Portfolio submitted in fulfilment of the requirements for the

Professional Doctorate in Counselling Psychology

Missing voices:

Men's experiences of mental health and well-being

Anna-Lize Botha

City, University of London

Department of Psychology

August 2020

Table of Contents

City, University of London
Northampton Square
London
EC1V 0HB
United Kingdom

T +44 (0)20 7040 5060

THE FOLLOWING PARTS OF THIS THESIS HAS BEEN REDACTED FOR COPYRIGHT AND DATA PROTECTION REASONS:

I. List of Tables and Diagrams

Section B

Section C

Section D

II: Acknowledgements

To the participants, thank you for your precious time and openness throughout our encounter.

To my supervisor, Dr Kate Scruby, thank you for your unwavering support. Words cannot describe what an honour and pleasure it was to have you as a mentor.

To my family, I am so grateful for all you have done and cannot emphasise enough what you have meant to me throughout this process.

To my husband, thank you for accompanying me on my journey, once again affirming your unconditional love and support!

III. Declaration

I grant powers of discretion to the University Librarian to allow this thesis to be copied in whole or in part without further reference to me. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

Section A: Preface

This portfolio contains three separate pieces of work however intertwined with my journey on becoming a counselling psychologist. My clinical experience varied across three very different placement settings: a staff psychological service, a problem gambling service and working therapeutically with primary school children. As Rogers (1989) wrote, "I regard it as a deep privilege to have had the opportunity to know such a diverse multitude of people so personally and intimately" (p. xvii). The clients all inspired me in different ways, and as such, I shall demonstrate how the clinical work influenced my growth and found its place within this portfolio. However, counselling psychologists contribute beyond therapeutic interventions alone, including "research, policy development and new and innovative contributions to society" (Milton, 2010, p. xxi). My drive to make a difference in the wider world is an essential part of my counselling psychologist identity. I hope to instigate change through my contributions, starting with raising awareness of men's mental health and well-being in this portfolio.

i. Theme throughout the Portfolio

The content of this doctoral portfolio was not developed around a specific topic, however, one important commonality from the separate pieces of work is the focus on male mental health and well-being. As a feminist and counselling psychologist in training I advocate for equality of sexes. Research found that male respondents were less likely to consult professionals for mental health problems compared to their female counterparts, therefore unsurprisingly, less men were treated in mental health services than women in developed countries (Dezetter et al., 2013; Gagné, Vasiliadis & Préville, 2014; Wang et al., 2005). Evidently some barriers exist for men when it comes to seeking support for mental health issues, such as perceptions of healthcare professionals and services, stigma i.e. associated with mental illness, and notions of masculinity (Clement et al., 2012; Ellis, 2018; Hoy, 2012). A meta-ethnographical review found "idealized masculinity" acts as a barrier for help seeking; men felt the need to "hide their true feelings and vulnerabilities" (Hoy, 2012, p. 219). Furthermore, the author found men reported maladaptive coping strategies, for example "alcohol, drugs and 'bottling up' feelings until they erupted in more socially accepted masculine reactions such as anger and violence" (Hoy, 2012, p. 219). This cultural barrier therefore could also negatively impact suicide-prevention. The

traditional male gender role was found to impede protective factors such as help-seeking and social support, consequently increasing the risk of suicide (Houle, Mishara & Chagnon, 2008).

I felt it was imperative to give men individual voices but also a collective voice in my research. I hoped to provide a platform for men to showcase their "true feelings" and open up, apposed to "bottling up" what they might perceive as vulnerabilities. My research therefore focussed on male mental health nurses' experiences as an under-represented sample in eating, and mental health nursing literature. I hold the belief that if we (mental health professionals, researchers, etc.) can raise more awareness of the true representation of male mental health issues and well-being through men's voices, they can normalise these experiences and change the narrative of "idealized masculinity".

ii. Sections of the portfolio

Section B: Doctoral Research Project

The research part of the portfolio (section B) explored mental health nurses' experience of eating: an interpretative phenomenological analysis. To orientate the reader, I will explain what led me to choose this topic for investigation. During my training I had the opportunity to work within a psychological service offering NHS staff psychological support. I was struck by the frequency both men and women referenced occupational stress as the main reason for referral to the service. My experience working therapeutically with clients, particularly nurses, set me on the course to advocate on their behalf by giving voice to their experiences through my research. In order to meet work demands, nurses often reported not being able to take sufficient breaks or leave work on time. The literature search gave me insight how these occupational factors could impact nurses' eating. This guided me towards employee rights and needs. Maslow's hierarchy of needs are described as "good preconditions" to facilitate personal growth, termed "self-actualization" (Maslow, 1970, p. xxv). Maslow proposed these conditions, "supply him with the basic human necessities and 'rights' which permit him to become strong enough, and person enough, to take over his own fate" (Maslow, 1970, p. xxv). Maslow suggested satisfaction of the physiological needs such as eating, are "stronger" than safety, love and self esteem needs (Maslow, 1970, p. 98). As described above, eating is one of the basic human needs

and rights, and this inspired me to wonder about nurses' experience of eating? I particularly wanted to give voice to inpatient mental health nurses, as I was familiar working in such a demanding environment as a healthcare worker.

Section C: Professional case study:

The clinical case study (section C) was based on my therapeutic work at a problem gambling service, titled: "Gambling as a coping mechanism for negative affect: How social comparison on Facebook could impact self-esteem and contribute to low mood". I chose this particular case due to its complexity. This gave me the opportunity to reflect more in-depth on my practice to facilitate growth as a counselling psychologist. This particular session reminded me of the ever evolving digital age and how social media could play a role in mental health, something I have never even considered until this point of my training.

Section D: Publishable article

Section D is based on my research, written in the format of a publishable article. This piece of work is a succinct version of the analysis, as two super-ordinate themes were not reported as portrayed in section B. Due to the journal word count requirements I merged "everything fell by the wayside" and as a direct consequence of missing meals, "hunger is frustrating". I felt this flowed organically as a narrative. For this piece of work I wanted to keep the reported analysis focussed on nurses' experience, rather than universal 'human being' experiences such as "you want to be healthy, don't you?" which included existential issues. I maintained the struggle to stay healthy as a nurse, which was summarised in the remaining themes.

In summary, this portfolio highlights the importance of advocating for men's mental health and well-being. I hope that the 'missing' male voices were heard, as this was ultimately the aim of the research and case study. My passion to promote men's psychological well-being comes from the simple fact that: one day my, or your grandfather, father, uncle, brother, nephew, friend, husband/partner or son, etc. could need that potential life-saving psychological support.

References

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans- Lacko, S., Bezborodovs, N., . . . Thornicroft, G. (2015). What is the impact of mental-health related stigma on help- seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine*, *45*, 11-27.

Dezetter, A., Briffault, X., Bruffaerts, R., et al. (2013). Use of general practitioners versus mental health professionals in six European countries: The decisive role of the organization of mental health-care systems. *Social Psychiatry and Psychiatric Epidemiology, 48*, 137-149.

Ellis, K. (2018). Identifying and addressing barriers to men seeking help for depression. British Journal of Mental Health Nursing, 7(3), 130-136.

Gagné, S., Vasiliadis, H.M., & Préville, M. (2014). Gender differences in general and specialty outpatient mental health service use for depression. *BMC Psychiatry, 14*, 135.

Houle, J., Mishara, B.L., & Chagnon, F. (2008). A test of a mediation model of the impact of tra- ditional make gender role on suicidal behaviour in men*. Journal of Affective Disorders, 107*, 37- 43.

Hoy, S. (2012). Beyond men behaving badly: A meta-ethnography of men's perspectives on psychological distress and help seeking. International Journal of Men's Health, 11(3), 202-226.

Maslow, A.H. (1970). *Motivation and Personality*. (2nd ed.). New York, NY: Harper & Row.

Milton, M. (2010). Introduction: Therapy and beyond: Counselling psychology contributions to therapeutic and social issues. In M. Milton (Ed.), *Therapy and beyond: Counselling psychology contributions to therapeutic and social issues* (pp.xxi–xxvi). London: Wiley-Blackwell.

Rogers, C.R. 1989. (Kramer, P.D.). (1995). *On becoming a person: A therapist's view of psychotherapy*. New York: Houghton Mifflin.

Wang, P.S., Lane, M., Olfson, M., et al. (2005). Twelve-month use of mental health services in the United States: Results from the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 629–640.

Section B: Doctoral Research Project

Mental health nurses' experience of eating: An Interpretative Phenomenological Analysis

Abstract

In this qualitative study, we aimed to investigate inpatient mental health nurses' experience of eating. Previous literature indicated that mental health nurses experienced high occupational stress. In light of national shortages of nurses, nurses reported that high workload led to the inability to stay hydrated, eat or use the toilet. Research suggested that nurses most commonly used eating as a stress-reduction method, tentatively concluding that stress-induced eating could exacerbate the obesity epidemic. Seven male inpatient mental health nurses participated in semi-structured interviews via telephone. Interviews were transcribed verbatim, and analysed using Interpretative Phenomenological Analysis. Three master themes emerged: "Part and parcel of the nature of the job", which included "The pressure of work", "Everything else fell by the wayside" and "Eating is not your priority"; "Try to sort of compensate", which included "Hunger can be frustrating", "Eating more than I should have" and "Hang on, what am I doing?"; and "So I am getting healthier. Just not healthy", which included, "You want to be healthy don't you?", "I have a window of opportunity to eat" and "I just have to find the balance". Employers need to encourage cultural change by providing a supportive environment to facilitate healthy eating amongst mental health nurses, including managerial supervision, incident debriefing and appropriate psychological interventions, which can include psychoeducational leaflets, workshops, group support and 1:1 CBT sessions.

Keywords: Nurses, male, eating, self-care, stress, work culture

1 Introduction

1.1 Overview

In this chapter, the reader will be presented with a clear rationale as to why this study is valuable in the current political context, and how it can contribute to existing literature and fit within counselling psychology. The chapter concludes with a description of the study's aims.

1.2 Rationale

Clews and Ford (2009) reported workforce data on 30,000 NHS staff within 17 NHS trusts. They indicated that stress and associated psychological problems represented 15% of all sickness days in 2008, compared to 4% of sickness days amongst 40,000 non-NHS employees in various professions. Furthermore, they suggested that nurses have more stress-related absences compared to other NHS staff across the sample (Clews & Ford, 2009). Research may be insufficient to establish the most stressful mental health setting for professionals, for example, forensic compared to non-forensic domains (Brown, Igoumenou, Mortlock, Gupta & Das, 2017). However, findings do suggest unique stressors are present in different fields of nursing as stressors are dynamic and ever changing in the current organisational climate (Qi et al., 2014). The authors found that mental health nurses experienced higher stress in patient care, working environment and resources compared to general nurses, however, they experienced lower stress in terms of workload and time pressure. Nonetheless, literature indicated mental health nurses experienced high occupational stress (Edwards & Burnard, 2003). Research showed that particular occupational hazards, such as violence and aggression, were pertinent to inpatient mental health settings; nurses reported incidents of verbal aggression occurring most frequently (Stone, McMillan, Hazelton & Clayton, 2011); and of 68,683 physical assaults of NHS workers between 2013 and 2014, 69% occurred in the mental health domain, mainly in inpatient settings (Renwick, et al., 2016).

In addition to the above-mentioned occupational stressors, the Migration Advisory Committee (2016), commissioned by the government, acknowledged the national shortage of nurses. Questionnaire data from the Royal College of Nursing (RCN, 2017) indicated

55% of the 30,865 nursing staff surveyed experienced shortages of one or more registered nurses on their last shift, while 34% of 1,300 shifts from mental health inpatient settings had insufficient numbers of registered nurses and 42% were short of health care support workers. Such shortages have adverse effects on patient care but also on nursing staff's physical and emotional well-being; high workload due to shortages of staff result in personal costs to nursing staff, such as the inability to stay hydrated, eat or use the toilet (RCN, 2017). Donnelly (2014) found that staff shortages were a significant source of occupational stress, which would invariably impact on nurses' mental health. Stress, burnout, lack of job satisfaction and work environment were often named as causes for leaving the nursing occupation (The Migration Advisory Committee, 2016). The Royal College of Nursing (2017) stated, "for the first time in years there are now more nurses and midwives leaving the NCM register than joining" (RCN, 2017, p. 2). The current shortage of nurses, along with the occupational stress, impacts staff's work performance, as well as the recruitment and the retention of nurses.

Nahm, Warren, Zhu, An, and Brown (2012) reported that nurses most commonly used eating as a stress-reduction method. Studies tentatively concluded that stress-induced eating could exacerbate the obesity epidemic (Adam & Epel 2007; Torres & Nowson, 2007). Obesity has become a worldwide phenomenon and much attention has been focused on it in health promotion (WHO, 1997). The UK National Institute for Health and Care Excellence (NICE, 2006) introduced occupational guidance for the prevention and management of obesity in the workplace, such as addressing weight, diet and activity. Blake, Mo, Lee, and Batt (2012) suggested that NHS staff's lifestyle behaviours were important as role models for the public, as well as for the individual's health and for patient care. A study found nurses who exercise regularly were more inclined to suggest physical activity as treatment (McDowell, McKenna, & Naylor, 1997). Blake et al. (2012) reported questionnaire data (n=7,085) from a single acute NHS hospital that 43% of employees stated they were overweight (30.3%) or obese (12.9%). In this study, the highest responding occupation was nursing (38.2%), followed by administrative categories (25.5%). These statistics should be viewed with caution as the response rate from employees was low (21%), and therefore the results may be considered to be an unrepresentative sample. The Migration Advisory Committee (2016) estimated that there are 630,000 registered nurses in the UK. With nursing representing the largest workforce in the NHS (HSCIC, 2013), and taking into consideration the impact on work performance,

unhelpful coping, and unhealthy lifestyle behaviours such as unhealthy diet and lack of exercise, it is evidently important to consider the mental health and physical well-being of nurses.

The Nursing and Midwifery Council workforce comprises of 36% male and 64% female staff (NMC, 2016). A cross-sectional study of 4,996 registered nurses, working nurses and midwives showed that being overweight and obese was significantly correlated with male gender (Bogossian et al., 2012). Research suggests there may be various gender differences in terms of eating behaviours; in addition, males reported higher levels of over-eating compared to females in a community sample (Opwis, Schmidt, Martin & Salewski, 2017; Striegel-Moore et al., 2009; Wansink, Cheney & Chan, 2003). Research indicates that current diagnostic criteria for eating disorders are more relevant to female symptoms, and more is needed to understand male presentations (Mitchison & Mond, 2015; Smith et al., 2017). Due to the lack of research in this area, it is essential to focus on the male population as an under-represented sample in eating and mental health nursing literature.

Overall, this study aims to give voice to male mental health nurses' experience of eating in the current political climate of national shortages. It is important to highlight the experience of nurses for the purposes of patient care, staff retention and future recruitment. As a Counselling Psychologist in training working with persons struggling to cope with their mental health, I see how important it is to safeguard arguably one of the most vulnerable groups in our society, namely inpatients in mental health settings. Therefore, it is fundamental to take a wider view of the systemic impacts on patient care. Mental health nurses are often the primary carers of inpatients and therefore their well-being is crucial.

1.3 Pertinent Terminology

First and foremost, pertinent terminology is important to define and illuminate relevant contextual subjects. Using pertinent terminology allows the reader a better position from which to understand how this study fits within the theoretical and political context. For this reason, occupational stress, disordered eating, gender considerations, and inpatient mental health settings are defined below.

1.3.1 Occupational stress

It is important to differentiate between acute and chronic stress, therefore a distinction will be made below, followed by a theoretical model describing chronic occupational stress. Particular stressors within mental health nursing will be discussed in section 1.4.1.

Acute or short-term stress stimulates the 'fight-or-flight' response in order to manage the immediate threat (Shimizu & Okabe, 2007; Waterhouse & Campbell, 2011). The stress response releases adrenaline, increasing heart rate and pupillary dilation and stimulates release of energy to 'fight' or 'flee' danger (Waterhouse & Campbell, 2011). The intensity of a stressor influences the duration of recovery after the source of stress has ceased (Márquez, Belda & Armario, 2002). Lundberg and Cooper (2011) suggested acute stress does not normally cause any major health concerns, and in fact, are associated with many positive outcomes. However, when "physical strength" is not required as a method of coping with the stressor, such as in the case of "mental stress" or "psychosocial stress", Lundberg and Cooper (2011) states that the physiological stress response (as described above) increases the risk of cardiovascular disease. The authors also listed numerous negative consequences of chronic or long-term stress, including; diminished performance, memory and immune functions. Furthermore, Lundberg and Cooper (2011) suggested chronic stress, as well as prolonged high physical demands, could diminish performance. This may be particularly relevant, as literature has indicated that mental health nurses experience high occupational stress including particular occupational hazards, such as violence and aggression (Edwards & Burnard, 2003; Stone et al., 2011).

The Health and Safety Executive defines stress as "the adverse reaction people have to excessive pressure or other types of demand placed upon them" (HSE, 2001, p. 7). This

definition comes mainly from the theoretical job demand-control (JDC) model (Karasek, 1979) that predicts psychological strain when employees have high job demands but experience low job control. Furthermore, Karasek (1979) suggested that high control would buffer against stress caused by high demands. A more recent cross-sectional study (Baba, Tourigny, Wang, Lituchy & Monserrat, 2013) revealed that the updated job demand-control-*support* (JDC*S*) model (Johnson & Hall, 1988) has universal significance. The JDCS model suggests social support also acts as a buffer for high demand situations.

Figure 1 shows a diagrammatical representation of the JDC model. According to Karasek and Theorell (1990), the interactions between high and low levels of demand and job control predict four types of work situations: (1) high strain situations – workers experience high occupational stress, poor health, and perform lower than average at work; (2) low strain situations – workers experience low levels of occupation stress, and are more content and healthier; (3) active situations – workers experience high demands, however, they have the authority to utilise all of their capabilities (i.e. problem-solving) which could result in learning and growth; and (4) passive job situations – workers lack job challenges which could result in de-motivation and gradual loss of skills.

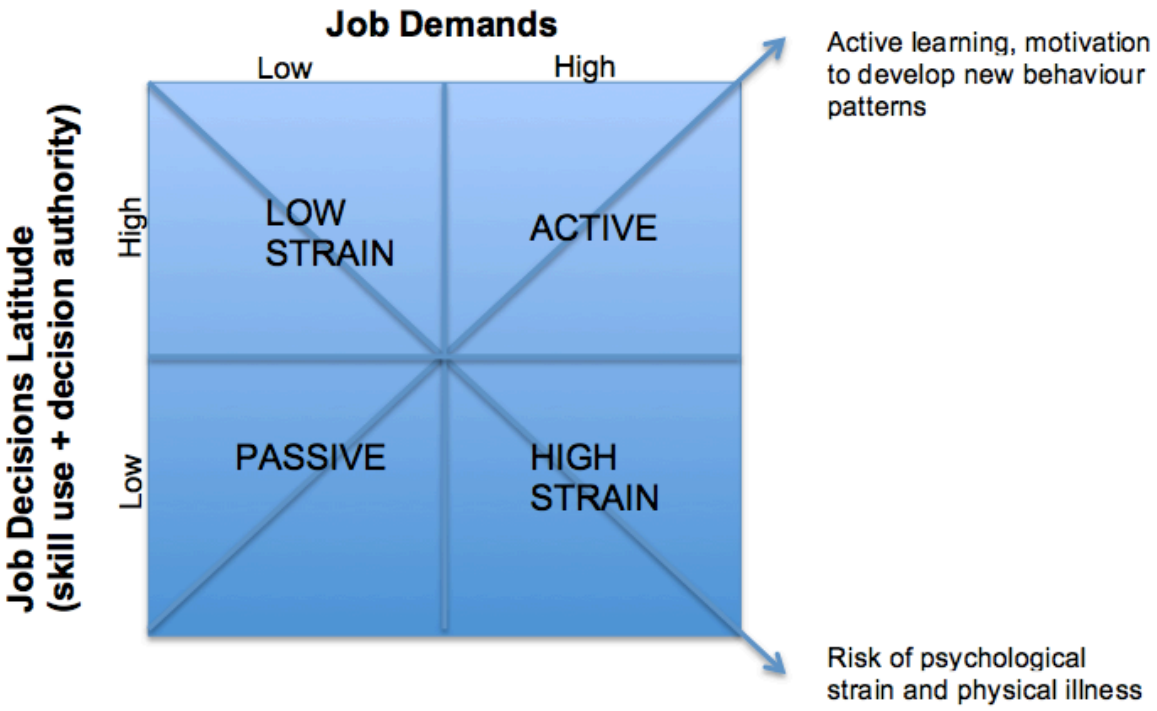

Figure 1: The Job Demand-Control Model (Karasek, 1979; Karasek & Theorell, 1990; diagram representation by Schnall, Landsbergis, & Baker, 1994).

This theoretical representation suggests developing nurses' skills and increasing their authority on job decisions may reduce stress and prevent possible burnout. Prolonged exposure to stress could result in "emotional exhaustion" (Maslach & Jackson, 1981, p. 99), otherwise known as 'burnout' in "response to chronic occupational stress" (Dickinson & Wright, 2008, p. 82).

1.3.2 Disordered eating

Disordered eating is important to define as Nahm et al. (2012) found nurses most commonly used eating as a stress-reduction method, and participants reported irregular meal patterns such as skipping meals due to a lack of time and inability to take a break.

Eating Disorders (EDs) include anorexia nervosa, atypical anorexia nervosa, bulimia nervosa, atypical bulimia nervosa, over-eating associated with other psychological disturbances, vomiting associated with other psychological disturbances, other eating

disorders, and eating disorders (unspecified). There is a list of criteria to be fulfilled as set out by a classification system, such as the ICD-10, in order for an individual to be diagnosed with an ED (WHO, 1993). Disordered eating is linked with unhealthy eating behaviours that could lead to serious medical problems (APA, 1994). For the purpose of this study, *disordered eating* is limited to eating behaviours associated with EDs only.

Some of the eating behaviours identified within EDs are described by ICD-10 (WHO, 1993):

> (1) self-induced vomiting; (2) self-induced purging; (3) alternating periods of starvation; (4) use of drugs such as appetite suppressants, thyroid preparations or diuretics … excessive exercise … Recurrent episodes of overeating … in which large amounts of food are consumed in short periods of time … Persistent preoccupation with eating and a strong desire or a sense of compulsion to eat (craving). (pp. 135-136)

Distorted self-perception of body shape and weight is considered an essential feature in disordered eating (APA, 1994). Research suggests that perceived media, peer and family pressure might influence body dissatisfaction and the drive for thinness in women or muscularity in men (Klein, Brown, Kennedy, & Keel, 2017; Pritchard & Cramblitt, 2014; Rodgers, Paxton & Chabrol, 2010). Some of the eating behaviours described above, therefore, may be purposefully utilised in an attempt to counteract the perceived 'fattening effect' of food and the belief of being 'too fat' (WHO, 1993). Alternatively, over-eating or binge eating may be "triggered by dysphoric mood states, inter-personal stressors, intense hunger following dietary restraint, or feelings related to body weight, body shape, and food" (APA, 1994, p. 546). King, Vidourek and Schwiebert (2009) therefore also included "distorted body image, emotional eating, inability to moderate and maintain a healthy intake of food" (p. 862) in their definition of disordered eating.

1.3.3 Gender considerations

Research indicated "men with eating disorders are currently under-diagnosed, undertreated, and misunderstood by many clinicians who encounter them" (Strother, Lemberg, Stanford & Turbeville, 2012, p. 346). Räisänen and Hunt (2014) proposed that

cultural constructions of EDs could potentially offer an explanation as men "did not come to consider the possibility of having an ED because of the inappropriateness of an ED as a socially available explanation for them as *men*" (p. 6.). Therefore the authors' qualitative study suggested the male participants perceived EDs largely as a "female problem", and therefore only identified their EDs symptoms once they became "entrenched". Furthermore, participants generally experienced a lack of awareness of EDs in men, limited availability of gender-specific resources and consequently delayed recognition and treatment.

Duncan, Ziobrowski and Nicol (2017) found that men had a lower prevalence of lifetime EDs than women, 2.22% and 4.93% respectively. Furthermore, a clinical sample of male (n=386) and female (1,487) participants' scores on the Eating Disorder Examination Questionnaire (EDE-Q) and the Eating Disorder Inventory (EDI-3) were compared (Smith et al., 2017). The authors reported that females' scores were generally higher than males'. They concluded that one explanation might be that females' disordered eating presentations are more severe in partial or residential treatment, or alternatively that the ED psychopathology domains lack symptoms more relevant to males (i.e. muscularity orientated) and that this might explain under-diagnosis. Murray, Griffiths and Mond (2016) recommended expanding the current diagnostic and classification schemes of EDs to allow for male presentations, such as behaviours that stem from "a drive for muscularity" since "hegemonic masculine gender roles often embedded in the pursuit of muscularity" (p. 415). Mitchison and Mond (2015) suggested that although over-evaluation of weight and shape are associated with distress in men, more is needed to establish a framework comprising behavioural, emotional and cognitive features relevant to EDs in men.

Gender differences in disordered eating symptoms were also reported within community samples. Some research suggested significantly more male participants over-eat, whereas a larger number of female participants reported a loss of control whilst eating (Striegel-Moore et al., 2009). Furthermore, Striegel-Moore et al. (2009) found around 10% of men and 20% of women checked their body size "very often" within the past 3 months; however women showed significantly higher levels of avoidance (avoiding checking weight or shape). Forrester-Knauss and Zemp Stutz (2012) reported more Swiss women were dissatisfied with their weight and tried to lose weight during the past year, even though more men stated being overweight. In addition, no gender differences were found in the

frequency of irregular eating and binge eating categories. Furthermore, Anderson and Bulik (2004) observed no gender difference in exercise as a compensatory behaviour. Authors suggested exercise was bidirectional; a strategy utilised for weight loss (women's 'drive for thinness') and weight gain (men's drive for 'muscle mass').

As described above, it is feasible that hegemonic masculinity may be accountable for the drive towards 'muscularity' in men. With this view in mind, eating behaviours could therefore stem from "'doing gender' in a culturally specific way" (Connell, 2005, p. 68). Connell's (2005) defined "masculinity" as follows; "'Masculinity' ... is simultaneously a place in gender relations, the practices through which men and women engage that place in gender, and effects of these practices in bodily experience, personality and culture" (p. 71). Connell & Messerschmidt (2005) suggested "masculine embodiment for identity and behaviour emerges in many contexts" (p. 851), including eating behaviours such as consumption of meat. "Gender is always relational, and patterns of masculinity are socially defined in contradistinction from some model (whether real or imaginary) of femininity" (Connell & Messerschmidt, 2005, p. 848). Thus, research suggests eating large quantities and red meat is perceived to be masculine, and consumption of fruit and vegetables is considered feminine in Western societies (Bock & Kanarek, 1995; Ruby, 2012; Sumpter, 2015).

More specifically, "hegemonic masculinity" refers to the "patriarchal dividend, the advantage men in general gain from the overall subordination of women" (Connell, 2005, p. 79). This may translate to food, meal preparation and eating as follows; Sobal (2005) suggested opposing masculine and feminine foods are often contested in shared marital meals - meat frequently centred in the debate showcasing the "wider patterns of male dominance" (p. 135); furthermore, research found that cooking was perceived to be the female counterpart's responsibility within heterosexual couples, however researchers noted this pattern was different among the younger, higher educated and professional couples - men took on more meal preparation responsibilities in these couples (Lupton, 2000). This generational divide poses a dilemma within the hegemonic masculinity theory, therefore the concept of "multiple masculinities" were introduced to allow for more diversity. Connell & Messerschmidt (2005) wrote: "gender orders construct multiple masculinities ... [i.e.] patterns vary by class and generations" (p. 835) furthermore

“masculinities are not simply different but also subject to change. Challenges to hegemony are common, and so are adjustments in the face of these challenges” (p. 835).

However, non-western societies may have unique cultural factors influencing food preparation and eating practices such as religion. An example of ‘doing gender’ in a ‘culturally specific way’ therefore might present as follows; in Islamic society women are expected to be the “culture-bearers” – preparing traditional and celebratory meals from “scratch”, including passing down recipes to the younger generation (Ludwig, Cox & Ellahi, 2011). In addition, the authors reported males also held the responsibility of continuing traditional practices; male dominance over food preparation and consumption therefore makes it difficult for women to change family diet and defy their “duty”. It is important to note however, that the above-mentioned notions of ‘masculinity’ may be incompatible with some non-westerners (i.e. two participants in this study identified as Black, Asian, Minority or Ethnic, BAME) and western societies as Connell (2005) suggests:

> All societies have cultural accounts of gender, but not all have the concept of ‘masculinity’... A culture which does not treat women and men as bearers of polarized character types [masculinity v.s. femininity] ... does not have a concept of masculinity in the sense of modern European/American culture. (pp. 67 - 68)

Hofstede (1998, 2001) explains more masculine-based cultures encourage greater divisions within normative behaviours for men and women. Furthermore, notions of gender inequality are heightened – the mother holding a lower position of power in the familial hierarchy. In contrast, more feminine cultures (i.e. the Netherlands), beliefs of gender equality dominate – there are more convergence of gender roles and decreased occupational and educational discrimination.

Exploring the lived experience of male participants would therefore enrich current research and give voice to a marginalised gender group, not only within nursing but also within eating research.

1.3.4 Inpatient mental health settings

It is important to briefly describe and discuss inpatient mental health environmental settings and mental health nursing for the reader in order to consider the literature in context, political or otherwise.

Although there is a modern movement away from long-term residential psychiatric care in inpatient settings and towards encouraging independent living and care and integration within the community, psychiatric inpatient facilities maintain an essential role in the mental health care system (Curtis, Gesler, Fabian, Francis, & Priebe, 2007; Sabes-Figuera et al., 2016). Psychiatric inpatient settings provide care in a variety of service sectors, such as acute inpatient services (admission for acute psychiatric illnesses), psychiatric intensive care units (PICU; secure wards with controlled entry and exit of patients due to the level of risk posed to themselves or others during an acute phase of serious mental illness), forensic services (patients in secure units, sectioned under the Mental Health Act and usually having committed an offence), recovery and rehabilitation services (severe and enduring mental health problems, cannot be cared for in the community), Child and Adolescent Mental Health Services (CAMHS), Tier 4 inpatient services, dementia assessment (patients display severe behaviours requiring hospital settings), and specialist services (i.e. eating disorder, learning disability, obsessive compulsive/anxiety, personality disorder, autism, and substance misuse) etc. (NHS Confederation, 2012).

The Care Quality Commission (CQC, 2017) stated that they had inspected “all 54 NHS mental health trusts in England and all 221 independent mental health services.” (p. 10). These include the following total number of inpatient mental health wards: 54 child and adolescent mental health wards, 86 acute wards for adults of working age and psychiatric intensive care units, 134 long stay/rehabilitation mental health wards for working-age adults, 65 wards for older people with mental health problems, 77 wards for people with a learning disability or autism, and 85 forensic inpatient/secure wards (CQC, 2017). The NHS Confederation (2012) acknowledged that an ‘inpatient bed’ in mental health might have been inconsistently defined in the past and therefore set out to provide consistency in both language and understanding.

The authors of the NHS Confederation report (2012) defined a mental health inpatient service as:

> A unit with 'hospital beds' that provides 24-hour nursing care. It is able to care for patients detained under the Mental Health Act, with a consultant psychiatrist or other professional acting as responsible clinician. This does not mean that all, or even a majority of, patients will be detained. All units should have access to the full range of skills of the multi-professional team ... Such a unit may be in a hospital campus or a community setting ... Day-to-day needs for food, utilities and so on are provided by the 'hospital' rather than by benefits. (p. 6)

Due to the nature of nursing, staff may work night or day shifts. Furthermore, shift lengths can vary between short (<8 hrs), medium (9-12 hrs) and long (>12 hrs) (RCN, 2017). The definition of the inpatient service includes patients sectioned under the Mental Health Act and as such, the Department of Health (2008) describes the criteria for admission for assessment below:

Patients may be detained in hospital for assessment on the grounds that they:

- are suffering from mental disorder of a nature or degree which warrants their detention in hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and
- ought to be so detained in the interests of their health or safety, or with a view to the protection of others. (p. 27)

In 2016/17, 45,864 new detentions were reported (41,268 in NHS Mental Health and Learning disabilities, 1,782 in NHS Acute and 2,814 in independent providers), however, the report stated that not all mental health providers submitted data, therefore the actual figures might be even higher (NHS Digital, 2017).

The Nursing and Midwifery Council (NMC, 2015) states there are four different fields of nursing within the UK, namely adult nursing, children's nursing, learning disabilities nursing and mental health nursing. Although there are fundamental differences between nursing fields, there are also standards for competence that overlap (NMC, 2015).

The Nursing and Midwifery Council (NMC, 2015) states:

> Although these are different fields of nursing, registered nurses will be expected to meet the essential mental and physical health needs of people of all ages and conditions including those needing end-of-life care. Some nurses qualify in multiple fields and so will be registered with us in more than one field. (p. 3)

Inpatient psychiatric nurses often described inter-personal engagement and building the nurse-patient relationship as a key aspect of their role, followed by maintaining safety by vigilance and awareness of potential escalating situations that could result in violence. Also highlighted as important was providing education and information to empower and enable patients to manage their symptoms (Delaney & Johnson, 2014). Other more formal descriptions of the psychiatric nursing role might be geared towards standards of practice, such as admission and discharge, caring for patients' basic needs, documenting assessment notes, administering medication, monitoring medication effects, working in collaboration with inter-disciplinary team members, maintaining a safe environment and assisting patient recovery (Seed, Torkelson & Alnatour, 2010).

1.4 Research Context

The following section will focus on placing the reader within the research context of this study, providing the rationale behind investigating eating behaviour. This will include reviewing mental health nursing stressors, linking occupational stress to eating behaviour and obesity, and reviewing nursing obesity prevalence. Due to the lack of research focusing on inpatient mental health nurses, the literature presented within the topics below will be a combination of general hospital nursing and mental health nursing literature. Due to the nature of nursing, some elements of the different domains overlap, and these will be explored as such.

1.4.1 Mental health nursing stressors

The Migration Advisory Committee (2016) commissioned by the government acknowledged the national shortage of nurses. Questionnaire data indicated that 55% of

the 30,865 nursing staff surveyed experienced a shortage of one or more registered nurses on their last shift, 36% respondents stated that due to lack of time care was left 'undone', 59% reported insufficient breaks and 65% worked on average 53 minutes unplanned overtime (93% of those staff reported not being paid) (RCN, 2017). Specifically, 34% of 1,300 shifts from mental health inpatient settings were short of the planned number of registered nurses and 42% were short of health care support workers (RCN, 2017). The aforementioned figures may have adverse effects on patient care but also on nursing staff's physical and emotional well-being; high workload due to shortages of staff resulted in personal costs to nursing staff, such as inability to stay hydrated, eat or use the toilet (RCN, 2017). This research suggests that high workload due to shortage of staff is collectively evident across nursing as a whole, regardless of whether this is in the NHS or independent/private sectors. The Care Quality Commission indicated a decrease of 12% of NHS mental health nurses between 2010 and 2017 (CQC, 2017). Based on 47 NHS staff interviews, Carter et al. (2013) suggested that factors such as workload and organisational culture could be maintaining bullying in the workplace. The NHS survey revealed startling figures of staff reporting being bullied (20%) or witnessing bullying (35%) in the preceding 6 months (Carter et al., 2013).

A systematic review of research undertaken in the UK indicated mental health nurses (MHN) experience high occupational stress (Edwards & Burnard, 2003). The authors reported, some of the most common causes of occupational stress were attributed to administration that organisational matters, patient-related concerns, high workload, inter-professional conflict, lack of resources, professional self-doubt, home/work conflict, staff shortages, changes in health service, maintaining standards, lecturing, long wait lists and poor supervision. A qualitative study of health workers (n=12, 7 of whom were nurses) in an adult eating disorder inpatient service reported high workload and job dissatisfaction due to organisational factors such as time constraints and amount of paperwork (Davey, Arcelus & Munir, 2014). Furthermore, shortages in staff, poor team communication, shift work and financial issues were also reported (Davey et al., 2014). Consistent with the JDCS model, social support from colleagues was valued by staff working in inpatient settings (Davey et al., 2014). Forensic MHN reported that the main sources of occupational stress were inter-professional conflicts, workload, and not being involved during decision-making (Dickinson & Wright, 2008). This literature review found evidence of stress and burnout in staff working within mental health settings. Tummers, Janssen,

Landeweerd and Houkes (2001) suggested that mental health nurses displayed greater levels of emotional exhaustion compared to general nurses.

Burnout can be defined as “emotional exhaustion” (Maslach & Jackson, 1981, p. 99) in “response to chronic occupational stress” (Dickinson & Wright, 2008, p. 82). Furthermore, authors determined that nurses’ sense of power, decision-making and control were all protective factors against burnout, which is consistent with the JDCS model (Dickinson & Wright, 2008). A literature review study found that clinical supervision provided support and helped reduce stress when applied in nursing practice (Brunero & Stein-Parbury, 2008). However, Tobias, Ives and Garnham (2016) found that in a London-based nursing staff in an adult mental health and learning disability service supervision rarely happened. There was insufficient opportunity to reflect on practice, and time constraints reduce supervision to a ‘box-ticking exercise’. Supervision also increased workload, and consequently, some respondents described having to sacrifice their own time to do supervision. Research also reported that high workload and limited social support predicted emotional exhaustion in MHN (Tummers et al., 2001). It is therefore clear that emotional exhaustion is associated with job dissatisfaction, which in turn may predict the intention to leave the mental health profession (Yanchus, Periard & Osatuke, 2017). In addition, stress, burnout, lack of job satisfaction and poor work environment were often named as causes for leaving the nursing occupation (The Migration Advisory Committee, 2016). This has led to the staff recruiting and retention difficulties as stated by the Royal College of Nursing (2017): “for the first time in years there are now more nurses and midwives leaving the NCM register than joining” (RCN, 2017, p. 2).

The JDCS model therefore gives a better understanding of the stressors predicting psychological strain in mental health nursing. As the above-mentioned studies described, staff shortages, high workload, stress and emotional exhaustion/burnout appear to be present across nursing generally, but of particular interest regarding this study, in mental health settings. The occupational hazard of violence and aggression, however, seems to be more evident in inpatient mental health settings. Published figures indicate that 68,683 physical assaults of NHS workers occurred between 2013 and 2014, 69% in the mental health domain, mainly in inpatient settings (Renwick et al., 2016). Reported injuries transpired directly from patient assaults or during physical interventions (i.e., restraint) to maintain safety (Renwick et al., 2016). NICE (2015) suggested inpatient violence and

aggression is dependent on a complexity of intrinsic factors (i.e., personality characteristics, mental distress) and extrinsic factors (i.e., attitudes and behaviours of staff/other service uses, physical environment and involuntary restrictions on freedom). The NICE (2015) guidelines acknowledge that prevention of aggression and violence is not always achievable and therefore state that restrictive interventions (i.e., manual restraint, mechanical restraint, seclusion/confinement in a supervised locked room, or rapid tranquillisation) may only be used if de-escalation or other preventative measures have failed to avert situations that could result in violence and aggression. These measures are taken in order to maintain a safe environment and protect others from significant harm. A literature review indicated that the prevalence of situations requiring manual restraint on an average 20-bed adult mental health inpatient ward was around five incidents per month, where manual restraint was defined as "physically holding the patient to prevent or restrict movement" (Stewart, Bowers, Simpson, Ryan & Tziggili, 2009, p. 3). Through semi-structured interviews, Wilson, Rouse, Rae, and Ray (2017) found restraint to be a generally negative experience for both mental health inpatients and staff. The authors suggested that more support is required for staff and patients in managing the negative emotional, physical, and relational impacts of restraints, such as through supervision, counselling, and/or in-depth debriefs.

Ward (2013) found that nurses working in an acute inpatient mental health setting described violence and "fear of the unexpected" as "being part of the job", to some extent due to the unpredictability of patients' behaviour. Additionally, interviewees experienced work pressure as impeding patient care and observation, which in turn could cause miscommunication between nursing staff and patients, potentially resulting in violence (Ward, 2013). Research suggested that incidents of verbal aggression were most often reported in mental health settings, and that swearing caused distress for nurses (Stone et al., 2011). Furthermore, 83% of 411 mental health employees working in inpatient units reported exposure to some form of violence over a 12-month period, with 33% of these reporting psychological distress (Tonso et al., 2016). The low response rate (26%) may indicate skewed prevalence rates, as individuals affected by violence might be more likely to participate in this research area. However, prevalence of non-physical inpatient aggression towards MHN at work, in East London, UK, was also reported, at a high level of 80-90% for verbal abuse and threats, and 68% for sexual harassment and intimidation in the preceding 12-month period (Nijman, Bowers, Oud & Jansen, 2005). Severe physical

violence was reported by 16% of employees, and this was the strongest predictor of absenteeism.

Research found that inpatient assaults were associated with depression and anger (Kelly, Fenwick, Brekke, & Novaco, 2016). Furthermore, Lee, Daffern, Ogloff, and Martin (2015) concluded that MHN nursing is a challenging and stressful occupation, and combined with inpatient aggression plays a significant role in the development of post-traumatic stress disorder (PTSD). They found no significant differences between occupational stress levels or frequency of exposure to aggression reported by forensic and mainstream MHN. However, 14-17% of nurses met the diagnostic criteria for PTSD and 36% scored above the threshold for caseness. Furthermore, a Japanese research study indicated that 55% of psychiatric nurses (n=531, response rate 94.5%) had encountered inpatient suicide and 13.7% of nurses' Impact of Event Scale-Revised (IES-R) scores indicated high risk of PTSD (scored 25 or more on the 88-point IES-R) (Takahashi et al., 2011).

1.4.2 Linking occupational stress to eating behaviour and obesity

Studies have investigated eating behaviour when participants were exposed to real and/or perceived stress. Online survey data suggested there was an increased drive to eat when experiencing stress (Groesz et al., 2012). The women who participated in the survey ranged in weight from normal to obese. The small effect size shown in the study suggests that the results should be considered with caution; moreover, the authors drew attention to the unrepresentative sample (possibly lacking highly stressed individuals) and potential social desirability effect. However, other studies also found an inclination towards consuming high-calorie foods (sugars and fat) when individuals experienced stress (Torres & Nowson, 2007). Torres and Nowson (2007) reviewed animal and human research investigating stress, eating behaviour and obesity. They reported that stress could either increase or reduce eating. Additionally, they indicated that chronic life stress might be linked with high-calorie food consumption. However, they highlighted limitations regarding the longitudinal studies such as inaccurate reporting relating to long-term eating behaviour and also acknowledged that many studies tend to focus only on acute stress in laboratory settings (Torres & Nowson, 2007).

