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Exploring the experience of young people receiving treatment for an eating disorder: family therapy for anorexia nervosa and multi-family therapy in an inpatient setting

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Abstract

Background: Research indicates that family therapy for anorexia nervosa (FT-AN) and multi-family therapy (MFT) are effective treatments for adolescents experiencing anorexia nervosa (AN). However, less is known about young people's experiences of these two treatments, as there is limited qualitative research, and to date no qualitative research within an inpatient setting. It is argued that the lack of such insight limits the development of services for young people experiencing AN.

Method: Five young people were recruited to the study from a specialist inpatient unit who were receiving treatment on the AN pathway which included both FT-AN and MFT. Semi structured interviews were undertaken and analysed using Interpretative Phenomenological Analysis.

Results: Four superordinate themes and ten subthemes were developed from the data. The four superordinate themes were: 'Process of Understanding', 'Reviving Connection', 'Emerging from the Eating Disorder' and 'Development of I'.

Conclusions: There appeared to be two overarching concepts: the role of the individual and the role of others, that helpfully framed the results. The superordinate themes: 'Emerging from the Eating Disorder' and 'Development of I' focused on the development of the individual. Conversely, the superordinate themes: 'The Process of Understanding' and 'Reviving Connection' were centred on the relationships existing within the family system. The results could help inform future service developments regarding inpatient provision and service design.

Plain English Summary: The most widely used and recognised treatment for anorexia nervosa in young people is family therapy for anorexia nervosa (FT-AN). An alternative treatment is multi-family therapy (MFT). Both treatments are deemed to be effective and usually happen in the community. However, some hospitals provide these treatments while the young people are in-patients. There is no research exploring young people's experiences of these two treatments while in an in-patient unit.

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Young people who had received both FT-AN and MFT in an inpatient setting were asked to share their experiences of these two treatments. Their stories were analysed by a researcher. The analysis identified four themes: 'Process of Understanding', 'Reviving Connection', 'Emerging from the Eating Disorder' and 'Development of I'.

The results highlighted that the young people appeared to place more value on the role of others and perhaps others changing enabled them to change. The research highlighted the benefit in others' understanding and therefore how improving societal understanding more broadly would be helpful. The young people reflected that both they and their parents benefited from FT-AN and MFT in an in-patient setting and it is proposed that this could help inform future service developments regarding inpatient provision.

Keywords: Adolescent, Anorexia nervosa, Qualitative research, Family therapy for anorexia nervosa, Multi family therapy

Background

Anorexia nervosa

Anorexia nervosa (AN) is a serious condition associated with severe physical [1] and psychological complications [2], with one fifth of deaths associated with AN due to completed suicides [3]. AN is believed to have the highest mortality rate of all mental health conditions [4] and a higher mortality rate than physical health conditions such as asthma or diabetes [5].

Anorexia nervosa in young people

AN is predominately associated with adolescence, and prevalence studies have shown the median age of onset for AN to be 12.3 years [6], with incidence rates being highest amongst the 15–19 age range [5]. AN is reported as the third most chronic illness amongst adolescents [5], this chronicity and severity highlights the importance of both effective and timely treatment as lower age and reduced duration of illness are factors associated with better treatment outcomes [7]. The 'Access and Waiting Time Standard for Children and Young People with an Eating Disorder' document states that young people should have access to National Institute for Health and Care Excellence (NICE) compliant treatment in a timely manner [8]. The document provides guidance on standards for establishing services and the delivery of treatment.

Treatment for anorexia nervosa in young people

Family Therapy for Anorexia Nervosa¹ (FT-AN) is the first line intervention for adolescents experiencing AN, as defined by NICE guidance [9]. FT-AN is a treatment that empowers parents to 're-feed' their child, it is most commonly an outpatient treatment, delivered weekly to a single family facilitated by a single therapist. It consists of three phases which ultimately focuses on the young

person taking back control of their eating. In addition to FT-AN, multi-family therapy (MFT) [10], was developed as a group treatment approach with different families coming together for treatment. Up to eight families may form group therapy sessions, consisting of a range of activities and tasks, usually with two therapists.

Research reviewing the existing literature highlights the efficacy of FT-AN and MFT [7]; FT-AN was deemed to be significantly better than the comparison treatment at six and twelve month follow ups [11] and MFT also resulted in significantly better treatment outcomes [12]. However, there remains a limited number of randomised control trials (RCTs) exploring the effectiveness of both treatments; a meta-analysis exploring adolescent treatment only included seven RCTs including FT-AN [13] and the most recent systematic review on MFT contained 27 studies [14], of which only two were RCTs [12, 15] and two were conducted in an inpatient setting [15, 16]. Research is supportive of the adaption of FT-AN [17–19] and MFT [15, 16] in more intensive treatment programs. To the authors knowledge there have been no studies focused on these combined treatments in inpatient settings and the evidence to support the effectiveness of inpatient treatment is variable and largely inconclusive [20].

We also note that there has been little qualitative research looking at adolescents' experience of FT-AN. Some research has looked at adolescent experience of FT-AN in outpatient community settings [21–24], which highlighted the importance of family involvement. An even smaller body of qualitative research has been undertaken on young people's experiences of MFT [25–27], highlighting treatment acceptability and the benefits of the group process. There are clear benefits to understanding how young people experience treatment [20], it is useful both to inform service development [28], and provide insight into treatment acceptability and complexity, [29]. For example, young people appeared to value FT-AN, finding key aspects of the manualised treatment most helpful, even if it was challenging for them [29].

¹ Family Therapy for Anorexia Nervosa can also be referred to as Maudsley Family Therapy or Family Based Treatment.

Table 1 Participant demographics

Participant number	Name**
1	Morty
2	Lilly
3	Meghan
4	Lucy
5	Molly

**Pseudonyms have been allocated to maintain confidentiality

Furthermore, the 'Access and Waiting Time Standard for Children and Young People with an Eating Disorder' document highlights the importance of commissioners understanding the experiences of young people in order to improve access to services [8].

Method

Aims of the project

The principal objective of this research was to explore young people's experience of FT-AN and MFT in an inpatient setting in order to better understand the sense they make of the treatments provided and, from their perspective, treatment acceptability.

Ethics

Ethical approval was granted by the Health Research Authority.

Participants

Purposive sampling was used to recruit five participants to the study from a National Health Service inpatient unit for eating disorders (ED). The inpatient unit provided multiple treatment pathways, one being the AN treatment pathway which included having FT-AN and MFT as part of their inpatient treatment. Participants were recruited from the AN pathway; whilst on this individuals would receive manualised FT-AN and five days of MFT. Four of those days were held on consecutive weeks, with the fifth being held nearer to discharge. The MFT was a closed group with a maximum of eight families, facilitated by two clinicians. Individuals were referred to the inpatient unit via their community team as they were judged to be unable to remain at home due to the severity of their presentation. The young people were admitted and lived in the hospital unit without their family until they were deemed to be well enough to be discharged back to their community team. Family members were allowed to visit regularly, attended for therapy sessions and join other aspects of the unit's routine, such as mealtimes and recreational activities. The participants had either a diagnosis of AN or a diagnosis largely characterised by features of AN, such as Other Specified Feeding and Eating Disorders. Four

participants were female, and one was male, ages ranged from 10–18 with a mean age of 14.6 years. Three of the participants were nearing the end of their inpatient stay and were deemed to have completed MFT and FT-AN by the clinical team and the other two had recently been discharged. Pseudonyms have been allocated to participants to maintain confidentiality (see Table 1). The nature of the study meant that no additional demographics were collected regarding the participants. Although illness specific demographics were not obtained it is the case that participants conditions were sufficiently severe, at the time of admission, as to require inpatient care, and at the time of discharge they were well enough to be cared for by community teams.

Data collection

Participants engaged in semi-structured interviews designed to explore themes relating to the young person's experience of treatment and of change. The interview guide was cocreated with an expert by experience. The interviews varied in duration, ranging from 24 to 76 min with a mean duration of 37 min.

Data analysis

Interpretative Phenomenological Analysis (IPA) is a qualitative research method that focuses on examining how people make sense of their lived experiences [30]. It was particularly suited to this study as it was concerned with the sense young people make of their experience of receiving therapy in an inpatient unit. As IPA is concerned with the individual experience a small sample of participants was deemed appropriate [30], furthermore recruitment was limited due to the Covid-19 pandemic. Due to the interpretative nature of IPA and the existence of a 'double hermeneutic' (the researcher making sense of the participants own sense making), it was important to engage in reflexive processes. Due to the researcher's (EC) previous experience of working in EDs and role as a trainee clinical psychologist, it was important for the researcher to remain mindful of her experiences to ensure that she did not map her understanding of reality on to those of the participants and make assumptions about their experiences, bracketing off assumptions and understanding. Many processes were incorporated throughout the progression of IPA to enable reflexivity and to enable consideration of biases: supervision, IPA tutorial groups, keeping a reflexive diary and discussions with supervisors and colleagues.

Results

Four superordinate themes arose from the analysis of the data: 'Process of Understanding', 'Reviving Connection', 'Emerging from the Eating Disorder' and 'Development

Table 2 Overview of themes

Superordinate Theme	Subthemes	Participants contributing
Process of Understanding	Understanding you are not alone	All participants
	Others understanding	All participants
	I am understood	All participants except Meghan
Reviving Connection	Altering the system	All participants
	Taking it forward	All participants
Emerging from the Eating Disorder	Understanding the immersion	All participants except Molly
	The Eating Disorder as damaging	Lily, Meghan and Molly
Development of I	Adapting to the new norm	All participants except Lilly
	The process of evolving	All participants
	Finding my voice	All participants except Lilly

of I'. Each superordinate theme had a number of sub-themes (Table 2) which will be presented in further detail with associated quotes to support the development of the theme.

Process of understanding

The superordinate theme 'Process of understanding' related to the young people's experience that once others came to understand more about the ED then the young person felt more understood.

Understanding you are not alone

The theme 'Understanding you are not alone' arose from the sense that being with others, either professionals or peers, facilitated learning and change, as Lilly made sense of her experience of MFT: "I think it was nice to talk to other people, other parents, er, they knew they weren't alone and they gave them the tools to progress". Morty reflected on the impact of the groups on his parents' understanding: "groups and stuff for like parents to understand and stuff ... it helps like with my parents and stuff to understand and helps me to like try and deal with things a bit better".

Throughout this theme there was an overarching sense that the young people attributed the benefit of the treatment to the impact it had on their parents' understanding, as described by Molly: "it was almost Multi-Family Therapy was less for us, more for our parents, or at least that's what we felt." Despite the usefulness of connecting with others there was a sense that at times it could be unhelpful as Lucy explored: "...to hear people who had got re-admitted..." Notwithstanding the apparent difficult nature of learning about relapse described by Lucy, it is questioned if this experience enabled a greater understanding of the ED for Lucy and her parents. It was felt that aiding understanding in others was seen as beneficial to the young people.

Others understanding

When the young people talked about their experiences there was a sense that other people understanding more was central to their treatment experience, and this was enabled through the processes described in 'Understanding you are not alone'. This notion related largely to parents having a better understanding of the ED: "I think that they'd say that [pause] their [pause] view of anorexia has changed probably ... They see it as more a mental illness" as described by Lilly. There was a sense that the parents had gained a greater understanding of the illness itself but also the severity of the illness. The enhanced understanding appeared to sit within the context of supporting parents as described by Lucy: "it's helped them" to understand the ED but Lucy still felt that her parents would never be able to fully understand her experience: "obviously you can never be 100%...". This subtheme related to the young person valuing their parent having a greater awareness and understanding of the illness, which it felt enabled the young person to be better understood.

I am understood

The subtheme 'I am understood' was created through the interpretation of the data which conveyed a sense that the young people were better understood as a result of their parents increased grasp of the ED. Lucy described her parents as having a greater understanding of the emotional impact: "Erm [pause] helped them understand the emotions associated with it [pause] and how it's not one-sided ever. It's always two sides". Thus, sharing a sense that she is better understood and implying parental responses to her have been modified. The notion of modified parental responses was highlighted by Lilly who felt that her parents now knew how to support her: "Er, they know how to manage my meltdowns... and they know how to properly support me at mealtimes" and Molly described them as: "a lot more accepting".

Morty described the idea that now his parents' understanding had changed so had the way they made sense of his previous behaviour: "...I think she also thought like, about like I was choosing to be unwell and stuff but yeah." Morty's experience created a sense that his past behaviours were better understood in the context of the ED and raised the question as to whether there would be an improved interaction between Morty and his parents going forward due to this greater understanding of the young person. The increased understanding of the young person in the context of the ED appeared to highlight an improved interaction between the parents and young person.

Reviving connection

The superordinate theme of 'Reviving connection' centred around the notion that there was a newness to the connection the young people and their families were experiencing. There was a process through which disconnection had occurred but altering the system through treatment enabled the system to act differently and thus revive the connection.

Altering the system

The subtheme of 'Altering the system' centred on the idea that in order for the sense of disconnection to change then the system needed to be altered, with the alteration occurring through the interventions of FT-AN and MFT. The idea that someone external entering the system could facilitate change was offered by Molly: "...having someone a third party label it... makes it much easier to have conversations...I don't sometimes have to say what I really think but they still understand what's going on." Lucy further supported the sense that an external voice entering the system was of benefit as it was believed to be positive: "... having a voice from someone else...you need someone else to kind of have an input." The role of an external entering the system seemed to centre on the benefit of an outside voice as well as the role of FT-AN and MFT as highlighted by Meghan: "... we did a role play ... we were the parents [okay] and I think that sort of opened it up for a lot of us, sort of actually seeing sort of what it must be like in your parents' perspective...". The value in the role of treatment was situated in the context of enabling an alternative perspective. Meghan talks of understanding the situation from her parent's perspective, and Molly talked of her family becoming: "a lot more aware of each other". Supporting the notion that therapy has helped shift perspectives which has enabled the family system to act differently, as if the family scripts, which are the narratives the family hold are starting to become more fluid due to the input of others.

Taking it forward

The shifts in family systems as a result of altered perspectives and increased understanding were acknowledged by the young people as they started to make sense of what this meant for their families in a longer term capacity, figuring out how to take the changes forward with them. The role of an external voice entering the system and shifting perspectives led to the familial systems acting differently. Young people talked of improvements in their relationships with significant others as Lilly describes: "getting closer again" to her sibling, which was supported by Meghan's experience: "...not just like me and my family, my family's got closer with each other as well...". Molly explored the changes that had occurred for her family: "... being able to have more conversations, have like brother as an ally rather than someone to compete against," highlighting the revival of a sibling relationship and a sense that there is a version of normality emerging.

Although the young people reflected on these changes as positive, it was apparent that they were also challenging and required effort to embed in altered family scripts. Molly described: "...building on creating almost a new element of family is really difficult and still is...". Molly highlighted the challenges faced by the family and the use of the word 'building' supports the notion that this process of change is hard work and takes effort and thought. There was a sense that despite the hard work implemented by the families there were times when the new way of doing things was ineffective. Lucy further highlighted the idea of ineffective communication; making sense of it as her family became stuck as they are: "... going round in circles...".

There were further difficulties with embedding change within the family as highlighted by Morty who suggested that although talking was happening outside of therapy it was only: "sometimes" and: "not that much outside though", highlighting the role of therapy in facilitating relational shifts. There was a sense that the young people wanted to take the changes forward, but it was a complex process. The impact of the individual on the shifts in the relational changes is important to consider and as this research explored the experiences of the young people their experiences of individual change will be explored further.

Emerging from the eating disorder

The superordinate theme of 'Emerging from the eating disorder' resonated with the sense that at some point in the illness trajectory the young people experienced being consumed by the ED but as they progressed through treatment they came to gain a sense of perspective and to understand the ED as damaging.

Understanding the immersion

The young people shared experiences of the ED, which were understood in the context of being immersed in the illness, as Lilly came to realise the need for inpatient treatment: “it got to a point where I wanted to get better and I knew I couldn’t do that at home”. Lilly describes feeling: “upset” by the experience of hospital but it feels as if she came to a realisation that she was so immersed in the ED that she had no other option; she could not recover at home implying the ED was too strong. The idea of struggling to progress was shared by Lucy who explained: “I wasn’t really making enough progress in the community. So it was, yeah, I was sent there”, implying inpatient treatment enabled her to emerge from the ED.

There was a sense that the young people were fighting to return to a previous way of being, as Morty described: “they’ve helped with like, er, trying to get, er, back into like eating different foods.” The sense that Morty needed help to ‘try’ reinforces the gravity of the challenge the young people faced when trying to regain a sense of normality in the context of eating. Meghan used eating as a measurement of change: “...I look back and realise how bad I used to actually ...I’m eating now, but like a couple of months ago, I probably wouldn’t eat anything at all.” The striking feature of Meghan’s account is the power in her realisation of how immersed she was; the young people needed facilitated recovery to enable them to reflect and realise the impact of the eating disorder on themselves. There is a sense that the ability to reflect on the past is key to their understanding and that the young people would not have understood the immersion at the time. The subtheme feels centred around the realisation of where one was in terms of the illness as opposed to evaluating the impact of the immersion.

The eating disorder as damaging

There was a unanimous experience that the young people came to understand the illness as damaging; Lilly described it: “what it would look like it would be like spikey...” when trying to make sense of how she would externalise the ED. The word spikey is suggestive of causing harm to those on the exterior but perhaps also harmful to self as it ensures others are repelled and keep a distance. The notion of distance was supported by Lilly as she reflected an impact of the ED on her relationships: “We’re definitely not as close..., I really took it out on her.” Lilly highlighted the lasting impact it had on her sibling relationship whilst indicating she felt a sense of responsibility for these changes. Molly further contributed to this sense of damage caused to others and self as she described: “just the relief ... you’re not forcing your parents into that situation anymore is incredible... it’s really difficult because you’re constantly lying”, this is

suggestive of damage incurred due to the coercive nature of the ED but there is also a reinforcement of the responsibility or guilt that is experienced by the young people.

