MEDICAL TOURISM: EXPERIENCES OF INTERNATIONAL PATIENTS SEEKING INPATIENT TREATMENT FOR ANOREXIA NERVOSA AT AKESO MONTROSE MANOR

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MASTERS IN CLINICAL SOCIAL WORK

By

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ABSTRACT

This study explored the concept of medical tourism and the subjective experiences of international patients seeking inpatient eating disorder (ED) treatment at a private inpatient ED clinic in South Africa. This research aimed to shed light on what patients with Anorexia Nervosa (AN) feel are essential features of a high-quality ED service at Akeso Montrose Manor specifically, and what they found to be concerning about ED treatments received prior, especially in the United Kingdom.

The research aimed to explore the participant's reasons for seeking treatment at Akeso Montrose Manor, their expectations of treatment, their experience of treatment and their recommendations regarding the treatment of international patients. Ex-patients from the United Kingdom were chosen for this study, as a high number of admissions for treatment at Akeso Montrose Manor are from the United Kingdom. This therefore provoked an interest in exploring the reasons why these patients search for specialised out-of-country treatment.

The research was conducted using a qualitative research design. Twenty participants were selected using purposive sampling by the researcher. They were interviewed face-to-face and via Skype using a semi-structured interview schedule. The data obtained was analysed using qualitative methods. The findings of this study highlighted several difficulties experienced in the United Kingdom when seeking treatment and also highlighted the value of residential inpatient treatment centres, extended treatment for ED's and the importance of specialised ED treatment teams and units.

The results included that participants came to South Africa, due to challenges experienced in accessing treatment in the United Kingdom and treatment largely being dictated by weight and focused mostly on weight restoration. Expectations met during their stay in South Africa, included structure, safety and specialised ED treatment and staff and expectations not met whilst in treatment at Akeso Montrose Manor included limited time with the dietician and psychiatrist, and their belief that they would be fixed post-discharge. Participants made recommendations for the clinic with regards to the treatment of international clientele, which included more focus on post discharge planning and support. Further recommendations were made for improved service delivery at Akeso Montrose Manor as well as further research.

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CHAPTER 1: PROBLEM FORMULATION

1.1 INTRODUCTION

This study explored the concept of medical tourism and the subjective experiences of international patients seeking inpatient eating disorder (ED) treatment at a private inpatient ED clinic. Chapter one describes the problem formulation, the context and rationale of the study, the main research questions, the research aims and objectives for the study, clarification of important concepts, the main ethical considerations, reflexivity and concludes with an outline of the chapters in the dissertation.

1.2 STATEMENT OF THE PROBLEM

Medical Tourism refers to cross-border health care motivated by lower cost, avoidance of long wait times, or services not available in one's own country. Generally, it is the 'travel with the aim of improving one's health' (Bookman & Bookman, 2007: 23). In the traditional model for international medical tourism, patients from developing countries have travelled to first world countries for medical care and treatment (Hopkins et al., 2010). However, in today's medical tourism industry, patients are travelling in both directions, especially from developed, first world countries to developing countries such as South Africa (SA) (Reddy & Brannon, 2010: 2) The basic element underlying medical tourism is unavailability in that people need or desire something that is not on offer in their own country (Botterill, Pennings & Mainil (2013: 13). This study aims to explore why patients with Anorexia Nervosa (AN) from first world countries choose to come to SA, a developing country for treatment and what their expectations are of treatment. Beat (2019: 1) estimates that 1.25 million people in the United Kingdom (UK) have an ED, and 10 percent of this number suffer from AN. The lives of people with ED in the UK are put at risk because they have to wait up to three years for NHS (National Health System) treatment and some people wait so long they are forced to pay for help privately or get help abroad (Beat, 2017: 3).

1.3 GEOGRAPHICAL LOCATION OF THE STUDY

Akeso Clinics in Cape Town are a group of registered, dedicated Mental Healthcare facilities offering specialised private inpatient care. The researcher is currently employed as a social

worker at this unit. The unit has 22 beds and the multidisciplinary team includes a unit manager, a clinical manager, an occupational assistant therapist, two social workers, a counselling psychologist, a consulting dietitian and psychiatrist, psychiatric nurses, a biokineticist, a movement therapist, drama therapist, art therapist and an aromatherapist (Montrose Manor; 2019). All of the therapeutic staff are referred to as "therapists" in the unit and will be discussed here in the same way. Therapists run groups and family therapy as well as manage a caseload of patients. There is also a nursing manager and psychiatric nurses who work in shifts and provide support, supervision and containment of patients.

1.4 RATIONALE

Despite AN being associated with significant psychiatric and medical morbidity and mortality, many individuals with AN do not receive treatment for their eating-related problems (Evans et al., Hepworth & Paxton, 2007: 12). It is estimated that only 20-45% of those patients diagnosed with AN ever seek specialised care. A study conducted by Escobar-Koch et al., (2010: 65) on service users' views of ED services in the UK and US found patient concerns involved poor availability and accessibility of care. Participants not only described the difficulties in accessing care for those that do not have health insurance, but also stated that people with insurance face serious problems because insurance of companies' denial of payment for treatment for EDs. This research also described a lack of availability of specialist ED services in the NHS, which at times results in patients who require inpatient care being hospitalised in general psychiatric wards where specialised treatment is lacking. Barriers to care identified by UK participants included the role of general practitioners, only patients who are severely underweight, are offered care and long waiting lists of up to 2-3 years. This was also described as the reason for some service users seeking private and often costly treatment, and possibly a contributing factor for many international patients seeking medical treatment outside of their own countries.

Further research conducted on the subjective experiences of international patients that choose to come to SA for ED treatment may allow for a deeper understanding of the barriers to treatment experienced, the expectations of treatment and what can be done to improve these circumstances for ED patients in the future. This research may shed light on what patients with AN feel are essential features of a high-quality ED service at Montrose Manor (referred to as MM) specifically, and what they find concerning about ED treatments/services. This may also

serve to improve services offered at MM, in order to improve programme development. The researcher chose to focus on patients from the UK as many of the patients admitted for treatment at MM are from the UK and therefore it would be of interest to research the reasons why these patients search for specialised out-of-country treatment.

1.5 THE RESEARCH TOPIC

Medical Tourism: Experiences of International Patients Seeking Inpatient Treatment for Anorexia Nervosa.

1.6 MAIN RESEARCH QUESTIONS

1. What were the participants' reasons for seeking treatment at Montrose Manor instead of seeking treatment in their own country?
2. What were the expectations of treatment at Montrose Manor?
3. What have been the positive experiences of receiving treatment at Montrose Manor?
4. What have been the negative experiences of being at Montrose Manor?
5. What recommendations would be made to Montrose Manor regarding the treatment of international patients?

1.7 MAIN ASSUMPTIONS

Some assumptions include that UK patients come to MM for treatment because it may be a low cost option compared to private treatment in their own country, another assumption with regards to expectations of treatment; is that patients may expect that treatment is not only focused on the food, but also has a psychological component to it. The researcher assumes that patients' positive experiences of treatment may include that the facility is specialised in ED and a negative experience could be that patients are far from their family and reintegration back home may be difficult because of this. Lastly, it was assumed that participants could make recommendations for improving services.

1.8 RESEARCH OBJECTIVES

A. To explore participants' reasons for seeking treatment at Montrose Manor instead of seeking treatment in their own country.

B. To explore what participants' expectations of treatment were when they decided to come to Montrose Manor.
C. To explore in what way these expectations were met.
D. To explore in what way these expectations were not met.
E. To explore what recommendations they would make to Montrose Manor regarding the treatment of international patients.

1.9 CLARIFICATION OF CONCEPTS

Medical tourism: "a rapidly emerging manifestation of global commercialisation of healthcare." It is also referred to as 'health tourism' or 'medical travel' (Hopkins, Labonté, Runnels & Packer, 2010: 1).
Inpatient treatment: treatment in which a patient is provided with 24- hour care at a live-in facility. Both psychiatric and physical health assistance are included in this treatment (Wilson, Grilo & Vitousek, 2007).
Eating disorders (ED): For the purpose of this study, Anorexia Nervosa, Bulimia Nervosa and Binge-Eating disorder will be defined under the definition of Eating Disorder's.
Anorexia Nervosa (AN): The diagnostic criterion for AN according to the DSM-5 seen as the refusal to maintain body weight at or above a minimum normal weight for age and height. It is also characterised by an intense fear of gaining weight, denial of the seriousness of the current low body weight and the absence of at least three consecutive menstrual cycles. There is a restricting type, where the person does not regularly engage in binge-eating or purging behaviour. There is also a binge-eating/purging type where the person will engage in these behaviours (APA, 2013).
Explore: For the purpose of this study, it means to examine a subject carefully in order to find out more about it (Oxford Dictionary, 1988).
Experience: is defined as the knowledge and skill that the participants have gained through having an Eating Disorder (Oxford Dictionary, 1988).

1.10 MAIN ETHICAL CONSIDERATIONS

The following ethical issues pertain to the study:

Avoidance of harm: The fundamental ethical rule of research is that it must bring no harm to participants. Subjects can be harmed in a physical and/ or emotional manner (Strydom in De

Vos, Strydom, Fouche and Delport, 2011: 115). Participants were informed beforehand about the potential impact of the investigation. This allowed the participants the opportunity to withdraw from the study if they wished to. The researcher also screened participants beforehand for predictable risk.

Informed Consent: refers to a written agreement to participate in the study which includes all possible information on the goal of the research, the expected duration of the participant's involvement, the procedures which will be followed during the investigation, the possible advantages, disadvantages and dangers to participants may be exposed, as well as the credibility of the researcher (Strydom in De Vos et al., 2011: 117). Information about the research was communicated openly with the participants and they were asked for their permission to include them in this research project. Participants completed a consent form, see appendix 1.

Deception of respondents: refers to misleading participants, or deliberately misrepresenting facts or withholding information from participants (Strydom in De Vos et al., 2011: 118). All the necessary information about the study was clearly shared with participants prior to the onset of the study.

Violation of privacy/ anonymity/confidentiality: Every participant has the right to privacy but it is important that the researcher be reminded of the importance of safeguarding the privacy and identity of participants, and to act with the necessary sensitivity where the privacy of participants is relevant. It was important for participants to be informed of all possible limits to this principle as well as the steps that would be taken to protect it (Strydom in De Vos et al., 2011: 119). The researcher ensured that the information gathered for the purpose of the research was protected and not accessible to the public in order to protect the privacy of the participants. Babbie (2001: 472) in the Chapter by Strydom in De Vos et al., (2011: 120) distinguishes between anonymity and confidentiality, and states that confidentiality implies that only the researcher and a few members of his or her staff should be aware of the identity of participants and that this information is viewed as privileged.

Anonymity means that no one, including the researcher, should be able to identify any participant. Confidentiality was therefore upheld by protecting the information shared by participants in the interviews, this information was not shared with others except for the

researcher's supervisor and assistant. The facilities and health professional's names that were mentioned by participants in this study were also changed in order to maintain confidentiality. The information from participants were also retrieved in a private setting. In addition, all manuscripts were kept private and locked away in the researcher's clinical office at MM. Confidentiality was communicated and emphasised to the participants before interviews were conducted.

Debriefing of participants: Debriefing sessions are sessions during which participants get the opportunity, after the study has taken place, to process their experience of participating in the study. Debriefing constitutes one of the possible ways in which the researcher can assist the participants in the study and minimise harm (Strydom in De Vos et al., 2011: 122). The therapists at MM were available to assist with debriefing sessions after the research had taken place, none of the participants needed debriefing.

Actions and competence of the researcher: Researchers are ethically obliged to ensure that they are competent, honest and adequately skilled to undertake the proposed investigation (Strydom in De Vos et al, 2011: 123). The researcher's training in Social Work had enabled her with the appropriate research skills in order to undertake this study. She also received supervision throughout the research process.

Release of publications: The findings of the study must be introduced to the public in written form and the information must be formulated and conveyed clearly in order to minimise misappropriation of participants, general public and colleagues (Strydom in De Vos et al., 2011: 126). The study and its results will be available on the University of Cape Town library portal for access to public reading. Participants will also be provided with an opportunity to receive results.

1.11 REFLEXIVITY

Reflexivity is thought to be a defining feature of qualitative research as researchers should be aware of their role in the expansion of knowledge (Finlay, 2002: 211). This suggests that the researcher has an impact on data collection and analysis therefore giving rise to questions around the transparency of the research. Reflexivity can be understood in terms of the subjective self-awareness of the researcher in light of the fact that "research is co-constituted,

a joint product of the participants, researcher and their relationship" (Finlay, 2002:212). The researcher chose this specific topic because she has always had a passion for the treatment of ED. She works as a social worker in the treatment of ED and most of her clients come to SA for treatment from abroad. She has at times heard disappointing accounts of client experiences of treatment in their own countries, especially regarding the lack of accessibility of specialised ED treatment, and therefore this influenced the researcher's interest in the topic. As this was the researcher's first experience of research at this depth, it was a daunting, yet valuable process. An attitude of reflexivity before, during, and after the process, combined with supportive supervision, enabled this research to take shape in a trustworthy manner.

1.12 STRUCTURE OF THE RESEARCH REPORT

This report comprises of five chapters. Chapter one presents the problem formulation. Previous literature is presented in chapter two. The methodology is discussed in chapter three. Chapter four reports the findings and the final chapter will include the researcher's concluding remarks and recommendations.

1.13 CONCLUSION

This chapter introduced the problem formulation and context of the study, the rationale and significance of the research. The main research questions clarification of concepts, and ethical considerations were discussed, Reflexivity was also discussed. The following chapter presents the literature review.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

The literature review discusses the theoretical frameworks that underpin this research as well as policy and legislation which informs inpatient treatment of mental health in SA. The chapter will include theory of medical tourism, the reasons for seeking inpatient treatment in SA, the theory of AN, the treatment approach for AN and inpatient treatment in the UK. The challenges experienced by patients in inpatient treatment, what patients find useful in inpatient treatment, residential treatment for ED and lastly, recovery and psychosocial adjustment post discharge will be elucidated. This chapter will end with a conclusion.

2.2 THEORETICAL FRAMEWORKS

The following section will discuss the theoretical frameworks that underpin this study.

2.2.1 THE BIOPSYCHOSOCIAL APPROACH

The Biopsychosocial model developed by Dr George Engel in 1977, provides a key to understanding biological, psychological and social aspects that combine in the aetiology, presentation and treatment of AN. Despite the relevance of ED in the past years, the core of these mental disorders remains unknown (Jauregui-Lobera, 2017: 1). The biopsychosocial model creates a lens to understand and to improve the biological, psychological, and social approaches in managing these disorders, especially as ED can be at times severe and often devastating for patients and their families. Biological, psychological, and social factors are always involved in these disorders, and knowledge about the influence of these factors helps to better understand ED. This approach is used in mental healthcare for the assessment and management to ensure that all the needs of an individual are met in terms of a comprehensive intervention (Baumann, 2015: 8).

The Biopsychosocial approach has three components: **The biological component** looks at the physical aspects of the clinical assessment (Maine, Samuels & Tantillo, 2015: 134), this is particularly important in the case of AN as the range of physical morbidity is extensive. Every patient suspected of having an ED should be physically examined by a medical practitioner and other causes of weight loss should be excluded. This can become complicated in that many of the physical complaints are state dependent and are likely to resolve with the restoration of nutritional status and the stabilisation of eating behaviours (Maine, Samuels & Tantillo, 2015:

134). Attention should also be paid to the likelihood of depression and the associated problem of suicidality. If other comorbid psychiatric conditions are diagnosed, treatments for such conditions should be prescribed (Frank, 2016: 12). Ultimately, the dominant biological intervention is that of nutritional rehabilitation. The restoration of appropriate eating and weight restoration in AN and the stabilisation of eating patterns should be a central focus of treatment because the restoration of nutritional status is critical, given the impact of nutrition on cognition and the threat to life posed by these disorders (Frank, 2016: 17). The choice of treatment setting either as an inpatient or as an outpatient will be determined by the severity of the clinical picture as well as factors such as past history, level of functioning and support systems.

The psychological component should explain how the patient developed certain predisposing psychological vulnerabilities, why these vulnerabilities make current events in the patient's life particularly stressful, the patient's thoughts and feelings as a result of these stressors, and how the patient attempts to cope with these stressors (Campbell & Rohrbaugh, 2013: 23). Limited insight into the illness and resistance of patients to receive help are obstacles to effective intervention and overcoming these aspects of the presentation forms the major challenge of treatment. The therapist needs to conceptualise these illnesses within an integrated biopsychosocial framework. Attention needs to be paid to the family and other carers, both as a means of support and rehabilitation and because they themselves may be overwhelmed by feelings of hopelessness and helplessness. A therapeutic alliance involving trust and respect is crucial to a positive outcome (Campbell & Rohrbaugh, 2013: 23).

The social component involves the patient's social life because there is abundant data suggesting that patients who are subjected to acute and chronic social stressors are more likely to develop, or have more frequent exacerbations of their psychiatric illness. Categories in this area that may cause stress, include; family, friends/significant others, social environment, education, work, housing, income, access to healthcare services and legal problems/crime (Campbell & Rohrbaugh, 2013: 24). Attention may also need to be paid to the prevailing value system, in particular the belief that being thin is a significant determinant of social acceptance (Frank, 2016: 16). This theory is an appropriate framework for this study as it explains a holistic approach to treatment for AN and how it is important treat both the symptoms and the psychological components of the illness. It is also important that culture is looked at, especially when treating clients from different countries and the inclusion of family members in the

treatment process, as they will be responsible for the client when they return to their own country.

2.2.2. THE HEALTH BELIEF MODEL

The Health Belief Model (HBM) was developed in the 1950's by social psychologists in the US Public Health Service to explain the widespread failure of people to participate in programmes to prevent and detect diseases (Champion & Skinner, 2008:46). The model is based on the theory that a person's willingness to change their health behaviors is primarily due to the six following factors:

The first factor is **Perceived Susceptibility**, which means that people will not change their health behaviours unless they believe that they are at risk (Champion & skinner, 2008: 47). Many people with ED are in denial about their illness and once they come to terms with having an ED, they are more likely to seek treatment for it (Akey, Rintamaki & Kane, 2013: 247). **Perceived Severity** means that the probability that a person will change their health behaviours to avoid a consequence depends on how serious he or she considers the consequence to be (Champion & skinner, 2008: 47). Once participants acknowledged the severity of their illness, they were more likely to seek treatment. **Perceived Benefits**, it is difficult to convince people to change a behaviour if there is not something in it for them (Champion & skinner, 2008: 48). The extent to which people feel a specific course of action will effectively manage a problem or be beneficial to their overall well-being greatly predicts the likelihood of engaging in treatment seeking. When treatment is perceived to be ineffective or inappropriate it will unlikely be pursued (Akey, Rintamaki & Kane, 2013: 247).

