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Acceptability and feasibility of self-help Cognitive Remediation Therapy For Anorexia Nervosa delivered in collaboration with carers: A qualitative preliminary evaluation study

Katie Lang [a], Janet Treasure [a,b], Kate Tchanturia [a,b,c,*]

[a] King's College London (KCL), Psychological Medicine, Section of Eating Disorders, Institute of Psychiatry, Psychology and Neuroscience, PO59, London SE5 8AF, UK
[b] South London and Maudsley NHS Trust Eating Disorders Adult National Service, UK
[c] Illia State University, Department of Psychology, Georgia

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ABSTRACT

Anorexia nervosa (AN) is an eating disorder without a recommended first-line treatment. Cognitive Remediation Therapy (CRT) is showing great promise in helping patients reduce cognitive inflexibility and excessive detail focus, thinking styles that could make engaging in psychological therapies difficult. CRT has shown to be effective, feasible and acceptable in both individual and group formats, and positive qualitative data has been gathered from both service users and clinicians. The aim of the current study was to assess the use of CRT as a self-help treatment for individuals with AN delivered in collaboration with carers. Six families underwent a six-week self-help CRT intervention. Feedback was gathered from qualitative interviews and analysed using thematic analysis. Neuropsychological outcomes were also collected. Participant feedback regarding the intervention was generally positive, with participants describing a number of benefits such as it creating a space for families to spend time together outside of the eating disorder, acting as a 'gateway' for more emotional work and helping participants to gain insight into their cognitive profiles. These preliminary findings suggest that self-help CRT delivered in collaboration with carers is an acceptable form of treatment, and adds to the growing literature supporting CRT for AN.

1. Introduction

Anorexia nervosa (AN) is an eating disorder characterised by persistent restriction of calorie intake, a fear of gaining weight and a disturbance in body perception (DSM-5, APA, 2013). AN carries one of the highest morbidity rates amongst mental health disorders (Arcelus et al., 2011), and is associated with significant carer stress and burden (Treasure et al., 2003; Graap et al., 2008). Despite this, there is currently no established first-line treatment for AN (Bulik et al., 2007). One reason psychological treatments may be less than optimal for this disorder could be due to inefficient information-processing systems that have been observed within this population (Treasure and Schmidt, 2013). Both clinical observations and robust experimental evidence have identified a certain neuropsychological profile marked by inefficient set shifting (i.e., cognitive inflexibility) and weak central coherence (i.e., poor global processing with excessive bias towards detail) in adults with AN (e.g. Tchanturia et al., 2012a; Lang et al., 2014a). The data regarding the neuropsychological profile of children and adolescents with the disorder have thus far has been inconsistent (Lang et al., 2013; Lang and Tchanturia, 2014b). Some studies have demonstrated worse performance by children with AN compared to healthy controls on neuropsychological tasks (McAnarney et al., 2012; Andres-Perpina et al., 2011), whereas some have shown comparable performances (Sarrar et al., 2011; Rose et al., 2014). There is also evidence of a genetic component, as inefficient cognitive processing has also been shown to be present in unaffected sisters of those with AN (Holliday et al., 2005; Roberts et al., 2010) as well as some preliminary evidence of their presence in unaffected parents. Goddard reported that mothers with offspring with EDs demonstrated a strong bias toward detail-focussed processing coupled with poor global integration, as well as showing lower levels of cognitive flexibility in comparison to mothers of healthy offspring (Goddard, unpublished Ph.D. thesis). These experimental observations within the adult AN literature have been translated back into clinical practice and as a consequence, Cognitive Remediation Therapy for AN (CRT) has been developed to tackle these underlying mechanisms (Tchanturia,

* Corresponding author at: King's College London (KCL), Psychological Medicine, Section of Eating Disorders, Institute of Psychiatry, Psychology and Neuroscience, PO59, London SE5 8AF, UK.
E-mail address: kate.tchanturia@kcl.ac.uk (K. Tchanturia).