Molly further described the damage experienced by the ED in the context of damage to self: “I feel like I chose it because I did it to myself.” Molly describes her experience as believing she made a choice in terms of her actions and it is felt that this is experienced as guilt for the impact of the ED; therefore providing an alternative stance on the ED as damaging as it appears to be damaging from an internal stand point for Molly. Interestingly, Molly questions if her beliefs about choice are: “an anorexic thought”, implying time might enable a shift away from her experience of responsibility. There was a sense that the young people experienced the ED as damaging due to the impact it had on others and the emotional impact on themselves because of the perceived sense of responsibility for the damage. However, there was a sense this could shift over time and this had occurred during their inpatient experience.

Development of I

The superordinate theme of ‘Development of I’ was focused on experiences of individualised change for the young people. Throughout the theme there appeared to be a sense of questioning and almost hesitance in identifying and naming changes for them as individuals. It is important to consider the impact of individualised change on the system. Yet the value placed on change for the individual appeared less than that of the value placed on others changing and the systems changing.

Adapting to the new norm

There was a sense that the young people experienced adjusting to a new sense of normal. Their experience of entering hospital was described as difficult, the young people felt they were entering the unknown, as described by Lucy: “It was hard...I just think being like taken away from your home is really difficult”. Molly reiterates the idea of the unknown: “...you’ve just suddenly moved into like a new place and you’re living with people [inaudible], so I was very scared when I first got here.” Despite the sense that coming into hospital was challenging, Molly appears to be suggesting that this was her initial experience and it changed over time.

The changes in an individual’s experience was attributed to the connection with others by Meghan: “...it was scary... then you make friends and ... close relationships with people, [pause] it’s not as bad” whereas Morty seemed to make sense of it as: “it just feels a bit more like, just a bit more like you get used to it...” Thus there was an overarching awareness of the role of time that appeared to facilitate adaption, Lucy explained: “I think,

as time went on, it became more and more valuable and different activities we did”, reinforcing the idea that time enabled the individual to develop to a point where they valued the input. The young people reflected on the challenging experience of entering an inpatient facility and how time enabled a shift in the way they felt, enabling an adaption.

The process of evolving

The subtheme ‘The process of evolving’ related to the idea that there had been change for the young person as an individual and they experienced a process of change. Lucy recognised that over time her contribution to therapy evolved: “... throughout my stay I became more [pause] involved in the session”, it is questioned how the sense of involvement facilitated change for Lucy. Other young people noticed an emotional shift in themselves as Morty reflected: “...I’ve got more, er, calm with, er, sort of being in hospital, I guess..., the therapy like sort of changed how like I sort of felt as well...”. Although Morty recognised a shift in his internal state, he highlights the hesitance that surrounded the young people when discussing the evolution of themselves. It is questioned if this relates to a difficulty in expressing oneself or a reluctance to prioritise the role of I in this process. The idea of a change in one’s internal state is supported by Lilly: “My mental state is much different to the state it was in, feeling less upset, less tearful”, highlighting a positive evolution in her mental state.

Furthermore, the young people described a sense of evolving to be in a position where they better understood themselves as described by Meghan: “...it’s not just figuring out my problems, ... I feel like [pause] I’m more confident, just as a social [yeah] person as well as before I came in here as well.” Meghan highlighted the benefits of her experience of treatment as not solely focused on the problem but a wider impact on the development of her as an individual, reflecting on how she evolved and how this differed from her former self. The young people reflected on an experience of evolving in their understanding of themselves, which led to a change in their internal states, and how they acted.

Finding my voice

The final subtheme to be presented further explores the process of self-development and how the young people emerged from the process as an evolved version of their former selves. The idea that the young people had found a voice arose from the interpretation of the data as Meghan describes a change in how she approaches things: “... I wouldn’t dare to say anything before [yeah], I was very a keep to myself type of person, I can’t really do that here [laugh]”. There is a sense that Meghan was

previously hesitant to use her voice and it feels as if the change in using her voice is associated with her sense of self-development. It is questioned if there was a sense of fear regarding using her voice and perhaps the power it held. There was a sense that practicing using their voices enabled them to find their voice as Lucy described: “... one of the things we did talk about in family therapy was how to deal with other people...now I can deal with it. So, I think that – talking about it definitely did help.”

There is a sense that by practicing using her voice it enabled it to become the norm and perhaps this impacted on the previously perceived repercussions of using their voices. Morty reinforces the notion that finding his voice, and subsequently using it, became the norm: “maybe it’s just because, er, I’ve been with loads of people on the ward and talking to them, maybe I’m a bit more used to talking.” It is suggestive that through a process of finding their voices and talking, the young people had developed a sense of who they were and thus enabled them to share their lived experience of FT-AN and MFT in an inpatient setting.

Discussion

Analysis of the data resulted in the development of four superordinate themes within two overarching concepts: *the role of the individual* and *the role of others*. The themes generated from this research highlighted that young people valued being understood and the revival of interrupted connection, they placed less emphasis on their experiences of change and the role of the individual within this experience.

The role of the individual

The themes ‘Emerging from the eating disorder’ and ‘Development of I’ centre around the experience for the individual. The young people acknowledged the damaging nature of the ED in the theme ‘Emerging from the eating disorder’; which is consistent with Eaton [2] who described individuals as having a ‘pivotal moment of realisation’ regarding the damage caused by ED. However, the idea of a defining moment did not emerge from the transcripts; Eaton’s Meta-Ethnography is focused on the experiences of adult females and therefore it is possible that young people have a different experience. Existing research reported a deterioration in interpersonal relationships in the context of damage caused by the ED [2, 31–33], as opposed to damage to significant others and the impact on the individual in terms of responsibility for the damage caused to others as was evident in this research.

The young people explored the impact the ED had on their self-development, giving consideration to how they had evolved through the process during their reflections

in the theme ‘Development of I’. Research supports the notion of an individual losing their sense of identity in an inpatient context [20, 34, 35], highlighting that inpatient settings can foster dependency [34]. However, the unique nature of the inpatient unit in terms of the use of FT-AN and MFT, combined with the encouraged parental involvement, may have prevented a sense of dependency developing.

The impact of individual change on the wider familial system could usefully be explored further as the young people participating in this research placed an emphasis on a shift in parental understanding, which is suggestive, that parental shift enabled individual change. It is believed systemic change, in the context of parental containment in FT-AN is needed in order to support individual change [24], reflecting the experience of the young people in this research. It is noteworthy that this still occurs for the individuals when undertaking FT informed treatments whilst removed from the family environment.

The role of others

‘The process of understanding’, followed by ‘Reviving connection’ centred on others and focussed less on the individual. Within FT it is felt that an individual can be understood in the context of the familial system and this system is utilised to facilitate change [36], which is consistent with these themes.

A disconnect within the family was described by the young people in the theme ‘Reviving connection’, which is again supported by the literature. Research highlights the anxiety provoking nature of an ED and how this impacts on parents and consequently interconnection within the family [24]. Whitley and Eisler [37] reported that families adapt to centre around an illness, causing disruption to family life and magnifying existing patterns of family functioning. Therefore, the removal of the individual from the system in the context of an inpatient admission may disrupt this ‘centralisation of the illness’ and therefore provide a space to facilitate and enable change to occur.

The themes ‘The process of understanding’ and ‘Reviving connection’ were interconnected in the idea of learning and altering actions facilitated by the treatments. A Meta-Synthesis exploring young people’s experiences of FT-AN in community settings highlights the improvement in familial relationships via the process of therapy [29]. The notion of improved relationships was apparent in the experiences described by the young people in this research, highlighting similarities in the young people’s experiences of FT-AN in an inpatient context when compared with the existing literature. If young people detail a similar experience it is questioned if this supports the

efficacy of the treatment outcomes as FT-AN and MFT are only researched in community settings.

Clinical implications

A number of recommendations can be made in regard to service provision. The young people placed value in others learning and understanding about the ED which helped them to feel understood, and such training and education could form part of an intervention pathway, perhaps initially with further training and education to professionals. Individual ED services could provide training to primary care and third sector services to enhance recognition, understanding and signposting which could then be shared with parents and families.

The outcome of the research highlights treatment acceptability for young people in an inpatient setting. The young people appeared to value the treatments offered, and even when they did not value them for the benefit to themselves, they identified the value to parents. Furthermore, as the inpatient unit offers a novel way of delivering inpatient treatment the findings support the notion that young people benefit from this approach and value the support offered, recognising the value this could bring in terms of changing the family focus on illness.

At a wider level improving the societal understanding of EDs has potential clinical value as this may result in a more helpful response by parents when experiencing a child with an ED for the first time. In addition, ongoing support to parents was deemed valuable in this data set, which is supported by research evidence highlighting the acceptability of online support platforms [38] and anecdotal reports of the value of face-to-face support groups for parents.

Limitations

There are limitations that need to be considered with this research project. The sample size was small, with a total of five participants, and whilst recruitment issues were unavoidable due to the service constraints and the Covid-19 pandemic, it does limit the findings and the potential for missing important experiences. However, qualitative research is typically associated with small sample size enabling rich, detailed accounts to be obtained through semi structured interviews providing insight into lived experience in a way that is unattainable in quantitative research. Furthermore, recruitment was carefully considered to ensure that a homogenous group of participants were recruited to enhance the understanding of this particular group. The value in a homogenous sample in qualitative research is that it enables an in-depth exploration of a particular group of people sharing a particular experience in a given context.

Future research

Further research into the area of FT-AN and MFT in an inpatient setting would be of value to build on these findings, inform service provisions, as well as enhancing the understanding of young people's experiences and acceptability of treatment modalities available to them.

Conclusions

The research highlighted the process of evolving through treatment, for both the individual and their familial system. There was a sense that damage could be caused by the ED, yet treatment enabled repair. The research evidenced the importance of others learning and understanding EDs, which has implications for treatment services, as well as wider society.

Abbreviations

AN: Anorexia nervosa; ED: eating disorder; FT-AN: Family therapy for anorexia nervosa; IPA: Interpretative phenomenological analysis; MFT: Multi-family therapy; NICE: National Institute for Health and Care Excellence; RCTs: Randomised control trials.

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Author contribution

EC collected, analysed and interpreted the data, as well as writing the manuscript. GJ provided triangulation throughout the analysis and contributed to the writing of the manuscript. All authors read and approved the final manuscript.

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Availability of data and materials

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

Ethical approval was granted by the Health Research Authority. The research received a favourable opinion from West Midlands – Solihull Research Ethics Committee (IRAS ID: 257778).

Consent for publication

Consent for publication was obtained from all participants, either via consent of the individual or their legal guardian.

Competing interests

The authors declare no competing interests.

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Care experiences of young people with eating disorders and their parents: qualitative study

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Background

Perspectives of young people with eating disorders and their parents on helpful aspects of care should be incorporated into evidence-based practice and service design, but data are limited.

Aims

To explore patient and parent perspectives on positive and negative aspects of care for young people with eating disorders.

Method

Six online focus groups with 19 young people aged 16–25 years with existing or past eating disorders and 11 parents.

Results

Thematic analysis identified three key themes: the need to (a) shift from a weight-focused to a more holistic, individualised and consistent care approach, with a better balance in targeting psychological and physical problems from an early stage; (b) improve professionals' knowledge and attitude towards patients and their families at all levels of care from primary to 'truly specialist'; (c) enhance peer and family support.

Conclusions

Young people and parents identified an array of limitations in approaches to care for young people with eating disorders and raised the need for change, particularly a move away from a primarily weight-focused treatment and a stronger emphasis on psychological needs and individualised care.

Declaration of interest

None.

Keywords

Qualitative research; anorexia nervosa; bulimia nervosa; carers; eating disorders NOS.

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Eating disorders are serious conditions of increasing prevalence among young people.¹ In the UK, out-patient treatment² was historically delivered in generic child and adolescent mental health services (CAMHS) or highly specialised eating disorder services, with significant regional variation in provision.³ Although there is growing evidence about the efficacy of particular treatments,² our knowledge about the impact of different clinical settings on treatment outcomes is limited. Studies suggested that specialist service provision may lead to better case identification, greater consistency of care and be more cost-effective,^{4–7} but the data are limited. In England, there has been recent investment in specialist community eating disorder services for young people in all regions,⁸ the impact of which is unknown. These developments are contemporaneous with increasing emphasis on patient-led recovery approaches to eating disorders as well as patient and carer participation in service design, for which data on patient and carer perspectives are important.

Qualitative research can facilitate a better understanding of what patients perceive as optimum care.⁹ In the field of eating disorders such understanding mostly comes from qualitative studies in adults, with research on adolescents' perspectives of treatment and recovery more recently emerging. Previously identified themes highlighted the role of family, peers and professionals, family therapy, the in-patient setting, emphasis on physical versus psychological aspects and conceptualisation of recovery among adolescents with anorexia nervosa.¹⁰ Most previous qualitative research has focused on anorexia nervosa rather than broader eating disorder diagnoses.¹¹ However, current service provision does not typically provide distinctive care pathways or services for different types of eating disorders. Research also focused on experiences of specific treatment settings, particularly in-patient care and parallel

exploration of young people's and parents' perspectives is limited. Greater satisfaction with treatment and more positive experiences of family therapy have been reported by parents compared with adolescents with anorexia nervosa.¹² Our study aimed to explore young people's and parents' experiences of care for eating disorders, both positive and negative, across various treatment settings and the ways care could be improved by using thematic analysis. We hypothesised that, despite the ego-syntonic features often encountered in eating disorders, young people want good care towards recovery, and their views would be similar to those of parents on what constitutes good healthcare.

Method

Participants

A purposive, non-probability sampling method was used to identify individuals who were likely to have experience of a range of different eating disorder service provisions. Young people aged 16–25 years who had an ongoing or past eating disorder and had contact with healthcare services in relation to their eating disorder, and parents of young people in the same situation, were recruited through Beat using an online advertisement. Beat is the UK national eating disorder charity, which has supported extensive research in this field by facilitating recruitment (<http://www.beateatingdisorders.org.uk>). Attention was drawn to the advertisement via Beat's email database and its Facebook and Twitter profiles. Responders to the study advertisement were provided with further information about the study via email. Recruitment continued until saturation of themes was reached (i.e. the point at which no new ideas emerge

from additional data collection).¹³ All participants gave written consent to take part via email. Ethical approval was granted by the University of Exeter Medical School Research Ethics Committee (REC REF Apr15/B/062).

Data collection

Participants completed a baseline questionnaire covering demographic information, details of healthcare services used in relation to their eating disorder, or, in the case of parent participants, those of their child's eating disorder. Focus groups for young people and parents were facilitated separately. In order to provide a balance of experience of different service provision in each group (out-patient and in-patient, generic and specialist, child and adult services), we drew on the baseline questionnaire data on type of healthcare services they had used for eating disorders to allocate participants, as much as possible, given the response rate and participant availability. Each of the four online focus groups with young people included a mixture of younger and older participants (i.e. below and above the mean age for the sample), also of mixed diagnosis and treatment status (except for one group where by chance all participants had anorexia nervosa and were no longer receiving treatment). Each parental group included a participating father; one group included parents of a child with anorexia nervosa and mixed treatment status, and the second group included parents reporting more than one diagnostic category and whose children were no longer in treatment for their eating disorders.

Each focus group was convened as a synchronous 'chatroom' for a maximum of seven individuals in the Chat Blazer software (www.chatblazer.com). Each participant was provided with a unique, non-identifying username and password. Participants had no access to others' personal information except for their chosen usernames. Each group was run by an experienced Beat moderator and a group facilitator from the research team. The facilitator led the group by introducing the topics of the semi-structured guide, which included open questions and prompts. The topics were identified through a review of the existing literature.^{10,14,15} and from the authors' clinical experience and covered the following areas: overall experience of services including accessibility, flexibility, medical assistance, professional encounters, key professional qualities/skills, individual and family support and important treatments; helpful aspects of care; unhelpful aspects of care, potential changes to these and desired impact of change; views on specialist services versus generic CAMHS; views on community versus in-patient services; views on age division within services and experience of adult services; and suggestions for service improvement (see Supplementary Material, available at <https://doi.org/10.1192/bjo.2018.78>).

The moderator was responsible for setting the 'ground rules', monitoring for any sensitive issues and rejecting any unsuitable comments prior to them being shared. Each participant typed their answers, which, after being approved by the moderator, were displayed on screen for others to read and respond to. Each group had a chat supervisor (member of the research team) who provided support to distressed participants through private online communication (separate closed chatroom). This included the recommendation to contact a healthcare professional such as their general practitioner (GP) (the research team did not have participants' consent to make contact directly on their behalf) and signposting to other support services (only one participant required this). Each group lasted between 60 and 90 min. All participants were invited to comment on the transcript of the group they participated in and on a summary of findings.

Data analysis

Focus group transcripts were generated automatically by participants' typed responses (mean word count 6043, s.d. = 1351.8,

range 3587–7258 words). All transcripts were analysed in NVivo software (<http://www.qsrinternational.com/nvivo/nvivo-products>) using thematic analysis.¹⁶ This involved a detailed reading and re-reading of the transcripts, identifying and labelling codes in each transcript, arranging the codes into themes and summarising the themes. This process was carried out iteratively with the team of researchers moving back and forth between transcripts and emerging themes. In order to address potential preconceptions of the main rater, three transcripts of two groups with young people and one with parents were independently coded and extracted themes were subsequently compared and discussed until full agreement on final themes was reached.

