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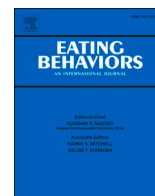
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Experiences of inpatient eating disorder admissions: A systematic review and meta-synthesis

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ABSTRACT

Objective: There has been a significant increase in the number of inpatient admissions for individuals with eating disorders and, with the most critical cases requiring inpatient treatment, it is essential that we continue to improve associated outcomes. The aim of the study was to synthesise the available qualitative literature on the experiences of inpatient admissions for eating disorders to understand individuals' experiences and identify areas that may require further research and/or service development.

Method: Searches were performed on the following online databases: PsycINFO, PsycArticles, PsycTherapy MEDLINE, Embase, CINAHL, ASSIA, Scopus and Proquest Open Access Theses. Only papers with qualitative data regarding individuals' experiences of inpatient eating disorder treatment were considered. The CASP qualitative checklist was used to assess studies and relevant data items were extracted. Thematic synthesis was used to integrate the findings in the identified studies. GRADE-CERQual was used to rate the confidence in the findings.

Results: Twenty-eight studies were identified which the CASP assessment considered to be adequate. The synthesis produced 5 main themes; 'Care and control', 'Inpatient bubble', 'Being supported and understood', 'Challenges of living with others' eating disorders' and finally 'Relationship to eating disorder'. The GRADE CERQual framework rated findings with high or moderate confidence.

Conclusions: Findings reaffirmed the importance of patient-centred care and the significant impact of being separated from normal life with others also experiencing an eating disorder.

1. Introduction

Eating disorders (ED) are associated with a mortality rate of 5 to 7 times that of general population (Arcelus, Mitchell, Wales, & Nielsen, 2011; Iwajomo et al., 2021), along with increased physical health risk (Mehler et al., 2018), disability (Smink, van Hoeken, & Hoek, 2013), reduced quality of life and high levels of psychiatric comorbidity (Ágh et al., 2016; Himmerich et al., 2019). The most critical cases require inpatient treatment (National Institute for Health and Care Excellence, 2017 guidelines) and post COVID-19 we have seen significant increases in the number of inpatient admissions for individuals with eating disorders (Gilsbach et al., 2022; Devoe et al., 2022; Solmi, Downs, & Nicholls, 2021). While inpatient units play an essential role within a spectrum of eating disorder service provision, admissions can be lengthy (Kan, Hawkins, Cribben, & Treasure, 2021) and costly both to the

individual (van Hoeken & Hoek, 2020), and to the health service (Le & Mihalopoulos, 2021; Streatfeild et al., 2021). Furthermore, only a third of patients discharged from inpatient units tend to be in remission after a year (Danielsen et al., 2020) and the mortality risk for people after inpatient treatment for anorexia nervosa (AN) is over five times higher than for age and gender matched people in the general population (van Hoeken & Hoek, 2020). There is clearly an ongoing need to develop and innovate inpatient treatment and care for individuals experiencing an eating disorder.

Engagement with service users is one important approach to improvement in inpatient treatment. Within the UK, the Health and Social Care Act (2012) outlines the responsibility of services to work in partnership with those in their care to involve and enable them to make decisions relating to their treatment. This extends to service development, with legislation requiring user consultation in the development of

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mental health services (National Health Service and Community Care Act, 1990; National Service Framework for Mental Health, 1999). Moreover, quality standards for inpatient and community eating disorder services champion patient engagement and choice (Royal College of Psychiatrists (2022), Royal College of Psychiatrists (2019)). Using existing research on the experiences of inpatient eating disorder treatments provides an essential lived experience perspective and foundation to begin to enhance care and treatment within inpatient settings.

Qualitative research of patient perspectives is a means to step out of the clinical lens and consider the experience holistically. Broader aspects of inpatient treatment which are impactful for those receiving care may otherwise be overlooked (Perkins, 2001; Zaitsoff, Pullmer, Menna, & Geller, 2016). Historically, engaging directly with service users has been neglected within ED research (Newton, 2001; Wade, Hart, Mitchison, & Hay, 2021). This is now changing with more qualitative literature on the experience of ED and treatment being generated. This kind of research can help to identify elements of treatment which may otherwise be missed (Bell, 2003; Busetto, Wick, & Gumbinger, 2020) and can provide a platform for more nuanced innovations in treatment led by lived experience, and associated quantitative evaluation of efficacy.

Several existing systematic reviews consider EDs and inpatient treatment from the perspectives of service users. Babb, Jones, and Fox (2022) reviewed literature on individuals' perspectives of ED treatment in both inpatient and outpatient services. While the review was able to provide insight into ED services in general, it did not aim to capture the specific experience of an inpatient admission that is essential for a focused exploration of these unique treatment environments. In addition, it did not include grey literature, and excluded papers in which multiple stakeholders perspectives were represented thus resulting in the exclusion of some relevant and diverse insights. Wood and Alsawy (2016) systematically reviewed the qualitative literature exploring the experience of generic psychiatric inpatient care but their research was not specific to individuals with an ED. There are very specific experiences associated with ED admissions including weight gain, limitations on movement/exercise, and nasogastric feeding that require further exploration.

The aim of the current review is therefore to gain a clear understanding of ED inpatient admission experiences through the collection and analysis of qualitative data. In so doing, it aims to identify those aspects of inpatient care which may benefit from further research and/or service development.

2. Methods

This study is reported in line with the Preferred Reporting for Items for Systematic Reviews and Meta-Analyses checklist (PRISMA) (Page et al., 2021) and was pre-registered on PROSPERO (PROSPERO ID 225133). Since the registration of the protocol, there have been changes to the terms to include all ED diagnosis as search terms and an extension of the search dates to March 2023.

2.1. Eligibility criteria

Studies were selected for the systematic review if they included qualitative data regarding direct experience of ED inpatient treatment. There was no specification regarding the country in which the data was collected. However, only studies available in the English language were included in order not to lose the nuance of the data through translation (Van Nes, Abma, Jonsson, & Deeg, 2010). A time frame was set from January 2000 to March 2023 to focus on contemporary experiences. Peer reviewed and unpublished papers were included.

2.2. Information sources

Searches were performed on: PsycINFO, PsycArticles, PsycTherapy MEDLINE, Embase, CINAHL, ASSIA, Scopus, and Proquest Open Access

Theses and Dissertations data base. The final searches were performed on the 1st March 2023.

