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Adolescent client views towards the treatment of anorexia nervosa: a review of the literature

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Accessible summary

- Anorexia nervosa (AN) affects many young people but they can be reluctant to accept treatment. If we understood the views of young people with AN we might be able to develop more acceptable treatments. At the moment, most of what we know about their views is taken from studies of girls and young women.
- For some young people, having AN means being able to control something, but AN can also be an illness that controls the person. Confusion about control is one of the things that make AN hard to treat.
- It is difficult to find the right combination of treatments for the physical and psychological symptoms of AN. The research evidence we have does not offer enough guidance for clinicians.
- Good relationships with clinicians can be difficult to achieve. Young people with AN want clinicians to look after them but at the same time they may resent it when clinicians tell them what to do. However, once they have recovered they often say that they needed firm treatment in order to get better.

Abstract

This paper reviews current literature in which adolescents with anorexia nervosa (AN) were consulted about their views of their treatment. Published research was systematically retrieved and interrogated during 2009–2010 and analysed using a four-stage model. Eleven studies met the inclusion criteria. Three core themes were identified. AN was perceived as a means of taking control and also something that controlled the individual. Tensions were recognized between client preferences for psychological interventions and treatments that prioritized physical care. Therapeutic alliance emerged as a strategy for overcoming these difficulties but was challenged by client ambivalence towards treatment. Most included studies were qualitative. Young males and individuals who dropped out of treatment were underrepresented in the studies. Adolescents' perspectives on treatment for AN were characterized by paradoxes and tensions. Egosyntonic theory was used as a theoretical construct to interpret findings.

Introduction

Eating disorders (EDs) appear to be a large-scale problem in the UK. The Royal College of Psychiatry estimated that at any one time around 60 000 people were receiving treatment for anorexia nervosa (AN) or bulimia nervosa (American Psychiatric Association 2000), a figure that Beat argues is closer to 90 000 (Beat 2009). This impacts upon all aspects of an individual's life including their physical, psychological and social health (Polivy & Herman 2002).

Anorexia nervosa is most commonly diagnosed in adolescence (Hoek & Hoeken 2003). It has an estimated life time prevalence of 0.6% and a median onset age of 18–21 years (Hudson *et al*. 2007). In the context of treatments,

outcomes seem more positive for adolescents than adults (Lask & Bryan-Waugh 2008), suggesting that younger age groups may be a sensible focus for research.

This paper aims to present a synthesis of published research regarding adolescent client views towards treatments received for AN. In the context of EDs, client views were highlighted as important and in need of examination in Bell (2003). This was a narrative review of qualitative research and questionnaire surveys with individuals who had experienced an ED, or received treatment for it. Bell's review identified gaps in the ED literature and informed subsequent studies, highlighting a need for further research into adolescent views towards treatments of AN. This review aims to build on Bell's paper by commenting on literature specifically relating to adolescent views towards treatments they received for AN, and applies theory to help explain results.

This paper's focus on AN rather than other EDs reflects a trend in the research literature, in which other EDs in young people have received less attention (Royal College of Psychiatrists 1992). The literature suggests that improving understanding of client perspectives may be an important step towards improving engagement and treatment outcomes in AN contexts (World Health Organization 1990, Department of Health 1999). This view represents a shift towards client-centred approaches that is already evident in care delivery (Hoencamp 1999).

A dominant theoretical construct of AN concerns its egosyntonic nature, which results in weight loss being acceptable to the ego and goals of the individual with AN (Rieger *et al*. 2001). This concept was established in the AN literature by Lasègue (1997), who proposed that a component of the illness is extreme emaciation that is not perceived by the individual to be a problem – rather, it is valued by them (Theander 1995). The theory suggests that individuals with AN may view their symptoms as achievements and thus resist treatments offered. The evidence synthesis presented here will explore the effects this distinctive feature of AN could have on client views of their treatment.

