



ORIGINAL ARTICLE

‘It stopped you thinking about food’ – The experiences of mealtimes and attending a post-meal support group for young people with anorexia nervosa

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ABSTRACT: Anorexia nervosa presents as an international public health concern as it is the mental health problem with the greatest risk of mortality, and the average age of onset is decreasing. For those experiencing anorexia nervosa, mealtimes have long been recognized as a difficult and distressing time when young people need additional support. However, the post mealtime period can be associated with even greater distress, yet there is little research on interventions to support young people in this vulnerable time, and even less on how young people experience these interventions. This study, therefore, explores young peoples’ perceptions of mealtimes and a post mealtime support group. Using a qualitative descriptive design, telephone interviews were conducted with a purposive sample of six young people who participated in a post-meal support group while an inpatient in a Child and Adolescent Mental Health Unit. Using a semi-structured interview guide, participants were asked about their experiences of this support group and their perceptions of how to improve this intervention. Content analysis resulted in the development of three themes: ‘The Challenges of Mealtimes and Post Mealtimes’, ‘The Benefits of Post-meal Support Groups’, and ‘Improving Unhelpful Aspects of Post-meal Support Groups’. Findings are reported in accordance with COREQ guidelines and suggest that for young people experiencing anorexia nervosa, post mealtimes are often more distressing than the meal itself and that participants found post-meal support groups to be a helpful intervention in reducing post-mealtime distress. Post-meal support groups can be improved by ensuring a consistent approach from staff and providing staff with the training and knowledge required to support those affected by eating disorders.

KEY WORDS: anorexia nervosa, eating disorders, mealtimes, post-meal support, qualitative descriptive, young people.

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INTRODUCTION AND BACKGROUND

Anorexia Nervosa (AN) is a serious and potentially chronic mental illness which peaks in adolescence, with 20–40% of new cases beginning during this life stage (Herpertz-Dahlmann 2021,) with increasing incidence in younger girls (Van Eeden *et al.* 2021). Internationally, an increase in AN has been reported in a number of countries, including the UK, where the prevalence among 10- to 14-year-olds has increased from 2.5 per 100 000, to 7.5 per 100 000 since 2000 (Herpertz-Dahlmann & Dahmen 2019). Increasing trends have also been reported in younger cohorts between the ages of 7 and 13 in Germany, Portugal, and Italy (Herpertz-Dahlmann & Dahmen 2019). The highest overall incidence rates of anorexia nervosa occur in females aged 15–19, while the highest incidence rate for males occurs in the 10–14-year age group (Micali *et al.* 2013; Van Eeden *et al.* 2021).

Outcomes for those with AN are poor; approximately 20% remain chronically unwell (Mewes *et al.* 2008). In addition, 10% of those who present with AN will die prematurely from the disorder within 10 years of its onset, and it is the mental illness with the highest rate of mortality (Hoang *et al.* 2014), with mortality rates higher among those who have received inpatient treatment (Van Eeden *et al.* 2021). Cause of death is commonly linked to physical complications, with one third dying from cardiac dysfunction (Spaulding-Barclay *et al.* 2016). Approximately 20–30% of patients with AN will require intensive, in-patient treatment to recover (Herpertz-Dahlmann 2021). Refeeding programmes, with the aim of restoring a healthy body weight, are a common aspect of the treatment process (Herpertz-Dahlmann 2021).

Mealtimes are known to be a difficult period for those experiencing an eating disorder (Levinson *et al.* 2018; Long *et al.* 2012). For most with AN, mealtimes are associated with emotions such as guilt, confusion, fear, and anxiety (Long *et al.* 2012). Many people experiencing AN struggle with high levels of anxiety during meals and strong eating disorder cognitions such as fear of weight gain and a feeling of fatness. These ED cognitions during meals culminate in ED behaviours after meals including restriction, weighing oneself, body checking, over-exercising, purging, or other compensatory behaviours (Levinson *et al.* 2018). The importance of mealtimes in re-establishing normal eating behaviours, and the anxiety associated with this, means that mealtime support is a key feature of inpatient treatment of people with an eating disorder (Hage

et al. 2017a). However, while there is a body of literature focusing on how young people can be supported by mental health nurses during mealtimes (Bakker *et al.* 2011; Beukers *et al.* 2015), there is little research available on the provision of support for young people in the important period directly after mealtimes.

