their inability to recognize such personal disregard in the moment or overall lack of insight in that they

were too invested in their patients' emotional states to the extent that they neglected their own.

Importance of communication and support. Participants acknowledged the importance of communication and working in a supportive environment when treating patients with EDs, similar to the experiences of other ED nurses (Bakker et al., 2011; Davidson, 1999; Long et al., 2012) as well as nurses in other medical and mental health fields (Hilliard & O'Neill, 2010; Lindahl & Norberg, 2002; Wangensteen et al., 2008). Four participants stressed the importance of communication within the nursing team and across disciplines as essential for effective treatment outcomes and overall staff efficiency. Furthermore, feeling supported among colleagues and supervisors was necessary for maintaining one's own mental health and a desire to return to work. Being interpersonally connected is essential for all humans, contributing to a higher sense of purpose and value (Yalom & Josselson, 2011). This is especially important in a profession built on the premise of caring for others.

Seven participants experienced positive outcomes as a result of feeling supported. These outcomes increased confidence as a result of positive feedback, improved patient care as a result of positive communication, increased the nursing voice within the treatment team as a result of support from supervisors, and promoted a continued desire to treat EDs despite initial hesitations. For nurses, in general, increased perceived support enhances job performance and decreases overall stress (AbuAlRub, 2004; Bassett, 2002; Davidson, 1999). Furthermore, feeling appreciated further enhances job satisfaction among ED nurses as well (Pryde, 2009). This holds true across multi-disciplinary teams in psychiatric units, as dedication and communication across disciplines is a predictive

factor in positive job outcomes and positive quality patient care (Van Bogaert, Wouters,

Willems, Mondelaers, & Clarke, 2013).

Three participants acknowledged feeling unified as part of a team in treating child

and adolescent patients, akin to that within a familial environment. With this also came

an increased sense of responsibility to heal their patients, in which participants often

compared their role as nurses to that of parents. With regard to treatment interventions

and discharge planning, research shows that "the responses of RNs [registered nurses]

mirrored those of parents" (Turrell et al., 2005, p. 121) in child/adolescent ED treatment

facilities. In these programs, nurses have increased contact with parents and often try to

translate that familial atmosphere into the treatment setting. However, this maternalistic

and nurturing approach inherent to ED treatment (Malson & Ryan, 2008; Turrell et al.,

2005) also carries into the treatment of adult ED patients in that one main role for nurses

becomes to protect patients from potential death via starvation or medical complications.

Participants employed on the adult ED unit also reported feeling a sense of responsibility

akin to that of a parent at times as well.

Though perceived as an integral component to effective nursing care, five

participants in this study endorsed experiencing a lack of support and a lack of

communication between nurses at times, as well as with those from other disciplines

within the treatment team, perceiving the nursing voice as unheard. Nurses across fields

often perceive challenges in obtaining effective communication and support, which can

increase stress and negative outcomes (Davidson, 1999; Feng & Tsai, 2012; Olofsson et

al., 2003). Furthermore, there is often conflict among different disciplines within a

treatment team, even within the medical team (e.g., between nurses and physicians), which may decrease nurses' confidence to assert themselves (Lindahl & Norberg, 2002).

Several participants also noted discord with colleagues at times. Specifically, they reported feeling dismissed by the mental health therapists, viewing them as more challenging to work with than as an asset. Team climate and perceived social support, both inside and outside of the workplace, acts as a moderating factor between various work stressors and one's inability to regulate emotions (Cheng et al., 2013; Kilfedder et al., 2001). Furthermore, positive team interactions and regular meetings with those from various disciplines appear to reduce the likelihood of feeling burnt out (Cheng et al., 2013) while improving overall nursing performance and job satisfaction (Van Bogaert et al., 2013). This held true with the current participants in that those who endorsed having positive team interactions typically endorsed having more positive experiences in the workplace and fewer symptoms of burnout. These participants reported that feeling appreciated and supported helped them be better equipped to provide high quality patient care.

Fragmented roles. Eleven participants felt some level of fragmentation in their nursing roles. The aforementioned uncertainty at the time of initially entering the ED field was partially a result of the multifaceted nature of their roles, which often lacked clarity amongst the nursing and rest of the treatment team. Additional challenges also arose from a lack of hierarchy in nursing roles, in that participants often felt less respected and valued at the ED hospital, believing that they lacked control over patients' treatment. This is often true across nursing disciplines. Many nurses may struggle to find or claim their roles, which often seem ambiguous (Kilfedder et al., 2001; Lindahl &

Norberg, 2002) or as though they were too all-encompassing and overwhelming (Pryde, 2009). Subsequently, role conflicts can arise from contradictory or unclear demands put upon them and can ultimately lead to emotional exhaustion (Hem & Heggen, 2003; Kilfedder et al., 2001).

Emotional labor is often associated with the difficulty of tasks placed upon nurses in their daily work (Bassett, 2002). Not only did participants in this study feel "expected" to take on multiple roles, but they also found many of these roles to be exhausting, built upon unrealistic and often "unfair" expectations. Many participants acknowledged their tendency to be overworked, while some also struggled to "act like a therapist," lacking the prior mental health experience and/or therapeutic (counseling) skills to be comfortable enough in doing so. This often elicited a sense of incompetence. Research demonstrates that tension is created when nurses, themselves, become the instruments of therapy due to role conflicts (Hem & Heggen, 2003).

Similar to reports from nurses in various fields (Hilliard & O'Neill, 2010; Johansson & Lindahl, 2011; Lindahl & Norberg, 2002; Olofsson et al., 2003; Wallerstedt & Andershed, 2007), participants endorsed time constraints that made their jobs more challenging. They felt pulled in multiple directions and unable to complete all of their job tasks, let alone complete them correctly and provide adequate patient care. Participants felt obligated to work overtime. This experience is similar to a common sentiment in nursing, in which nurses become self-critical and disappointed in their ability to meet (often unattainable) professional standards (Hem & Heggen, 2003). Specifically, ED research demonstrates that being "understaffed and overstretched" can result in inadequate patient care and nursing distress (Reid et al., 2010, p. 394).

Five participants acknowledged a split or divide within their respective treatment teams, particularly between the medical and mental health factions. These participants felt unappreciated, dismissed, and/or disrespected by other members of the team. Feeling dismissed, as if all the work had been left for them, along with an overall lack of acknowledgement and recognition can elicit a variety of negative emotional experiences among nurses and can exacerbate existing uncertainties, a lack of confidence, and a sense of powerlessness (Allcock & Standen, 2001; Olofsson et al., 2003; Wangensteen et al., 2008). Though it is important for nurses to speak up for their discipline in a courageous manner (Bassett, 2002), many participants expressed having difficulty in challenging these negative interactions within the treatment team. Participants' lack of experience in nursing, specifically in treating EDs, was perhaps influential in their decisions to not challenge existing unfairness that they perceived within the system.

Several participants acknowledged the importance for them to fully assess their patients, take charge of managing the entire milieu, and enforce the rules, common roles among ED nurses (Halek, 1997; Wolfe & Gimby, 2003). However, one participant noted the ways in which this often placed greater stress upon the nurses when compared to mental health staff. Subsequently, the nurses often viewed other nurses as their only means of support who they could consistently "count on," since the mental health team did not appear to understand their circumstances and struggles. Nursing literature supports this sentiment in that nurses often report thinking that only another nurse would be able to understand what he or she has experienced and provide him or her with adequate support (Hilliard & O'Neill, 2010).

Pessimism. Fostering a culture of empathy is integral in nursing in order to promote better nurse and patient outcomes (Schell & Kayser-Jones, 2007). Nurses who report having ambition and dedication often convey positive attitudes (Wallerstedt & Andershed, 2007). Research demonstrates that new nurses may be more apt to identify such positive experiences (Wangensteen et al., 2008). However, pessimism often still arises in hospital environments. Many participants in the current study acknowledged feeling some inherent pessimism that encompasses ED treatment. Negative experiences with patients, including medical complications, resistance to treatment, stressful family dynamics, worry over patients' health, lost hope, and overall negative attitudes among colleagues, made trying to maintain a positive attitude when leaving work for the day often seem impossible. Research supports similar assertions, demonstrating the challenges that negative attitudes and experiences create for nurses in treating ED patients (Bakker et al., 2011; Snell et al., 2010).

Four participants reported that working with a predominantly female staff tended to increase existing tension and pessimism. As one participant referred to it, "intense female personalities" often contributed to discord due to gossiping at work. Just as several participants in this study endorsed struggles of working with primarily women, research shows that managing gender role and identity issues in empowering female patients with EDs can also be challenging (Malson & Ryan, 2008). This held true for many participants. Though not a major theme, some participants also reported that working with male patients was easier in that they "are more straightforward." Furthermore, perhaps similar gender dynamics arose when working among all female staff. This could have played a role in that female participants struggled to use their

respective voices to maintain their positions when interacting with male members of the treatment team, (e.g., physicians and psychiatrists).

Five participants endorsed challenges in maintaining hope as a result of treating EDs, a common experience among nurses in this field (Davidson, 1999; Ramjan, 2004; Sansone et al., 1988; Snell et al., 2010). Many patients were medically compromised and/or seemed "stuck" in their EDs, unable to change their perception of their bodies and their EDs. Thus, nurses often negated their respective abilities to sustain recovery. In addition, participants discussed the struggle for nurses to quantify change in that successes with ED patients were often so small. Thus, even positive changes were difficult to see, rewards were not tangible, and often the more quantifiable successes happened after patients had discharged from inpatient treatment. Furthermore, the high rate of recidivism among ED patients was an influential factor that made it difficult for nurses to maintain hope for the future. Patients with EDs often do not fully recover upon discharge from treatment, but rather "control their condition and hospital readmission occurs when the control lapses" (Wright, 2010, p. 159).

Managing resistance. Seven participants noted the need for, and accompanying stress involved with, managing resistance from ED patients, which often came in the form of rude attitudes or defiance. Negative attitudes, labile and severe mood changes, and lying were challenging issues for many nurses. Disrespect was especially triggering for participants. For example, two nurses reported that patients did not value their time, which often led to anger and annoyance on their part. These challenges often made it difficult for nurses to maintain empathy at times and to remain objective. The ED research repeatedly illustrates the tendency for ED patients to lack treatment adherence

and motivation (King & Turner, 2000; Reid et al., 2010; Snell et al., 2010). Furthermore, though a nurse's intentions may be good, an increased sense of responsibility and exertion of control over patients, especially for those acting out behaviorally or defiantly, may actually increase the amount of resistance with which they are met (Malson & Ryan, 2008).

Having managed similarly stressful situations before provides nurses with increased confidence and an ability to handle such stress when it arises (Benner, 1982; Wangensteen et al., 2008). However, most participants who reported difficulties in managing resistance as a negative outcome were newer nurses. Thus, their lack of experience may have contributed to such outcomes. That said, it might appear contradictory that Evangeline, a nurse for many years, endorsed many of the same struggles. For her, specifically, her lack of perceived support within the team, a facet integral to successful nursing outcomes (AbuAlRub, 2004; Bassett, 2002; Hilliard & O'Neill, 2010), decreased her job satisfaction and her overall ability to manage stressful situations. Therefore, though experience is important in promoting confidence, social support within an ED treatment team also appears to be integral to positive nursing outcomes (Bakker et al., 2011; Snell et al., 2010).

Emotional Awareness and Outcomes

Nurses traditionally experience a myriad of emotions as caregivers (Allcock & Standen, 2001; Hilliard & O'Neill, 2010; Olofsson et al., 2003), many of which are conflicting or may seem frustrating (Wallerstedt & Andershed, 2007). However, though some emotions may be perceived negatively, a minimal amount of anxiety is necessary and often helpful in providing motivation and a sense of purpose (Yalom & Josselson,

2011). Furthermore, though some participants in this study provided detailed descriptions of each emotion that they experienced, some just provided a general context for their emotional experiences. Thus, descriptions of emotional experiences were separated for some participants (e.g., described emotion by emotion), while aggregated into a general emotional experience for others.

In this study, all 12 participants described feeling some degree of emotional intensity toward their work. Four participants described a combination of conflicted feelings, often felt simultaneously. Prior research demonstrates that managing emotional labor often involves experiencing various emotions at once (Bassett, 2002; Cheng et al., 2013; Hochschild, 1983; Zammuner et al., 2003). Furthermore, all participants acknowledged the "uniqueness" in treating EDs, which elicited uncertainty and/or excitement dependent upon the participant. These latter feelings are common among ED nurses and are often associated with a recent entry into the field (Cordery & Waller, 2006; King & Turner, 2000; Mehler & Andersen, 2010).

Emotional rollercoaster. Given the "shared humanity" (Walsh, 1999, p. 5) of patients who require treatment, nurses gain compassion and empathy for patients by humanizing and trying to understand each individual experience (Walsh, 1999). However, with caring for patients, comes a certain amount of "emotional pressure" (Bassett, 2002, p. 36). In the current study, most participants endorsed feeling "stressed," "exhausted," or "drained," in which a lack of confidence and/or challenges in limit-setting often precipitated such experiences. However, two participants reported that their specific nursing role, excessive responsibilities, and/or tendency to "care too much," felt "overwhelming" and led to burnout. However, this commonly was not initially

recognized in the moment. Research demonstrates that high levels of empathic engagement with patients can elicit decreases in one's personal sense of accomplishment, occupational commitment (Omdahl & O'Donnell, 1999), and/or an increase in other negative emotional and physical symptoms (Hem & Heggen, 2003). Some nurses still experience unresolved, negative emotions years after having worked with certain patients (Lindahl & Norberg, 2002).

