The therapeutic process – Client's perception of success promoting factors in an and ARFID – Qualitative study

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Research Article

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Abstract

This study aimed to analyze the perception that individuals have of success-promoting factors on their own therapeutic process. We intended to understand which aspects influenced their perception and which factors were considered relevant to the decision to seek help, not to abandon treatment and their motivation to change. The study involved patients with anorexia nervosa (AN) and avoiding food intake disorder (ARFID), with intervention within the scope of different therapeutic models.

Background: In Portugal, anorexia nervosa is an eating disorder with a significant increase in recent years, having been responsible for 4,485 hospitalizations between 2000 and 2014 in Portuguese public health services. Portugal has scarce research in eating disorders, although they are a serious mental health problem both in this country and in Europe.

Methods: The study included a sample of 9 participants who responded to the request for participation posted on the different electronic platforms. The data recollection occurred through a semistructured interview, and the information was subjected to thematic analysis.

Results: This study included a total of 9 participants, 5 with a diagnosis of AN and 4 with a diagnosis of ARFID. All the participants were women between 19 and 52 years of age (an average of 38.4 years). Similarities were found in both groups for and differences.

Discussion: The desire to improve/not cause suffering to family members and the availability of social/emotional support were considered relevant aspects inherent to the client. One hundred percent of the participants considered that certain professional and personal qualities of the professional/therapist were the most relevant aspects to promote the success of the therapeutic intervention. The sample size of this study is small and therefore does not allow generalizations.

Conclusions: The main objective of this study was to obtain knowledge that would allow professionals to reflect on their practice and adapt the intervention to the needs and concerns of the clients. Despite the limitations of the study, our participants provided detailed and relevant information, so we consider the results obtained to be pertinent for the proposed objective. Further research in these areas is needed to deepen the knowledge.

Plain English Summary

This study aimed to analyze the perception that individuals have of success-promoting factors on their own therapeutic process. It involved patients with anorexia nervosa and avoiding food intake disorder, with intervention within the scope of different therapeutic models. Portugal has scarce research in eating disorders, although they are a serious mental health problem both in this country and in Europe. The study included a sample of 9 participants, all women, with ages between 19 and 52 years of age, 5 with a diagnosis of AN and 4 with a diagnosis of ARFID. The data recollection occurred through a semistructured interview, and the information was subjected to thematic analysis. The desire to

improve/not cause suffering to family members, the availability of social/emotional support and personal qualities of the professional/therapist were indicated as the most relevant aspects to promote the success of the therapeutic intervention. The sample size is small and therefore does not allow generalizations, but participants provided detailed and relevant information. Further research in these areas is needed to deepen the knowledge.

Background

Anorexia nervosa and avoidant/restrictive food intake disorder are eating disorders (EDs) that share a dysfunctional pattern of eating, with a significant negative impact on physical health and/or psychosocial functioning due to inadequate levels of food consumption [1]. Although AN and ARFID may share some similarities, they have significant differences [2–4].

Anorexia nervosa (AN) is one of the eating disorders with the most negative impact on people's lives. It affected 408,000 people in the USA in 2018/2019, according to the Deloitte Report [5]. In Portugal, between 2000 and 2014, 4,485 of the hospitalizations in the Portuguese public health services were due to this eating disorder [6].

People with AN live on a voluntary strict and selective restriction of food intake that results in a significant decrease in weight, considering the normal values for age, sex and natural physical constitution of the individuals. This decrease in food intake is associated with an intense fear of gaining weight, frequently supplemented by excessive physical exercise, self-induced vomiting, misuse of laxatives or diuretics as a weight control strategy [2, 7–9].

A distorted self-image perception and the influence of weight or body shape on self-assessment feeds this fear and averts the person from recognizing the risks for their health [10–12].

Anorexia nervosa has a studied negative impact on a person's health succeeding in serious physical limitations, significantly reducing the number of live quality years and increasing the risk of suicide behaviors [13–16]

Avoidant Restrictive Food Intake Disorder (ARFID) was included in the DSM-5 in 2013, which is why there is less research in this area [17–19]. It can develop in children, adolescents or adults and has specific clinical diagnostic criteria [1, 3, 20].

This ED is also characterized by a significant weight loss resulting from decreased food intake, resulting from fear of food consumption consequences, such as choking, vomiting, and/or nausea; appetite absence or disinterest in food; and food selection or restriction due to sensory issues (e.g., related to smell, taste, texture). This ED does not result from a lack of food or cultural/religious practices and has a significant negative impact on the psychosocial functioning of individuals [1, 3, 21, 22].

People with ARFID and AN are characterized by low weight due to restricted food intake, which is why these disorders may seem similar and still be sometimes diagnosed only as AN. Despite physically

similar consequences, people with ARFID do not show excessive concern with their body image, shape or weight and do not have an altered perception of their body image that characterizes AN situations [3, 21, 23, 24].

