THE EFFECTS ON STAFF OF WORKING IN AN

EATING DISORDERS UNIT

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SUMMARY

Following an awareness of an increased turn over of staff in the eating disorder unit as compared with other specialised units, in a psychiatric hospital in Johannesburg, South Africa, Tara Hospital, the researcher was motivated to investigate the issue.

An exploratory, descriptive based research was chosen to explore and gain information about the topic and its implications. A qualitative research approach was used to gain insight into the perceptions and needs of the team working on the unit. The case study method was used. A pilot study was undertaken to test the validity of the interview schedules. The sampling category was a non- probability one.

Individuals were selected from the population of staff working on the unit. Participants were selected from two groups, those who were presently working on the unit and those who had previously worked on the unit and now working in other units.

Interview procedure involved personal semi-structured interviews conducted by the researcher and analysed qualitatively and a structured interview questionnaire analysed quantitatively. The researchers assumption that many staff members move from working in an eating disorders unit was confirmed and is due to the following:

Staff turnover is due to constant exposure to occupational stress and burnout. Feelings of helplessness, a sense of being unappreciated and excessive exposure to conflict from the patients. In addition, staff experience minimum rewards leading to lowered job satisfaction due to the patients slow recovery rates and a poor prognosis of the illness. Staff also experience a change in their eating patterns and an increased awareness around food and food issues. Recommendations to the staff include:

- Psycho-education on eating disorders.

- Implementation of strategies to provide supportive care for all staff members.

- Education on stress management and strategies to prevent staff burnout and lowered job satisfaction.

- A multidisciplinary teamwork approach by the staff, when working in the unit.

Key terms: Psychiatric hospital, exploratory research design, pilot study, team work, psycho-education, the multidisciplinary team, the unit, the patients, Anorexia Nervosa, Bulimia Nervosa.

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CHAPTER 1

GENERAL ORIENTATION

1.PROBLEM FORMULATION

The researcher and the team have noticed that there has been a regular turnover of staff on the eating disorders unit as compared with other units in the hospital setting. This motivated her to investigate the issue. In addition there was an impression that team members in the unit became more conscious of their eating patterns and food intake while working on the unit. Consequently there seemed to be a practical need to obtain information around the problem. Staff in the unit appeared to be exposed to occupational stress on a daily basis. Psychiatry has been considered to be one of the most stressful medical specialities whose common link would be attention to severely ill patients with poor hopes of recovery and chronic or incurable diseases (Fothergill et al 2004). Clinical work in mental health may be considered stressful. Classic examples of demands are overwork and the limited capacity to alter the course of certain disorders. Day to day work demands a more or less profound empathetic relationship with the patients over what may be a lengthy period, seems to cause a lot of stress (Maslach 1996).

2.MOTIVATION

Reasons for choosing this area of investigation.
There appeared to be gaps in the knowledge of why staff turnover is so great on the unit and practically this knowledge will be valuable to ensure the more effective running of the unit.

Freudenberger (1974) used the term burnout to describe a state of physical and mental exhaustion, which seemed to apply to human sciences especially to health staff.

This evidence seems to highlight the necessity to acquire more knowledge and information that would promote staff awareness and would enhance the interaction between themselves and their patients. Based on this it was decided to carry out this research study, which is relevant to social work theory and practice.

The theories I present to approach the research project will be Roger's (1961) Person Centred Approach and System's Theory (1960)

2.1 Literature review

The eating disorders are characterised by an excessive concern related to weight and body shape, with consequent impact on eating attitudes and behaviour so that physical, emotional, cognitive and social functioning is impaired (David, Garner; and Garfunkel, 1997).

David et al (1997) state that there is a general tendency to begin to withdraw socially, together with low frustration tolerance. Such observations have a tremendous significance for the management team looking after the patients insofar as the process of nutritional rehabilitation, physical well-being and reversal of behaviour problems associated with the illness and the effects, these behaviours have on the staff dealing with them. Those cases of Bulimia who engage in binge eating and purging behaviour have a difference with regard to personality style, those with the restriction type being more obsessive and those with binge eating/ purging type being more impulsive.

The sub-typing of the condition provides useful information regarding the range of associated behaviour which the team have to experience and confront.

Lacey (1992) states that nursing patients with eating disorders is a multi-faceted endeavour, which includes attention to the physical, psychological, environmental and social domains of clients. There has been no consensus about "the best approach" to dealing with patient treatment and this reflects the helpless feelings of many clinicians experience when striving towards successful treatment.

Lacey (1992) outlines the difficulties inherent in staff who work with patients suffering from anorexia nervosa. Professional caregivers often experience feelings of being scared, fearful, panicky and angry in interaction with their clients. Negative aspects of patients' behaviour remains magnified and imprinted in the staff's perception and attitude.

According to Lemberg (1992), multidisciplinary team involvement, collaboration and consistency are important components in treatment for all in a psychiatric setting. It is important that nursing staff have the knowledge, skill and attitudes required for such patient care.

Happell (2003) states that within the nursing profession, stress and burnout are considered to be unduly present and problematic and these factors tend to impact negatively on job satisfaction and ultimately affect the retention of nurses. Psychiatric health nursing as a speciality is considered to be a highly stressful environment.

Despite the importance of the need to investigate stress and in particular burn out, there is a dearth of published South African research amongst health workers. However, Happell (2003) demonstrates that there is an increasing outcome of unpublished studies conducted locally to investigate stress, burnout and coping mechanisms among case workers, citing Booysen (1993), Govender (1995), Levert (1999), and Pretorius (1991). The common striking finding in such studies is that there is a need for further research, as the findings cannot be generalised. These findings of burnout and stress are known effects and in this study we want to explore if there are additional effects known in working with anorexic patients, as Anorexia, is a unique clinical entity.

Stress and burnout can have a dramatic effect on staff in psychiatric settings. Stress has been described as a universal and complex phenomenon, which manifests in the lives of all individuals. The environment does not automatically gratify our needs and we are often, and perhaps increasingly faced with personal and environmental obstacles. Bailey, Steffen and Grout (1980) maintain that stress researchers need to place the individual worker within an historical, social and political context.

Slaby (1991) states that whereas too little stress can cause boredom, excessive amounts of stress or stress experienced over extended periods of time can cause physical ill health, impaired task performance, post traumatic stress disorder and burnout. Ross (1997) states that burnout is conceptualised as the last stage of stress.
Landeen et al (1996) and Ross (1997) state that individual reactions to stress can be analysed on 3 levels, namely emotional, physiological and behavioural responses. Stress as the accumulation of difficulties in an individual's environment can, according to the conflict theory, include major types of stress such as frustration, conflict and pressure. Evolutionary theory views social change and tension as the inevitable accompaniment of social development and transition, which can be stressful. Stress as the interaction of characteristics of the person and factors of the environment would include the cognitive transactional model of stress.

McGrath and Reid (2003) argue that stress is neither a stimulus nor a response but rather a stimulus response transaction in which the person feels threatened. According to Ross (1997), the ecosystem, as part of the ecological metaphor, which is based on general systems theory, allows us to focus on transactional relationships between living systems and their environments in the present life space and over time. Organisational factors can also be attributed to job stress and burnout.

Pines and Aronson (1988) state the distinction between burnout and stress must be made, as these two concepts are not identical. Often people are able to prosper in stressful, demanding situations if they feel valuable, appreciated and their work has significance. Unmoderated or unsuccessful attempts at mediating chronic stress results in burnout. Stress and burnout exist in a complex interactive system. Maslach and Jackson (1981) identified three components of the burnout syndrome namely: emotional exhaustion results from the stress of emotional over load in interpersonal contact situations. This may be expressed in feelings of emotional over-extension and fatigue. Depersonalisation incurs the psychological distancing of oneself. This condition may commonly correlate with the deterioration of physical well being. This may include apathy, emotional detachment, and in the case of health care professionals, callous and indifferent attitudes toward patients. Feelings of low personal accomplishment are related to unfulfilled expectations pertaining to work environment and a sense of personal inefficiency, and feelings of lack of successfulness in terms of professional work.

Pines (1982) states that this may be expressed through emotions such as guilt, inadequacy, incompetence and failure. Govender (1995), and Ross (1997) state that previous studies show that nursing decisions often had to be carried out quickly, which can bring the phenomenon of a constant sense of urgency. Kaplan, Sadock and Grebb (1994) posit that specific psychic stress may be unconscious conflict that causes homeostatic disequilibrium that contributes to the development of psychosomatic disorder.

The aforementioned literature motivated the researcher to conduct empirical research on the effects on the multidisciplinary team of working in an eating disorders unit in a psychiatric hospital.
The researcher, in order to gain further information to determine the need for the research investigation, implemented the following by researching hospital records.

2.2 Hospital records

In 2006 and now in 2007 there is a gradual increase in the number of verbal and written requests for information about eating disorders from the general public and other psychiatric hospitals, i.e. Weskoppies Hospital, Sterkfontein Hospital, Helen Joseph Hospital and the Johannesburg General Hospital. In addition requests also come from general practitioners, psychologists in private practice and social workers.

In addition, patients' family and relatives require knowledge about ongoing outpatient treatment. This is time consuming for the staff members in the unit who have requested relief in the form of a unit clerk.

Hospital records also indicate a gradual increase in the number of patients admitted each month to the eating disorders unit. The psychiatric nurses have complained about their increased workload to such an extent, that they requested relief in the form of a higher complement of nursing staff in the unit through the creation of more posts.

Records indicate that there is an increase in the number of problems in the unit and that the difficulties in the management of their problems relate either to staff / patient conflict or difficulties between staff members.

In addition the human resource department indicates there is an increase in sick leave for all team members in the unit. This creates more pressure for existing staff and consequently nursing staff have refused to continue working extra hours and have requested agency nursing staff to be employed to reduce the potential for stress and burnout.

3. AIMS AND OBJECTIVES

3.1 Aim

The aim of this research was to gain insight, and knowledge about the effects of working in the eating disorders unit at a psychiatric hospital.

3.2 Objectives

In order to achieve the above aim, the following three objectives were set for the study:

1. To explore perceptions, experiences, needs and difficulties facing the staff in the eating disorder unit.
2. To enable the staff to draw conclusions from new insights gained highlighting the areas perceived to be unsatisfactory. To provide new guidelines to assist in working with clients.
3. To develop coping strategies and make recommendations for improvement.

4. RESEARCH QUESTION

These research questions reflect the issues covered in the objectives and are the basis of the entire discussion.

1. Do staff members, after working in the eating disorder unit for three months, begin to experience signs of stress and burnout?
2. Does the staff's relationship to food and eating patterns change as a result of working in this unit?
3. Does the client's slow response to treatment and poor prognosis contribute to staff's sense of helplessness, reduce their self-esteem and contribute as a reason to leave the unit?

5. RESEARCH DESIGN

5.1 Type of research design.

An exploratory, descriptive design was selected by the researcher for the purpose of this research study. The purpose of the study was to gather information on the area under study i.e. to gain insight and knowledge about the effects on the staff of working in an eating disorders unit in the psychiatric hospital. The researcher found that very little was known about the field of study. In fact, this particular topic was not well developed and there were no theories propounded.

This study was intended to gain insight into staff's experiences while working in the unit, highlight the areas of dissatisfactions and provide guidelines to assist staff and ultimately the social worker to provide an improved service to the patients. By the utilisation of an exploratory design, the researcher gathered information which could be explored later with more precise and hence more complex research designs and methodologies.

5.2 Guidelines for the investigation.

The guidelines for structuring the investigation in such a way that relevant information could be obtained were as follows:

Sources of Information
The sources of information included reviews of the published literature on stress and burnout of staff caring for psychiatric patients i.e. eating disordered patients. In addition discussions were held with the multidisciplinary team in ward 1 at Tara Hospital about their experiences.

5.3 The research procedure

The research conducted comprised of the following steps:

A comprehensive theoretical study was conducted. Aspects that were studied were the following:

1. Stress and burnout
2. Effects of emotional exhaustion
3. Staffs' attitudes and behaviour
4. Loneliness
5. Therapeutic relationships
6. Job satisfaction / dissatisfaction
7. Coping strategies
8. Better practice / treatment approaches

- The researcher obtained the permission of the principal psychiatrist of Tara Hospital to conduct the research with staff on the eating disorders unit at the hospital. Permission was also granted to obtain statistics by inspecting the staff duty register for the last 3 years.
- Prior to the research the interviewer contacted staff members in the unit and those who had recently left to invite them to participate in the study.
- Staff members were informed that the results of the study would be confidential. They could remove themselves from the study at any time. The staff signed consent forms agreeing to participate in the study.
- A sample was selected, (see 5.7 for more details) i.e. 20 staff members working on the unit and 5 staff members who had left the unit. The sample size was considered adequate for the purpose of the research.

- An interview schedule was designed by the researcher to explore further and to describe the phenomenon of the understudy. The interviews utilised semi-structured questions were used qualitatively. The interviews lasted approximately 40 to 60 minutes and were conducted at the hospital. The study uses a qualitative research methodology and was an exploratory and descriptive design. A structured questionnaire was also administered and was used quantitatively.

- A pilot study with 2 staff members was undertaken to test the schedule.

- The schedule was then modified on the basis of the pilot study. The order of some of the questions was reorganised to facilitate the staff's responses.

- The schedule was then personally administered to the staff members. The researcher introduced herself and the schedule to each staff member.

- The purpose of the schedule was explained to the staff members and in all cases except one case, these staff members were willing to cooperate with the researcher.

- The data obtained from the interview schedules were recorded and tables comprising the responses of the staff were drawn up. On the basis of the results reflected in the tables, the data were evaluated, analysed and inferences were made in terms of the existing literature and theories.

- The research questions were evaluated.

- On the basis of the results, recommendations were made by the social worker to develop and implement strategies needed for the staff to function more effectively and thus provide an improved service.

DATA COLLECTION

5.4 Data collection method

The data collection method selected to gather qualitative information for this research study is that of unstructured interviewing. Interviewing refers to the interaction process between the interviewer and the respondent. The case method study was used, the researcher used semi-structured interview schedules. This interview schedule was administered to 25 staff members: 20 of the sample are presently working in the unit at ward 1 at Tara Hospital and 5 of the sample who were working on the unit and had recently left..

A human survey questionnaire (structured interview) was used quantitatively which comprised of 22 questions and was administered to 20 staff members that were working in the unit and 5 staff members who had left the unit.

5.5 Method of data presentation.

The scale of measurement will be a nominal scale. Case study data will be collected to observe i.e. themes, patterns, sentences and words.

5.6 Validity and reliability of data collection.

To ensure validity of the research instrument a pilot study was carried out on two sets of staff members: Those who were working in the unit and two who had left the unit.

5.7 Sampling procedure

Individuals were purposefully selected from the population of the staff working in the unit during the year 2007. Prior arrangements were made by the researcher with the multidisciplinary team members working on and off the unit. The sampling category is non-probability sampling. Using non-probability sampling does not enable the researcher to attest to the representativeness of the sample. The sample was reliant on available subjects, (convenient sampling). Individuals are purposefully selected from the population of staff who are working in the unit or had recently left.

5.7.1 Selecting the sample

Participants were selected from 2 groups:
1. Those selected from the present multidisciplinary team who were presently working in the unit.
2. Those selected from the multidisciplinary team who had worked in the unit and who had left and who are now working in other units in the hospital or other hospitals (retrospective study).

 The choice of selecting participants from both groups was to look at similarities and differences experienced by both groups.

5.7.2 Criteria for choosing participants

- Staff working in the unit for at least 3 months.
- Staff in the unit willing to participate.
- Staff in the unit willing to verbalise experiences to the interviewer.

The selected sample were those staff members from the 2 groups who adhered to the above criteria.

N.B. Participants must have worked on the unit for at least 3 months so that there is an opportunity for them to have experience of the effects of the unit programme.

5.8 The Interview procedure

Personal interviews conducted by the researcher.

5.8.1 Case study interviews

Interview (semi-structured)

The study uses semi-structured interviews as a primary source of data collection which will be created and defined by the researcher herself.

The aim is:

1. To create and define own interview techniques.

2. To aim to identify themes and connect them.

3. To look for similarities/differences between the 2 groups represented.

The scope of the interview is limited to certain sub-topics and key questions can be prepared in advance.

5.8.2 Human resource survey interviews (structured)

The study uses a structured interview questionnaire to add to the case study interviews. The interview questionnaire was used quantitatively. The researchers aims were the following:

1. To administer a structured interview consisting of 22 questions of job related feelings. It uses a 5 point Likert-type scale with scale descriptions, once a month", "a few times a month", " once a week", " a few times a week", " everyday".

2. To aim to identify levels of job satisfaction / dissatisfaction.

3. To look for similarities and differences between the 2 groups represented.

5.9 Data analysis

Data will be analysed for both quantitative and qualitative data. The qualitative data, will be analysed for themes related to time and critical events from the semi-structured interviews. The quantitative data, from the Human resource survey will be analysed in terms of levels of job satisfaction / dissatisfaction and a correlation will be made between the results of those staff working on the unit and those working off the unit. A ward survey will be analysed quantitatively in terms of the number of staff leaving the unit per year.

6. LIMITATIONS

- The researcher's affiliation with the unit may stir up hostile feelings in ex-team members who left the organisation on a sore note. These individuals may give exaggerated reports regarding their reason for leaving.

- The respondents could possibly fail to tell the truth regarding their reason for terminating service. Their reason for being evasive may be as Douglas (Mouton a Marais) (1990:84) says "primarily a fear of exposure".

- The data collection process may pose a problem if respondents are difficult to contact. The reason why the student has identified this as a possible problem is that there are a limited number of respondents. Some of them may have relocated and working on a different unit. They may not have the time or enthusiasm to be part of the team.

- The Tara research committee may be unhappy that University of South Africa has not yet got the official ethical committee and may not accept the proposal if it is not first sanctioned by such a committee.

- The student realises the importance of explaining the goal of the research project clearly to all respondents. The latter must be assured of the confidentiality. Rubin and Babbie (1993), suggest that all names and addresses should be removed from questionnaires.

- Since only a small group of staff members were studied, the research findings do not necessarily reflect the opinions of all the staff in the unit, nor can the study be generalised to the population of psychiatrically trained staff in an eating disorder unit as a whole.

- Attitudes and perceptions of working in the Unit are dependent to an extent on the professionals involved at the time, which implies that perceptions may change when those of the professionals move or are replaced. In addition, it may also change depending on the patients in the unit and when they move and are replaced.

- Part of the study, namely perceptions and feelings of working in the unit compared with working now in another unit, is retrospective in nature and therefore relies upon the accuracy of memory. It is furthermore noted that attitudes and feelings may have changed over time.

- The nature or extent of stress or burnout may affect both the respondents' level of participation and response to the interview.
- The process of termination could affect members' responses.
- Criteria for stress / burnout, effects on working in the centre are not the same for all people and may be dependent to some extent on patients' socio-economic background, culture, level of intellectual functioning and personal preferences and perceptions.

The unpredictability of staff turnover, and the difficulties to contracting staff members who have left the unit and the limited time available for the research has limited the availability of a larger sample to be studied.

7. DEFINITIONS OF TERMS

7.1 Tara Hospital

Tara Hospital is an acute, psychiatric hospital in Hurlingham, Johannesburg, South Africa treating the mentally ill. Patients are managed in specialised units, either as in or out patients. Admissions are either by voluntary consent or are assisted admissions.

The staff at Tara Hospital adopts a holistic humanistic approach in the care of each patient.
They act as advocates for them in terms of the Mental Health Act (No. 25 of 2000), which ensures for the protection of the individual's human rights. Each Unit/Ward comprises a multi-disciplinary team, and all staff members are psychiatrically trained which adequately prepared for working in each specialised unit.

7.2 The multidisciplinary team

Each unit in the hospital has a multi-professional team comprising of psychiatrist, psychologist, social worker, occupational therapist, and a professional nurse. They strive to ensure the physical, social, emotional and psychological needs of each client in the unit.

7.3 The unit (bed occupation)

The eating disorder unit has a bed occupancy of 14. Ten beds are allocated for patients suffering from Anorexia Nervosa, and 4 beds are allocated for patients with Bulimia Nervosa.

7.4 The DSMIV (1994)- Classification of Anorexia Nervosa

The essential features of Anorexia Nervosa are the individual's refusal to maintain a minimally normal body weight, an intense fear of gaining weight as well as significant disturbances in the perception of the size of his/her body.

