Responsibility for participation in treatment of anorexia nervosa in female adolescents and young women: Qualitative research

Odpowiedzialność za współudział w leczeniu dziewcząt i młodych kobiet chorujących na jadłowstręt psychiczny – badanie jakościowe

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Abstract

Background. Anorexia nervosa (AN) is an eating disorder, which is difficult to treat. Denial of illness and ambivalence about agreeing to treatment make the process of recovery very complex. Taking responsibility for the process of treatment is an important factor in the process of a successful recovery.

Objectives. The study investigated the personal experiences of females diagnosed with AN who took responsibility for the participation in treatment and recovery.

Material and methods. A qualitative study was carried out examining 11 AN females by using a semi-structured interview supported by a "Blank Sheet of Paper Test" by Wciórka, which is an unstructured clinical measure of a projective character. The data was analyzed using the IPA approach.

Results. The qualitative analysis of the obtained data revealed several patterns of behavior with regards to the patients taking responsibility for their treatment: 1. taking responsibility, 2. not taking responsibility, and 3. taking partial or ambiguous responsibility for participation in treatment. A comparative characteristics of all patterns exposed the potential risk and protective factors in the course of therapy of AN. It was found that the way patients experienced the crisis connected with the disorder was of key importance for taking responsibility for treatment. Taking responsibility was accompanied by having the support of the patient's relatives, satisfactory peer relationships, future goals, and a lack of mood distortions. Not taking responsibility was accompanied by not perceiving health as value, experiencing the mother's disinterest and a breakdown of family bonds.

Conclusions. The results indicate areas of nursing and therapeutic interventions in preparing AN sufferers for recovery and suggest areas for further clinical research.

Key words: anorexia nervosa, recovery, treatment, responsibility

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Streszczenie

Wprowadzenie. Podczas leczenia jadłowstrętu psychicznego pojawia się wiele trudności. Zaprzeczanie chorobie i ambiwalentny stosunek wobec terapii utrudniają proces dochodzenia do zdrowia. Istotnym czynnikiem w tym procesie jest podejmowanie odpowiedzialności za współudział w leczeniu.

Cel pracy. Analiza osobistych doświadczeń pacjentek chorujących na jadłowstręt psychiczny na polu podejmowania odpowiedzialności za współudział w leczeniu.

Materiał i metody. W badaniu jakościowym opartym o analizę częściowo ustrukturalizowanych wywiadów i wyników zastosowania narzędzia projekcyjnego ("Próby kartki" Wciórki) wzięło udział 11 osób płci żeńskiej z rozpoznaniem jadłowstrętu psychicznego. Przyjęto Interpretacyjną Analizę Fenomenologiczną (IPA) jako metodę analizy zebranych danych.

Wyniki. Analiza jakościowa uzyskanych danych pozwoliła wyróżnić 3 wzory zachowania się przebadanych osób w trakcie leczenia: 1. podejmowanie odpowiedzialności; 2. niepodejmowanie odpowiedzialności; 3. częściowe lub niejednoznaczne podejmowanie odpowiedzialności za współudział w leczeniu. Przedstawiono porównawczą charakterystykę poszczególnych wzorów. Okazało się, że kluczowy dla wzięcia odpowiedzialności za przebieg leczenia był sposób przeżycia kryzysu w związku z chorobą. Poczuwanie się do odpowiedzialności współwystępowało z: otrzymywaniem wsparcia ze strony najbliższych, satysfakcjonującymi relacjami rówieśniczymi, umiejętnością planowania przyszłości i brakiem zaburzeń nastroju. Niepodejmowaniu odpowiedzialności zaś towarzyszyły: niepostrzeganie przez dziewczęta zdrowia jako wartości, koncentrowanie się matek pacjentek na problemach ich rodzeństwa, rozpad więzi rodzinnych.

Wnioski. Wyniki badania wskazują obszary interwencji terapeutycznych wspierających proces leczenia osób chorujących na jadłowstręt psychiczny oraz stanowią implikację do dalszych badań klinicznych.