Little is known about AN prevalence in adolescent males, although the available evidence suggests a male to female prevalence ratio of approximately 1:11 (Van Hoeken *et al*. 2003). This suggests a potential influence of gender on prevalence, something that resonates with evidence concerning the influence of gender on client views (Harvey & Robinson 2003). The prevalence statistic should be viewed with caution however. There may be misdiagnosis as a result of old assumptions that EDs are female illnesses, while stigma attached to EDs may prevent young males seeking treatment (Harvey & Robinson 2003). Gender and gender assumptions therefore may influence both prevalence of and perspectives on AN. Potentially, this also applies to other EDs. The limitations of the literature suggest that the evidence base may be biased towards adolescent girls receiving inpatient treatment, and the implications of this will be explored throughout the paper.

The nature of AN may implicate the credibility and validity of data (Watson & Leatham 1996, Noble *et al*. 1999), because the egosyntonic nature of the disorder potentially influences client views (Bell 2003) along with participation rates, which are poor (Rosenvinge & Klismeier 2000, Swain-Campbell *et al*. 2001). These influences on the data can be understood as a product of the condition: clients may be demonstrating reluctance to participate in research, resulting from a characteristic lack of insight into the need for help, along with treatment avoidance and subsequent attrition and relapse (Vitousek *et al*. 1998). Additionally, client views may be liable to change in response to treatment, and therefore may represent only the temporary views of individuals with AN while they are unwell. Notwithstanding, research into healthcare provision appears to help shape appropriate services (Macdonald & Sheldon 1997) and client views into AN offer valuable insights into an area which, apart from Bell (2003), has received little attention in reviews.

Although the literature contains a number of papers about the views of individuals suffering from AN, less has been published on adolescent and male perspectives and the impact of egosynticity on their views. In view of the scale of the problem, the weak evidence base, difficulties in treatment and the potential of adolescents' views to inform treatments, the function performed by this review addresses an important gap in research knowledge.

Method

A search of electronic databases was carried out, including: MEDLINE (1966 to January 2010), PsycINFO (1979 to January 2010), Embase (1980 to January 2010), British Nursing Index (1985 to January 2010) and CINAHL (1982 to January 2010). Reference lists of identified papers were searched by hand and specialist opinion was sought. Key search terms were divided into three groups: the target population (e.g. boy, girl, female, adolescent, teenager, young adult, eating disorder, anorexia nervosa), treatment and interventions (e.g. treatment, inpatient, outpatient, hospital, community, voluntary, compulsory) and client views (e.g. view, experience, opinion, satisfaction). In the literature, there appears no clear consensus on a definition of adolescence and therefore search parameters included all potentially relevant terms and age ranges. Searches were conducted during 2009–2010.

Criteria for inclusion were: English language and a focus on adolescent views of treatment received for a diagnosis of AN. The intention was to focus on the research literature, so although a large quantity of grey and non-academic literature was identified, including Internet-based resources, forums and support groups, it was not included. No time limit was placed on studies included, due to limited research in this area (Bell 2003). In view of reported problems surrounding the application of scientific quality criteria to lay persons' views (Dixon-Woods & Fitzpatrick 2001), no restrictions were placed on study design. In order to include a wide spectrum of treatment modalities including inpatient and outpatient methods and different therapies, no limits were placed on treatment type.

A thematic analysis of the literature was conducted, similar to the four-stage model approach described in Smith (1995). Stage 1 is the researcher's initial encounter with the text. In stage 2 initial themes are identified. In this paper these were mainly descriptive. They were revised in stage 3 and clustered into conceptual themes. At this point egosyntonic theory was identified as a construct for interpretation of findings. In stage 4 a summary table was produced (see Table 1).

Results

Eleven studies met the inclusion criteria. These are included within Table 1, which also shows key characteristics of the papers. Approximately half of the studies considered patient views associated with inpatient treatment; two looked specifically at views of community-based treatments, while two incorporated both inpatient and outpatient treatments. Most papers considered only female views. Those which included males only managed to recruit a small number and these views were not clearly distinguished from those of females.

