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FEATURE ARTICLE

Restoring normal eating behaviour in adolescents with anorexia nervosa: A video analysis of nursing interventions

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ABSTRACT: *An important part of inpatient treatment for adolescents with anorexia nervosa is to restore normal eating behaviour. Health-care professionals play a significant role in this process, but little is known about their interventions during patients' meals. The purpose of the present study was to describe nursing interventions aimed at restoring normal eating behaviour in patients with anorexia nervosa. The main research question was: 'Which interventions aimed at restoring normal eating behaviour do health-care professionals in a specialist eating disorder centre use during meal times for adolescents diagnosed with anorexia nervosa?' The present study was a qualitative, descriptive study that used video recordings made during mealtimes. Thematic data analysis was applied. Four categories of interventions emerged from the data: (i) monitoring and instructing; (ii) encouraging and motivating; (iii) supporting and understanding; and (iv) educating. The data revealed a directive attitude aimed at promoting behavioural change, but always in combination with empathy and understanding. In the first stage of clinical treatment, health-care professionals focus primarily on changing patients' eating behaviour. However, they also address the psychosocial needs that become visible in patients as they struggle to restore normal eating behaviour. The findings of the present study can be used to assist health-care professionals, and improve multidisciplinary guidelines and health-care professionals' training programmes.*

KEY WORDS: *adolescent, anorexia nervosa, eating behaviour, nursing intervention, video analysis.*

INTRODUCTION

Anorexia nervosa is a severe psychiatric illness that mainly affects girls and young women. The disorder has a lifetime prevalence of 2–4% in women (Keski-Rahkonen *et al*. 2007; Smink *et al*. 2012). The mortality rate in adolescents with anorexia nervosa is 1.8%, and the rate of recovery is estimated at 57%. Approximately 17% of adolescents with anorexia nervosa remain ill in the long term (Steinhausen 2009).

Due to the severity of the illness, patients with anorexia nervosa are preferably treated in specialist eating disorder clinics (Dutch Committee for the Development of Multidisciplinary Guidelines in Mental Health Care 2006; Van Ommen *et al*. 2009). A number of these specialist centres have been established in the Netherlands for the treatment of patients with severe manifestations of anorexia.

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The first objective of these specialist treatment programmes is to restore the patient's normal body weight; considered a prerequisite for the patient's subsequent personal and social recovery. To restore normal body weight, patients are offered a highly-structured treatment programme, with one of the key goals being to break through the compulsive fasting pattern associated with anorexia nervosa (Van Elburg & Rijken 2004). Nutritional advice from a dietician provides the basis for this objective.

Health-care professionals play a prominent role in helping patients relearn normal eating patterns during meal times. They teach patients how to follow nutritional advice and how to replace anorectic eating patterns with normal eating patterns. Both patients and specialist nurses consider this support during mealtimes an essential nursing intervention in the first phase of treatment (Bakker *et al*. 2011; Van Ommen *et al*. 2009; Zandian *et al*. 2007).

In previous research into nursing care for patients with anorexia nervosa, both patients and specialist nurses indicated that a directive and structured nursing approach during meals is highly beneficial for patients in the first stage of treatment (Bakker *et al*. 2011; Van Ommen *et al*. 2009). This approach means that nurses take responsibility for a patient's healthy food intake. The physical presence of nurses during mealtime, the presence of a peer group that provides support, and psycho-education about anorexia nervosa are also mentioned by patients and specialist nurses as essential components of effective nursing care for this patient group (Bakker *et al*. 2011; Van Ommen *et al*. 2009).

Various studies make clear that nursing interventions can only be effective within a trusting therapeutic relationship in which nurses support, encourage, and guide patients (Ramjan & Gill 2012; Ryan *et al*. 2006). It is therefore important for nurses to pay attention to both the physical aspects of recovery and the patient's psychosocial and emotional needs (Button & Warren 2001; Colton & Pistrang 2004; Tierney 2008).

