






Qualitative study of the impact on recovery of peer relationships between female inpatients during treatment for anorexia nervosa in the United Kingdom

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Abstract

Objective: Admissions to hospitals for people with anorexia nervosa (AN) often last over 2 months, during which significant time is often spent with other patients, but there is little qualitative research on the impact on recovery of the inter-patient relationships. Our aim was to conduct qualitative interviews with people with a history of inpatient treatment for AN, focusing on the impact of interactions and relationships between patients during hospital admission on recovery, including short-term and long-term effects.

Method: We conducted nine semi-structured, one-to-one interviews, specifically exploring the helpful and unhelpful aspects of inter-patient relationships during inpatient treatment for AN. No type of relationship was either included or excluded. Participants were recruited as volunteers in response to an online advertisement; all who met the eligibility criteria were selected. Interviews were transcribed and analyzed using thematic analysis.

Results: Thematic analysis identified five themes: (1) comparison and justification, (2) learnt unhelpful behaviors, (3) dealing with distress, (4) compassion, and (5) role-modeling. All participants expressed conflicting feelings about their relationships with other patients, but generally described developing more resilience to negative effects as they got closer to recovery. Positive effects, such as compassion, appeared to hold significance long term in participants' recovered lives.

Discussion: The detailed exploration of themes in this study provides a deeper understanding of inter-patient relationships during inpatient treatment for AN. This could aid clinical decision-making when choosing appropriate treatment settings for individual patients as well as informing clinical practice in hospital.

Lucy Biddle and Helen Bould are senior authors.

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Public Significance: This study closely examines the effect on recovery of relationships with other patients during hospital treatment for AN, a severe eating disorder. Findings might help hospital staff to understand the feelings of those they look after and develop ways to protect patients from the negative effects of peer relationships and enhance the positive ones, to support recovery in hospital.

KEYWORDS

admission, anorexia nervosa, eating disorder, hospital, inpatient, interview, peer, recovery, relationship, treatment

1 | INTRODUCTION

Anorexia nervosa (AN) is a severe eating disorder, estimated to increase the mortality rate by between five and nine times when compared with the general population (Arcelus et al., 2011; Auger et al., 2021; Iwajomo et al., 2021; van Eeden et al., 2021). Features of AN include pervasive behaviors to control weight, fear of weight gain, and psychological disturbance surrounding body image (World Health Organisation, 2023). The optimum setting for treatment of AN is debated among literature. Outpatient treatment is appropriate in the majority of cases, and there is a suggestion that inpatient treatment may risk prolonging eating disorder symptoms. A significant minority of people with AN are treated in inpatient settings (Bezance & Holliday, 2013; Smith et al., 2016). Even still, in the year 2019/2020, there were 2271 hospital admissions in the United Kingdom where AN was the primary diagnosis (NHS Digital, 2021).

The mean length of stay in hospital globally for someone with AN is 76 days, during which time patients share significant time and space with others (Kan et al., 2021). Bezance and Holliday (2013) and Rankin et al. (2023) reviewed literature which explored experiences of AN treatment using the qualitative approach. Inter-patient relationships were identified by both as key to admission experience. Literature suggests that for people with AN, these relationships have both positive and negative effects in the inpatient setting. Close association with peers can be helpful for learning coping mechanisms and reducing social isolation (Bezance & Holliday, 2013; Colton & Pistrang, 2004; Rance et al., 2017; Rankin et al., 2023; Smith et al., 2016). Thabrew et al. (2020) found that patients benefitted from strong emotional support based upon mutual understanding, which could be accessed even over short admissions. However, there may also be negative impacts: unhelpful comparison, further embedding of the “anorexic” label, and emotional distress (Smith et al., 2016). Patients fear being judged by others and idealize those with the thinnest rather than the healthiest bodies, which risks worsening AN pathology (Rance et al., 2017). Also described widely is a contagion effect, where methods to hide food and covertly exercise are noticed in others and copied (Colton & Pistrang, 2004; Rance et al., 2017; Thabrew et al., 2020).

Although identified as a major factor in recovery, no prior study has focused on inter-patient relationships exclusively

(Bezance & Holliday, 2013). Therefore, we aimed to conduct online, one-to-one interviews with people who have personal experience of inpatient treatment for AN, to explore in detail the impact of interactions with other patients during their admission on recovery, including short- and long-term effects, ultimately to further understanding of how to make inpatient treatment a more positive experience.