Fryer, Waller and Kroese (1997) suggested that disordered eating is an emotion-focused coping strategy for stress. Stress-induced eating could potentially be a contributing factor to obesity. A review paper searched conceptual models of the inter-relationships between obesity and the occupational environment by utilising PubMed database. The authors found that obesity could be correlated with occupational hazards such as work stress and long working hours (Pandalai, Schulte & Miller, 2013). As discussed above, nurses are continuously exposed to such occupational hazards.

1.4.3 Nursing obesity

The prevalence of being overweight and obese amongst nurses was reported as 50.6%, 55% and 59% of the population samples in the following studies respectively (Coomarasamy, Wint, Neri, & Sukumaran, 2014; Han, Trinkooff, Storr & Geiger-Brown, 2011; Nahm et al., 2012). However, the majority of respondents were women (95%) in all the above-mentioned studies reporting prevalence rates of obesity, and therefore the findings cannot be generalised to the male gender.

However, a cross-sectional study of 4,996 registered nurses, working nurses and midwives in Australia (n=3,144), New Zealand (n=778) and the United Kingdom (n=1,074) showed 61.87% were categorised outside the healthy weight range, and prevalence of obesity surpassed the general national populations by 1.73% to 3.74% (Bogossian et al., 2012). Furthermore, being overweight and obese was significantly correlated with the male gender. Although male nurses and midwives only made up 9.35% of the total respondents, the majority of male participants were overweight (45.22%) or obese (22.84%). Most of the participants in this study resided in Australia, so the findings might not hold for other parts of the world, and the potential social desirability effect when self-reporting weight may be a limitation of the study design. However, Fernandes, Portela, Rotenberg & Griep (2013) also found that Brazilian male nurses (n=298) were more likely to be overweight compared to female nurses (n=1,981).

Kirk, Cockbain and Beazley (2008) suggested that hospital nurses underestimated their body weight and size, however, they were more accurate in perception than lay people. Similarly, Zhu, Norman and While (2014) found that only 68% of qualified nurses (n=409) and 77% of student nurses (n=355) accurately self-perceived their weight status. They

found that being overweight, as classified by BMI scores, was significantly associated with weight status misperceptions for both qualified and student nurses. Furthermore, black ethnicity and having family histories of obesity were also significantly associated with weight misperceptions in student nurses. The authors suggested raising that self-awareness amongst nurses might encourage healthy living. Limitations of this study included: a convenience sample and therefore bias through selective recruitment; small sample of males (10%); and self-reported BMI scores that may have been under- or over-estimated. Miller, Alpert and Cross (2008) inferred that motivation played a key role in change, as although 53% of nurses (n=760, 92% female) stated they were overweight, they reported not having the discipline to change their lifestyle behaviours. The low response rate (15.5%) may indicate selection bias.

Han et al. (2011) showed that there was a significant correlation between long working hours, decrease in job-related activities and obesity. The authors concluded that the lack of quality and quantity of sleep in turn reduced the likelihood of healthy behaviour. This study used self-reported questionnaires, which might have limited the participants' responses, or led to inaccurate reporting of weight. Similarly, Smith, Fritschi, Reid and Mustard (2013) found a significant correlation, albeit weak effect, between higher BMI scores and Canadian female nurses working night and mixed shifts rotas compared to regular daytime shifts. This association was also observed in male participants, however was not statistically significant, potentially due to the small sample size.

The above-mentioned research indicated that individual factors, such as motivation and self-awareness, and occupational factors, for example, shift work and long hours, might be associated with obesity. The World Health Organization (1997) suggested that identifying environmental and behavioural factors exacerbating weight gain is complex, but determined that reduced physical activity and overconsumption of high-fat energy-dense foods played a fundamental role.

1.5 Literature Review

As discussed above, eating plays a central part in the general health and well-being of nurses. Therefore, the aim of the literature review was to identify male mental health nurses' experience of eating within a ward-based mental health setting. A search strategy was devised to combine the following key parts of:

Participants: Nurses, male and/or female. Initial "men"/"male" key words failed to identify research with male-only participants or mental health nurses, key words included "mental health nurses", "mental health nursing", "psychiatric nurses" and "psychiatric nursing"; therefore comparable research included female and male participants in all nursing fields. Final key words used: "nurses" and "nursing".
Context: The literature review aimed to include hospital/ward-based or similar occupational settings in any country. Initial narrow search including "hospital" as a key word failed to identify research. Final key words: "workplace" and "occupation".
Topic: The review aimed to include eating and food. Key words: "eating", "healthy eating", "disordered eating", "abnormal eating", "eating behaviour", "diet" and "nutrition"; furthermore other aspects related to eating was also explored such as "health behaviour", "lifestyle behaviours", "physical health", "general health", "weight", "overweight", "obesity", "barriers" and "self-care", as identifiable keywords by other relevant journals investigating nurses' eating behaviours.

The keywords were entered into "Google" search engine, as well as, a literature search engine – the University "CityLibrary Search" that included multidisciplinary databases providing access to scientific journals. Studies were therefore selected based on the following criteria: 1) majority of the participants must be qualified nurses, 2) nurses working in hospitals or ward-based settings and 3) results included eating behaviour. Quantitative and qualitative research was included, and journals must be written in English. Exclusion criteria were studies primarily with student nurses/other staff.

Nineteen studies were included in the literature review, five were qualitative in design and 14 were cross-sectional in design - using self-administered questionnaires. See Table 2.1 for a summary of literature included in the review:

Author	***Design***	***Setting & Country***	***Participants***	***Data collection method***	***Strength/s***	***Weakness/es***
Almajwal (2015)	Cross-sectional	Two hospitals in Saudi Arabia	Nurses (n=362)	Questionnaire	-Systematic random sampling -Pilot-tested questionnaire	-Only female participants -Possible inaccurate self-reporting -Survey potentially limits participant responses
Blake & Patterson (2015)	Cross-sectional	Acute NHS hospital trust in UK	Paediatric nurses (n=67)	Questionnaire	-Standardised measures used where possible -Pilot-tested questionnaire	-Primarily female participants (88%) -Low response rate (23%) thus potential selection bias -Potential response bias (i.e. social desirable responses) -Survey potentially limits participant responses
Coomarasamy et al. (2014)	Descriptive, cross-sectional, survey design	Public hospitals in Malaysia	Nurses (n=1086)	Questionnaire	-Large sample size -High response rate -Survey was pilot-tested for validity and reliability (Cronbach's coefficient alpha of 0.7)	-Only female respondents - Majority of respondents were between 31-60years of age (74.4%) -Survey potentially limits participant responses
Faugier et al. (2001a)	Cross-sectional	Six acute hospitals and two NHS sites in UK	Nurses (n=126)	Questionnaire	-Two-part study (quantitative and qualitative)	-Did not report gender of participants -Purposive sampling (potential selective bias)

Faugier et al. (2001b)	Qualitative interviews and observation	Six acute hospitals and two NHS sites in UK	Nurses (n=24)	Unstructured qualitative interviews and observation	-Two-part study (quantitative and qualitative) - Observational methods (observe the use of catering facilities)	-Did not report gender of participants -Purposive sampling (potential selective bias)
Fernandes et al. (2013)	Analysis of Cross-sectional data	18 Public hospitals in Brazil	Nurses (n=2279)	Questionnaire	-Large sample size	-Primarily female participants (87.3%) -Small male participant size – cannot establish statistical associations -Survey potentially limits participant responses
Jinks et al. (2003)	Cross-sectional	Hospitals in Wales	Hospital staff (n=1021)	Questionnaire	-Large sample size -Pilot study used to test questionnaire presentation, appropriateness and ease of understanding (amendments in light of comments were made)	-Primarily female participants (84.6%). -Only 48% participants were nurses -30% of respondents failed to answer questions related to healthy food options -Survey potentially limits participant responses

King et al. (2009)	Cross-sectional	Health sites in USA	Registered & LPN nurses (n=435)	Questionnaire	-Random selection - Large sample size (272 participants were required to be representative of the population)	-Primarily female participants (95%), Caucasian and over 31 years of age. -Low response rate (47%) -Survey potentially limits participant responses
Malik et al. (2011)	Cross-sectional, comparative	Teaching hospital (in NHS Trust) in UK	Pre-registered nurses (n=325) and Registered nurses (n=551)	Questionnaire	-Large sample size	-Primarily female participants (91.4%). -Survey potentially limits participant responses -Causal relationship cannot be determined
Naghashpour et al. (2013)	Cross-sectional, comparative	Six hospitals in Iran	Nurses (n=55 day-time nurses, n=43 shift working nurses)	Questionnaire	-Three-stage sampling design (random sampling selection applied to; hospitals, volunteers, and categorization of day/night shift) -Recognised measures used (i.e. Beck Depression Inventory) -Nutritionist reviewed participant food recall.	-Only female participants -Survey potentially limits participant responses -Potential inaccurate self-reporting (nutrition)

Nahm et al. (2012)	Cross-sectional, descriptive	Urban teaching hospital in US	Nurses (n=169), And Administrator/manager (n=10)	Questionnaire	-Used some open-ended questions -Applied items successfully used in other studies & recognised measures (i.e. Perceived stress Scale)	-Primarily female participants (95%) -Small study -Potential inaccurate self-report (recall bias) -Low response rate
Nicholls et al. (2017)	Integrative mixed method review	Nurses in any country	Nurses (26 publications)	-Integrative literature review - Social-ecological framework - Thematic analysis	-Qualitative and quantitative studies included -Quality appraisal by two researchers using standardised checklists	-Results dependent on publications reviewed, these studies' limitations included; low response rate, recruitment bias and questionnaires not validated/standardised.
Persson & Martensson (2006)	Qualitative, descriptive	Health sites & home visits in Sweden	Night-shift Nurses (n=27)	Critical Incident Techniques & Semi-structured Interviews	-Highly homogenous group -Pilot interviews tested questions	-Non-ward-based nurses (Included in review due to unique insight in eating behaviours during night-shifts) -Only 2 male nurses
Phiri et al. (2014)	Qualitative (Thematic analysis)	5 Public hospitals in South Africa	Nurses (n=102) & management (n=9)	12 focus groups, 7 interviews	- Large sample size (gaining information from both focus groups and interviews) -Independent transcriber -Qualitative Data Analysis Software used as an additional tool	-Gender of participants were not reported -Small number of night-shift (n=9) -Potential social conformity/ social desirability bias in group interviews with fellow colleagues

Power et al. (2017)	Qualitative	Hospital in Scotland	Nurses (n=16)	16 semi-structured interviews	-Achieved data saturation at interview number 16	-Gender of participants were not reported -Potential social desirability bias
Sahu & Dey (2011)	Cross-sectional	Public hospitals in India	Nurses (n=75)	Questionnaire	-Participants chosen at random from different government hospitals -Food consumed measured with standard spoon	-Gender of participants were not reported -Potential social desirability bias
Tada et al. (2014)	Cross-sectional	Nursing institutions in Japan	Nurses (n=5536)	Questionnaire	-Large sample size	-Only female participants -Potential social desirability bias (self-reported questionnaire)
Wong et al. (2010)	Cross-sectional	Acute hospital in Hong Kong	Nurses (n=378)	Questionnaire	-Standardised measures used (DEBQ)	-Primarily female participants (91.5%) -Modest sample size and response rate may limit generalizability
Zapka et al. (2009)	Cross-sectional	Six hospitals in USA	Nurses (n=194)	Anthropometric measurements and questionnaire	- BMI physically measured (not self-reported)	-Primarily female participants (92.6%) - Potential selection bias (Response rate 54%) -Limited generalizability (small number of hospitals) - Potential recall bias and/or social desirability

Table 2.1: Summary of literature review

The studies included in this review will be discussed below in two parts; 1.5.1 Nursing eating behaviour, and factors affecting healthy eating in 1.5.2 Health behaviour and limiting behaviour.

1.5.1 Nursing eating behaviour

Malik, Blake, and Batt (2011) reported healthy eating included the consumption of five portions of fruit or vegetables on a daily basis. It is important to define what 'healthy eating' may look like, particularly in the case of nurses, before discussing further literature. See Figure 2 for healthy eating guidelines (Nicholls, Perry, Duffield, Gallagher and Pierce, 2017, p. 1053):

Adhere to a normal day and night pattern of food intake which is rich in fruit, vegetables, pulses, whole grains and nuts
Eat a variety of food choices: 'complete' meals (animal foods and/or protein rich vegetable foods + non-starchy vegetables and fruits) or vegetarian meals and 'high quality' snacks (from complete and/or vegetarian food groups)
Avoid foods and beverages classified as 'low quality snacks' (alcohol or food products with added sugar)
Avoid an over-reliance on (high-energy content) convenience foods and high-carbohydrate foods and avoid sugar-rich products and non-fibre carbohydrate foods
Maintain regular meal times
Divide the 24-hour intake into eating events with three satiating meals
Avoid or restrict eating between midnight and 6 am; eat at the beginning and end of each shift and avoid eating large meals (>20% of daily energy intake) before sleep
Allow adequate time between shifts for meal preparation and sleep
Maintain a healthy lifestyle when not working (exercise, regular meal times, good sleep hygiene)

Figure 2: Guidelines for healthy eating for nurses (Adapted from Lowden, Moreno, Holmbäck, Lennernäs & Tucker, 2010, pp. 159-160).

Malik et al. (2011) investigated health behaviour in 325 pre-registered and 551 registered nurses in a NHS trust. The results of the self-administered health and lifestyle

questionnaire showed that 42.5% ate foods containing high fats and sugar daily, and 64.8% reported not consuming five fruits or vegetables per day. The large sample size increases generalizability of results however, the majority of respondents were female (91.4%). The cross-sectional design cannot infer causality, however authors suggest the current study provides some knowledge regarding health behaviours of nurses. In addition, the self-reported data is subject to a social desirability bias. Nevertheless, a smaller study indicated a similar trend in the lack of health behaviours – of the 67 paediatric nurses 79% did not consume the recommended five portions of fruit or vegetables daily (Blake & Patterson, 2015). Although the standardised measures and a pilot-tested questionnaire were used to increase internal validity, the response rate was low (23%) and therefore potential selection bias and high percentage of female participants (88%) may result in an unrepresentative sample.

A cross-sectional online survey study invited US nurses to participate in the investigation of their self-care behaviours (Nahm et al., 2012). Using questionnaires successfully applied in previous literature, recognised measures and some open-ended questions, increased the internal validity of this study. The participants reported irregular meal patterns (54%) such as skipping meals due to lack of time and inability to take a break. Work stress was also reported to be associated strongly with irregular meal patterns. In addition, participants reported eating as the main stress-reduction method, followed by exercise. The low response rate, small sample size and the majority of participants being Caucasian and also female (95%), were some of the limitations associated with the above-mentioned study. The authors suggested that although nurses are well aware of healthy living, their knowledge is not implemented in their own self-care. A psychological theory to understand nurses' self-neglect may come in the form of the Schema Therapy framework. The notion is that nurses may have an "excessive focus on the desires, feelings, and responses of others, at the expense of one's own needs" (Young, Klosko & Weishaar, 2003, p. 17). This can be termed subjugation, which is an "excessive surrendering of control to others because one feels coerced - submitting in order to avoid anger, retaliation, or abandonment" (Young et al., 2003, p. 17), or self-sacrifice, defined as the "excessive focus on voluntarily meeting the needs of others in daily situations at the expense of one's own gratification" (Young et al., 2003, p. 17). *Others* in the context of nursing may refer to patients in the nurses' care. Nurses may feel coerced into subjugating

their needs in order to meet work demands, such as skipping meals due to the lack of time.

A Malaysian study of 1,086 female nurses found similar results; 37.2% reportedly skip a meal per day (Coomarasamy et al., 2014). The authors concluded that missing meals was attributed to working conditions, such as long working hours, work schedules and work demands. Furthermore, they found that 18.4% of the sample indicated eating when stressed. While this study had a large sample size, high response rate and included a pilot-tested questionnaire (tested for validity and reliability), the sample was female-only, mostly Malaysian and middle-aged nurses, therefore not representative of all nurses and survey data could have limited their answers.

Similarly, King et al. (2009) found a significant correlation between high occupational stress and disordered eating amongst licensed practical and registered nurses (n=435). In categories marked 'frequently' or 'always' the nurses reported eating when stressed (33%), bored (34%) and upset (31%). Participants reported feeling guilty (11.6%) and out of control (11.1%) after eating. In addition, they found that there was an increased risk of disordered eating when nurses perceived occupational stress as high and body satisfaction as low. This study had a low response rate of 47% due to inviting participants by post. However, the strength of this study included random selection and a large participant size, which satisfied the requirement of a minimum of 272 participants to be representative of the population. Nonetheless, the sample responding to the survey was residing in America, mostly female, Caucasian, over the age of 31 and therefore not representative of all nurses.

In a separate study, acute hospital nursing respondents (n=378, 91.5% female) in China were shown to have abnormal emotional, external and restraint Dutch Eating Behaviour Questionnaire (DEBQ) scores, indicating a total of 66.4% of participants eating in response to emotional arousal, 61.4% eating in response to sight and smell of food, and 64.0% over-eating after a period of dieting (Wong, Wong, Wong & Lee, 2010). Furthermore, they found that shift work was correlated with abnormal emotional eating and restraint eating. Only 8.5% of respondents were male, and the study therefore potentially mostly encapsulated female eating behaviours. In addition, the modest sample size, response rate and potential cultural differences could limit this study's generalisability.

In addition, Almajwal (2015) investigated eating habits, physical activity, shift duty, BMI and reported barriers of 362 non-Saudi female nurses residing in Saudi Arabia. This study's strengths included systematic random sampling and the use of a pilot-tested questionnaire. They found that nurses reporting skipping breakfast regularly and eating fast food frequently predicted significantly higher BMI overweight and obesity scores. Furthermore, the author reported that nurses working night shifts scored significantly higher on BMI than day shift staff. The limitations of this study include the possible inaccurate self-reporting of weight and height for BMI calculation, physical activity and reported food intake. Nonetheless, it is important to explore and acknowledge the resultant impact of potential differences in eating and health behaviours of nurses working day shifts and night shifts. These findings are briefly discussed below.

Sahu and Dey (2011) indicated that eating might differ in day shifts and rotating shifts (morning, afternoon and night shifts). The authors found that nurses working night shifts in eastern India had significantly less overall food intake over a 24-hour period, decreased appetite and eating satisfaction, but higher snack consumption, compared to day workers. The authors suggested that rotating shifts disrupt eating patterns, as nurses eat outside of their preferred meal times, which therefore results in eating dissatisfaction and gastrointestinal problems. They also suggested that nurses working night shifts eat less during dinnertime and attempt to compensate by eating snacks during the night. However, nurses also mentioned the lack of facilities to have full meals during night shifts. Although 40 nurses working rotating shifts and 35 general nurses were randomly selected, the small sample size limits the generalisability of these results.

By contrast, Naghashpour, Amani, Nematpour, and Haghighizadeh (2013) found no difference in overall energy consumption between female hospital nurses in Iran working day shift (n=55) and shift work (n=43), compared to working outside normal daylight hours or weekends. The authors indicated that shift work is correlated with unhealthy lifestyle behaviours, for example, nutritional deficiencies, including lacking vitamin B, magnesium and iron. Strengths of this study included random sampling, recognised measures (i.e. Beck Depression Inventory) and a nutritionist review. Limitations of this cross-sectional comparative design study are that causality cannot be inferred; participants are not a representative sample (only female participants) and micronutrients did not measure nutritional status.

Questionnaire data of 5,536 Japanese female nurses revealed that working rotating shifts was significantly associated with higher BMI scores, drinking more sugary beverages, and sleeping less compared to their day shift counterparts (Tada et al., 2014). The large sample size is the major strength of this study, increasing the generalisability. Limitations of this study included: female participants only; causal relationship cannot be established; self-reported questionnaires (social desirability bias); and response rate of 65.9% (selection bias).

In summary, research indicates that it is common for nurses to engage in unhealthy lifestyle behaviours such as low physical activity levels and unhealthy diets (high content of fats and sugar). Furthermore, nurses described irregular meal patterns, such as skipping meals due to a lack of time and inability to take a break. Nurses reported emotional eating when stressed, bored, and upset, as well as restraint and external eating. Research suggests that nurses perceiving occupational stress as high and body satisfaction as low results in an increased risk of disordered eating. Night-shift eating, however, appears to evidence some differences when compared to day-shift eating. Although these studies reported inconsistent data on overall food consumption during night shifts compared to day shifts, by and large nurses on night shifts appear to drink more sugary beverages, have nutritional deficiencies, higher snack consumption, disrupted eating patterns, engage in less physical activity and have higher BMI.

1.5.2 Health promoting and limiting behaviour

An integrative systematic review found that the nursing occupational environment had a negative influence on nursing staff's dietary intake (Nicholls et al., 2017). In particular, long working hours and shift work were perceived as barriers to healthy eating. Eating behaviour is a complex phenomenon and authors suggested that variables such as social factors, for example, eating with colleagues, personal characteristics, for example, self-efficacy, motivation, and knowledge, and the physical environment, for example, availability of healthy food at work, all played an important role in nurses' eating behaviour. Two researchers quality appraised the studies included in the above-mentioned systematic review paper, using standardised checklists to increase reliability of the results.

A qualitative descriptive design study found two principle areas potentially influencing healthy lifestyle behaviours of nurses working night shifts, namely coping ability at work and coping ability during leisure hours (Persson & Martensson, 2006). The authors suggested that at work, participants were influenced by colleagues, for example, craving junk food when others were eating, and by the disruption to their circadian rhythms, resulting in craving sweet foods, preferring fast food due to lack of time, and eating unhealthy food as a means to stay awake. Furthermore, the authors proposed that recovering from disrupted circadian rhythm during leisure hours meant that participants perceived, for example, that they were hungry and peckish for something sweet and due to tiredness refrained from exercise. In addition, participants reported that high work demands increased stress and subsequent unhealthy eating, such as consumption of junk food. However, the authors stated that in general participants had healthy eating habits. The small sample size (typical of qualitative research) and the fact that in this Swedish study there were only 2 male participants out of 27 community nurse participants means generalisability is questionable. However, the study gives valuable insight into the potential barriers to healthy eating during night shifts in this homogenous group.

A study commissioned by the NHS Executive North West found nurses' shift patterns and failure to take breaks to be key barriers to healthy eating (Faugier, Lancaster, Pickles & Dobson, 2001a). Of the 126 participating nurses, 6% 'never', 15% 'almost never' and 16% 'sometimes' took meal breaks. The most common reasons given for not taking regular breaks were: too busy due to workload; low staffing levels; breaks too short to eat due to work demands. However, a complementary qualitative study of 24 unstructured interviews gave a more in-depth understanding of breaks, staffing levels and workload issues within nursing work arrangements (Faugier, Lancaster, Pickles & Dobson, 2001b). The authors reported that nurses perceived an expectation to miss meals in some clinical areas, but in other areas staff were encouraged to take breaks. One interviewee suggested that "Nurses are their own worst enemy because they care – it is not possible to leave a patient if they need you." However, Faugier et al. (2001b) suggested that the clinical areas observed were busy and had a high rate of patient admissions, frequently perceived by nurses to 'dictate' breaks. Furthermore, some nurses acknowledged that skipping breaks could potentially cause tiredness, stress and mistakes. The authors reported that skipping breaks usually resulted in nurses eating 'on the run' and 'inappropriately' later in the day.

In addition, a qualitative study reported that food availability, variety, and distance from catering facilities were also barriers in healthy eating among nurses (Faugier et al., 2001b). Nurses reported that healthy food options were restricted between core lunch hours, therefore, evening and night shift staff had to bring in their own prepared meals or have takeaway food. Nurses also perceived the food choices at the work canteen to be generally limited and dull. Faugier et al. (2001a) reported that 70% of nurses found eating easier during the day due to the broader choice of food on day shifts. Furthermore, participants found the distance from the catering facilities wasted their 'time', as it was a long way to walk and they had to queue for food (Faugier et al., 2001b). In the first part of the study, potential selection bias due to the purposive sampling may have been a limiting factor, and the study did not report demographical information such as gender (Faugier et al., 2001a). The second part of the study gathered and collaborated subjective and objective information through the means of qualitative interviews and observations (Faugier et al., 2001b). This strengthened the conclusions drawn. Together, this two-part study gave a better insight into healthy eating barriers perceived by nurses.

A South African qualitative study investigated barriers to healthy living identified by state hospital nurses (Phiri, Draper, Lambert & Kolbe-Alexander, 2014). They found that nurses working night (n=57) and day shifts (n=93) reported factors associated with their working environment: increased workload, including shortage of staff; occupational stress; family conflict due to feeling irritable, work demands and 12-hour shifts decreasing family time; weight gain; and coping strategies such as maladaptive eating behaviours and alcohol abuse (Phiri et al., 2014). Some nurses stated that they ate throughout the day due to occupational stress. Furthermore, the participants deemed the available food at their workplace to be generally unhealthy, and found the healthier options more expensive. The strengths of this study included results drawn from focus groups and 1:1 interviews, an independent transcriber and Qualitative Data Analysis Software utilised. However, participant gender was not reported, only a small number of night-shift participants (n=9) were included and potential social conformity in focus groups may have been associated with the limitations of this study.

A qualitative study used a theoretical framework to summarise the perceived barriers to healthy eating and physical activity reported by North East Scotland hospital nurses (Power, Kiezebrink, Allan & Campbell, 2017). The authors determined that data saturation

was reached after 16 interviews. They found that environmental, inter-personal and intra-personal factors influenced nurses' eating behaviour. Power et al. (2017) suggested that the availability of unhealthy food at work triggered over-eating, such as sweets given by patients' relatives. Factors such as distance from, cost, and unavailability of healthy food consequently led to nurses eating unhealthy food such as burgers or crisps. Furthermore, shift work was perceived as "long", "busy" and "erratic", and participants described going "long spells" without eating as they struggled to "fit in breaks". Nurses in this study perceived that adequate breaks were fundamental in eating well and preventing "pigging out" at home after a shift at work. Nurses described healthy eating and physical activity as more difficult when they wanted to be "social" and "savour" their days off. The authors also reported that 10 nurses perceived being "exhausted" due to shift work and consequently their eating and physical activity was impacted. Some nurses also reported eating "junk" food when feeling stressed, and "comfort" eating when dealing with work-related stress. The authors determined that one limitation of investigating the perception of eating behaviours might be that participants do not have full awareness of their own eating behaviours; research indicated that the majority of daily eating-related decisions are made unaware. Similarly, when participants reported eating behaviour, perhaps perceived to be unhealthy, potential conscious or unconscious social desirable answers may have resulted.

Phiri et al. (2014) suggested that nurses perceived colleagues to influence their health behaviours in both positive and negative ways. Some nurses described colleagues as providing helpful support and information regarding healthy food choices, whereas others were reportedly made to feel guilty by colleagues if they declined unhealthy foods such as cakes. Similarly, Power et al. (2017) found that nursing colleagues were both a motivating factor in healthy behaviours and a barrier. They suggested that support from a colleague could motivate engagement in physical activity, however, social pressure might encourage eating unhealthy food a colleague had brought in.

Zapka, Lemon, Magner and Hale (2009) suggested that cultural norms amongst colleagues might support the lack of healthy behaviours, i.e. unhealthy diet. They reported 62% of the 194 nurses surveyed (7.4% male) were undertaking a method of weight loss. Respondents indicated their average daily consumption of fruit and vegetables were lower and fat consumption was higher than the recommended US government guidelines. Male

respondents were more likely to report higher daily intakes of fruit and vegetables. The limitations of this study were the low response rate (54%), potential selection bias, social desirability and the use of a survey (limits respondents' answers). In contrast, Callaghan (1998) found social support did not increase nurses' health-promoting behaviour except for eating fruit. An internal locus of control was a higher correlating factor with healthy living in this UK-based study. A cross-sectional survey was used and therefore cause and effect cannot be attained. However, some research has suggested that nurses conversing about diet and exercise increased their belief in their capacity to engage in health behaviours and that having supportive colleagues made it easier to decline unhealthy food offers (Persson & Martensson, 2006).

Fernandes et al. (2013) found that Brazilian male nurses (n=298) were more likely to be unhealthier; more likely to be overweight and obese, reporting higher consumption of fried foods and eating less fruit and vegetables compared to female nurses (n=1,981). Although this study had a large sample size, authors cautioned the male-female statistical associations presented due to the small male participant comparable group. Nonetheless, perhaps a lack of awareness may contribute to unhealthy lifestyle choices – a study by Jinks, Lawson and Daniels (2003) reported an absence of knowledge about health behaviours amongst male participants. The authors' descriptive questionnaire study of NHS staff's (n=1,021, 48% nurses) health needs in North Wales indicated that 84% wanted to improve their health, such as by increasing physical activity, managing stress more effectively and eating more healthily. This study's strengths included a large sample size and pilot-tested questionnaire.

1.5.3 Summary

In summary, occupational factors such as staff shortages and high work demands in the nursing profession may increase occupational stress. Nurses report being too busy and subsequently going "long spells" without eating as well as skipping meals due to struggling to "fit in breaks". Nurses described "pigging out" at home after a shift if they had inadequate breaks. Nurses also described weight gain, over-eating after a period of restraint, and maladaptive coping strategies such as emotional eating behaviours and alcohol abuse, as well as eating "junk" food for "comfort" when feeling stressed. Furthermore, research suggested that the availability of unhealthy food at the workplace

triggered nurses to over-eat (external eating). Nurses expressed being “exhausted” due to shift work, which impacted on their eating and meant that they refrained from physical activity due to tiredness. Research suggests that disruption to circadian rhythms potentially led to nurses craving sweet foods, choosing fast food due to lack of time, and eating unhealthy food as a means to stay awake. Furthermore, factors such as distance from the canteen, as well as cost and unavailability of healthy food, led to nurses eating unhealthy food. Nurses appear to drink more sugary beverages, have greater nutritional deficiencies, higher snack consumption, more disrupted eating patterns, engage in less physical activity and have higher BMI when working on night shifts. Research found that nurses perceived family roles and responsibilities to be in conflict with prioritising health behaviours, meaning they were left with less time for eating healthy. The aforementioned studies showed a high prevalence of overweight and obese nurses. Research indicated that the majority of nurses reported low physical activity levels and unhealthy diets. Maladaptive coping styles such as emotional eating and low levels of physical activity are associated with weight gain in nurses.

1.6 Purpose of the Study

The literature review has given some insight into the global concerns of occupational stress, eating behaviours and obesity within the nursing environment. However, the studies included in the review had the following limitations, see table 2.1 for details; 1) Limited generalizability - some studies reported selection bias (low response rates), and recruitment bias (purposive sampling), additionally, a few studies did not report gender of participants at all, and the majority of studies reported low-to-modest participant population sizes comprised of mostly female participants, masking male voices; 2) Validity of questionnaires – some of the studies’ questionnaires were not validated, for example, with pilot studies or previous utilised questionnaires, and majority of studies developed closed-ended questions instead of open-ended questions, therefore making the establishment of validity more difficult as well as potentially limiting participants’ responses. Furthermore, potential response bias on self-reported questionnaires such as social desirability on the subject of health behaviours and BMI, and recall bias on nutritional diaries could affect the accuracy of the results.

There is evidently a gap in the research for more qualitative studies, as shown in table 2.1; of the 19 studies included in the literature review, five were qualitative in design and 14 were cross-sectional in design - using self-administered questionnaires. This method of gathering data such as surveys and Likert-type scales lend themselves to a reductionist approach. Furthermore, most of the research on eating focused on general registered hospital nurses. Therefore, mental health nurses' experience of eating is unrepresented in the current literature and is an important avenue to explore for the sake of the retention of MHN. Ultimately, the national shortage and poor retention rates affect the care of the more vulnerable populations within our society, such as mental health inpatients. In addition, as the majority of research participants in the field of nursing appear to be female, selecting male participants may provide unique insight, and may represent the 36% of staff that are male in the Nursing and Midwifery Council workforce (NMC, 2016). Other authors also made suggestions for future research; for example, Nahm et al. (2012) suggested exploring ways employers could help promote healthy behaviours in their policies. King et al. (2009) highlighted the importance of determining the factors increasing the risk of disordered eating amongst nurses and the potential role of occupational stress.

The literature review identified a lack of qualitative research focusing on inpatient mental health settings, nurses' holistic lived experience of eating, and male participants. As a result, the research focus for this study is: Male mental health nurses' experience of eating: An interpretative phenomenological analysis. This will elicit rich in-depth accounts that could benefit organisations and potentially inform organisational policies to promote healthy living among male mental health nurses.

1.7 Relevance of the Study to Counselling Psychology

Counselling psychologists enjoy an increasingly active role in the NHS (Frankland & Walsh, 2005). The British Psychological Society regards counselling psychologists competent to work within both the Employee Assistance Programmes and Occupational Health Settings (BPS, 2001). However, Gyllensten, Palmer and Farrants' (2005) qualitative study demonstrated organisational resistance to counselling stress interventions. Research recommended counselling as a beneficial intervention for nurses in their workplace, including increasing effective coping skills to promote nurses' well-being and managing the negative emotional, physical, and relational impacts of restraints, such as

through supervision, counselling, and/or in-depth debriefs (Chen & Haller, 2015; Donnelly, 2014; Wilson et al., 2017). Enhanced understanding of the subjective lived experiences of nurses has the potential to inform future workplace practices. Most of the research mentioned in the literature review is from an organisational or occupational perspective and less from the counselling or clinical psychological perspective. A focus on the latter would inform the counselling psychologist of the increasing variety of clinical presentations and challenges in occupational health settings, including how to support MHN within their workplace.

1.8 Aim of the Study

This Interpretative Phenomenological Analysis (IPA) research aims to elicit "rich, detailed, first-person account" experiences (Smith, Flowers & Larkin, 2009, p. 56). Before I present the specific aims of this study, it is important to define what "an experience" is.

Smith et al. (2009) state:

> At the most elemental level we are constantly caught up, unselfconsciously, in the everyday flow of experience. As soon as we become aware of what is happening we have the beginnings of what can be described as 'an experience' as opposed to just experience … When people are engaged with 'an experience' of something major in their lives, they begin to reflect on the significance of what is happening and IPA research aims to engage with these reflections. (pp. 2-3)

The overall research question of this study is: What is mental health nurses' experience of eating in an inpatient setting?

The study's specific aims are:

1. To explore the participants' reflections on their eating behaviour, through their thoughts and feelings.
2. To understand how the participants make sense of their eating behaviour, in and out of their occupational setting.
3. To consider a) the similarities and differences of eating behaviour across cases; and b)

eating behaviour and the well-being of male mental health nurses.

2 Methodology and Procedures

2.1 Overview

This chapter starts by introducing the rationale behind the chosen qualitative research design, including a discussion of the epistemological underpinnings. Thereafter, the overview and evaluation of Interpretative phenomenological analysis (IPA) (Smith, Flowers & Larkin, 2009) is discussed, followed by reflexivity considerations. And finally the data collection, ethical considerations and method of analysis relevant to this project are presented.

2.2 Choice of Methodology and Philosophical Considerations

2.2.1 Rationale for choice of methodology

As described in my literature review, there was a lack of research in both quantitative and qualitative studies representing mental health nurses' experiences of eating. I felt it was essential for my study to portray the fuller picture of the experiences of inpatient mental health nurses as an unrepresented sample in eating literature. This was my initial starting point to formulate my research question. Qualitative research therefore was the most obvious way to accomplish my aim in exploring this novel area. As Smith and Osborn (2003) stated, "IPA is especially useful when one is concerned with complexity, process or novelty." (p. 55). According to Strauss and Corbin (1998), the rationale for utilising a qualitative approach is when the researcher wants to find out from participants *what it was like to* experience certain conditions. I wanted to know what it was like for mental health nurses to eat within (and out) of their working environment. This entailed exploring how participants made sense of the world by their reflections, thoughts and feelings. Therefore I was essentially interested in the participants' meaning-making process and the meaning they attributed to events.

Smith et al. (2009) stated, "each major approach (the various versions of narrative, phenomenological, discursive and grounded methods) will offer a different view of what constitute 'data', what might be inferred from it, and what an analysis might seek to achieve" (p. 43). The authors therefore suggested that not all research questions would align with all qualitative approaches. To determine the appropriate qualitative approach, an

initial consideration was made between IPA and grounded theory (GT). GT aims to generate new theory that is *grounded* within the data collected (Willig, 2013). Therefore GT could have been an appropriate approach if the goal was to develop a theory to explain "how do mental health nurses' experience eating?" The method of GT involves guidelines on how to categorise descriptive labels, code categories, compare similarities and differences through comparative analysis, find examples that do not support categories through negative case analysis, and move from descriptive to analytic level. Further data can be collected if required for theoretical saturation, and if no new theory emerged with further data collection and data analysis, memo writing would be initiated (Willig, 2013).

The unique feature of grounded theory is the integration of data collection and analysis. The researcher attempts to *ground* the theory and reach theoretical saturation when no new categories emerge (Willig, 2013). The method does not specify a fixed order; it is an active process of reviewing and changing if new data surfaces (Willig, 2013). IPA and GT (abbreviated version) have similarities. Both approaches aim to produce or identify a cognitive conceptualisation of the participants' perception of the world through themes and theory emerging from the data. The systematic approaches are similar in the way they combine higher order units (core categories or master themes) through a cyclical process of constant comparisons of data and codes that evolve from the text. They aim to capture the essence (IPA) or fundamental process (GT) of all sets of data (Willig, 2013). However, Willig (2013) proposed that grounded theory has two major limitations; firstly, critics suggests the approach has a positivist epistemology, which disregards reflexivity; and secondly, the focus on "contextualised social processes" (p. 99) veers away from the phenomenological inquiry.

Smith et al. (2009) wrote:

> Clearly there is an overlap between IPA and what grounded theory can do, and both have a broadly inductivist approach to inquiry. On the whole, however, an IPA study is likely to offer a more detailed and nuanced analysis of the lived experience of a small number of participants with an emphasis on the convergence and divergence between participants. By contrast, grounded theory study of the same broad topic is likely to wish to push towards a more

> conceptual explanatory level based on a larger sample and where the individual accounts can be drawn on to illustrate the resultant theoretical claim. (Smith et al., 2009, p. 202).

Willig (2013) suggested that "research questions about the nature of experience are more suitably addressed using phenomenological research methods" (p. 79). Therefore an IPA approach would be more appropriate to answer this study's research question by capturing the "nature or essence of phenomena" (Willig, 2013, p. 99). I have taken a pragmatic approach in deciding on my overall research design. Due to the consideration of the time constraints applied by the doctoral course, recruiting participants in order to reach theoretical saturation as required by GT may not be feasible in a practical sense. IPA therefore was chosen as the most appropriate approach to give voice to mental health nurses' lived experience of eating, as opposed to generating new theory. The research approach and methods chosen depended primarily on the goal of my study and the epistemological stance that I took as the researcher. This epistemology will be discussed in the next section.

2.2.2 Epistemological underpinnings

Merleau-Ponty (1962) wrote, "all knowledge takes its place within the horizons opened up by perception" (p. 241). The prerequisite to 'know' is therefore to first and foremost perceive, however to infer meaning, subjective interpretation is required: "All my knowledge of the world, even my scientific knowledge, is gained from my own particular point of view, or from some experience of the world without which the symbols of science would be meaningless" (Merleau-Ponty, 1962, p. ix).

To further illustrate how perception can be influenced by the subjective I refer to a quote by Merleau-Ponty (1962):

> The inadequacy of my perception was taken as a *de facto* inadequacy resulting from the organization of my sensory apparatus; the presence of my body was taken as a *de facto presence* springing from its constant action on my receptive nervous system; finally the union of soul and body, which was presupposed by these two explanations, was understood, in

> Cartesian fashion, as a *de facto union* whose *de jure* possibility need not be established, because the fact, as the starting point of knowledge, was eliminated from the final result. (p. 109)

Ultimately, as suggested here, there is a 'flaw' in our perception with regard to the subjectivity of the 'soul'. Here the author sums up perfectly how the 'fact' is eventually completely eliminated through the processing of information. I therefore reject the positivist epistemological position, the assumption that our perception of the world (objects, events, phenomena) is a direct representative of the 'truth'. Willig (2013) wrote that, "it is now generally accepted that observation, and description are necessarily selective, and that our perception and understanding of the world are therefore partial at best" (p. 4), however, there is widespread disagreement about the "extent to which our understanding of the world can approach objective knowledge, or even some kind of truth, about the world" (p. 4). Willig (2013) suggests there are two views, which lie at the opposite ends of the continuum: naive realism that is affiliated with positivism, and extreme relativism that rejects the idea of 'knowledge' or 'truth' entirely. Where my epistemological standpoint sits will be discussed in more detail below, but for now the idea that knowledge is somewhat intertwined with subjective perception is paramount, and partly explains why I did not pursue quantitative research.

Epistemology is concerned with the nature of knowledge. The acquisition of this knowledge could be through *facts of* experience as empiricism suggests, such as through our senses. However, to 'know' something as 'real' we first have to consolidate our own subjective frame of reference before we can make interpretations (Willig, 2013). Relativist epistemology could be defined as having a view that knowledge is relative to social context and historical moments, that is, to society, culture, time and place (Siegel, 1986). In this way knowledge is constructed by individuals' subjective experiences and therefore it is possible that many meanings or different 'realities' may exist of the same phenomenon. *What it is like* for the participant or the "phenomenological knowledge ... knowledge of the quality and texture of the experience itself" (Willig, 2013, p. 16) may be different for different people.

Concurrent with my own beliefs concerning the interaction between epistemology and ontology, this study will take a critical realist epistemological standpoint. I belief that

although I am investigating the subjective experiences of participants, their experiences are based on objective life events. Therefore a critical realist approach assumes that the data collected can inform us of the 'real world', however not at face value (as described above), as interpreting the data will showcase the underlying forces that create the phenomenon (Willig, 2013). Even though these interpretations made by the researcher could be unknown to the participant, they would be considered 'real' in the critical realist approach. This is concurrent with the hermeneutic ideology in IPA.

2.3 Interpretative Phenomenological Analysis (IPA)

2.3.1 Overview of IPA

Smith et al. (2009) proposed that IPA's three main theoretical underpinnings are phenomenology, hermeneutics and idiography.

Smith and Osborn (2003) stated:

> The approach is phenomenological ... in that it involves detailed examination of the participant's life-world; it attempts to explore personal experience and is concerned with an individual's personal perception or account of an object or event, as opposed to an attempt to produce an objective statement of the object or event itself. (p. 53)

Phenomenology has its roots in the philosophy of Husserl, and in Husserl's sense comprises investigating human experience by discovering how an individual would come to know his or her own experience of a phenomenon. Husserl argued that for this to occur the individual would engage deeply and rigorously to be able to recognise the 'essential qualities' of their experience (Smith et al., 2009). IPA's methods are informed by the ideas of Husserl such as 'reduction' – to return to the experiential content, and 'bracketing'. Bracketing is a technique of putting to one side prior knowledge or understanding as far as possible, to focus fully on the participant's phenomenological experience without influence (Smith et al., 2009).