7.5 The DSMIV (1994) – Classification of Bulimia Nervosa

The essential features of Bulimia Nervosa is that the individual has recurrent episodes of binge eating, recurrent, inappropriate compensatory behaviour and this is in order to prevent weight gain. The binge eating and inappropriate compensatory behaviours, such as self induced vomiting, misuse of laxatives, diuretics, enemas or other medications, fasting or excessive exercise. both occur on average, at least twice a week for 3 months. Self-evaluation is unduly influenced by body shape and weight. This disturbance does not occur exclusively during episodes of Anorexia Nervosa.

8. PRESENTATION OF CONTENTS

This dissertation is divided into five chapters:

- Chapter 1 is a general orientation towards the study.

- Chapter 2 is a literature review where relevant previous research and the theoretical backgrounds are outlined and discussed.

- Chapter 3 is the research design.

- Chapter 4 presents the research findings.

- Chapter 5 contains the conclusions and recommendations, including the feasibility of implementing these recommendations in social work practice in South Africa.

CHAPTER 2

LITERATURE REVIEW

It was noticed that there is a continuous staff turnover in the eating disorders unit in the hospital and there appears to be a lack of knowledge in relationship to this phenomenon. Despite the appearance of staff enjoying their work, it is recorded that the annual staff turnover in this unit is high. The literature review will illustrate the areas that could possibly be the reasons for the high turnover.

1. STRESS AND STRAIN

Cheetham (1997) states that one of the functions of social work research is to highlight the aetiology of social / personal problems.

Fagin, and Brown (1996), states that working as a carer in the psychiatric context is seen as challenging and can cause feelings of stress and strain, caused by carers coping with complex and potential stressful situations on a daily basis. Staff in psychiatric in-patient settings spend a great deal of time in intense interaction and it could be crucial to find a balance between distance and getting too close. Maslach; Schaufeli; and Leiter (2001) argued that psychiatric nurses face unique job challenges compared to their counterparts who work in non-psychiatric units. The patients in the eating disorders unit have a prolonged stay with slow recovery and have persistent, excessive demands and experience difficulty in communicating. Menzies (1970) states that feelings of stress and strain may lead to defence reactions which can impact negatively on the nurse-patient relationship and the quality of care. Unmanageable job-related stress can cause burnout which then results in reduced energy for their work duties. Maslach and Jackson (1981) mentions a state of depersonalisation which is the process which obstructs nurse-patient interaction. Fagin and Brown (1996) identified that hospital nurses showed high levels of emotional exhaustion and depersonalisation for their patients which led to reduced job satisfaction, positive attitude to caring is diminished which results in staffs' poor health and limitations in their social life.

Staff in eating disorders unit often comment on taking their problems home and feeling too tired to have a fulfilling personal life. Maslach and Jackson (1981) state that depersonalisation is reflected in the way that staff members take care of their patients in an impersonal manner, and that the staff member feels responsible for the problems of the patient. In caring for anorexic patients, staff often feel impotent and are disappointed when patients' recovery rate is minimal. The nurse-patient interaction suffers as a result of the nurses' focus on work related tasks. This exclusion is often reflected in patients complaining about staff's lack of attention and uncaring attitude. Staff often feel totally responsible for the patient's illness. Sullivan (1989) discusses the relationship between burnout and job responsibility, organisational hierarchy and interpersonal support. In eating disorders units, staff members have multiple tasks, sometimes with inadequate staff numbers leading to feelings of lack of support from their colleagues and managers.

Lack of job influence, work overload and organisational inefficiency have been identified as factors that contribute to burnout (Sullivan 1989; Melchior 1997).

Bull, Bernet, Dietrich and Kopf (2006) mentioned that the care of a person with a mental illness involves multiple burdens, possibly leading to burnout. Professional and non-professional caregivers face a similar degree of burden and need support to perform their caring tasks. They mentioned that studies relating to an acute in-patient unit for eating disorders led to fears about staff stress, burnout, job dissatisfaction, negative effects on psychological wellbeing and poor morale. Jansen (1996) confirms that stress is a problem for the unit-based mental health nurse. The implication for this is that we need models of the stress process that are empirically based to reduce the impact of stresses on nurses plus the knowledge to deliver stress management intervention for the staff members. Employee stress can have profound effects on an organisation such as an increase in workers compensation claims and cost of production.

2. BURNOUT

Hellersoy, Grenhaug, and Kvitasteur (2000) and Maslach (1982) view burnout as a major problem in the helping professions such as nursing, medicine, social work, law enforcement and education. Factors associated with job burnout are threats to job control, difficulty of training, workload and interpersonal relationship with colleagues. As a result of burnout people develop negative self concepts and become detached, apathetic, angry or hostile in their workplace. Kilfedder, Power and Wells (2001), and Edwards, Fothergill and Burnod (2004) state that hospital based psychiatric nurses may be more prone to experiencing burnout other than other nursing groups.

According to Maslach and Jackson (1981), burnout is characterised by emotional exhaustion, depersonalisation and reduced personal accomplishment. Kilfedder, Power and Wells (2001) states that even before a workday begins, people feel tired and powerless and that this experience is often reflected in staff members' level of absenteeism and staff turnover in the unit as noted in the eating disorders units. They state that burnout encompasses feelings of indifference towards patients and their fate and the feelings of emotional hardening. The staff member senses a low personal competence with little success. Their life feels beyond hope and devoid of positive influence. Staff in eating disorders unit often feel helpless with the sense of hopelessness.

These experiences can be seen in eating disorders units where patients' slow recovery rates and high mortality rates induce staff having similar experiences.

Job burnout has a cumulative effect on mental health, quality of life, family life and productivity. According to Shimizu, Feng and Nagata (2005), turnover and burnout among Japanese hospital nurses in a cross-sectional study suggest that nurses' burnout would result in them leaving. Other reasons for turnover were lack of supervisory support, health problems, inadequate career development, low job satisfaction, familial issues, poor working conditions, low job control, high job demands and depressive status. McCarthy (1985) says that burnout is a syndrome constructed by progressive physical and emotional exhaustion. If unchecked it will lead to a deterioration in the quality and quantity of nursing care perceived by the patient.

Job burnout is increasingly recognised as one of the most serious occupational health hazards resulting in job dissatisfaction, lower productivity, absenteeism, high turnover

and a state of disequilibrium. Work related factors such as work pressure without support, ever changing expectations and new job syndrome results in job burnout. Personality traits such as idealism and the need for self affirmation and unit orientation can increase the risk of job burnout. Fagin et al (1996) attributed burnout amongst psychiatric nurses to staff shortage, health service changes, poor morale and not being notified of changes before they occur. There is a lack of literature about job burnout amongst psychiatric nurses.

There is an increasing outcome of unpublicised studies Booysen (1993); Govender (1995), Levert (1999) and Pretorius (1991) conducted locally to investigate stress, burnout and coping mechanisms amongst health care workers.

Cam (2001) mentioned that work settings is the most significant predictor of emotional exhaustion, depersonalisation, burnout and job satisfaction. As Bauer; Kleen, Lukesch, and Unterholzen (1993) showed, graduate psychiatric nurses express higher job satisfaction than psychiatric student nurses, which is in turn inversely related to burnout. Ewers (2002) stated that most qualified nurses cope with stressful situations and which ultimately helps to reduce the risk of burnout. Pranger and Brown (1992) mentioned that occupational therapists and mental health professionals frequently feel emotional exhaustion and a reduced sense of personal accomplishment as do the other team members.

Ross (1997) posits that if stress and burnout manifests in poor service delivery, ill health and patients' neglect, then continuing research and actions are required.

Most of these studies were conducted in Europe and the United States of America and have focussed primarily on nurses in general. There is a lack of literature about working conditions and job burnout amongst psychiatric nurses in the South African context. Musick (1997) mentioned that psychiatric hospital nurses experienced a greater degree of emotional exhaustion than medical nurses and that job burnout has a cumulative effect on mental health, quality of life, family life and work life. Maslach, and Schaufeli (2001) state that job burnout is a response to chronic interpersonal and emotional stressors on the job resulting in negative feelings such as incompetence, lack of achievement and reduced productivity at work. Gerits (2005) mentions that psychiatric nurses deal with atypical patients and receive less recognition by the administrative authorities and community in general.

Greenglass; and Burke (2002) stated that as a type of stress, job burnout was seen as being increasingly recognised as one of the most serious occupational health hazards

which results in job dissatisfaction, lower productivity, absenteeism, high turnover and disequilibrium. Constanti (1997) state that work related factors such as work pressure without support, ever changing expectations, new job requirements, role conflict and role ambiguity comprise some of the stresses which can cause job burnout.

3. THE EFFECTS ON THE TEAM

Williams, Pieri, and Sims (1998) state that doctors dealing with chronic illness should be able to tolerate stress and negativism and still offer support, control of symptoms and effective treatment. This often requires prolonged consistent care and a positive therapeutic stance. Butterworth (1994) states that for this to happen, doctors require good supervision, to include patients' views inservice planning and emphasize the development of good communication skills.

Connor (2005) states that Bulimia and Anorexia are difficult problems to address. Failure to recognise and respond appropriately can exhaust staff. Patients with Bulimia and Anorexia are prone to view their carers as people who are attempting to control rather than help them. Connor (2005) states that it is crucial that carers avoid falling into the trap of trying to control the eating behaviours of people with Anorexia or Bulimia. Caregivers who attempt to coerce food intake, proper nutrition and prevent purging are met with deception and anger and self destructive behaviour. The results are often avoidance or defiance of the caregiver. In addition, these patients will engage with staff by asking questions to create the possibility of compromise but in reality leads to arguments in which the patient is always in control. Connor (2005) states that patients suffering from eating disorders are prone to sincere fabrication and to report abuse and neglect by their carers and cause splitting amongst the treatment staff. Staff caring for eating disordered patients have to tolerate repeated episodes in which patients become argumentative and defiant regarding eating assigned work activities and purging behaviour.

Patients with severe Bulimia can demand a lot of attention, be disruptive to others causing other patients to become frustrated, angry and afraid. Staff should avoid arguments and power struggles that result in a defiant stance.

Such interaction ultimately reinforces oppositional, defiant and obsessive behaviour. Connor (2005) recommends that staff will need additional training supervision, emotional support and the availability of the team. Caregivers and peers get mixed messages from patients as they fail to understand the rigid and persistent nature of the patients' obsessions. Connor (2005) mentions that the behaviour seen by staff includes arguing over food, low frustration tolerance, emotionality and pleas to staff to keep Bulimic behaviour and information secret from other staff. Patients' shame and guilt is expressed by their withdrawn and aberrant behaviour. They often become argumentative or aggressive if ignored and resist attempts of staff members to form close and confiding relationships. Refusal to eat and then agreeing to eat are all tactics employed to continue their partial starvation and purging routine and this is increased if staff attempt to prevent or control their behaviour. Connor (2005) states that staff must be supported to deal with patients in a client-centred way by showing patience and compassion and not entering into or creating power struggles which would reinforce patients' obsession and their negative stance.

4. THE STAFFS' ATTITUDE

Bernis–Vitousek (1997) mentioned that staff working with eating disordered patients often reflect the same angry feelings as their patients. They feel that they are unable to make a difference and that their patients will not improve. They feel frustrated and unsure of how to approach them. Staff have numerous anxieties in treating these patients as society has a stereotyped view of eating disordered patients and media portrays the care given to the eating disordered as poorly managed. Patients have a number of perceptions which conspire to retard their recovery rate, namely, their distorted perception of their illness, being victims of the caregivers and other negatively reinforcing personal and professional experiences. Bernis–Vitousek (1997) states that staff members should first break down the barriers to treatment by the development of the staffs' genuine empathy for the anorexic experience.

The staffs' developing and understanding of their own attitudes and expectations enables them to approach their patients more openly, less challenged by the illness and its associated behaviours and to see the patients as individuals rather than a disorder. When this is achieved a paradigm shift occurs in the staff.

The treatment programmes are viewed differently by the patients once an empathetic approach is adopted. This allows staff more time to engage with patients, develop trust and create a non-judgemental dialogue which enables staff to be aware of the unique experiences of their patients' illness. Bernis-Vitousek (1997) states that staff that are focussed on managing opposition rather than facilitating goal achievement create the negative aspects of patients' behaviour. These aspects remain magnified and imprinted on staffs' perceptions and attitudes. An example of this, is that, instead of looking at complete nutritional rehabilitation, the staff should look at improvements in the nutritional states, which result in fewer medical complications for the patients.

Patients are not always synchronised with what health professionals believe will be best for them. Staff should remain focussed on those for whom the treatment is intended, remain encouraging, non-judgemental and attempt to motivate the patient beyond their comfort zones.

5. DEVELOPING MOTIVATION FOR CHANGE

Bernis-Vitousek (1997) stated that staff need to develop the motivation for change by developing empathy and establishing the desire to understand the patients' experience prior to treatment. They need to respond to patients' behaviour rather than react to it. To address the difficulties experienced by the patients, staff should combine knowledge of the patients with established rapport and empathy. Staff should be educated on recommended therapeutic strategies which will help staff members feel more comfortable and competent in providing care to their patients.

6.. LIMITATIONS OF KNOWLEDGE

Jaspers (1970) states that difficulties in understanding often occurs when staff are looking after patients with severe mental illnesses. Staff feel that they have limited knowledge. Jaspers (1970) describes a phenomenon which he calls the "boundary situation". The carer-patient relationship can be seen as a "boundary situation" where the staff member can choose to see the patient from a spectator's point of view.

Norman (1999) states that the patient is seen as a psychiatric case that is using a symptom orientated approach instead of seeing the patient as a person.

The patient becomes transformed into a case and loses his freedom as a human being. Friedman (1983) states that the staff member uses pathology and psychology to predict and control the patients rather than applying a person-centred approach.

Norman (1999) also suggests that a participating perspective which is similar to a person- centred approach should be adopted. Lindstrom (1995) states that using this kind of focus it is possible to see the patient's needs for mutuality and human contact. This perspective is important for patients suffering from eating disorders, particularly because their stay in the ward is usually a long and demanding one, both for the multidisciplinary team and for the patients themselves. It is important that staff members see the person who is concealed behind the patient's label.

Polivy and Herman (2002) suggest that cognitive factors such as obsessive thoughts, inaccurate judgements and overgeneralisation and rigid thinking patterns may contribute to eating disorders and a lack of self efficacy.

7. LONELINESS

Murphy (2000), McInnes and White (2001), and Lindstrom (1995) mentioned that a wellknown phenomenon in psychiatric care, which could be applied to patients with eating disorders is the patients feeling of loneliness, a feeling that has been found to be strong and never decreasing. This could relate to their long stay in hospital. People with long term mental illness often experience difficulties speaking on their own behalf, partly because of their illness and the way that society reacts to them. They experience great difficulties getting what they want or need without special assistance, (Swedish National Board of Health and Welfare 1992).

Staff anguish may be a consequence of working closely with acutely disturbed patients i.e. eating disordered patients who are often cognitively impaired and who are constantly demanding and challenging for the staff. The staff difficulties in maintaining the work have been reported by Fisher (1995), Breeze and Repper (1998) and Helzen (1999) who found that staff struggled to gain or retain the feeling of control.

8. THERAPEUTIC RELATIONSHIPS

George (1997) suggests that anorexic patients possess a psychological profile characterised by a phobia of weight gain, fear of loss of control, lack of introspection, mistrust of self and others, cognitive dysfunction, low self esteem and depression created as a result of starvation.

In order for a relationship to be therapeutic, it needs to be characterised by the following qualities: i.e. empathy, unconditional positive regard, acceptance, warmth, trust, genuineness and a non-judgemental attitude. These also reflect the social work values. This suggests that health professionals receive adequate education before working with such patients and their knowledge be regularly updated. They should receive regular clinical supervision and support. Bernis-Vitousek (1997) discussed the development of genuine empathy for the anorexic experience. Staff's views treatment options differently once they can empathise with the patients' perspectives.

Ramjan (2004) mentioned that staff caring for these adolescents with Anorexia Nervosa face a particular set of problems in seeking to establish therapeutic relationships. The themes that emerge relate to various struggles, namely.for understanding of the complexity of the illness and its recovery process, the struggle for control which looks at the power play between nurses and patients and the mutual distrust and the struggle to develop therapeutic relationships. i.e. the difficulties in establishing therapeutic alliances with the adolescents. Genuine therapeutic relationships should be part of all treatment programmes for patients with Anorexia Nervosa.

9. BETTER PRACTICE

Staff working in psychiatric units care for some of the most vulnerable needy patients within the health services and suffer the highest level of job dissatisfaction and burnout. Poor staff morale is bad for patient care and is economically wasteful. Richards et al (2006) identified a number of strategy evaluations to improve staff morale. These include educational interventions and psycho-social interventions. Butterworth (1994) illustrated that staff need to provide optimal practices which are suitable service supports, the creation of the right milieu, user involvement, patients' ownership of services and for staff members to work with a holistic approach. Maisel, Epston, and Borden (2004) mentioned ways of increasing a therapeutic environment. They suggest that substituting coercive practices with collaborative, accountable and nurturing ones within the multidisciplinary team. A nurturing relationship can be created by checking with patients as to what is helpful or problematic about the counselling process from their viewpoint. In regard to eating disordered patients, the therapist often loses sight of this approach and focuses only on eating and the fear of weight gain.

10. COPING STRATEGIES

Maslach (1976) studied ways by which people cope in stressful jobs and discussed that coping startegies are important for peoples jobs, behaviour and professional identity. Jungbauer, Wittmund, Dietnich and Angermeyer (2004) state that the more intense the degree of caregiving leads to a higher occurrence of burnout. Emotional exhaustion and depersonalisation increases with the amount of time spent caring for the mentally ill patient. Maslach (1996) indicated that people who took care of mentally ill patients require support as they are at risk for lower motivation, increased resignations, physical exhaustion and increased their alcohol intake which will prevent them from continually caring for the patients in the future.

Enzmann and Kleuber, (1989), Reschke (2002) and Rosing (2003) indicate that numerous publications about intervention programmes exist for nursing staff specialising in either the work environment or in the outlining of strategies for coping with stress and the managing of burnout.

Maslach (1996) states that we require our knowledge in order to deliver stress management interventions for staff and introduce wellness programmes. Employers should provide a conducive environment for employees to talk freely and confidently about their problems. Hospitals should provide regular training programmes for nursing staff and stress management courses and develop healthy coping strategies to neutralise the negative impact of the workload. Prior organisational support, self management and healthy coping skills play a key role in preventing high risk nurses from burnout. Brown (2002), Burke, (2003) and Armstrong-Stassen (2004) suggests involvement of psychiatric liaison services as a possible method to provide nurses with adequate supervisory and organisational support, peer relationships, individual training courses to provide quality patient care and diminish the chances of post traumatic stress disorder, job dissatisfaction and burnout. Jansen and co-workers believed that instead of changing the work content, we can decrease the feeling of burnout by paying attention to supervisory support, peer relationships and individual training programmes and a continual assessment of the nursing staffs' working performance.

Greenglass and Burke (2002) recommended regular training courses for nursing staff to manage stress and develop coping strategies to neutralise negative impacts of workload, prior efficiency planning and good coping skills to help to prevent nurses at risk from job burnout. Fawzy (1983) suggests involvement of psychiatric liaison services as a method to support nurses. Fothergill, Edwards and Burnard (2004) mentioned that psychiatry is a stressful profession and coping strategies include support for colleagues and outside interest. Ewers (2002) stated that special training is especially needed because psychiatric nurses deal with demanding patients. This demanding work environment needs qualified nurses who are better prepared to work with severely disabled patients and thus better prepared to deal with feelings of helplessness and frustration which may initiate the burnout process.

Taris (2003) stated that stress management has a pivotal role in controlling job-induced stress and burnout.

11. SUMMARY

In this chapter, basic assumptions which form the base of the study were highlighted. These assumptions refer to the fact that psychiatric patients i.e. those with an eating disorder in an in-patient programme, have a strong influence on the attitude and behaviour of staff working on the programme. The staff members running the programme have expertise in their respective fields i.e. social, emotional and practical skills together with knowledge to implement the programme. Despite this, both patients and staff report that the programme offered on the unit creates challenges for both the patients and the staff. An attempt was made to give a global biographical sketch depicting the main features of the effects of working with patients suffering from an eating disorder.

