

## **Regulating ‘Untrustworthy Patients’: Constructions of ‘Trust’ and ‘Distrust’ in Accounts of Inpatient Treatment for Anorexia**

**Su Holmes<sup>1</sup>, Helen Malson<sup>2</sup> and Joanna Semlyen<sup>1</sup>**

1. Su Holmes, University of East Anglia, UK

2. Helen Malson, University of the West of England, Bristol. UK

1. Joanna Semlyen, University of East Anglia, UK

### **Abstract**

Trust has been seen as a lynchpin of therapeutic relationships. Yet due to perceptions that anorexia is one of the most difficult illnesses to treat and that patients are ‘treatment resistant’, achieving trust between patient and treatment provider may be challenging. This article draws on qualitative data from 14 semi-structured interviews with women who have experience of inpatient treatment for anorexia in order to analyse how trust and distrust figured in treatment contexts. In so doing, the article draws upon feminist approaches which are critical of conceptions of the ‘devious’ ‘anorexic’ and of the clinical discourses within

which these constructions are produced. Our analysis suggests a lack of trust shown toward patients in inpatient contexts—particularly a disqualification of ‘voice’ —which has a number of consequences for participants’ subjectivities, including the erosion of self-esteem; demotivation; dropping out/ termination of treatment; and triggering experiences of trauma. As such, our analysis raises serious questions about what participants described as routine treatment practices in inpatient treatment for anorexia, and about the serious consequences of constructing ‘anorexics’ as manipulative and untrustworthy.

**Key Words**

Anorexia, Trust, Inpatient treatment, Feminism, Manipulative, Voice

**Corresponding author**

Su Holmes, School of Art Media and American Studies, University of East Anglia, Norwich Research Park, Norwich, NR4 7TJ, UK.

Email [susan.holmes@uea.ac.uk](mailto:susan.holmes@uea.ac.uk)

The importance of the therapeutic alliance is often foregrounded in explaining treatment outcomes for anorexia (Marzola et al., 2019; Masson & Sheeska, 2009; Ramjan, 2004; Sly et al., 2014). This concept stresses the importance of honesty, empathy, commitment, confidentiality and a non-judgemental attitude, but it is *trust* which is the crucial lynchpin here (Morse, 1991; Ramjan, 2004). As Ramjan observes, ‘without a trusting, therapeutic ... relationship, the treatment and recovery of people with anorexia can be unnecessarily impeded and prolonged’ (2004, p.496). Yet achieving trust between patient<sup>1</sup> and treatment provider has been seen as challenging because anorexia is often perceived as ‘difficult’ to treat (Vitousek, Watson & Wilson, 1998, Ziser et al., 2018): where patients may be resistant to weight gain, their goals may thus be viewed as being at odds with those of the health professionals treating them (Murray et al., 2011; Sly et al., 2014). As Lester observes, ‘anorexics’, are often constructed as ‘notoriously ... manipulative, and conniving. [Clients] “will”, in other words, is thought to be oriented toward remaining sick rather than getting well – they are seen as the quintessentially noncompliant patients’ (2019, p.171). Whilst feminist work has critiqued these conceptions (Lester, 2019; Malson & Ryan, 2008; Orbach, 1986), several studies also emphasise the conflict and *mutual* distrust between patients and staff, especially in the context of inpatient treatment (Malson & Ryan, 2008; Ramjan, 2004; Vandereycken & Devidt, 2010). Although there have been recent developments in qualitative work on client experiences of eating disorder (ED) treatment, considerably more work is still needed to explore issues of trust here (Boughtwood & Halse, 2008; Sly et al., 2014). Indeed, a *lack* of trust has been cited by patients as a key reason for dropout from inpatient care (Vandereycken & Devidt, 2010). Given that drop-out rates for adults in ED inpatient treatment may be as high as 56.2% (and relapse rates remain high) (Roux et al., 2016), this is clearly a serious issue that demands attention.

This article draws on qualitative data from semi-structured interviews with 14 women with experience of inpatient treatment for anorexia. Our aim is to explore and understand the impact of trust – and its absence - in these contexts. The article focuses on participants’ conceptualisations and experiences of trust/distrust in inpatient treatment contexts and the implications of this for their subjectivities and treatment trajectories. In so doing, the article draws upon feminist approaches to anorexia which are critical of pathologising conceptions of the ‘devious’ ‘anorexic’ and of the clinical discourses within which these constructions are produced (Gremillion, 2003; Lester, 2019; Malson, 1998; Orbach, 1986).

#### *Feminist perspectives on ‘anorexia’ and its treatment*

Lester’s (2019) perspective cited above emerges from feminist work on EDs which challenges mainstream constructions of ‘anorexic’ subjectivities and the treatment practices with which they are associated (Bell, 2006; Boughtwood & Halse, 2008, Gremillion, 2003; 2010, Holmes, 2018; Malson, 1998; Saukko, 2008). In questioning biomedical constructions of anorexia as an individual psychopathology (Levine & Smolak, 2014, p.159), feminist approaches have sought to politicise self-starvation in relation to the contexts of cultural gender ideologies (see Malson & Burns, 2009) and thus understand eating problems as emerging from constructions and experiences of *normative* femininities (and other intersectional categories) in terms of both conformity and resistance (Bordo, 2009; Thompson, 1994).