With the exception of Halverson & Heyerdahl (2007), Krautter & Lock (2004), Paulson-Karlsson *et al*. (2006) and Roots *et al*. (2009), most papers reported on small qualitative studies. Some papers considered both client and parent views (Krautter & Lock 2004, Paulson-Karlsson *et al*. 2006, Ma 2008, Roots *et al*. 2009); however, it was possible to identify and report on the views of adolescents separately from those of parents, in accordance with the inclusion and exclusion criteria. The age range of young people in this review was 11–26 years, reflecting the retrospective nature of some papers.

Findings

The presentation of findings focuses on three interlinking themes, which were identified in the literature: control, tensions between what the client wants and clinical interventions, and therapeutic alliance.

Control

It was evident that some clients experienced an internal battle around their perceptions of AN, perceiving AN as both friend and foe, which could allow them to take control of their life *yet al*so control them (Colton & Pistrang 2004). This finding was reinforced by Tierney (2008), in which data from semi-structured interviews highlighted a failure to recognize AN as controlling until low food intake resulted in physical illness or hospitalization. Interestingly, clients seemed eventually to acknowledge the necessity of such interventions. Findings suggested that they initially disliked having their control removed, but several studies reported that, with hindsight, many clients considered this to be a life-saving part of their treatment (Neiderman *et al*. 2001, Colton & Pistrang 2004, Offord *et al*. 2006, Tierney 2008).

Not all views towards treatment appeared to alter with time. Neiderman *et al*. (2001, p. 445) used data from self-report questionnaires following nasogastric feeding to show that clients 'hated it then and . . . hate it now'. Although the research related to a specialist treatment, these findings resonate with Colton & Pistrang's argument that the key to recovery is the client's own desire and motivation to change (Colton & Pistrang 2004). This is further supported by Halverson & Heyerdahl (2007), which reported a follow-up study conducted on average 8.8 years after the commencement of treatment. Here, researchers found that clients viewed their wish to recover and their will and determination to do this as important influences on recovery. The structured diagnostic interview method adopted by Halverson & Heyerdahl (2007) identified factors that clients found helpful in treatment, although it did not allow for reasons behind such views to be explored further.

Tierney (2008) found evidence to suggest that readiness to change is important because without the desire to change, treatment could fail and there is a risk of relapse on discharge. By using open-ended questions with a sample of 10 adolescents, Tierney's (2008) study generated insights to help 'understand social phenomena in natural rather than experimental settings' (Pope & Mays 1996, as cited in Tierney 2008, p. 369). Drawing on findings from an adolescent sample of nine females and one male with AN, Tierney recognized that similar issues were raised and discussed by both genders. The focus, however, was different: males aimed to be more muscular while females aimed to be thin (Tierney 2008). This difference is echoed in the wider adult literature (Harvey & Robinson 2003).

