

BMJ Open Perspectives of general psychiatric inpatient care for persons with anorexia nervosa: an integrative literature review

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ABSTRACT

Objectives Persons diagnosed with anorexia nervosa (AN) may receive care in general psychiatric inpatient care (GPIC) for several reasons including severity of their condition, comorbidities and lack of access to specialised inpatient care. However, scant research has explored how this specific setting may impact persons with AN, either positively or negatively. Additionally, there is limited evidence regarding the most effective form of care for AN within GPIC. This integrative literature review provides a comprehensive overview of research focusing on care for AN in GPIC settings, shedding light on person-centred care and power within this specific context.

Design The review was conducted according to the methods of Whittemore and Knafelz. We searched the academic databases PubMed, CINAHL and PsycInfo, with the latest search conducted in March 2025, in accordance with a specific search strategy and analysed the data using a constant comparison method. The review is reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses checklist for systematic reviews.

Results The synthesis revealed three perspectives of care for persons with AN in the context of GPIC: *management of the symptoms, treatment of the patient and support for the person*. Overall, the findings suggest that GPIC can aid in weight gain, but the impact on recovery is unclear.

Conclusion Research indicates that GPIC possesses the biomedical knowledge necessary to save lives, but there is a lack of research focusing on the perspectives of persons with AN. This gap in understanding may affect treatment outcomes, the possibility of recovery and the personal experience of care for those with AN in this context.

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INTRODUCTION

Psychiatric inpatient care can be perceived as a closed system that holds specific expectations and assumptions for both the staff and the patients.¹ A person who has a psychiatric condition that severely challenges everyday life may be offered or compelled to psychiatric inpatient treatment at a hospital.² The challenges faced by such persons might include self-harm or harm to others, the need for assessment and medical treatment or the management of comorbidities.³ Psychiatric inpatient care involves multiple professions with diverse ideologies, making

STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ A person with lived experience of anorexia nervosa in general psychiatric inpatient care was invited as a co-researcher and contributed expert knowledge and experience, participated in the process of selecting articles and read and commented on the manuscript.
- ⇒ The review was conducted in accordance with a previously published protocol.
- ⇒ An integrative literature review includes studies with different methods and, therefore, enables a broader understanding of the phenomena studied.
- ⇒ The generalisability of the included studies is limited due to variations in study populations, healthcare settings and methodological approaches, which may affect the applicability of results across contexts.

it difficult to define a universally accepted purpose.³ Furthermore, care in this context is characterised by strict regulations, locked doors and limited autonomy.⁴ This situation can be stressful for patients, but at the same time, being in a hospital environment can create a sense of safety.²

Psychiatric inpatient care varies globally in content and approach. Some psychiatric inpatient wards specialise in the treatment of specific diagnoses such as eating disorders, while others are general and treat various mental health diagnoses.⁵ Hence, in general psychiatric inpatient care (GPIC), persons with diverse diagnoses are typically accommodated in the same facility. Consequently, there is a mixture of persons with varying needs⁴ and a mixture of professions with varying expertise.³ Since most research on anorexia nervosa (AN) has been conducted in specialised eating disorder wards, this study aimed to explore the content and significance of care for AN in GPIC settings.

BACKGROUND

AN is a global issue affecting persons of various genders and ages. Research has consistently



shown that AN is more commonly diagnosed in women.⁶ Furthermore, there has been an increase in the incidence of AN among younger individuals (aged <15) in recent decades, but the exact cause of this trend remains unclear, and further research is needed.⁷ Persons with AN often experience a significantly diminished quality of life, and severe long-term cases of AN carry a heightened risk of premature death due to physical strain or suicide.⁸ The illness is often associated with societal ideals of femininity, where thinness, self-discipline and bodily control are seen as desirable traits. However, this perspective risks reinforcing traditional gender norms by focusing on weight restoration rather than addressing the underlying psychological factors that contribute to AN.⁹ The psychological underpinnings of AN encompass feelings of self-criticism, low self-esteem, isolation, being trapped by the illness and a sense of hopelessness regarding the prospects of a fulfilling life.¹⁰ On one hand, AN is a psychiatric diagnosis that profoundly impacts social abilities,^{5 11} but on the other hand, it can hold psychological significance.^{12–14} For instance, strict regulations regarding diet and physical activity can provide structure and predictability in daily life. Moreover, AN can serve as a coping mechanism to evade distressing emotions and contribute to feelings of control and inner strength.^{15 16}

