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Hospitalization due to eating behavior disorders. Patient and family satisfaction

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Objective. In this paper, we assess the quality of an inpatient unit for eating disorders from the patients' and their parents´ perspective in order to clarify some clinical questions concerning inpatient treatment.

Method. A satisfaction questionnaire was designed with open and closed questions separately for the patients and their relatives. The first type of items (53 for patients and 15 for relatives) were analyzed by the standard statistical methods. The second type (one question per questionnaire) was studied with the help of qualitative techniques. It was sent to all discharged patients (n = 299). We obtained the data from the answers (n = 174) and then looked for correlations with factors as compulsory admission at the hospital, age of patients and duration of the disorder.

Results. A high level of general satisfaction was obtained by patients and parents answering the closed questions. The open one, discriminates among shades of meaning. coercive factors, such as compulsory admission, did not affect the level of satisfaction in our study. While most patients were concerned about excessive supervision and lack of privacy, many parents considered control measures as scarce and asked for support upon discharge.

Conclusion. Along general lines, hospitalization has been satisfactory for both the patients and their family. Forced admission did not significantly intervene in the subsequent satisfaction of the patient.

Key words:
Satisfaction. Quality. Eating disorder. Hospital admission. Anorexia nervosa. Bulimia nervosa.

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Hospitalización por trastornos de la conducta alimentaria. Satisfacción de pacientes y familiares

Objetivo. Valoramos la calidad de una unidad de ingreso hospitalaria para trastornos de la conducta alimentaria desde la perspectiva de pacientes y padres para clarificar algunas cuestiones clínicas referidas al tratamiento hospitalario.

Método. un cuestionario de satisfacción fue diseñado con preguntas abiertas y cerradas, tanto para pacientes como para familiares. Se mandó a todos los pacientes dados de alta en la unidad (n = 299). Obtuvimos los datos de las respuestas (n = 174) y buscamos correlaciones con factores como el ingreso forzoso, la edad de los pacientes y la duración del trastorno.

Resultados. Obtuvimos un alto nivel de satisfacción tanto de pacientes como de padres en la respuesta a las preguntas cerradas. La abierta mostró un marco más amplio de opiniones. Factores coercitivos como el ingreso forzoso no afectó al nivel de satisfacción de nuestro estudio. Mientras que la mayor parte de pacientes estaban preocupados por el excesivo control y la falta de privacidad, muchos padres consideraron las medidas de control como escasas y pidieron apoyo al alta.

Conclusiones. En líneas generales, el ingreso es satisfactorio tanto para pacientes como para familiares. El ingreso forzado no interviene significativamente en la satisfacción posterior del paciente.

Palabras clave:
Satisfacción usuario. Calidad asistencial. Trastorno alimentario. Hospitalización. Anorexia nerviosa. Bulimia nerviosa.

INTRODUCTION

In recent years, there have been an increasingly greater number of studies that analyze psychiatric health care programs from the user satisfaction perspective. Most of the experts in this area consider that the evaluation of the patient's perspective is a fundamental method both to im-

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prove medical advances and for the establishment of specific programs designed to correct errors.[1] It has been established that greater satisfaction is associated with greater adherence, less absenteeism and greater progress in improvement.[2]

Eating disorders have specific characteristics that differentiate them from other psychiatric problems. For example, some of their core features, such as extreme thinness and importance of control are given the greatest value by the patient. This is why the subjective evaluation of the efficiency programs in the treatment of these aspects could be negative. However, most of the authors believe that the characteristics of the patients who suffer an eating disorder, as the conservation of cognitive and expressive capacity, allow them to be good informers compared to the patients who suffer other types of disorders.[3] Another factor to take into account is the influence that the parents have on their disorder and course, especially with the younger patients, since parental attitudes are essential in compliance and continuity of the treatment.[4] Therefore, the opinion of the parents must be considered when evaluating the quality of a treatment program.[5]

Another aspect that is discussed is involuntary admission. Some authors state that most of the patients admitted involuntarily consider *a posteriori* that it was necessary and show a good attitude during their hospitalization.[6]