To our knowledge, no previous research has been published on specific nursing interventions during mealtime aimed at restoring normal eating behaviour in patients with anorexia nervosa. More insight into such interventions can give us a better understanding of how health-care professionals support adolescents with anorexia nervosa, while breaking through their anorectic eating pattern and replacing this with a normal eating pattern. Therefore, in the present study, we examined in detail nursing interventions during meals in a best-practice, specialist treatment setting for patients with anorexia nervosa. The main research question was: 'Which interventions aimed at restoring normal eating behaviour do health-care professionals in a specialist eating disorder centre use during meal times for adolescents diagnosed with anorexia nervosa?'.

MATERIALS AND METHODS

Research design

The present study used a descriptive, qualitative design to analyse and describe the meal time nursing interventions used for adolescents with anorexia nervosa. Video recordings made it possible for the researchers to analyse these nursing interventions in detail through direct observation. Within the context of this descriptive design, we applied thematic data analysis (Joffe & Yardley 2004).

Setting

The present study was conducted in a unit of a specialist inpatient clinic for the treatment of patients with eating disorders. This clinic has the quality mark of the Dutch Foundation of Top Clinical Health Care (Foundation of Top Clinical Health Care 2013). The relevant unit treats adolescents in the 12–18-year age group, and treats eight-to-10 patients at a time. The treatment results are successful as far as weight recovery is concerned. Van Ommen *et al*. (2009) carried out a study in the same treatment setting, and showed that in 1 year, 14 of their 15 patients with anorexia nervosa were discharged with a body mass index (BMI) within the normal range (standard deviation: >−1.5, corresponding with a BMI of approximately 19 kg m^{-2} for adults).

In our clinic, a professional team is responsible for the treatment of adolescent patients with eating disorders. This team consists of a psychiatrist, nurses, social workers, a clinical nurse specialist, a community mental health nurse, a dietician, a family therapist, a clinical psychologist, a psychomotor therapist, an activity coordinator, a creative therapist, and a school counsellor.

The treatment programme is based on Prochaska and DiClemente's (1986) Stages-of-Change model. Nursing interventions are based on (cognitive) behavioural therapeutic principles and focus on the following areas: the eating disorder and related behaviours, comorbidities, personal development, family functioning, social functioning, and education. The programme is group based, emphasizing the promotion of healthy behaviours in patients. Information about individual patients is shared within this group, enabling mutual support and the purposeful use of group pressure to support patients in behavioural change. Patients who are in different stages

of treatment are brought together in one treatment group to facilitate these group dynamics. This treatment strategy creates an open atmosphere where patients cannot hide behind their privacy, thus maintaining their anorectic behavioural pattern. For a more detailed elaboration of the treatment programme, see van Ommen *et al*. (2009) and Bakker *et al*. (2011).

Before hospitalization, the patients and their parents are informed verbally and in writing about the content and principles of the treatment programme, including the structured protocol that is followed during the meals; that is, patients are expected to strictly follow the nutritional advice of a dietician, for which they receive the support of the health-care professionals and fellow patients during the meals.

This best-practice setting was purposefully chosen so that we could benefit from the expert knowledge of the health-care professionals. This allowed us to examine and describe highly-specialized care, and thereby search for tacit knowledge of health-care professionals.

Population

Participants were selected on the basis of a convenience sample; that is, health-care professionals who worked at the centre during data collection and patients who were hospitalized at that time.

Health-care professionals, eligible patients, and their parents were informed about the study, both orally and by information letter. The health-care professionals were included in the study after they gave their consent. Patients were included after both patients and parents gave their informed consent.

Eight health-care professionals were included in the study and were videotaped during meal times. All health professionals had a degree in Nursing or Social Work. Prior to the research, all participants received training from the Dutch Academy of Eating Disorders, focusing on diagnostics, motivational aspects of the treatment programme, cognitive behavioural therapy, family therapy, (relapse) prevention, and dietetics. An inclusion criterion was that they had at least 1 year of clinical working experience with patients with anorexia nervosa in the 12–18-year age group. In addition, four health-care professionals were trained as cognitive behavioural therapeutic workers. All of the health-care professionals were also employed at the eating disorder centre for at least 24 hours per week.