Słowa kluczowe: jadłowstręt psychiczny, rekonwalescencja, leczenie, odpowiedzialność

Background

Anorexia nervosa (AN) has been found by practitioners and researchers to be one of the most challenging conditions in terms of treatment. To date, most research related to treatment and recovery from AN has drawn the conclusion that there are a number of difficulties on the part of patients (loss of weight perceived as a success, denial of the problem, lack of interest in changing), the functioning of their families (unconscious maintenance of the symptoms, helplessness vs exaggerated control), as well as professionals (fear for the health and life of the patients, exaggerated focus on symptoms instead of causes, unclear definition of recovery).^{1–3}

Difficulties in treating AN appear at practically every stage of the process. In the initial stage, patients do not perceive their condition as an illness, or they lack the motivation to pursue a recovery program. While convalescing, weight gain and the changing shape of the body are barely tolerable for the patient.^{5,6} As AN is a disorder strongly associated with negative somatic changes in the body, serious health hazards and even the risk of death, undertaking proper and quick treatment is of utmost importance.² The decisive factor determining successful recovery is whether or not the patient takes on responsibility for participation in the process. The acknowledgment of their responsibility for the healing process might significantly increase the probability of a full recovery. Nevertheless, clinicians' findings reveal a great number of difficulties in the process of treating anorexia, which may suggest that patients have deficits in considering themselves responsible for participation in the treatment.^{5,7,8}

Difficulties in treating anorexia nervosa

All recovery procedures should be supported by an adequate personal image of the disorder by the patient, as well as an appropriate self-perception of their condition. Yet many people struggling with AN do not perceive their behavior as morbid, they deny the existence of the illness, or do not take it seriously. AN sufferers lack the awareness of the disorder, and therefore do not acknowledge the necessity of needing to cure it. Even having accepted the existence of the symptoms, AN patients do not see the importance of treatment. They very rarely seek help by themselves, as it is the loss of weight and cutting down on eating that give AN patients a sense of satisfaction.^{8,9}

Another issue in treating AN is the motivation for treatment. Readiness to engage in and persevere with healing procedures is a significant component of the human psyche. The more personal the character of the decision about starting treatment is (internal motivation), the greater the chance of full recovery. Female patients struggling with AN reveal a very low level of motivation. They confuse motivation for treatment with motivation for putting on weight, which increases their reluctance and resistance to the therapy. In light of the current research, it appears that AN patients rarely undergo treatment on their own initiative - it is very rare that the first consultation is initiated by the patient. If an individual decides to seek help, it is usually an effect of external motivation, i.e., pressure from the family. Frequently, the incentive to undergo treatment also comes from friends or colleagues. $^{8,10-12}$

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Another difficulty in running therapy with patients suffering from AN is the their lack of interest in changing, which results from their perception of their personal health as desirable. Girls and young women often reject any change to their weight or eating habits, even though they may have expressed their consent to therapy. 13 With regards to the readiness for change, Vitousek, Watson and Wilson proved that reluctance to change is significantly higher among anorexics than people suffering from bulimia, agoraphobia or simple phobias.9 This lack of readiness to change behavior and appearance, and eliminate symptoms, considerably hinders full recovery. Apart from threats to health and life, changes are only possible with the patient's participation and commitment.14 Rushford found that AN patients are motivated to change when entering a critical situation.⁷ Moreover, success is achieved by those who are characterized by an increased sense of threat from the morbidity of their symptoms, while those who are able to recognize the loss of weight as a health hazard are also more likely to recover.⁷

The therapeutic process is also supported by the need for anorexics to renounce control over their weight and eating habits, i.e. by resigning from what is perceived as the source and manifestation of their strength. Acceptance of the need to put on weight is also troublesome.⁸ Perseverance with the treatment is equally important for recovery. Rejecting the existence of a disorder and rejecting therapy are the most frequent causes of terminating treatment.^{9,13}

In summary, the problems that appear during treatment of anorexia nervosa are: lack of acknowledgment of the disorder, rejection of treatment, termination of therapy, a lack of internal motivation to treatment, a lack of interest in changing, a lack of commitment to healing procedures, fear of putting on weight, confusing morbid symptoms with achievement, difficulties with changing habits in eating and controlling weight. Limited research exists on AN patients demonstrating the impact of personal responsibility on their recovery. In the literature there is no account of the views held by AN patients with regard to their responsibility for the improvement, or continuation of their anorexic syndromes.