Results

Characteristics of the young people who participated in the study are described in Table 1. A total of 19 females aged 16–25 years (mean age 20.7, s.d. = 3.3) took part in four online focus groups. Only one participant was from an ethnic minority. Nearly two-thirds had or were recovering from anorexia nervosa and the remainder had or were recovering from bulimia nervosa, 'other/atypical eating disorders' or a combination of these. Mean illness duration was 6 years (s.d. = 3.6, range 15 months to 13 years).

Eleven parents took part in two online focus groups. Most were mothers ($n = 9$), none were from an ethnic minority and the majority had a daughter ($n = 9$) rather than a son ($n = 2$) with an eating disorder, mostly anorexia nervosa. One participant reported a combination of anorexia nervosa and binge-eating disorder (Table 2). Mean age of their child at the point of diagnosis was 14.7 years (s.d. = 2.1, range 11–17). Mean duration of their child's illness was 5 years (s.d. = 4.1, range 12 months to 15 years). As a result of the anonymity assured by our protocol, we were not able to establish the overlap between the young people and parent samples (although three participants disclosed this).

Most young people had used a mixture of healthcare services. Use of private healthcare was scarce (young people 16%, $n = 3$; parents 18%, $n = 2$). For both samples, nearly two-thirds of young people were no longer in treatment (young people 63%, $n = 12$; parents 64%, $n = 7$).

Three main themes emerged from participating young people's and parents' accounts of their experiences of care. Each main theme and its subthemes are discussed in turn and illustrated by participants' first-hand quotations. The source of each quotation is indicated by the participant's study ID number (YP, young person; PA, parent). Three secondary themes and supporting quotes are presented in Table 3.

Early, holistic, individualised and consistent care

All participants' accounts (young people and parents) suggest an imbalance between physical and psychological aspects of care. Most participants described good experiences of the care addressing physical health needs, but reported that there was too much focus on patient's weight while neglecting psychological aspects and more personalised, life-long skills.

Early intervention

Participants viewed referral to services and admission for treatment as largely dictated by the patient's weight, setting a threshold that appeared to promote weight loss as a means of accessing support. Delaying intervention as the patient was 'not ill enough' was seen as likely to hinder recovery, as opposed to early consideration of relevant emotional and behavioural symptoms:

Table 1 Information about the young people who participated

Study ID	Age, years	Diagnosis	Total illness duration, years	Treatment status	Healthcare services and interventions used
YP1	21	Anorexia nervosa	6	Ongoing	Out-patient, in-patient, day-patient, paediatric, CAMHS, AMHS, CYP-EDS, AEDS
YP2	24	Anorexia nervosa and bulimia nervosa	13	Ended	Out-patient, hypnotherapy, psychotherapy, dietetics
YP3	16	Anorexia nervosa	1.25	Ongoing	Out-patient, in-patient, day-patient, paediatric, CAMHS
YP4	24	Anorexia nervosa	8	Ongoing	Out-patient, day-patient, AMHS, AEDS (also private services)
YP5	17	Anorexia nervosa	3	Ended	Out-patient, CYP-EDS, AEDS (also private services)
YP6	25	Anorexia nervosa	8	Ended	Out-patient, CAMHS, AMHS, AEDS
YP7	20	Bulimia nervosa	4	Ended	Out-patient, CAMHS, AMHS, CYP-EDS, AEDS
YP8	24	Other/atypical eating disorder	10	Ended	Individual and group psychotherapy (CBT, mindfulness)
YP9	20	Anorexia nervosa	4	Ongoing	Out-patient, AMHS, AEDS, counselling (university)
YP10	25	Other/atypical eating disorder	12	Ended	Out-patient, in-patient, CAMHS, AMHS, CYP-EDS
YP11	19	Anorexia nervosa	3.25	Ongoing	Out-patient
YP12	16+ ^a	Anorexia nervosa and bulimia nervosa	7	Ended	Out-patient, in-patient, day-patient, CAMHS, AMHS
YP13	22	Anorexia nervosa	3	Ended	Out-patient, AMHS
YP14	16	Anorexia nervosa	1.25	Ended	Out-patient, CAMHS
YP15	18	Anorexia nervosa	2	Ended	Out-patient, in-patient, day-patient, paediatric, CAMHS
YP16	24	Anorexia nervosa and bulimia nervosa	9	Ended	Out-patient, CAMHS, AMHS (also private services)
YP17	18	Anorexia nervosa	5	Ongoing	Out-patient, AMHS, AEDS
YP18	24	Anorexia nervosa	10	Ongoing	Out-patient, CAMHS, AMHS, CYP-EDS, AEDS
YP19	16	Anorexia nervosa, bulimia nervosa and other/atypical eating disorder	4	Ended	Out-patient, in-patient, day-patient, CAMHS

CAMHS, child and adolescent mental health services; AMHS, adult mental health services; CYP-EDS, child and adolescent (specialist) eating disorder services; AEDS, adult (specialist) eating disorder services; CBT, cognitive-behavioural therapy.
a. YP12 did not wish to disclose her exact age but stated that she fulfilled the inclusion criteria (i.e. aged between 16 and 25 years) and had used adult mental health services.

‘...specialist services are simply brought in too late. They’re supposed to catch you, but often you have to fall quite a way to get there.’ (YP9)

‘One of the main challenges is getting help early enough. There is too much attention paid to weight loss and not enough to the behaviour patterns and so they are dangerously low in weight before you get referred...It is the strange behaviour around food and rituals that indicate a problem. They may not be dangerously low in weight at this stage but far more retrievable.’ (PA9)

‘Seeing the whole person’

Most participants experienced professional help as being targeted towards reaching a ‘minimum healthy weight’ with limited psychological input. This often led to deterioration and relapse as their underlying difficulties of how to ‘deal with emotion and lack of

control’ persisted. They advocated a holistic approach aiming towards ‘recovery in body and mind’:

‘I recovered physically and got back to a healthy weight, but then with that recovery comes a huge psychological struggle and thus high risk of relapse, which certainly wasn’t addressed at the time...’ (YP3)

‘Really what you need is someone who sees the whole person – the link between the medical and psychological condition and treats both together.’ (PA1)

Many young people described upsetting sessions that revolved around ‘the number on the scale’ and frequent weighing ‘like a pig at the fair’, while their thoughts and emotions were ‘brushed off’. One recalled:

‘...I was feeling really positive about my recovery after reading a book about someone who had recovered and “seeing the

Table 2 Information about the parents who participated

Study ID	Young person's age at diagnosis, years	Young person's diagnosis	Total duration of young person's illness, years	Young person's treatment status	Healthcare services and interventions used
PA1	17	Anorexia nervosa	2	Ended	CAMHS
PA2	11	Anorexia nervosa	3.5	Ongoing	Out-patient, in-patient, day-patient, paediatric, CAMHS, CYP-EDS
PA3	16	Anorexia nervosa	3.6	Ongoing	Out-patient, in-patient (also private services)
PA4	11	Anorexia nervosa	1	Ongoing	Out-patient, in-patient, day-patient, paediatric, CAMHS, CYP-EDS (also private services)
PA5	16	Anorexia nervosa	2.8	Ongoing	Out-patient, CYP-EDS, AEDS
PA6	17	Anorexia nervosa	2	Ended	Out-patient
PA7	14	Anorexia nervosa and bulimia nervosa	9	Ended	Out-patient, in-patient, day-patient, CAMHS, AMHS, CYP-EDS, AEDS (also private services)
PA8	16	Anorexia nervosa	4.1	Ended	Out-patient, in-patient, day-patient, paediatric, CAMHS, AMHS, CYP-EDS
PA9	16	Anorexia nervosa	3	Ended	Out-patient, AMHS
PA10	14	Anorexia nervosa and binge-eating disorder	15	Ended	Out-patient, in-patient, CAMHS, AMHS, CYP-EDS, AEDS
PA11	14	Anorexia nervosa	8	Ended	Out-patient, paediatric, CAMHS, AMHS, dietetics

CAMHS, Child and Adolescent Mental Health Services; CYP-EDS, Child and Adolescent (Specialist) Eating Disorder Services; AEDS, Adult (Specialist) Eating Disorder Services; AMHS, Adult Mental Health Services.

Table 3 Secondary themes

Theme	Sample quotes
Access to care The 'postcode lottery' (geographical variation in type and quality of care)	'...it's just very difficult to comprehend if you haven't experienced it day in day out. This is maybe why there's value in groups? But again, very much a postcode lottery – there isn't one anywhere near me.' (YP9) 'We live in a rural area I feel the service was understaffed and poorly trained and supported. We withdrew from treatment as it was causing more harm...I know of several specialised units based in the larger towns around us but we did not have access to them.' (PA9)
Resources and waiting lists	'...I was put on a 6-month waiting list for counselling, and within 3 months was in A&E in critical condition. Unless you are critically ill, it is very difficult to access any form of service.' (YP15) '...CAMHS have such long waiting lists and they're in a rush to get you out of there...this in turn led to a relapse.' (YP7)
Out-of-hours care	'...there were many crisis points which of course were out of hours and it was very difficult to get the help we needed. CAMHS was helpful overall – just the crisis points were what nearly finished me.' (PA1)
Flexibility	'...they weren't/aren't very flexible with the time slots available which means missing important aspects of school and my parents find it hard to fit appointments in with work.' (YP19)
Generic psychotherapeutic skills	'I can't fault the staff I have encountered...the qualities that are most important to me are that they form a really good relationship and are very kind and caring. They should establish complete trust with the patient, in such a way that you feel comfortable telling them anything...Also being funny and happy is a great help when you're feeling very low yourself' (YP3) 'For me the key thing in any treatment she was given was to be listened to and not just be treated as someone with anorexia. She received this from only 4 professionals out of the 14 or so she had dealings with.' (PA11)
Professional communication 'Joined up thinking'	'My number one priority would be joined up thinking – GPs, A&E staff, general mental health services, adult and CAMHS services talking to each other.' (PA10)
Information sharing and follow-up	'...registering as a temporary patient and seeing someone who has no idea of your medical records etc. is distressing and anxiety provoking and the temptation is to slip off the radar – I don't know if there could be some form of correspondence between Uni and home GPs?' (YP9)

A&E, accident and emergency department; CAMHS, child and adolescent mental health services; GP, general practitioner.

light" a bit but when I arrived at my session, stepped on the scales and had lost weight the whole session turned to be about food. I never even got to mention the book and how it made me feel.' (YP6)

The interplay between a weight-driven approach to treatment and the 'competitive nature' of eating disorders could create a vicious cycle. One participant felt she was 'taken more seriously' the lower her weight was, which 'fed the illness itself' as her eating disorder would see this as being 'successful'. Another felt she needed to make herself worse to ensure support:

'I spoke to my psychiatrist once I got to a healthy weight and she said there isn't much they can do if I'm not ill which really upset me...Just focus more on the emotional side...I still don't really know how to get better. I wish she hadn't said there was nothing she could do because I wasn't ill physically because that makes you think you need to make yourself ill to get help which shouldn't be the case!' (YP14)

Young people talked about the complex nature of their condition that 'consumes every single aspect' of their lives. They felt that treatment should address 'how to live long term' and ways of 'keeping the eating disorder at bay':

'...anorexics think about their condition every second of the day...even in my dreams I still have the condition...Recovery shouldn't be just meal times and weight focused.' (YP12)

Some parents highlighted the absence of the recovery topic in professional contacts and their struggles to find 'actual evidence that people could recover'. For others, the recovery message was conveyed in unhelpful ways:

'Our initial treatment didn't promise "recovery" but...they did...stress that full recovery was possible...It just seemed

that they sort of blamed the parents before 18 and the patient after 18 if that didn't happen!' (PA10)

Individualised approach

Many participants experienced a 'one size fits all' approach, where professionals were 'treating the condition not the person' and evidence-based interventions were applied with 'little understanding of individuals recovering differently'. They recommended a more personalised approach that would help them find their 'own positive reasons to recover':

'I disagree with the homogeneity of treatment methods. Where I am at the moment, they are very good at tailoring recovery to the individuals' needs...my therapist...has a way of putting my recovery in my hands.' (YP1)

Consistency and continuity

Several participants experienced frequent, disruptive changes in professionals and 're-telling the same story' at each new clinical encounter:

'...building up relationships with individual counsellors, etc. takes time, and having to cut and change as the services chop and change has been quite unsettling.' (YP17)

A key issue was the gap in treatment provision when young people made the transition from child and adolescent to adult services, which often triggered clinical deterioration:

'CAMHS gave up on me when I was about 17 and 2 months and I couldn't start adult treatment until 18 – that gap was when I made the biggest decline.' (YP6)

This transition takes place 'right in the middle of the struggle years' and the disconnection between services was described as an 'artificial divide'. Suggested alternatives were changing the age

boundary to 25 years, a flexible approach 'dictated by needs rather than age' or an 'integrated 8–80 specialist eating disorder team'.

Knowledge of eating disorders at all levels of care

A salient issue in both young people' and parents' accounts concerned the insufficient knowledge of the nature and clinical management of eating disorders among various professionals working across all levels of care.

Knowledge at primary care level

Primary care practitioners have a gatekeeping role, crucial for early identification and referral. Although willing to help, they often lacked knowledge in the identification of eating disorders and when and where to refer:

'The general opinion of the GP when I first visited was to go away for a month and come back if there was still a problem. For an eating disorder, I think this is very poor considering how much weight you can lose in a month...' (YP17)

'If I were to express any misgivings, it will be about the time it took to get a referral from her GP to CAMHS...there is a huge variety of awareness on eating disorders among GPs, some of the responses given to my daughter were appalling and wouldn't even have registered with the Ladybird book on eating disorders.' (PA8)

'True' specialist services

Many participants experienced 'an extreme lack of experience and knowledge in eating disorders' among various professionals working in general hospitals, emergency services, generic mental health and more specialist eating disorder services:

'...the NHS mental health service I was with had seemed to take people who had jobs as counsellors, physios, dieticians...they thought that they would be helpful but because they are not specialists it made it ten times worse.' (YP5)

'...you get referred for "more specialist" advice to someone who knows a LOT less about the subject than the nurses doing the referring.' (PA10)

Professionals who 'know their stuff about eating disorders' and have 'real hands-on experience of eating disorders' were 'invaluable'. These skills were not necessarily linked to service type: specialist eating disorder services were seen as beneficial as long as they were 'truly specialist not just in name only':

'We reacted best to people who had experience of eating disorders, who calmly said yes, we will help you get out of this.' (PA4)

Professionals' knowledge appears key in avoiding inconsistent or incorrect information being given to families. Several participants recalled feeling 'bewildered' and having to make 'the first move in every direction'. Many participants highlighted the need for early psychoeducation including clear information about standard and crisis care:

'I think giving families information around the causes of eating disorders and also how to act/miss a crisis. How to talk about things and strategies to plan for stressful times.' (YP16)

'There is no clear route to treatment in the early weeks. CAMHS was unable/unwilling to lay out the possible treatment pathways, so every family would start the long education process right from scratch.' (PA4)

Professionals' attitude

Many participants described professionals who were 'far too judgemental' and made 'devaluing' comments, that hindered help-

seeking and therapeutic engagement. They sometimes felt openly criticised for 'misbehaving', 'making a fuss' and 'choosing a career' of having an eating disorder. Parents felt blamed for their child's condition and their 'inappropriate use of resources' when seeking help:

'... personal treatment can make a big impact...Even just sort of a helping hand to doctors to sometimes be a bit more sensitive with the stuff they say, for instance comments regarding "superficial self-harm" or that a weight loss/weight gain isn't "serious" just ways of phrasing stuff that can be quite triggering.' (YP18)

'I do think that many clinicians (not necessarily eating disorder specialists, we haven't had this from them) genuinely believe that parents cause eating disorders.' (PA10)

Professionals' attitude was linked to their misunderstanding of eating disorders, inexperience, focus on patient's weight and tendency to compare the patient to others with a similar condition or to healthy individuals:

'...when eating snacks my psychiatrist would talk non-stop about the calories and how she was eating more than me and had already finished hers...not helpful!' (YP9)

Peer and family support

Talking to someone with a similar experience seemed vital as it gave participants a better understanding of eating disorders, motivation and hope:

'I did like all the people that were trying to help me, they did their best. I just didn't feel like they ever completely got me. In fact the people who did make me feel that way were often people that had experienced an eating disorder as well.' (YP2)

'A lot of support has come from recovered anorexics telling her the struggle to recover is worth it and to keep going. They have helped her through some of her blackest days.' (PA9)

Peer support was often unavailable locally, contributing to a sense of isolation:

'It's funny they tell you about the amount of people suffering with it but I didn't know anyone.' (YP13)

Parents described a similar need for talking to others with related experience:

'I couldn't have got through without being able to discuss the worst aspects with another mum who'd been through it. Some things you can only talk about with others who've experienced it.' (PA1)

Many participants highlighted the need for young people and parent support groups and respite care. Support for family members would relieve some of the burden so that 'in turn they can support the patient':

'I think allowing my family to breathe and have a break away from me, maybe a chance to meet others supporting patients would have been helpful...Especially for my brothers.' (YP17)
'We had no family support...The professionals only offer care for a short time. Remember the families support the sufferer the rest of the week. Also it impacts on the whole family.' (PA9)

Discussion

Participants' experiences of type, availability and quality of care were mixed. Positive experiences often concerned care addressing physical health needs, alongside sporadic reports of treatment

tailored to individual needs, consistency from keyworkers, a good therapeutic relationship, contact with eating disorder specialists and peer support. Common negative experiences, however, suggest a raft of limitations with service provision and the need for change. It is clear that some participants were not offered or accessing an evidence-based psychological intervention. Identification and clinical management appeared dominated by a young person's weight, linked in some cases to professionals' understanding of eating disorders and service thresholds for referral and treatment. Clinical practice thus seemed to contradict the advice some professionals gave to participating young people to stop thinking about diet and weight.