Scientific research reveals the negative impact and harshness of the suffering caused by living with AN or ARFID. Thus, high levels of dropout of the therapeutic process (20–50%) [25–29] could promote the recovery and improvement of this patient's live quality [28, 30, 31].

According to several studies, the dropout of the therapeutic process does not present significant differences related to different therapeutic models or different formats of the intervention. Higher dropout rates appeared in situations where the interventions were not limited in time and had no evidence-based intervention protocols [28, 32]. Higher dropout rates also emerged in situations with younger clients, in which a specific diagnosis was not identified, and/or in the situations of clients with a diagnosis of eating or personality disorder [27, 28, 33, 34].

Considering all the aforementioned data and the Deloitte report that reveals a premature mortality rate of 5.86 times higher than the general population for patients with ED [5], it seems important to understand what motivates people to seek help, what contributes to their decision to drop out or remain involved in the therapeutic process.

Methods

This study aimed to understand how each individual perceives their own therapeutic process, what motivated them to seek help, and what impacts their process of adherence, maintenance and change in the different therapeutic proposals to adapt the intervention to their specific needs [35–39].

We opted for a qualitative study, as our purpose was to determine the participants' perception [40–43].

Qualitative studies permit a profounder comprehension of the phenomena, as they are grounded on the individual's perception of their own experiences. The participants' main selection criteria were their experience or passage through a therapeutic process and being 18 years old or older [15, 44–46].

We selected Thematic Analysis to analyze the study data. Using this method, the researchers are able to organize the information based on the identification, analysis and description of patterns or themes that result from the interpretation and comprehensive reading of the information, systematically adjusting the interpretive analysis of the data [46–48].

A flexible theoretical approach in the qualitative analysis of the data creates space to integrate the individual experiences of the participants and the motivations underlying their actions [46–48].

The data recollection technique we chose was an open question semi-structured interview. We built the interview script based on the model proposed by McAdams [49] and Neiva's [50] adaptation of that model.

The 5 subdivision parts of the script were kept, as it allows a more structured recollection of the information. According to Neiva's [50] adaptation, the first item includes the project presentation and treatment of the formal aspects of the interview (e.g., study objectives, informed consent) as well as sociodemographic information. The second item allows the participants to refer to their development process and perception of their experiences, covering the participant's life history. The perception of living with an eating disorder, the impact of that experience in their life course, self-perception and relationships at the time, and their strategies choices to cope with the situation are explored in the third and fourth items. The last item covers the participants' perception of the successful or unsuccessful change-promoting factors in the therapeutic process and the impact of that process in their lives.

To better understand the adequacy of the questions, evaluate if they were easily understood, raised doubts or were difficult to answer, the interview was subject to a pre-test. The pre-test interview was tested with an individual fulfilling the same criteria as the participants. Due to this pre-test, small changes were made [49, 51, 52].

Study participant recruitment was carried out through the social networks Facebook, Instagram and WhatsApp, given the limitations created by COVID-19. The conditions were explained, and the interviews were scheduled after the individual's manifestation of interest to participate in our study.

This study is part of a larger study including participants with anxiety, depression and ED (AN and ARFID) diagnosis developed within the scope of a doctoral thesis at the University of Santiago de Compostela. For the present study, having a clinical diagnosis of anorexia nervosa or avoidant restrictive food intake disorder was also defined as a participant inclusion criterion. The willingness to participate in the study was expressed by nine participants, all of whom complied with the requirements.

The researcher carried out all the interviews using the Zoom platform and a mobile phone recorder. Before starting the interview, participants were informed of the ethical and deontological procedures of this study through the informed consent form. This form contained information about the participants' understanding of the investigation, including authorization for the audio recording of the interview as well as the use of data collected [53, 54]. The participants expressed their authorization in the audio recording of the interview due to the limitations imposed by the mandatory lockdown of the COVID-19 pandemic.

A simple numerical code was randomly assigned to each participant to preserve their identity and anonymity. A number identified the participants in all documents referring to this study after that moment, including the audio recording of the interview. Upon conclusion of the study, the audio recordings will be deleted.

The full transcription of the interviews and the registration of other ways of communicating are important aspects of this methodology due to the relevance and meaning they may have to the topic under study (e.g., pauses, sighs, interruptions, hesitations, laughs, among others). The inductive coding of the data occurred after the full transcription of the interviews without reference to pre-existing theoretical approaches [48, 55]. This process was very dynamic, as the different stages required frequent

adjustments in the categorization of the information, resulting from the reflection and review of the data [46–48].

Results

The data in Table 1 shows that this study included 9 women with a diagnosis of AN (5) and ARFID (4). The women’s ages averaged 38.4 years (ranking between 19 and 52 years of age). Forty percent of the participants in this group were single, and 60% were married. Sixty percent had 1 or more children, and 40% of participants were childless. One hundred percent of the participants completed the 12th year, 40% had a degree and 20% had a master's degree. Forty percent of the participants were still studying, and 60% had a professional activity. Eating disorder onset occurred in childhood/adolescence for 78% of participants, and 22% of the participants had symptoms in adulthood. The interviews were carried out with a minimum time of 48 minutes and a maximum time of 1 hour and 20 minutes, with an average interview time of 55 minutes.