Perceived Barriers are one of the major reasons people don't change their health behaviours as they think that doing so is going to be difficult (Champion & skinner, 2008: 50). In the context of ED, barriers translate to all things that restrain people from accessing or utilising support to better manage their illness.

Cues to Action are external events that prompt a desire to make a health change (Champion & skinner, 2008: 50). These may include informing a patient with an ED about the possible treatment options available to them. The final factor is **Self-Efficacy** which looks at a person's belief in his/her ability to make a health-related change (Champion & Skinner, 2008: 48). There are two key issues regarding self-efficacy, which involve the ability to articulate the need for

support and social withdrawal. The first of the two involved what individuals described as an inability to articulate their need for help. They may have known they needed to ask for help, but were rendered either unsure how or emotionally unable to do so. Lastly, there were concerns about stigma, shame or fear of hurting others, which prevented people from seeking help (Akey, Rintamaki & Kane, 2013: 252).

The Health Belief Model provides a lens to help understand the barriers to treatment and what makes treatment accessible to patients. This approach could explain why clients with AN would seek treatment and explain their expectations for treatment as well as their perceived barriers to seeking treatment. Understanding what prevents people from seeking or accessing help can assist in improving ED outcomes. The following section discusses the policy and legislation relevant to this study.

2.3 POLICY AND LEGISLATION

The development and adoption of the South African Mental Health Care Act 17 of 2002 was one of the first and notable advancements in South African legislation as it emphasises the human rights of persons with mental illness as well as access to services for persons with mental illness. The *Mental Health Care Act 17 of 2002* has created a platform for inpatient facilities such as MM to treat patients with ED and has also informed staff on what is expected of them and how patients should be treated. This Act states that persons that are mentally ill should receive care, treatment and rehabilitation. This Act recognises that health is a state of physical, mental and social well-being and that mental health services should be provided as part of primary, secondary and tertiary health services. It also states that if a mental health care user voluntarily applies for care at a health establishment, the establishment should provide appropriate care to her or refer the health care user to an appropriate health establishment (The Presidency, 2002). An understanding of this Act is thus crucial in understanding the work done by the research site.

A further important step forward was taken by the National Health Council in July 2013 when the Mental Health Policy Framework (MHPF) for SA and the Strategic Plan 2013-2020 was adopted. Similarly, the *National Mental Health Policy Framework and Strategic Plan (2013-2020)* was implemented in order to promote evidence-based, affordable and effective treatment and rehabilitation interventions. It also enshrines the human rights of people with mental

disorders, providing specific mechanisms for the protection and promotion of those rights, and broadens the range of practitioners and other stakeholders, including mental health care users, who can contribute to improving the mental health status of South Africans (The Presidency, 2014). The National Mental Health Policy Framework and Strategic Plan (2013-2020) provides a scope for specialised psychiatric hospitals, stating that further care, treatment and rehabilitation of mental health care users will be provided in specialised psychiatric hospitals. These two legislative documents have contributed directly to the field of mental health as the focus for its development, but also as a way in which to guide treatment centres/ professionals on the appropriate care to be delivered to persons with mental illness.

2.4 MEDICAL TOURISM

Medical tourism is a relatively new industry and is suitable for elective, rather than emergency procedures. Patients often choose to come to developing countries for treatment, as it is more affordable and there are often shorter waiting periods. It also provides privacy and anonymity for the patient because professionals and other patients are unlikely to know who they are (Lee, Han & Lockyer, 2012: 317).

There is limited research on medical tourism relating to addiction or mental health. Most of the research conducted is on medical and surgical procedures. Most medical tourists to SA come from the UK, making up 122,000 patients in six years between 2003 and 2008. Official South African data on tourist entries is of limited use as the Immigration Act of 2002 provides for the issue of "medical permits" but only to people who intend to stay in SA for periods in excess of three months. Since the majority of medical tourists enter for shorter periods, any data on the issue of medical permits would only capture a small proportion of the market (Crush, Chikanda & Maswikwa, 2012:13). The purpose of entry is also unhelpful as there is no medical option on visa applications or entry forms and most people give "holiday" as their reason for coming to SA, which generally entitles them to a 90- day stay (Crush, Chikanda & Maswikwa, 2012: 14). The subsequent section will discuss the reasons for seeking inpatient treatment in SA.

2.5 REASONS FOR SEEKING INPATIENT TREATMENT: FROM THE UK TO SA

The current global trend toward a more integrated world is challenging our understanding of public health. National borders are becoming more permeable with regards to public health as in recent years, more and more patients have decided to seek medical treatment in countries

where they are not resident (Hart, Granillo & Jorn, 2011: 68). The reasons for this increasing international mobility of patients are various.

A European study conducted by Richard (2005: 345) on the care provision for patients with ED, found that effective care, at affordable costs, for patients with ED is a challenge in all European countries (and beyond). These disorders, especially if they become chronic, are associated with elevated risk for physical illness, psychiatric disorders, suicide and mortality. One of the reasons that patients may seek treatment in other countries is because treatment is costly, and not always successful in their own country. This is especially true for AN, which generates the highest average cost by diagnosis and consistently yields longer inpatient stays than any other psychiatric condition (Wilson, Vitousek, & Loeb, 2000: 306).

A British study, found that participants viewed referral to services and admission for treatment largely dictated by the patient's weight, therefore setting a standard that appeared to promote weight loss as a means of accessing support (Mitrofan et al, 2019: 23). There was often a delay in intervention as the patient was not "sick enough" for treatment and participants in this study noted that this often hindered their recovery process as specialist services were brought in too late. This is echoed by other authors who have also found that in the UK there are concerns around poor availability and accessibility to care for ED concerns (Escobar-Koch et al., 2010: 557; Wilson, Vitousek, & Loeb, 2000: 306) and identified the importance of easily and rapidly accessible services, available to all those in need (Escobar-Koch et al, 2010: 557).

2.6 ANOREXIA NERVOSA

The core characteristics of AN include: relentless restriction of calorie intake in the successful pursuit of a substantially reduced body weight, accompanied by a minimisation of the resulting psychological and physical impairment and by a distorted assessment of body shape and weight. The current DSM-5 criteria require that the individual's weight to be below the body mass index (BMI) of 18.5. Medical complications such as amenorrhea are associated with AN, and their presence supports the diagnosis (American Psychiatric Association, 2013).

There are two subtypes of AN. The restricting type describes individuals who have not engaged in binge eating or purging behaviours in the last three months and whose low weight results solely from restricted food intake and/or exercise. The binge eating-purging type of AN,

describes patients who engage in recurrent episodes of binge eating or purging behaviour (e.g., self-induced vomiting, misuse of laxatives or diuretics) (APA, 2013; Zipfel et al, 2015).

Individuals with AN often describe thinking about food all the time, including obsessional thoughts about food calories, ingredients, and preparation. They often impose rigid rules for themselves regarding food intake, including the types and quantity of foods consumed, rituals around eating behaviour and timing and rate of consumption (Zipfel et al, 2015: 1099). There may be periods of fasting during the day and slowed rates of chewing or sipping of allowed foods (Micali, Hagberg, Peterson & Treasure, 2013: 4).

AN is a complex behavioural disorder and its etiology is multifactorial, including biological and environmental elements. There is evidence to support biological and genetic contributions to the development of AN. Family studies have demonstrated that AN aggregates in families, and twin studies have identified that genetic factors contribute greatly to its formation. AN occurs in environments in which there is both adequate food supply and cultural elements that value thinness (Zipfel et al, 2015: 1099).

AN is associated with high rates of medical and psychiatric morbidity and a mortality rate as high as that associated with any psychiatric illness (APA, 2013). Despite its long history, AN remains a challenge to treat because its core behaviours often become entrenched and are difficult to reverse, especially for adult patients who have been ill for longer periods of time (Brownell and Walsh, 2017: 176).

2.6.1 The influence of Anorexia Nervosa on the individual, the family and society

In the acute phase of the illness, patients seem to get some satisfaction of having AN as they often feel more in control of their lives. However, as the illness progresses, the influence of the illness becomes apparent in terms of loneliness, despair and intense mood swings and the rigid control which was once a positive experience tends to "kill life" as other people know it, and indeed as the patient herself has known it (Treasure, Schmidt & Van Furth, 2003: 205).

The social influence is often seen as isolation, as the person with AN begins to experience chronic malnutrition, a limited range of interests and few free choices due to their illness (Treasure, Schmidt & Van Furth, 2003: 206). AN can lead to developmental delay, emotionally as well as socially (Turton, Cardi, Treasure & Hirsh, 2018: 707). Many individuals do not

obtain full independence, but stay with relatives in a dependent relationship, with a limited range of interests, neither completing an education nor holding a job (Cardi et al, 2018: 11).

Family daily routines are usually disrupted, with meal times becoming a battle that causes distress for the entire family and often the family eating pattern is altered in an attempt to help the patient eat. In addition to the isolation and secretiveness that often surround ED, patients may engage in antisocial behaviours such as lying, stealing, or substance misuse. Therefore, causing the patient to become the focus of attention in the family, resulting in the family spending less time with friends and less time involved in social activities (Turton, Cardi, Treasure & Hirsh, 2018: 707).

Families may become isolated and believe that what they are going through is a unique and shameful experience (Cardi, et al., 2018: 13) and the role of family in the treatment of ED has been a matter of clinical interest for some time. Parents are appreciated as an important resource in the treatment of AN, especially as they are often part of the support system that the patient goes back to after treatment (Rienecke, Accurso, Lock & Le Grange, 2016: 2). In inpatient settings it is often the staff who take primary responsibility for the patients' recovery, not giving the parents much opportunity to develop and strengthen their own skills and resources in relation to their child, since they are usually for the most part isolated from the therapeutic process (Scholz et al, 2005: 138). Scholz et al., (2005: 139) note that there is a place for inpatient treatment for AN, but family therapy should continue during or post discharge to adequately equip families caring for a relative with AN.

2.7 THE GLOBAL TREATMENT APPROACH FOR ANOREXIA NERVOSA

Interventions for people with AN include a number of individual, group and family therapy approaches, and a range of medication and nutritional supplements. Treatment settings include specialist inpatient units, general psychiatric units, outpatient services and day hospitals (Solmi, Hotopf, Hatch & Treasure, 2016: 370). The relative merits of these settings and treatments are so far unclear, and relatively little is known about the efficacy of interventions for AN at any age.

Available interventions for AN can be separated into medical management and Psychotherapy, although the two are usually combined to maximise treatment success. Medical management focuses on physical aspects of the disorder, such as weight restoration, and monitoring physical

state, and may be conducted in inpatient or outpatient settings, depending on the need of the patient and the severity of their illness (Solmi, Hotopf, Hatch & Treasure, 2016: 370). According to The National Eating Disorders Collaboration (NEDC) (2014: 7) all patients with ED must be treated for the physical, psychological, nutritional and functional aspects of their ED. These four components of treatment must work together, with progress in one domain enabling and supporting progress in each of the other domains. Therefore, the capacity to work collaboratively in assessment, treatment planning and treatment review is essential for safe treatment.

The NEDC (2014:3) stress the necessity for access to a suite of services, regardless of geographical location, age, or economic circumstances. The NEDC (2014: 4) have implemented national standards for ED which state that services provided to ED patients should be done by a multidisciplinary team and a range of treatment and support options is required to enable the provision of individually tailored interventions that are congruent with the person's circumstances and experience. A stepped model of service should be implemented with varying levels of intensity of service in order to meet the differing needs of individuals at each stage of illness, delivered as an integrated sequence of care to reduce the risk of relapse and recurrence.

The aims of ED treatment include: the reduction in ED behaviours, restoration of nutritional health, treatment of physical complications, enabling family support through the provision of family education and therapy, helping patients to identify and change dysfunctional thinking, attitudes, beliefs and emotions and development of new coping mechanisms, reduction in extreme weight and shape concerns, treatment of associated psychiatric conditions and lastly, prevention of relapse (NEDC: 18). The following section will discuss the treatment approach for AN in the UK.

2.8 TREATMENT APPROACH FOR ANOREXIA NERVOSA IN THE UNITED KINGDOM

The National Institute for Clinical Excellence (NICE, 2017) has established treatment guidelines for the treatment of AN. In the UK, the current trend is towards a "stepped approach" which means that the primary focus is on outpatient, day-patient and inpatient care in sequence (Solmi, Hotopf, Hatch & Treasure, 2016: 370). This model is significantly compromised by a lack of specialist units and the variation in services nationally, which often leads to admissions

to distant units which are delayed and expensive and are not coordinated with a local treatment programme extending over a longer period. The quality of service provision is also understood to vary significantly (NICE, 2017, Richards, 2003: 364).

Outpatient care in the UK is therefore the primary mode of treatment, and inpatient care is considered when there is psychological or medical threat or if there has not been sufficient progress in terms of outpatient care (NICE; 2017). The decision to hospitalise patients with AN should be based on psychiatric and behavioural grounds (APA, 2000). AN patients with a high medical risk and lack of capacity require intensive care such as that offered by a specialised inpatient unit in a hospital setting, although it could be argued that day patient care can also give the requisite level of intensity of care (Treasure, Schmidt & Van Furth, 2003: 225).

In the UK patients should gain 1-1.5 kg per week (Vandereycken, 2003: 365). This is achieved through various means, including supported meals, nasogastric tube feeding, total parenteral nutrition and surgical interventions (Birkbeck, 2018: 31). Patients are weighed twice a week and their weight is tracked on a weight chart to see it's trend over time (Wales et al, 2016: 9)., Inpatient treatment in the UK now will be discussed.

2.9 INPATIENT TREATMENT IN THE UNITED KINGDOM

The focus on outpatient treatment, as mentioned in the previous section, is because inpatient admissions can be lengthy (Palmer et al., 2000: 112, Kaye et al., 2015: 8) and costly (Striegel-Moore, Leslie, Petrill, Garvin & Rosenheck, 2000: 132). The frequent failure of generating an outcome whereby patients sustain the weight gained in treatment has been understood to indicate that these inpatient treatments fail to adequately address the psychological aspects of the condition (Malson & Ryan, 2008; Colton & Pistrang, 2004).

The response to treatment is problematic as less than half of individuals fully recover and approximately 20% experience chronic symptoms. Those in recovery tend to present with poor weight management after treatment, while there is an increased risk for relapse and readmission amongst those treated as inpatients (Vandereycken, 2003: 125). Dropout rates are high in this population, suggesting dissatisfaction with treatment and/ or services (Mahon, 2000: 203).

The question to be asked is- what constitutes a high-quality service in an inpatient unit? Concerns have arisen about the harmful effect of removing patients from their usual environment and the risks of institutionalisation. It has been suggested that admission may actually be harmful, perhaps because it disrupts long term treatment, however, this may not be the case if inpatient treatment forms part of a comprehensive and integrated treatment programme, delivered by a consistent clinical team (Treasure, Schmidt & Van Furth, 2003: 364).

Admission to inpatient units is not always perceived negatively by the patient. Particularly in settings where attention is given to psychological aspects of the disorder, the patient may well see these as supportive. Sometimes the understanding and care of professional staff exceeds that experienced outside the hospital setting, while the peer group and educational settings within the ED unit is perceived as a safer environment, divorced from the stressors of life in the outside world (Gowers, Shore, Hossain & Elvins, 2000: 140).

2.10 INPATIENT TREATMENT FOR EATING DISORDERS

Several studies have reported short-term improvements from inpatient treatment for individuals with AN (Lowe et al., 2003; Colton & Pistrang, 2004; Keel & Brown, 2010). Inpatient and day treatment units no longer are home to long-term or chronic cases, but more often serve to stabilise acute patients before a more long-term transition into less restrictive care such as outpatient or individual therapy.

Clinical experience and research strongly suggest that patients with AN should be treated in specialist units whenever possible and that those treated on general psychiatric or medical wards tend to have poorer outcomes. There are a number of reasons for this; firstly, effective treatment depends on an integrated team which shares a common philosophy and understanding of the disorder and secondly, AN is a complex disorder and is difficult for non-specialist teams to be able to offer the range of skills needed for effective treatment. Successful inpatient treatment requires contributions from a number of professional disciplines, who need to work closely together as an integrated team treatment (Richards, 2003: 365).

In response to the changing dynamics of inpatient treatment and the less intensive alternative option of outpatient or individual therapy, many patients and providers have turned to non-hospital based, residential programs for longer-term, intensive treatment (Frisch, Herzog &

Franko, 2006: 434). However, there are very few published studies of the results of treatment of patients who have been treated in residential treatment programs (RTC's). Bean et al. (2008: 34) reported positive short-term outcomes in 107 patients (72 females and 35 males) with AN treated at a residential program. RTC's offer the advantage of a long-term, structured, and intensive treatment setting outside of the sterile environment of a hospital setting, generally at a lower cost (Brewerton & Costin, 2011: 117).

RTCs are appropriate for patients who are medically stable, who manifest poor-to-fair motivation but can generally cooperate with a structured treatment, have failed outpatient interventions, and need supervision at all meals or they will restrict eating, binge and/or purge. It is also a good option for patients with severe family conflict or dysfunction, or the absence of family support (APA, 2006). The following section will discuss RTC programmes and what these consist of.

2.11 RESIDENTIAL TREATMENT PROGRAMMES

2.11.1 Multidisciplinary Team

In these units, the therapeutic team plays a major role in the assessment and treatment of the primary illness. In RTC's a consultant psychiatrist usually provides clinical leadership. The psychiatrist's specific contributions include the diagnosis of ED and secondary psychiatric illnesses, the management of medical complications and the prescription of medication. Psychotherapy is essential to the treatment of patients with AN and may be provided by professionals from a variety of disciplines. In some units, a family therapist is included in the team (Redenbach & Lawler, 2003: 148).

Social workers are essential members of a multidisciplinary team. The social worker's role in RTCs would include direct clinical contact with patients and their families. Tasks may include helping clients' problem solve and cope with life stressors; linking individuals with resources, services, and opportunities (Gehlert & Browne, 2019: 26). They also conduct an evaluation of the strengths and needs of individuals and members of their social support network as part of a social work assessment to identify assets and potential barriers to care (Gehlert & Browne, 2019: 26).

Nursing patients with AN requires a high level of skill and is most likely to be effective when carried out by a nursing team with experience and training in this area. It is important that nursing staff have an understanding of the complex and ambivalent feelings which patients have about gaining weight and the way in which these reflect fears of psychological change (Snell, Crowe & Jordan, 2010: 352). Nurses need to strike a difficult balance between firmness and sensitivity. The therapeutic alliance is one of the crucial tasks in nursing ED patients. Patients are likely to respond badly to staff whom they perceive as rigid and authoritarian, but at the same time are unlikely to feel safe unless those caring for them are able to set clear and appropriate boundaries (Wolfe, Dunne & Kells, 2016: 213).