2.3. Search strategy

A standardised search strategy was employed to collect papers across the databases (Table 1, STARLITE table (Booth, 2006)). Three key search terms relating to diagnosis, inpatient admission and qualitative data were used with limitations on date and language.

2.4. Selection process

After the searches concluded, and duplicates removed, papers were screened using Covidence. The first investigator screened all papers (IP) by title and abstract and a co-investigator (LC) screened a 10 % sample. All remaining papers were read in full by two investigators independently (IP and JLC) and there was 85 % agreement between reviewers. The conflicts were discussed and those not meeting the criteria excluded. The data extraction was performed by both investigators independently on 100 % of the sample (IP and JLC). There was 87 % agreement between reviewers in this process and discrepancies were resolved mutually between the respective reviewers with a third reviewer (FD) consulted if required.

2.5. Data items

Specified data items regarding participant characteristics and study methodology were recorded from the selected papers (see Supplementary Table 5). Missing data was recorded as not reported. In line with requirements for thematic synthesis (Thomas & Harden, 2008), all text under the heading of "Results" was extracted.

Table 1
STARLITE search strategy.

STARLITE summary of search strategy	
Sampling strategy	Purposeful sampling using online databases which specifically include medical, nursing and social sciences literature, as well as grey literature searches.
Types of study	Any studies which include qualitative data from interviews, focus groups and surveys.
Approaches	Electronic databases for search
Range of years	Papers written after January 2000 up to March 2023
Limits	Papers must be published in the English language
Inclusion and exclusions	<i>Inclusion:</i> English language, published after Jan 2000, Qualitative data regarding the experience of inpatient eating disorder treatment, Participants must be receiving or have received inpatient treatment for a primary diagnosis of an eating disorder <i>Exclusion:</i> Exclusively quantitative, are a case study or opinion based. Study focusing on specific evaluation of a treatment. Papers in which proved impractical to separate stakeholder responses were excluded.
Terms used	Term 1: eating disorder diagnosis EATING DISORDER* OR ANOREXI* OR BULIMI* OR BINGE EATING DISORDER* OR EDNOS OR OSFED OR ARFID OR AVOIDANT RESTRICTIVE FEEDING INTAKE DISORDER Term 2: Inpatient treatment INPATIENT* OR RESIDENT* OR ADMISSION* OR HOSPITAL* OR WARD* Term 3: Qualitative experience EXPERIENCE* OR PERSPECTIVE* OR PERCEPTION* OR ATTITUDE* OR FOCUS GROUP* OR QUALITATIVE
Electronic sources	PsycINFO, PsycArticles, PsycTherapy MEDLINE, Embase, CINAHL, ASSIA and Scopus. Proquest Open Access Theses and Dissertations data base will be used to search for unpublished academic research.

2.6. Study of risk of bias assessment

2.6.1. Individual papers

Included studies were assessed using the Critical Appraisal Skills Programme qualitative checklist (CASP, 2018) with an additional question regarding the theoretical underpinnings of the study methodology (Long, French, & Brooks, 2020). The CASP assessed risk of bias

and quality through 10 questions covering various areas such as the methodological features, study design, data collection and recruitment relevant to the study aims. All areas are rated as ‘Yes’, ‘No’ or ‘Can’t tell’. The final papers were rated by two independent investigators (100 % by both IP and LC) and there was an 85 % agreement between reviewers in this process.