Smith and Osborn (2003) acknowledged that the researcher calls on their own conceptions to be able to interpret the lived experience of a participant, and therefore, the

double hermeneutics theory of interpretation is applicable. These ideas are the basis of the relativist ontology of IPA.

Smith and Osborn (2003) stated:

> IPA also emphasizes that the research exercise is a dynamic process with an active role for the researcher in that process ... the researcher's own conceptions ... are required in order to make sense of that other personal world through a process of interpretative activity. Thus, a two-stage interpretation process, or a double hermeneutic, is involved. (p. 53)

Merleau-Ponty developed the notion of embodiment; human beings' acquisition of knowledge is "partly through our bodily engagement" (Smith et al., 2009, p. 198). This has played a key part in the epistemology of IPA. The meaning of experience is dependent on the context of the lifeworld of the participant. Heidegger's terms "intersubjectivity" and "person-in-context" demonstrate the shared commonality and relational nature of an individual's interaction with the world (Smith et al., 2009, p. 17). Additionally, Sartre contributed to this idea of 'context' by highlighting the importance of personal and social relationships (Smith et al., 2009).

The idiographic nature of IPA means that the analytic procedure highlights the individual and 'distinct voices' as well as the shared essence of the experiential master themes across all participants, and this suggests theoretical transferability. IPA's aim therefore is to capture the participants' lived experiences and how they make sense of these (Smith et al., 2009).

2.3.2 Limitations of IPA

Mason (2002[1958]) suggested that good qualitative research should be: 1) strategically, systematic and rigorously conducted; 2) generalizable; 3) capable of producing explanations or arguments; 4) consistent in philosophy and practice; 5) capable of displaying critical self-scrutiny; 6) capable of displaying active reflexivity; 7) accountable for quality and its claims; and finally, 8) able to foreground moral practice with regard to

political context. These factors will be discussed within the IPA approach by acknowledging weaknesses and strengths.

One of the major limitations of IPA as identified by Giorgi (2011) is that its methodological procedure is not in keeping with standardised scientific criteria, since replication of its method is not possible due to its requirement for flexibility. Smith (2004) suggested that their guidelines of the IPA method are not to be followed as a 'cookbook', but rather leave enough flexibility to be adapted and developed by the researcher. Rigour has been identified as the thoroughness of the research including the suitability of the sample, research question, quality of interview, and the depth of analysis (Smith et al., 2009). To demonstrate rigour in qualitative research I refer to Finlay's (2006) dimensions of the '*5 Cs'* (*Contribution, Clarity, Credibility, Communicative resonance and Caring/Ethical).* Concurrent with the *contribution* dimension, Smith et al. (2009) encourage a literature review to identify a gap in the knowledge as well as to build a rationale for the proposed study by highlighting strengths and weaknesses of the main contributions to the existing body of research. IPA research also attempts *clarity* by describing clearly each stage of the research process in the write-up, including participant selection, interview schedule development, conduct of the interview and stages in analysis (Smith et al., 2009). IPA's guidelines depict a systematic engagement in the transcript, ensuring that the occurring themes maintain their close to idiographic content, not only highlighting the experience of the individual but the collective themes of the homogeneous sample. By doing so the researcher presents a *credible* account in the write-up of quotations from the transcripts relating to each of the themes identified (Smith et al., 2009).

As Smith et al. (2009) state, the aim of IPA is to elicit the experience of a particular participant, and how that individual is making sense of it. This case would then be examined in relation to the other cases to expose the convergences and divergences. The authors go on to say that more general claims applicable to the *communicative resonance* dimension can then be considered in terms of the homogenous sample. Since IPA does show evidence for each of Finlay's (2006) *5Cs* dimensions, on the surface it demonstrates some rigour. However, there are some aspects of rigour that need to be evaluated more thoroughly in IPA, such as generalisability and reflexivity, which are perhaps vulnerabilities present in all qualitative studies.

It is important to acknowledge the main factors that traditional scientific studies would use to conduct and evaluate research, namely reliability, validity and generalisability (Finlay, 2006). Kisely and Kendall (2011) suggested, however, that there are qualitative counterparts of reliability, validity, statistical power, bias, and generalisability. The authors describe qualitative research to purposely recruit participants for theoretical saturation (consistent with the GT approach), which is equivalent to statistical power in quantitative research. However in IPA this is not the case, due to the small sample sizes used, which mean that researchers are required to do in-depth analysis at the expense of breadth to enable them to report detail and stay true to the idiographic nature of IPA (Smith, 2004). Smith et al. (2009) wrote that direct assertions are constrained to the homogenous group studied, but that "theoretical generalization" can be contemplated. It has been argued that case studies carry an 'essence' of shared humanity (Giorgi & Giorgi, 2003) and therefore the term 'transferability' or 'applicability' would be appropriate to represent the qualitative nature much like generalisability in quantitative research (Kisely & Kendall, 2011).

Before reflexivity can be considered, the philosophical underpinning will firstly be discussed. For a phenomenological method to be sound, the following aspects have to be included: corresponding phenomenological philosophy or theory, and a demonstration of how the method is justified and consistent (Finlay, 2009). Giorgi (2011) has criticised IPA, stating that it does not correspond to continental philosophical phenomenology. Finlay (2008) in particular suggested that research which claims to use the method of bracketing whilst following hermeneutic traditions is "naive and confused" (Finlay, 2009, p. 8). Smith (2007), by contrast, wrote that bracketing and interpretation (double hermeneutic) methods are utilised at different stages of the research process. Smith wrote that when interviewing the participant he first attends fully to the individual, facilitating their meaning making. This is the stage where he would bracket or at least acknowledge his preconceptions. The second part of the process is to engage with the script containing the participant's own words. Interpretation or the process of double hermeneutics can then begin, whereby analysis would also be discussed within psychological literature (Smith, 2004). Finlay (2008) pointed out the importance of critical self-awareness of the researcher, to be able to recognise how it might implicate the research process and findings. This point has been considered within IPA as Smith et al. (2009) suggested the interview schedule should be short (6-10 questions), open-ended and expansive so that the participant can engage in their subjective lived experience, rather than the researcher imposing their own

understanding of the phenomenon i.e., with leading, closed or manipulative questioning. It is evident, therefore, that the IPA approach has considered these concerns and responded to the issues of bias/subjectivity in reflexivity. Furthermore, research subjectivity is deemed to be unavoidable and recognised within phenomenology (Finlay, 2009). Giorgi (1994) suggested that removing subjectivity is not the answer, and objectivity can only be reached when subjectivity is acknowledged. During Golsworthy and Coyle's (2001) own evaluation of their IPA study they recognised that the process of analysis is subjective (double hermeneutic), and therefore no two analysts would propose the same assertions. Because of this, they questioned the validity. However, as Smith et al. (2009) stated, good IPA is dependent on how the claims are rooted within the verbatim extracts, suggesting that as long as the claims correspond to the participants' content and are plausible, the account is valid. Lastly, the dimension of *caring* is relevant to ethical approval, which must be sought in psychological research (BPS, 2014). Considering the political context, and the national shortage of nurses, the research is not for any political gain but to place the participants' experience at the centre of the picture.

As discussed above, these important aspects as mentioned by Mason (2002[1958]) exposed some vulnerabilities in IPA, such as difficulties with replication, generalisability, continental philosophical phenomenology, reflexivity and researcher bias. Nevertheless, I hope to have acknowledged these weaknesses and highlighted how IPA has responded to these concerns regarding reliability and validity.

2.4 Reflexivity

2.4.1 Epistemological reflexivity

Phenomenology appears to have two contrasting branches: descriptive and interpretative phenomenology. Giorgi (2012) suggested that in "description there is an acknowledgement that there is a 'given' that needs to be described precisely as it appears and nothing is to be added to it nor subtracted from it" (p. 6). In this way, descriptive phenomenology attempts to "get as close as possible to the personal experience of the participant" (Smith et al., 2009, p. 37). Husserl's 'reduction' and bracketing techniques help the researcher to overlook prior knowledge and fully focus on the participant's phenomenological experience without influence (Smith et al., 2009). This is in contrast with the interpretative phenomenology, as described Smith and Osborn (2003), where, "one is trying to get close

to the participant's personal world, to take ... an 'insider's perspective', but one cannot do this directly or completely. Access depends on, and is complicated by, the researcher's own conceptions" (p. 53). Therefore, "the researcher is trying to make sense of the participants trying to make sense of their world" (Smith & Osborn, 2003, p. 53).

Hermeneutic phenomenology can therefore arguably allow for a deeper understanding by "analysing, illuminating, and making sense of something" (Smith et al., 2009, p. 36). Smith et al. (2009) explained how descriptive and interpretative phenomenology interact together to form the basis of IPA.

Smith et al. (2009) stated:

> IPA requires a combination of phenomenological and hermeneutic insights. It is phenomenological in attempting to get as close as possible to the personal experience of the participant, but recognizes that this inevitably becomes an interpretative endeavour for both participant and researcher. Without the phenomenology, there would be nothing to interpret; without the hermeneutics, the phenomenon would not be seen. (p. 37)

In my attempt to make the phenomenon be "seen", I felt conflicted during the initial part of the analysis process. There was a continuous reflexivity in terms of using the participants' own words compared to interpreting the accounts. As I attempted to stay as close as possible to the MHN participants' experiences, initially I was purely descriptive. As the analysis progressed through the stages I was pulled more and more into the direction of interpretation. Osborn and Smith (1998) best described participants' attempts to make sense of, and communicate their own experiences: "we believe they are complex, dynamic and shifting entities formed and reformed, in this case, as patients struggle to make sense of their condition and to articulate that struggle to the listener." (p. 80). Therefore I was compelled to engage in a more interpretative analysis to produce a deeper level of understanding. The reflexivity during analysis kept my interpretations grounded within the participants' verbatim data. The cyclical process helped develop the depth of interpretations I reached at the writing up stage. I believe that both phenomenological and hermeneutic insights were held in balance, including in the themes, for which I combined the words of the participants with the interpretative knowledge.

2.4.2 Personal reflexivity

I have some insight into the contextual issues described in the introduction chapter, such as occupational stress and shortages of staff, because of my experience as a healthcare worker in an inpatient mental health setting. I worked closely with registered nurses to care for and support service users on medium and low secure inpatient wards. My own experience gave me insight into the impact of occupational factors on eating behaviours. I experienced irregular meal patterns during the above employment, which negatively impacted on my energy levels; eating during a 12-hour shift was a high priority for me. Furthermore, I recognised my own unhealthy eating behaviours developed during 12-hour night shifts, not while working in the mental health setting, but during a previous employment as a care assistant in a nursing home. I found myself eating high carbohydrate snacks such as biscuits during the night.

However, I am also aware that others might have different experiences. Therefore, during the interview stage I strove to bracket my own preconceptions to fully focus on the participants' sense-making. For example, I asked open-ended questions to guard against leading the participant to answer in a particular way, such as to suggest a relationship between stress and eating as the literature review had indicated. I kept reflective notes to record my own thoughts and initial responses. The aim of these notes was to capture both my reflection in-action (during the interview) and on-action (after the interview) to reduce the likelihood of my preconceptions and prior ideas influencing the data collection process.

Nevertheless, during the interviews I found myself being biased towards my own conceptions of ‘what it is like’ to eat or, not eat as the case may be, within an inpatient mental health setting as a healthcare worker. I was made aware of my biases at these times, for example, I found myself suddenly jolted back to Ben’s lifeworld when he spoke of being assigned to dispense medication to patients and how this impacted on his eating due to a scheduling clash. Suddenly I was being made aware of Ben’s unique experience, the perspective of a nurse instead of mine as a healthcare worker.

Husserl (1970) stated:

> As soon as one has progressed far enough in the reorientation of the epoché to see the purely subjective in its own self... one becomes more astonished at each step by the endless array of emerging problems and important discoveries to be made. (p. 169)

I was further "astonished" when Ben explored this further as he made sense of "hardly ever" eating during day shifts and experiencing weight loss. It was at these times that I realised once again the importance of bracketing my previous experiences and re-engaging or refocusing on the participants' lived experience. On reflection post-interview, I felt that I would not have been able to understand or empathise with the participants' experiences at the level I did without such an occupational background as described above. Furthermore, for the most part it was easy to explore the phenomenon in a "fresh way" (Finlay, 2008, p. 21) as the participants were both MHN and male. Taking part in the process of reduction also meant engaging in "phenomenological understanding as a whole" (Finlay, 2008, p. 21), not only engaging with aspects of eating as a male and a MHN, but as a person in general.

It is important, however, to acknowledge that bracketing cannot be fully achieved, as the researcher and the participant inevitably influence each other.

Kvale (2007) explained:

> The research interview is an inter-view where knowledge is constructed in the inter-action between two people. The interviewer and the subject act in relation to each other and reciprocally influence each other. The knowledge produced in a research interview is constituted by the interaction itself, in the specific situation created between an interviewer and an interviewee. With another interviewer, a different interaction may be created and a different knowledge produced. (pp. 13-14)

The data collection is therefore already a double hermeneutic process. For example, the participants were already making sense of, or interpreting, their experience based on their

subjective knowledge. During the semi-structured interview I asked the participant follow-up questions to better understand their meaning of what had been said and by doing so I had to rely on my subjective knowledge to interpret their sense-making in order to ask the questions. In this way, our mere interaction created a co-construction of meaning.

2.5 Procedures

2.5.1 Sampling and participants

Smith and Osborn (2003) suggested that 5-6 participants are a 'reasonable' number for an IPA study, however, Smith et al. (2009) suggested that sample size was dependent on the researcher's commitment to the depth of analysis. In this study semi-structured interviews were conducted with seven participants. I arrived at this particular number of participants after consideration of the time constraints applied by the doctoral course, while bearing in mind the aim of including the maximum number of subjective experiences.

As discussed in the introduction chapter, mental health nurses (MHN) work in various inpatient settings. This study did not require participants to work or have worked in a particular inpatient setting (i.e. acute inpatient, forensic or recovery and rehabilitation services, etc.) but rather sought the experiences of inpatient settings as a collective. This study did require MHN participants to be willing to talk about their eating behaviours, work or have worked in some type of inpatient setting, and be or have been a full-time member of staff. Due to research indicating potential gender differences in eating behaviours, as discussed in the introduction chapter, the question of seeking male or female MNH was addressed at the early stages of recruitment. An opportunistic sampling strategy was employed, whereby participants were recruited via an advertisement poster on social media (see appendix 2). The first respondents were male MHN, and thereon in only male MHN were recruited for this study. Word of mouth produced a snowballing effect and seven male MHN were recruited.

2.5.2 Participants

The participants were seven male MHN working in various inpatient mental health settings. For confidentiality reasons, table 2.2 below displays the demographic information

collectively, including age, ethnicity, years of experience, and employment setting (mental health providers).

Age	Mean = 42	Range = 27 - 56
Ethnicity	White British = 5	Black and Minority Ethnic = 2
Years of qualified experience	Mean = 14	Range = ±1 to ±25
Inpatient mental health provider	NHS = 3	Independent = 4

Table 2.2: Summary of participant characteristics

2.6 Interview Schedule

2.6.1 Pilot interview

Semi-structured interviews are the most commonly incorporated in IPA studies for the method of data collection (Smith & Osborn, 2003). Initial interview questions were developed as suggested by Smith et al. (2009) to facilitate an in-depth interview, for example, including descriptive, narrative, evaluative, contrasting, circular, and comparative questions. Possible prompt and probe questions were also devised, though in reality during the semi-structured interviews these kinds of questions developed organically. The approach was idiographic and therefore the interview questions were non-directive and open-ended.

To help me become more comfortable in 'the researcher' role, a female friend working as a mental health nurse agreed to be interviewed in order to give verbal feedback on the sensitivity of the interview questions and the schedule structure. The pilot interview led me to add one more warm-up question, and to reword some of the questions to make them more understandable, for example, "Can you describe your experience of eating?" was changed to "Can you describe, in as much detail as you can, what your eating is like?"

The pilot interview was most helpful in allowing me to move away from the 'trainee counselling role' and practise asking questions as a researcher. The *researcher's* line of questioning felt much more directive at times, for example, when following the interview

schedule or when having to bring the participant back to the topic at hand. As Kvale (2007, p. 15) states, the researcher "initiates, and defines the interview situation, determines the interview topic, poses questions and decides which answers to follow up". As a result of the pilot interview, the questions I asked felt much more led by the research and less by the person being interviewed. Although there is some flexibility when conducting semi-structured interviews, I initially found this position at odds with my more natural role as a psychologist. Kvale (2007) suggests that the focus during a research interview is on "knowledge production", whereas a therapeutic interview puts the emphasis on "personal change" (p. 17). Thus, as Kvale (2007) described, "the interview is an instrumental dialogue ... a means for providing the researcher with descriptions, narratives and texts, to interpret and report" (p. 15). As I had the opportunity to practise stepping into the researcher role, I believe that directing my focus to "knowledge production" became more organic. I became more comfortable with moving between 'structure' and 'flexibility', such as when being led by the participants' experience within the research topic.

2.6.2 Participant interviews

In this study, an audio-recorded semi-structured interview via telephone was conducted for each individual participant and subsequently transcribed. Although the researcher was guided by the interview schedule (see appendix 7), the semi-structured approach allowed the researcher more flexibility to follow what was important and meaningful for the participants. This is in accordance with the IPA philosophy to facilitate the participants' communication of their lived experience, because it is the participants who are seen as the "experiential experts on the subject" (Smith & Osborn, 2003, p. 59).

Cachia and Millward (2011) found that telephone interviews produced rich and in-depth data, a 'complementary fit' for semi-structured interviews. Furthermore, due to MHN's working conditions, including long working hours, I found that telephone interviews allowed the participants more flexibility to schedule the interviews at a time convenient for them. The interviews were therefore conducted over the telephone and in the comfort of their own homes. The interviews were between 30-60 minutes in duration. Although some interviews appeared short, the verbatim data produced was considerably rich and in-depth. In addition to the interviews, a questionnaire was also used to collect personal data including contact details and relevant demographic information (see appendix 5). Ethnicity

was included in this questionnaire as research showed a significant association between ethnicity and workplace stress (Health and Safety Executive, 2005). This information could be important in the context of the idiosyncratic nature of analyses. Ethnic minorities will not be excluded on the basis of a homogenous sample, nor any other factors potentially increasing the risk of occupational stress, as the interview will focus on the participants' experience of eating.

2.7 Ethical considerations

Ethical approval was granted by City, University of London Psychology Department Research Ethics Committee (see appendix 1). All research was carried out in accordance with the British Psychological Society's Code of Human Research Ethics and Code of Ethic and Conduct (BPS, 2014a; BPS, 2014b; HCPC, 2015), and the Data Protection Act 1998 (2005).

Participants were given an information sheet prior to meeting with the researcher, detailing what would be expected of them if they did decide to participate (appendix 3). Participants were given at least 24 hours to read this information before consenting to participate. The consent form (see appendix 4) was sent via email prior to the telephone interview (to be signed and scanned, and emailed back to the researcher). On the day of the interview, participants were given an opportunity to ask the researcher any questions they had regarding the information sheet. The consent form was read out loud to the participant by the researcher, and any questions/clarifications answered. Therefore, verbal and written informed consent was obtained from the participants prior to the interview, and this covered confidentiality and limitations, data protection, the right to withdraw and the permission to audio-record the interview for transcription, etc. After the interview the participants were verbally debriefed and the researcher answered any further questions. A debrief information sheet (see appendix 6) was emailed to the participant. Although the risk of participating in this study was deemed low, the debrief sheet included information about supportive services should these be required (e.g. signposted to GP). None of the participants expressed any psychological distress during or after the interview. The participants were given the opportunity to receive a report of the main findings of this study. All participants requested a copy.

Lastly, all research was carried out in accordance with the Data Protection Act 1998 (2005). Information provided by the participants was kept confidential. No identifiable personal data were or will be published. The identifiable data were not and will not be shared with any other organisation. The data was electronically stored, and kept in a locked filing cabinet on an external hard drive, access to computer files were password encrypted, and data identifiers were kept in a separate password-protected electronic file.

2.8 Transcription

The interviews were recorded on a digital voice recorder and transcribed to produce verbatim data. I transcribed the interviews myself, not only for confidentiality reasons but also to become more acquainted with the data. As mentioned above, the interview was a co-creation of meaning and as such the transcribing was a continuation of that process. The participant interviews were transcribed verbatim, including the vocal utterances (hmm, uh, etc.), broken words or sentences, and grammatical errors.

2.9 Analytic Method

The stages set out below explain the specific analytic techniques that were followed to systematically guide the researcher using IPA for data analysis, as described by Smith et al. (2009).

Stage One – *Notes.* During this stage the researcher read and re-read the text produced by the participant, noting down initial responses in the right-hand margin. This included descriptive comments (focusing on the participant's subjective experience), linguistic comments (focusing on language use) and conceptual comments (i.e. the context of the participant's experience and abstract conceptions to guide the researcher's understanding of the verbatim account).

Stage Two – *Identifying themes.* During this stage the researcher identified and labelled in the left-hand margin the emergent themes corresponding to the particular section of the transcript. Theme labels captured what had been voiced within the text, and the experiential nature and interpretation of respondents. Psychological terminology was utilised at this point.

Stage Three – *Clustering and structure of themes.* The researcher started to analyse the relationship between all the identified themes, clustering the themes together by giving them appropriate labels that represented the essence, such as words participants had used themselves or by description. Smith et al. (2009, pp. 96-98) suggested that the techniques that could be implemented for clustering were as follows: 1) abstraction – connecting "like with like", which could then be labelled as a higher-level theme; 2) subsumption – an emergent theme given "super-ordinate status" to include other emergent themes; 3) polarisation – showcasing themes that are polar opposites; 4) contextualisation – focusing on the "contextual or narrative elements"; 5) numeration – the frequency or prevalence of a theme; and 6) function – grouping themes that share similar functions. These clusters were structured either by concept (sharing meaning or references) or by hierarchical connections. An important feature of this stage is the cyclical process; the researcher reduced or 'returned to' the original data, going back and forth to make sure the themes, clusters and initial structure fit the essence of the experience of the respondents.

Stage Four – *Summary table.* The structured themes were summarised with the corresponding extracts of the verbatim account to reflect each theme within a cluster. The themes included in the summary were only those relevant to the quality of the participants' experience of the phenomena. A summary table was produced for each case individually by bracketing the previous participant's analysis as far as possible, therefore focusing on the idiosyncratic nature of the participant experience "on its own terms" (Smith et al., 2009, p. 100).

Stage Five - *Integration of all cases.* The researcher endeavoured to integrate all accounts to produce a set of master themes representative of the group as a whole. The same cyclical process was used as in stages three and four to produce a summary table of master themes reflecting all participants' quotations corresponding to these themes. The process was finished when integration of all themes was complete.

3 Analysis

3.1 Overview

The write-up of the analysis is a crucial part of the study, in order to convey the researcher's findings to the reader. Thus, I will firstly justify the content and thereafter describe the outline of the analysis.

3.1.1 Content

In the analysis write-up I strive to present a transparent account by showcasing the raw data beside my own interpretations, in a double hermeneutic sense-making process. I aim to give voice to all the participants in this comprehensive narrative account of what I have learnt throughout this analysis process. The extracts I chose were primarily to illustrate, as well as possible, the participants' foremost essence of experience within the themes. Therefore, some participants' quotes may be more represented in a particular theme while other participants' quotes are more of a supporting feature. I provide a list of verbatim extracts representative of all participants within each super-ordinate theme (see appendix 10). Furthermore, a table showing the frequency of participant representations of the super-ordinate themes is available in appendix 11.

In this results section, I decided not to integrate theoretical knowledge, as it would distract the reader from the lived experience of the participants. Thus, I have focused my attention on interpreting the idiosyncratic nature of the participants, moving between the similarities and differences in the super-ordinate themes as I endeavour to represent the shared experience of all cases.

3.1.2 Analysis outline

In my analysis I found that there were three distinct, albeit complementary, master themes representative of the shared experiences of all the participants. These themes encapsulate the distinct voices, and the core phenomenon of the inpatient mental health nurses' eating at work and at home, whilst also giving consideration to their general health and well-being. For this study to display both the 'interpretative' and the 'phenomenological'

elements, I named the themes in order to represent the words of the participants, but with psychologically informed knowledge. The themes are presented below in Table 3.1, followed by a detailed narrative account of each. The first master theme, “Part and parcel of the nature of the job”: External locus of control, describes how participants perceive their environment to be beyond their control and how eating fits within this setting. The second master theme, “Try to sort of compensate”: Satisfying physical and emotional hunger, explores how eating behaviours counteract the working conditions, both physically and emotionally. Lastly, the third master theme, “So I am getting healthier. Just not healthy”: The struggle to live a healthy lifestyle, depicts the difficulty for nurses to maintain health, work-life balance and self-care.

Master Themes	Super-ordinate Themes
“Part and parcel of the nature of the job”: External locus of control	“The pressure of work”: Mindless eating
	“Everything else fell by the wayside”: Involuntary food restriction
	“Eating is not your priority”: Subjugation of needs
“Try to sort of compensate”: Satisfying physical and emotional hunger	“Hunger can be frustrating”: Physical hunger at work
	“Eating more than I should have”: Over-eating at home
	“Hang on, what am I doing?”: Triggers of over-eating
“So I am getting healthier. Just not healthy”: The struggle to live a healthy lifestyle	“You want to be healthy don’t you?”: Health concern
	“I have a window of opportunity to eat”: The struggle of healthy eating
	“I just have to find the balance”: The difficulty in establishing self-care

Table 3.1: Master themes and representative super-ordinate themes

3.2 "Part and parcel of the nature of the job": External locus of control

This master theme endeavoured to encapsulate how eating fits within mental health nurses' unique environmental setting. Three super-ordinate themes were organised to form the foundation. Firstly, "the pressure of work" describes specific eating habits transpiring from their work environment. Secondly, "everything fell by the wayside" addresses environmental factors, which lead to delayed or missed meals. Lastly, "eating is not your priority" explores the subjugation of needs and feelings. Overall there appears to be a sense of acceptance amongst the participants, as they perceive a lack of control to be "part and parcel of the nature of the job".

3.2.1 "The pressure of work": Mindless eating

This super-ordinate theme aims to encapsulate how occupational stress translates to the participants' eating behaviour. Two situations emerged when the nurses explored their eating behaviours at work. Firstly, the pressure of the workload, and secondly, the anxiety-provoking high-risk situation when eating with inpatients, both of which impacted on eating behaviours. This eating as described by all participants could be defined as *mindless*. This phenomenon will be discussed in the following section.

Daniel describes the shortage of staff, particularly "across NHS and across nursing" (2, 79-80), and how this impacts on his experience of eating.

> "[...] because of the the high workload you don't really enjoy, you know, your lunch because you are thinking of things that you want to do or, you know, it's constant even though you are on your break. [...] especially when you're short of staff or you are the only qualified on the shift, you just don't enjoy your break." (Daniel: 4, 130-137)

My understanding here is that the workload is relentless, a "constant", meaning there is no rest as he continues to be preoccupied by his thoughts and distracted throughout his break due to the overwhelming number of tasks he must complete. He describes the difficulty of mentally disconnecting, particularly when he holds clinical responsibility for the shift or if the team is short staffed. Perhaps, whilst Daniel is struggling to disconnect, this detracts from his enjoyment as his focus is away from eating and therefore constitutes being

mindless. Furthermore, Daniel described eating as solely serving the function of having enough “energy for the day” (3, 85). Similarly to many other participants, Daniel mentioned the limitation of time, and eating in a “rush” (9, 299). Adam gives some insight into how such eating transpires.

> “But then the time constraints as well at work, the pressure of work, it pushes you to to adapt some different eating habits. So for me it would have to be eating a lot faster, and I don’t enjoy my meal if I have to eat quickly.” (Adam: 14, 484-488)

Adam’s account suggests that he does not perceive himself to have any internal locus of control; the work pressure he is under moulds his eating behaviour to meet work demands. Adam also perceived the need to “keep up with people” (14, 480) and “rush” (6, 189) his meals when he eats with patients. Adam mentions the negative implication on his body, such as “indigestion” (14, 481), and this may account for reduced enjoyment in addition to mindless eating.

In a similar thread, Gregory talked about the “quick wind” (13, 445) nature of eating at work, most particularly not allocating time for meals. He described dual tasking whilst eating, most often sitting at his desk to resume work. His experience parallels that of Fredrick, in that they both depict an environment where eating is ‘on the go’.

> “Uh... while, where I work now I am as bad as everybody else. We don’t, tend to be a little table with the old chocolate biscuits and chips, crisps and all the stuff you shouldn’t touch um... there, I am much more likely to grab uh.. a cookie um, um and sit at a computer and um and throw that down my throat [...] Um... but that’s that’s the norm.” (Fredrick: 10, 333-341)

Fredrick appears to compare his own behaviour to that of others; however, the use of “we” depicts cohesion with his working colleagues. My understanding is that this may be a way of rationalising his “bad” habits by diffusion of responsibility and so reinforcing a cultural “norm” at work. Furthermore, this excerpt depicts the convenience in which he can “grab” the unhealthy foods so readily available and eat mindlessly in a, “throw that down my throat” manner whilst sitting “at a computer”. Mindless eating is also evident in other

participants' accounts when they describe eating with patients. Quite often the accounts portray the participants' "mind" (Daniel: 7, 213) or "focus" (Edward: 6, 190) being on the patient or engaged with monitoring risk, and not on their eating.

> "So the eating just becomes a function of observing people." (Ben: 12, 400-401)

Here Ben suggests that the purpose of eating is to maintain the safety of the environment, and actual eating is secondary. Similarly, in Colin's interview he talked about eating with patients in a locked dining room. He described some of the measures taken to secure safety, such as counting cutlery before patients have access to it and counting it back in at the end. Although Colin mentioned he has never experienced any major incidents during a meal sitting, he is aware of such events. When he was asked to explain what it is like to eat whilst facilitating a meal sitting, this was his response:

> "I guess you are a little bit on edge? But you have to be observing and stuff so you are not concentrating too much on your food, like a normal meal I guess but um... err... yeah I, it's alright, I've got used to it I suppose... uhh..." (Colin: 10, 332-336)

The mitigator "a little bit" could be construed as trying to weaken or minimise the impact of Colin's anxiety, perhaps to conceal any perceived vulnerability in this unpredictable environment. Colin here talks about concentrating on observing his surroundings, a need for hypervigilance to spot a possible threat, therefore contributing to the feeling of being "on edge". "Not concentrating too much" on food indicates how mindless eating emerges in this situation.

In summary, participants depicted an environment with a high workload, and a sense that there is a constant time pressure to complete their daily tasks. Having to observe patients whilst they are eating can be anxiety provoking. The underlying feature is the perception of an external locus of control – participants do not feel they have any control over their workload, and the unpredictability of their environment whilst eating with patients is similarly beyond their control. This high-pressured environment moulds nurses into certain eating habits, such as rushing and multitasking, that could be defined as mindless eating.

The second super-ordinate theme will continue to explore how the environmental factors impact on their eating behaviour.

3.2.2 "Everything else fell by the wayside": Involuntary food restriction

This super-ordinate theme aims to address the unpredictable nature of the job, where certain aspects of their working environment are outside of the participants' locus of control. The theme explores how these environmental factors impact on the nurses' eating, or more accurately, the resultant food restriction.

Many of the participants spoke about occasions on which they had missed meals during a nursing shift. Most participants, however, described occasions when they simply could not find the time to eat, due to being too busy at work. Daniel's account gives a more detailed description of what other participants might have referred to as being "busy". Daniel describes the emotional content of such an instance in depth.

> "But sometimes when you, you know, are under pressure, I mean in any other job you are under pressure sometimes you forget to eat sometimes, especially when there is a new admission and there is a lot of, there's a lot of um... documentations to do, paperworks to do, sometimes you forget, you don't have a break and you forget to eat and you know um..." (Daniel: 9, 312-318)

Daniel repeating "under pressure" here might refer to an overwhelming sense of having to complete his daily tasks in a timely fashion. This echoed other occasions when he spoke of his workplace being "strict" (10, 339) on documentations due to auditing. Daniel repeating "a lot of" suggests that the sheer amount of admin can be immensely overwhelming. The pressure to complete the mountain of work before the shift is over consequently leads him not to take a break. This mental task is all-consuming, leaving little space for him to think about his physical needs and therefore he forgets to eat, as it is not perceived to be a priority. Adam explores this "very hectic environment" (18, 610) and construes that the missed meals are due to the unpredictability of the inpatient setting.

> "It disrupts your eating patterns as well because the day is so unpredictable. You are never guaranteed to be able to sit down at a

> particular time and have your meal. So it is a very unpredictable day, sometimes you may go without eating if it is very busy." (Adam: 18, 610-615)

Adam here speaks in the second-person, having changed from first-person perspective right before this section, shown by his use of "your" and "you" throughout. This perhaps creates narrative distance, and shows how Adam perceives having no internal locus of control in this "unpredictable" day. It seems that nurses are not "guaranteed" an allocated time for eating and are mostly at the mercy of their work environment. This resonated with Gregory's account; he talked about not having a dedicated time out or any particular "routine" (5, 141) to his eating. This depicts a working arrangement where eating occurs around nursing duties, but not the other way round. In this sense, eating seems to be an afterthought, where physical needs take a backseat to the needs of the job. Many participants described certain incidents that take priority over all else and which are commonplace in mental health settings. Most participants suggested these incidents might also lead to nurses missing meals. Edward summarised many of these incidents.

> "Um... but, so violence and aggression would be one, management of um... physical health incidents we had quite a few patients with epilepsy when I first started on [name of ward] so you might be dealing with incidents of that, err.. self-harm, um we had numerous self-harmers [...]" (Edward: 10, 335-340)

My understanding here is that Edward describes matters of life and death as "violence", "self-harm", and that medical incidents could all result in serious bodily harm or death of patients and staff. Edward changed from first-person to second-person perspective, moving from "I" to "you", suggesting a narrative distancing when he mentions dealing with these types of incidents. Furthermore, he talks about "dealing" with these situations in a very matter of fact way, which might be a way of disconnecting or detaching from the emotion such incidents bring. Adam, however, describes the emotional content.

> "I suppose I was just consumed by the intensity of the incident I had to deal with. So that became my priority and everything else fell by the wayside." (Adam: 7, 215-218)

Here my understanding is that Adam was absolutely absorbed by the severity of the incident, physically, emotionally and mentally. This might suggest that his body reacted by physical arousal as the "adrenaline" (11, 351), as Daniel described it, pumps through his body to "deal with" the threat. This incident became Adam's priority overriding everything else, including his own needs of satisfying hunger at the time.

Most striking was Ben's account when he talked about his eating patterns at work.

> "So yeah when I am on days I normally lose weight as well, 'cause I can go the whole shift without eating." (Ben: 7, 211-213)

Ben describes how he "hardly ever" (6, 204) gets to eat, and therefore his weight goes down. Ben gave similar reasons for missing meals, namely being "busy, you get caught up" (6, 208-209). He mentions that missing meals is also due to scheduling clashes; if he is assigned to dispense medication he is not able to attend and supervise the meal sittings with patients. Ben is the participant with the most experience, at around 25 years as a mental health nurse. He therefore has been exposed to this setting longer than all the other participants. Ben has also been diagnosed with type 2 diabetes. He chose to control his condition with medication rather than through diet alone. The nature of irregular eating at work described by Ben and others could therefore have influenced his choice.

In summary, this theme explores the occupational factors that directly impact nurses' eating, and perhaps the long-lasting effects on health, such as the possibility of losing weight. The participants depicted an environment where workload is high, time is limited, and the unpredictability of the nature of the job can disrupt their eating patterns and consequently create the conditions for involuntary food restriction at work and unhealthy eating patterns.

3.2.3 "Eating is not your priority": Subjugation of needs

This super-ordinate theme explores how the participants respond to their environment, which as described above, can cause them to miss meals. Gregory described going "above and beyond" (12, 407-408) to manage his workload and reach his own acceptable

standards of service delivery. Gregory, in common with many of the participants, reacted by accepting this as “part and parcel” of nursing:

> “[...] I guess, and my colleagues will probably support me in this, probably part and parcel of the nature of the job really. Um... So I wouldn’t say that it makes me feel a particular way to miss lunch or even breakfast. It is something that I... and I know it is very unhealthy, but it is something I am quite used to doing.” (Gregory: 6, 192-198)

My understanding here is that Gregory perceives his colleagues to be ‘in the same boat’ as him, therefore there is a real comradery in “support” which acts as a protective factor for Gregory in coping with this sense of surrender. Gregory describes that missing meals does not make him “feel a particular way”, as he is “quite used to doing” it. This suggests he has succumbed to the environment due to his perception of having no internal locus of control. He recognises it is unhealthy but feels there is nothing he can do about it. Ben’s account appears to go a step further in describing the helplessness around eating at work.

> “And it is the same with meals at work. I hardly ever get to have them so I sort of don’t worry about it.” (Ben: 10, 317-319)

Here Ben suggests there is no hope as the result is definite (“hardly ever”), and possibly perceives it as a pointless activity to “worry” or care about something he cannot change. Ben appears to rationalise this behaviour by stating that he does not “double over with hunger pains” (19, 662-663) and that he “can go quite a long time without eating” (20, 665). In Colin’s account this phenomenon appears to be similar. He also attempts to cope with the cognitive dissonance created by missing meals.

> “No, I’ve got a lot, a bit of, I’ve got some fat isn’t it? So you know what I mean, you can go 12 hours without having any food, which is better, coffee is food innit, so I can drink coffee. That’s enough yeah.” (Colin: 12, 413-416)

My understanding here is that Colin is trying to cognitively justify or find reasons why this behaviour is tolerable. He appears to find a rationale for why missing meals is “better” or even healthy by using his beliefs around “fat”; “I just, I need to lose a little bit of weight...”

(5, 153). Colin perceives going 12 hours without food as something his body is capable of due to his excess weight. He suggests that drinking coffee is in his control ("can"), and that is good enough for him.

Fredrick's account described a different experience. He talked about being "actively encouraged" (9, 296) to eat with the patients, however, he chooses to continue with his workload at hand. He mentions that he feels a "sit down lunch would be a waste of time" (9, 319-320). It appears that over time the participants succumb to their environment.

> **"**Um... it's just, I am not in the habit of taking a break uh... or any break, let alone... or or especially to eat." (Fredrick: 9, 306-308)

A "habit" suggests it is a settled behaviour, and as Fredrick has worked in nursing for around 15 years, he might be finding his behaviour difficult to change. Fredrick appears to be a product of his environment, where subjugating his needs (not "taking a break") is the result. Here my understanding is that eating is a last priority as he uses the terms "let alone" and "especially" to refer to eating. In Gregory's account he demonstrates the awareness of neglecting his own physical needs in the context of being a nurse with professional expertise in healthy living.

> "I think as nurses we are often preaching to our patients about the importance of a healthy diet and I think it is something that we as individuals often neglect for ourselves." (Gregory: 19, 627-630)

My understanding here is that Gregory uses "preaching" to demonstrate the hypocrisy of advocating a healthy diet to others when he is not practising this himself. "Neglect", therefore, could mean that he perceives his own needs to be disregarded at times. Daniel explored the notion of self-care.

> "I think [exhaling loudly] I think food is, eating is not your priority, when when you are working [...] I think I really should be more [inhaling loudly] should be looking after myself, and that's what we say, you know, 'you should be looking after yourself before you look after your patient' you know, that's what they say." (Daniel 9, 306-312)

Daniel suggests that work is prioritised over eating and the loud sigh may indicate a feeling of hopelessness in the situation. Daniel appears to grapple (when inhaling, and repeating "should") with the self-awareness that his needs have to be prioritised in order to take care of himself. The interchange between the pronouns from "we say" to "they say" could be construed as Daniel perceiving "they" to be the 'authority' but also the 'outsider'. It appears that the 'outsider' may dictate what "should" be happening, however, Daniel does not perceive this to be realistic working 'on the shop floor'.

In summary, the participants have succumbed to their pressured environment by subjugation of their biological needs such as eating. They appear to attempt to reduce their cognitive dissonance by rationalising, and eventually accept missing meals as a part of the job. This acceptance and hopelessness is only exaggerated by the perception of having no internal locus of control.

3.3 "Try to sort of compensate": Satisfying physical and emotional hunger

This master theme aims to explore how participants respond to physical and emotional hunger at work and at home. The first super-ordinate theme, "hunger can be frustrating", captures the participants' experience of hunger at work. The second super-ordinate theme, "eating more than I should have", addresses over-eating created by environmental conditions, and both the physical and emotional compensation behaviours. The third super-ordinate theme, "Hang on, what am I doing?", captures the triggers of over-eating as described by the participants.

3.3.1 "Hunger can be frustrating": Physical hunger at work

This super-ordinate theme explores how the participants react to physical hunger – emotionally, physiologically and cognitively. Some participants spoke of their concerns about undertaking their duties when they are hungry.

In Ben's interview, he was asked how he manages hunger at work:

> "Ah, a lot of the time, that's just tough!" (Ben: 20, 674)

“That’s just tough” appears to be an unsympathetic response; perhaps Ben experiences the working environment as unforgiving. It depicts a situation, particularly by his tone of voice and exclamation (“!”), that it is not by choice, but an involuntary action to wait, determined by his occupational environment. “A lot of the time” can be construed as meaning this is his experience on most occasions. However, Ben indicated that there are other times when he attempts to satisfy his hunger.

> “So I will drink that and have a few biscuits and then... your body feels like, yep I have eaten. I imagine it is just a sugar thing, like a sugar rush and you’ve tricked your body into thinking it had a proper meal.” (Ben: 20, 676-680)

Ben suggests that biscuits are not nutritionally sufficient but perhaps just give him enough energy to continue. Here Ben interchanges from the first person “I” to second person “you” perspective, always referring to the “body” in second person perspective. This might be interpreted as him having separateness from his body. Perhaps the ‘body’ is therefore perceived to be a separate autonomous entity, “it” – a body described as “thinking”. This might also suggest a way of compartmentalising hunger for Ben, so that he does not have to pay much attention to it. Ben, like other participants, described how he does not always recognise hunger until he gets “home” (6, 205).

Daniel’s account gives some insight as to why awareness of hunger might be delayed. He talks about managing incidents where patients “kick off” (11, 355) when becoming mentally unwell, on top of the high workload such as the documentation part of the job.

> **“**But you know, the feel that you are starving you don’t feel that unless you know after the dust have settled. And then that’s when you feel like you are tired or you know, you are really hungry, you know, you weak or you feel like your blood sugars gone low.” (Daniel: 11, 359-364)

To my understanding the “dust” can be construed as the physicality required to manage these incidents; in a way you can imagine the metaphorical dust would be unsettled or kicked up from the ground if a struggle took place. “After” perhaps refers to the come down of the “adrenaline” (11, 351) from responding to the incident. Daniel suggests that after such an episode he notices feeling hunger, tiredness, weakness and “low” blood sugar.