Many RTCs also use recovered staff in the treatment team to openly serve as role models and patients have consistently reported that speaking to someone who is recovered is a crucial factor in their recovery (Redenbach & Lawler, 2003: 148).

2.11.2 Dietary Guidance

The dietician also has a central role in supervising the patient's nutritional rehabilitation. Many also play a part in nutritional education. Meal times in inpatient units should be taken as a group as this encourages socialisation and can provide additional support, as well as making supervision easier. All meals should be supervised by a nurse. Nursing staff can also model normal eating by sharing the meal with patients (Wolfe, Dunne & Kells, 2016: 215). In many units, patients are also supervised for a defined period after meals in order to prevent them concealing food or purging. At a later stage in treatment, they may eat their meals without supervision (Treasure, Schmidt & Van Furth, 2003: 243). Many treatment centres practice exposure therapy, where they propose that patients are exposed to their fear foods and/or other ED related situations, in order to reduce avoidance and facilitate habituation to anxiety surrounding the anticipation of these feared events. The exposure therapy therefore aims to increase flexibility in food choice and caloric consumption, and hence to improve the ability to maintain weight and prevent relapse (Koskina, Campbell & Schmidt: 2013: 198).

Brewerton, and Costin (2011: 121) note that a homely RTC often allows patients to have hands-on experience with food that simulates real life. Patients often get the opportunity during their treatment process to utilise the kitchen and make their own food. A graduated level system allows for patients to gradually get increased responsibilities for taking care of their own nourishment. With help from the staff, eventually patients can learn to portion, shop for,

prepare and cook their own snacks and then meals. These experiences are often not available in larger programs using institutionalised kitchens and dining rooms.

2.11.3 A Range of Therapeutic Interventions

A study conducted by Frisch, Herzog and Franko in the USA (2006: 437) noted that, RTC therapeutic teams interviewed, reported using an eclectic, integrative approach to the treatment of AN. However, therapeutic orientation techniques varied widely among treatment programs, such as the use of Cognitive Behavioural Therapy, Dialectical Behavioural Therapy and Psychotherapy. Brewerton, and Costin (2011: 120) found that each week, every patient received individual psychotherapy with their assigned therapist, sessions with the dietician, a session with the psychiatrist and medical physician, group sessions with the exercise trainer and several forms of group therapy.

RTC's often also promote the 12-step fellowship for ED (Weinstein, Zlatkes, Gingis & Lejoyeux, 2015: 191) 12-step fellowship meetings and support groups have shown to be useful tools in continuing recovery and accessing support post discharge.

2.11.4 Preparation for Discharge

Discharge from an inpatient unit requires an enormous adjustment in terms of resumption of responsibilities and obligations relating to eating and otherwise, while it can also be experienced as involving a significant loss of support. Not infrequently, life outside of an inpatient setting is seen as tough and when this results there can often be a return of anorexic behaviours, and the possibility of return to inpatient treatment is perceived by the patient, not negatively, but as an opportunity for further escape (Gowers, et al., 2000: 140).

Preparation for discharge and subsequent follow-up treatment is therefore essential if improvement is to be maintained and admission is to serve a purpose beyond weight gain alone. Before discharge patients should be helped to optimise their skills in managing their own illness; this may be addressed particularly during the maintenance phase of treatment (Dror, 2015: 275). Concurrently, it is important to educate carers, such as the patient's family, in providing the appropriate level of support.

Once discharged, the patient should be offered appropriate help in managing their own eating, while continuing to work on underlying psychological issues (Dror, 2015: 275). Social support

can improve an individual's ability to cope with stress. (Weinstein, Zlatkes, Gingis & Lejoyeux, 2015: 191). Support groups enable participants to help each other cope with shared problems. They offer a supplemental form of interpersonal assistance to its members, and the support group can be used as an adjunct to professional treatment. The benefits of support groups include coping with disease, obtaining specialist knowledge, and improving personal relationships (Mccormack, 2010: 12). ED day units and psychotherapeutic supported accommodation can offer a useful 'half-way house' between inpatient care or residential care and independent living (Treasure, Claudino & Zucker, 2009: 376).

The above section highlighted in-patient residential treatment and the following section will explore the challenges experienced by patients in inpatient settings.

2.12 CHALLENGES EXPERIENCED BY PATIENTS IN INPATIENT SETTINGS

Research has demonstrated that individuals with ED often fail to acknowledge the severity of their illness and have limited knowledge about the disorder and available resources (Akey, Rintamaki & Kane, 2013; Leavey, Vallianatou, Johnson-Sabine, Rae & Gunputh, 2011; Mond, Hay, Paxton, Rogers, Darby, Nillson, Quirk & Owen, 2010). Not only individuals with ED, but also often the public perceive ED as a lifestyle choice rather than a severe mental illness requiring professional help (Ebneter & Latner, 2013: 283). These beliefs, in combination with a reluctance to disclose information regarding their eating behaviour may result in delayed access to treatment. Research has shown that when those who do seek professional help make contact with treatment services, it is most often after a long delay (a median of 15 years for anorexia) (Browne, Wells & McGee, 2006: 362, Hart et al., 2011:729).

Tierney (2008: 367) noted that service users can play a significant role in shaping services and making a valuable contribution through their feedback. The lack of knowledge and expertise of general practitioners prevented early diagnosis and led to delays in the access of specialised treatment (Tierney, 2008: 368). Patients preferred non-healthcare service settings (such as RTC's), with hospital and psychiatric settings contributing to feelings of stigma and lowered self-esteem (Vanderecycken, 2011: 289). Patients also reported a lack of appropriate services, with initial referrals made to generic services with non-specialist clinical staff. At non-specialist services, patients mentioned that they had little trouble deceiving nurses in a general ward who did not understand their condition, in contrast to staff at a more specialised unit who

were prepared for potential means that patients were likely to use to falsify their weight or to hide food (Tierney, 2008: 371).

Patients have expressed that being together (with other ED patients) in an inpatient unit that specialises in AN may be beneficial in the sense of promoting support, but that it may also entail a series of negative effects that can increase stress e.g., patients may compete for thinness. Being together with other patients can also mean learning new bad habits concerning eating behavior, which may make patients feel even worse (Vandereycken, 2011: 291; Colton & Pistrang, 2010: 230)

It was reported that when being admitted into general wards, patients with AN were often overlooked by staff who, they felt, regarded anorexia as self-inflicted and treated them as though they were wasting valuable healthcare resources. Patients' perceptions of being labelled by professionals as "anorexics" rather than as individuals led to feelings of frustration, reduced trust in professionals and treatment engagement difficulties (Tierney, 2008: 370; Gremillion, 2002: 13).

The neglect of psychological issues in treatment led to treatment engagement difficulties and patients feeling unskilled and at risk of relapse post-discharge (Tierney, 2008: 370). The next section will explore what patients find useful in inpatient settings.

2.13 BENEFITS OF IN-PATIENT SETTINGS

Studies examining patients' perspectives provide valuable clinical insight regarding the qualities of treatment considered most important to patients. These include the desire to be treated as an individual rather than defined by their AN diagnosis, and request a focus on psychological treatment not just weight restoration (Birbeck, 2018: 37). Bell (2018: 186) demonstrated that support and empathic relationships are critical to recovery and treatment. Several studies have reported the importance and value of specific non-therapeutic skills, including being non-judgmental, having good communication skills, being available, engaging well with patients and the development of a supportive working relationship (Colton & Pistrang, 2004: 2; Tierney, 2008: 12; Nishizono-Maher et al., 2011: 414). Specifically, Van Ommen et al (2009: 2803) reported professional attitudes such as reliability, respect for individuals, physical and emotional availability, and firmness as essential for normalising

eating patterns and improving body weight. Patients reported that when they were able to develop a trusting therapeutic relationship, they were more likely to talk about difficult topics and the pursuit of goals post-discharge (Ommen et al, 2009: 8).

Experiences outside treatment significantly impact on recovery in particular the presence of supportive relationships. This suggests that education and support to families and carers should be provided in all specialist services (which families themselves value). It also points to a possible role for ecological/biopsychosocial treatment approaches (Bell, 2008: 187; Nishizono-Maher et al., 2011: 414). Psychological interventions that addressed underlying psychological issues in addition to physical symptoms were consistently reported in this study as the most helpful.

Individual therapy and specific treatment components including psychoeducation, identifying dysfunctional thoughts, behavioural strategies such as diary keeping were valued by patients (Whitney, Easter & Tchanturia, 2008: 13; Colton & Pistrang, 2010: 312). Drug treatments were seen as useful for addressing comorbid mood difficulties but not for the improvement of core ED psychopathology (Williams, Goodie & Motsinger, 2008: 3). Group therapy and being in an inpatient setting with other ED patients were perceived as helpful due to additional peer support, learning positive coping skills and reducing feelings of isolation (Colton & Pistrang, 2004: 2; Offord et al., 2006: 12; Tierney, 2008: 5).

Patients also expressed finding it beneficial to have some control over the process and pace of treatment. This again confirmed the importance of training and supervision for staff working with ED in order to develop and maintain a collaborative working relationship with patients (Bell, 2008: 188). Similar findings were reported by Colton and Pistrang (2010: 313) who posit that the availability and willingness of staff to listen to patients as well as patients actively being part of their treatment process was important. Van Ommen et al (2009: 14) highlighted that the following key practices contributed to patients' feelings of empowerment: the provision of clear information and treatment goals, meal preparation work, plotting personal weight charts and being given more freedom. It was also noted that patients felt the opportunity for collaboration in their treatment plan enhanced the therapeutic environment and increased feelings of control.

With regards to transition from inpatient care to home, patients reported feeling a significant difference between hospital treatment structure and life post-discharge. Planned transitions and continued support from specialist services following discharge were seen as essential to prevent relapse (Offord, Turner & Cooper, 2006: 3). The next section will discuss recovery and psychosocial adjustment post discharge.

2.14 RECOVERY AND PSYCHOSOCIAL ADJUSTMENT POST DISCHARGE

In the field of mental health generally, and specifically related to ED, 'recovery' seems to be a difficult concept to define, measure and understand (Bonney & Stickley, 2008). However, the literature in this area can be understood within the context of two predominant models; the medical model and the recovery model.

Within the medical model, recovery is understood as the absence of symptoms outlined by the DSM or ICD diagnostic criteria, thereby focusing on weight gain and behavioural change as the key indicators of recovery (Roberts & Wolfson, 2004: 43). In contrast, the recovery model views recovery as a more subjective process involving a person's journey towards an improved quality of life.

NICE (2017) has attempted to incorporate both of these models by recognising the importance of focusing on both the physical and the psychological components of ED. However, the medical model is still the dominant approach to recovery practice, mainly due to difficulties in assessing the subjective aspects of psychological and environmental change that are emphasised in the recovery model (Couturier & Lock, 2006).

The World Health Organisation (WHO) states that 'well-being' is where the individual realises their own abilities, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO, 2005: 12). De Vos et al.,(2017: 7) states that there are six criteria to establishing ED recovery and these include: positive relationships with others, self-acceptance, autonomy, personal growth, improved ED behaviour/cognitions and self-adaptability/resilience.

While it is well understood that the course of recovery from an ED is slow, what remains unclear is an understanding of what factors support a favourable outcome. Having the opportunity to identify and express feelings and to receive empathic, non judgemental

responses was said to promote movement toward health. Connecting with individuals who had recovered was reported to be particularly helpful, as this contact generated feelings of acceptance and provided hope for the future. Participants also noted that applying the nutritional knowledge and psychological skills learned in programmes, was identified as helpful in maintaining recovery behaviours (Cockell, Zaitsoff and Geller, 2004: 2).

Factors that hinder the process of recovery often include the loss of structure that is inherent in inpatient treatment centres, which participants struggled to implement in real life situations. Participants also reported missing the support that they received in inpatient, and the transition from 24-hour support, to support once or twice a week was a big transition (Cockell, Zaitsoff and Geller ,2004: 2). Many individuals also reported that daily challenges, which they often were protected from in treatment, triggered slips and relapse patterns (Cockell, Zaitsoff and Geller (2004: 3). It is therefore important that these observations provide guidance to healthcare professionals providing discharge support and follow-up care for patients who have completed intensive residential ED treatment.

2.15 CONCLUSION

Medical Tourism is a fairly new industry and there is limited knowledge around the act of traveling abroad for mental illness or addiction, although patients from the UK are seeking ED treatment in SA. The literature review explored medical tourism, the theoretical frameworks, policy and legislation and literature pertaining to this study. The third chapter presents the methodology of the study.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter presents the methodology of the research including the research design, population and sampling, sampling techniques, sampling characteristics, sampling procedure, the data collection method, data collection instrument, data analysis, data verification and lastly, the limitations of the study.

3.2 RESEARCH DESIGN

Qualitative research aims to understand and capture the meaning, perceptions and experiences people attach to certain social phenomena (Fouche & Schurink in De Vos et al, 2011). This meaning is discovered through the use of language. In making sense of the social world qualitative researchers are committed to the naturalistic perspective that there is no single truth, but rather a socially and personally constructed reality that can only be determined by the active involvement of the subjects in the research; It is an approach that generates non-numerical data and has added a new dimension to research in evaluating human behaviour (Fouche & Schurink in De Vos et al, 2011). A qualitative approach was used as it takes a stance that is person-centered and holistic. This approach also allowed the researcher to develop an understanding of the participants and their lives (Holloway & Galvin, 2016: 200). It allowed the researcher to gather information that has depth and knowledge that is rich in order to present a picture of the participants' reality and social context. This design is also well suited to research where there is not a large body of information on a subject, which is the case regarding this research topic as indicated by Holloway and Galvin, (2016: 201).

A phenomenological research design was used which aims to understand and interpret the meaning that research participants give to their everyday lives. Creswell (1998) cited in Delport and Fouche in De Vos et al., (2011:270) regards a phenomenological study as a study that describes the meaning of experiences of a phenomenon, topic, or concept for various individuals. Through this approach, the aim is to understand and enter the participants "life world" by analysing the conversations and interactions had with the participants in the study (Delport & Fouche in De Vos et al., 2011: 270). Phenomenological research requires a researcher to focus on people's experiences of a phenomenon to obtain comprehensive details

that provide a basis for reflective structural analysis that ultimately reveals the essence of the experience (Bliss, 2016: 14). This research design was relevant for this study, as participants' were seen as the expert of their own experience and were able to lead the researcher into understanding their own experience of treatment.

3.3 SAMPLING

A sample is a subset of the population in which the researcher is interested (Greeff in De Vos et al., 2011). The population for this study is defined as previous female clientele that have completed treatment at MM for the diagnosis of AN and that are originally from the UK. With regards to the sampling technique, purposive sampling was used for this study as particular cases were chosen because they illustrate some feature that is of interest for this particular study. Greeff in De Vos et al (2011: 392) refers to this kind of sampling as typical case sampling in qualitative research where typical cases are sought and selected for the study. This type of sample is based entirely on the judgment of the researcher, in that the sample is composed of elements that contain the most characteristic, representative or typical attributes of the population that serve the purpose of the study best. The researcher therefore selected participants based on a specific purpose.

The researcher is an employee of MM and therefore did not interview any of her previous clients as this could have introduced bias to the study in the form of respondents feeling uncomfortable about giving negative feedback about their experience at the clinic. The characteristics of this sample included females from the age of 18 who have been formally diagnosed with AN according to the DSM-V criteria and participants had to be no more than five years post discharge from MM in order for participants to provide rich and uninterrupted descriptions of their experiences. The researcher was mindful of the ethical issues in the research particularly in relation to being a Social Worker employed by the company and also taking on the role as a researcher at the same facility. This was discussed in detail during supervision and the researcher was mindful of her ethical responsibility toward the participants throughout the research process.
Hence with regards to the sampling procedure, in order to gain access to the intended participants, the researcher obtained permission from the hospital manager (See Appendix 3) as well as ethical clearance from the University of Cape Town (see Appendix 4). The researcher

compiled a list of 48 possible participants that met the criteria for the study and emailed each of them. The first twenty participants to respond were selected for the study.

3.4. DATA COLLECTION APPROACH

The data collection method consisted of semi-structured, in-depth interviews. Researchers use semi-structured interviews in order to gain a detailed picture of participants' beliefs about, or perceptions or accounts of a particular topic. This method gives the researcher and participants more flexibility (Strydom in De Vos et al, 2011: 351). The researcher was able to follow up particular interesting avenues that emerged in the interview, and the participants were able to give a fuller picture. Semi-structured interviews are especially suitable when one is particularly interested in a complex and personal issue, and therefore the researcher deemed this data collection method appropriate for this study (Strydom in De Vos et al, 2011: 351)

With the semi-structured interviews, the researcher had an interview schedule (Appendix 2), but the interview was guided rather than dictated by the schedule. Although the interview was guided by a set of questions in the schedule and was constructed using the research objectives as the key areas to explore, the open-ended nature helped to illicit the views and opinions of the participants and allowed them to steer the researcher in a direction that may not have been initially thought of (Greeff in De Vos et al, 2011; Creswell, 2017). Participants were able to share more closely in the direction of the interview and they could introduce an issue the researcher had not thought of. By this, participants could be perceived as the expert on the subject and could therefore be allowed maximum opportunity to tell their story as suggested by Strydom in De Vos et al, (2011: 352).

A pilot study was conducted as literature states that it is important to conduct a pilot study as it allows the researcher to review the literature in relation to the study, identify themes for further investigation and assess the feasibility of the study (Strydom & Delport in De Vos et al, 2011). Furthermore, the researcher is able to test the effectiveness of the data collection instrument and make the necessary modifications to the interview schedule prior to the main investigation (Strydom & Delport in De Vos et al, 2011). A pilot study was conducted with two prior MM patients selected by the social worker. No changes were made to the interview schedule after the pilot study was conducted.

The researcher used Skype in order to conduct interviews with participants still living in the UK, and face to face interviews with those still in SA. Skype opens up new possibilities by allowing us to contact participants worldwide in a time efficient and financially affordable manner, thus increasing the variety of our samples (Iacono, Symonds & Brown, 2016: 1). The data collection apparatus used in this study was a Dictaphone. This was done with the permission of the participant and the data obtained was transcribed at a later stage. A Dictaphone provides a fuller record of the data as compared to the distraction of note taking and allows for observation of non-verbal cues. In doing so, Greeff in De Vos et al (2011) suggests that the researcher is able to fully concentrate on the interview and its content. Interviews ranged from 60 minutes to 120 minutes in duration.