Table 1
Papers meeting the inclusion criteria

Author (year)	Country	Aims	Sample	Method	Findings
Colton & Pistrang (2004)	UK	To provide a detailed description of how adolescents experience inpatient treatment for AN	9 adolescents	Semi-structured interviews	Positive and negative views of inpatient treatment for AN expressed. These were characterized by dilemmas and conflicts: clients questioned what the illness was; if they wanted to recover; benefits vs. disadvantages of others; being perceived as anorexic vs. an individual and collaborating in treatment vs. being treated
Halse *et al*. (2005)	Australia	To examine the range of meanings female adolescents with AN attach to NGF	23 adolescents	Semi-structured interviews	Several meanings were attached to NGF: an unpleasant physical experience, which was necessary or helpful; a physical or psychological signifier of AN; a struggle from control, attaching multiple, contradictory meanings to NGF
Halverson & Heyerdahl (2007)	Norway	To investigate and compare how adolescents who had received treatment for AN and their parents retrospectively report their perceptions of therapists and if this was associated with treatment outcomes and characteristics	46 adolescents	Diagnostic interviews and questionnaires (retrospective)	More sessions of FBT was significantly correlated with perceptions of the therapist. Own willpower, determination and wish to recover were important factors relating to treatment. Therapists interpersonal skills were viewed positively but some did not feel understood by the therapist or that they could help
Krautter & Lock (2004)	USA	Assess the satisfaction and perspectives of families treated with manual-driven FBT for adolescents with AN	34 adolescents and families who had manual-driven FBT	Survey	Therapeutic support, whole family involvement, re-feeding process, separating the illness from the individual were helpful, however, exclusive focus on AN, lack of individual therapy was unhelpful
Ma (2008)	China	To allow families to voice their subjective experiences of FBT	24 adolescents and families who had FBT in China	Interviews (retrospective)	Therapist's empathy, care and interpersonal skills were viewed essential in establishing trustful, therapeutic relationships
Neiderman *et al*. (2001)	UK	To provide insight into the subjective experiences from adolescents who have received NGF and their parents	21 adolescents and their families from two ED units who had received NGF	Self-report questionnaire	Positive and negative views in relation to NGF were reported. Some were unable to alternatives to NGF; however, some only viewed it as negative
Offord *et al*. (2006)	UK	To explore views about inpatient treatment for AN during adolescence, experiences of discharge, impact of admission on control and low self-esteem	7 adolescents treated in general psychiatric units	Semi-structured interviews	Clients felt a sense of removal from normality, that their developmental needs were not always met. Support from peer relationships were given importance while authoritarian approaches compounded feelings of ineffectiveness, worthlessness and isolation
Paulson-Karlsson *et al*. (2006)	Sweden	To examine adolescent expectations and satisfaction of FBT approach	54 adolescents and their families	Questionnaire	Pretreatment expectations were met. Some felt-helped even though initially did not want help. Individual sessions were favourable and beneficial when part of FBT
Roots *et al*. (2009)	UK	To assess adolescent's and parent's satisfaction with CAMHs outpatient, specialist outpatient and inpatient treatment	215 adolescents and families receiving inpatient and community treatment as part of a RCT	Questionnaires and focus groups	Specialist services were rated as more satisfactory than generic services. Too much focus on psychological aspects of treatment and not enough on physical. Interpersonal skills of the therapist were important
Tierney (2008)	UK	To explore the views of adolescents being treated for AN	10 adolescents receiving inpatient treatment	Semi-structured interviews	Elicited five themes: accessing appropriate care; balancing physical and psychological; professional qualities; help from non-professionals and perceived progress
Van Ommen *et al*. (2009)	The Netherlands	To develop from adolescent patients' perspective a model explaining the effectiveness of inpatient nursing care	13 adolescents receiving inpatient treatment	Semi-structured interviews	Nurses contributed significantly to recovery from AN. Themes emerging were concerned with: normalization and structure and responsibility; the focus of which shifted during treatment

AN, anorexia nervosa; CAMH, children and adolescent mental health; ED, eating disorder; FBT, family-based therapy; NGF, nasogastric feeding; RCT, randomized controlled trial.

Recommendations, practice and what clients want

There appears to be a tension between guideline recommendations, what occurs in practice and what clients want from their treatment. Current UK guidelines recommend family-based therapy (FBT) for treatment of adolescent AN (National Collaborating Centre for Mental Health 2004, National Institute for Clinical Excellence 2004). FBT is supported in the USA and Australia (American Psychiatric Association 2000, Royal Australian and New Zealand College of Psychiatrists 2009). Outside the Western world, FBT does not always appear to be the treatment of choice. This is the case in China, for example, where a possible explanation is that child and adolescent services are greatly influenced by the biomedical model (Ma *et al*. 2004). Randomized control trials comparing FBT treatment outcomes with individualized therapy appear to support guidelines which recommend FBT, suggesting that FBT is an effective treatment for adolescent AN (Russell *et al*. 1987, Le Grange *et al*. 1992, Dare & Eisler 1997, Robin *et al*. 1999, Eisler *et al*. 2000, 2007, Lock & Le Grange 2005, Paulson-Karlsson *et al*. 2006). The transferability of the findings from these studies may be limited by the use of differing methodologies, since some adopted manualized models whereas others did not.