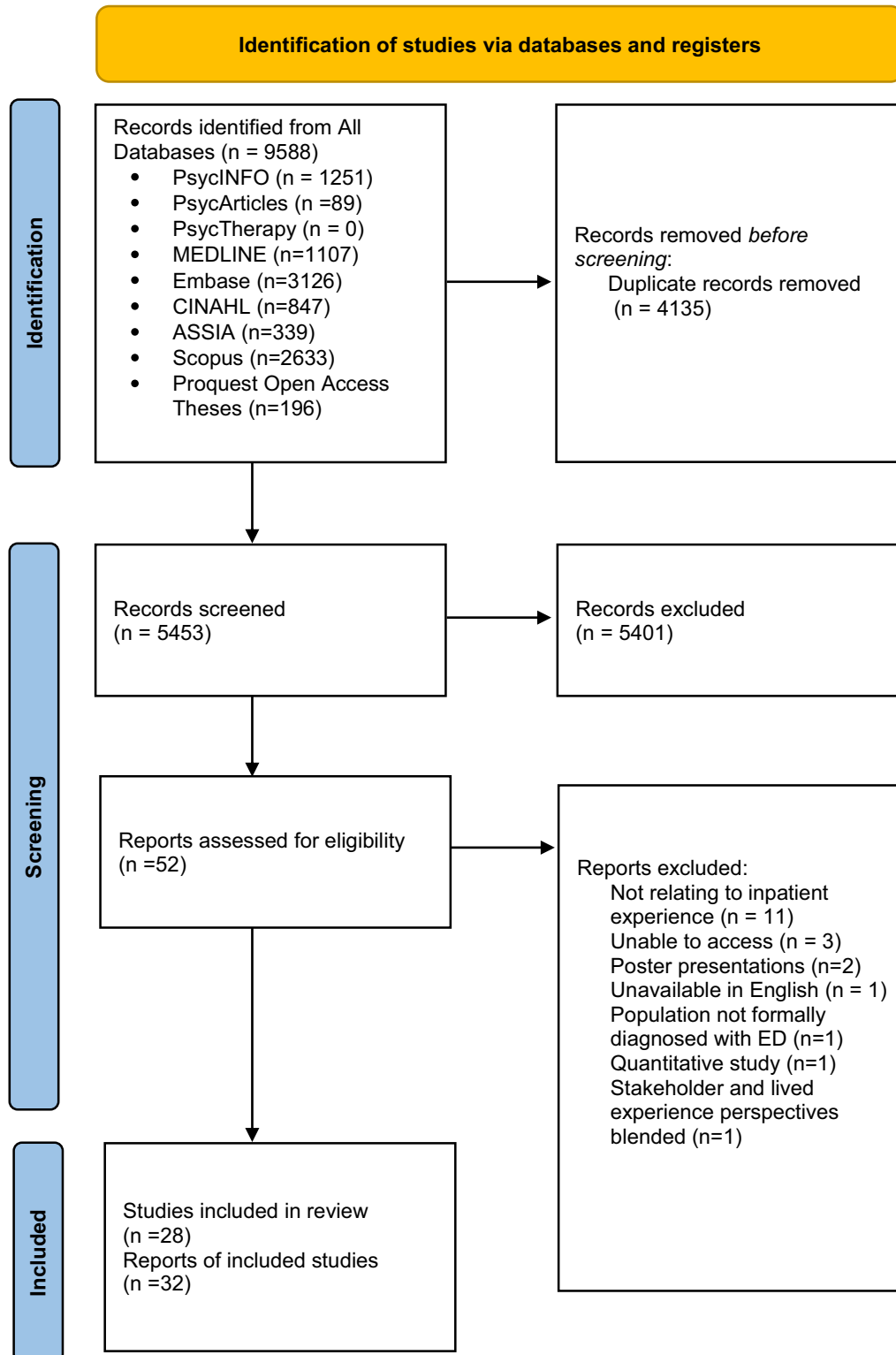


Fig. 1. PRISMA flowchart.

2.7. Synthesis methods

The primary investigator (IP) used thematic synthesis (Thomas & Harden, 2008) to synthesise the review literature. Thematic synthesis was chosen owing to its inductive approach and its previous use within healthcare research. It was developed to be used when reviewing literature of healthcare interventions and combines approaches from meta-ethnography and grounded theory, summarising and going beyond the evidence (Barnett-Page & Thomas, 2009). It is also appropriate for use with different forms of qualitative data collection methods. The extracted data were hosted on Nvivo (SOFTWARE), read multiple times and coded line by line. The descriptive themes were developed from the initial codes. Finally, analytical themes were generated with the aim of 'going beyond' the extracted data.

2.8. Reflexive statement

Reflexivity is an important endeavour within qualitative research. It is necessary to continually engage in questioning one's position as a researcher and the bias and lens we bring to interpretation (Finlay, 2002). To address their own positionality and engage in reflexivity, the primary investigator discussed analysis with supervisors and a University ED research group which included those with lived experience of eating disorder inpatient admissions.

2.9. Critical appraisal of synthesis finding

The GRADE CERQual was used to assess confidence in the systematic review findings (Lewin et al., 2018) according to four components: methodological limitations, coherence, adequacy of data and relevance. Each finding was rated for confidence in each component from 'Very low', 'Low', 'Moderate' to 'High' to develop an overall judgement. The first investigator (IP) undertook the appraisals of the findings.

3. Results

The databases searches returned 9588 papers (Fig. 1). After duplicates were removed, investigators completed screening and identified 32 suitable papers representing 28 studies. For the four studies with multiple papers, all papers were used (Nilsen, Hage, Rø, Halvorsen, & Oddli, 2019; Nilsen et al., 2021; Smith, 2012; Smith et al., 2016; Spivack, 2010; Spivack & Willig, 2010; Zugai, Stein-Parbury, and Roche, 2018a, b; Zugai, Stein-Parbury, & Roche, 2019).

3.1. Study characteristics

Eighty one percent of the papers were published ($n = 26$) and 19 % were dissertations ($n = 6$). The dates of publication spanned from 2003 to 2023. All but one study (i.e., Diary entries, Solhaug Storli and Alsaker, 2021) used semi-structured interviews. A range of data analysis approaches were used (see Table 2).

3.1.1. Sample characteristics

The studies included a total of 360 participants. Ninety four percent of the sample identified as female ($N = 340$), 2.7 % male and <1 % identified as non-binary (2.5 % Not Reported). More than two thirds of the studies had exclusively female samples ($N = 18$, 64.3 %). Eighty one percent of the sample were diagnosed with anorexia nervosa or EDNOS/OSFED ($N = 294$), with one study centred on the experiences of bulimia nervosa (Total with BN $N = 6$; Warchol, 2013, $n = 5$) (Warchol, 2013). ED diagnosis was not reported in a proportion of the studies ($N = 50$, 13.9 %). Participant ages ranged from 12 to 56 years, with 50 % of studies ($n = 14$) focusing exclusively on the experiences of adolescents. More than half of the studies did not report on ethnicity demographics (60.7 %).

Most of the studies recruited from specialist eating disorder units (N

$= 17$, 60.7 %) with a smaller proportion being recruited from general psychiatric units ($N = 7$, 25 %) or from a mix of general and specialist services (Mix of settings $N = 2$, 7.1 %; Not reported $N = 2$, 7.1 %). The studies were mainly from western English-speaking countries (UK, $N = 11$; Australia, $N = 5$; Canada, $N = 1$; USA, $N = 3$; New Zealand, $N = 1$) with studies also from the Netherlands ($N = 1$), Norway ($N = 3$), Sweden ($N = 1$), China ($N = 1$) and Israel ($N = 1$).

3.2. Quality assessment of selected studies

All studies were considered to have adequate methods according to the CASP qualitative checklist (Table 3). All studies stated their aims and explained the relevance of a qualitative methodology. Most studies described their methodology, recruitment strategy and analysis sufficiently. Several of the studies were unclear about relationships to the participant (e.g., (Boughtwood & Halse, 2010) and the theoretical positioning (e.g., Thabrew, Mairs, and Taylor-Davies (2020)).

4. Synthesis

From the thematic synthesis, 5 themes were developed which included; 'Care and control', 'Inpatient bubble', 'Being supported and understood', 'Challenges of living with others' eating disorders' and finally 'Relationship to eating disorder'.

4.1. Theme 1: Care and control

In almost all the studies, participants described treatment as highly regimented. Owing to the strict nature of inpatient settings, participants experienced care and control as synonymous.

4.1.1. Being controlled

Though there was an understanding of the need for rules, the rules in the inpatient settings were perceived as copious, and participants felt controlled. There were reports of inpatient settings having rules covering visits, supervision during mealtimes and using the bathroom, all implemented to limit ED behaviours. The strict rules led participants to describe their admission 'like you're almost in prison' (Spivack, 2010; Spivack & Willig, 2010). The sense of being continually supervised by the inpatient regime resulted in participants feeling stripped of agency.