Many participants endorsed experiencing anxiety, fear, and worry regarding their patients' medical conditions, safety, psychological unpredictability, and uncertainty with how to effectively intervene. This emotional discomfort contributed to them experiencing difficulties in building strong, therapeutic patient relationships and/or to an overall dissatisfaction with their work. Research shows similar findings in that many types of nurses experience fear and uncertainty concerning how a patient might respond in any given situation (Winship, 1995), especially when treating and caring for patients with mental illness and/or EDs (Martin et al., 2013; Satir et al., 2009; Van Sant & Patterson, 2013). One participant reported feeling worried about her future, fearful of potentially having to raise a child with body image concerns and/or an ED. Furthermore, negative emotional undertones on the unit, conflict amongst colleagues and patients, and a lack of perceived support and communication also increased anxiety.

Frustration was common among participants, often resulting in anger if not dealt with appropriately. This frustration often stemmed from confrontations with specific ED behaviors (e.g., patients refusing to eat), power struggles involved in treating patients and/or managing family dynamics, encountering defiance and disrespect, and an overall lack of time had to complete nursing duties. Research shows that these experiences are

common among nurses treating various types of illnesses (Carlsson et al., 2004; Hilliard & O'Neill, 2010), including EDs (Irwin, 1993; King & Turner, 2000; Snell et al., 2010; Thompson-Brenner et al., 2012). Similar to other emotions, frustration and anger made it difficult at times for participants to maintain compassion and understanding for patients. Thus, nurses' abilities to effectively intervene and treat patients were at times compromised by their negative emotional experiences. One participant experienced countertransference towards patients at times, along with frustration and anger. Research illustrates that this experience is common among ED health care professionals (Satir et al., 2009).

Sadness, grief and loss, and vicarious trauma among participants increased the propensity for other negative emotional responses. Seven participants endorsed sadness, which was often related to witnessing patients' physical and depressive symptoms (e.g., self-loathing), a perceived inability to recover, and recidivism. Sadness and issues of grief and loss became most evident when hearing of patients' deaths. Bearing witness to patient suffering can elicit self-reflection regarding one's own vulnerability (Eifred, 2003) and further one's anxiety surrounding isolation, meaninglessness, and ultimately death (Yalom & Josselson, 2011). Furthermore, nurses who had worked in the field for long periods and/or experienced EDs, themselves, often endorsed an increased sense of responsibility as well as guilt. These nurses appeared to take on more than they felt they could handle, often suffering as a result.

Generally, nurses may report symptoms of vicarious trauma when treating patients with chronic conditions. This is often reported by mental health (Maier, 2011; Pearson, 2012) and medical (Bush, 2009; Maytum et al., 2004) nurses as one of the most

challenging parts of the job, often precipitating burnout. Three participants in this study endorsed symptoms of vicarious trauma. Associated symptoms were related to various events, including physically holding patients to administer injections, years of exposure to patients' physical malnourishment and traumatic experiences, and hearing of patient suicides. A similar concept of emotional contagion, or personally taking on the symptoms of patients, reduces a sense of personal accomplishment (Omdahl & O'Donnell, 1999); therefore, it is plausible that participants also felt less competent and/or ineffective following the experience of vicarious trauma.

Conversely, some participants reported feeling emotionally distant from their patients. There is an inherent vulnerability involved in becoming close to anyone; thus, many nurses often fear becoming too close to patients at times (Hem & Heggen, 2004; Van Sant & Patterson, 2013). Due to a lack of trust (in both themselves and in patients) or due to an effort to mitigate negative emotional experiences, two participants tended to avoid becoming emotionally "connected" with their patients. This reduced the possibility of becoming inundated with negative emotions, specifically sadness and anxiety. Furthermore, when caring for patients became too demanding, participants emotionally distanced themselves to not only try and view patients more objectively, but to also regroup and reassess their own value system (King & Turner, 2000; Van Sant & Patterson, 2013).

Johansson and Lindahl (2011) identified nurses' need to balance distance and closeness in their relationships with patients as a means of self-protection. Nurses must find a balance between being professional and being human when forming emotional ties with patients. The professional way to know patients and to build relationships with them

includes incorporating some emotional distancing, with patients needing to recognize and take responsibility for their own emotions, in addition to nurses' maintaining respect for their privacy (Allan & Barber, 2005).

Increased empathic engagement was common among participants. Similar to the experience among most nurses, empathy helps nurses to build relationships and also fosters empowerment among patients (Bassett, 2002; Ryan et al., 2006). However, some participants questioned if their "caring too much" was the cause for subsequent burnout. Research illustrates that emotional exhaustion may increase based on higher levels of empathic engagement among nurses and/or an overall negative affect or psychological distress (Kilfedder et al., 2001; Omdahl & O'Donnell, 1999).

Burnout, however, was a less common experience among the participants in this study. Perhaps it was not frequently endorsed given that most participants were newer to the field and/or generally reported satisfaction with their current positions. The two nurses who were older than the rest and had worked in the field longer were the two who had also recently quit their nursing positions. Therefore, as reported by participants in this study, burnout was related to length of time in the field. In addition, burnout, at times, is also associated with higher levels of personal accomplishment (Kilfedder et al., 2001). Though not an ideal emotional reaction, it appears as though nurses who tend to burn out may be those who perceive themselves as working harder. This notion was not true of participants in this study, though would be an interesting topic to assess in the future after many of these new nurses have gained more time in the field.

Negative emotional experiences (e.g., high levels of stress and/or burnout) led to negative coping strategies among some participants. These participants took on more than

they had initially wanted (e.g., working overtime), had difficulty maintaining boundaries with patients, and/or stopped engaging in self-care for periods of time. Lack of self-care included poor diet and exercise, increased alcohol consumption, and an overall sense of feeling "run-down, fatigued, and tired." Though more often focused on therapists, research demonstrates ways in which increased stress in treating EDs lead to negative coping strategies. The ED treatment providers have reported drinking alcohol, smoking cigarettes, and even engaging in self-injury in order to cope (Warren et al., 2012). King et al. (2009) found an increased rate of disordered eating among nurses in general. This negative coping style was not specifically endorsed among the participants within this study. In fact, appreciation for food as "health" was a more common experience, though one participant reported witnessing this negative coping style among colleagues. For example, dieting, food, and weight were common discussion topics among nursing staff behind closed doors.

Nurses have reported that, even when treating terminally ill patients, there is some meaning and value in being part of such a monumental event (Johansson & Lindahl, 2011). Yalom and Josselson (2011) stated, "One of our major life tasks is to invent a purpose sturdy enough to support a life" (p. 313). This sense of meaning and value for nurses can be identified in this study. Few participants endorsed symptoms of compassion fatigue or vicarious trauma. Perhaps the value in being part of such an important treatment process, treating life-threatening illness and saving lives, helped to combat such potential negative symptoms. In fact, half of the participants endorsed positive feelings, such as happiness and excitement, as central to their experiences in treating EDs. Such happiness often stemmed from building relationships with patients

and/or witnessing success in recovery, even if only small improvements. These positive sentiments support the intrinsic nature and desire of all humans to attain a sense of purpose (Yalom & Josselson, 2011).

Witnessing recovery. Witnessing recovery enhances ED nurses' ability to create meaning in their work, an important facet for sustaining emotional well-being (Hilliard & O'Neill, 2010) and for maintaining a greater sense of purpose (Yalom & Josselson, 2011). Six participants reported witnessing recovery as being a valuable component of their work. The "excitement" in seeing patients recover involved both witnessing the physical transformation as well as hearing of patients who had maintained recovery after discharge. These positive emotions help balance nurses' experiences, counteracting the more challenging components of the work and providing them with a reason to continue treating patients with such complex and challenging diseases.

However, half of the participants did not specifically endorse witnessing recovery as being central to their experiences. There are two plausible explanations for this. First, perhaps some participants' newness to the field prevented them from yet witnessing such sustained recovery. A second possibility is that an increased focus on negative experiences at times during the interview process could have jaded participants from identifying the positive. Though anxiety can have negative professional and personal consequences (e.g., decreased competence at work, decreased focus on self-care, and adaptive coping strategies) (King et al., 2009; Warren et al., 2012), it is also a motivating force. For example, anxiety surrounding life's ultimate concerns is a natural experience for all people. Confrontation of this anxiety is what drives people to create goals and subsequently follow through (Yalom & Josselson, 2011). Thus, though participants often

focused on challenges in treating EDs, this focus perhaps drove them to work harder. Subsequently, participants derived meaning from their work, though not always explicitly stated.

Four participants conveyed hope for their patients' recovery through their artifact descriptions. Witnessing recovery and patients' newfound appreciation for life enabled these nurses to become more hopeful for their patients' futures. Strong therapeutic relationships between ED healthcare professionals, including nurses and ED patients, increases hope and optimism for recovery (Wright & Hacking, 2012). Although not a central theme among participants, there was a notable contrast in the experience of hope when comparing nurses who worked with adults versus those who worked with adolescents. Hope was more common among participants working with adolescents, given the reduced time frame that many younger patients had struggled with their EDs. Adolescents were often less "entrenched" in their EDs, starting ED behaviors as a means of seeking attention from their families or friends or gaining control in their lives (Berge et al., 2011; Turrell et al., 2005).

These perspectives of increased hope are contrary to some assertions presented in the literature. For example, many nurses who treat adolescents diagnosed with EDs have reported increased frustration, challenges to their value system, and an overall "disenchantment within their nursing practice" (King & Turner, 2000, p. 145). There is the tendency to place blame on ED symptoms and assume that patients can simply change, given the volitional nature of their symptoms (Ramjan, 2004; Ravenaeau et al., 2014). Though these negative sentiments were present among participants in the current study, those who treated adolescents generally conveyed increased hope when compared

with previous research (Malson & Ryan, 2008; Ramjan, 2004). Perhaps, as was the case for many conclusions drawn from the data, being relatively new to the field helped to mitigate a negative outlook. For some, research demonstrates that positive impressions and overall job satisfaction tend to decrease with time (Sansone et al., 1988).

Body image awareness. Five participants stressed how treating EDs had increased their own awareness about body image. Three reflected upon their increased recognition of body image issues in society, while one elaborated that she became so attuned to body image concerns that she often mislabeled body types as having EDs when they in fact did not (e.g., believing that someone who is thin must have anorexia nervosa). Self-consciousness at work was a common experience for two participants, who made certain to eat and dress in a "healthy" way to avoid misperceptions that they had an ED. One participant became distressed by the degree to which the nursing staff focused on food and weight while at work. Research shows that disordered eating is common among nurses in general (King et al., 2009), let alone among ED nurses, a topic yet to be researched. Finally, two participants conveyed having developed more positive body images as a result of treating EDs. They now valued their own bodies more so, not wanting to be "sick" like their patients. They also endorsed a newfound respect for food and health and decreased sense of judgment regarding their own physical imperfections.

Growth. Personal and professional growth occurs from a culmination of positive and negative experiences. As a new nurse to the field, one gains competence through clinical exposure and practice (Wangensteen et al., 2008). Participants in this study reflected upon their own personal growth as nurses during their time treating EDs, referencing increased competence/skills, gaining compassion for patients, and learning

how to more effectively communicate and build relationships with patients and colleagues. Furthermore, one participant equated being challenged with a positive experience/growth, finding ways to quickly create solutions and improve future outcomes. Though often perceived as stressful, gaining such competence, skill, and awareness are essential to a nurse's professional growth (Feng & Tsai, 2012; Hilliard & O'Neill, 2010; Lindahl & Norberg, 2002; Van Sant & Patterson, 2013).

Implications

Several implications emerge from this study that nurses should consider when treating patients diagnosed with EDs. These include specific concerns that nurses experience with regard to their initial attitudes, conditions of treatment, and emotional awareness and outcomes. The findings from this study can be interpreted and applied through an existential theoretical framework. From this perspective, fears of isolation are common experiences for all humans (Yalom & Josselson, 2011). Yet, such issues are pervasive among ED patients, many of whom have experienced damaged interpersonal relationships as a result of their illness (Garner et al., 1982; Mehler & Andersen, 2010). Therefore, those caring for these patients may vicariously experience such isolation, in addition to having such feelings exacerbated through isolation within the treatment teams, in which nurses may feel unsupported or alone (Coomber, 2010; Davidson, 1999; Pryde, 2009). Furthermore, this perspective helps to fuse the fields of nursing with psychology by providing a unifying human connection in that all people struggle with the same life concerns (Yalom & Josselson, 2011).