Furthermore, Daniel considers the consequences of hunger on his ability to provide "quality" (11, 375) work:

> "[...] as much as you want to maintain the standard that you know, you want, but I mean you don't have energy to do that anymore." (Daniel: 11, 377-379)

Daniel perceives that low blood sugar affects his quality of work in a negative fashion. Here he repeats, "want", illustrating that even though he aims to maintain the standard performance, he physiologically cannot. Adam also explored the impact of hunger, deeming hunger to be "destruction" (18, 593).

> "Sometimes it can be frustrating, hunger can be frustrating you know. And you need the energy to concentrate, to focus on difficult decisions you have to be alert because of safety, so it is not helpful at all to have that break and not to have a good food intake you normally crave for." (Adam: 13, 428-432)

Here Adam explores how his lack of energy could ultimately impact on safety. He perceives hunger to affect many cognitive abilities that are important to the work of a mental health nurse, such as concentration ("focus"), decision-making and alertness. On the other hand, Adam suggests that when he is able to satisfy this "need" (Adam 18, 595), he is able to focus on pertinent issues and have better interactions with people.

Colin, however, has a different relationship with hunger and perceived a couple of days of "fasting" (8, 260) to be healthy. He believes that this sort of fasting, by choice or otherwise, does not impact on him as long as he drinks "plenty of fluids" (8, 258). This, therefore, could mean that Colin's meaning of hunger lies towards the extreme end of the continuum, where he reaches his limit.

> "I mean I can go without, when you get to the point you can't go without, you know what I mean, I am really f*cking hungry I will have to make some food." (Colin: 12, 402-404)

Colin uses the term “have to”, which indicates his hunger is so extreme at this point that he is forced to eat. “I can go without” suggests that Colin has established a belief that he does not require food during a working shift, and can bear the hunger for as long as he deems necessary.

In summary, these participants described the frustration of hunger at work, some exploring the impact of low energy levels on their ability to maintain the standards of nursing they expect of themselves. They highlighted crucial cognitive abilities that are required to maintain a safe environment, which some perceive to be impaired due to hunger. Furthermore, it appears that work demands take precedence over eating. However, when hunger affects ability to meet work demands, participants perceive it to be acceptable to eat.

3.3.2 “Eating more than I should have”: Over-eating at home

This super-ordinate theme explores two facets of over-eating at home: firstly, the dynamic between missing meals at work and physical hunger; and secondly, occupational stress and emotional hunger. All participants except Ben spoke of some sort of compensating eating behaviour when exploring the interplay between eating at work and home.

Many participants discussed their experience of eating on days when they had missed meals due to environmental factors. Daniel summarises the effect on his eating:

> “[...] I tend to eat a lot. A lot, you know, try to sort of compensate you know during the day which you did not even or you don’t, you didn’t eat properly. So sometimes you eat quite a lot during the night.” (Daniel: 12, 407-412)

“Did not even” suggests that at times Daniel does not eat at all during the day, or that at other times does not eat sufficiently or “properly”. Daniel repeats “a lot”, suggesting that he would eat a larger portion at home to counterbalance the nutrition he lacks in the day. Furthermore, in Daniel’s interview he talked about eating “more than I should have” (13, 420) on such occasions, suggesting that it is unlike his normal food intake. This also indicates that he perceives eating so “heavily” (12, 418) in the evening to be not ideal. Adam here explores the impact of eating a heavy meal late in the evening:

> "[...] I eat quite late. So I know if I have a very filling meal I will not sleep comfortably so I decided to, well I did not decide to, but I gave myself a generous portion. I actually remember going for seconds as well despite um all that. I really felt, felt hungry, but it was not my usual sort of appetite." (Adam: 7, 235-240)

Here Adam suggests that his sleeping is somewhat uncomfortable after eating a filling meal at night. "I did not decide to" suggests that when Adam feels this intensity of hunger he selects his portion size to some degree unaware. "Despite" might mean that even though he is conscious of the negative impact on his sleeping, going back to get a second plate of food is a forced choice due to the need to satisfy his unusual appetite. Like the other participants, Gregory also talked about having "bigger" (7, 220) portions when having missed meals at work. He also perceived an inclination to certain foods on these occasions.

> "Um... and I would say I tend to go more in the direction of carbs if I skipped meals during the day." (Gregory: 7, 221-223)

It appears that carbohydrate foods are preferred, perhaps due to the nutritional energy they provide, and to compensate for the dietary deficiency during the workday. Colin offers some insight into how he eats when he is hungry after skipping meals at work, including an interpretation of his choice of food.

> "Yeah probably bit too rushed and err probably just eat anything. Yeah... maybe, yeah maybe, yeah maybe, not as much thought into that but... because I guess I am a bit too hungry. Maybe some junk food." (Colin: 9, 284-287)

"Rushed" may be construed as wanting to satisfy the need for nutrition as soon as possible. Colin describes not making thoughtful choices about his food selection due to experiencing this level of hunger, which therefore leads him to eat unhealthy ("junk") food. Yet he has a different experience of hunger to the other participants, one which could be construed as part of his relationship with food. In Colin's interview he suggested that the

“best thing is hunger” (11, 372), because otherwise he feels “bad” (11, 371) when he has “eaten too much” (11, 371).

My understanding here is that hunger allows him, or acts as a permission giving thought to, overindulge without feeling guilty at the time, or at least feeling less guilty. Colin’s account most significantly addressed the way he felt about over-eating on the “last day of work” (20, 683) when he has not “eaten all day” (20, 683).

> “Uhh, I don’t really think about it at the time. I think I am addicted to crisps. You know what I mean I... yeah... um... when I start eating them I just keep eating them, until they are all um.. yeah no, it’s just bad, you know what I mean, they’re bad for you, too much salt and fatty foods isn’t it [breathing out deeply] yeah.” (Colin: 20, 691-696)

It seems Colin eats habitually, as he states that he does not consider the amount he is eating at the time. This eating appears to be mindless, as he “just keep[s] eating” the crisps until they are all gone. “It’s just bad” could be interpreted to mean that he deems his over-eating behaviour to be “bad”. But also “they’re bad” suggests that he perceives the crisps to be unhealthy due to the “salt and fatty” content, which could lead him to feel some sense of regret or guilt afterwards. This sense of guilt is supported by his response “aw f*ck, look how much I’ve been eating” (21, 705). The big sigh at the end of the extract, however, demonstrates the emotional struggle to deal with the remorse over his eating but also perhaps illustrates him feeling “bad” about himself as the failure to do anything about his habitual eating behaviour leads him to feel shame.

Fredrick, on the other hand, generally describes himself as a “binger” (5, 170) struggling to grasp “portion control” (6, 193). In his account, Fredrick talks about consuming a “large” (13, 455) amount of food at breakfast time which will sustain him “through to the next day” (14, 456-457) when working on late shifts. Moreover, he perceives it to be the “norm” (10, 330) for him not to eat at all at work. Fredrick explored why he believed his bingeing behaviour had developed.

> “So I think, yeah I think my... possibly [inaudible], my possibly old bingeing comes from... from time management yeah, from practicalities of doing the role.” (Fredrick: 9, 291-294)

Considering Fredrick's eating behaviour, as described so far, my understanding here is that he perceives that the only way he can manage his workload is to gain 'extra' time somehow. Eating quickly or not at all can free up much-needed time during the working day to successfully fulfil his role. This implies that his workload is prioritised over his own biological needs in a subjugating manner. Thus, Fredrick suggests that bingeing at home is an attempt to make it unnecessary to eat at work, and therefore is a practical solution in order to cope with the workload. Not only is this compensatory eating evident on his working days, but also on his days off. In Fredrick's account he talks about eating in the "opposite" (15, 492) way compared to his workdays.

> "I will just constantly feel hungry just constantly eat uh... and yeah just carry on. I need to, I have to consciously go 'hang on what am I doing here... uh... I need to go, I need to go out." (Fredrick: 15, 500-503)

Fredrick describes feeling hungry constantly, particularly on "sitting in front of the TV days" (15, 498-499). This hunger therefore could be arguably more aligned to emotional hunger, as a way to escape boredom on days when there is "nothing in the diary" (15, 494). Fredrick uses the term "consciously", suggesting that his eating happens in a habitual way and therefore he is mostly unaware of it. He appears to catch this eating behaviour as he attempts to interrupt it – "I need to go out".

Edward's account explored emotional eating more directly. He considers the way in which he eats outside of the occupational environment.

> "Um outside of work um as I say, I, I would eat lots and quite harshly [...] lots of energy-giving foods [laughs] and as I said again comes into the comfort eating thing as well." (Edward: 6, 192-197)

Here Edward describes eating "lots" and eating "harshly", which depicts over-eating. He directly considers emotional eating as playing a role in this eating behaviour. Edward described being more inclined to eat "carbohydrates" (6, 195) when comfort eating, which makes him feel "content" (8, 245) afterwards. Over-eating outside of work therefore does not only seem to be due to physical hunger but also emotional hunger as Edward describes eating when "stressed" (16, 530).

In summary, it appears that the occupational environment traps some nurses in a cycle of involuntary food restriction and compensating eating behaviour. Over half the nurses responded to stressors by over-eating to satisfy physical hunger during day shifts, including Fredrick who pre-empted this by binge eating beforehand. Therefore, it appears that there is some sort of balancing act established during the working life of a nurse, and for some this eating becomes habitual. Furthermore, for some nurses emotional eating is used as a coping strategy to deal with unwanted feelings by avoidance or escape. This will be explored in more detail in the next theme.

3.3.3 "Hang on, what am I doing?": Triggers of over-eating

This super-ordinate theme explores the relationship of eating to emotion. Four participants construe eating to go beyond satisfying physical hunger by directly linking emotion and eating. Adam talks about finding eating "relaxing" (4, 135) after a "long day" (4, 134) at work. Adam explores the role of eating and the "stressful things on his mind" (17, 578) that he attributes to his occupational environment.

> "Sometimes I just need to disconnect from that you know crazy world, and just be myself and make time for myself, my friends, my family. I find food plays a part in getting me into that zone where I can actually interact appropriately with family or friends without the burden of um you know leaning on them with my problems from work." (Adam: 17, 580-586)

Here my understanding is that Adam considers food as assisting him to disconnect cognitively as eating takes him "away" (17, 577) from these ruminating thoughts, "worry" (4, 126) and "anxieties" (4, 123) induced by the stressful environment ("crazy world"). "Just be myself" may be construed as food grounding him, in the sense that it "takes [you] away from [...] work" (16, 533-534), and also helps him "keep[ing] in touch" (15, 516) with his own identity by connecting with his "culture" (16, 537). The "zone" Adam refers to therefore might indicate achieving this separateness from the work stress, to be able to socialise without having things on his mind. Nevertheless, Adam appears to lean rather on food to manage the stress than on people. Adam perceives that his problems would become a "burden", too much for others to bear, which therefore indicates how overwhelmingly uncontainable Adam experiences this stress.

Similarly, Edward states that he comfort eats “particularly when stressed” (3, 109). He explored this emotional eating by comparing his current occupation to that of nursing.

> “I suppose I don’t have the stresses I did when I was doing nursing I probably still say I eat to a degree comfort eat when I am feeling down but not in the same ways. I don’t have the same stresses but you know when you have a day when you are feeling down and you just want to sit around the house, veg on the sofa and what not, and you think you will have your favourite food and ice cream and what not, and watch a film.” (Edward: 11, 355-363)

In this excerpt Edward perceives a difference in stress levels compared to when he was working as a nurse. He suggests he still comfort eats, but not “in the same ways”, and that could mean he comforts eat less frequently or that he eats smaller amounts. Similarly to other participants, Edward’s “veg on the sofa” and eating behaviour therefore acts as a coping strategy to escape negative feelings such as stress or sadness, making him feel temporarily “content” (8, 245). Other participants also described eating at times when they experienced certain emotions, such as boredom. In Gregory’s account he explored the nature of nursing during a night shift, describing a reduced workload and therefore involving less “rushing around” (15, 513).

> “In the moment I guess boredom took in the night shift as generally it is the slowest. [...] I would say it is very easy to fall into that grazing habit.” (Gregory: 15, 511-516)

Here, “boredom took in” suggests that Gregory was submerged in the feeling. He appears to find boredom difficult to manage as he suggests he can “easily fall into” an unhealthy eating habit to get rid of boredom. Therefore for Gregory to “occupy” (15, 514) his time, eating can become habitual without much thought or awareness. Gregory described himself in such moments of eating “completely unaware” (14, 472).

> “Um... so I would say kind of, walking past and picking things up um.. and then I would say moments of realisation when you walk past the final time and actually there is nothing there. Um... so that’s that’s quite a realisation.” (Gregory: 14, 479-483)

Here the account suggests that the availability of food acts as a trigger to eat, as Gregory is visually stimulated when walking past. In other words, the convenience of the availability of food perpetuates this grazing habit. Gregory describes the moment of shock when there is nothing left, as he suddenly becomes aware of how much he has eaten without even paying attention to it at the time. Gregory stated that night shifts are "terrible for snacking" (14, 465) and perhaps a cultural norm in the workplace. As Gregory described, there will "always be someone" (14, 466) providing the snacks. Colin describes similar types of foods he used to consume when working on night shifts.

> "Yeah, just loads of sweets, sweets yeah yeah. You know chocolate or anything with sugar in. [...] I would not always eat it, some nights I wouldn't even eat any of it, but some nights just eating the whole lot yeah. I think it was just, you know what I mean, time you spent craving a boost." (Colin: 14, 465-474)

Colin appears to have varying eating habits during night shifts as he describes some nights when he eats "the whole lot" and other times when he doesn't eat at all. Here, however, Colin mentions that he would be more inclined towards foods with higher sugar content, therefore "craving a boost" could be interpreted as feeling the need to increase his energy levels as he "gets tired" (14, 479).

In summary, these nursing participants described eating as a way of managing their negative emotions by means of escaping feelings such as stress and boredom. Often, however, the foods they are most likely to turn to are carbohydrates and sugars, including unhealthy snacks. Following on from here, the next master theme will aim to investigate "the struggle to live a healthy lifestyle".

3.4 "So I am getting healthier. Just not healthy": The struggle to live a healthy lifestyle

The nursing environment, including shift work, has a great impact on nurses, not only at work but also at home. This master theme captures the struggles of the participants to maintain a healthy lifestyle, not only as nursing professionals but also simply as human beings. Participants raised their own concerns of physical health in the first super-ordinate

theme “you want to be healthy don’t you?”. In addition, they explore the meaning of time, the long working hours as a nurse and the impact on their eating – “I have a window of opportunity to eat”. Lastly, participants interpret their struggle to take care of themselves in the super-ordinate theme “I just have to find the balance”.

3.4.1 “You want to be healthy don’t you?”: Health concern

This super-ordinate theme encapsulates some of the participants’ awareness of physical health risks, including those associated with nursing and shift work. Many of the participants identified particular times in their lives that precipitated health consciousness, or even a change in diet or exercise.

Colin explores the reasons why he changed his diet and became a vegetarian.

> “I don’t think anything actually... I think probably because she was pregnant, I was thinking more about health for myself, looking after myself, you know, I don’t want to die old, die young and anything like that. Maybe, I was just being lazy and I don’t want to cook two meals? So, I dunno but um... yeah is... yeah... stuck anyway.” (Colin: 6, 187-193)

Colin appears to struggle to make sense of the reasons why he changed his diet, which is highlighted with such utterances as, “don’t think anything” and “I dunno”. Colin, however, reflects on his partner’s pregnancy which appears to have elicited thoughts of his own mortality. Perhaps by “I don’t want to die young” he meant that he would not be able to support his child in the future. In the same breath, however, he also considers the effort it takes to prepare two separate meals. Colin seems to be undecided on the exact reasons for his decision, however, “health” seems to be pertinent to the change.

Understandably, health and mortality often appear together in participants’ accounts as they strive to make sense of how their lifestyles impact their health. Perhaps aging stimulates people to consider existential issues and the eventuality of death. This means that for some of the participants, ageing is a turning point when health becomes more of a concern. In Gregory’s account, he mentions the fact that he is ageing and that as a nurse he is “more aware of the health risks that that carries” (16, 539-540). Similarly, Fredrick perceives age to have “ticked a little switch” (11, 386).

> "I am more concerned now, [...] about health way or being body consciousness, weight than I was, or ever have been before. [...] getting old really.. [...] think 'well I am much more likely to be developing diabetes and chronic health conditions if I don't actually decide to look after the one and only body I've got'." (Fredrick: 12, 387-394)

It appears that regardless of being more concerned about health risks, Fredrick is somewhat undecided, and speaks of "if" change is needed. Fredrick appears to recognise the stakes to be high as he states that his body is the "one and only body I've got", seemingly weighing up the potential "developing" threat. In Fredrick's account, however, he explains that "I have to take responsibility for my choices [...] if I wasn't happy with them there will be a pressure to change them" (22, 755-758). It seems that awareness alone does not necessarily equate to motivation to change. Ben's account perhaps highlights this retrospectively.

> "No, I always knew I should eat better and more regular and more healthy. See my history tells me that." (Ben: 20, 699-700)

Here Ben appears to acknowledge that he had the awareness of how he "should" have eaten, however was not able to prevent "type 2 diabetes" (6, 190).

> "They said to me, do you want to take tablets or do you want diet control. And I am a great believer in taking drugs, rather than like having to do things, so I said just give me the medication." (Ben: 18, 619-622)

Here my understanding is that "having to do things" is too demanding for Ben, as he appears to experience some sense of helplessness. He stated earlier in his interview there is "nothing much I can do about it [...] I have done that for [...] God knows how long" (8, 270-272) when he referred to his eating pattern. Ben therefore prefers to choose medication rather than attempting to change his diet too radically as his eating habits have been established for such a long time. Nevertheless, Ben has gone through "a phase of six months" (5, 174) of exercising and eating a healthier diet, triggered by his awareness of his unhealthy eating. A "phase" suggests that there are points in time when Ben does try to change his eating behaviour but that these are difficult to sustain. It appears therefore that

some participants are more reactive than proactive with their lifestyles, regardless of prior awareness.

Gregory, on the other hand, has taken into account his age, weight and health risks to try and prevent something "that is avoidable" (16, 540) by changing his diet.

> "I don't always want to carry this extra weight around um... and it is only me that can change that. Um... and I would say that that was the driving factor behind it." (Gregory: 16, 525-528)

Gregory refers to himself here – "it is only me" that can bring on change, which shows that he perceives himself having an internal locus of control. Gregory wanted to change, therefore this motivation was "driving" him to take action. Edward perceived that a significant life event, that is, when he "split up" (15, 506) with his wife, was what induced a focus on health. Here Edward explores his "attitude towards food" (11, 363-364) and the ongoing cycle of change:

> "At points in time it will fluctuate or decide to go through a health kick and get myself fit. Last year I decided I want to lose weight and get fit so I lost three stone and got quite fit swimming and cycling and altered my diet to make it more protein based to to gear towards doing that" (Edward: 11, 364-369)

Edward's fluctuating attitude towards food could be construed as the peaks and troughs of motivation to change his eating behaviour at various "points in time". This suggests that these "health kicks", come and go, and come around again. "Going through" a health kick might be interpreted as the full process of change, from making the decision to following it through. Here Edward describes deciding to "lose weight" as the essential feature of his "health kick", changing both his diet and exercise routine.

For many participants, as discussed above, on the surface concerns regarding weight appear first and foremost linked to the physical health benefits they bring rather than to psychological benefits. However, participants' accounts seemed to be full of contradictions. This might be due to the simple fact of trying to make sense of it all, particularly when it comes to exposing participants' vulnerabilities. When Edward was

asked in his interview how he felt about being overweight he said that he didn't "think about it that much" (12, 393-394) and that he was content with his "body shape and size" (12, 399-400). However, as discussed before, it appears that losing weight has on occasion been his primary objective, above getting fitter.

In Fredrick's account he talks about the generational differences in perception of body image. He described not caring about having "a six pack, happy to have a keg" (11, 377-378), but nevertheless suggested that there were times where he was unhappy with his waistline.

> "So yeah actual waistline that makes me feel a little bit [...] aw that's a bit rubbish, sort my life out" (Fredrick 11, 356-359).

Here, the extract suggests, Fredrick's waistline may be larger than he wants, causing him to feel down about it, or "rubbish". "Sort my life out" suggests that Fredrick contemplated doing something about it, but this appeared to be a fleeting thought and action did not necessarily materialise. It appears that participants have variable motivation for change, and particularly when it comes to their weight. Perhaps initially Gregory experienced being overweight as something he was "used to" (534-536) in a pre-contemplative stage. Similarly, other participants contemplated losing weight, but described inaction, as they were not ready for change, or motivation was low. In Colin's interview he was asked how he felt when he ate too much. He responded that he perceived himself to be "lazy" (16, 544) as he interpreted the problem not to be the amount he consumed but to do with "exercise and doing too little" (16, 545). He spoke of needing to exercise, as he believed dieting alone would not cause him to "lose weight" (19, 661). However, he stated that his inaction was due to "excuses" (17, 574). Colin nevertheless attempts to control the amount of food he consumes and he "tr[ies] not to" (5, 144) "eat too much" (5, 144). This appears to be part of an ongoing struggle to stay healthy.

> "Try to be healthy food, try and, try, and try to never have takeaways or anything like that." (18, 597-599)

The repeating of "try" might mean that Colin does actively attempt to eat healthily, but that temptation, for whatever reason, might be at times too much.

In summary, participants appeared to display some concerns about their health, and these concerns have come at different times in their lives where health issues have been brought to the fore. These triggers might have been mortality or a significant event or time in their lives that brought considerations of change. Weight has been an underlying theme here, as being physically healthy also entails having a healthy weight. Nurses seem to be aware of healthy living, but implementing change can be more difficult. This leads us to the next super-ordinate theme, which considers factors of the occupational environment, such as long hours, and the impact of these on nurses' eating outside of work.

3.4.2 "I have a window of opportunity to eat": The struggle of healthy eating

Nurses are known to work long hours. This super-ordinate theme aims to explore the participants' perception of time outside of the workplace and the impact on their eating.

Most participants, apart from one, referred to time in the context of eating in some capacity during their interviews. Colin concluded that he spends "more time cooking" (19, 635) since he became vegetarian whereas Ben, on the other hand, states that he does not "spend any time preparing food" (16, 544), describing his behaviour as a "lazy way of eating" (17, 582). In some participants' accounts, however, they explored the meaning of time in more depth. Some perceived a connection between their working environments, time, and eating outside of work. Fredrick has been working as a nurse for around 15 years.

> "But um.. food, bingeing is more the fact that I don't really have a healthy lifestyle [...] and the fact that I sort of I don't know always worked shifts or um.. never really had enough time to sort of eat three square meals [...] 'right now I have to eat, I have a window of opportunity to eat' bang you eat something or drink something or do something and then go to bed." (Fredrick: 8, 258-268)

Here Fredrick describes in absolute terms how he "never" had the time to eat three proper meals in a day. Fredrick construes the nursing occupational environment and shift work as having contributed to his bingeing behaviour. Therefore, nursing appears to have influenced Fredrick's eating habits after prolonged exposure over 15 years. Here Fredrick suggests that the only way to consume his daily calories is to do it in less than three meal

sessions, which encourages bingeing. Furthermore, Fredrick suggests that the "window of opportunity" is so small that the options for activities after work are limited to one, either eating or doing something else. This appears to suggest that there is some sort of sacrifice, either the evening meal or another activity.

In addition, the lack of time appears to be detrimental to the participants, particularly around breakfast time. Adam simply does not "do breakfast" (5, 165), sacrificing a meal due to time limitations. Skipping breakfast, however, appears to have further health implications. Fredrick described consequently grazing during the day on "sugary carbohydrate-laden biscuits" (13, 460) when working early shifts, due to not having "time to eat" (13, 458) breakfast. In Daniel's account he considers what the time constraints means for him.

> "Sometimes you, when, sometimes you don't have time especially in the mornings you don't have time to prepare for lunch or for your packed lunch." (Daniel: 5, 145-147)

Here Daniel repeats "don't have time", suggesting that finding time to prepare lunch for the following day can be extremely difficult. As discussed before, Daniel describes how the occupational environmental factors could prevent him from eating "properly" (9, 303). My understanding here is that not having "packed lunch" available could contribute significantly to this issue.

Gregory explored how lack of time could have impacted on his choice of foods prior to his new diet, particularly "taking short cuts in meal preparation" (7, 234).

> "[...] with work being very busy I try to free up my time as much as possible when I am not at work, [...] I wouldn't say I... was considerate of picking healthy options, so within kind of choosing very convenient, always pre-prepared meals [...] I probably went for something that was going to taste amazing but was terrible for me [laughs]." (Gregory: 7, 242-249)

It appears that one way of freeing up "time" would be to reduce time spent on food preparation. "Convenient" could mean that it takes less effort; Gregory appears to desire

more free time to do as he pleases without his actions being dictated by a further workload ("busy") at home. Furthermore, he perceives "taste" to be prioritised over health at those times. Unhealthy food selection due to time restrictions appears to feature in other participants' accounts too.

> "It just depends what will be happening at work. If I finish late, for example, I will stop and get a takeaway, which is not very healthy." (Adam: 18, 608-609)

Here, "depends what will be happening at work" directly implies that the working environment influences Adam's food choices. Adam talks about finishing "late", which may mean that he has worked overtime due to the occupational demands. This therefore reduces his time available outside of work, and it appears that finishing late does not inspire cooking, as that may take time or effort that Adam does not feel he has. Adam therefore appears to choose convenience over health. Similarly, Daniel spoke of getting takeaway food, not only because of the convenience but also because "after a long hard day you just want to treat yourself" (12, 390). This suggests that after a "long hard day" at work nurses may not have the motivation or the time to cook something healthy.

Participants explored how nursing conditions could encroach on their personal time and contribute to the difficulty of establishing a work-life balance. They considered the implications of the long working hours on their own free time and the often harsh reality of needing to sacrificing food and healthy eating to enable them to do other activities in the "window of opportunity". This theme has given insight into how important time is in the lives of nurses. This brings us onto the last super-ordinate theme – why it might be so difficult for nurses in particular to establish a balance.

3.4.3 "I just have to find the balance": The difficulty in establishing self-care

This super-ordinate theme captures the difficulties nurses face in achieving a work-life balance. Many participants use the word 'try' and 'struggle' to convey the effort it takes to maintain a healthy way of life as a nurse and a person. Daniel explores the reason why he perceives himself to be struggling to find a balance of "spiritually, physically, and everything" (8, 260-261).

> "So that's I mean, I think it is just me, I think it is just inexperience really. I just have to find the balance how to, how to look after myself and be focused on the job." (Daniel: 10, 321-324)

Daniel suggests that the task of self-care can be challenging in the midst of doing his job. My understanding here is that currently there is an imbalance, a subjugation geared towards attending to his job rather than himself. In Daniel's account he also considered other factors that "affected" (16, 545) his eating such as relocating, the close proximity of fast food restaurants to his home, and still "adjusting to the work" (16, 544). Daniel attributed his struggle to "inexperience". Nonetheless, other participants, regardless of how many years they had worked as a mental health nurse, talked about their own difficulties in finding a "balance". Daniel, as previously discussed, perceived time to be the constraining factor that prevented him from organising food for the following working day. Needless to say, he was not the only participant to highlight this.

> "I try to make food that's there for the next day or whatever. If I've been too lazy to do that, then yeah... just be um... a bun I guess or just some, I dunno, microwave rice or something like that?" (Colin: 7, 229-233)

Here my understanding is that Colin attempts to make food for the next working day, but when he fails to do so he attributes his inaction to being "lazy". It appears that Colin finds it difficult at times to prepare lunch, and therefore ends up having processed "microwave rice" if his occupational setting allows him to get "around" (7, 229) to it. Adam has a different take on his "struggle" (5, 159) to eat earlier in the evenings, suggesting that it is "a habit I can't seem to shake" (5, 148-149). Adam attempts to cook plenty of food for the following days, but doesn't always manage it ("it is not always the case" (5, 157)). Gregory has made some changes in his diet, and managed to break some of his eating habits in pursuit of health, but maintaining it seems to be an additional challenge. Gregory indicates that eating healthily is "a conscious effort to do... I have to allocate the time for it" (11, 377-378). This applies not only for "sit down [...] meals" (11, 360) but also for cooking. In Gregory's account he appears to have recognised that the only way to instigate change is to be "much more prepared for it" (12, 417).

As discussed in the previous super-ordinate theme, time is an essential factor in maintaining a healthy diet and pattern, however, it is important to explore the wider implication of time on nurses' general well-being. Gregory's account explores why, as a nurse, it may be so difficulty to protect "personal time".

> "So I would say in general time is really important to me because I... with the nature of my job being quite demanding I would say that that time, can often all too easily creep in to my personal time" (Gregory: 12, 391-394)

Here my understanding is that the job demands may require extra time from Gregory, therefore he finds it difficult to maintain a firm time boundary. "Creep" suggests that job demand encroach on his time without his awareness, and can catch him by surprise if he does not pay attention to the boundary, as it is "too easily" crossed. In Gregory's account he suggested that "the kind of person you come across within nursing [...] it is something we will often accept" (12, 404-406). Again, this implies that the workplace's needs are prioritised, whilst the nurses subjugate their own needs.

Time is also essential in maintaining relationships and being able to spend time with significant others. Gregory explores how being on a time schedule "different from everyone else's" (17, 598-599), such as night shifts, impacts on a well-balanced lifestyle.

> "[...] with nights shift, it tends to throw everything out, [...], you are trying to fit in with home life still and having meals at home with family, partner um... and still very much trying to hold that routine, but it's much more difficult to do that on a night shift." (Gregory: 17, 567-572)

"Trying" and "difficult" seems to portray the real struggle to keep a routine during night shifts and how this affects other people too. "Throw everything out" could be construed as throwing home-work life out of balance. Gregory appears to express the strain in being a part of ("fit in") other people's lives. Night shifts seem to dictate that his "life" happens in parallel with that of others, but with little crossover between the two. Time, so important for a well-balanced or healthy lifestyle, can be complicated when working shifts as a nurse.

Participants do not only indicate time to be a factor in establishing a healthy living routine. In Adam's account he offers a wider explanation as to why, as a nurse, it can be difficult to

uphold an exercise routine. He talks about coping with “immense pressure” (3, 81) in a “challenging” workplace.

> “[...] it takes its toll, you know, on the body and on the mind. [...] I’ve been doing really well going to the gym consistently, but lately I have felt so drained I have stopped doing you know, things that I enjoy. So yes it is very challenging and takes a lot out of you.” (Adam 4, 106-115)

Adam describes feeling “drained”, suggesting that the pressure of coping in this working environment depletes him both mentally and physically. Even though Adam tries to keep up a routine of physical exercise, at times the occupational environment does not leave him with any energy to pursue the gym, or any other activities he “enjoys”. My understanding here is that Adam finds it difficult to establish self-care and that this could lead to ‘burnout’.

In summary, when participants reflected on their struggles to sustain healthy living, they highlighted the combination of occupational demands, working overtime, maintaining work-life time boundaries, feeling drained by the working environment, being on opposing schedules to others when on night shifts, and finding eating habits difficult to break as contributing to the struggle of finding a work-home life balance and satisfactory level of self-care.

3.5 Bringing Super-ordinate Themes Together

3.5.1 “Part and parcel of the nature of the job: External locus of control”

Participants described situations at work over which they felt they had no control. This is encapsulated with the notion that they perceive an external locus of control and therefore surrender to learnt helplessness as “part and parcel of the job”. This was evident throughout the super-ordinate themes. Firstly, “the pressure of work” and the real threat of danger forced participants to adapt their eating. Secondly, “everything fell by the wayside”, as nursing duties were associated with life and death and therefore prioritised over all else including food. Lastly, “eating is not your priority” showed how nurses accepted their situation and felt they had no internal locus of control. These experiences therefore

portrayed how little, if any, control nurses have over these events and ultimately the nursing environment.

3.5.2 "Try to sort of compensate: Satisfying physical and emotional hunger"

This master theme can best be described as exploring "physical and emotional hunger". Across all three super-ordinate themes participants explored and endeavoured to make sense of their hunger. The themes interacted in a way that displayed the balancing act between participants' work-home life, as one cannot exist without the other. There were two distinct "compensatory" eating behaviours, due to the occupational environment: 1) involuntary food restriction at work and over-eating at home, and the dynamic between them; and 2) eating to ease or compensate for emotional impact (stress and boredom).

3.5.3 "So I am getting healthier. Just not healthy": The struggle to live a healthy lifestyle

The underlying theme holding the three super-ordinate themes together was the "struggle to live a healthy lifestyle". The first super-ordinate theme, "You want to be healthy don't you?", encapsulated the health concerns described by the participants as well as exploring fluctuating motivation for change. "I have a window of opportunity to eat" explored the struggle to eat healthily when the long working hours put constraints on time. And lastly, "I just have to find the balance" specifically looks at the difficulty nurses have in establishing and maintaining a healthy lifestyle, which includes self-care.

4 Discussion

4.1 Overview

In this chapter, the study's rich in-depth analysis of interviews with male mental health nurses (MHN) regarding eating will be integrated with previously described literature and conceptualised within existing research, psychological knowledge and relevant theories. The discussion will be presented within the distinct super-ordinate and master themes as far as possible, though some features may overlap. These themes can be distinguished but not separated, since the experience of eating is multi-faceted and multi-layered. Moreover, with the phenomenological approach, it was possible to access the male MHN participants' individual experiences of eating and their underlying processes, in order to further address the gap in the current literature about males, eating and nursing. The master themes will be presented first, followed by the accompanying three super-ordinate themes.

4.2 External locus of control: "Part and parcel of the nature of the job"

This master theme has three super-ordinate themes. The underlying feature of the super-ordinate themes "*pressure at work"*, "*everything else fell by the wayside*" and *"eating is not your priority"* is the experience of an external locus of control. Rotter (1966) suggested that if a person does not perceive an outcome of an event to be directly resultant from his or her own action, the outcome is attributed to external forces such as luck, chance or under the control of powerful others. However, when such an event is interpreted as subject to the person's own behaviour, Rotter labelled this "a belief in internal control" (1966, p. 3). Participants experience a high workload and the unpredictability of their environment appears to be beyond their control. The analysis of participants' accounts suggested that their eating behaviours are subject to their occupational environment; therefore, the participants are considered to experience a high external locus of control. This perception of external locus of control leads to learnt helplessness as implied by the master theme, "part and parcel of the job".

The '*learned helplessness hypothesis'* suggests that "when events are uncontrollable the organism learns that its behaviour and outcomes are independent, and that this learning

produces ... motivational, cognitive, and emotional effects" (Maier & Seligman, 1976, p. 3). Maier and Seligman (1976) suggested that human subjects experience similar learned helplessness to animals, such as when dogs fail to try and escape electric shocks if they have previously learnt that they are *inescapable*. This suggests that regardless of whether aversive conditions are physically escapable or not, dogs and humans subsequently lack motivation to try, as cognitively they believe there is no relationship between their actions and the outcome. Ben's account was a clear example of this learned helplessness, particularly when he said "there is nothing much I can do about it". This illustrates that participants experience the working environment as an external force beyond their control and therefore accept it as 'the way it is', following repeat exposure to the *inescapability* of work demands and previous failed attempts to effect a different outcome, such as having regular meals at work. Jinks, Lawson and Daniels (2003) found similar results; out of 1,021 hospital staff (n=490 nurses), 92% reported that they would find changing their health habits "pretty tough" or "almost impossible".

4.2.1 Mindless eating on day shifts: "The pressure of work"

The super-ordinate theme, *"the pressure of work: mindless eating"*, encapsulated how the participants experienced their eating in terms of the occupational setting. Two examples of mindless eating emerged when the male MHN explored eating at work, firstly, mindless eating due to the pressure of the workload and, secondly, mindless eating in the anxiety-provoking high-risk situation of eating with inpatients in a dining room. Both of these impacted on the way they ate. This type of eating was described by all participants and will be discussed below.

The definition of mindfulness as given by Kabat‐Zinn (2003) is, "the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment" (p. 145). It is clear from this definition that what participants described was the opposite of mindful eating. *'Mindless'* eating is clearly evident in their accounts.

Daniel described the shortage of staff, particularly "across NHS and across nursing", and how this impacted on his experience of eating. He described the difficulty of mentally disconnecting during breaks, particularly when he held clinical responsibility, such as being

the only qualified MHN on shift, or if the team was short-staffed. Daniel described being preoccupied by his thoughts and distracted throughout his break due to the overwhelming number of tasks he had to complete. He described this as: “thinking of things that you want to do”. Daniel’s description reveals mindless eating, as his focus is not on the ‘present moment’ but on the tasks that lie ahead. The RCN (2017) found that 34% of 1,300 shifts from mental health inpatient settings were short of the planned number of registered nurses and 42% were short of health care support workers. The aforementioned shortages have adverse effects on nursing staff’s physical and emotional well-being; high workload due to shortages resulted in personal costs to nursing staff, such as the inability to stay hydrated, eat or use the toilet (RCN, 2017).

Participants most commonly described eating faster, and consuming food whilst sitting at their desk, as the direct implications of time constraints at work. As with many other participants, Daniel mentioned the limitation of time, and eating in a “rush[ed]” manner. Adam gave some insight into how such eating transpired. He explained how “time constraints” and the “pressure of work” “pushe[d]” him to eating “a lot faster” or more “quickly” than he desired. Adam also referred to trying to “keep up with people” and “rush” his meals when he ate with inpatients. Mesas, Muñoz-Pareja, López-García and Rodríguez-Artalejo’s (2012) systematic review included eight studies investigating eating speed and weight, all of which reported that faster eating rates were associated with excess weight.

Gregory talked about the “quick wind” nature of eating at work, most prominently not allocating time for his meals. He described dual-tasking whilst eating, most often sitting at his desk to resume working. His experience parallels that of Fredrick, in that they both depicted an environment where eating is *on the go*. Fredrick described mindless eating when referring to the manner in which he eats – “throw that down my throat” – and attending to work whilst eating.

Ogden et al. (2013) found that food consumption was higher when participants were distracted whilst eating. The authors suggested that their study supported the notion of eating ‘mindlessly’ in terms of the cues to both start and stop eating. They suggested that the subjects failed to notice their decreased desire to eat after consumption of food. This

research therefore suggests that male MHN may over-eat when their attention is being diverted at work.

Mindless eating was also evident in participants' accounts when they described eating with inpatients in the dining room. Quite often the accounts portrayed the participants' "mind" or "focus" being on the patients or monitoring risk, and not on their eating. Ben suggested that eating with inpatients became a "function of observing people". Nijman et al. (2005) indicated that inpatient aggression was high, therefore the probability that MHN would be severely injured at some point during their professional careers was also deemed to be high. Participants reflected on facilitating inpatient meal sittings whilst locked in a dining room, with some perceiving it as a high-risk situation due to a real possibility that they could be on the receiving end of patient aggression and violence, perhaps particularly when inpatients had potential weapons (cutlery) available. Colin described some of the measures taken to secure safety in a locked dining room, such as counting cutlery before patients had access to it and counting it back in at the end. Although Colin mentioned that he had never experienced any major incidents during a meal sitting, he was aware of such events. When he was asked to explain what it was like to eat whilst facilitating a meal sitting, he described feeling "a little bit on edge". He described concentrating on observing his surroundings to spot a possible threat and "not concentrating too much" on food. This indicated how mindless eating emerges in these situations, unlike when eating a "normal meal". Therefore, it is not too surprising that these participants described focusing on 'threat-detection' rather than on their food. Although this eating can be termed *mindless* due to distracted attention, focusing on threat-detection may also be explored in terms of the biological *stress* response, which will be discussed in the next subsection.

In summary, MHN participants depicted an environment with a high workload, high pressure and significant time constraints. This high-pressured environment moulds nurses' eating habits, resulting in rushing and multi-tasking, which could be defined as mindless eating. Furthermore, eating whilst having to observe inpatients during meal sittings can be anxiety provoking. Attention is paid to threat-detection and not to eating. Research suggests that mindless eating, including eating quickly, could potentially lead to weight gain. We will return to mindless eating in more detail later and look at the contexts in which it occurs – see the superordinate theme headings 4.3.2 and 4.3.3, *"triggers of eating"* on night shifts, and *"eating more than I should have".*

4.2.2 Involuntary food restriction on day shifts: "Everything else fell by the wayside"

This section will continue to explore how environmental factors impact on male MHN's eating behaviour. This super-ordinate theme aimed to address the unpredictable nature of the job, where certain aspects of their working environment were outside of participants' locus of control. The theme explored how these environmental factors impacted on the nurses' eating, or more accurately, their resultant involuntary food restriction.

All participants described the reason for missing meals at work as being too busy and not having time to eat. Most striking was Ben's account of his eating patterns at work: "when I am on days I normally lose weight as well, 'cause I can go the whole shift without eating". Ben described how he "hardly ever" gets to eat, and therefore his weight goes down. Ben gave similar reasons for missing meals – being "busy, you get caught up". He mentions that missing meals is also due to scheduling clashes; if he is assigned to dispense medication he is not able to attend and supervise the meal sittings with patients. Ben is the participant with the most experience, at around 25 years as a mental health nurse. He has also been diagnosed with type 2 diabetes.

Daniel's account gives a more descriptive example of what other participants might have referred to as being "busy". Daniel's account most pertinently summed up the experience of feeling "under pressure" to meet work demands, particularly in circumstances when MHN experience a shortage in staff. For example, new patient admissions, a large amount of administrative work, pressure to complete all paperwork in a timely matter due to "strict" occupational auditing practices, and unpredictable incidents all contribute to high work demand, which consequently leads him to "forget" to eat or to take a break. Similarly, research indicated that failure to take breaks, low staffing levels and high workload were key barriers to nurses' healthy eating practices (Faugier et al., 2001a; Faugier et al., 2001b). Work stress was also reported to be strongly associated with irregular meal patterns (Nahm, Warren, Zhu, An, & Brown, 2012). Nahm et al. (2012) found that nurses reported irregular meal patterns (54%) such as skipping meals due to a lack of time and the inability to take a break. Coomarasamy, Wint, Neri and Sukumaran (2014) concluded that missing meals was attributed to working conditions, such as long working hours, work schedules and work demands.

Adam explored this “very hectic environment” and construed that the missed meals were due to the unpredictability of inpatient settings. He suggested that the “unpredictability” disrupted his eating pattern as there was no guaranteed time to eat, stating that he might “go without eating if it is very busy”. This resonated with Gregory’s account; he talked about not having a ring-fenced time or any particular “routine” to his eating. This depicts a working arrangement where nurses are mostly subjected to, or at the mercy of, their occupational setting, and eating occurs around nursing duties, but not the other way round. A randomised controlled trial found that regular meal patterns potentially support weight control and metabolic health (Alhussain, Macdonald & Taylor, 2016). This suggests that nurses’ working environments do not support their physical metabolic health and therefore could leave them at higher risk of becoming overweight. Consistent with the overall findings described above, an integrative systematic review found that the nursing occupational environment had a negative influence on nursing staff’s dietary intake (Nicholls, Perry, Duffield, Gallagher & Pierce, 2017).