Furthermore, in drawing on Foucauldian analyses of medicine (Foucault, 1975), feminist scholars, pointing to the history of medicine’s ‘collusion’ with patriarchy (Bell, 2006, p.264), have emphasised how medical discourses and practices actively contribute to the

reproduction of ‘anorexia’, not only through diagnosis, but also in creating the very clinical conditions which *produce* ‘anorexic’ subjectivities (Gremillion, 2003; Sesan, 1994). Bell even argues that treatment centres are ‘distinctly disciplinary environments ... which reinforce societal control over women’s bodies and the disciplinary boundaries of normative femininity’ (2006, p.287). Inpatient treatment is read by these scholars, then, as disallowing women’s autonomy over their own bodies, and returning them to the realm of masculinist control (Bell, 2006, p.263). This is all the while that the social and cultural contexts of women’s eating and bodily distress go largely unheard within treatment—with feminist approaches to EDs often excluded or marginalised within mainstream clinical contexts (Bell, 2006; Holmes, 2016a, 2017).

Although little work has focused primarily on notions of ‘anorexics’ as manipulative ... secretive, dishonest, sneaky [and]... sly...’ (Lester, 2019, p.290), concerns about these constructions have permeated feminist work for decades (Boughtwood & Halse, 2010; Gremillion, 2003; Lester, 2019; Malson & Ryan, 2008; Orbach, 1986). Hence, feminist scholars have ‘criticise[d] assumptions that patients should submissively acquiesce to the authority and expertise of medicine and medical practitioners’ (Boughtwood & Halse, 2010, p.84) – seeing patients’ responses to treatment as legitimate challenges to restrictive, disempowering and potentially unethical practices. Equally, feminist scholars have critiqued related constructions in popular and clinical discourses of ‘anorexics’ as untrustworthy (see Malson & Ryan, 2008; Ramjan, 2004). So just as beliefs that idealised images of slimness ‘cause’ anorexia pivot on a long history of discourses which construct girls and women as passive, irrational and ‘susceptible’ media consumers (Bray, 2005; Holmes, 2016b), so ideas about manipulation are seen as highly gendered and infantilising (Malson & Ryan, 2008). Patients emerge as ‘dangerous and deceitful’ subjects who, echoing broader patriarchal constructions of femininity (cf Beauvoir, 1984), are simply *not what they seem*. Feminist

scholars have thus questioned whether inpatient contexts are conducive to developing the trust and healing that are arguably necessary for recovery (Orbach, 1986; Sesan, 1994). Researchers have noted the challenges faced by clinicians in ED treatment when ‘core values’ such as trust and honesty are ‘replaced by an inner turmoil of ... sadness, anger and being disheartened’ (King & Turner, 2000, p.142). Yet, to date, little attention has been given to patients’ perspectives on trust. Although health professionals’ perspectives are clearly important, it is vital that we also ask about *patients’* experiences – those who are subject to distrust on a daily basis.

Before moving to our analysis, it is important to provide some background about aspects of ED inpatient treatment which are relevant to this study. In the UK, ED inpatient treatment is provided by both National Health Service and private healthcare providers. It is variously provided in general hospital wards; psychiatric wards; and specialist ED wards and residential settings (Beat, 2015). Inpatient treatment has become increasingly multidisciplinary and multi-modal, moving beyond a singular focus on weight and food (Dalle Grave et al., 1993a; Ziser et al., 2018). Nevertheless, behaviour modification techniques remain prominent and systems of ‘rewards and punishments ... pervade treatment centres using the most current evidence-based therapies and treatment practices’ (Matusek, et al., 2010, p.446). Unsurprisingly, scholars and clinicians have questioned the ethics of ED behaviour modification programmes (Bruch, 1974; Dalle Grave et al., 1993a; 1993b; Eivors et al., 2003; Geller et al., 2006; Matusek & O’Dougherty, 2010). The UK’s National Institute of Clinical Excellence (NICE) guidelines (2004) for ED treatment in fact stated that ‘rigid inpatient behaviour programmes should not be used’ (although the updated version [NICE, 2017] notably omits guidance on this matter at all). Others have also argued that standardised inpatient behaviour modification programmes can be strict, inflexible and detrimental to

patient progress, (Offord et al., 2006; Orbach, 1986; Sesan, 1994). As Dalle Grave et al. observe:

the issue of ethics arises whenever the application of rigid behavioural methods are in question. It is debateable whether rigid methods are at all necessary when more flexible alternatives exist. Instead, perhaps it is more desirable to rehabilitate the patients with a lenient approach that exists on a therapeutic relationship based on mutual respect and trust. (1993, p.166-7)

Early work by Touyz et al. (1984) in fact demonstrated that a more lenient approach (without strict target weights and surveillance of food intake) to treating anorexia did not necessarily have poorer outcomes than stricter ones. Thus, although the present study focuses specifically on experiences of trust in treatment, it simultaneously provides crucial insights into current clinical practices in inpatient contexts, and their implications for patient subjectivities and recovery.