2 | METHODS

Ethical approval was granted by the University of Bristol Health Science Student Research Ethics Committee (reference: 10509).

2.1 | Reflexivity statement

In the interest of transparency, it is important to include reflexive practice when using the qualitative method (Finlay & Gough, 2003). EL is a medical student and RB is a foundation year one doctor and psychiatry foundation fellow. Both became interested in eating disorder research and inter-patient relationships after speaking to peers about their experiences in informal conversation. EL sought a medical school placement on an inpatient eating disorder ward to deepen understanding of the clinical setting. HB and GC are a consultant child and adolescent psychiatrists. HB's research has focused on eating disorders for more than 10 years. LB is a social scientist specializing in illness behaviors and mental health. None of the authors have firsthand experience of an eating disorder. Our experiences of AN in social and professional settings will have informed our interpretation of the data and therefore generation of themes. We took steps to log and reflect upon the likely influence of our subjectivity throughout the study. EL recorded her immediate impressions and emotional response in a reflexivity diary after each interview following examples suggested in the literature (Silverman, 2022). HB and EL held regular meetings to discuss each interview and the evolving analysis. Collaborative discussion between EL and RB took place during analysis to share and challenge interpretations and common understandings of themes.

2.2 | Participants

We recruited participants through an advertisement on the social media accounts of three University societies affiliated with Beat and Tastelife (UK charities providing ED support). Interested individuals filled out a survey to determine their eligibility for the study and we invited all those screened as eligible to take part. Participants were given detailed written information about the study at least 2 days before the interview and gave written consent. At the start of the interview, participants were invited to ask any questions and to verbally confirm their consent to participate. The information sheet given to participants is included in Data S1. We gave participants a £10 voucher to thank them for their time.

2.3 | Inclusion and exclusion criteria

Inclusion criteria required participants to have personal experience of inpatient treatment for AN, and to have been recovered from AN for a year or more. We excluded participants who had not been recovered from AN for a year or more, who had a current ED other than AN, or who were currently receiving hospital treatment for a mental or physical illness. As there is no consensus on what defines recovery from AN (Dawson et al., 2015). We defined this as not using specialist services and not having AN symptoms disturbing their daily activity. Participants self-determined fulfillment of these criteria.

2.4 | Sample size

We left the advertisement open and interviewed all eligible participants, using the concept of information power to direct decisions around sample size (Malterud et al., 2016). This meant continuing to collect data until we were satisfied that in-depth open data had been obtained in a context where probing had occurred, from a varied group of participants who offered good specificity in relation to the study aims, and until there was deemed to be consistency within the responses obtained. Pragmatic considerations, namely time allocated to the project and the nature of the participants responding to the study advertisement also impacted upon the composition and size of the sample. Recruitment ceased when we considered sufficient information power had been achieved to gain a satisfactory understanding of our topic area. Notably, several participants were able to reflect upon multiple hospital admissions thereby providing more than one episode for analysis, which enhanced information power.

2.5 | Interviews

Semi-structured interviews were used to allow participants to answer in their own terms, raising issues we may not have been able to pre-empt and encouraging participant reflection on the significance of the events they describe. We defined “peer relationship” to participants as any type

of interaction they had with people who were being treated as an inpatient for an eating disorder at the same time as them. We used a brief topic guide (see Data S2) flexibly throughout the interviews, along with open-ended questioning and probing techniques. Where new topics were raised, we also explored these with subsequent participants.

EL conducted interviews online one-to-one with each participant in a private setting and recorded them using the video conferencing software Microsoft Teams. After each interview, EL took notes about non-verbal cues and any concerns over participant distress.