Many participants described certain incidents that take priority over all else and which are commonplace in inpatient mental health settings. Edward summarised many of these incidents as aggression and violence, self-harm and physical health incidents. Most participants suggested that these incidents might also lead to nurses missing meals. Adam described being “consumed by the intensity of the incident”. Such incidents become Adam’s priority, overriding everything else including his own needs of satisfying hunger at the time. Daniel described his physiological arousal when faced by an incident, as “adrenaline” pumped through his body to “deal with” the immediate threat. Firstly, it is important to reflect on the body’s physiological response to stress and thereafter the impact on eating. The *autonomic nervous system* (ANS) controls primitive internal functioning such as blood vessel muscles and the gastrointestinal tract (Waterhouse & Campbell, 2011). It is theorised that physiological homeostasis is achieved by alternating stimulation of the two subsystems of the ANS, namely the *sympathetic nervous system* (SNS), associated with the ‘fight-or-flight’ response, and the counteracting position called the *parasympathetic nervous system* (PSNS), or the ‘rest and digest’ state (Shimizu & Okabe, 2007). The fight-or-flight response directs blood away from non-essential areas (gut and skin) and towards the muscles activating the central nervous system in order to manage the immediate threat (Waterhouse & Campbell, 2011). The SNS releases

adrenaline, increasing heart rate and pupillary dilation, decreases digestive movements and stimulates release of energy, such as glucose, lactate, fatty acids, glycerol and amino acids, to 'fight' or 'flee' danger (Waterhouse & Campbell, 2011). Therefore, it appears that the body reacts by releasing energy to enable potential life-saving physical activity such as running away or 'fighting'. Additionally, research suggests that the intensity of a stressor might influence the duration of recovery after the source of stress has ceased (Márquez, Belda & Armario, 2002). This would correspond with Daniel's account of becoming aware of hunger, feeling weak and having low blood sugar only after the "dust [had] settled".

Sapolsky, Romero and Munck (2000) suggest that loss of appetite is one of the immediate physiological consequences of the stress response. This might therefore explain why 'eating less' is a prevalent response to stress (Stone & Brownell, 1994). Edward also stated in his account that he lost "lots" of weight due to "the stresses" he initially experienced at the start of his career as a MHN. However, studies found that an individual can also respond to stress by eating more (Torres et al., 2007; Stone & Brownell, 1994). The relationship between stress and eating will be discussed in the 'emotional eating' section (4.3.3), with special reference to participants who responded by eating more when stressed.

In summary, all participants described that the reasons for missing meals at work were being too busy and not having time to eat. Some participants felt "under pressure" to meet work demands and attributed missing meals to administrative work, incidents, and a higher workload due to being short-staffed consequently forgetting to eat or not taking a break. One participant suggested that scheduling clashes, such as being assigned to dispense medication, meant he was not able to attend and supervise the meal sittings with patients and as a result did not get to eat. Other participants spoke of not having a ring-fenced time or any particular "routine" to their eating. Regular meal patterns potentially support weight control and metabolic health. However, the mental health nursing occupation creates the conditions for involuntary food restriction at work and unhealthy eating patterns. Loss of appetite is one of the immediate physiological consequences of the stress response. Occupational factors, such as high workload and stress could directly impact male MHN's eating patterns and potentially lead to long-lasting effects on health, such as weight loss.

4.2.3 Subjugation of needs: "Eating is not your priority"

Many participants seemed to display behaviour directed towards meeting the needs of *others.* Some participants appeared to feel coerced into prioritising occupational demands above their own physiological needs. Others, however, described a more voluntary attitude, for example, they "can" go "without" food. Some nurses described trying to meet internalised standards as they went "above and beyond". Therefore it could be hypothesised that subjugation and/or self-sacrificing of basic biological needs such as eating (this study and others), staying hydrated, or using the toilet (RCN, 2017) might be maladaptive. As Gregory indicated, he was aware of missing meals being "very unhealthy" and recognised that as nursing professionals he and his colleagues often "neglect" these aspects of themselves. Correspondingly, a thematic analysis study found a similar theme – *embodied care 'my own physical and mental health is sacrificed to be a nurse'* (Huntington et al., 2011).

The Schema Therapy framework might help to explain the above-mentioned tendencies (Young, Klosko & Weishaar, 2003).

Young et al. (2003) stated that Early Maladaptive Schemas are:

> Self-defeating emotional and cognitive patterns that begin early in our development and repeat though-out life. Note that, according to this definition, an individual's behaviour is not part of the schema itself; Young theorizes that maladaptive behaviors develop as *response* to a schema. (p. 7)

There are two *early maladaptive schemas* that could be hypothesised to be significant in some of the male MHN participants' experiences. I will therefore refer to '*subjugation' and 'self-sacrifice'* as part of Young's *'other-directedness'* schema domain (Young et al., 2003). The other-directedness domain refers to an "excessive focus on the desires, feelings, and responses of others, at the expense of one's own needs ... Usually involves suppression and lack of awareness regarding one's own anger and natural inclinations" (Young et al., 2003, p. 17). Daniel recognised in "hindsight" that he "should be looking after" his own well-being before looking after that of his patients. "Hindsight", however, suggests that Daniel has perhaps not reflected on his eating prior to the interview, when he was able to

voice his “natural inclinations”. This means that he could have been unaware of the scope of the impact on his own health. Although Daniel feels he “should” be taking care of himself, he felt “under pressure” or coerced to suppress his own needs. For example, his place of work is “quite [...] strict on the paperworks because they do a lot of audits so you do have to do finish it otherwise you get a lot of emails [...] I hate that [...] overwhelmed by work that you forgot to eat”. This can be termed subjugation, which is an “excessive surrendering of control to others because one feels coerced – submitting in order to avoid anger, retaliation, or abandonment.” (Young et al., 2003, p. 17). Colin stated that there was nothing in particular that might have “stopped” him from eating, but suggested that, “if I am busy I am busy” and that sometimes he “forget[s]” to eat and just “carr[ies] on working”. All participants spoke of missing meals due to being “busy” or lacking “time”. It appears that this prioritisation of workload or needs of the workplace (the *other*) equates to subjugating their own physiological needs such as food intake. In addition, Adam’s account indicated that work demands “pushed” or coerced him to “adapt” his eating involuntarily, such as by eating faster.

Young et al. (2003) suggest that there are two main facets of subjugation: “A. Subjugation of needs: Supressing of one’s preferences, decisions, and desires. B. Subjugation of emotions: Suppression of emotions, especially anger” (Young et al., 2003, p. 17). Participants may perceive that their “desires, opinions, and feelings are not valid or important to others” (Young et al., 2003, p. 17). In light of the above theory, Ben’s unsympathetic response when hungry in the workplace – “that’s just tough!” – appears to show how he perceived *others* to disregard his desires, opinions and feelings at work. In addition, this *subjugation* emerges as “excessive compliance” and “feeling trapped” (Young et al., 2003, p. 17) as implied by Gregory’s statement, “part and parcel” of the job. As Ben said, “I hardly ever get to have [meals at work] so I sort of don’t worry about it”. This acceptance can be understood by the *compliant surrender* aspect of dysfunctional coping, which suggests that the individual submits to an activated schema, “becoming once again the passive, helpless child who must give in to others” (Young et al., 2003, p. 44).

Young et al. (2003) suggest that subjugation could lead “to a buildup of anger, manifested in maladaptive symptoms (e.g., passive-aggressive behaviour, uncontrolled outbursts of temper, psychosomatic symptoms, withdrawal of affection, “acting out”, substance abuse)”

(p.17). Adam's description of "animosity [...] over a meal" parallels this "buildup of anger", at a time when he missed a meal due to being too busy at work. He described the situation as being "frustrating", and feeling "upset" with his colleagues for not "saving" him a meal. He described thinking how "inconsiderate" they were not to think of him (and his needs). He spoke about reacting towards them in a way that was "not my usual self". This situation perhaps demonstrates the subjugation of emotions and needs, which may lead to feelings of anger and resentment in the workplace.

In the participants' accounts, subjugation of needs due to perceived coercion appears to be the most prominent maladaptive behaviour in the workplace. However, it is possible that some of what has been described might be construed as self-sacrifice. Young et al. (2003) defined self-sacrifice as "excessive focus on voluntarily meeting the needs of others in daily situations at the expense of one's own gratification" (p. 17). Young et al. (2003) stated that the most common reasons for self-sacrifice are: "to prevent causing pain to others, to avoid guilt from feeling selfish, or maintain the connection with others perceived as needy" (Young et al., 2003, p. 17). Colin, for example, stated, "I can go without". Yet when he reached a "point" when he couldn't go without and was really "hungry", he stated, "I will have to make some food". "Can" might be interpreted as, *I can go without but others who are more needy (patients) cannot, and therefore I only eat when I have no choice (self-sacrifice) OR I can go without if I must to meet my work demands (subjugation).* Since all participants described the reasons they missed meals as due to lack of time and being "busy", and depicted a high workload that coerced them into missing meals, subjugation appears to be more applicable than self-sacrifice in this context.

Another early maladaptive schema that could contribute to behaviour that leads to missing meals is *unrelenting standards/hypercriticalness*.

Young et al. (2003) defined unrelenting standards/hypercriticalness as:

> The underlying belief that one must strive to meet very high *internalized standards* of behavior and performance, usually to avoid criticism. Typically results in feelings of pressure or difficulty slowing down and hypercriticalness towards oneself and others ... Unrelenting standards typically present as (a) ***perfectionism,*** inordinate attention to detail, or an underestimate of how good

> one's own performance is relative to the norm; (b) ***rigid rules***, and "shoulds" in many areas of life, including unrealistically high moral, ethical, cultural, or religious precepts; or (c) preoccupation with ***time and efficiency***, the need to accomplish more. (p. 17)

Fredrick's account possibly reveals unrelenting standards/hypercriticalness as he described how he does not take a "break", "let alone to eat", even though he stated that staff were actively encouraged to take opportunities to eat. He mentioned that a "sit down lunch would be a waste of time" as he would "rather" "get on with" the work at hand. Therefore it appears that Fredrick's drive to accomplish more, and meet his internalised standards of performance, prevents him from slowing down (and eating). Gregory was asked how he felt when work crept into his personal time, such as from overtime; he stated "we are used to kind of going above and beyond what is expected of us". The unrelenting standards/hypercriticalness schema may play a role here for Gregory and colleagues as they strive to "get our jobs done to the standard we are happy with". These high internalised standards are experienced as pressure to "go above and beyond" and may contribute to neglect of one's own needs such as achieving a work-life balance.

It can therefore be hypothesised that with the attitude of going "without" food during working shifts, male MHN participants subjugate and/or self-sacrifice their basic needs (nutrition) in order to meet the needs of *others*. This is either because they feel coerced by the demands of *others* (subjugation), because voluntarily meeting the needs of others is detrimental to their own needs (self-sacrifice), or because they are striving to meet unrelenting standards/hypercriticalness to avoid repercussions such as criticism, anger, retaliation, abandonment, guilt from feeling selfish, and/or to maintain the connection with others perceived as needy.

This subjugation or self-sacrificing of emotions and needs is consistent with unassertive behaviour. Alden and Safran's (1978) findings suggest that cognitive factors might play a role in unassertiveness. Authors specifically mentioned irrational beliefs related to "perfectionistic standards and an overconcern with the feelings of others" (Alden & Safran, 1978, p. 363), such as proposed by Lange and Jakubowski (1976): "I must be loved and approved of by significant others in my life"; "I must be completely competent at everything

I attempt"; and "It is terrible when things do not go the way I want them to go" (Alden & Safran, 1978, p. 358).

Assertiveness as defined by Alberti and Emmons (2008) is as follows:

> Assertive self-expression is direct, firm, positive – and when necessary, persistent – action intended to promote equality in person-to-person relationships. Assertiveness enables us to act in our own best interests, to stand up for ourselves without undue anxiety, to exercise personal rights without denying the rights of others, and to express our needs and feelings (affection, love, friendship, disappointment, annoyance, anger, regret, sorrow) honestly and comfortably. (pp. 45-46)

Male MHN appear to subjugate their needs and emotions in the workplace by behaving in an unassertive way, such as not exercising their personal rights to have a break and/or eat. As stated by the Royal College of Nursing (2017, p. 8), "taking a break at work is not a luxury but a basic right protected by employment law".

4.3 "Try to sort of compensate": Satisfying physical and emotional hunger

As with the first master theme, this master theme also has three super-ordinate themes. Across all three super-ordinate themes participants explored and endeavoured to make sense of what they interpret as *hunger*. The themes interacted in a way that displayed the balancing act between participants' work and home life, as one cannot exist without the other. There were three distinct over-eating or *compensatory* eating behaviours borne from the occupational environment: 1) involuntary food restriction – and the dynamic between hunger at work and consequent over-eating at home; 2) emotional eating – to ease stress and boredom at work; and 3) eating to compensate for the tiredness experienced on night shifts.

These relationships will be discussed within the super-ordinate themes below, "Hunger can be frustrating", "Eating more than I should have", and "Hang on what am I doing?".

4.3.1 Ethical implication of physical hunger: "Hunger can be frustrating"

Four participants spoke of how they dealt with hunger at work. However, many participants reported that they only became aware of hunger at the end of the working day (Adam, Ben and Daniel), realised later on they had missed a meal (Colin), or spoke of only becoming aware of missing meals when thinking about dinner on the way home (Gregory). This may be explained by the idea that hunger first of all requires to be noticed, and thereafter can be modified by the amount of attention paid to hunger (Ogden et al., 2013). This might explain why some participants do not perceive hunger when they are "busy", and when they do they can modify hunger at work by confining their attention to the symptoms, or focusing attention elsewhere if required by the job.

Participants may be able to cope with hunger at work, however, it is important to explore the potential implication of food deprivation on the participants and their nursing duties. Adam and Daniel particularly reflected on the negative impact of hunger on their functioning, such as lapses in concentration and focus, decision-making skills, alertness, hunger pains, headaches, feeling irritable and frustrated, low energy levels, physical weakness and low blood sugar. Meeusen (2014) suggested that not only is the maintenance of neural pathways dependent upon satisfactory nutrition, but temporary changes in the intake of food could influence cognitive functionality.

The Nursing and Midwifery Council (NMC, 2015) provides four competency domains that MHN have to demonstrate: 1) Professional values; 2) Communication and interpersonal skills; 3) Nursing practice and decision-making; and 4) Leadership, management and team working. It is therefore evident that hunger could influence essential competencies of MHN. Irritability and frustration could influence the interpersonal skills required in a nursing team as well as how nurses manage complex inpatient presentations. Furthermore, nurses require optimum cognitive functioning for "medicines management" (NMC, 2015, p. 20), such as administering the correct and appropriate medication. I would argue, therefore, that hunger could have potential life-threatening consequences and puts patients at risk. Lapses in concentration and focus can make "difficult" decisions even more complicated.

The MHN environment requires nurses to manage potential life and death situations, as the following extract will demonstrate:

> Work positively and proactively with people who are at risk of suicide or self-harm ... in situations that are potentially challenging, such as times of acute distress; when compulsory measures are used ... using interventions that balance the need for safety with positive risk-taking ... giving priority to actions that enhance people's safety, psychological security and therapeutic outcomes, and by ensuring effective communication ... (NMC, 2015, p. 19)

This therefore raises an ethical concern with regard to hunger potentially compromising the cognitive functioning of nurses and therefore having a detrimental impact on challenging situations that require positive risk-taking. Levy, Thavikulwat, and Glimcher (2013) found that participants became less risk-averse when they became hungrier and thirstier. The participants in the deprived session were asked to withhold from drinking and eating for only 4 hours beforehand. In a 12-hour nursing shift, missing one meal could potentially make nurses less risk-averse, which could compromise safety. De Ridder, Kroese, Adriaanse and Evers (2014) suggested that the level of hunger plays an important role in determining the degree of influence in decision-making. The study suggested that moderate levels of hunger benefited participants, however, extreme hunger may have hindered their decisions.

In summary, as hunger at work could potentially compromise the cognitive functioning of MHN in ways that could influencing their decision-making capabilities, such as becoming less risk-averse, this raises an ethical concern with regards to their ability to manage challenging situations appropriately.

4.3.2 Over-eating at home: "Eating more than I should have"

As stated in the analysis, it appears that the male MHN occupational environment encourages a cycle of involuntary food restriction and compensatory eating behaviour. The dynamics between missing meals at work, physical hunger and over-eating will be discussed in this section. The second area – over-eating when experiencing negative emotions – will be discussed under the next subheading, "triggers of over-eating". All participants apart from Ben stated some sort of compensatory eating behaviour when

exploring the interplay between eating at work and home. It is important that it is made explicit that participants in this study described subjective disordered eating behaviours such as 'fasting' and 'bingeing'. Although these behaviours are associated with eating disorders, as described by ICD-10 (WHO, 1993), 'alternating periods of starvation' and 'recurrent episodes of over-eating', this is by no means a clinical diagnosis of eating disorders. However, I shall draw upon research in the non-clinical and clinical population of disordered eating behaviour to discuss my findings. Together this literature might give some insight into the possible dynamics between food restriction and the over-eating behaviour described by participants.

Many participants discussed their experience of eating on days they had missed meals due to the working environment. Fredrick, on the other hand, pre-empted hunger by consuming a "large" amount of food at breakfast time which would sustain him "through to the next day" when working on late shifts. Fredrick generally described himself as a "binger", struggling to grasp "portion control". Moreover, he perceived it to be the "norm" for him not to eat at work at all. Fredrick perceived that his bingeing behaviour had developed due to "time management [...] from practicalities of doing the role". Thus, Fredrick suggested that bingeing at home is an attempt to make it unnecessary to eat at work (creating extra time), and therefore a practical solution to the high workload.

Daniel summarised the effect on his eating by stating that he "tr[ies] to sort of compensate [...] eat[s] a lot during the night" and eats "more than I should have" on these occasions. Adam also gave an example of when he had a "generous portion" and went for "seconds" after missing a meal during his day shift and feeling very "hungry". Faugier et al. (2001b) also reported that skipping breaks usually resulted in nurses eating 'on the run' and 'inappropriately' later in the day. Consistent with these results, Polivy's (1996) literature review suggested that food restriction, including starvation and dieting, induces binge eating when food becomes available.

Colin's account most significantly addresses the way he feels about over-eating on the "last day of work" when he has not "eaten all day". Colin appears to eat mindlessly as he "start[s] eating" and "just keep[s] eating" crisps until they are all gone. Colin states that "it's just bad", which could be interpreted to mean that he deems his over-eating behaviour to be "bad". Colin also says, "they're bad", suggesting that he perceives the crisps to be

unhealthy due to the “salt and fatty” content, which could lead him to feel some sense of regret or guilt afterwards.

Han, Duhachek and Agrawal (2014) proposed:

> Guilt’s tendency to draw behavior-specific appraisals activates local appraisal tendencies ... whereas shame’s tendency to implicate the entire self activates global appraisal tendencies ... differences between guilt and shame only held when the emotions arose from actions rather than from inaction situations. (p. 1047)

Colin’s account corresponds to this description of guilt as he appraised his eating behaviour as bad. This sense of guilt is also supported by Colin’s response, “aw f*ck, look how much I’ve been eating”. However, his big sigh at the end of this statement could potentially demonstrate his appraisal of the entire self as “bad”, leading him to feel shame. Piqueras-Fiszman and Jaeger (2016) found that memories primed by episodes of over-eating were associated with junk food images and feelings of guilt and shame, compared to memories of positive meals amongst 710 UK consumers. Furthermore, authors found that individuals reporting high dietary restraint had a greater link with guilt and shame emotions.

Colin referred to eating “a bit rushed” when hungry, after skipping meals during the day at work. A study found that individuals who ate quickly were more likely to be male, and had a higher BMI (Lee et al., 2016). However, Colin also perceived not making thoughtful choices about his food selection due to hunger, therefore leading him to eat unhealthy “junk” food. Gregory also talked about having “bigger” portions for his meals and going “more in the direction of carbs” if he “skipped meals during the day”. This is consistent with Placanica, Faunce and Soames Job’s (2002) findings. They found that female undergraduates’ attention was more drawn towards higher calorie foods to satisfy hunger when they skipped both breakfast and lunch. Research using functional magnetic resonance imaging (fMRI) found that fasting and hunger biased the brain reward system towards high-calorie foods (Goldstone et al., 2009; Siep et al., 2009). This might be explained in terms of epigenetic mechanisms – authors suggested that increasing the intake of palatable food after a period of restriction is likely to have an evolutionary

advantage in times of deprivation and depletion in calories, as found in mice (Pankevich, Teegarden, Hedin, Jensen, & Bale, 2010). MHN therefore may be more likely to eat more palatable or "junk" foods and over-eat because they have previously eaten in a "rushed" *mindless* manner when they miss proper meals during their shifts. Additionally, research indicated that individual factors, such as impulsivity, influence the way in which individuals respond to food cues (Hou et al., 2011). However hunger might play a role; a study found that moderate hunger (4-hour abstinence from food) is adequate to make impulsive individuals buy unhealthy foods and have a considerable increase in food consumption (Nederkoorn, Guerrieri, Havermans, Roefs & Jansen, 2009). These studies suggest that humans are driven by underlying biological and evolutionary factors to seek out higher calorie foods when hungry and help explain why MHN may struggle to select 'healthy' choices when in this state, particularly the more compulsive among them.

Colin highlighted that restricting food intake might be a means of weight management. Colin suggested that he could go without food for 12 hours due to having some "fat", and also stated in his account that he needed to "lose" weight. Schaumberg and Anderson (2014) showed that some at-risk college students (n=186, 44.7% male) reported a perceived improvement in body image after a 24-hour fast. They suggested that these individuals therefore received reinforcement for caloric deprivation. Furthermore, participants evidenced a reduction in weight after the 24-hour fast. Although participants were blind to this information, the authors determined that a relative state of caloric deprivation was achieved. In light of Schaumberg and Anderson's (2014) research, it may be possible that some at-risk nurses are therefore rewarded by a boost in their body image, and perhaps by the awareness of weight loss when restricting their food intake either involuntarily or voluntarily during a nursing shift. The trans-diagnostic theory of eating disorder pathology suggests that "over-evaluation of eating, shape and weight and their control is of primary importance in maintaining the disorder" (Fairburn, Cooper & Shafran, 2003, p. 510). And this *core psychopathology* drives maladaptive behaviour, such as extreme weight-control behaviour, body checking and avoidance, and preoccupation with thoughts about eating, shape and weight. Schaumberg, Anderson, Reilly and Anderson (2015) suggested that the risk of developing disordered eating as a result of fasting is dependent on three variables: motives for fasting, biological characteristics, and psychological characteristics. Research suggested that fasting for weight control was a predictor for future recurrent binge eating and bulimic pathology in a five-year longitudinal

study following 496 adolescent girls (Stice, Davis, Miller & Marti, 2008). Schaumberg et al. (2015), however, did not find any significant disordered eating after a fasting period in a low-risk college student population reporting minimal episodes of irregular eating. This suggests that only some at-risk nurses may be vulnerable to developing disordered eating if they use food deprivation to manage weight.

Colin's words, "not that I am fasting but", suggest that it is not a voluntary eating behaviour for him to "go without" food during a shift. However, he may believe it benefits him, in the sense that he may lose weight. Colin's main motive to lose weight, stated throughout his account, appears to be due to health reasons; this will be discussed further in subsection 4.4.1, *Health concern*.

In summary, it appears that the occupational environment traps some nurses in a cycle of involuntary food restriction and over-eating behaviour. Research indicated that this cycle of starvation or dieting encourages unhealthy eating behaviour, such as bingeing when food becomes available and eating high-calorie foods. MHN who experience hunger after skipping meals may eat more quickly, and potentially be at risk of gaining weight as they try to compensate for their caloric deprivation. At-risk nurses may also experience a perceived improvement in body image after fasting, and therefore may reinforce this cycle of food deprivation. Furthermore, MHN who fast for weight control might develop future recurrent binge eating and bulimic pathology.

4.3.3 Triggers of over-eating: "Hang on, what am I doing?"

Triggers can be described essentially as, "what causes individuals to eat" (Tomiyama, Mann & Comer, 2009, p. 72). As, Peciña and Smith (2010) stated, "we like and want food when we are hungry but also at times even when our needs for energy and nutrients are fully met" (p. 35). Many MHN participants reported eating when feeling down, stressed, bored or tired. Feeling stressed, bored or down were more apparent at home, and feeling bored or tired were most relevant in the workplace, in particular during night shifts. Three participants construed eating to be functional beyond satisfying physical hunger, for example, by directly describing emotional states as a trigger of eating. These findings correspond to findings of previous literature. King et al. (2009) found that nurses reported eating when stressed, bored or upset. Research reported that nurses most commonly

used eating as a stress-reduction method, suggesting that disordered eating is an emotion-focused coping strategy (Fryer, Waller & Kroese, 1997; Nahm, Warren, Zhu, An & Brown, 2012).

Emotional eating "refers to the tendency to overeat in response to negative emotions" (van Strien et al., 2007, p. 106). In line with the above, Geliebter and Aversa (2003) found that overweight participants reported eating more than normal or underweight participants when experiencing negative affect. In addition, studies found an inclination towards consuming high-calorie foods (sugars and fat) when individuals experienced stress (Groesz et al., 2012; Torres et al., 2007). In the present study, Edward described eating "lots" and "harshly" when "comfort eating" and appeared to be inclined towards "carbohydrates" such as "palatable" and "stodgy" foods when feeling down or stressed. He described feeling "content" after comfort eating. Wansink, Cheney and Chan (2003) wrote; "comfort foods are foods whose consumption evokes a psychologically comfortable and pleasurable state for a person" (p. 739). This appears to be aligned with the 'affect regulation model' that proposes over-eating is a learnt behaviour triggered in response to negative emotions by eating for comfort and distraction (Hawkins & Clement, 1984). Edward's "comfort" or emotional eating was also described in the context of occasions when he would "veg" on the sofa with a film. "Veg" suggests that perhaps at these times he uses eating (and watching a film) in attempt to block or escape thoughts. Heatherton and Baumeister (1991) developed the 'escape theory', proposing that binge eating is a cognitive effort to escape or move attention away from aversive self-awareness by avoiding wider meaningful thought. Spoor, Bekker, Van Strien and van Heck's (2007) research supported the affect regulation model and the escape theory, as the authors found that both were associated with emotional eating and applicable to individuals with an eating disorder and in the non-clinical female population. Adam also considered food to assist him to disconnect cognitively as eating took him "away" from thoughts, "worry" and "anxieties" induced by his stressful working environment and got him in a "zone" where he did not have "stressful things" on his mind.

Gregory described emotional eating when feeling bored. He suggested that eating is a way to occupy his time during night shifts when work is at its "slowest". In a study of 139 undergraduates (mostly females of normal weight) boredom was reported as the emotion most likely to trigger eating above all other emotions (Koball, Meers, Storfer-Isser, Domoff,

& Musher-Eizenman, 2012). Research suggested that eating more likely functions as a negative reinforcement (to escape boredom) rather than a positive reinforcement (the rewarding stimulation), as participants were just as likely to eat as they were to give themselves voluntarily electric shocks when bored (Havermans, Vancleef, Kalamatianos, & Nederkoorn, 2015). Boredom was also reported as one of the most pertinent precursors to binge eating episodes (Stickney & Miltenberger, 1999). Kelly, Cotter, Tanofsky-Kraff and Mazzeo (2015) found that self-reported binge eating in men was associated with higher body mass index than in non-binge-eating individuals. This therefore supports the current literature that binge eating in men could potentially contribute to obesity (Duncan, Ziobrowski & Nicol, 2017). Although the authors suggested that overweight individuals were more likely to have disordered eating, these results should be interpreted with caution, as a correlational relationship was established but causality was not.

Eating when bored was also evident in Fredrick's account. He described a scenario of over-eating on his days off as he perceived himself to be constantly hungry, particularly on "sitting in front of the TV" days when he has nothing "planned". Ogden et al. (2013) found that individuals ate more when they were distracted by television compared to when driving or when in a social context. These findings support the concept of *mindless* eating. Wansink (2004) suggested that distractions could impede an individual's capacity to monitor their eating and increase the time spent consuming food, even to the point past satiation; in essence eating without conscious processing. Fredrick summed this up when he said "[I] constantly eat uh... and yeah just carry on [...] I have to consciously go 'hang on what am I doing here'"? Here Fredrick explores the struggle to regulate food intake as eating appears to be largely unconscious. Due to the experience of eating being multi-faceted and multi-layered, it is important to discuss other eating cues that can co-occur with emotional eating.

Bilman, van Kleef and van Trijp (2017) wrote:

> Inadequate regulation of food intake plays an important role in the development of overweight and obesity, and is under the influence of both the internal appetite control system and external environmental cues. Especially in environments where food is overly available, external cues seem to override

> and/or undermine internal signals, which put severe challenges on the accurate regulation of food intake. (p. 2825)

As Fredrick explains above, it appears that food is overly available when he is at home and this makes him continue to eat throughout the day. This suggests that external cues may also feed into his "bingeing" behaviour, not only at home but also at work. External eating is defined as "the tendency to overeat in response to external food-related cues, such as the attractive sight and smell of food" (van Strien et al., 2007, p. 106). Wansink, Painter, and Lee (2006) also highlighted that proximity and visibility were major factors in consumption. They found participants consumed more snack food when: 1) the chocolates were located on their desk compared to further away; and 2) the chocolates were in a clear bowl (visible). Similarly, a large field study at Google suggested that employees ate significantly more snacks (up by more than half) when using a drink station located in proximity to a snack station (Baskin et al., 2016). Additionally, men were found to be significantly more likely to snack at the near station as opposed to the far station. Authors proposed that this meant that a man weighing 180 pounds, situated closer to the drink and (near) snack station, could theoretically consume 81 more snacks a year and gain an extra 2.5 pounds annually. Likewise, Fredrick described eating snack foods (chocolates, biscuits, crisps) at his workplace that were available to "grab" on a "little table". He acknowledged the unhealthy nature of these foods and suggested that they "add[s], to the waist". Fredrick stated, "I am probably always putting something in my face [laughs], just the wrong thing um... at the wrong time". These descriptions appear to be consistent with the above-mentioned research, suggesting both proximity and visibility of snack foods in the MHN environment could promote consumption of unhealthy foods and, as Fredrick suggested, contribute to weight gain. Furthermore, research found that men were more likely to start eating due to environmental factors than women (Tuomisto, Tuomisto, Hetherington & Lappalainen, 1998).

Eating triggered by external or emotional cues, as described above, could become habitual if reinforced over time. Habitual behaviours are predominately triggered by situational cues such as physical, social or psychological environmental ones (van't Riet, Sijtsema, Dagevos, & De Bruijn, 2011). Habit in relation to food would mean a "repeated behaviour, a diet or an established eating pattern" (van't Riet et al., 2011, p. 586). Bargh and Chartrand (1999) suggested that cognitive processes become automatic when

repeated over time in the same situations, and that individuals are not aware when these automatic processes are activated in these specific circumstances, as the *acquisition of automaticity* is unintentional and unconscious. For example, time availability and mealtimes were shown to induce eating rather than hunger (Tuomisto et al., 1998; Waterhouse, Buckley, Edwards, & Reilly, 2003). This suggests that eating can be triggered by situational cues rather than by internal forces such as hunger. Gregory described eating completely "unaware" when grazing on "crisps" or "chocolates" during a night shift. He gave an example of walking past and "picking" up snack food, and the moment of shock when there was nothing left. He suggested that to "occupy" his time during night shifts eating could become habitual, without much thought or awareness. Adriaanse, de Ridder and Evers (2011) proposed preliminary findings to support habitual strength as a predictive factor in eating snack food. Similarly, Waterhouse et al. (2003) found night workers' food type and frequency of consumption were significantly more likely to be determined by habit than by appetite. Night shift workers were more likely to consume snack foods compared to day workers (Waterhouse et al., 2003).

Colin appeared to have varying eating habits during night shifts as he described some nights when he would eat "the whole lot" of sweets he purchased and other times when he would not eat at all. Research has shown that acute sleep deprivation causes a greater reward response in anticipation of food, along with increased hunger and appetite for high-calorie foods in normal-weight males (Benedict et al., 2012). Colin suggested that he would be more inclined towards foods with higher sugar content, therefore "craving a boost" could be interpreted as feeling the need to increase his energy levels as he "gets tired". Persson and Martensson (2006) also found that the disruption to nurses' circadian rhythms during night shifts resulted in craving sweet foods and eating unhealthy as a means to stay awake. This subsequent desire for high-calorie foods and increased consumption following sleep deprivation could play a role in the development and maintenance of obesity (Greer, Goldstein & Walker, 2013; Pardi, Buman, Black, Lammers & Zeitzer, 2017). Research suggested that both homeostatic factors (i.e. the compensatory response to nocturnal energy deficits) and hedonic factors (i.e. the rewarding, calorically dense foods) might induce over-eating after sleep deprivation in men (Hogenkamp et al., 2013). Furthermore, authors indicated that the findings have particular applicability for shift workers due to overnight wakefulness and disrupted sleep-wake cycles (Benedict et al.,

2012; Hogenkamp et al., 2013). Night shift duration was statistically significantly correlated with higher BMI amongst men (Pepłońska et al., 2014).

Breaking habitual eating behaviours could be made more difficult when peers influence eating in a negative way. Fredrick mentioned that his unhealthy eating at work was "as bad as everybody else". This might indicate a diffusion of responsibility and so reinforce a cultural "norm" of snacking at work. Similarly, Gregory stated that he would "often" buy snack foods for night shifts, not only for himself but for other people around him and vice versa. He described it as a "shared experience". Although this might be construed as camaraderie, snack food as described above may increase the risk of weight gain. Research found that nurses perceived colleagues to encourage unhealthy eating through social pressure, or by being made to feel guilty if they declined unhealthy foods (Phiri, Draper, Lambert, & Kolbe-Alexander, 2014; Power et al., 2017).

Other triggers of over-eating could be considered, such as conforming to the male norm: masculine embodiment for identity and behaviour. Edward said he was "renowned" for eating "huge amounts". Perhaps, this eating behaviour became part of his masculine identity as he suggested eating large quantities were "a kind of, not talking point but". This behaviour is consistent with the hegemonic masculinity research stating men eat large amounts (Bock & Kanarek, 1995). However, Campos, Bernardes and Godinho's (2018) suggested the relationship between conformity to stereotypical masculine behaviour and food consumption (i.e. eating meat) is potentially context-dependent. Similarly, Edward stated; "I used to get into the eating competitions ... I would not normally eat like that unless it was for a specific purpose". Berg (2003) suggested men predominately participate in eating competitions, which frequently centre on meat-eating.

In summary, male MHN may over-eat in response to negative emotional states such as stress and boredom. Research showed an inclination towards consuming high-calorie foods (sugars and fat) when individuals experienced stress, and boredom induced binge eating episodes. *Mindless* eating described by the MHN in this section impeded their capacity to monitor eating such as the amount of time spent consuming food, even to the point past satiation. Especially in environments where food is overly available, external food-related cues such as the attractive sight and smell might induce eating. Readily available snack foods in the MHN environment could promote consumption of unhealthy

foods. Unhealthy eating could become habitual if it is repeated and reinforced over time, and breaking habitual eating behaviours could be made more difficult when peers encourage unhealthy eating. Furthermore, MHN working night shifts might experience acute sleep deprivation, which causes a greater reward response in anticipation of food, increasing hunger and appetite for high-calorie foods in normal-weight males. All of the eating behaviours described above might contribute to weight gain.

4.4 "So I am getting healthier. Just not healthy": The struggle to live a healthy lifestyle

The "struggle to live a healthy lifestyle" was the third and final master theme, holding the three super-ordinate themes together. The first super-ordinate theme, "You want to be healthy don't you?", encapsulated the health concerns described by the participants, and explored fluctuating motivation for change. "I have a window of opportunity to eat" explored the struggle to eat healthily when the long working hours caused a constraint on time. And lastly, "I just have to find the balance", specifically looks at the difficulty nurses have in establishing and maintaining a healthy lifestyle, which includes self-care.

4.4.1 "You want to be healthy don't you?": Health concern

Health and mortality often appeared together in participants' accounts. For some of the participants ageing was a turning point when health became more of a concern. Perhaps ageing stimulated participants to consider existential issues and the eventuality of death. In Gregory's account he mentions that due to his knowledge as a nurse he is "more aware of the health risks" that ageing "carries". Similarly, Fredrick perceived age to have "ticked a little switch" as he was "getting old" and more likely to develop "chronic health conditions". Participants deemed mortality to be an important feature in triggering at the very least reflection on unhealthy behaviours such as eating, being overweight and inactivity, if not a full commitment to pursuing healthy behaviours. For example, Colin reflected on his partner's pregnancy, which appeared to have elicited thoughts of his own mortality, and "health" reasons seemingly pertinent to becoming vegetarian, as he did not want to "die young". Yalom (1980), an existential therapist, suggested that ''the idea of death saves us ... plunges us into more authentic life modes, and it enhances our pleasure in the living of life'' (p. 33). This could be construed as the awareness of the eventuality of death

motivating and/or determining behaviour in some way. More specifically, Goldenberg and Arndt (2008) introduced the terror management health model (TMHM) to suggest how the awareness of mortality impacts on health decisions. In *Proposition 1*, the authors suggested that health concerns (either triggered or followed by conscious thoughts about death) could motivate individuals to initiate health behaviours such as exercising or eating healthily, as a preventative measure or to decrease conscious vulnerability to death. Moreover, the *protection motivation theory* postulates that human beings will take protective action against health threats motivated by the process of cognitive appraisal if the probability, severity and efficacy of recommended action (to prevent danger) are perceived as high (Rogers, 1975). This ties in with Ben's account when he said he was "trying" to change his unhealthy lifestyle as he went through "a phase of six months" exercising and eating more healthily on medical advice after his type 2 diabetes diagnosis.

This cognitive appraisal is also evident in Fredrick's account; it appears that regardless of the increased concerns about health risks, Fredrick is somewhat undecided "if" change is needed (ambivalence to change). Fredrick appears to recognise that the stakes are high as he states, it is the "one and only body I've got", seemingly weighing up the potential of "developing" diabetes or chronic health conditions. In Fredrick's account, however, he explains that "I have to take responsibility for my choices [...] if I wasn't happy with them there will be a pressure to change them". It seems that awareness alone does not necessarily equate to motivation to change. Fredrick appraised the severity of the health threat to be high and recommended actions (healthier diet and exercise) to be effective in prevention, but perhaps did not perceive the probability of his developing these illnesses – "given my age, and things" – to be high. Gregory, on the other hand, took into account his age, weight and health risks in order to try and prevent something "that is avoidable" by changing his diet. In this way, Gregory reacted as the TMHM would predict, by taking a preventative measure, such as a healthier diet, to decrease conscious vulnerability to death.

Evidence supports this theory, as Bevan, Maxfield, and Bultmann (2014) also found that adults reported higher levels of intention to initiate health behaviours directly after being made consciously aware of mortality (motivated to remove focal attention away from death thoughts). However, they found that after a delay, intentions to partake in health behaviours decreased or reversed, suggesting that when thoughts of mortality vanish so

do intentions of health behaviour. This might explain why in some participants' accounts thoughts of mortality only initiated contemplation to change but did not always predict follow-through actions. Research has shown awareness of mortality could both increase and decrease health-risk-related behaviours (Arndt et al., 2013). For example, they found that smokers with high cravings increased their intensity after exposure to mortality awareness, while low craving smokers, by contrast, decreased their smoking intensity. Goldenberg and Arndt (2008) explained this phenomenon by suggesting that individuals would utilise threat-avoidance strategies to reduce awareness of mortality, in particular suppression and denial. They proposed that individuals suppress self-reflection and thoughts of mortality by means of *escape*, potentially via health-risk behaviours such as over-eating, alcohol and smoking. In addition, individuals might cope with conscious awareness of the eventuality of death by denying potential risk factors, for example, through cognitive bias ("not me, not now") or through believing in eternal living (Goldenberg & Arndt, 2008). Edward's account at times depicted such threat-avoidance strategies, for example when he suppressed or denied the risk factors by stating "I am not massively overweight [...] BMI, I am classified as obese but I don't think I am", which shows him engaging in defence mechanisms, perhaps against thoughts of mortality.

Nurses seem to be aware of healthy living; however, implementing successful behavioural change can be more difficult. Ben suggested that he was always aware that he "should eat better and more regular and more healthy", and stated his type 2 diabetes diagnosis did not come as a surprise. Research indicates that lifestyle behaviours such as diet, sedentary behaviour, smoking and alcohol consumption are environmental risk factors associated with type 2 diabetes (Bi et al., 2012). As mentioned earlier, Ben had been exposed to the mental health nursing environment longer than any other participant (25 years).

Consistent with Prochaska and DiClemente's (1992) transtheoretical model of change, research on eating behaviours has shown that respondents in the early stages of behavioural change (pre-contemplation, contemplation, and preparation) had higher fat diets compared to those in the latter stages of change (action and maintenance), reporting eating less fat, and more fibre, fruits and vegetables (Glanz et al., 1994). According to Prochaska and DiClemente's (1992) transtheoretical model, there are five stages an individual would have to pass through to achieve behavioural change. They suggest that

individuals in the *pre-contemplation stage* display no signs of wanting to change their problematic behaviour, may be unaware of the consequences of the behaviour, or simply believe the behaviour is not problematic. Prochaska and DiClemente (1992) suggest that some individuals might be resistant to change, to the point where they avoid any consideration of the problematic behaviour. Alternatively, the authors suggest that individuals might be disheartened due to previous failed attempts to change, or the perception that they do not have the capacity to change. This might be evident in Ben's account when he stated that there is nothing he can do about it [his eating behaviour], as that his "eating pattern is just, I mean I have done that for a lo... God knows how long". In contrast, Gregory refers to himself, stating that it is "only me" who can bring on change, which shows that he perceives himself to have an internal locus of control. Callaghan (1998) suggested that internal locus of control correlated strongly with healthy eating.