Gaining a sense of meaning and value is an integral part of the ED nursing experience, in that it facilitates personal and professional growth and other positive

outcomes (Johansson & Lindahl, 2011; Wallerstedt & Andershed, 2007). Furthermore, nurses treating EDs also face issues of mortality, potentially eliciting fear surrounding one's own death and recognition of their own vulnerability as humans (Eifred, 2003; Johansson & Lindahl, 2011). This type of self-reflection can be valuable, helping nurses to understand their experiences and to develop more adaptive coping strategies. However, nurses should also recognize that such awareness may elicit negative outcomes, such as increased stress or burnout, as a result of anxiety.

Many nurses enter the ED field unaware of issues specific to ED treatment. This study, along with support from previous research, clearly conveys the uncertainty and unpreparedness felt by many nurses when commencing their work in treating EDs. A result of this lack of training and/or fears surrounding the complexity of the disease (Cordery & Waller, 2006; Fleming & Szmukler, 1992; Ramjan, 2004; Reid et al., 2010) is an important issue to address. It is essential that nurses treating EDs be prepared to manage such complex diseases for their own sake and for that of their patients. Furthermore, prior understanding and knowledge of what to expect will help to mitigate potentially negative consequences, such as overwhelming stress, burnout, or negative coping strategies, all of which are common to professionals in the ED field (AbuAlRub, 2004; Kilfedder et al., 2001; Oloffson et al., 2003; Snell et al., 2010).

Mental health training courses are provided in the United States and in other countries (e.g., Australia) through nursing organizations, though they often bear an extra financial burden (Ramjan, 2004). However, ED nurses can obtain continuing education credits through webinars from the American Psychiatric Nurses Association, which are typically inexpensive (American Psychiatric Nurses Association, n.d.; National Eating

Disorders Association, n.d.) An integral role in the field of psychology is providing psychoeducation for others. Therefore, as a future consideration, perhaps mental health professionals in the field, such as counseling psychologists, could aid in promoting nursing confidence through providing mental health/ED training for medical professionals at the medical and nursing school levels. Psychologists play an active role in working to improve communication across disciplines within the ED treatment team, helping to bridge the gap between nursing and mental health. Furthermore, gaining exposure, education, and clinical practice has been shown to bolster nursing confidence and subsequent nurse and patient outcomes in medical settings (Feng & Tsai, 2012; Wangensteen et al., 2008).

Gaining a greater understanding of nurses' emotional experiences is relevant to the field of counseling psychology and its strengths–based approach. Though the experience of negative emotions is not unique to ED nurses (AbuAlRub, 2004; Hilliard & O'Neill, 2010; Olofsson et al., 2003), negative emotions, such as vicarious trauma and grief/loss, may be more pervasive when treating ED patients who have often experienced trauma themselves and/or who may be at risk of dying. Psychologists play an integral role in the creation and management of ED treatment facilities. Therefore, increased awareness surrounding nurses' experiences will improve psychologists' abilities to provide context and effective training protocols for medical professionals, further enhancing program development. Psychologists can aid in minimizing adverse emotional outcomes and maximizing benefits through bolstering emotional support for nurses. Subsequently, this will also increase the meaning and effectiveness of psychologists' roles in treating EDs. Furthermore, given ED psychologists providing therapy may only

meet with patients once or twice a week, they can also learn from nurses' experiences, given the 24-hour care they provide, and integrate such knowledge into their own practices with ED patients.

Traditional nursing roles do not involve managing patient resistance; most medical patients want help. However, resistance is common when treating patients diagnosed with EDs (Bakker et al., 2011; Irwin, 1993; Reid et al., 2010; Snell et al., 2010; Warren et al., 2012). The current study conveys nurses' stress in managing resistance among ED patients. Participants were often caught off guard and/or unsure of how to manage this type of behavior. Being prepared of ways to manage resistance could help nurses feel more comfortable and confident in doing so. Research illustrates that training in ED treatment, specifically training on managing resistance provided by master– and doctoral–level counselors, improves medical providers' knowledge and skills in treating EDs (Linville, Aoyama, Knoble, & Gau, 2013). Furthermore, trainings and webinars specifically for mental health nurses and nurses treating EDs are also effective means of preparation (American Psychiatric Nurses Association, n.d.; National Eating Disorders Association, n.d.). Participants in this study who had engaged in specific ED training above and beyond their required trainings (e.g., Certified Eating Disorders Specialist training) reported increased levels of competence and comfort in treating their patients. Engaging in such training, in addition to also learning motivational interviewing techniques specifically from mental health professionals (e.g., psychologists) to help work with ambivalence, will help nurses to develop relationships with patients and increase effectiveness/adherence to treatment.

Several conditions of treatment are often stressful for ED nurses to manage. These include issues of fragmented roles and a generalized pessimism within the workplace. Though these issues are common among nurses in general (AbuAlRub, 2004; Feng & Tsai, 2012; Olofsson et al., 2003), they can present differently in ED treatment facilities. For example, having to act like a therapist is stressful for nurses with no background in mental health. Furthermore, though nursing is a female-dominated profession, ED treatment units are one of the few environments in which both the staff and patients are primarily female. Thus, nurses entering the ED field should become aware of such facets beforehand to determine if they feel ready to face these additional stressors and to prepare to seek out support as needed. Furthermore, training of basic therapeutic skills by psychologists can decrease feelings of uncertainty, increase competence, and aid nurses in developing personal ways to cope (e.g., stress management and relaxation techniques) (American Psychiatric Nurses Association, n.d.).

From the findings of this study, nurses may also glean a sense of what not to do when treating patients diagnosed with EDs. There is a consensus between the findings from this study and previous research regarding nursing attitudes of stigmatizing mental illness and EDs (Harms, 2010; Zolnierek & Clingerman, 2012). The ways in which these biases increase challenges in building patient relationships (Bjorkman et al., 2008; Harms, 2010; Zolnierek & Clingerman, 2012), ultimately increasing negative emotional outcomes for nurses, is important for nurses to examine prior to entering the ED field.

Awareness of these factors, in addition to the need to find and maintain emotional balance, the importance of engaging in consistent communication and obtaining support, and the accompanying challenges and subsequent emotional outcomes, are important

factors with which to be familiarized prior to entering the ED field. This may help nurses and psychologists better acclimate to such new environments, avoid ineffective coping strategies, and prepare ways to cope/reach out for support before experiencing symptoms of vicarious trauma or burnout (Bassett, 2002; Maytum et al., 2004; Olofsson et al., 2003).

Limitations

As with most qualitative research, readers should use their own judgment when assessing the applicability of this study to their own work in that not all findings are transferable (Creswell, 2007; Merriam, 2009). Furthermore, from both social constructionist and existential perspectives, all nurses interpret their experiences individually and construct their internal worlds subjectively to create personal meaning (Crotty, 1998; Patton, 2002; Yalom & Josselson, 2011). Even if nurses share similar experiences, the specific circumstances surrounding treatment for each professional may vary, and each may add their own uniqueness to their experiences. Therefore, it is important to take the aforementioned findings and assertions with caution.

There were both strengths and limitations to the current study. First, my prior experience working in an ED hospital and my position in the mental health field as a psychologist–in–training could have impacted the findings. For example, some participants may have been hesitant to disclose information because they were familiar with me and know that I am a therapist. Research examining medical nurses' experiences in working with other members of treatment teams, such as mental health therapists, illustrates that nurses often experience having a lack of confidence, feelings of powerlessness, and an inability to assert themselves within the treatment team (Olofsson

et al., 2003; Wallerstedt & Andershed, 2007). These factors could have influenced the amount of information that participants disclosed during the interviews.

Furthermore, these factors could have also affected who volunteered to participate in the study. Those who were uncomfortable or fearful of disclosing information to a therapist may have decided against volunteering. Therefore, given this study only reflected the views of those who chose to participate, a large portion of perspectives may be missing. Perhaps those who were not willing to participate felt more strongly about certain topics and could have added alternative viewpoints to enhance the richness of the data. It is also plausible that participants who did engage in the study felt responsible to portray both themselves and the hospital more favorably, neglecting to disclose more sensitive information.

Though I attempted to use maximum variation sampling (Merriam, 2009), 10 out of 12 participants were Caucasian. And though most nurses treating EDs tend to be female, including all female participants may have also elicited a skewed perspective. Furthermore, all participants were raised in and practiced nursing in the United States, limiting the ability to obtain broader, more diverse perspectives more likely to transfer across contexts. Including participants who are male, of diverse racial and ethnic backgrounds, and from varied geographic locations could elicit a more diverse perspective and increase transferability. In addition, two participants in the study had recently quit their positions as inpatient ED nurses. Though only a short amount of time had elapsed, this study may have introduced an element of recall bias.

Triangulation in this study is also lacking. Half of the participants did not engage in member checks, neglecting to provide their impressions of the textural–structural and

composite descriptions. Though I assumed this was indicative of their agreement with the results, it is possible that some participants might have chosen to add to or alter some of their thematic structure.

Future Research Directions

The current study extended ED nursing research beyond its traditional constraints, obtaining a deeper understanding of the subjective experience. Potential directions for future research have emerged from the interpretations of its findings.

Given that nursing research alludes to the importance of recognizing emotional intelligence among nurses, specifically the connection between emotional labor and burnout (McQueen, 2004), perhaps future research could extend this focus by examining potential correlations between emotional intelligence in ED nurses and their subsequent emotional outcomes. Exploration of these constructs could help to identify which of these emotional experiences are self-identified and understood by ED nurses, in addition to which facets of emotional labor as experienced by ED nurses directly affect subsequent burnout. With this knowledge, psychologists in management positions at ED hospitals could better train and support nurses to become more self-aware in identifying their emotions and to develop more adaptive coping strategies when experiencing stress.

Exploration of gender roles and specific negative coping strategies also could be avenues for research. In this study, all participants were female and many endorsed struggling to work with and treat primarily women. Furthermore, research illustrates challenges in empowering female patients with EDs (Malson & Ryan, 2008). Perhaps future research could compare relational dynamics between male nurses and other members of the treatment team (e.g., other male and female nurses and male and female

therapists) to identify potential similarities and differences. Given the small number of male patients who nurses in this study had treated, it may also be helpful to understand these dynamics between ED nurses of either gender and male patients. In addition, though researchers have examined negative emotional experiences and coping strategies among ED nurses (Pryde, 2009; Snell et al., 2010), there has yet to be any exploration of EDs among nurses who treat EDs. Given that King et al. (2009) illustrated disordered eating among general medical nurses, one might expect an increase of these symptoms among nurses exposed to the additional stressors of ED treatment in addition to the constant exposure to, and discussion of, food, weight, and body image.

Finally, mixed methods research could also be useful in examining nurses' experiences in treating EDs. Not only could such research enhance empirical validation, but it could also help to better assess certain symptomatology. For example, vicarious trauma can be a delicate topic to address directly. Nurses may not be fully aware of such symptoms and may not endorse them if asked in an open-ended manner, potentially feeling uncomfortable or embarrassed. Given the challenges in assessing such symptoms via qualitative inquiry, a quantitative measure may provide an easier, more indirect way of assessing these symptoms, in addition to decreasing potential embarrassment or perceived stigma.

Conclusion

Nurses' experiences in treating EDs affect various members of the multidisciplinary treatment team and subsequent treatment outcomes. Thus, such experiences are significant to explore for both the fields of nursing and counseling psychology. Much existing ED research not only takes a quantitative focus, but also

examines specifics facets of nurses' work, perhaps ignoring the broader experience. This study contributes to the field in a unique way, assessing the subjective experience through both benefits and challenges. Therein also lay a need for future researchers to gain additional insight into ED nurses' subjective experiences, examining positive aspects of their work to help promote a strengths-based approach to improve staff and patient outcomes and avoid pessimistic undertones.

Fostering increased understanding of ED nurses' experiences and providing workplace support is imperative across all disciplines within an ED treatment team, though especially important for mental health professionals. Counseling psychologists are often the ED providers directly communicating with nursing staff, in addition to providing their mental health training. Thus, it is imperative that counseling psychologists and nurses work together in continuing to bridge the gap between the medical and mental health perspectives of ED treatment. This can help to promote a healthier working environment, enhance positive experiences for all ED providers, and improve treatment outcomes. Furthermore, I stress the importance for all members of these treatment teams to not only convey interest, but also actively pursue understanding of their counterparts' experiences to improve communication and better inform their collective support structure and treatment decisions. Evangeline best summarized this outlook. She stated:

> Early on, I felt it was very much a team. We had daily team meetings where you met with the physician, the psychiatrist, and that person's primary [therapist]. Oh, and the dieticians. I loved it and thrived in it. We communicated with each other and worked very closely. They'd say, "What's going on on the nursing side?" and we'd say, "What's going on on the dietary side?" And I thought we worked together so well and I loved those team meetings. I thought we all had an important role to play. And then we started growing by leaps and bounds. . . . And then at some point, we changed the model. . . . We became less a part of the team

and I could quickly see how the nurses would gripe about the therapists and the dieticians . . . Over time there was less connectedness.

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APPENDIX A

INSTITUTIONAL REVIEW BOARD APPROVAL

UNIVERSITY *of*
NORTHERN COLORADO

Institutional Review Board

DATE: January 29, 2013
TO: Diana Levas-Luckman
FROM: University of Northern Colorado (UNCO) IRB
PROJECT TITLE: [403375-3] Working with Medical and Psychological Illness: A
                     Phenomenological Exploration of Nurses' Experiences in Treating Eating
                     Disorders
SUBMISSION TYPE: Amendment/Modification
ACTION: APPROVED
APPROVAL DATE: January 29, 2013
EXPIRATION DATE: January 29, 2014
REVIEW TYPE: Expedited Review

Thank you for your submission of Amendment/Modification materials for this project. The
University of Northern Colorado (UNCO) IRB has APPROVED your submission. All research
must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on applicable federal regulations.