2.6 | Analysis

All interview recordings were transcribed verbatim and anonymized. We sought to understand the subjective meanings attributed by our participants to their experiences of peer relationships during in-patient care and used interpretivist epistemology to direct our enquiry. Analysis proceeded based upon a reflexive thematic approach and the six steps outlined by Braun and Clarke (2006, 2019). As part of this approach, we reflected on how our researcher identities may have shaped the process of data collection and analysis. After deep familiarization with the data through reading and re-reading the transcripts, EL used an inductive, open coding approach to label segments of text within the data set according to their content and expressed meaning. Codes were then displayed and grouped into categories according to a “central organizing concept” (Braun & Clarke, 2013) to generate the main themes. To ensure a rich understanding of the data, a second researcher (RB) also independently explored the transcripts to derive themes. EL and RB then worked collaboratively to discuss possible meanings and themes, synthesizing their understandings to reach a comprehensive interpretation of the data. All authors checked the interpretation and organization of themes before finalizing. When generating the timeline in Figure 1, timestamps were marked at the appearance of each code and then organized across the data.

3 | RESULTS

3.1 | Demographic data

Twenty-eight people volunteered, and of these, nine (all female) were study-eligible and were interviewed. Interviews lasted between 31 and 61 min. Eight participants had experience of being admitted to hospital voluntarily and one had experience of detention under a section of the Mental Health Act 1983. The median age of participants at the time of study participation was 25 years (IQR 3.5) and the median age at most recent admission was 19 (IQR 5). Four participants self-identified as White, two as Black, one as Roma, one as Ashkenazi Jewish, and one as Asian British. Our participants had collectively experienced admission for treatment of AN in adolescent, adult, specialist eating disorder, general psychiatric, and medical wards. Several had experienced multiple admissions to different types of treatment environments. We did not request that participants were specific about which comments applied to each type of admission.

3.2 | Thematic analysis

We identified five key themes within the interview transcripts, outlined in Table 1.

3.3 | Comparison and justification

Immediately upon admission, participants described feeling “like a fraud” (P3). Some described this as stemming from a lack of insight into their own illness. One participant described feeling like an intruder in comparison to people whom she saw as “extremely frighteningly underweight”:

I felt like I didn't belong there. I didn't think I had an illness, and I didn't have a diagnosis, so I didn't understand why I was there.

(P5)

Another participant expressed similar feelings and suggested that body dysmorphia was a contributing factor:

I guess you're not seeing yourself as you are and you are convinced that you are double the size of everyone else in there, it kind of confirms ... what you were thinking. Oh look, see I'm not actually that ill.

(P4)

Comparison continued to be a prominent feature for those already on the unit during every admission of new patients. New admissions “sent a ripple” (P8) through the group. The thinness of new patients was the cause of reflexive “resentment” and “jealousy” (P2). However, these negative emotions were often described as passing quickly:

When someone just comes in when they're new, there's a lot of resentment towards them ... I was jealous of them having a lower weight ... but as time goes on as you get to know them, you don't just see their illness anymore. You actually start to see them as a person, and you actually care about them.

(P2)

TABLE 1 Table outlining themes and codes with definitions.

Theme	Codes	Exemplary quotes
Comparison and justification	<ul style="list-style-type: none"> • Sense of being an imposter with comparison to others based off body size and illness severity. • Feeling a need to justify admission using illness behaviors. • These feelings settling as admission progressed but reoccurring as new patients were admitted to the ward. 	<p>“I think they couldn't understand why someone like me was there... I wasn't that thin really... ‘what are you [is she] doing taking up a hospital bed?’” P3</p> <p>“There were people who would judge other people because they thought they didn't need to be there ... that's including myself to some extent.” P1</p>
Learnt unhelpful behaviors	<ul style="list-style-type: none"> • Learning new techniques to harm oneself and embedding ED pathology. • Anger is expressed at others exhibiting triggering behavior. 	<p>“It was hard not to pick up on behaviours.” P2</p> <p>“I guess it just made me a bit angry and frustrated because I felt like I was trying to not talk about that kind of stuff at all and just be encouraging and supportive, and I don't understand why other people wouldn't do the same, I suppose.” P4</p>
Distress	<ul style="list-style-type: none"> • Unpleasant emotions in response to others' distress. • Feeling guilt over distress they might have caused. • Adapting their own behavior to prevent distress in others. 	<p>“[Other's distress is] something that you are not really prepared to deal with ... it was genuinely kind of scary.” P4</p> <p>“I definitely didn't cope well at the beginning. I guess over time I learned to deal with it better.” P1</p> <p>“Where someone is in a lot of distress and you feel quite conflicted because they might tell you in confidence, but you recognise your obligation if they are at risk to tell someone.” P5</p>
Compassion	<ul style="list-style-type: none"> • Helpful relationships forming over time. • Experiencing mutual understanding and compassion. 	<p>“Friendship came later on because at that point, I didn't know who to trust and who not to trust, but I knew I needed help, and I cannot be on my own.” P6</p> <p>“I think we had those friendships because we met each other at our, literally, lowest of our lives and that's what bonded us together.” P2</p> <p>“I thought I needed people around me who would just push me towards a goal ... I didn't realise that I needed people who were empathetic and kind and selfless.” P5</p>
Role-modeling	<ul style="list-style-type: none"> • Receiving support and encouragement from those further along in recovery. • Seeing the possibility of recovery from those further along. • Letting go of unhelpful friendships and aspiring to helpful ones. • Pride at becoming the role model. 	<p>“It helped to have others cheering you on.” P2</p> <p>“The way that people were distracting themselves or getting over certain hurdles... seeing people progressing, leave and get discharged was helpful.” P9</p>