3.5 DATA ANALYSIS

Creswell and Poth (2017: 112) state that data analysis includes the procedure of; preparing and organising the data; grouping related topics to form themes; and presenting the data in the form of tables or discussions. Thematic qualitative data analysis method described by Fourie and De Vos in De Vos et al (2011:334) was complimentary and appropriate for this study. Thematic analysis is a technique, commonly known by qualitative research data analysis, used for recognising, examining, and reporting patterns within data (Braun & Clarke, 2006: 78). The six-step methodology outlined by Braun and Clark (2006: 79) was utilised. In **step one**, the researcher familiarised herself with the data collected by being fully immersed and actively engaged in the data by transcribing the interviews. She listened to recordings and read field notes and noted down initial ideas. In **step two**, once familiar with the data, the researcher started generating preliminary codes. These were related to the data that the researcher found interesting and meaningful. In **step three**, she searched for themes and the relevant data extracts were sorted according to overarching themes. In **step four**, themes were reviewed and the researcher decided whether to combine, refine, separate or discard initial themes. In **step five**, the researcher defined and named themes and created potential subthemes within the data and lastly, in **step six**, the researcher transformed the analysis into writing by using extract examples that related to the themes, research question and literature.

3.6 DATA VERIFICATION

There are four criteria that should be considered by researchers in pursuit of a trustworthy study, (1) **credibility**, which demonstrates that the enquiry was conducted in such a manner as

to ensure that the subject was accurately identified and described (Lincoln & Guba, 1985: 292). This was ensured by accurately capturing and reflecting the participants' views by rechecking information gathered by participants with them, and by discussing findings with participants in order to get further commentaries or clarifications, (2) **Transferability** is concerned with the extent to which the findings of one study can be applied to other situations. This was done by transcribing the research thoroughly and presenting it accurately and comprehensively. The researcher provided a dense description of the research methodology employed, and how the research methodology was proven suitable to be applied in other related contexts that are not part of the study,

(3) **Dependability** refers to the researcher's attempts to account for changing conditions in the phenomenon chosen for the study as well as changes in the design created by increasingly refining understanding of the setting (Lincoln & Guba, 1985: 293). Due to the academic nature of this dissertation, the researcher's supervisor at the University of Cape Town has carefully supervised the research process. (4) **Conformability** is the final construct which captures the traditional concept of objectivity and it is a measure of how well the inquiry's findings are supported by the data collected (Lincoln & Guba, 1985: 294). The researcher aimed to do this by applying introspective reflexivity, by demonstrating an unbiased view toward the participant's views and by acknowledging participants as being the experts on the topic. The researcher also received supervision throughout this process, which also assisted in avoiding researcher bias.

3.7 LIMITATIONS

The limitations of the study pertain to:

Research design: This form of inquiry does not allow findings to be generalised to populations outside of those under the study, and in order to focus on the meaning of the participants' responses, the researcher had to rely on the subjectivity of the data (Creswell, 2014). Despite all research designs having their limitations; the qualitative paradigm was the most appropriate approach for the purpose of this study as the researcher was not seeking to obtain numerical data, and rather valued the active involvement of the participants. This approach better aided in understanding their experiences of seeking treatment.

Data Collection Method: The response to semi-structured interviews becomes problematic when the subjects are untruthful about their experiences and therefore relies heavily on the researcher's ability to probe (Greeff in De Vos et al, 2011). There was a concern that participants would feel pressurised to provide positive feedback to the researcher as it may impact how the treatment team views that individual. In order to minimise this, the researcher clarified with each participant that their participation and individual responses will be kept confidential. In addition, an informed consent form explained this in writing and was given to each participant at the beginning of the interview (Appendix 1).

Interviews were mostly conducted over Skype, where "technological problems in some cases can lead to issues in sound quality making recording difficult" (Deakin & Wakefield, 2014: 613). The researcher tried to minimise this complication by having an extra internet source available or by asking participants to turn off their video function if the internet was slow on their side. The inclusion of a pilot study aided in preparing the researcher for the data collection process.

A Dictaphone has the advantage of easing the possibility of data overload and allows the researcher to focus solely on the interview. However, the limitation lies with the fact that the quality of the data may be jeopardised by the possibility that some participants could be affected by the presence of a recording device, despite giving their consent. The researcher adhered to Greef in De Vos et al (2011) suggestion in overcoming this limitation, by placing the instrument unobtrusively so as to avoid distracting the participants.

Data analysis: Thematic Analysis does not allow researchers to make claims about language use. While this method is flexible, this flexibility can lead to inconsistencies and lack of coherence when developing themes derived from research data (Nowell et al.,2017: 2). It was important for the researcher to make sure that she understood exactly what the participant was saying in the interviews in order to be clear about what had been said with regards to language use during the analysis. The researcher did this by activity clarifying with participants what they meant by certain statements made, especially when the researcher was left unsure of what participants meant in their explanations of their treatment experience. The process of data gathering as well as data analysis was time consuming and labour intensive, especially in light of the fact that twenty females participated in the study.

Sampling: The small sample is not representative of the larger UK population and is relatively limited in its selection of participants. According to Strydom and Delport in De Vos et al (2011) non-probability purposive sampling is not generalised to the larger population and relies too prominently on the judgement of the individual researcher. In saying this, each patient from the UK with AN who had treatment at MM was not provided with an opportunity to be selected for the sample. Although the researcher was unable to meet the requirements of a larger sample, new participants were brought into the study until the data replicated. Morse and Pooler (2002: 63) refer to this as the process of saturation for the purpose of increasing the scope and appropriateness of the data. Furthermore; the opinions voiced by this sample are in-depth and assist in evaluating the effectiveness of the existing services offered by MM and added to increased awareness of the treatment experiences of UK AN patients.

Researcher bias: There are limitations to a Phenomenological design including the researcher's bias (Creswell, 2014: 23). The researcher included the integration of biases, beliefs and values upfront in the study. The researcher countered this by attending supervision throughout the research process in order to avoid any bias.

3.8 CONCLUSION

In closing, having been guided by the type of research question, a qualitative research design was identified as the most appropriate for this study. By conducting semi-structured interviews with participants the researcher was able gather in depth and rich data appropriate for the study and to therefore enhance knowledge pertaining to this area of research. The penultimate chapter presents the findings of the research.

CHAPTER 4: FINDINGS

4.1 INTRODUCTION

In this chapter, the findings of the study are discussed. The profile of the participants will be indicated and findings will be presented within a framework of analysis. The findings will further be categorised under the research objectives. A conclusion will complete the chapter.

4.2 PROFILE OF PARTICIPANTS

Table 1

Partic.	Age	Sex	Marital Status	Age of onset	Year of diagnosis	Admission to MM	Duration of treatment	No. prior admissions
1	22	F	Single	17	19	2018	3 months	1
2	23	F	Single	5	21	2018	4 months	0
3	21	F	Single	7	13	2018 2018	1 month 2.5 months	3
4	24	F	Single	8	19	2016	4 months	0
5	27	F	Single	12	16	2018	3 months	4
6	20	F	Single	15	15	2018	4 months	4
7	21	F	Single	12	13	2019	4 months	1
8	24	F	Single	22	23	2018	5 months	1
9	27	F	involved	15	17	2016 2018	3.5 months 3 months	2
10	31	F	Single	14	15	2017	4.5 months	1

Table 1 continued

Partic.	Age	Sex	Marital Status	Age of onset	Year of diagnosis	Admission to MM	Duration of treatment	No. prior admissions
11	23	F	involved	14	19	2016 2017	6 weeks 4 weeks	0
12	27	F	Single	9	16	2017	3 months	1
13	20	F	Single	15	15	2017	4 months	2
14	22	F	Single	13	21	2019	6 months	2
15	20	F	Single	11	11	2018	3 months	1
16	20	F	Single	16	19	2018	15 weeks	1
17	21	F	Single	11	13	2018	5 months	2
18	29	F	Single	15	18	2019	11 weeks	0
19	28	F	Single	15	21	2017 2018	3 months 3 months	0
20	25	F	involved	17	20	2019	3 months	0

The participants in this sample were aged between twenty and twenty-eight years old; and started to see symptoms of their ED between the age of five and twenty-two years old. The participants were all female and were formally diagnosed with AN between thirteen and twenty-three years of age. ED appear almost exclusively among females, and according to the APA (2013) ninety percent of all ED are found in women.

4.3 FRAMEWORK OF ANALYSIS

Table 2

	Theme	Category	Sub-Category
4.3.1	Participants reasons for seeking treatment at MM instead of seeking treatment in their own country.	1. Treatment seeking in the UK	1. Delay in treatment 2. Lack of psychological intervention 3. Lack of specialised treatment 4.. Inpatient vs outpatient care
		2. Treatment seeking in SA	
4.3.2	Participants expectations of treatment when they decided to come to MM.	1. Fears prior to admission	1. Worried about weight gain 2.Belief that the team would be strict 3. Clinical setting 4. Able to act out
4.3.3	How participants expectations were met.	1. Expectations that were met for participants	1. Structure 2. Holistic approach and focus on root causes 3. Specialised centre and staff 4. Homely environment
		2. The most helpful aspects of the therapeutic programme	1. A Range of therapeutic interventions and exposure therapy 2. The importance of practice opp 3. Therapy
		3. Most helpful aspects of being at MM for treatment	1. Community setting 2. Meal plan 3. Blind weighing 4. Nursing
		4. Expectations met post discharge	1. Saved life 2. Improved relationships 3. Employment and studies 4. Independence

4.3.4	How participants' expectations were not met.	1. The most challenging aspects of being at MM	1. Letting go of control 2. Comparing 3. Feelings of being infantalised
		2. Parts of the therapeutic programme that participant's did not find beneficial	1. Individual sessions with a specific therapist 3. Limited time with the dietician 4. Limited time with the psychiatrist
		2. Expectations not met for participants post discharge	1. Glamorising what life would be like post discharge
		4. Returning to the UK	1. Feelings of isolation 2. Life in the UK the same, individual changed 3. Transition home, difficult adjustment
4.3.5	Participants recommendations to MM regarding the treatment of international patients.	2. Recommendations to other patients	1. Highly recommended if potential client's want recovery
		3. Recommendations to MM pre-admission	1. Contact with primary therapist at MM 2. Outdated website 3. Connect with past clients
		4.Recommendations to MM during their stay	1.Discharge planning 2. Promote fellowship for discharge 3. Promote step-down facilities
		5. Recommendations post discharge	1. Skype with MM therapist post discharge 2.Online support group for UK client's 3.Connect with past clients

4.4.1 OBJECTIVE ONE: **To determine participants' reasons for seeking treatment at Montrose Manor instead of their own country.**

4.4.1.1 Experience of treatment seeking in the United Kingdom

The researcher explored the participants' experience of seeking treatment in the UK and what led them to seeking treatment in SA. Four areas that emerged:

4.4.1.2. (1) Delay in treatment

Nearly all the participants reported a delay in receiving treatment and many expressed being denied treatment in the UK for not being in a certain weight bracket. Secondly many participants reported having to wait months for an admission and often by the time they were able to go to the NHS they had deteriorated or had to be admitted elsewhere.

"and then to be told, basically on the NHS if I was going to get any treatment it was up to a three to four month wait, by which point I either would've been dead or changed my mind about the whole thing" (Participant, 18).

"But at my lowest BMI which was about 15, they [NHS] said they wouldn't see me unless I was 13 or below. So to be told that, you know you're desperately seeking help because you're very unwell and underweight, but to be told you're not ill enough, it made me want to act out more, and, because it made me want to, or made anorexia want to prove a point that I was really, really sick" (Participant, 20).

These findings concur with research done in the UK, where participants viewed referral to ED services and admission to inpatient units largely dictated by the patient's weight, and delay in intervention up to three years as indicated in one study (Mitrofan et al., 2019:23; Beat, 2017; Escobar-Kock et al.,2010: 557).

4.4.1.2. (2) Lack of psychological intervention

Several participants that had been admitted to treatment in the UK, especially in the NHS, reported on the limited psychotherapy offered in inpatient treatment. This was due to participants being severely ill and the focus of treatment being on weight restoration. This

meant that there was no focus on the underlying issues behind the ED, and therefore a greater possibility for readmission

"All I did was lie in a bed for about 7 months. There was no therapy. No therapy, I did therapy once...I was this 19-year old, scared out of my brain, like 'what am I doing here,' I got no help, no therapy, nothing. You get no groups. It was literally; you eat, you're supervised, you eat, you're supervised, that was absolutely it" (Participant, 6).

"I actually know of somebody who's been in and out of hospital, goes on the drip, gets better, tube fed, comes out and relapses straight away because you go in, and at the hospitals there's no therapy, there's no nothing. It's just focusing on your weight, which I know is important, obviously physical does have have to play a massive part in it, but it's not the only part." (Participant, 20).

These findings concur with the literature that highlights that unless patients are adequately supported with psychotherapy during admission and following discharge, they may not maintain the weight gains they had achieved. This method of treatment is in stark contrast to the Biopsychosocial model of treatment, which looks at the importance of biological, psychological and social components when treating ED patients (Striegal-Moore et al, 2000: 132; Campbell & Rohrbaugh, 2013: 23).

4.4.2. (3) Lack of specialised treatment

A lack of specialised treatment emerged and this was due to two factors: (1) The lack of specialised treatment and (2) the lack of supervision due to inadequately trained staff for the treatment of ED, which resulted in participants' continuation of acting out behaviours in inpatient treatment units.

"But I was acting out there [NHS treatment] and there were so many opportunities to act out I mean-it was the complete and utter opposite of Montrose. People were shoving food every- left, right and center and hiding it and exercising and just, it's not a recovery space" (Participant, 14).

"The staff weren't trained and were usually from an agency and had no clue about mental health at all, let alone eating disorders" (Participant, 6).

“I think I was there for a month, and they couldn’t really help the eating disorder, because they didn’t have much specialised training in it. So I was just able to go there, pace around the whole time, be refusing to eat lunch, like all of those things” (Participant, 3).

The participants’ experiences coincide with the literature as a British study found that 40 percent of participants opted for private care due to the lack of specialist ED treatment. In non-specialist services patients were able to deceive nurses in a general ward whereas staff at a more specialised unit were prepared for when patients tried to falsify their weight or to hide food (Tierney, 2008: 371; Wilson, Vitousek & Loeb, 2000: 11)

4.4.1.2 (4) Inpatient vs outpatient care

Several participants indicated that their ED was so unmanageable at the time of seeking treatment and that they were unable to participate in outpatient treatment. Many participants mentioned, that they believed that without 24-hour supervision they would not manage their ED.

“Both times I was there, it made me think ‘I actually don’t know how anyone does this in outpatient’ both in terms of just managing the practicalities of eating the right amount and all the rest of it, but also just not having people around you the whole time, inpatient treatment was just so beneficial” (Participant, 19).

“In the UK, outpatient comes first, and to me it goes the other way around. It’s a great stepping stone after full time but the thing is you cannot treat this unless it's all-inclusive. It need to be full on, all the time, because you have to deal with food the whole time. You need that complete control taken away from you because you have a fucking eating disorder, you can’t deal with food” *(*Participant, 9).

The research on ED treatment in the UK supports these findings as the primary source of treatment is outpatient based according to their “stepped approach” (Richards, 2003: 364). Inpatient treatment is only considered when there is a psychological or medical threat, or if there has not been sufficient progress in terms of outpatient care (NICE, 2017).

The following section describes the process and motivation of seeking treatment in SA

4.4.1.3 Treatment seeking in SA

Many participants reported that they had been recommended to come to MM by professionals in the UK, because of its' good reputation. Several of the participants interviewed acknowledged that one of the reasons they had decided to come to SA for treatment was due to the cost, because three months of treatment in SA, costs the same as 28 days at private facilities in the UK. Many participants also reported that they found it beneficial to be treated in a different country, as the physical distance between themselves and their lives at home, allowed them to focus solely on their treatment process.

"The psychiatrist and then also the treatment centre I was in there (UK) said Montrose was the best in the world for eating disorders" (Participant, 8).

"The Life Works programme is 28 days typically, and at the end of the 28 days my health insurance ran out and I was like 'I can't, I can't leave, like I'm fucked.' So I had to ring my parents and be like 'please will you help me,' which is such a difficult phone call, but actually they have been nothing but supportive. But it was very expensive, UK treatment is 6000 pounds a week, and not actually that specialised or beneficial" (Participant, 12).

"Because of the exchange rate, it was like a third of the price. It kind of felt like all of the stars had aligned and, you know, because that was the one that was number one recommended, and then also bonus it turns out it's actually the cheapest option" (Participant, 17).

"Also, I felt like I needed that amount of distance between myself and my family to actually get that separation, not just physically, but also emotionally, because even though I was barely seeing my family and even now just being in the same country, I sometimes feel very claustrophobic" (Participant, 10).

These findings concur with the literature that states that inpatient treatment in the UK is often lengthy and costly (Striegel-Moore, Leslie, Petrill, Garvin & Rosenheck, 2000: 132) and this often results in patients who do not have medical insurance, seeking treatment in more cost effective, developing countries (Reddy, York & Brannon, 2010: 512). This is also in line with

the National Mental Health Policy Framework and Strategic Plan (2013-2020) which was implemented in order to promote evidence-based, affordable and effective treatment and rehabilitation services in SA. Literature on medical tourism states that patients benefit from privacy and anonymity when receiving medical treatment outside their own country (Lee, Han & Lockyer, 2012: 317).

The findings under objective one reveal that before seeking treatment in SA, participants' generally felt that their ED had become unmanageable and had negatively impacted on their social, relational and family life. Many participants attempted to seek treatment in the UK and due to cost and lack of specialised services, were recommended to seek treatment in SA. The following section will discuss objective two.

4.4.2 OBJECTIVE TWO: **To determine participants' expectations of treatment when they decided to come to Montrose Manor.**

This section will discuss participants' feelings about coming to SA as well as participants' expectations prior to admission to MM.

4.4.2.1 Fears prior to admission

All of the participants had fears prior to admission to MM including gaining weight; believing that the team would be strict; that the treatment centre would be too much like a hospital setting and lastly, that they would still be able to continue acting out on their ED.

4.4.2.1 (1) Worried about weight gain

Nearly all of the participants interviewed had anxiety about having to restore weight whilst in treatment. They acknowledged that they knew this was part of treatment, but many of them still seemed to obsess around trying to calculate how much weight they would need to gain over the period of their admission. The quotations below also describe the level of denial these participants had- knowing that they were diagnosed with AN, but still believing that they did not have to gain weight.

"I think the three meals and three snacks. I was absolutely terrified with that. I think that was my biggest worry. I think before I went I was calculating in my head I could just do that for a month and come back out and then I can just start this off again. I don't have to eat

that much, I don't have to gain that much weight...I was really scared of the food" (Participant, 1).

"Before I left I did the calculation, I was like 'ah well I need to gain this much weight and then I want to maintain my weight blah blah blah' So I knew before I went that I wanted to stay for at least four months, so I had it in my head that I was going to do it but it is terrifying still" (Participant, 8)

"I think as much as I wanted like help and I felt really vulnerable, I also didn't want to be gaining weight that I didn't feel that I needed to be gaining" (Participant, 12).