Many of the participants perceived that major life events precipitated health considerations. For example, Edward perceived "split[ting] up" with his wife and Colin's partner's pregnancy induced a focus on health, whereas Ben's diagnosis of diabetes prompted changes in his health behaviours. In the *contemplation stage* individuals start to consider change, by balancing up the pros and cons of the problematic behaviour. However, at this point they are still ambivalent towards change (Prochaska & DiClemente, 1992). In the *preparation stage*, individuals have made a decision to change their problematic behaviour and start preparing to instigate change, yet may still display some ambivalence (DiClemente & Velasquez, 2002). Gregory's newly gained motivation from weighing up the pros and cons were "driving" him to instigate change to lose weight. The *action stage* is determined when individuals start implementing change that they have prepared and planned for, including overcoming unforeseen barriers (Prochaska & DiClemente, 1992). Finally, the *maintenance stage* involves the individual maintaining the behavioural change. DiClemente and Velasquez (2002) suggest that this process of change could result in relapses, or repeating of previous stages numerous times before behavioural change is successful. Edward's account portrays the circular process of change; his ambivalence and motivation "will fluctuate" (as described in pre-contemplation and contemplation stages), going through peaks and troughs at various "points in time". He then describes deciding to "lose weight" and "going through" a "health kick" (preparation stage) by changing both his diet and exercise routine (action and maintenance stage). Edward describes going through a "health kick" on a few occasions,

therefore suggesting that he experiences relapses as he strives to successfully change his behaviour. Prochaska and DiClemente's (1992) transtheoretical model of change theory therefore explains the reality of facilitating change and the dedication and effort it takes to maintain this as the individual moves through the stages, often repeating stages before successful behavioural change occurs.

Weight was an underlying theme for the male MHN participants in this study, as being physically healthy also constitutes having a healthy weight. For many participants, concerns regarding weight appear on the surface, first and foremost linked to physical health. However, although some participants overtly stated that they were content with "body shape and size", such as Edward, they also contradictorily wanted to lose weight at times. For example, Fredrick stated not caring about having "a six pack, happy to have a keg" in the context of generational differences in the perception of body image, but nevertheless suggested that there were times when he felt a bit "rubbish" about his waistline. Other participants stated not wanting to "plough on the weight" (Ben) or not wanting to "carry this extra weight around" (Gregory). Therefore perhaps some participants do have an 'ideal' weight or shape. Research showed that males' body satisfaction decreases when exposed to the 'ideal male body', that is, a slender and muscular one (Blond, 2008; Galioto & Crowther, 2013). Festinger's (1954) social comparison theory suggests that individuals have a drive to compare themselves to others for evaluative purposes. Consistent with these findings, Jonason, Krcmar and Sohn (2009) asserted that male body satisfaction is reliant on one of two pathways: 1) body satisfaction is directly related to body size (BMI); or 2) body satisfaction is the result of a process of appraisal via social comparison, for example via muscular images in the media. Supporting this model, research in the United States found that higher BMI was correlated with lower weight satisfaction (Kuk et al., 2009). Furthermore, 93% and 95% of men indicating weight dissatisfaction reported an intention to change diet and increase physical activity, respectively. Similarly, research suggested that midlife men and women's (age 55-59) body appraisal could lead to setting weight management goals (Newton, Russell, & McAdams, 2017). Therefore, a drive to pursue body satisfaction could also instigate an intention to change health behaviours.

It is pertinent to note that other social forces may also have influenced participants' decision to change their diet, for example becoming vegetarian. As described above, Colin

and Fred identified as vegetarian, opposing the hegemonic masculinity hypothesis of eating meat. However, theoretical ideas around the formation of multiple 'masculinities' may provide an alternative explanation: both these participants arguably described the "green politics" of masculinity, termed by Connell (2005). Connell (2005) suggests the participants separated themselves from masculinity norms and created a masculinity to have "leverage, so to speak, on its participants' emotional life" (p. 126), such as "valuable, relationships with women" (p. 126) and/or nature; "diet is an important part of the relationship with nature" (p. 128). Fred gave two reasons for becoming a vegetarian; "moral consciousness that drove it ... and I want to get laid". This suggested that the participant perceived vegetarianism to have a sexual advantage over other male 'bodies' - meat-eating men. Perhaps, as Nath (2011) suggested, men who "subvert the social norm of eating meat" (p. 274) might construct a new masculine identity by making him "surprising ... and ... distinct" (p. 275). Conceivably, displaying moral consciousness may 'score points' with the opposite sex. Colin justified his decision to become vegetarian on the grounds of health, as well as "animals killed every year ... I just feel bad". However, he also said "my girlfriend is vegetarian ... I don't want to cook two meals", contradicting research showing masculine and feminine foods are contested in shared marital meals, however supports the suggestion that higher educated couples forego hegemony such as cooking being the female partner's role (Lupton, 2000; Sobal, 2005). Similarly, Fred said "cooking ... that's what I do, that's my role". These instances supports the idea that men adjust "in the face of" challenges to hegemony (Connell & Messerschmidt, 2005, p. 835).

In summary, participants appeared to display some concerns about their health, and these concerns have come at different times in their lives where health issues have been brought to the fore. These triggers might have been mortality or a significant event or time in their lives that would bring on considerations of change. Weight has been an underlying theme here, as being physically healthy also constitutes being a healthy weight. Nurses seem to be aware of healthy living, however, implementing change can be more difficult, especially for nurses as described in the following two super-ordinate themes, *"I have a window of opportunity to eat"* and *"I just have to find the balance"*.

4.4.2 "I have a window of opportunity to eat": The struggle of healthy eating

In all participants' interviews apart from one, "time" was mentioned to some degree when referring to food outside of work, mostly when talking about food preparation. Ben stated that he didn't "spend any time preparing food", describing it as a "lazy way of eating". In some participants' accounts however, they explored the meaning of time in more depth. Some perceived a connection between their working environments, time, and eating outside of work.

Gregory explored how the lack of time impacted on his choice of foods prior to his new diet, particularly when "taking short cuts in meal preparation" such as choosing "convenient, always pre-prepared meals" in order to "free up" some time when not at work. Candel (2001) found employees working more than 30 hours a week were significantly more convenience orientated compared to those working less than 9 hours per week. Furthermore, Buckley, Cowan, and McCarthy (2007) found 49% of the British national representative sample reported a convenience-seeking food lifestyle. They reported that, in a bid to save time and effort, these individuals tend to choose convenient food options, for example, sacrificing fresh ingredients. Authors also found these participants were less prone to plan meal shopping or meals and more inclined to snack between meals. In the present study, Ben stated that he does not "plan" when he goes food shopping, but rather selects food on a whim. Research found that meal planning was associated with eating more healthily and with reduced obesity in male participants (Ducrot et al., 2017). Ben stated that his cooking does not get too "complex", mentioning some of his meal choices such as instant noodles and oven-prepared meals. Men were found to view ready meals more positively, and they possessed fewer cooking skills than women (van der Horst, Brunner & Siegrist, 2010). Furthermore, the authors suggested that lack of cooking skills might be a barrier to healthy eating, as it was a strong predictor of ready meal consumption, as well as associated with being overweight. Male MHN therefore may have fewer cooking skills than women and potentially more inclined to consume unhealthy ready meals. However, hegemonic masculinity theory may have a different explanation; the "patriarchal dividend, the advantage men in general gain from the overall subordination of women" (Connell, 2005, p. 79). Ben suggested he would much rather "graze"; "well only because I have to cook it... If I lived with someone ...". Perhaps this statement is in line with Lupton's (2000) research, proposing cooking was perceived a female counterpart's

responsibility within heterosexual couples. However, the participant's explanation for grazing was; "I will ... spend an awful lot of time cooking and cleaning pots and pans and ... really wouldn't want to do that". Therefore not cooking may be more about saving time.

Many participants considered how time constraints influenced their eating, particularly in the context of having the recommended three meals a day (Nicholls et al., 2017, p. 1053). Fredrick described in absolute terms that he "never" had the time to eat three proper meals in a working day shift. He construed the nursing occupational environment with its shift work as having contributed to his bingeing behaviour. Fredrick suggested that the only way to consume his daily calories was to do it in less than three meal sessions, which encourages binge eating. Furthermore, Fredrick suggested that the "window of opportunity" is so small that the options of activities after work are limited to one, either eating or doing something else but not both. This appears to suggest that there is some sort of sacrifice, either the evening meal or engagement in another activity. Research suggests that when individuals are hungry they prefer to engage in eating behaviour rather than any other enjoyable activities (Raynor & Epstein, 2003).

Lack of time appears to be particularly detrimental to participants, not only during work hours but also outside of work such as around breakfast time, and consequently they may skip this first meal of the day. Callaghan, Fun and Yee (1997) found only 57% of nurses reported eating breakfast daily. Some research indicated there was no significant difference in daily energy intake between breakfast and non-breakfast eaters, suggesting that participants consumed enough energy to compensate for the missed breakfast (Halsey et al., 2011). However, a Japanese study found that skipping breakfast was significantly correlated with increased waist circumference and BMI (Watanabe et al., 2014). This study found that individuals who skipped breakfast tended to: 1) eat snacks late night; 2) have dinner after 8pm; and 3) consume more snacks and soft drinks, all of which the authors suggest may lead to obesity. Consistent with these findings, Fredrick described that due to not having time to eat breakfast when working early shifts, he consequently grazed during the day on "sugary carbohydrate-laden biscuits". Therefore, skipping breakfast could potentially have further health implications such as weight gain.

Working overtime due to high workload reduces time available outside of work, and Adam talked about occasions when he would get "takeaway" food when finishing "late" at work. It

appears that finishing late would not inspire Adam to cook, as that might take some time or effort that he does not perceive himself to have. Similarly, Phiri et al. (2014) suggested that nurses perceived that their tiredness after a long working day and lack of time impeded healthy meal preparation, and that they found fast foods more convenient. Daniel stated that the lack of time at home makes preparing his work lunch difficult. It appears that Colin also struggles to prepare lunch for the next working day, attributing his inaction to being "lazy", and therefore might end up having "microwave rice" at work. Convenience foods and time appear to be intrinsically linked, as male MHN struggle to maintain a healthy diet at work and outside.

The difficulty in breaking unhealthy habits may also contribute to participants' struggles to eat healthily. Adam suggested that he struggled to eat earlier in the evenings, stating that this was "a habit I can't seem to shake". Adam attempts to cook plenty of food for the following days, but doesn't always manage it. Individuals appeared to repeat strong habitual behaviours regardless of intention (Ji & Wood, 2007). In Daniel's account he considered how his recent relocation had made his diet unhealthier, particularly the close proximity of fast food restaurants near his home. A significant part of daily eating behaviours are thought to be habitual, therefore individuals need less information to make decisions as eating is largely triggered by situational cues (van't Riet et al., 2011). Perhaps Daniel initially bought food from the fast food restaurant for convenience after a "long hard day". Subsequently, as Daniel passed the fast food restaurant on a daily basis, he may have started to repeat this behaviour; the premise itself may now act as a cue/trigger for habitually buying unhealthy food.

Ji and Wood's (2007) findings also suggested that habitual behaviours were relevant in understanding repeated purchases. This is consistent with Gregory's account when he spoke about purchasing the 20%-fat mincemeat because it was cheaper and was something he "always used". However, he spoke of having to make a "conscious effort" to buy healthier options. This further supports the idea that habitual behaviour is triggered by situational cues, and happens largely unconsciously as described previously. Gregory's awareness of the situational triggers allows him to change his behaviour, although he states that it was an "effort". Gregory indicated that eating healthier is "a conscious effort to do... I have to allocate the time for it", not only for "sit down [...] meals" but also to cook.

Gregory appears to have recognised that the only way to instigate change is to be “much more prepared” for his working environment.

In summary, time appears to play a crucial part in the male MHN eating behaviour, both during and outside of work. Long working hours and overtime could potentially impede healthy eating and meal preparation, such as skipping breakfast, and finding it difficult to prepare a packed lunch for the next day of work. In a bid to save time and effort after a long day at work, MHN are more convenience orientated in their food selection, for example, eating “takeaway” food. In addition, the lack of meal planning and cooking skills might be a barrier to healthy eating in male MHN. Furthermore, repeated strong habitual eating and food purchase behaviours may be difficult to break, regardless of intention. These eating behaviours may have a negative impact on health, such as weight gain.

4.4.3 “I just have to find the balance”: The difficulty in establishing self-care

“I just have to find the balance” captures the difficulties participants faced in achieving a work-life balance. Many participants used the words “try” and “struggle” to convey the effort it took to maintain work-life balance, self-care and well-being. Poulose and Sudarsan (2017) defined work-life balance as the “balancing act of an individual between the three-dimensional aspects of life, namely organizational, societal and personal life” (p. 427). The authors found that all work-life dimensions mediated work satisfaction. In particular, they reported that Indian nurses experienced more work-related strains impacting on their personal lives than personal life-related strains on their work. Furthermore, Cushway, Tyler and Nolan (1996) found that the ‘home-work conflict’ subscale was highly correlated with poorer mental health outcomes in MHN. Bressi and Vaden (2017) suggested that the aim of self-care is “to maintain equilibrium or homeostasis within a self system such that the professional self does not impinge on the [functioning of the] personal self and vice versa ... worker burnout results from a self that is not in balance” (p. 34).

Self-care behaviour by and large means to create a healthy balance of all five dimensions of the self, which includes physical, emotional, mental, social and spiritual aspects (Eckstein, 2001). More conventional self-care practices might incorporate physical activity, sufficient sleep and a healthy diet (Bradley, Whisenhunt, Adamson & Kress, 2013; Eckstein, 2001). Daniel suggested that he struggled to find a balance of “spiritually,

physically, and everything". In Daniel's account he suggested that his ongoing adjustment to his new job and his "inexperience" might have contributed to his unhealthy eating. A phenomenological study found that newly qualified MHN feel they are 'thrown in the deep end', including feeling pressure to do tasks they are not confident in doing (Walsh, 2015). In this respect, Daniel therefore might experience more "pressure" to meet the work demands than any of the other participants, which could impact on work-life balance.

Adam's account also offers an explanation as to why he finds it difficult to have a balance and uphold an exercise routine. He talks about coping with "immense pressure" in a "challenging" workplace. Adam describes feeling "drained", suggesting that the pressure of coping in this working environment depletes him both mentally and physically, which appears to be consistent with the definition of *burnout*; "to fail, wear out, or become exhausted by making excessive demands on energy, strength, or resources" (Freudenberger, 1974, p. 159). Even though Adam tries to keep up a routine of going to the gym, at times the occupational environment does not leave him with enough energy to pursue exercise, or any other activities he "enjoys". Research also found that stress decreased motivation and impaired efforts to engage in physical activity (Geiker et al., 2018; Stults-Kolehmainen & Sinha, 2014). However, physical activity may reduce burnout (Naczenski, de Vries, van Hooff & Kompier, 2017). Coomarasamy et al. (2014) found that 58.7% of nurses surveyed reported no exercise regime. The authors hypothesised that participants might be too tired after a long day at work to engage in physical activity, but also lack the time to exercise and rest. This is also described by participants of this study.

Research indicated that 12-hour nursing shifts do not only impact patient care, but also lead to an increase in reported burnout and impact negatively on job satisfaction compared to shifts of 8 hours or less (Ball et al., 2017; Dall'Ora, Griffiths, Ball, Simon, & Aiken, 2015). However, these findings have been challenged (Stone et al., 2006); Angrave and Charlwood's (2015) 'environmental fit theory' endeavours to explain these contradictory findings. According to the theory, individuals experienced lower subjective well-being scores when there was a difference between their preferred and actual working hours. Therefore, personal preference or 'environmental fit' may offer an explanation regarding the inconsistent reports on nurses' job satisfaction and working hours.

Nevertheless, Robson and Robson (2015) found that work-family conflict was associated with NHS nurses' intention to leave their job, suggesting that nurses face difficulties in prioritising their time and resources. This work-family conflict may be most apparent during night shifts. Gregory portrayed the real struggle to keep a routine during night shifts and to incorporate friends and family too. He explored how being on a time schedule "different from everyone else's" could impact on a well-balanced lifestyle, and hinder the ability to spend time with significant others. His description of "throw everything out" could be best construed as referring to work-family conflict, throwing work-life out of balance. NHS digital data showed that 11,297 nurses and health visitors left their job during April and June 2017, and 1,416 of these stated the reason to be work-life balance (McKew, 2017).

Gregory's account explored the difficulty in protecting his "personal time". He appears to suggest that job demands may require him to work overtime and therefore a firm time boundary may be difficult to maintain. Leary, White and Yarnell (2014) found that specialist lung cancer nurses left work undone due to workload. In addition, 70% of nurses regularly reported working unpaid overtime (one or more hours a week). NHS England (2018) found that 58% of NHS staff reported working additional unpaid hours, 38% of staff felt unwell due to occupational stress in the preceding 12 months, and reported lower satisfaction with the quality of work and care they are able to deliver. Although these findings reflect NHS staff's experiences, they do seem to parallel with the male MHN participants in this study. As Gregory summed up, "we are used to kind of going above and beyond what are expected of us to get our jobs done to the standard we are happy with". Watanabe and Yamauchi (2016) investigated the impact of overtime on nurses' well-being (603 female, and 38 male respondents). They found respondents perceived involuntary overtime to create a work-nonwork imbalance, such as having a negative effect on hobbies, family time and leisure.

Lastly, consideration of the ethical implications of nurses' lack of self-care will be discussed below.

Germer and Neff (2015) wrote:

> For someone to develop genuine compassion toward others, first he or she must have a basis upon which to cultivate compassion, and that basis is the

> ability to connect to one's own feelings and to care for one's own welfare ... Caring for others requires caring for oneself. (p. 48)

As nursing requires treating service users with compassion (NMC, 2015), self-compassion needs to be instilled in nurses as role models during these therapeutic encounters. Furthermore, self-care is also considered to be ethically imperative in the caring professions.

Barnett, Johnston and Hillard (2006) suggested:

> Self-care is not an indulgence. It is an essential component of prevention of distress, burnout, and impairment. It should not be considered as something 'extra' or 'nice to do if you have the time' but as an essential part of our professional identities. (p. 263)

Therefore if nurses' needs are not met through self-care, this could potentially lead to them violating professional boundaries in order to satisfy their own personal needs (Pope & Vasquez, 1991). This could be harmful for the patient as "boundary violations can result when there is confusion between the needs of the nurse and those of the patient" (NCSBN, 2014, p. 4).

In summary, having enough internal resources, such as energy and motivation, appears to be essential for self-care practices, for example, engaging in physical activity. But time is also an important element in achieving a balance between organisational, societal and personal life. As described above, eating sufficiently healthily is part of self-care behaviour.

4.5 Conclusion

This study aimed to convey male mental health nurses' holistic lived experience of eating, eliciting rich in-depth accounts that could potentially inform organisational policies to promote healthy living amongst male MHN.

As discussed in the introduction chapter, literature indicated that mental health nurses experience high occupational stress: "the adverse reaction people have to excessive

pressure or other types of demand placed upon them" (HSE, 2001, p. 7). Consistent with this study's participants' verbatim accounts, previous research identified stressors such as; violence and aggression, heavy workload, home/work conflict, staffing levels and maintenance of standards (Edwards & Burnard, 2003; Stone et al., 2011). The male MHN participants suggested that acute and chronic occupational stress have a negative impact on their eating. Acute stressors such as hyper vigilance during patient meal sittings may encourage mindless eating, whereas episodes of violence and aggression or medical/emergency incidents, contributed to the pre-existing high workload; notwithstanding how the stress response potentially impact hunger and eating (more/less) thereafter. The male MHN participants described a working environment that encourages unhealthy eating behaviours due to chronic stress, and prohibits the establishment of a healthy lifestyle both within and out of work. Referring back to figure 1 in segment 1.3.1, Karasek's (1976) JDC model describes and predicts occupational stress in "high strain job situations", consistent with this study's findings. Participants reported high job demands, i.e. lacking "time", "busy" and feeling "under pressure", whilst experiencing low job control, i.e. "there is nothing much I can do about it"; as described in the first master theme: External locus of control. These "job situations" encourages the following unhealthy eating behaviours, including: skipping meals due to a lack of time and inability to take a break; consequent irregular meal patterns and; unhelpful coping strategies such as eating when stressed and upset; and potential weight gain. Additionally, the JDC model predicts "passive job situations" that lack job challenges resulting in de-motivation and gradual loss of skills; low work demands and low work control conditions. This may be the case when participants described night-shifts as "slow" and reported unhelpful coping strategies such as eating when bored. Both the "high strain job situations" and the "passive job situations" encourage unhealthy eating that may become habitual over time as described in the master theme: Satisfying physical and emotional hunger. Furthermore, consistent with previous research, the male MHN participants' shift patterns, including long working hours and night shifts, impede healthy eating (Nicholls et al., 2017). Particularly, male MHN participants described a "window of opportunity to eat", suggesting shift work does not allow for much personal time outside of work, i.e. participant sacrifice eating healthily and choose convenience foods that are often high in calories. Consequently, these job situations as explained by Karasek (1976), may result in staff de-motivation and creates emotional exhaustion caused by chronic occupational stress that could lead to difficulties

in self care practices and resultant burnout as discussed in the final master theme: The struggle to live a healthy lifestyle.

As this is the first qualitative study exploring male MHN's experience of eating in inpatient occupational settings through a counselling psychologist perspective, additional insights of the underlying processes and new areas for exploration have been summarised in Table 4.1:

Master Themes	Super-ordinate Themes	Relevant Psychological Knowledge	Consequences for Male MHN
"Part and parcel of the nature of the job": External locus of control	"The pressure of work": Mindless eating	Mindless eating due to high workload such as rushing and multi-tasking AND/OR due to hyper vigilance during meal sittings (stress response)	- Over-eating & potential weight gain - Over- or undereating & potential weight gain or weight loss
	"Everything else fell by the wayside": Involuntary food restriction	Food deprivation due to high workload Stress response due to incidents (i.e. aggression and violence, self-harm or medical)	- Unhealthy eating patterns (i.e. skipping meals) detrimental to weight management and metabolic health - Over- or undereating & potential weight gain or weight loss
	"Eating is not your priority": Subjugation of needs	Subjugation of needs (nutrition) and emotions Or Self-sacrifice And/or Unassertive behaviour	- Excessive surrendering of control to others because one feels coerced (by work demands) - Inability to exercise personal rights (i.e. eat)
"Try to sort of compensate": Satisfying physical and emotional hunger	"Hunger can be frustrating": Managing physical hunger at work	Hunger due to food deprivation at work	- Impact cognitive functioning - Becoming less risk-averse
	"Eating more than I should have": Over-eating at home	Food deprivation at work leads to over-eating at home	- Over-eating when food becomes available - Eating high-calorie foods

	"Hang on, what am I doing?": Triggers of over-eating	Emotional eating External eating Habitual eating Sleep deprivation Mindless eating	- Over-eating due to negative affect - Over-eating due to external cues - Unconscious (unhealthy) eating habits form over time - Over-eating high-calorie foods - Lack of monitoring food intake
"So I am getting healthier. Just not healthy": The struggle to live a healthy lifestyle	"You want to be healthy don't you?": Health concern	Terror management health model (TMHM) Transtheoretical model of change	- Awareness of mortality could initiate health behaviours - Individuals often repeat some of the 5 stages of change to achieve healthier behaviours
	"I have a window of opportunity to eat": The struggle of healthy eating	Long working hours, Shift work	- Impede healthy meal preparation - Convenience orientated food - Lack of meal planning - Habitual purchasing - Lack of cooking skills - Skipping breakfast - Habitual eating
	"I just have to find the balance": The difficulty in establishing self-care	Work-life (im)balance, Home-work conflict Night shift Lack of self-care (i.e. healthy diet, physical activity and sufficient sleep)	- Potential burnout - Lack energy after long "draining" day at work to go to the gym - Working involuntary overtime - Schedule "different from everyone else's" - Self-care ethically imperative (prevention of distress, burnout, impairment and keeping professional boundaries)

Table 4.1: Summary of discussion

This IPA study's analysis highlighted unique contributions particularly relevant to the inpatient mental health setting. The male MHN participants demonstrated mindless eating, such as distracted attention (threat-detection), when eating with patients during meal sittings and the pressure of work coercing MHN to eat in a rushed manner and/or whilst working (dual tasking). Participants suggested that a lack of time, being too busy, or 'incidents' may contribute to skipping meals. A major reported barrier is having no ring-

fenced time to eat, highlighting the unpredictability of the inpatient setting. This involuntary food restriction results in compensatory eating behaviour and consuming unhealthy foods, such as over-eating high-calorie foods when food becomes available. In addition, participants emphasised the physiological experience of the stress response on eating/hunger, for example, when 'incidents' such as aggression and violence, self-harm and incidents of a medical nature, which are commonplace in mental health settings, take priority. Eating at one's desk whilst working, eating in a rushed manner and skipping meals could be encompassed by the notion of subjugation or self-sacrificing of needs and emotions, including unassertive behaviour such as the inability to exercise personal rights (i.e. taking a break/eating). This study also draws attention to the ethical implications of experiencing hunger at work, as this could potentially have an impact on MHN's cognitive abilities and decision-making.

This study particularly demonstrated some of the situational triggers of over-eating relevant to male MHN (i.e. emotional eating, external eating, and eating when tired). Some participants over-ate in response to negative affect such as stress, boredom or feeling down. Maladaptive coping styles such as emotional eating and unhealthy food selection could potentially lead to weight gain. This study emphasised the contexts in which over-eating occurs, such as during day shifts, after work, on days off or on night shifts, and included an exploration of the impact of sleep deprivation on over-eating. In addition, this study highlighted how unhealthy eating may be triggered and perpetuated by external cues and habitual eating within the mental health nursing occupational context. Research suggests males report higher levels of over-eating and being overweight compared to females in non-clinical samples (Forrester-Knauss & Zemp Stutz, 2012; Striegel-Moore et al., 2009). Therefore this study does not only stress the importance of exploring men's eating behaviours but exposes the context in which over-eating may occur, which is essential knowledge for any type of intervention.

Although male MHN demonstrated that significant events or thoughts of mortality might initiate health behaviours, they also suggested that they struggled to maintain healthy eating and exercise, potentially due to occupational factors such as burnout and long working hours impeding healthy meal preparation and planning of meals (i.e. skipping breakfast due to lack of time and being convenience orientated). Another consideration might be that some male MHN also lack sufficient cooking skills. Participants deemed lack

of time to be a key barrier to establishing healthy living at work and at home, resulting in a work-life imbalance. The participants reported a lack of self-care such as eating unhealthily and struggling to establish a programme of physical activity. Furthermore, participants' absence of self-care could compromise their ability to do their jobs and potentially lead to unethical practices.

I would therefore recommend that employers prioritise supporting nurses within their workplace to establish and maintain healthy eating as set out in Lowden, Moreno, Holmbäck, Lennernäs and Tucker's (2010, pp. 159-160) research, including providing off-ward facilities (i.e. designated staff dining room, refrigerator and microwave), ring-fenced meal times (i.e. no pre-planned meetings during meal times), encouraging taking regular meal breaks and re-evaluating long working hours. There is a need for change in work-based culture on inpatient mental health wards, both in the NHS and the independent sector, to encourage a supportive environment for staff and potentially contribute to staff retention.

4.6 Implications for Counselling Psychology

First and foremost, this study gave valuable insight into the working environments and experience of male inpatient MHN eating from a counselling psychology perspective. The British Psychological Society regards counselling psychologists as competent to work within Employee Assistance Programmes and Occupational Health Settings (BPS, 2001). As a scientist-practitioner, I hope this research may inform potential clinical presentations of MHN and therapeutic interventions in the occupational health setting as well as give guidance for managers to implement clinical supervision which may provide support and help reduce stress in nursing practice (Brunero & Stein-Parbury, 2008). The research may also help managers support staff when debriefing after workplace 'incidents'.

4.6.1 Nurses' mental health

In a recent study, registered UK MHN (n=225, 71% female respondents) reported fairly low overall subjective well-being (Oates, Jones & Drey, 2017). The authors did not attribute their findings to occupational factors due to the results being "mixed and limited" (Oates et al., 2017, p. 399). However, the results depicted a worrying trend considering the problems

with retention rates of nurses (as discussed in the introduction chapter). All of this current study's participants reported high work demands as evidenced throughout their accounts, such as being too busy and lacking time to meet their most basic needs such as nutrition. Additionally, many participants described occupational stress explicitly. Research indicated that increased levels of stress among nurses were correlated with higher rates of depression and anxiety (Melnyk, Hrabe & Szalacha, 2013). Although Cognitive Behavioural Therapy (CBT) is recommended as an effective treatment for depression and anxiety (Hans & Hiller, 2013; NICE, 2009), regular exercise has also been associated with increased subjective well-being scores (Downward & Rasciute, 2011), reduced stress and increased mood (Esch & Stefano, 2010), and improved mental health, such as a reduction in depression and anxiety (Ströhle, 2009). Therefore, CBT for depression could potentially benefit from a greater emphasis on physical activity during behavioural activation (Pentecost et al., 2015). Physical activity may be particularly warranted in the MHN environment due to the increased risk of chronic illness. Research suggests that physical activity reduces the risk of diabetes, high blood pressure, arthritis and reporting 'fair' or 'poor' health (Humphreys, McLeod & Ruseski, 2014). I would therefore suggest that employees might benefit from professional-led stress seminars or workshops, or educational self-help intervention booklets provided by the employer that include information regarding appropriate third-party psychological services. Such information should also cover employer responsibilities such as providing a safe work environment, and address issues such as supervision, reflective practice and grievance procedures.

In addition to the MHN in this study experiencing stress, the work pressure coerced them to subjugate their basic needs such as nutrition to meet work demands. As discussed, MHN appear to behave in an unassertive way, such as not exercising their personal rights to have a break and/or eat – rights protected by employment law. A modified brief *assertiveness training* programme (2 sessions of 90 mins each, at a 1-month interval) has been found to increase general and psychiatric hospital nurses' and assistant nurses' assertiveness significantly, and this assertiveness was maintained at a 6-months follow-up (Nakamura et al., 2017; Yoshinaga et al., 2018). Therefore assertiveness training may be a beneficial intervention for male MHN to express their needs and emotions and stand up for their rights.

4.6.2 Eating behaviour

The participants described a variety of potential problematic eating behaviours – mindless eating, external eating, habitual eating, over-eating/binge episodes, involuntary dietary restriction, irregular eating patterns, and maladaptive coping mechanisms such as emotional eating. Pertinent psychological interventions will be described below.

Park and Shin (2015) suggested male-specific interventions and counselling directed at slowing eating down, which could potentially be a suitable treatment for weight management. Mindfulness-based interventions, such as eating meditations focusing on slowing down the act of eating, would increase awareness "of the experience of hunger, fullness, taste experience, taste satisfaction, and food choice" (Kristeller, Wolever & Sheets, 2014, p. 286). A review study indicated that mindfulness-based interventions evidenced reduction in 'automatic' or 'inattentive' eating (Mantzios & Wilson, 2015). Therefore, mindful eating skills training could benefit male MHN to slow down their food consumption, particularly when they experience time pressures during day shifts.

Mindless eating was also evident in the participants' accounts of their eating behaviours on night shifts, and in their accounts of over-eating/binge episodes at home. Mindfulness-based interventions were found to be effective in binge eating, emotional eating and external eating (i.e. triggered by visual food cues) (O'Reilly, Cook, Spruijt-Metz, & Black, 2014). Mantzios and Wilson (2015) suggested that mindfulness-based interventions are effective in reducing over-eating. Furthermore, mindfulness-based interventions were found to reduce cravings (Alberts, Mulkens, Smeets & Thewissen, 2010). Forman et al. (2016) found that mindfulness decision-making training significantly reduced snack consumption in 119 habitual snack food consumers in the week following training. The authors suggested that the cognitive skills acquired aided in de-automatising eating decisions. I therefore would recommend mindfulness-based seminars to teach male mental health nurses the skills they need to manage unhelpful eating behaviours.

Emotional eating "refers to the tendency to overeat in response to negative emotions" (van Strien et al., 2007, p. 106). However, Evers, Stok and de Ridder (2010) suggested that it was maladaptive emotion regulation strategies rather than emotions that led to increased food consumption. Gross and Jazaieri (2014) suggested that "emotion-regulatory

strategies refer to the ways in which individuals attempt to achieve their emotion-regulatory goals" (p. 394), for example "increasing or decreasing the magnitude or intensity of emotion experience, expression, or physiology" (p. 387). Jazaieri, Urry and Gross (2013) suggested that the use of problematic emotion-regulation strategies is prevalent in mental health disorders. According to Gross (2015), the *response modulation* affect–regulation strategy changes the "experiential, or physiological components of the emotional response after the emotion is well developed. Examples include using alcohol, cigarettes, drugs, and even food to alter one's feeling state" (p. 9). Gross (2015) suggested that providing training for individuals to learn healthier emotion regulation strategies is the most apparent intervention. The author indicated that cognitive reappraisal has been the major emotion regulation intervention. Thus when individuals modify the emotional meanings ascribed to a situation, *cognitive change* should alter their experiential, behavioural and physiological responses.

According to Corstorphine (2006), Cognitive Emotional Behavioural Therapy for eating disorders (CEBT-ED) is aimed at:

> Enabling patients with eating disorders to understand the experience and expression of emotions, so that they can identify and challenge their beliefs and attend and respond to their emotions adaptively. Such skills are needed to reduce the need for maladaptive emotional coping behaviours (i.e. eating behaviours and other impulsive and compulsive behaviours). (p. 451)

Male MHN may also benefit from healthy eating psychoeducation, such as the importance of maintaining an eating routine throughout their day and/or shift. Irregular eating patterns due to food restriction such as starvation and dieting could potentially lead to binge eating when food becomes available (Polivy, 1996). CBT for binge eating encourages a consistent eating pattern of every three to four hours (Fairburn, Marcus & Wilson, 1993).

Furthermore, as many of the participants talked about weight, and weight management such as diet and exercise, an "ideal" weight or body shape is inferred. Research showed that males' body satisfaction decreases when exposed to the 'ideal male body', that is, a slender and muscular one (Blond, 2008; Galioto & Crowther, 2013). Distorted self-

perception of body shape and weight is considered an essential feature in disordered eating (APA, 1994).

In summary, both the employer and the employee have a responsibility for self-care, as nurses' well-being is essential in providing high-quality psychiatric care. I therefore recommend that employers provide psychoeducational leaflets for MHN to encourage healthy living, including information on healthy eating and self-help stress management. These leaflets should contain information regarding appropriate third-party psychological services if Employee Assistance Programmes or Psychological Services within Occupational Health Settings are absent. If such services were available to employees, I would recommend offering group psychoeducational stress management seminars, support groups, assertiveness training and mindfulness-based skills training workshops, as well as the opportunity to be referred to the psychological services for assessment for 1:1 CBT sessions. However, these leaflets and trainings proposed will only be helpful for nurses if they are fully supported to take this time and focus on self-care. Therefore cultural change is essential alongside any other interventions.

4.7 Limitations and Further Research

The first limitation of the study warranting further exploration is the small sample size, and the sample makeup of male only and mainly white British participants. I acknowledge that this IPA study analysis focused on depth at the expense of breadth in order to report detail rather than assuming general claims (Smith, 2004). Smith et al. (2009) wrote that direct assertions are constrained to the homogenous group studied, but that nevertheless "theoretical generalization" could be contemplated. It has been argued that case studies carry an 'essence' of shared humanity (Giorgi & Giorgi, 2003). Although this study gave valuable insight into male MHN's experience of eating, more qualitative and quantitative research is needed to understand the potential gender differences.

A quantitative study specifically geared towards MHN in inpatient settings would complement this study, possibly with regard to the prevalence of disordered eating (including emotional eating, over-eating/binge episodes, irregular eating patterns and dietary restriction) and issues of weight management, BMI, exercise and health promotion in the UK. Gender should be taken into consideration in such a study. Neall, Atherton and

Kyle (2016) also highlighted the need for a comprehensive study on nurses' health-related behaviours such as smoking, physical activity, alcohol consumption and dietary habits.

On this note, I would recommend qualitative research to explore alcohol consumption further. Interestingly, five out of the seven male MHN participants in this study talked about alcohol consumption, some directly or indirectly connecting drinking to coping with occupational stress. This may imply that some male MHN use alcohol consumption to *escape* or as *affect regulation*, to avoid negative emotions such as stress. Kunyk (2015) found that the prevalence of substance use disorders amongst registered nurses was representative of the general population. However, a Brazilian study showed a worrying trend in psychoactive substances intake amongst hospital nurses; the more negatively they experienced their occupational environment, the more psychoactive substances (including alcohol) they consumed (Scholze, Martins, Galdino & Ribeiro, 2017). Furthermore, Trinkoff and Storr (1998) found that nurses who worked night shifts, rotating shifts, or shift longer than 8 hours were more likely to report alcohol use. In addition, research found a significant correlation between long working hours and harmful daily alcohol intake (Schluter, Turner, & Benefer, 2012). Furthermore, 13.9% of the Australian and New Zealand nurse and midwife participants (n=4419) in the Schluter et al. study were assessed as drinking harmful amounts of alcohol daily. I believe this may be an important area to explore, as maladaptive coping strategies such as alcohol use or misuse can have mental and physical health implications. Additionally, further research is also required to understand the experience of night shift eating in more detail. I only explored night shift eating with three of the participants, as all the participants were mainly on day shift duties.

As discussed in the introduction chapter, previous research suggested eating-and-related-behaviour could potentially be driven by conformity to the male norm and perceived male gender role. The participants' experiences in this study demonstrated masculine embodiment for identities and behaviour, some consistencies with both 'hegemonic masculinity' and 'masculinities' theories. In addition to those examples described within the discussion, Adam's account was most prominently in line with the (red) meat-eating hypothesis of masculine embodiment (Sumpter, 2015). Adam said he craves "steak" at times, "all I want is just meat". Adam revealed; "I suppose it goes back to ... your upbringing and ... your background ... you are having something that may be considered luxury which mean you are doing ok for yourself". This description, in my opinion, lends

itself to cultural circumstances, perhaps even within the realm of poverty - to be able to afford an expensive piece of meat such as steak, which others may not have the luxury to afford. Donaldson and Poynting's (2004) research, the "daily lives of ruling class men" suggested wealth might serve as a way of dominance over other men through "conspicuous consumption". In this light, the masculine identity emerges through eating practices such as consumption of expensive steak. Similarly, Ben described mostly eating at Michelin star restaurants; "at restaurants you take your time, you enjoy the atmosphere you enjoy the company ... I must admit if I go to restaurants, say generally tend to have Michelin stars, so you get really good service, you get, yeah.. really good cooking. Everything is right about it ... if I am going to pay load of money for food, I am going to make sure I am going to enjoy it". Therefore further qualitative research to better understand "what does it mean to eat like a 'man'?" (Nash & Phillipov, 2014, p. 205), could benefit from a study with a social constructionism epistemological position, focussing on 'masculinities' theory as Connell (2005) wrote:

> The social construction of masculinities ... To use Satre's term, it studies various projects of masculinity, the conditions under which they arise and produce. Such knowledge will not support a positivist science of masculinity. It will however, illuminate social practice; and in that respect has much in common with the knowledge of masculinity coming from social movements. (pp. 38 – 39)

Exploration of such social constructions through the methodology and methods, including interview questions and analysis, may provide a different lens through which one could investigate men's experiences and create a new avenue to better understand male mental health nurses' experience of eating.

Another potential limitation was the use of mobile telephones as the method of collecting interview data. During some of the interviews, the lack of signal on the mobile phones briefly interrupted the conversation; this might have contributed to words being inaudible during the transcription. However, on only one occasion did I have to stop a participant for a couple of minutes to regain a stronger network signal. Trier-Bieniek (2012) suggests that these interruptions might disrupt the natural rhythm of interviews. However, after reminding the participant of the question, he appeared to continue where he left off. Furthermore, I found the lack of visual cues in phone interviewing to be challenging, as pauses were

difficult to interpret (i.e. no visible facial expression such as thinking, confusion, etc. to relay as an interviewer). Thus, I believe I might have interrupted participants at times by interjecting unnecessarily. Novick (2008) suggests that visual cues provide contextual and non-verbal data, and the lack thereof could undermine rapport building, probing and compromise interpretation. It is reasonable to hypothesise that contextual and non-verbal data would have provided other avenues for interpretation. Nevertheless, Cachia and Millward (2011) made the case that interview transcripts provide rich textual data, more than sufficient for a valid analysis account.

4.8 Reflexivity

Birch and Miller (2000) suggested that even experienced interviewers can struggle to keep distinctive boundaries between 'rapport', 'friendship', and 'intimacy' to prevent the depths of 'counselling' and 'therapy'. Therefore, negotiating the 'trainee counselling psychologist/ researcher' role dilemma has the potential to create blurred boundaries (Manderson, Bennett, & Andajani-Sutjahjo, 2006). However, I felt that I transitioned well from 'trainee counselling psychologist' to 'researcher' and was able to keep the two roles separate. Furthermore, I felt prepared to sign-post participants to third-party services if needed. During the interview I also continued to develop an empathetic rapport, while maintaining social distance. When I debriefed my participants, no participant became, or reported having become psychologically distressed during the interview, nor did I feel any participant needed to be sign-posted, although such information was available to them in the debrief information sheet.

I initially grappled with the engrained view of traditional scientific rigour, namely, positivism and objectivity. As I explained in the methodological chapter, I believe with Polkingthorne that "it is not possible to achieve objective knowledge because the only knowledge available to humans is subjective and relative" (Polkingthorne, 1989, p. 27). I therefore did not consider that my prior knowledge of working in an inpatient mental health setting as a healthcare worker or the research topic would be in conflict with my ontological or epistemological stance. As this study aimed to explore lived experience through the process of the double hermeneutic, I had already dismissed 'objectivity' from the moment I chose my methodology. In fact, I felt that my position as an 'insider' was well balanced with my position as an 'outsider'. Having a perspective from the view of a health care assistant

meant that I understood the occupational environment, yet could stay inquisitive with regard to the perspective of a MHN as the job roles are distinctively different. In addition, interviewing male MHN also gave me a unique perspective from my own 'reality'.

Finlay (2008) suggested that research which claims to use the method of bracketing whilst following hermeneutic traditions is "naive and confused" (Finlay, 2009, p. 8). Smith (2007), however, wrote that bracketing and interpretation/double hermeneutic methods are utilised at different stages of the research process. Although I would agree that *bracketing*, or at least acknowledging, your preconceptions is crucial to conducting a reflexive interview and maintaining an unbiased line of questioning, i.e. without leading, closed or manipulative questions, I would suggest that the researcher enters the process of double hermeneutics from the interview stage. Having completed the data collection, transcription and analysis, I am more inclined to agree with Finlay. The interaction between the participant and me during the interview had already entered the double hermeneutic cycle, as I, the researcher, interjected with questions to further explore and clarify the participants' meanings based on my own interpretation of what was said or meant. Therefore, during both the interview and the analysis we constructed collaborative meanings. Furthermore, I would also suggest that the transcription of the data is a collaborative meaning-making process, as certain words that sound similar could be transcribed as the same depending on the interpretation of the researcher in the 'context'. For example, I had to replay and listen to one particular word, "destruction", many times, before I could refute another plausible word, 'distraction'.