'It was horrible, the lack of control you'd have, because they'd literally decide everything for you.' (Offord, Turner, & Cooper, 2006).

Social relationships were also felt to be restricted during admission. Participants had reduced contact with families and friends owing to specified visiting hours and requirements relating to improvements in physical health conditional for time out of the inpatient setting. Participants reported that inpatient friendships were discouraged and that the Healthcare professionals (HCPs) 'tell you not to make friends, don't they?' (Holmes, Malson, & Semlyen, 2021). Participants felt as though they were being controlled through their social relationships.

To add to their frustration, many participants felt as though the rules were not properly explained. Participants who sought to understand the purpose of some rules were met with no justification. This made them feel untrusted, with some participants sensing they were perceived to be 'troublemakers' (Holmes et al., 2021) when they asked for explanation of the rules. The lack clarification prevented them engaging with their care, furthering their sense of being controlled.

The strict application of rules and restrictions led participants to view HCPs as authoritarian. HCPs monitored adherence to rules, with participants perceiving them to be hostile and as though 'their eyes were always on you' (Zugai, Stein-Parbury, & Roche, 2013). Participants reflected that this made their care feel like punishment and was ultimately 'demotivating' (Zugai et al., 2018a, b). It was considered by some to be damaging to the therapeutic dynamic.

Table 2
Study characteristics.

Author (year) location	Aim	Sample characteristics	Inpatient setting	Data collection	Analysis
Birkbeck (2018) UK	To understand patients experiences of in-patient treatment and develop improvements for enduring AN [†] .	N = 11, 100 % F Dx: 100 % AN Age: 28.8 (19–43) 81 % White British, 9 % British Chinese, 9 % British-Turkish	Mix of specialist and general inpatient, adult and CYP [§] units.	Semi structured interviews	Grounded theory
Boughtwood and Halse (2010) Australia	To understand therapeutic alliance in inpatient treatment for AN.	N = 25 100 % F Dx: All AN Age: Age = 14.8 (12–18) 92 % White-Australian, 4 % Italian, 4 % Chinese	NR	Semi structured interviews	Discourse analysis
Colton and Pistrang (2004) UK	To understand experience eating disorder inpatient treatment for adolescents.	N = 19 100 % F Dx: 100 % AN Age: 15.4 (12–17) 92 % White British, 4 % White Irish, 4 % British Afro-Caribbean	Specialist CYP unit	Semi-structured interviews	IPA ^{††}
Eli (2014) Israel	To explore experiences of eating disorder inpatient treatment.	N = 13 91.7 % F, 8.3 % M Dx: 92.3 % AN/EDNOS, 7.7 % BN Age: 30 (18–38) Ethnicity NR [‡]	Specialist unit	Semi-structured interviews	IPA
Fox and Diab (2015) UK	To explore experiences of eating disorder inpatient treatment.	N = 6 100 % F Dx: 100 % AN Age: 27 (19–50) 100 % White British	Specialist unit	Semi-structured interviews	IPA
Holmes et al. (2021) UK	To explore experiences of eating disorder inpatient treatment and how trust is experienced.	N = 14 100 % F Dx: 100 % AN Age: 30 (20–42) 78.6 % White British, 21.4 % White Jewish, 7.1 % White American, 7.1 % Other	NR	Semi-structured interviews	Thematic analysis
Kezelman et al. (2016) USA	To explore experiences of eating disorder inpatient implementing rapid-refeeding protocol for adolescent.	N = 10 100 % F Dx: 100 % AN Age: 17.5 (16–19) Ethnicity NR	Specialist unit	Semi-structured interviews	Thematic analysis
Long et al. (2020) UK	To investigate in-patient experiences of mealtimes in inpatient treatment.	N = 12 100 % F Dx: 100 % AN Age: 22 (17–29) Ethnicity NR	Specialist unit	Semi-structured interviews	Thematic analysis
Thorpe (2019)	To investigate the role and importance of education to adolescents with eating disorders.	N = 2 100 % F Dx: 100 % AN Age: 16 (15–17) Ethnicity White British	Specialist CYP unit	Semi-structured interviews	IPA
Monaghan and Doyle (2023)	To explore the experiences of young people with anorexia of mealtimes and attendance at post meal support group in an inpatient setting	N = 6 NR Gender Dx: 100 % AN Age: NR (13–18) Ethnicity NR	General CYP unit	Semi-structured interviews	Content analysis
Nilsen, Hage, Ro, et al. (2019) and Nilsen, Hage, Ro, et al. (2019) Norway	To understand experiences of eating disorder inpatient treatment.	N = 37 89 % F, 11 % M Dx: 100 % AN Age: 15.8 (12–19) Ethnicity NR	Specialist CYP unit	Semi-structured interviews	Thematic analysis
Offord et al. (2006) UK	To explore perspectives on inpatient eating disorder treatment whilst admitted to a general adolescent psychiatric unit.	N = 7 100 % F Dx: 100 % AN Age: 19.5 (16–23) 100 % White British	General CYP unit	Semi-structured interviews	IPA
Pemberton and Fox (2013) UK	To understand emotional management of eating disorders in inpatient treatment.	N = 8 87.5 % F, 12.5 % M Dx: 100 % AN Age: NR Ethnicity NR	Specialist unit	Semi-structured interviews	Grounded theory

(continued on next page)

Table 2 (continued)