The study carried out by Crawford et al.[7] is of special interest in this subject since they evaluated the sensation of malaise in patients who had been discharged within a period of 5 months from an eating disorders hospitalization unit. Their conclusion was that there were two variables associated with a high level of dissatisfaction in the admission procedure: the negative opinion on the care received and poor disease awareness. However, some authors consider that forced admission may be counterproductive and could deteriorate the patient's conditions, substituting the internal battle with the disease for a fight with the therapists.[8]

There are few works that evaluate the opinions of the patients with an eating disorder on the quality of treatment received. We could mention that of Swain-Campbell et al.,[3] who also used structured questionnaires and open questions as we did. In 2003, Bell[9] made a review of 23 works made with qualitative methodology and found that they supplied relevant information on data that were not in the questionnaires in spite of the frequency of methodological errors. In 2004, Colton and Pistrang[10] performed a qualitative study with a sample of 19 patients discharged from two eating disorders units. Federici and Kaplan[11] studied the experience of 31 women discharged from a hospital eating disorders unit using a qualitative methodology. On their part, Nilsson and Hägglöff[12] studied a sample of 38 subjects treated as outpatients for an eating disorder to evaluate the subjective evaluation of their improvement process. In addition, several works that have studied the experience of the relatives of patients who suffered an eating disorder with qualitative analysis methods and who received treatment have been published.[13]

Our study has aimed to evaluate the level of satisfaction of patients admitted to an Eating Behavior Disorders Unit of the Hospital Universitario La Fe (Valencia) (Spain) and the level of satisfaction of their parents with the form of treatment received. Furthermore, we studied if factors such as the voluntary or involuntary nature of the admission, the patient's age or duration of the disorder could influence their opinion.

METHODOLOGY

The data for this work has come from the Eating Behavior disorders Unit of the Hospital Universitario La Fe of Valencia (Spain), with 10 beds. It has a mixed population with no restrictions in admission age range. All of the admissions are programmed. The therapeutic plan is based on a combination of strict behavior measures, constant and specialized nursing cares and individual and group psychotherapy. In the Unit, the patients under go strict restrictive measures, that become more flexible as they progress in their clinical course.

The patients are referred by Mental Health professionals who generally do not report the characteristics of the admission procedure. On their arrival, the patients are received by the staff who inform both their parents and them of the unit characteristics. They are shown the ward and are introduced to the rest of the patients. During their hospitalization, the staff collaborates in the progressive process of transferring the responsibilities to the patients and the improvement of the autonomy. Given the importance of the attitude and way of treatment of the staff in the patient's progress, periodic meeting are organized to avoid emotional overload, facilitate the empathy with the patient and establish clinical management limits. The purpose of the treatment includes psychological as well as medical improvement. In this sense, individual psychotherapy is performed to analyze the underlying character traits and the interpersonal difficulties that intervene in the disorder with the eclectic therapeutic approach.

We designed a satisfaction questionnaire specifically for this work in order to evaluate the care quality. The first section of this questionnaire is aimed at patients and is made up of 53 items that are evaluated by scoring and one open question. They could be classified as following: 5 descriptive items (age, gender, source of referral to the unit, voluntary or involuntary nature of the admission, duration of the disorder); 48 multiple choice questions (yes/no and Likert scale) that include the following sub-

jects: hospital environment, relationship with the staff, effectiveness of the therapeutic intervention and general degree of satisfaction with the hospitalization. The test ends with an open question on aspects of the unit that could be improved.

The second part of the questionnaire was sent to the address of the patient's parents. It is made up of 31 items that evaluate: evaluation of the hospital environment, of the nursing and medical staff. As in the case of the patients, the questionnaire was competed with an open question on possible improvements in the unit.

With the approval of the hospital's Ethics Committee, the questionnaire was sent to all the patients who were discharged from the unit (n = 299). A stamped envelope with the Hospital address was included so that it could be returned once it was filled out. The questionnaires were sent within one month after hospitalization was terminated and was accompanied by a note explaining the interest of the Hospital in evaluating the service provided. Sincerity was requested in their answers and anonymity was assured. The questionnaires were sent to the Site Administration.

A total of 174 questionnaires that were filled out were received (58% of those sent). Only 171 of then 857%) were valid for use in the study. Those patients who did not answer the survey were ruled out. The questionnaire was not resent and no other equivalent attempts were made to receive them, so we do not know why there was no collaboration.