Finlay (2008) pointed out the importance of the critical self-awareness of the researcher, to be able to recognise how this might implicate the research process and findings. Occupational stress was a subtheme that transpired organically from most participants' accounts, and was apparent right from the interview warm-up questions when they were asked to describe what a MHN does "day-to-day". This was intended to 'set the scene' and give some context and understanding. When stress or pressure were mentioned, I pursued the follow-up questioning along the lines of, "how do you manage stress?" As a researcher, giving importance to the topic with this line of questioning (perhaps here I was aware that research has found that female nurses report eating most commonly when stressed) might have influenced some participants' answers in a particular direction. However, although I acknowledge that this might have been the case, I would argue that

this exploration was only conducted after the participants themselves had brought the topic up. Occupational stress caused by high workload was deemed an important topic amongst the participants and found to play a crucial role in eating behaviour. My critical self-awareness enabled me to focus in on this topic in the interviews.

References

Adam, T. C., & Epel, E. S. (2007). Stress, eating and the reward system. *Physiology & Behavior, 91*, 449-458.

Adriaanse, M. A., de Ridder, D. T. D., & Evers, C. (2011). Emotional eating: Eating when emotional or emotional about eating? *Psychology and Health, 26*(1), 23-39.

Alberti, R. E., & Emmons, M. L. (2008). *Your perfect right: Assertiveness and equality in your life and relationships* (9th edn). Atascadero, CA: Impact Publishers.

Alberts, H. J. E. M., Mulkens, S., Smeets, M., & Thewissen, R. (2010). Coping with food cravings: Investigating the potential of a mindfulness-based intervention. *Appetite, 55*, 160-163.

Alden, L., & Safran, J. (1978). Irrational beliefs and nonassertive behaviour. *Cognitive Therapy and Research, 2*(4), 357-364.

Alhussain, M. H., Macdonald, I. A., & Taylor, M. A. (2016). Irregular meal-pattern effects on energy expenditure, metabolism, and appetite regulation: A randomized controlled trial in healthy normal-weight women. *The American Journal of Clinical Nutrition, 104*, 21-32.

Almajwal, A. M. (2015). Correlations of physical activity, body mass index, shift duty, and selected eating habits among nurses in Riyadh, Saudi Arabia. *Ecology of Food and Nutrition, 54*, 397-417.

American Psychological Association (1994). Eating disorders. In *Diagnostic and statistical manual of mental disorders (DSM-IV)*, 4th edn, pp. 539–550. Washington, DC: American Psychiatric Association.

Anderson, C. B., & Bulik, C. M. (2004). Gender differences in compensatory behaviors, weight and shape salience, and drive for thinness. *Eating Behaviors, 5*(1), 1-11.

Angrave, D., & Charlwood, A. (2015). What is the relationship between long working hours, over-employment, under-employment and the subjective well-being of workers? Longitudinal evidence from the UK. *Human Relations, 68*(9), 1491-1515.

Arndt, J., Vail, K. E., Cox, C. R., Goldenberg, J. L., Piasecki, T. M., & Gibbons, F. X. (2013). The interactive effect of mortality reminders and tobacco craving on smoking topography. *Health Psychology, 32*(5), 525-532.

Baba, V. V., Tourigny, L., Wang, X., Lituchy, T., & Monserrat, S. I. (2013). Stress among nurses: A multi-nation test of the demand-control-support model. *Cross Cultural Management, 20*(3), 301-320.

Ball, J., Day, T., Murrells, T., DallOra, C., Rafferty, A. M., Griffiths, P., & Maben, J. (2017). Cross-sectional examination of the association between shift length and hospital nurses job satisfaction and nurse reported quality measures. *BMC Nursing, 16(*26), 1-7.

Bargh, J. A., & Chartrand, T. L. (1999). The unbearable automaticity of being. *American Psychologist, 54*(7), 462-479.

Barnett, J. E., Johnston, L. C., & Hillard, D. (2006). Psychologist wellness as an ethical imperative. In L. VandeCreek & J. B. Allen (Eds.), *Innovations in clinical practice: Focus on health and wellness* (pp. 257-271). Sarasota, FL: Professional Resources Press.

Baskin, E., Gorlin, M., Chance, Z., Novemsky, N., Dhar, R., Huskey, K., & Hatzis, M. (2016). Proximity of snacks to beverages increases food consumption in the workplace: A field study. *Appetite, 103*, 244-248.

Benedict, C., Brooks, S. J., O' Daly, O. G., Almèn, M. S., Morell, A., Åberg, K., ... Schiöth, H. B. (2012). Acute sleep deprivation enhances the brain's response to hedonic food stimuli: An fMRI study. *The Journal of Clinical Endocrinology & Metabolism, 97*(3), E443-E447.

Berg, J. (2003). *Bring Back the Belt: Nathan's Hot Dogs and American Nationalism.* Paper Presented to the Association for the Study of Food and Society (ASFS).

Bevan, A. L., Maxfield, M., & Bultmann, M. N. (2014). The effects of age and death awareness on intentions for healthy behaviours. *Psychology & Health, 29*(4), 405-421.

Bi, Y., Wang, T., Xu, M., Xu, Y., Li, M., Lu, J., ... Ning, G. (2012). Advanced research on risk factors of type 2 diabetes. *Diabetes Metab Res Rev, 28*, 32-39.

Bilman, E., van Kleef, E., & van Trijp, H. (2017). External cues challenging the internal appetite control system-overview and practical implications. *Critical Reviews in Food Science and Nutrition, 57*(13), 2825-2834.

Birch, M., & Miller, T. (2000). Inviting intimacy: The interview as therapeutic opportunity. *Int. J. Social Research Methodology, 3*(3), 189–202.

Blake, H., & Patterson, J. (2015). Paediatric nurses' attitudes towards the promotion of healthy eating. *British Journal of Nursing, 24*(2), 108–112.

Blake, H., Mo, P. K., Lee, S., & Batt, M. E. (2012). Health in the NHS: Lifestyle behaviours of hospital employees. *Perspectives in Public Health, 132*(5), 213-215.

Blond, A. (2008). Impacts of exposure to images of ideal bodies on male body dissatisfaction: A review. *Body Image, 5*, 244-250.

Bock, B. C., & Kanarek, R. B. (1995). Women and men are what they eat: The effects of gender and reported meal size on perceived characteristics. *Sex Roles, 33*, 109–119.

Bogossian, F., Hepworth, J., Leong, G., Flaws, D., Gibbons, K., Benefer, C., & Turner, C. (2012). A cross-sectional analysis of patterns of obesity in a cohort of working nurses and midwives in Australia, New Zealand and the United Kingdom. *International Journal of Nursing Studies, 49*, 727–738.

Bradley, N., Whisenhunt, J., Adamson, N., & Kress, V. E. (2013). Creative approaches for promoting counselor self-care. *Journal of Creativity in Mental Health*, *8*, 456–469.

Bressi, S. K., & Vaden, E. R. (2017). Reconsidering self care. *Clinical Social Work Journal, 45*, 33-38.

British Psychological Society (2001). Chartered counselling psychologists' training and areas of competence. *Counselling Psychology Review, 16,* 41–43.

British Psychological Society (2014a). *The British Psychological Society: Code of human research ethics*. Retrieved 24 Jan 2016 from: http://www.bps.org.uk/system/files/Public%20files/code_of_human_research_ethics_dec_2014_inf180_web.pdf

British Psychological Society. (2014b). *Code of ethics and conduct. Guidelines published by the ethics committee of the British Psychological Society*. Leicester: BPS.

Brown, D., Igoumenou, A., Mortlock, A., Gupta, N., & Das, M. (2017). Work-related stress in forensic mental health professionals: A systematic review. *Journal of Forensic Practice, 19*(3), 227-238.

Brunero, S., & Stein-Parbury, J. (2008). The effectiveness of clinical supervision in nursing: An evidenced based literature review. *Australian Journal of Advanced Nursing, 25*(3), 86-94.

Buckley, M., Cowan, C., & McCarthy, M. (2007). The convenience food market in Great Britain: Convenience food lifestyle (CFL) segments. *Appetite, 49*, 600-617.

Cachia, M., & Millward, L. (2011). The telephone medium and semi-structured interviews: A complementary fit. *Qualitative Research in Organizations and Management: An International Journal, 6*(3), 265-277.

Callaghan, P. (1998). Social support and locus of control as correlates of UK nurses' health-related behaviours. *Journal of Advanced Nursing, 28(*5), 1127-1133.

Callaghan, P., Fun, M. K., & Yee, F. C. (1997). Hong Kong nurses' health-related behaviours: Implications for nurses' role in health promotion. *Journal of Advanced Nursing, 25*, 1276-1282.

Campos, L., Bernardes, S., & Godinho, C. (2018). Food as a way to convey masculinities: How conformity to hegemonic masculinity norms influences men's and women's food consumption. *Journal of Health Psychology, 00*(0), 1-15.

Candel, M. J. J. M. (2001). Consumers' convenience orientation towards meal preparation/ Conceptualization and measurement. *Appetite, 36*, 15-28.

Carter, M., Thompson, N., Crampton, P., Morrow, G., Burford, B., Gray, C., & Illing, J. (2013). Workplace bullying in the UK NHS: A questionnaire and interview study on prevalence, impact and barriers to reporting. *BMJ Open, 3*, e002628.

Chen, C. P., & Haller, S. (2015). The role of career counselling in supporting career well-being of nurses. *Australian Journal of Career Development, 24*(1), 15-26.

Clews, G., & Ford, S. (2009). NHS stress driving up nurse sick leave levels. *Nursing Times, 105*(14), 1.

Connell, R. W., & Messerschmidt, J. W. (2005). Hegemonic masculinity: Rethinking the concept. *Gender and Society, 19*(6), 829-859.

Connell, W. R., 1995 (2005). *Masculinities (2nd ed.)*. Berkeley: University of California Press.

Coomarasamy, J. D., Wint, N. N., Neri, D. L. E., & Sukumaran, S. (2014). Prevalence of obesity and daily lifestyles of the registered nurses in Malaysia. *International Journal of Innovation and Applied Studies, 7*(3), 1202-1208.

Corstorphine, E. (2006). Cognitive–Emotional–Behavioural therapy for the eating disorders: Working with beliefs about emotions. *European Eating Disorders Review, 14,* 448-461.

CQC (2017). *The state of care in mental health services 2014 to 2017: Findings from CQC's programme of comprehensive inspections of specialist mental health services*. Newcastle upon Tyne: CQC

Curtis, S., Gesler, W., Fabian, K., Francis, S., & Priebe, S. (2007). Therapeutic landscapes in hospital design: A qualitative assessment by staff and service users of the design of a new mental health inpatient unit. *Environment and Planning C: Government and Policy, 25*, 591-610.

Cushway D., Tyler P. & Nolan P. (1996). Development of a stress scale for mental health professionals. *British Journal of Clinical Psychology 35*, 279-295.

Dall'Ora, C., Griffiths, P., Ball, J., Simon, M., & Aiken, L. H. (2015). Association of 12-hour shifts and nurses' job satisfaction, burnout and intention to leave: Findings from a cross-sectional study of 12 European countries. *BMJ Open, 5*(e008331), 1-7.

Data Protection Act (2005). *Data Protection Act 1998* (Chapter 29). Norwich: The Stationery Office Limited.

Davey, A., Arcelus, J., & Munir, F. (2014). Work demands, social support, and job satisfaction in eating disorder inpatient settings: A qualitative study. *International Journal of Mental Health Nursing, 23*, 60-68.

de Ridder, D., Kroese, F., Adriaanse, M., & Evers, C. (2014). Always gamble on an empty stomach: Hunger is associated with advantageous decision making. *PLoS ONE 9*(10), e111081.

Delaney, K. R., & Johnson, M. E. (2014). Metasynthesis of research on the role of psychiatric inpatient nurses: What is important to staff? *Journal of the American Psychiatric Nurses Association, 20*(2), 125-137.

Department of Health (2008). Mental Health Act 1983. London: The Stationary Office.

Dickinson, T., & Wright, K. M. (2008). Stress and burnout in forensic mental health nursing: A literature review. *British Journal of Nursing, 17*(2), 82-87.

DiClemente, C. C., & Velasquez, M. M. (2002). *Motivational interviewing and the stages of change*. In W. R. Miller & S. Rollnick (Eds.), *Motivational interviewing: Preparing people for change* (2nd ed., pp. 201–216). New York: The Guilford Press.

Donaldson, M., & S. Poynting. (2004). *The time of their lives: Time, work and leisure in the daily lives of ruling-class men.* In Ruling Australia: The power, privilege & politics of the new ruling class, edited by N. Hollier. Melbourne: Australian Scholarly.

Donnelly, T. (2014). Stress among nurses working in an acute hospital in Ireland. *British Journal of Nursing, 23*(13), 746-750.

Downward, P., & Rasciute, S. (2011). Does sport make you happy? An analysis of the well-being derived from sports participation. *International Review of Applied Economics, 25*(3), 331-348.

Ducrot, P., Méjean, C., Aroumougame, V., Ibanez, G., Allès, B., Kesse-Guyot, E., ... Péneau, S. (2017). Meal planning is associated with food variety, diet quality and body weight status in a large sample of French adults. *International Journal of Behavioral Nutrition and Physical Activity, 14*(12), 1-12.

Duncan, A. E., Ziobrowski, H. N., & Nicol, G. (2017). The prevalence of past 12-month and lifetime DSM-IV eating disorders by BMI category in US men and women. *European Eating Disorders Review, 25,* 165-171.

Eckstein, D. (2001). A F.A.M.I.L.Y. approach to Self-care: Creating a healthy balance. *The Family Journal: Counseling and Therapy for Couples and Families*, *9*, 327–336.

Edwards, D., & Burnard, P. (2003). A systematic review of stress and stress management interventions for mental health nurses. *Journal of Advanced Nursing*, *42*(2), 169–200.

Esch, T., & Stefano, G. B. (2010). Endogenous reward mechanisms and their importance in stress reduction, exercise and the brain. *Archives of Medical Science, 6*(3), 447-455.

Evers, C., Stok, F. M., & de Ridder, D. T. D. (2010). Feeding your feelings: Emotion regulation strategies and emotional eating. *Personality and Social Psychology Bulletin, 36*(6), 792-804.

Fairburn, C. G., Marcus, M. D., & Wilson, G. T. (1993). Cognitive-behavioral therapy for binge eating and bulimia nervosa. In C. G. Fairburn, & G. T. Wilson (Eds.), *Binge Eating: Nature, Assessment, and Treatment* (pp. 361–404). New York: Guilford Press.

Fairburn, C.G., Cooper, Z., & Shafran, R. (2003). Cognitive behaviour therapy for eating disorders: A 'transdiagnostic' theory and treatment. *Behav Res Ther, 41*, 509–528.

Faugier J., Lancaster, J., Pickles, D., & Dobson, K. (2001a). Barriers to healthy eating in the nursing profession: Part 1. *Nursing Standard 15*(36), 33–36.

Faugier, J., Lancaster, J., Pickles, D., & Dobson, K. (2001b). Barriers to healthy eating in the nursing profession: Part 2. *Nursing Standard, 15*(37), 33–35.

Fernandes, J., Portela, L., Rotenberg, L., & Griep, R. (2013). Working hours and health behaviour among nurses at public hospitals. *Revista Latino-Americana de Enfermagem (RLAE), 21*(5), 1104–1111.

Festinger, L. (1954). A theory of social comparison processes. *Human Relations*, 7, 117–140.

Finlay, L. (2006). 'Rigour', 'ethical integrity' or 'artistry'? Reflexively reviewing criteria for evaluating qualitative research. *The British Journal of Occupational Therapy, 69*(7), 319-326.

Finlay, L. (2008). A dance between the reduction and reflexivity: Explicating the 'phenomenological psychological attitude'. *Journal of Phenomenological Psychology*, *39*, 1-32.

Finlay, L. (2009). Debating phenomenological research methods. *Phenomenology & Practice,* 3(1), 6-25.

Forman, E. M., Shaw, J. A., Goldstein, S. P., Butryn, M. L., Martin, L. M., Meiran, N., ... Manasse, S. M. (2016). Mindful decision making and inhibitory control training as complementary means to decrease snack consumption. *Appetite, 103*, 176-183.

Forrester-Knauss, C., & Zemp Stutz, E. (2012). Gender differences in disordered eating and weight dissatisfaction in Swiss adults: Which factors matter? *BMC Public Health, 12*(1), 809.

Frankland, A., & Walsh, Y. (2005). Counselling psychology in the NHS. *Mental Health Review Journal, 10*(3), 31-34.

Freudenberger, H. J. (1974). Staff burn-out. *Journal of Social Issues, 30*(1), 159-165.

Fryer S., Waller G., & Kroese B. S. (1997). Stress, coping, and disturbed eating attitudes in teenage girls. *International Journal of Eating Disorders, 22,* 427–436.

Galioto, R., & Crowther, J. H. (2013). The effects of exposure to slender and muscular images on male body dissatisfaction. *Body Image, 10*, 566-573.

Geiker, N. R. W., Astrup, A., Hjorth, M. F., Sjödin, A., Pijls, L., & Markus, C. R. (2018). Does stress influence sleep patterns, food intake, weight gain, abdominal obesity and weight loss interventions and vice versa? *Obesity Reviews, 19*, 81-97.

Geliebter, A., & Aversa, A. (2003). Emotional eating in overweight, normal weight, and underweight individuals. *Eat Behav, 3*, 341–347.

Germer, C. K., & Neff, K. D. (2015). Cultivating self-compassion in trauma survivors. In V. M. Follette, J. Briere, D. Rozelle, J. W. Hopper, & D. I. Rome (Eds.), *Mindfulness-oriented interventions for trauma: Integrating contemplative practices* (pp. 43–58). New York, NY: The Guilford Press.

Giorgi, A. (1994). A phenomenological perspective on certain qualitative research methods. *Journal of Phenomenological Psychology*, *25*(2), 190-220.

Giorgi, A. (2011). IPA and science: A response to Jonathan Smith. *Journal of Phenomenological Psychology, 42,*195-216.

Giorgi, A. (2012). The descriptive phenomenological psychological method. *Journal of Phenomenological Psychology, 43*, 3-12.

Giorgi, A., & Giorgi, B. (2003). Phenomenology. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods*. London: Sage.

Glanz, K., Patterson, R. E., Kristal, A. R., DiClemente, C. C., Heimendinger, J., Linnan, L., & McLerran, D. F. (1994). Stages of change in adopting healthy diets: Fat, fiber, and correlates of nutrient intake. *Health Education Quarterly, 21*(4), 499-519.

Goldenberg, J. L., & Arndt, J. (2008). The implications of death for health: A terror management health model of behavioral health promotion. *Psychological Review, 115*(4), 1032–1053.

Goldstone, A. P., Prechtl de Hernandez, C.G., Beaver, J. D., Muhammed, K., Croese, C., Bell, G., Durighel, G., Hughes, E., Waldman, A.D., Frost, G., & Bell, J. D. (2009). Fasting biases brain reward systems towards high-calorie foods. *The European Journal of Neuroscience, 30*, 1625-1635.

Golsworthy, R., & Coyle, A. (2001). Practitioners' accounts of religious and spiritual dimensions in bereavement therapy. *Counselling Psychology Quarterly, 14*(3), 183-202.

Greer, S. M., Goldstein, A. N., & Walker, M. P. (2013). The impact of sleep deprivation on food desire in the human brain. *Nature Communications, 4*, 2259.

Groesz, L. M., McCoy, S., Carl, J., Saslow, L., Stewart, J., Adler, N., … Epel, E. (2012). What is eating you? Stress and the drive to eat. *Appetite, 58*, 717-721.

Gross, J. J. (2015). Emotion Regulation: Current Status and Future Prospects. *Psychological Inquiry, 26*, 1-26.

Gross, J. J., & Jazaieri, H. (2014). Emotion, emotion regulation, and psychopathology: An affective science perspective. *Clinical Psychological Science, 2*(4)*,* 387-401.

Gyllensten, K., Palmer, S. & Farrants, J. (2005). Perception of stress and stress interventions in finance organizations: overcoming resistance towards counselling. *Counselling Psychology Quarterly, 18*(1), 19-25.

Halsey, L. G., Huber, J. W., Low, T., Ibeawuchi, C., Woodruff, P., & Reeves, S. (2011). Does consuming breakfast influence activity levels? An experiment into the effect of breakfast consumption on eating habits and energy expenditure. *Public Health Nutrition, 15*(2), 238-245.

Han, D., Duhachek, A., & Agrawal, N. (2014). Emotions shape decisions through construal level: The case of guilt and shame. *Journal of Consumer Research, 41,* 1047-1064.

Han, K., Trinkooff, A. M., Storr, C. L. & Geiger-Brown, J. (2011). Job stress and work schedules in relation to nurse obesity. *The Journal of Nursing Administration, 41*, 488-495.

Hans, E., & Hiller, W. (2013). A meta-analysis of nonrandomized effectiveness studies on outpatient cognitive behavioral therapy for adult anxiety disorders. *Clinical Psychology Review, 33*, 954-964.

Havermans, R. C., Vancleef, L., Kalamatianos, A., & Nederkoorn, C. (2015). Eating and inflicting pain out of boredom. *Appetite, 85*, 52-57.

Hawkins, R. C., & Clement, P. F. (1984). Binge eating: Measurement problems and a conceptual model. In R. C. Hawkins, W. J. Fremouw, & P. F. Clement (Eds.), *The binge purge syndrome: Diagnosis, treatment, and research* (pp. 229–251). New York, NY: Springer.

Health and Care Professions Council. (2015). *Standards of proficiency*. Practitioner psychologists. London: HCPC.

Health and Safety Executive (HSE) (2005). *Ethnicity, work characteristics, stress and health.* Research Report 308, Health and Safety Executive, HSE Books: Sudbury.

Health and Social Care Information Centre (HSCIC). (2013). *NHS workforce: Summary of staff in the NHS Results from September 2012 census.* Retrieved 20 May 2015 from: http://www.hscic.gov.uk/catalogue/PUB10392 .

Heatherton, T. F., & Baumeister, R. F. (1991). Binge eating as an escape from self-awareness. *Psychological Bulletin, 110*(1), 86–108.

Hofstede, G. (1998). *Masculinity and femininity: The taboo dimension of national cultures.* Thousands Oaks, CA: Sage Publications.

Hofstede, G. (2001). *Culture's consequences. Comparing values, behaviors, institutions, and organizations across nations.* Thousand Oaks, CA: Sage.

Hogenkamp, P. S., Nilsson, E., Nilsson, V. C., Chapman, C. D., Vogel, H., Lundberg, L. S., Zarei, S., Cedernaes, J., Rångtell, F. H., Broman, J., Dickson, S. L., Brunstrom, J. M., Benedict, C., & Schiöth, H. B. (2013). Acute sleep deprivation increases portion size and affects food choice in young men. *Psychoneuroendocrinology, 38*(9), 1668-1674.

Hou, R., Mogg, K., Bradley, B. P., Moss-Morris, R., Peveler, R., & Roefs, A. (2011). External eating, impulsivity and attentional bias to food cues. *Appetite, 56*, 424-427.

HSE. (2001). *Tackling work-related stress: A managers' guide to improving and maintaining employee health and well-being* (HSG218), Health and Safety Executive, HSE Books: Sudbury.

Humphreys, B. R., McLeod, L., & Ruseski, J. E. (2014). Physical activity and health outcomes: Evidence from Canada. *Health Economics, 23*, 33-54.

Huntington, A., Gilmour, J., Tuckett, A., Neville, S., Wilson, D., & Turner, C. (2011). Is anybody listening? A qualitative study of nurses' reflections on practice. *Journal of Clinical Nursing, 20*, 1413-1422.

Husserl, E. (1970). *The crisis of European sciences and transcendental phenomenology*. Evanston, IL: Northwestern University Press. (Original work published 1936).

Jazaieri, H., Urry, H. L., & Gross, J. J. (2013). Affective disturbance and psychopathology: An emotion regulation perspective. *Journal of Experimental Psychopathology*, *4*(5), 584-599.

Ji, M. F., & Wood, W. (2007). Purchase and consumption habits: Not necessarily what you intend. *Journal of Consumer Psychology, 17*(4), 261-276.

Jinks, A. M., Lawson, V., & Daniels, R. (2003). A survey of the health needs of hospital staff: implications for health care managers. *Journal of Nursing Management, 11*, 343–350.

Johnson, J. V., & Hall, E. M. (1988). Job strain, workplace social support and cardiovascular disease: a cross-sectional study of a random sample of the Swedish working population. *American Journal of Public Health, 78*, 1336-1342.

Jonason, P. K., Krcmar, M., & Sohn, S. (2009). Male body image: The role of muscle magazine exposure, body mass index, and social comparison in men's body satisfaction. *Social Behavior and Personality, 37*(5), 627–630.

Kabat‐Zinn, J. (2003). Mindfulness‐Based interventions in context: Past, present, and future. *Clin Psychol Sci Prac, 10*, 144-156.

Karasek, R. A. (1979). Job demands, job decision latitude and mental strain: implications for job redesign. *Administrative Science Quarterly, 24*, 285-306.

Karasek, R. A. & Theorell, T. (1990). *Healthy Work: Stress, Productivity, and the Reconstruction of Working Life*. New York: Basic Books.

Kelly, E. L., Fenwick, K., Brekke, J. S., & Novaco, R. W. (2016). Well-being and safety among inpatient psychiatric staff: The impact of conflict, assault, and stress reactivity. *Adm Policy Ment Health, 43*, 703-716.

Kelly, N. R., Cotter, E. W., Tanofsky-Kraff, M., & Mazzeo, S. E. (2015). Racial variations in binge eating, body image concerns, and compulsive exercise among men. *Psychology of Men & Masculinity, 16*(3), 326-336.

King, K. A., Vidourek, R., & Schwiebert, M. (2009). Disordered eating and job stress among nurses. *Journal of Nursing Management, 17*, 861-869.

Kirk, S. F. L., Cockbain, A. J., & Beazley, J. (2008). Obesity in Tonga: A cross-sectional comparative study of perceptions of body size and beliefs about obesity in lay people and nurses. *Obesity Research & Clinical Practice, 2,* 35-41.

Kisely, S., & Kendall, E. (2011). Critically appraising qualitative research: A guide for clinicians more familiar with quantitative techniques. *Australasian Psychiatry, 19*(4), 364-367.

Klein, K. M., Brown, T. A., Kennedy, G. A., & Keel, P. K. (2017). Examination of parental dieting and comments as risk factors for increased drive for thinness in men and women at 20-year follow-up. *International Journal of Eating Disorders, 50*, 490-497.

Koball, A. M., Meers, M. R., Storfer-Isser, A., Domoff, S. E., & Musher-Eizenman, D. R. (2012). Eating when bored. Revision of the emotional eating scale with a focus on boredom. *Health Psychology*, *31*(4), 521–524.

Kristeller, J., Wolever, R. Q., & Sheets, V. (2014). Mindfulness-based eating awareness training (MB-EAT) for binge eating: A randomized clinical trial. *Mindfulness, 5,* 282-297.

Kuk, J. L., Ardern, C. I., Church, T. S., Hebert, J. R., Sui, X., & Blair, S. N. (2009). Ideal weight and weight satisfaction: Association with health practices. *American Journal of Epidemiology, 170*, 456-463.

Kunyk, D. (2015). Substance use disorders among registered nurses: Prevalence, risks and perceptions in a disciplinary jurisdiction. *Journal of Nursing Management, 23*, 54-64.

Kvale, S. (2007). *Qualitative research kit: Doing interviews.* London: SAGE Publications.

Leary, A., White, J., & Yarnell, L. (2014). The work left undone. understanding the challenge of providing holistic lung cancer nursing care in the UK. *European Journal of Oncology Nursing, 18*, 23-28.

Lee, J. S., Mishra, G., Hayashi, K., Watanabe, E., Mori, K., & Kawakubo, K. (2016). Combined eating behaviors and overweight: Eating quickly, late evening meals, and skipping breakfast. *Eating Behaviors, 21*, 84-88.

Lee, J., Daffern, M., Ogloff, J. R. P., & Martin, T. (2015). Towards a model for understanding the development of post‐traumatic stress and general distress in mental health nurses. *International Journal of Mental Health Nursing, 24*, 49-58.

Levy, D. J., Thavikulwat, A. C., & Glimcher, P. W. (2013). State dependent valuation: The effect of deprivation on risk preferences. *PLoS One, 8*(1), e53978.

Lowden, A., Moreno, C., Holmbäck, U., Lennernäs, M., & Tucker, P. (2010). Eating and shift work — effects on habits, metabolism, and performance. *Scandinavian Journal of Work, Environment & Health, 36*(2), 150-162.

Ludwig, A. F., Cox, P., & Ellahi, B. (2011). Social and cultural construction of obesity among Pakistani Muslim women in Worth West England. *Public Health Nutrition, 14*(10), 1842-1850.

Lundberg, U., & Cooper, C. L. (2011). *The science of occupational health: Stress, psychobiology and the new world of work*. Ames, Iowa; Chichester, West Sussex, U.K: Wiley-Blackwell.

Lupton, D. (2000). 'Where's me dinner?': Food preparation arrangements in rural Australian families. *Journal of Sociology, 36*(2), 172–186.

Maier, S. F., & Seligman, M. E. P. (1976). Learned helplessness: Theory and evidence. *Journal of Experimental Psychology: General, 105*(1), 3-46.

Malik, S., Blake, H., & Batt, M. (2011). How healthy are our nurses? New and registered nurses compared. *British Journal of Nursing, 20*(8), 489–496.

Manderson, L., Bennett, E., & Andajani-Sutjahjo, S. (2006). The social dynamics of the interview: Age, class, and gender. *Qualitative Health Research, 16*(10), 1317–1334.

Mantzios, M., & Wilson, J. C. (2015). Mindfulness, eating behaviours, and obesity: A review and reflection on current findings. *Current Obesity Reports, 4*, 141-146.

Márquez, C., Belda, X., & Armario, A. (2002). Post-stress recovery of pituitary–adrenal hormones and glucose, but not the response during exposure to the stressor, is a marker of stress intensity in highly stressful situations. *Brain Research, 926*, 181-185.

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Organizational Behaviour, 2,* 99-113.

Mason, J. (2002[1958]). *Qualitative researching* (2nd ed.). London: Sage.

McDowell, N., McKenna, J., & Naylor, P. J. (1997). Factors that influence practice nurses to promote physical activity. *British Journal of Sports Medicine, 31*(4), 308-313.

McKew, M. (2017). One in eight who quit nursing cite lack of work-life balance. *Nursing Standard, 32*(12), 7-8.

Meeusen, R. (2014). Exercise, nutrition and the brain. *Sports Medicine, 44*(S1), S47-S56.

Melnyk, B. M., Hrabe, D. P., & Szalacha, L. A. (2013). Relationships among work stress, job satisfaction, mental health, and healthy lifestyle behaviors in new graduate nurses attending the nurse athlete program: A call to action for nursing leaders. *Nursing Administration Quarterly, 37*(4), 278-285.

Merleau-Ponty, M. (1962). *Phenomenology of perception.* London and New York: Routledge & K. Paul.

Mesas, A. E., Muñoz-Pareja, M., López-García, E., & Rodríguez-Artalejo, F. (2012). Selected eating behaviours and excess body weight: A systematic review. *Obesity Reviews, 13*, 106-135.

Migration Advisory Committee. (2016). *Partial review of the Shortage Occupation List. Review of nursing*. Retrieved 11 August 2017 from: https://www.gov.uk/government/news/migration-advisory-committee-mac- report-on-nursing-shortage

Miller, S. K., Alpert, P. T., & Cross, C. L. (2008). Overweight and obesity in nurses, advanced practice nurses, and nurse educators. *Journal of the American Academy of Nurse Practitioners, 20*, 259-265.

Mitchison, D., & Mond, J. (2015). Epidemiology of eating disorders, eating disordered behaviour, and body image disturbance in males: A narrative review. *Journal of Eating Disorders, 3*, (20), 1-9.

Murray, S. B., Griffiths, S., & Mond, J. M. (2016). Evolving eating disorder psychopathology: Conceptualising muscularity-oriented disordered eating. *The British Journal of Psychiatry, 208*, 414–415.

Naczenski, L.M., de Vries, J.D., van Hooff, M.L.M., & Kompier, M.A.J. (2017). Systematic review of the association between physical activity and burnout. *Journal of Occupational Health, 59*, 477-494.

Naghashpour, M., Amani, R., Nematpour, S., & Haghighizadeh, M. H. (2013). Dietary, Anthropometric, Biochemical and Psychiatric Indices in Shift Work Nurses. *Food and Nutrition Sciences, 4*, 1239 -1246.

Nahm, E., Warren, J., Zhu, S., An, M. & Brown, J. (2012). Nurses' self-care behaviors related to weight and stress. *Nursing Outlook, 60*, E23-E31.

Nakamura, Y., Yoshinaga, N., Tanoue, H., Kato, S., Nakamura, S., Aoishi, K., & Shiraishi, Y. (2017). Development and evaluation of a modified brief assertiveness training for nurses in the workplace: a single-group feasibility study. *BMC Nursing, 16*(29), 1-8.

Nash, M., & Phillipov, M. (2014). Introduction to the special issue: Eating like a 'man': Food and the performance and regulation of masculinities. *Women's Studies International Forum, 44*, 205-208.

Nath, J. (2011). Gendered fare?: A qualitative investigation of alternative food and masculinities. *Journal of Sociology, 47*(3), 261-278.

National Council of State Boards of Nursing. (2014). *A nurse's guide to professional boundaries.* Chicago: NCSBN. Retrieved 20 March 2018 from: https://www.ncsbn.org/ProfessionalBoundaries_Complete.pdf.

National Institute for Health and Care Excellence. (2006). *Obesity: Guidance on the Prevention, Identification, Assessment and Management of Overweight and Obesity in Adults and Children*. London: NICE. Retrieved 5 July 2015 from: http://www.nice.org.uk/guidance/cg43 on 5 July 2015.

National Institute for Health and Care Excellence. (2009). *Depression in adults: recognition and management.* London: NICE

National Institute for Health and Care Excellence. (2015). *Violence and aggression: short-term management in mental health, health and community settings*. London: NICE.

Neall, R.A., Atherton, I.M., & Kyle, R.G. (2016). Nurses' health-related behaviours: protocol for a quantitative systematic review of prevalence of tobacco smoking, physical activity, alcohol consumption and dietary habits. *Journal of Advanced Nursing, 72*(1), 197–204.

Nederkoorn, C., Guerrieri, R., Havermans, R. C., Roefs, A., & Jansen, A. (2009). The interactive effect of hunger and impulsivity on food intake and purchase in a virtual supermarket. *International Journal of Obesity, 33*, 905-912.

Newton, N. J., Russell, S. A., & McAdams, D. P. (2017). Body appraisal, weight management goals, and well-being among midlife men and women. *Journal of Adult Development, 24,* 31-39.

NHS Confederation. (2012). *Defining mental health services. Promoting effective commissioning and supporting QIPP*. London: NHS Confederation Events & Publishing.

NHS Digital. (2017). *Mental Health Act Statistics, Annual figures 2016/2017*. Surrey: Experimental Statistics.

NHS England (2018). NHS Staff Survey 2017: National Briefing. England: Survey Coordination Centre. Retrieved 15 March 2018 from: http://www.nhsstaffsurveys.com/Caches/Files/P3088_ST17_National%20briefing_v5.0.pdf

Nicholls, R., Perry, L., Duffield, C., Gallagher, R., & Pierce, H. (2017). Barriers and facilitators to healthy eating for nurses in the workplace: An integrative review. *Journal of Advanced Nursing, 73*(5), 1051-1065.

Nijman, H., Bowers, L., Oud, N. & Jansen, G. (2005). Psychiatric nurses' experiences with inpatient aggression. *Aggressive Behavior*, *31*, 217–227.

Novick, G. (2008). Is there a bias against telephone interviews in qualitative research? *Research in Nursing & Health, 31*, 391-398.

Nursing and Midwifery Council. (2015). *Standards for competence for registered nurses*. London: NMC.

Nursing and Midwifery Council. (2016). *Annual equality and diversity report 2015-2016*. NMC, 1-36. Retrieved 5 April 2018 from: https://www.nmc.org.uk/globalassets/sitedocuments/annual_reports_and_accounts/equality-and-diversity-report-2015-16.pdf.

O'Reilly, G.A., Cook, L., Spruijt-Metz, D., Black, D.S. (2014). Mindfulness-based interventions for obesity-related eating behaviours: a literature review. *Obes Rev, 15*, 453–461.

Oates, J., Jones, J., & Drey, N. (2017). Subjective well‐being of mental health nurses in the United Kingdom: Results of an online survey. *International Journal of Mental Health Nursing, 26*, 391-401.

Ogden, J., Coop, N., Cousins, C., Crump, R., Field, L., Hughes, S., & Woodger, N. (2013). Distraction, the desire to eat and food intake. Towards an expanded model of mindless eating. *Appetite, 62*, 119-126.

Opwis, M., Schmidt, J., Martin, A., & Salewski, C. (2017). Gender differences in eating behavior and eating pathology: The mediating role of rumination. *Appetite, 110,* 103-107.

Osborn, M., & Smith, J. A. (1998). The personal experience of chronic lower back pain: An interpretative phenomenological analysis. *British Journal of Health Psychology, 3*, 65-83.

Pandalai, S. P., Schulte, P. A. & Miller, D. B. (2013). Conceptual heuristic models of the interrelationships between obesity and the occupational environment. *Scandinavian Journal of Work, Environment & Health, 39*(3), 221-232.

Pankevich, D. E., Teegarden, S. L., Hedin, A. D., Jensen, C. L., & Bale, T. L. (2010). Caloric restriction experience reprograms stress and orexigenic pathways and promotes binge eating. *The Journal of Neuroscience, 30*(48), 16399-16407.

Pardi, D., Buman, M., Black, J., Lammers, G. J., & Zeitzer, J. M. (2017). Eating decisions based on alertness levels after a single night of sleep manipulation: A randomized clinical trial. *Sleep, 40*(2), 1-8.

Park, S., & Shin, W-S. (2015). Differences in eating behaviors and masticatory performances by gender and obesity status. *Physiol Behav, 138*, 69–74.

Peciña, S., & Smith, K. S. (2010). Hedonic and motivational roles of opioids in food reward: Implications for overeating disorders. *Pharmacology, Biochemistry and Behavior, 97*, 34-46.

Pentecost, C., Farrand, P., Greaves, C.J., Taylor, R.S., Warren, F.C., Hillsdon, M., Green, C., Welsman, J. R., Rayson, K., Evans, P. H. & Taylor, A. H. (2015). Combining behavioural activation with physical activity promotion for adults with depression: findings of a parallel-group pilot randomised controlled trial (BAcPAc). *Trials, 16*(367), 1-15.

Pepłońska, B., Burdelak, W., Krysicka, J., Bukowska, A., Marcinkiewicz, A., Sobala, W., Klimecka-Muszyńska, D., & Rybacki, M. (2014). Night shift work and modifiable lifestyle factors. *International Journal of Occupational Medicine and Environmental Health, 27*(5), 693-706.

Persson, M., & Martensson, J. (2006). Situations influencing habits in diet and exercise among nurses working night shift. *Journal of Nursing Management, 14*, 414–423.

Phiri, L. P., Draper, C. E., Lambert, E. V., & Kolbe-Alexander, T. L. (2014). Nurses' lifestyle behaviours, health priorities and barriers to living a healthy lifestyle: a qualitative descriptive study. *BMC Nursing, 13*(38), 1-11.

Piqueras-Fiszman, B., & Jaeger, S. R. (2016). The incidental influence of memories of past eating occasions on consumers' emotional responses to food and food-related behaviors. *Frontiers in Psychology, 7,* 943.

Placanica, J.L., Faunce, G.J., & Soames Job, R.F. (2002). The effect of fasting on attentional biases for food and body shape/weight words in high and low eating disorder inventory scorers. *International Journal of Eating Disorders, 32*, 79–90.

Polivy, J. (1996). Psychological consequences of food restriction. *Journal of the American Dietetic Association, 96*, 589–592.

Polkingthorne, D.E. (1989). Changing Conversations about Human Science, in Kvale, Steinar (Ed): *Issues of Validity in Qualitative Research* (pp.13-45). Lund: Studentlitteratur.

Pope, K., & Vasquez, M. (1991). *Ethics in psychotherapy and counseling*. San Francisco, CA: Jossey-Bass.

Poulose, S., & Sudarsan, N. (2017). Assessing the influence of work-life balance dimensions among nurses in the healthcare sector. *Journal of Management Development, 36*(3), 427-437.

Power, B. T., Kiezebrink, K., Allan, J. L., & Campbell, M. K. (2017). Understanding perceived determinants of nurses eating and physical activity behaviour: A theory-informed qualitative interview study. *BMC Obesity, 4,* 18.

Pritchard, M., & Cramblitt, B. (2014). Media influence on drive for thinness and drive for muscularity. *Sex Roles, 71*, 208-218.

Prochaska, J.O., & DiClemente, C.C. (1992). The transtheoretical approach. In J.C. Norcross & M.R. Goldfried (Eds.) *Handbook of psychotherapy integration*. NY: Basic Books.

Qi, Y., Xiang, Y., An, F., Wang, J., Zeng, J., Ungvari, G. S., … Chiu, H. F. K. (2014). Nurses' Work-Related stress in China: A comparison between psychiatric and general hospitals. *Perspectives in Psychiatric Care, 50*, 27-32.

Räisänen, U., & Hunt, K. (2014). The role of gendered constructions of eating disorders in de- layed help-seeking in men: A qualitative interview study. *BMJ Open, 4*, e004342.

Raynor, H.A., & Epstein, L.H. (2003). The relative-reinforcing value of food under differing levels of food deprivation and restriction. *Appetite,* 40, 15–24.

Renwick, L., Lavelle, M., Brennan, G., Stewart, D., James, K., Richardson, M., Williams, H., Price, O., & Bowers, L. (2016). Physical injury and workplace assault in UK mental health trusts: An analysis of formal reports. *International Journal of Mental Health Nursing, 25,* 355-366.

Robson, A., & Robson, F. (2015). Do nurses wish to continue working for the UK National Health Service? A comparative study of three generations of nurses. *Journal of Advanced Nursing, 71*(1), 65-77.

Rodgers, R. F., Paxton, S. J., & Chabrol, H. (2010). Depression as a moderator of sociocultural influences on eating disorder symptoms in adolescent females and males. *Journal of Youth and Adolescence, 39*, 393-402.

Rogers, R. W. (1975). A protection motivation theory of fear appeals and attitude change. *The Journal of Psychology, 91*, 93 – 114.

Rotter, J. B. (1966). Generalized expectancies for internal versus external control of reinforcement. *Psychological Monographs, 80*(1), 1-28.

Royal College of Nursing. (2017). *Safe and effective staffing: Nursing against the odds*. London: Royal College of Nursing.

Ruby, M. B. (2012). Vegetarianism: A blossoming field of study. *Appetite, 58*(1), 141–150.

Sabes-Figuera, R., McCrone, P., Csipke, E., Craig, T. K. J., Rose, D., Sharma, B., & Wykes, T. (2016). Predicting psychiatric inpatient costs. *Social Psychiatry and Psychiatric Epidemiology, 51*, 303-308.

