A qualitative analysis of aspects of treatment that adolescents with anorexia nervosa identify as helpful

Shannon Zaitsoff\textsuperscript{a,b}, Rachelle Pullmer\textsuperscript{a,*,} Rosanne Menna\textsuperscript{b}, Josie Geller\textsuperscript{c,d}

\textsuperscript{a} Department of Psychology, Simon Fraser University, Burnaby, British Columbia, Canada
\textsuperscript{b} Department of Psychology, University of Windsor, Ontario, Canada
\textsuperscript{c} Eating Disorders Program, Saint Paul's Hospital, Vancouver, British Columbia, Canada
\textsuperscript{d} Department of Psychology, University of British Columbia, British Columbia, Canada

\textbf{A R T I C L E  I N F O}

Article history:
Received 5 December 2015
Received in revised form 2 February 2016
Accepted 19 February 2016
Available online 21 February 2016

Keywords:
Anorexia nervosa
Adolescents
Treatment
Alliance

\textbf{A B S T R A C T}

This study aimed to identify aspects of treatment that adolescents with anorexia nervosa (AN) believe are helpful or unhelpful. Adolescent females receiving treatment for AN or subthreshold AN (n = 21) were prompted during semi-structured interviews to generate responses to open-ended questions on what they felt would be most helpful or unhelpful in treating adolescents with eating disorders. Eight codes were developed and the two most frequently endorsed categories were (1) Alliance, where the therapist demonstrates clinical expertise and also expresses interest in the patient (n = 21, 100.0%), and (2) Client Involvement in treatment (n = 16, 76.2%). These two top two categories were shared by participants with AN versus subthreshold AN and participants with high versus low readiness to change their dietary restriction behaviours. Development of the coding scheme and sample participant responses will be discussed. The integration of identified factors into empirically supported treatments for adolescent AN, such as Family-based Treatment, will be considered. This study provides initial information regarding aspects of treatment that adolescents identify as most helpful or unhelpful in their treatment.

\section{1. Introduction}

Anorexia nervosa (AN) significantly affects adolescents' social, emotional, cognitive, and physiological developmental processes in a detrimental manner (Loeb et al., 2011; Quine, 2012). Although various medical complications associated with AN may improve with recovery, potentially irreversible sequelae pose a serious threat to adolescents' current and future health status (Loeb et al., 2011). Given that the onset of AN typically occurs in adolescence, early intervention is crucial.

Anorexia nervosa is notoriously difficult to treat due to the egosyntonic nature of the disease. Consequently, adolescents with AN are commonly referred to treatment against their own will (Vitousek et al., 1998). Over the past few years, significant progress has been made in developing and testing psychotherapeutic treatments in adolescents with eating disorders. Family-based treatment (FBT), specifically the Maudsley approach, is currently considered to be the first-line therapy for adolescent AN (Lock, 2010; Sperry et al., 2009; Rutherford and Couturier, 2007).

However, recent research indicates that FBT is not as effective in routine clinical care settings for youth with lower initial body weights as it is in randomized controlled trials (Accurso et al., 2015). Notably, access to FBT is somewhat limited and many adolescents with AN receive individual therapy (Couturier et al., 2013a; Von Ranson et al., 2013). It is therefore imperative that further research is conducted to ultimately improve therapeutic engagement as well as the efficacy of psychotherapeutic interventions that are commonly used in clinical settings (Hay, 2013; Quine, 2012; Sperry et al., 2009).

Increasing our understanding of adolescent patient views towards eating disorder treatment may improve therapeutic engagement and perhaps overall treatment outcomes (Westwood and Kendal, 2012; Bell, 2003). Westwood and Kendal (2012) conducted a systematic review, and identified 11 studies that assessed adolescent patient views towards the treatment of AN. Altogether, their findings underscore the importance of the therapeutic alliance and the role that the clients' need for control plays in producing tension between treatment and what the client desires. However, several of these studies focused on the perspectives of inpatient adolescents with AN, and none of the studies specifically inquired what aspects of treatment adolescents find helpful, or importantly, unhelpful.