Table 1. Sociodemographic Information

Items	Anorexia Nervosa		ARFID	
	N 5	100%	N 4	100%
Age Group				
18 – 25	2	40%	3	75%
26 - 35			1	25%
46 – 55	3	60%		
Civil Status				
Single	2	40%	4	100%
Married/Cohabitation	3	60%		
N of children				
0	2	40%	4	100%
1 or more	3	60%		
Educational Level				
10 – 12º Grade	2	40%	2	50%
College degree	2	40%	2	50%
Master degree	1	20%		
Occupation				
Student	2	40%		
Professionally active	3	60%	4	100%
Symptoms				
Childhood			3	75%
Adolescence	3	60%	1	25%
Adulthood	2	40%		
BMI				
13/14		40%	2	50%
15/16	3	60%	2	50%
16/17	2			

The study participants, given the early onset of symptoms for most of them, underwent a high number of interventions with psychologists and psychiatrists. Initially, they were referred by family members or

family doctors and were monitored in different health responses and by various health professionals. Most of the participants had multiple follow-ups with psychologists and psychiatrists. During the process, 75% of the participants were initially referred for support by family members and doctors; however, at some point in adulthood, they all sought help on their own initiative. Bearing in mind their path and specific vulnerabilities, the participants named a set of factors that they considered promoters or inhibitors of therapeutic intervention success related to the professional and to the client. Table 2 shows different categories related to these factors.

Table 2. Therapeutic Process

CATEGORIES	SUB CATEGORIES	Specific Categories	Participants	
			aN 5	PIAE 4
1. The therapeutic process – client's perception of Success promoting factors	1.1. The Professional Personal and professional qualities	1.1.1. Empathetic, interested in listening the client	100%	100%
			20%	100%
		1.1.2. Guides to solutions without pressure	80%	100%
			60%	100%
		1.1.3. Provides security/support/care	100%	100%
			20%	100%
		1.1.4. Provides a safe place/ has time	20%	100%
				75%
		1.1.5. Doesn't judge, helps understand	80%	100%
			80%	100%
	1.2. Client related factors	1.1.6. Informs about diagnosis/process	80%	100%
				100%
		1.1.7. Doesn't give up, believes in client recovery		
		1.1.8 Validates/respects the Clients feelings thoughts		
		1.1.9. Has experience and knowledge in the field		
		1.1.10. Teaches coping techniques/strategies		
		1.2.1. Motivation to change/improve	60%	100%
			80%	
		1.2.2. Trusts in the therapist and process	20%	
		1.2.3. Cognitive abilities	40%	75%
		1.2.4. Faith /spirituality	60%	100%
		1.2.5. Self-initiative on the search for help	100%	
			100%	75%
		1.2.6. Desire to stop causing suffering to her family	80%	75%
		1.2.7. Improvement of symptomatology		
		1.2.8. Social/emotional support		

The entire sample of the study participants (100%) identified the professional's interpersonal skills in the psychotherapeutic intervention as fundamental for promoting the success of the intervention. The professional competence to demonstrate empathy, interest and availability in listening to the client, an attitude of acceptance without judgment, validation and recognition of the client's capabilities, feelings and opinions, and building a reassuring relationship were the main aspects referred to by the participants.

"Listening, really wanting to know how I feel, not judging me or saying that what I feel or think is ridiculous or doesn't make sense, respecting my suffering and what's important to me." P3

"She wanted to understand me, get to know me, it was very different from others, she wanted to understand my relationship with food, I liked it a lot." P8

"It was very important, she never judged me, was always very sweet, feeling that I'm not being judged, I am not being a burden, that helped a lot. The feeling that she won't give up on me..." P2

"I felt very anxious, but she seemed very relaxed, she smiled like the others didn't, she was really available, so I let myself go..." P4

The majority of the participants also considered the technician's attitude/competence to be very important in teaching the client appropriate techniques/strategies to deal with her situation; in having time to be with the client in a safe therapeutic space; and in explaining the diagnosis, negotiate and adjust the intervention to the client's specific needs and characteristics.

"The doctors who helped wanted to understand, they helped me deal with the situation and didn't judge me, helped me calm me down, gain weight naturally, they gave me time. They didn't rush me" P1

"It is important to explain things and not make people feel that their fears are stupid, they make us think that, in their facial expressions and in their words" P4

"She was trying to use my reality, what I was learning in college, to explain and address the topic. My biggest fear was getting fat and the fact that she didn't tell me that that was the goal helped me or I had run away." P2

"She gave me strategies to use when it got worse, it was very important".