The literature has highlighted differences between perspectives of clients and health professionals, suggesting that clients prefer their AN treatment to take a holistic approach which considers their psychological and social needs, rather than a sole focus upon physical concerns (Colton & Pistrang 2004, Offord *et al*. 2006, Paulson-Karlsson *et al*. 2006, Tierney 2008, Van Ommen *et al*. 2009). The client view also appears to contrast with clinical guidelines. Clients report that the most beneficial aspects of FBT are the individualized elements and do not appear to support FBT as a stand-alone treatment unless an individualized therapy component is incorporated. Krautter & Lock's study of family perspectives of manualized FBT found that clients viewed it as unhelpful to focus exclusively on physical aspects of AN (Krautter & Lock 2004). Paulson-Karlsson *et al*.'s use of questionnaires to examine expectations and experiences of treatment at 18-month follow-up supports Krautter & Lock's suggestion to use individualized sessions as part of FBT (Krautter & Lock 2004, Paulson-Karlsson *et al*. 2006). These results may not represent views of individuals receiving other forms of FBT. However, similar views appear in other studies, where clients propose that if thought processes are not altered, then relapse is more likely (Colton & Pistrang 2004, Offord *et al*. 2006, Tierney 2008).

Hospitalization for AN is usually due to complications surrounding low body weight. From a professional standpoint, treatment may initially need to focus upon physical elements of AN, such as stabilizing body weight, before addressing psychological concerns. This contrasts with client views towards treatment. The egosyntonic model of AN might predict that clients will dislike treatments, such as weight gain, that challenge the intrinsic components of AN. Nonetheless, health professionals may see these treatments as vital for improvements to occur (Offord *et al*. 2006). Client views about the limitations of treatment that focuses on physical complaints illustrates inherent tensions in perceptions of AN treatments between health professionals and young people. Contrasting evidence emerged from a recent mixed-methods study in which 215 adolescents who had experienced different forms of treatment for AN were consulted on their views. Findings suggested that they felt there was too great an emphasis on the psychological elements of treatment compared with physical focus (Roots *et al*. 2009). The range of contrasting views expressed in the literature indicates the need for better understanding of AN treatments.

Therapeutic alliance

Therapeutic alliance has been defined as the quality of the relationship established between therapist and client (Horvath & Symonds 1991) and was a core theme arising in all 11 papers. Establishing good therapeutic relationships appears difficult in acute mental health settings (Thurston 2003). This difficulty is echoed by suggestions within ED literature, where the egosyntonic nature of AN causes clients to be unable to perceive themselves as ill or requiring treatment (Vitousek *et al*. 1998). The potential difficulty in establishing therapeutic relationships appears to result in negative nursing attitudes and perceptions, which include the views that individuals with AN want to be unwell and are attention-seeking (Cameron 1996, Ramjan 2004, Tierney 2008) especially when perceived to oppose or sabotage treatment (Fathallah 2006).

Other people involved in the client's care are seen to potentially influence the establishment of a therapeutic alliance. There appeared to be polarized views concerning the influence of peers in inpatient settings. Advantages such as support and a sense of identification were identified, alongside concomitant disadvantages such as learning negative behaviours and competing to be the 'best anorexic' (Colton & Pistrang 2004, Offord *et al*. 2006, Tierney 2008, Roots *et al*. 2009). Clients may confide in each other, believing that 'only those with anorexia could fully appreciate what they were going through' (Tierney 2008, p. 37). This highlights the importance of empathic relationships between staff and clients: if staff convey a willingness to understand then a trusting therapeutic relationship may evolve (Ma

2008). This further supports Bell's work which concluded that supportive and emphatic relationships with staff appear essential to the development of positive views surrounding treatment experience (Bell 2003).