Nine patients provided informed consent and were videotaped during meal times. They were all aged between 12 and 18 years and diagnosed with anorexia nervosa according to the criteria of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association 2002). Two patients were in the first phase of treatment, and therefore, were the primary focus in our study. A third patient in the first phase of treatment did not provide informed consent. This patient was excluded from video recordings and placed on a seat outside and away from the camera. However, the health-care professional who provided support to this patient was seated inside and near the camera, thus allowing us to include the nursing interventions she carried out in our analyses, while respecting the refusal of informed consent by the patient. The remaining six patients were partly recovered patients who were no longer in the first phase of treatment. Individual material for these patients was only used when they interacted with the patients who were in the first phase of treatment. Although patients were included in this study and asked for informed consent, the primary focus was on the health-care professionals and the interventions they provided to these patients.

The study was approved by the Dutch Medical Ethical Committee.

Data collection and analysis

Data were collected by means of video recordings. Over the course of 5 days, recordings were made of the principal meals on each day; that is, breakfast, lunch, and dinner. The meals had an average duration of 30 min, which yielded a total of 8 hours of video data. The camera was placed beside the dinner table. Health-care professionals and patients in the first phase of treatment were asked to take a seat facing the camera. This allowed the researchers to collect optimal data for analysis, with every aspect of the patients' and health-care professionals' behaviour being visible.

The video recordings were analysed using Transana, a software programme for the qualitative analysis of video and audio data (Woods & Fassnacht 2010). In the first step, the primary investigator repeatedly viewed the whole videotapes, in order to obtain a first insight into the nursing interventions carried out and the related interaction processes between the health-care professionals and patients. In the second step, relevant video clips concerning nursing interventions and related health-care professional–patient interactions were selected for analysis. These clips were transcribed verbatim, and the concomitant non-verbal behaviour was described and attached to the transcriptions. The first video recording was used to create a preliminary list of code words that reflected health-care professional–patient interactions related to patients' eating behaviour. New code words

were added to the original code tree for each analysis of subsequent video recordings. Categories were created from this code tree that reflected the core nursing interventions used to help patients restore their normal eating pattern and weight.

The primary researcher (LB) analysed the data. To ensure the quality of the research, the process of data analysis was under the direct supervision of one of the co-authors (BvM). The descriptions and interpretations made by the primary researcher were checked by two experts in the field of eating disorders (TB and AvE).

RESULTS

The nursing interventions used to restore normal eating behaviour in patients with anorexia nervosa can be divided into four main categories: (i) monitoring and instructing; (ii) encouraging and motivating; (iii) supporting and understanding; and (iv) educating. These categories will be further elaborated in the following sections. The final section will describe the attitude of the health-care professionals while using these interventions.

Monitoring and instructing

The health-care professionals used mealtimes for the structured observation of patients. By sitting next to the patient, they were able to monitor every detail of the patient's eating pattern throughout the entire meal. Health-care professionals mainly carried out their observations inconspicuously, but when needed, they also conspicuously checked whether patients were following nutritional advice and strict eating rules. They kept track of time, and regularly let patients know how much time they had left before the meal was over:

> Did you put the right amount of butter on your bread? May I see, please? (Clip 674, health-care professional no. 5)

Besides monitoring the patients' eating habits, the health-care professionals continuously instructed patients on normal eating habits. These instructions were highly detailed and concerned various aspects of eating. They gave different instructions in succession and repeated them until the patient had succeeded in following them and reached a satisfactory level of food intake at mealtimes. They instructed the patients throughout the entire meal and explained the reasons behind their instructions:

> Take a bigger bite of food. . . . Try to take a bigger bite, because you have to bring the sandwich to your mouth over and over again, and each time it is very difficult for you. By taking bigger bites, you can take fewer bites. (Clip 174, health-care professional no. 2)