"It's important to have a diagnosis, it's important to have a name, to know what to call things, to explain, because people don't know and blame themselves for being sick, they think they chose the situation." P2

"I felt so bad and guilty about being anxious, if they had explained to me what it was, what was happening, I wouldn't have thought that it was something I was doing wrong and that it was my fault". P4

"The first doctor who saw me didn't have much knowledge, but she could have referred me to someone who could help me" P24

“I was always so nervous the days before the appointments, so afraid of not gaining weight that I would lose weight, just the idea that they were going to weigh me down made me so nervous. Until a doctor listened to me and stopped weighing me, it made all the difference, I'm not so nervous anymore, and I managed to gain weight”. P1

The success-promoting aspects of the therapeutic intervention related to the client had some differences between the AN and ARFID groups.

In the AN group, 100% of the participants considered the most relevant factors the desire not to cause more suffering to their family members and the perception of improvements in their symptoms after the therapeutic intervention.

“When I saw my mother and dad so bad, I realized I couldn't do that to them. They were really worried, and the situation caused them a lot of suffering. "P3

"I don't do anything for myself, I do it for my mother, for my sister, for my boyfriend, I know it's important for them that I look good, I don't want to cause them suffering".

"I realized that I was causing a lot of damage to my family, my children, I was going too far, so I decided to look for help." P30

One hundred percent of the ARFID participants highlighted the client's motivation and wish to change and improve, as well as being of her own initiative the request to help the most relevant success-promoting factors of the therapeutic intervention.

“What kept me going was holding on to my truth, if others don't understand it's not my fault, holding on to myself, my wanting to improve and trying to get them to help me.” P4

“Whenever I left there, I felt better, so I wanted to keep going...” P24

The availability of social/emotional support, trust in the professional and therapeutic processes and people's faith and spirituality were also considered relevant for the majority of participants in both groups.

Participants reported that the absence of the aforementioned positive characteristics makes it difficult for the client to become involved and promotes the abandonment of the therapeutic process. Table 3 shows the specific categories related to these factors.

Table 3. Successful and Inhibiting Factors

CATEGORIES	SUBCATEGORIES	Specific Categories	Participants	
			aN 5	ARFID 4
2. success Obstacles/inhibiting factors	2.1. Professional Personal and professional characteristics	2.1.1. No Experience /training/knowledge	60%	100%
		2.1.2. No time or Interest in listen to the client	60%	100%
		2.1.3. Does not negotiate objectives tasks	40%	100%
		2.1.4. Apply rigid protocols	60%	100%
		2.1.5. Use of Inadequate strategies	80%	100%
		2.1.6. Passive, cold, distant attitude		100%
		2.1.7. Does not inform Diagnosis /T		100%
		2.1.8. Medication, doesn't explore alternatives		100%
		2.1.9. Devalues / doesn't validate the client's feelings		
		2.1.10. Doesn't teach strategies to deal with the situation		
		2.1.11. Wrong diagnosis		
	2.2. Client related factors and main difficulties experienced	2.2.1. Accept the need for help / get started	80%	
		2.2.2. Adverse life events		100%
		2.2.3. Multiple interventions/negative/imposed	40%	100%
		2.2.4. Comorbidity with other PM		100%
		2.2.5. Inadequate Procedures	40%	
		2.2.6. Fear of failure/disappoint others	60%	
		2.2.7. Resist constant urge to give up	80%	
		2.2.8. AN Advantages (Control/attention/praise)	60%	

2.2.9. Extreme tiredness/internal and external struggle

2.2.10. No hope of recovery/ in the therapist

As success inhibiting factors of the therapeutic intervention related to the professional, 100% of the ARFID participants and between 60–80% of the AN participants referred to the lack of interpersonal skills (empathy, interest and availability to listen to the client, a non-judgement attitude) as particularly important. Not validating the clients' feelings, opinions and thoughts, not involving the client on her own therapeutic process by not informing, negotiating and/or adapting the intervention to the person's particular characteristics and needs was also felt as relevant to inhibit the success of the therapeutic process.

"I've been to several psychiatrists before and the experiences were not very good, it was just medication, the consultations were horrible" P2

"I went to several psychologists, psychiatrists, they didn't help much, or gave me medication or said I had to eat and that was the last thing I wanted to hear. They didn't care too much about what I felt. I even had one who told me that when I got married it would pass." P3

"I went to a psychiatry department; she didn't explore why I couldn't eat; she thought it was for imaging reasons. And she didn't even try to listen, she didn't really want to know. I didn't go back there..." P4

"I went to a doctor, I don't know if she was a specialist, we talked and she told me to have positive thoughts, I stopped going..." P24

"I had some good doctors, but there were doctors who don't care, don't strive to help." P1.

"I went to a doctor because I had a lot of fears, and he rubbed things in my face. I said I wasn't comfortable with that approach, but he didn't want to know, I didn't go there anymore..." P4

The factors identified as most relevant for inhibiting the positive results of the therapeutic process referring to the clients in the AN group were the difficulty in accepting/recognizing that they were sick and needed help and the perceived advantages of maintaining AN.