Participating young people and parents' negative experiences are consistent with the findings of an cross-national (USA, UK) survey in adults with eating disorders highlighting the limited availability and inequity in geographical distribution of services, lack of knowledge of eating disorders among GPs, limited access to care unless severely underweight and long waiting lists in the UK sample.¹⁴ Qualitative exploration among adult patients portrays recovery from eating disorders as a wider phenomenon that goes beyond weight restoration.¹⁷ Suggested strategies to address control issues and ambivalence towards treatment in adult patients include consideration of wider psychological issues and a sensitive approach, linked to specialist expertise.¹⁸ Similarly, issues around priority given to physical over psychological recovery, lack of individualised care and need for sensitivity from healthcare staff were noted in a number of qualitative studies of adolescents' experiences of in-patient treatment (as well as out-patient treatment in one study) for anorexia nervosa.^{19–24} Both a positive and a negative impact of peers on adolescents' recovery from anorexia nervosa in an in-patient context has been described.^{12,19,20,24,25} It is worth noting that almost all of these studies were published more than 10 years ago. Qualitative explorations of parents' experiences of their child's care for eating disorder, also dating back 10 years or more for most studies, highlighted the importance of personalised intervention²⁶ and specialist knowledge in eating disorders.^{12,27} Peer support for parents has been supported in the literature, sometimes reported as one of the most helpful aspect of care.^{27,28}

The main contributions of our study stem from bringing together the combined experiences of young people and parents of treatment in multiple services, and the emerging emphasis on psychological aspects of eating disorders from very early stages and having appropriately trained professionals working across a wide range of services rather than a single specialist service. Qualitative investigations into the meaning of anorexia nervosa to adolescent and adult patients support psychodynamic and cognitive theories of its connection with the development of individuals' own identity and control systems, with a subsequent impact on their help-seeking behaviour and treatment outcome.²⁹

Furthermore, a recent qualitative synthesis into the perspective of recovered adult patients suggested four dimensions of psychological well-being – positive relationships with others, self-acceptance, autonomy and personal growth – and self-adaptability/resilience as fundamental criteria for eating disorder recovery in addition to symptom remission.³⁰ In a study using a multidimensional recovery model, adults with eating disorders placed more emphasis on the combined psychological, emotional and social functioning and evaluation of one's own appearance criteria compared with clinicians.³¹ In line with these findings from the adult literature, our study highlights two important aspects in addressing the psychological well-being criteria for recovery and the development of a 'healthy' identity in young people with eating disorders, according to both patients and parents: an earlier consideration of psychological aspects of these conditions that should start at identification in primary care and referral to specialist treatment, as well

as enhanced professionals' knowledge of eating disorders and attitude towards patients and families across all levels of care.

Eating disorder services for children and adolescents in England have received a significant investment, and are undergoing major restructuring,⁸ which should address many of these concerns, in particular timely access to psychological interventions independent of weight status. Our findings support the importance of these changes to improve the quality of patient and parent experience, regardless of the cost-effectiveness arguments. However, these standards are not yet applicable to adult eating disorder services, which remain patchy and underresourced. Eating disorder services in Wales are currently subject to a major review for which this study provides timely evidence.

Gaps in health professionals' ability to recognise and treat eating disorders and the negative attitude that some express towards individuals with eating disorders have been previously highlighted as more prevalent compared with other mental or physical illnesses.^{32,33} Our findings are in line with a recently published report highlighting the poor experience of mental health services often encountered by children and young people in the UK.³⁴ Others have reported short comings in service provision and suggested strategies for a more consistent and smooth transition to adult mental health services, tailored to the young person's needs and taking into account other simultaneous life changes.^{35,36}

Strengths and limitations

This study recruited a national sample of young people and parents not bound by setting or treatment group. It used synchronous online discussion (i.e. all focus group members temporally co-present) that has recognised similarity to a traditional, face-to-face focus group,³⁷ but has the advantage of providing an anonymous online environment. This has previously been identified as preferable by young people when discussing sensitive topics because of its private and less judgemental nature.³⁸ The young people's age range ensured access to experiences of both child/adolescent and adult services as well as the transition.

The gender imbalance and preponderance of anorexia nervosa are a likely effect of the means of recruitment and self-reported diagnosis, although it is consistent with anorexia nervosa being the dominant presentation of eating disorders to CAMHS services. The recruitment and data collection methods limited participation to consenting older young people and also meant that individuals with easier access to and familiarity with internet use were more likely to participate. Findings may therefore not pertain to all young people with eating disorders and their carers, particularly younger children, males and those from ethnic minorities, and may not generalise to non-UK healthcare settings. Methodological issues around gender and ethnicity imbalance in this field have been previously reported.^{19,20,23}

Our recruitment may have skewed the perspective towards negative experiences. Most participating young people were over 18 years of age at the time of the study, had relatively long illness durations and experienced treatment in multiple services, often in-patient or day services, with likely poor initial response to treatment. More than half of them were no longer receiving treatment at the time of the study. Although potentially allowing for more reflective accounts, our sample characteristics may explain the differences between our findings and those of Roots *et al*,¹² which were more positive, particularly regarding specialist services. Their study included adolescents with an average duration of illness of just over 1 year, thus perhaps better representing the patient population in child/adolescent services with relatively short illness duration, good response to out-patient treatment and no need of in-patient care or transfer to adult services. The two

studies thus provide different, complementary perspectives on treatment experiences and suggest the likelihood of more positive experiences if receiving early, specialist intervention. Our findings do echo other similar studies and, rather than the experiences of a dissatisfied minority, they replicate and add to the existing evidence of shortcomings and needed changes in care provision for young people with eating disorders.

Implications

There was a strong consensus that treatment should not just focus on weight but also address psychological and relational aspects from an early stage. An individualised treatment approach that addresses physical and psychological recovery in parallel, from an individual's first contact with health services throughout their therapeutic journey, is more likely to lead to full recovery and minimise the risk of relapse. Carefully planned peer support for young people, as well as support for parents and siblings would be highly beneficial. Although such changes in care provision may be challenging for many overstretched services, they seem essential in the long term by preventing delayed intervention and longer illness duration, both well recognised predictors of poor clinical outcome.³⁹

The role of professionals' knowledge of eating disorders and treatment pathways was perceived as crucial at all levels of care, from primary to 'truly specialist'. Specialty training, such as general practice and core psychiatry training should provide more opportunities to enhance eating disorder knowledge and understanding of patient and family experience of eating disorders among junior doctors. This should particularly target misconceptions around weight loss as a sole or primary factor in the referral and treatment process.

Improving professionals' knowledge at all levels is clearly key to achieving early diagnosis and intervention,⁴⁰ but equally important is to ensure that treatments have a better balance between the necessary focus on restoring nutrition and physical health and psychological well-being. In England, this has been extensively highlighted in the literature and recently brought forward by the new commissioning guidance for children and young people with eating disorders⁸ and advocacy efforts to increase awareness among GPs of the clinical, particularly psychological, indicators of eating disorders and importance of early referral for specialist assessment. However, these efforts will only be effective where specialist services exist and have the capacity to respond. Further research is needed to assess the potential positive impact of these initiatives. The historical nature of retrospective accounts means that some of the issues raised here may have already been addressed in national guidance and service provision. Nonetheless, qualitative data supporting these changes adds impetus to these priorities.

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Supplementary material

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REVIEW

The value of including families in the treatment of anorexia nervosa

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Abstract

The aim of this paper is to consider family and wider carer involvement in the treatment of anorexia nervosa, and how this can be used to add value to services. We discuss widely adopted interventions involving the family that have been manualised and studied in trials that have outcome measures that are of relevance to illness costs. The therapeutic targets of these interventions range from a focus on feeding to the wellbeing of the whole family. The theoretical models that underpin interventions involving the family/wider carers include both intra and interpersonal processes, with the exception of family-based therapy, which in its original form holds an agnostic stance towards aetiology. Although formal evaluation of the cost effectiveness of these interventions is minimal, there is evidence that involving the family can reduce bed use and improve the wellbeing of both patients and family members. Moreover, for the most part, these interventions are acceptable to patients and carers. Finally, we consider how these approaches can be disseminated and scaled up more widely into services.

KEYWORDS

anorexia nervosa, eating disorders, family therapy, Maudsley model, systemic therapy

1 | INTRODUCTION

The clinical features of anorexia nervosa (AN) such as the median age of onset at 15 years (Micali et al., 2013), the average illness duration of 10 years, and the stunting of physical and psychological development as a consequence of starvation underline the need to consider how the transition from care within the family of birth to the family of choice may be derailed, warranting attention across the course of the illness. For example, an individual with a pre-pubertal illness resistant to treatment and managed in child and adolescent services may be fast forwarded into a

service that expects adult level autonomy with disconnection from the family just because the eighteenth birthday or some arbitrary marker has been passed (Winston et al., 2012). This disconnect between chronological and developmental age needs to be considered when formulating a case and developing a plan of treatment. Parents are usually intimately involved when the illness develops in childhood and early adolescence. Later, a wider social network including siblings, partners or friends/colleagues may also be needed to bridge developmental gaps. Sadly, social support (e.g. practical and emotional help and care from others) often diminishes over time, leaving patients

Abbreviations: AN, anorexia nervosa; CBT, cognitive behavioural therapy; FBT, family-based therapy; NMCC, New Maudsley Collaborative Care.

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isolated within the illness (McKnight & Boughton, 2009). Many patients remain financially and socially dependent on their parents or the state over their life time (Hjern et al., 2006). In addition to age, duration and timing of the illness, other facets such as severity and comorbidity (in particular, autistic spectrum disorder (ASD) traits) impact on social connections. Social emotional functioning and its impact on relationships are recognised to be both a risk and maintaining factor for AN (Cardi, Turton, et al., 2017; Treasure et al., 2020). Therefore, targeting social and family functioning is important throughout the course of the illness. This paper aims to discuss why family involvement is important in treatment for AN, discusses examples of how the family can be involved in treatments for AN, possible benefits in terms of resource use and symptom outcomes and what research might be needed next to advance this field.

1.1 | The impact of anorexia nervosa on families and the social network

The diverse presentation of AN (child/adult onset, acute/chronic, severe/mild malnourishment, comorbid/simple) mean that the use of the term 'carer' can be problematic. This term is used in this paper in its broad political sense in order to tap into the policy and resource that may be available. It may include friends, as well as family, or even draw on a compassionate part of the self for those who have become isolated. Eating disorder symptoms are visible and disruptive, and so, the impact on close others is profound. Systematic reviews of carer functioning report high levels of burden which can be associated with anxiety and depression (Anastasiadou, Medina-Pradas, Sepulveda, & Treasure, 2014). These stressors can impact on interpersonal relationships, leading to high levels of expressed emotion (overprotection, criticism and hostility and lower levels of warmth), accommodation to the illness because of anxiety in the source of support and fragmentation of support (Treasure & Nazar, 2016).

Close others can inadvertently accommodate the illness and be drawn into avoidance and safety behaviours such as reassurance seeking and calibration with others which allow the illness to take a tighter hold. This adaptation may manifest around food and eating, exercise or social behaviours (Treasure & Nazar, 2016; Treasure et al., 2020). In addition, carers can be drawn into enabling illness habits, such as providing money for binge food or ameliorating negative consequences in the bathroom and kitchen. Preliminary surveys to establish the requirements of carers highlight their need for information about the illness and guidelines about how to help (Haigh & Treasure, 2003; Mitrofan et al., 2019; Whitney et al., 2005).

Highlights

- Several interventions for anorexia nervosa describe the involvement of families in treatment
- These interventions are acceptable to both patients and family members, reduce bed use and improve wellbeing in family members
- These approaches can be scaled up more widely into services

1.2 | What treatment models have been developed to help with these challenges?

In the following section, we sketch out the underpinning models for family involvement for those interventions that describe how theory or strategy is put into action explicitly in treatment manuals (we are aware that other methods of working on social connection have been developed, but manuals are not yet publicly available). Interventions involving adolescents usually have a focus on the outcomes of the individual patients, whereas treatments delivered to those with a more chronic or adult presentation may consider the broader social impact. All except for family-based therapy (FBT) have a model which suggests that families can maximise their effectiveness in providing support towards recovery through optimising interpersonal relationships.

2 | SYSTEMIC FAMILY THERAPY

The model in systemic family therapy is that the problem is not located in the individual themselves but instead lies within interpersonal relationships, social interactions and narratives about the problem. There is no specific emphasis on regular eating or weight restoration, but if these are problems that families bring to sessions, then the therapist will work with them to identify strengths and resources within the family to help them to find new solutions to these difficulties. Manuals are available (Pote, Stratton, Cottrell, Boston, & Shapiro, 2001; Pote, Stratton, Cottrell, Shapiro, & Boston, 2003).

2.1 | Family-based therapy also known as the Maudsley Model of family therapy

FBT is a form of systemic family therapy established at the Maudsley Hospital and used as one of the arms of

therapy given post-discharge from inpatient care in a seminal randomised controlled trial (Eisler et al., 1987; Russell Szmukler, Dare, & Eisler, 1987). It was later adapted and developed as the primary treatment for first episode adolescent AN. FBT, in its manualised form, takes an atheoretical stance as a means of presenting a non-blaming attitude towards families (Lock & Le Grange, 2015). However, some later derivations have been modified to encompass the idea that families may become organised around the illness (Eisler, 2005), and a formulation is used with families. FBT is problem focused, and the treatment targets are clearly re-establishing regular eating, weight restoration and the reduction of illness behaviours like purging. In the original form, this treatment consists of three phases. Phase one mobilises parents to take the lead on weight restoration. Phase two focuses on transitioning control over food back to the individual at an age-appropriate level. Phase three focuses on other issues related to typical adolescent development. Other versions of this treatment have been developed whereby the parents and child are predominately seen separately (Le Grange Eisler, Dare, & Russell, 1992), Intensive parent coaching is provided to improve non-response identified at session 4 of treatment (L'Insalata et al., 2020), or groups of family members are seen together (multifamily therapy; Eisler, 2005). Also, versions have been developed for emerging adults (Dimitropoulos, Farquhar, Freeman, Colton, & Olmsted, 2015).

These family-based approaches can be contrasted with the approach taken in Cognitive Behavioural Therapy (CBT) which has been used to treat adolescent AN (Dalle Grave et al., 2019) and to view the source of the problem as being within the individual (e.g. the over evaluation of eating, shape and weight and their control). CBT focuses on encouraging the individual to understand and manage their eating disorder behaviours (Dalle Grave et al., 2019). In contrast to FBT, where the family is actively involved, CBT views the family role as useful but not crucial and suggests parents may be involved in treatment and could, for example, be helpful in supporting the individual to implement new behaviours (Fairburn et al., 1999). For adolescents, a three component 'CBT oriented family module' is provided within treatment where families are provided with a mixture of educational sessions. These involve understanding the CBT formulation of the eating disorder, supporting with assisting the individual with eating during meal times as a family and creating the optimal family environment to support the patient's efforts to change (Fairburn, 2008).

3 | THE NEW MAUDSLEY MODEL FOR COLLABORATIVE CARE

New Maudsley Collaborative Care (NMCC) was developed for carers of adults and those with treatment resistant AN. The cognitive interpersonal model upon which this is based describes intra and interpersonal maintaining factors (Schmidt & Treasure, 2006; Treasure & Schmidt, 2013; Treasure & Nazar, 2016; Treasure et al., 2020). These are targeted in treatment with the aim of bridging isolation and fostering healthy connections (Treasure et al., 2015). A shortened form of the intervention is encompassed within the Maudsley Model of outpatient treatment (MANTRA) (one of the treatments of AN recommended by NICE 2017 for adult outpatient care) and in TRIANGLE (Cardi, Ambwani, et al., 2017) and its precursors to augment inpatient care (Hibbs et al., 2015; Magill et al., 2016) or adolescent outpatient care (Hodsoll et al., 2017).

Within NMCC, the definition of carer is not limited to parents, but broadened to include any suitable source of support, such as a friend, sibling, partner or child. NMCC utilises a flexible format to equip carers with skills to not only care for the individual but also to manage their own response to the disorder. This includes building resilience, communication and emotion regulation skills, and addressing accommodation and enabling behaviours and the tendency for fragmentation within the support network (Treasure & Nazar, 2016). The first phase of treatment is to share state-of-the-art understanding of the risk and maintaining factors of the illness, in particular, those that impact on social functioning and eating regulation. Phase 2 involves a consideration of how carers themselves may have become entangled with the illness possibly in unhelpful ways through their own anxiety, reassurance and accommodation to the illness. Carers are introduced to high level communication and behaviour change strategies so that they can optimise their secure, age appropriate listening family base. By modelling changes in their behavior, not only do they show commitment, but this forms a context for vicarious learning of self-management skills. At stage 3, guiding individual recovery, they are taught compassionate communication skills attuned to the complex eating disorder emotions and motivational interviewing skills to help elicit change talk and planning. These support skills facilitate connection and change and can be taught using various media, including a carer and therapist manual (Langley et al., 2018; Treasure et al., 2009) and videos (Cardi et al., 2015) and through diverse formats including workshops, guided online/phone and group and

individual/group support from trained carers with lived experience.