The most obvious effects of working with psychiatric patients related to both burnout and stress. These conditions appear to be enhanced by the prolonged treatment programme, patients difficulties and slow recovery rate and patients' resistance to engage in the treatment programme. Stress is further enhanced by the misinterpretation and denial of patients' needs by the staff.

In addition it was shown that the perceived lack of knowledge experienced by the staff members impinged upon their ability to implement the programme which resulted in their awareness of the communication gap, the staff's feelings of helplessness, loss of control, loneliness and antagonism toward patients. Staff also experienced a sense of patient-staff rejection.

CHAPTER 3

RESEARCH DESIGN

In this chapter the researcher reflects how the research questions were tested by using the following procedure:

1 .DATA REQUIRED TO RESEARCH THE OBJECTIVES:

1.1 Multidisciplinary team

Members from the multidisciplinary team were identified and selected to be interviewed.

These were:

- 13 Psychiatric Nurses
- 2 Psychiatrists
- 2 Social Workers
- 1 Clinical Psychologist
- 2 Occupational Therapists
- 5 Intern Psychologists

1.2 Compliance

- Those staff members who were willing to be interviewed and had spent at least three months on the eating disorder program were interviewed.

- Staff members who had already left the programme were identified and agreed to be interviewed (retrospective feedback).

2. TYPE OF RESEARCH DESIGN

The study undertaken may be viewed according to Tripodi, Fellen and Meyer (1975) as a hybrid of explorative-descriptive design, as the objectives of the research are to explore and describe staff's experiences and evaluation of these experiences i.e. the effects it has on each team member.

The study was also to gather facts and information on the area under study i.e. learning about attitudes of staff members, frustration, leading to stress and potential burnout in the workplace.

As stated previously, the researcher found that there was little research about the field of study. This topic was not well developed and there were no theories propounded. The study was introduced to refine and develop more effective methods for staff to work in an eating disorder unit. By the utilisation of an exploratory design, the researcher gathered information which could be explored later with more precise and hence more complex designs and methodologies.

2.1 The research plan

The researcher will now proceed to discuss the research plan of this study according to the first three phases of Thomas' Developmental Research model (1981) namely. The analysis, design and development phases.

2.1.1   Analysis phase.

This was conducted by means of a literature study and consultation with experts in the field of eating disorder and working in a psychiatric setting (see chapter 2)

2.1.2   Design phase

This phase consisted of conducting a literature study regarding the effects of working in a psychiatric setting with special reference to the effects of working in an eating disorder unit i.e. stress, burnout and the appropriate interventions strategies to address these effects.

2.1.3   Developmental Phase:

This phase consisted of the pilot implementation and evaluation of the programme. The pilot implementation of the programme were presented to two individuals who had worked in the unit and were members of the multidisciplinary team. The two members were volunteers. Thus for the purpose of this study it can be concluded that the researcher used an accidental non probability sample. (Bailey 1987:75).

The pilot evaluation was the process by which the present programme was evaluated. The aim of the pilot evaluation was to evaluate the process as well as the outcome of working in an eating disorder unit.

The researcher utilised qualitative methods to evaluate the process of the programme, that is the researcher's verbal feedback from participants i.e. from the case study interviews and semi-structured questionnaires completed by respondents after two sessions.

DIAGRAM 5.4

Collection of data by the researcher to identify the need for research
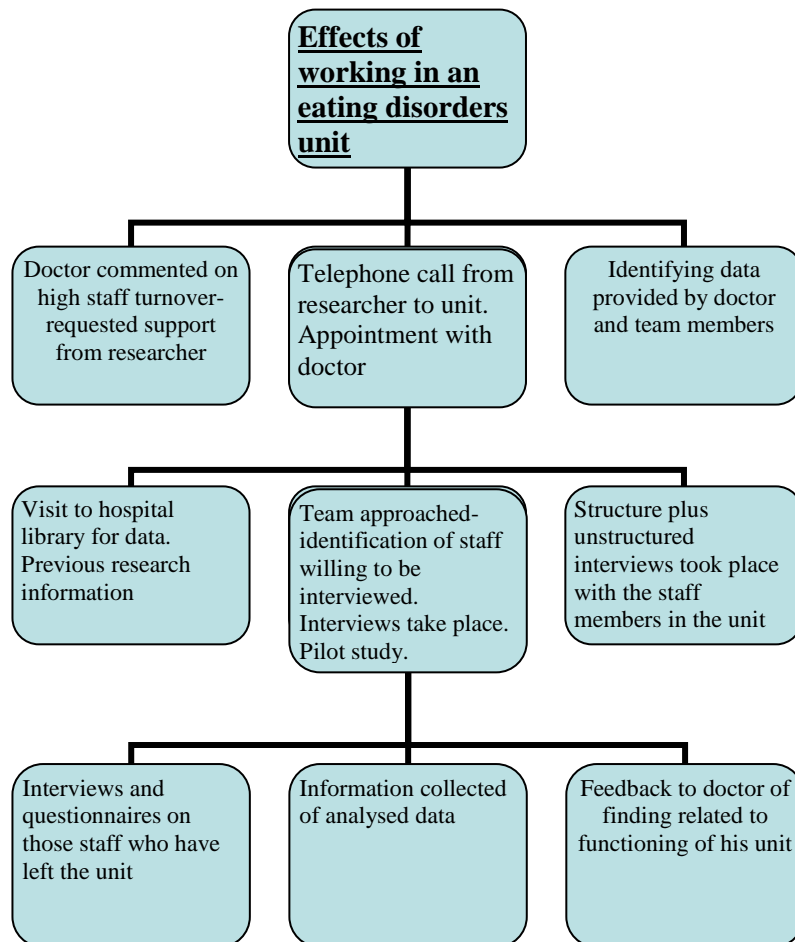
3. SAMPLING DESIGN

Individuals were selected from the population of staff who were working or who had worked in the eating disorders unit.

The sample size consisted of 25 members, 20 were actively working in the unit and 5 members had left the unit.

Criteria for selecting participants

  a. Staff working in the unit for at least three months.
  b. Staff in the unit willing to participate.
  c. Staff in the unit willing to verbalise experiences to the interviewer.

NB: Participants had worked on the unit for at least 3 months so there was an opportunity for the effects to manifest themselves. The staff participating were all professionals, who were psychiatrically trained nurses, social workers, occupational therapists, psychiatric registrars, psychologists, and intern psychologists.

The selected sample were those staff members from the 2 groups who adhered to the above criteria.

4. METHOD OF DATA COLLECTION

4.1 Selection of participants
Participants were selected from two groups as follows:

1. Participants were selected from the present multidisciplinary team who were presently working on the unit.

2. Participants who had previously worked on the unit and had now left and were working on other units (retrospective study)
NB: The choice of selecting participants from both groups was to look at both similarities and differences experienced by both.

4.2 Interview procedures

1. Personal interviews conducted by the researcher
2. Tape recording and transcribing the interviews by the researcher.
3. Researcher providing a semi-structured, open ended interview depending on the patients' willingness to disclose.
4. Researcher adopting own sequencing and wording of the questions to each particular interview.
5. Data collection method. The qualitative approach was used. The case study method showed how the researcher looked intensively at one social system i.e. the eating disorder unit in a psychiatric hospital.

4.2.1 Data collection phases

Data was collected in two phases:

1. Semi-structured interviews (attached in appendix 1) with the researcher who had worked with staff in the eating disorder unit in order to gain an understanding of all the factors involved in the study and to get information on the staff's experiences while working in the unit. The interviews were the primary source of data collection.

2. Information was gathered from all participants via the administration of a questionnaire (attached in appendix 2). The questionnaire was individually administered to the team members by the researcher personally.

Both the case study interview and the questionnaire were pilot tested with 2 staff members on the team. The members were able to complete the questionnaire in an average of 5-10 minutes. The semi-structured interview varied between 40 to 60 minutes to complete. The data was manually analysed and themes were identified by the researcher.

5. DATA ANALYSIS

Data obtained from the interview schedules was analysed, organised and presented in :

- A qualitative and a descriptive form. The semi-structured interviews, the case studies was analysed for themes related to time and critical events. Two examples of themes were: staffs' frustration towards patients and staffs' awareness of changes in their eating patterns.

- A quantitative form. The structured interviews from the Human Resource survey, was analysed in terms of levels of job satisfaction / dissatisfaction. A correlation between the two results was made.

In addition a ward survey was analysed quantitatively to view the annual staff turnover.

CHAPTER 4

EMPIRICAL RESEARCH FINDINGS

1.PRESENTATION OUTLINE

The aims of the present study are to define "The effects on staff of working in an eating disorders unit".

The researcher will present the results of the study in the following sequence:

The qualitative data will be highlighted first. The case study interviews (semi-structured) will be presented in terms of identified themes. The results will be discussed in terms of each theme, individually, and then illustrated in the form of three tables.

Diagram1 will illustrate the six major themes

in all three tables.

Table 1 will reflect the major themes experienced by the staff members who are presently working on the unit.

Table 2 will reflect the themes experienced by the staff members who have left the unit.

Table 3 will reflect the changes experienced by staff members since they left the unit.

A comparison of the three diagrams will be made. This will highlight the differences and similarities between the three diagrams.

The human services survey will be presented secondly and the results will be illustrated and discussed in the form of two diagrams.

Table 1 will reflect the level of job satisfaction / dissatisfaction for staff members while working in the unit.

Table 2 will reflect the level of job satisfaction/dissatisfaction for those staff members who have left the unit. A correlation of the results from the two diagrams will be made. This will highlight the similarities and differences between the two results.

The ward survey report will be presented at the end and the results will be illustrated diagrammatically. A correlation will be made from the results of the two interviews with the results of the ward survey report.

Diagram 1

The diagram below describes the major themes experienced in the case studies

```
                    ┌─────────────────┐
                    │    Theme 1      │
                    │                 │
                    │ Staffs' awareness│
                    │  of food issues.re│
                    │ amounts, attitudes│
                    │ to weight, growth│
                    │ and development │
                    └─────────────────┘
  ┌─────────────┐            │           ┌─────────────┐
  │  Theme 6    │            │           │  Theme 2    │
  │             │            │           │             │
  │Staffs' experience│       │           │Staffs' frustration│
  │   of job.   │            │           │towards patients│
  │satisfaction/│            │           │ and parents │
  │dissatisfaction│          │           │             │
  └─────────────┘    ┌───────────────┐   └─────────────┘
           \         │Multidisciplinary│        /
            \        │     team      │        /
             ────────│in eating disorders│────
            /        │     unit      │        \
  ┌─────────────┐    └───────────────┘   ┌─────────────┐
  │  Theme 5    │            │           │  Theme 3    │
  │             │            │           │             │
  │   Staffs'   │            │           │Staffs' sense of│
  │Communication│            │           │ helplessness│
  │  problems:  │            │           │             │
  │staff – staff,│           │           └─────────────┘
  │staff - patient│   ┌─────────────┐
  └─────────────┘    │   Theme 4   │
                     │             │
                     │Staffs' Challenges│
                     │   to ward   │
                     │  programme  │
                     └─────────────┘
```

Themes:

1. **Staffs' awareness of food**
2. **Staffs' frustration towards patients and parents**
3. **Staffs' sense of helplessness**
4. **Staffs' challenges to the ward programme**
5. **Staffs' communication problems**
6. **Staffs' experience of job, satisfaction/dissatisfaction**

2 CASE STUDY INTERVIEWS OF STAFF WORKING IN THE UNIT:

RESULTS OF THEMES ANALYSED

Theme 1

2.1 Staffs' awareness of food.

Ninety Five Percent (95%) (19/20) of the staff took on some of the habits of the girls they were looking after, i.e. stated to become conscious of food, some using excessive amounts of condiments, excessive use of laxatives and diet pills. Ten percent (10%) (2/20) said their energy levels were increased. Eighty five percent (85%) (18/20) were more aware of the diets, the amounts and also were more conscious of the calorie values.

They were also more conscious about regular balanced diets. Eighty percent (80%) (16/20) stated that their thinking changed about their eating and they became more aware about good / bad habits. Fifty percent (50%) (10/20) were more aware about whether their weight had varied and others became more perceptive of others' weight. Fifty percent (50%) (10/20) stated that their increase of awareness and insight was helpful to them, to their friends and to the general public as they could now give psycho education.

One hundred percent (100%) (20/20) of the staff were more aware of the effects of the media and eating disorder themes being linked to success and happiness. Thirty five percent (35%) (7/20) commented on the cultural views related to weight gain and style of eating. Most of these staff members felt that black girls should not have eating disorders, that it was not culturally acceptable.

Thirty five percent (35%) found it unacceptable and found that food should be appreciated. One hundred percent (100%) (20/2) commented they were more self aware in terms of their own eating, their weight and their good and bad eating habits. Once away from the eating environment, their pattern of eating appeared to change and they appeared happier. Fifteen percent (15%) 3/20 stated that binging/vomiting behaviour started when surrounded by food, i.e. chocolate cake.

Staff were afraid to weigh themselves or did the opposite and weighed more frequently. They became aware of clothes fit and became more conscious of their body image. Only five percent (5%) (1/20) said that they had experienced no changes.

One hundred percent (100%) of the staff commented that they ate differently when out of the unit and were happier about this. Forty percent (40%) (8/20) stated that the unit was extremely busy, food was constantly available, staff ate more than 3 meals a day and sometimes more.

Black staff stated that all food eating was an enjoyable activity and these staff members had increased their diet intake.

- Awareness of change

Ten percent (10%) (/20) were aware that staff either over or under eat in the unit and there was a change in eating when they arrived at the unit. There appeared to be an unconscious communication balance. Twenty five percent (25%) (5/20) of the staff had a reduced eating intake. They only ate at the end of the day. If they ate it would be snack food, biscuits etc.

It seemed abnormal to be seen as eating in front of the patients. Twenty percent (20%) (4/20) wondered what the eating effect would have on the patients. At tea times, staff would eat together which could have been interpreted as binging by the patients. Staff would take these issues of anxiety about the patients to discuss in their therapy sessions. Ten percent (10%) (2/20) said the awareness of food on the ward was related to health issues and less emphasis was related to the symbolism.

Fifteen percent (15%) (3/20) of staff looked at what the patients were trying to portray, by looking at clothes, TV ads and modelling magazines. Not all staff were affected with the changed eating patterns but one hundred percent (100%) stated that their awareness of food was highlighted. Five percent (5%) said that they were focussed on exercises for prevention of illness not just for health reasons.

Fifteen percent (15%) (3/5) said they could relate to the anorexic thinking but not to the same extent.Fifteen percent (15%) now had a better body image and believed that being thin was now not so optimal. Fifteen percent (15%) (3/5) felt that they cooked more consciously and that their eating patterns were more conscious.

Forty percent (40%) (8/20) served food more consciously. African staff started to change their cultural way of eating by eating different groups of food separately rather than mixing in the traditional manner. Twenty five percent (25%) (5/20) stated that they had taken on board the eating style of their patients to lose weight i.e. they would use laxative, drink excessive amounts of water, or use condiments i.e. chilli, pepper, paprika to aid their digestion and to lose more weight.

When on night duty they were exposed to less food and their weight decreased. One hundred percent (100%) (20/20) of staff became more aware of the eating problems in the community, i.e. noticed it at shopping centres and when going to gym.

Five percent (5%) (1/20) of the staff said due to the stress in the unit they were exposed to overuse of alcohol.

Theme 2A

2.2 Staffs' frustration with patients

This can be related to different aspects:

- Eating habits

Sixty percent (60%) (12/20) of staff were affected by patients' eating habits. Patients have abnormal eating rituals, cut up food into small pieces and different sections, either eat excessively, like the bulimic patient or very slowly like the anorexic patients. In addition patients complain at every meal time about the type of food and the quantity presented. Patients take a long time to complete their meals and these issues became very depressing for staff members. Forty percent (40%) (8/20) feel that patients complaints are focussed on the staff and that they cannot be effective. At meal times there is an excessive amount of condiments used. Patients become non compliant even though rules are reinforced which creates frustration and conflict between patients and between staff and patients.

New staff members feel apprehensive to serve food in case they get it wrong and are confronted by patients. Patients cheat and hide their food in clothes, in tissues or in tea cups. This causes pressure on other patients to copy them. Staff feel responsible for all the complaints made by patients even though they did not prepare or cook the food. Working with patients is time consuming or frustrating as the job is extremely competitive. Anorexic girls are usually highly intelligent and motivated. This motivation is not applicable to the hospital setting where recovery is seen as slow.

Patients often drink excessive amounts of water to help digest the food quicker, and constant monitoring is required by the staff. Staff members feel exhausted by reinforcing the rules but know that it can be a life and death issue and so must be vigilant with supervision.

Patients constantly ask for favours, staff feel sad and have to maintain the structure and boundaries set. Staff need constant education to assist with maintaining the program to and comprehend that they are not bad nurses and be encouraged to be resourceful in their work situation. Staff admire the anorexics' ability of self control but cannot understand their constant experience of being overweight. The high stress levels often precipitates resentment to patients when emotions become uncontained and consequently staff's ability to show empathy is reduced.

Staff are affected by the patients attitudes which results in a high staff relapse rate. Patients who come in at a low weight and return at an even lower weight is a cause of further frustration. Patients cause alliances with each other against the staff which causes further conflict within the team.

Eating disorder patients are always complimentary to others but extremely negative of themselves and of their own progress. Staff feel frustrated by this as they see the potential future for their patients and cannot rush the process.

Patients are highly sensitive to all comments which often causes unnecessary conflict. Patients are totally obsessed by their own development i.e. fetishes around food and eating issues. Staff often feel that their own body is being observed by the patients. This idea is expelled with further knowledge on eating disorders as patients are only relating everything to themselves.

The staff feel as if they have overeaten when they constantly supervise patients' mealtimes. In addition they have the sense of being "watchdogs" at patients' mealtimes. Patients feel highly sensitive with self esteem issues and a limited view of the real world. They have huge demands on staff to be perfect and staff become irritated when they cannot meet their expectations. Patients require 100% input from staff., this is impossible as the illness takes too long. Staff realise that recovery cannot just happen with use of medication and short term therapy, but needs prolonged, in-depth therapy for patients and in addition supportive counselling for their parents.

- Toilet habits

Patients brush their teeth regularly to escape into the bath room where they can use this time to vomit or exercise in secret.

Patients keep getting off their bed and being non compliant on the program and move around to lose weight.

Staff find laxatives, diet pills and other self medicating items in patients lockers. This leads further to staff frustration as they have to do regular clothes and locker searches. Patients lie consistently to staff i.e. stating that their property has been stolen. These are manipulative manoeuvres so that their parents will remove them from the programme. Staff feel blamed and upset that they have been accused of stealing.

- Lack of attention

Patients constantly comment that staff are not interested in them or caring sufficiently. They lie about their sleeping habits, stating they are not sleeping when they are. Patients expect staff to give 100% input and more to their caring and this is still insufficient. This causes further staff frustration.

- Therapy sessions

Patients take a long time to gain weight and their thinking is often cognitively impaired.

Patients' individual therapy starts later in the programme and when it does patients show resistance in making use of both individual and group sessions, showing no sense of enthusiasm and displaying a sense of depression and helplessness. These feelings are often then transferred to the staff member who themselves become emotionally drained.

Theme 2B

2.2 Staffs' frustration with parents

Part of the healing process for the patient is that the parents assist by being involved in the programme.

Thirty percent (30%) (6/20) of staff commented that:

Parents often find it difficult to understand the process of the illness even when offered family therapy.

Many parents are difficult to please. Many have little insight into eating disorders. Some appear to be dysfunctional and are unable to take responsibility.

Some of the parents are grateful for the programme in the unit but can't identify their part in it.

The staff members require parents to take more responsibility in helping with problems to gain more insight and knowledge.

Psycho-education on the illness to patients is given and is helpful but 30% (6/20) feel that often due to the complexity of the illness, understanding the process of the illness is still difficult for many of them to grasp. Parents are often seen as experiencing burnout due to dealing with family dynamics besides that of a family member with Anorexia Nervosa. Parents will comment that they want to help but then respond with infrequent visits. Parents are often divorced which further creates additional difficulties for the patients.