Please remember that informed consent is a process beginning with a description of the project
and insurance of participant understanding. Informed consent must continue throughout the
project via a dialogue between the researcher and research participant. Federal regulations
require that each participant receives a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this
committee prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others and SERIOUS and
UNEXPECTED adverse events must be reported promptly to this office.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly
to this office.

Based on the risks, this project requires continuing review by this committee on an annual basis.
Please use the appropriate forms for this procedure. Your documentation for continuing review
must be received with sufficient time for review and continued approval before the expiration date
of January 29, 2014.

Please note that all research records must be retained for a minimum of three years after the
completion of the project.

If you have any questions, please contact Sherry May at 970-351-1910 or
Sherry.May@unco.edu. Please include your project title and reference number in all
correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within
University of Northern Colorado (UNCO) IRB's records.

APPENDIX B

LETTER OF INTENT TO PARTICIPANT

UNIVERSITY *of*
NORTHERN COLORADO

Dear Interested Participant,

My name is Diana Luckman and I am a doctoral student at the University of Northern Colorado (UNC), currently working on my dissertation. I am researching the experiences of nurses treating patients diagnosed with eating disorders in order to gain a better understanding of nurses' roles, the challenges and benefits they perceive, and the ways in which prior knowledge, training, and social support have affected their work. To gather information, I would like to interview you to discuss your experiences as a nurse on an inpatient eating disorder unit and your relationships with both patients and colleagues. All of your responses will be kept entirely confidential. The interview will last approximately 60 minutes and will be conducted in a quiet, confidential location of your choice, such as an office, private room, or other confidential space.

If you are interested in participating in this study, or if you would like to learn more, please contact me by phone (xxx) xxx-xxxx or e-mail diana.luckman@unco.edu. Thank you for your consideration!

Sincerely,

Diana Luckman, M.A.
Doctoral Candidate, Counseling Psychology
University of Northern Colorado

APPENDIX C

**INFORMED CONSENT FORM FOR HUMAN
PARTICIPANTS IN RESEARCH:
SITE AGREEMENT**

UNIVERSITY *of*
NORTHERN COLORADO

Project Title: *Working with Medical and Psychological Illness: A Phenomenological Exploration of Nurses' Experiences Treating Eating Disorders*

Researcher: Diana Luckman, M. A., Department of Counseling Psychology
(xxx) xxx-xxxx leva8472@bears.unco.edu

Research Advisors: Mary Sean O'Halloran, Ph.D., Department of Counseling
Psychology, (xxx) xxx-xxxx sean.ohalloran@unco.edu

Jeffrey Rings, Ph.D., Department of Counseling Psychology
(xxx) xxx-xxxx jeffrey.rings@unco.edu

My name is Diana Luckman and I am a Doctoral student in Counseling Psychology at the University of Northern Colorado. I am conducting a qualitative research study to understand the experiences of nurses treating patients diagnosed with eating disorders (EDs). In doing so, I hope to better understand ED nurses' experiences overall and identify factors that influence such experiences in positive or negative ways.
If your organization agrees to participate in this study, chosen participants (nurses) will first be asked to complete one page of background information, such as their ages and other demographic information. Immediately following this, they will then be asked to participate in an interview, lasting approximately one hour, which will be audio taped. Interviews will take place in a quiet location of participants' choice (e.g., their office, a private room, or another confidential space at their work or at UNC campus). Various questions will be asked to gain a better perspective of how they experience treating EDs from a nursing perspective: essentially, how they make meaning of their experiences. I will ask them how they define their experiences, to explain benefits and challenges from their work, and how their prior training has affected their experiences. I will also ask questions about their relationships with patients and colleagues and ways in which they engage in self-care. In addition, I would welcome any visual representation (e.g., drawing or piece of art) that they may want to provide that represents their experiences working as ED nurses. After the interviews, I will contact participants by phone to provide them with an opportunity to meet again to review the emerging findings from their interviews for accuracy and see if they fit with their experiences. Ultimately, I will report my findings as part of my doctoral dissertation and may present the results at a professional conference and/or in the form of a manuscript for professional publication. Participants are welcome to request a copy of the final paper to review before I submit it for presentation or publication.

Participants' confidentiality will be protected to the best of my ability. Signed informed consent forms (such as this document) will be stored in a locked filing cabinet and kept for three years. I will audio-record interviews on a password protected audio-recording

device, which will later be transcribed. Prior to recording the interview, I will ask participants to choose pseudonyms that I will refer them as during the interview. After the interview, I or another member of my research team will transcribe the interviews. The members of the research team will be Masters or Doctoral students in Counseling or Psychology and will be trained in confidentiality and ethics. Because participants will only be referred to as their pseudonyms on the audio recording, the research team members will only know them as their pseudonyms, and not their real name. Only participants and I will know their identities and such information will not be shared with anyone. Furthermore, if any information is revealed during the interview that could identify participants, I will remove the information on the transcript. Once the interviews are transcribed, the audio-recordings will be deleted. Only pseudonyms will be used in the final report.

Please note that as a mandated reporter in the State of Colorado, I am required to break confidentiality for the following reasons:

- Suspected or reported child abuse or neglect
- Reported suicidal or homicidal plans or intent

While I will do my best to inform participants if I need to break confidentiality because of one of these reasons, I am not required to do so.

I foresee minimal to no risks to participants in this study. The minimal foreseeable risks may include participant discomfort in discussing personal experiences in treating eating disorders, specifically if experiences were negative. If, during the interview, participants experience discomfort or uncomfortable emotions, they may end the interview at any time, and everyone will be provided with a referral list of mental health providers. Foreseeable benefits of this study include time for participants to reflect on personal experiences of their work and ways in which they were challenged, which may lead to new personal insights regarding working as an ED nurse. Also, this study may benefit other nurses and other mental health providers by helping them to better understand the experiences of working with EDs from a medical perspective and potentially lead to improved training, support, and treatment outcomes.

Participation is voluntary. Participants may decide not to participate in this study and if they begin participation they may still decide to stop and withdraw at any time. Such decisions will be respected and will not result in loss of benefits to which they are otherwise entitled. Having read the above and having had an opportunity to ask any questions, please sign below if you would like your organization to participate in this research. A copy of this form will be given to you to retain for future reference. If you have any concerns about your selection or treatment as a research participant, please contact the Office of Sponsored Programs, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-2161.

If you have any questions or concerns, please do not hesitate to ask me in person or contact me via phone or e-mail.

Thank you for participating.

_____   _____
Participant's Printed Name   Date

_____   _____
Participant's Signature   Date

_____   _____
Researcher's Signature   Date

APPENDIX D

**INFORMED CONSENT FORM FOR HUMAN
PARTICIPANTS IN RESEARCH:
PARTICIPANT AGREEMENT**

UNIVERSITY *of*
NORTHERN COLORADO

Project Title: *Working with Medical and Psychological Illness: A Phenomenological Exploration of Nurses' Experiences Treating Eating Disorders*

Researcher: Diana Luckman, M. A., Department of Counseling Psychology
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Research Advisors: Mary Sean O'Halloran, Ph.D., Department of Counseling
Psychology, (xxx) xxx-xxxx sean.ohalloran@unco.edu

Jeffrey Rings, Ph.D., Department of Counseling Psychology
(xxx) xxx-xxxx jeffrey.rings@unco.edu

My name is Diana Luckman and I am a Doctoral student in Counseling Psychology at the University of Northern Colorado. I am conducting a qualitative research study to understand the experiences of nurses treating patients diagnosed with eating disorders (EDs). In doing so, I hope to better understand ED nurses' experiences overall and identify factors that influence such experiences in positive or negative ways.

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I will report my findings as part of my doctoral dissertation and may present the results at a professional conference and/or in the form of a manuscript for professional publication. You are welcome to request a copy of the final paper to review before I submit it for presentation or publication.

Your confidentiality will be protected to the best of my ability. The signed informed consent form (this document) will be stored in a locked filing cabinet and kept for three years. I will audio-record your interview on a password protected audio-recording device, which will later be transcribed. Prior to recording the interview, I will ask you to choose a pseudonym that I will refer to you as during the interview. After the interview, I or another member of my research team will transcribe the interviews. The members of the research team will be Masters or Doctoral students in Counseling or Psychology and will be trained in confidentiality and ethics. Because you will only be referred to as your pseudonym on the audio recording, the research team members will only know you as such pseudonym, and not your real name. Only you and I will know your identity and such information will not be shared with anyone. Furthermore, if any information is revealed during the interview that could identify you, I will remove the information on the transcript. Once the interview is transcribed, the audio-recording will be deleted. Only the pseudonym will be used in the final report.

Please note that as a mandated reporter in the State of Colorado, I am required to break confidentiality for the following reasons:

- Suspected or reported child abuse or neglect
- Reported suicidal or homicidal plans or intent

While I will do my best to inform you if I need to break confidentiality because of one of these reasons, I am not required to do so.
I foresee minimal to no risks in this study. The minimal foreseeable risks may include your discomfort in discussing personal experiences in treating eating disorders, specifically if experiences were negative. If, during the interview, you experience discomfort or uncomfortable emotions, you may end the interview at any time, and you will be provided with a referral list of mental health providers. Foreseeable benefits of this study include time for you to reflect on personal experiences of your work and on ways in which you were challenged, which may lead to new personal insights regarding working as an ED nurse. Also, this study may benefit other nurses and other mental health providers by helping them to better understand the experiences of working with EDs from a medical perspective and potentially lead to improved training, support, and treatment outcomes.

Participation is voluntary. You may decide not to participate in this study and if you begin participation you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled. Having read the above and having had an opportunity to ask any questions, please sign below if you would like to participate in this research. A copy of this form will be given to you to retain for future reference. If you have any concerns about your selection or treatment as a research participant, please contact the Office of Sponsored Programs, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-2161.

If you have any questions or concerns, please do not hesitate to ask me in person or contact me via phone or e-mail.

Thank you for participating.

_____   _____
Participant's Printed Name   Date

_____   _____
Participant's Signature   Date

_____   _____
Researcher's Signature   Date

APPENDIX E

DEMOGRAPHIC INFORMATION SHEET

Pseudonym:_____

1. Age: _____

2. Gender: Male _____   Female _____   Transgender_____

3. Ethnicity/Race:

   _____

4. Highest level of education completed/Licensure:

   _____

5. Type of Nurse at your current job (e.g., medication nurse, floor nurse, charge nurse):

   _____

6. How long have you been employed at your current job? _____ __

7. What types of nursing environments have you worked in and for how long? _____

   _____

8. How many years have you worked in the mental health field? _____

9. How many years have you worked specifically with eating disorders? _____

10. Approximately how many patients who have been diagnosed with eating disorders have you worked with? _____

    _____

11. Have you worked with both adults and adolescents? _____

    a. With which population are you currently working? _____

12. Prior to accepting this job, what were your experiences with eating disorders? ____

    _____

13. Please check the statement(s) that represent why you began working with eating disorders:

    _____ I have had a prior ED diagnosis
    _____ I have always been interested in treating this population
    _____ I just happened to need a job when this facility was hiring
    _____ Other: Please explain

    _____

14. Please include any other demographic information that you believe would be important for me to know about you for the purposes of this study:

    _____
    _____

15. May I contact you after the interview to gather more information or verify research findings? Yes_____   No_____

    a. If yes, please fill in. Phone_____

APPENDIX F

INTERVIEW GUIDE

General questions

- What has been your (emotional) experience working with eating disorders?
- How has your training in mental health and eating disorders affected, influenced, and/or prepared you for your work?
  - If lack of training → how did you deal with that?
- How has working with eating disorders fared when compared with working in other settings where you have previously worked?
  - Compared with other medical settings? Psychiatric settings?
  - Similarities? Differences?
- Explain your role(s) as a nurse treating ED on your unit?
  - If you've had different roles, what have been your preferences?
- What benefits do you identify from your work? What is meaningful and valuable?
  - Please provide an example of a specific situation
- What have been challenges in your work?
  - Please provide an example of a specific situation
- How would you describe the relationship between you and your patients diagnosed with eating disorders?
  - What factors were influential in forming and maintaining the relationship with your patients? What factors helped to facilitate building relationships?
    - On your part? On the part of the patient?
  - What factors were influential in challenging the relationship with your patients? What has made relationships difficult?
    - On your part? On the part of the patient?
- What differences, if any, have you noticed working with anorexia nervosa vs. bulimia vs. binge eating? Adults vs. adolescents? Males vs. females?
  - How have such differences affected your ability to build and maintain relationships?
- How would you describe your relationships with your colleagues and supervisors? With about with other members of the treatment teams?
- How does support at the workplace impact and influence your relationships with your patients? With your colleagues and supervisors?
- How has working with eating disorders affected your own body image/eating habits?
- How does self-care play a role in your work?
- Is there anything else you would like to add?