Some described that when new patients were admitted, they would “reliv[e] [their] first day” (P5), with a recurrence of thought patterns from their own admission: feeling the need to justify their place in hospital with their weight and “anorexic” behaviors. But over time, many described this fading and being replaced by genuine care for the other individuals. Friendships were described as taking time to form, perhaps in part due to new patients introducing feelings of inadequacy and jealousy to the group.

With comparison came an assumption of competitiveness from others and lack of trust within the group. One participant described a reluctance to trust others on her first day in hospital, recounting her reaction to another patient sharing practical advice to make breakfast food more tolerable:

Are they trying to be competitive, is there something loaded in this ... is this kind of sabotage?
(P5)

In this evidently heightened state of anxiety, P5 feared that the intention of her peer was to encourage her to eat breakfast in order to gain weight while the peer did not. Such an assumption of competition may act as a barrier to the formation of meaningful peer relationships.

Another participant, whose experience was on a medical ward, still felt the need to justify her place in hospital when surrounded by medical patients:

Different people came and went, and I think they all felt the same thing really. You know, “What’s she doing here? She doesn’t look ill. It’s up to her if she wants to eat or not.”
(P3)

This participant described feeling an ongoing need to justify receiving treatment throughout her admission, in contrast to patients who had experienced admissions to mental health wards, who more often described this feeling of being undeserving of treatment easing over the course of their admissions:

I felt uncomfortable because I did feel I was a fraud and that’s what people were indicating I think to me.
(P3)

3.4 | Learnt unhelpful behaviors

Participants explained that other patients would share new ways to “cheat weight,” hide food, or self-harm. It was difficult not to “pick up new behaviours” (P2) during admission, or increase the frequency of behaviors they already engaged in when observing others:

I hadn’t really done that stuff before [head-banging] ... but you do it more I think when other people are doing the same.
(P1)

One participant described how powerful the temptation was to give in to these behaviors:

Someone could come in with all the will in the world and it’s kind of like heroin in front of someone saying—oh have you tried this before, it’s delicious.
(P5)

Participants described that they “didn’t have much sympathy” (P1) for those who were causing others to stumble in their recovery, responding with “anger” (P1) and “frustration” (P4), sometimes even physical aggression. Part of the anger appeared to stem from recognizing in themselves the same traits, perhaps arising from their eating disorders, which allowed unhelpful behaviors to spread. One described seeing her ED as:

Vicious competitive nature, highly manipulative, quite selfish and difficult, temperamental and tempestuous, all of these things ... It can make you resent yourself.
(P5)

3.5 | Distress

Participants almost unanimously described an intense emotional response to seeing peers’ distress, describing these situations as “tense” (P2), “uncomfortable” (P2), “scary” (P4), and “something [she was] really not prepared to deal with” (P4).