## **Method**

### *Participants*

Once ethical approval was granted<sup>2</sup>, participants were interviewed between July and September 2019. The interviews followed a semi-structured schedule and lasted approximately one hour. Participant information sheets were provided in advance and consent was given verbally and in writing at the start of each interview. Depending on participants' preferences and geographical locations, interviews were conducted either in person (1), or via Skype (2) or telephone (11). Participants were recruited via the online research page and social media accounts of Beat, the UK National ED charity. Under the title '*Trust*' in ED Treatment: Patient Experiences of In-patient Contexts, our recruitment post invited

participation from anyone, 18 years or over, of any gender, sexual orientation and ED diagnosis who had experience of inpatient treatment for an ED and who was interested in discussing their experiences of trust in treatment. We included everyone who volunteered to participate in the study and despite our effort to recruit a more diverse sample, we recruited 14 cis-gender women, aged between 20 and 42 years of age, living in the UK. Eleven participants identified as white British, whilst the remaining three identified as white Jewish, white American and 'other'. All participants had experience of anorexia. Some considered themselves to be recovered from their ED, whilst others did not, but all had experienced between one and five inpatient admissions and most described experiences within the last 5 years. Precisely because 'anorexic' voices are often rendered suspect (Lester, 2019; Saukko, 2008), we deliberately refrain from indicating in our analysis below whether participants identified as recovered or not, preferring instead to view participants as women whose experiences and *critiques* of their treatment are rational, legitimate and valuable.

### *Data collection*

Trust is clearly a 'complex, multidimensional concept, making it difficult to operationalize, measure and interpret' (Simpson, 2007, p. 264). We did not explicitly interrogate participants' understandings of this term during the interviews but, rather, asked them to discuss their experiences of 'trust' in the context of inpatient treatment. Participants were asked:

- Please tell me as much as you like about your inpatient experience(s).
- Tell me about 'trust' in this context. Was it something that had to be earned? How did that make you feel? Can you give examples?
- Were there any significant relations with staff in terms of trust?

- What about relations with other patients? How were relations between patients perceived by staff?
- Could treatment be different in terms of trust? If so how?

Feminist researchers have sought to reduce the power differentials between ‘expert’ and participant, often including discussions of personal experiences and reflexivity in ways which are not silenced by objectivist concerns over ‘bias’ and ‘distortion’ (Oakley, 1981; Tang, 2002). In this regard, the interviewer [SH] chose to briefly disclose her own history of long-term anorexia and admission to a UK inpatient clinic. Although gender congruence and shared experience do not guarantee non-hierarchical relationships between participants and researcher (Tang, 2002), the self-disclosure was offered as a form of reciprocity that felt congruent to the interviewer who was very aware of shifting in the interviews between the positions of feminist researcher and ‘eating disorder sufferer’.

### *Analysis*

The interviews were audio-recorded, transcribed and anonymised, including removal of any clinic or staff names. The data were then analysed by all three authors within a poststructural, discourse-analytic framework which enabled us to attend to the ways in which identities or experiences were constituted in the interview transcripts. Feminist poststructural work sees discourses as actively constitutive *of* identities and experiences (Foucault, 1973), producing subjectivities within relations of power (Moola, Gairdner, & Amara, 2015). This position acknowledges that whilst identities are constructed within discourse, subjects nonetheless exist as ‘social agent[s] capable of resistance... produced out of the clash between contradictory subject positions and practices’ (Weedon, 1987, p.124). Hence, we explored

how participants moved through multiple positions during the interviews, internalising, negotiating and critiquing constructions of ‘anorexic’ subjectivities within treatment.

Within this poststructural framework, we drew on the coding strategies of thematic analysis (Braun & Clarke 2006), and worked together in generating themes (Gauntlet-Gilbert et al., 2015). This interactive approach had the explicit aim of drawing from multiple perspectives, allowing our assumptions to be challenged (Phoenix et al., 2016). The first stage involved familiarization with the data, reading and re-reading transcripts, producing notes on preliminary ideas and observations. Second, this process was used to generate initial codes across the full data set. Third, these codes were then used to generate broader thematic categories across the dataset, focusing particularly on recurrent themes which we discuss below.

## **Findings**

### *‘You were meant to hate it. That’s the point’: Treatment as punishment*

All but one participant recounted how, when they were first hospitalised, they were shown absolutely no trust by staff and described how trust was something they had to ‘earn’. They understood ward rules as inextricably linked to this lack of trust and, whilst participants often also took part in other interventions such as individual and group psychotherapy and occupational therapy, discussions of restrictive regimes played a central role in the interviews. Participants described having restricted (or sometimes no) access to family, mobile phones, social media, television or books; being prohibited from moving around the clinic or ward freely; not being allowed outside; supervision after meals and snacks; supervision in the bathroom (and sometimes 24-hour supervision); no personal access to

running water; and no permission to shower (in one case, for nearly 3 weeks). Often the range and severity of these rules reduced over time: some participants reported that they ‘earned’ these ‘privileges’ back, whilst others did not. Aside from rules regarding post-meal or bathroom supervision (which participants understood to be about limiting purging, even if they did not all agree with such rules or find them helpful), the women were often given no clear rationale as to why particular regimes existed. This is despite clinical research suggesting that treatment rationales should always be clear for patients (Offord, Turner & Cooper, 2006). Participants made such comments as:

There are rules that they don’t explain at all. (P9)

They would just say ‘That’s the way it has always been done and that is the way we do it’. (P4)

There wasn’t often a rationale. It was often just ‘you’re ill’ or ‘you’re angry’... it made me feel untrusted, and like I wasn’t worth listening to. And like I was crazy...(P13)

I always asked for rationales but rarely got them. I was that nightmare patient [laughs]... But then you’d get fed up of arguing because then you’d get a bit of a name for yourself as like a troublemaker...so I’d just keep my head down. (P2)

In addition to the dismissal and invalidation of patients’ voices, as developed in more detail below, we can see here the perceived risks of questioning treatment rationales. In P2’s response, simply by ‘asking’ for rationales she believes that she will be quickly reframed as an argumentative ‘troublemaker’ and even a ‘nightmare patient’. Indeed, this quote makes clear that ‘choices’ for patients are limited: either comply unquestioningly or risk being further pathologised as ‘treatment resistant’ (Lester, 2019, p.172). The power of this framework is further clarified below:

I was told if you comply, then you'll get on a lot better here... I saw very quickly how my mind-set changed to being that of the oppressed... the patient. I went in as a young woman ... who knew her rights ... to being part of a system very quickly. (P5)

The loss of individuality, voice and agency is striking here, as is the construction of a 'system' in which the position of 'patient' is particularly delimited. This absence of clear rationales for treatment decisions was central in many participants' accounts, where it was associated with a view of treatment as punitive and as based on a misrecognition of 'anorexics' as manipulative and untrustworthy. One participant, for instance, recalled reading treatment guidelines warning clinicians to 'be very afraid - [patients] ... will be extremely manipulative and will club together to split staff members up ...' (P10), whilst others discussed how these discourses were *openly* drawn upon by some health professionals:

The ward manager came in ... and she said 'I know what you're all like. You all think that we're not watching you and that we don't know what you do but trust me, we *are* watching you ... You say you just want to go out for a quick walk... but I see you running around the grounds of the hospital'. I mean no patient did that while I was there so I don't know what she was talking about... She said 'don't forget that big brother is always watching: we've got cameras everywhere.' .... I remember ...thinking *you* are talking to a group of mentally ill, vulnerable young women. Who on *earth* do you think you are? I was horrified. (P5)

With the clinic represented here as a literal system of 'total surveillance' (Foucault, 1975; Bell, 2006), the presence of a 'quasi-penal' theme (Ramjan, 2004, p. 298) with references to treatment as 'sentences' (P11) and 'doing time' (P9) is not surprising. As one participant

commented: ‘Everyone hated it. You were meant to hate it. *That’s the point*’ [our italics] (P9). A key issue here is the effect of these rules - and the pervasive lack of trust – on the participants.

*Dehumanisation: The consequences of mistrust*

Lester’s observation that constructions of patients with anorexia as devious and manipulative ‘often sit at odds with clients’ own experiences [of themselves]’ (Lester, 2019, p.290) also appeared as a frequent but contradictory theme in our data. Whilst participants vociferously criticised their treatment regimes, they also sometimes drew upon these constructions themselves:

There’s this assumption that [we] ... will lie... It’s a shame... I used to hate it. But I kind of get it as I was as guilty as the next person... But I guess you have to earn that trust: if you’re lying about one thing, you can’t expect them to believe you about everything else. (P2)

It would be remarkable if participants’ self-constructions were *unaffected* by dominant clinical discourses. Moreover, the strict, surveillance-based regimes of inpatient treatment have also been seen as actively *instigating* strategies to avoid weight gain (such as purging, water-loading or exercising) rather than functioning as a space to explore or ‘cure’ them (Gremillion, 2003). But it is clear in the responses above that participants construct these strategies (as well as the treatment regimes themselves) as both violating *and* reasonable, even whilst they struggle with their ethical dimensions.

However, for the most part, participants rallied against the lack of trust shown to them upon admission, the consequences of which they described as including eroded self-esteem; demotivation; dropping out/ termination of treatment and triggering experiences of trauma. This disjuncture between clinical constructions of ‘anorexics’ (as pathological and untrustworthy) and patients’ experiences (of themselves as individuals) is vividly illustrated below:

I didn’t expect my eating disorder to change how people perceived me as a person? ... I’d always been seen as very ... trustworthy... a very honest person... so I naively assumed I would be trusted within the context of ... treatment ... And so when I went in and I was immediately seen as untrustworthy and that it was a default position ... that was pretty polar to how I’d been seen in other areas of my life. That was both really surprising and really distressing as these were things that I really valued in myself ... They very quickly eroded a sense of myself as being a good person – as if my eating disorder had eroded my character ... (P12)

What this participant articulates as an ‘erosion’ of character appeared in other accounts:

I think it contributed to my self-loathing and negative self-worth. And I already felt so confused in the eating disorder and then these rules and the lack of trust were ... like an additional tier of entrapment and confusion... I was like so low that this sort of punishment system – I didn’t know if I was in a sort of place to fight it (P3).