Therapeutic alliance appeared affected by the perceived knowledge and competency of staff. Clients found it was unhelpful if staff were inexperienced because they felt more able to deceive professionals, which caused them to feel unsafe (Offord *et al*. 2006, Tierney 2008, Roots *et al*. 2009, Van Ommen *et al*. 2009). The paradox of not wanting to gain weight or have control removed, while also wanting the safety of more experienced staff whom they cannot deceive, could again be linked to the idea of egosynticity, in that client views on treatment may be characterized by ambivalence and fluctuations, which could have implications for treatment opportunities.

Discussion: the contribution of egosyntonic theory

The complex insights obtained from this literature review add important new knowledge to our understanding of young client views of AN treatments, which could inform treatment approaches and enhance outcomes. Conceptualizing AN as an egosyntonic condition provides a unifying theory to explain the tensions and paradoxes which have been highlighted in many of the review findings. For instance, treatment resistance can be interpreted with the understanding that clients do not perceive themselves as unwell or requiring treatment (Vitousek *et al*. 1998), which may help explain their initial dislike of elements of treatment that go against the intrinsic elements of AN (e.g. removal of control and weight gain).

Ambivalence about recovery

Individuals may not wish to get better, and through not eating and losing weight they may gain a sense of achievement. Arguably, any interventions that address the implications of low body weight, or in fact challenge the individual's control over what they eat, may be viewed as a threat to the individual's autonomy or sense of self (Rieger *et al*. 2001). Recovery may therefore threaten a sense of identity which the individual has developed around their AN. This point is illustrated in Halse *et al*. (2005, p. 268), in which some individuals reportedly saw the nasogastric tube as 'an integral part of their sense of self'. There appears to be an inherent ambiguity around treatments for AN, in which clients are resistant to treatment, leading to poor compliance and reduced clinical improvement. A clinical implication of this is that treatments need to work with, not against, clients' ideas of AN. Further exploration of these complex phenomena could inform appropriate and useful treatment approaches.

The review findings also suggest that interventions have to be acceptable. Acceptability has been acknowledged as key to treatment success and a suitable focus of inquiry in the development of interventions (Mays *et al*. 2005). Theory and empirical evidence indicate that acceptability can be enhanced if, during the course of recovery, control around eating is returned to clients. If not, recovery may be hampered by accompanied detrimental feelings of punishment and resentment (Offord *et al*. 2006).

Benefits and challenges of therapeutic alliance

This review also found evidence to suggest the importance of delivering treatment in the context of a therapeutic alliance, which supports the idea that therapeutic alliance could offer a means of addressing the paradoxes of control and the egosyntonic nature of AN. The messages from the research literature considered here are consistent with Bell's work (Bell 2003), which argued that therapeutic alliance is important throughout treatment. All the included papers made reference to this theme, which may indicate that therapeutic relationship plays a significant role in the treatment process, by influencing client opinions regarding treatment. However, because no papers considered the views of clients who dropped out of treatment, a definite link between therapeutic alliance and client attitudes towards treatment cannot be made. Further work in this area could be valuable.

In the context of limited research evidence, this issue raises questions about treatment acceptability and the influence it may have on the therapeutic alliance. Therapeutic alliance may in turn impact on decisions to continue or drop out of treatment. Some studies suggest that staff difficulties in treating EDs are possibly due to the illness's egosyntonic nature (Vitousek *et al*. 1998), and it may not be surprising that there are contrasting views about what is and is not considered acceptable treatment. Clients appear to oppose interventions challenging intrinsic components of AN such as weight gain, structure and control. With hindsight, however, clients appear to acknowledge the importance of staff initially having control over their treatment. This may hold implications for practice because staff need to establish a balance between making treatment acceptable while having some level of structure needed to allow clients to retake control of their eating and gain weight.