In the study setting, post-meal support groups (PMSGs) were introduced to the Child and Adolescent Mental Health Services (CAMHS) inpatient unit as a therapeutic intervention to support young people with eating disorders. The groups are primarily facilitated by mental health nurses and occur directly after main meals lasting for 30 min. At the beginning of the group, a soothe box is passed around and participants are encouraged to take an item to self-soothe (e.g., stress ball, fidget toy, hand cream). The group opens with a recovery-focused discussion, where the safe expression of emotions is facilitated, and participants are encouraged to share their thoughts and provide peer support for others sharing their experiences. This is followed by distraction/wind down activities to prepare for school/visitors and reduce their emotional vulnerability. The gap in the literature on the provision of the post-meal support group for young people experiencing an eating disorder, and the need to understand their experiences of this group provided the rationale for this study. Consequently, the aim of this study is to explore the experiences of young people with anorexia nervosa of mealtimes and attendance at a post-meal support group in an in-patient setting.

METHODS

A qualitative descriptive design was adopted for this study, facilitating participants to recount their individual experiences of attending a PMSG. This design can provide rich, descriptive information from the participant's perspective (Doyle *et al.* 2020), which recognizes the subjective nature of the issue, the contrasting experiences of participants, and allows findings to be presented in a way which reflects the language used by participants (Bradshaw *et al.* 2017; Doyle *et al.* 2020). The design, methods, and reporting of study findings adhere to the COREQ checklist (Tong *et al.* 2007).

Sample and recruitment

Most qualitative samples are purposive, meaningful samples selected due to their capacity to provide richly textured data relevant to the phenomenon being investigated. They are information-rich samples that have

greater efficiency than random samples in qualitative studies (Vasileiou *et al.* 2018). A purposeful sample of young people who had attended PMSGs in the study site was sought as they were best-positioned to answer the research question – which was ‘what are the experiences of young people with anorexia nervosa of meal-times and attendance at a post-meal support group?’ The inclusion criteria for the study were young people who had attended at least one post-meal support group, were aged between 12 and 18 years, and who were at least 1-month post-discharge from hospital. The study site was a large Child and Adolescent Mental Health Service in Dublin, Ireland which comprised both in-patient and community settings. Permission to access the site was sought and granted from the Director of Nursing and the Clinical Director. A gatekeeper, who was a member of the administration team without direct patient contact, facilitated the display of information posters in the outpatient service of the study site which detailed the aim/purpose of the study and contact details to obtain further information including the participant information leaflet.

Ethical approval was sought and obtained from the Research Ethics Committee of both the University (Ref 191106) and the study site. As this study involved young people under 18 years of age, both informed written parental consent and written participant assent was required. Assent and consent forms were posted to participants and their parents/guardians for their perusal and signature. Signed forms were then returned to the researcher before the interviews could be set up.

Data collection

Semi-structured interviews were used as the data collection approach with questions which encouraged participants to explore their experiences, whilst allowing prompting from the interviewer (Seah *et al.* 2018). The interviews were undertaken by the first author, who was not known to the research participants. The guidance by Kallio *et al.* (2016) for the development of a semi-structured interview guide (File S1) was used which enhances the rigour of qualitative research. Interviews were arranged for a time convenient for the participant. Face-to-face interviews were not permitted due to COVID-19 restrictions; hence, telephone interviews were conducted. Telephone interviews have been identified as a useful data collection tool in qualitative research with participants viewing telephone interviews favourably (Ward *et al.* 2015). To ensure accuracy of the data, interviews were audio-recorded, with

assent/consent from the participants/parents. All participants were in their own homes for the telephone interviews, which ranged in length from 15 to 31 min, with an average of 20 min.