Staff appear frustrated with parents who often show insufficient effort in assisting their family member's recovery.

At times it appears that there is little appreciation given to staff and to the treatment programme offered. This is frustrating for the staff.

Family members often created more pressure for the staff by their constant phoning and demanding requests often as a result of their own anxiety. Parents will remove their child from the programme without consultation with the team members .This leads to staff frustration and demotivation.

Theme 3

2.3 Staffs' sense of helplessness

Patients admitted to the unit are usually 15% or more underweight and cognitively, their thinking is often impaired. One hundred percent (100%) (20/20) of the staff related to having a sense of helplessness and hopelessness, related to patients being severely underweight and taking at least 6 months to recover.

Staff experienced not only slow recovery but also a sense of resistance to change i.e. non-compliance and an unwillingness to engage in therapy.

Thirty percent (30%) (6/20) of the staff stated that gratification is often minimal, patients discharge themselves early but later return more underweight, staff call this process "happy returns!".

Staff felt demoralised, unappreciated and their jobs not worthwhile. They were aware that weight loss can be a life or death issue. There was a great sense of fear for all the team members who felt emotionally drained and who realised they were not omnipotent and consequently had a grave sense of hopelessness. Staff made comments such as "I can't make it right for them", "I feel very tired", "I don't have the right answers or any answers", "I feel I have to keep quiet".
Forty five percent (45%) (9/20) of the staff felt helplessness around food issues. Patients complained about the amount and type of food given to them. Staff felt angry and helpless as they are not responsible for the cooking or preparation.
They felt affronted and blamed by the patients. Forty percent (40%) (8/20) of the staff felt there was a sense that they couldn't do more, even though they wanted to, as boundaries were in place.

They experienced being at the "end of the road". Staff wondered what the future held for these patients, 30% or 6/20 of the staff would like to have continued out-patient therapy with their patients. Ten percent (10%) of the staff wanted to be seen as human and acknowledged. Patients become too independent and don't want a change. Staff felt that they wanted to give their patients " a bang on the head" as nothing they did

could create a difference, they felt that they were facing a brick wall and they couldn't win. Staff kept trying, got tired which resulted in interpersonal conflict, while patients had high expectations and staff rewards were less than in other units in the hospital. The staff's therapy seems ineffective creating a sense of burnout.

Twenty percent (20%) (4/20) of the team said they lost the passion to work in the unit, felt frustrated and unsupported and a failure in their work.

Forty five percent (45%) (9/20) commented that the unit's atmosphere was emotionally tense. Nurses had continual fears that they would serve food incorrectly and be blamed.

Staff constantly had to reinforce the rules and experience an unpleasant silence at meal times. Patients manipulated staff to provide meals which suited them. Twenty five percent (25%) (5/20) of the staff said that they had gained insight into the aetiology of the illness which had taken time and thus successful therapy was slow. Twenty percent (20%) (4/20) stated they felt inadequate arriving on the unit compared with staff who knew the unit and had more insight.

Five percent (5%) (1/20) felt a sadness related to the ghost-like empty appearance of the anorexic patients. They described them as "the nameless', who appeared to have lost all the qualities relating to the female form and had thus disregarded their sexuality.

Therapy was difficult, slow in progress, patients were often cognitively impaired and their thinking was distorted. Twenty percent (20%) (4/20) became frustrated, emotionally drained and distanced themselves from their patients and their difficulties. Twenty percent (20%) of the staff commented on the display of control and the strictness the patients showed.

Fifteen percent (15%) (3/20) of the staff felt scared and apprehensive to work with anorexic patients, as in the back of the staff members' minds, they wondered if the patients might die. As the patients lost weight, the therapists feelings of omnipotence was severely challenged as sometimes their recovery was in doubt.

Thirty five percent (35%) (7/20) felt that patients' lack of insight revealed a sense of helplessness in them and therapists felt that it would be better for them to leave and be readmitted when they would be more motivated and compliant.

Thirty percent (30%) (6/20) commented that patients' families were often too enmeshed and not supported by the programme.. This caused a ripple effect to the team adding a further sense of stress and helplessness to the staff. Patients suffering from eating disorders are often high achievers. Staff felt a sense of sadness that they may never achieve their full potential and contribute to society.

Staff get frustrated with patients lying and cheating. At meal times food is hidden in clothes or vomited into cups. This creates stress around food management and affects other patients who are trying to be compliant on the programme.

Patients who leave the programme early and underweight create the sense of helplessness in staff who feel their hard work has been wasted and probably readmission is inevitable. Staff need to be patient and empathetic but combine it with strict boundary setting.

Ninety percent (90%) (18/20) of the staff felt this could only be done if the team was supported which was not always the case. This led to a further sense of helplessness. Not all staff experienced a sense of helplessness. Twenty percent (20%) (4/20) felt that they had faith in the programme, felt positive and believed in patients' recovery.

Theme 4

2.4 Ward programme

The unit operates two programmes simultaneously i.e. the anorexic programme and the bulimic programme. One hundred percent (100%) (20/20) of the staff stated that the staff need to familiarise themselves well with each programme as there are subtle differences which could cause conflict and misunderstanding in nurse-patient relationships.

Patients experiencing these disorders eat together although their diets and eating rituals are different. Patients have different styles of eating. The anorexic patient eats very slowly while the bulimic very quickly. Due to this, careful meal supervision is required by the unit staff. Often there is a limited number of staff to supervise which can cause challenges. Forty percent (40%) (8/20) of the staff complain at the type of food served and the frequency of it. State hospital menus are very limited and do not relate to the diet that most patients eat once discharged and at home.

One hundred percent (100%) of the staff supervising meals find meal supervision long and tedious and staff not always able to be creative and prevent boredom. Weekend meal duties can be experienced as challenging as limited staff are available to rotate duties and to prevent frustration and burnout. Thirty five percent (35%) of staff commented that different patients at different times respond better to the programme. The atmosphere in the unit is constantly changing. One hundred percent (100%) (20/20) commented that a specialised unit is different from the other units in the hospital, staff have to familiarise themselves well to the programme so as to be comfortable and knowledgeable. The programme can be challenging to new comers.

Thirty percent (30%) (6/20) of the staff state that patients admitted to the programme have strong personality styles and exceptional self control. This is a challenge to the programme and the team. Some team members can adjust easily to the programme. Staff need to enjoy the type of work and understand the dynamics.

Staff are not always able to enforce boundaries and stay consistent to the programme. Splitting can occur which causes conflict and chaos between patients and staff and between staff members themselves.

Forty percent (40%) (8/20) of the staff commented that staff can become punitive to patients and staff members due to burnout from lack of implementation of appropriate boundaries. This leads to lack of energy, decreased motivation and the inability to follow through. The unit is difficult to understand. All cultural groups must be treated on the same programmes to avoid confusion and conflict. Thirty percent (30%) (6/20) of staff stated that admitting too many patients at once requires a lot of man power as extra care is required for severely underweight patients. This creates extra stress on all team members. The equilibrium of the ward is upset when new patients arrive on the programme.

Older patients are challenged by the thinness of the new arrivals. This upsets the rhythm of the ward causing staff- patient conflicts and patient conflicts.

Ten percent (10%) of staff note that the kitchen and stores departments do not always provide regular stock for the programme. Staff have to rely on other departments to ensure that the programme will be effective and sometimes this is not satisfactory.

Theme 5

2.5 Staffs' communication

Eighty percent (80%) (6/20) of the staff comment about the problems related to the communication between team members. This poor communication creates problems between the ward doctor and the team. Lack of adequate structure and boundaries often create the potential for conflict. This sometimes occurs when new staff members arrive on the unit. To understand the dynamics of a specialised unit often takes time as it is completely different from other units in the hospital. Thirty five percent (35%) (7/20) comment that staff members often appear harsh and punitive in their interaction both with staff members and with patients.

Staff are aware that the unit is stressful and transference of patients' feelings to staff members is common. There appears also confusion around the eating disorder as an illness in relationship to cultural views. Twenty five percent (25%) felt confused with African patients having an eating disorder. Five percent (5%) felt that patients don't appreciate the finance and the time which is felt wasted in caring for patients with their illness. Staff become less empathetic. Twenty percent (20%) of staff feel a lot of frustration is created by insufficient numbers. Shortage of staff creates high anxiety levels and this can spill over. This creates chaotic difficulties in containing patients and creates a less therapeutic environment. Twenty percent (20%) of staff feel that those who were enthusiastic are left to do a lot of work which created a lack of responsibility for others. This illustrated staff's negativity to each other plus an attitude of laziness. Some of the staff who had been longer in the unit portrayed an attitude of inflexibility to new members and new ideas. They become unsupported and very rigid. Conflict related to cultural beliefs and attitudes around religion and eating patterns. Thirty five percent (35%) of staff felt it is hard to gain satisfaction of their jobs as staff were defending themselves constantly from other team members. Fifteen percent (15%) of the staff commented on the complexity of the ward that learning has to be ongoing, patients conditions change slowly and there is a lot of non-compliance of patients to the program, which caused conflict between the staff members. Thirty five percent (35%) of staff confronted patients in an unethical and unprofessional way, which creates an aggressive environment. Thirty five percent

(35%) of staff felt unsupported by the rest of the team, are on the defensive and there is an interaction of attacking and defending all the time.

Twenty percent (20%) who are content said that they interacted well with other team members from other disciplines. The doctor and the nursing team and the psychologist interacted well.

Twenty percent (20%) of the team also commented that they are given positive feedback on the usefulness of their interventions and their contributing input to the programme.

Thirty six percent (36%) commented on the competitive nature between staff members all wanting to be in charge and take the credit which created an unpleasant and aggressive attitude and thus creates a snow balling effect to other team members. Staff have difficulties in enjoying their work and they feel harshly judged. Old staff members are perceived as rigid and non accommodating, taking advantage of the good nature of others i.e. taking longer lunch hours and not sharing the work load.

Not all staff members shared the same level of professionalism. A lot of issues are related to culture in terms of food and priority of respect in terms of age. African girls are not permitted to be thin. Thinness was related to diseases such as TB, HIV/ AIDS. Overweight was related to the use of contraception or being pregnant. Ten percent (10%) of the staff said the team all had an impact on each other. This effect is ongoing and would change as patients change and staff meetings are held. Confusion and misunderstanding occurs in individual therapy. Staff must be aware to look at their own behaviour and see how it affects the environment and patients that they interact with.

Interaction in the ward helps to reflect what could be happening in the patients' own home illustrating the microcosm of the macrocosm. Twenty percent (20%) of staff conflict is triggered by different levels of staff communication. New staff members have insufficient knowledge at the beginning to understand the complexity of the programs. This often creates feelings of inadequacy. Staff are often seen as splitting which causes further conflict and ineffectiveness in the ward program. The team

needs to be supportive as care of the patients is often a life/death issue. Thirty five percent (35%) of the staff comment on the team being manipulated by their patients which resulted in staff showing less real investment on their patient and work just becoming a job and portraying a lack of empathy. Staff challenges are to be empathetic but able still to maintain the structure and boundaries of the program.

Thirty five percent (35%) felt unfair off duties were implemented and lack of their appreciation of work caused further problems in communication. New staff members were afraid to express their views as they were feeling inadequate. Eighty five percent (85%) of the staff expressed a need to have better understanding of the illness so that they could be more effective with their patients. Forty percent (40%) of the staff felt the staff members were not well informed and did not want to be on the unit. Staff should be given a choice as to where they wish to work to improve staff communication. Ten percent (10%) of the staff felt that team members need to follow the lead of the patients rather than leading themselves. This would give them insight into better communication of what was being expressed. Trying to understand their viewpoint and put themselves in the patients' shoes would create a deeper awareness.

Only 10% of the staff felt that they communicated well with other team members and were acknowledged for their contributions.

Theme 6

2.6 Staffs' job satisfaction/dissatisfaction

Eighty five percent (85%) of staff have a positive experience while working in the unit.

Forty percent (40%) (8/20) expressed a sense of emotional draining leading to potential burnout and the possibility of leaving the job.

Those staff members having a positive experience expressed their job as interesting and stimulating and enjoying being involved in research.

Thirty five percent (35%) of the staff feel that working on the specialised unit with its intensity has helped them develop not only as a therapist but also with personal development i.e. self growth. They stated they have experienced ongoing learning due to the complexity of the unit and were grateful for this.

Twenty five percent (25%) (5/20) of the staff felt that being involved with research was a great benefit to patients' care and recovery.

One hundred percent (100%) of the staff commented that working in a specialised unit is stimulating despite the recovery rate being slow and rewards only seen on recovery of the programme. Thirty percent (30%) (6/20) conveyed their enjoyment in working in a psychiatric setting. Twenty five percent (25%) (5/20) stated that the eating disorders unit was their first choice. Staff enjoyed the continuous learning experience and the ongoing research being executed.
They made comments such as "they loved the job, wouldn't change it, looked forward to coming to work and would continue to put energy into the programme".

Fifteen percent (15%) (3/20) of the staff feel that their job was a calling, despite the negatives reported so far, and they themselves want to assist their patients to find meaning to life other than their eating disorder.

Staff feel their experience in the unit allows them a view inside into the challenges experienced by the patients' families. Staff can thus have an empathetic approach when giving psycho education to patients and families.

Forty percent (40%) (8/20) of the staff feel satisfied with their job but feel upset with interpersonal relationships with staff members and the staff's hierarchical structure in the ward. Twenty five percent (25%) of the staff is aware of conflict between the staff of different ranks. New staff on the unit are challenged by older staff who were less qualified but have more unit experience.

This creates issues related to the hierarchy of commands with some staff refusing to follow instructions. This interpersonal conflict in the unit created challenges to staff's job satisfaction.

Fifteen percent (15%) (3/20) of the staff members are confused about the effects of eating disorders on black teenage girls as there has been an increase in the admission rate to the unit. Staff struggled to understand culturally why different race groups are affected by the disorder. Staff commented that in the rural areas that an eating disorder is extremely rare in the African culture but becoming more prevalent in the urban areas.

Ten percent (10%) (2/20) of the staff feel that the work was not their main focus and that work combined with a healthy personal life was important.

One hundred percent (100%) (20./20) feel that patient care was extremely challenging and often resulted in the volatile and conflicted environment which could precipitate stress between staff members, patients and staff and patients.

Twenty five percent (25%) (5/20) of the staff are of a similar ages to their patients. Staff said their job was made easier to understand in terms of the age-related experiences and views. Twenty five percent (25%) (5/20) stated that the negative aspect is that staff often found difficulty in maintaining an emotional distance and professional boundaries.

Staff want to follow up patients on discharge and feel responsible. Staff found the patients are of a higher functioning level and this makes it easier to be empathetic and of value.

Fifty percent (50%) (10/20) feel that a deterioration in their job satisfaction is due to a combination of issues. This includes team members not working as a team, frustration from patients whose long recovery rate and excessive demands cause staff to be emotionally drained. This leads to burnout.

In addition, frustrated staff create more conflict between team members and amongst patients themselves. Twenty percent (20%) (2/20) feel excited and motivated when "the light bulb goes on" and the patients thinking changed becoming more positive and weight issues started to be resolved.

One hundred percent (100%) (20/20) of the staff stated that staff similarly became disappointed and demotivated when patients constantly stay the same weight or lose weight especially if seen on an ongoing basis. Staff feel they become emotionally drained, burnt out, can't function as effectively and this reflects on the unit's therapeutic environment. Thirty five percent (35%) (7/20) of those who are enthusiastic team members stated that they wanted to put more energy into the work, are willing to go the extra mile and work hard, however twenty five percent (25%) (5/20) of the team members feel at times taken advantage of by others' laziness and have to complete their jobs without any prior agreements. Staff demotivation is also created by patients' slow recovery rate, lack of rewards and a sense of being taken for granted.

Staff feel empowered when competent to manage the programme and gain in sight into the illness. They realise that conditions are not about weight but about control. A team member related it to "peeling an onion", and not understanding the illness until getting to the core of the issue.

Eighty percent (80%) (4/5) of staff who are leaving the programme, as on a rotation basis to work in other units, stated they would like to return to the unit to gain more insight into the disorders. Forty five percent (45%) (2/5) feel that the work is enjoyable despite the long hours and high stress levels. However, working in a public hospital is not financially viable and adds to the reason to leave the programme.

Ten percent (10%) (1/20) enjoy the team approach of working with the patients and being exposed to different perspectives. Staff find the patients complex with not just one aspect of illness to address, while 20% (4/20) feel working in the unit has helped them have a better body image and that being skinny is not so important.

Eighty five percent (85%) (17/20) of the staff at the beginning appear to enjoy the ward, feel eventually they were beginning to understand the illness and are able to make a difference in their work. Ten percent (10%) (2/20) have a theoretical interest in the eating disorders as a whole and are shocked and scared when seeing the patients in reality. Within one month they were able to look beyond the physical and look at the psychological view. Thirty five percent (35%) (7/20) of the younger staff members state they loved the job as they love working with young people of a similar age to themselves. Ten percent (10%) (2/20) state that they think about their patients after work and state that they would like to be more involved and look forward to coming to work. Sometimes it is difficult not to take on board clients' feelings, and at times staff members feel personally responsible for clients' progress.

Thirty five percent (35%) (7/20) say the love of the work and the people have made them create a lot of self pressure on themselves. These staff members have a lot of empathy and are able to tolerate the long process of recovery.

Twenty five percent (35%) (5/20) of the staff's attitude to the ward has changed. The reasons included new staff members arriving who are less friendly and less enthusiastic. This resulted in a feeling of lack of warmth and support for each other in the team which can lead to staff leaving to find new positions and jobs.

2 CASE STUDY INTERVIEWS OF STAFF WHO ARE NO LONGER WORKING IN THE UNIT

RESULTS OF THEMES ANALYSED

Theme 1

2.1 Staffs' awareness of food.

One hundred percent (100%) (5/5) of the staff were more aware of food and food issues. Eighty percent (80%) (4/5) felt that they ate a balanced healthy diet and that not a lot had changed in the amount and in the way that they had eaten. Sixty percent (60%) (3/5) stated that they had enjoyed the research aspect of gaining knowledge to help patients engage more effectively with the programme. Sixty percent (60%) (3/5) felt that working in the unit had highlighted their eating patterns and they had become more conscious of improved eating habits. Sixty percent (60%) (3/5) had commented upon the staff's eating on the unit and the effects it may have on the patients. They felt that it might be experienced that the staff members were binging and consequently staff would eat secretly so as not to be seen. One hundred percent (100%) (5/5) of all of the staff members were more aware of food, the amounts and the calories while working in the unit and had a heightened awareness after leaving the programme. One hundred percent (100%) (5/5) felt that they had advanced as people and were more empowered after having been on the programme.

Theme 2A

Staffs' frustration with patients

Sixty percent (60%) (3/5) felt frustrated towards patients' constant demands. Forty percent (40%) (2/5) felt that patients' parents needed to be more contained as staff experienced a constant flow of telephone calls and requests which indicated that parents needed more support and psycho-education. Sixty percent (60%) (3/5) felt that whatever they did for the patients was not good enough. They forgot that the staff were human and it was not possible to be perfect all of the time. This type of

frustration made them want to leave the unit. Eighty percent (80%) (4/5) felt that parents did not take responsibility for their contribution to patients' illness but still wanted a lot of input from nursing staff in terms of recovery. Parents made constant unrealistic requests which were experienced as emotionally draining to staff members. Frustration from patients has a ripple effect on the multidisciplinary team resulting in not only patient/staff conflict, but conflict between staff members. This was experienced by eighty percent (80%) of the staff.

Theme 2B

Staffs' frustration with parents

Eighty percent (80%) (4/5) of staff felt that parents could be more involved in the programme. They were either enmeshed or totally withdrawn. It was felt by one hundred percent (100%) (5/5) of the staff that more psycho-education should be given to the parents about the illness to assist them in being jointly involved.

Theme 3

Staffs' sense of helplessness

Eighty percent (80%) (4/5) experienced a sense of helplessness and hopelessness due to patients' slow recovery and prolonged illness. Sometimes the prognosis for recovery was poor leading to further sense of frustration and helplessness, poor gratification with very few results. Sixty percent (60%) (3/5) experience patients as highly sensitive which often created misunderstandings between staff and patients. Sixty percent (60%) (3/5) of staff experienced patients as non compliant despite the constant reinforcement by staff to assist them in compliance with the programme.