3.1 | Possible benefits of family inclusive interventions

3.1.1 | Resource use outcomes—systemic family therapy and family-based therapy

The previously described challenges presented by the complex impact of AN on the individual and the social network mean that a discussion of cost effectiveness ideally should consider not just the individual but the family too. In this discussion of evidence to date, we use bed use (e.g. number of days in hospital) as one proxy marker of costs, as bed costs heavily dominate inpatient costs. However, it is often difficult to determine bed days due to discrepancies in studies categorising this as patient 'drop out' rather than a form of 'rescue treatment' (Albano et al., 2019; Gregertsen et al., 2019). Additionally, we include time spent caregiving as a proxy measure of carer costs where this is available.

As exemplified in the NICE guidelines, decision making for planning services is guided in part by cost effectiveness. However, this is not the only driver of evidence-based practice. Patient/care giver preference and clinical knowledge are also of relevance. However, there is a paucity of these strands of evidence in eating disorders. In the following section, we aim to consolidate what is known by extracting the highest level of evidence from systematic reviews and meta-analysis of cost effectiveness, clinical moderators and patient and carer feedback where possible.

The literature base for the evidence of family-based therapy for early stage illness in adolescent AN is the longest and largest. Nevertheless, a recently updated Cochrane review (Fisher et al., 2020) concluded that the overall strength of the evidence was low to moderate. Most studies have focused on patient body mass index (BMI) at the end of treatment as the primary outcome, with less information about the rest of the family.

Despite the large literature base, few studies have utilised a spread of key outcomes, such as length of hospital stay (see Table 1). Studies that do refer to resources used during treatment are often qualitative, referring to feedback from families and professionals regarding costs of treatment (Grange & Gelman, 1998; Krautter & Lock, 2004).

As shown in Table 1, in an adolescent inpatient context, FBT was associated with around half the number of days in hospital and around half the number of overall readmissions than systemic family therapy. It should be

noted that in this study (Lock et al., 2016), around 1 in 10 participants were male, and so more work is needed to understand whether these findings are relevant to all genders. As shown in Table 1, the Parents in Charge (PIC) approach, a component of FBT, which sees clinicians empowering parents/carers to take charge of meals, when used in an adolescent outpatient context, was associated with the need for around 50% fewer hospital admissions, a shorter length of stay where an admission was required and a reduced use of nasogastric feeding than a non-specific therapy which involved expert driven psychoeducational family sessions. This suggests that fewer resources are required when families are involved in treatment and although limited by the small number of studies with small sample sizes; these data may indicate that supporting parents to take control of meals may be useful, at least for younger adolescent patients.

There is some evidence that variation in baseline variables or the form or content of family treatment can moderate outcome. The first example was the finding that FBT was not superior to individual therapy for adults with a protracted illness or for people with adult onset of illness (Eisler et al., 1987; Russell et al., 1987). A further example is that different family presentations, such as high levels of maternal criticism, respond better to separated family therapy rather than conjoint (Eisler et al., 2007), suggesting FBT may not be appropriate for all family dynamics. Agras et al. (2014) found that Systemic Family Therapy resulted in significantly more weight gain for individuals who presented with greater obsessive-compulsive psychopathology; however, those with lower scores gained a greater amount of weight with FBT, indicating that whilst FBT is an effective form of support, it is not 'one size fits all'.

3.2 | Patient and carers' feedback on family-based therapy

Some parents reported positive experiences with FBT as a structure to directly utilise their strengths and knowledge in their child's care (Parent & Parent, 2008). Individuals themselves also report that their parents' involvement was beneficial to their recovery (Chen et al., 2010). FBT has sometimes been promoted as a gold-standard, fully effective intervention; the implication that follows is that any failure is due to those implementing the model that is the parents (Conti et al., 2017; Wufong et al., 2019). As a result some parents experienced guilt, anxiety and a sense of parenting failure if they were unable to achieve weight restoration in FBT (Conti et al., 2017; Wufong et al., 2019). The limited focus on refeeding in the early stage with elements of a wider formulation such as comorbidities and

TABLE 1 A summary of family-based therapy studies that provide outcome data on bed use and extent of treatment

Author	Clinical sample	Comparison	Participants	Demographics	Main outcomes
Lock et al. (2016)	Adolescent inpatient	FBT versus SyFT	FBT: <i>n</i> = 78 SyFT: <i>n</i> = 80	Mean age: 15.4 (SD = 1.8) years, range: 12–18 years Gender: 89.2% female	Number of days in hospital: SyFT: 655 FBT: 369 Rehospitalised after first 5 weeks of treatment: SyFT: 6 patients (13 rehospitalisations) FBT: 2 patients (6 rehospitalisations)
Gusella et al. (2017)	Adolescent outpatient	PIC versus NST	PIC: <i>n</i> = 32 NST: <i>n</i> = 14	PIC (<i>M</i> = 13.07 years, SD = 1.89), (3 males, 29 females) NST (<i>M</i> = 14.36 years, SD = 1.37), (0 males, 14 females)	Required hospitalisation on a psychiatric unit for weight restoration NST: 71.4% PIC: 34.4% Number of days in hospital: NST: 50.0 days PIC: 19.1 days Required tube-feeding: NST: 42.9% PIC 6.3%

Abbreviations: FBT, family-based therapy; NST, non-specific therapy; PIC, parents in charge; SD, standard deviation; SyFT, systemic family therapy.

environmental exposures relegated to the third stage was problematic for some families, especially if challenging premorbid temperamental and developmental traits were present (Williams et al., 2020). Other families expressed concern that they were not taught how to manage their child's distress, and commented on the trauma this produced for the family (Conti et al., 2017).

Moreover, this intervention requires a significant amount of resources from the family, by asking them to engage in intensive treatment for large periods of time, potentially spanning years (Wufong et al., 2019). Whilst this aspect of the intervention has not been assessed adequately, many parents report having to leave employment to care for their child (Parent & Parent, 2008) or are fearful about losing their jobs (Williams et al., 2020). Not all families have the financial ability to commit to this level of care.

3.3 | Resource use outcomes—the New Maudsley Model for collaborative care

A systematic review and meta-analysis of self-management approaches for carers of people with AN included two that used the NMCC (Albano et al., 2019). Drop out (including rescue treatment) was reduced, but clinical outcomes were similar. Bed use and carers' time from recent studies using NMCC are shown in Table 2. The intervention in both the adult and adolescent group produced a moderate sized reduction in time spent caring, and at the same time, bed use was reduced. Moreover there was a small to moderate improvement in the wellbeing of both carers and patients in the intervention group (Hodsoll

et al., 2017; Hibbs et al., 2015; Magill et al., 2016). A similar pattern of less bed use and improved wellbeing was found using a hybrid intervention of NMCC and recovery MANTRA for patients (Adamson et al., 2019). Taken together these findings suggest that NMCC (a guided care management with moderate costs) can offer an intervention that can reduce service costs.

3.4 | Patient and carers' feedback on the New Maudsley Model for collaborative care

In one implementation of the NMCC, carers were asked to rate their experiences of the intervention and reported that it was easy to understand, the facilitators were knowledgeable, the intervention was of a high standard and they would be highly likely to recommend the intervention to others with mean scores from 4.18/5 to 4.91/5 (Pépin & King, 2013). Feedback elicited from patients whose caregivers had accessed the intervention shows a positive attitude to their caregivers' involvement, with feedback that they had acquired new skills and information, their relationship had improved, their caregiver had changed their approach to the illness and showed an increase in compassion towards them. Patients also reported that caregivers showed reduced anxiety and greater confidence and hope. In addition to this positive feedback, patients also raised concerns that they had to adjust to their caregivers new behaviours, that they were worried about possible blurring of boundaries between their caregiver and clinical team, and patients also

TABLE 2 A summary of New Maudsley Collaborative Care studies that have outcome data on bed use, readmissions and carer time spent caring

Author	Clinical Sample	Comparison	Participants	Family Outcome	Service Outcome
Hibbs et al. (2015)	Adult inpatient	TAU ^a versus NMCC + TAU	NMCC: <i>n</i> = 86 Age median 23.16 (range 12.52–62.72) Gender: Female <i>n</i> = 83 Male <i>n</i> = 3 Carer: <i>n</i> = 134 Age median 52.22 (22.22–78.54) Gender: Female <i>n</i> = 80 Male <i>n</i> = 54	TSC at 6 months after discharge: NMCC + TAU: 22 (range = 0–478 h/month) TAU: 31.90 (range = 0–378 h/month) (<i>p</i> = 0.05; estimated group difference = 0.63) TSC at 12 months after discharge: NMCC + TAU: 17.50 (range = 0–466 hours/month) TAU: 20 (range = 0–379 h/month) (SC = 0.29) (<i>p</i> = 0.88); estimated group difference = 1.04	Length of stay: NMCC + TAU median = 148 (IQR = 28–991) TAU median = 163 (IQR = 33–570) Inpatient days (by 6 months): NMCC + TAU 927 days TAU: 1276 days Inpatient days (at 12 months): NMCC + TAU: 499 TAU: 1495 Readmission rate (at 1 year): NMCC + TAU: 27% TAU: 32%
Hodsoll et al. (2017)	Adolescent outpatient	TAU ^a versus NMCC + TAU	TAU <i>n</i> = 50 TAU plus NMCC with guidance <i>n</i> = 50 NMCC without guidance TAU <i>n</i> = 49 Patients: Mean age 16.9 years (range: 13–21) 92% female Carers: Mean age = 48 years (SD = 5.2)	NMCC carers spent less time care giving (<i>D</i> = 0.4, <i>p</i> = 0.04) at one year	Rescue admission (1 year) 19% versus 28%
Adamson et al. (2019)	Adult inpatient	TAU ^b versus NMCC + GSC + TAU	Patients <i>n</i> = 31 (all female) Mean age: 27.0 (8.8) Carers <i>n</i> = 21 (80% female)		WWG: NMCC+GSC+TAU: 0.51 kg TAU: 0.47 kg Mean LOS (SD): 88 (34) versus 112 (71)

Note: Estimated group difference is a coefficient estimating the treatment effect of NMCC + TAU minus TAU.

Abbreviations: *D*, Cohen's *D* effect size estimation; GSC, guided self care; IQR, Interquartile range; kg, kilograms; LOS, length of stay; NMCC, New Maudsley Collaborative Care; TAU, Treatment as usual; TSC, Time spent caring (hours per month); WWG, weekly weight gain.

^aTAU comprised of inpatient or day-patient treatment.

^bTAU comprised of nutritional and medical interventions as well as individual and group psychotherapy.

expressed that their caregiver would need ongoing support and skills training to continue to support their recovery (Goddard, Macdonald, & Treasure, 2011).

3.5 | Implementation, reach and spread of family-based therapy and the New Maudsley Model for collaborative care

There has been widespread implementation of FBT in child and adolescent services. Interventions involving collaborative partnership working with parents and

carers (NMCC) have also been disseminated (with a variety of accessible training materials) and implemented often through charities and voluntary organisations (BEAT, 2020; Rhind et al., 2014). The involvement of families is regarded as good practice within integrated care for adults with AN. There is however a gap in our knowledge about what works for whom and how and why and there is need to consider how to help families with features that portend a less good prognosis. Questions remain as to whether involving families more effectively at an early stage (Brown et al., 2018) can be an effective form of secondary prevention and whether a

greater involvement of a wider net of social support is of greater value for later stages. Further, the evidence base largely encompasses studies conducted in the United States, Canada, Australia, United Kingdom and Western European countries, and it will be important in future work to investigate whether the same family based approach will have equal utility in other countries and settings and what adaptations might be useful to support families with EDs from a wider range of backgrounds.

4 | CONCLUSIONS

The overall conclusion is that involving the family and/or wider forms of social support in the management of AN can be an effective strategy to augment professional help. Another benefit, although not widely measured in the literature, is reduced resources in the form of reduced bed use, with less need for nasogastric feeding, allowing families to avoid being separated with loved ones in hospital for extended periods. However, clinical judgment is needed to shape the optimal form of the intervention. For example, most of the evidence for FBT is for patients in the early stage of illness and involves patients with no or minimal comorbidities. It may be that those with premorbid comorbidity such as ASD or obsessive compulsive disorder may require a different approach. Also, the costs for the family/social support also need to be considered; even if this is freely given, especially for those with features signaling a poor prognosis, a mixed model of care, in which the family members are involved at a developmentally appropriate level (with the proviso that development may be profoundly delayed because of both physical and social factors), as an essential component of integrated care is needed.

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CONFLICT OF INTEREST

Janet Treasure receives publisher remuneration for Langley et al. (2018). *Caring for a Loved One with an Eating Disorder: The New Maudsley Skills-Based Training*

Manual. Routledge and Treasure, Smith, & Crane (2016). *Skills-based caring for a loved one with an eating disorder: The new Maudsley method*. Routledge. Amy Harrison, Stacey Parker, and Oyenike Oyeleye declare that they do not have any conflicts of interest.

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RESEARCH REPORT

Young people's theories of anorexia nervosa and obesity

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ABSTRACT *One hundred and forty-seven participants completed a 108-item questionnaire, based on that used by Furnham and Hume-Wright in 1992 (Journal of Clinical Psychology, 48, 20-36) that looked at their beliefs about the causes and cures of anorexia nervosa and obesity. The four parts of the questionnaire were individually factor analysed and an interpretable factor structure emerged for each. While age and knowing someone with anorexia nervosa or obesity did not correlate with the factors obtained, sex, actual body size, estimated body size and having experience of an eating disorder were found to correlate significantly with a number of factors. Factors of cause and cure were not correlated regarding anorexia nervosa, but were for obesity. Several correlations within cause and cure, across both disorders, were also significant. The implications of these findings and how they relate to the theories described in the Introduction are considered in the Discussion.*

Introduction

The increase in both the scientific literature and popular press about eating disorders (especially anorexia nervosa) and obesity attests to increasing interest in this topic. Anorexia nervosa and obesity have many things in common. The prevalence of both is increasing; both are considered to have specific health risks and many researchers have made attempts to deal with the two together as eating disorders (Bruch, 1973; Stock & Rothwell, 1982; Brownell & Foreyt, 1986).

Anorexia nervosa is defined as a condition in which the patient has an abnormally low body weight, 25% below the original body weight, a disturbance of body image, an intense fear of becoming fat, no known medical illnesses leading to weight loss and other features such as amenorrhoea, suggesting a disordered physiology (Palmer, 1980). The disorder is sometimes also divided into primary and secondary anorexia. The sex ratio of female to male sufferers lies between 20:1 and 15:1 (Thompson, 1993). The higher incidence of anorexia nervosa in females is suggested to be because of social factors affecting them (Hsu, 1983), which are different to those affecting males. The mortality rates are described by some as 'alarmingly

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high' (Malson, 1992) at 10–15%, and while some may recover symptomatically, there is concern over whether many can be described as fully recovered.

There are a number of different theories of the cause of anorexia prevalent in the academic literature. One of these, and indeed one of the oldest, is that of *family pathology*, whereby anorexia nervosa is seen 'in a broader context as a link in a chain of non-linear, circular and self-regulatory interactions among all family members' (Strober, 1986). While many emphasize potential problems with family pathology theory—that the studies are retrospective (Hsu, 1983), few are properly controlled and that anorexia nervosa is a heterogeneous syndrome (Garfinkel & Garner, 1982)—few would deny that it has many potentially useful aspects. There are several models of the 'anorexic family'. One popular idea is that of the family being characterized by a dominant mother and an inoffensive or aloof father (Crisp, 1980), although others disagree and prefer to describe a 'typical anorectic family interaction pathology' (Hsu, 1983; p. 232). Garner and Garfinkel see the family as 'culture bearers', positioning them as a 'significant force in adapting the growing child to his culture' (Garfinkel & Garner, 1982, p. 175), which, they suggest, also raises the question of whether families magnify aspects of culture and whether this might be a predisposition to the illness. Family dynamics and characteristics could be seen to create and maintain the condition of anorexia nervosa (Malson, 1992), but this approach alone is not sufficient to explain the complexities of such a heterogeneous disorder as anorexia nervosa. Further, lay people still endorse this theory (Furnham, 1988).

An attempt to account for the sexual inequalities of the disorder is the *socio-cultural theory* of anorexia nervosa. The fact that anorexia nervosa is more common in a particular sex, age and social class, and that the incidence of the disorder is increasing, suggests that socio-cultural factors play a large part in determining the disorder in those who are predisposed to it (Garfinkel & Garner, 1982; Fallon & Rozin, 1985). Evidence that anorexia nervosa is more common in dance and modelling students, where there is an exaggerated pressure to be slim, might support this view (Garner & Garfinkel, 1980). Many of these theorists, however, have stressed that, since many more women experience these pressures than become anorexic, the ones who do become anorexic must be in some way predisposed.

There have also been many attempts to formulate a *physiological*-based theory of anorexia nervosa. One such theory looks at the way in which, before the onset of puberty, both males and females are very much alike in their physical appearance and size (Crisp *et al.*, 1982). However, females begin developing more dramatically around 2 years before their male counterparts. Consequently, the adolescent female, in her bigger form, attempts to minimize the difference by reducing her shape by dieting, when nutritionally her needs have increased (Furnham & Hume-Wright, 1992). Within the field of *physical theories*, particular interest has been directed towards the study of *primary hypothalamic disorder*. Hormone changes occurring at puberty have far-reaching biochemical influences, which can influence eating behaviour (Strober, 1986). However, a direct relation of hypothalamic disorder to anorexia nervosa has not been established and this approach has been criticized by many. The lack of separation of cause and effect is a fault noted by various writers

(Garfinkel & Garner, 1982; Logue, 1991) who cite evidence of the recovery of normal hypothalamic function after weight gain and normal eating has resumed, the craving of food and experience of hunger that anorexics feel which sufferers of hypothalamic tumours do not (Hsu, 1983), while others have criticized it for its lack of an explanation of the gender bias of the disorder (Malson, 1992).