Health-care professionals began their instructions by informing the patients how to physically sit in their chair at the table and when to pick up their fork and knife. Once the bite of food had been prepared, they prompted the patients to bring their fork to their mouth to start eating, or when patients had already begun, to continue eating. They also instructed patients to increase the pace at which they ate by telling them to chew faster and to prepare new bites of food while chewing. Many of the health-care professionals' instructions concerned quantities of food: more butter or toppings on a sandwich or bigger bites of food. They also informed patients when to vary between sorts of food:

> Sit closer to the table . . . yes . . . open the pack of butter . . . pull off the top completely . . . yes . . . and then divide the butter in two and spread half on your sandwich. (Clip 165, health-care professional no. 1)

The health-care professionals also openly named and discussed the patients' anorectic eating habits during meals and urged patients to stop this behaviour. They did this, for example, when the patients crumbled their food to minimize intake, took very small bites, sliced their food excessively, moved their food around to stall, did not vary between foods, or just stared at their food. After they instructed the patients to stop these anorectic eating habits, they then immediately instructed them to assume normal eating habits. When patients did not seem to understand the health-care professionals' instructions, the health-care professionals demonstrated what they meant:

> No, don't take such small bites, that's too small. . . . Yes, and take this piece with that too, because otherwise it is still not big enough. (Clip 414, health-care professional no. 3)

Encouraging and motivating

The health-care professionals constantly encouraged patients to start or continue eating. They did this with short phrases, such as 'come on' or 'keep going' when the patients decreased their eating pace or stopped eating completely:

> Come on . . . bring the fork to your mouth. (Clip 686, health-care professional no. 8)

Besides these short but powerful encouragements, the health-care professionals also used more extensive methods to promote awareness and motivate patients. They frequently motivated patients by setting small and attainable goals during the meal:

> Eat up that bite of food and try to go a step further than yesterday. (Clip 26, health-care professional no. 1)

The health-care professionals also encouraged the patients in more general terms to fight the eating disorder and to take back control. They did this throughout the entire meal:

> Fight against your thoughts, try to be stronger. . . . You won't let these thoughts win, will you? You won't let them rule your life? That's what's happening now. I know it's scary, but this is how the thoughts keep coming. The only way to break through this cycle of thought is to oppose it and to eat. (Clip 528, health-care professional no. 5)

The health-care professionals specified the negative consequences when patients displayed anorectic eating habits or when they did not follow their instructions:

> Try taking the first step. . . . Try to fight against it. . . . Every bite is progress and a little less replacement nutrition. (Clip 620, health-care professional no. 4)

As well as highlighting these negative consequences, the health-care professionals also informed patients of the positive consequences of a normal eating pattern or of following their instructions. They reminded patients about what they could do in the future if they persisted in healthy eating behaviour:

> I thought you were motivated to go to school, weren't you? . . . Try to think of that . . . those are things that will be within your reach when you have a normal eating pattern again. (Clip 539, health-care professional no. 2)

The health-care professionals also supported the patients' (extrinsic) motivation by stressing the positive response that family members and friends would have if the patient succeeded in restoring a normal eating pattern and weight:

> Is there anyone for whom you are willing to eat?. . . . Your parents, little sisters, and your friends?. . . . Well, you should try for them. I think they would be very happy to see you get well. (Clip 570, health-care professional no. 6)

Supporting and understanding

The health-care professionals supported the patients during the meals, mainly by complimenting them when they followed their instructions and nutritional advice. They also sympathized with the patients and asked patients about their feelings and thoughts when they saw them struggling with their obsessive habits. They were understanding of the patients' stress and anxiety when confronted with nutritional advice, instructions, and prompting:

> I can see your struggle, and I understand that this is very difficult for you, but we are fighting it together. (Clip 691, health-care professional no. 6)

The health-care professionals invited the patients to communicate with them or others around them, and to not withdraw into their inner world of anorectic thoughts and resistance. Instead, they suggested alternative cognitions that were helpful to them at stressful moments during mealtimes:

> Try to look around you and see how the others are eating. It can help you pull yourself out of your own world. (Clip 191, health-care professional no. 3)

Furthermore, the health-care professionals mobilized the support of other partly-recovered patients present at the same meal. These fellow patients were used as role models, and were able to share their previous experiences and difficulties, while restoring a normal eating pattern during the first phase of treatment. These partly-recovered patients supported the new patients by sharing their experiences and encouraging them to eat:

> You have the support of your fellow patients who all know how difficult this is. (Clip 532, health-care professional no. 5)

Educating

During meals, the health-care professionals provided patients with information about the eating disorder. They educated patients on the specific characteristics of anorexia nervosa and its effect on patients' behaviour and emotions. In this way, they contributed to the patients' understanding of the disorder and its manifestations and consequences. They also educated patients on normal eating habits and the rationale behind the nutritional advice, thus enabling the patient to understand what a normal eating pattern means. In addition, they gave patients tips on easing the process of adopting a normal eating pattern:

> Those little bites you take, that's what you do because your eating disorder tells you to, isn't it? That is not something you have always done, right? (Clip 419, health-care professional no. 1)

> No. (Patient)

> Do you understand that this needs to change? That we want you to do that differently? That is not normal eating behaviour. (Clip 419, health-care professional no. 1)

Attitude

The attitude of the health-care professionals was directive and controlling. They were insistent and focused on a

change in eating behaviour. They made their expectations concerning the patient's eating behaviour clear, and they did not deviate from their strict eating rules. They took control and exerted well-dosed pressure to move the patient towards a normal eating pattern.

This directional, controlling approach was always underpinned with kindness, empathy, and understanding for the patient's struggle to normalize her eating pattern. That is, the health-care professionals were supportive, motivating, and emotionally available at the same time. They tried to ally themselves with the patients by telling them that they were fighting alongside them against their eating disorder. They explained their actions to the patients and the process that the patients' were engaged in. The health-care professionals also served as role models for the patients by displaying normal eating habits.

The patients showed anxiety and stress in their non-verbal behaviour when confronted with the structured nutritional regimen: they had fear in their eyes, stiffened their bodies, and sometimes even cried. This was already visible before the health-care professionals actively intervened, caused by the knowledge that they had to eat the portion of food that was put in front of them. The follow-up interventions of the health-care professionals caused an increase in the patients' stress and anxiety levels, as seen in their body language. At the same time, the health-care professionals managed to decrease these anxiety and stress levels with their supportive and empathic attitudes. As patients attended more meals, the nursing interventions seemed to provide the patients with clarity of what was expected from them, and the resistance of the patients against eating gradually decreased.

DISCUSSION

Qualitative analysis produced four categories of interventions from the data: (i) monitoring and instructing; (ii) encouraging and motivating; (iii) supporting and understanding; and (iv) educating. The data further showed an attitude of direction and control, but this was always underpinned by kindness, empathy, and understanding. These categories are closely interrelated. They can be differentiated from one another, but cannot be seen as separate.

The observations revealed that the health-care professionals' directional and controlling interventions and attitudes were essential for the patients to break through their compulsive anorectic eating habits; only then did they feel the urge to adopt normal eating habits. This concurs with the findings of Bakker *et al*. (2011) and Van Ommen *et al*. (2009), who described this as 'taking over all eating related responsibilities', and the role of the health-care professionals as 'substitute decision makers'. Colton and Pistrang (2004) also described the necessity of taking control.

To achieve changes in their eating pattern, patients needed the health-care professionals to be insistent and firm, to focus on every detail of the patients' eating behaviour, to continuously repeat instructions during the entire meal, and to leave little, if any room, to deviate from eating behaviour that complied with the dietician's nutritional advice. A less directive and controlling approach seemingly made it harder for patients to resist their compulsive anorectic eating habits.