Of the sample used (valid questionnaire), 7.6% of the patients were men versus 92.4% women. The mean duration of treatment prior to hospitalization was less than 5 years in 77.4% of the patients while 22.6% had spent more than 5 years in treatment. In relationship to the type of admission. 64% of the sample were admitted voluntarily, while 36% were admitted involuntarily.

The data were analyzed with the SPSS 12.0 program for Windows.

We decided to use the qualitative method to analyze the open question formulated at the end of the questionnaire for patients and relatives. To do so, we grouped all the narratives presented by the responders and divided the content into categories and subcategories according to the subject matter dealt with, in a procedure similar to the known «grounded theory».[14]

RESULTS

We have classified the results of the quantitative and qualitative variables into two sections, patients and parents.

Answers to the questionnaire

Patients

The results in percentage to the patients evaluated are shown in table 1. They were classified in accordance to the already mentioned questionnaire structure and the most significant items were studied.

Parents

The quantitative answers of the survey elaborated for the parents were also divided into section, in this case four (table 2).

As can be observed, the structure of the survey aimed at the patients and family is very similar.

After analyzing the relationship of each one of the questionnaire items with the voluntary/involuntary nature of admission using the Chi-square test, we concluded that there was no correlation between this factor and the grade of satisfaction of the patient. Only the question regarding the initial impression of the unit significantly differentiated both patient groups: 80.6% of the patients admitted involuntarily had a «bad/very bad» first impression of the Unit versus 59.8% of those admitted voluntarily ($\chi^2 = 7.76$; df = 1; $p < 0.01$).

As was explained in the introduction have also studied if the disease duration (more than or not more than 5 years) or the patients' age (over or not over 20 years) significantly influenced the evaluation of the care given.

Thus, a shorter duration of the eating disorder (less than 5 years vs. more than 5 years) was significantly associated only with a worse initial impression of the Unit (79.1% vs. 50.0%; $\chi^2 = 6.24$, df = 1; $p < 0.05$) and less knowledge of the admission conditions (79.1% vs. 50.0%; $\chi^2 = 11.99$, df = 1; $p < 0.01$).

Younger patients, compared to those over 20 years, had significantly more involuntary admissions (51.1% vs. 20.2%; $\chi^2 = 17.8$, df = 1; $p < 0.001$), worse impression of the Unit (76.7% vs. 58 %; $\chi^2 = 6.8$, df = 1; $p < 0.01$), they considered the first days of admission as harder (96.7% vs. 86.7%; $\chi^2 = 5.7$, df = 1; $p < 0.05$) and they felt they were less supported and understood by the staff (sometimes, never or almost never: 34.9% vs. 18.5%; $\chi^2 = 5.68$, df = 1; $p < 0.05$). Binary logistic regression analysis, in which the dependent variable was the patients' age (over/under 20 years), shows that only the type of admission (voluntary/involuntary) maintains a significant association with the age of the patients after introducing all the equation factors. That is, the involuntary character of admission, significantly more frequent among the young patients, is the variable that measures the initial significant associations of the others with age.

Table 1 Answers of the patients (%) to the principal items of the questionnaire

Patients	Items	Answers	%
Initial admission conditions	First impression after admission	Very good or good	32.1%
	Difficulties during the first days	Much or considerable	92.65%
	Feelings of loneliness	Much or considerable	40.7%
	Strictness of the rules	Much or considerable	98.8%
Need of restrictions	Need to restrict visits in the beginning	Yes	74.7%
	Continuing control	Very good or good	65%
	Feelings of harassment by the staff	Little or none	23.3%
	A posteriori need of the hospitalization conditions	Yes	86.4%
Evaluation of the health care staff	First impression after admission	Very good or good	72%
	Respect for the patients privacy	Always or almost always	83%
	Care given by the staff	Very good or good	91.1%
	Relationships between the patient and staff	Very good or good	80.5%
	Communication with the staff	Very good or good	85.4%
	Support and understanding given by the staff	Always or almost always	73.2%
	Need for greater flexibility	Yes	75.2%
Evaluation of the psychiatric intervention received	Psychological improvement	Much or considerable	83%
	Efficient work	Much or considerable	90.3%
	Communication with the psychiatrist	Very good or good	84%
	Attitude that inspires confidence	Much or considerable	92.3%
	Utility of the psychological help	Much or considerable	86.5%
	Transmission of an adequate view of the disorder	Much or considerable	90.3%
	Capacity to understand the patients problem in depth	Much or considerable	85.1%
Global evaluation of the hospital stay		Excellent/good	66.9%
		Normal	28.8%

Answer to the open question

We are going to present the categories used in the work. The content corresponding to them will be outlined in the discussion.