The comments support the point, made by renowned psychiatrist Hilde Bruch (1974) over 40 years ago, that restrictive and stringent inpatient treatment may dehumanise patients, impede the therapeutic relationship and enhance patients’ feelings of ineffectiveness and low self-

worth. Although Bruch was talking here of earlier models of inpatient treatment based explicitly around social deprivation via isolation and enforced bed-rest (the latter of which had only been experienced by a minority of our participants), the *effects* of treatment practices over 40 years apart emerge in strikingly similar ways.

For some participants, the implications of some of these practices had further consequences. One, for example, spoke of being under 24-hour surveillance as follows:

It was awful. I don't know how a healthy person would do in that situation. You've got someone no more than a metre away from you watching you even as you are sleeping. ... With the bathroom it seemed almost as if they were trying to punish me. They'd have the door wide open – more than it needed to be ... I'd say 'can you close it a bit more?' and they'd say 'no [we]... need to be able to see you and make eye contact with you'... [One professional]... persisted to make eye contact with me while I was going to the loo... I don't understand why anyone would do that. ... It's humiliating and degrading and invasive. I mean I have had issues with sexual assault ... and there's something that is comparable – having no control over your own body. So someone witnessing that – it does seem like it's more of a spectacle to them – like they don't see you like a human. (P9)

Dehumanisation can be observed again here, yet with a specific inflection: the participant links this moment of surveillance with her previous experience of sexual assault. The relationships between sexual abuse and EDs have been explored widely (Hall et al., 1989; Sanci et al., 2008) and feminist work on EDs has given particular focus to such issues (Bordo, 1993; Gutwill & Gitter, 1994; Thompson, 1994)—seeing them as 'socially induced

injuries’ (Thompson, 1994, p.8) that particularly affect women. Whilst feminist research on ED treatment has long since questioned whether ‘acts of “care” that look like – and feel like – harm ... actually provoke the very conditions they are supposed to treat’ (Lester, 2019, p.177; see also Gremillion, 2003), the quotes above emphasise the importance of listening to women’s views about the treatment practices that are ‘allegedly helping them’ (Saukko, 2008, p.43). Indeed, the idea of inpatient treatment as a form of ‘trauma’ in its own right appeared across multiple interviews, and the term was frequently used to describe lasting anxieties, ‘nightmares’, habits and fears that resulted directly from *clinical practice* on the ward.

*‘A walking eating disorder’: Disqualifying the voice, privileging the body*

Previous studies have highlighted the theme of being treated as ‘an individual versus just another anorexic’ (Colton & Pistrang, 2004, p.2). A key theme in our data was certainly the experience of having one’s speech and actions perpetually reduced or attributed to the anorexia. Participants often saw this as an outcome of distrust:

It was a one-size-fits-all approach. It was just assumed that I was going to be lying – because there was *no* trust. Like if the blinds were shut in my room, it wasn’t because I was getting dressed, it was because I was exercising - which I’d never had a problem with. [original emphasis] (P5)

This idea of actions, choices and words being reduced to the ED appeared frequently in other accounts:

If I chose something, it was always assumed that the eating disorder chose it... So we had ice cream one day and we had like four different flavours... I chose vanilla, because that is what I wanted. It was automatically assumed that I chose

it due to calories. I didn't know the calories in the bowl of ice cream ....I didn't want to be a walking eating disorder. I was tired of being viewed through this lens of the eating disorder behaviour... Even if I said 'I miss my family I want to go home' they'd just say 'that's your eating disorder talking.' (P8)

Given that vanilla ice cream was on the menu, even complying with treatment is rendered suspect here, foregrounding the difficulty of patients achieving 'epistemic authenticity' (Lester, 2019, p.265) when they are perceived as untrustworthy. Similarly, in simply missing her family, this participant is again constituted as an unreliable subject whose voice becomes delegitimised (Lester, 2019; Saukko, 2008).

It is also important to recognise here that assumptions about patients being untrustworthy had real *consequences* for the treatment practices and trajectories experienced by participants. As one explained:

Everything was always seen as the eating disorder's fault ... Everything had to be perfect, and I ... don't think they realised when things were genuinely wrong or were accidents ... Like there was one morning when I accidentally spilt milk [from my glass] and it was a genuine accident. But it was considered that I was in-compliant and I had lots of consequences for it... I asked to refill the milk because I had genuinely spilt it but they said I had deliberately thrown it so I had to have the supplement stuff and I wasn't allowed on the walks for the rest of the week.

Interviewer: How did that make you feel?

Like I might as well have thrown the milk ... and I think it irritated me more because I offered [to refill it] – and it took me a lot to offer to get it replaced. (P1)

Anorexia has been historically associated with perfectionism (Bruch, 1974), yet this participant effectively turns this construction back on *treatment* and its unrealistic expectations of patients. Any form of ‘agency’ here is automatically seen as illegitimate (and symptomatic of ‘anorexia’) (Lester, 2019), again evoking a sense of demotivation (‘Like I might as well have thrown the milk’). This response also offers a sharp insight into disparities between the participant’s own reality and that of the clinic: she understands herself as working hard (‘it took me a lot to offer to get it replaced’) but feels that this is completely unseen by staff who only view her through an ED ‘lens’.