Treatments for AN are provided in various settings and use different approaches to address the needs of each person. These treatment settings are organised into several levels of care, ranging from least to most intensive: outpatient treatment, intensive outpatient treatment, day treatment, residential treatment, inpatient treatment and medical inpatient treatment.^{17 18} Psychiatric inpatient treatment includes GPIC and specialised eating disorder inpatient care; however, these inpatient settings are rarely separated in research.¹⁹ Common reasons for inpatient treatment are medical instability, risk for self-harm and suicide and severe malnutrition.^{17 20}

According to the guidelines provided by the National Institute for Health and Care Excellence (NICE)²¹ and the American Psychiatric Association,²² the treatment approach for AN should encompass psychoeducation, close monitoring of weight and the evaluation of mental and physical health as well as risk factors. It is essential for care to be multidisciplinary and involve the participation of family members. These recommendations emphasise the importance of helping persons with AN achieve a healthy body weight, as weight restoration is crucial in facilitating other necessary psychological, physical and quality of life changes that contribute to improvement or recovery.

To allow the patient to embark on a path towards recovery, care must prioritise both their physical and their psychological well-being.²³ Research focusing on patients' experiences in GPIC highlights a desire for less emphasis on food and weight and more on the psychological aspects of AN.²⁴ Persons with AN desire care tailored to their individual needs and greater control over their treatment.²⁴ Research highlights how the concept of recovery

may hold different meanings for staff and persons with AN.²⁵ From a biomedical perspective, recovery might be equated with the absence of symptoms, whereas for persons with AN, it can be described as a personal and individualised journey.^{25 26} Personal recovery from AN is characterised by being seen and understood as a person, by receiving support in finding meaning in life despite illness, by feeling hope for recovery and by regaining control and assuming responsibility over life.²⁷ Furthermore, staff working in GPIC often express challenges in transitioning between the different needs of patients²⁸ and voice a desire for strategies and resources to provide meaningful care.²⁹ In person-centred care, this could be enhanced through empowering the patient to actively engage in their own treatment, enabling good relationships and perceiving the individual beyond their illness.³⁰ The present review therefore placed a special focus on identifying person-centred aspects of care.

Despite the existence of clear treatment guidelines, there is a substantial gap in our understanding of how persons with AN experience care within GPIC and how these settings address their unique needs. Existing research has overlooked the distinct challenges of care in GPIC, where patients with diverse diagnoses are housed together and staff with differing knowledge and expertise work simultaneously, creating a complex care environment.³ In order to improve treatment outcomes, it is essential to understand the dynamics within GPIC, address the dissatisfaction of persons with AN and identify ways to support healthcare staff. This study seeks to bridge these knowledge gaps, offering insights that could lead to better care for persons with AN in GPIC settings.

Aim

The aim of this study was to synthesise existing knowledge on GPIC for persons with AN.

The research questions were:

- ▶ How is the content of care described?
- ▶ What outcomes are described?
- ▶ How are persons experiencing AN described?
- ▶ How is AN described?
- ▶ Which factors influence care for persons with AN?
- ▶ Are gender or power perspectives included in the studies?
- ▶ How is person-centred care described?

METHODS AND ANALYSIS

In preparation for the integrative literature review, a comprehensive review protocol was developed.³¹ A small number of changes from the protocol have been made. First, the title was changed to better represent the content. Second, two of the original research questions (*What is the focus of these descriptions? Opportunities/limitations?*) were merged with the first question (*How is the content of care described?*) as the latter inherently addresses these aspects. Finally, we chose not to focus specifically on gender but rather on power, as the gender perspective in this context can primarily be explained in terms of power.