Data analysis

Audio recordings were transcribed *verbatim*, and content analysis was conducted using the six-stage framework by Newell and Burnard (2011). As part of the ethical approval granted for this study, participants were afforded the opportunity to have a transcript of their interview, but none requested a copy. Stage 1 of data analysis involved making reflective notes after each interview of any thoughts/ideas that came from the discussion with each participant. Stage 2 involved reading through the transcripts, becoming immersed in the data, and taking notes on general themes. In the next stage, transcripts were re-read, and key words or phrases that summarized participant responses were noted in a process of open coding, resulting in 25 category codes. In stage 4, similar categories were combined resulting in the development of nine higher-order category codes. In the next stage, the researcher returned to the transcripts with the final categories, matching sections of text to the corresponding category ensuring all data were captured and categorized appropriately. Coding was undertaken by the first author and coding decisions discussed with the second author. At this stage, the categories were condensed into three larger, overarching themes. In the final stage, the findings were written up, under three themes, using quotations from the data.

Strategies used to ensure trustworthiness of the data included the framework by Lincoln and Guba (1985). In summary, this involved meticulous record keeping, displaying a concise decision trail, tracking data analysis and highlighting the origin of findings, and ensuring the interpretations of the data were consistent and transparent. Rich *verbatim* accounts of participants' experiences were provided to support and evidence the findings.

RESULTS

Six participants were recruited to the study, all were female and were aged between 13 and 18 years. All participants had a previous diagnosis of anorexia nervosa, had received inpatient treatment for AN where they attended post-meal support groups, and were discharged a minimum of 6 months from hospital.

Three themes were developed following data analysis: 'The Challenges of Mealtimes and Post Mealtimes', 'The Benefits of Post-meal Support Groups', and 'Improving Unhelpful Aspects of Post-meal Support Groups'.

The challenges of mealtimes and post mealtimes

For all participants, mealtimes and post mealtimes were associated with distressing emotions and strong eating disorder cognitions, particularly in the early stage of their inpatient admission. Most participants reported feeling scared of food and found the experience of mealtimes to be stressful, while some also experienced ambivalence, whereby part of them wanted to eat, and to recover, however the 'anorexic voice' told them not to eat.

It felt scary. There was part of me that wanted to eat, to get better and get home, but then there was the anorexia telling me not to eat and that I was fat. It was really confusing. (P1)

Participants recollected how mealtimes were a constant source of worry for them throughout the day and that it was difficult to escape from this worry which focused on food, calories, and what others were eating. Most participants described feeling 'bad' and 'guilty' at mealtimes. It was also noted by several participants that they experienced anger; feeling angry at themselves and angry at staff as they felt 'forced to eat'; however, they often found it difficult to express this anger.

I could tell the nurses or my psychologist when I felt afraid. But I didn't really talk about being angry. It's just really hard to say you're angry, so for ages I just tried to keep it inside. (P5)

Some participants described how, during mealtimes, it was difficult to avoid comparing themselves to others with eating disorders, and they found themselves watching what others were eating. This often left them feeling distressed. Many felt they learned new eating disorder behaviours at mealtimes such as cutting up, crumbling, hiding, or smearing food.

I saw other people cutting up and crumbling and smearing food at meals and I felt like I had to do it as well. Even though I never did it before. (P6)

Participants also described how they experienced physical discomfort after meals, particularly in the early stages of their admission.

I felt so full, it was painful. (P3)

Several participants acknowledged that it was helpful to sit with staff at mealtimes and reported that support from staff was needed. Many felt that eating with staff at mealtimes made the experience feel more 'normal' and that general 'chat' helped distract them from their distress.

Many participants felt that post mealtimes were more difficult than mealtimes. They described how they may have felt motivated during the meal; however, once the meal was over, they were overwhelmed with ED cognitions. Participants expressed how they experienced feelings of guilt, regret, hopelessness, and self-hate after meals.

Straight away I'd regret that I'd eaten it even though I had to. I used to feel guilty for letting myself eat. I hated myself for eating. (P6)

Several participants reported feeling 'fat' post mealtimes. When asked to explain what 'feeling fat' was like for them, they described how there was usually an underlying emotion, such as fear, disgust, or sadness.

When I felt fat, it was like I felt really disgusted at myself, and that made kind of sad. But I think it's easier for people to say they feel fat, than say they feel sad. (P2)

Some participants described how intrusive thoughts about their weight post mealtimes resulted in them engaging in body checking behaviours, such as measuring their wrists or legs.

I used to put my hands around my legs and wrists to keep a measure. (P2)

Several participants also reported that they experienced strong urges to engage in ED compensatory behaviours such as exercise or purging post mealtimes.