Patients

Of the valid questionnaires, 61.54% of the patients answered this question, obtaining a total of 332 different answers. After the consensus of the investigators, the answers were classified into 7 different dimensions of the therapeutic experience:

1. Therapeutic alliance. 16 answers were obtained.
2. Type of treatment. This area received the largest number of comments (149). We subdivided them into:
   - Type of therapy (5 comments).
   - Follow-up after discharge (3 comments).
   - Explanation of treatment and steps to follow, both to the patients and their parents (4 comments).
   - Involuntariness (1 comment).
   - Desire to divide the patients into groups, separating them by diagnosis or by their clinical condition (2 comments).
   - Frequency of visits/telephone calls (10 answers).
   - Restriction of privileges (4 comments).
   - Rest (1 comment).
   - Physiotherapy (2 comments).
   - Time to eat (4 comments).
   - Surveillance during meals (5 comments).

Table 2 Answers given by the family or relatives

Parents	Items	Answers	%
Evaluation of the setting	First impression after the admission of the patient	Very good or good	80.4%
	Adequate setting for the patient	Yes	93.2%
	Strictness of the rules	Much or considerable	73.2%
	A posteriori adaptation of the rules	Yes	93.3%
Evaluation of the healthcare staff	Kindness of the care received	Yes	97.6%
	Telephone assistance	Very good or good	97.5%
	Help when they are doubts	Almost always or always	85.9%
Evaluation of the psychiatric intervention	Sufficient information on the disorder	Much or considerable	89.43%
	Clear explanations on the family evolution	Much or considerable	93.8%
	Number of interviews	Sufficient	77.6%
	Clear instructions after discharge	Much or considerable	70.4%
Global evaluation of the hospitalization	Progress of the patient during hospitalization	Very good or good	93.8%
	Satisfaction with the service received	Much or considerable	96.9%

- Nutritional information. There were 5 answers that asked for more information in this area.
- Weight and food (5 answers).
- Rules for rest (17 answers).
- Privacy (15 comments).
- Schedule (8 comments).
- Relationship with other patients (6 comments).
- Individual and group therapy (17 patients).
- Attention to both medical and social aspects (2 comments).
- Means of control of the unit. 6 answers.

3. Profession competence (39 comments).
4. Material aspects of the unit (96 comments).
5. Opinions on overall functioning (22 comments).
6. Personal observations (4 comments).

Parents/relatives

In regards to the comments given by the parents of the patients, our group has groups the qualitative analysis of the comments as follows:

1. Therapeutic alliance (24 comments).
2. Therapeutic progress (10 comments).
3. Type of treatment. This area received the largest number of comments. We subdivided them into:
   - Follow-up after discharge more frequent (6 comments).
   - Need for more treatment for the patients and their families (23 comments).
   - Involuntariness. (1 comment).
   - Frequency of visits/calls (9 comments).
   - Privileges (6 comments).
   - Nutritional information (3 comments).
   - Weight (5 comments).
   - Privacy (1 comment). There was one comment asking for improvements in the patient's privacy.
   - Cohabitation with other patients (2 comments).
   - Individual and group treatment (14 comments).
   - Degree of rigidity of the unit (3 comments).
4. Professional competence (10 comments).
5. Condition of the services.

- Room and waiting room (11 comments).
- Kitchen (2 comments).
- Air conditioning (2 comments).
- Activities (8 comments).
- Increase in number of spaces available (21 comments).

6. Overall satisfaction with the unit (25 comments).

7. Personal opinions (6 comments).

DISCUSSION

According to our knowledge of the literature on the subject, this is one of the few works that provide a qualitative and quantitative evaluation of satisfaction in an eating behavior disorders unit and that evaluates both the parents and patients. We have tried to avoid biases in the population evaluated, sending the questionnaire to all the patients who have been discharged in the unit.