It seemed the shock of seeing others in distress eased over time, but a feeling of responsibility for others’ distress then became a challenge. With time, participants developed an awareness of the effect of their behavior on others. They were “very careful with [their] words” (P5, P7) and constantly tried to avoid exhibiting behaviors which were “too anorexic” because of a fear of “setting someone else off” (P8):

It made me uncomfortable to be around because I could see how it [a peer group promoting exercising in rooms] was affecting other people.
(P4)

I think you felt responsible a little bit for, not other people’s recoveries, but for other people’s distress. You always felt it was you that had caused it.
(P8)

Participants described experiencing “intense guilt and shame” (P8) if they thought they had worsened someone else’s suffering. Participant 8 further expressed that this led to setbacks in her own recovery:

I think because then [if you felt you’d caused distress] the critical voices would kind of set in ... you’d restrict [food] or you’d do something, whatever was your coping mechanism.
(P8)

Views differed on the long-term effect that this awareness of others' distress had on recovery. Some felt that consciously controlling "anorexic" behaviors for the sake of others prevented their own engagement in them, which they felt may have been beneficial in the long term. Others described carrying an extra emotional burden which slowed down their own recovery. P2 described her fear that her friend might act on her thoughts of suicide:

[I] felt it was my responsibility to always look out for them because staff won't do that. So, I was always scared every day that my friend is going to die today ... that was why I so desperately wanted to get out because that was just so stressful.

(P2)

Another described feeling responsibility for others because of perceived lack of staff support:

I'd say "let the staff deal with it" but then sometimes the staff just wouldn't. I did have to intervene in something that I shouldn't have had to, but they were my friends, they might have been hurt.

(P1)

In contrast, many participants saw a benefit in looking outside "their own heads" (P8) in an illness which can leave you "caught up in yourself" (P8). For one participant, this was central to her regaining a sense of purpose:

Being able to bear someone else's pain. Being able to pray for someone else and not thinking that you're the only victim.

(P6)

This empathetic response to distress was part of enabling the compassionate acts that were considered so important to participants, as explored in the theme below.

3.6 | Compassion

Participants expressed that admission would have been "excruciating" (P2) without the "distraction" (P2) provided by the presence of other people, and they frequently used communal spaces as an escape during periods of personal distress. It was obvious however that many relationships evolved into something deeper than just helpful distraction. "Kindness, respect and compassion" (P8) built on mutual understanding and common experience was a positive influence. One participant explained:

It was nice sometimes just to be able to say to someone "I'm feeling awful" ... and not have to explain it because they understood.

(P4)

Some described experiencing compassion from other patients in hospital which sparked a lasting aspiration for future friendship:

I remember the first few days I felt like I had a family, these for me were the people offering support that I didn't usually have.

(P7)

I thought I needed people around me who would just push me towards a goal ... I didn't realise that I needed people who were empathetic and kind and selfless.

(P5)

There seemed to be agreement that these "bonds" (P2) were unique; unable to be replicated in any other circumstance. When distressed, participants could access care and support from other patients (as explored in the theme above); they gave that same care back to others. A compassionate group response is illustrated by P8:

If you had to have an NG tube put down or ... had a difficult meal or something, there'd be a lot of kindness shown, people would write really lovely notes and put it under your door and draw you pictures and give you hugs and just be really motivational and caring.

(P8)

P2 expressed feelings of pity in the face of seeing other young people being admitted:

I remember there was one patient who was only 12 years old... I just remember feeling so sad, looking at her. Like, with with her whole life ahead of her.

(P2)

Despite being a teenager herself, she did not extend the same feelings to her own situation.

3.7 | Role-modeling

Participants described their friendships evolving alongside the recovery process and that simply seeing people closer to recovery was motivating. One participant found herself supported by a couple of patients who were "driven to recover" (P4) and so were good role models. Because of hearing their aspirations for the future, she began to form her own:

Being around people who really desperately wanted their lives back and really desperately wanted to get better and would talk about things they wanted to do and things that they were looking forward to once they were healthy was something that really changed my mindset ... made me realise that I did want those things as well.

(P4)

[When I was struggling to finish a meal] instead of leaving she [in-patient peer] sat next to me and was just talking to me and encouraging me and when I finished my meal she was clapping and cheering so that was a memory, the first time I ever finished a whole meal on the ward. And she's quite a big part of that memory and was very encouraging. (P4)

There was agreement that those closer to recovery were viewed as “full of life” (P8), popular and fun to be around, and those struggling as isolated and “unpopular” (P8). For “self-preservation reasons” (P5) associating with those closer to recovery was essential, so letting go of unhelpful friendships became a part of life.