Theme 4

Ward programme

Sixty percent (60%) (3/5) of staff found the programme difficult to implement at the beginning. The understanding to learn the programme and become competent took time. There were two programmes running simultaneously and to be effective in implementing the programme, staff needed to be competent.
The unit's routine can be conflicting and monotonous and staff members need to be self motivated and creative.

Theme 5

Staffs' communication

Eighty percent (80%) (4/5) of the staff experienced conflict with other team members. Staff members were competent but conflicting with many of them wishing to be in charge. Team members find it difficult to work in such a rigid unsupportive environment. Sixty percent (60%) (3/5) of them made reference to the above. Eighty percent (80%) (4/5) felt a more relaxed atmosphere with staff members who were supportive would create a more therapeutic environment in which to work for both patients and staff.
There were cultural issues for some staff members who found it difficult to accept that Black patients suffered from an eating disorder. Sixty percent (60%) (3/5) of the staff had this experience. Eighty percent (80%) (4/5) of the staff agreed that there was a conflict due to a lack of communication. It took time for staff members to acclimatise themselves to the unit.

Theme 6

Staffs' job satisfaction/dissatisfaction

One hundred percent (100%) (5/5) of the staff had high levels of job satisfaction. However after three months, it appeared that staff started to experience frustration due to patients' demands and challenges from other team members. Eighty percent (80%) (4/5) of the staff members felt that not all instructions were carried out appropriately and staff members were selective in carrying out the instructions which led to conflict. Sixty percent (60%) (3/5) experienced emotional draining leading to job dissatisfaction. One hundred percent (100%) (5/5) felt that they had good experience and forty percent (40%) (2/5) would like to return to gain more experience, especially in the areas of research. Twenty percent (20%) (1/5) felt that this was an unusual, valuable experience which would always be of a long term benefit. Eighty percent (80%) (4/5) felt burnt out from a sense of helplessness from the prolonged caring of their patients. The constant demands, with little satisfaction increased frustration and lowered job satisfaction. Forty percent (40%) (2/5) of the staff however were those members who were not involved with the organisation of mealtimes. Consequently the level of stress experienced appeared to be less. Of the staff who have left the programme, 100% (5/5) are grateful for their experience in the unit, have enjoyed the opportunity to work in a specialised unit, 60% (3/5) and indicated that they will return to get more experience.

2. CASE STUDIES INTERVIEWS (Semi-structured interviews)

Refer to table 4.1

Case studies were carried out on 25 staff members: 20 who were working in the unit
and 5 who were working either in other units in the hospital or other hospitals.
The semi-structured interviews identified 6 major themes which reflected issues
experienced by all the staff members.
The main themes are as follows:

1a. A greater awareness with regard to food and food issues, i.e. amounts, calories

.   weight.

1b. An awareness of self growth/self development

2a. A greater sense of frustration with patients

2b. A greater sense of frustration with parents.

3.. An increase sense of helplessness.

4. The challenges of the ward programme.

5. Communication issues arising in the unit.

6. The level of job satisfaction / dissatisfaction i.e. in relation to emotional
    draining and burnout.

TABLE 4.1

The table below reflects the number of respondents who experienced the following themes while working in the unit.

Themes		No.of staff members	No. of respondents	Percentage
Theme 1	a)Greater awareness of food issues	20	18	90%
	b) Awareness of self development	20	7	35%
Theme 2	a)Frustration toward patients	20	16	80%
	b) Frustration toward parents	20	6	30%
Theme 3	Sense of helplessness while working in unit, limited rewards, patients' slow recovery rate.	20	17	85%
Theme 4	The challenges of the ward programme	20	11	55%
Theme 5	Communication issues within the team	20	17	85%
Theme 6	a) Job satisfaction.	20	17	85%
	b)Emotional draining leading to potential burnout and leaving the job	20	8	40%

The following information could be derived from table 4.1

Eighty five percent (85%) of the respondents indicated their satisfaction with their job experience. Forty percent (40%) of the respondents, despite enjoying their job, felt the effects of emotional draining leading to potential burnout with the desire to leave the unit.
Ninety percent (90%) of the respondents had a greater awareness of food and food issues, in addition, thirty five percent (35%) of the respondents had an awareness of self development and self growth.
Eighty five percent (85%) of the respondents had a sense of helplessness while working in the unit related to slow recovery of the patients and limited rewards.
Eighty five percent (85%) of the respondents experienced communication issues within the team.
Fifty five percent (55%) of the respondents experienced challenges related to the ward programme.
Eighty percent (80%) of the respondents experienced frustration toward patients.
Thirty percent (30%) of the respondents experienced frustration toward the parents.

The above Table 4.1 is graphically displayed on Bar Chart 1 on the following page.

BAR CHART 1. Refer to Table 4.1
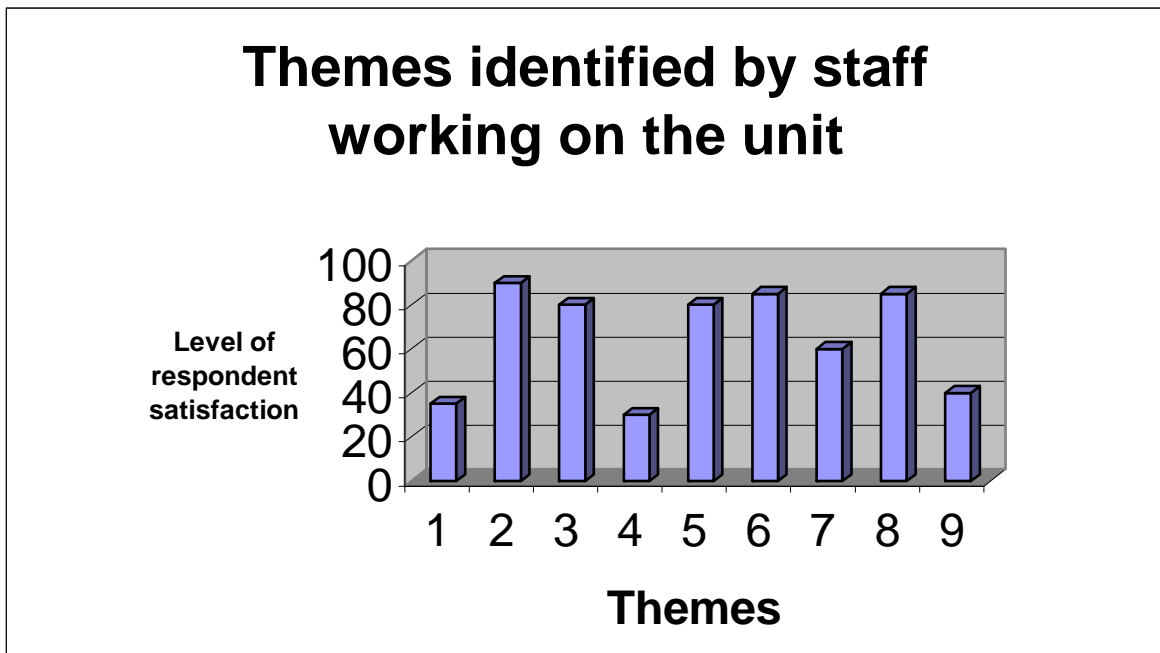
Themes identified by staff working on the unit

Key:

1-Self Awareness

2-Awareness of food issues

3-Frustration to patients

4-Frustration to parents

5-Sense of helplessness

6-Communiaction issues

7-Challenge of ward program

8-Job Satisfaction

9-Level of Emotional Draining

2.1 CASE STUDY RESULTS (Semi-structured interviews)

The results in Table 4.1 illustrated that eighty five percent (85%) of the staff were satisfied with their jobs but have challenges related to frustration, a sense of helplessness and poor communication between staff members which appear to impact on the ward programme. Fifty five percent (55%) were challenged by this. This could lead to a decline in the level of job satisfaction, forty percent 40% of the staff commented on the effects of emotional draining leading to potential burnout. Thirty five percent (35%) of the staff had an awareness of growing while on the programme, while ninety percent (90%) had a greater awareness of food issues.

TABLE 4.2

The table below reflects the number of respondents who have left the unit, but recall experiencing the following themes during their stay in the unit.

Themes		No.of staff members	No.of respondents	Percentage
Theme 1	a)Greater awareness of food issues	5	5	100%
	b) Awareness of self development	5	3	60%
Theme 2	a)Frustration toward patients	5	3	60%
	b) Frustration toward parents	5	2	40%
Theme 3	Sense of helplessness in working in unit, limited rewards. Patients' slow recovery rate.	5	4	80%
Theme 4	The challenges of the ward programme	5	3	60%
Theme 5	Communication issues within the team	5	4	80%
Theme 6	a) Job satisfaction.	5	5	100%
	b)Reduction in job satisfaction.	5	4	80%
	c)Emotional draining leading to potential burnout and leaving job.	5	3	60%

The following information could be derived from Table 4.2:

One hundred percent (100%) of respondents indicated their satisfaction with their job experience

Sixty percent (60%) of the respondents despite enjoying their job felt that the effects of emotional draining led them to potential burnout with the desire to leave the job.

Eighty percent (80%) of the respondents indicated a reduction in job satisfaction.

One hundred percent (100%) of the respondents had a greater awareness of food and food issues while 60% were aware of their own self development.

Sixty percent (60%) of the respondents felt a frustration towards patients while forty percent (40%) felt a frustration towards parents.

Eighty percent (80%) of respondents had communication problems with other staff members.

Sixty percent (60%) of respondents had challenges with the unit programme.

2.2 CASE STUDY RESULTS (Semi-structured interview)

It appears that staff working in the unit, refer to Table 4.1 and those who had left the unit, refer to Table 4.2, both identified similar themes. The response to these themes was also similar. The difference appears only in relationship to the level of job satisfaction. Those who left the unit recalled having a higher job satisfaction while on the unit than those who are working on the unit at present. This level of satisfaction was greatly reduced however, an 80% (eighty percent) reduction was quoted as one of the reasons for some members leaving the programme.

TABLE 4.3

The table reflects the number of respondents who had left the unit and who are experiencing changes in the identified themes..

Themes		No of staff members.	No of respondents	Percentage
Theme 1	a) Awareness of food issues	5	5	100%
	b) Awareness of self development.	5	4	80%
Theme 2	Reduction of frustration to patients	5	5	100%
	Reduction of frustration to parents	5	5	100%
Theme 3	Reduced sense of helplessness, increased reward rate, faster recovery rate.	5	5	100%
Theme 4	Reduction in challenges of work programme.	5	5	100%
Theme 5	Reduced communication issues between staff/ patients.	5	5	100%
Theme 6	Reduction in job dissatisfaction levels.	5	5	100%
	Reduced sense of emotional draining and burnout.	3	5	60%
	Preference for new job. appointment and job satisfaction.	3	5	60%
	Equal job satisfaction.	2	5	40%

The following information could be derived from the Table 4.3 which identified the changes perceived in the identifies themes:

Theme 1: One hundred percent (100%) of respondents had a greater awareness of food / food issues.
Eighty percent (80%) of respondents had an increase in self development due to their new job   opportunities.
Theme 2: One hundred percent (100%) of the respondents had reduced frustration from their patients and patients' parents in comparison to that of the eating disorder unit.
Theme 3: One hundred percent (100%) of respondents, although found their new job challenging did not experience the same sense of helplessness and lack of rewards.
Theme 4: Challenge of ward programme. 100% of respondents found new job programme easier.
Theme 5: One hundred percent (100%) of respondents felt in their new job a better sense of communication amongst staff members and patients.
Theme 6: Sixty percent (60%) of the respondents felt less emotionally drained. Sixty percent (60%) preferred their new job appointment. Forty percent (40%) said both job appointments gave them equal satisfaction
The above Table 4.3 is graphically shown in the Bar Chart 2 on the following page.

Bar Chart 2.   Refer to Table 4.3
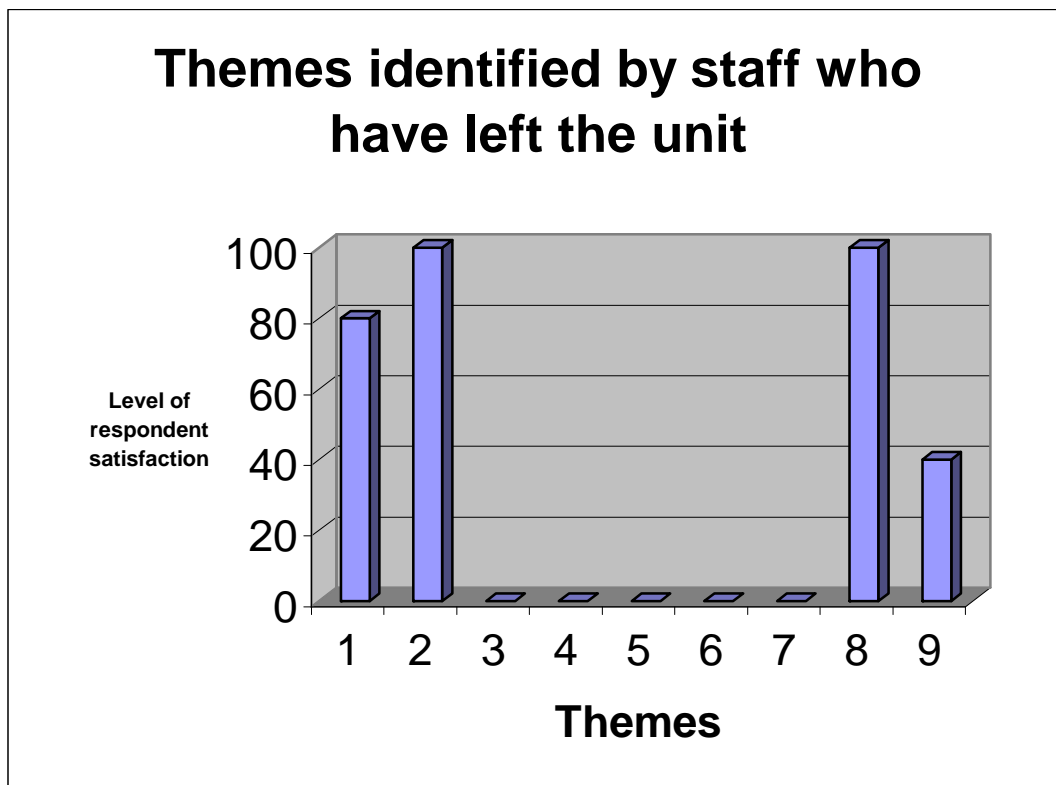
Themes identified by staff who have left the unit

Key:

1-Self Awareness

2-Awareness of food issues

3-Frustration to patients

4-Frustration to parents

5-Sense of helplessness

6-Communiaction issues

7-Challenge of ward programme

8-Job Satisfaction

9-Level of Emotional Draining

2.3 CASE STUDIES RESULTS (Semi-structured interviews)

A comparison of the results between staff members working who are currently working and those who had left the unit.

The themes that were identified in both groups, those working on the unit and those who had left were the same, and the themes were commented on with the same frequency. There was a change in the level of awareness and perceptions of all themes when the staff members left the unit, i.e. the awareness of food and food issues. This can be seen in Tables 4.1 and 4.2 and comparing them with table 4.3. Table 4.3 indicates an increase in the awareness of food. There was a reduction in the number of times that some of the themes were commented upon. i.e. frustration levels, a sense of helplessness and communication problems. It appears that negative themes relating to job dissatisfaction were reduced and that there was an increase in positive themes i.e. a heightened sense of self awareness, a positive awareness around food and food issues and an increase in job satisfaction which could be related to the increase in self awareness measuring 80%.

3. HUMAN SURVEY QUESTIONNAIRES AND RESULTS

3.1. HUMAN SERVICE SURVEY

Structured interview

A human service survey was administered to 25 staff members, 20 who were working in the unit and 5 who had left the unit. The survey consisted of 22 questions of job-related feelings. The function of the survey was to explore how helping professions view their jobs and their interaction with their patients. The questionnaire was analysed quantitatively to assess the level of job satisfaction / dissatisfaction between the members of the two groups. A 5 point Likert-type scale was used to evaluate the frequency of the responses.

This survey was used in the pilot study and proved to be satisfactory.

3.2. Results of Human Service Survey

Structured interview.

TABLE 4.4

The table below describes the level of job satisfaction / dissatisfaction of the
multidisciplinary team working in the eating disorders unit.

No of Staff in Unit	Percentages	Level of Satisfaction	Level of Dissatisfaction
6	30%	80%	0%
1	5%	70%	0%
9	45%	60%	0%
1	5%	5%	0%
3	15%	0%	10%
Total: 20	100%	85% were satisfied	15% were not satisfied

The following information could be derived from Table 4.4

Eighty five percent (85%) of the respondents showed that their jobs were satisfying.

Thirty percent (30%) of the respondents were 80% satisfied.

Five percent (5%) of the respondents were 70% satisfied.

Forty five percent (45%) of the respondents had 60% satisfaction.

Five percent (5%) of the respondents had 5% satisfaction.

Fifteen percent (15%) of the respondents had 10% dissatisfaction.

The above Table 4.4 is graphically displayed on Bar Chart 3 on the following page.

Job Satisfaction of Staff Working in Unit

Level of satisfaction

80
60
40
20
0

5   45   5   30

Percentage of Staff

Job Dissatisfaction of staff working in unit

Level of dissatisfaction

10

5

0

15

Percentage of people
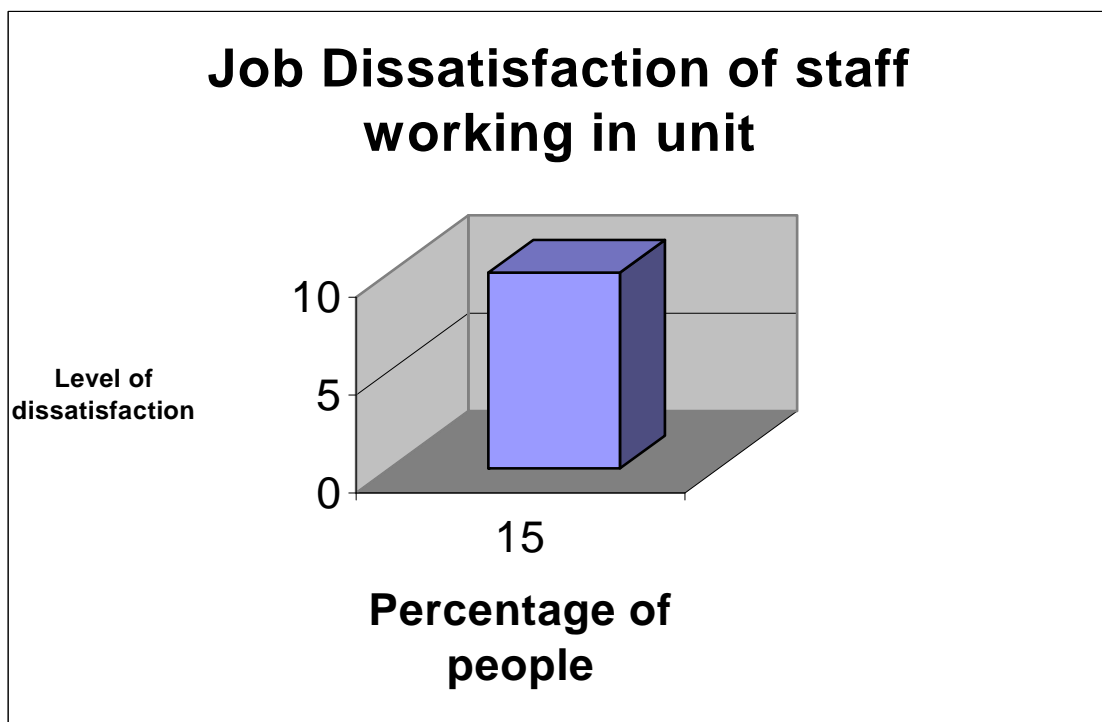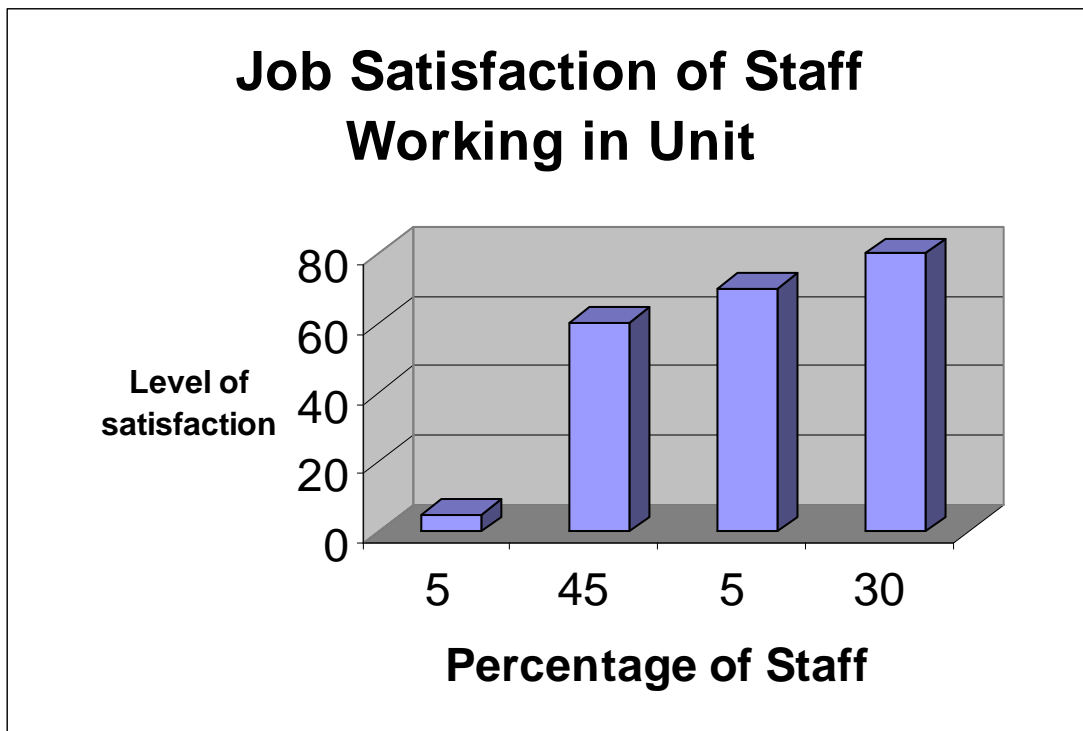
3.3. Results of Human Service survey

Structured interview.