Responsibility for participation in treatment

Following Kościelska's psychological concept of responsibility, and due to the aforementioned difficulties in the treatment of anorexia nervosa, it has been assumed that responsibility for participation in the treatment and recovery of AN consists of: 15,16

1. Consciousness of the disease, acknowledgment of the necessity to undergo treatment and readiness for recovery; this means that the individual does

- not deny being afflicted, is aware of the need to undergo healing procedures and actively wants it.
- A sense of agency in the course of treatment individuals see themselves as agents whose activity accounts for improvement in their health.
- 3. Self-control the patient yields to established therapeutic goals, which in AN patients involves: putting on weight and accepting it, as well as maintaining the desired weight once achieved; changing their eating habits 'normal' eating (without controlling the amount and quality of food), as well as consent to control of their diet by their parents and/ or hospital staff; perseverance in a diet imposed by doctors and nutritionists; active participation in psychotherapy; withdrawal from activities aimed at cutting down their weight, and perseverance with the treatment.¹⁷
- Consciousness of the consequences of certain behaviors in the course of treatment being able to predict the effects of personal decisions.
- Knowledge of the disorder and of the therapeutic requirements for improving their health.
- 6. A perception of their own health as being valuable. Observations of AN patients allow us to draw the conclusion, that in the initial stage of therapy the responsibility for health lies mainly with the professionals providing the treatment, and the carers (parents), not with the patients themselves. This is mainly a result of the clinical image of the disorder. Therefore, a number of questions arise; namely, whether patients assume responsibility for their treatment and recovery, what are their experiences with taking on responsibility for their participation in treatment, or which factors determine whether or not patients are responsible for participation in treatment.

The purpose of this research was to explore the experiences of female patients suffering from AN in terms of their responsibility for treatment and recovery.

Material and methods

The present research was designed and implemented using the paradigm of qualitative research, specifically in terms of the phenomenological and hermeneutic, as well as idiographic approach.¹⁹ As a methodology, Interpretative phenomenological analysis (IPA) was used, which is becoming increasingly popular in the medical and social sciences. This approach involves a detailed analysis of individual cases, methodical description of research participants' experiences, and presentation of the data, as interpreted by the researchers.²⁰

Sample

The research included 11 Caucasian females, aged between 15 and 28, with a diagnosis of anorexia nervosa.

The participants were recruited from psychiatric hospitals and mental health outpatient clinics all over Poland, based on anorexia nervosa diagnosed according to ICD-10 criteria. The group was not homogenous with regards to the length of treatment. The scope of the therapy length varied between 2 months and 8 years. Among the examined girls and young women were 3 who had undergone psychiatric hospitalization more than once; 4 were currently hospitalized for the first time on the day of the examination, and the remaining patients were outpatients.

Ethics

The research project received a positive opinion from the Bioethics Committee at the Collegium Medicum of Nicolaus Copernicus University.

Measures

The phenomenon of responsibility for participation in treatment was investigated using individual, semi-structured interviews supported by a "Blank Sheet of Paper Test" by Wciórka, which is an unstructured clinical measure of a projective character described below.²¹

The designed interview scenario consisted of open questions. The general subject of the conversation and main issues were covered, although both the respondent and the interviewer were still able to formulate their statements freely.¹⁹ The following topics were discussed during the interview: the course of the illness and its treatment; the patient's current condition; patient's awareness of the state of health and their illness; knowledge of the disorder and its treatment; attitude towards the illness, its treatment, the therapists, doctors, weight loss and starvation, and the emotions and difficulties experienced with the illness and its treatment. Some of the questions that the participants were asked are written below: "Tell me about the course of your treatment, and the feelings you've experienced during it. Tell me what anorexia means to you. In your opinion, how much does your health depend on you, and how much on other people?"

Participants were individually interviewed at the hospitals or outpatient clinics in a setting made as comfortable as possible for them. Each participant was assured full anonymity, and offered an opportunity to end the interview at any point. Interviews lasted approximately 60 to 120 minutes.

The "Blank Sheet of Paper Test", originally proposed and used by Wciórka, estimates the attitudes of respondents toward their illness. This allowed us to ascertain "an alternative image of the readiness an ailing person has for taking certain actions against the disorder, which is different from the image obtained through an interview". ²¹ In the test, the participants are given a blank sheet of A4 paper, and are asked to imagine that it is a representation

of their illness. Next, they are asked to do whatever they want with the sheet of paper. Due to the projective nature of the test, it is assumed that the participants will display (or project) their attitudes towards their illness.

Analysis

The data was analyzed using the IPA approach.²⁰ The interviews were audio-taped and transcribed verbatim. Each transcript was read several times, and examined separately for key elements of responsibility covered in the theoretical background of this paper. Data collected from interviews, observations and remarks recorded during the research were sorted, and collectively analyzed for common, unique or differentiating areas in the experiences of the study's female participants.