This disqualification of voice was inextricably linked to, and made possible by, a construction of bodies as valorised sites of ‘truth’. As Lester (2019) argues in her ethnography of an American inpatient unit:

[T]he body comes to assume centre stage in eating disorder treatment and is believed to ‘tell the truth’ about a person’s willingness to get well in a way that she herself is thought to be incapable of doing... Biological markers like lab results, weights, vital signs and body changes are treated as bearers of truth ... to the extent that they come to elide the client herself and reinforce the notion that her body – sick and starving though it may be – is more authentic, more trustworthy and more reliable than she is. (p.172)

This body/voice hierarchy was frequently highlighted by our participants too:

If you didn’t gain [weight]... it wasn’t assumed that the meal plan wasn’t working. They assumed that you had been sabotaging it in some way. So not only would they increase it, but you would have privileges taken away. (P1)

As this extract suggests, biological markers of ‘progress’ had very material consequences for patients including increased calories or withdrawal of freedom. In one particularly evocative example, a participant, who had already reached a ‘healthy’ BMI, was denied a trip home because she was 100g below her target weight (even though she had been exercising with permission just one hour before). The extent to which patients’ bodies were sometimes interrogated as sites of ‘truth’ is again brought into sharp relief below:

... Water and water loading [excessive drinking to inflate weight] became a very charged issue within my treatment ... Any time my weight dropped, it was assumed that the weight prior to it had been falsified... [T]hey started spot weighing me incessantly... between meals and trying to calculate the weight of a meal and the weight of the fluid that I’d been consuming... I also wasn’t allowed in the shower for a week and I was having to do wet-wipe washing at the sink because they couldn’t trust that I wouldn’t be deliberately drinking some of the shower water ... They would frequently make me lie on the bed and palpate my bladder and tell me whether or not they could feel that I was holding too much fluid... (P12)

Note here the participant again has no legitimate voice or agency (they would ‘tell me whether or not *they* could feel that *I* was holding too much fluid’), and unsurprisingly she viewed such strategies as ‘taking her *out* of [her] ... body’ [original emphasis] (P12) rather than ‘healing’ it. Given that a key aim of treatment is ostensibly to restore a ‘normal’ and ‘healthy’ relationship with weight and food, such micro-monitoring of the participant’s weight here is striking, as is her account of her body being *physically* manipulated to yield its biological ‘truths’. In fact, this scenario returns us to Bell’s (2006, p.283) argument that

anorexia is deemed threatening because it represents ‘women’s seemingly autonomous manipulation of their own bodies’ (rather than acquiescing to patriarchal control). The suspicion that the participant had disrupted the ‘transparent’ recording of her weight was grounds for physical intervention and denying her basic washing facilities. As the participant continued:

So they would say “It’s not safe for you to exercise if we don’t know your real weight”. But I felt like what they were really punishing was the idea that I’d been deceptive and like somehow challenged the system. (P12)

Her account thus clearly resonates with the theme of punishment, discussed above, in which responses to patients who challenged their treatment regimes harboured ideological underpinnings that appeared detached from therapeutic or medical rationales.

#### *Staff as ‘pockets’ of resistance*

Some participants found that the issues discussed so far—being treated as an untrustworthy and thoroughly pathological ‘anorexic’—militated against constructive relations with health professionals:

They think I’m trying to trick them and I think they’re trying to trick me ...  
That’s another way of saying I don’t trust them because they don’t trust me, and the way they’ve demonstrated that is by not knowing me as an individual. (P9)

Participants also pointed out that while they were shown little to no trust when admitted, they were expected to hand over *intimate* trust of their food and bodyweight to complete strangers.

But although our participants were critical of their treatment, there were also examples of positive, trusting and therapeutic relations with staff. As in other studies (Colton & Pistrang, 2004; Sly et al., 2014), participants valued staff who treated them as more than just an ‘anorexic’, who got to know them as a person, and who offered a ‘safe’ space to discuss struggles or relapses without fear of punishment or recrimination.

Yet it was often precisely the expectation of a wider punitive system that framed relations with specific staff as positive and trusting. That is, staff who *themselves* expressed critiques of treatment were especially valued by participants. For instance, a participant who was seen as resisting treatment was sent ‘home for a week to think about the reasons for ... [her] admission’ (P11). When she returned, distraught and unwell, she felt as if the ‘massive rupture of trust’ created by her removal was partially ameliorated by a helpful male psychiatrist:

...I went into the therapy session on the Friday and ... he was absolutely aghast at what had happened and his honesty kind of made it OK [she begins to cry]. Sorry for the emotion, I feel really emotional talking about it... He’d said he had no idea what was happening and that they were meant to have stopped using [withdrawal of care] ... as a treatment thing. He thought it had been agreed that it was untherapeutic ... He was just very honest... He said ‘you were saying lots of important things with insight and rationality and the consultant didn’t seem to be hearing it’. (P11)

In another instance, a participant recounted a moment of solidarity with a staff member after she was shouted at by the ward manager:

I was hyperventilating and crying hysterically. About three, four members of staff walked by and not one of them tried to offer me any sort of comfort. ... I went to my room... traumatised... One of the student nurses followed me in and said 'I am not supposed to be nice to you and give you a hug but the way they are *treating* you...' I remember thinking 'you are so lovely' [original emphasis]. (P5)

As these examples suggest, there are clearly wider hierarchies of power in treatment affecting people's ability to intervene or speak out. Whilst our analysis demonstrates how patients' voices are often de-legitimised, there are also power differentials within staff structures: the psychiatrist (P11) is able to openly criticise a treatment decision, while the student nurse (P5) offers a more transitory and private form of support.