Author (year) location	Aim	Sample characteristics	Inpatient setting	Data collection	Analysis
Ramjan and Gill (2012) Australia	To explore the experiences of adolescents and nurses of inpatient eating disorder treatment.	N = 10 89 % F, 11 % M Dx: 100 % AN Age: 14.8 (11–18) Ethnicity NR	Specialist CYP unit	Semi-structured interviews	Comparative analysis
Ross and Green (2011) UK	To understand experiences of inpatient eating disorder treatment from a psychodynamic perspective.	N = 2 100 % F Dx: 100 % AN Age: NR >18 years Ethnicity NR	Specialist unit	Semi-structured interviews	Narrative thematic analysis
Sheth (2003) USA	To consider the impact the design of inpatient setting on children's experiences of eating disorder treatment.	N = 10 90 % F, 10 % M Dx: 100 % AN Age: 14.8 (10–15) Ethnicity NR	General CYP unit	Interviews and photo maps	Content analysis
Sly et al. (2014) UK	To explore experience of therapeutic alliance in inpatient eating disorder treatment	N = 8 100 % F Dx: 100 % AN Age: 25 (18–34) 100 % White	Specialist unit	Semi-structured interviews	IPA
Smith (2012); Smith et al. (2016) UK	To explore experiences of eating disorder inpatient treatment.	N = 21 100 % F Dx: 100 % AN Age: 25.2 (18–14) Ethnicity NR	Specialist unit	Semi-structured interviews	Thematic analysis/ IPA
Solhaug Storli and Alsaker (2021)	To explore how patients with severe eating disorder experience everyday in hospital treatment and how do they value the impact of their experiences in treatment?	N = 3 NR Gender Dx: NR Age: NR (18–30) Ethnicity NR	General unit	Diary entries	Thematic analysis
Spivack (2010); Spivack & Willig, (2010) UK	To explore experiences of eating disorder inpatient treatment.	N = 8 100 % F Dx: NR Age: 14.5 (12–17) Ethnicity NR	Specialist unit	Semi-structured interviews	IPA
Strand, Bulik, et al. (2017) Sweden	To explore experiences of a self-admission eating disorder inpatient treatment.	N = 16 94 % F, 6% M Dx: 100 % AN Age: 31 (18–56) Ethnicity NR	Specialist unit	Semi-structured interviews	Content analysis
Thabrew et al. (2020) New Zealand	To understand adolescent the experiences of eating disorder inpatient treatment.	N = 9 100 % F Dx: 100 % AN Age: 16 (15–17) 77.8 % White, 22.2 % Asian	Specialist unit	Semi-structured interviews	Thematic analysis
Van Ommen et al. (2009) Netherlands	To develop a model of inpatient nursing of adolescents with AN.	N = 13 100 % F Dx: 100 % AN Age: 15 (13–17) Ethnicity NR	Specialist CYP unit	Semi-structured interviews	Grounded theory
Warchol (2013) USA	To describe the experience of social comparison of women in residential treatment for BN [†] .	N = 5 100 % F Dx: 100 % BN Age: 23.4 (20–31) 80 % White, 20 % mixed White Asian	Specialist unit	Semi-structured interviews	Phenomenological analysis
Williams, O'Reilly, and Coelho (2020) Canada	To understand adolescent experience, access and outcomes of inpatient eating disorder treatment.	N = 39 96.6 % F, 3.4 % NB Dx: NR Age: 2.2 (17–24) Ethnicity NR	General CYP unit	Semi-structured interviews	Thematic analysis
Wu and Harrison (2019) China	To understand the experiences of adolescent eating disorder inpatient treatment in China.	N = 4 100 % F Dx: 100 % AN Age: 17.5 (16–19) 100 % Chinese	General CYP unit	Semi-structured interviews	IPA
Zugai et al. (2013) Australia	To understand the therapeutic alliance in inpatient treatment for AN.	N = 8 100 % F Dx: 100 % AN Age: 14.8 (14–16) Ethnicity NR	General CYP unit	Semi-structured interviews	Thematic analysis
Zugai, Stein-Parbury, and Roche (2018a, 2018b) Australia	To understand nursing therapeutic alliance in inpatient treatment for adolescents with AN.	N = 34 97 % F, 3% M Dx: 100 % AN Age: 20 (NR) Ethnicity NR	Mix of specialist and general units	Semi-structured interviews	Thematic analysis

- † AN: anorexia nervosa.
- ‡ BN: bulimia nervosa.
- § NR: not reported.
- ¶ CYP: child and young person.
- †† IPA: interpretative phenomenological analysis.

Table 3
CASP summary.

	1	2	3	4	5	6	7	8	9	10	11
Birkbeck, 2018	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Boughtwood & Halse, 2010	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Colton & Pistrang, 2004	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Eli, 2014	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Fox & Diab, 2015	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Holmes et al., 2021	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Kezelman et al., 2016	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Long et al., 2020	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Thorpe, 2019	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes
Monaghan & Doyle, 2023	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Nilsen, Hage, Rø, et al., 2019	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Offord et al., 2006	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Pemberton & Fox, 2013	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ramjan & Gill, 2012	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ross & Green, 2011	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sheth, 2003	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sly et al., 2014	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Solhaug Storli & Alsaker, 2021	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Smith, 2012	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Spivack, 2010	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Strand, Gustafsson, et al., 2017	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Thabrew et al., 2020	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Van Ommen et al., 2009	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Warchol, 2013	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Williams, O'Reilly, & Coelho, 2020	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Wu & Harrison, 2019	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Zugai et al., 2018a, 2018b	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Zugai et al., 2013	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes

‘When they’re more forceful it makes me always want to pull against and try harder at doing the wrong things.’

(Colton & Pistrang, 2004).

In a proportion of the studies, participants considered their treatment to be standardised and not tailored to their needs. Participants described their irritation at having to follow rules irrelevant to their presentation which added to their perception of being ‘another anorexic’ (Nilsen, Hage, Rø, et al., 2019; Nilsen, Hage, Ro, Halvorsen, & Oddli, 2019). Some participants felt powerless, and therefore ‘didn’t bother trying’ (Birkbeck, 2018) to influence their care to better shape their needs.

In many of the studies, participants judged treatment to be focused on weight gain, with one study describing it as a ‘feeding clinic’ (Birkbeck, 2018). Participants felt discouraged by this as their ED was not addressed holistically and that the focus on weight goals made them feel ‘more obsessed’ with ‘weight than ever’ (Solhaug Storli & Alsaker, 2021).

4.1.2. Taking back control

Participants across the studies described different responses to feeling controlled. For some, the inpatient setting rules relieved them of fighting with their ED and gave them their ‘own sense of mind back’ (Spivack, 2010; Spivack & Willig, 2010). For others, their response was to submit to treatment solely to facilitate a faster discharge. This approach was characterised by passive compliance instead of meaningful engagement with treatment. For some this extended to bingeing to gain weight for a faster discharge. In other studies, participants rebelled against their treatment. They reported that having HCPs assume they engaged in covert ED behaviours led them to engage in ‘mischief’ (Boughtwood & Halse, 2010) to sabotage their treatment, such as disrupting overnight feeds and secretive exercising. In contrast, there

were examples in a few studies where participants were provided with the opportunity to engage and guide their own care. Participants seized the chance to have agency and gain control, describing feeling heard and as though they ‘had a part in’ their treatment (Colton & Pistrang, 2004).