Study design

This integrative literature review was conducted according to the method of Whitemore and Knaf. ³² The reason for choosing this method was to allow us to cover a large number of studies and to avoid excluding any research on the basis of method.

Patient and public involvement statement

Patients have a right to have an input in research, as this can reduce power imbalances, bring a lived-experience perspective and increase relevance and transparency in research. ³³ To broaden the creation of knowledge and to create space for the patient perspective, a person with lived experience of GPIC for AN (HL) was involved as a co-researcher in the research process. The collaboration was initiated following the publication of the study protocol. The forms of involvement were agreed on through joint discussions. The role of the co-researcher was deemed appropriate based on HL's professional experience and her availability, which allowed her to take a part-time position as a research assistant to engage in the study. The involvement included active participation in screening articles from the database searches to select the final articles included in the study, as well as in the analysis and production of the results from the outset to the final product, and giving feedback regarding the content, interpretation and readability from a patient perspective.

Inclusion and exclusion criteria

The studies included in the review were restricted to those describing the content of care for persons with AN in a GPIC setting. Our definition of GPIC settings encompassed any psychiatric inpatient setting offering care for persons with diverse psychiatric conditions, that is, units that did not cater exclusively to a specific diagnostic group. Studies describing general psychiatric care for persons of all ages with AN were included. We also included studies describing interventions in GPIC for persons with AN, with a patient, relative and/or staff perspective. Only original, peer-reviewed studies published in scientific journals were included. Studies focusing on eating disorders in general were excluded.

Information sources

Guided by the study's specific aim and defined inclusion and exclusion criteria, we conducted a systematic search for relevant knowledge and insights within studies published across three academic databases ^{32 34}: PubMed, CINAHL and PsycINFO, using medical subject headings (MeSH), ³⁵ CINAHL headings and phrases related to AN and inpatient care. The databases were searched from inception to 31 December 2024, with the latest search conducted in March 2025. We also hand-searched the reference lists of research and review studies to make sure that all relevant material had been captured; however, no additional studies were found by this method.

Search strategy

The key concepts in this study were AN and GPIC. Using GPIC as a search term would have narrowed the search too much and could possibly have excluded studies matching the inclusion criteria. The search terms were combined using the Boolean operators AND and OR. ³⁵ A block search was performed with the search terms in the form of MeSH-terms, ³⁵ CINAHL headings and free text. No restrictions were placed on study design or publication date in the search, and equivalent searches were conducted across all databases (table 1). A Preferred Reporting Items for Systematic Reviews and Meta-Analyses flow diagram (see online supplemental figure 1) was used to organise and summarise the search process. ³⁶ Finally, a bibliography of the included studies was distributed to the authors. The literature search strategy was developed in collaboration with a librarian specialised in systematic reviews at Luleå University of Technology.

Data management and selection process

The results of the literature search were uploaded to Rayyan, an online software platform designed to facilitate collaboration among reviewers during the study selection process, ³⁷ and then examined according to the matrix method. ³⁸ After the removal of duplicates, two authors independently examined the collected studies using our predetermined level 1 questions (table 2). We downloaded full copies of the studies that appeared to meet the inclusion criteria or where there was any uncertainty,

Table 1 PubMed

Database: PubMed			
Date: 31 March 2025	Search terms	Limitations	Number of results
#1	anorexia nervosa [MeSH Terms] OR anorexia(Title/Abstract)		39 862
#2	inpatients [MeSH Terms] OR hospitalization [MeSH Terms] OR inpatient care(Title/Abstract)		342 493
#3	#1 AND #2	Full text, English, Swedish, published up until 2024	1105
MeSH, medical subject headings.			