Analysis of the interviews for responsibility elements and reactions of the study participants during the "Blank Sheet of Paper Test" revealed some repeated functioning patterns. Ultimately, this revealed specific typologies of responsibility for co-participation in the treatment by individuals suffering from anorexia: 1. taking responsibility, 2. not taking responsibility, and 3. taking partial or ambiguous responsibility. Participants from the first group met all or most of the responsibility criteria outlined in the theoretical part. Participants from the second group met only several criteria, and to an insufficient degree. People from the third group met several criteria and at the same time revealed an ambivalent attitude towards the disease and its treatment, which prevented them from being assigned to either the first or second group.

The analysis was performed by this author, who is experienced in clinical mental health research and practice, and was supervised by a person experienced in performing and analyzing qualitative research, and who works as a clinical professional. During the analysis of reactions in the "Blank Sheet of Paper Test", the researchers used their clinical psychological knowledge, and took a psychodynamic approach to reveal defense mechanisms of the patients and the unconscious motives of behaviors and feelings.

Results

The qualitative analysis revealed 3 core patterns of behavior among girls and young women struggling with AN. The first was recognized as taking responsibility for participation in treatment, and was identified among 6 examined females. The second pattern, which was represented by 3 females, was defined as not taking responsibility for participation in treatment. The third one was called taking ambiguous or partial responsibility for participation in treatment, and was identified among 2 females. The characteristics of these patterns are presented below.

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Taking responsibility for participation in treatment

The sample included 6 AN girls and young women who displayed this pattern of behavior. The length of their participation in AN treatment had varied between 2 months to 3 years. Females within this sample were psychiatric in-patients (3 people), current outpatients with a history of multiple psychiatric hospitalizations (1), non-psychiatric inpatients (1), as well as out-patients (1).

They were all fully aware of their illness, and had accepted the necessity of treatment. They gave critical opinions about their symptoms, and perceived their weight loss not as a manifestation of beauty but of the illness. The majority wished that they had not become ill. They acknowledged the necessity of seeking professional help, and accepted the fact that without it they would not really recover. The interviews revealed that they did indeed wish to recover. Their decision to participate in treatment (psychological therapy or hospitalization) had been made consciously and voluntarily.

The moment the participants had accepted the existence of the disorder and the necessity of treatment occurred when they comprehended the threat posed by the symptoms. Their feeling of threat came from the considerable increase in symptoms, the feeling of having no control over them, the appearance of somatic complications of anorexia that were hazardous to life and health, hospitalization, and family crisis (illness of other family members or stress experienced by the whole family).

The AN sufferers who took responsibility for participation in treatment perceived their condition as (to quote): "a problem", "something bad", "a curse" and "a mess". During the "Blank Sheet of Paper Test" they presented the following rejection behavior: 1. tearing up the paper, 2. tearing it up and throwing it in the bin, 3. crumpling it up and throwing it at the bin.

The girls and young women who were identified as being responsible attributed themselves with moderately high, yet adequate agency in their treatment. They were conscious of the fact that their health lies in their own hands, and that their activity determines their recovery. They also acknowledged the contribution of other people: their family, psychologists, therapists, doctors, and friends. They bent their behavior to the set objectives of the treatment, and made proper and desirable choices throughout its course.

The outpatients refrained from controlling the amount and quality of food they ate, and tried to eat healthily and rationally. They also declared that they were honest with their closest relatives and friends about the amount of food they consumed, and refrained from trying to lose weight, compulsively checking their weight, and most importantly, they maintained a constant body weight, even if they perceived it as being too high. Moreover, they made appointments with psychol-

ogists and/or psychiatrists personally, and kept those appointments.

The inpatients consumed or tried to consume all of their recommended meals, were honest with medical personnel about their meals, and did not overindulge before routine weight checks. They also refrained from extensive physical exercise, and participated in classes offered at the ward, occupational therapy, music therapy, choreotherapy. They also kept in mind that they could only partially participate in classes involving physical activity. They were aware of the consequences of their decisions during treatment and possessed sufficient knowledge of anorexia and the corrective health requirements. They knew that losing weight could lead to serious body damage and severe somatic effects, and they were conscious of the probability of death unless they participated in treatment. This was particularly observed in patients who had lost a lot of weight (21–35 kg), and whose health was seriously threatened. Moreover, they perceived their health as valuable: "My health is the priority", "Health is one of the most important things in life".