4.2. Theme 2: Inpatient bubble

Across the studies, participants demarcated between the ‘outside world’ (Thorpe, 2019) and inpatient ‘microcosm’ (Strand, Bulik, von Hausswolff-Juhlin, & Gustafsson, 2017).

4.2.1. Artificial pause

In some studies, participants experienced the inpatient admission as an enforced break from normal life, removed from their routines felt to be both a relief and frustration. Some participants experienced their admission as a ‘break from all those hard things’ (Strand, Gustafsson, Bulik, & von Hausswolff-Juhlin, 2017) whereas others perceived it as a ‘void’ (Offord et al., 2006), with everything in life having come to a stop.

Younger participants particularly were aware of an interruption to their development, with a sense that life continued for their peers and felt like a ‘pause’ for them (Ramjan & Gill, 2012). They feared returning to school and how to integrate back into friendship groups once they were discharged. Participants were demotivated by the perception of having missed out and wanted to ‘get back to life’ (Kezelman et al., 2016).

4.2.2. Inpatient microcosm

The rules and new social dynamics created a ‘microcosm’ (Strand, Gustafsson, et al., 2017) unique to the inpatient setting. Participants experienced it as distinct from reality owing to the clinical nature of the environment and the particular social dynamics. One participant described the unit as ‘a Green house’ (Eli, 2014) with the intensity of the

social dynamics between staff and patients contained in a 'sterile' clinical environment outside of normal life. The inpatient settings were felt to have developed their own specific contained environment separate from reality, having the feeling of 'a really long dream' (Spivack, 2010; Spivack & Willig, 2010).

4.2.3. Separation from the outside world

The inpatient admission led to participants feeling socially isolated from family and friends. The separation caused them to feel distanced and as though they did not 'belong in the family' (Offord et al., 2006). In some studies, participants held the belief that their family were handing over responsibility to the inpatient setting. For those who felt supported by their families, they felt at a loss without them. Participants described how they found it difficult to maintain their friendships outside of the unit — feeling as though their friends 'seemed to act differently around' them (Fox & Diab, 2015). The inpatient admission heightened the 'feelings of loneliness, isolation and separation from peers' (Thorpe, 2019). Participants believed that visits from friends helped them keep 'in contact with the outside world' (Ramjan & Gill, 2012).

4.3. Theme 3: Being supported and understood

During their inpatient admission, in some studies participants reported being supported by therapeutic staff, predominately from the nursing team, and their inpatient peers.

4.3.1. Seeing past the eating disorder

Participants noted HCPs as particularly supportive when they focused on the individual and were able to separate them from their illness, being able to 'see the person behind the anorexia' (Colton & Pistrang, 2004). Unfortunately, some participants felt that some HCPs perceived them as part of the 'conveyor belt of anorexics' (Colton & Pistrang, 2004). They felt they had been stripped of their identity and placed in a homogenous group. This was contrasted by HCPs actively seeking out participants' individuality rather than focusing on their ED, which was felt to be hugely beneficial. This approach allowed the individual to see how the ED was impacting them and helped them 'to see how the anorexic side' 'was being really harsh on the normal side' (Fox & Diab, 2015).

4.3.2. Modelling

In some studies, participants were supported by both peers and HCPs through modelling recovery behaviour. Inpatient HCPs were well placed to demonstrate 'normal' eating behaviour which made participants feel more comfortable during mealtimes. In other studies participants described inpatient peers as modelling recovery. Participants benefitted from observing peers who were able to advise on how to contend with the ED. Participants described how they could 'learn how different people cope with things' and see if they also worked for them (Offord et al., 2006).

4.3.3. Understanding

In many of the studies, participants reported feeling understood by HCPs and inpatient peers. The HCP therapeutic relationships were integral to inpatient admission experience. HCPs who took the time to engage and understand participants made them feel valued. The staff who were able to develop a beneficial therapeutic dynamic could encourage individuals to 'open up even more and more' (Nilsen, Hage, Rø, et al., 2019; Nilsen et al., 2021).

In addition, in some studies, participants detailed the support received from inpatient peers with a shared experience of an ED. Participants reported that they were able to speak honestly to their peers who shared the 'similar demons' (Eli, 2014) and understood them in a way that they had not previously experienced. Being with others with an eating disorder reduced their sense of loneliness and gave them 'comfort knowing that you're not the only one' (Kezelman et al., 2016).

Unfortunately, in some of the studies, participants noted HCPs who were inconsistent or unable how to support those with EDs. Staff who were less experienced and did not understand EDs were often inconsistent or not as confident when challenging their behaviours. The participants noted that when HCPs were inconsistent or lacked confidence their 'illness just plays into that', and would take advantage of HCPs inexperience (Birkbeck, 2018).

4.4. Theme 4: Challenges of living with others' eating disorders

A few studies described the difficult dynamic of being with other inpatients who were also diagnosed with an ED. Participants were having to manage their own distress during their admission, whilst being exposed to peers' distress.

As peers' concerns were like their own, they had a compounding impact. One participant described experiencing the emotions of others as inescapable and as 'mirrors' to their own experience (Eli, 2014). They noted that particularly during mealtimes when they were all brought together, they were aware of 'experiencing everyone else's troubles' (Thabrew et al., 2020). They were not only having to manage their own experience, but were pulled into the others around them, and 'at risk for over-identification and intensified illness' (Eli, 2014).

Participants in several studies provided insight into the sharing of ED behaviours between inpatient peers. One study reported it was not that individuals sought these behaviours out, but rather witnessing others meant they were vulnerable to adopting them 'because you see everyone else making rituals' (Eli, 2014). Participants described sharing ideas on how to avoid weight gain, with one participant describing it as a 'toxic environment' (Nilsen, Hage, Ro, et al., 2019; Nilsen et al., 2021).

Within the inpatient group, there was potential for competition and comparison between peers. One study reported participants competed to be the 'best anorexic' (Colton & Pistrang, 2004; Offord et al., 2006). Comparison of physique, clothes sizes and meal plans served to add to their distress, captured by one participant who noted 'I never win when comparing myself to someone else' (Warchol, 2013).