There were all the thoughts about wanting to exercise or even make myself throw up. They were bad after meals. (P5)

The distressing emotions and cognitions experienced by participants during mealtimes and post mealtimes highlights the need for effective post meal support for people experiencing eating disorders.

The benefits of post-meal support groups

All participants reported that attending PMSGs had been an overall positive experience for them and had a beneficial impact on their recovery. Several noted that

the PMSG provided structure and routine, which alleviated some of their distress. Many found that being with staff after meals was reassuring and felt that when they established a therapeutic rapport with staff, they could confide in them and express how they were feeling.

The nurses were good for getting everyone motivated and involved. After a while you get to know the nurses really well and you got used to talking to them. And it was ok to say I'm having a bad day, or I'm really fed up or angry. (P3)

Participants voiced that it was helpful to be around others after meals. They valued being with other young people with eating disorders and listening to their experiences. They described how there was a shared understanding of the struggles they all experienced post mealtimes, and it brought comfort to know that others had similar thoughts and feelings.

It helps to hear other people talk who are surrounded by the same kind of feelings as you have. Being with others who understand. Hearing that things can get better, it kind of gives you hope. (P6)

When asked what the most helpful aspect of the post-meal support group was, many participants explained that it offered them a sense of not being alone.

The best thing about them was just being with others and knowing you're not alone. (P4)

Several participants noted that engaging in the group prevented them from engaging in harmful ED behaviours such as exercising or purging. Some participants explained how it was beneficial that those partaking in post-meal support groups were at different stages of recovery as it was helpful and motivating to hear from those who were further in their recovery.

I liked listening to others who were further along than me talking about getting leave and going home. That helped me stay motivated. I used to think if they can do it, I can do it. (P4)

In addition to receiving support and advice from their peers within the group, some participants felt they in turn could help and support others, which resulted in an improved sense of self-worth.

Participants felt it was important that young people were offered the opportunity to talk after meals and given time to express their feelings, thoughts, and worries before they could effectively engage in distraction techniques.

It was good to start with the talking part first. You can't just go straight into distraction. You need to work through the thoughts before the distraction. Or else the distraction won't work because the thoughts are still there. (P1)

All the participants noted that they found the distraction element of the PMSG helpful as it eased or stopped ED cognitions.

It was good to take your mind off things. It stopped you thinking about food and the guilt and feeling fat. And sometimes it was fun. (P6)

Many participants reported that they enjoyed playing games such as 'stop the bus' and '30 s'. Other helpful distraction activities identified were art, knitting, quizzes, and 'chatting' about topics that were relevant at the time such as movies or concerts. One participant describes how distraction activities created a sense of normality.

It made me feel normal, so you wouldn't think you were different to anybody else. (P3)

Several participants recalled that they found using a soothe box during post meal support groups beneficial which contained items such as bubbles, fidget toys, or stress balls. They described how they often felt agitated and stressed after meals and how items from the soothe box helped them feel calmer and more relaxed.

The soothe box was good too. To have something in your hands to squeeze if you were feeling stressed. Just to have something to focus on and try stay calm, like a stress ball or something. (P3)

Some participants described how, after they were discharged from hospital, their families facilitated post-meal support for them at home. They explained how staff had supported family members to help the young person manage their post mealtime distress, and this was helpful in their transition home.

Staff told my parents about post meal support groups. So, when I started having meals with my family, they did the same with me at home, like just being with me after meals and maybe doing an activity or something, that definitely helped. (P1)

Improving unhelpful aspects of post-meal support groups

While overall participants described their experience of attending PMSGs as helpful, some unhelpful aspects

were identified and suggestions for improvement were made. Several participants noted that there was a lack of consistency in staff members' approach to facilitating the group.

Not all staff did the group the same way, with some staff you didn't know what they were going to do. (P5)

This lack of consistency often resulted in a sense of uncertainty or anxiety among the young people. One participant described how she felt she receiving a 'mixed message' from some of the staff members who facilitated the group. This participant described some staff as 'quite strict' in redirecting certain behaviours such as micro exercising, e.g., shaking legs; however, some staff were more lenient and did not address such behaviours.