**Table 2** Screening and extraction form

Level 1: title and abstract review	
Is this title written in English or Swedish?	Yes/no
Does the study seem to address AN in GPIC?	Yes/no
Level 2: full-text review	
1. Is there any reason this study should be excluded?	Yes/no
If yes: what is the reason for exclusion?	1. Not in English or Swedish 2. Not about AN in GPIC 3. Does not describe the content of care 4. Not an original study 5. Not peer-reviewed and/or published in a scientific journal
If no: what is the bibliographical information?	1. Author/s 2. Country 3. Publication year
What type of publication is it?	1. Qualitative 2. Quantitative
AN, anorexia nervosa; GPIC, general psychiatric inpatient care.	

and these were reviewed according to our level 2 questions (table 2). 14 of these studies could not be found in full text despite all our efforts and hence were excluded. For each of the others, we read through the abstract and then reviewed the study to determine if it corresponded to the inclusion and exclusion criteria. Studies not meeting the inclusion criteria were removed, and the reasons for excluding studies were recorded. Any disagreement between the authors was solved by discussion. Neither of the review authors was blind to the journal titles, study authors or institutions.

Quality appraisal

To appraise the methodological quality of studies with different types of methods (ie, qualitative, quantitative and mixed-methods studies), the mixed methods appraisal tool³⁹ was used (see online supplemental table 3). This tool guides users through four steps: (1) two screening questions are applied to all studies, (2) for each relevant study, the type of design is determined, and the corresponding criteria are used to appraise the study's quality, (3) two independent reviewers conduct an appraisal process and (4) an overall quality assessment is determined for each study.³⁹ Because of the aim of this review, no studies were excluded due to quality; instead, we present quality assessment in online supplemental table 3 and provide further reflections under the subheading Results.

Data extraction, analysis and synthesis

Data were analysed using a constant comparison method as described by Whittemore and Knafel.³² The analysis

can be described as inductive and iterative, where data relevant to the research questions were organised into a table, providing an overview of the collective data of the included studies on the issue. The analysis was conducted in four distinct steps: (1) data reduction, (2) data overview, (3) data comparison and conclusions and (4) verification of data. In the first step, the selected studies were read repeatedly for an overall picture of the content. The second step took inspiration from the matrix method³⁸ by organising the data in a spreadsheet to create an overview of the key characteristics of interest, including authors, year of publication, aim, sample size, design, methodology and key findings (see online supplemental table 4). Each study was coded with a number, making it easier to trace the data back to the primary sources. In the third step, the answers were sorted into preliminary subcategories and compiled into a matrix (a data overview), and new patterns and relationships were identified both within and outside the primary data sources, leading to new subcategories and categories. The fourth and final step comprised summarisation and verification of the data in accordance with Whittemore and Knafel.³² Data extraction was conducted by the first author and independently verified by another author to minimise bias and reduce extraction errors. Discrepancies were solved through discussion. This method allowed us to explore and summarise the findings both within and between the studies. Our synthesis is presented in a narrative textual form in the following section.

RESULTS

The 25 studies included in this review^{40–64} were published between 1991 and 2024. Most of them (n=24 studies) were evenly distributed between 2000 and 2024, with only one study dating from before 2000. All but four of the studies met 80% or more of the criteria used in the quality assessment (see online supplemental table 3). Notably, all the qualitative studies (n=4) met 100% of the quality criteria, indicating high quality, while all of the randomised controlled studies (n=3) demonstrated some shortcomings in terms of quality. Half of the studies focused on child and adolescent psychiatry, while the other half addressed general inpatient psychiatry for adults. The research represented 10 different countries: six studies from England, five from Germany, three from Japan, two each from Sweden, USA, Poland and France and one each from Ireland, Denmark and Canada.

Three overall perspectives were identified in the analysis. They are presented below, followed by a synthesis of the reviewed studies in which the perspectives are used to answer each research question.

Perspectives

The analysis revealed three different perspectives applied in research on GPIC for persons with AN. It is important to note that we do not view these perspectives as mutually exclusive categories, but rather as

overlapping frameworks that highlight different aspects of the care context. While each perspective emphasised specific elements in care, they were interconnected and collectively contributed to a more comprehensive understanding of care for persons with AN in GPIC (see online supplemental table 5).