"I know I'm sick, but I don't think I'm sick" P2

"When I started to lose weight, people started praising me, saying how beautiful I was, the guys start taking an interest in me, I liked feeling that way, I didn't want to lose it". P3

"There were things I couldn't handle, I couldn't do things the way I wanted to, I felt trapped between perfectionism and lack of control, I was the only thing I could control. "P30

"At the beginning I didn't have a negative body image, it was rebellion, my way of protesting, but when I got thin, I started to like seeing myself thinner, I was able to wear other things." P30

In the ARFID group, 100% of the participants mentioned the occurrence of several adverse life events, multiple previous negative intervention experiences, comorbidity with other MDs and their perception of the procedures applied by the therapist as inadequate as significant obstacles to the success of the therapeutic intervention related to the client.

"The lack of understanding, of answers, everything was unknown, no one understood or helped me, people thinking that I wanted to be like this, if I was asking for help it was because I didn't want to be like that. "P4.

"Some situations were very difficult, I was hospitalized because I wasn't well, and the staff and some nurses made critical comments, because they thought I didn't want to get fat (do you think you're that fat?) and things like that. I knew I was thin and that wasn't what I wanted, it caused me a lot of suffering and I just wanted to give up on everything. "P1.

With regard to the patient's reflection on their change process (Table 4), 100% of the group study participants reported the perception of positive results subsequent to the therapeutic intervention after meeting a professional with whom they identified. One hundred percent of the participants stated improvements regarding the ability to ask for help.

Table 4. Participant Change Perception

Categories	Subcategories	Specific Categories	Participants	
			aN 5	ARFID 4
3. Reflection on the main changes process	3.1. Positive outcome after therapeutic intervention	3.1.1. Increased positive internal speech	60%	50%
		3.1.2. Improved ability to ask for help	100%	100%
		3.1.3. Self-care strategies and symptom relief	60%	100%
			60%	50%
		3.1.4. Confidence dealing with people/situations	60%	50%
		3.1.5. Learning to use adaptive strategies	60%	75%
		3.1.6. Healthy self-acceptance/self-esteem	60%	75%
		3.1.7. Adjusted reality perceptions and Beliefs		
		3.1.8. Less stress/ impact of others judgments		
	3.2. Absence of positive results after therapeutic intervention	3.2.1. Increased symptomatology	60%	100%
		3.2.2. Reinforcement of unhealthy coping strategies	60%	100%
			60%	100%
		3.2.3. Increased resistance to intervention	60%	100%
		3.2.4. Skepticism regarding positive results	100%	100%
	3.3. Changes related with MD	3.2.5. Dropout of the therapeutic process		
		3.3.1. More compassionate/understanding/attentive	100%	100%
			100%	75%
		3.3.2. Less judgmental	80%	50%
		3.3.3. Desire to help others		

One hundred percent of the ARFID participants and 60% of the AN participants mentioned progress related to the use of self-care strategies and symptom relief.

“I know how to be careful now and take care of myself and not go back to the same thing” P30

More than 50% of all the participants reported improvements referring to the use of positive internal speech, feeling more confidence when dealing with people and/or situations and learning how to use adaptive coping strategies.

"I am more stable, now I know how to deal with the problems." P1

"The way I deal with anxiety has changed a lot, before I was completely blocked, now I try to understand what is triggering those thoughts in my head because I know that's where it comes from" P4

The development of a healthier self-acceptance/self-esteem and a more adjusted perception of reality and personnel beliefs were also referred to as positive results by 60–75% of the participants. The same percentage of participants mentioned feeling a decrease in the stress/impact caused by the judgments of others

"I started to feel calmer, less anxious." P3

"I learned to understand how my brain works; there are no right or wrong thoughts, only thoughts." P2

"It had an impact, it had a positive impact on me feeling more comfortable with others, working on shyness, not caring about what others think and that changed, I feel more comfortable with people saying what I think, that helped me a lot. "P24

A negative experience with multiple therapeutic interventions felt inadequate by the participants reinforced the maintenance and worsening of unhealthy behaviors and disorder symptoms in 100% of the ARFID participants and 60% of the AN participants. It also increased intervention resistance and skepticism in positive results in 60% of the AN participants and in 100% of the ARFID group. At some point, all the study participants dropped out of their therapeutic process.

"They weighed me down in every consultation, which made me feel worse. I knew I would be weighed and just the idea of that number, I would stop eating, used laxatives, vomited and all I could remember... that number had to be low. I was getting worse. It wasn't until I found a psychiatrist who listened to me, noticed what was happening and stopped doing that (I'll always be grateful to her for that). Only then I started to get better." P2

"It was good for people to have more training, to know how to deal with others so as not to do harm" P4

"It would be good not to generalize, because by doing so they are hurting more than helping" P1

Between 75% and 100% of the participants reported being more compassionate and understanding issues related to mental health. The participants considered that there was a decrease in their negative critical judgment in relation to people with MD after therapy. A desire to help others grapple with mental health challenges was expressed by 80% of the AN participants and 50% of the ARFID participants.