The rate of response was 58%. We consider this data to be satisfactory given that the percentages found in the literature are in agreement with this value. For example, in the Swain-Campbell et al. study,[3] the rate of response was 57% while in the Rey et al. study,[4] it was significantly lower, 41%. Längle et al.,[15] in a study that evaluated the satisfaction of patients in a general psychiatry admission unit (above all schizophrenics), found a 52% response rate.

In the first place, we are going to discuss all the quantitative date found in the questionnaires:

Patients

Control measures

A large percentage of the sample study accepted the control measures. Specifically, 86% of the sample considered the necessary after discharge. The most important coercitive factor is undoubtedly involuntary admission. In this sense, a key discovery of our work was the lack of association between patient satisfaction and voluntary or involuntary admission after being discharged, an important subject given the debate maintained in the literature on the use of involuntary admission. This result coincides with the postulates of Crawford et al.[7] and contradicts the position of Tan et al.[8] mentioned at the beginning of the article. Given the importance of the subject, it is likely that clinical improvement provide a retrospective meaning to the measures that are the most difficult for the patient to measure initially, as has also been shown by Watson et al.[6]

Role played by the health care staff in the satisfaction of the patients

In the quantitative evaluation, there was a high level of satisfaction with the treatment given by the healthcare staff. This is an essential feature in the clinical improvement of the hospitalized patient. In a work by Nguyen et al.[16] on users of general hospitalization services, satisfaction was correlated mostly with the quality of handling given by the healthcare staff and not so much by the clinical outcome of the admission.

The relationships with the staff are especially difficult in patients who suffer and eating disorder, given the intense ambivalence they have with their interpersonal relationships and the frequent conflict between the need for external control and independence seeking. Ramjan[17] describes the constant tensions generated between the staff and the patients in an eating behavior orders unit due to the continuous demands, the interpersonal deficits and the difficulty of the patients to establish healthy bonds. In the Doran et al.[2] study on the satisfaction of the patients discharged from a unit specialized in anorexia nervosa care, the critical factor was how the staff made the patients feel and the way that they treated them.

We have obtained a similar rate of satisfaction in the treatment given by the staff, the alliance with the psychiatrist and the global satisfaction.

Parents

In regards to the questionnaire addressed to the parents, the satisfaction level is very high (generally about 90%), somewhat superior to that expressed by the patients, except in satisfaction with the number of visits to the psychiatrist. This point does not coincide with that found in other publications. For example, in the Sharkey-Orgnero et al.[18] work, it was found that the parents considered the mental health care professions as useless and characters of guilt.

The importance of individual treatment and the opportunity to speak to be listened to our important keys, as has previously been shown in other works.[19] Lask and Waugh[20] also stressed the importance that the family gives to receiving sufficient information on the problem and its treatment. In general, the high satisfaction with the care given by the halls care staff reflected by the questionnaire could justify the high rate of global satisfaction, independently of the clinical results. Thus, the work of Lambert et al.[21] in a child's mental health care unit in which satisfaction of the parents with the service received was evaluated concluded that there was no correlation between clinical improvement and grade of satisfaction. In fact, Rey and Plapp[4] proposed that the satisfaction of the parents could basically depend on the time

and quality of the attention given, independently of the clinical improvement

Analyses of the open question

1. Patients

The most frequent subjects indicated referred to the treatment. The perspective shown by the patients was much more negative than not reflected in the questionnaire. Malaise was more oriented towards the control to which the patients were subjected during the hospitalization and lack of privacy that some of them live as a difficult intrusion to support. This ambivalence with the restrictions is indicated by Clinton et al.,[22] and the contrast is observed between the patients who see the control measures as abusive and those who consider them as useful to establish a structuring of the environment, to give stability and to achieve therapeutic objectives. Some patients were more unsatisfied with the staff and responded to the open question, harshly criticizing their attitude. This intense ambivalence between the attempt of control and the interpersonal relationships of a group of patients may be found in their comments on this subject.

The high percentage of satisfaction obtained from the closed questions is contrary to the mentioned comments. This could be justified by supposing that the group of unsatisfied patients and those who had a worse experience in their hospitalization would tend to express it more frequently in the open question than those who had a satisfactory experience.