* Correspondence to: Weight and Eating Laboratory, Simon Fraser University, RCB 5305, 8888 University Drive, Burnaby, BC V5A 1S6, Canada.
E-mail address: rpullmer@sfu.ca (R. Pullmer).

http://dx.doi.org/10.1016/j.psychres.2016.02.045
0165-1781/© 2016 Elsevier Ireland Ltd. All rights reserved.
Although research exist on perceptions of treatment quality and helpful therapist characteristics in adults with eating disorders (de la Rie et al., 2008; Gulliksen et al., 2012), research on adolescent perspectives is limited (Westwood and Kendal, 2012).

To ultimately engage adolescents with AN in treatment and enhance available interventions, it is imperative that researchers and clinicians have a clear understanding of aspects of treatment that these adolescents believe are helpful or unhelpful. Therefore, the primary purpose of this study was to identify aspects of therapeutic interventions that adolescents with AN and subthreshold AN perceive to be related to the overall effectiveness of treatment. Specifically, this study employed semi-structured interviews to determine helpful and unhelpful components of eating disorder treatment. Additionally, given that adolescents with AN vary on readiness to change their dietary restriction behaviours (Geller et al., 2001), this study also examined whether identification of helpful and unhelpful aspects of treatment differed amongst adolescents with high versus low readiness to change.

2. Methods

2.1. Participants

Twenty-one adolescent females ($M_{\text{age}} = 16.30$, $SD = 1.30$) under the age of 19-years with a current Diagnostic and Statistic Manual-IV-TR (DSM-IV-TR; American Psychiatric Association, 2000) diagnosis for AN ($n = 15$, 71.4%) or subthreshold AN ($n = 6$, 28.6%) participated in this study. Given that the majority of adolescents presenting at eating disorder programs are female, males were excluded. To maximize variability in experiences in therapy, participants were at various stages of treatment (i.e., intake assessment, active treatment in an inpatient or outpatient program, and follow-up treatment). Participants were recruited from four Canadian treatment centers, including: (1) British Columbia Children’s Hospital (BCCH; $n = 7$, 33.3%) in Vancouver, British Columbia (BC), (2) North Delta Mental Health center (NDMH; $n = 2$, 9.5%) in Surrey, BC, (3) Alberta Children’s Hospital (ACH; $n = 9$, 42.9%) in Calgary, Alberta, and (4) the Bulimia and Anorexia Nervosa Association (BANA; $n = 3$, 14.3%) in Windsor, Ontario.

The mean body mass index (BMI) for the study sample was 17.86 ($SD = 1.66$). The mean socioeconomic status according to the Hollingshead (1975) rating system was 1.85 ($SD = .90$), indicating middle to upper socioeconomic status. Information on participant’s ethnicity, diagnostic classification, and treatment experiences at the time of measurement are displayed in Table 1.

2.2. Procedure

Ethics approval for this study was obtained from the University of Windsor’s Research Ethics Board, and the four aforementioned treatment centers. The study procedures are outlined below according to the consolidated criteria for reporting qualitative research (COREQ; Tong et al., 2007). Care providers at eating disorder treatment programs informed their patients about the study. If patients indicated an interest in participating, they were contacted by a research assistant to arrange a meeting time. Patients and their parents were encouraged to discuss the study before deciding whether or not to participate. It was stressed that their decision would not affect their on-going treatment and that they could withdraw from the study at any stage without explanation. Parental and adolescent consent was obtained for all participants under the age of 18, and adolescent consent was obtained for all 18-year-old participants.

After agreeing to participate, adolescents read vignettes as part of another study examining their perceptions toward motivational and directive interventions for eating disorders. All participants then completed a demographic questionnaire, the Readiness and Motivation Interview (Geller and Drab, 1999), and were asked two open-ended questions: “Overall, what kinds of things could a therapist say or do that would be helpful in treating adolescents with eating disorders?” and “Overall, what kinds of things could a therapist say or do that would be unhelpful in treating adolescents with eating disorders?”. Completion of the questionnaires and interviews took approximately two hours. The interviews were conducted on an individual basis by two female researchers at the facility where adolescents received their treatment, and were audio taped and transcribed to allow for coding of responses to the open-ended questions. Both interviewers (S.Z. and M.B.) had bachelor degrees in Psychology, and one interviewer (S.Z.) was completing her Master’s in clinical psychology at the time of the study. Members of the research team were not directly involved in the treatment of any of the participants.

2.2.1. Interview guide and development of a coding scheme

Participants were prompted during the audio taped interviews to generate as many responses as possible to the two open-ended questions on helpful or unhelpful aspects of eating disorder treatment. The interviewers made summary and rephrasing responses on helpful or unhelpful aspects of treatment to ensure understanding of the participants’ responses. Before asking the second open-ended question, interviewers asked participants the following question: “Is there anything else that a therapist say or do that would be helpful [or unhelpful] in treating adolescents with eating disorders?” The interviewers repeated the procedure of asking the open-ended question, clarifying participants’ answers, and then asking whether participants had any additional responses until they indicated that they did not.

A coding scheme was developed by S.Z. and R.M. using the transcripts of a random sample of responses ($n = 5$). Responses to each question were grouped thematically into categories. The raters discussed each of the categories they had developed, and decided on a final list of categories along with their defining features to use for coding the two open-ended questions. Participant’s responses were coded and each category was rated as present or absent.

To assess the reliability of the coding scheme, ten transcripts
were randomly selected from a larger transdiagnostic eating disorder sample (n=36) and were coded independently by two raters (S.Z. and R.M.) using the coding scheme as part of independent research questions (please refer to Zaitsoff et al. (2015) for a full description of the larger sample). Discrepancies were discussed, and when necessary, categories were collapsed or additional rules for deciding between categories were added to the coding instructions. Prior to coding, a research assistant reviewed the coding scheme and discussed the categories (including examples) with the primary researcher (S.Z.). The primary researcher then coded the remainder of the open-ended responses, and the research assistant coded a random sample (n=5) of these responses to assess the reliability of the coding system. The percentage of agreement between raters (that a particular statement fell into one of the eight categories) was 84%. Cohen’s kappa for the reliability check was .82. Of the random sample, three participants were included in this study.

2.3. Measures

2.3.1. Demographics

Participants were asked to provide their age, height, weight, and ethnic-racial group. Weight and height were used to determine BMI. To calculate socioeconomic status (SES) using the Hollingshead Four-Factor Index (Hollingshead, 1979), participants were asked to describe their mothers’ and fathers’ highest level of education and occupation. Total scores range from 1 to 5, with lower scores reflecting higher SES. Participants were also asked to indicate the types of treatment they had been involved in. The list of treatments presented included individual, group, dietitian, school counseling, hospitalization, and family therapy. Participants were also asked if a physician was currently monitoring them for reasons related to their eating disorder, and whether their parents were attending a support group.

2.3.2. Eating disorders inventory-2

(EDI: Garner, 1991). The EDI-2 is a 91 item self-report measure of eating disorder symptoms. In completing the measure, participants answer a number of questions about their shape, weight, and eating on a 6-point scale ranging from never to always. The EDI-2 has 11 sub-scales, three of which were used in this research to describe the severity of participants’ eating disorder pathology (i.e. Drive for Thinness (DT), Bulimia (B), and Body Dissatisfaction (BD)). Extensive psychometric support for this instrument and norms for adolescents are available in the treatment manual (Garner, 1991). Internal consistency for the current sample was excellent (α=.96).

2.3.3. Readiness and motivation interview

(RMI; Geller and Drab, 1999). The RMI is a semi-structured interview, and was employed to generate eating disorder diagnoses, and report on readiness to change eating disorder symptoms in the current sample. Using the Eating Disorders Examination (EDE; Cooper and Fairburn, 1987), the RMI assesses the extent to which individuals are actively working at changing (action), seriously thinking about changing (contemplation), and not wanting to change (precontemplation) each of their ED symptoms. Interviewees are asked to describe the percentage of themselves that is in each of the three stages such that the sum of the three stages totals 100% (Geller and Drab, 1999). The RMI has been validated for use in adolescents (Geller et al., 2008). Research indicates that the RMI Restriction scores, particularly with respect to precontemplation scores at baseline, predict enrollment in treatment and treatment outcomes in patients with eating disorders (e.g., dropout rates; Geller et al., 2005). Thus, a median split was conducted on participants based on their RMI restriction scores to determine whether frequency of endorsement of helpful and unhelpful categories differed amongst participants with high versus low readiness to change their dietary restriction behaviours.

2. Results

2.1. Participant characteristics

Age, BMI, SES, EDI-2, and RMI Restriction scores are displayed in Table 2 according to whether participants met criteria for full or subthreshold AN.

2.2. Helpful and unhelpful components of eating disorder treatment

With respect to aspects of treatment that would be helpful or unhelpful for adolescents with eating disorders, the most frequently endorsed category was Alliance (n=21, 100.0%), followed by Client Involvement (n=16, 76.2%), Assumptions (n=13, 61.9%), Support (n=12, 57.1%), Judgments (n=9, 42.9%), a Non-Body Focus (n=8, 38.1%) and providing Nutritional Information (n=4, 19.0%) (See Table 3). Alliance refers to instances where the therapist expresses an interest in the client as a person and not just the eating disorder, and demonstrates understanding of the clients’ feelings. The importance of developing a positive Alliance was emphasized by an adolescent with AN Restricting Type (AN-R): “Have a good relationship with them, bond with them ... get to know them and not just the eating disorder because I think that is the really important part”. An adolescent with AN Binge-Eating/Purging Type (AN-BP) states: “You really need to see the person and... relate to that person and then... say somebody's buried in there, it is just, you have to help pull that person out”.

Factors identified as contributing to the development of Client Involvement in treatment goals included emphasizing the clients’ choice to change their eating disorder behaviours, and presenting change as an experiment. An adolescent with AN-R explained: “If you force them they will rebel even more, especially people my age. You will rebel and continue what you are doing. If you have a choice, you can kind of say Ok, I’ll give this a try”. An adolescent with AN-BP elaborated upon this statement by explaining how therapists should propose treatment options to their clients: “Try it this way for now... if you are really, really not happy you can go back. Even just thinking that makes you feel better. It makes you feel like you have an option after you do it this way then hopefully by the time you've done it this way you will feel confident enough not to go back”.

Table 2

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Demographic information, eating disorders inventory – 2 (EDI-2) and readiness and motivation interview (RMI) scores across participants with full and partial anorexia nervosa (AN).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full AN (n=14)*</td>
</tr>
<tr>
<td>Age (years)</td>
<td>16.29 (1.38)</td>
</tr>
<tr>
<td>Body mass index (BMI)</td>
<td>17.30 (1.37)</td>
</tr>
<tr>
<td>Socioeconomic status (SES)</td>
<td>2.13 (10)</td>
</tr>
<tr>
<td>EDI-2 Drive for Thinness</td>
<td>13.93 (5.51)</td>
</tr>
<tr>
<td>Body Dissatisfaction</td>
<td>18.14 (8.37)</td>
</tr>
<tr>
<td>Bulimia</td>
<td>2.21 (1.97)</td>
</tr>
<tr>
<td>RMI restriction Pre-contemplation</td>
<td>50.33 (29.67)</td>
</tr>
<tr>
<td>Contemplation</td>
<td>18.00 (20.60)</td>
</tr>
<tr>
<td>Action</td>
<td>31.67 (28.70)</td>
</tr>
</tbody>
</table>
* All data missing for one full AN participant.
The importance of genuine Support (i.e., demonstrating belief in the clients’ ability to change and providing encouragement to keep trying) was emphasized by numerous participants. One adolescent with AN-R stated the following: “If you’re doing it alone, like you feel like you have to hold the entire thing up yourself, but if you feel like someone else is there you don’t feel like such a weight on your shoulder... you can feel like ‘Well, I have support and I have someone here with me so maybe I can [change]’ and I think that would give me more confidence”. Another adolescent with AN-R provided more concrete recommendations for the therapist: “Just let them know that whatever they do they’ll just be there for them, as long as they want to get better, they know that they will, they will be able to get better. They might have their ups and downs but it’s, it’s not an impossible thing to do”.

The importance of the therapist avoiding Assumptions regarding the clients’ thoughts, feelings, and actions as well as avoiding Judgments (e.g., expressing disappointment or magnifying slips in behaviour) was highlighted by several participants. One adolescent with AN-R stated: “Just putting words into my mouth and just talking the whole time... It makes me feel like, they’re not listening to me, they’re not interested in how I’m doing. They just want me to take whatever... and put it towards getting better”. Another adolescent with AN-R stated: “...Well they say, ‘You’re gonna get through this’. I don’t know, I just don’t like that because I don’t want to get through it at that point. I wanna keep doing it. I got real mad, when I first came here and my therapist said, “You’re gonna get through this, you’re gonna do better”... I wanted to be skinny and anorexic”.

Several adolescents indicated the importance of avoiding Unrealistic Goals (i.e., goals that are too big or too fast) in therapy, and one adolescent with AN-R stated: “Don’t make Unrealistic Goals and don’t make the patient feel pressured... It’ll put stress on them and then they resort back to the eating disorder”. Although endorsed slightly less frequently than avoiding Unrealistic Goals, the value of a Non-Body Focus in therapy (i.e., where treatment does not focus exclusively on shape, weight, or food-related issues) was emphasized by several participants, including an adolescent with AN-BP: “Try to see the person without the eating disorder... try to see past that and focus on other things... try to see the reasons behind the eating disorder instead of trying to be like, let’s try to eat”. When asked why it's important to understand the reasons behind the eating disorder, this adolescent responded: “Because... it kinda feels like there's a hole missing and you try to fill it with the eating disorder... you kind of, have to figure out what that hole is... I think a therapist can help you... help you figure out what that void is”. Alternatively, an adolescent with subthreshold AN describes how asking clients what they “wanted to do in the future, like, what they plan on doing in school...what they want to do when they're older” as opposed to focusing on the eating disorder would be helpful “cause it puts things in perspective”.

The influence that providing Nutritional Information during treatment (i.e., health information and what a normal serving of food consists of) can have on increasing one’s confidence to change is described by a participant with AN-BP: “Really tiring in how the world works and how society works... how big is a normal portion? How normal is it to go out for food? Things that other people have to go through too, but you just see them differently because you have a problem with them... it would bring my confidence level up and I would then... know how to go about things”.

2.3. Helpful aspects of treatment based on diagnostic status and readiness to change restriction behaviours

Adolescents with AN (n=15) and subthreshold AN (n=6) shared the top two categories (Alliance and Client Involvement) for helpful aspects of eating disorder treatment. Although adolescents with AN and subthreshold AN reported similar factors as helpful and unhelpful in their treatment, providing genuine Support was endorsed as frequently as Client Involvement for adolescents with AN, but less frequently for adolescents with subthreshold AN. Adolescents who reported high (n=10) and low (n=11) readiness to change their dietary restriction behaviours as indicated by the RM I Precontemplation Restriction score also shared Alliance and Client Involvement as the two most helpful aspects of treatment. Although these adolescents also reported similar helpful and unhelpful aspects of treatment, avoiding Assumptions was endorsed as frequently as Client Involvement for adolescents who reported low readiness to change their dietary restriction behaviours, but not for adolescents who reported high readiness to change.

3. Discussion

Participants were asked to discuss the most helpful or unhelpful things that a therapist could say or do for adolescents with eating disorders and were able to generate a number of factors related to this question. All adolescents reported that the
therapeutic alliance was an important component of helpful interventions. Factors identified as contributing to the development of Alliance included therapists demonstrating a genuine interest in clients as people, not simply an eating disorder, and expressing understanding regarding their clients' feelings. These results are in keeping with studies summarized by Westwood and Kendal (2012), which found that the therapeutic alliance plays an integral role in the treatment of adolescent inpatients with AN.

Responses regarding the importance of Client Involvement also parallel results described by Westwood and Kendal (2012), which emphasize the need of adolescents with AN to have control over the treatment process. However, several studies demonstrate that when reflecting back on their treatment process, adolescents with AN consider the removal of control a life-saving aspect (Westwood and Kendal, 2012). Thus, prior to providing treatment options to adolescents with AN, it may be vital to effectively appraise the morbidity and mortality risks that can occur if initial treatment aspects (i.e. re-feeding) are not administered immediately.

As indicated by participants' responses on the importance of providing Support and avoiding Assumptions, the value placed on genuine Support may be due to a cyclical effect. That is, support provided by the therapist may lead to a stronger therapeutic alliance, which in turn may generate further support and encouragement. The findings regarding the value placed on avoiding judgments in therapy highlight that maintaining an open mind regarding clients' thoughts and feelings while simultaneously avoiding verbal assumptions and judgments may be important aspects to consider when treating adolescents presenting with symptoms consistent with AN.

A Non-Body Focus (i.e. avoiding focusing exclusively on shape, weight, or food related issues) was only endorsed by less than one third of participants, and Providing Nutritional Information during treatment was the least frequently endorsed category. However, despite the fact that the majority of participants did not verbally acknowledge the value of a Non-Body Focus in therapy, focusing on other aspects in therapy (e.g. the personal interests or concerns of the client) may help foster the therapeutic alliance and build a connection between the therapist and client.

This study also indicated that commonalities may exist between groups of adolescents with respect to helpful and unhelpful aspects of treatment. The top two categories reported (i.e., Alliance and Client Involvement) did not differ among adolescents with full AN versus subthreshold AN, and among adolescents who were considered high versus low with respect to readiness to change their dietary restriction behaviours. Thus, the findings from this study provide preliminary evidence that Alliance and Client Involvement may be particularly important aspects of treatment to consider when enhancing and refining existing treatment programs for adolescents with AN or subthreshold AN who may be at different stages with respect to readiness to change their dietary restriction behaviours.

3.1. Integrating adolescents' perspectives into FBT for AN

Currently, FBT for AN has the greatest empirical support for adolescents with eating disorders (Couturier et al., 2013b). Some of the aspects of treatment that adolescents have identified as helpful fit obviously into this treatment approach. For instance, a main focus of the initial individual component of treatment sessions for FBT is the development of the alliance with patients (Zaitsoff et al., 2008). Additionally, FBT emphasizes the therapist taking a supportive stance. However, new research is questioning the necessity of the therapeutic alliance in predicting treatment outcomes in adults, and future research in this area is therefore essential (Brown et al., 2013).

Other aspects identified by adolescents may initially seem more difficult to integrate with FBT (i.e. Client Involvement). However, when discussing issues related to control, it was rare for adolescents to advocate that they should be able to continue with their eating disorder behaviours. Instead, participants suggested that it would be helpful for them to have some choice in steps towards recovery or be made to feel like they could view change as an experiment. Therefore, it may be possible to effectively integrate some aspects of this factor into FBT, because although control over eating is initially handed over to parents, it is gradually given back to the adolescent.

3.2. Limitations

Given the preliminary nature of this research, a qualitative design is an appropriate and cost effective method for exploring adolescents’ thoughts and feelings regarding eating disorder treatment. However, given that the sample does not contain male participants, the generalizability of the findings is limited. Additionally, the opinions of clients who dropped out of treatment (prior to participating) are not included in this study. Therefore, the views surrounding the role of the therapeutic alliance may be positively biased.

3.3. Future research

Additional qualitative and quantitative research utilizing DSM-5 criteria (American Psychiatric Association, 2013) and a diverse adolescent population is needed to further examine perspectives regarding eating disorder treatment. Recruiting male and female adolescents and engaging in alternate research methods will serve to contribute more generalizable data that can be effectively used to further clarify and delineate the views of adolescents with eating disorders on helpful and unhelpful aspects of treatment. Since it is theoretically possible that therapeutic strategies perceived by adolescents as unhelpful might actually lead to good outcomes, and strategies perceived as helpful might lead to bad outcomes, it is imperative that future research examines whether incorporating adolescents’ perspectives into extant interventions actually results in improved recovery rates.

4. Conclusion

Adolescence is a unique stage of life characterized by relatively rapid changes in social, emotional, cognitive, and physiological developmental processes. To improve the quality of care for adolescents with AN, there is a need for refined treatment programs that adequately encapsulate the distinctive experiences associated with this stage of life. Although the insights obtained from this study contribute to our current understanding of adolescent views on helpful and unhelpful aspects of treatment for AN, it is vital that methodologically rigorous research in this field continues in order to effectively improve therapeutic engagement and treatment outcomes for adolescents with eating disorders.

Acknowledgements/disclosure of conflicts

None of the authors are in any financial or personal conflict of interest regarding this work. The data in this paper was collected as part of Dr. Shannon Zaitsoff’s Masters Thesis, which was funded by an Ontario Graduate Student Scholarship, the Ontario Women’s Health Scholar award, and a grant from the Hospital for Sick Children Foundation. We thank Dr. Robert Clark and Dr. Mollie Bates for their help with data entry, transcribing, and coding of the interviews.
References