A fourth theory that looks at the adaptation to change by the anorexic, as well as reactions of family and peers, is the theory of '*maladaptive psychosocial adjustment to the challenges of adulthood*' (Furnham & Hume-Wright, 1992). There are numerous links between food and emotion (Bruch, 1973), and meals play an important part in family life. It is the symbolic link between emerging sexuality and eating, biological maturity and the implications for the family, in which the development of anorexia nervosa is embedded (Crisp, 1980). Anorexia nervosa is preceded by a maturational crisis, which the subsequent illness serves to resolve. Anorexia nervosa is seen as an attempt to eradicate the biological signals of impending adulthood and emancipation, avoiding independence and its consequences (Wallen *et al.*, 1989). Refusing food enables the child to stay within the safety of childhood, where others care for them as they did when they were children.

An alternative theory regarding anorexia nervosa is *feminist theory*, which has taken various forms. One of the most often cited feminist theories is that of the conflict between the traditional female role and that of the liberated woman who takes control of her own life, in a culture that praises thinness and fragility in women (Orbach, 1979). Women are encouraged to become more competitive in relation to men and to achieve in their professional careers, yet at the same time are expected to take care over their appearance and often cope with caring for others. Their changing bodies during adolescence is completely out of their control and may result in feelings of confusion, fear or powerlessness. Denying the feelings of hunger they may have may be one area in which they are winning, gaining control or power. The various conflicts leave the growing woman feeling out of phase with what is going on and, paradoxically, the power to overcome hunger, to become strong, has left her in a position where she becomes weak and even more reliant on others (Thompson, 1993).

These theories of the cause of anorexia are not mutually exclusive and several researchers stress the importance of a multi-dimensional perspective (Hsu, 1983). Each theory advocates a specific therapy according to their specific constructs, but the therapies, like the theories, overlap.

Just as there are various theories of anorexia nervosa, there are a range of suggestions as to the aetiology of obesity. Some of them have points in common with the theories regarding anorexia nervosa, but the overall emphasis in the literature seems somewhat different. Obesity is described as a condition in which the energy stores of the body are excessively large (Garrow, 1986). The condition is commonly characterized by use of the Body Mass Index (BMI), a system in which body mass is expressed in terms of weight in kilograms divided by height in metres squared, and has been shown to provide the best estimates of total body fat content, correlations being 0.7 and 0.8 between the BMI measures and body fat measures of body density.

Obesity, like anorexia nervosa, is considered a growing problem, both in the US and in Great Britain, and is thought to be generally increasing in Western societies (Report of the Royal College of Physicians, 1983). The prevalence is suggested to depend on the criteria used to define it. Some have suggested that the ratio of obesity in females of low and high socio-economic status is 6 to 1, with the ratio in men being 2 to 1. There are many different types of obesity, some of which have clear genetic determinants, others which may have underlying genetic factors which are influenced by environmental variables (Thompson, 1993). There are a small number of patients whose obesity is due to a specific disease or condition (Stock & Rothwell, 1982). There are also abnormalities of fat distribution and obesity related to mental retardation and physical disability (Jung, 1991).

Twin studies have been performed in order to look at whether there is a *genetic substrate* upon which environmental influences act. Evidence does seem to exist that monozygotic twins are more likely to be of similar weights, whether raised together or apart (Thompson, 1993). This, alongside evidence of siblings from the same environment displaying marked differences in weight, has been taken to suggest that the tendency to be obese is inherited (Craddock, 1978). But such evidence does not account for the resemblance in fatness between unrelated spouses and pets and their owners (Dietz, 1987).

There has been much interest in the mechanisms of *energy storage* in obese patients, particularly the role of brown fat or adipose tissue and metabolic rate. It has been suggested by some that obesity is a condition where the adipose tissue (the lipid store of the body) is enlarged (Bjorntorp, 1987). This is claimed to be due to genetic, endocrine and metabolic factors. Others, however, suggest that this generalization from animal experimentation may be premature (Jequier, 1987), and in any case would be inadequate to explain the aetiology or persistence of obesity (Garrow, 1986).

Several different *psychological* theories have been suggested for obesity, with some writers going so far as saying that 'in the long run, all obesity is psychological' (Dally & Gomez, 1980). Some have suggested that the obese have certain *personality* characteristics, one psychoanalytic description being, 'passive dependence and a wish for bigness and exaggerated growth'. This theory also emphasizes the overvaluation of food as soothing anxiety and frustration.

There have also been several suggestions as to *family variables* in the development of obesity. Obesity has been found to be related to lower socio-economic class and level of parental education and has a reciprocal relationship with family size, as it is most prevalent in only children, and decreases in prevalence as family size increases (Dietz, 1987). Childhood obesity has also been suggested to be linked to the separation of the child from its mother (Kahn, 1973). Bruch (1973) characterizes the obese 'family frame', which is characterized by much family discord and open fighting. She suggested that food can come to stand for love, satisfaction, security or power and can express rage and hate and be a substitute for sex. Such uses of food are suggested to arise from the *learning* that goes on in early infant-caregiver interaction (Bruch, 1973).

The *externality hypothesis*, prompted by Bruch's suggestion that obese individuals are unable to differentiate among internal arousal states and frequently interpret such states as hunger, claims that while normal-weight individuals' eating behaviour was influenced by internal cues of hunger, obese people are affected by external cues such as the taste and sight of food. There are various suggestions as to how appetite, hunger and satiety can be affected by variables such as palatability, eating styles and situational determinants. Suggestions have been made that obesity is related to locus of control and delay of gratification (Striegel-Moore & Rodin, 1986). It has also been suggested that a number of obese patients show a distortion in *body image*, which often persists after excess weight has been lost (Stunkard & Mendelson, 1973). This often presents itself in a loathing of the body. Bruch (1973) suggests that there are previously obese individuals who may be called 'thin fat people', for whom loss of weight could pose mental health hazards.

There are clearly many different interpretations of the causes of obesity: genetic factors, disruptions in fat storage and maintenance, personality characteristics, family variables and the related learning of food behaviour, mistaken cues of eating behaviour, distorted body image and obesity as a reaction to stress. In addition, some have suggested that lack of exercise plays a subsidiary but important part. Some of these theories seem to have parallels with theories of anorexia nervosa, as do the treatments, which are varied and tend to relate to the specific causal theory which is adopted.

This study is about lay people and their theories—in this case, a population at risk—theories of the causes and cures of both anorexia nervosa and obesity. Both are eating disorders that affect young people and may have serious health consequences. There has been an increasing interest during the last few years in the perceptions of the lay individual regarding various psychological issues such as delinquency (Furnham & Henderson, 1983), homosexuality (Furnham & Taylor, 1990) and phobia (Furnham, 1995). In response to the suggestion that studying the perceived efficacy of various 'cures' and 'therapies' is of practical and theoretical importance Furnham and Henley (1988) and Furnham and Hume-Wright (1992) have looked at lay theories of anorexia nervosa in the belief that it would yield 'valuable insights into the cognitive and behavioural strategies that people use when experiencing a problem or helping others' which may, in addition, 'suggest methods of enhancing the effectiveness of psychological therapies' (p. 21). While the study of anorexia nervosa is gaining considerable interest, it might be claimed that there is still a paucity of research into lay people's understanding of eating disorders, especially the notion of obesity as an eating disorder. It would seem, then, that lay people have adequate opportunities to formulate beliefs about the causes and cures for obesity as they have with anorexia nervosa (Furnham & Hume-Wright, 1992). Some researchers have suggested that lay and medical opinion on the cause and proper treatment of obesity vary, with lay people placing more value on the efficacy of dieting (Dwyer *et al.*, 1973).

Clearly, lay theories are important: they are related to how they perceive those with anorexia and obesity, and the theories of sufferers could contain insights which clinicians should heed. The aim of this study was to:

- (1) To look at the range, type and agreement with a number of statements reflecting lay theories of anorexia nervosa, and similar statements regarding obesity, in 16–19 year olds.
- (2) To look at the factor structure underlying these responses to see which of the proposed 'scientific' theories emerge and their similarity to those found by Furnham and Hume-Wright (1992)
- (3) To examine the relationship between the factors found for the four parts of the study (anorexia: cause and cure, and obesity: cause and cure) both within and between disorders.
- (4) To examine various demographic correlates of the lay theories of anorexia nervosa and obesity.

The rationale for this particular study is fourfold. It was hypothesized that the factor-structure of the lay theories of anorexia would be very similar to that found by Furnham and Hume-Wright (1992). It was also hypothesized that the factors emerging from the factor analysis of the causes of obesity would be interpretable in terms of the major theories in the area. Finally, it was hypothesized that theories of cure and cause would be logically and statistically correlated.

Method

Participants

In total, 147 pupils attending a coeducational, state-run Sixth Form College in Norfolk took part in this study, 71 of whom were male and 76 were female. The age range was 16–19, with a mean age of 17.16 ($SD = 0.60$). The mean height was 68.39 inches ($SD = 3.94$), while the mean weight was 144.26 pounds ($SD = 3.94$). Altogether 46 considered themselves overweight, 17 underweight and 84 'about right'. Nine (6.1%) said that they had at some time experienced an eating disorder, while 63 (42.9%) said that they knew, or had known, somebody who suffered from anorexia nervosa and 123 (83.7%) said that they knew, or had known, someone who was obese. Five (3.4%) believed that they knew a lot about eating disorders and 61 (41.5%) said they knew quite a lot, while 80 (54.4%) believed that they knew a little and 1 said that they knew nothing. However, 109 (74.1%) reported that they could distinguish between anorexia, bulimia and compulsive eating. Eighty-five (57.8%) believed that obesity was simply the reverse of anorexia nervosa. Twenty-three wrote additional comments on the back of their questionnaires, 13 of which wrote about the issues raised, while 10 wrote about the questionnaire itself (structure, length etc.). In a question asking why the participants thought that mainly females and not males become anorexic, 60 (41%) mentioned the pressure on females to be thin, 67 (46%) believed that it involved women being more concerned about their appearance than men and 79 (54%) wrote about 'ideal' and 'perfect' images of supermodels in magazines and the media. Other ideas mentioned were those of peers and family teasing females about fatness, diet campaigns being aimed at women, sexual abuse and rape, emotional problems, vulnerability and fear at puberty and anorexia nervosa as a means of control. It was also mentioned that male role models are often more muscular and that the pressure on men was of a different kind.

Questionnaire

Participants were asked to complete a four-part, 108-item questionnaire on the subject of different eating habits. Each of the four parts contained 27 items, which were to be responded to on a 7-point scale (7 = agree, 1 = disagree) with an additional option for 'don't know' responses. The first section was headed 'beliefs about anorexia nervosa—causes', the second 'anorexia nervosa cures', the third 'beliefs about obesity—causes', and the fourth 'obesity cures'. The anorexia nervosa questions were based on those used by Furnham and Hume-Wright (1992) who had previously carried out in-depth interviews to derive a list of the causes of anorexia nervosa, the typical behaviour of anorexics and how to 'cure' anorexics, with the most common statements being retained for use in their questionnaire. The 'cause' and 'cure' sections of this questionnaire were taken and slimmed down in order to make it more suitable for use with 16–18 year olds. This was carried out in consultation with several individuals, some of whom were from the targeted age group. The chosen statements were then assessed for their appropriateness in a questionnaire regarding obesity. The statements either remained the same as they were in the anorexia nervosa questionnaire, or otherwise individual words were changed which altered the participant (i.e. from anorexia, thinness, etc., to obesity, fatness, etc.), to make the statement relevant to obesity, but did not change the ideas behind the individual statements. Some of the anorexia nervosa questions had no obvious equivalent in terms of obesity and were also left out of the questionnaire. This was not common and their omission did not seem to affect the overall content of the questionnaire. The final questions were again shown to around half a dozen individuals in order to assess its comprehensiveness and its suitability for the chosen age group. The resulting questionnaire therefore represented a wide range of beliefs that lay people have about 'causes' and 'cures' of anorexia nervosa, with equivalent questions representing the same ideas but in a form relevant to the subject of obesity.

Procedure

All participants were asked to complete the questionnaire during the same tutorial period, which lasted 50 minutes, at their Sixth Form College. Most of the questionnaires handed out were returned, and the majority (94%) of the returned questionnaires were completed correctly.

Results

Factor analysis of the 'causes' of anorexia nervosa

Table I shows the results of the first part of the study, the 'anorexia nervosa cause' section. The statements are arranged in descending order of agreement. It seems that there were quite a wide range of responses, and differing amounts of non-responses, from 2 to 34, which could be considered quite low. Participants tended to agree most with statements regarding societal pressures and those concerning the anorexic's beliefs that thinness is good. In contrast, statements regarding the family were most commonly rejected, and the item for which most participants replied 'don't know' (23%) was concerned with the anorexic's mother usually being quiet and passive.

These items were then treated to a Varimax rotated factor analysis to reveal the underlying factor structure, following Furnham and Hume-Wright (1992). Nine factors were found that had eigenvalues > 1 . Four of these factors emerged from a scree slope test as being satisfactory and accounted for 39.3% of the variance. The first factor that emerged was labelled *Rebellion*, as the statements which loaded on it at 0.40 and above were concerned with rebelling against parents and coping with adulthood and change. The second factor to emerge was labelled *Social Pressure*, as

items loading onto it were concerned with the anorexic's pursuit of thinness as a result of society's ideals. A third causal factor was labelled *Family*, as statements loading highly onto it were concerned with family determinants of the disorder. The fourth factor was labelled *Coping*, as items loading upon it involved ideas of how anorexia might be used to get attention in an attempt to solve other problems.

Factor analysis of the 'cures' of anorexia nervosa

Table II shows the results of the second part of the study, the 'anorexia nervosa cure' section. The statements most frequently endorsed by participants seemed to be those concerned with psychotherapeutic treatment, i.e. those involving the development of self-worth and confidence, and involving the family in treatment. Those least often endorsed were those suggesting medical interventions involving drugs and strict regimes. Treatments which were perceived to be most effective also seemed to have the most frequent endorsement. The number of non-responses ranged from 1 to 37. The item with the highest number of non-responses (25%) was concerned with the anorexic's feelings of conflict.

The Varimax analysis yielded eight factors with eigenvalues > 1 , and from a scree test five of these, which accounted for 44% of the variance, were extracted. The first factor which emerged was labelled *Self-Worth*, as the items which loaded upon it were concerned with promoting personal worth and confidence and helping the anorexic and the family understand her/his actions. A second factor was labelled *Authoritarian*, as it involved bed rest and drug treatments, with the doctor being in control. *Change* was the label given to the third factor as items loading upon it were concerned with the need for the anorexic her/himself to want to change. The fourth factor that emerged was labelled *Food* as it involved the need to change the eating habits of the anorexic. The fifth factor was labelled *Freedom*, as the items loading upon it suggested that the disorder itself was the concern of the sufferer and should not be interfered with.

Factor analysis of the 'causes' of obesity

Table III shows the results of the third part of the study, the 'obesity cause' section. The statements most frequently agreed with seemed to involve many different theories, mainly those concerning food, societal pressures and stress at change. Family-orientated statements were once again rejected most frequently. Interestingly, the scores were, on the whole, much lower than those for the 'anorexia nervosa cause' statements. The number of non-responses ranged from 6 to 35 and seemed, on the whole, slightly higher than those from any other part of the questionnaire. The item which elicited the highest number of 'don't know' responses (24%) was again the statement concerned with an obese person's mother being quiet and passive.