Not taking responsibility for participation in treatment

The research group included 3 girls and young women who did not take responsibility for their participation in treatment. These participants differed by the length of their illness: they had struggled with AN for either a very short period (5 months, and almost a year), or a very long time - 8 years, on and off. These 3 participants revealed deficits in their sense of their own responsibility for their recovery. They were not fully aware of the illness, and their openness to recovery was negligible. They denied the existence of the illness, or did not take it seriously. They were convinced that sessions with a psychologist did not make sense, and that anorexia could not be cured, as it is "impossible to reconcile being slim and being healthy". These AN sufferers did not take up treatment voluntarily; they did so under pressure from their mothers, or because of threats or emotional blackmail. One of the females claimed that the illness was the only thing she had, which gave meaning to her daily functioning.

During the "Blank Sheet of Paper Test" 1 person was crumpling the paper for a relatively long time, while smiling at the same time. After puzzling over what to do with it, she decided to leave it as it was because if she had thrown it away, she would have been left alone. Another participant did not have a clue what to do with the piece of paper. After a while, she decided to take the paper – her illness – to a doctor. She declared her intention to take the sheet of paper with her in her bag; however, in the end she forgot about it, and left it in the examining room. Such reactions manifest an ambivalent attitude towards the illness.

The sense of agency among females who did not take responsibility for their participation in treatment was either very low or unrealistically high. These patients could barely control their behavior during treatment or their mothers controlled them. One of the outpatients, who had previously been hospitalized a number of times, had difficulties in maintaining proper body weight, continued losing weight, limited her eating, did not eat rationally, and even took a dietary supplement that enhanced weight loss, despite somatic damage to her body. The remaining 2 girls acquiesced to their parents' wishes and ate, did not purge themselves, did not exercise, and put on weight, but none of them accepted the fact that they were ill, and both declared that as soon as their parents' control was loosened, they would go back to losing weight. Moreover, these patients did not make appointments with their psychotherapists personally, and were dependent on their relatives.

The girls and young women who revealed this pattern of behavior wanted to be slimmer than on the day of their last examination, were not satisfied with themselves and could not accept their appearance. They made improper choices, and were not aware of the consequences of certain behavior during treatment: they stopped taking the medication prescribed by the psychiatrists, consumed slimming and dieting drugs, and would eagerly give up the treatment and therapy. They did not perceive their health as valuable, did not take the somatic complications seriously, and wished to return to a weight loss regime, despite the damage (namely, cardiological problems).

The fact that none of these patients had been supported by their parents is noteworthy – mainly because it would have drawn attention to their other children, but also because of the reluctance and a lack of concern from the mothers. The parents of all 3 patients were divorced, and their fathers maintained somewhat occasional, superficial contact with them, hardly participating in their daughters' lives. The siblings of the girls and young women from this group had suffered from chronic diseases, including cerebral palsy, asthma and autism. Developing anorexia symptoms could have been an attempt to gain attention. The members of this group also manifested signs suggesting depression: they had a significantly worse mood, were pessimistic about the future, tearful, resigned, and had suicidal thoughts.

Taking ambiguous or partial responsibility for participation in treatment

This pattern of behavior was manifested by 2 participants. They revealed deficits in several components of their sense of responsibility for participation in treatment. Both were inpatients.

One of the girls from this group was in the course of her first psychiatric inpatient treatment. Her hospitalization lasted for 1 month. She had lost 35 kilograms, and had

difficulties with motor activity, suffered from swollen legs and pains around the heart area. She also stopped menstruating, and was diagnosed with osteoporosis. It was only when she reached a life-threatening condition, and was taken to hospital that she realized she was seriously ill and needed help.

As a teenager, she acknowledged the existence of the illness and accepted the necessity of treatment, but not in its current form, i.e. based on a behavioral program. She expressed her deep dissatisfaction at being unable to contact her parents or friends. She complained that the treatment only focused on the physical side, and not the psychological. The girl showed a good readiness for recovery. During the "Blank Sheet of Paper Test" she tore the paper up, and threw it away. She attributed herself with average and adequate agency in her treatment, saying that "recovery depends on me, on my attitude towards eating and whether or not I want to recover". She also tried to match her behavior to the objectives of the treatment. However, she did not stop thinking about losing weight, even though she declared herself to be "fighting" this. Similarly to the remaining participants in the research, she had sufficient knowledge of the disorder and the requirements for improved health. Nevertheless, she was not fully aware of the possible consequences of her choices. Possibly, the desired change in her thinking had not yet occurred. In her current somatic condition and state of significant deterioration of her body, she was still eager to terminate treatment. She claimed that she was able to cope with the illness on her own, despite having considerable difficulties in giving up slimming before she was taken to hospital. Moreover, she did not perceive health as valuable, pointing out that health is important to her, but it's not the most important thing.

The early stage of treatment and a short period of therapy were probably factors in explaining the teenager's initial partial feeling of responsibility for participation in treatment.

The second girl to manifest this pattern of behavior revealed many ambiguities in her statements and research measures. Her attitude toward the illness was ambivalent. She perceived the illness as an obstacle and a loss of certain values, but at the same time compared her illness to friendship: "Anorexia is probably the worst thing that has happened to me. It's something that hinders my daily functioning. [...] I sometimes treat anorexia as my best friend, who is attached to me and does not want to leave me". This teenage participant acknowledged, however, that her recovery depended to a great extent on herself: "My health is in my hands [...]. I know that if I want to, I will recover. If I deny this and withdraw from treatment, I will be lost to it".

This girl had gone through a single 5-month hospitalization, and was currently in the course of a second inpatient treatment. During the first hospitalization she had tried to exercise in secret, and had hidden her food. She returned to her old, damaging habits shortly after being

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discharged the first time. During her second stay, the girl made more proper choices with regards to her recovery: she abstained from physical activity, and did not lie to other people about the amount of food she consumed during the day. However, the fact that she gorged herself, probably in order to attain the desired body weight quicker in order to leave hospital, was alarming.

The strong motivation for the teenager to leave hospital and return home, together with her extensive consumption of food and ambivalent attitude towards the disorder, imply the probability of her again returning to previous, destructive habits.

Discussion

Despite numerous difficulties in treating AN, girls and young women suffering from this disorder can take responsibility for their treatment. In the present study, 6 out of 11 AN patients took responsibility for participating in their own treatment.

One of the factors motivating the participants to take responsibility for their treatment was experiencing a serious threat resulting from the symptoms of the disorder. Such threats to the life and health of both the patients and their families were also connected with a sense of being unable to cope with the symptoms of the illness and subsequent creation of family crises. Therefore, it appears that a real threat from the illness and its symptoms can persuade anorexics to take responsibility for participating in their own treatment, which is consistent with Rushford's observations.⁷

Analysis of the research results allowed us to determine other factors coexisting with the assumption of responsibility for participation in one's own treatment among girls and young women diagnosed with anorexia nervosa. These factors are: peer and family support; satisfactory peer relationships; having plans for the future, and the absence of affective disorders that commonly appear with anorexia. This partly conforms with the findings of Tozzi, Sullivan, Fear, McKenzie and Bulik, who proved that the strongest incentives for recovery from the patient perspective were supportive extrafamily relationships, therapy and maturation. Incentives for not taking responsibility are: a perception of health as being inessential; siblings with serious and chronic diseases that require great attention from their mothers; being the child of a single-parent family, and depressive symptoms.²² It seems that AN sufferers who do not take responsibility for their participation in treatment will try to gain perceived benefits through their anorexia, namely the attention of others, especially family. The fact that depressive symptoms also create eligibility for hospitalization of AN sufferers makes it difficult to take responsibility for participation in treatment, is also noteworthy.²³

Conclusions

The current research had its limitations. The sample group was not very large, or varied by age and length of history with the illness. The results may not be generally representative of the entire population of girls and young women suffering from anorexia. The research may also have been influenced by the quality of the relationship the researcher developed with the patients. Use of a semistructured interview format could mean that respondents were able to deliberately choose the information they wanted to reveal. Although some attempts were made to establish good contact with the research participants, and projection tools were used, it is still possible that the answers provided during the interviews could had been declarative in nature, simply to make a good impression on the researcher. Depending on the treatment stage and the participant's progress with psychotherapy, AN sufferers may in fact be exhibiting varied insight. Answers given could also have been distorted by memory.

But despite this, the results are significant for clinical practice as they could sensitize researchers to the problem of the responsibility of AN patients for their own treatment, and draw attention to the need for diagnosis from this perspective. The array of elements presented, which contribute to the assumption of responsibility for participation in treatment of one's own anorexia, as well as certain coexisting factors, could help clinicians in their therapeutic work. Due to the exploratory character of the research presented herein, it seems worthwhile to carry out further studies on the correlates of taking responsibility for participation in treatment, such as the personality variables of the patients, ²⁴ the multidimensional etiology of the disorder, the quality of the therapeutic relationship, or the kind of therapeutic actions undertaken. ^{25,26}

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