AN is an ED characterised by relentless pursuit of thinness and a fear of gaining weight despite the presence of a significantly low body weight. This finding also speaks to the Health Belief Model, which states that people will not change their health behaviours unless they believe that they are at risk which can be challenging with ED patients in denial of their illness (Champion & Skinner, 2008: 47; Akey, Rintamaki & Kane, 2013: 247; Brownell & Walsh, 2017: 16).

4.4.2.1 (2) Beliefs about the team

A few of the participants interviewed expressed that before admission, they expected that the team would be very strict. Some of the participants were told this by past patients, and many of them knew beforehand that there would be certain expectations of them.

"Yeah so when Phil, who is my therapist, said that they are very strict; he always said Í will warn you, they are very strict" (Participant, 10).

"I knew going in that I was probably going to have to eat everything and I wouldn't get a choice and it was going to be a lot more rigid than Life Works" (Participant, 12).

"Yeah, I thought it would be like everybody in a straight jacket and then I kind of rationalised that, that probably wasn't it" (Participant, 2)

These findings correlate with the literature which states that it is important for staff to strike a balance between firmness and sensitivity. The therapeutic alliance is a crucial factor in treatment as patients' are more likely to respond badly to staff whom they perceive as rigid and

authoritarian, but at the same time are unlikely to feel safe unless those caring for them are able to set clear and appropriate boundaries (Snell, Crowe & Jordan, 2010: 352).

4.4.2.1 (3) Clinical Setting

Many of the participants spoke about their expectation that MM would be a very clinical/ hospital setting and not as homely and family orientated as it was.

"I expected it to be much bigger, weirdly. Much more like clinical. So when I walked into the living room, with the views and stuff, I was like 'what the fuck' and I guess like yeah, much less family orientated. Like we were one big family" (Participant, 8).

"I thought it would be more clinical than it was, I think. I guess you see rehabs in the movies, that's the only place I had seen them, and they were always a bit more clinical" (Participant, 4).

"I wondered, is it a hospital environment and am I going to feel like I'm in a hospital for three months" (Participant, 18).

These findings confirm the literature, that states that currently inpatient and day treatment units more often serve to stabilise acute patients before a more long-term transition into less restrictive care such as outpatient or individual therapy (Frisch, Herzog & Franko, 2006: 434). Patients have been reported to prefer non-healthcare service settings, with hospital and psychiatric settings contributing to feelings of stigma and lowered self-esteem (Vanderecycken, 2011: 289).

4.4.2.1(4) Acting out

A few participants believed that they would be able to continue acting out when they were admitted, or that other patients around them would be acting out and would therefore create a sense of unsafety for them.

"I fluctuate a lot. Half of it was like, 'There's no way in hell I will be doing that [restoring weight], there will be a bathroom and I'll still be able to throw up and exercise...I thought that there would definitely be wiggle room and ability for me to manipulate the situation'' (Participant, 2).

"I thought that people would be acting out more and that I'd feel less safe" (Participant, 17).

"I remember expecting there to be a lot of tears at the table and people throwing food and people running out of the dining room screaming" (Participant, 19).

These findings concur with the literature on the experiences of patients' in ED units, where patients' have reported that in non-specialist services, patients' had little trouble deceiving nurses in a general ward who did not understand their condition, in contrast to staff at a more specialised unit who were prepared for those patients who could falsify their weight or hide food (Tierney, 2008: 371).

In summary the participants' reported their expectations prior to admission. Most of the participants were afraid of the weight gain, that the team at the clinic would be strict, and that treatment would be facilitated in a clinical setting. A few of them believed that they would still be able to act out in treatment. The following objective will explore the participants' expectations that were met.

4.4.3 OBJECTIVE THREE: **To determine in what way participants' expectations were met.**

Four areas will be discussed under this objective.

4.4.3.1 (1) Daily Structure

Most of the participants interviewed expressed that they really enjoyed having structure in their day, and that the structure created a sense of safety.

"It was really nice to have some kind of structure when I was learning new things and actually doing something that can help me" (Participant, 1).

"Just the structure was really really good. the organisational structure and the therapy sessions. and then the way it was broken up with being able to get out to a meeting" (Participant, 4).

"One of the things I miss the most is knowing that when I wake up, I'll go and get my meals and there will be a safe structure for the day" (Participant, 7).

These findings echo Cockell, Zaitoff and Geller (2004: 2) who mention that structure is a factor which contributes to recovery. Structure is an inherent part of inpatient centres and patients often relapse due to the lack of structure implemented in real life situations.

4.4.3.1 (2) Holistic approach and the focus on root causes

Nearly all of the participants expressed that their expectation that there would be an emphasis on the psychological part of treatment, was met. Participants reported that they were able to gain deep insight into their illness and themselves.

"Montrose really teaches you that it is not about the food- Montrose helps you to get to be healthier and does all the blood tests and physical aspects but whilst also treating your mind and I think that combination is amazing. I think that sort of holistic approach will always be what makes Montrose special" (Participant, 11).

"I think it felt much less weight focused...it felt much more holistic on general well-being and way of life rather than getting you to the point where you are physically healthy" (Participant, 7).

"There was a lot of root, kind of therapy" (Participant, 12).

These findings are in accordance with the Biopsychosocial Model which focuses on the the psychological factors that drive the disease. (Campbell & Rohrbaugh, 2013: 23). Inpatient treatment that focuses primarily on weight restoration, has frequently failed to generate an outcome whereby patients sustain the weight gained in treatment. This has been understood to indicate treatment programs failure to adequately address the psychological aspects of the condition (Bell, 2003; Malson & Ryan, 2008; Colton & Pistrang, 2004).

4.4.3.1 (3) Specialised treatment for ED

Almost all of the participants mentioned that their expectation was met that MM was a specialised ED facility, with trained staff in the treatment of ED and that all of the patients had a primary diagnosis of an ED.

"So [my expectations] were definitely met in the sense that it was specialised for eating disorders, that much was obvious. Everybody was there primarily, whether they had other issues or not, they were primarily there for an eating disorder. Everybody, all the staff were trained for eating disorders, or they had experience, which was great" (Participant, 12).

"I just felt like at Montrose it was very specialist. I felt like everyone was just very specialist on eating disorders whereas in the UK when I've seen therapists it's like they are more there for general mental health" (Participant, 4).

"And then thirdly [what was helpful] is just having a treatment centre that was specialised for eating disorders and everybody there having some form of eating disorder" (Participant, 11).

These findings are in accordance with The National Mental Health Policy Framework and Strategic Plan (2013-2020) which provides a scope for specialised psychiatric hospitals, stating that further care, treatment and rehabilitation of mental health care users will be provided in specialised psychiatric hospitals. According to the Health Belief Model, when treatment is perceived to be ineffective or inappropriate (when there is no specialised treatment, or long waiting periods for treatment) it will unlikely be pursued (Champion & skinner, 2008: 48).

4.4.3.1 (4) Homely environment

Several participants expressed that they really appreciated MM providing a homely and friendly environment which promoted recovery.

"The house is beautiful; I mean the actual clinic is beautiful. I felt immediately at home" (Participant 11)

"It was a very friendly environment. It didn't feel like I was in hospital even though there were hospital elements with the nurses' station, but I kind of felt, in a way, like being in a home away from home" (Participant, 20).

"Being away was amazing. The house is gorgeous; the weather is so nice. You can get very affected by weather and surroundings so being able to do therapy in such a beautiful place

and then to go outside and see the sun and to see beautiful sunsets every single night" (Participant, 2).

The literature concurs with the finding, as patients have expressed preference for non-healthcare service settings (such as RTC's), with hospital and psychiatric settings contributing to feelings of stigma and lowered self-esteem (Vanderecycken, 2011: 289).

This section concludes the expectations that were met for participants. The following section will discuss what the participants reported were the helpful aspects of the therapeutic programme at MM.

4.4.3.2 **Helpful aspects of the therapeutic programme**

This section will discuss four areas:

4.4.3.2 (1) A Range of Therapeutic Interventions

Nearly all of the participants reported that they found the range of therapeutic interventions offered at MM to be helpful and almost all of the participants expressed how helpful exposure therapy was in their process. It allowed them to expose themselves to areas in their lives that they were fearful of.-.

"So much of it was amazing. The variety of therapy, the direct health on so many levels. I thought that was amazing like having the nurses, psychiatrists, psychologists, the sports instructor, and the dietician and all the rest. I think that was very amazing that you have that sort of holistic approach" (Participant 11).

"The treatment was incredibly varied, and that was fantastic. All of the different sessions, it was very varied and it was a good mix of group therapy, smaller classes. I remember the exposure therapy on a Tuesday I found that very useful." (Participant, 20).

"The one that was the most helpful by far was the exposure therapy. Exposure by far was my favourite, the toughest one but by far my favorite because if you don't expose yourself to that then you're never going to get over it" (Participant, 6).

These findings correspond with the literature which noted that RTC's reported using an eclectic, integrative approach to treatment. Many treatment centres practice exposure therapy, where they propose that patients are exposed to their fear foods and/or other ED related situations, in order to reduce avoidance and facilitate habituation to anxiety surrounding the anticipation of these feared events (Koskina, Campbell & Schmidt: 2013: 198; Frisch, Herzog & Franko, 2006: 437).

4.4.3.2 (3) Practice opportunities

Several participants that experienced phase three of the programme which aims to allow patients to have an opportunity to put into practice everything that they learned in phase one and two, was very helpful. These patients need to start preparing for normal life, cooking food for themselves and managing their days as they would in the outside world.

"For me it was the bit where I went into the flat and started to actually practice life, because I had done the treatment, I had done the therapy a lot and that kind of aspect was just like I kind of 'tra la la la' through it. Whereas actually taking responsibility and going about planning things and being in a flat and thinking about life outside of treatment was huge" (Participant, 5).

"Like I did expect that we would have more progressed independence and stuff like that, which I think we had quite a bit of at Montrose, like at first you have not really any independence and then at the end, when you're in phase 3 and phase 4, you get a bit more, you start to do cooking for yourself in the flat and feed yourself and take some day trips out and stuff. I think that was one of the things that I was expecting which we did do was have more progress towards independence" (Participant, 16).

Brewerton, and Costin (2011: 121) note that a homely RTC often allows patients to have hands-on experience with food that simulates real life. These experiences are often not available in larger programs using institutionalised kitchens and dining rooms.

4.4.3.2 (4) Therapy

Individual and Family therapy is an important component of the treatment process offered at MM. Several participants noted that they found their individual therapy to be an important part of their process and the majority of participants found family therapy to be beneficial.

"Yeah I did [like my individual sessions]. I always struggled with the whole opening up thing, vulnerable thing, like really significantly, and then my counsellor, I actually adored...I thought she was brilliant" (Participant, 12).

"I think individuals with [my therapist] were incredibly helpful. Yeah, I really, he was amazing. So to be honest that would probably be the number 1 [most helpful aspect of the program]" (Participant, 19).

"Yeah I did find the family sessions beneficial], definitely. It was really good to have family week there, it was quite emotional. But it was very beneficial to have that and get out and be with family" (Participant, 16).

This supports the research conducted by Frank (2016: 17) which states that a therapeutic alliance involving trust and respect is crucial to a positive outcome (Colton & Pistrang, 2004: 2; Tierney, 2008: 12; Van Ommen et al., 2009; Nishizono-Maher et al., 2011: 414). These findings are also supported by the social component of the biopsychosocial model, where clinicians are interested in a patient's social life because there is evidence that patients who are subjected to acute and chronic social stressors are more likely to develop, or have more frequent exacerbations of their psychiatric illness (Campbell & Rohrbaugh, 2013: 24). Several authors have also written about the important role that the family play in the treatment of the ED patient (Cardi et al., 2018: 11; Rienecke, Accurso, Lock & Le Grange, 2016: 2).

This section concludes what patients found helpful in the therapeutic programme at the clinic. The next section what participants felt were the most helpful aspects of being at MM for treatment.

4.4.3.3 Helpful aspects about being at MM for treatment

Four core areas emerged when the participants were asked about this area.

4.4.3.3 (1) Community setting

Nearly all of the participants expressed that being treated in a group of patients experiencing similar problems, was beneficial as it created a sense of support and a sense of community.

"Definitely beneficial [being in a community] because everybody helped each other a lot and for me it was really important because I met some girls who, you know when I was freaking out about the fact that I was terrified that I wouldn't make friends, they would just turn to me and be like, "You're not here to make friends you're here for you" (Participant, 2).

"One hundred percent [found it beneficial to be in a community]. Definitely. I still talk to a couple of the girls from there. We still meet up, still check in on each other. It's just very motivating having someone to cry with and share these ridiculous stories but you don't think anyone else will understand." (Participant, 4).

These findings concur with research conducted, which elucidated that group therapy and being in an inpatient setting with other ED patients were perceived as helpful, due to additional peer support, learning positive coping skills and reducing feelings of isolation (Colton & Pistrang, 2004: 2; Offord et al., 2006: 12; Tierney, 2008: 5).

4.4.3.3 (2) Benefits of a Meal Plan

Most of the participants expressed that they found benefit in receiving a structured, regular and moderate meal plan that was simple to follow.

"I think definitely the regular eating. Like actually getting a stable meal plan and actually knowing what to expect. I'd wake in the morning knowing what I was going to eat because I had the meal plan for the day which was quite comforting" (Participant, 1).

"It's more of a healthy meal plan, you know it's not way over what you should be eating. It's more of a realistic one, like it's enough to gain if you need to but not to the point of like, eat three times the normal amount so that you can gain weight really quickly and then leave. So in that sense it's way more helpful" (Participant, 2).

"Honestly, like, a big thing is the meal plan. It's very easy, like, you know, it's three meals, three snacks" (Participant, 17).

These findings are in stark contrast to the literature which states that in the UK it is recommended that patients should gain 1-1.5 kg per week. This is achieved through various means, including supported meals, nasogastric tube feeding, total parenteral nutrition and

surgical interventions (Vandereycken, 365; Birkbeck, 2018: 31). MM manages patients that are not critical, and therefore the focus is more on a ‘normal’ eating plan.

4.4.3.3 (3) Blind-weighing

Several participants expressed that they appreciated that MM managed their weight through ‘blind-weighing’ which therefore contributed to the focus being more on the patient’s therapeutic need. It also allowed patients to focus on other things, other than their weight and therefore prevented them from being distracted from treatment.

“In England you get weighed every time and you know your weight and that was the worst thing ever. Two days a week, people were crying about their weight and at Montrose, having the blind weigh-ins and not knowing when you were going to get weighed was so refreshing and really important” (Participant, 7).

“[The blind weighing] was amazing. I mean I hated it. But within a couple of months there was absolutely no way I wanted to know” (Participant, 8).

“I really liked that we didn’t know our weight. I still don’t know my weight which is nice. And I think it just, I don’t know, seems more caring than the NHS. The NHS was like ‘oh you’re just a person, you’re just someone we’ve got to get your weight up and get you out” (Participant, 1).

Previous research indicates that the NHS often focuses primarily on patients reaching a “minimum healthy weight’ with little emphasis on the underlying issues experienced, therefore leaving patients’ feeling as though they are just people that need to get their weight increased (Mitrofan et al., 2019: 24). This does not concur with the approach at MM, where only the medical professionals and the dietitian manage the patients’ weights so that the focus can be on other parts of treatment.

4.4.3.3 (4) Relationship with nursing staff

A few of the participants reported that the nursing team was a very helpful part of their treatment at MM as they were there to support patients when they were struggling.

"I think the nurses are extremely helpful and just having someone there that I could talk to" (Participant, 14).

"I felt that there was a lot of reliance on the nurses who were the biggest help for me throughout the whole thing" (Participant, 11).

"The team of nurses are incredible. At Life Works there was only just one person, who would, kind of, supervise you around and again that's why I could get away with quite a lot" (Participant, 15).

These findings are in line with the theory, which states that nursing patients with AN requires a high level of skill and is most likely to be effective when carried out by a nursing team with experience and training in this area. The therapeutic alliance is one of the crucial tasks in nursing ED patients (Snell, Crowe & Jordan, 2010: 352). The following section will discuss the expectations met for participant's post discharge.

4.4.3.4 Expectations met for participant's post discharge

Participants expressed that treatment helped them make significant, positive changes to their lives. These changes will be discussed in below.

4.4.3.4 (1) Saved life

Most of the participants reported that treatment at MM saved their life and changed them for the better.

"I guess and I hope that it has made me a better person, made me a more productive member of society. I don't know, like, before I went into treatment I kind of was like 'this is it I need treatment or I'm basically going to kill myself.' I don't know if I ever would've gone through with it, like it's impossible to say now. So, but at the time I did feel like treatment really saved my life" (Participant, 12).

"I'd say going to Montrose saved my life. I wouldn't have been surprised if I had done something really drastic to myself if I hadn't gone away. Surely, I'd have felt like not wanting to be in the world anymore" (Participant, 2).

"I mean I can one hundred percent say that treatment saved my life. I don't think that I, it's very heavy, I get quite upset when I think about it but I do think I might have hurt myself if I'd had to stay much longer in the UK without support and I just really did not see a way out of where I was so I could say hands down it saved my life" (Participant, 4).

The findings in this study have found that treatment received at MM actually 'saved' their lives and allowed them to be better, more functioning members of society. This is also in line with the literature which states that recovery is strongly related to the concept of 'well-being' where where the individual realises his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO, 2005: 12).

4.4.3.4 (2) Improved relationships

Almost all of the participants expressed that post discharge, they had improvement in their relationships and were able to form connections and communicate better with loved ones, as opposed to when they were in active ED.

"I guess it's more in the way I communicate with others. Particularly family members and how I try at least to open up a bit more than I used to. I still find it very difficult" (Participant, 10).

"I talk about how people make me feel. I tell them how things make me feel. I turn up for stuff. I eat" (Participant, 8).

"I have talked about my feelings a fuckton. I feel less ashamed around certain things, like around certain trauma's, my diagnosis as well. I feel kind of like I want to help other people to be able to talk about their shit, like I feel willing to talk about my stuff and I'm not so scared of being judged for it" (Participant, 17).

These findings support the literature which states that social support from professionals, family and friends have been identified as helpful in maintaining recovery behaviours. Having the opportunity to identify and express feelings and to receive empathic, non judgemental responses was said to promote movement toward health (Cockell, Zaitsoff & Geller, 2004: 2).

4.4.3.4 (3) Employment and studies

Several participants expressed that before treatment they either had to take a leave of absence from their employment, stop working completely and discontinue their studies. After treatment at MM, many of them continued to work and study.

"Montrose changed my life. If it hadn't have been for Montrose I would never have been able to go back to studying. There is no way, I wouldn't have been able to study" (Participant 11).

"I feel like I've gotten my life back since I left. Before I was just kind of existing I wasn't doing anything apart from drinking everyday and slowly dying. Now I'm actually living and I've got things that I love doing, I love crafts and I love studying" (Participant, 1).

