

PATIENTS' EXPECTATIONS AND EXPERIENCES OF A DAY WARD TREATMENT FOR EATING DISORDERS *

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The purpose of the present study was to evaluate a day ward treatment program for eating disorders by examining the patients' expectations and experiences of treatment. Previous research suggests that patients' expectations are important variables to be considered in the treatment of eating disorders as they have shown to influence treatment outcome in various ways. The present study included 38 patients who had completed the day ward treatment and fulfilled the criteria for either anorexia nervosa, bulimia nervosa or eating disorder-not otherwise specified. Data was collected using the self-report questionnaire Eating Disorder Patients' Expectations and Experiences of Treatment (ED-PEX) which measures patients' expectations prior to treatment as well as their experiences directly after treatment termination. Data was also collected using ten half-structured interviews which were held 3-18 months post treatment. Diagnosis criteria were used to assess the treatment outcome. At treatment termination 23 of 38 patients were diagnosis free. The results indicated that the control-focused interventions were most helpful according to the patients. It was also revealed that the patients desired more specific information about the purpose of the treatment components prior to, as well as during, the treatment process.

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INTRODUCTION

The subject of eating disorders is both important and current in our society, with the prevalence of eating disorders ranging from 1%-4% in young women (Clinton, 1994). The consequences are sometimes extreme, both physical and psychological, and yet research shows that eating disorders are one of the psychological problems least likely to be treated (APA, 1998). According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 2002), eating disorders include anorexia nervosa (AN), bulimia nervosa (BN), and eating disorder-not otherwise specified (ED-NOS) (for diagnostic criteria, see appendix a). AN has a prevalence of 1–2% whereas BN occurs in 2–4% of the female population (Cochrane, 1998 referenced in Seongsook, 2004)

According to Nevenon (2000) AN, BN and ED-NOS share certain common features, but are clearly distinguishable as separate syndromes. AN is characterised by a persistent quest for thinness (Goldner, Cockell & Srikameswaran, 2002) which manifests in a phobia of weight gain and self-committed weight loss while BN is characterized by episodes of binge eating followed by self-induced vomiting and/or laxative abuse. More than one third of eating disorder patients do not fully meet the criteria for AN or BN, but still engage in eating disordered behaviour, and are instead diagnosed as ED-NOS (Nevenon, 2000). These patients tend to have milder eating disorder symptoms though comorbidity with other disorders, such as depression, is higher. Eating disorders typically affect female adolescents but can also be found in males, and patients of various ages (Schmidt, Lee, Perkins, Eisler, Treasure, Beecham, Berelowitz, Dodge, Frost, Jenkins, Johnson-Sabine, Keville, Murphy, Robinson, Winn & Yi, 2008).

Perfectionism and control in eating disorders

A perfectionistic nature is often considered a core feature of eating disorder patients as they strive for the perfect diet, perfect weight, and perfect body shape (Goldner, et al., 2002). Clinical perfectionism includes demanding too much of oneself and striving towards difficult or unreachable goals. It involves a desire to *be* the best, not just better than most. For example, for those who suffer from AN it is not only about being 'pretty and thin', instead it becomes a necessity to diet to the extreme so as to feel valued as a person (Ghaderi & Parling, 2007). Perfectionism is often associated with negative styles of thinking, which seem to be related to experiences of anxiety, anger and sadness (Anthony & Swinson, 1998). This desire to perform to perfection can often lead to a feeling of never being 'good enough', regardless of how competent or capable one is. People who suffer from clinical perfectionism feel that they have failed in achieving their goals even though they have done their very best (Ghaderi & Parling, 2007). Behaviours that are associated with perfectionism actually help to maintain the problem. By engaging in these behaviours one prevents oneself from testing out and disproving ones perfectionistic thoughts (Anthony & Swinson, 1998).

In addition to perfectionism the desire for control is another central part of the development and maintenance of eating disorders. People in general need to feel that they are capable of fixing things themselves, can influence situations, and are in control of

various aspects in life. In the beginning phase of an eating disorder the need for control is fulfilled and a feeling of accomplishment is the result. However the desire to be the best causes one to exert oneself even more in the fight to be 'thin'. This in turn may lead to a vicious circle of total focus on weight, food, eating and having the perfect figure, which is considered to be a life necessity (Ghaderi & Parling, 2007). These patients are often characterised by having dichotomous thinking, i.e. the 'all-or-nothing' principle. Either you fight for complete control or you have no control at all (Clark & Fairburn, 1997; Ghaderi & Parling, 2007).

Fairburn (Clark & Fairburn 1997; Ghaderi & Parling, 2007) has developed a CBT model which explains the maintenance of AN and BN. According to this view perfectionism, as well as control over weight and diet, are central features of both disorders (see Fig. 1 & 2).

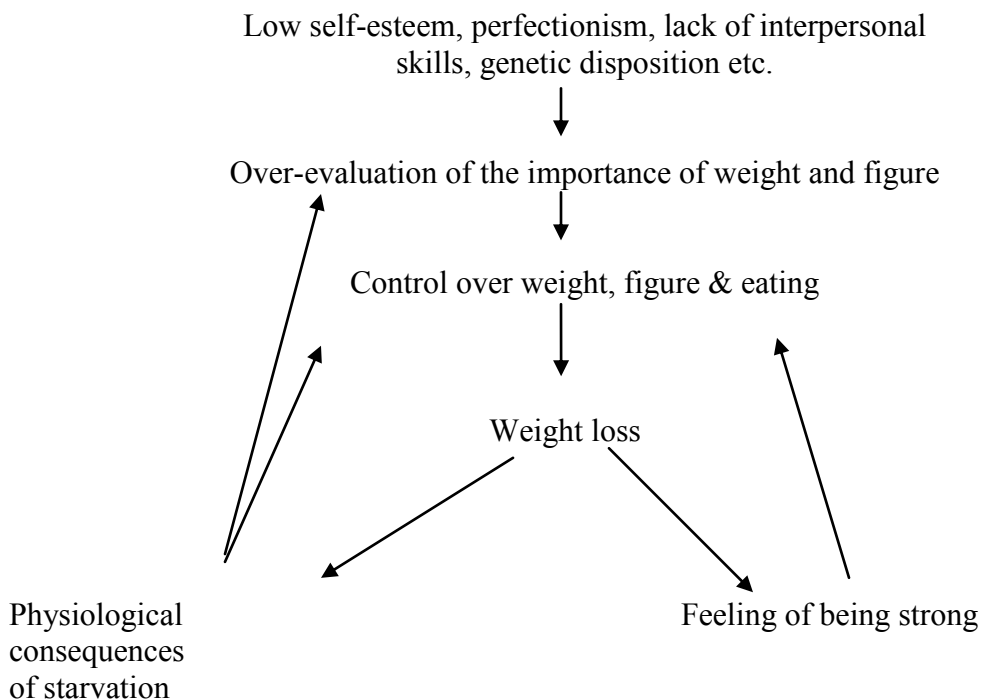


Figure 1. *CBT-model for the maintenance of AN.* (Figure adapted from Ghaderi & Parling, 2007).

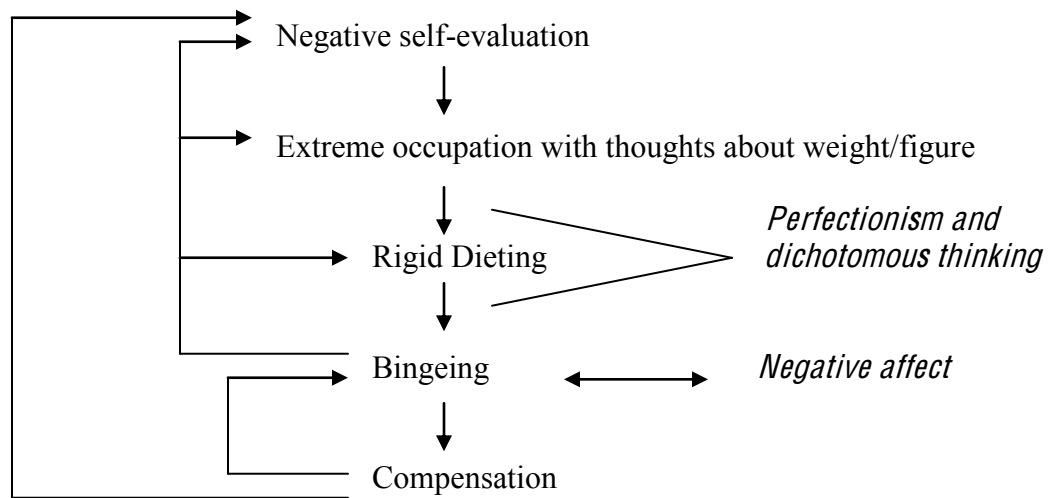


Figure 2. *CBT-model for the maintenance of BN.* (Figure adapted from Clark & Fairburn, 1997).

Expectations and experiences of treatment interventions

Little research has been done on patients' expectations of treatment, not least eating disorder patients and it is therefore of particular interest and demands attention (Clinton, 2001). The research that has been done has shown that expectations can influence treatment outcome (Clinton, 1996), which gives additional reason to why further research is indeed necessary.

Patients' expectations are an important untapped area of research for various reasons not only because information on what patients expect of treatment may help therapists engage patients more in the treatment process, (Clinton, 1996) but also because a link has been found between treatment expectations and consequent treatment satisfaction (Williams, Weinman, Dale, & Newman, 1995). Also the research that *does* exist has focused on expectations of treatment results rather than expectations of particular treatment components (Clinton, 2001), which are examined in the present study. It has been suggested that increased understanding of what patients expect of different treatment components could potentially be useful in the treatment planning process especially if patients tend to have negative expectations about certain treatment components (Clinton, 1994). Discussing patients' expectations could also be useful in explaining and reducing the risk for drop-out (Clinton, 1994; Clinton, Björck, Sohlberg & Norring, 2004) which is a particular concern among eating disorder patients.

Eating disorder patients' expectations and experiences of Treatment Questionnaire (EDPEX)

Eating disorder patients' treatment expectations have originally been studied with a self-report measure called EDPET (Eating Disorder Patients' Expectations of Treatment). A shorter and more psychometrically robust version has now been developed called EDPEX, which includes both patients' expectations and subsequent experiences (Clinton,

2001). EDPEX has clinically been used when planning treatment with patients and it is this self-report measure which has been used in the present study.

It is important to note that in both EDPET and EDPEX “the range of possible treatment expectations, (as well as experiences) is confined by the number of items in the questionnaire” (Clinton, 1994, pp 21). This results in the lack of opportunity for the individual to express any “spontaneous treatment expectations”. To overcome this weakness qualitative research could be done in addition to EDPEX so as to provide “an important methodological complement” (Clinton, 1994, pp 21).

Stockholm’s Centre for Eating Disorders and Idun

There are several treatment programs for eating disorders in Sweden with a unit within Stockholm’s County Council’s regional health services, Stockholm’s Centre for Eating Disorders (SCÄ), being the largest specialist service in the country. SCÄ has “outpatient, day patient and inpatient services, as well as a mobile unit, a school and two apartments for family treatment” (SCÄ, 2008).

Idun is one of the day ward treatment programs at SCÄ and it is this day ward that is evaluated in the present study. More specifically, Idun provides a 22 week interval-based treatment. The treatment is for both adolescents and adults and it extends daily from 9am till 3pm every third week. The staff consists of psychologists, nurses, doctors and dieticians (SCÄ, 2008).

The purpose of the two week intervals between treatment weeks is to give the patients the opportunity to implement their newly-learnt skills. The treatment is composed of:

- Daily individual therapy sessions
- Mealtimes
- Music therapy
- Art therapy
- Dance therapy
- Theme group
- Qi gong

Typically the program follows a psycho-educational model, teaching the patients about food and the body so as to help them overcome their eating disorder symptoms. Additional therapy forms in a group setting are also part of the treatment program so as to “increase self-awareness and creativity” (SCÄ, 2008). At Idun each patient has daily individual therapy sessions. What is done in these therapy sessions varies according to the therapist, as well as what problems are central for the patient in question. Some of the therapists at Idun have completed basic training in Cognitive Behavioural Therapy (CBT), for example, and these therapists therefore adopt a CBT approach with their patients.

During the treatment weeks at Idun the patients are given food vouchers for a group of local restaurants where they are expected to eat lunch. The patients themselves are

allowed to choose which of these restaurants they wish to eat at and which group members they wish to go there with. In contrast to other treatment programs, no therapists are present during mealtimes, although meals are of course discussed during individual therapy sessions.

At Idun there are also three arts-based therapy components which are each held once a week in a group setting; music therapy, art therapy and dance therapy. The idea behind these different arts-based therapies is to bring about personal growth and positive change in clients (Frisch, Franko & Herzog, 2006).

In music therapy patients are taught how to “utilise music as a therapeutic tool” (Frisch et al., 2006, pp 134). More specifically in the treatment of eating disordered patients it is primarily used as a method for relaxation and as a “tool for self-discovery” (Justice, 1994; Parente, 1989; Robarts & Sloboda, 1994, referenced in Frisch et al., 2006, pp 134).

In art therapy the patients each construct a piece of artwork once a week. The idea is that this type of therapy supports non-verbal expression and the symbolism that can be found within these pieces of art is used as a tool for insight. In other words, drawing or constructing art is considered as “an alternative means of expression and exploration of feelings” (Frisch et al., 2006, pp 136).

In dance therapy the patients do various exercises which encourage body acceptance (Frisch et al., 2006). More specifically this type of therapy has been defined by the American Dance Therapy Association (ADTA) as a process that “uses movement to further the emotional, cognitive, social and physical integration of the individual” (ADTA, 2001).

Another treatment component is the so-called theme group, where a variety of topics involving eating disorders is discussed in a group setting. The themes, which change every week, include nutrition, health risks, managing conflict, fear, shame etc.

Qi gong is an additional component which has recently been added to Idun’s treatment program. It consists of “simple movement exercises, breath and sensory awareness, and relaxation techniques” (Gallia, 1999, Pg 1).

Though evaluations of outpatient and inpatient treatment programs occur, systematic evaluations of day ward treatments are not common practice and consequently deserve more attention. Evaluating this form of treatment program is also of essential importance as improving treatments should be a perpetual goal within the health system. More specifically no empirically valid studies exist on the effects of arts-based therapies on eating disordered patients, yet they are frequently used as an adjunctive form of therapy in treatment programs (Frisch et al., 2006). The few studies on art-based therapies that do exist are related to the treatment of trauma and other more general psychiatric disorders but “the outcomes are inconsistent between studies” and there is no evidence that these results would be “applicable to the unique characteristics of the eating disordered client” (Frisch et al., 2006, pp 138). The only work that *has* been published on arts-based

therapies related to eating disorders focuses on case studies and theoretical discussions rather than on outcomes (Reynolds, Nabors, & Quinian, 2000 referenced in Frisch et al., 2006). This fact provides an additional reason as to why evaluations of day wards that include these components are particularly important. If no benefit of arts-based therapies exists then there is an evident need for the development of new treatment programs.

Day treatment programs are typically comprised of a host of potentially therapeutic components but it is unknown which of these may be of particular importance, or whether it's a question of the treatment package as a whole that is successful. It is therefore particularly important to explore expectations and experiences of such packages in order to start to build an idea of what actually works. Recently data on patients' expectations and experiences has been gathered at Idun and so was consequently available for use in the present study.

OBJECTIVES

The main purpose of the present study was to evaluate, from the perspective of former patients, the effectiveness as a whole of Idun, a day ward treatment program for eating disorders. More specifically the study examines the prior expectations of patients who have participated in the treatment program as well as their subsequent experiences after treatment termination.

1. Which treatment aspects did the patients expect to be helped by?
2. Which treatment components did the patients experience as helpful at termination?
3. Do patients who recover from an eating disorder have different treatment expectations than those who do not recover?
4. Do patients who recover from an eating disorder have different treatment experiences than those who do not recover?
5. What are patients' expectations and subjective experiences of what is useful, useless and/or missing in treatment?
6. Which aspects of the treatment do patients continue to find useful even after treatment termination?

METHOD

Participants

Completed EDPEX data for 47 patients has been collected by the Knowledge Centre for Eating Disorders (KÄTS) over the past 2 years. All available data was to be used for the quantitative analysis; however nine participants were excluded from the study because of missing information on diagnosis or the global assessment of functioning scale (GAF). A total of 38 patients therefore participated in the quantitative part of the present study: AN

(n=18), BN (n=5), ED-NOS (n=15). Twelve of the original 47 patients were also randomly chosen to be interviewed for the qualitative part of the study. The specific demographics of the interviewees are not given so as to protect their anonymity; however they did represent all three diagnosis groups. All 38 patients, excluding one, were female and they ranged in age from 16 to 38 (M = 24.7; SD = 5.8). All patients had an eating disorder diagnosis, according to DSM-IV, prior to treatment. All patients completed the entire course of treatment which lasted between six and eight weeks (approximately six months altogether including the interval weeks at home). GAF scores at start ranged from 25 to 60 (M = 42).

Measures

EDPEX

The EDPEX questionnaire consists of two parts; the first part is completed at initial assessment prior to treatment and focuses on patients' expectations of treatment interventions (see Appendix B). The second part is completed at treatment termination or follow-up, and asks patients about their subsequent experiences of the interventions referred to in the first part. Both parts consist of 14 items comprising three subscales: Control, Insight, and Support. "Control emphasizes practical strategies for structuring and mastering eating problems, typical of cognitive-behavioural approaches, such as diary-keeping and meal planning. Insight focuses on self-reflection and understanding of the patient's problems, typical of psychodynamic approaches. Support emphasises an active, emotional engagement of the therapist in solving the patient's problems".

Items are rated on a six point scale: "disagree completely", "mostly disagree", "agree somewhat", "mostly agree", "agree", "agree completely" (Clinton, 2001, pp 363). An example follows:

(Pre-EDPEX) "I need a treatment that can help me to clarify my feelings."

(Post-EDPEX) "It has been important that my treatment has helped to clarify my feelings."

Since 2006 EDPEX data material has continuously been collected from SCÄ by KÄTS. At the time of commencing this study KÄTS had already collected data, though the results had not yet been examined. As the effect of patients' subjective expectations of treatment outcome was also an important aspect of this study, data on diagnosis and GAF was collected before and after treatment. To collect this data, patient records at SCÄ were accessed.

Diagnosis

The presence of diagnosis at treatment termination was used to assess treatment outcome in the quantitative part of the present study.

GAF

The Global Assessment of Functioning (GAF) (see Appendix C), which is used to assess treatment outcome at Idun, is a numeric scale (0 through 100) used by mental health clinicians and doctors to rate the social, occupational and psychological functioning of adults. For example 91-100 is "superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her

many qualities. No symptoms” and 1-10 is “persistent danger of severely hurting self or others OR persistent inability to maintain minimum personal hygiene OR serious suicidal act with clear expectation of death” (DSM-IV, 2002, pp. 34-35).

Qualitative Interview

In order to obtain qualitative data on subjective treatment expectations and experiences the ‘general interview guide approach’ as described by Patton (2002), was used. The aspiration was that the interviews would be open discussions concerning the different questions. However, the same core questions in all the interviews were used as a main theme (see interview guide, Appendix D). During the process of developing the interview most of the Idun personnel were interviewed, this included the manager of Idun, four therapists, the dietician and the resident psychiatrist. Additionally both of the authors participated in the different components of the treatment programme. The purpose with these interviews and participation was to achieve a better understanding of the different aspects of Idun and the treatment process there.

Interviews were carried out in addition to analysing the quantitative data so as to achieve a deeper understanding of patients’ expectations and consequent experiences.

Procedure

Each author conducted five interviews as well as an additional sample interview each. The purpose of the sample interviews was to assist in checking and modifying the interview guide.

The interviews lasted between 60 and 90 minutes and were recorded on audiotape before being transcribed. One of the sample interviews took place at a location at the University of Stockholm while the rest were held at SCÅ.

Interviews were conducted and analysed in Swedish and the selected extracts which have been used to illustrate particular themes are provided in English, translated by the authors.

From the original 47 patients, letters (see appendix E) were sent to 15 randomly selected patients for interview. Reminders were sent two weeks later to those who had not yet replied. A further two weeks later letters were sent out to an additional ten patients, as enough interview participants had still not been recruited. At this point ten interview participants had been procured so letters were sent to an additional six and thus two more were obtained. Out of these 12 the first two were used as sample interviews.

Analysis of data

The quantitative data was analysed with the statistical program, SPSS version 16. The effect of expectations as well as the effect of experiences on eating disorder diagnosis was analysed using independent samples t-tests.

The qualitative data material from the interviews were analysed using an inductive thematic analysis method (Patton, 2002). This method, rather than the hypothesis deductive method, was chosen as there is no hypothesis in the present study (Patton, 2002). Each author listened to and transcribed the other author's interviews. This helped to ground both authors in all the interview material. After the interviews were transcribed both the authors read through the material several times so as to achieve an overview of the material and consequently find recurring comments that were related to the purpose of the study. Preliminary themes and patterns were discovered during this first perusal. The material was then read through repeatedly until preliminary themes emerged which were then sorted into categories. Different colours were used for the different interview text extracts so that every quote within a theme could be traced easily back to the specific interview. This helped bring order and clarity to the process of thematic analysis. These initial stages of analysis were conducted independently by each author and were then conjointly compared, contrasted and modified.

In order to control that the modified material had been sorted into appropriate categories each category was then judged by whether they had "internal homogeneity" and "external heterogeneity". Internal homogeneity demands that the data within the categories is connected in a consequential way, whereas external heterogeneity concerns the extent of the differences between how clear the groups of themes are (Patton, 2002). This process led to further modification of the categories. Through a process of joint reflection and discussion the categories were eventually sorted into 15 categories overall.

Ethical consideration

The ethical principles for research of the humanities and social sciences were adhered to throughout the present study (Swedish Research Council). All interview participants provided verbal informed consent to the interviewers and were free to withdraw from the study at any time. Apart from the authors no one else, including the staff at SCÄ, was privy to the personal details of each interview participant. Furthermore data gathered from the interviews was made anonymous. Upon study completion all audio tapes and notes were destroyed so as to further assure the anonymity of participants.

R E S U L T S

Both quantitative and qualitative data have been used in the form of specific empirically supported self-report questionnaires called EDPEX and ten individual semi-structured, in-depth interviews. The first four research questions are predominantly answered by the EDPEX data using quantitative data analysis SPSS, while the treatment interviews assist in answering questions five and six.

Q u a n t i t a t i v e R e s u l t s

At treatment termination 23 of 38 patients' symptoms had decreased to the extent that they no longer met the criteria for an ED diagnosis. Of the remaining 15 patients with diagnosis, six had a changed diagnosis: five from AN to ED-NOS and one from BN to

ED-NOS. GAF scores at termination ranged from 40 to 85. At treatment termination the average GAF score was 62.

The quantitative results are displayed in accordance with the particular questions the study addressed.

Which treatment components did the patients expect to be helped by?

Table 1 shows the average scores, on a scale of 1-6, of which treatment components patients expected to be helped by prior to treatment commencement. On average patients expected to be helped most by “support and encouragement” and least by the “food diary”. Numbers beside each EDPEX item have been provided to demonstrate the original order of these items on the questionnaire.

Table 1. Average pre-EDPEX scores on item level, arranged hierarchically.

Item	Min	Max	Mean	SD
5. I need support and encouragement	2	6	5,16	1,13
11. I need to be helped by my T getting involved in my problems	3	6	5,08	0,85
10. Important that my T understands and confirms me	3	6	4,95	1,11
13. I need to be met with care and consideration	1	6	4,87	1,32
14. Reflecting on recurring patterns in my life would help	1	6	4,87	1,38
7. I need a T who likes me	1	6	4,87	1,23
6. I need help to understand my unconscious	1	6	4,84	1,18
12. I need a treatment that can help me sort out my feelings	1	6	4,76	1,13
8. I need help to eat regular meals	2	6	4,39	1,29
2. I need help to put my thoughts & feelings into words	1	6	4,37	1,34
9. I would be helped by researching my childhood	1	6	4,12	1,60
4. I need help to plan meals	1	6	4,05	1,33
1. I need help to gain control over my eating habits	1	6	3,53	1,67
3. Keeping a food diary would help	1	6	3,29	1,60

Which treatment components did the patients experience as helpful at termination?

Table 2 shows the average scores, on a scale of 1-6, of which treatment components patients experienced that they were helped by at treatment termination. On average patients experienced that they were helped most by “regular meals” and “being met well”, and least by the “food diary”.

Table 2. Average post-EDPEX scores on item level, arranged hierarchically.

Item	Min	Max	Mean	SD
8. I've been helped by eating regular meals	2	6	5,21	1,17
13. It's been important to have been met with care and consideration	2	6	5,21	1,09
11. I've been helped by my T getting involved in my problems	3	6	5,18	0,98
5. I've been helped by someone who supported and encouraged me during treatment	3	6	5,13	1,17
10. It's been important that my T has understood and confirmed me	2	6	5,05	1,16
7. I've been helped by the fact that my T has liked me	1	6	4,65	1,51
14. I've been helped by reflecting on recurring patterns in my life	2	6	4,55	1,43
1. I've been helped by increasing control over my eating habits	1	6	4,47	1,57
12. It's been important that treatment has helped me sort out my feelings	2	6	4,47	1,27
4. I've been helped by planning meals	2	6	4,42	1,33
2. I've been helped by putting my thoughts & feelings into words	1	6	4,37	1,30
6. I've been helped by understanding my unconscious	1	6	3,84	1,50
9. I've been helped by researching my childhood	1	6	3,13	1,56
3. Keeping a food diary has helped me	1	6	3,00	1,69

Do patients who recover from an ED have different treatment expectations than those who do not recover?

No significant differences were found, neither on an item or sub-scale level, when analysing the data using an independent samples t-test. That is to say patients' who did not have an ED diagnosis at treatment termination did not differ significantly from those who still had an ED diagnosis.

Do patients who recover from an ED have different treatment experiences than those who do not recover?

An independent samples t-test analysing the effect of item-level experiences on eating disorder diagnosis found that the items "food control" ($t=2.51$, $p=0.02$), "regular mealtimes" ($t=2.85$, $p=0.01$) and "my therapist likes me" ($t=2.01$, $p=0.05$) were significant. the item "planning meals" was almost significant ($t=1.92$, $p=0.06$).

An independent samples t-test analysing the effect of sub-scale level experiences on eating disorder diagnosis found that the sub-scale "control" had a significant effect ($t=3.04$, $p=0,004$). These results indicate that patients who recovered from an eating disorder had significantly different experiences of the treatment than the patients who did

not recover. More specifically, the recovered patients' experiences of control, both on item and subscale level, differed significantly compared to those who did not recover.

To summarise, those patients who scored higher on their experiences of "food control", "regular mealtimes" and "my therapist likes me" were more likely to recover from an eating disorder. Those patients who scored higher, on a whole, on their experiences of the interventions included in the sub-scale "control" were also more likely to recover from an eating disorder.

Qualitative Results

The results of the qualitative analysis aid in answering research questions five and six. This analysis resulted in fifteen categories which have been divided into two groups; Patients' Expectations and Patients' Experiences, with seven and eight categories respectively. Excerpts from patient interviews illustrating the different themes are given below.

Patients' Expectations

Lack of Specific Expectations

Despite many general expectations, some patients found it difficult to formulate any specific expectations. Some patients were hesitant about expressing any expectations at all as this could lead to disappointment.

Patient 1: I hoped, but I didn't dare to completely trust, that it would work. I don't think I thought about it that much. I didn't want to persuade myself that it would work.

On the other hand others felt that they were too involved in their eating disorder to be able to formulate any specific expectations of how the treatment would be or how it would affect them.

Patient 2: If I'm being honest I didn't think about it at all, I didn't look that far ahead. I just couldn't. I couldn't look beyond here and now, actually I couldn't really consider here and now either, I was so involved in myself. It wasn't like I went around dreaming, and had big plans for later when I am better. It wasn't like, 'when I'm finished I can actually do this and this', instead it was more like, 'if this works...' Otherwise it (eating disorder) will just continue and then I don't know.

Influence of lack of information about treatment components on expectations

A consistent theme was the lack of information given to the patients. The patients claimed that they were provided with no information about the purpose of the various treatment components.

Patient 3: I had no idea what it would mean, how it would work...I had heard about the different therapies, but didn't know what their purpose was...there were many

questions and thoughts...It would be good if information was provided on paper...about dance therapy and art and music, what they involved and their purpose.

The lack of information led some patients to form negative expectations about the various components.

Patient 4: I was like, 'what is this...like is this going to help me?' I thought, 'God, are we going to dance and things?' Everything was a little bit, 'Shit, what are these things?'

Patient 2: (Dance) I just felt stupid. For me, it felt like there wasn't any point in it at all. It was something that I was forced to go to as it was on the schedule.

While others thought that they were not given any information about the purpose as some of the components were activities without any therapeutic purpose at all.

Patient 5: With dance and music, it felt that it wasn't properly thought through; it was more like something to occupy us.

In contrast, others were not explicitly aware of a purpose but assumed nevertheless that one existed.

Patient 6: We maybe didn't feel either that it was "yes" and we jumped and bounced every time we went to dance but it's part of the treatment and hopefully they have an idea about why we should have dance therapy, that it will help us in some way...

Expectations of responsibility

The majority of patients had the expectation that personal responsibility would play an important role in the treatment program at Idun. Some felt that this would be essential for their recovery.

Patient 6: I also knew that it was a treatment that demands a lot from oneself. There isn't anyone who will come and give you a solution. It's your own responsibility.

Patient 7: I knew that it depends a lot on me, that I must decide.

It was clear to some patients that responsibility would be of particular importance during the weeks at home in between treatment.

Patient 7: Here it is every third week. So it's a lot more personal responsibility.

Influence of previous experiences on expectations

As eating disorders are often persistent, several of the patients interviewed had experience of previous treatment elsewhere prior to Idun. The previous experiences often

had an influence, both positive and negative, on their expectations of the present treatment.

Patient 6: I was actually very sceptical in the beginning. I had been in therapy before "Ok am I going to sit there and open up? I won't have anything to say. I won't be able to open up as I'm not someone who talks about feelings especially easy."

One patient was critical towards the general treatment for eating disorders in Sweden. This criticism was not specifically directed towards Idun, but her previous experiences still influenced her expectations.

Patient 8: For several years I tried to get help, (but the help that I got) I wouldn't call help. When you have such severe anorexia you are just given medicine and 'go home and eat'. That was the answer I got. I wasn't offered anyone to talk to, I was too thin to be susceptible...that's what they told me. So I am very bitter about the care provided for eating disorders! So I find it quite difficult having expectations about things, as I don't want to be disappointed.

One patient's particular previous treatment experience led to her positive expectations of Idun.

Patient 7: I participated in a really good treatment (before)...there was a psychologist who was trying out a new CBT treatment for anorexics...with a concrete approach, that you do homework and things. And I thought that the way they work here sounded similar to his way. It was like it was built on the same basic idea. With personal responsibility and stuff...that was why I thought it (Idun) would be so good.

Expectations of social interaction

Some patients considered how being treated in a group would affect them, the treatment process and consequently their recovery.

Patient 7: I hoped it would be good, to be a little bit social, to have a little company. But actually it depends upon, that it is people who are approximately on the same level. This is important if you want to get anything out of group therapy and theme group.

The effect of wanting to compete with each other was one particular worry.

Patient 5: It's going to be damn hard if you sit there together with others who have exactly the same difficulties and it will be...some kind of competition...like, 'how big are the others?' You think that you're the biggest regardless... you look at the others, I don't want to have this (food), will she leave (food), should I leave? It will be a long drawn-out struggle.

Influence of perfectionism on expectations

The majority of patients mentioned their tendency to be perfectionistic and how this affects them.

Patient 1: *It's incredible...the kind of thought patterns you get stuck in. Good girl. You have to be good. You have to offer to do everything anyone suggests. You really believe that. It was just so nice to hear that you were actually sick.*

Patient 6: *You become incredibly egocentric when you only ever think about your appearance, food and exercise. You can't get any more superficial.*

Their perfectionism sometimes led to unrealistic expectations of their capabilities.

Patient 6: *My intention was to work; 'I will be able to do both the treatment and work.' That was my biggest problem...when I knew that I'd got in but 'oh how is it going to be now?' Then it (my intention) was completely destroyed when I arrived here. 'It won't work; you'll have to be on sick-leave.*

This perfectionism was also linked to a competitive nature and comparing oneself to others, which negatively affected some of the patients' expectations.

Patient 5: *It's going to be really hard if you sit there together with others who have exactly the same difficulties...we are often very competitive, and it's important to perform well.*

Patient 5: *(Art therapy) Performance anxiety, I guess most of us thought that, it's very difficult to forget other people and think "I don't care about what they think.*

Patient 4: *(Dance therapy) Everyone will look and everyone will think I'm stupid.*

Expectations of support

Receiving support was mentioned as an expectation by several of the patients. The patients expected this support to come from several directions. Being able to relate to others was seen as one form of support.

Patient 3: *I thought it would be good being in a group. That one could meet others with similar problems...you know that you're not alone, there are so many who have problems, but... one can feel lonely sometimes, or that it's difficult...that people don't really understand.*

It was expected that a lot of support would come from their personal therapists.

Patient 3: *I hoped to receive the kind of support that I needed and good contact with my therapist so that I would dare...to make an effort to be healthy.*

Others expected to find additional support from their family and social network.

Patient 9: *I got a lot of support at home, or from my husband, which meant that I thought that this would go well.*

One patient however, was sceptical towards the weeks in between treatment as she thought she would not receive enough support.

Patient 2: *Not everyone can handle it, doing it on your own at home. There is still so much time you have for yourself and it's exactly that time that you can't cope, if you don't have that support around you.*

Patients' Experiences

Specific interventions

When discussing their positive experiences of treatment, the patients focused specifically on their individual therapy sessions. Some felt that these individual sessions were the key to their improvement.

Patient 6: *Without the individual therapy I don't think I would have gotten better. It was the most important (part of the treatment).*

Patient 8: *The individual therapy sessions... have given me everything.*

Patient 9: *You got the chance to open up and get help with your thoughts and juggle those parts, in general, talk.*

An important aspect of the individual therapy sessions was certain specific interventions, which varied according to therapist as well as the patient's given problem. Many patients were given homework, which gave them the opportunity to practice newly acquired skills at home and also helped them to test and generalise new behaviour.

Patient 7: *It was really good (to be given homework). You know these concrete things, that you do homework and such. With personal responsibility.*

Especially in the beginning stages of treatment there is a lot of focus on food. For example, information is provided on how often and how much one can eat and patients are also encouraged to complete a food diary.

Patient 9: *I...think a lot about (the food schedule) and look at the pictures, that you should eat...breakfast, lunch, dinner and snacks. (and also look at) the list of what you can also eat additionally in a week and I try to accept 'ok I can actually eat this; you can eat 2 proper meals a day without getting fat.' So I would say that I still think about them every day, these tools.*

Patient 6: *(The food diary) was really good. I wasn't at all conscious about how I ate and what I ate. I thought my food was really varied, but it definitely was not. It was really good to see. To handle different food dishes that you've had different delusions about. We even wrote down the feelings we associated with food.*

Another appreciated intervention was a specific strategy, which helped some patients deal with their anxiety provoking thoughts. Many patients continue to use some of these interventions.

Patient 6: *To allow the anxious thought to come. Before they weren't allowed to, try and think about something else, but it doesn't work, they will still come back. But now it is 'let them come', and more like 'hello hello, here you are again,' instead of fighting it. 'I know that you're here...but I don't need to obey you.' I feel much calmer now.*

Patient 10: *She gave me tips like you can count...a hundred minus 7, minus 7, minus 7...and I actually use that...a month ago I...got a lot of anxious thoughts and I panicked...but then I remembered, focus on this...like mindfulness, which it's called...and then I did (the counting) or focused a lot on the music I was listening to, what the lyrics are about, and that's how I taught myself to handle the situation.*

Some patients learned to accept that there are things that cannot be changed. This helped some to accept their bodies more easily.

Patient 9: *(I'm) good enough as I am... to say (that) in front of a mirror, every day.*

Patient 4: *I've learnt about myself. To like myself. Accept who I am. Not everyone can be thin, not everyone can be fat. Everyone has different bodies. To quite simply start to like oneself. To get better self-confidence. To see life positively.*

Performance anxiety

Several of the patients brought up how performance anxiety affected them negatively when partaking in dance, music and art therapy.

Patient 3: *Help! I'm so bad at painting...I had performance anxiety about everything... art, music and dance... in music therapy I had a lot of performance anxiety.*

This performance anxiety led to many finding these treatment components useless and unpleasant.

Patient 9: *Dance therapy was not my favourite and I felt bad during it as I thought it was mostly performance anxiety...you felt worse than it actually helped...even though we talked about it, it didn't help...there was still pressure to be good.*

Patient 1: *The stuff with movement (dance therapy) was definitely the most difficult but I thought it would be like that even before, there was one time when I ran away from there. You feel so uncomfortable... You just have to expose yourself to it.*

Challenges

Though performance anxiety caused many to dread and avoid these treatment components, some were able to overcome their fear. They were able to see these components as a challenge, which though difficult, was ultimately positive as with repetition it became easier.

Patient 2: *I might not dare to do something....but then I practice with everything just like I practised here. Just that I do it anyway, what can happen? How dangerous is it? Just try and see...It's incredibly hard, it's so hard that I do everything to avoid it. But you get such a reward when you've managed it. So do it anyway, next time it might not feel as hard. ...I know if I just continue and do it anyway and fight for it then I can relax, that this is fun. So I really have that with me...do it anyway. And then suddenly you're standing there and you can handle things. I do difficult things anyway because I know the reward will come later.*

Patient 3: *With dance...it became so much better after a while...we talked about performance anxiety...(the purpose) I guess, was to let go, to be aware of your body and...let go of any expectations. Like just being here and now.*

Eating was one of the more obvious challenges that the patients also needed to overcome.

Patient 6: *(It was) so difficult...You were supposed to sit there without any idea of what you'd get. Of course there was a menu, but restaurant food isn't food you've eaten before voluntarily. It was a real challenge... the further we came the more we were challenged.*

Many patients were not used to relaxing or simply sitting still and found that it took time before they were comfortable doing so. In this sense being inactive was a challenge in itself.

Patient 5: *It was terrible in the beginning, sitting still, being quiet...and restless. Didn't see the point. But then...I learnt to sit still and take it easy...It was healthy to understand that you don't have to run around, you could sit in the sofa. It was good because before after I'd eaten I used to run off the calories...Just to sit after you've eaten instead of running around you could see that nothing happened during the day. Even though I've only been sitting, my body has taken care of it. I can read the newspaper instead. I don't have to get up straight away.*

Social interaction

Most of the patients felt that they both influenced, and were influenced by, the other patients in the group. The group at times affected some of the patients negatively. This

was especially apparent when some patients chose not to participate in the group activities.

Patient 6: I thought it was a real shame that many chose not to participate. Some days there was very bad attendance, and then it's not the same. Then I became more irritated. That people come there with a resistant attitude "I won't participate." It might have been really good if everyone participated and pepped up.

Mealtimes were also situations where patients felt affected by the group in different ways.

Patient 9: When we went out for lunch and you could see that the others had already come quite far and could eat up the food on their plate etc., I somehow got an encouraging kick.

In contrast at times some patients would find it difficult to eat and then the others could be aggravated.

Patient 6: Towards the end, I at least, became very provoked when new girls came with comments like 'it's ok if I don't eat today, right?'

Some were aware of their influence on the other group members and therefore made a concerted effort to set a good example.

Patient 1: You have to damn well think about the others, not only yourself. You're sitting with others who are also struggling; you have to consider them.

There were also a couple of patients who felt that the group did not influence them at all as they were at different stages in their life.

Patient 8: They were a lot younger, and yes it felt like it didn't give me anything...I didn't get any exchange there.

Pleasant moments

Some patients did not feel that their eating disorder was particularly helped by some specific treatment components. They did not experience any performance anxiety and therefore did not see these activities as a challenge. Instead they experienced these activities as pleasant and relaxing but lacking or unclear in purpose.

Patient 6: I like to paint, it appeals to me. The same with chi-gong, which I thought was pleasant. I could relax a little.

Patient 6: Art therapy has helped but it was mostly because it was a pleasant moment, it was nice.

Patient 5: *I imagine it was about sharing (your work) and daring to show what you thought...But for me it didn't give me anything, it was just nice. I got to stand in a corner and paint a little how I wanted. Yeah, it was quite pleasant, I could disconnect...do a little of what I wanted.*

Increased self-awareness

A few patients found it helpful to talk about their past as it increased their self-awareness. They felt that in understanding past behaviour they could break any behavioural patterns that were detrimental for their recovery.

Patient 6: *Towards the end there was more talk about what had happened when I was 15...I got a better understanding for 'ok now I know what I have to look out for so I don't end up there again.' Like more aware of myself."*

Patient 8: *There was a lot about how I am and how I work with my stuff, backwards and forwards and where I stand in my life...I have probably worked more with myself lately than other people might ever do during their whole lifetime. So, I think, I know myself inside out, pretty much.*

Support

The majority of patients were very positive about how much support they received and how this affected their treatment.

Patient 3: *I think...that the group was really good, I got incredible support... We talked about difficult things, but we could talk about it, we could cry and we got support from each other.*

The support received from the Idun personnel came in the form of entrusting the patients. One patient strived for recovery not only for herself, but also for those who believed in her.

Patient 2: *Everyone (who worked at Idun) knew who you were...and they believed in you, they really believed you could do it, even if you didn't believe it yourself. I didn't want to disappoint them. Shit, they believe in me, I have to manage this.*

Support was especially appreciated at meal times.

Patient 6: *It was a lot easier and (I got) a lot more support than I ever could have imagined. We all looked forward to going out and eating together.*

Responsibility

Taking personal responsibility helped the patients in their treatment progress. This was especially apparent during the weeks in between treatment at home as well as during mealtimes.

Patient 7: *(What has helped most is) that you have to take responsibility yourself and you are treated like an adult... You are not served everything. Instead they trust*

that I can handle this, that they will help me, but I will do it myself. That is what has helped the most...For example you don't eat with the staff who supervise you... Here it is clear that everything you do, you do for your own sake.

Experiencing first hand that they were capable of taking care of themselves helped the patients understand that they could cope on their own without being solely dependent on others.

Patient 2: I have learnt that I have control myself...I have the power anyway and I can actually, for the most part, steer it myself, I'm not powerless. I really got to test it myself...when I finally managed things, that which I did, I did, home alone without anyone around. I managed it myself...it's all about responsibility.

Patient 10: (It was) really good to get to practice at home and then come back with material you can work on. It was cool to realise that you can manage a lot by yourself, like even when you're not here.

DISCUSSION

The primary purpose of the present study was to evaluate a day ward treatment program for eating disorders from the perspective of former patients. More specifically the aim was to examine patients' expectations and experiences and how these may have affected treatment outcome. Data was gathered using EDPEX as well as treatment interviews. The methods used and how they may have influenced the results are discussed. The results are then discussed in further detail followed by a summary and suggestions.

Discussion of Results

General discussion

The differences between diagnosis and GAF before and after treatment suggest that Idun can be regarded as a fairly successful treatment program.

Though there were many differences between expectations gathered quantitatively with EDPEX, and expectations gathered qualitatively with the treatment interviews, there were also a few similarities. These similarities consequently provide some support for the validity of EDPEX.

The quantitative results show that patients expected to be helped most by "support and encouragement". This item was also rated highly on what items they *experienced* they were helped by during treatment. This is confirmed by the theme "support" found in the qualitative data, which was one of two themes that was revealed in both expectations and experiences of treatment. However, interestingly the sub scale named "support" for both expectations and experiences, was found to have no influence on treatment outcome, as measured in the present study. The reason for this may be because the item "food diary"

is also part of the sub-scale 'control' and this item scored the least on both PRE-EDPEX and POST-EDPEX.

The item "regular meals" scored relatively low on what patients expected to be helped by yet patients claimed that they were most helped by this item. These results suggest that the importance of "regular meals" was not evident to patients prior to treatment but its significance was appreciated afterwards. This may be because prior to treatment many patients had not eaten regular meals for many years and therefore the importance of doing so was perhaps overlooked. During treatment, however, they learnt that eating regularly is the best way to prevent binges and purges and also helps keep the body at a stable weight (Ghaderi & Parling, 2007).

None of the pre-EDPEX subscales showed a significant effect on treatment outcome but the subscale "control" (as well as several items) on post-EDPEX did. The EDPEX subscale "control" has been defined as consisting of typical cognitive-behavioural approaches such as meal-planning and dietary advice (Clinton, 1994). This seems to be reflected in the qualitative themes "specific interventions" and "responsibility". In "responsibility" the patients reveal how they have been helped by learning that they are not a slave to their eating disorder. Instead they have learnt that they have the power to control it. Similarly in the theme "specific interventions" the patients discuss the different methods that they have learnt which have helped them to gain control over their disorder. However, in contradiction to these findings, the "food diary" is also considered to be a cognitive-behavioural tool and part of the "control" subscale yet the patients judged this to be the item they were least helped by. The reason for this is perhaps because it is considered a preparatory tool rather than a treatment tool in itself. It is both time-consuming and tedious but necessary (Ghaderi & Parling, 2007). To be able to successfully control eating patterns, for example, information first needs to be gathered on what eating patterns already exist. Control of eating patterns is considered particularly important as it was found to have a significant effect on eating disorder diagnosis.

The fact that the results of the present study show that "control" has a significant effect on treatment outcome is particularly interesting considering many believe that an excessive need to control eating is the fundamental characteristic of eating disorders (Fairburn, Shafran & Cooper, 1998). In essence then, control is key to the development of an eating disorder but also seems to be key to recovering from an eating disorder. Perhaps through treatment these patients learnt that they can shift their need for control in a more positive direction. Instead of controlling their weight by not eating at all, they learn to control their weight by eating regularly instead. They are still in control but they are no longer risking their health.

Previous research on EDPEX has shown similar results, which implies good reliability. In this previous study however, "support" as well as "control", were the best predictors of overall satisfaction (Clinton et al., 2004). The fact that the sub-scale 'support' did not achieve statistical significance in the present study may be due to the small sample size. However, as the focus of the aforementioned study was treatment satisfaction, 'support'

may not have been found to be significant as it perhaps only influences overall satisfaction and has no significant effect on actual treatment outcome.

According to the interviews, the individual therapy sessions were considered as the most essential part of the treatment program. The interviewed patients gave specific examples of how these therapy sessions helped them in their recovery. One appreciated intervention was a specific strategy that helped patients deal with anxiety provoking thoughts. However, as the individual therapists worked differently according to their training, this was only available to some patients. More research should be done on what specific interventions introduced in individual therapy sessions are particularly effective and then, where possible, generalize these interventions among all the therapists.

Very few patients mentioned qi gong at all during the interviews and the little information that was gathered about this treatment component was insufficient for the purpose of discussion. This is perhaps due to the fact that some patients did not have the possibility of participating in this treatment component as it has quite recently been introduced to Idun.

The arts-based therapies

It is clear from the interviews that many of the patients disliked the arts-based therapies. The fact that many patients with eating disorders have problems in identifying, describing and working with their own feelings (meeting with supervisor David Clinton, Oct 16, 2008) certainly plays an important role here. It seems that another reason for this aversion is based upon the fact that many patients experienced performance anxiety when partaking in these treatment components. This perhaps comes as no surprise considering a large number of eating disorder patients are highly perfectionistic (Goldner, Cockell & Srikameswaran, 2002). Hewitt & colleagues (Hewitt et al., 2003) proposed that perfectionism includes the need to “conceal imperfections... (which) involves neither demonstrating nor admitting to perceived shortcomings to avoid criticism and protect self-esteem.” These people in general do not engage in situations in which personal mistakes and weaknesses may be revealed (Goldner, et al., 2002, pp. 329). One can assume from this that partaking in music, art and dance therapy in a group setting, where others can clearly see any imperfections, would be particularly difficult for them as it is precisely these situations that perfectionistic people tend to avoid. One can therefore speculate that eating disorder patients are perhaps not suited to these types of therapies as their perfectionism acts as a hindrance to any potential benefits that may otherwise have been produced by these treatment components. Of course this argument could also be applied to other therapy forms that involve some sort of “performance”, e.g. the use of an eating diary. However, in the present study the patients only discussed performance anxiety in relation to the arts-based therapies.

On the other hand, some patients experienced performance anxiety but managed to overcome their fear through repeated exposure to these anxiety-provoking situations. This phenomenon is reflected in the theme “challenges” and refers not only to the arts-based therapies but meal times and the quiet time after meals as well, which some patients also found anxiety-provoking. It seems that challenging a patient in the face of

their anxiety proved to have a positive effect for several of the patients, though it is clear that others found that they could not overcome their performance anxiety and therefore found the challenge more detrimental to their treatment than helpful. It seems that this discrepancy depended predominantly upon the fact that most patients did not understand the purpose of the arts-based therapies. Due to lack of information many patients were left to create their own meaning of how these treatment components would help them in their recovery. It seems that those who could not find a meaning tended not to be helped by these components, whereas those who decided that the aim of the components were to overcome their fears, felt that these treatment components were more useful. Creation of meaning in an ambiguous situation could also be seen as one of the therapeutic challenges. However, it should be noted that traditionally the purpose of arts-based therapies is not to expose patients to anxiety-provoking situations, though interestingly perhaps due to many of the patients' perfectionistic qualities, this is how they seemed often to interpret the purpose of these situations. As it has been theorised that perfectionism plays a central role in eating disorders, one can also hypothesise that similar expectations and experiences would be found in all eating disorder patients who partake in similar arts-based therapies.

This aforementioned effect can be understood in terms of exposure therapy which is an integral part of cognitive behavioural therapy. Exposure therapy is when a person is confronted with the thing or situation they fear and by exposing themselves their anxiety eventually reduces because of habituation (Barlow, 2008). The results of the qualitative part of the present study suggest that exposure therapy could potentially be used as an important part of treatment for eating disorders. This could either be incorporated into the arts-based therapies, if they are to remain as treatment components, or exposure therapy could be introduced separately. One suggestion is that the arts-based therapies could be seen as opportunities for exposure. In this case the positive effects of exposing oneself to doing things badly should be highlighted. For example patients could be instructed to create ugly pieces of artwork and therefore expose themselves to the performance anxiety that is born out of doing this. Regardless of how exposure therapy is introduced into the treatment program it is imperative that a treatment rationale and appropriate psycho-education is provided for the patients.

As perfectionism seems to be such an integral part of the development and maintenance of eating disorders it seems prudent to target this aspect of these disorders. Recently CBT methods to treat perfectionism have been developed for anxiety disorders (Hirsch & Hayward, 1998) so there is ample opportunity to incorporate these methods into the treatment of eating disorder patients. A recent pilot study investigating guided self help to reduce perfectionism with CBT found positive results for patients with bulimia nervosa. These promising results show potential for the use of CBT focusing on perfectionism (Steele & Wade, 2008). It should also be noted that research has found that perfectionism can influence other aspects of treatment. One study on depressed patients, for example, found a significant negative effect of perfectionism on treatment outcome. In this study it seemed that those who scored high on perfectionism were more likely to complete treatment but were also shown to have less improvement (Blatt, Zuroff, Quinlan & Pilkonis, 1996). Additional research should be done to see if perfectionism has a similar

influence on treatment outcome for eating disordered patients. If this proves to be the case then this would offer an additional reason as to why treatment should focus more on this aspect of eating disorders.

It has been suggested that arts-based therapies might assist in improving a more general well-being and consequently may facilitate cooperation with the treatment staff. This in turn may help the treatment process (Ghaderi & Parling, 2007). This seems to be reflected in the theme “pleasant moments” that was found in the qualitative part of the present study, which described some patients’ experiences of the art-based therapies as enjoyable activities, though not particularly relevant in regards to treatment for their eating disorder.

As EDPEX does not focus on the arts-based therapies the results that are presented here are only based on the qualitative data gathered from the treatment interviews. As this data is based on subjective experiences rather than actual treatment outcome it is also possible that some patients felt that the arts-based therapies were irrelevant but the techniques were in fact still effective. An interesting future study could therefore look at the effectiveness of day ward treatment programs, comparing specific experimental conditions with and without particular therapeutic ingredients.

As Frisch, Franko and Herzog (2006) imply, if the art-based therapies are to be used, they should be scientifically studied with standardized forms in the treatment for eating disorders. Most importantly further research is required on the arts-based therapies and when used it is vital that the purpose of them is clarified to the patients, be it exposure, relaxation or something else.

Interviews with therapists prior to study

In the preparatory phase of the present study the staff at Idun was interviewed. The purpose was to gather information so as to achieve a better understanding of how Idun works and what the treatment involves. An interesting issue revealed through these interviews is that many of the therapists were unsure themselves of the purpose of the arts-based therapies. This perhaps influenced the patients’ understanding of the purpose for these different treatment components as well, which is one of the more extensive themes discovered in the qualitative part of the present study; “influence of lack of information on expectations.” These findings suggest a need for research to study further how therapists look at treatment and the potential implications of that.

Discrepancy between patient and therapist expectations, particularly expectations on goals and tasks of therapy, has previously been researched and studies suggest that it can influence the therapeutic alliance, the therapeutic process and consequently treatment results. It is critical that both the patient and therapist believe that the procedures used as part of a treatment will be beneficial to the client (Wampold, 2001). If both patient and therapist are unsure of the purpose it is possible that this will influence the treatment process negatively. Discrepancy in expectations between different therapists is another point which is important to emphasise. It might be troublesome working on a unit where people don’t understand why they themselves or others are doing things a certain way.

There is also empirical evidence that suggests that patient drop-out is influenced by differences between patients and therapist expectations of the effectiveness of potential treatment interventions (Clinton, 1996; Clinton, 2001) and in one study it was found that those patients who successfully completed treatment had a tendency to have similar expectations to their therapists and vice versa (Clinton, 1994). It has therefore been suggested that open discussions on patients' expectations prior to treatment is imperative. These discussions would aid therapists in discovering whether patients have unrealistic expectations and consequently therapists can help patients acquire more realistic expectations (Clinton, 1996).

However, it should be noted that as these interviews were not implemented systematically, any conclusions here should be tentative. It is nevertheless clear that the expectations of therapists and how they relate to patients expectations is an area that warrants further research.

Method Discussion

One obvious limitation of the present study was the small sample size. The downfalls of a small sample size are that it can lead to unreliable results and lack of statistical power, which in turn limits generalisability. A larger sample size would have possibly therefore produced more reliable quantitative results.

A problem that was discovered during the process of interviewing was that many patients found it difficult to formulate any specific expectations. This problem is reflected in the theme "lack of specific expectations" and may perhaps be due to the fact that some of the patients interviewed had finished treatment up to a year and half prior to interview and therefore found it hard to remember what they had expected of the treatment program prior to starting. Lack of specific expectations could also be due to cognitive aspects of eating disorders and general difficulties in reflective self-awareness. Many of the patients were also contradictory, stating at first that they had had no expectations and then later going on to describe expectations that they had had. It is possible that many of the patients might not have reflected over their expectations at all prior to the treatment interviews and consequently found it difficult to explain their prior expectations in hindsight. To be able to gather more reliable qualitative data on expectations, and additionally avoid the aforementioned problems, it would have been more desirable to interview patients about their treatment expectations prospectively rather than retrospectively to treatment. Unfortunately the time plan for the present study did not allow for that.

Though every effort was made to secure the anonymity of patients unfortunately all but one interview was held in the same building as Idun. This made it possible for the treatment staff to see which patients participated in the interviews, and therefore there is a possibility that some patients' confidentiality was jeopardised to a certain extent.

A potential problem was the influence of EDPEX on the implementation and analysis of the treatment interviews. To avoid this problem the EDPEX data was not gathered and analysed until after the interviews had been conducted and analysed.

The results of the present study can be generalised to a certain extent, though one should be cautious with any interpretations as the sample size is small and for both the quantitative and qualitative parts of the present study the data gathered is from patients from only one specific treatment program. There are no other day-wards which are identical to Idun which affects the generalisability of the qualitative part of the present study; however it should be noted that many of the same treatment components are used in other treatment programs, such as the arts-based therapies. One can therefore speculate that patients' expectations and experiences of the arts-based therapies can be generalised to a certain extent as these treatment components are often used when treating eating disordered patients.

As EDPEX is an instrument which is not designed for any specific treatment program there is no problem with generalisability of patients' expectations analysed quantitatively. However there are other limitations of this quantitative measurement for treatment expectations and experiences which need to be examined further. In particular, the choice of possible treatment expectations is limited by the number of items in the questionnaire (Clinton, 1994) which means that there is the possibility that patients may have found other questions not included in EDPEX, more relevant. As the EDPEX is not designed in accordance to any particular treatment program for eating disorders it also lacks specificity. As with many questionnaires there is the possibility that patients will interpret the questions differently, this in turn could influence their answers. For example the statement "I need help to understand my unconscious" does not define the abstract concept of the "unconscious" and therefore leaves the interpretation to the patient.

GAF and diagnosis as measurements of treatment outcome are also limited. GAF measures the general level of functioning in life and not specifically the symptoms of an eating disorder. Also, as there are no detailed directives, it is difficult to understand the difference between one GAF score and another. What is the difference between GAF 41 and 42, for example? Furthermore both GAF and ED diagnosis are fairly subjective measurements as in most cases the same therapist, who also treated the patient, has assessed the patient both prior to and after treatment termination. It should also be noted that the therapists who assess improvement work at Idun and so are possibly influenced by this. As the treatment spans over nearly six months it should also be highlighted that there is no control over other variables that could have influenced recovery apart from the treatment program, such as other life events.

Another weakness when considering measurements of treatment outcome is that in the present study patients were divided into only two groups "diagnosis" and "no-diagnosis" rather than divided into the three relevant diagnoses. Several patients assessed at treatment termination, for example, had gone from an AN or BN diagnosis to filling the criteria for ED-NOS. As ED-NOS is measured as a diagnosis they remained in the "diagnosis" group even though this could be considered an improvement to AN or BN.

Unfortunately this could not be taken into account in the present study, as there were too few participants to analyse them separately in different diagnosis groups. It would be interesting to analyse this with larger samples, and also use other assessments when measuring improvement, such as differences in GAF before and after treatment termination.

In the present study participation was voluntary which leaves room for speculation about why some patients volunteered while others did not. Out of the 31 patients who were invited to take part in the interviews, as many as 19 chose not to participate. It is possible that this group of volunteers is not representative of typical patients who have completed the treatment program at Idun. As all of the interview participants were, in general, satisfied with their treatment one can speculate that they do not represent a typical group of Idun patients. Perhaps those who were dissatisfied did not wish to be interviewed as they did not want to be reminded of their time at Idun. This is an important issue that should be considered in the future research and evaluation of treatment. One possibility is to use planned follow-up interviews with all patients after treatment termination. It is of course also possible that the participants *are* representative if the treatment program in general was effective.

Finally, it should be noted that the present authors have both completed basic training in CBT and this has undoubtedly influenced both the interpretation of the qualitative results as well as the topics approached in the discussion.

Summary and Suggestions

To summarise, the quantitative part of the present study suggests that experiences of interventions focusing on increased control had a significant effect on treatment outcome as measured in terms of diagnostic status. These results suggest that interventions which are considered to deal with control should be introduced into treatment programs for eating disorder patients. Further research is needed to see if some techniques work better for some diagnosis groups but not others.

The qualitative part of the present study suggests that though the majority of patients were satisfied with the treatment program at Idun in general, there were some components which the patients felt were less useful. If the purpose of these treatment components is to simply improve the well-being of patients then one possibility is to remove these components and introduce in their place other types of therapy that are more evidence-based such as acceptance and commitment therapy. Additionally patients could also be taught effective relaxation techniques to improve their wellbeing.

Another possibility is to address patients' perfectionism which seems to have been the catalyst for many experiencing performance anxiety. Clinical perfectionism could possibly be treated with CBT methods such as exposure therapy. The arts-based therapies could then perhaps be incorporated into this type of therapy by using these treatment components as opportunities for exposure. It should be noted that previous research has

shown that cognitive-behavioural treatments are very effective interventions in the treatment of eating disorders (Fairburn, Norman, Welch, O'Connor, Doll & Peveler, 1995) but these treatments seem to focus primarily on challenging cognitive distortions rather than focusing on exposure. It seems therefore that more research in this area is required.

Another topic dealt with the lack of information provided prior to treatment commencement. As this seemed to have an effect on patients' expectations it is perhaps necessary for therapists to both discuss in more detail patients' expectations of what the program will entail, and also to provide more comprehensive information about the purpose of the various treatment components. A preliminary motivational phase including these aspects could potentially be very useful (Franzen, Backmund & Gerlinghoff, 2004).

In conclusion the authors would like to highlight that the majority of the patients interviewed had very positive experiences of Idun and feel either free from their eating disorder or on their way to being so.

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Appendix A

DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) criteria for eating disorders.

Anorexia Nervosa:

1. Refusal to maintain body weight at or above a minimally normal weight for age and height (eg, weight loss leading to maintenance of body weight less than 85% of that expected or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).
2. Intense fear of gaining weight or becoming fat, even though underweight.
3. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
4. In post-menarchal females, amenorrhea i.e., the absence of at least three consecutive cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, eg, estrogen administration.)

Specify type:

- **Restricting Type:** During the current episode of anorexia nervosa, the person has not regularly engaged in binge-eating or purging behavior (ie, self-induced vomiting or the misuse of laxatives, diuretics, or enemas).
- **Binge-Eating/Purging Type:** During the current episode of anorexia nervosa, the person has regularly engaged in binge-eating or purging behavior (ie, self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Bulimia Nervosa:

1. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:(1) Eating, in a discrete period of time (eg, within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.(2) A sense of lack of control over eating during the episode (eg, a feeling that one cannot stop eating or control what or how much one is eating).

2. Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas or other medications; fasting or excessive exercise.
3. The binge eating and inappropriate compensatory behaviours both occur, on average, at least twice a week for 3 months.
4. Self-evaluation is unduly influenced by body shape and weight.
5. The disturbance does not occur exclusively during episodes of anorexia nervosa.

Specify type:

- **Purging type:** During the current episode of bulimia nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics or enemas.
- **Non-purging type:** During the current episode of bulimia nervosa, the person has used inappropriate compensatory behaviours, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics or enemas.

Eating Disorder Not Otherwise Specified:

Includes disorders of eating that do not meet the criteria for any specific eating disorder.
Examples include:

1. For females, all of the criteria for anorexia nervosa are met except that the individual has regular menses.
2. All of the criteria for anorexia nervosa are met except that, despite significant weight loss the individual's current weight is in the normal range.
3. All of the criteria for bulimia nervosa are met except that the binge eating and inappropriate compensatory mechanisms occur at a frequency of less than twice a week or for duration of less than 3 months.
4. The regular use of inappropriate compensatory behaviour by an individual of normal body weight after eating small amounts of food (eg, self-induced vomiting after the consumption of two cookies).
5. Repeatedly chewing and spitting out, but not swallowing, large amounts of food.
6. Binge-eating disorder: recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviours characteristic of bulimia nervosa.

Appendix B

EDPEX-pre and EDPEX-post Questionnaire

Eating Disorder Patients' Expectations and Experiences of Treatment
(EDPEX)

Expectations

What do you think would help you during treatment?

The following statements concern what you expect would be of help in the treatment of your eating problems. Please read each statement and decide which alternative suits you best at present. Then place a cross (X) in the square under the appropriate alternative. Please choose only one alternative for each statement.

	disagree completely	mostly disagree	agree some- what	mostly agree	agree	agree completely	
1. I would be helped by increasing control over my eating habits.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	C
2. It will be important to help me put my thoughts and feelings into words.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I
3. Keeping a diary of my eating habits and discussing it during treatment would help me achieve better control of my eating problems.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	C
4. I need help to plan my meals.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	C
5. I need someone who can support and encourage me during treatment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	S
6. I need help to understand my unconscious.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I
7. I need a therapist who likes me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	S
8. I need help to eat regular meals.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	C

9. I would be helped by exploring the relationship between my problems and my childhood.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I
10. It's very important that my therapist understands me and confirms my feelings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	S
11. I need a therapist who can actively get involved in my problems and show me how to deal with them.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	S
12. I need a treatment that can help me to sort out my feelings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I
13. I need to be met with care and consideration.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	S
14. I would be helped by reflecting on recurring patterns in my life.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I

Subscales: C = Control, I = Insight, S = Support

Experiences

What helps or did help you during treatment?

The following statements concern what helps now or did help you during treatment of your eating problems. Please read each statement and decide which alternative suits you best at present. Then place a cross (X) in the square under the appropriate alternative. Please choose only one alternative for each statement. If a statement does not pertain to your treatment (i.e. did not take place), then please choose the "not applicable" column at the far right.

	disagree completely	mostly disagree	agree somewhat	mostly agree	agree	agree completely	Not applicable	
1. I've been helped by increasing control over my eating habits.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	C
2. I've been helped by putting my thoughts and feelings into words.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I
3. Keeping a diary of my eating habits and discussing it during treatment has helped me achieve better control of my eating problems.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	C
4. I've been helped by planning my meals.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	C
5. I've been helped by someone who has supported and encouraged me during treatment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	S
6. I've been helped by better understanding my	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I

unconscious.								
7. I've been helped by the fact that my therapist has liked me.	o	o	o	o	o	o	o	S
8. I've been helped by eating regular meals.	o	o	o	o	o	o	o	C
9. It has helped me to explore the relationship between my problems and my childhood.	o	o	o	o	o	o	o	I
10. It's been very important that my therapist has understood me and confirmed my feelings.	o	o	o	o	o	o	o	S
11. I've been helped by my therapist getting actively involved in my problems and showing me how to deal with them.	o	o	o	o	o	o	o	S
12. It's been important that treatment has helped me to sort out my feelings.	o	o	o	o	o	o	o	I
13. It's been important to have been met with care and consideration.	o	o	o	o	o	o	o	S
14. I've been helped by reflecting on recurring patterns in my life.	o	o	o	o	o	o	o	I

Subscales: C = Control, I = Insight, S = Support.

Appendix C

The Global Assessment of Functioning (GAF)

91-100 Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many qualities. No symptoms.

81-90 Absent or minimal symptoms, good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns.

71-80 If symptoms are present they are transient and expectable reactions to psychosocial stresses; no more than slight impairment in social, occupational, or school functioning.

61-70 Some mild symptoms OR some difficulty in social, occupational, or school functioning, but generally functioning pretty well, has some meaningful interpersonal relationships.

51-60 Moderate symptoms OR any moderate difficulty in social, occupational, or school functioning.

41-50 Serious symptoms OR any serious impairment in social, occupational, or school functioning.

31-40 Some impairment in reality testing or communication OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood.

21-30 Behaviour is considerably influenced by delusions or hallucinations OR serious impairment in communications or judgment OR inability to function in all areas.

11-20 Some danger of hurting self or others OR occasionally fails to maintain minimal personal hygiene OR gross impairment in communication.

1-10 Persistent danger of severely hurting self or others OR persistent inability to maintain minimum personal hygiene OR serious suicidal act with clear expectation of death.

0 Not enough information available to provide GAF.

Appendix D

Interview guide

- How was your life before treatment (eating habits etc)?
What did you think would help you?
- What made you seek help/How did you end up at Idun?
- How much did you know about Idun and the treatment before you started there?
- Based on the information you had, what were your expectations? (Treatment in general, the specific components, how the treatment would affect you etc)
- What was most/least helpful?
What was most/least useful in terms of treating your eating disorder?
- To what extent were your expectations fulfilled?
- What have you learned? How?
- Was there any part of the treatment which you did not expect to be helped by but you were pleasantly surprised?
- What did you expect to be helped by but weren't?
- Is there anything from the treatment that you still have use of? What and how?
Is there anything from the treatment programme that you think of when you meet difficulties? Is there anything you remind yourself of?
- What is your life like today?

Appendix E

Letter to participants

2008-06-02

Hello!

Time has passed since you were treated at the day ward treatment programme, Idun, at SCÄ. We are two psychology students from Stockholms University, and together with the staff at Idun, we are planning on doing an evaluation of patients' expectations and experiences of the treatment programme at Idun. We are hereby contacting you as we would very much like to interview you about your experiences. Your opinions are of up most importance as they can contribute to the improvement of the treatment programme at Idun.

This study will include several interviews which will help us to deepen our knowledge about how you have experienced the treatment programme. The interview, which will take approximately an hour, will be held by one of us. All material from the interviews will be depersonalised so that none, apart from the person who interviews you, will have access to your personal details.

The interviews will be held during week 23 and 26. If you wish to participate we will contact you and organise a suitable time and place. We hereby send you a form that you can return to us if you wish to partake in an interview. Please fill in your name, phone number, and when is a suitable time for us to call you and organise an interview. Please return the form in stamped addressed envelope provided, preferably within a week. Alternatively you can call Laura Härkönen on *****.

If you require any more information please do not hesitate to call Laura, Ronnie (*****) or Karin (*****)).

Best regards,

Josephine Bonde
Laura Härkönen

I can participate in an interview ____

I cannot participate in an interview ____

Name

Telephone Number

I can best be reached at these times:

Please send this answer form in a stamped addressed envelope preferably within a week. Thank you!