The perspective *management of the symptoms* focused strictly on the treatment of physical ailments related to the diagnosis of AN. Predetermined approaches to solving the negative physical consequences of AN were highlighted, along with potential hindrances to treatment. This perspective was found in all the reviewed studies and was the most frequently occurring perspective of care in this research.

The perspective *treatment of the patient* looked beyond the physical dysfunctions of AN to include the psychological dimensions of treatment, even though care was still limited to the inpatient context. This perspective viewed GPIC as using a multidisciplinary approach to help the patient change their AN behaviours and thoughts through activities, therapy and distraction techniques.

The perspective *support for the person* went beyond both the illness and the inpatient context, covering care that involved a variety of dimensions in treating the person with AN. While this perspective acknowledged the need for care providers to know about AN and about the context in which the patient was admitted, it highlighted the simultaneous need for them to put aside this understanding and meet the person in front of them.

Many of the studies may encompass multiple perspectives. Online supplemental table 6 gives an overview of how the perspectives were distributed within and between the studies in relation to the research questions.

Content of care

When applying a *symptom management* perspective, the studies underscore the necessity of medical interventions, as persons with AN admitted to GPIC may have severe medical conditions related to the disorder. Similarly, using a *treatment* perspective, care aims to reduce AN behaviour by using a predetermined approach and structure; the intention is not just to restore weight, but to find new ways to think and feel or to normalise eating. Content of care in these two perspectives aims at reducing dysfunction to enable a life without AN. When adopting a broader perspective with the focus on *support for the person* with AN, research suggests that although strict regulations concerning food and eating may be initially effective in treatment, their significant disparity from real-life situations renders the interventions ineffective in the long term. Instead, studies indicate that the most appropriate *support for the person* with AN is a trusting staff-patient relationship that enables staff to look beyond the illness and see the person. This then makes it possible for the person with AN to express their feelings and for the staff to see and address underlying issues.

Outcome

From a *symptom management* perspective, the outcomes show that GPIC can alter a life-threatening condition, though without guaranteeing a change in mindset. Similarly, when applying the perspective *treatment of the patient*, the outcomes reveal that persons with AN often feel unseen and unheard within a care system focused on forcing behavioural change. This is particularly evident in challenging situations, such as mealtimes, where a standardised approach is applied, leaving little room for individualised support. However, in the *support for the person* perspective, it becomes evident that when staff spend time with the patient, the outcomes include the development of trusting relationships and personalised care. These trusting relationships enable persons with AN to begin releasing their attachment to a condition and often serve multiple functions in their lives. Additionally, the findings emphasise the value of peer support—whether receiving or providing it—which can foster a sense of self-worth in persons with AN.

Descriptions of persons with AN

When using a *symptom management* perspective on care, persons with AN are described in terms of their diagnosis, which leads to rules designed to treat AN. Conversely, research with the perspective of *treating the patient* highlights the negative impact that AN has on a person's ability to make informed decisions and engage in treatment. Further, persons with AN are described as hard to understand, controlling and known to be unsatisfied with care. The perspective of *supporting the person* is rare in research; but from this perspective on care, it is stated that persons with AN must be understood as a part of their family arrangements.

Descriptions of AN

When applying a *symptom management* perspective, persons with AN are primarily described in terms of their age, height, weight and gender. This quantifying approach is essential for conducting quantitative research, which may explain the emphasis on these parameters. From a *treatment* perspective, research describes AN as deviant and as a physical and behavioural problem that needs to be solved. These two perspectives have some commonalities in highlighting factors from within the patient, while the third perspective, *support for the person*, highlights the consequences of AN in a life perspective. Studies which take the third perspective describe AN as being known to negatively affect quality of life both socially and sexually. In some cases, eating restraint and seeking to control body weight have also been interpreted as a way to communicate emotional needs and seek care, especially in close relationships such as within the family. Nonetheless, this perspective is seldom described in the literature.