The observations revealed that patients experienced considerable anxiety and stress during meals, because they knew they were expected to eat. The health-care professionals' directional and controlling interventions seemed to cause these anxiety and stress levels to increase; however, they seemed to provide clarity for the patients. Westwood and Kendal (2012) and Van Ommen *et al*. (2009) showed that, in hindsight, patients appear to acknowledge the importance of nurses initially taking control of their behaviour. The patients from these studies felt that the structured approach and the nurses' directive attitude were essential to their recovery during this first stage of treatment.

The fact that health-care professionals acted with kindness in their directional and controlling interventions helped to balance the emotions of the patients. The health-care professionals' empathy and understanding, and their support and motivation, helped the patients effectuate their behavioural change. In doing so, the health-care professionals were also addressing the psychological aspects of the patients' struggle to restore their eating behaviour. Bakker *et al*. (2011) referred to this as 'expressing empathy and safety'. Colton and Pistrang (2004) also cited the importance of patients experiencing the care they receive as supporting and encouraging, as they are then better able to cooperate in their treatment.

It is challenging for health-care professionals who work with adolescents who have anorexia nervosa to merge these two contrasts – the directional attitude and the empathic attitude – into one approach. It requires experienced health-care professionals with knowledge of anorexia nervosa who are able to recognize and understand the anorectic eating behaviour, and to intervene effectively with a balanced mix of directive and empathic interventions, as also described by Tierney (2008), Westwood and Kendal (2012) and Zugai *et al*. (2013). This indicates

that health-care professionals should be specialized in this area in order to provide the highly-complex care required for adolescent patients with anorexia nervosa.

LIMITATIONS

The findings of the present study must be considered in the light of a number of methodological issues. The main limitation of the video-based approach was a possible change in the participants' behaviour due to the presence of the video camera. However, this effect diminished over time, as participants themselves indicated that they became used to the camera (see also Haidet et al. 2009; Latvala et al. 2000).

Another limitation was the limited sample size. However, the small sample size in the study resulted in a detailed examination of the nursing interventions. The use of video recordings made it possible to capture detailed nursing interventions and health-care professional–patient interactions, and to observe and analyse the same situation multiple times. Additionally, because the present study was purposefully carried out in a best-practice setting, the results reflect highly-specialized nursing care.

The analysis of best practices does however allow for the identification and elaboration of essential building blocks for the development of future evidence-based interventions (van Meijel *et al*. 2004). Another strength of this study was that field experts checked the descriptions and interpretations to ensure credibility of the findings.

CONCLUSION

The findings of the present study give a detailed description of the interventions health-care professionals use for patients with anorexia nervosa, in particular in the first treatment stage when the patient suffers from extreme underweight and persisting anorectic behaviours. The intervention categories that emerged from the data were: (i) monitoring and instructing; (ii) encouraging and motivating; (iii) supporting and understanding; and (iv) educating. These interventions were combined with an attitude of direction and control, underpinned by empathy and understanding. The health-care professionals focused on patients changing their eating pattern behaviour, but they also addressed the patients' psychosocial needs and their personal struggle to restore normal eating behaviour. Helping adolescent patients with severe anorexia nervosa to restore their normal eating pattern, ultimately leading to restored weight, requires specialized treatment and specialist nursing skills.

The findings of the present study could contribute to health-care professionals' training programmes and guidelines by deepening our knowledge of nursing interventions and attitudes when attempting to restore normal eating behaviour during treatment of adolescent patients with anorexia nervosa. Such knowledge will ensure that health-care professionals are better prepared to care for this vulnerable group of patients.

RECOMMENDATIONS

We conducted a study of limited size carried out in a best-practice setting for patients with severe anorexia nervosa, aged 12–18 years. We used video analysis to obtain preliminary insight into nursing interventions carried out during meals. Based on this, we recommend further larger-scale research in other settings and with other age groups, offering the possibility to expand and synthesize research data on this research topic. We also recommend the selection of best-practice settings for these research activities, so as to use the research data for future intervention development and testing. We expect that the implementation of these interventions could significantly contribute to improvements in the quality of care for patients who have severe anorexia nervosa. Such evidence-informed intervention programmes could also be of great value for education curricula in mental health nursing.

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