A phenomenon experienced in a couple of the studies, was the challenge of new admissions. When a new individual was admitted to the unit who presented at a lower weight, their appearance served as a frustration for participants owing to their own weight gain in treatment. By way of contrast, others saw it as a reminder of what they wanted to move away from and 'motivated [them] to carry on' as they 'didn't want to go back again' (Offord et al., 2006).

4.5. Theme 5: Relationship to eating disorder

An inpatient admission presented an opportunity for participants to reflect on their ED, what it meant to their sense of self.

Some participants were initially resistant to separate themselves from their ED. Participants described 'battling' (Spivack, 2010; Spivack & Willig, 2010) with their ED and finding it difficult to 'distinguish what is me and what is the eating disorder' (Smith et al., 2016 (Smith, 2012; Smith et al., 2016)). However, their admission forced them to address the role of the ED in their lives.

Studies noted participants' relationships to their ED changed as they contemplated recovery. Initially, many participants appeared to be ambivalent with uncertain expectations of recovery. In a few of the studies, participants discussed their fears about returning to the community. They were concerned that once they were discharged they would 'hear this voice [their ED] saying...It will be you and me again' (Smith, 2012; Smith et al., 2016).

Some studies presented participants' expectations of recovery. They perceived it as a challenging process, but were able to see positive outcomes. They described the shift as gradual and that with greater freedoms they considered recovery as 'much more fun than having an eating disorder' (Van Ommen, Meerwijk, Kars, Van Elburg, & Van Meijel, 2009).

4.6. Assessment of confidence in findings

Confidence in the majority of the systematic review findings was rated between ‘Moderate’ and ‘High’ (Table 4). Most findings were felt to have minor methodological concerns regarding methodological limitations, coherence and adequacy, and no or minor concerns for relevance.

5. Discussion

This systematic review explored the experiences of inpatient ED admissions with qualitative analysis. Themes developed detailed participants' perception of control during the admission, separation from normal life, feeling supported, the difficulties being with others with an ED, and their relationship with ED and recovery.

The current findings suggest inpatient ED treatment can be experienced as controlling, standardised and disproportionately focused on weight gain. Participants were frustrated by feeling controlled and without agency. This is consistent with a previous review of stakeholder perspectives of ED treatment (Johns, Taylor, John, & Tan, 2019) that found it to be experienced as restrictive, and ultimately led to resistance. The heightened risk in inpatient settings may require greater restriction and surveillance to ensure safety which would align with Babb et al., 2022 review which noted control as a more significant feature of inpatient treatment compared to outpatient. Our findings suggest that patients need to be given an active role in their care (Boardman & Dave, 2020). McKay, Ariss, and Rudnick (2021) explored patient centred care provided in involuntary psychiatric treatment, and outlined patients preference for being given choices and when this was not possible, for HCPs to acknowledge the power imbalance.

An inpatient admission was experienced as a suspension from normal life, halting individuals' normal social development, which has been acknowledged as particularly impactful for young people (Lindstedt, Neander, Kjellin, & Gustafsson, 2018). Inpatient units were also experienced as a distinct from normal life, a finding that aligns with both Wood and Alsawy's (2016) review of general psychiatric inpatient care which conceptualised the inpatient environment as safe and Webb et al.'s (2022) interviews with HCPs, who recognized inpatient treatment as isolating. The current review added to the literature by acknowledging an additional perception of the suspension of the inpatient environment as challenging. The differences in experience of the pause of typical life from something welcoming and safe to adverse, highlight the need to tailor care and adjust treatment to suit patients (Drake, Cimpean, & Torrey, 2009).

Our review highlighted the role of HCPs in enforcing rules and providing support which was experienced as both positive and negative by different individuals. HCPs were felt to be particularly unhelpful when they were either too authoritarian or did not understand EDs enough to challenge them, supporting the individual in the process. HCPs have reported that a lack of confidence prevents them challenging disordered behaviour (Hage, Rø, & Moen, 2017). HCPs require the knowledge and confidence to challenge ED behaviours and support adherence to treatment non-negotiables (Hage, Rø, & Moen, 2015, 2017). Our review findings provided clear examples of positive experience of HCP support, with both the current and previous reviews (Babb et al. (2022)) outlining this as being integral in generating hope for recovery and encouraging of separation of the participant from their ED. There is a clear need for robust training for HCP's to provide the compassionate and knowledgeable care required to support individuals with eating disorders during their admission.

Our findings suggest inpatient peers were able to both provide support and have the potential to indirectly entrench ED. The findings acknowledge inpatient peers can be a point of comparison, pass on disordered behaviour, as well as, be role models for recovery. Various view pieces by clinicians have framed inpatient peer relationships as damaging (Allison, Warin, & Bastiampillai, 2014; Vandereycken, 2011)

Table 4
GRADE CERQual summary.

Summary of review finding	Studies [†]	CERQual assessment of confidence	Explanation of CERQual assessment
Individuals admitted for inpatient eating disorder treatment can experience care as controlling. This is experienced though inpatient rules, standardisation of care and the focus on weight gain. The perception of control impacted upon relationships with HCPs and engagement in treatment.	1,2, 3, 4, 5, 6, 7, 8, 9, 10,11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 27, 28	High	There no concerns relating to the relevance, adequacy and coherence of the data from the 25 studies. Only minor methodological issues were felt to present.
The inpatient setting can be experienced as a unique and separate to normal life. The admission was perceived as a pause on normal life, in which participants were separated from their normal activities and relationships. They also were entered into the specific environment of the inpatient setting.	2, 4, 5, 7, 11, 13, 14, 15, 17, 19, 20, 21, 22, 23, 24	Moderate	There were minor concerns regarding the adequacy and relevancy of the data of the 14 studies contributing to the finding. There were minor methodological issues in the studies included.
Relationship with therapeutic staff can experienced as positive in providing support through understanding their eating disorder, modelling healthier behaviours, and encouraging individuals.	3, 5, 6, 8, 9, 11, 12, 14, 16, 17, 18, 21, 22, 23, 24, 28	High	Minor methodological concerns. No or minor concerns regarding coherence, relevance and adequacy of the data supporting the finding.
Relationships formed with inpatient peers with eating disorders can be supportive and provide comfort, and they can role model recovery behaviour.	3, 4, 6, 7, 9, 11 17, 18, 19, 21, 23	Moderate	There were minor concerns relating to the relevancy, adequacy, coherence of the data and the studies methods.
Inpatient peers were felt to expose individuals to their distress and disordered eating behaviours and were able to pick disordered behaviours	1, 2, 3, 4, 5, 6, 8, 9, 11, 12, 17, 19, 20, 21, 24, 26, 27, 28	High	There were minor methodological issues from the data for this finding. There were no concerns regarding coherence, relevance and adequacy relating to the data for the finding.
Individual comes to terms with their eating disorder and has struggle to place it within their relationship with it. Individual contemplating recovery and begin to engage with motivation	1,2,3, 4, 5, 6,7, 8,, 9, 10, 11, 12, 13, 14, 15, 17, 19,20, 22, 24, 28	Moderate	There were minor concerns relating to the coherence, relevancy, and adequacy of the data. There were also minor concerns regarding the methods of the studies included.

[†] Number relate to the following studies 1 – Birkbeck (2018), 2 – Boughtwood and Halse (2010), 3 – Colton and Pistrang (2004), 4 – Eli (2014), 5 – Fox and Diab (2015), 6 – Holmes et al. (2021), 7 – Kezelman et al. (2016), 8 – Long et al.

(2020), 9 – Monaghan and Doyle (2023), 10 – Nilsen, Hage, Ro, et al. (2019), 11 – Offord et al. (2006), 12 – Pemberton and Fox (2013), 13 – Ramjan and Gill (2012), 14 – Ross and Green (2011), 15 – Sheth (2003), 16 – Sly et al. (2014), 17 – Smith (2012); Smith et al. (2016), 18 – Solhaug Storli and Alsaker (2021), 19 – Spivack (2010), 20 – Strand, Gustafsson, et al. (2017), 21 – Thabrew et al. (2020), 22 – Thorpe (2019), 23 – Van Ommen et al. (2009), 24 – Warchol (2013), 25 – William (2012), 26 – Wu and Harrison (2019), 27 – Zugai et al. (2013), 28 – Zugai et al. (2018a, 2018b).

and yet, recent evidence describes that these relationships can be supportive (Galloway & Pistrang, 2019). The current findings present a balanced view of the influence of these relationships indicating further research may be required in interventions to support individuals in navigating this unique interpersonal experience.

Finally, the inpatient admission was an opportunity for individuals to address their ED recovery. Participants described the process of de-identification from the ED aligned with holistic understandings of recovery (Wetzler et al., 2020). There have been recent developments in recovery literature, valuing the lived experience perspectives in defining recovery (Richmond et al., 2020). Wetzler et al. (2020) noted elements of the recovery process including identity, as seen in this review, hope, meaning and purpose, supportive relationships and empowerment as relevant. LaMarre and Rice (2021) cited the challenges of recovery as non-linear, which can provide hope for those who face readmission. Richmond et al. (2020) highlighted that patients and parent carers valued psychological wellbeing over aspects, with patients valuing physical measures as the least relevant aspect of recovery. Inpatient treatment is critical stage for individuals to reflect on their holistic recovery, and how to balance and reflect on this within an acute inpatient environment where physical measurements and associated risk may be prioritised.

5.1. Limitations

A key limitation of the study is the lack of sample diversity, with most of the sample being made up of young white women with anorexia. Many of the studies were considered the experience of treatment for anorexia, with the exception being bulimia nervosa. The review does not include experiences of inpatient treatment for BED or ARFID as there was no research available, though research into treatment other than inpatient does exist (Hilbert et al., 2019; Isserlin, Spettigue, Norris, & Couturier, 2020; Kambanis & Thomas, 2023). Proportionally inpatient services are used more frequently for individuals with anorexia than other ED diagnoses (Mehler et al., 2018; Morris, Simpson, & Voy, 2015). Also, the lack of ethnic and gender diversity is serious limitation of much ED research, and this study only emphasises this problem (Halbeisen, Brandt, & Paslakis, 2022).

Though the studies were adequate according to the CASP qualitative checklist, the methodologies often did not report theoretical stance. Unfortunately, theoretical stance can often be overlooked even though it is an integral part of qualitative research (Pope and Mays, 2020).

In addition, the review may have benefitted from input from an individual with lived experience (Musić et al., 2022). However, investigators aimed to generate a review which was reflective of the experiences presented in the studies.

5.2. Future research

The sample homogeneity within the systematic review highlights the need for more research into diverse eating disorder inpatient experiences. There is limited research and understanding of experiences of diagnoses other than anorexia (Herman et al., 2014) or of those with an ED who do not identify as a cis-woman (Duffy, Henkel, & Earnshaw, 2016; Thapliyal, Conti, Bandara, & Hay, 2020) or as white (Rodgers, Berry, & Franko, 2018). It is overlooked experiences such as these that require more attention and improvement in services, with greater access

to appropriate treatment (Sonneville & Lipson, 2018). To genuinely improve inpatient services, all these perspectives should be considered, with emphasis on researching experiences that are marginalised.

The findings of the review could be the basis for research into inpatient service development. For example, the review used lived experience to identify various aspects of inpatient care that could be developed, such as training, inpatient management of inpatient rules, patient collaboration in care and inpatient relationships with staff and peers. These areas could be developed in further research and evaluated using quantitative methodologies.

6. Conclusions

This systematic review summarised the current literature and highlighted key considerations for ED inpatient treatment. It is unlikely that the need for inpatient ED admission will reduce and there should continue to be a focus on how to improve the quality and effectiveness of these admissions and this needs to be led by a lived experience perspective.

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CRedit authorship contribution statement

Author A completed the design, screening, synthesis, and critical appraisal for the review and wrote up the manuscript. Author B took part in screening and data extraction. Author C took part in screening and critical appraisal. Author D and E were supervisors for the review and contributed to the design and the final manuscript.

Open access

For the purpose of open access, the author has applied a Creative Commons Attribution (CC BY) licence to any Author Accepted Manuscript version arising from this submission.

Declaration of competing interest

There were no conflicts of interests to declare from any of the authors.

Data availability

Data will be made available on request.

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