The changeable nature of friendships formed in the ward environment was accepted as a reason to hold them lightly, and participants generally expressed an ability to seek out positive relationships:

I think a lot of people are resistant to change at the beginning, you might cling on a little bit more to people who are at that point with you. Once you are ready to move on from that, they kind of get left behind because you don't really, especially in that situation where you've got no control, you don't really want to

find yourself in a case where your best friend in there, is someone who is still on one-to-one observations or one-to-one meals or being actively very distressed because it will, quite literally, hold you back. (P5)

P4 described being aware that by the end of admission, she had become a role model herself:

I used to look up to these people [being discharged] and think “I can't wait to be in that position” and then when I was there myself, I always wondered if people thought the same thing about me and some people did say things like that. When I found out I was getting discharged in a week, I had someone say to me “I find you really inspiring.” (P4)

3.8 | Timeline

During analysis, we noticed that themes followed evolutionary trends during the hospital stay. We have presented this visually in Figure 1. While not all participants experienced every theme/code, the order in

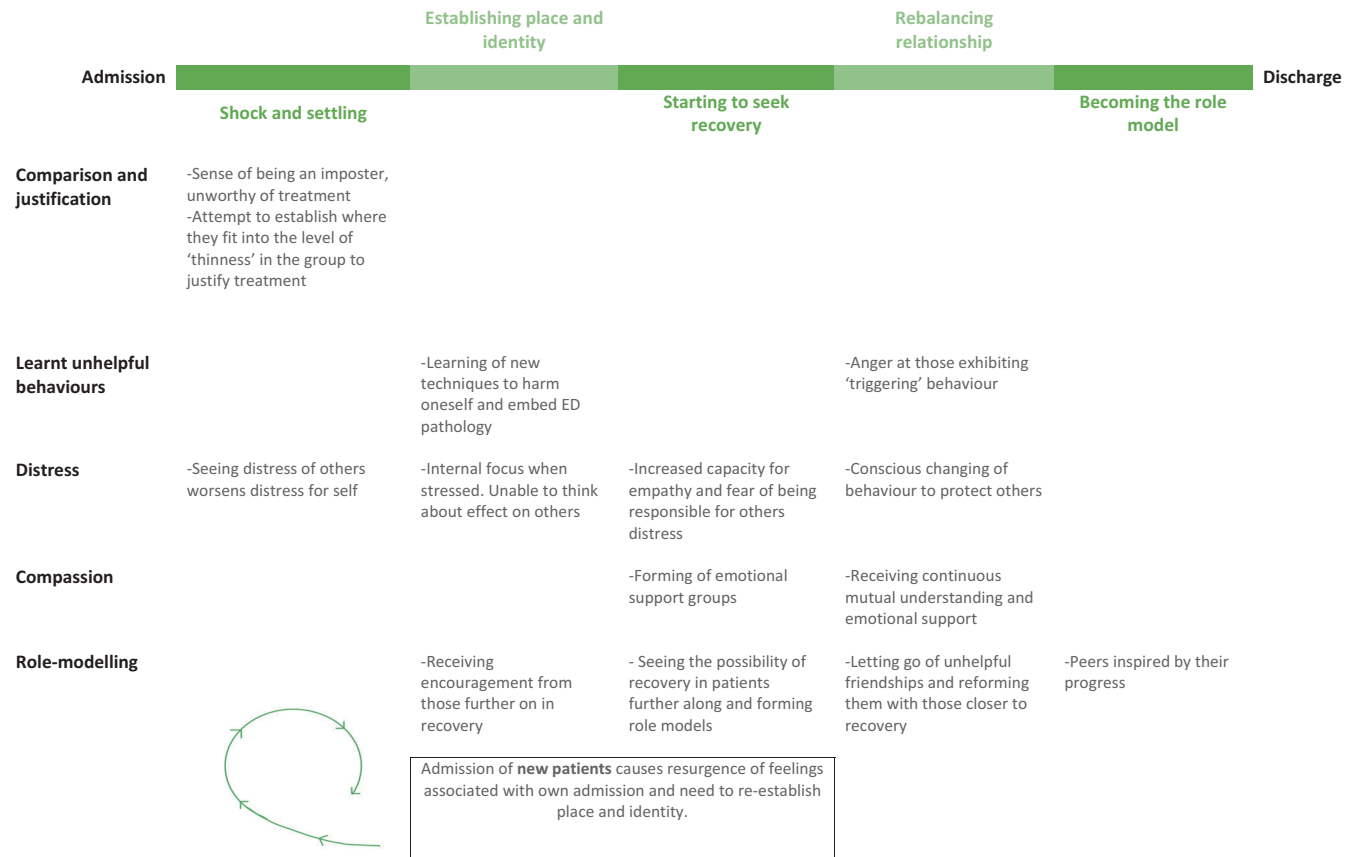


FIGURE 1 Timeline showing evolution of themes from admission to discharge.