Factors influencing care

In a *symptom management* perspective, the patient's weight, treatment duration and compliance significantly impact



care. These are facts about the patients that staff can observe and follow from a distance. In contrast, when considering care from a *treatment of the patient* perspective, it is understood that establishing a staff-patient relationship is essential for effectively engaging the patient in their treatment. Moreover, if patients feel that they are being treated differently from others in the ward or if they encounter uncooperative staff, this can negatively impact their recovery. Instead, from the perspective of *support for the patient*, a person with AN being accepted for who they are can have a positive influence on their care. This type of support often comes from peers in the ward. In this perspective, it is important for persons with AN to be involved in their own care, to involve parents in treatment and for staff to have the ability to recognise individual and family needs. Each perspective varies, and the content of the care provided may differ significantly depending on which perspective is dominant.

Gender and power

Due to the narrow focus in the perspective of *managing symptoms*, studies with a gender and power perspective are scarce; the main thing that is clear is that boys with AN are under-researched. Looking from a *treatment* perspective, studies highlight power hierarchies between staff and persons with AN, for example, by problematising that the staff have almost all the power in care while the persons with AN are subordinated and often feel coerced into treatment, even when care is voluntary. This power imbalance can make it difficult for persons with AN to express their full range of emotions. The *support for the person* perspective recognises that treatment often includes a significant loss of control in life. Persons with AN describe being unable to make decisions about seeing family members or participating in activities; this represents a major intrusion into their lives, which highlights the lack of shared decision making. Moreover, the frequent use of coercive measures in the care of persons with AN is an exercise of power that violates personal boundaries and potentially causes trauma. Notably, the involvement of parents in care tends to be uneven, with fathers often being less included by staff compared with mothers.

Person-centred care

Person-centred care is hardly ever mentioned in the different perspectives. However, from a *symptom management* perspective, person-centred care is not in focus; the only individualised adjustments in care are target-tailored weight control. The *treatment of the patient* perspective highlights the adjustment of treatment according to personal experiences of AN; for example, what is helpful to one person can cause anxiety for another. Studies using the *support for the person* perspective involve components of person-centred care, in that staff see the person with AN as an individual and aim to build a relationship with that person in order to learn their individual care needs. In this perspective, person-centred care is characterised as an approach that views AN merely as a symptom of more

fundamental problems, including emotional and social needs. This approach also emphasises the importance of understanding each person's unique context, acknowledging that families differ widely in terms of available resources, dynamics and support needs—factors that need to be taken into account in care.

DISCUSSION

The aim of this integrative literature review was to synthesise existing knowledge about GPIC for persons with AN. Although no time restrictions were placed on the literature search, the review includes 25 studies, highlighting the scarcity of research in this area. Notably, over 2000 studies were excluded because they focused exclusively on specialised eating disorder units; this further emphasises the limited amount of research in the specific context of AN treatment in GPIC. Furthermore, it was notable that there was little to no information on the physical environment in the included studies. Given its potential impact on both treatment and the patient's experience of care, further research on this aspect is needed.

This review highlights the predominance of the biomedical approach in research regarding AN in GPIC, where illness and treatment are viewed through a biological lens. This focus on the biomedical model may diminish the patient perspective. It can also lead to neglecting broader care aspects, such as discharge preparation and staff attitudes.^{65 66} The studies included in this review suggest that contextual factors are frequently under-represented in discussions about AN care, with little attention given to how these factors might impact treatment outcomes. As a result, the specific challenges and nuances of treating AN in a GPIC context remain underexplored in the existing literature. The consequence, as we anticipated even before this study, is that there is currently only limited understanding of the content and significance of care for persons with AN in GPIC, due to the lack of research.