Sahu, S., & Dey, M. (2011). Changes in food intake pattern of nurses working in rapidly rotating shift. *Al Ameen Journal of Medical Sciences, 4*(1), 14–22.

Sapolsky, R. M., Romero, L. M., & Munck, A. U. (2000). How do glucocorticoids influence stress responses? Integrating permissive, suppressive, stimulatory, and preparative actions. *Endocrine Reviews, 21*(1), 55-89.

Schaumberg, K., & Anderson, D. A. (2014). Does short-term fasting promote changes in state body image? *Body Image, 11*, 167-170.

Schaumberg, K., Anderson, D. A., Reilly, E. E., & Anderson, L. M. (2015). Does short-term fasting promote pathological eating patterns? *Eating Behaviors, 19*, 168-172.

Schluter, P. J., Turner, C., & Benefer, C. (2012). Long working hours and alcohol risk among Australian and New Zealand nurses and midwives: A cross-sectional study. *International Journal of Nursing Studies, 49*, 701-709.

Schnall, P. L., Landsbergis, P. A. & Baker, D. (1994). Job Strain and Cardiovascular Disease. *Annual Review of Public Health, 15*, 381-411.

Scholze, A. R., Martins, J. T., Galdino M. J. Q, & Ribeiro, R. P. (2017). Occupational environment and psychoactive substance consumption among nurses. *Acta Paul Enferm, 30*(4), 404-411.

Seed, M. S., Torkelson, D. J., & Alnatour, R. (2010). The Role of the Inpatient Psychiatric Nurse and Its Effect on Job Satisfaction. *Issues in Mental Health Nursing, 31*,160-170.

Shimizu, H., & Okabe, M. (2007). Evolutionary origin of autonomic regulation of physiological activities in vertebrate phyla. *Journal of Comparative Physiology A, 193*, 1013-1019.

Siegel, H. (1986). Relativism, truth, and incoherence. *Synthese, 68*, 225-259.

Siep, N., Roefs, A., Roebroeck, A., Havermans, R., Bonte, M.L., & Jansen, A. (2009). Hunger is the best spice: an fMRI study of the effects of attention, hunger, calorie content on food reward processing in the amygdala and orbitofrontal cortex. *Behav Brain Res, 198,* 149–158.

Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, *1*, 39-54.

Smith, J. A. (2007). Hermeneutics, human science and health: Linking theory and practice. *International Journal of Qualitative Studies on Health and Well-Being, 2,* 3-11.

Smith, J. A., & Osborn, M. (2003). Interpretative Phenomenological Analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 53-80). London: Sage.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretive Phenomenological Analysis: Theory, method and research*. London: Sage Publications.

Smith, K. E., Mason, T. B., Murray, S. B., Griffiths, S., Leonard, R. C., Wetterneck, C. T., … Lavender, J. M. (2017). Male clinical norms and sex differences on the eating disorder inventory (EDI) and eating disorder examination questionnaire (EDE-Q). *International Journal of Eating Disorders, 50*, 769-775.

Smith, P., Fritschi, L., Reid, A., & Mustard, C. (2013). The relationship between shift work and body mass index among Canadian nurses. *Applied Nursing Research, 26*, 24–31.

Sobal, J. (2005). Men, meat, and marriage: Models of masculinity. *Food and Foodways, 13*(1–2), 135–158.

Spoor, S. T. P., Bekker, M. H. J., Van Strien, T., & van Heck, G. L. (2007). Relations between negative affect, coping, and emotional eating. *Appetite, 48*, 368-376.

Stewart, D., Bowers, L., Simpson, A., Ryan, C. & Tziggili, M. (2009). Manual restraint of adult psychiatric inpatients: a literature review. *Journal of Psychiatric and Mental Health Nursing, 16*(8), 749–757.

Stice, E., Davis, K., Miller, N.P., & Marti, C.N. (2008). Fasting increases risk for onset of binge eating and bulimic pathology: A 5-year prospective study. *Journal of Abnormal Psychology, 117*(4), 941–946.

Stickney, M. I., & Miltenberger, R. G. (1999). Evaluating direct and indirect measures for the functional assessment of binge eating. *International Journal of Eating Disorders*, *26*, 195–204.

Stone, A. A., & Brownell, K. D. (1994). The stress-eating paradox: Multiple daily measurements in adult males and females. *Psychology and Health, 9*, 425–436.

Stone, P. W., Du, Y., Cowell, R., Amsterdam, N., Helfrich, T. A., Linn, R. W., Gladstein, A., Walsh, M., & Mojica, L.A. (2006). Comparison of nurse, system and quality patient care outcomes in 8-hour and 12-hour shifts. *Medical Care, 44*(12), 1099-1106.

Stone, T., McMillan, M., Hazelton, M., & Clayton, E. H. (2011). Wounding words: Swearing and verbal aggression in an inpatient setting. *Perspectives in Psychiatric Care, 47*, 194-203.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research techniques and procedures for developing Grounded Theory* (2nd ed.). London: Sage Publications.

Striegel-Moore, R. H., Rosselli, F., Perrin, N., DeBar, L., Wilson, G. T., May, A., & Kraemer, H. C. (2009). Gender difference in the prevalence of eating disorder symptoms. *The International Journal of Eating Disorders, 42*(5), 471-474.

Ströhle, A. (2009). Physical activity, exercise, depression and anxiety disorders. *Journal of Neural Transmission, 116*, 777-784.

Strother, E., Lemberg, R., Stanford, S. C., & Turbeville, D. (2012). Eating disorders in men: Un- dergdiagnosed, undertreated, and misunderstood. *Eating disorders, 20*, 346-355.

Stults-Kolehmainen, M. A., & Sinha, R. (2014). The effects of stress on physical activity and exercise. *Sports Medicine, 44*, 81-121.

Sumpter, K. C. (2015). Masculinity and meat consumption: An analysis through the theoretical lens of hegemonic masculinity and alternative masculinity theories: Masculinity and meat consumption. *Sociology Compass, 9*(2), 104-114.

Tada, Y., Kawano, Y., Maeda, I., Yoshizaki, T., Sunami, A., Yokoyama, Y.,… Togo, F. (2014). Association of body mass index with lifestyle and rotating shift work in Japanese female nurses. *Obesity, 22*(12), 2489–2493.

Takahashi, C., Chida, F., Nakamura, H., Akasaka, H., Yagi, J., Koeda, A.,… Sakai, A. (2011). The impact of inpatient suicide on psychiatric nurses and their need for support. *BMC Psychiatry, 11*, 38.

Tobias, C., Ives, J. E., & Garnham, A. P. (2016). Nursing supervision: Challenges and opportunities for success. *Learning Disability Practice, 19*(6), 33-38.

Tomiyama, A. J., Mann, T., & Comer, L. (2009). Triggers of eating in everyday life. *Appetite, 52,* 72-82.

Tonso, M. A., Prematunga, R. K., Norris, S. J., Williams, L., Sands, N., & Elsom, S. J. (2016). Workplace violence in mental health: A Victorian mental health workforce survey. *International Journal of Mental Health Nursing, 25*, 444-451.

Torres, S. J., & Nowson, C. A. (2007). Relationship between stress, eating behavior, and obesity. *Nutrition, 23*, 887-894.

Trier-Bieniek, A. (2012). Framing the telephone interview as a participant-centred tool for qualitative research: a methodological discussion. *Qualitative Research, 12*(6), 630-644.

Trinkoff, A. M., & Storr, C. L. (1998). Work schedule characteristics and substance use in nurses. *American Journal of Industrial Medicine, 34*, 266-271.

Tummers, G. E. R., Janssen, P. P. M., Landeweerd, A., & Houkes, I. (2001). A comparative study of work characteristics and reactions between general and mental health nurses: A multi‐sample analysis. *Journal of Advanced Nursing, 36,* 151-162.

Tuomisto, M., Tuomisto, T., Hetherington, M., & Lappalainen, R. (1998). Reasons for initiation and cessation of eating in obese men and women and the affective consequences of eating in everyday situations. *Appetite, 30*, 211-222.

van der Horst, K., Brunner, T. A., & Siegrist, M. (2010). Ready-meal consumption: associations with weight status and cooking skills. *Public Health Nutrition, 14(2*), 239-245.

van Strien, T., van de Laar, F.A., van Leeuwe, J.F.J., Lucassen, P.L.B.J., van den Hoogen, H.J.M., Rutten, G.E.H.M., & van Weel, C. (2007). The dieting dilemma in patients with newly diagnosed type 2 diabetes: Does dietary restraint predict weight gain 4 years after diagnosis? *Health Psychology, 26*, 105–112.

van't Riet, J., Sijtsema, S.J., Dagevos, H., & De Bruijn, G. (2011). The importance of habits in eating behaviour. An overview and recommendations for future research. *Appetite, 57*, 585-596.

Walsh, A. (2015). Are new mental nurses prepared for practice? *Mental Health Review Journal, 20*(2), 119-130.

Wansink, B. (2004). Environmental factors that increase the food intake and consumption volume of unknowing consumers. *Annual Review of Nutrition, 24*, 455–479.

Wansink, B., Cheney, M. M., & Chan, N. (2003). Exploring comfort food preferences across age and gender. *Physiol Behav, 79*, 739–747.

Wansink, B., Painter, J. E., & Lee, Y. (2006). The office candy dish: Proximity's influence on estimated and actual consumption. *International Journal of Obesity, 30*, 871-875.

Ward, L. (2013). Ready, aim fire! Mental health nurses under siege in acute inpatient facilities. *Issues in Mental Health Nursing, 34*, 281-287.

Watanabe, M., & Yamauchi, K. (2016). Psychosocial factors of overtime work in relation to work-nonwork balance: A multilevel structural equation modeling analysis of nurses working in hospitals. *International Journal of Behavioral Medicine, 23*, 492-500.

Watanabe, Y., Saito, I., Henmi, I., Yoshimura, K., Maruyama, K., Yamauchi, K., Matsuo, T., Kato, T., Tanigawa., T, Kishida, T., & Asada, Y. (2014). Skipping breakfast is correlated with obesity. *Journal of Rural Medicine, 9*(2), 51-58.

Waterhouse, J., & Campbell, I. (2011). Reflexes. Principles and properties. *Anaesthesia & Intensive Care Medicine, 12*(5), 214-219.

Waterhouse, J., Buckley, P., Edwards, B., & Reilly, T. (2003). Measurement of, and some reasons for, differences in eating habits between night and day workers. *Chronobiology International, 20*(6), 1075–1092.

WHO. (1993). *The ICD-10 classification* of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. Geneva: World Health Organization.

WHO. (1997). *Obesity: Preventing and Managing the Global Epidemic: Consultation on Obesity. WHO/NUT/NCD/98.1.* Technical Report Series Number 814. Geneva, Switzerland, 1997. Retrieved 23 August from: 2014http://www.who.int/nutrition/publications/obesity_executive_summary.pdf.

Willig, C. (2013). *Introducing qualitative research in psychology* (3rd ed.). Maidenhead: Open University Press.

Wilson, C., Rouse, L., Rae, S., & Ray, M. K. (2017). Is restraint a 'necessary evil' in mental health care? Mental health inpatients' and staff members' experience of physical restraint. *International Journal of Mental Health Nursing, 26*, 500-512.

Wong, H., Wong, M. C. S., Wong, S. Y. S., & Lee, A. (2010). The association between shift duty and abnormal eating behavior among nurses working in a major hospital: A cross-sectional study. *International Journal of Nursing Studies, 47*, 1021-1027.

Yalom, I. (1980). *Existential psychotherapy*. New York: Basic Books.

Yanchus, N. J., Periard, D., & Osatuke, K. (2017). Further examination of predictors of turnover intention among mental health professionals. *Journal of Psychiatric and Mental Health Nursing, 24*, 41-56.

Yoshinaga, N., Nakamura, Y., Tanoue, H., MacLiam, F., Aoishi, K., & Shiraishi, Y. (2018). Is modified brief assertiveness training for nurses effective? A single‐group study with long‐term follow‐up. *Journal of Nursing Management, 26*, 59-65.

Young, J. E., Klosko, J. S., Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. New York: The Guilford Press.

Zapka, J. M., Lemon, S. C., Magner, R. P. & Hale, J. (2009). Lifestyle behaviours and weight among hospital-based nurses. *Journal of Nursing Management, 17*, 853-860.

Zhu, D., Norman, I. J., & While, A. E. (2014). Nurses' misperceptions of weight status associated with their body weight, demographics and health status. *Public Health Nutrition, 17*(3), 569–578.

Appendices

Appendix 1 – Ethical Approval Letter

Psychology Research Ethics Committee
School of Arts and Social Sciences
City University London
London EC1R 0JD

04 August 2017

Dear Anna-Lize Botha and Katy Scruby

Reference: PSYETH (P/L) 16/17 214

Project title: Mental health nurses' experience of eating: An Interpretative Phenomenological Analysis.

I am writing to confirm that the research proposal detailed above has been granted approval by the City University London Psychology Department Research Ethics Committee.

Period of approval
Approval is valid for a period of three years from the date of this letter. If data collection runs beyond this period you will need to apply for an extension using the Amendments Form.

Project amendments
You will also need to submit an Amendments Form if you want to make any of the following changes to your research:

(a) Recruit a new category of participants
(b) Change, or add to, the research method employed
(c) Collect additional types of data
(d) Change the researchers involved in the project

Adverse events
You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee (anna.ramberg.1@city.ac.uk), in the event of any of the following:

(a) Adverse events
(b) Breaches of confidentiality
(c) Safeguarding issues relating to children and vulnerable adults
(d) Incidents that affect the personal safety of a participant or researcher

Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Should you have any further queries then please do not hesitate to get in touch.

Kind regards

Katy Tapper
Co-Chair
Email: Psychology.ethics@city.ac.uk

Richard Cook
Chair
Email: Psychology.ethics@city.ac.uk

Appendix 2 – Participant Recruitment Advertisement

Department of Psychology
City University London

MENTAL HEALTH NURSES NEEDED FOR RESEARCH ON EATING

Are you a mental health nurse in a full-time position?

Do you work on an inpatient mental health setting?

Would you be willing to talk about your eating?

We are looking to recruit volunteers to take part in a thesis project. You would be asked to participate in a 60-minute semi-structured Skype or telephone interview, talking about your eating.

Your participation would involve *one* session,
which is approximately *70-90* minutes.

For more information about this study, or to take part,
please contact the researcher:

Researcher*: Anna-Lize Botha via e-mail:* [redacted]

Research Supervisor*: Kate Scruby via e-mail:* [redacted]

This study has been reviewed by, and received ethics clearance through the Psychology Research Ethics Committee, City University London.
Ethics Approval Code: PSYETH (P/L) 16/17 214.

If you would like to complain about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee on 020 7040 3040 or via email: Anna.Ramberg.1@city.ac.uk

Appendix 3 – Participant Information Sheet

Title of study: Mental health nurses' experience of eating: An Interpretative Phenomenological Analysis

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

The purpose is to give voice to mental health nurses' experience of eating. The aim is to elicit rich in-depth accounts of the lived experiences previously only explored through questionnaires. This information could potentially inform organisational policies to promote healthy living amongst mental health nurses.

This study will be part of the thesis for a Professional Doctorate in Counselling Psychology programme.

Why have I been invited?

Inclusion criteria for the thesis project are:

1) Mental Health Nurse (full-time)
2) Experience of working at an inpatient mental health setting

Do I have to take part?

Participation in the project is voluntary, and you can choose not to participate. You can withdraw at any stage of the project without being penalised or disadvantaged in any way. You have the right to avoid answering questions which are felt to be too personal or intrusive.

It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. Participants will be given at least 24 hours to read this information before consenting to participate. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen if I take part?

Participants are only required to meet the researcher once, via telephone or Skype. Prior to the interview a consent form and a personal information questionnaire will be sent via e-mail to be completed and signed. At the telephone or Skype meeting, additional participant questions will be answered before the interview. A semi-structured interview will be held for 60 minutes. A debrief session will be provided, therefore the whole meeting will last between 70-90 minutes. The audio recordings of the interviews will be transcribed. This data will be used to make sense of your experience through psychological knowledge.

What do I have to do?

You will be asked to fill in one questionnaire as outlined above. You will then be asked some pre-prepared questions around your eating, and at times some questions to expand on your answers.

What are the possible disadvantages and risks of taking part?

The disadvantages and risks of taking part in this research are considered to be minimal. Despite this, taking part in the research may result in you feeling distressed during or following your

participation (e.g. more tearful than usual, nervous etc.). You are therefore invited to contact the researcher with any concerns, so that you can be sign posted to appropriate services, or, you can contact one of the following organisations directly; your GP which has the means to refer you on to supportive services or Mind (www.mind.org.uk) or the Samaritans (www.samaritans.org): call free on any phone, at any time on 116 123.

What are the possible benefits of taking part?
This study will give the opportunity for mental health nurses to voice a more holistic lived experience of eating. This study will also contribute to knowledge within this specific occupational setting and therefore hope to inform occupational policies.

Will my taking part in the study be kept confidential?
All data collected during the research will be kept confidential in accordance with the Data Protection Act (1998) and the researcher will abide by the code of ethics outlined by the British Psychological Society. During the study, data will be kept on the University computer system, and a personal laptop computer; access to electronic files will be available by password only (encrypted). All data will be electronically transported by an encrypted memory stick. Data will also be stored on an external hard drive, held securely in a locked filing cabinet. Only the chief investigator will have access to the data.

There are limitations to confidentially, which are as follows; in the event of you reporting violence, abuse, self-inflicted harm, harm to others, criminal activity, the appropriate services will be notified.

If concerns are raised regarding ability to perform duties as a mental health nurse (i.e. impact on patient care etc.) the following action will be taken; a) participants will be advised to contact occupational health only if the participants themselves raise concerns about their ability to perform their duties, (b) the researcher only to report an issue if there is a danger that the participant may harm either themselves or others.

What will happen when the research study stops?
Personal information (i.e. contact information) will be destroyed as soon as it is no longer needed. All research data collected (consent form, interview audio and transcription) will be held securely in a locked filing cabinet. This data will be stored electronically on an external hard drive and to be destroyed as soon as it is no longer needed (maximum 5 years); access to electronic files will be available by password only (encrypted). Only the chief investigator will have access to the data.

What will happen to the results of the research study?
The results from the interviews will be analysed, written up as part of a thesis project undertaken by the researcher and possibly published in a peer-reviewed journal. All information and any quotes taken from interviews will be strictly anonymous and will not allow for you to be identified. You will not be contacted again after participating in this research.

If you wish to see the results or findings of this research as a whole, please let the researcher know either at the interview or via email.

What will happen if I don't want to carry on with the study?
You are free to withdraw from the study without an explanation or penalty at any time.

What if there is a problem?

If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: Mental health nurses' experience of eating: An Interpretative Phenomenological Analysis.

You could also write to the Secretary at:
Anna Ramberg
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London
EC1V 0HB
Email: Anna.Ramberg.1@city.ac.uk

City University London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Who has reviewed the study?
This study has been approved by: City University London Psychology Research Ethics Committee. Ethics code: PSYETH (P/L) 16/17 214.

Further information and contact details
Researcher Contact details: [redacted]
Research Supervisor Contact details: [redacted]

Thank you for taking the time to read this information sheet.

Appendix 4 – Consent Form

CITY UNIVERSITY LONDON

Title of Study: Mental health nurses' experience of eating: An Interpretative Phenomenological Analysis

Ethics approval code: PSYETH (P/L) 16/17 214

Please initial box

1.	I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will involve • completing a questionnaire asking me about my personal information • being interviewed by the researcher • allowing the interview to be audiotaped	
2.	This information will be held and processed for the following purpose(s): t*o answer the research questions* I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation. AND I understand that data will electronically stored, data will be kept in a locked filing cabinet on an external hard drive, access to computer files will be available by password only, data will be transported by an encrypted memory stick, and data identifiers will be kept in a separate password protected electronic file. This will be done to protect my identity from being made public. AND I understand that confidentiality cannot be guaranteed for information which I might disclose in the interview with regards to; disclosing violence, abuse, self-inflicted harm, harm to others, and criminal activity.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

_____ _____ _____

Name of Participant Signature Date

Name of Researcher	Signature	Date

When completed, 1 copy for participant; 1 copy for researcher file.

Note to researcher: to ensure anonymity, consent forms should NOT include participant numbers and should be stored separately from data.

Appendix 5 – Personal Information Questionnaire

Title of study: Mental health nurses' experience of eating: An Interpretative Phenomenological Analysis

Ethics Approval code: PSYETH (P/L) 16/17 214

DATE:

1. Name _____

2. Date of Birth_____

3. Current Job Title_____

4. What is your ethnic background?

_____
_____

Contact details - (Only if you wish to be contacted by the researcher)

Mobile no:_____

Telephone no:_____

Email address:_____

Appendix 6 – Debrief Information Sheet

Mental health nurses' experience of eating: An Interpretative Phenomenological Analysis

DEBRIEF INFORMATION

Thank you for taking part in this study. Now that it is finished we would like to tell you a bit more about it.

The Department of Health (2011) reported 30% of nurses indicated occupational stress and 31% were thinking of leaving the profession. Studies reported mental health nurses experience high work related stress, additionally, that occupational stress has negative consequences on mental and physical well-being of employees.

Studies have cautiously concluded that there may be a causal link between occupational stress and emotional eating.

This study aims to capture mental health nurses' holistic lived experience of eating.

Specific studies relating to the nursing profession have reported eating behaviour to increase when nurses are, stressed, bored or upset. Furthermore, studies have reported nurses most commonly used eating as a stress reduction method. It is therefore hypothesised this eating behaviour could exacerbate weight gain.

This study would provide additional knowledge only previously explored through surveys and therefore could potentially identify recommendations for organisational policies.

The disadvantages and risks of taking part in this research are considered to be minimal. Despite this, taking part in the research may result in you feeling distressed during or following your participation (e.g. more tearful than usual, nervous etc.). You are therefore invited to contact the researcher with any concerns, so that you can be sign posted to appropriate services, or, you can contact one of the following organisations directly; your GP which has the means to refer you on to supportive services or Mind (www.mind.org.uk) or the Samaritans (www.samaritans.org): call free on any phone, at any time on 116 123.

We hope you found the study interesting. If you have any other questions please do not hesitate to ask.

Researcher Contact details: [redacted]

Research Supervisor Contact details: [redacted]

Ethics approval code: PSYETH (P/L) 16/17 214

Appendix 7 – Interview Schedule

Mental health nurses' experience of eating: An Interpretive Phenomenological Analysis
Ethics approval code: PSYETH (P/L) 16/17 214

Interview schedule

Interest area

Eating

Warm-up questions

1. What attracted you to nursing in the first place?

2. Can you tell me what you do day-to-day as a Nurse?

Main Questions

3. How would you describe your relationship to food?

Prompts

Has it always been like this?

How do you feel about this?

4. Can you describe, in as much detail as you can, what your eating is like?

Prompts

Can you describe what your eating is like at work? And at home?

Can you give me an example?

How do you feel when you have eaten differently to how you would like to?

5. Can you tell me how you started eating this way?

Prompts

Can you describe your first memory of eating this way?

What was it like?

Prompts

Why do you think these times happen?

Can you give me examples of these?

How did you feel after eating on that occasion?

6. What do you think others think about your eating?

Prompts

Can you give me examples of this?

Can you tell me a bit more about that?

What do you mean by ....?

7. How do you think your life would be different if you did not eat in this way you have described?

Prompts

Can you tell me a bit more about that?

What do you mean by ....?

8. Is there anything that we have not talked about that you think is important, or you would like to talk about before we finish?

Appendix 8: Sample transcript

	453	**I: If you could cast your mind back, can you tell me what eating would be like on a night shift? (25.58)**	
	454		
	455		
	456	So, I... for me personally on a night shift I would try not to break out of a routine too much. Um, so I would often, so obviously with working night shifts your whole pattern is reversed, so you are sleeping in the day and you are awake at night. But I would still try to keep my meals relatively similar, so I would have my evening meal before going to the night shift and I would have my breakfast typically when I came home or kind of a couple of hours before my shift ending. Um... but I would say nightshifts are notoriously terrible for snacking. There would always be someone on the nightshift that will bring snacks in, whether it was me or another colleague um... before you know it you have grazed your way through a packet of crisps or there's a chocolate bar and um obviously at two, three in the morning you are just grazing and to be really honest we would be doing it completely unaware.	Reversed pattern *Terrible – meaning bad or unhealthy habit?* "Someone always" - commonplace, a norm? Grazing because it is there? Something to do? Bored? Unaware - Unmindful eating.
	457		
	458		
	459		
	460		
	461		
	462		
	463		
	464		
Snacking (night shifts)	465		
	466		
	467		
	468		
Eating unaware (night shift)	469		
	470		
	471		
	472		
	473		
	474	**I: You talked about doing it unaware, can you give me an example if any come to mind when you realised what you were doing perhaps at that time? (27.14)**	
	475		
	476		
	477		
	478		
Eating when visually stimulated? (night shift)	479	Um... so I would say kind of, walking past and picking things up um.. and then I would say moments of realisation when you walk past the final time and actually there is nothing there. Um... so that's that's quite a realisation.	Eating when visually stimulated (trigger)?
	480		
	481		
	482		
	483		
	484		

Appendix 9: Table of super-ordinate themes for Gregory

Participant Name: Gregory	Page, Line	Verbatim extracts
Super-ordinate Theme 1: Job demands "Going above and beyond"		
Subtheme 1: Eating dependent on time - "if I got time"		
a. Frequently skip breakfast	5,138-142	Quite frequently I would skip breakfast
b. No routine in eating pattern	5,138-142	I wouldn't say I would sit down in a kind of routine fashion to have my meals. It is kind of, as and when I can fit them into the day.
c. No breakfast due to lack of time	5,156-161	I didn't have any cereal bars or anything today, just because I didn't get time.
d. Reasons for skipping meals	5,173-183	There may be a clinical situation on the ward which I am responding to, sometimes [..] people often will schedule in meetings during kind of your regular lunch hours
Subtheme 2: Eating at work - "Quick wind"		
a. "Quick wind"	12,415-424	So at work I would, I'm very much within quick wind
b. Food at work – quick preparation	13,431-436	I haven't got to prepare anything I don't really have to give it much time um..
c. Sitting at desk, dual-tasking	13,441-445	Nine times out of ten I will sit at my desk.. continue working whilst I am eating.
d. no dedicated time out	13,441-445	So not a dedicated time out
Subtheme 3: An acceptance – "part and parcel of the job"		
a. Part and parcel o the job	6,190-198	Probably part and parcel of the nature of the job really. Um.. So I wouldn't say that it makes me feel a particular way to miss lunch or even breakfast.
b. Surrender to environment?	6,190-198	It is something that I.. and I know it is very unhealthy, but it is something I am quite used to doing.
c. An acceptance	12,402-409	I think it is something we will often accept (inhales)
d. Pressures (external & internal) to reach professional standard	12,402-409	We are used to kind of going above and beyond what are expected of us to get our jobs done to the standard we are happy with.
e. Neglecting self	19,627-630	As nurses we are often preaching to our patients about the importance of a healthy diet and I think it is something that we as individuals often neglect for ourselves.
Super-ordinate Theme 2 [Job role] "creep in to personal time"		
Subtheme 1: "Free up time"		
a. Reduce time spent on food	7,242-249	With work being very busy I try to free up my time as much as possible [..] choosing very convenient, always pre-prepared meals, I wouldn't say I went for the best options
b. Time saving - "Quick wind"	7,232-237	Taking short cuts in meal preparation
c. Convenience in preparation	10.341-347	If I was going to make a pasta dish with [inaudible] I would use sauce from a jar [..] very convenient and I would probably buy fresh pasta to go within that.
d. Convenient foods	10,340-341	I was on a much richer diet, and there was much more convenience to it
e. Unhealthy	7,232-237	Unhealthy in that sense that the food I ate prior to my diet was much more processed
f. Choosing enjoyment over health?	8,245-249	I... was [not] considerate of picking healthy options, so [..] very convenient, always pre-prepared meals, [..] went for something that was going to taste amazing but was terrible for me
f. Unhealthy relationship with food (prior diet change)	4,128-130	Um, prior to going on a diet I wouldn't say I had the most healthy relationship with food.
Subtheme 2: work-life balance - "meal times ... you can claim back some um.. time"		
a. Claim back time	18,610-613	Um.. so as I said it is social so tend to be much more conversation over meal times. Um, and I guess that is an area which you can claim back um.. some time.
b. Eating – sociable activity	18,593-595	Um, so I am a sociable creature [..] I enjoy my personal time, so I enjoy sitting down with friends, family, partner to have a nice meal.
c. Job "creep in to personal time"	12,391-394	With the nature of my job being quite demanding I would say that that time, can often all too easily creep in to my personal time
d. Difficulty maintaining work-personal time boundary	12,394-395	the personal time that I do have and I do manage to protect
Subtheme 3: Nightshift - "your time is different from everyone else's"		
a. your time is different from everyone else's	17,597-599	And like I said with nightshift that aspect of going out somewhat, because your times are very different from everyone else's. With day shift it is easier.
b. "with night shift, it tends to throw everything out"	17,567-570	with nights shift, it tends to throw everything out, so that kind of, you are trying to fit in with home life still and having meals at home with family, partner um..
c. Struggle to hold routine	17,570-572	trying to hold that routine, but it's much more difficult to do that on a night shift.
Super-ordinate Theme 3		

Eating out of the ordinary: [what] "...we wouldn't typically eat is what we would kind of go for on nights"		
Subtheme 1: Preference for sugary foods during nights?		
a. "Sugary stuff"	15,492-494	I would say the sugary stuff, that we wouldn't typically eat is what we would kind of go for on nights
b. Night shifts – snack food	15,488-489	Um,,, I mean I guess kind of eating on night shifts does tend to be more,,, rubbish.
c. Snacking (night shifts) - "not typically things we will have; the snacks"	15,489-492	Um,,, that kind of I wouldn't eat generally and also my colleagues around me, they're not typically things we will have; the snacks, chocolate bars, crisps
d. Night shift - "Sugar crash in the morning"	15,495-497	You would definitely kind of experience kind of a sugar crash in the morning
Subtheme 2: Emotion and eating (self and others)		
a. Night shift – eating when bored	15,511-516	In the moment I guess boredom took in the night shift as generally it is the slowest [,,,] very easy to fall into that grazing habit.
b. Eating when visually stimulated	14,479-480	Um,,, so I would say kind of, walking past and picking things up
c. Enjoyable for others	16,547-549	my eating is probably quite um.. enjoyable for others because I would often buy for other people around me as well
d. Shared experience	16,550-553	I will bring some bits in and they may well bring some bits in. Um,,, people tended, kind of a shared, shared experience.
Subtheme 3: Mindless eating (night shift)		
a. Moments of realisation	14,480-483	um.. and then I would say moments of realisation when you walk past the final time and actually there is nothing there. Um,,, so that's that's quite a realisation
b. eating unaware	14,468-472	before you know it you have grazed your way through a packet of crisps or there's a chocolate bar and um obviously at two, three in the morning you are just grazing [..] completely unaware."
Subtheme 4: Consequences of skipping meals		
a.Portion size	7,219-221	So,,, I definitely, kind of portion size wise, I would say that my next meal would be bigger than if I've eaten both meals during the day.
b. Carbohydrates	7,221-223	Um,,, and I would say I tend to go more in the direction of carbs if I skipped meals during the day."
c. Skipping meal - realisation	6,204	So it is quite often on the drive home from work.
Super-ordinate Theme 4 Change in diet: a "conscious effort"		
***Subtheme 1: "I've made a decision"**	10,326-329	I've made a decision to go on the diet to moderate [,,,] but also to encourage me to be more proactive about taking a routine to my day
Overweight	10,323-324	So I... am overweight. I needed to make a change to my diet
Change in diet – health?	16,537-541	as I got older [..] obviously within the nursing profession I am more aware of the health risks that that carries and it is something that is avoidable so if I can avoid it I am going to
Age & Health – trigger for change?	16,522-525	I think I mean I am in my 20s and I would say that I have typically carried more weight than I should have, and I would say that that was really the defining moment in this
Weight accepted - "used to"	16,534-536	I mean it is something that I am used to, something that, as I said I kind have always carried more weight around than I should have.
Subtheme 2: Self as implement of change		
a. Self as implement of change	16,526	it is only me that can change that
b. Proactive in change	16,554-557	I'm much more prepared with my meals [,,,] I don't have bars of chocolate, I don't have an excessive amount of sweet stuff.
c. Choosing healthier options (now)	11,353-356	So I would say those are the conscious differences now where I will opt for the leaner options and I will prepare meals from scratch to be fully aware of what exactly is in there.
d. Meals apposed to snacking	17,557-560	And my diet is much more simpler like I said, tending to [inaudible], vegetables and lean meat, and meals as apposed to snacking.
e. Avoiding snacks	16,555-556	I also tend to avoid the snacks that other people enjoy
***Subtheme 3: Cooking – conscious effort**		
a. Cooking – conscious effort	11,376-378	I enjoy cooking, but as I said it is something I have to make a conscious effort to do,,, I have to allocate the time for it.
b. Cooking is an activity	11,367-369	I have taken the time to prepare it and cook my meal um from scratch
c. Cooking is rewarding	11,366-367	So,,, I enjoy my food much more now and I probably appreciate it much more
d. Making time to eat	11,358-359	I do make much more of an effort to make time in the day to sit down and eat my meals
e. Healthy ingredients - Less guilt?	11,356-360	And I would say kinda going from my choices before to choices now, I actually enjoy my food much more

Appendix 10: Table of group super-ordinate themes

1 "Part and parcel of the nature of the job": External locus of control	**Page, Line**
a. "The pressure of work": Mindless eating	
Daniel "You can eat but it is very sort of like rush, you know, you don't yeah."	**9, 298-9**
Gregory "So not a dedicated time out which is again why I say it is all a quick wind at work"	**13, 443-5**
Adam "So for me it would have to be eating a lot faster"	**14, 486-7**
Fred "get stuff done and eat. But generally it was kind of like, 'I've got to go and do something else'"	**9, 285-7**
Ben "watch what the patients are doing, make sure they are not having arguments with knives in their hands."	**11, 398-9**
Colin "I'll be eating but um.. um.. I am eating and deescalating everybody at the same time."	**11, 355-6**
Edward "one of the weirdest things uh.. would be when we would eat on the wards with the patients [...] it was quite a high risk situation [...] you have to monitor all the guys"	**6, 182-186**
b. "Everything else fell by the wayside": Involuntary food restriction	
Daniel "sometimes you forget, you don't have a break and you forget to eat and you know um.."	**10, 317-8**
Gregory "Quite frequently I would skip breakfast, I will eat lunch either if I got time to buy it or I brought something in"	**4, 138-140**
Adam "You are never guaranteed to be able to sit down at a particular time and have your meal. So it is a very unpredictable day, sometimes you may go without eating if it is very busy"	**18, 612-5**
Colin "Yeah, just 'cause you are too busy at work. Sometimes you don't get the chance to do it... to eat."	**7, 223-4**
Fred "It will be everyday, it's much much much rarer that I would sit down and eat. It's a norm for me to not eat at work."	**10, 328-30**
Edward "It might be that you just didn't get round to it basically, because it is too busy and you couldn't find the time to do so."	**10, 333-5**
Ben "So yeah when I am on days I normally lose weight as well, 'cause I can go the whole shift without eating."	**7, 211-3**
c. "Eating is not your priority" Subjugation of needs	
Daniel "I think [exhaling loudly] I think food is, eating is not your priority [...] hindsight, I think I really should be more [inhaling loudly] should be looking after myself"	**9, 306-9**
Adam "pressure of work, it pushes you to to adapt some different eating habits"	**14, 485-6**
Gregory "I think as nurses we are often preaching to our patients about the importance of a healthy diet and I think it is something that we as individuals often neglect for ourselves."	**19, 627-30**
Colin "I've got some fat isn't it? So you know what I mean, you can go 12	**12, 413-5**

hours without having any food, which is better"	
Fred "I would just see sit down as a waste, sit down lunch would be a waste of time."	**9, 319**
Edward "unless for whatever reason I missed out on the evening meal if the ward was busy"	**9, 302-4**
Ben "And it is the same with meals at work. I hardly ever get to have them so I sort of don't worry about it".	**10, 317-9**
2 "Try to sort of compensate": Satisfying physical and emotional hunger	
a. "Hunger can be frustrating": Physical hunger at work	
Daniel "And then that's when you feel like you are tired or you know, you are really hungry, you know, you weak or you feel like your blood sugars gone low."	**11, 361-4**
Adam "hunger is a destruction anyway. If you are hungry you would not be able to focus on what you need to focus on"	**18, 593-5**
Colin "I mean I can go without, when you get to the point you can't go without, you know what I mean, I am really f*cking hungry I will have to make some food."	**12, 402-4**
Ben "Ah, a lot of the time, that's just tough!"	**20, 674**
Edward **Fred** **Gregory**	
b. "Eating more than I should have": Over-eating at home	
Daniel "A lot, you know, try to sort of compensate you know during the day which you did not even or you don't, you didn't eat properly"	**12, 408-11**
Gregory "So.. I definitely, kind of portion size wise, I would say that my next meal would be bigger than if I've eaten both meals during the day."	**7, 219-21**
Adam "I was at home and I was really hungry. And then I ended up eating more than I should have."	**7, 225-7**
Colin "aw f*ck, look how much I've been eating"	**21, 705**
Fred "I will just constantly feel hungry just constantly eat uh... and yeah just carry on."	**15, 500-1**
Edward "Um outside of work um as I say, I, I would eat lots and quite harshly"	**6, 192-3**
Ben	
c. "Hang on, what am I doing?": Triggers of over-eating	
Gregory "I guess boredom took in the night shift [...] it is very easy to fall into that grazing habit."	**15, 511-6**
Adam "If I were to just sit down, as I am doing now after a long day um,	**4, 133-5**

just watch TV. But one way I find relaxing is say, having a good meal. You know?"	
Colin "Yeah yeah when you get tired innit, you know what I mean, when you when you have some sugar in you, it makes you feel a little, I dunno.."	**14, 479-81**
Edward "I suppose I don't have the stresses I did when I was doing nursing I probably still say I eat to a degree comfort eat when I am feeling down but not in the same ways."	**11, 355-8**
Fred "so if I get up and I got nothing planned and there is nothing in the diary as such [...] catch up with the old TV series [...] have a large breakfast.. um.. probably fried.. uh.. and then I will probably just keep on eating all day.	**15, 493-8**
Daniel	
Ben	
3 "So I am getting healthier. Just not healthy": The struggle to live a healthy lifestyle	
a. "You want to be healthy don't you?": Health concern	
Gregory "as I got older I have become more aware, obviously within the nursing profession I am more aware of the health risks that that carries"	**16, 537-40**
Colin "I think probably because she was pregnant, I was thinking more about health for myself, looking after myself."	**6, 188-90**
Fred "I am more concerned now, [...] about health way or being body consciousness, weight than I was, or ever have been before."	**12, 387-90**
Edward "it's when I split up with my wife I had a health kick then as well, and that's when I gave up coke and what not"	**15, 504-8**
Ben "I am quite aware it is unhealthy... but err, uff, I am trying to.. when I do sort of eat healthier [laughs] and exercise [...] I went through a phase of six months doing that."	**5, 171-4**
Daniel	
Adam	
b. "I have a window of opportunity to eat": The struggle of healthy eating	
Daniel "sometimes you don't have time especially in the mornings you don't have time to prepare for lunch or for your packed lunch"	**5, 145-7**
Gregory "with work being very busy I try to free up my time as much as possible when I am not at work, so I would say it is bit tied into that. [...] choosing very convenient, always pre-prepared meals"	**7, 242-7**
Adam "I never have breakfast, um I never have time for breakfast, so I don't do breakfast."	**5, 164-5**
Fred "But um.. food, bingeing is more the fact that I don't really have a healthy lifestyle uh and therefore, and the fact that I sort of I don't know always worked shifts or um.. never really had enough time to sort of eat three square meals.."	**8, 258-62**
Ben "I, I don't spend any time preparing food [...] I am quite happy to eat a pot noodle sweet and sour"	**16, 543-50**
Colin "spend more time cooking now than I did when I wasn't vegetarian"	**19, 635-6**

Edward **c.** "I just have to find the balance": The difficulty in establishing self-care	
Daniel "So that's I mean, I think it is just me, I think it is just inexperience really. I just have to find the balance how to, how to look after myself and be focused on the job."	**10, 321-4**
Gregory "I enjoy cooking, but as I said it is something I have to make a conscious effort to do.. I have to allocate the time for it"	**11, 376-8**
Adam "I've been doing really well going to the gym consistently, but lately I have felt so drained I have stopped doing you know, things that I enjoy."	**4, 112-4**
Colin "I just, maybe when I was younger I was more... uhh.. you know, into exercise and stuff as I get bit older.. Uhh.. It's.. become lazy... Um.. I had injuries, you make excuses for yourself don't you.. yeah."	**17, 571-4**
Ben "got type 2 diabetes, don't eat rice' and things like that, it took a lot of things away [...] I mean I am not meant to be eating bread but you know, you can't give everything up."	**8, 273-6**
Fred **Edward**	

Appendix 11: Table of frequency of occurrence of super-ordinate themes across participants

	Dan	Greg	Adam	Colin	Fred	Ed	Ben
Master Theme 1 *"Part and parcel of the nature of the job": External locus of control*							
a. "The pressure of work": Mindless eating	X	X	X	X	X	(X)	(X)
b. "Everything else fell by the wayside": Involuntary food restriction	X	X	X	X	(X)	X	X
c. "Eating is not your priority": Subjugation of needs	X	X	X	X	X	(X)	X
Master Theme 2 *"Try to sort of compensate": Satisfying physical and emotional hunger*							
a. "Hunger can be frustrating": Physical hunger at work	X		X	(X)			X
b. "Eating more than I should have": Over-eating at home	X	X	X	X	X	X	
c. "Hang on, what am I doing?": Triggers of over-eating		X	X	X	X	X	
Master theme 3 *"So I am getting healthier. Just not healthy": The struggle to live a healthy lifestyle*							
a. "You want to be healthy don't you?": Health concern		X		X	X	X	X
b. "I have a window of opportunity to eat": The struggle of healthy eating	X	X	X	(X)	X		(X)
c. "I just have to find the balance": The difficulty in establishing self-care	X	X	X	X			(X)

Key: (X) Only barely mentioned, X Present

City, University of London
Northampton Square
London
EC1V 0HB
United Kingdom
T +44 (0)20 7040 5060

THE FOLLOWING PARTS OF THIS THESIS HAVE BEEN REDACTED FOR DATA PROTECTION REASONS:

Section C: Professional case study

THE FOLLOWING PARTS OF THIS THESIS HAVE BEEN REDACTED FOR COPYRIGHT REASONS:

Section D: Publishable Article