*'Well, they tell you not to make friends, don't they?': Trusting fellow patients*

A further and related theme in the data pivots on the value of relationships with fellow patients. Most participants stated that friendships with other patients were largely discouraged by staff. Although reasons for this were not always given, participants felt that this might have been because of concern that they would 'plot against' staff (P2) and 'club together' to divide them (P10). The potential threat to the status quo was articulated explicitly by some participants:

I also think there is an element of...like... if patients collectively spoke about the injustice that is going on and spoke up together, would they have to take it more seriously? ... I think a lot of it was about ... keeping us silent ... There was no space for collective resistance. Individual resistance is much easier to do away with. (P12)

Given feminist analyses of inpatient treatment for anorexia as a medical panopticon (Bell, 2006; Gremillion, 2003), the opposition to patient friendships is particularly significant. The panopticon separates the watched ‘prisoners’, creating the docile bodies of individualised subjects (Foucault, 1975). In the quote above, what is at stake is not just interaction but the threat of a collective ‘voice’ to clinical authority.

Other reasons participants gave for why friendships were discouraged included staff perceptions, that were also occasionally shared by participants, of anorexia as ‘competitive’ and ‘triggering’. But for the most part participants rejected this caution, questioning what they saw as the absurdity of not engaging with fellow patients: ‘They say “You’re not in here to make friends” and I’m like “How is that possible? I’m living in this house for half a year!” [laughs]’ (P4). Others highlighted what they saw as the ludicrous idea that interactions with fellow patients should not include discussions of EDs: ‘So there was a sense that the anorexia should just be kind of omitted from that relationship [laughs]’ (P7) – a particularly contradictory expectation given that, as we have seen, patients were often reduced *to* the ED in treatment contexts. Unsurprisingly, participants often did not refrain from discussing anorexia, but rather foregrounded it as a shared source of connection, trust, strength, support and mutual recognition:

...I had really close friends there. ... I still keep in contact with some people today from all those years ago. They were great and I trusted them a lot... They were closer to my age and that was very helpful as I felt like I had someone to go to. Like with the staff, the [other patients]... would stand up for me as they knew I wouldn’t do the ...type of thing [I was accused of]... We could also commiserate about the treatment process. (P8)

Participants spoke far more frequently of trusting fellow patients than trusting staff (and it is possible that such bonds with peers may be seen as *more* important, given the distrust experienced more widely in these contexts). Yet, resonating with perceptions of being reduced to the ED, some participants felt that staff could not *see* the relationships for what they were. For example, one participant spoke warmly of her close friendship with another patient and their frustration at being separated by staff.

To meet someone like her – it was amazing... They put us in a room together as we went in [to the clinic] at the same time. And we got on so well, and we'd be like chatting until 2 am, but they decided that we obviously weren't chatting about the right things. And we were fuming because never in any of our chats had we mentioned our BMIs or spoken about our weight... They actually split me and [her] up. We were so frustrated because they were like 'stay away from each other', and I was thinking 'but she's the best thing that's happened to me'... And I'm like 'she's my friend - she *really* is...[original emphasis]'. (P4)

The pleading here to be recognised ('she's my friend - she *really* is...') reflects back on the difficulty of patients achieving 'authenticity' within these contexts, whilst further demonstrating how 'in clinical settings, some people's realities are considered "truer" than others'. This both legitimizes and maintains power hierarchies with very real consequences for patients (Lester, 2019, p.288).

## **Discussion and Conclusion**

Given the centrality of trust to the therapeutic alliance, and the fact that lack of trust has been cited as a key reason for patient drop-out in inpatient contexts (Masson & Sheeska, 2009; Vandereycken & Devidt, 2010), our analysis raises serious questions about what the

participants described as routine treatment practices. The sample is obviously limited in terms of its size and demographic reach and participants' accounts are of treatment for anorexia and not other ED diagnoses. In part, this may reflect the fact that anorexia is more likely to result in inpatient admission than other EDs but it is regrettable that we were unable to recruit participants beyond the white, cisgender female samples that predominate within wider clinical, qualitative (Bezance & Holliday, 2013, p. 357) and feminist ED research (Bordo, 2009). Additionally, the fact that only one of the 14 interviews was conducted in person might also be seen as a limitation but in practice telephone and Skype interviews seemed to work just as well. And, while we did not mention negative experiences in our recruitment posts, it is possible that the study attracted participants who were particularly *critical* of their treatment. Nevertheless, it is difficult not to acknowledge that the experiences participants described are both disturbing and shocking. According to our participants, punitive behavioural regimes are still in operation, and patients are required to 'earn' trust in ways that they experience as dehumanising and de-motivating. This is especially important given that, as discussed above, there is evidence that more lenient approaches to treating anorexia do not produce drastically different outcomes (Touyz et al., 1984). Yet despite the clinical significance of this earlier finding, there is little evidence to indicate that this has been followed up in mainstream clinical research *or* treatment practice. Although inpatient treatment has developed substantially over the last 30 years, our findings indicate that authoritarian approaches still loom large – despite empirical data which raises serious questions over efficacy and ethics in this regard (Offord et al., 2006).