TABLE 4.5

The table below describes the level of job satisfaction/dissatisfaction of the multidisciplinary team who had recently left the programme.

The following information could be derived from Table 4.5

No of Staff in Unit	Percentages	Level of Dissatisfaction	Level of Satisfaction
1	20%	15%	0%
1	20%	9%	0%
2	40%	7%	0%
1	20%	0%	3%
5	100%	80% were not satisfied	20% were satisfied

Eighty percent (80%) of the respondents were dissatisfied.

Twenty percent (20%) of the respondents were 15% dissatisfied.

Twenty percent (20%) of the respondents had a 9% dissatisfaction.

Forty percent (40%) of the respondents had a 7% dissatisfaction.

Twenty percent (20%) of the respondents had a 3% satisfaction.

It appears that staff members who leave the unit (Table 4.5) have had a substantial decline in the level of their job satisfaction. Initially staff members had an 85% job satisfaction but upon leaving, only 20% were satisfied.

The above Table 4.5 is graphically displayed on Bar Chart 4 on the following page.

Job Satisfaction of staff who have recently left the program

Level of Satisfaction

3
2
1
0

20

Percentage of Staff

Job Dissatisfaction of staff who have recently left the Program

Level of Dissatisfaction

15
10
5
0

20   20   40

Percentage of Staff
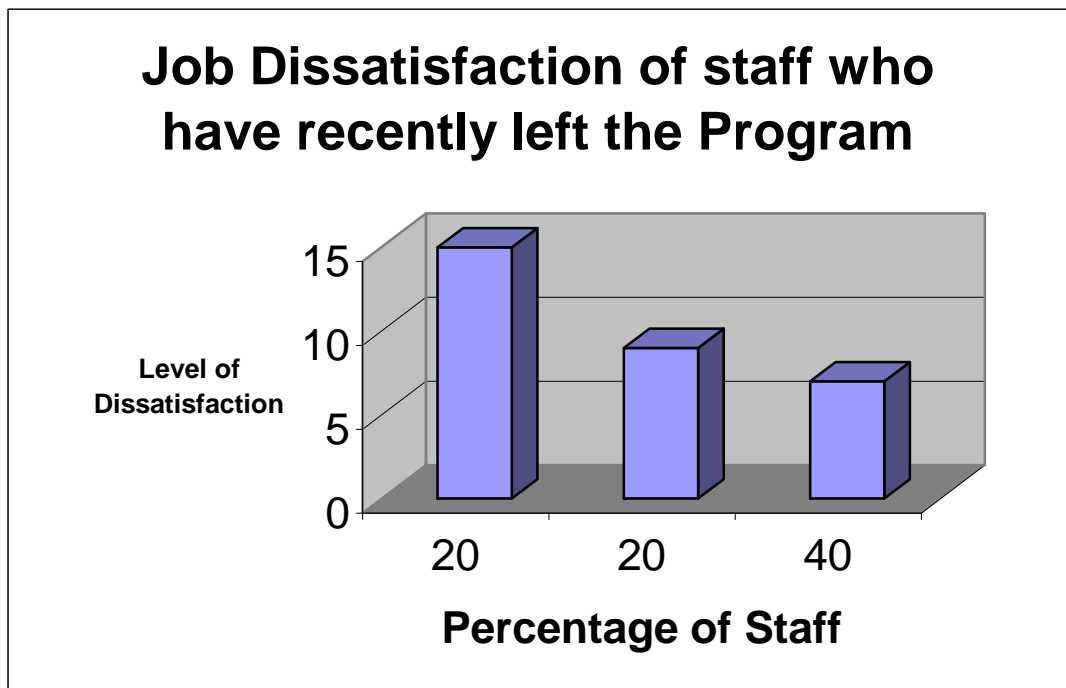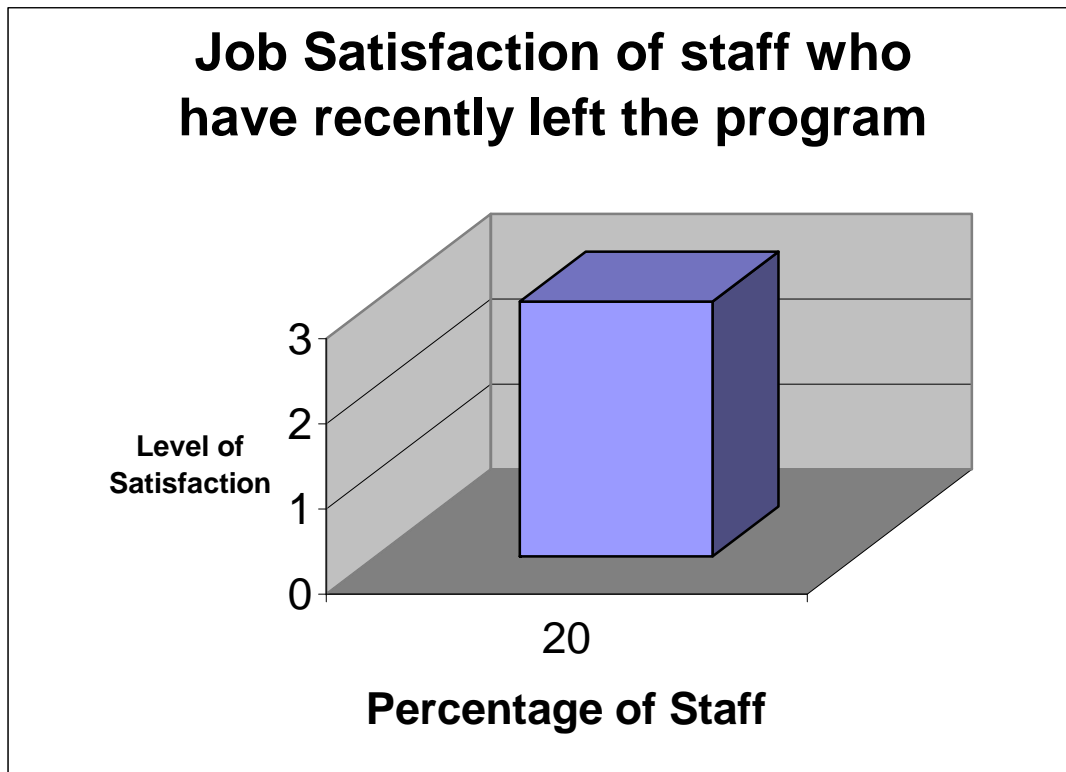
3.4. Human Service Survey

Summary of results with reference to Tables 4.4 and 4.5

Those staff members working in the unit showed varying levels of job satisfaction. Eighty five percent (85%) of the unit staff showed levels of job satisfaction while 15% reflected levels of dissatisfaction. Fifty percent (50%) of the staff had between 50% and 70% levels of satisfaction, while 35% had levels between 70 % and 90%. Refer to table 4.4

In contrast 80% of the members who had left the unit had varying levels of job dissatisfaction. Only 20% had a 3% level of job satisfaction. Refer to table 4.5.

In addition to these results, the survey reflecting job turnover in the unit indicated the number of staff members leaving the unit is between 40% to 60% annually over the last 3 years. Refer to Table 4.6. There appears to be a correlation between job turnover in the unit and the level of job dissatisfaction.

4.STAFF SURVEY AND RESULTS

Refer to Table 4.6

A survey was carried on the multidisciplinary team to assess the staff turnover over the last three years in the unit. Information was taken from the ward's off duty book which reflected the following results:

In 2005, there was a 60% turnover i.e. Out of the nine staff members, seven resigned from the hospital and two were transferred to other departments.

In 2006, there was a 40% turnover i.e. of the total of six staff members, three resigned and three were transferred to other units.

Staff turnover in 2007: There was a turnover of 60%. All these staff members resigned from the hospital.

In 2008, a 20% turnover had already resigned by the end of January.

In 2006, there was an increase in the number of patients admitted to the unit and an increase in incidents related to inadequate patient treatment. This was related to excessive demands made on the staff which related to increased staff sick leave. Hospital records indicated an increase in complaints made by psychiatric nurses about that increased workload.

TABLE 4.6

The table below describes staff turnover between 2005 and 2008 in the
eating disorders unit.

Staff turnover survey.

	No. of staff in the unit.	Occupational Therapists	Nurses	Social Workers	Doctors	Psychologists	Total staff who left the unit	Percentage of staff who left the unit
2005	15	1	5	1	1	1	9	60%
2006	15	1	4	1	0	0	6	40%
2007	15	2	4	2	0	1	9	60%
2008	15	0	2	1	0	0	3	20%

The following information could be derived from Table 4.6

In the last 3 years in the unit it appears that the turnover in staff has been between
40% and 60% per annum.   In 2005, 60% turnover.

                                 In 2006, 40% turnover.

                                 In 2007, 60% turnover

                                 In 2008, 20% turnover by end of Feb

The results of Table 4.6 could be correlated with those of Table 4.3.

Staff turnover in the unit may be linked to emotional draining and frustration
leading to burnout.

5. SUMMARY OF TOTAL RESULTS

The results illustrated in tables 4.1, 4.2, 4.3, 4.4, 4.5 and 4.6

The results of the two sets of interviews i.e. the semi-structured interviews of the case studies and the structured interviews of the Human Service survey correlated with one another. In addition there appeared to be a further correlation which could be made with the staff turnover as illustrated in the Staff Turnover survey.

The case study interviews highlighted the themes experienced by the staff members. These themes identified can affect the effective functioning of the staff in the unit i.e. frustration and helplessness, which in turn can lead to emotional draining and burnout. The structured interviews further reflected the correlation between job satisfaction and the effectiveness of staff functioning in the unit. The results illustrated that when staff members feel ineffective in the work situation and severely challenged, this feeling can lead to a decrease in job satisfaction due to emotional draining and burnout which can lead to staff turnover as reflected in the Staff Turnover survey.

6. LITERATURE STUDY IN CORRELATION WITH RESEARCH FINDINGS

The literature view correlates with the findings as illustrated by both the case studies and the semi-structured interviews. Some of the themes illustrated in the case study interviews were also illustrated in the literature study. Bernis-Vitousek (1997) mentioned that staff working with eating disordered patients commented upon their frustration with patients and often reflected the same angry feelings as their patients. They feel frustrated and unsure as to how to approach their patients and the staff are stereotyped by society and the media. Staff anguish may be a consequence of working closely with acutely disturbed patients, as eating disordered patients are often cognitively impaired. This relates to theme 2 in the study. In relationship to the challenges of the ward programme, theme 4, the literature comments that staff difficulties in maintaining control in their work found that staff struggled to gain and retain the feelings of control. There was often, for the staff, a feeling that they couldn't make a difference and that their patients would not improve. This aspect reflects theme 3.

George (1997) suggests that genuine empathy for the anorexic's experience, seeing the patient as an individual rather than a disorder, will assist with treatment programmes. Therapeutic relationships need to be characterized by empathy and a non-judgmental attitude that reflects social work values. Seeing a patient as an individual rather than as a disorder reduces difficulties in understanding the illness.

Patients, due to their long illness often receive punitive treatment from staff members because of their frustration and sense of helplessness rather than an attitude of respect, mutuality and human contact. This relates to themes 2 and 3. Staff have communication difficulties with patients .This is because patients have difficulties in speaking on their own behalf and expressing what they need or want due to their illness and the way society relates to them. This precipitates patients' feelings of loneliness.

Psychiatric patients i.e. those with eating disorders on an in-patient programme have a strong influence on the attitudes and behaviour of staff members working on the programme. Both patients and staff report that the programme is challenging. The most obvious effect is related to both burnout and stress. This relates to themes 2,3 and 4.

The conditions appear due to the prolonged treatment programme, patients' difficulties and slow recovery rates and patients' resistance to engage in the programme. Stress is further enhanced by the misinterpretation and denial of the patients' needs by the staff. Bernis-Vitousek (1997) states that the sense of lack of acknowledgement experienced to make a difference to the treatment, results in an awareness of the communication gap, staff feelings of helplessness, loss of control and antagonism towards patients relating to themes 2 and 3. Staff also experience a sense of patient / staff rejection and a high level of job dissatisfaction and burnout correlating to theme 6. Staff morale is bad for patient care. Richards, (2006) suggested strategies to improve staff morale and this includes educational interventions, psycho-social interventions and organisational interventions.

Maisel, Epston, and. Borden (2004) mention ways of increasing the therapeutic environment by creating collaborative, accountable and nurturing practices within the multidisciplinary team and to work within a system of holistic approach. Connor (2005) commented that patients are prone to sincere fabrication and report abuse and neglect by caregivers and cause splitting amongst the treatment staff. Patients view their caregivers as people trying to control rather than help them. Connor (2005) recommended that staff have additional training supervision, emotional support and availability of the multidisciplinary team.

7. FINAL SUMMARY

The eating disorders unit experienced high staff turnover and to evaluate this, staff members working on the unit and those who had left the unit were interviewed to find reasons for this. These staff members were both given a qualitative case study interview and a human service survey i.e. a structured questionnaire, which was evaluated quantitatively. The results of this indicated that there was a correlation between the two .i.e. that prolonged stay in the eating disorders unit can lead to emotional draining, potential burnout and reasons to leave. In addition a staff survey was analysed which reflected staff turnover in the unit for the last three years. There appears to be a correlation amongst the three surveys. The literature review also correlated with the findings of the three surveys.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

1. CONCLUSIONS

1.1 Objectives

The objectives of the study were to:

- To explore perceptions, experiences, needs and difficulties facing the staff in the eating disorders unit.

- To assist staff to gain insight and highlight the areas perceived to be unsatisfactory.

- To provide new guidelines to assist staff in working with patients.

The conclusions of the research will now be discussed in terms of each of the objectives as listed above.

- To explore perceptions, experiences, needs and difficulties facing the staff in the eating disorders unit.

The researcher is able to gather ample amount of information on the perceptions, experiences, needs and difficulties facing the staff in the eating disorders unit.

The researcher collated information into 6 major themes which represented the sum total of the experiences of the staff members that were interviewed. Some of the themes that were highlighted are positive and enhance job satisfaction while the majority of the themes are challenging and can, if not dealt with promptly and properly, lead to stress and eventually burnout.

The themes in relation to the issues are:

- A greater awareness with regard to food and food issues and a sense of personal development.

- A development of a sense of frustration towards patients and patients' parents.

- An increased sense of helplessness / hopelessness relating to patients' slow recovery rate and poor prognosis.

- The numerous challenges of the ward programme, communication issues arising in the unit and the development of job satisfaction / dissatisfaction in relation to job burnout.

The literature study correlates with the themes. The sense of frustration is well illustrated in the study and focuses on the annoyance and anger experienced by the staff due to patients' manipulative behaviour and their decrease in cognitive awareness. There is the sense of helplessness expressed by staff, as a result of them feeling that they unable to make a difference and that their patients will not improve. Patients are fearful and prevent staff from engaging closely with them. This prevents them from expressing the needs of their illness which in turn limits the forming of effective therapeutic relationships. There is a transference from patients which negatively influences the attitudes and behaviour of staff members working on the programme. This can contribute to staff's cumulative stress and eventually may lead to burnout. This is illustrated in both in the themes and in the literature study.

Feelings of helplessness, loss of control and antagonism towards patients is also experienced by staff who feel inadequate to meet the challenges.

The literature relates to the lying, cheating and manipulation by the patients that project further frustration and creates the feelings of hopelessness for staff which leads to emotional draining. This creates inadequate communication issues and reduced level of job satisfaction.

- To assist staff to gain insight and highlight the areas perceived to be unsatisfactory.

The second objective follows on from the first objective. Staff gain insight by participating in the interview survey. As a result of this, all staff members become more aware of the rewards and challenges of their job and due to increased awareness are now able to label them.

In the process of interviewing staff members working on and off the unit, a comparison of the negative effects on them are drawn. Staff gain greater insight into their own needs. Staff can re evaluate the effect of the themes and explore alternative ways of dealing with their patients. Staff can self reflect on their own behaviour, gain

insight and choose to behave more constructively in terms of patient care. In addition, the results of the literature study also reflected similar themes i.e. burnout, frustration, job dissatisfaction and staff's antagonism toward patients. It also reflects themes not previously highlighted i.e. loneliness experienced by patients, staff needs to reevaluate their attitudes to the treatment programme and the importance of adopting a social work perspective to patients' care. The importance of a therapeutic relationship with their patients, reflecting a non-judgemental attitude and a client-centred approach can create a shift in the clients' healing process.

- To provide new guidelines to assist staff in working with patients.

New guidelines to assist the staff can be jointly created using the above insights gained from the staff in the multidisciplinary team, from the literature study and from the researcher's own findings and these have been implemented in the recommendations.

1.2 Research questions

- Do staff members after working in the eating disorder unit for 3 months begin to experience signs of stress and burnout?
- Does the staff's relationship to food and eating patterns change as a result of working in the unit?
- Is the staff turnover due to the patients' slow recovery rate, poor prognosis, staff's reduced self worth and sense of helplessness?

The answer to the 3 research questions are all answered in the identified themes. The staff members begin to experience the potential for stress and burnout after working for 3 months in the unit as illustrated with the research indicating a forty percent (40%) awareness of this fact.

Staff's relationship to food and eating patterns mostly change to some degree after 3 months in the unit, and ninety percent (90%) of the staff commented that there was a change in their relationship to food and food issues.

Staff turnover appears to be the result of a combination of patients' slow recovery rate, poor prognosis together with staff members' feeling of a reduced sense of self worth and sense of helplessness and reflects that 85% of staff members who felt similarly.

1.3 Relevance to social work

Social work values i.e. respect, unconditional positive regard, empathy and warmth that have been highlighted in this research and that need to be implemented in an eating disorders unit. This emphasises the importance of the person-centred approach for social work education and practice.

The research has illustrated the importance of Rogers' Person-Centred approach and Systems Theory as staff and patients need to develop a therapeutic relationship implementing these values in a therapeutic environment. The implementation of this new model to staff members in the unit will create a paradigm shift in the patients' willingness to more readily engage in their own therapy.