Artifact description
- Describe the object(s) you brought that symbolize your work treating eating disorders.
- How do these objects represent or characterize your experience of working as n ED nurse?

APPENDIX G

MENTAL HEALTH RESOURCES

Emergency for Denver County Residents (psychiatric, drug/alcohol):
Denver Health Medical Center (formerly Denver General)

777 Bannock St.	303 602-7221
	303 602-7236
Metro Crisis Services	888-885-1222

Emergency for non-Denver County Residents:
Call Crisis Lines for Community Mental Health Centers

Adams County Mental Health Center	303 853-3500
Arapahoe Mental Health Center	303 730-3303
Aurora Community Mental Health Center (North office)	303 617-2400
Jefferson Center for Mental Health	303 425-0300

Note: This line rolls over to Inpatient Pavilion for University of Colorado
Health Sciences Center at night (12605 E. 16th Ave – Colfax & Ursula)   720 848-5197

Suicide Hotline

COMITIS Helpline	303 343-9890
National Suicide Prevention Lifeline	1-800-273-TALK (8255)
	1-888-628-9454 (Spanish)

Eating Disorder Treatment

ACUTE Center for Eating Disorders at Denver Health	1-877ACUTE4U
Eating Disorder Center of Denver	866 771-0861
La Luna Center, Boulder	720 470-0010
La Luna Center, Fort Collins	970 282-8282

http://www.edreferral.com/states/co.html

Denver Community Resources

Addiction Treatment Center	303 647-5403
Denver County Department of Human Services	720 944-3666
Denver County Legal Assistance	303 837-1313
Denver County Sheriff's Department	720 337-0194
Denver Police Department	720 913-6010
North Colorado Medical Center Emergency Room	970 350-6366
Porter Adventist Behavioral Health Center	303 778-5774
West Pines Psychiatric Hospital	303 239-4000
United Way: Resource Referral Directory	211

APPENDIX H

MANUSCRIPT DRAFT

Working with Medical and Psychological Illness:

A Phenomenological Exploration of Nurses'

Experiences in Treating Eating Disorders

Diana Levas-Luckman, Mary Sean O'Halloran, and Jeffrey Rings

University of Northern Colorado

Abstract

Eating disorders (EDs) have become an epidemic within the United States, with medical and psychological consequences that can be lethal. Treatment for these diseases is complex and demanding, requiring an integrated treatment approach by a multidisciplinary team in which nurses play an integral role. Research has demonstrated a wide array of both positive and negative experiences among nurses in traditional medical and mental health settings, as well as among ED nurses. However, the literature neglects to focus upon the broader experiences of nurses, including perceived benefits and challenges, in treating both adult and adolescent ED patients. The current study employed qualitative, phenomenological methodology to explore the experiences of nurses in treating EDs. Interviews were conducted with 12 nurse participants and were analyzed via a phenomenological method of analysis. The outcome was the development of textural–structural descriptions for participants and composite themes capturing the essence of their experiences. Three primary thematic categories emerged: initial attitudes, conditions of treatment, and emotional awareness and outcomes. Understanding these experiences will help psychologists to improve education/training for nurses entering the field, increase support and communication with the treatment teams, mitigate negative emotional experiences, and highlight the benefits that such ED nurses experience.

Keywords: eating disorders, nurses, experiences, qualitative

Working with Medical and Psychological Illness:

A Phenomenological Exploration of Nurses'

Experiences in Treating Eating Disorders

Eating disorders (EDs) have become an epidemic within the United States,

affecting approximately eight million Americans nationwide (National Institute of Mental

Health, 2014). Though symptom presentation can vary dependent upon the specific type

of ED (e.g., anorexia nervosa, bulimia nervosa, or binge eating disorder), the medical and

psychological consequences can be lethal (National Association of Anorexia Nervosa and

Associated Eating Disorders, 2014; National Institute of Mental Health, 2014).

Furthermore, ED patients may experience a myriad of comorbid mental health issues as

well as struggle to develop and maintain interpersonal relationships or socially connect

with others (Budd, 2007; Mehler & Andersen, 2010).

An ED treatment is complex and demanding and typically requires a unified,

integrated treatment approach by a multidisciplinary team (Davey, Arcelus, & Munir,

2014; Mehler & Andersen, 2010). Nurses play an integral role in ED treatment at the

inpatient level of care. Managing the various needs of patients, nurses provide 24-hour

care, manage the milieu as a whole, and are integral in maintaining effective

communication among the team (King & Turner, 2000; Mehler & Andersen, 2010;

Ramjan, 2004; Ryan, Malson, Clarke, Anderson, & Kohn, 2006; Snell, Crowe, & Jordan,

2010; Turrell, Davis, Graham, & Weiss, 2005).

Research has demonstrated a wide array of both positive and negative experiences

among nurses in traditional medical settings. Having sufficient knowledge within their

field, support from colleagues, a sense of meaning, and engaging in regular self-care

often elicit positive outcomes such as patient success, increased confidence, happiness, and personal and professional growth among nurses (Bassett, 2002; Feng & Tsai, 2012; Hilliard & O'Neill, 2010; Johansson & Lindahl, 2011; Zammuner, Lotto, & Galli, 2003). Furthermore, some nurses are able to internalize positive experiences/successes from their patients and experience vicarious resilience (Grafton, Gillespie, & Henderson, 2010). However, medical nurses also experience challenges due to their job demands and subsequent high levels of stress. Such challenges may include feeling a lack of support, poor communication among the treatment team, and/or difficulty building relationships with patients and their families (Feng & Tsai, 2012; Lindahl & Norberg, 2002; Olofsson, Bengtsson, & Brink, 2003). Furthermore, these nurses encounter many, often negative, emotional experiences including sadness, fear, anxiety, powerlessness, guilt, compassion fatigue, and burnout (Allcock & Standen, 2001; Bassett, 2002; Figley, 1995; Hilliard & O'Neill, 2010; Maytum, Heiman, & Garwick, 2004; Olofsson et al., 2003; Snell et al., 2010).

The literature on mental health nurses' experiences illustrates similar findings, emphasizing additional factors specific to managing psychologically-based illnesses. For example, there is an increased focus on the importance of group supervision (Maier, 2011; Winship, 1995). Mental health nurses, including those who treat EDs, may also experience additional negative consequences, including increased challenges in building patient relationships as a result of societal stigmas towards patients with mental health diagnoses (Bjorkman, Angelman, & Jonsson, 2008; Harms, 2010; Hem & Heggen, 2003, 2004; Van Sant & Patterson, 2013; Zolnierek & Clingerman, 2012); struggling with role dilemmas, unsure of whether to act more as a nurse or a therapist (Hem & Heggen, 2003,

2004; Snell et al., 2010); distress and fear surrounding the emotional unpredictability of patients (Carlsson, Dahlberg, Lutzen, & Nystrom; 2004; Winship, 1995); and vicarious trauma, the potential for caretakers to take on their patients' traumatic symptoms when exposed repeatedly to their stories of trauma (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995).

Despite literature examining nursing subjective experiences in treating EDs, few researchers have provided in-depth examinations of both the benefits and challenges experienced by these nurses in treating adolescents and adults in inpatient ED treatment settings. The existing research does highlight the challenges that they do encounter. Such challenges may include having a lack of prior knowledge and understanding of EDs, which increases anxiety and decreases confidence (King & Turner, 2000; Reid, Williams, & Burr, 2010; Snell et al., 2010), difficulty in building relationships with patients (Irwin, 1993; King & Turner, 2000; Malson & Ryan, 2008; Micevski & McCann, 2005; Moulding, 2006; Ramjan, 2004), and the struggle to find balance between maintaining boundaries and fostering patient empowerment (Bakker et al., 2011; van Ommen, Meerwijk, Kars, van Elburg, & van Meijel, 2009). However, such research has yet to examine the subjective experiences of nurses in managing resistance, grief and loss, vicarious trauma, and positive experiences, such as vicarious resilience, in treating EDs.

The purpose of this study was to provide an in-depth exploration of the experiences of ED nurses, revealing their lived experiences in order to more fully understand the value of their work to them in both emotional and educational terms. Given that psychologists and nurses frequently work together to treat EDs, this study

hopes to help bridge the gap between the two fields and promote an important area for

further research. The specific research questions addressed were:

1.   How do nurses describe their experiences in treating patients with EDs?

2.   What do nurses perceive as meaningful and valuable in their work?

3.   What do nurses see as factors or challenges that impede their work with

       ED patients?

4.   How has their education, training, and preparedness impacted their

       experiences in working with those suffering from EDs?

Method

We utilized a phenomenological methodology to capture the essence of nurses'

experiences in treating patients diagnosed with EDs. Such an approach draws upon

psychology, education, and strong philosophical origins in an effort to ultimately

understand the shared structure or meaning of an identified phenomenon or experience

(Creswell, 2007; Merriam, 2009; Patton, 2002). We aimed to gain an understanding of

both the idiographic and common experiences of being a nurse in such an environment,

identifying both challenges and benefits, to gain a better understanding of the essence of

this phenomenon.

The theoretical framework provides context for the research process and grounds

the logic of the research (Crotty, 1998; Ponteretto & Grieger, 2007). Social

constructionism posits that meaning is individually interpreted through social

constructions and symbolic interactions, uniquely by all humans. Subsequently, meaning

and ideals are best understood through examination of individual perspectives (Crotty,

1998). Because both the fields of nursing and psychology value and posit that effective

treatment must take into account and value individual characteristics, culture, values, and preferences (American Psychological Association, 2003), this framework fits well in guiding the research. Furthermore, the main tenets of existentialism can be used concordantly. This humanistic theory promotes a phenomenological view of people, all confronted with the same ultimate concerns with regard to human suffering: freedom, isolation, meaninglessness, and death (Yalom & Josselson, 2011).

The Researcher

The researcher remains the key instrument of data collection in qualitative research, engaging in a process of reflexivity in which the ways roles and potential biases may impact the research are continually examined (Creswell, 2007). The primary researcher has a background in treating EDs, having worked with adult and adolescent ED patients and nurses in inpatient hospital settings. Working alongside medical professionals contributed to her commitment and dedication in the research topic, to understand nurses' experiences as well as how the general field of psychology can work to further enhance nurses' positive experiences. Entering the field of counseling psychology, she highly values gaining empathy for others through learning about their ideographic experiences via their own words and stories.

Participants and Setting

After obtaining Institutional Review Board approval for this study, hospital personnel were contacted via e-mail and provided with a detailed description of the proposed study via informed consent documents. Upon their approved consent, participants were recruited via the company's listserv with the same letter of intent. Those who were interested in participating were asked to contact the primary researcher

directly, and times were then arranged to meet. Upon meeting, each participant signed

informed consent paperwork with the same detailed explanation of the study to ensure

that each person understood the purpose of the study and that his or her identity and other

names mentioned remained confidential. At this point, each participant also chose her

own pseudonym in order to protect confidentiality (Creswell, 2007).

In order to obtain a broad range of perspectives from nurses treating EDs on

inpatient units, we employed a purposeful sampling strategy, choosing participants from

both the adult and adolescent units in hopes to provide in-depth insight and understanding

to the emotional experiences of nurses (Bloomberg & Volpe, 2012; Merriam, 2009). This

was done via a criterion approach, trying to obtain a sample representative of the

experienced phenomenon being examined through assuring that all participants met an

inclusion criterion (e.g., at least 18 years of age, hold at least an Associate Degree in

Nursing, have completed background checks, and have attended some initial training at

the facility) (Creswell, 2007; Merriam, 2009). The specific sampling of information

sources used were ideally based on a maximum variation sampling method, individually

selecting participants that representing diverse samples of nurses (Creswell, 2007;

Merriam, 2009).

All participants interviewed in this study resided in the United States and

currently worked as nurses at this ED hospital (with the exception of two—one who had

recently quit her position). Seven participants primarily worked with adults, while five

primarily worked with adolescents. The number of years the participants worked treating

patients diagnosed with EDs ranged from one year to over 20 years. Two participants had

earned an Associate of Science in Nursing, nine had a Bachelor of Science in Nursing,

and one had a Master of Science in Nursing. All participants were female. The ages of the

12 nurse participants in the study ranged from their 20s to 50s, with an average age of

33.9 years and a median age of 30.5 years. The majority were Caucasian, with one

participant identifying as Hispanic and another participant identifying as multiracial.

Additionally, three participants reported having had an ED or some type of disordered

eating in the past and noted this as a salient reason behind their interest in the field. The

specific information about each participant is reported in Table 1.

Research was conducted on two separate inpatient units (adult and adolescent)

within one private behavioral health ED hospital in the United States that serves clientele

worldwide. Both units have a comfortable and nicely decorated feel, containing artwork,

warm colors, and mantras/quotes on the walls to enhance relaxation and promote

recovery. Ideally, a quiet, secluded conference room within each facility was used for

interviews in order to minimize distractions and to increase focus and attention towards

the interview goals and processes. However, if such a space was not available or

participants wanted to meet during days in which they were not at the facility, another

quiet space was used for interviews (e.g., private room at a public library or the living

room at the primary researcher's home as a last resort).