Staff training that focuses on egosynticity as an explanatory model of AN may offer possible solutions to the issues raised in the literature. Such training could assist in the development of a trusting therapeutic relationship, by increasing staff knowledge and competence. This could potentially lead to better understanding of AN, a reduction

in negative attitudes and perceptions towards AN, improvements in clients' feelings of safety, and improving the therapeutic quality of peer relationships in inpatient settings. Ultimately, training could support staff to treat clients as individuals rather than merely an anorexic, something clients report to be key in the development of therapeutic relationships (Colton & Pistrang 2004, Krautter & Lock 2004, Halse *et al*. 2005, Offord *et al*. 2006, Tierney 2008, Van Ommen *et al*. 2009).

Parental involvement

The new insights support the continued delivery of FBT as a treatment of AN, provided that individual sessions are included. This would allow best practice guidelines to be incorporated with client recommendations, potentially influencing acceptability of treatment and in turn dropout and recovery rates. Some of the studies included in this review suggest that parents often have key roles in supporting adolescents to access services for help with their ED (Paulson-Karlsson *et al*. 2006, Tierney 2008). Parents are also involved with interventions such as FBT and play a key role in helping their child retake control of their eating behaviours (Ma 2008). Therefore, there may be a relationship between parental involvement and support for FBT that could be explored further.

In the UK, parents may consent to treatment on behalf of a child below 18 years of age; this sometimes happens when a young person has capacity and is refusing treatment (Department of Health 2001, Offord *et al*. 2006). Parental involvement can be a positive influence on treatment compliance and dropout rates (Paulson-Karlsson *et al*. 2006). This is important because people who drop out of treatment are unlikely to recover alone (Pike 1998) and long-term outcomes for these individuals are poor (Beaumont *et al*. 1993). However, once the AN client reaches 18 years, their parents cannot consent to treatment on their behalf so they are able to decline treatment.

Noncompliance with treatment could be seen as an expression of control on the part of the individual suffering from AN. Potentially, treatment acceptability and outcomes could be enhanced by finding a balance between removal of control surrounding eating and allowing clients to take responsibility for their own recovery.

Study limitations

Only the views of clients who consented to participate are reflected, failing to include those who dropped out. The experiences of professionals may have influenced clients' decision to drop out and not take part in research, so views regarding therapeutic alliance may be biased and display more positive views than those of non-participants. No definite link between these variables can be established because none of the included papers considered the views of individuals who dropped out.

It appears that research into adolescent views towards treatments of AN still requires attention. For instance, much of the published literature has focused on inpatient populations; additionally, there are few studies that incorporate both male and female adolescent views. Therefore, views expressed throughout the review appear to be biased towards adolescent females receiving inpatient treatment.

More knowledge could influence practice by exploring whether adolescent males and females require different treatment approaches. Difficulties in recruiting adolescent males were reported in Tierney's (2008) work and further research could attempt to access young male perspectives on AN treatment as well as the views of individuals who drop out of treatment.

Having reviewed the literature into adolescent views towards treatment of EDs, there appears to be a limited range of research designs utilized in this area of research. Results of the current review reflect a qualitative method approach using opportunistic samples, which has allowed access to what appears to be an under-researched population in mental health (Bell 2003). The nature of this approach to research inquiry is that the findings about patient views may lack transferability (Lincoln & Guba 1985). Again, this could be related to egosynticity and the influence of this on client views when unwell. Alternative research methods could contribute data that can be generalized to wider populations of young people with AN.

Papers adopting a retrospective approach may increase the risks of missing significant information while being subject to retrospective bias (Paulson-Karlsson *et al*. 2006). This further questions the credibility of views towards treatment that are obtained when clients are unwell. Retrospective data collection, however, allows for the identification of change in clients' attitudes and views, which may only occur after the event of being unwell and receiving treatment. This may again be interpreted through the egosyntonic model of AN and the influence of this upon client views regarding treatment.

Conclusion

The egosyntonic theory of AN means that all treatments pose some form of threat to the individual's sense of self, and therefore negative views may be anticipated from clients who are unwell. This model could inform future research design and practice development, leading to better understanding of young clients with AN and more beneficial treatment outcomes.

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