which they appeared was consistent. Participants' attitudes toward other patients tended to change with their recovery: the ability to resist "anorexic" behaviors improved alongside the ability to resist competition/comparison, and motivation for recovery grew alongside engagement in positive relationships.

As an illustrative example, P4 described fondly a memory of "graduating" to a table where she was observed less directly by members of staff at mealtimes and where peers she had admired sat:

I remember that being quite a big goal for a lot of people [to get onto the table] because it felt a little less like you were a child, being observed.

(P4)

Also, P8 reflected on how her self-identity developed during her admission, as a response to regular encouragement from other patients during weigh-ins:

They'd help you question your eating disorder a bit ... I struggled to see myself as separate to the eating disorder, but I think from hospital I began to see how you could.

(P8)

These feelings of empowerment seem to be integral to not only the practicalities of discharge but the development of motivation and a more positive sense of self-worth. As their sense of self-worth developed, through achievements such as requiring less observation, relationships were more easily maintained and comparison to others lessened.

4 | DISCUSSION

We interviewed nine people with experience of hospital admission for treatment of AN. Thematic analysis established five themes around inter-patient relationships during inpatient treatment of AN. Participants struggled with comparing their behaviors, weight, and illness severity to other inpatients; learning new unhelpful behaviors while trying to resist engaging in them; dealing with seeing others' distress and feeling a sense of responsibility for causing it. But participants also reported compassion and understanding within the peer group, and benefits from seeing others recover. Moreover, in general, participants reported that the positive impacts of inter-patient relationships became more influential with progress toward discharge.

AN has often been considered an isolating mental illness (Rance et al., 2017; Ross & Green, 2011) and was described as such by our participants. Lee et al. (2021) suggested that loneliness itself is a risk factor for mental health problems more generally. They discuss that the relationship between loneliness and mental illness is likely bidirectional, as with isolation comes increased automatic negative beliefs around social interaction as well as a loss of firm self-identity which makes it more difficult to reinstate friendships. Datta et al. (2021) discussed barriers to friendships in people with AN and found high levels

of competition, not just in relation to food and weight but also with respect to life achievements. This competitive barrier was reported by more people with AN than controls. With these factors in mind, avoiding loneliness, gaining mutual understanding, regaining a self-identity, and supporting others could play a role in recovery from an ED (Datta et al., 2021; Lee et al., 2021; Ross & Green, 2011). Participants in this study identified all these factors as important in progress toward recovery, as well as highlighting the value of friendships with people who had a personal understanding of the complexities of their illness, and this set apart hospital-from-home friendships.

Allison et al. (2014) discussed the powerful force of "pro-ANA" groups and collective "anorexic" identity, discussing that the effect of social contagion is worsened in the inpatient treatment environment when compared with outside friendship groups. Qualitative literature exploring the inpatient experience has reported the negative impact of social contagion (Colton & Pistrang, 2004; Rance et al., 2017; Thabrew et al., 2020). Participants in our study also reported a competitive influence of "anorexic behavior" which they found distressing and disruptive: being drawn into unhelpful conversations about calorie-counting, hiding food, and methods of self-harm. Despite the negative influences, Thabrew et al. (2020) previously identified that peer support is a good source of recovery motivation. Our study identified a positive "role-modeling effect" of seeing others at a later stage in their recovery, which allowed participants to believe recovery to be a possibility, often for the first time. This has similarities to findings from the self-harm literature: Winstone et al. (2023) found that watching online positive recovery stories is helpful for lifting mood and inspiring hope for the future. Furthermore, patients closer to recovery were viewed by some as more popular, so there was a social pressure toward being able to join them, co-existing with opposing pressure to pull back into an "anorexic" identity.