Data Collection

We conducted semi-structured, approximately one-hour-long, interviews with

participants, each recorded on two digital audio-recording devices. We also engaged in a

visual elicitation technique in which participants were contacted before the interview and

encouraged to bring an artifact or any other meaningful personal document with which

they felt comfortable sharing that symbolized their time treating ED patients. Interviews

were subsequently transcribed and re-checked for accuracy. In follow-up conversations via e-mail, participants reported that the extracted themes accurately depicted their experiences and no additional information was provided. Data were collected until it was saturated and no new themes emerged (Creswell, 2007; Crotty, 1998), determined through member review, peer review, and expert consultation. The primary researcher also kept a detailed reflexive journal throughout the data collection process to identify struggles and bridle personal biases, examining the precise ways that her personal biases influence the data to gain a more equitable sense of the phenomenon of inquiry (Dahlberg, 2006). The entire research processes were also recorded through an audit trail (Creswell, 2007; Merriam, 2009).

Data Analysis

We then employed Moustakas' (1994) phenomenological approach as a method of analysis. We engaged in a horizontalization process, a preliminary grouping procedure that involved listing every significant statement relevant to the experience, giving each equal value. We then determined the invariant constituents of the experience through reducing and eliminating data, making sure each statement (a) contained moments of experience sufficient for understanding and (b) was capable of being extracted and labeled. If such requirements were not met or statements were repetitive or vague, statements were eliminated or refined. Next, we clustered these invariant constituents; clusters of meaning were extracted through organizing statements into themes or meaning units while removing repetitive and overlapping statements to further enhance the richness of the data (Creswell, 2007; Merriam, 2009). These became the core themes of the overall experience. We engaged in an application validation, checking the invariant

constituents and themes against complete transcriptions of each participant. We assessed if participants had expressed each statement explicitly and if statements were compatible. If not, they were deleted.

Subsequently, we created descriptions through scrutinizing more evident content as well as underlying meanings. We created textural and structural descriptions, two integral components to phenomenological research (Moustakas, 1994). Textural descriptions explain participants' experiences, including their attributed meaning and verbatim examples from transcriptions. Structural descriptions were created from these textural descriptions, describing how participants experienced the phenomenon. These descriptions involved seeking divergent perspectives, finding all possible meanings (including more deeply-imbedded characteristics, such as feelings and thoughts), and varying the frames of reference about the phenomenon (Creswell, 2007). Finally, the textural–structural descriptions of the essence for each participant incorporated invariant constituents and themes. Through further reducing such descriptions, we gained a comprehensive understanding and created a composite description, which provided the overall, shared essence, or invariant structure, of nurses' experiences treating ED patients (Creswell, 2007; Merriam, 2009; Patton, 2002).

Trustworthiness

To enhance the overall rigor and trustworthiness of the current study, several methods were utilized during the research process. Triangulation methods were utilized; using multiple sources of data to confirm the findings that emerged, such as multiple methods of data collection (e.g., interviews and observations), multiple sources of data (e.g., using participants from both the adult and adolescent units, as well as various types

of nurses), multiple methods of data analysis, and various theoretical lenses from which the data were interpreted (e.g., constructivist with existential underpinnings), acknowledging the pluralism that exists through multiple ways of knowing and understanding (Creswell, 2007; Merriam, 2009).

To enhance credibility, we utilized a semi-structured interview protocol to standardize the questioning strategy; we used audio recordings to create verbatim transcriptions to assure participants' words or ideas were taken in context. A thorough interview guide with detailed questions bolstered the rigor of the interview process. The interviews themselves, as well as the use of multiple researchers to transcribe the data, resulted in prolonged engagement in the field, further enhancing the study's dependability. We became further immersed in the data through reading and re-reading all the transcriptions and subsequently provided rich, detailed verbatim descriptions of the participants' lived experiences through the use of quotes. The nature of thick descriptions, rich, detailed, and providing context within the data, enable readers to "compare the 'fit' with their situation" (Merriam, 2009, p. 226) and determine whether or not such findings are transferable (Merriam, 2009). In this regard, we asked a variety of detailed questions within the interviews, frequently asking for follow-up or elaboration when needed. Utilization of a multi-site design (Merriam, 2009), using participants from two units within the larger umbrella company, increased transferability.

An audit trail accounted for events and changes throughout the research process and maintained a system of checks and balances (Creswell, 2007). We engaged in an external check of the research process through a peer debriefing, having one colleague in counseling psychology, trained in qualitative methods, review the transcripts and assess

our methods, meaning, and subsequent interpretations (Creswell, 2007; Merriam, 2009).

Finally, we used member checks, soliciting feedback on the emerging findings from the

participants through showing them the transcribed interviews in which they partook

(Creswell, 2007; Merriam, 2009).

Results

All participants were encouraged beforehand to choose an artifact that symbolized

their experiences treating EDs. A total of five of the participants shared an artifact,

including a poem, a small gray rock, a yellow star, cards/drawings from patients, and a

tree. Among these artifact descriptions, two primary themes emerged: (a)

stability/grounding and (b) hope.

Two participants conveyed themes of stability and grounding through describing

their artifacts. Willow described a stone that, though simple in its appearance, possessed

an immense amount of power for her. She used it as a grounding force during her world

travels and now gave it to patients for the same support when they were feeling anxious

or overwhelmed. Amy also conveyed a sense of stability and grounding through her

description of a tree. She described a deeply grounded root system that symbolized

patients' ability to attain stability in their lives and ultimately heal. She compared this to

other important support systems in her own life, such as friends and family.

Four participants conveyed themes of hope through their artifact descriptions.

Evangeline discussed her use of a poem to emphasize the ability of all patients to

transcend illness and become hopeful for the future. She read the poem to patients to

provide inspiration, as well as to herself to enhance her own ability to "work through"

feelings of hopelessness in her work. Amy conveyed hope through the description of the

tree. Despite living a "barren" existence for years and feeling as though all hope is lost, patients could grow into something beautiful. Paige described a yellow star representing the rewards she had experienced from witnessing patient recovery, eliciting hope for future patient success. Finally, Jane conveyed hope through the cards and drawings that she kept from previous patients. Despite their illnesses becoming severe enough to necessitate inpatient hospitalization, patients since had taken steps to promote their recovery and healing and felt appreciative for life. This provided inspiration for future patients as well as the nurses who cared for them.

Initial Attitudes

Every participant mentioned feeling somewhat uncertain about what to expect upon starting, given their lack of specific training in EDs. However, five participants emphasized this as central to their experiences, with varying perspectives as to whether it felt exciting or to be more of a challenge. Jackie described her initial lack of knowing "nothing" about EDs. She did not interpret this as stressful because her love of learning quickly allowed her to adapt and grow. Amy also emphasized her lack of understanding of EDs at the onset of her work. She discussed her pre-existing understanding that much learning is self-taught and was happy to teach herself. Both Jackie and Amy sought additional ED training.

Some participants viewed the lack of training and preparedness as more of a negative experience. Though Evangeline conveyed her love of learning, she reported feeling stressed when having to "teach (her)self" certain medical procedures. Given the physical fragility of many patients, this became unnerving at times. Pat described her level of "shock" at the onset of her employment at the hospital in that she had never seen

such clinical presentations before and felt incompetent in her ability to intervene. Sarah

described feeling "nervous," given the fragile state of the patients, this being her first job

out of nursing school and that she had no training in EDs.

Nine participants explicitly acknowledged ways in which the complexity of ED

treatment created further challenges in their work. Willow and Sarah disliked the

ambiguity of treating patients diagnosed with EDs. They both emphasized liking

predictability and straightforward protocols, common to medical nursing settings. Willow

noted that dealing with "crises" and never knowing what to expect was stressful and

decreased her confidence. She stated, "That's when it's hard for me to leave everything at

the door—when there's the possibility that someone could have gotten really hurt and I

could have done something wrong." Sarah reported that having less opportunity to

prepare when dealing with psychiatric issues was "really tough."

Comorbidity is common among patients diagnosed with EDs. This includes the

combination of medical and psychiatric symptoms of the ED, itself, as well as potentially

multiple psychiatric diagnoses among any patient (e.g., depression, anxiety, etc.).

Willow, Jackie, Cassandra, and Little Girl identified challenges related to treating

comorbid issues. Jackie and Cassandra acknowledged that this was the first job in which

they had to integrate both medical and psychological skills, and being uncertain of how to

approach situations made it more challenging. Cassandra illustrated a specific challenge

with a patient who had significant medical and psychiatric concerns in addition to

resistance towards her treatment. She stated, "I think she got a little stir crazy from being

here too long and just started pulling out her [nasogastric] tube any chance. I mean I was

putting in probably two to three tubes a day for a while." Willow identified her struggle

with illusions of health in that ED patients often appeared healthy to the naked eye, while in fact they struggled with many psychiatric concerns or perhaps less evident medical problems. Little Girl commented on the increase in both comorbidity and patient severity that she had witnessed over the last five years. She further stated that despite many patients needing insight-oriented psychotherapy and skill building, such goals were often unattainable in that their acute medical issues (e.g., starved brain) prevented them from being able to concentrate and retain information.

Many participants struggled at times to differentiate patients from their EDs, given they were often so intertwined. Behavioral acting out or rude attitudes made this especially challenging, as many nurses' natural instincts were to become angry. Evangeline and Morgan sometimes had difficulty maintaining compassion for patients, forgetting that their negative attitude or resistance was often a result of their starved brains. Sarah also struggled to remain objective at times, stating, "I think it's about keeping an open mind and not just looking at a patient who's screaming at you or trying to hit you and just getting angry with them, because it's not them; it's their ED." Having now worked in the field for several years, Amy had become better at reminding herself of these two sides to every patient when she would notice herself getting frustrated. She stated:

> You have to realize it's part of their disease and part of their illness; it's not actually them. Even here that's something that I constantly tell myself and I tell staff, "They are sick." If you can't realize that there are two different parts of them at that point in time, then you are going to have a hard time working with this population.

Conditions of Treatment

Nine participants identified building relationships with patients as providing meaning to their work, many reflecting upon this factor as being the most valuable part of being a nurse treating EDs. Amy acknowledged, "Developing those relationships and wanting the best outcomes for the patients here is what I find the most meaningful." Evangeline and Paige noted that building relationships and "helping others" was the primary reason for being a nurse, and Emily noted that "just being there for part of their journey" was what was important. Though she had previously doubted her own communication skills and ability to build rapport, Willow noted that supporting patients during their recovery process was a "pretty amazing gift." Sarah and Morgan appreciated the longevity of ED treatment. Having the ability to build rapport over an extended period of time and witness a broader range of patients' journeys towards recovery enabled them to build stronger relationships. Pat and Cassandra further identified the value in being a part of the recovery process.

Seven participants identified the need to find and maintain balance as integral parts of their experience treating EDs. This balance took many forms, such as finding balance in patient relationships, balance within nursing roles, and balance within their lives as a whole (e.g., between work and personal issues). Jackie acknowledged the importance of maintaining compassionate and firm boundaries/structure as important facets of fostering balance in patient relationships. Paige, Sarah, Cassandra, and Amy all agreed that nurses needed to foster balance when interacting with patients to both promote effective nursing and foster patient success. In referencing the vacillating sides of her role, Paige stated, "Sometimes they may see me as being mean and sometimes I

may look like their best friend because I am giving them what they want." Both Paige and Morgan identified that, through this balance, the use of humor also became important in attempting to alleviate the perceived severity of many situations (for both patients and nurses).

Several participants emphasized the importance of balancing life with self-care. Paige and Emily discussed the importance of "practicing what you preach." They recognized the hypocritical nature of promoting health among patients if nurses were not also being healthy themselves. Amy and Cassandra reiterated the need to take time to decompress and let go of work.

Jackie, Evangeline, Paige, and Amy discussed the general importance of communication and support within an inpatient ED environment. They all stressed the value of communication within the nursing team (and among the treatment team as a whole) as integral to the maintenance of an efficient hospital and successful patient outcomes. Furthermore, feeling supported among colleagues and supervisors was necessary for maintaining their own mental health and desire to return to work.

Some participants also noted experiencing positive outcomes as a result of feeling supported. Willow endorsed that strong feelings of support had enabled her to continue working at the hospital despite her initial hesitations. Pat appreciated the positive feedback she had recently received from her supervisor. Morgan felt as though she experienced good communication among the treatment team, which helped her to provide better patient care. However, she felt hesitant at times to report problems because she did not want to be the person always needing her supervisor. Sarah felt supported by her supervisor, stating: "My [supervisor] is great at speaking up for the nursing

department as a whole, especially to other members of the treatment team, saying that nursing has a voice." In addition, Amy, Cassandra, and Jane identified feeling as though they were part of a family working on an adolescent team. Unfortunately, not all participants felt supported. Evangeline noted that as her time with the hospital progressed, she felt less supported by all members of the treatment team, including her fellow nursing staff.

However, four participants viewed communication and their perceived support at work more negatively. Cassandra noted a lack of communication with members of the treatment team, especially between the nursing and the dietary teams. She stated, "We don't necessarily butt heads. We are just on two separate sides." Sarah noted that she often felt discord with colleagues, which sometimes led to her feeling unsupported and/or unable to effectively communicate. Jane and Pat endorsed an overall lack of support at work at times, either by other nurses or by other disciplines within the treatment team. Pat believed that nurses in general were often dismissed by the therapists, referring to them as her "biggest enemy."