"We have to learn from what happens, but since I have to go through this, let it be to help someone, to listen to someone, to give affection, attention." P2

"I think it made me more tolerant towards others, I was always very demanding, perfectionist, strict, then I realized that we all have our weaknesses, that sometimes an appearance of security hides many facets

and weaknesses.” P30

“It made me try to understand more about others, how they are and how they feel. As I felt firsthand what it's like to be criticized and judged for situations that people don't understand, I think well before I speak and try to put myself in the other's shoes.” P1

Discussion

Our study aimed to understand how the participants perceived their therapeutic process, what motivated them to remain in the process and what factors they attributed to the success or failure of the intervention.

Eighty-eight percent of the total number of participants in our study went through several mental health specialists, resulting in multiple therapeutic experiences. The same person reported completely different experiences and perceptions regarding the therapeutic process, taking into account the professional who was accompanying her in different moments.

In this journey, according to their experiences, the participants chose a set of factors that they considered to be promoters or inhibitors of the success of the therapeutic intervention, related to the professional and to the client.

As evidenced by the results of several investigations in this area, the participants of our study considered that the intervention model/approach was not particularly relevant in determining the success of the therapeutic process [28, 39, 56].

All participants considered that the professional/therapist with certain personal/interpersonal and professional qualities was the most relevant aspect to determine the chances of success of the intervention [37, 57–59].

Similar to what has been indicated by other investigations, the therapist's ability to demonstrate empathy, his availability and genuine interest in listening to the patient; being able not to pass judgment or criticism; and understanding and helping the client understand what is happening to them were considered by this group the most relevant factors for the success of the therapeutic process [60–63]. The professional being capable, available and interested in teaching techniques/strategies appropriate to the client's situation, which will allow them to deal with ED symptoms in the future, were also considered relevant factors to promote the success of the therapeutic intervention [64, 65].

Corroborating the criteria identified by multiple studies, patients participating in this study mentioned the importance of the professional ability to guide the client in the process of finding solutions that are appropriate to their characteristics and conditions, without pressuring them [39, 57, 60, 65, 66].

The participants also highlighted the importance of the therapist having time to be with the client in a safe therapeutic space, without the pressure of the clock [67–69].

Validating, respecting, acknowledging the suffering, capabilities and opinions of the client, negotiating and adjusting the intervention to their needs and characteristics is another fundamental aspect in promoting the therapeutic process [36, 70, 71]. The lack of these factors was referred to by the participants as the reason for the dropout of their previous therapeutic processes.

In line with findings from other studies, the participants also mentioned that they considered it essential to identify and recognize the factors that promote the success of the therapeutic process related to the clients [36, 39]. They identified as especially significant aspects the client's motivation for change and their desire to improve; the availability of social/emotional support that guarantees support to the client during the process; and the client's trust in the therapist and in the therapeutic process [36, 60, 65].

The Participants of AN group identified as the most relevant factors inherent to the client that could make the therapeutic process unfeasible, the client's difficulty in accepting their condition as a person with ED, the perceived advantages of the AN, the lack of hope in recovering, resisting the urge to give up and the tiredness of the struggle [34, 72, 73].

For the ARFID group, adverse life events, multiple negative interventions with inadequate procedures and comorbidity with other MDs were referred to as the main negative factors inherent to the client [3, 22, 74]. All the participants highlighted the importance of identifying these aspects so that therapists could include them in the intervention, thus minimizing their potential negative impact [36, 39].

All participants reported the perception of progress after the therapeutic intervention. They reported significant improvements in self-perception/self-care, recognition of personal and social skills, problem-solving skills and the use of more adaptive coping strategies. One hundred percent considered their therapeutic process to have positive aspects, even though it was not completed. They reinforced the idea of considering the professional and his personal/interpersonal and professional qualities as the determining factor in the success of the intervention [58, 63, 65, 75, 76].

For the ARFID participants, what motivated them to continue the therapeutic process was related to the desire to improve and the social/emotional support that they mentioned as fundamental throughout the process. For the AN group, their motivation was related to the desire not to cause more suffering to their family and the improvement of symptoms after the intervention [77–79].

Significant changes were perceived by the participants in the way they understood MD and “saw” the person with MD after their therapeutic process. The participants in both groups reported being more understanding (100%), less judgmental of others (88%) and less critical in most situations. The desire to help others was mentioned by 80% of the AN group and 50% of the ARFID group.

The need to promote events and initiatives that allow the free discussion of these topics to end prejudice and facilitate early access to qualified help was also emphasized by both groups of participants [80–83].

Conclusions

EDs have been classified, analyzed and referenced throughout history according to different trends, approaches, criteria and interpretations to understand and effectively intervene in these types of disorders [84–86].

Despite the efforts made by the scientific community in recent years, the information and resources available are still insufficient to satisfactorily achieve the development of effective responses in terms of prevention and intervention in EDs [17, 18, 87, 88].