4.1 | Clinical implications

Clinician awareness of commonly arising themes for people experiencing hospital admission for AN can enable ward environments to maximize the positive impacts of peer relationships and minimize the negative impacts.

4.2 | Strengths and limitations

To our knowledge, this is the first qualitative study to explore exclusively the impact of inter-patient relationships during inpatient admissions on recovery from AN and describe how such relationships evolve across a hospital stay. The nine participants had experiences with different types of admission, and several were able to draw on experiences from multiple admission events adding additional "cases" for analysis. We were able to include participants from a range of ethnic backgrounds.

However, all participants identified as women and, within the time constraints of the study, we were unable to recruit any male participants. Furthermore, due to ethical concerns, participants were all

reflecting on their experiences at a point when they had been out of treatment for at least a year and considered themselves to be recovered. Therefore, results cannot be extrapolated men or to those who have not recovered. Also, we did not explore the effect of ages of our participants. It would be useful for further research to explore how peer relationships differ by age of admission. Our research is strengthened by collaborative coding, but member checking was not possible within the scope of the project. A larger sample size would have enhanced findings.

The content of the topic guide and the words we used to describe relationships between patients likely informed the content of the interview. We used the words “peer” and “inter-patient” alongside “relationship” and “interaction” interchangeably during discussions about the study and during the interviews. Participants' interpretations of these words will affect the content of discussion. All participants spoke about friendships and simple interactions, and none described any romantic relationships. We also made it clear that our aim of the study was to explore both positive and negative impacts of these relationships, implying that both were present. Every participant explored both positive and negative impacts to varying degrees when prompted. Without such prompts, participants may have tended to focus on either negative or positive impacts depending on which were most important to them.

During the interview, two participants wished to keep their cameras off, which is generally considered appropriate in this participant group. However, it stimulated discussion around a limitation of qualitative method: we cannot confirm the identity and experiences of individuals. There is growing evidence of dishonest participation in qualitative studies, especially when using online recruitment and non-synchronous methods of data collection (Hewitt et al., 2022; Jones et al., 2021; Roehl & Harland, 2022). Safeguarding against this is challenging while maintaining participant privacy; a level of trust must be granted to participants without threatening methodological rigor.

4.3 | Conclusions

Our study of inter-patient relationships in the inpatient setting found that participants described those inter-patient relationships having both positive and negative effects on their progress toward recovery. Over the course of hospitalization, the impact of inter-patient relationships evolved from generally negative impacts to more positive ones, with some positive experiences having lasting impacts on participants' recovered lives. It seems that these changes evolved alongside changing attitudes to their illness during the recovery process. Our work has implications for ensuring thoughtful support from clinicians in inpatient settings as they aim to maximize the beneficial aspects of inter-patient relationships while attempting to protect patients from negative ones. It would be useful to extend the work to include experiences of different ages, genders and of those who have yet to recover, and to explore the experiences of ward staff. Further longitudinal research investigating how relationships may change during admission would be valuable.

AUTHOR CONTRIBUTIONS

Elizabeth Lotery: Conceptualization; data curation; formal analysis; funding acquisition; investigation; methodology; project administration; writing – original draft; writing – review and editing. **Rebecca Bell:** Formal analysis; writing – review and editing. **Gillian Combe:** Writing – review and editing. **Lucy Biddle:** Data curation; methodology; supervision; writing – review and editing. **Helen Bould:** Conceptualization; data curation; funding acquisition; investigation; methodology; project administration; supervision; writing – review and editing.

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CONFLICT OF INTEREST STATEMENT

We have no conflicts of interest to disclose.

DATA AVAILABILITY STATEMENT

Not open access data. Due to the sensitivity of the data involved, these data are published as a restricted data set at the University of Bristol Research Data Repository data.bris, at <https://doi.org/10.5523/bris.s86ib5oksflj25kebp3vxjvl5>. The metadata record published openly by the repository at this location clearly states how data can be accessed by bona fide researchers. Requests for access will be considered by the University of Bristol Research Data Service, who will assess the motives of potential data re-users before deciding to grant access to the data. No authentic request for access will be refused and re-users will not be charged for any part of the this process.

ETHICS STATEMENT

Ethical approval was granted by the University of Bristol Health Science Student Research Ethics Committee (reference: 10509).

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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