Another possibility is that the negative responses came from a subgroup of patients who did not benefit from the therapeutic measures used in our unit. The existence of different subgroups of eating disorders has been proposed from the psychodynamic point of view.[23,24,25] The patients who responded critically to the attitude of the staff into the control measures could belong to a subgroup that did not benefit from the hospitalization or who would respond better to less restrictive measures and would require greater effort by the staff for the establishment of a collaboration attitude. Verification of this hypothesis could be useful in the modification of the usual protocols in the eating disorder units. In this sense, Federici y Kaplan[11] have pointed out in their work that for a subgroup of patients, intensive hospital treatment does not stimulate a psychological change and studies are needed on its applicability to clinical subgroups.

One of the most important sections, with 16 comments, refers to the different experiences of the quality of the therapeutic relationship with the psychiatrist. The literature has repeated the importance of the therapeutic alliance in the favorable evolution of the patients to suffer from eating behavior disorder.[5,11,26] The comments recorded range from great satisfaction to marked dissatisfaction, standing out both the tendency of this type of patient to experience extreme emotional relationships and the intensity of the bond formed with the therapist, which for many patients was key in the satisfaction grade.

2. Tendencies of the parents

The already mentioned tendency, by which the most unsatisfied parents would respond more to the open question, could explain the low level of response of the parents to the question (41%).

We have observed how the subjects that cause concern logically diverge from those expressed by the patients. Most of the objections refer to concern with the psychological condition of the patients after the discharge and fear of relapse. On this subject, there is a clear demand for greater psychological attention and support after the discharge, including prolongation of the hospitalization. There is a strong petition for more hospital resources to facilitate the admission. In general, there are no complaints on the control measures, even though they are considered insufficient in some cases. This marked difference between the interests and concerns of the parents and the patients respond to a pattern characterized by the concern of the patient to maintain independence as well as ambivalence towards the correction of the core symptoms of the disorder (purgative behaviors, eating restrictions, weight control). In the same way, intense and unstable relationships are maintained with those persons they depend on.[27] However, the parents maintain a protective attitude, they are concerned about the control of the children and have an ambivalent position towards them and their disorder, that makes them hypervigilant. The medical literature has repeated similar descriptions. Thus, Steiner et al.[28] indicate that there is a relationship between overprotective families, with rigid interaction styles and difficulties in the handling of the interpersonal conflicts and the appearance of anorexia nervosa.

Emerging therapeutic proposals and the study limitations

On the practical level, the answers of the parents in patients have led us to consider modifications in our hospital admission program. the first is the elaboration of the discharge protocol in which the information provided by the families is controlled more exhaustively and it is clearly established when and where the patient must go for the following outpatient control. We have also developed a closer control with the reference units and with the psychiatrists and psychologists responsible for the follow-up. Finally, we have established two group therapy sessions per week with the patients and families to clarify the problems they have in the unit.

One advantage that our work offers is the high number of participants in relationship to the low number of subjects evaluated in a qualitative study. Recently, Pettersen y Rosenvinge[29] pointed out how one of the most frequent limitations in the literature is the exclusive use of qualitative methods and the limited sample size, problems that we have attempted to solve. We have tried to avoid the bias that generally occurs in this type of works with the sample selection, as Bell indicates in his review, attempting to evaluate all the patients discharged in the unit without any exception.

However, our work has limitations. Thus, we have not established a correlation between the answers and variables such as the level of severity of the disorder or subtype of the eating disorder. Furthermore, we do not know if there is any correlation between these variables and the lack of response to the survey. In fact, we could not totally say if those patients who are more dissatisfied are the most severe and have the least awareness of the problem, although the comments suggest this possibility. The question of the study of the cases that did not respond to the questionnaire is pending. It is logical to think that among them, the degree of satisfaction is much less, but we have not been able to gain solid data in this regards and our thoughts remain in the area of supposition.

Finally, we would like to indicate that, as occurs with qualitative studies in general, the content of the responses to the open questions cannot the generalized. The objective of their analyses is found in generating hypotheses close to the complexity and subjectivity, gaining in validity that which could be lost in reliability.

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