One of the most significant issues to emerge in this study is the denial of patient 'voice'. The construction of 'anorexic' voices as being 'outside of the true' (Saukko, 2008, p.69) is nowhere more evident than in these experiences of inpatient treatment. These women found

that their voices were consistently delegitimised, silenced or ignored as pathological (in environments which seek to (conceptually and therapeutically) *separate* the subject from the ED). The stark reality of this framework is highlighted by Lester who describes how ‘viewing clients as manipulative legitimates a relational strategy within which the non-acknowledgement of the clients’ claims to agency and/or authenticity can be construed as optimal care....’ (2019, p.290). Given that ‘authenticity’ is often seen as foundational to psychological health (Lester, 2019, p.265), these pathologising discourses should not be underestimated. Not only can they function to position people as beyond clinical intervention (Lester, 2019) (for example, via treatment termination), but pathologisation can also ‘strip people of their civil liberties’ (Day & Keys, 2008, p. 8). This fact is worth remembering given that inpatient treatment for anorexia may be both punitive *and* involuntary, and that its subjects are primarily girls and women.

Although relations with staff were not experienced wholly negatively by our participants, they were more likely to form trusting relations with fellow patients. Staff who did not reduce patients to their ED, who genuinely listened to participants and provided a ‘safe’ space in which to articulate struggles, were valued by participants. But the moments most remembered (often vividly) were those in which staff criticised or challenged ‘the system’ on their behalf. This in itself speaks to the oppression and denial of agency which participants saw as endemic to their clinical experiences, but also the precarious nature of staff-patient relations in wider environments of constant mistrust.

There is little work examining the positive aspects of peer relations in ED treatment, and from clinical discourses to the history of public concern over ‘pro-ana’ sites, such interactions

have been largely figured as dangerous, unhealthy and pathological. This is not how relationships with peers were experienced in this study, even though treatment strategies often militated against the formation of supportive and trusting bonds. These relationships were often framed as misunderstood and undervalued by staff in ways which may be detrimental to treatment and patient recovery.

Although this article has drawn on feminist approaches which theorise inpatient regimes as ‘distinctly gendered undertaking[s]’ (Bell, 2006, p.285), bound up with conceptions of normative femininity, the highly delimited subject positions outlined here raise questions that are relevant to *any* patient deemed ‘untrustworthy’, and regardless of their gender. At the same time, participants’ responses demonstrate more widely the consequences of silencing feminist approaches to eating problems as part of routine, mainstream treatment—aiming as they do to challenge the biomedical emphasis on individual pathology and to situate EDs within the broader structural context of gender relations.

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### **Notes**

1. We use term ‘patient’ throughout this paper because it was used by our participants and is usually the term used in UK ED treatment contexts. Alternatives such as ‘client’ and

‘service user’ imply a willing and active engagement with treatment that is often incongruent with the subjectivities we analyse here.

2. Approval was granted by University of East Anglia General Research and Ethics Committee (GREC), reference: GREC 18-1531. 23<sup>rd</sup> July 2019

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<https://10.1002/erv.2590>

### **Biographical Note**

**Su Holmes** is Professor of TV Studies at the University of East Anglia. She has published widely on the interests of popular television, reality TV, celebrity and British TV history, as well as feminist approaches to eating disorders (with a particular focus on treatment). Recent articles on the latter have been published in *Feminism & Psychology* (2016), *Journal of Gender Studies* (2018), *Eating Disorders* (2017), *Sociology of Health and Illness* (2018), *Health* (2018) and *Women's Studies in Communication* (2020).

**Helen Malson** is an Associate Professor of Social Psychology at the University of the West of England, Bristol. She has published widely in the field of eating disorders and more

broadly on critical feminist approaches to gender subjectivities and embodiment particularly around media representations. Her books include *The thin woman: Feminism, post-structuralism and the social psychology of anorexia nervosa* (Routledge, 1998) and, with Maree Burns, *Critical feminist approaches to eating dis/orders* (Routledge, 2009). She is also a co-director of the Eating Disorders Health Integration Team in Bristol .

**Joanna Semlyen** is a Health Care and Professionals Council (HCPC) Registered Health Psychologist and a British Psychological Society (BPS) Chartered Psychologist and is Associate Professor of Psychology and Medical Education at Norwich Medical School at University of East Anglia. Her interdisciplinary research focus, utilizing qualitative and quantitative methodologies, is on minority experiences of health and health services and assessing health inequalities across the Equality Act protected characteristics. She particularly publishes in mental health research and has co-edited a forthcoming book *Sexual Minorities and Mental Health: Current Perspectives and New Directions* published with Palgrave Macmillan.

#### **Orcid numbers**

Su Holmes 0000 000342438337

Helen Malson 0000-0001-5176-9387

Joanna Semlyen 0000-0001-5372-1344