2. RECOMMENDATIONS

Recommendations were highlighted at the end of each identified theme. As some of the themes overlap, some of the recommendations may be seen to be applicable to more than one theme.

Each identified theme has its own recommendations. Extra recommendations will be included which were obtained from the literature study.

Attention should be given to the following six themes in relationship to staff care:

Theme 1

2.1 Staff's awareness of food

Working in the unit definitely has an effect on the awareness of food. It affects individuals' self awareness and a greater awareness of food in the general public. This has allowed staff to be more aware of the effects of their previous poor eating patterns and to make conscious choices in relationship to food.

Recommendations as follows:

- Educate all new staff members on the importance of healthy eating patterns and the potential eating problems that could occur in the unit i.e. weight and diet changes.
- Encourage staff to regulate working hours and meal times to avoid over-exposure to eating issues.
- Ensure that staff members eat meals off the unit and have regular breaks.
- Rotation of staff duties, particularly at weekends when they are expected to do more meal time duties, to reduce their levels of frustration.
- To implement a ward programme which ensures that staff members share duties related to serving of meals and their supervision.
- Staff members to be aware of their own weight and diet variations and to refer to a psychologist for assistance if required.
- Psycho-education to be given to staff by the dietician and psychologist. In-service training to include education about cultural views around diets and eating disorders.
- Staff to limit the boundaries around talking about food, diet and recipes at meal times to prevent more frustration.
- A staff psychologist should be available to tackle staff food issues if they arise. Transferring staff to other units should be made available if needed.

Theme 2A

2.2 Staffs' frustration with patients

- All staff members should be consistent with implementing the programme to ensure that boundaries are set at meal times to prevent manipulation by patients and to prevent splitting between patients and staff.

- Staff must maintain strict boundaries to maintain the programme i.e. to prevent talking about food, weight or dieting at the table. Sufficient staff members should be available to assist with supervision and with serving of meals and supervision to reduce stress on a single staff member.

- Ongoing psycho-education around food issues and the aetiology of the illness is essential to ensure greater awareness of the illness for team members. To create better atmosphere at meal times in the unit, relaxing music can be made available and at supervision time, table activities can be implemented to prevent boredom.

- Staff must be made aware of the potential length of the illness and rotate work activities to ensure minimal stress. Conflict management courses can be offered for staff to deal with their own stress while on the unit. A range of books and magazines could be available on a variety of topics not just those relating to issues around dieting and modelling.

- At long weekends, staff members should rotate their work to ensure they are not involved with serving of food at every meal time.

- Staff members must monitor their own level of stress management and self care. Staff should be educated about transference from their patients and take steps to be debriefed and have their own therapy supervision. Staff must be aware that they are not omnipotent in terms of the patients' recovery and acknowledge the success rate which they have achieved. Regular monitoring of patients' possessions to ensure no extra food, diet pills or laxatives are kept secretly in their lockers. Psycho-education to parents about the illness and the potential length of stay (to parents) should be reinforced on the patients admission to ensure parents' support.

- Staff members should set regular therapy times and be consistent to demonstrate their consistency in supporting their patients.

Theme 2B

2.2 Staffs' frustration with parents

As parents appear to have insufficient knowledge about eating disorders, the following are suggested:

- When the parents arrive at the unit they should be offered psycho-education on eating disorders. Regular feedback meetings should be held for parents to give them information about their child's progress when they are away at weekends.

- Parental counselling sessions should be offered on an ongoing basis.

- Systematic training in effective parenting (S.T.E.P.) programmes and family therapy could be offered to help relieve negative family dynamics. Support from the social work department and psychologist that deal with the parents is essential, to explore home and family dynamics.

- Preparation for discharge by holding meetings for parents to resolve food issues before discharge.

- Staff should ensure that appropriate referrals for patients are made and (set) discharge dates are set.

- Staff members should assist patients to individualise from the enmeshed family dynamics which are prevalent.

- Parents are recommended to continue follow up treatment for their child as an outpatient upon discharge. .

2.3 Staffs' sense of helplessness/ hopelessness

A sense of helplessness seems to be related to several aspects of the programme which interlink together.

- Psycho-education should be given to all new staff on the aetiology of eating disorders. This will give insight into the length of illness and the potential recovery rate. This will allow staff to value their work, know that rewards take time and to acknowledge that staff members are not omnipotent in the process of the patients' recovery.
- Staff should attend their own therapy sessions to assist with self reflection and to deal with emotional challenges presented by the program.
- The work program must be rotated to suit the needs of the staff for e.g. rotation of dining room duties which, is often stressful.
- In-service training to include job motivational sessions, relaxation therapy and stress management. Brainstorming to create new ideas to deal with conflict at meal times and alleviate long silences in the dining room
- Group counselling sessions to allow staff to express their own emotions relating to patients care will be beneficial.

Theme 4

2.4. Ward programme

- Ensure all team members familiarise themselves with both the ward programmes and support new staff in an orientation programme.
- Ensure that enough staff are available to supervise at meal times.
- Ensure creative activities can be implemented after meals to prevent a sense of time wasting.
- Staff schedules should be regularly rotated to prevent burnout especially for the weekend staff.
- Staff should be aware of the atmosphere in the unit and be flexible to adapt the programme to the needs of the patients and staff.
- Staff must be consistent in carrying out the structure and boundaries of the programme to avoid manipulation by patients and splitting of the staff's alliances
- Admission criteria to the ward must be regulated to prevent over pressurising staff members and causing conflict amongst patients and staff members.
- Ordering of stock from other departments should be done well in advance to ensure adequate supplies needed for the functioning of the programme.
- The introduction of a dietician to the programme would assist patients in planning their food menu on discharge and deal with food related issues while on the programme
- Ongoing psycho education to all staff particularly to new members.
- Staff should choose to work on the unit and unsuitable team members should be transferred.
- Acknowledge the difficulty staff have to be "watch dogs" at meal times. Ensure staff's attitudes is empathetic to patients while maintaining strict boundaries.
- Continue with research in the unit to provide a new body of knowledge for more effective treatment.
- In-service training to deal with limit setting.

- To provide emotional outlets for staff i.e. trauma debriefing, individual therapy and group sessions.
- Ensure staff members work in teams to prevent burnout.
- To provide a flexible programme to adapt to the needs of both patients and staff.
- To acknowledge staffs' contributions towards programmes.

Theme 5

2.5. Staffs' communication

- It is suggested to resolve conflicts and splitting between staff members, that tighter structures and boundaries should be in place. Issues should be addressed immediately as they arise. All new staff members should be educated into the program on arrival and be given a mentor for one month. Effective orientation must be in place.
- Ongoing in service training to keep up with research and maintain effective standards.

- Inter-team group discussions will be valuable to highlight areas of interest and ensure smooth running of the programme

- Social activities with the multidisciplinary team to foster good relationships i.e. supper evenings. A weekly event in the unit to create a positive environment i.e. a ward tea.

- All staff members to have the opportunity to be in their own therapy and have access to psychologists for debriefing. Group sessions offered in the unit for team members to help reduce conflict and assist with mediating conflict-ridden events.

- Within the nursing team, ward delegation of work both in the morning and afternoon be arranged to allow for correct job time allocation and fair rotation of work.

- Follow up on off duties to ensure fair and equal work opportunities and time off.

- Ensure that the hospital human resources department is available to assist in staff request. Address cultural issues on weight eating and dieting related to effective implementation of the ward program. There needs to be an emphasis on feedback for all team members. To prevent splitting of staff, staff should ensure strict boundaries are in place and adequate feedback is given to all staff members including those on night duty.

- It should be suggested that staff who want to work in the unit are given the opportunity to apply and be suitably placed.

- Those staff who feel inappropriately placed in the unit should be able to move to other units so as to express their full potential and save them from becoming frustrated and burnt out.

- All staff members should be exposed to regular supervision and ongoing in-service programs to keep abreast of knowledge, and to remain motivated to work in the unit which would reduce competition and conflict and promote equal opportunities for development.

Theme 6

2.6.Staffs' job satisfaction/dissatisfaction

- Regular in-service training for the multi-disciplinary team to ensure a stimulating job environment where all staff can contribute.
- Rotation of job activities to ensure that team members are not working in one particular stressful area.
- Ensure clear job description in the units.
- Provide increased job opportunities for staff showing interest in working with eating disorders i.e. giving outside lectures to schools, attending appropriate seminars.
- Allow staff members to make choices for job preferences. Allocate staff to eating disorders unit who show a preference to work in this unit. This ensures the unit has a motivated staff team.
- Provide on going psycho-education to staff on better understanding of the care of eating disorders.
- Offer stress management courses to the team. Ensure all staff are aware of stress management techniques to minimise emotional draining and staff burnout.
- All staff members should attend their own therapy sessions.
- Supervision time for patients therapy must be available.
- Create motivational team work opportunities i.e. team building activities to allow staff to bond.
- Ensure debriefing facilities are available for all staff members.
- Provide incentive programmes for staff in the unit to assist their development and self growth.
- Arrange courses in conflict management to deal with staff issues.
- Acknowledge staff members for qualities shown i.e. patients' empathy congruence.
- Ensure human resources department is available to assist staff members in their personal issues.
- Ensure psycho-education can be given to both patients and parents to encourage both to have a greater knowledge base.

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APPENDICES (1-5)

APPENDIX 1

Informed consent form to be signed by the members of the multidisciplinary team.

Appendix 1

Consent Form

I hereby give consent to Marcia Kay to utilise material from my personal interviews for the purpose of research towards her master's degree in social work. I understand that all personal details and identifying information will be altered to protect my identity.

I understand that although known to the researcher, Marcia Kay, my name will not appear on any data records nor will it appear in the research paper. When the study is complete, all record sheets in the researchers possession will be shredded.

Name_____

Signed_____ Date_____

APPENDIX 2

Staff members' biographical details questionnaire.

Appendix 2

BIOGRAPHICAL DETAIL QUESTIONNAIRE

1.**Gender**_____**male**_____**female**
2.**Age**
29 Years or Younger   _____
30-49 Years   _____
50 Years or older   _____

3.Job Position
What is your primary job position?
Auxiliary Nurse _____
Enrolled Nurse   _____
Registered Nurse_____
Senior professional nurse _____
Chief Professional Nurse _____
Psychiatrist _____
Registrar _____
Occupational Therapist_____
Teacher _____
Psychologist _____
Intern Psychologist _____
Social Worker _____

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4. **Department of Service**
What is your main area of work?
Eating Disorder Unit _____
Child and family Unit _____
Adolescent Unit_____
Bio Chemical Unit_____
Psychotherapy Unit_____
Out Patient Department_____
Other (please specify) _____
5. **Working Shift**
Which shift are you currently working?
Day Shift_____
Night Shift_____
6. How long have I been on the eating disorders unit?
_____ years
7. **Home language**
Which language is your mother tongue?
English_____   Xhosa_____
Sotho_____   Zulu_____
Afrikaans_____   Venda_____
Other (please specify)

APPENDIX 3

Case study interview (Semi-structured interview schedule)

Appendix 3

Case study interview (Semi-structured interview questions)

Potential Questions for researcher to probe with interviewee:

1. Change in eating patterns/ weight/ issues relating to food.

2. Feelings related to serving of food at meal times and meal supervision

3. Potential Learning opportunities in ward programme.

4. Understanding of the illness and the needs of the staff members.

5. Enjoyment of being placed in an eating disorder unit and experiences gained.

6. Atmosphere in ward related to both patients and staff members

7. Feelings of level of competence, enjoyment and support.

APPENDIX 4

Human service survey (Structured interview schedule)

Appendix 4

HUMAN SERVICE SURVEY INTERVIEW QUESTIONNAIRE

The function of this section is to explore how helping professionals view their jobs and their interaction with their patients.
There are 22 questions of job related feelings. Please view each question and indicate if you ever feel this way about your job. If you have had this feeling, state how often you feel it by writing the number (from 1-5) that best describes how frequently you feel this way.

HOW OFTEN

> 1)Once a month or less 2) A few times a month 3) Once a week 4) A few times a week 5) Everyday

QUESTIONS
1)___I feel emotionally drained by my work
2)__ I feel used up at the end of a work day
3)__ I feel fatigued when I get up in the morning and have to face another day on the job
4)___I feel I treat some patients as if they were impersonal objects.
5)___Working with people all day is really a strain for me.
6)___I feel burnt out from my work.
7)___I become more callous toward people since I took this job.
8)___I worry that this job has hardened me emotionally.
9)___I feel frustrated by my job.
10)_ I feel I'm working too hard on my job.
11)__I don't really care what happens to some patients.
12) _Working with people directly puts too much stress on me.
13) _I feel I'm at the end of my rope.
14) _I feel patients blame me for some of their problems.

HOW OFTEN

> 1. Every Day 2. A few times a week. 3) Once a week . 4) A few times a month. 5) Once a month.

1)___I can easily understand how my patients feel about things.
2)___I deal very effectively with problems of my clients.
3)___I feel I'm positively influencing other peoples' lives through my work.
4)___I feel very energetic.
5)___I can easily create a relaxed atmosphere with my patients.
6)___I feel exhilarated after working closely with patients.
7)___I have accomplished many worthwhile things in this job.
8)___In my work I deal with emotional problems very calmly.

APPENDIX 5

Summaries of case study interviews of 25 staff members, 20 interviewed while working on the eating disorders unit and 5 interviewed on leaving the eating disorders unit in the year 2007.

Appendix 5

Summaries of case study interviews of staff who are working in the eating disorders unit (1-20):

Staff member 1

There was a change in eating patterns, the staff member was involved with lots of vomiting and binging. The member was afraid to weigh herself. There was weight fluctuation and her clothes did not fit her. She was trying to limit her food intake but still drank a lot of water, copying the eating disordered patients. Her getting fat made her feel old. The food availability made eating challenging but food intake was recently reduced. Patients frustrated her as they ate slowly and she couldn't understand their need not to eat. There was an ambivalence around eating and the sickness. The teamwork was seen as good with other disciplines in the unit but this was changeable and depended on the personalities of the team members. The member had a positive view about patients' recovery rate. Culturally she has now changed in the way she eats food, more carefully in mixing the food types, eating less and become more conscious in relationship to eating.

Staff member 2

Staff member involved with serving of food daily affected her eating habits. She took on board the patients styles of eating and their techniques of losing weight. She overused condiments to help her digestion and weighed herself more frequently. She lost weight on night duty. Her alcohol intake increased as a result of the stressful job. She found it emotionally difficult to detach from her patients, thought about them after work and related more to adolescents rather than adults. She took on their needs personally, developed a strong bond and became frustrated when there was no follow up on the patients discharge. She became enmeshed with patients as they confided in her. She said they opened up for the first time with her. She loved the patients and put a lot of pressure on herself to cope. The treatment programme was difficult. The patients repeated themselves and became monotonous. There was conflict with other staff members regarding the management of the programme related to differences in culture. At work she was overactive, snacked on biscuits and had no time for lunch breaks. She felt sorry for the patients and could tolerate the long supervision at mealtimes. She felt challenged by being a new, inexperienced member and avoided conflict. She felt the that staff were inflexible towards her. She used to enjoy coming to work, but since the staff were less friendly and lazy, she felt abused and less enthusiastic. She was now looking for a new job away from the poor environment. She concluded that there was no warmth from the nurses.

Staff member 3

Since arrival on the ward, her appetite increased, she ate three meals a day, unsure of her weight, but her clothes fitted. She had more energy than before but worried that she was gaining weight. She was frustrated with patients who manipulated her as she was new. She said it was a new type of ward, she was unsure about food servings but wanted to learn and get used to it. She stopped cooking at home. It became a problem for her to make food for her family as she felt she couldn't dish up as she was sated, so she served herself less.

Staff member 4

She loved working in Psychiatry as it was to her, the best option. It was like a dream come true. She liked working in the unit, which is what she wanted to do as long as she could remember. She became more aware of herself and her own illnesses, being prone to depression and diabetes. In the past, had always blamed her depression on the environment. Since studying she now loved her job. Her eating changed, being involved with food and she become more aware of her diabetes. Communication with staff was conflicted around the issue of working hours and there was competition over job expertise. She felt there was a need for staff to have patience over meal supervision. There was a lot of frustration between staff members and patients as patients were manipulative. She felt there was a danger of her soft nature being manipulated. She felt sorry for them but was learning to be more strict. She enjoyed the work, had no plans to leave, she was interested in research and wanted to build up a more academic background. She suggested that the internal conflict in the unit could be resolved by running group programs, which she was willing to facilitate.

She suggested that self growth could be aided by involving more staff in research and resolving conflict with patients by having more in-service staff training.

Staff member 5

Staff mentioned that the unit was different from other psychiatric units i.e. specialized. Staff felt they had to give 100% patients requests, patients expected a lot from her. She learned a lot but found it difficult to work on the programme., as patients were slow to change their eating patterns. Patients required more than you can give and staff member felt irritated by the length of time it took to be rewarded, in other units, it was quicker. Staff member spoke to patients, gave them attention and felt it made no difference. She now felt that she had no further passion and says she had no more to give, not made to do it i.e. frustrated and burnt out. However she didn't feel that she would have this experience again in her career. She found it hard to get satisfaction in the unit, especially because staff were unsupportive, as everybody wanted to be in charge. It was important to work together as it appeared difficult to enjoy one's work with personality clashes. Staff appeared to be on the attack all of the time, an attitude of rivalry. The ward was complex, staff must learn all of the time, patients improvement was slow and there were lots of patients complaints around the dishing up of food. There was been no change in the staff's eating pattern, she perceived herself as a healthy person since working in the unit, enjoyed food and would not punish herself to overeat. She suggested that staff should be continuously given education on eating disorders. She recommended staff to have their own therapy, to set time for relaxation and to be offered monthly massage treatments. Staff must take their regular lunch hour breaks. She saw staff as intelligent but lazy and unprofessional. These issues should be addressed.

Staff member 6

Staff member felt emotionally drained and burnt out. She found it difficult to watch patients struggling to eat but knew it was important for patients to gain weight which in some cases was a matter of life and death. The relapse rate was high, staff felt demoralized and named this "happy returns". She felt tired of patients cheating and lying, knew the reasons for it but found it hard to nurse and keep repeating the programme rules. She felt that her reason to leave was that she was burnt out. She felt sad for her patients and at the beginning of her working in this ward felt inexperienced as it took time to understand the illness but felt she could now manage. The nature and complexity of the illness was very volatile. It was experienced as time consuming, patients ate slowly and were emotionally exhausting however the staff member felt competent to manage and gained insight into the disorders. Staff from black cultural groups were unaccepting of black girls having eating disorders as these illnesses are generally unheard of in black cultures, particularly in rural areas.

She mentioned that she had no weight fluctuation but was aware of her students weight variation and constant weighing of themselves while on the unit. She stated that she had had good experience and had learnt a lot while working with young people.

Staff member 7

There was no change in her eating habits but was more aware now of the amount that she was eating. She did not cut out food and she ate the same as before without comfort eating. She practiced calorie counting especially around pastries and confectionary at unit round tea time. There was no change in her weight or her frequency of self weighing. She was concerned about the effects of eating in front of the patients. She felt guilty about snacking but enjoyed a good meal and she commented that her body image was fine. She couldn't understand why her patients felt fat. She commented about the conflict and squabbling between staff members about their patients care. Patients themselves created divisiveness between staff members and between themselves. There appeared to be insufficient emotional containment. Limits needed to be set in order to prevent complaints from patients. She commented that nursing inter communication was inadequate which caused pressure on the doctor as patients became manipulative. At times this staff member felt helpless as at the beginning she had insufficient knowledge about the illnesses and took time to gain insight. Patient's recovery was slow, relapses were high and in addition patient's families were seen to have little insight. She felt that she had gained a lot of experience but it had taken time.

Staff member 8

Staff member was aware of how the patients' view of themselves is distorted due to their illnesses. She herself didn't want to eat in front of her patients as she felt that they may comment that she was overeating and consequently binging. At the ward round teas, where there was a lot of food, eating was not a problem. On the ward, as a black therapist, she felt that she was chided by the black nursing staff that appeared jealous and commented on her body size. Patients preferred to engage with her as she had a slimmer figure in comparison to the other black nursing staff. There needed to be more responsibility taken on by parents who often appeared dysfunctional. More intervention for parents in the form of psycho-education must be given. In the unit there was a shortage of staff members, this created increased anxiety levels amongst staff and chaos in containing patients. Increased staff numbers created a better therapeutic environment. Staff members became emotionally overloaded with their work demands. This created high stress levels and resentment. This staff member had problems related to low pay, poor living conditions and extended work hours which affected her job satisfaction.