Seven factors emerged from the Varimax analysis with eigenvalues > 1 . A scree test suggested that five of these factors were appropriate and accounted for 50.9%

TABLE I. Means, standard deviations, number of 'don't know' responses and factor loadings from the Varimax analysis of Part 1 of the questionnaire. Causes: possible causes of anorexia nervosa and factors more likely to contribute to the development of the disorder

Statements	M	SD	Unknown	Factors			
				1	2	3	4
People who get anorexia think that to be thin will bring them happiness	5.99	1.18	4		0.75		
Anorexia is due to a distortion in how sufferers see their bodies	5.82	1.49	6		0.49		
People get anorexia because of a fear of getting fat	5.48	1.43	2		0.43		
Anorexia is a result of Western ideals of physical thinness	5.15	1.70	20		0.57		
Anorexia grows from a belief that to lose weight is always good	5.04	1.52	6		0.52		
Anorexics are people who are affected negatively by society's emphasis on health and fitness	4.87	1.54	9		0.64		
Anorexics are people who cannot cope with the social pressure to be slim	4.75	1.65	6		0.51		
Anorexia in women reflects a need for status and self esteem as a woman	4.41	1.53	14		0.47		
People are less likely to get anorexia if they have seen a sibling suffer from it first	4.31	1.72	22	0.42			
Anorexia could perhaps be described as a reaction to stress at puberty	3.79	1.58	10				
You are more likely to get anorexia if food was used as a way of rewarding good behaviour or punishing bad behaviour in childhood	3.25	1.80	31	0.70			
Anorexia reflects an inability to cope with change	3.21	1.52	15	0.48			
Anorexics lose weight to get attention so that others will help them work out how to live their lives	3.13	1.66	3				0.69
People get anorexia because their mothers fixed how much, what and when they should eat so they did not learn to control their eating	3.07	1.56	17	0.49			- 0.41
Anorexia reflects a desire to stay within the family and not move into more public peer relationships	2.55	1.36	32				
Anorexia in women reflects the rejection of the role of a woman	2.54	1.47	25	0.41		0.48	
Anorexics are rebelling against their parents' ideas of what is right	2.53	1.49	8	0.65			
Anorexics are trying to prove they are able to cope with the responsibilities of adulthood	2.48	1.44	19	0.58			

TABLE I (continued)

Statements	M	SD	Unknown	Factors				
				1	2	3	4	
Anorexics come from families where the members are not very caring towards one another	2.18	1.35	12			0.63		
Anorexia results from children not being allowed to change from children into adults by their family	2.15	1.28	17			0.46		
Anorexia reflects a child's refusal to accept a mother's love by refusing her cooking	2.03	1.38	11	0.50				
The anorexic's mother is usually quiet and passive, allowing the more dominant father to control the family	2.02	1.46	34	0.60				
Anorexia results from children not being given privacy by their family	2.01	1.10	15				0.52	
If someone in your family is very fat you will probably not get anorexia	1.80	1.45	2			0.53		
Anorexics cannot help becoming thin—it's in their genes	1.59	1.10	7			0.45		
Anorexics come from mainly uneducated families	1.42	1.00	8			0.60		
A person who becomes anorexic was probably quite difficult and naughty as a child	1.38	0.75	11	0.44				
Scale: Agree 7 6 5 4 3 2 1 Disagree				Eigenvalue	4.82	2.65	1.57	1.56
				Variance (%)	17.9	9.8	5.8	5.8

of the variance. The first of these factors, which accounted for over a quarter of the variance, was labelled *Coping* as items loading upon it were concerned with the way in which sufferers might use their excess weight as a way of dealing with various stresses. The second factor was labelled *Family*, as items loading upon it were concerned with various aspects of the family of the obese person. *Apathy* was the name given to the third factor, as it involved ideas of how the obese person rejects social norms and how they may have been passive and accepting. The fourth factor was entitled *Size Perception*, as items loading upon it were concerned with how the obese person might perceive themselves and weight. The fifth factor was labelled *Change*, as items loading upon it were concerned with how the disorder might be due to poor coping abilities regarding change.

Factor analysis of the 'cures' of obesity

Table IV shows the results of the 27 'obesity cure' statements. Participants seemed to prefer the psychotherapeutic-type treatments, as they did with the anorexia nervosa cures. Once again, therapies involving drug treatment and strict behavioural regimes were considered the least effective. Non-responses in this section ranged

TABLE II. Means, standard deviations, number of 'don't know' responses and factor loadings from the Varimax analysis of Part 2 of the questionnaire. Cures: possible outcomes of anorexia nervosa and therapies that might contribute to the anorexic's improvement

Statements	M	SD	Unknown	Factors				
				1	2	3	4	5
Parents and family need to be helped to a greater understanding of the problem and need to become involved in treatment	5.92	1.24	2	0.52				
One problem in trying to cure anorexia is that the doctor wants them to put on weight but the anorexic does not want to	5.89	1.48	3	0.47				
Treatment should involve a way for the anorexic to develop personal worth and self-image as being adequate and successful in solving conflict and problems	5.88	1.23	6	0.57				
The most important thing to do to help anorexics is to get to understand their way of thinking	5.88	1.36	2	0.42				
To be fully cured, anorexics would probably have to grow in confidence in their ability to solve their daily problems	5.54	1.38	1	0.64				
Anorexics must have some wish for change or escape from their illness before they can get better	5.40	1.56	6	0.44		0.51		
It is important that someone who exerts some kind of authority points out that a person is anorexic as early as possible	5.01	1.60	12	0.55			0.43	
If the whole family is involved in therapy it is probable that the anorexic will get better a lot quicker	5.01	1.48	5			0.61		
The problem with trying to help severely ill anorexics is that they will not be able to imagine ways of getting better	4.81	1.56	14			0.54		
It is probably possible to help anorexics by telling them why they are doing what they are doing	4.78	1.47	11	0.56				
Anorexics could be said to be better when their lives no longer revolve around maintaining control over their food	4.73	1.58	19				0.61	
Only when anorexics realize they are sick will they seek treatment	4.63	2.11	3					0.62
The therapist should be clear and particular in telling sufferers to eat sensibly to improve their health	4.61	1.59	12	0.46	0.43			
A complete cure would probably involve moving out of a demanding environment into one where self-satisfaction is easier to attain	4.50	1.57	12	0.55				
Pointing out a possible anorexic before you are sure could be encroaching on their right to do as they think fit with their own bodies	4.34	1.74	22					0.63

TABLE II (*continued*)

Statements	M	SD	Unknown	Factors					
				1	2	3	4	5	
Bed rest and rewarding weight gain with greater freedom and privileges is probably the best way to treat anorexia	4.10	1.77	25						
It is probably rather difficult to help anorexics until they are severely ill physically	3.73	2.05	11		0.41	0.50			
An anorexic's mother should make all the family eat the same, thereby maintaining family solidarity	3.59	1.70	19				0.62		
An anorexic has to learn to give up demanding attention from being anorexic	3.53	1.59	17			0.58			
A good therapy would be bed rest and a high calorie diet until the patient reaches their 'appropriate' weight (calculated on the basis of height, age and build)	3.31	1.99	19		0.52				
Anorexia probably should not be treated psychiatrically, as this may represent defeat and weakness and be a personal stigma	3.18	1.73	19		0.51				
The best form of therapy would probably be to take control for what anorexics eat out of their own hands	3.14	1.70	13				0.40	-0.41	
It is probably impossible to work on anorexics' feelings of conflict until they are at a more viable weight	3.07	1.66	37		0.41				
It is probably not necessary to have the anorexic's co-operation early in therapy; the doctor should take control	2.75	1.73	14		0.60				
The use of drugs that increase appetite is probably a good way of treating an anorexic	2.51	1.76	15		0.53				
An authoritarian approach, i.e. telling sufferers they must eat, is probably the best approach in therapy	2.34	1.71	5		0.66				
The only way anorexics can actually die of the disorder is if they get so depressed they commit suicide	1.58	1.14	8						
Scale: Agree 7 6 5 4 3 2 1 Disagree				Eigenvalue	4.47	3.03	1.59	1.42	1.37
				Variance (%)	16.6	11.2	5.9	5.3	5.1

from 3 to 28, the statement with the most 'don't know' responses (19%) was that concerning obese people demanding attention from being obese.

The Varimax analysis yielded eight factors, while a scree test suggested that five factors provide a satisfactory model, accounting for 48.8% of the variance. The first

TABLE III. Means, standard deviations, number of 'don't know' responses and factor loadings from the Varimax analysis of Part 3 of the questionnaire. Causes: possible causes of obesity and factors more likely to contribute to the development of the disorder

Statements	M	SD	Unknown	Factors				
				1	2	3	4	5
You are more likely to become obese if food was used as a way of rewarding good behaviour or punishing bad behaviour in childhood	4.02	1.71	13			0.52		0.43
Obesity is due to a distortion in how sufferers see their bodies	3.75	1.93	9				0.63	
Obesity could perhaps be described as a reaction to stress at puberty	3.74	1.70	14					0.68
Obesity sufferers are people who are not affected by society's emphasis on health and fitness	3.62	1.87	9			0.52		
People become obese because their mothers fixed how much, what and when they should eat so they did not learn to control their eating	3.37	1.82	9					
Obesity reflects an inability to cope with change	3.28	1.56	11					0.65
People are less likely to become obese if they have seen a sibling suffer from it first	3.25	1.86	15				0.66	
Obesity sufferers are people who cannot cope with the social pressure to be slim	3.01	1.98	15		0.60			
Obese people cannot help being fat—it's in their genes	2.91	1.87	7			0.54		
Obesity reflects a desire to stay within the family and not move into more public peer relationships	2.88	1.68	32	0.54		0.42		
People who become obese think that being fat will bring them happiness	2.83	1.75	8				0.67	
Obesity grows from a belief that to put on weight is always good	2.77	1.63	10	0.62			0.40	
Obese people are demonstrating that they are unable to cope with the responsibilities of adulthood	2.74	1.65	9		0.53			0.42
Obesity is a result of rejecting Western ideals of physical thinness	2.73	1.66	21	0.57				
Obesity in women reflects the rejection of the role of a woman	2.72	1.73	14			0.40		
Obesity in women reflects no wish for status or self esteem as a woman	2.72	1.75	6		0.46	0.41		
Obese people gain weight to get attention so that others will help them work out how to live their lives	2.65	1.57	11	0.64				
Obesity reflects a child's acceptance of a mother's love by accepting her cooking	2.60	1.54	10			0.48		

TABLE III (continued)

Statements	M	SD	Unknown	Factors				
				1	2	3	4	5
Obese people are rebelling against their parents' ideas of what is right	2.47	1.51	9	0.55				
A person who becomes obese was probably quite passive and well behaved as a child	2.44	1.63	30			0.58		
Obesity results from children being forced to change from children into adults by their family	2.39	1.34	20	0.73				
Obesity sufferers come from families where the members are not very caring towards one another	2.39	1.58	12		0.56			
People become obese because of a fear of becoming too thin	2.31	1.74	7	0.58			0.51	
Obesity results from children not being given privacy by their family	2.22	1.36	17		0.68			
The obese person's mother is usually quiet and passive, allowing the more dominant father to control the family	2.12	1.48	35	0.49		0.41		
If someone in your family is very thin then you will probably not become obese	2.07	1.57	6		0.63			
Obese people come from mainly well educated families	1.88	1.43	13		0.73			
Scale: Agree 7 6 5 4 3 2 1 Disagree			Eigenvalue	7.44	2.01	1.52	1.43	1.36
			Variance (%)	27.6	7.4	5.6	5.3	5.0

factor was entitled *Understanding* as items loading upon it were concerned with the promotion of understanding in parents, therapists and the sufferer. The second factor was labelled *Authoritarian*, as items loading upon it were concerned with doctors taking control of the situation and an authoritarian approach to treatment. The third factor was labelled *Self Realization*, as items loading upon it involved ideas about how the sufferer must come to terms with their illness. *Eating* was the label given to the fourth factor, as it involved the items suggesting that the obese person must control their food, and also how the problem was not a psychiatric one. The final factor was entitled *Exercise*, as items loading upon it were concerned with the use of exercise in treatment.

Correlations between factors and various demographic variables

In order to examine the demographic determinants of beliefs about the causes and cures of anorexia nervosa and obesity, various correlations were computed. Table V shows the correlations of each of the factors obtained from the Varimax analysis,

TABLE IV. Means, standard deviations, number of 'don't know' responses and factor loadings from the Varimax analysis of Part 4 of the questionnaire. Cures: possible outcomes of obesity and therapies that might contribute to the obese person's improvement

Statements	M	SD	Unknown	Factors				
				1	2	3	4	5
The most important thing to do to help obese people is to get to understand their way of thinking	5.42	1.56	5	0.47		0.57		
Parents and family need to be helped to a greater understanding of the problem and need to become involved in treatment	5.42	1.56	4	0.68				
Treatment should involve a way for the obesity sufferer to develop personal worth and a self image as being adequate and successful in solving conflict and problems	5.17	1.60	13	0.57				
To be fully cured, obese people would probably have to grow in confidence in their ability to solve their daily problems	5.12	1.56	8	0.52		0.55		
Obese people must have some wish for change or escape from their illness before they can get better	5.05	1.80	7	0.43				
If the whole family is involved in therapy it is probable that the obese person will get better a lot quicker	4.97	1.67	3	0.56				
The problem with trying to help severely ill obese people is that they will not be able to imagine ways of getting better	4.68	1.60	11			0.59		
It is probably possible to help obese people by telling them why they are doing what they are doing	4.62	1.72	9	0.59				
Only when obesity sufferers realize that they are sick will they seek treatment	4.55	1.82	12			0.69		
The therapist should be clear and particular in telling sufferers to eat sensibly to improve their health	4.46	1.64	9	0.59				
Pointing out a possible obese person before you are sure could be encroaching on their right to do as they think fit with their own bodies	4.36	1.73	22			0.51		0.46
It is important that someone who exerts some kind of authority points out that a person is obese as soon as possible	4.35	1.66	14	0.53				
Obese people could be said to be better when they are more concerned with maintaining control over their food	4.18	1.64	14				0.43	
A complete cure would probably involve moving out of a demanding environment into one in which self-satisfaction is easier to attain	4.17	1.68	13	0.69				

TABLE IV (continued)

Statements	M	SD	Unknown	Factors				
				1	2	3	4	5
A good therapy would be exercise and a low calorie diet until the patient reaches their 'appropriate' weight (calculated on the basis of height, age and build)	4.16	1.90	7					0.71
Exercise and rewarding weight loss with greater freedom and privileges is probably the best way to treat obesity	4.10	1.69	12					0.57
One problem in trying to cure obesity is that the doctor wants them to lose weight but the obese person does not want to	4.09	2.16	8		0.60			
An obese person's mother should make all the family eat the same, thereby maintaining family solidarity	3.56	1.68	17				0.62	
An obese person has to learn to give up demanding attention from being obese	3.33	1.62	28		0.48			
It is probably rather difficult to intervene to help obese people until they are severely ill physically	3.31	1.85	11		0.62			
Obesity probably should not be treated psychiatrically, as this may represent defeat and weakness and be a personal stigma	3.10	1.64	22				0.63	
The best form of therapy would probably be to take control for what obese people eat out of their own hands	2.81	1.56	15		0.46		0.42	
It is probably impossible to work on obese people's feelings of conflict until they are at a more viable weight	2.79	1.44	16		0.54		0.40	
It is probably not necessary to have the obese person's co-operation early in therapy; the doctor should take control	2.65	1.68	11		0.71			
The use of drugs that decrease appetite is probably a good way of treating an obesity sufferer	2.49	1.66	11		0.46			
The only way obesity sufferers can die of the illness is if they get so depressed that they commit suicide	2.38	1.87	13			- 0.45		
An authoritarian approach, i.e. telling sufferers they must not eat, is probably the best approach in therapy	2.36	1.78	4		0.61			
Scale: Agree 7 6 5 4 3 2 1 Disagree			Eigenvalue	5.31	3.63	1.58	1.40	1.26
			Variance (%)	19.7	13.5	5.8	5.2	4.7

TABLE V. Correlations between the factors and various demographic variables

	Sex	Age	Size	Estimation	History	Acquaintance
Correlations between anorexia nervosa cause factors and demographic variables						
1. Rebellion	-0.11	-0.01	-0.13	0.05	-0.07	-0.10
2. Social pressure	-0.21*	0.04	-0.15	-0.01	-0.10	0.05
3. Family	0.27***	-0.07	0.19*	-0.08	0.21**	0.04
4. Coping	-0.15	0.15	-0.03	0.20*	-0.13	-0.13
Correlations between anorexia nervosa cure factors and demographic variables						
1. Self-worth	-0.14	0.24**	-0.18*	-0.04	-0.19*	0.01
2. Authoritarian	0.30***	-0.09	0.17*	-0.08	0.11	0.06
3. Change	-0.08	0.10	0.10	0.09	-0.04	-0.14
4. Food	0.03	0.03	0.10	-0.04	0.06	-0.06
5. Freedom	-0.16	0.03	-0.07	0.03	0.05	-0.08
Correlations between obesity cause factors and demographic variables						
1. Coping	0.14	-0.07	-0.13	-0.03	0.08	-0.03
2. Family	0.14	0.00	0.11	-0.11	0.12	0.07
3. Apathy	0.20*	-0.02	0.25**	0.05	-0.10	-0.07
4. Size perception	-0.06	0.01	-0.06	-0.12	0.10	0.13
5. Change	-0.30***	-0.13	-0.13	0.19*	-0.24**	0.10
Correlations between obesity cure factors and demographic variables						
1. Understanding	-0.17	0.06	-0.11	0.03	-0.05	0.07
2. Authoritarian	0.13	-0.18*	0.06	0.07	0.00	-0.03
3. Self realization	-0.23**	0.09	-0.13	-0.05	-0.21*	0.05
4. Eating	0.14	-0.03	0.05	-0.03	0.08	0.04
5. Exercise	-0.03	0.12	0.07	-0.01	0.01	0.09

* $p < 0.05$. ** $p < 0.01$. *** $p < 0.001$.

with each of the subject demographic variables of age, sex and size, as well as correlations with the participants' assessments of their size as overweight, underweight or about right (Estimation), whether they had suffered from an eating disorder (History) and whether they knew anyone who had suffered from anorexia nervosa or obesity, where appropriate (Acquaintance).

The variables most related to causal beliefs about anorexia nervosa were sex of participant and not having suffered from an eating disorder. While females are more likely to see social pressure as a causal factor, males are more likely to consider the family as an important determinant of the disorder. Not having suffered from an eating disorder was also related to a belief that the family was involved in the development of the disorder, as were larger participants. Those who considered themselves overweight are more likely to see anorexia as a way of getting attention in order to cope with problems. Demographic correlates of beliefs about the cure of anorexia nervosa showed that male participants put particular emphasis on an authoritarian-type approach, while older participants were more likely to favour the promotion of self-worth, as did smaller participants and those who had had experience of an eating disorder. Larger participants, like the males, seemed to put more emphasis on an authoritarian approach towards the disorder.