This review reveals that while there is an extensive focus on how to help persons with AN gain weight in GPIC, there is less research focused on the psychosocial aspects of AN. The content of care in the included studies primarily targets the reduction or elimination of specific symptoms and behaviours associated with AN. Persons with AN describe weight gain as the primary goal imposed by the staff and as their ticket out of the ward; however, without trusting relationships and adequate support from the staff, the risk of relapse is high.^{65 67 68} To enable the staff to meet individual needs and expectations, it seems important to broaden the treatment approaches and not rely solely on the biomedical model.^{65 69} Hospitals and medicine may be seen as having the power to decide right and wrong and primarily identify patients through their disease, with treatment aimed at getting them back to normal⁷⁰ and adjusting their behaviour in accordance with clinical expectations.⁶⁶ Hence, the biomedical focus frequently marginalises the patient perspective and disregards individual needs.^{65 71}

Despite the emphasis on measurable outcomes in medical research, no well-conducted randomised controlled trials on GPIC effectiveness were identified. That is, while GPIC seems to have a positive impact on weight gain, we know very little about whether it is superior or inferior to alternative interventions, or which specific components are responsible for which effects. However, there is some research that emphasises the value of person-centred, recovery-oriented care in psychiatric settings,^{72–74} focusing on interventions that foster connection, hope and empowerment, rather than solely reducing symptoms.⁷⁵ Furthermore, there are studies that evaluate these interventions based on the experience of the recipient, not on the reduction of symptoms.^{65 75} However, this understanding of care is not reflected in the findings of the present review, which may influence both the content and outcomes of the care provided for persons with AN in this context.

While the biomedical model dominates research, alternative frameworks such as recovery-oriented care emphasise patient agency and long-term well-being. According to recovery-oriented care, patients must own their narratives to be able to establish a sense of security and communicate their expectations and desires regarding treatment and goals.¹ This approach aligns with the desire expressed by persons with AN to let go of their illness, rebuild their identities and find meaning and hope beyond their condition and in their lives outside the ward.⁷⁶ However, the results show that research within GPIC tends to focus elsewhere, rarely considering individual needs or the broader context in which the person with AN is situated. This oversight may hinder personal recovery from AN, which involves being recognised and understood as an individual, finding meaning in life beyond the illness, nurturing a sense of hope for recovery and regaining control and taking responsibility over one's life.²⁷ Being seen as an individual enables the person with AN to engage in recovery-oriented activities,⁷⁷ highlighting the critical role that staff in GPIC play in shaping the treatment experience.

How staff perceive patients directly affects the care provided and the treatment outcomes,⁷⁸ and the studies in this review indicate that staff in GPIC perceive persons with AN as a difficult group to encounter. This perception can evoke feelings of uncertainty among staff, which may increase their tendency to rely on standardised guidelines in the treatment of persons with AN, instead of seeking more personalised approaches.⁷⁹ Moreover, the findings of this review suggest that the biomedical focus in many studies may impact how staff perceive persons with AN. When the studies constantly depict AN as difficult to treat and patients as hard to engage in treatment, ambivalent towards care and fearful of weight gain, these portrayals may influence staff perceptions and ultimately shape their treatment approaches.

Three perspectives emerged from the analysis of this literature review: *management of the symptoms*, *treatment of the patient* and *support for the person*. These perspectives