The lack of clear information identifying and understanding the underlying pathophysiological mechanisms that enhance the emergence and maintenance of different EDs delays the selection/development of effective intervention models adjusted to the needs of these populations [4, 16, 25].

The 4 participants in the ARFID group of our study, who were subject to multiple follow-ups over several years after 2013, when ARFID was included in the DSM-5 [1], were diagnosed by different services with AN, for which they did not meet the criteria. This led to interventions felt inadequate and precipitated the dropout of the therapeutic process in several situations, delaying access to adequate intervention. It is fundamental to ensure the training of technicians and auxiliary personnel to provide adequate and timely intervention in people with these eating disorders [3, 14, 23, 89].

Participants mentioned the desire to improve, not to cause suffering to family members in the case of the AN group (motivation for change) and the availability of social/emotional support as the factors that motivated them to seek help and to remain in the therapeutic process. These were considered the most relevant aspects inherent to the client for the success of the therapeutic process [36, 60, 65].

In the evaluation of their therapeutic process, 100% of the participants considered that the professional/therapist with certain professional and personal qualities was the most relevant aspect to determine the chances of success of the intervention [37, 57–59]. This information can serve as a basis for reflection and self-analysis by the therapist and a good resource to support the organization, negotiation and preparation of therapeutic intervention processes.

Professional practice presents increasingly more challenges. As therapists, this should be one of the guiding principles of our intervention to make the other our equal in the sense of empowering, emancipating and respecting the client. Sharing what we have, clinical knowledge, our experience and presence, so that the other can find their answers, at their own pace, in their own time, according to what meets their needs. To know these needs, we need to listen to those who feel them.

This project faced significant limitations. The sample size of this study is small and therefore does not allow generalization. The project was initially conceived for application in a hospital context at the Hospital de Magalhães Lemos in the city of Porto, Portugal. The Hospital's Ethics Committees approved the project, but several reformulations were required due to the pandemic context of COVID-19. The project application in a hospital context would have allowed the inclusion of more participants, obtaining

more detailed information regarding the participants and greater interaction with other technicians, which would integrate different perspectives in the study.

Despite these obstacles, the main objective of this study was to obtain knowledge that would allow professionals to reflect on their practice and adapt the intervention to the needs and concerns of the clients. Despite the limitations of the study, our participants provided relevant information for the proposed objective. Although further research in these areas is needed to deepen the knowledge, their information allows professionals to distinguish what the participants perceive/feel as particularly relevant in the intervention. This knowledge makes it possible to adjust the intervention to reinforce the relevant areas, promoting greater effectiveness of the strategies and techniques used in the psychotherapeutic intervention. It increases the chances of more positive results with improvements in people's quality of life, the main objective of the intervention [39, 57, 66, 90].

Abbreviations

AN: Anorexia nervosa; APA: American Psychiatric Association; DSM-5: Diagnostic and Statistical Manual of Mental Disorders; ARFID; Avoidant/Restrictive Food Intake Disorder; ED: Eating Disorders; MD; Mental Disorder

Declarations

Ethical approval and consent to participate

This study does not provide for psychotherapeutic intervention or the application of techniques or methodologies that may call into question the ethical principles of intervention provided for in the code of ethics subscribed by the Portuguese Psychologists Association and approved in annex to Regulation No. 258/2011, published in the 2nd Series of the Journal of the Republic on April 20, 2011, so the approval of the Ethics Committee was not required. Informed consent was obtained from the participants for publication of this study.

Consent for publication

All authors have consented to the publication of the manuscript.

Availability of data materials

Supporting data are unfortunately unavailable as a consequence of the strict regulations regarding the privacy of the patients.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

Not applicable

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References

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. Washington, DC: American Psychiatric Association; 2013.
2. Moore CA, Bokor BR. Anorexia nervosa. Treasure Island (FL): StatPearls Publishing LLC; 2022.
3. Seetharaman S, Fields EL. Avoidant/restrictive food intake disorder. *Pediatr Rev.* 2020;41:613-22.
4. Treasure J, Duarte TA, Schmidt U. Eating disorders. *Lancet.* 2020;395:899-911.
5. Deloitte Access Economics. The Social and Economic Cost of Eating Disorders in the United States of America: A Report for the Strategic Training Initiative for the Prevention of Eating Disorders and the Academy for Eating Disorders. June 2020. Available at: <https://www.hsph.harvard.edu/stripped/report-economic-costs-of-eating-disorders/>.
6. Cruz AM, Gonçalves-Pinho M, Santos JV, Coutinho F, Brandão I, Freitas A. Eating disorders-related hospitalizations in Portugal: a nationwide study from 2000 to 2014. *Int J Eat Disord.* 2018;51:1201-6.
7. Botha D. Analysing anorexia nervosa: digital logic provides alternative meanings of its nature, leading to alternative forms of psychotherapy. *Neofit Rilski.* 2020;13:286-307.
8. Gorwood P, Blanchet-Collet C, Chartrel N, Duclos J, Dechelotte P, Hanachi M, et al. New insights in anorexia nervosa. *Front Neurosci.* 2016;10:256.
9. Hinrichsen H, Waller G, Dhokia R. Core beliefs and social anxiety in the eating disorders. *Eat Weight Disord.* 2013;12:e14-8.
10. Costa MB, Melnik T. Effectiveness of psychosocial interventions in eating disorders: an overview of Cochrane systematic reviews. *Einstein (Sao Paulo).* 2016;14:235-77.