Eleven participants noted feeling some form of fragmentation in their roles as nurses. These nurses often felt a general uncertainty at the onset of their hire, given their typical lack of understanding ED treatment and the multifaceted nature of their role. Paige felt that her role lacked clarity amongst the treatment team, in that both patients and staff often mistook her role for that of another nurse on duty. Jane reported that as the hospital expanded, duties that she had once performed were split amongst other staff and she was left wondering what she was meant to do. Willow also identified the challenges that arose from a lack of hierarchy in the ED nursing role. To her, nurses seemed more

respected and valued in traditional hospital settings, in that in such settings they were often in charge of patients' treatment.

Seven participants felt as though there were unrealistic expectations placed upon them as nurses in this hospital. Little Girl and Morgan commented on the general tendency of nurses to be overworked, having to work holidays, weekends, and overtime. Another significant problem for some nurses was the emphasis placed on therapeutic (counseling) skills. Willow and Pat noted that their lack of mental health experience, including rapport building and de-escalation skills, caused them to feel as though they were at a disadvantage. They believed that what was expected of them was unfair, such as having to "act like a therapist." Furthermore, Willow noted that feeling like she had to be the "enforcer" of rules when other disciplines often did not support her made her role increasingly challenging. Jackie, Evangeline, and Emily also acknowledged that a lack of time to complete all the necessary tasks during a shift played a huge role. There had become such an uneven nurse–to–patient ratio that it often felt almost impossible to get all of one's work completed during a shift. Emily stated,

> I started to get crabby and I realized that I was not able to keep these people safe
> and was not able to provide any type of decent care. We are just going on a wing
> and prayer that nothing serious goes wrong and that's, emotionally, that's just
> scary.

Five participants felt a lack of integration between the nursing and mental health teams, in which they felt unappreciated, dismissed, and/or disrespected. Sarah noted the lack of appreciation of the "nursing voice" among the mental health team, often feeling as though therapists or dieticians implemented new additions to patients' treatment plans

without having consulted with the nursing team. Sarah and Cassandra often felt dismissed, while Willow and Pat sometimes felt as though they were deliberately treated poorly by therapists who often disregarded the value of the nursing role of setting boundaries. Furthermore, Little Girl compared her own experiences of being both a nurse and a therapist. She stated that nursing was far more challenging in that as a nurse, one has to manage the entire milieu at once. She felt as though the mental health staff often did not understand this.

Given the fragile state of many ED patients, eight participants discussed the inherent pessimism in their work. Sarah discussed how such negative experiences, especially regarding patients' struggles, made it challenging for her to let go of work issues when leaving for the day. Paige acknowledged her struggle to manage negative family dynamics. Jackie discussed the shocking and upsetting nature of some patients' medical states. This often elicited feelings of excess worry, which could further provoke negativity or hopelessness in more severe circumstances. An interesting theme contributing to negative attitudes was working with a predominantly female staff. Amy, Sarah, Jane, and Cassandra all acknowledged that working with almost all women often increased tension and pessimism. Sarah commented that intense female personalities often contributed to discord at work. Jane discussed the stressful environment in which she worked, referring to the "gossipy" nature of the workplace in which "everyone tells each other everything."

Sarah and Jackie both identified challenges in maintaining hope. Jackie thought about the older adults who were so medically compromised, wondering if they could possibly sustain recovery. Sarah witnessed adolescents so "stuck" in their EDs that she

sometimes felt unsure about their ability to change. Though not a personal struggle, Little

Girl discussed the difficulty for many nurses to quantify change, given successes that ED

patients achieved were often so small and potentially hard to see. Thus, nurses

continuously struggled to identify the positive, even when it may have existed,

subsequently losing hope. Jackie added to this in stating that there typically was not a

concrete reward (no tangible outcome), while Emily acknowledged that the nature of

inpatient treatment did not allow nurses to witness patients living in a recovery–focused,

healthy state. Amy further noted that the high recidivism rate of patients diagnosed with

EDs made it challenging to believe at times that recovery was possible.

Hope was more common among nurses working with adolescents, given the

length that many such patients had dealt with their EDs. For example, Jane acknowledged

the fact that children and adolescents were less "entrenched" in their EDs, which in fact

made it easier to maintain hope in their recoveries. Kids often just wanted attention from

their families or friends or wanted to gain some control at a developmental point in their

lives when they often had little. Amy recognized this as well, stating, "They [adolescents]

are not as biased as adults."

Seven participants identified struggles with managing resistance from ED

patients, which often presented as rude attitudes or defiance. Little Girl emphasized that

despite her developed clinical skills, she still struggled to manage resistance at times.

Paige commented on her inability to tolerate "snotty" attitudes or outright lying, stating,

"defiance makes it harder." Willow identified her struggles in dealing with labile moods

that seemed "extreme." Both Willow and Pat wanted to be liked by their patients and

were challenged and surprised when treated disrespectfully. Evangeline and Emily noted

that being treated like a "servant," in that their time was entirely de-valued, was triggering and they often became annoyed or angry. Finally, Sarah acknowledged that experiencing such negative feelings often made it challenging to remain objective and/or maintain empathy for patients.

Emotional Awareness and Outcomes

All participants, except for Jane, Little Girl, and Morgan, explicitly stated feeling "stressed," "exhausted," or "drained" as integral to their emotional experiences in treating EDs. However, two of those participants still conveyed these emotional undertones in other parts of their descriptions. For example, Jane discussed her lack of confidence in her abilities at times and her struggle in setting limits with patients as challenges for her. Little Girl discussed the ways in which her role was often "too much." This level of stress led to burnout in Evangeline, which she had not even recognized in the moment.

Sadness was also a common emotional experience, as endorsed by seven participants. Jane and Sarah were saddened to watch children and adolescents struggle with deeply embedded depression, self-loathing, and physical symptoms of their EDs. Amy, Cassandra, Willow, and Paige were saddened by the perceived inability of some patients to recover as well as recidivism. Amy stated, "The biggest challenge is . . . working so hard with certain people and seeing them come back sicker than when they left." Finally, Emily, Little Girl, and Paige reported feeling sad (as well as grief and loss) surrounding hearing of patients' deaths. Little Girl was the only participant who endorsed an accompanying sense of guilt.

Four participants conveyed anxiety. Jackie, Sarah, and Emily worried constantly about their patients' health and safety, while Jackie also worried about her future

potential encounters with EDs. Could she have a child with an ED? Cassandra discussed the ways in which not only her uncertainty around treating EDs elicited some anxiety, but also the ways in which the emotional undertones on the unit increased anxiety. For example, an overall anxious milieu of patients often elicited increased anxiety among the nursing staff. She stated, "I think it can just get everyone a little on edge when things are chaotic."

Five participants reported feeling frustrated, which often led to anger. Willow felt frustrated by the ED behaviors, and she struggled sometimes to understand why patients would not just eat. Paige became frustrated by the inherent power struggles of treating patients with EDs, acknowledging that it was difficult "fighting against the ED and knowing that you might not win." Evangeline, Pat, and Emily were frustrated and angered by patient defiance and disrespect. Evangeline and Emily were also frustrated by the lack of time to complete nursing duties and the poor nurse–to–patient ratios.

Three participants endorsed feeling some vicarious trauma. Jane became tearful when discussing her experiences of having to physically hold children and administer injections when they became unsafe towards themselves or others. This experience was quite traumatic for her. Pat described her struggles with hearing of patient suicide as especially traumatic (and personal) in that she had experienced suicide within her own family. Evangeline reported a general sense of vicarious trauma after years of exposure to patients' physical malnourishment and own traumatic experiences. Conversely, Morgan and Pat reported feeling emotionally distant. They stressed the importance of trying to not get too emotionally "connected" with their patients and their struggles. This prevented them from becoming engulfed in negative emotions, feeling sad and overwhelmed, and

enabled them to keep working treating EDs. Pat also stated that she did not want "people [patients] to get too attached," since she had a difficult time trusting some people with mental illness.

Six nurses endorsed feeling happy and/or excited. Amy, Jane, and Paige discussed the happiness they each experienced from building relationships with patients. Cassandra, Sarah, Little Girl, and Jane emphasized the joy that they each experienced when witnessing a patient succeed. Jane stated,

> We have a patient that really struggled like every single day. She would get anxious and throw up, anxious, throw up, anxious, throw up and she thought there was nothing she could do to stop it. And she worked, worked, worked, and now she is doing amazing. She had such a flat affect and now she's so bright.

Little Girl referenced the excitement in witnessing the "small" steps and successes in recovery. She stated, "Any time you are able to work with a patient and get them to comply with something they need for their recovery is a meaningful situation. . . . It may have only worked for an hour, but it worked!"

Many nurses experienced conflicting feelings, often simultaneously. Amy reflected on her experience witnessing patients struggle: "There are some people that you really connect with so it can be hard and stressful." Jane had a similar experience that was quite upsetting for her. She stated,

> We just heard she's not doing well at all and it sucks because the few moments you would see her outside of her ED, she was the funniest kid you've ever met. She's the one that makes me kind of cry.

On the positive side, Little Girl noted that witnessing patient success was the most "exciting" and rewarding part of the job. Jackie also reported "feeling grateful" that she, or no one close to her, suffered from an ED.

Six participants reported witnessing recovery as a valuable component in their work. Little Girl acknowledged her "excitement" over the years in seeing patients recover, reminding her of her own recovery from anorexia nervosa (the reason behind her wanting to help other ED patients). Paige stated, "Success stories are super cool." She relished in the ability to witness a patient's recovery, especially when working with the adults in that they had been living "in their EDs" for so long. Evangeline added her delight in witnessing the physical transformation of patients, gaining brightness back to their eyes. Sarah and Amy identified their satisfaction after hearing of patients who had maintained recovery after discharge. Cassandra also acknowledged the happiness she experienced from witnessing recovery. She stated,

> I find that when a patient does go home and you really think they're going to be successful, at least in the short term, that's probably the biggest success. And then they'll write us a year later and they are still doing great. That is probably the biggest joy I get out of the job.

Though not a central themes to all of their interviews, many participants stressed the way in which working with EDs had increased their general sense of awareness about body image. Paige, Amy, and Jackie discussed their increased awareness of body image issues and EDs in general, becoming more attuned to issues within society. Amy further discussed how nurses working with EDs often became overly attuned to body image concerns in that they misattributed certain body types as having EDs simply because of

their size (e.g., a thin woman out in the community was now perceived as having anorexia nervosa). The amount that staff focused on food and weight while at work, discussing foods they were avoiding or what diet they were trying, often bothered Jackie. She stated, "I'm not absorbed in it, which I'm thankful for." Emily and Sarah noted that they had become more self-conscious at work. Emily worried what others might think of her small frame and fast metabolism. Sarah made a consistent effort to always ensure she was dressed appropriately so as to not trigger any patients. She made sure not to wear clothing that was too revealing or too tight, as this might draw an unnecessary focus to her body.

Two participants conveyed their positive experiences related to body image. Jane shared that becoming more aware of body image issues actually enhanced her own body image for the better. This increased focus amplified her desire to "learn to be happy and not focus on stuff [dieting] like that." Evangeline finally learned to come to peace with her own body after years of struggles with bulimia nervosa. She stated, "I never equated their bodies with mine. I just saw the sickness of it."

Four participants identified experiencing professional growth as nurses, including increasing competence and skills and gaining compassion for patients. Evangeline and Willow reported gaining a better handle on concrete nursing skills. Evangeline vastly increased her medical knowledge, while Willow learned how to better communicate and interact with patients on a personal level. Morgan noted that she thrived when feeling challenged. For her, not knowing what to do or having prior experience to reflect upon was a positive learning experience. She was able to quickly create solutions as she encountered problems and subsequently learned how to improve outcomes in the future.

With regard to gaining compassion, Jackie and Morgan discussed their initial struggles in being empathetic towards ED patients. Not understanding that much of their negative symptoms came from the EDs themselves took time for them to learn and understand.

Discussion

Several implications emerge from this study that nurses should consider when treating patients diagnosed with EDs. These include specific concerns that nurses experience with regard to their initial attitudes, conditions of treatment, and emotional awareness and outcomes. The findings can be interpreted and applied through an existential theoretical framework. From this perspective, fears of isolation are common experiences for all humans (Yalom & Josselson, 2011). Yet, such issues are pervasive among ED patients, many of whom have experienced damaged interpersonal relationships as a result of their illness or other factors and yearn for social connectedness (Budd, 2007; Mehler & Andersen, 2010). Therefore, those caring for these patients may vicariously experience such isolation, in addition to having such feelings exacerbated through isolation within the treatment teams, in which nurses may feel unsupported or alone (Coomber, 2010; Davidson, 1999; Pryde, 2009). Furthermore, this perspective helps to fuse the fields of nursing with psychology by providing a unifying human connection in that all people struggle with the same life concerns (Yalom & Josselson, 2011).