Participants felt that the group worked better and was more beneficial when the staff member facilitating the group adhered to the correct structure of the group, which involved beginning the group by offering participants the opportunity to talk and then moving on to distraction techniques. Overall, participants voiced that the effectiveness of the group could be improved by ensuring that all staff provide a consistent approach.

It would be better if all the nurses had one point of view, and if they all did the group the same way. (P2)

One participant reported that during the group, she sometimes worried about triggering others when voicing her feelings or worries following a meal. Another participant explained how there were times when others in the group brought up topics which were triggering for her.

Sometimes people said things that were triggering, like talking about weight or food or how much they ate. And that wasn't good because that could just make you feel worse. (P1)

Another participant suggested that using worksheets may be helpful to allow young people to express their thoughts or feelings without triggering others.

When we did worksheets, it was a bit easier because you could have your own thing, you didn't have to share it with everyone except maybe the nurse, so you were less worried about triggering people, but you were still getting the thoughts out. (P3)

Some participants expressed how they struggled with comparing themselves to others in the group.

Comparing yourself to other people...if someone didn't come into the group and sit down that would

make me feel bad, so I'd think I shouldn't be sitting down either. I'd think Oh God they're skinnier than me and they're not even sitting down for rests...that was the bad side of it I suppose. (P5)

DISCUSSION

Whilst the need for effective mealtime support is evident in the literature (Bakker *et al.* 2011; Beukers *et al.* 2015; Hage *et al.* 2017a), there is little research on the experience of post mealtimes for those with an ED or on effective interventions for reducing post-meal-related distress. A significant finding of this study is that all participants described how the distressing feelings of fear, guilt, anger, and anxiety they experienced during mealtimes remained with them after meals, often increasing in intensity. In keeping with findings of a study by Levinson *et al.* (2018), many participants also described how they continued to experience intrusive and distressing ED cognitions post mealtimes, particularly in relation to weight and body image. These distressing cognitions resulted in body checking behaviours such as measuring their legs or wrists post mealtimes. For those experiencing an ED, body checking may offer a sense of control over their weight and shape and decrease their distress (Smeets *et al.* 2011); however, it is associated with maintenance of weight concerns and continued dietary restraint in people with an eating disorder (Calugi *et al.* 2017). Participants described how the post mealtime period was also associated with a strong desire to engage in compensatory ED behaviours, such as exercising or purging, which are common features of eating disorders (Kontić *et al.* 2010). Excessive exercise poses a risk due to the physical health complications associated with eating disorders (Nicholls *et al.* 2011), while purging can cause electrolyte abnormalities, which can result in dangerous cardiac arrhythmias (Westmoreland *et al.* 2016). The risks associated with these compensatory behaviours emphasize the importance of providing support to people with eating disorders when they are experiencing urges to engage in them. The level of distress, and the intensity of the harmful ED cognitions experienced by participants of this study post mealtimes, is a significant finding which demonstrates the need for effective post-meal support.

All participants of this study reported that attending PMSGs had been a positive experience which reduced their post-meal distress and intrusive ED cognitions and prevented them from engaging in harmful ED compensatory behaviours. Participants appreciated the

routine of the PMSG and were comforted by knowing how the group would be structured. It is evident that structure, predictability, and expectations of their daily routine provided young people with a safe environment which helped to contain their distress. These findings are relevant as they indicate that daily structured PMSGs offered participants a secure, consistent therapeutic milieu during a time when they felt extremely overwhelmed and frightened of letting go of their ED. Muhlheim (2018) has also identified that it is easier to begin the process of recovery from an ED in a structured environment as predictability, consistent expectations, and structure can reduce anxiety.

Many participants voiced how they valued their therapeutic relationships with staff and felt that they benefitted from being with staff after meals. A therapeutic relationship can enhance treatment outcomes, ensure a positive inpatient experience, and promote recovery in adolescents with AN (Zugai *et al.* 2013). Participants described how staff offered support and reassurance during PMSGs, and with the development of a therapeutic relationship, participants were able to confide in staff and accept support.

It has been identified that being supported by people who were recovering or had recovered from an eating disorder can be an important component of an individual's own recovery (Linville *et al.* 2012). In this study, many participants spoke about how it was helpful to be with others experiencing an eating disorder in the post-meal support group. The group offered young people a sense of commonality and acceptance among peers with a shared understanding of the struggles they were all experiencing. Participants spoke about how others in the group often offered them support and advice on how to manage their distress. Similarly, some felt that they had been able to help others in the group, which in turn improved their sense of self-worth. This is significant as low self-worth and low self-esteem are common features in people experiencing AN (Adamson *et al.* 2019). Some participants described how peers in the group who were further in their recovery often gave them hope and improved their motivation. This is an important finding as it highlights the potential of peer support in the treatment of eating disorders.

The importance of distraction activities to ease distress post mealtime has been identified in a small number of studies (Bibb *et al.* 2016; Griffiths *et al.* 2015). Distraction post mealtime provides the opportunity for the young person to focus on other activities which minimizes the potential for ED cognitions. In this

study, the distraction element of the support group, e.g., playing games, was well-received by participants who reported that it eased their anxiety about the meal they just had and importantly reduced the urge to engage in compensatory ED behaviours. While there is a very limited body of research on the effectiveness of activities post-meal, there is some evidence to suggest that post-meal distress may be multidimensional, requiring the use of specific mechanisms beyond general distraction, for example quizzes and visuospatial games (Griffiths *et al.* 2015).

Another beneficial element of the post-meal support group was the use of a soothe box when engaging in group discussion. As many participants reported feeling irritable and agitated post mealtimes, using items from the soothe box helped them sit with their distress and resist urges to engage in harmful behaviours. The use of a soothe box in PMSG is to encourage the young person to self-soothe and show themselves compassion. Teaching self-compassion is an effective intervention for adolescents experiencing a negative view of themselves (Neff & McGehee 2010). Participants suggested that it was helpful to have bubbles, fidgets, and stress balls in the soothe box to be passed around at the beginning of the group. Sensory modulation, including the touch-based sensory approaches described by participants in this study, has been shown to reduce post-meal distress by 10–20% in participants who use this approach (Clarke 2014). This aspect of PMSG also teaches young people to develop distress tolerance skills which can enable a person to endure distressing emotions and ED cognitions and resist the urge to engage in harmful ED behaviours (Claes & Muehlenkamp 2016). It is significant that all participants of this study reported to benefit from the use of distress tolerance skills post meals. This highlights the importance of teaching young people with EDs the ability to engage in such skills to help them manage meal-related distress.

Whilst all participants felt that attending the post-meal support groups had been a positive experience, some unhelpful aspects also emerged. Unfavourable comparisons to others during mealtimes were identified by participants that appeared to follow through to the post-meal support group. Participants reported how they compared themselves to others around mealtimes, watching what others were eating or how they were behaving, resulting in an element of rivalry. At the post-meal support group, it was reported that some participants felt triggered by what others said during the group, particularly when there were discussions on

food, weight, or shape. This has been previously reported in a review of studies exploring the role of friends and peers in adolescent body dissatisfaction. In this review, group conversations among young people which had an emphasis on weight, dieting, and exercise were found to negatively impact on body dissatisfaction (Webb & Zimmer-Gembeck 2014). These findings suggest that while peer support can be beneficial to young people experiencing an eating disorder, there is also a requirement for caution as findings from this study and others suggest that peer influence may negatively impact eating pathology in in-patient hospital settings (Allison *et al.* 2014). This is further evidenced by the finding in this study that some young people reported acquiring new eating disorder behaviours in hospital. How mental health nurses manage the potential for this requires some consideration. It highlights the importance of staff having the ability to recognize inappropriate topics of conversation during the group, preventing prolonged discussion on such topics, and having the skills to redirect the conversation to a recovery-orientated one (Treasure *et al.* 2017). Skills are also required by staff to uncover the negative emotions that often underpin the difficulties with, and discussion of, food and weight (Lask & Bryant-Waugh 2013). Participants in this study acknowledged that it was often easier to speak about feeling 'fat', than it was to disclose distressing emotions. This is a significant finding which demonstrates the need for a skilful approach to the facilitation of post-meal support groups.