"Luckily, I've been in employment ever since coming back so yeah that's the longest time I've been employed without being signed off sick because of having an eating disorder" (Participant, 10).

These findings correlate with the literature which states that the criteria for recovery includes the concept of 'well-being' which encompasses ones' ability to realise their abilities, to be able to cope with normal stressors of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO, 2005: 12). One of the criteria for recovery is autonomy and personal growth (De Vos, et al, 2017:7).

4.4.3.4 (4) Developing Independence

Most of the participants expressed that in active ED they were quite dependent on others, because they could not care for themselves. Post discharge most of the participants, especially those in good recovery, reported becoming more independent.

"I mean, it not only kept me alive- I can eat food, I'm healthy, I'm happy, I live here, I'm in recovery, I have the most amazing friends, I have the most amazing boyfriend, I'm building a life- I had written myself off, and now I'm building a life" (Participant, 9).

"I've really tried to look to the short-term future and set things up that will keep me stable and I think I have been much more responsible for that and I have been less reliant on

people around me for picking me up when I'm down and taken more responsibility for my treatment" (Participant, 7).

"So yeah definitely became more social and became more independent which I wanted before but I just couldn't do it because I was too sick" (Participant, 1).

These findings echo Cardi et al., (2018: 11) who noted that many individuals with AN, do not obtain full independence, but stayed with relatives in a dependent relationship, with a limited range of interests, neither completing an education nor holding a job. Once participants had completed treatment for AN, they were able to achieve independence, this concurs with the literature by De Vos et al (2017: 7) which mentions autonomy, self-adaptability/resilience and personal growth as criteria for recovery.

In this section, participants were able to identify a number of positive aspects of the service received at MM. Many of their expectations were met with regards to treatment and post-discharge. Participants reported appreciating the holistic approach adopted by MM, and also enjoyed being treated in a community setting where other patients understood and shared their experience.

4.4.4. OBJECTIVE FOUR: **To determine in what way these expectations were not met.**

This section will explore the unmet expectations of the participants. This section is divided into two parts, namely (1) Challenges about being at MM and (2) What participants did not find beneficial about the therapeutic programme.

4.4.4.1 Challenging aspects about treatment at Montrose Manor

In this section, the most challenging aspects of treatment experienced by participants are discussed. These include:

4.4.4.1. (1) Letting go of control

Most of the participants interviewed expressed that what they found difficult being at MM was having to let go of control. For example, they do not have any control with regards to food or exercise.

"At the beginning it was the lack of control. Constantly being watched, being held accountable for everything. I hated that in the beginning but that was the bit that I needed because whenever I was given any freedom that was when my eating disorder would run riot" (Participant, 4).

"I came straight from another treatment programme, so it was a little bit less of an adjustment than it would've been, but it was still quite a big adjustment having to be like, letting go of control and stuff, was very difficult still" (Participant, 16).

"I think it was, at the beginning, giving up all control of the food and trusting that with other people and with the chef's, not being the one preparing my food, not being the one- at the beginning you're not even the one serving your food, [so] giving up that control was the hardest part" (Participant, 6).

These findings are in accordance with a study conducted by Treasure, Schmidt and Van Furth (2003: 206) which states that in the acute phase of AN, patients do seem to get some satisfaction of having anorexia, as they often feel more in control of their lives. Hence, once the control of the ED is taken away during treatment, patients tend to find it very difficult to manage without their primary coping mechanism.

4.4.4.1 (2) Comparison with other patients

A few participants reported that they often struggled with comparing themselves with other patients' in the facility.

"on the flip side of being in a community, it also bred comparison especially at the beginning and throughout, even towards the end. I was always comparing the way I looked with people" (Participant, 4).

"So it can be quite difficult to be around a lot of people with the same illness because people compare" (Participant, 18).

"I would say, I guess other people's bodies. The comparing, yeah. And the knowing, the trying to understand when I'm being triggered genuinely or whether it's my own shit" (Participant, 8).

These findings correlate with studies conducted where it was noted that patients expressed that being together with other ED patients may be beneficial in the sense of promoting support, but that it may also entail a series of negative effects that can increase stress e.g., patients may compete for thinness (Vandereycken, 2011: 291; Colton and Pistrang (2010: 230).

4.4.4.1 (3) Feelings of being infantalised

Several participants reported that as they progressed through treatment and as they needed to take on more responsibility, they often felt that they were being infantalised, which they found difficult.

"Maybe I wanted to run before I could walk, but I think you get to a stage where not being treated at all like an adult becomes quite difficult, and I felt like I was two people almost, like I was this pathetic child with no responsibilities or who couldn't be trusted by anyone when I was at Montrose, and then I was adult me who has friends and a job and a degree outside of there. And it was, that was quite difficult, towards the end. Both times when I got there I really wanted to be treated like a child and I really welcomed that, and it was very, again, freeing" (Participant, 19).

"You feel like a child sometimes. I think sometimes when you're questioned over things and you're like 'I might have an eating disorder and be incapable in that way but I'm still a functioning human'" (Participant, 9).

These findings relate to the literature, where patients have reported finding it beneficial to have some control over the process and pace of treatment. This again confirmed the importance of training and supervision for staff working with ED in order to develop and maintain a collaborative working relationship with patients (Bell, 2008: 188). Similar findings were reported in a study where patients reported that the availability and willingness of staff to listen to them as well as being actively part of one's' own treatment process was seen as important (Colton & Pistrang, 2010: 314).

<u>4.4.4.2 What participants did not find beneficial about the therapeutic programme</u>

This section will discuss what participants did not find beneficial in the therapeutic programme. These included:

4.4.4.2 (1) Individual sessions with a specific therapist

A few participants expressed their difficulties that they had with a specific individual therapist. Participants expressed that this was challenging because they found their sessions to not be as beneficial as they would have liked them to be and raised anxiety about how this would influence their treatment process.

"I would say one of the most challenging things was my relationship with my therapist because I really felt like I was wasting a lot of time whilst being there because of it…that was probably the worst, that was probably the most damaging part of treatment and the most unbeneficial" (Participant, 2).

"I don't feel like I got a lot out of the therapy with my counsellor, which was a shame because I was here for so long, but I think I used the other therapists around me in a positive way. Paying a lot of money and a lot of time and, to not get that much out if it is difficult" (Participant, 14).

Previous literature emphasises the importance of the therapeutic alliance, as participants reported having difficulties with their individual therapist and reported their concern that it would negatively impact their treatment process. Bell (2008: 186) demonstrated that support and empathic relationships are critical to recovery and treatment.

4.4.4.2 (1) Limited time with the dietician

Several participants expressed that they would have liked more time with the and they felt that they had limited, weekly, individual time with the dietician. They would have liked to leave treatment with more knowledge and confidence in making healthy food choices.

"I would've liked more dietetic support, in terms of I would've liked more information. I think I did expect to come away with a bit more knowledge and confidence in making nutritional choices and sort of understanding food as nutrition...I feel like having 5 minutes with [the dietician] every week is not enough, and the [food] groups are not sufficiently

helpful enough to make up for the fact that you have very limited individual time” (Participant, 19).

“I didn’t find I had long enough with [the dietician] on an individual one-to-one basis each week. I get that that’s because there’s one of her and like 20 clients, or I think there were like 15 of us at the time. But I didn’t find like it was long enough to actually go into stuff and I just felt like it was a very quick run-through” (Participant, 12).

The dietitian has a central role in supervising the patient’s nutritional rehabilitation and many also play a part in nutritional education (Treasure, Schmidt & Van Furth, 2003: 243). It is clear from the findings, that because this relationship is so important, that more time with the dietitian would have been helpful.

4.4.4.2 (1) Limited time with the psychiatrist

A few participants reported that they felt that they did not have enough time with the psychiatrist. Participants felt that more psychiatric input would have been beneficial, especially whilst completing treatment in an environment where they could be monitored by a professional team. They also felt that the team were making psychiatric decisions for them without their input.

“Maybe having more than one introductory session with him would’ve been beneficial because we had one like, at the start for like an hour and he was really a nice guy and I don’t know if you have the same one now but, like a follow up one maybe every four weeks or something like that, because I felt like he was making medical decisions for me having chatted with the team about it, and not chatting with me” (Participant, 12).

“I did find it quite difficult as well, not being able to see the psychiatrist properly. Like whenever I asked to see him it was always like ‘we will see if the counsellors will send a message to him’ but then I never really got to see him. But even that I found quite difficult that I almost couldn’t speak about the medication side, and that felt almost quite controlled in a way, that I couldn’t even have access to my own, to be able to speak to someone who’s in charge of my medication” (Participant, 3).

In most ED specialised treatment centres, a consultant psychiatrist plays a crucial role in the management of patients (Redenbach & Lawler, 2003: 148). It is clear that the psychiatrist at MM fulfills this role, even though participants would have liked more time with him during their time in treatment.

The above section discussed what participants did not find beneficial about the therapeutic programme at MM and the following section will discuss the expectations not met by participants.

4.4.4.3 Expectations not met at Montrose Manor

This section will discuss the expectations not met at MM, which was the expectation of life post discharge.

4.4.4.3 (1) Expectations of life post-discharge

A few participants expressed that they glamorised what life would be like for them post discharge- that they would be much better, that they would love themselves, that MM would save them- and then they felt disappointed when this did not come to fruition post discharge, as recovery is hard and the journey only really starts when the patient returns home.

"You know how you glamorise things? I think I was glamorising what my future would be when I left. Like, 'oh you know I'm much better now. I can go out for a meal and have so much energy now and it's going to be brilliant. 'But then I didn't when I got home. It was like everything was scary" (Participant, 1).

"I thought that I'd leave Cape Town loving myself and I didn't and that for me was probably the hardest thing about having to leave Montrose. That's when I felt really let down by Montrose" (Participant, 2).

"I expected Montrose to save me. Which was a very unrealistic expectation to have in the first place" (Participant, 13).

These findings concur with the literature. Studies have found that patients find inpatient treatment easier than home-life as they are often protected from daily hassles which can trigger slips and relapse patterns (Cockell, Zaitsoff & Geller, 2004: 3; Offord, Turner & Cooper, 2006:

3). Therefore, when returning to their home environment, patients' may feel that they can manage life better, but still need to remember that there will often be more obstacles to overcome. The following section will discuss the experience of participants returning to the UK after treatment.

4.4.4.4The experience of returning to the United Kingdom after treatment

The following section describes how participants felt when they returned to the UK and reports on the challenges faced when they were back home.

4.4.4.4 (1) Feelings of isolation

Several participants expressed feeling alone when they returned to the UK after being in a supportive community at MM.

"I felt much lonelier on returning. When I came back it was much more of a shock, like 'oh my god, you are by yourself" (Participant, 7).

"I've found the loneliness hard because of being here with so many people and then not having the same connections. I've found it hard to not be with the people that I had made such good, strong, friendships with in treatment" (Participant, 14).

"The first time I left I really missed the community. I think shifting from a community environment to being on your own a lot of the time is very difficult...So yeah, I think that played into starting to feel quite depressed quite quickly, just feeling so lonely, not feeling like I was ever going to get back that sense of being around people who cared about me and who I cared about, and who I understood" (Participant, 19).

These findings are in accordance to a study contacted by Cockell, Zaitsoff and Geller (2004: 2) which stated that patients' in ED units have the opportunity to identify and express feelings and to receive empathic, non judgemental responses which was said to promote and create a sense of community. When patients are discharged from treatment, they have reported missing that sense of support.

4.4.4.4 (2) Life in the United Kingdom continued to be the same, even when the individual had changed post treatment.

Many participants expressed the difficulties that they had returning home and feeling different and behaving differently whilst the system at home remained unchanged and how they struggled to navigate this.

"So I moved straight back out to my place with my housemates and it was really difficult being with people who, you know, they would still do drugs, they would still drink, they would still exercise a lot" (Participant, 2).

"I feel quite different. I feel like I can't really connect well with people at uni about all them joking about drinking and talking about how much food they want to eat and how hungry they are. So it is quite hard in that sense" (Participant, 1).

"I came back with the attitude of shame instead of pride with what I had achieved and just straight back to old habits, old environments and I blamed the environment and I was like if I just stayed in South Africa or if I just moved away, I've got to migrate to be better and obviously that isn't plausible" (Participant, 5).

These findings show the importance for a therapist to conceptualise these illnesses within an integrated Biopsychosocial framework and explain why clinicians working in inpatient settings are frequently faced with 'their' patients losing weight as soon as they leave the protective setting of the unit due to the family system not being equipped to manage the patient at home. (Frank, 2016: 17; Scholz et al, 2005: 138)

4.4.4.4 (3) Difficult transition to home

Most of the participants who did not go to tertiary care felt that the transition from primary care back home, was a big transition.

"I went from Montrose into another relatively structured, safe environment, rather than just leaving, and I think had I gone straight back to the UK I probably would have struggled a lot more" (Participant, 12).

"Yea I think that is probably what I needed [a step down facility]. I think I underestimated how overwhelmed the experience would be leaving. I was so excited to go home and see my cat" (Participant, 1).

"So I went straight to another clinic when I landed in England...just to make sure that I didn't relapse. And I think, had I not had that, it would've been a lot harder. Had I just gone home and gone back to my flat, I wouldn't have coped, like no way" (Participant, 18).

These findings echo the literature which states that the transition from inpatient care to home can be big. Patients have reported feeling a significant difference between hospital treatment structure and life post-discharge. Planned transitions and continued support from specialist services following discharge were seen as essential to prevent relapse (Offord, Turner & Cooper, 2006: 3).

Objective four described the unmet expectations of the participants. These included what participants felt were challenging aspects of being at MM for treatment and what participants did not find beneficial in the therapeutic programme. Some of these findings included their experience of being in treatment and their struggles with comparing with other patients and feeling infantalised by the team. The limited time with therapists also did not meet their expectations of treatment. Participants also described their experience of returning home and the difficult transition from inpatient treatment to being back home. The following objective will discuss the recommendations participants made to MM regarding the treatment of international patients.

4.4.5 OBJECTIVE FIVE: **To determine what recommendations they would make to Montrose Manor regarding the treatment of international patients.**

The following section will firstly discuss participants' recommendations for new patients'

4.4.5.1 Recommendations for people wanting to be admitted to Montrose Manor

4.4.5.1 (1) Montrose Manor recommended if there is a desire for recovery

Nearly all of the participants expressed that they would recommend other people going to MM for treatment but expressed that one needs to want recovery before being admitted to treatment because it is a difficult process and that without motivation, recovery will not happen.

"Like you can be in the best treatment facility in the world and if you don't want it for yourself, it's not going to happen" (Participant, 12).

“Oh 100 percent. I’ve actually recommended it to a couple of people. I, 100, 100 percent would recommend it. I would not recommend it enough really. it’s incredible” (Participant, 6).

“I’d 100 percent recommend it, but I’d say only come if you’re willing to get better because otherwise you’re going to waste your time” (Participant, 14).

The Health Belief Model looks at a person’s willingness to change their health behaviours due to their perceived susceptibility. The extent to which people feel a specific course of action will effectively manage a problem greatly predicts the likelihood of engaging in treatment seeking. Therefore, if patients are not ready to change their behaviour, they will struggle to engage in treatment (Champion & Skinner, 2008: 47; Akey, Rintamaki & Kane, 2013: 247).

4.4.5.2 Recommendations to Montrose Manor with regards to meeting the need of international client’s pre-admission

This section will discuss the recommendations that participants make to MM regarding pre-admission.

4.4.5.2 (1) Contact with their therapist

Several participants mentioned that it would have been beneficial to have contact with their primary therapist prior to admission.

“I really liked the fact that we got a Skype with * I think maybe a second one from her would have been very nice just the day prior- even the person who is going to be your therapist, just so you kind of know another face I suppose” (Participant, 10).

“Maybe like a skype call with their chosen therapist before getting there. I think because I had a lot of anxieties before I went there so yeah, that could be good” (Participant, 1).

“Just meeting (Name of the individual) was really good for me but I wonder whether it would have felt better to know that [the therapists] also knew something about me” (Participant, 2).

These findings concur with research which states that in RTC, the therapeutic team plays a major role in the assessment and treatment of the primary illness (Redenbach & Lawler, 2003:

148). This creates an understanding as to why participants may feel it beneficial to be in contact with their primary therapist prior to admission in order to create a sense of safety and to help soothe their anxieties prior to arrival.

4.4.5.2 (2) Need to update the website

A few participants expressed that the MM website was outdated and recommended that it be updated so that people flying across the world can have a better idea of where they are going and also more information on the facility.

"I couldn't find out a lot of information from the website. The photos are very outdated, so it would've been nice to have some more up to date information" (Participant, 20).

"the website's quite poor, or it was when I came for the first time, so there should definitely be more information there" (Participant, 19).

"I'd had a look at some of the photos online and the brochure but it was quite vague and it turns out actually a lot of the photos were old" (Participant, 12).

In the Health Belief Model, Cues to Action, are external events that prompt a desire to make a health change (Champion & skinner, 2008: 50). These may include informing a patient with an ED about the possible treatment options available to them. Therefore, it is important that information regarding the facility is up to date in order for patients to make informed decisions regarding the treatment they would receive.

4.4.5.2 (3) Contact with past clients

A few participants expressed that it would have been nice to be connected with past clients' that had been through the process at MM, so that they could ask them further questions.

"The biggest and most helpful thing for me was speaking to someone who had been there themselves...because it's very easy for a counsellor to sit here and tell you this is the program, but it's completely another level to see someone who's gone through it and gone out the other side and is in recovery" (Participant, 12).

"Like a skype, with someone who'd left, who'd lived in the country I live in. But yeah, a skype with someone just for them to ask questions would have been really amazing" (Participant, 8).

"Yeah completely. I think that would be really beneficial [to be in contact with UK clients] and I know if only there was a weekly drop in, I would definitely try make the most of it. Go as many times as I could" (Participant, 10).

The literature confirms that connecting with individuals who had recovered was reported to be particularly helpful, as this contact generated feelings of acceptance and provided hope for the future (Cockell, Zaitsoff & Geller, 2004: 2).

4.4.5.3 The recommendations participants would make to Montrose Manor with regards to meeting the needs of international client's during their stay

In this section, participants expressed their recommendations to MM with regards to their stay at the facility.

4.4.5.3 (1) Implementation of a Discharge plan

Several participants expressed that it would have been beneficial to have had more support with regards to the discharge plan, and they recommend that more focus be put on the discharge plan for current patients during their stay at MM.

"I think I could've definitely been helped a bit more in my discharge and, really having a structured plan, I mean my counsellor didn't even look at my discharge plan, or didn't even ask for it in the end" (Participant, 14).