11. Hay PJ, Touyz S, Claudino AM, Lujic S, Smith CA, Madden S. Inpatient versus outpatient care, partial hospitalisation and waiting list for people with eating disorders. *Cochrane Database Syst Rev*. 2019;1:CD010827.
12. Piñar-Gutiérrez A, Dios-Fuentes E, Remón-Ruiz P, Del Can-Sánchez D, Vázquez-Morejón A, López-Narbona M, et al. Description of characteristics and outcomes of a cohort of patients with severe and enduring eating disorders (SE-ED). *J Eat Disord*. 2021;9:135.
13. Beveridge J, Phillipou A, Jenkins Z, Newton R, Brennan L, Hanly F, et al. Peer mentoring for eating disorders: results from the evaluation of a pilot program. *J Eat Disord*. 2019;7:13.
14. Fisher MM, Rosen DS, Ornstein RM, Mammel KA, Katzman DK, Rome ES, et al. Characteristics of avoidant/restrictive food intake disorder in children and adolescents: a "new disorder" in DSM-5. *J Adolesc Health*. 2014;55:49-52.
15. Leonidas C, Dos Santos MA. Emotional meanings assigned to eating disorders: narratives of women with anorexia and bulimia nervosa. *Univ Psychol*. 2017;16:189-201.
16. Watson HJ, Yilmaz Z, Thornton LM, Hübel C, Coleman JRI, Gaspar HA, et al. Genome-wide association study identifies eight risk loci and implicates metabo-psychiatric origins for anorexia nervosa. *Nat Genet*. 2019;51:1207-14.
17. Le LK, Barendregt JJ, Hay P, Mihalopoulos C. Prevention of eating disorders: a systematic review and meta-analysis. *Clin Psychol Rev*. 2017;53:46-58.
18. Nicely TA, Lane-Loney S, Masciulli E, Hollenbeak CS, Ornstein RM. Prevalence and characteristics of avoidant/restrictive food intake disorder in a cohort of young patients in day treatment for eating disorders. *J Eat Disord*. 2014;2:21.
19. Norris ML, Spettigue WJ, Katzman DK. Update on eating disorders: current perspectives on avoidant/restrictive food intake disorder in children and youth. *Neuropsychiatr Dis Treat*. 2016;12:213-8.
20. Cooney M, Lieberman M, Guimond T, Katzman DK. Clinical and psychological features of children and adolescents diagnosed with avoidant/restrictive food intake disorder in a pediatric tertiary care eating disorder program: a descriptive study. *J Eat Disord*. 2018;6:7.
21. Cañas L, Palma C, Molano AM, Domene L, Carulla-Roig M, Cecilia-Costa R, et al. Avoidant/restrictive food intake disorder: psychopathological similarities and differences in comparison to anorexia nervosa and the general population. *Eur Eat Disord Rev*. 2021;29:245-56.
22. Zanna V, Criscuolo M, Mereu A, Cinelli G, Marchetto C, Pasqualetti P, et al. Restrictive eating disorders in children and adolescents: a comparison between clinical and psychopathological profiles. *Eat Weight Disord*. 2021;26:1491-501.

23. Katzman DK, Stevens K, Norris M. Redefining feeding and eating disorders: what is avoidant/restrictive food intake disorder? *Paediatr Child Health*. 2014;19:445-6.
24. Keery H, LeMay-Russell S, Barnes TL, Eckhardt S, Peterson CB, Lesser J, et al. Attributes of children and adolescents with avoidant/restrictive food intake disorder. *J Eat Disord*. 2019;7:31.
25. Kan C, Eid L, Treasure J, Himmerich H. A meta-analysis of dropout and metabolic effects of antipsychotics in anorexia nervosa. *Front Psychiatry*. 2020;11:208.
26. Linardon J, Hindle A, Brennan L. Dropout from cognitive-behavioral therapy for eating disorders: a meta-analysis of randomized, controlled trials. *Int J Eat Disord*. 2018;51:381-91.
27. O'Keeffe S, Martin P, Goodyer IM, Wilkinson P, Consortium I, Midgley N. Predicting dropout in adolescents receiving therapy for depression. *Psychother Res*. 2018;28:708-21.
28. Swift JK, Greenberg RP. Premature discontinuation in adult psychotherapy: a meta-analysis. *J Consult Clin Psychol*. 2012;80:547-59.
29. Vinchenzo C, McCombie C, