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# *Patient Satisfaction with Treatment in Eating Disorders: Cause for Complacency or Concern?*

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**The present study explored treatment satisfaction among eating disorder patients participating in a Swedish multicentre study ($N = 469$) who had been followed up 36 months after initial assessment. Satisfaction was measured using a questionnaire focusing on initial reception at the treatment unit, suitability of treatment, ability of staff to listen and understand, confidence in the unit and agreement on treatment goals. After 36 months, 38% of patients were 'highly satisfied' with treatment, while 39% were 'satisfied' and 23% were 'unsatisfied'. Satisfaction was predicted by treatment interventions focusing on support and increased control of eating problems. Although unsatisfied patients were characterized by significantly higher levels of eating disorder psychopathology and psychiatric symptoms as well as more negative interpersonal profiles at follow-up, these patients had been virtually indistinguishable from the other groups at initial assessment, with a few notable exceptions. Unsatisfied patients had previously been less prepared to change their eating habits, had higher levels of conflict with their fathers, had a lesser degree of present weight acceptance and tended to expect less from treatment interventions focusing on control of eating problems. It is concluded that, although we may be successful in engaging and satisfying patients who are predisposed to therapeutic strategies focusing on support and control of eating problems, we may be less successful with those who have a greater number of interpersonal problems and who are not as focused on their symptoms of disordered eating.** 

Keywords: anorexia nervosa; bulimia nervosa; eating disorders; treatment; satisfaction; expectations

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## INTRODUCTION

In recent years, there has been an upsurge of research into the question of patient satisfaction with treatment. As Crawford and Kessel (1999) have pointed out, this has probably been due to the demand for health services that are responsive to the views of users. Previously there was a reluctance to seek such views, since mentally disordered patients tended to be seen as unable to make 'valid' comments about their treatment. Such reservations have, however, been largely overcome and treatment satisfaction is now considered to be an essential aspect of outcome (Williams, 1994).

On the whole, the picture appears to be a positive one. Recent studies of community treatment of serious mental disorders (Gerber & Prince, 1999), psychiatric patients (Nabati, Shea, McBride, Gavin, & Bauer, 1998) and drug and alcohol problems (McLellan & Hunkeler, 1998) suggest that patients are generally satisfied with the treatment they receive. Measuring satisfaction has also been argued to be a relatively straightforward matter. The influence of acquiescence on ratings of satisfaction has been found to be low and non-significant (Hansson & Hoeglund, 1995), as have correlations between satisfaction and social desirability (Gaston & Sabourin, 1992). Nabati and co-workers (1998) found satisfaction to be unidimensional in terms of its factor structure. However, other researchers have found it to comprise a wide variety of components such as communication, interpersonal aspects of care, client involvement in treatment, information practices, patient participation, support, and respect for confidentiality (Hardy, West, & Hill, 1996; Parker, Wright, Robertson, & Gladstone, 1996; Sixma, Spreeuwenberg, & van der Pasch, 1998; Williams, Coyle, & Healy, 1998; Gerber & Prince, 1999).

Taking a more critical stance, it has been maintained that satisfaction is in fact a complex concept and that the quantitative measures used in many studies may actually underestimate dissatisfaction (Williams, 1994; Williams et al., 1998). Other researchers have criticized previous work for not focusing sufficiently on the roles of the patient–practitioner relationship (Sixma et al., 1998) and patient expectations (Williams, Weinman, Dale, & Newman, 1995; Crawford & Kessel, 1999).

Within the eating disorders field, little attention has been paid to patient satisfaction. What data there are appear to touch upon the issue indirectly. Thiels, Schmidt, Treasure, Garthe, and Troop (1998), for example, used a satisfaction measure when studying the usefulness of a self-care manual for short-term treatment of bulimia nervosa. Chronic eating disorder patients who were unsatisfied with treatment have reported negative experiences with treatment, especially behaviour therapy, tube feeding and admission to a hospital (Noordenbos, Jacobs, & Hertzberger, 1998). Yarnold, Michelson, Thompson, and Adams (1998) noted the importance of expressive qualities of staff, particularly physicians and nurses, for satisfaction among eating disorder patients. Taken as a whole, these results suggest that better knowledge of patient satisfaction with treatment in the eating disorders could aid in both the overall evaluation of existing treatment programmes and individual treatment planning.

The present study aimed to examine satisfaction with treatment in a large unselected sample of eating disorder patients. This was done within the framework of the CO-RED (Co-Ordinated Evaluation and Research at Specialist Units for Eating Disorders in Sweden) project, a longitudinal study that investigates the treatment of eating disorders at 15 specialist centres across Sweden. Participating units offer a wide variety of treatment forms, such as inpatient, day patient, outpatient, individual psychotherapy, family and group therapy, psychoactive drugs, expressive forms of treatment, etc. The specific aims of the present study were to explore: (1) how satisfied eating disorder patients are with treatment; (2) how satisfaction relates to eating disorder and concomitant psychopathology; and (3) what predicts satisfaction.

## METHOD

### *Subjects*

All patients who had been treated at participating units and who had been assessed at 36-month follow-up by June 2002 were included in the study ($N = 469$). No exclusion criteria were applied; simply being treated at the unit provided the basis for inclusion in the study. The distributions of DSM-IV diagnoses were: anorexia nervosa (AN) = 94 (20.0%), bulimia nervosa (BN) = 175 (37.3%), binge-eating disorder (BED) = 25 (5.3%) and eating disorder not otherwise specified (EDNOS) = 175 (37.3%). All subjects had provided informed consent. Age ranged from 18 to 51 years ($M = 25.4$ years, SD = 6.5) and all participants were female with the exception of seven males. Mean duration of eating disorder at presentation was 8.4 years (SD = 6.4).

 

### Measures

The Rating of Anorexia and Bulimia (RAB) Interview was used to assess eating disorder and related psychopathology (Clinton & Norring, 1999; Nevonen, Broberg, Clinton, & Norring, 2003). The RAB is a 56-item semi-structured interview with graded response formats covering a wide range of eating disorder symptoms, related psychopathology and background variables; it generates operational DSM-IV eating disorder diagnoses and is widely used in Sweden. It has satisfactory internal consistency and interrater reliability; kappa ranged from 0.47 to 0.92 ($M = 0.74$) for the variables used in the present study (Nevonen et al., 2003). The diagnoses used in the present study were based on RAB data together with expert ratings of specific DSM-IV criteria. Further assessment of eating disorder symptoms was made using the Eating Disorders Inventory-2, EDI-2 (Garner, 1991). Psychiatric symptoms were measured using a shortened (63-item) version of the Symptom Check List-90, SCL-90 (Derogatis, Lipman, & Covi, 1973). The SCL-90 was shortened by removing the phobic anxiety, paranoid ideation and psychoticism subscales, along with four of the items that comprise additional scales. Interpersonal dimensions were assessed using the Structural Analysis of Social Behaviour, SASB (Benjamin, 1974, 2000). More specifically, the SASB Intrex questionnaire for assessing self-image was used (i.e. SASB self-image [3rd surface]). Responses on the SASB can be used to delineate individual interpersonal profiles that comprise eight separate clusters of self-image: (1) self-emancipation; (2) self-affirmation; (3) active self-love; (4) self-protection; (5) self-control; (6) self-blame; (7) self-hate and (8) self-neglect. Expectations and experiences of treatment were assessed using the Eating Disorder Patient's Expectations and Experiences of Treatment Questionnaire, EDPEX (Clinton, 2001). The EDPEX is a 14-item questionnaire in two versions, one for expectations and one for subsequent experiences of specific treatment interventions for eating disorders. Items are grouped according to three subscales: control of eating problems, insight, and support. The EDPEX was used to examine the relationship between satisfaction and both pre-treatment expectations and subsequent experiences of specific interventions. Previous work with an earlier version of this instrument suggests that pre-treatment expectations can be useful in explaining why eating disorder patients drop out of treatment (Clinton, 1996).

Satisfaction was measured using the Treatment Satisfaction Scale (TSS), a short questionnaire developed for the CO-RED project. Patients were first asked to rate five questions (on a three-point scale): experiences of reception at the treatment unit, suitability of treatment programme, ability of staff to listen and understand, confidence in the staff, and agreement on treatment goals. (See Appendix A for the full version of the questionnaire.) Based on these questions, two satisfaction variables were calculated. The first was a continuous measure of overall satisfaction computed by summing the scores of individual items. Overall interitem consistency of this variable was high (Cronbach's $\alpha = 0.87$). The second variable was a categorical measure computed by classifying patients as 'highly satisfied', 'satisfied' or 'not satisfied', based on responses to the questionnaire. A patient was classified as 'highly satisfied' if she responded with the most satisfied alternatives to all questions. If a patient gave at least one intermediate reply, she was classified as 'satisfied'. Finally, if a patient chose at least one of the least satisfied alternatives, she was classified as 'unsatisfied'.

### Procedure

The CO-RED project utilizes a repeated measures design to investigate eating disorder patients at initial assessment, and subsequently after 6, 12, 18 and 36 months. Data were collected by staff at the units, for the most part either qualified psychiatrists or clinical psychologists with experience in the assessment and treatment of eating disorders, although other professionals, such as experienced nurses and social workers, also took part. Initial assessments took place within 2–4 weeks of commencing treatment. In the present study, those patients who had completed 36-month follow-ups were examined.

## RESULTS

### Satisfaction with Treatment after 36 Months

Using the categorical definition of satisfaction, 38% of the sample was classified as 'highly satisfied' with treatment 36 months after initial assessment, while 39% was 'satisfied' and 23% was 'unsatisfied'.

One-way ANOVA, with post-hoc Scheffé tests, was used to compare the groups on other relevant measures at 36 months. On the EDI-2, ANOVA was significant (i.e. $p < 0.05$) on all variables except maturity fears (which only approached

 

significance). When pairwise Scheffé tests were carried out, unsatisfied patients had significantly higher scores (i.e. $p < 0.05$) compared to highly satisfied patients on drive for thinness, bulimia, ineffectiveness, interoceptive awareness, asceticism, disturbed impulse regulation and social insecurity. Compared to both satisfied and highly satisfied patients, unsatisfied patients had significantly higher scores on bulimia and disturbed impulse regulation. On the SCL, ANOVA was significant on all subscales. Significant pairwise differences were found between unsatisfied and highly satisfied patients in terms of obsession-compulsion, interpersonal sensitivity, depression and anxiety. When interpersonal profiles were examined using the SASB, ANOVA was significant on all SASB clusters except self-control. Pairwise comparisons on the remaining SASB clusters suggested that, compared to satisfied and unsatisfied patients, highly satisfied patients presented with significantly more positive interpersonal profiles in terms of higher scores on self-affirmation and active self-love as well as lower scores on self-blame, self-hate and self-neglect. Using the continuous measure of satisfaction, there were no significant differences between diagnostic groups (as assessed initially) in terms of treatment satisfaction at 36 months.

### *Satisfaction with and Experiences of Treatment Interventions*

In order to explore the relationship between experiences of treatment interventions and satisfaction, stepwise multiple linear regression analysis was conducted. The relationship between the overall measure of satisfaction and individual EDPEX items was highly significant ($R = 0.56$, $R^2 = 0.31$, $p < 0.0001$). Of the 14 possible EDPEX items that could be used as predictors in the equation, two were entered (experiencing help with planning meals, standardized beta $= -0.36$, and having being met with care and consideration, standardized beta $= -0.30$). In other words, the extent to which a patient had experienced help in planning meals during treatment, together with the extent to which she had been met with care and consideration during treatment, predicted 31% of the variance in overall treatment satisfaction.

### *Satisfaction and Initial Status*

In order to explore the relationship between treatment satisfaction at 36 months and initial status prior to treatment, one-way ANOVA was conducted on the EDI-2, SCL, SASB, EDPEX and the RAB, using the categorical measure of satisfaction as the independent variable.

Despite pronounced differences between highly satisfied, satisfied and unsatisfied patients at follow-up, the three groups had been largely similar at initial assessment, with a few notable exceptions. No significant initial differences between groups were found on the SCL. On the SASB, although no significant initial differences were found between groups, preliminary statistical analysis did suggest that there may be subgroups of eating disorder patients with distinct interpersonal profiles that influence subsequent treatment satisfaction. However, detailed analysis of the exact nature of these differences fell beyond the scope of the present study. On the EDPEX, significant differences were found on insight ($F = 3.4$, d$f$ 2/432, $p < 0.05$) and control ($F = 3.3$, d$f$ 2/432, $p < 0.05$). Patients who later became unsatisfied with treatment had expressed significantly higher expectations of interventions focusing on insight and significantly lower expectations of interventions focusing on control. When the EDI-2 was examined, significant differences were found on bulimia ($F = 3.8$, d$f$ 2/453, $p < 0.05$), perfectionism ($F = 6.4$, d$f$ 2/454, $p < 0.01$), interoceptive awareness ($F = 3.4$, d$f$ 2/453, $p < 0.05$), impulse regulation ($F = 5.0$, d$f$ 2/452, $p < 0.01$) and social insecurity ($F = 3.1$, d$f$ 2/453, $p < 0.05$). Patients who later became unsatisfied had scored significantly higher on these subscales at initial assessment. On the RAB, significant differences were found on weight phobia ($F = 3.6$, d$f$ 2/418, $p < 0.05$), acceptability of present weight ($F = 12.4$, d$f$ 2/441, $p < 0.001$), the importance of losing weight ($F = 9.1$, d$f$ 2/445, $p < 0.001$), eating regular meals ($F = 5.0$, d$f$ 2/450, $p < 0.01$), impaired relationships with the opposite sex ($F = 3.2$, d$f$ 2/384, $p < 0.01$), impaired relationships with mother ($F = 3.2$, d$f$ 2/438, $p < 0.05$), impaired relationships with father ($F = 6.6$, d$f$ 2/421, $p < 0.01$), ability to deal with conflicts with father ($F = 5.5$, d$f$ 2/446, $p < 0.05$) and preparedness to change eating habits ($F = 6.9$, d$f$ 2/442, $p < 0.001$). On the relationship-related items from the RAB that had significant $F$-values, unsatisfied patients had scored significantly higher at initial assessment. On the items related to eating disorder psychopathology, unsatisfied patients also had significantly more pathological scores on all items with significant $F$-values except weight phobia, where unsatisfied patients were judged to have the least pathological values.

The relationship between initial status and subsequent satisfaction with treatment was further

 

explored by conducting stepwise linear regression and using the above items with significant *F*-values as possible predictors of treatment satisfaction at 36 months ($R = 0.37$, $R^2 = 0.14$, $p < 0.0001$). Variables that were entered into the equation after four steps were: RAB preparedness to change eating habits (standardized beta = 0.16), RAB conflicts with father (standardized beta = 0.19), RAB acceptability of present weight (standardized beta = 0.19), EDPEX control (standardized beta = −0.15). In other words, patients who became unsatisfied with treatment after 3 years tended at initial assessment to be less prepared to change their eating habits, had a higher level of conflict with their fathers, had a lesser degree of present weight acceptance and tended to expect less from treatment interventions focusing on control of eating problems.

## DISCUSSION

The present research aimed to examine treatment satisfaction in eating disorders, an issue that has previously received little attention. On the one hand, the questionnaire used to this end could be criticized for being methodologically limited, since satisfaction was measured using only five questions rated on a three-point scale. Psychometrically, it could have benefited from the use of a greater number of relevant questions and an increased number of response alternatives. For example, given the high initial proportion of highly satisfied patients in the present study, it could have been worthwhile to utilize a greater number of response alternatives at the positive end of the scale. On the other hand, the questionnaire had a high level of interitem consistency and could easily be integrated into other assessment batteries for future use. Most importantly, however, the present research provides some important initial findings and a point of departure for researchers interested in following up on the question of treatment satisfaction in eating disorders.

The most promising finding was that a majority of eating disorder patients appear clearly satisfied with treatment 36 months after initial assessment. This would seem to be in keeping with the literature from other fields (McLellan & Hunkeler, 1998; Nabati et al., 1998; Gerber & Prince, 1999) and it will no doubt come as good news for practitioners. When patient experiences of treatment interventions were examined, the data suggested that strategies focusing on active control of eating habits and support were the best predictors of overall satisfaction. This will also be encouraging for the majority of practioners who utilize treatment methods such as individual and group CBT, psychoeducative programmes and the like, which focus on such issues.

However, the present promising results provide no grounds for complacency. Almost a quarter of patients were judged to be unsatisfied with treatment after 36 months. Based on the literature (Williams, 1994; Williams et al., 1998; Crawford & Kessel, 1999), there are sufficient grounds to warrant concern that this could likely be more of an underestimate rather than an overestimate.

When the three groups of patients were compared in terms of initial status, there were very few differences. In terms of initial eating disorder symptoms, patients who later became unsatisfied with treatment after 3 years tended at initial assessment to accept their weight to a lesser extent and were less prepared to change their eating habits. They also had a higher level of conflict with their fathers. In terms of treatment expectations, they tended to expect less from treatment interventions focusing on control of eating problems and more from interventions focusing on insight and reflection. These findings raise the question of whether there are distinct subgroups of eating disorder patients with different degrees of receptiveness to particular treatment strategies, perhaps based on differences in underlying problems, motivational factors or treatment expectations. It may be that we are relatively successful in engaging and satisfying patients who are predisposed to therapeutic strategies focusing on support and control of eating behaviour. However, we may be less successful with those who have a greater degree of initial interpersonal problems and those who are not as focused on their symptoms of disordered eating. These patients may be less predisposed to symptom-focused forms of treatment and more predisposed to reflective and interpersonal forms of treatment.

This, in turn, raises the question of the role of the patient–therapist relationship for outcome. Previous research suggests that the treatment process can be jeopardized when the expectations of patients and therapists diverge (Clinton, 1996). Regardless of therapeutic approach, it may, therefore, be essential for therapists to listen more carefully to their patients and consider their own and their patients' expectations when planning and providing treatment. Unfortunately, this may not be happening, at least in relation to those patients who subsequently become dissatisfied with treatment. The present finding that unsatisfied patients expressed more pathological interpersonal profiles

 

on the SASB at follow-up also raises the possibility that these patients may accuse themselves rather than the therapist for breakdowns in the treatment process. According to interpersonal theory, self-image is central to a person's ongoing interactions with others (Sullivan, 1953). For example, blame from others can be transformed internally into self-blame, which in turn may lay the groundwork for perceiving others as blaming in future interactions (Benjamin, 1996). In the present study, unsatisfied patients may have become unsatisfied due to an initial lack of therapeutic progress that is interpreted within the confines of their more pathological interpersonal style, for example, by perceiving the therapist as blaming the patient for her lack of progress.

The present research gives some idea of why most patients appear satisfied with treatment and why others are unsatisfied, but there is still important work to be done. Future research could utilize a measure that attempts to capture more of the variance in satisfaction and help us to judge whether the present high levels of satisfaction are indeed realistic or an overestimate. We also need to know more about what is going on in the treatment process and how this relates to both satisfaction and outcome. It will also be important to examine patients over even longer follow-up intervals and more closely explore the relation of satisfaction to actual clinical improvement. For the time being, although the present study does indeed present a promising message of encouragement, it also suggests that there is cause for concern.

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## APPENDIX A

### *Treatment Satisfaction Scale (TSS)*

How well were you treated when you first came to the unit?

[0]☐ I was treated well.
[1]☐ No opinion.
[2]☐ I was not treated so well.

How suitable has the treatment programme been for you?

[0]☐ It has suited me well.
[1]☐ No opinion.
[2]☐ It has suited me less well.

Do you think that the staff have been able to listen and understand the things you've taken up during treatment?

[0]☐ Yes, to a great extent.
[1]☐ Yes, to some extent.
[2]☐ No.

Do you feel trust and confidence in the staff?

[0]☐ Yes, to a great extent.
[1]☐ Yes, to some extent.
[2]☐ No, not sufficiently.

Were you and the staff in agreement about the goals of treatment?

[0]☐ Yes, to a great extent.
[1]☐ Yes, to some extent.
[2]☐ No.

 