Gaining a sense of meaning and value is an integral part of the ED nursing experience, in that it facilitates personal and professional growth and other positive outcomes (Johansson & Lindahl, 2011; Wallerstedt & Andershed, 2007). Furthermore, nurses treating EDs also face issues of mortality, potentially eliciting fear surrounding

one's own death and recognition of their own vulnerability as humans (Eifred, 2003; Johansson & Lindahl, 2011). This type of self-reflection can be valuable, helping nurses to understand their experiences and to develop more adaptive coping strategies. However, nurses should also recognize that such awareness could elicit negative outcomes, such as increased stress or burnout, as a result of anxiety.

Many nurses enter the ED field unaware of issues specific to ED treatment. This study, along with support from previous research, clearly conveys the uncertainty and unpreparedness felt by many nurses when commencing their work in treating EDs. A result of this lack of training and/or fears surrounding the complexity of the disease (Cordery & Waller, 2006; Fleming & Szmukler, 1992; Reid et al., 2010) is an important issue to address. It is essential that nurses treating EDs are prepared to manage these complex diseases, not only for their own sake but also for that of their patients. Furthermore, prior understanding and knowledge of what to expect will help to mitigate potentially negative consequences, such as overwhelming stress, burnout, or negative coping strategies, all of which are common to professionals in the ED field (AbuAlRub, 2004; Kilfedder, Power, & Wells, 2001; Oloffson et al., 2003; Snell et al., 2010).

Mental health training courses are provided in the United States and in other countries (e.g., Australia) through nursing organizations, though they often come with an extra financial burden (Ramjan, 2004). However, ED nurses can obtain continuing education credits through webinars from the American Psychiatric Nurses Association, which are typically inexpensive (American Psychiatric Nurses Association, n.d.; National Eating Disorders Association, n.d.). Furthermore, as a future consideration, perhaps mental health professionals in the field such as counseling psychologists could aid in

promoting nursing confidence through providing mental health/ED training for medical

professionals. Psychologists could also play an active role in working to improve

communication across disciplines within the treatment team, helping to bridge the gap

between nursing and mental health. Furthermore, gaining exposure, education, and

clinical practice has been shown to bolster nursing confidence and subsequent nurse and

patient outcomes in medical settings (Feng & Tsai, 2012; King & Turner, 2000;

Wangensteen, Johansson, & Nordstrom, 2008).

Gaining a greater understanding of nurses' emotional experiences is relevant to

the field of counseling psychology and its strengths-based approach. Though negative

emotions are not unique to ED nurses (AbuAlRub, 2004; Hilliard & O'Neill, 2010;

Olofsson et al., 2003), specific negative emotions, such as vicarious trauma and

grief/loss, may be more pervasive when working with ED patients who have often

experienced trauma themselves and/or who may be at risk of dying. Therefore, providing

context and training for medical professionals regarding such symptoms should also be a

focus of counseling psychology. Furthermore, psychologists can aid in bolstering

emotional support for nurses experiencing these negative outcomes.

Traditional nursing roles do not involve managing patient resistance; most

medical patients want help. However, resistance is common when treating patients

diagnosed with EDs (Bakker et al., 2011; Irwin, 1993; Snell et al., 2010; Warren,

Schafer, Crowley, & Olivardio, 2012). The current study conveys nurses' stress in

managing resistance among ED patients. Participants were often caught off guard and/or

unsure of how to manage this type of behavior. Being prepared of ways to manage

resistance could help nurses feel more comfortable and confident in doing so. Research

illustrates that training in ED treatment, specifically training on managing resistance provided by master– and doctoral–level counselors, improves medical providers' knowledge and skills in treating EDs (Linville, Aoyama, Knoble, & Gau, 2013). Furthermore, trainings and webinars specifically for mental health nurses and nurses treating EDs are also effective means of preparation (American Psychiatric Nurses Association, n.d.; National Eating Disorders Association, n.d.). Participants in this study who had engaged in specific ED training above and beyond their required trainings (e.g., Certified Eating Disorder Specialist training) reported increased levels of competence and comfort in treating their patients. Perhaps engaging in such training, in addition to also learning motivational interviewing techniques specifically from mental health professionals (e.g., psychologists) to help work with ambivalence, could help nurses to develop relationships with patients and increase effectiveness/adherence to treatment.

Several conditions of treatment are often stressful for ED nurses to manage. These include issues of fragmented roles and a generalized pessimism within the workplace. Though these issues are common among nurses in general (AbuAlRub, 2004; Feng & Tsai, 2012; Olofsson et al., 2003), they can present differently in ED treatment facilities. For example, having to "act like a therapist" is stressful for nurses with no background in mental health. Furthermore, though nursing is a female-dominated profession, ED treatment units are one of the few environments in which both the staff and patients are primarily female. Thus, nurses entering the ED field should become aware of such facets beforehand to determine if they feel ready to face these additional stressors and to prepare to seek out support as needed. Furthermore, training of basic therapeutic skills by psychologists can decrease feelings of uncertainty, increase competence, and aid nurses

in developing personal ways to cope (e.g., stress management and relaxation techniques) (American Psychiatric Nurses Association, n.d.).

From the findings of this current study, nurses may also glean a sense of what not to do when treating patients diagnosed with EDs. There is a consensus between the findings from this study and previous research regarding nursing attitudes of stigmatizing mental illness and EDs (Malson & Ryan, 2008). The ways in which these biases increase challenges in building patient relationships (Bjorkman et al., 2008; Harms, 2010; Zolnierek & Clingerman, 2012), ultimately increasing negative emotional outcomes for nurses, is important for nurses to examine prior to entering the ED field.

Awareness of these factors, in addition to the need to find and maintain emotional balance, the importance of engaging in consistent communication and obtaining support, and the accompanying challenges and subsequent emotional outcomes are important factors with which to be familiarized prior to entering the ED field. This may help nurses acclimate to such new environments, avoid ineffective coping strategies, and prepare ways to cope/reach out for support before experiencing symptoms of vicarious trauma or burnout (Bassett, 2002; Maytum et al., 2004; Olofsson et al., 2003).

There were both strengths and limitations to the current study. First, my prior experience working at this ED hospital and my position in the mental health field as a psychologist–in–training could have impacted the findings. For example, some participants may have been hesitant to disclose information because they not only knew me, but also knew that I am a therapist. Research examining nurses' experiences in working with other members of treatment teams, such as mental health therapists, illustrates that nurses often experience having a lack of confidence, feelings of

powerlessness, and an inability to assert themselves within the treatment team (Allcock & Standen, 2001; Olofsson et al., 2003; Wangensteen et al., 2008). These factors could have influenced the amount of information that participants disclosed during the interviews.

Furthermore, these factors could have also affected who volunteered to participate in the study. Those who were uncomfortable or fearful of disclosing information to a therapist may have decided against volunteering. Therefore, given this study only reflected the views of those who chose to participate, a large portion of perspectives may be missing. Perhaps those who were not willing to participate felt more strongly about certain topics and could have added alternative viewpoints to enhance the richness of the data. It is also plausible that participants who did engage in the study felt responsible to portray both themselves and the hospital more favorably, neglecting to disclose more sensitive information.

Though I attempted to use maximum variation sampling (Merriam, 2009), 10 out of 12 participants were Caucasian. And though most nurses treating EDs tend to be female, including all female participants may have also elicited a skewed perspective. Furthermore, all participants were raised in and practiced nursing in the United States, limiting the ability to obtain broader, more diverse perspectives more likely to transfer across contexts. Including participants who are male, of diverse racial and ethnic backgrounds, and from varied geographic locations could elicit a more diverse perspective and increase transferability. In addition, two participants in the study had recently quit their positions as inpatient ED nurses. Though only a short amount of time had elapsed, this study may have introduced an element of recall bias.

Triangulation in this study is also lacking. Half of the participants did not engage in member checks, neglecting to provide their impressions of the textural–structural and composite descriptions. Though I assumed this was indicative of their agreement with the results, it is possible that some participants might have chosen to add to or alter some of their thematic structure.

Future Research Directions

The current study extended ED nursing research beyond its traditional constraints, obtaining a deeper understanding of the subjective experience. Potential directions for future research have emerged from the interpretations of its findings.

Given that nursing research alludes to the importance of recognizing emotional intelligence among nurses, specifically the connection between emotional labor and burnout (McQueen, 2004), perhaps future research could extend this focus by examining potential correlations between emotional intelligence in ED nurses and their subsequent emotional outcomes. Exploration of these constructs could help to identify which of these emotional experiences are self-identified and understood by ED nurses, in addition to which facets of emotional labor as experienced by ED nurses directly affect subsequent burnout. With this knowledge, psychologists in management positions at ED hospitals could better train and support nurses to become more self-aware in identifying their emotions and to develop more adaptive coping strategies when experiencing stress.

Exploration of gender roles and specific negative coping strategies also could be avenues for research. In this study, all participants were female and many endorsed struggling to work with and treat primarily women. Furthermore, research illustrates challenges in empowering female patients with EDs (Malson & Ryan, 2008). Perhaps

future research could compare relational dynamics between male nurses and other members of the treatment team (e.g., other male and female nurses and male and female therapists) to identify potential similarities and differences. Given the few number of male patients who nurses in this study had treated, it may also be helpful to understand these dynamics between ED nurses of either gender and male patients. In addition, though researchers have examined negative emotional experiences and coping strategies among ED nurses (Kilfedder et al., 2001; Omdahl & O'Donnell, 1999; Snell et al., 2010), there has yet to be any exploration of EDs among nurses who treat EDs. Given that King, Vidourek, & Schwiebert (2009) illustrated disordered eating among general medical nurses, one might expect an increase of these symptoms among nurses exposed to the additional stressors of ED treatment in addition to the constant exposure to, and discussion of, food, weight, and body image.

Finally, mixed methods research could also be useful in examining nurses' experiences in treating EDs. Not only could such research enhance empirical validation, but it could also help to better assess certain symptomatology. For example, vicarious trauma can be a delicate topic to address directly. Nurses may not be fully aware of such symptoms and may not endorse them if asked in an open-ended manner, potentially feeling uncomfortable or embarrassed. Given the challenges in assessing such symptoms via qualitative inquiry, a quantitative measure may provide an easier, more indirect way of assessing these symptoms, in addition to decreasing potential embarrassment or perceived stigma.

Conclusion

Nurses' experiences in treating EDs affect various members of the multidisciplinary treatment team and subsequent treatment outcomes. Thus, such experiences are significant to explore for both the fields of nursing and counseling psychology. Much existing ED research not only takes a quantitative focus, but also examines specifics facets of nurses' work, perhaps ignoring the broader experience. This study contributes to the field in a unique way, assessing the subjective experience through both benefits and challenges. Therein also lies a need for future researchers to gain additional insight into ED nurses' subjective experiences, examining positive aspects of their work to help promote a strengths-based approach to improve staff and patient outcomes and avoid pessimistic undertones.

Fostering increased understanding of ED nurses' experiences and providing workplace support is imperative across all disciplines within an ED treatment team, though especially important for mental health professionals. Counseling psychologists are often the ED providers directly communicating with nursing staff, in addition to providing their mental health training. Thus, it is imperative that counseling psychologists and nurses work together in continuing to bridge the gap between the medical and mental health perspectives of ED treatment. This can help to promote a healthier working environment, enhance positive experiences for all ED providers, and improve treatment outcomes. Furthermore, I stress the importance for all members of these treatment teams to not only convey interest, but also actively pursue understanding of their counterparts' experiences to improve communication and better inform their

collective support structure and treatment decisions. Evangeline best summarized this outlook. She stated:

> Early on, I felt it was very much a team. We had daily team meetings where you
> met with the physician, the psychiatrist, and that person's primary [therapist]. Oh,
> and the dieticians. I loved it and thrived in it. We communicated with each other
> and worked very closely. They'd say, "What's going on on the nursing side?" and
> we'd say, "What's going on on the dietary side?" And I thought we worked
> together so well and I loved those team meetings. I thought we all had an
> important role to play. And then we started growing by leaps and bounds. . . . And
> then at some point, we changed the model. . . . We became less a part of the team
> and I could quickly see how the nurses would gripe about the therapists and the
> dieticians. . . . Over time there was less connectedness.

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Table 1

Participant Demographics

Participant	Age	Gender	Race	Education	Yrs. in nursing	Yrs. treating EDs
Jackie	20s	Female	Hispanic	BSN	7	2.5
Evangeline	40s	Female	Caucasian	BSN	10	2.5
Emily	20s	Female	Multiracial	MSN/BSW	8.5	3.5
Willow	30s	Female	Caucasian	BSN	3	2
Little Girl	50s	Female	Caucasian	BSN/MA (Counseling)	35	8
Paige	20s	Female	Caucasian	ASN	5	2
Pat	20s	Female	Caucasian	ASN	3.5	2
Sarah	20s	Female	Caucasian	BSN/MA (Child Develop.)	1	1
Morgan	20s	Female	Caucasian	BSN	3.5	2
Jane	30s	Female	Caucasian	BSN	6.5	2.5
Cassandra	20s	Female	Caucasian	BSN	7	2.5
Amy	30s	Female	Caucasian	BSN	6.5	3.5

Note. ED = eating disorder; BSN = Bachelor of Science in Nursing; MA = Master of Arts; ASN = Associate of Science in Nursing.