Demographic correlates of the beliefs about the causes of obesity showed that while males and larger participants regarded obesity as a problem characterized by the sufferer's passive nature, females were more likely to see it as a problem caused

by poor coping abilities regarding change. Participants who saw themselves as overweight, along with those who had personal experience of an eating disorder, also considered stress at times of change as an important causal factor. The variable that related most to beliefs about the cures of obesity was sex. Females were more likely to favour treatment which involved helping the sufferer and family understand the problem, and also believed that the obese person must realize they are sick and learn to come to terms with their illness, as did those who had suffered from an eating disorder. Younger participants were more likely to favour an authoritarian approach to the illness.

Relationships between 'causes' and 'cures' of anorexia nervosa and obesity

In order to examine the relationship between the various beliefs regarding the causes and cures of anorexia nervosa and the causes and cures of obesity, a partial correlation was computed between all factors, partialling out those demographic variables found in Table V to relate to these factors, namely sex, size, self-assessment of size and history of an eating disorder. Table VI shows the partial correlations between beliefs about the causes and cures of anorexia nervosa. The highest correlation found was between the belief that anorexia is caused by rebellion and coping with adulthood (anorexia cause factor 1) and the idea of the anorexic needing to change (anorexia cure factor 3). This causal factor was also correlated with the belief in an authoritarian approach to treatment (anorexia cure factor 2). The belief in the need to promote self-worth in anorexia sufferers (anorexia cure factor 1) was correlated both with the idea of anorexia being caused by social pressure (anorexia cause factor 2) and by family determinants (anorexia cause factor 3). The notion of social pressure as a causal factor (anorexia cause factor 2) was also correlated with a belief in the need to change the anorexic's eating habits (anorexia cure factor 4). The belief that the family was in some way responsible for the disorder (anorexia cause factor 3) was also correlated both with the idea that the anorexic should change her/his eating habits (anorexia cure factor 4) and the notion of the disorder itself being the concern of the sufferer her/himself (anorexia cause factor 5). This curative factor regarding personal freedom (anorexia cause factor 5) was also found to be correlated with the causal factor that characterized anorexia as being a way in which the sufferer attempts to cope or signals problems in doing so (anorexia cause factor 4).

Table VII shows the partial correlations between beliefs about the causes and cures of obesity. A belief in an authoritarian approach in treatment (obesity cure factor 2) correlates most highly with the idea that family characteristics are in some way responsible for the disorder (obesity cause factor 2). It also correlates significantly with the belief that obesity is a way of coping with stress (obesity cause factor 1), that it is characterized by a passive nature (obesity cause factor 3) and with the idea that obesity is a result of how the sufferer might perceive themselves (obesity cause factor 4). The belief that obesity might be cured by helping the sufferer and her/his family to understand the problem (obesity cure factor 1) was correlated with the notion of inability to cope with change (obesity cause factor 5),

TABLE VI. Partial correlates between cause and cure factors of anorexia nervosa, partialling out effects of sex, size and having suffered from an eating disorder

Anorexia cure factors	Anorexia nervosa cause factors			
	Rebellion	Social pressure	Family	Coping
1. Self-worth	0.14	0.32***	-0.23**	-0.02
2. Authoritarian	0.26**	0.04	0.10	-0.10
3. Change	0.35***	0.15	-0.03	0.03
4. Food	-0.06	0.18*	0.18*	-0.07
5. Freedom	0.03	0.11	-0.20*	0.17*

* $p < 0.05$. ** $p < 0.01$. *** $p < 0.001$.

the perception the sufferer might have regarding her/his size (obesity cause factor 4) and negatively correlated with the belief in the family as a causal factor (obesity cause factor 2). A belief that obesity might be a way of coping with various pressures (obesity cause factor 1) was found to correlate with the curative factors involving eating control (obesity cure factor 4) and the need for exercise (obesity cure factor 5). The belief that the obesity sufferer is characterized by a passive nature (obesity cause factor 3) is also correlated with the need to control eating (obesity cure factor 4), and the belief that obesity reflects an inability to cope with change (obesity cause factor 5) is correlated with the notion that obesity sufferers must come to terms with their illness (obesity cure factor 3).

Table VIII shows the correlations between beliefs about the causes of anorexia nervosa and the causes of obesity. The highest correlation found was between the idea of anorexia nervosa being an attempt to rebel and cope with adulthood (anorexia cause factor 1) and obesity as a way of coping (obesity cause factor 4). This belief regarding anorexia was also found to correlate significantly with obesity signifying a passive character (obesity cause factor 3) and obese people having problems in coping with change (obesity cause factor 5). A belief in anorexia as being caused by social pressure (anorexia cause factor 2) was found to correlate highly both with the notion of obese people being unable to cope with change (obesity cause factor 5) and to a slightly lesser extent with the way obese people perceive their size (obesity cause factor 4). A belief in anorexia being caused by family determinants (anorexia cause factor 3) correlated highly with both the belief that obesity was caused by various aspects of the family (obesity cause factor 2) and the passive nature of obesity sufferers (obesity cause factor 3).

Table IX shows the partial correlations between beliefs about the 'cures' of anorexia nervosa and obesity. The most significant correlation, indeed the most significant of all the partial correlations, was between the beliefs of an authoritarian approach to the treatment of both anorexia nervosa and obesity (anorexia cure factor 2; obesity cure factor 2). Both of these factors also had very similar items loading upon them. The authoritarian approach to anorexia was also correlated with the need for obesity sufferers to control their eating (obesity cause factor 4) and negatively correlated with a belief that the obese person must come to terms with

TABLE VII. Partial correlates between cause and cure of obesity, partialling out effects of sex, self-assessment of size and having suffered from an eating disorder

Obesity cure factors	Obesity cause factors				
	Coping	Family	Apathy	Size perception	Change
1. Understanding	0.06	- 0.23**	0.00	0.25**	0.31***
2. Authoritarian	0.31***	0.44***	0.28***	0.33***	0.11
3. Self-realization	0.02	- 0.05	- 0.16	0.00	0.24**
4. Eating	0.18*	0.07	0.20*	0.11	0.06
5. Exercise	- 0.23**	0.12	0.10	0.11	- 0.06

* $p < 0.05$. ** $p < 0.01$. *** $p < 0.001$.

their illness (obesity cure factor 3). A belief in the need to promote self-worth in anorexia sufferers (anorexia cure 1) was correlated most highly with the promotion of understanding of the disorder in obesity sufferers and their families (obesity cure 1) and to a lesser extent with the need for exercise (obesity cure factor 5). A belief that anorexics must want to change was correlated with an authoritarian approach to obesity treatment (obesity cure factor 2) and with a belief that the obesity sufferer must come to terms with the illness (obesity cure factor 3). A belief that the anorexia is the concern of the sufferer (anorexia cure factor 5) is highly correlated with the belief that the obesity sufferer must come to terms with the illness (obesity cure factor 3).

Discussion

The results of this study suggest that young people in the 16–19-year-old age group hold moderately accurate beliefs about the causes and cures of both anorexia nervosa and obesity. While similarities were found between this study and Furnham and Hume-Wright (1992) regarding the type of statements most agreed with the

TABLE VIII. Partial correlates between the causes of anorexia nervosa and obesity, partialling out effects of having suffered from an eating disorder, size and self-estimate of size

Obesity cause factors	Anorexia nervosa cause factors			
	Rebellion	Social pressure	Family	Coping
1. Coping	0.37***	- 0.01	0.10	0.16
2. Family	0.16	- 0.04	0.32***	- 0.05
3. Apathy	0.17*	0.13	0.24**	0.12
4. Size perception	- 0.04	0.28***	- 0.01	0.01
5. Change	0.18*	0.35***	0.04	- 0.03

* $p < 0.05$. ** $p < 0.01$. *** $p < 0.001$.

TABLE IX. Partial correlates between the cures of anorexia nervosa and obesity, partialling out effects of sex, and having suffered from an eating disorder

Obesity cure factors	Anorexia nervosa cure factors				
	Self-worth	Authoritarian	Change	Food	Freedom
1. Understanding	0.42***	0.08	0.14	0.13	0.04
2. Authoritarian	0.09	0.49***	0.23**	0.08	-0.11
3. Self-realization	0.14	-0.17*	0.19*	0.10	0.36***
4. Eating	0.02	0.35***	-0.04	0.11	0.13
5. Exercise	0.32***	0.07	-0.05	0.03	-0.08

* $p < 0.05$. ** $p < 0.01$. *** $p < 0.001$.

consensuality of beliefs (evident from the standard deviations), there were fewer 'don't know' responses on the whole, and the underlying factor structure of the anorexia nervosa items seemed quite different, especially in the way they related to one another.

The lay participants in this sample, like those in the study by Furnham and Hume-Wright (1992), seemed to see the factor of social pressure affecting the development of anorexia as most important. This mirrors the responses participants gave at the beginning of the questionnaire, where 41% mentioned the pressure on women to be thin, and 54% mentioned the influence of the media in explaining the preponderance of female anorexics, suggesting that this might also be the way in which many of them acquire their beliefs. In addition to the factor of social pressure, the factor analysis of the 'anorexia causes' section of the questionnaire also yielded the factors of rebellion, family and coping. The factor labelled *rebellion* has similarities with the ideas of Bruch (1973), in that there are important emotions connected with food, which a person might use as a weapon against her/his parents or which might be used by parents themselves. This factor might also be seen as having certain points in common with the theory of maladaptive psychosocial adjustment to adulthood. The factor labelled *family* seems similar to other family systems theories and to a certain extent that of Crisp *et al.* (1982), and was also present in the factors found by Furnham and Hume-Wright (1992). The factor labelled *coping* has similarities with the factor labelled rebellion; however, the emphasis of this factor suggests that anorexia is a result of difficulties in coping and may have parallels with the psychophysiological theory of anorexia.

The participants in this study hold various different beliefs about the possible 'cures' of anorexia. The factor labelled *self-worth* was considered to be the most important and was similar to the factor identified as self-worth in the study by Furnham and Hume-Wright (1992). The factors identified as being concerned with food-related and authoritarian cures of anorexia suggest that young people are aware of different medical treatments for anorexia, although these factors had low mean ratings and were not supported as important, as in the Furnham and Hume-Wright (1992) study. The participants in this study were also aware of the need to promote

ideas of change in the anorexic, that the anorexic must want to change in order for treatment to be effective. This suggests that young people appreciate the problems involved in trying to get people who are wilfully starving themselves to eat and gain weight. This is emphasized by the finding of a fifth factor, labelled *freedom*, which suggests that the participants in this study thought that anorexia may be seen as a personal choice and is unlikely to be treated until the sufferers themselves seek treatment.

A range of responses were also found regarding the causes of obesity, which were different in many ways to those regarding anorexia nervosa. There was a much lower endorsement of all statements involved, suggesting that they did not adequately describe what the participants felt to be the issues behind the development of obesity, or perhaps a lack of exposure to such theories. The notion of obesity being genetically caused was not widely supported by participants. The factor analysis yielded factors concerning coping, family, apathy, size perception and change. On the whole, these factors do not seem as well supported as those concerning anorexia, which underlines the observation made above. The first factor, coping, seems to contain ideas about how obesity might be a result of attempts to cope with various stresses, which might be seen as similar to ideas of compulsive or comfort-eating (Craddock, 1978), notions of stress-induced or 'reactive obesity' (Bruch, 1973) and also elements of personality theories. As in the anorexia section of this study, a factor was obtained which seems to suggest the importance of the family in the development of the disorder. Although this factor had certain elements in common with Bruch's (1973) idea of a 'family frame', there were several elements which were different, such as the significance of food which did not appear to be included in this factor. The notion of the obese person as suffering from some kind of apathy was also found to be a factor characterizing the way in which young people in this study regard the disorder. This factor included ideas of how an obese person may have been passive and accepting, while rejecting social norms of the desirability of thinness, and has similarities with personality theories of obesity. A factor of size perception was also identified, which suggested that obese people somehow see weight or being fat differently, which is reminiscent of the neurotic personality theory. The belief that obesity may be caused by problems in coping with various changes in life might also be said to have similarities with ideas of obese people having certain personality characteristics. It seems that young people's theories of the causes of obesity are largely related to various different perceived personality characteristics of the obesity sufferers themselves.

As was found with anorexia, the most favoured treatment regarding obesity seemed to involve ideas of promoting self-worth and understanding the disorder, which has similarities with behavioural self-control programmes (Thompson, 1993). The young people in this study were also aware of the idea that obesity might be a personal choice, which reflects the need to understand the sufferer and help them develop confidence and ways of getting better. They also identified a factor that suggested that obese people would not want to lose weight and would often be severely ill before intervention was sought, which would require an authoritarian approach. Participants also supported a view that obese people should relinquish

control over their eating, with doctors, not psychiatrists, taking charge of them. In addition, participants identified a factor of exercise, which was concerned with the use of rewarding weight loss and exercise in treatment. The fact that the first two factors mentioned in this section were rated more highly than the second three factors suggests that young people favour more psychotherapeutic approaches towards the disorder.

As was found in the study regarding anorexia nervosa by Furnham and Hume-Wright (1992), the most salient demographic correlate of lay beliefs about anorexia nervosa and obesity was that of sex of participant. However, unlike the aforementioned study male participants tended to hold strong beliefs about the causes and cures of anorexia, while females tended to hold stronger beliefs about the causes and cures of obesity, although neither of these trends were particularly consistent, with females favouring social pressure as a cause of anorexia and males supporting the notion of the passive nature of obesity sufferers. Although sex did seem to be a significant demographic correlate of the causes and cures of anorexia and obesity, it did not seem to be consistently significant over the range of factors and despite the fact that males and females did seem to differ in their beliefs about the causes and cures, it might be argued that this age group were fairly homogeneous in their beliefs.

Unlike the study by Furnham and Hume-Wright (1992), significant correlations were also found with size of subject and experience of an eating disorder. Not having had experience of an eating disorder seemed to lead to a belief in the importance of family determinants of anorexia, it seems that those who have experience of an eating disorder were more likely to hold strong beliefs about the cures of anorexia and the causes and cures of obesity. Considering that a most of those who indicated that they had suffered from an eating disorder will have suffered from either anorexia or bulimia, it seems that this experience has not helped them to understand the causes of the disorder, but may have helped them formulate ideas about the treatment of the disorder and may also have lead them to form ideas about the causes and cures of obesity.

Neither age nor acquaintance with someone who has suffered from anorexia nervosa or obesity had a consistent significant effect on beliefs held, suggesting that beliefs did not differ significantly in the 16–19-year-old age range and that knowing someone with either disorder had not enabled the individual to achieve any greater insight into the disorder.

Correlations between the various factors yielded some interesting findings. In contrast to the findings of Furnham and Hume-Wright (1992), the anorexia cause and cure factors yielded many fewer significant correlations, suggesting that young people do not hold many beliefs that link cause and cure of the disorder. Unlike the study by Furnham and Hume-Wright (1992), there did not seem to be a belief in physiological treatments regardless of which causal factor they favoured, although between them the authoritarian and food curative factors did correlate with three out of the four causal factors. The relationship between causes and cures of anorexia seems to be more specific for this age group compared to those in the aforementioned study.

There were also a number of significant correlations between the perceived causes and cures of obesity. On the whole the correlations seem more significant than those for anorexia. An authoritarian approach to treatment was significantly correlated with all but one of the perceived cause factors, suggesting that authoritarian approaches to obesity are considered relevant whatever their cause. However, an approach which includes the promotion of understanding was also significantly correlated with notions of obesity being caused by the perception of weight and poor coping abilities in the face of change, and negatively correlated with the notion of obesity being caused by family variables.

Correlations within cause and cure for both anorexia and obesity revealed that participants perceived the two disorders as having certain factors in common. Within-cause correlations were found between the causal factor of family regarding anorexia and both the idea of obesity being a result of family variables and of apathy regarding social norms. Clearly, the participants in this study considered the family as having an important role in the development of both the disorders. The notion of social pressure as causing anorexia was also found to correlate with differences in size perception of obesity sufferers and problems in coping with change, suggesting that social or external factors were deemed to be common to both. In addition, a significant correlation between the anorexia causal factor of rebellion and the obesity causal factor of coping suggest that the notion of an eating disorder being used in some way, or being symbolic of something, is common to both.

Within-cure correlations seem to signify important similarities in the perception of treatment of the two disorders, suggesting that beliefs about cure are somewhat more distinct. The most significant correlation was between the authoritarian approach in treatment of both the disorders, suggesting that a similar authoritarian approach to treatment is considered appropriate for both disorders. An approach that involves the promotion of understanding and self-worth also seems to be supported for both disorders, while ideas regarding the disorders as a result of free will to behave in a certain way was also a common element. However, there were important differences, especially regarding the factors of food, eating behaviour and exercise, which, although one might expect them to be correlated, were not. The similarities between these factors suggest that young people believe in, and favour, treatment which helps the sufferer (and the family) to understand her/his problem, and acknowledge the importance of the sufferer's co-operation in therapy, for both obesity and anorexia nervosa, while also believing that an authoritarian approach is applicable to both disorders.

Although the young people in this study shared some of the beliefs about causes and cure of anorexia nervosa expressed in the study by Furnham and Hume-Wright (1992), and held several beliefs comparable to the so-called 'scientific' theories of both anorexia and obesity, findings suggest that lay persons of this age group do not have a coherently structured view of the disorders, or that they hold more specific ideas about the disorders. Similarities were found between the beliefs participants had about both anorexia nervosa and obesity, with notions such as family causes and authoritarian cures being common to both. However, findings such as the decline in agreement with all of the proposed causes of obesity, as well as differences in

underlying factor structure, suggest that lay persons of this age group believe that there are important differences underlying the two disorders, despite the fact that 57.8% of participants initially stated that they believed anorexia to be simply the reverse of obesity.

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