"I feel like by the time I left Montrose was very busy, so I didn't have that much support around me actually leaving. I don't know if my meal plan got checked properly, I don't know if my day plan got checked properly. I didn't have a plan for when I left, I didn't have volunteer places. I was actually going back to nothing" (Participant, 2).

"I think it would be good if you spent more time on your discharge plan with your counsellor, I felt you were slightly just left to do it by yourself" (Participant, 20).

These findings concur with the literature which states that discharge from an inpatient unit requires an enormous adjustment in terms of resumption of responsibilities and obligations relating to eating and otherwise, as it can be experienced as involving a significant loss of support. Preparation for discharge and subsequent follow-up treatment is therefore essential if improvement is to be maintained (Treasure, Claudino & Zucker, 2009: 376).

4.4.5.3 (2) Promotion of the 12-step meetings for discharge

During admission at MM, patients attend two to three fellowship meetings a week. A few participants recommended that MM should put more emphasis on the 12-step fellowship meetings and promote it more strongly for discharge in order to aid patients' recovery back home.

"I think in terms of Montrose there need to be more emphasis on the 12- step program. I think we needed to know...that coming back to London and just seeing a therapist once a week and a dietician, I mean, you're fucked immediately… you need to work the 12 steps and get a sponsor. Like that is shoved down our throats, I think that needed to be bigger" (Participant, 8).

"Not harnessing the 12-step programme as much- I do feel like it's kind of a disadvantage in a way" (Participant, 3).

"If [international client's] are going back [to the UK], they must have their meetings planned and [the team should] emphasise the importance of meetings and getting a sponsor" (Participant, 9).

These findings are in accordance with the literature. RTC's often promote the 12-step fellowship for ED because 12-Step group recovery has appeared to be effective in modifying the behavior of AN as it allows for social interactivity and the assistance of peer support systems (McAleavey, 2010: 730).

4.4.5.3 (3) Promotion of a step down facility

Several participants recommended that MM recommend a step-down facility for after inpatient treatment in order to assist an easier transition back home.

"I would say encouraging people of the fact that like, yes you've been here for three months but the reality is that it's very very early stages and you probably need more of a step-down approach and acknowledging that although phase 3, and I think you've got like a phase 4 now, but although that's really great, it's still, to some extent, miles away from what you'd be going home to" (Participant, 12).

"I went to Start to Stop, which was helpful as well. But it really helped me manage the integration back home. I think if I'd just come straight back and moved to London, I don't know how I would've coped, because it was so overwhelming...I know Cape Town's a city but it's so different, so different. Yeah, I think I needed a second holding period, for sure" (Participant, 17).

These findings support the literature which states that ED day units and psychotherapeutic supported accommodation can offer a useful 'half-way house' between inpatient care and independent living (Treasure, Claudino & Zucker, 2009: 376).

4.4.5.4 The recommendations participants made to Montrose Manor with regards to meeting the need of international client's post-discharge

In this section, the recommendations for post-discharge will be discussed. These include several areas:

4.4.5.4 (1) Need for Follow-up sessions

Many participants expressed that it would have been helpful to connect with their MM therapist post discharge via skype while they made the transition to normal life. Some had the experience of continuing with their therapist and found this to be very beneficial.

"I do think I was lucky to have a cross over with [my Montrose therapist] as well, which I think was quite important to give me time to get set up fully because you can book a dietician and therapist or whatever, but it might not work out or whatever. I think I did a month or 6 weeks with [my Montrose therapist] and that was a great stepping stone" (Participant, 9).

"I think you guys still do skype sessions with international clients, yeah. So that is brilliant" (Participant, 12).

"It's been a complete lifeline having [my Montrose therapist], and having regular sessions with him. So that was great that he was willing to skype with me in the evenings, but then also just for me, having someone who I knew and trusted and also having, I like felt, through [him] I was still holding Montrose's hand, and for me that felt, and still feels, really important" (Participant, 19).

It has been reported that patients may not maintain the weight gains they achieve in hospital unless they are adequately supported with psychotherapy, during admission and following discharge (Striegel-Moore, Leslie, Petrill, Garvin & Rosenheck, 2000: 132).

4.4.5.4 (2) Establishment of a support group

A few participants recommended that MM establish an online UK support group for those that could not attend the support group in SA. This therefore would provide patients with continued support post discharge.

"I stayed in South Africa for a month and a bit after I had been discharged from Montrose, and I was able to attend some of the aftercare groups. I don't know if maybe a skype one can be done for those that come back to the UK? I don't know some kind of support group or something" (Participant, 10).

"Maybe even like, having a skype session of people who have recently left. So it would be like an aftercare, but it would be like an international one or a UK one, and everyone can skype in" (Participant, 12).

"If I'm honest I get really jealous thinking about these people all going on a Wednesday afternoon and having aftercare, and it makes me annoyed like, it's frustrating because I've been through that treatment too and just because I don't live in Cape Town, I don't get that" (Participant, 20).

These findings correlate with research conducted by Moccormack, (2010: 12) which emphasises the value of support groups in the treatment of ED not only during hospitalisation. It also speaks to the Biopsychosocial Model which promotes social connectivity as a means of support (Campbell & Rohrbaugh, 2013: 24). Bell (2008: 187) also notes that experiences

outside of treatment significantly impact on recovery in particular the presence of supportive relationships.

4.4.5.4 (3) Promoting peer support

Several participants recommended that MM connect patients to past patients that had already been discharged in the UK. This would allow for continued support and the ability to connect with other people who had been through the treatment process and transitioned home. It was also recommended that a 'buddy system' be put in place, where past patients' could support a recently discharged patient so that they do not feel so alone on return to the UK.

"I don't know whether people would be willing to do this but if there was some kind of mentoring program in London where you could put old clients with people who were recently coming home, on the grounds that they don't have to keep up with them if they're not doing well…I don't know you can say like 'we really encourage you to go to coffee and go to your first ABA meeting and have dinner together within the first month of being back' and like do those three things and then if it takes off as a relationship then great, and if it doesn't then it doesn't matter, but a bit more of that like older people helping new arrivals back would be really useful" (Participant, 19).

"So you don't feel so alienated and you knew that you had people, like if you were going back to the UK, you had people you could meet up with" (Participant, 12).

These findings concur with the literature, as Cockell, Zaitsoff and Geller (2004: 2) have noted that connecting with individuals who had recovered was reported to be particularly helpful, as this contact generated feelings of acceptance and provided hope for the future.

Objective five discussed the recommendations that participants had for MM and the treatment of international patients. These recommendations focused on the facility, the needs of patients whilst in hospital and post-discharge.

4.5. CONCLUSION

Through the lenses of the Biopsychosocial model and the Health Belief model, this study has explored the experiences of twenty participants who received treatment for Anorexia Nervosa in South Africa. Their responses indicated the value of their treatment as well as the challenges they encountered. This has also served to provide insight into their psychosocial need during their treatment journey. The conclusions reached by most participants, despite the challenges they encountered, was that they had benefited from the treatment received at MM and would recommend the service to others. The final chapter presents the conclusions and recommendations of the study,

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter presents the conclusions and recommendations drawn from the findings of the study. The conclusions are discussed under each research objective. Recommendations are made in relation to improved practice and further research.

5.2. CONCLUSIONS

The conclusions are presented below:

5.2.1 **Objective one:** To explore participants' reasons for seeking treatment at Montrose Manor instead of seeking treatment in their own country.

It can be concluded that the participants had a number of reasons for seeking treatment in South Africa. These were primarily based around concerns that they had about the treatment in the United Kingdom. These concerns included a delay in treatment due to long waiting periods; inpatient treatment focused on weight restoration and the lack of psychotherapy. Other concerns included inpatient treatment not being specialised due to lack of training in ED or the use of agency staff who could easily be deceived which meant that the participants were able to continue their acting out behaviour in treatment.

Participants described their ED becoming unmanageable before getting the help that they needed. It affected all parts of their lives including their families lives, their social functioning and for some of them their education and work. Treatment in the UK was difficult to access due to weight restrictions and long waiting periods in the NHS and unaffordable treatment for some, particularly in the private sector

The focus on outpatient treatment in the UK was also noted as a reason for seeking treatment in South Africa, as many participants felt that they needed inpatient treatment with 24-hour supervision to assist in breaking their unhealthy relationship with food and exercise. Many felt that they were unable to comply with an outpatient treatment approach.

The influence of referrals from professionals is also evident in the study as participants sought treatment in SA, often due to a referral from their professional team in the UK. The referral was specifically for the participants to seek treatment at MM as these professionals highly recommended MM as a facility of choice.

The cost implications of treatment choices are also highlighted in this study and the cost of treatment in South Africa was also a motivating factor for the participants. The low cost and the nature of the programme at MM, meant that participants were able to receive extended treatment of about three months for the price of one month in a UK private facility.

It is interesting to note that despite the importance of family in supporting recovery, as has been documented in the literature review and findings, many participants found it beneficial to have treatment away from loved ones as this allowed them to concentrate solely on themselves and their therapeutic process.

5.2.2 **Objective two:** To explore what their expectations were of treatment when they decided to come to Montrose Manor.

It can be deduced from the findings that the participants had a number of expectations of MM pre admission and interestingly many of these expectations could have raised some anxiety for the participants, given the nature of AN. These included being worried about the weight they would gain in treatment as they knew they would have to comply with the meal plan set out by the dietician. There were also some expectations around the therapeutic team and many participants believed that the team at MM would be very strict and that they would be unable to act out during their time there. Paradoxically participants also believed that they would still be able to act out on their ED, even in MM. It was also noted that there were perceptions that MM would be a clinical setting.

5.2.3 **Objective three:** To explore in what way these expectations were met.

From the findings it is clear that many of the participants' expectations were met. Participants expressed that the structure of the programme created a sense of safety for them. The value of a holistic approach to treatment as underscored by the theoretical frameworks of this study also emerged as a clear finding. Other expectations that were met included that the treatment

focused on root causes of the illness as this allowed the participants to obtain better understanding of themselves and their ED.

The issue of the need for specialisation was reiterated and it was noted that expectations were met with regards to the centre being specialised in ED and the team being specialised in the treatment of ED. The physical environment and sense of belonging that this generated also seemed an important aspect for the participants.

The research also explored aspects of the programme which participants felt were helpful and these included the range of therapeutic interventions and exposure therapy, phase three of treatment, family therapy and individual therapy. Participants also noted that the community setting, the meal plan, blind weighing and the nursing staff contributed to a positive experience of treatment received at MM.

5.2.4 **Objective four:** To explore in what way these expectations were not met.
From the findings it is evident that many of the participants experienced challenges during their stay at MM. Some of these challenges included letting go of control and having to surrender to the guidance of team at the facility. EDS are understood to bring a sense of control to participants, and the letting go of their primary coping mechanism seemed to be a challenging experience. Other challenges included participants comparing themselves with other patients being treated at MM, which is common between ED patients as they can compete for thinness. Participants also reported that in the beginning of treatment, a few of them felt infantilised which spoke to the importance of patients being included in their treatment process in order to promote positive therapeutic outcomes.

The importance of have a good therapeutic alliance was evident from this study. A more collaborative approach, increased the value of the therapeutic alliance. The time spent with the dietician and the psychiatrist emerged as a positive and more time with these professionals was recommended, especially in a safe environment where psychiatric issues in particular, can be managed under the care of a medical team.

It can also be concluded that one expectation that was not met by MM was the belief that participants would be fixed post discharge as they often glamorised what life would be like when they returned home. The reality that recovery is difficult set in after discharge. The

challenges with transition to life post discharge was also evident in this study. This was often a disappointing realisation for participants, but this finding also speaks to the importance of emphasising post discharge support for continued recovery and support.

5.2.5 **Objective five:** To explore what recommendations they would make to Montrose Manor regarding the treatment of international patients.

A number of recommendations were made with the key one being that participants would recommend MM to other patients based on their experience of the service, and their insights around the need for professional support. Participants emphasised that patients should be motivated for treatment and want recovery before admission in order for the treatment process to work. Regarding recommendations pre-admission, participants reported that they would have liked contact with their therapist prior to admission in order to have a point of reference and to be able to ask more questions about the treatment process. They would have also liked to be in contact with past clients of MM who had been through the process themselves in order to be more informed.

The importance of the facility's website was clear and participants recommended that the MM website be updated so that patients' are more aware of the facility they are being treated at. They noted that the website was outdated and when they arrived at the facility, it was quite different to what they expected.

Participants also made recommendations to MM for patients during their stay at the facility. It was recommended that more emphasis be placed on the discharge plan so that patients feel more prepared to return home. They also recommend that the 12-step meetings are emphasised more in treatment, as these are a great form of support for discharge. Many participants felt that the transition from inpatient treatment to home was challenging, and therefore recommend that a step down facility be promoted in order to prepare patients for an easier transition home.

Post discharge, participants recommended that follow up sessions be implemented in order to increase emotional holding and improve the transition home. Many of them also recommended an online UK support group post discharge as another means of support and for MM to put patients in contact with past clients in order to promote peer support.

5.3 RECOMMENDATIONS

Based on the themes identified in the current study, a number of recommendations can be made for clinical practice and service provision for patients with AN. Recommendations are made to MM and future research in this field.

5.3.1 Recommendations to Montrose Manor

Allowing patients more input in their treatment process

An analysis of participants' narratives suggests the importance of providing individualised and collaborative care in treatment. In light of the fact that some participants experienced a loss of perceived control and felt infantalised, it follows that health professionals should allow for greater patient collaboration within treatment. The ability to attend Ward Rounds, consult with the psychiatrist and the team and receive regular feedback on progress could help to reduce feelings of uncertainty and may help patients' feel more included in the treatment process. There is also evidence from some of the findings that in early stages of treatment, even though the participants did not like it at first, they appreciated all control being taken away by the team, as they are often not able to give themselves permission to do certain things by themselves. The disadvantage of giving the patient control too early on in treatment, is that they may have limited insight into their illness, which may negatively impact the treatment process.

Family therapy and peer support during treatment

The current findings highlight that while inpatient treatment is perceived as essential for recovery, there remain existing challenges for patients regarding the transition to and from inpatient treatment settings. Health professionals, particularly clinical social workers can help prepare patients for inpatient treatment, facilitating the adjustment process. Scholz et al., (2005: 139) argue that greater involvement of family members and peers are needed in the inpatient treatment of adult patients with AN to sustain progress. Clinicians employed by MM, can provide educational information and training for patients' families to help them to assist with the rehabilitation programme when patients return home. Case managers can take the primary role of educating their own patients families about ED in order to not overburden one individual. At MM the unit manager usually does a family programme, but it may be helpful for her to do this using an online platform in order to reach more families at once and therefore she can prioritise doing this once a month, instead of every time a family visits the clinic, therefore reducing her workload and reaching a bigger audience.

Psychiatric support

Due to MM being a psychiatric facility, it is recommended that after the initial assessment by the psychiatrist, that the psychiatrist has individual sessions with each patient once a month during their stay at the facility. This will allow patients to feel that they are part of their own therapeutic process and to allow them to have more input in the psychiatric leg of the process. It will also assist patients in feeling supported by the psychiatrist. If this is not a feasible solution, it can be managed by MM offering placements to psychiatrists in training, which could reduce the workload of the current psychiatrist and assist in patients having their psychiatric needs met.

Dietetic support

Due to the nature of this illness, it is recommended that there be more dietetic support offered at MM. The dietician already sees each client individually each week and runs an ongoing food group which takes place for an hour each week. It may not be feasible for the current dietician to have more individual time with each client, but it may be beneficial to prioritise another food group in the week for patients. Another option would be to employ a dietician assistant that could share the work load with the primary dietician and also offer more individual support.

Ongoing training for health professionals

Consistent with previous research, treatment experiences were influenced by the quality of staff interactions with emphasises placed on therapist qualities which promoted a supportive and trusting therapeutic environment (Wolfe, Dunne & Kells, 2016: 213). It is recommended that therapeutic health professionals attend supervision biweekly with an individual therapist and group support once a month. It is also important for therapists to create an environment for which patients' feel open enough to discuss their concerns regarding the therapeutic alliance in order to promote successful outcomes. Training may be useful in this area by an external group therapist. This will therefore incur a cost to the company, but it is not recommended that supervision be conducted by an in-house facilitator, as this may impact the team's ability to be honest about their feelings to one another.

Transitional care post discharge

There is an identified need to focus on transitional care to help maintain patient recovery following discharge from inpatient settings. Previous research recommends the continuation of

a supportive therapeutic relationship during the transitional phase and allowing patients opportunities to make earlier connections with outside activities while in treatment to serve as an incentive to remain healthy when discharged (Koskina, Campbell & Schmidt: 2013: 198, Brewerton & Costin, 2011: 121). In line with these recommendations, participants in the current study perceived opportunities to practice eating skills (exposure therapy) in external social settings as essential for coping with life post-discharge. This suggests a need to consider a planned graded decrease of intensity of professional support over time and the transfer of increased responsibility to the patient within the treatment environment. If patients do not want to continue at a tertiary facility such as sober living, it is recommended that the therapeutic team at MM recommend outpatient services in the UK to their patients returning home. It is also recommended that therapists or case managers continue to see their patient once a week for the first month back home, in order to help sustain recovery. These sessions can be done via Skype at an additional cost. The inclusion of an online support group that fosters learning and shared experiences serves as a tangible form of social support. This could be offered fortnightly, or once a month by the clinical social worker. It need not be sourced within the practice, and may be outsourced by external professionals or organisations; however, outsourcing may incur additional costs. If the latter option is considered, patients could be charged a fee for joining the support group.

5.3.2 Recommendations for further research

The current findings relate to the treatment perceptions of one specialised adult inpatient unit explored using a qualitative design. Future quantitative studies may wish to use published measures such as the Eating Disorder Patients Expectations and Experiences of Treatment Questionnaire (EDPEX) (Clinton, 2001) and the Questionnaire for Eating Problems and Treatment (De La Rie et al., 2006) with patients with AN to evaluate treatment quality.

Participants' accounts also suggest a shift in perception over time. Many patients seem to do well post discharge from inpatient treatment in the first few months. Future research may wish to explore the process of recovery post inpatient treatment using a longitudinal qualitative, quantitative or mixed approach to identify how patients with AN sustain recovery post discharge. It would be of particular value to carry out interviews or administer evaluative questionnaires at different time-points in the participants' lives in order to identify any possible differences in views and experiences of life post discharge and overtime.

It may also be useful to further explore the experiences of patients who have dropped out of treatment to identify factors which may contribute to treatment dissatisfaction. Given participants' negative experiences of outpatient services, it would be interesting for further qualitative studies to explore patients' perceptions of different treatment settings for AN including outpatient treatment and day-patient services.

Additionally, the current study only focused on the treatment perceptions of adult female patients with a diagnosis of AN, so future research may wish to explore the experiences of inpatient treatment from the perspective of male patients or those with Bulimia Nervosa.