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2014a; Tchanturia et al., 2013), and is showing great potential as an effective and highly acceptable treatment. CRT targets thinking styles seen in AN, such as cognitive inflexibility and excessive focus on detail, without discussions about eating disorder symptom-related issues. It uses cognitive exercises to encourage a more flexible thinking style, as well as bigger picture thinking. Randomised controlled trials indicate improvements in cognitive processing post-intervention (Brockmeyer et al., 2014; Dingemans et al., 2014; Lock et al., 2013; for reviews, Tchanturia et al., 2014b; Dahlgren and Rø, 2014) and group CRT is also well received (Genders and Tchanturia, 2010; Pretorius et al., 2012). There is also positive preliminary evidence of its benefit with children and adolescents with AN (Wood et al., 2011; Pretorius et al., 2012; Dahlgren et al., 2013). In addition to improvements in neuropsychological function, important information regarding individual's experiences of the treatment has also been sought.

Qualitative analyses of patients' and therapists' end of therapy letters demonstrate that both parties feel positive about CRT, acknowledging improvements in motivation and neuropsychological function (Whitney et al., 2008; Easter and Tchanturia, 2011). In addition, qualitative feedback has demonstrated that clinicians feel that CRT is a powerful engagement tool that can be used to work with patients in a light-hearted and fun manner (Lounes and Tchanturia, 2014).

CRT's potential in individual and group formats, combined with the positive feedback received from both patients and clinicians suggest that it could be important to develop this resource further in the context of a family intervention (Lask, 2014). Another potential avenue that remains unexplored is the extension of CRT for AN to a self-help format. Cost effective treatment modalities, such as self-help, that can increase accessibility to services for patients as well as reducing costs relating to clinician input are very attractive in today's health service. Similarly, it is of increasing value to involve family and carers more in treatments for AN, as reducing carer stress and burden levels can lead to better coping abilities and ultimately lead to better treatment outcomes (Goddard et al., 2011).

The aim of the current study was therefore to assess the feasibility and acceptability of CRT through a self-help format to be delivered in collaboration with carers. This was evaluated through a pilot study using both qualitative and experimental measures.

2. Methods

2.1. Participants

A sample of 12 participants took part in the study, including six females with AN and six mothers. Participants were recruited from advertisements placed on the eating disorder charity Beat website, support groups and the Child and Adolescent Eating Disorder Service at the South London and Maudsley Trust hospital. The inclusion criteria for the study were as follows: (i) Both an offspring with a diagnosis of Anorexia Nervosa or EDNOS-AN (in-line with DSM-IV) and their mother were willing to participate; (ii) offspring was aged between 12 and 40 years of age. Exclusion criteria for the study included (i) brain injury, (ii) mother was unable to participate; (iii) insufficient English language. Written and informed consent was obtained from all participants, and the study was approved by the Dulwich Research and Ethics Committee (study number 12/LO/2015). The ages of the AN participants ranged from 14 to 32 years (S.D.=6.78), (see Table 1 for participant characteristics). Four participants were adolescents (14–18 years). The ages of the mothers ranged from 45 to 64 years. One of the mothers had a history of an eating disorder.

2.2. Materials

2.2.1. Treatment

2.2.1.1. CRT manual. Participants were each given a copy of the CRT self-help manual. The self-help CRT manual was adapted from the original clinician manual

Table 1
Participant demographics and pre and post-intervention questionnaire data.

Group	Age	BMI	Pre					Post				
			EDE-Q global	HADS	DFlex		WASAS	EDE-Q global	HADS	DFlex		WASAS
					Cognitive rigidity	Attention-detail				Cognitive rigidity	Attention-detail	
AN	19.52 (14.00–32.50) (6.78)	17.10 (1.70)	3.43 (1.43)	25.25 (7.41)	81.00 (34.27)	60.50 (11.62)	22.25 (14.66)	2.40 (0.79)	19.75 (3.59)	64.20 (38.89)	51.00 (13.65)	14.31
Mothers	53.80 (45.11–64.40) (7.28)	23.95 (2.46)	1.23 (1.01)	10.20 (7.85)	31.6 (6.88)	35.40 (22.03)	1.60 (4.00)	0.731 (0.42)	9.00 (5.29)	30.25 (4.71)	25.75 (13.50)	0.67 (1.15)

BMI: Body Mass Index; EDE-Q global=Eating Disorder Examination Questionnaire Global score; HADS=Hospital Anxiety and Depression scale; DFlex=Detail and flexibility questionnaire; WASAS=Work and Social Adjustment Scale.