can help us understand the common focus, outcomes and potential gaps in knowledge from existing research. Further, the perspectives highlight the power dynamics in care for persons with AN in GPIC and indicate a conflict between standardised inpatient care and the desire for individualised care expressed by persons with AN. As outlined in the introduction, the NICE guidelines for AN are: '... psychoeducation, close monitoring of weight and the evaluation of mental and physical health, as well as risk factors. It is essential for care to be multidisciplinary and involve the participation of family members. These recommendations emphasise the importance of helping individuals with AN achieve a healthy body weight, as weight restoration is crucial in facilitating other necessary psychological, physical and quality of life changes that contribute to improvement or recovery'.²¹ Our findings suggest that these recommendations reflect a symptom management perspective, which may exclude important aspects of the potential content of care. If a support-oriented perspective were incorporated into the formulation of recommendations, the patient's experience could become more central. This could be achieved, for example, by ensuring that the patient's wishes are acknowledged. A treatment approach for AN should prioritise the need for personalised care, placing the person's unique preferences and circumstances at the core of the process and emphasising that recovery is a deeply personal journey. Such an approach could also bring attention to alternative perspectives on treatment and show how these may influence both the content and the meaning of GPIC for persons with AN. By including a variety of viewpoints, the understanding of what constitutes good care can be expanded, making recommendations more relevant to the person's experiences and needs. Further, this review may encourage nursing staff in GPIC to advocate for their nursing expertise as an essential complement to the biomedical approach in care. This would help ensure that the voice and preferences of persons with AN are heard, allowing for care that is tailored to their needs beyond standardised interventions. Additionally, this review may prompt reflection on current care practices in relation to the perspectives presented, emphasising how the language we use and the way we conceptualise persons with AN can impact the care provided in GPIC.

In summary, the findings of this review underscore two main points. First, this literature review reveals a significant lack of research regarding the content and significance of GPIC for persons with AN, highlighting the urgent need for more studies in this area. Second, the limited existing research rarely adopts a *support for the person* perspective, which could be key to improving patient satisfaction within this type of care. Further, the imbalance in focus could contribute to the unsatisfactory treatment outcomes often seen in AN care. By shifting the focus from merely *managing symptoms* to *supporting the person* in their recovery journey, healthcare providers might play a more meaningful role in helping persons with AN rebuild their lives beyond the illness. This is



important, as a deeper understanding of how to provide person-centred support in GPIC could not only save lives but also promote long-term recovery for persons with AN.

Strengths and limitations

One strength of this study is that a person with lived experience of AN in GPIC participated as a co-researcher. Such cooperation challenges and broadens the creation of knowledge in research.

Another strength lies in the comprehensive incorporation of various forms of care, encompassing nursing, psychological interventions, pharmacological treatment and other modalities for individuals diagnosed with AN within the specified context. This inclusive approach facilitates a holistic understanding of the care content, mitigating potential biases in the interpretation of diverse care types.

The quality appraisal is also a strength, revealing a generally high quality among the studies. Only two studies were exceptions, likely due to their older publication dates.

Certain limitations warrant consideration. The chosen search strategy relied on three specific databases, which might have resulted in the omission of pertinent studies which are only listed in other databases. Additionally, the reliance on specific search terms might have led us to overlook relevant studies which did not include these terms in their titles or abstracts. Further, only studies published in English and Swedish were included, which may have led to the exclusion of relevant research published in other languages. This language restriction could introduce selection bias and limit the comprehensiveness of the evidence base. Future reviews should consider broader language inclusion and a wider range of study designs to enhance the robustness and applicability of the findings.

The generalisability of the included studies is limited, as variations in study populations, healthcare settings and methodological approaches may affect the applicability of the results to different contexts. Furthermore, the interpretation of GPIC may vary temporally and geographically, posing a risk of inadvertently encompassing psychiatric hospitals or private psychiatric wards.

We recommend that this study be repeated in a few years to assess whether the research landscape and focus have evolved. Future replications could also expand the methodology by incorporating additional languages, accessing a broader range of databases and considering alternative search terms. These adjustments would help ensure that relevant research is not overlooked due to methodological limitations. Nevertheless, the findings of the review contribute valuable insights to a comparatively underexplored domain, paving the way for further research to address knowledge gaps and optimise strategies for fostering personal recovery for these persons.

CONCLUSION

This is the first review, of which we are aware, that provides a comprehensive overview of research focusing on care for AN in GPIC, including a synthesis that illustrates how

different perspectives in care are associated with different outcomes. Existing research often overlooks structural and psychosocial factors, thus reinforcing a biomedical model of healthcare and reducing GPIC for AN to an oversimplistic matter of weight and nutrition. Finally, the finding of a relatively small number of studies investigating AN care in GPIC indicates a need for further research in this specific context.

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