In addition, an area for further qualitative research or quantitative research might be to explore the treatment process and outcomes of an inpatient facility in the UK compared to MM in order to understand the differences in treatment approach and how this may impact patient outcomes post discharge. This study highlighted difficulties in accessing appropriate treatment, inequities in specialist service provision and challenges associated with service transitions. Current ED research in this area remains limited and the experiences of patients with AN in the UK, regarding these challenges have not yet been explicitly explored. It may be worthwhile to explore how patients experience treatment accessibility and the transition between services. Such information would allow services to develop clearer integrated care pathways and further highlight the need for greater availability of specialist services.

5.4 CONCLUSION

This qualitative research study aimed to explore the experiences of international patients seeking inpatient treatment for Anorexia Nervosa and the study achieved this. The conclusions based on the findings indicate that most participants, despite the challenges they encountered, benefited from the service received and would recommend the service to others. Recommendations were provided to address these challenges as well as for further research.

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APPENDIX 1

Appendix 1

PARTICIPANT INFORMATION AND CONSENT FORM:

Title of Dissertation: Medical Tourism: Experiences of International Patients Seeking Inpatient Treatment for Anorexia Nervosa at Akeso Montrose Manor

Researcher: Lauren Aron

Contact Email: L.aron@montrosemanor.co.za

You are invited to take part in this research project. Please take some time to read the following information about this study. You are welcome to ask questions at any point. Please note that participation in this research is completely voluntary. If you agree to participate, you are still entitled to withdraw from the study at any point. The researcher is an employee of Akeso Montrose Manor and is undertaking this study as part of a Masters degree and not as a staff member at Akeso Montrose Manor. This study has been approved by the ethics committee of the University of Cape Town, as well as management at Akeso Montrose Manor.

What is this research about?

The aim of this study is to explore the concept of medical tourism and the experiences of international patients seeking inpatient treatment for Anorexia Nervosa at Akeso Montrose Manor. The researcher is interested in the way in which patients have benefited from treatment and recommendations that can lead to further programme development for Akeso Montrose Manor and the treatment of international patients.

Why have you been invited to participate?

You have have completed treatment at Akeso Montrose Manor for Anorexia Nervosa within the last two years and therefore are an expert of your own experience.

What will be required of you?

The researcher will interview you about your experience of treatment seeking in South Africa and the United Kingdom as well as your experience of treatment at Akeso Montrose Manor. This interview should take about one hour of your time. All interviews will be recorded via a

Dictaphone for transcription purposes only. These recordings will not be available to Akeso Montrose Manor.

The time and place of the interview will be determined by your convenience. As most participants live in the United Kingdom or overseas, these interviews will take place over Skype. Due to the personal nature of the interview, you may find that the interview covers sensitive topics. Should you feel uncomfortable with a question, you are under no obligation to answer it. If the interview brings up difficult memories or emotions, debriefing and counselling will be offered to you by Akeso Montrose Manor therapists at no cost.

How will participating benefit you?

Participation may not have any direct benefit to you at this stage, but sharing your experience may lead to the development of the profession within the practice and an improved service for other patients and family members. You will not be paid for your participation.

What will happen if you withdraw from the study?

Choosing not to participate in the study will in no way jeopardise your relationship with Akeso Montrose Manor.

Who will have access to this information?

Confidentiality will be carefully protected and your name will not be mentioned in this study. The Dictaphone recording will only be heard by the researcher and an independent transcriber, who is bound by confidentiality.

How public will this research be?

As per the Master's level dissertation procedure at the University of Cape Town, all studies are published on OpenAccess and therefore available to the general public. The findings of this study will also be shared with the team and management at Akeso Montrose Manor.

INFORMED CONSENT OF PARTICPANT:

I ____

agree to take part in this research study titled "Medical Tourism: Experiences of International Patients Seeking Inpatient Treatment for Anorexia Nervosa at Akeso Montrose Manor "

I agree that:

- I have read all the information provided.
- I understand the information given and it has been written in a language that I understand
- I have been offered an opportunity to ask questions about this research study and my questions have been answered adequately.
- I understand that my participation is voluntary and I have not been forced or pressurised to participate.
- I understand that I can choose to withdraw from this study, or not answer any questions that make me feel uncomfortable. There will be no consequences or prejudice from the researcher.

Signed at: ____________________ on the ____________________ 2019.

____________________	____________________
Signature of participant	Signature of Witness

APPENDIX 2

Appendix 2

Semi-Structured Interview Schedule

A) Demographic information:

- Name
- Age
- Relationship status
- How old were you when your eating disorder started?
- When were you first formally diagnosed with Anorexia Nervosa?
- When were you at Akeso Montrose Manor
- Duration of stay at Akeso Montrose Manor
- Number of prior admissions if any

B) To determine participants' reasons for seeking treatment at Akeso Montrose Manor instead of seeking treatment in their own country of residence.

1. Please tell me in your own words about your eating disorder history?
2. How have your concerns with food influenced your life?
3. Tell me about your history of seeking treatment in the United Kingdom?
4. What was your experience of seeking treatment in the United Kingdom?
5. What made you to decide to seek treatment in South Africa?
6. How did you hear about Akeso Montrose Manor?
7. What made you then choose to come to Akeso Montrose Manor for treatment?

C) To determine what their expectations were of treatment when they decided to come to Akeso Montrose Manor.

8. Once you had decided to come to Akeso Montrose Manor, what were your feelings about going there?
9. Before admission to Akeso Montrose Manor, what were your expectations of Akeso?

D) To determine in what way these expectations were met.

10. How, if at all, were these expectations met?
11. What was your experience of your arrival at Akeso Montrose Manor?
12. What were the most helpful aspects of the programme?
13. Looking back, what was the most helpful aspects of being at Akeso Montrose Manor for treatment?

E) To determine in what way these expectations were not met.

14. What were the most challenging aspects of being at Akeso Montrose Manor?
15. What aspects of the programme did you not find beneficial?
16. Looking back, what was the most challenging part of treatment?
17. Looking back, were any of your expectations not met?

18. What was it like leaving Akeso Montrose Manor?
19. What was it like being back at home in the UK?

F) To determine what recommendations they would make to Akeso Montrose Manor regarding the treatment of international patients.

20. How is your relationship with food since treatment?
21. How has treatment influenced your life, if at all?
22. What if anything, have you done differently since leaving Akeso Montrose Manor?
23. If someone had to ask you advice about coming to Akeso Montrose Manor, what would you tell them?
24. How has treatment at Akeso Montrose Manor differed to treatment received in the United Kingdom?
25. What recommendations would you make to Akeso Montrose Manor with regards to meeting the needs of international client's pre-admission?
26. What recommendations would you make to Akeso Montrose Manor with regards to meeting the needs of international client's during their stay?
27. What recommendations would you make to Akeso Montrose Manor with regards to meeting the needs of international client's post-discharge?

G) Closing

APPENDIX 3

DEPARTMENT OF SOCIAL DEVELOPMENT
UNIVERSITY OF CAPE TOWN
ETHCS REVIEW FORM

ETHICS REVIEW FORM: JOINT STATEMENT BY STUDENT & SUPERVISOR
This form is filled in jointly by the student and the supervisor

PROCESS:

- Student and Supervisor need to read the UCT/FACULTY ETHICS GUIDELINES on the WEBSITE.
- The ethics pertaining to the profession of Social Work also needs to be taken cognisance of in relation to social work students/candidates carrying out research with human participants.
- Once this ethics review form has been completed it is submitted to the Departments' Post Graduate Committee which according to the Guidelines laid down should consist of all academics who will do the reviewing.
- Once the Department approves the proposal/ethics then only is it sent through to faculty.
- **This form should be completed by the research student and then co-signed by student and supervisor: Tick the YES or NO box, and write in details where appropriate. Please read the UCT Ethics Guidelines involving Human Subjects before completing the form. Ask your supervisor for clarification and help if needed.**

Student researcher name:

Lauren Marie Aron

Student number:

ARNLAU007

Title of research project:

Medical Tourism: Experiences of International Patients Seeking Inpatient Treatment for Anorexia Nervosa at Akeso Montrose Manor

Degree:

Masters in Clinical Social Work

Supervisor:

Fatima Williams

1. Have you read the UCT Guidelines for Research involving Human Subjects? (available from supervisor or at the UCT web-site - go to Research/ go to Standards and Procedures)	YES			
2. Is your research making use of human subjects as sources of data?	YES			

3. Title of the Research Project:

Medical Tourism: Experiences of International Patients Seeking Inpatient Treatment for Anorexia Nervosa at Akeso Montrose Manor

4. Specify the Main Objectives of the Study?

A. To explore participants' reasons for seeking treatment at Akeso Montrose Manor instead of seeking treatment in their own country of residence.
B. To explore what their expectations were of treatment when they decided to come to Akeso Montrose Manor.
C. To explore in what way these expectations were met.
D. To explore in what way these expectations were not met.
E. To explore what recommendations they would make to Akeso Montrose Manor regarding the treatment of international patients.

5. METHODOLOGY

5.1. Research Design

This research study aims to utilise a **qualitative approach**, as it takes a stance that is person-centred and holistic. This approach also allows the researcher to develop an understanding of the participants and their lives (Holloway & Galvin, 2016: 200). This approach will allow the researcher to gather information that has depth and knowledge that is rich in order to present a picture of the participants' reality and social context. For this study the researcher will use a **phenomenological research design** which aims to understand and interpret the meaning that research participants give to their everyday lives. Creswell (1998) cited in De Vos et al.,(2011:270) regards a phenomenological study as a study that describes the meaning of experiences of a phenomenon, topic, or concept for various individuals. Through this approach, the aim is to understand and enter the participants "life world" by analysing the conversations and interactions had with the participants in the study (De Vos et al., 2011: 270).

5.2. Population and Sampling

5.2.1. Sampling Technique

Purposive sampling will be used for this study as particular cases will be chosen because they illustrate some feature that is of interest for this particular study. De Vos (2011: 392) refers to this kind of sampling as typical case sampling in qualitative research where typical cases are sought and selected for the study. This type of sample is based entirely on the judgment of the researcher, in that the sample is composed of elements that contain the most characteristic, representative or typical attributes of the population that serve the purpose of the study best. The researcher will therefore select participants based on a specific purpose. Sixteen participants will be chosen for the sample and participants will be approached telephonically and via email.

5.2.2. Sample Characteristics

- Female participants

- Age 18 and above
- Diagnosed with Anorexia Nervosa
- Must originally be from the United Kingdom and had previous treatment for their eating disorder
- They must be at least one-year post discharge from Montrose Manor
- The participants chosen may not be clients of the researcher

Reason for choosing UK participants: The researcher chose to focus on patients from the UK as many of the patients admitted for treatment at Akeso Montrose Manor are from the UK and therefore it would be of interest to research the reasons why these patients search for specialised out-of-country treatment.

5.2.3. Sampling Procedure[process involved in obtaining the sample]

- Access to the sample will be gained through Montrose Manor's client database. All previous client information is kept in a database which will make it easy for the researcher to obtain a sample
- The researcher will choose participants that have not been clients of hers.
- A meeting with hospital managers and directors will be held in order to obtain permission from them
- A copy of the research proposal will be submitted to management of Montrose Manor for their approval before gaining access to research participants

6. INFORMATION PROVIDED ABOUT RESEARCHER AND RESEARCH TO BE UNDERTAKEN

6.1. Will participants (research subjects) in the research have reasonable and sufficient knowledge about you, your background and location, and your research intentions?	**YES**			

6.2. Describe briefly how such information will be given to them. If there is any reason for withholding any information from participants about your identity and your research purpose, explain this in detail below.

I work at Montrose Manor as a therapist, and I will disclose this to participants. I will also disclose my credentials and that I am a current employee of Montrose Manor. I will also inform them about the objectives of the research and their rights as participants and give them the option if they want to be included or excluded from the study from the outset. This will be done in a written format so that they can refer to it if need be. I will also mention it in the first interview as a means of establishing rapport.

7. HOW PERMISSION WILL BE SOUGHT				
7.1. Will Participants will be fully informed when permission is sought from them to participate in the study?	**YES**			
7.2. Describe the process of how this will be done [letter seeking permission & details of study purpose/objectives, will initial contacting take place?)				
I will make contact via email with an attached letter seeking permission from the participants to be part of the study. I will also state in this letter details of the study as well as its purpose and objectives and what procedures I will follow. If they have any questions or concerns. I will follow up telephonically or via email depending on what they would prefer. Participants will have an opportunity to contact the researcher via email, during the initial contact, as well as the beginning of each interview to clarify any questions regarding the study and their participation.				

8. CONSENT				
8.1. Will you secure the informed written consent of all participants in the research?	**YES**			
8.2. If your answer is yes, Describe how you will do this below				
Each participant will be given a letter of consent to sign before their participation in the study. I will email this document to them. Only once written consent is given, will I proceed with the interviews. This letter will contain all the necessary information around their participation and rights to withdraw rom the study, as well as their protection in participating.				
8.3. If your answer is NO, give reasons below.				
N/A				
8.4. **Do the respondents have the right to withdraw?** Yes				
8.5. If yes, explain how this would e obtained? They are welcome to withdraw verbally or in writing, but I will ask them to put it in writing that they are withdrawing from the study as to have evidence of withdrawal. They may also refuse to participate in the study through not granting their informed consent and not signing the relevant consent form.				
8.6. Will respondents be informed of the use of data post-data collection?				
8.7. If yes, how This will be explained in the letter that I send to participants explaining the aims and objectives of the study and what will be expected of them. Participants will be informed that the data will be exclusively utilized for the research purpose of the study and that the data will be analysed for the purpose of the researcher writing a dissertation as part of the Clinical Social Work Masters programme.				

9. RESEARCH INVOLVING CHILDREN				
9.1. In the case of research involving children, will you have the consent of their guardians, parents /caretakers?	**N/A**			

9.2. If your answer is YES, briefly describe how this consent will be secured?				
[*Type here]* N/A				
9.3. If your answer is NO, give reasons below				
N/A				
9.4. In the case of research involving children, will you have the consent of the children as much as that is possible?	**N/A**			

9.5. If your answer is YES, describe briefly how this consent will be got from the children				
N/A				
9.6.If your answer is NO, give reasons below.				
N/A				
10. CONFIDENTIALITY, PRIVACY AND ANONYMITY				
10. 1. Are you able to offer Confidentiality, Privacy & Anonymity to participants?	**YES**			
10.2. If you answer YES then give details below as to what steps you will take to ensure participants' confidentiality. If there are any aspects of your research where there might be difficulties or problems with regard to protecting the confidentiality and rights of participants and honouring their trust, explain this in detail below				
10.2.1. How will Confidentiality be ensured?				
Confidentiality is defined by the parameters that names may be attached to information, but that it be held in confidence and/or kept secret from the public (Neuman, 2011:153). Confidentiality will therefore be upheld by protecting the information shared by participants in the interviews, this information will not be shared with others except for the researcher's supervisor. The information from participants will also be retrieved in a setting that does not allow people to overhear the information shared. In addition, all manuscripts will be kept private and locked away in the researcher's supervisor's office on campus. Confidentiality will be communicated and emphasised to the participants before interviews are conducted.				
10.2.2. How will Privacy be ensured?				
Researchers should protect the information on research participants from public disclosure (Neuman, 2011:152). The researcher will ensure that the information gathered for the purpose of the research is protected and not accessible to the public in order to protect the privacy of the participants. Interviews will also be conducted in a private space.				
10.2.3 How will Anonymity be ensured?				
Anonymity is defined as the people remaining anonymous or nameless (Neuman, 2011:152). Since the researcher will know the names of respondents, anonymity can not be upheld, although their information will remain private and confidential.				
11.POTENTIAL HARM TO RESPONDENTS				
11.1. Are there any foreseeable risks of physical, psychological or social harm to participants that might result from or occur in the course of the research?	**YES**			
11.2. If your answer is YES, outline below what these risks might be and what preventative steps you plan to take to prevent such harm from being suffered.				

Despite screening participants for predictable risk beforehand, it is possible that participants may become emotional recalling their experience of their eating disorder and treatment. It may bring up painful memories for them that may make them uncontained. I am a trained social worker and therapist and therefore I am able to use my own therapeutic skills to best contain the participant. I will also have trained therapists that work at Montrose Manor offer debriefing sessions to participants. In the biographical information I will ask the client for a contact for their current mental health service provider in order to refer them for intervention in the event that follow up services are necessary.

12. POTENTIAL FOR HARM TO UCT OR OTHER INSTITUTIONS				
12.1. Are there any foreseeable risks of harm to UCT or to other institutions that might result from or occur in the course of the research? e.g., legal action resulting from the research, the image of the university being affected by association with the research project, or a school being compromised in the eyes of the Education Ministry.	**YES**			
12.2. If your answer is YES, give details and state below why you think the research is nonetheless worthwhile.				
This research is also looking at how expectations of treatment were not met at Akeso Montrose Manor and therefore participants may express negative opinions of the organization- but this can be used to improve service delivery and therapeutic outcome. In the event, that during an interview the respondents make serious statements about the organization and its staff that could harm its reputation and image the researcher will refer the matter to the organisation through formal grievance lodging processes by documenting the statement in an incident report. This will be forwarded by the researcher to management to then be formally addressed by the organisation depending on the nature of the dissatisfaction and only with the consent of the respondent.				
13. Are there any other ethical issues that you think might arise during the course of the research? (e.g., with regard to conflicts of interests amongst participants and/or institutions)			**NO**	
13.1. If your answer is YES, give details and say what you plan to do about it.				
N/A				

SUPERVISOR: I have carefully considered all the ethical issues pertaining to this study as reflected in the proposal and at this stage cannot see any ethical obstacles

Supervisor Signature:

STUDENT: I have discussed the ethical issues with my supervisor and am forwarding this review form to the department's ethics committee for further consideration

Signed by candidate

Student Signature:

DSD ETHICS REVIEW COMMITTEE CHAIR (to sign)	Review meeting: Time spent	Date of completion of review
Chair :	30 minutes	11/11/2019

Departmentally approved (<u>YES</u>/NO)

APPENDIX 4

Registration No: 2009/003172/07
Practice No: 055 000 0481564

10th June 2019

TO WHOM IT MAY CONCERN

Dear Sir/Madam

RE:	**ARNLAU007**
Title of research project:	**Medical Tourism: Experiences of International Patients Seeking Inpatient Treatment for Anorexia Nervosa at Akeso Montrose Manor**
Degree:	**Masters in Clinical Social Work**
Supervisor:	**Fatima Williams**

This letter serves as confirmation that I, Annemarie Louw, Hospital Manager at Akeso Montrose Manor, gives permission to Lauren Aron to contact clients that have discharged from our facility, as part of her research for her Clinical Social Work Masters Degree.

Please feel free to contact me should there be a need for further confirmation.

Your:_

ANNEMARIE LOUW

Hospital Manager

021 7979270

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