A strong finding which emerged from the data was the need for a consistent approach from staff when facilitating post-meal support groups. In the context of in-patient care for people with eating disorders being provided by a team of staff across different disciplines, there is a need for consistency of approach between members of that team. However, several participants noted that the group was not always facilitated the same way and that not all staff members followed the same structure. When staff did not adhere to the usual structure of the group, it left participants feeling anxious and unsure of what to expect and disrupted the sense of familiarity and security that the group normally provided. Inconsistencies in approach towards young people with an eating disorder can heighten frustrations and anxieties (Gardner & Trueman 2021). Consistency among clinicians is a key element in the treatment of EDs, and a steady, unwavering approach is important to ensure that a young person's anxiety is not accentuated (Waller 2012). Recovery is often

hampered by inconsistency requiring the treating team to be consistent, cohesive, and focused in order to support the person's recovery (Lask & Bryant-Waugh 2013), while still allowing some degree of flexibility in certain situations (Hage *et al.* 2017b).

The lack of consistency from staff which emerged in the findings suggests that staff may, at times, struggle to facilitate post-meal support groups. Clinicians often find managing mealtimes with young people experiencing an eating disorder challenging. It may provoke anxiety among staff, particularly if a young person becomes distressed (Watt & Dickens 2018). Furthermore, some mental health nurses, particularly those with less experience, may feel uncomfortable acting authoritatively when working with young people with an eating disorder and have less confidence in doing so (Ryu *et al.* 2022; Zugai *et al.* 2019). Working with young people with eating disorders, particularly around mealtimes, can evoke strong negative emotional reactions in mental health nurses (Ryu *et al.* 2022), which can impact on interactions with the young person. This illustrates the need for extensive training and support for staff working in the area of eating disorders.

Limitations

Data collection was hampered by the COVID-19 pandemic, which necessitated a move from face-to-face to telephone interviews. This meant it was not possible to observe non-verbal responses to the questions put to participants. A further limitation is the small sample size of this study, and the fact that it was carried out in one Child and Adolescent Mental Health Service in Ireland limits the potential to generalize findings. The major strength of this research is its contribution to understanding the experience of post-meal support groups from the perspective of the young person, a topic on which there is a dearth of research evidence.

CONCLUSION

Post-meal support groups can be an important intervention to support young people through the difficult post-meal period when distressing emotions and intrusive eating disorder cognitions can escalate. The findings from this study that young people benefitted from taking part in these groups and that the attendance at the group prevented them engaging in compensatory ED behaviours such as exercising and purging directly after mealtime is an important one. The combination of activities which included group discussion, with

sensory and cognitive activities, worked well to sooth and distract the young person from their ED cognitions, which they described as becoming more intense post-mealtime. That some participants continued to use the structure of the post-meal support group with their families following discharge suggests the potential for application of this intervention outside of the inpatient treatment setting, thus enhancing sustainability. The positive findings do come with caveats and recommendations for education, practice, and research that are important for mental health nurses to consider. There is a requirement that mental health professionals facilitating the group are skilled in managing group discussions that may become too focused on food and weight and therefore become triggering for some participants. It is therefore recommended that there should be a particular focus in mental health nurse education on skills required to facilitate group work with young people with eating disorders. In addition, in practice, maintaining consistency and adhering to a group structure and routine when facilitating these groups is important for the young person to feel safe and secure. This research provides an important understanding of the experience of post-meal support groups for young people with eating disorders and offers insights into how to effectively support young people in the vulnerable post mealtime period and in doing so contributes to a very limited evidence based on this important topic. However, further research is needed in this area, and a larger study could build on these findings, while a study exploring post-meal support groups from the perspectives of staff would also be beneficial.

RELEVANCE FOR CLINICAL PRACTICE

In-patient Eating Disorder services need to develop strategies to effectively provide support to those with EDs post mealtimes. The implementation of post-meal support groups is one strategy to provide this support. These support groups should comprise a combination of group discussions in addition to sensory and cognitive tasks to sooth the young person and distract them from ED cognitions and associated compensatory behaviours. A consistent and skilled approach is needed from mental health professionals when facilitating post-meal support groups. Staff may therefore require specific training in facilitating these groups to provide this intervention successfully and skilfully and to effectively support young people in the vulnerable post mealtime period.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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SUPPORTING INFORMATION

Additional Supporting Information may be found in the online version of this article at the publisher's website:

File S1 Supplementary information: Interview schedule.