On a positive note she became more aware of her body, acknowledged that she had a healthy outlook on food which reinforced her self esteem. She felt better and looked younger than her colleagues. She was grateful and appreciated her own femininity. Patients could relate to her as they associated "thinness' with good health. She felt that she demonstrated to her black colleagues that being slim equates to good health. She was unlike the anorexic patients as she did not weigh herself or wear baggy clothes and was conscious of not losing weight. I.e. her clothes fitted.

Staff member 9

Staff member had own experience of an eating disorder in her own family which gave her some insight into caring for her patients. She was constantly reflecting to about her patients reality frame, also learning from textbooks and from engaging with the patients. She learnt about their tricks i.e. wearing insufficient clothes in winter. She admired their control and pondered the underlying issues that maintained this control which was related to not eating and over-exercising. Her own eating habits have not changed perhaps eating more as food is available. She does not weigh herself and gyms twice weekly. She was aware that patients are stereotyped by the team and she was skeptical about this. Patients parents appeared to have little insight and were difficult to please. Nursing staff were manipulative as there was conflict in communication. Staff were complaining, appeared to have no investment in their patients, their heart was not in it, it appeared to be just a job and a lack of empathy was evident. The staff member concluded that she enjoys her job, has learnt a lot but feels that her relationship to her patients is one of enmeshment. i.e. She has considered fostering some of her patients.

Staff member 10

Staff member had a greater awareness of food. She ate more and weighed herself more than previously. It was hard at the beginning to watch patients eating, dissecting food and wasting it by throwing it on the floor. She felt sad for patients' families who spent their money when food was wasted. She felt that supervising at mealtimes was a waste of time for herself and the patients. She felt that this time could be used more productively. In addition there were numerous complaints from the patients about the discrepancies in the amounts of food dished up by the different staff members these complaints became tiresome. She felt helpless and offended by the patients constant blaming and was manipulated into feeling guilty. Cheating and lying was frequent. Staff member suggested that rotating duties amongst the staff prevents burnout i.e. time a way from her having to serve food. She felt that patients did not appreciate the time spent on them, rewards were delayed, she felt angry inside when no appreciation was shown. i.e. No thank you's were given. Recently she weighed herself more and ate less. She felt that many patients were admitted for too short a stay which created extra pressure on the staff. Staff were leaving the ward and she queried if poor remuneration was the reason for this. She commented that she was used to the ward programme as it was demanding but she was able to be in control. Continual staff turnover resulted in her having to teach the duties continuously which caused her frustration. Patients have their favourite staff members which made the patients feel safe. Patients were not aware of being frustrating to staff. They say they have insight but this was not evident as they continued to cheat.

Staff member 11

Staff member was more conscious of eating in the ward and secretly ate his meals in his therapy room. He felt guilty about eating food in front of his patients , there was no change in his weight, diet or exercise programme. He was interested in going to the gym but wasn't aware of his food intake but now noticed that perhaps he was overweight and should contact a professional for advice. He wanted to have greater awareness of eating disorders. He was curious about anorexia and felt sad about their ghost like appearance which he referred to as "The nameless". He felt sad that they had lost their feminine form. He was interested in their selective dislike of certain foods and the reasoning behind those choices. He was also more aware of other people with food issues outside of the programme. He enjoyed working with younger people and it was not an enmeshed relationship. He did not think about his patients when leaving the unit. He commented on the punitive nature of the nursing staff towards the patients. He wondered if it was a black / white issue because the dynamic was so toxic and queried if some of the staff were adhering to their professional code in nursing the patients with the requisite respect and caring .He further questioned the appropriate placement of some of the staff members in the unit due to continual conflicted interaction between staff members and also between staff members and patients.

Staff member 12

The staff member was more aware of eating since arrival on the ward. The eating proximity to food made him more aware of food issues. He was exposed to a new environment, a lot of regulations around eating. The staff were not eating, it was seen as a taboo, not appropriate to talk about it or even be seen to eat however outside of the unit it was safe to talk about it, not such a big issue or concern. When in the unit he ate less and less frequently but snacking increased. If staff were seen as eating he wondered what was the impact on the patient and the transference effect in therapy. He wondered if this would be spoken about outside of therapy to other patients. It was evidence that there were cohesive alliances between patients in the ward as this could affect group transference especially in art therapy. Food was a symbolic issue on the ward and became an issue outside of the hospital. The ward was more about health issues rather than symbolic issues. Issues appeared to be more covert than overt. Staff members would not sit down to have lunch as this provided an unreality to the ward. On the ward the staff were aware of food, outside the ward they were aware of what they were eating. In the ward the focus was on the amount of food served and its healthiness. Outside the unit staff become more aware of thin people and wondered if there were potential eating difficulties. The therapists on the unit joked about not eating but in fact always ate a lot. They were aware that eating in the unit is perceived as negative. Staff member was interested in doing research and looked at the underlying concerns that triggered the eating disorder as each individual is unique in their presentation.

Staff member 13

Staff member enjoyed her work and looked forward to coming to the unit each day. She was the same age as the clients and said this made it easier for her to do therapy. Sometimes she felt overworked in the petty bureaucracy of the hospital but this was not related to the unit. She enjoyed her patients as they were high functioning but challenging. She related well to them being of a similar age but on the negative side at times she became emotionally involved i.e. thought about them when she went home. She respected the control of the anorexics and its discipline but felt sad around their eating disability as she herself found food so enjoyable. She also was felt upset about their constant readmissions. She felt she had grown as a person and wanted to create the opportunities for her patients to reflect on their own lives. She had a positive philosophy which she wanted to inculcate into her patients so that the focus was off food and into their potential. She became aware of her own vulnerability of self and her self growth. She commented that she felt that the unit had helped her do this. She started to understand that strict boundaries had to be in place and the team had to be consistent to prevent interpersonal conflict occurring between the patient and the therapist. She felt overworked, working in too many units but felt her opinion was accepted and appreciated. She loved her work, said she wouldn't change it and would even put more energy into it.

Staff member 14

Staff member stated that she was eating more especially when sweet things were available. More attention was given to food i.e. especially lemon creams. She ate more food in the unit as it was available. Focussing on dieting, food calories, caused her to binge more. She was frustrated with patients, their obsessive talking about food which was difficult to change. They were resistant to help and continued to lie and cheat. The staff member started to lose energy and incentive, burnout increased with the obsessive talking about food. She was irritated with their eating patterns, eating small pieces took a long time. There was poor team work amongst the staff and complaints around the working roster. Team members took advantage of each other. There was a sense of helplessness and failure as patients were difficult to treat, were unresponsive to therapy and progress was slow with poor results and exhausting for the team members. In other units treatment was stabilized quicker, progress was therefore more successful and patients and staff felt more quickly fulfilled. The staff member felt that black girls should not have eating disorders as this was unacceptable in her black culture. In addition being thin is related to HIV and Aids while being overweight related to being pregnant or using contraception.

Staff member 15

 Her eating was affected like the other staff members. She became conscious of gaining and losing weight as she did not want to look skinny in front of her patients. She ate three meals a day. Her idea was that patients modeled themselves on her example. She felt helpless at times not knowing how to help them or work with them. She stated that the patients struggled to make use of therapy so she felt that therapy was pointless which led her to feel frustrated and emotionally drained. She learned to distance herself from her patients and their difficulties. All patients appeared to have strict resistance to therapy. She felt frustrated with parents as eating disorder is a family problem. The therapist needed to work with the individual and the family. Some staff members appeared to become enmeshed with their patients, others rigid and inflexible. Staff members did not work as a team which created confusion around the programme boundaries. Alliances got created   which were similar to what happens in families. It seemed that more psycho-education needed to be given to the staff members on how eating disorders impact on the ward. The staff did have an impact on pathology just like the family does. Family members were concerned about the impact of the ward on the staff member in relationship to her weight. She herself was worried about what the patients would say. She made sure that she had three healthy meals a day to maintain her weight. Everything was about food on the unit, she felt that the unit tea times could be seen by patients as binging. She was more aware of the media, what it was saying and what the patients were trying to portray. i.e.drink this type of water and don't be underweight. Advertisments promoted the benefits of losing weight. She was aware of the fact that she was underweight and how that may be perceived by her patients and was willing to use that fact as it could enhance the therapeutic relationship with her patients. She found herself comparing her weight to that of her patients. In the beginning she was afraid to eat in front of her patients and ate secretly in the office but now it was acceptable for her as she felt it was part of being human and genuine. When the patients were eating she avoided invading their space as she felt she may have provoked anxiety as they may have felt pressurised to eat.

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She was not sure if this was her own anxiety or her patients'. She had enjoyed working in the unit, would come back as she would like to specialize in eating disorders. It has been a challenge, she has learnt a lot and could identify with the patients as she felt that she has developed as a person, she has done a lot of self reflection and has grown as a person. It had been a challenging experience, at times she had felt helpless and scared. In the back of her mind she thought that her clients could die from this condition which tested her own feelings of omnipotence i.e. that she couldn't fix everyone.

Staff member 16

This staff members eating pattern also changed. She started to eat a lot. The eating became more frequent when she started to serve food for her patients. Other staff members, at mealtimes dished up for their colleagues. This was often too much to eat but the member felt shy to refuse it in case of seeming separate from other members i.e. trying to be difficult or trying to look better than others. The staff member weighed the same but was aware that her trousers fitted too tightly. She ate three meals a day and sometimes four and this included desserts and biscuits. Her coffee intake increased but her tea intake has decreased. When she leaves the unit her diet returns to its former pattern. There has been no change in the way that she eats or in her use of condiments. When getting a taxi she told us that when she sees thin people she didn't think of HIV and Aids but related their appearance to an eating disorder. She felt bad for her patients as she enjoyed her food and was able to understand why black girls can have an eating disorder. She herself has had many personal challenges but she did not deal with them in by becoming eating-disordered. She wondered why eating has become such a big issue to her patients as it is "just' food. In her family it was common practice to mix all food types together and the diets given to the patients appeared very small to her. She felt helpless that she couldn't make it right for her patients, she wanted to improve her understanding of the illnesses. She noticed that her patients felt locked up in the unit but appeared anxious when having to go out. She got frustrated when patients ate slowly, cut food into small pieces, complained about meals being too big and looked at other patients food amounts. She was irritated by their lying, cheating, rudeness and complaining. Patients upset their parents which reflected badly on the staff which caused further inter-staff conflict. Upon her arrival to the unit she was informed by her new colleagues that this was the "racial ward". She herself had noticed many conflicts between the nurses. There was also conflict related to age as she was the new arrival, she was well qualified but young.

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This caused conflict in the work hierarchy as longer tenured staff members who were less qualified refused to take her instructions. The ward programme was confusing at the beginning but she was a quick learner. She commented that stricter and more consistent rules should be applied to the programme. At the beginning the job was satisfactory, but now she said that she felt indifferent. She was angry as she was falsely accused of stealing a patients money. The patient used this manipulative tactic to get her parents to remove her from the programme.

Staff member 17

Staff member said that she ate more because she was on day duty, the food was available and prepared. There was no change in the pattern of her eating, if she liked the food she ate more. Her weight fluctuated daily, increased on day duty and decreased on night duty. She was fine with her weight fluctuation. There was no change in her weighing pattern. She got frustrated with her patients as it was a problem to stop the over usage of condiments and she felt uneasy to confront them at mealtimes. Her having to repeat requests made her feel disrespected and unappreciated. She felt that anorexics took time to settle and this made her tired. The relapse rate was high and she felt that working at weekends was intense and boring due to ongoing supervision. Staff conflict was high due to patients cheating and lying. Outside the unit she was aware of people with potential eating disorders. In her self she became more conscious of her own eating pattern and her serving for herself was more precise. Culturally she could not understand how patients can hate eating food as most people love eating, its was fine to have some dislikes. She felt terrible for patients seeing as they had poor coping skills but at times felt emotionally drained.

Staff member 18

Staff member's eating had not changed but her thinking about eating had changed. She ate more healthily now. Exercise was done to be healthy not just to not be fat. At times she could relate to what the patients were saying about feeling fat but not to the same extent that it affected their lives. It was not great to be skinny but she had a healthier body image. She was more able to understand her friends who had features of an eating disorder. She realized how hard it was to communicate. She had a scale at home and was trying to cook more healthily. She was more focused on what is good for her and has always eaten a lot.. She got frustrated with her patients when they were not shifting, felt she can't get close to them. She realized that their thinking was distorted and this would change along with the eating. She wondered what the point was to feel so negative. She saw that all patients struggled to communicate their feelings to both staff and their parents, all of them thought that they were bad and put themselves down. They could encourage others to do well but couldn't see it in themselves. She got frustrated with their niceness shown to others. Whatever she said won't change their progress which was long and slow. At times she felt overwhelmed by running groups as patients become dependant on her. She felt like giving them a bang on the head. She felt like she was facing a brick wall. Her frustrations were taken out on her family after work and felt emotionally tired when she got home. She realized that patients have strong wills but realized that it is not just about their eating pattern but about their poor relationships, poor coping skills and poor self image. She started to understand the whole illness and saw similarities between Anorexia and Bulimia. Staff member enjoyed her work like the interpersonal interaction especially when patients started to change. She enjoyed the team approach, felt acknowledged by other staff members. She planned to leave to further her career but would like to work in the unit again as she can work in so many areas. It has helped her to have a healthier body image and to realize that it is not so great to be skinny.

Staff member 19

Staff member had no change in eating pattern but increased her snacking and her beverage intake. She had a greater awareness of food and food issues. She weighed herself daily but became more conscious of healthy eating patterns. She gained insight into her inappropriate eating rituals. She changed her perception about her body image, now preferred the slim curvy look rather than the skinny appearance of the anorexic patients. She got upset about patients eating patterns i.e. cutting up of food into small pieces, slow eating and hiding of food in their clothes. She had a sense of helplessness related to patients slow recovery and felt angry when patient returned feeling that her job was pointless and she lost enthusiasm to start the programme for the client, she was aware that perhaps her patient felt similarly. Parents were extremely demanding, wanting instant results and did not appear to have insight in their role in the illness. Even upon the patients discharge families appeared to be ill equipped to deal with the ongoing challenges. Outpatients appointment should be made before discharge for both patients and their families. The staff member was irritated by the constant need to repeat the rules and their continual lying, cheating and blaming which affected functioning of the ward programme. This in turn caused conflict between patients and between staff members leading to lack of enthusiasm of the staff in carrying out their duties. This lead to further pressure of staff members to take on extra duties from their burnt out colleagues. There was continuous conflict about the off-duty roster, daily work allocation and the taking of annual leave. Continual blaming affected staff competency and self esteem. Staff felt angry and defensive which resulted in punitive interaction with patients and colleagues. Ongoing in-service training was suggested to improve. The ward programme took time to understand and staff members took the brunt of the responsibility, worked long hours and did monotonous routine work with little immediate job satisfaction. The illness took long to understand and how to reconcile with their own feelings. Staff members felt disliked and anticipated blame, this resulted in poor job satisfaction due to an unhappy work environment.

Staff member 20

The staff member felt emotionally drained by working in the unit. There was a transference of patients' feelings of helplessness experienced by the staff member. She found it difficult to see patients having to eat so much food. She herself felt full when observing them and wished she had a better understanding of the disorder. She found it hard to work with these patients, felt irritated and manipulated and could understand how other members were burnt out.. Working in the unit can become tedious, patients were hypersensitive and small things became stressful. Patients were not interested in the outside world, they were self involved about their weight, obsessed by food and had many obsessive rituals and were too particular about their food preferences. Staff were concerned that patients were evaluating their body image but in fact they were too self involved with their weight and were constantly reading magazines about thin models and linked those images with happiness. At food serving time they projected that staff are bad and complained about the quantities and the type of food and these complaints seemed to be never ending. There was an overuse of condiments, the atmosphere in the dining room was tense. The staff member was aware of the increase in her eating patterns, weighing herself more and more conscious of her body image. The constant reinforcement of rules was difficult as patients were manipulative and were non compliant.. Patients appeared withdrawn and communication was difficult. Staff members felt that they were to blame for the pressure experienced by the patients. The ward atmosphere was intense, there was a shortage of staff and due to the cultural view of eating disorders being unacceptable to many of the black staff, this often caused an inflexible and a non empathetic approach. Staff member wondered how parents allow their children to become so thin.

Summaries of case study interviews of staff who have left the eating disorders unit (21-25):

Staff member 21

Staff member commented that her new position in a general psychiatric unit was less stressful. The work was less specialized i.e. the unit programme was less intense compared to the previous specialized unit where the work was overpowering due to it's demanding nature of dealing with anorexic and bulimic patients.. The patients illnesses were more varied and the treatment was more broad based. Her ward hours were more flexible with work on weekends. There appeared to be a quicker recovery rate for patients and the job appeared to be more rewarding and less frustrating as patients were seen less often and a more marked difference was seen in their health. There was less misunderstanding between staff members which reduced staff conflict and manipulation by patients. She commented that she loved her new job and felt that she was emotionally drained and burnt out before leaving the eating disorders unit.

Staff member 22

 Staff member commented that she was still aware of food and it's issues and aware of the amount that she ate. She had stopped counting food calories and was not conscious of others looking at what she was eating. She had no weight change however she continued to snack due to time issues on the ward. She appeared to have less conflict with nursing staff as communication was less conflicted. She was more confident in her position even though it was a specialized unit i.e. a childrens' unit. She found the illnesses easier to understand as they were well known. The family issues presented less problems as families had more insight. She was happy to leave the eating disorders unit, had learnt a lot extending her career opportunities. The work pressure in the unit had been aggressive, at present she still worked hard and had pressure but had more supportive colleagues. Her eating had not been affected as she always ate healthily. She was more aware of people with eating issues after her experience in the unit. Her new job made her feel that she was doing something worthwhile.

Staff number 23

The staff member felt that she had learnt a lot in the unit but had been burnt out, had lost her passion and was ready to leave. She no longer felt a failure, although still working in a demanding specialized unit, a general children's unit. She felt the recovery rate was quicker and thus better rewards for staff members. At present she said she gained new experiences in a new field and extended her career. She loved her new job, had less emotional stress and there was no staff manipulation. Consequently, there appearedto be a more supportive team with more work consistency. The results were not related to a psychological condition but a medical one .The work was less emotionally draining and the medication treatment worked more quickly. As a result patients and families were more appreciative of the staffs' efforts.

Staff member 24

The staff member had a greater awareness around food and food issues. Consequently it has had a lasting effect. Was aware of others in the community with potential eating problems i.e. Saw very thin girls in shopping centres and at the gymnasium. Worked in the unit stimulated the members interest in research regarding body image and abnormal behavior. Looked at all factors that precipitated the illness, not just food issues. At present he had no problems with eating and felt comfortable to eat with others when having an ample meal. In his new job there was no negativity for staff to eat in the workplace. He enjoyed his work in the unit and would be happy to return to do more research in the unit. He had no negative experiences of staff conflict or pressure of the ward programme.

Staff member 25

Staff member had more awareness of food, weight and weighing patterns. She realized how good she felt to be away from the programme and started to eat a more healthy diet. She commented that she had more energy. She was less aware of what she was eating, didn't snack as much and ate regular meals. There was no fear to eat and drink and she said that she had more energy. She forgot about eating disorders and the pressure and felt more carefree. She remembered when she saw an anorexic patient or a thin person in a magazine. However she was more aware of normal weights, observed that fewer people are really skinny in a community, most people are curvy and looked good to her. There were less rigid boundaries in her new job, other things to focus on in life other than eating disorders. She felt it is a narrow field, now that she was not there and wanted to extend herself to wider and more interesting pursuits. She was happy to be away from the staff conflict, her sense of helplessness and poor rewards she received. She felt better about herself and others. She enjoyed eating food and was not concerned about eating calories. She still remembered the attitude of parents and preferred a job where quicker rewards were forthcoming and worked in a positive environment. She felt more confident and empowered in her new position.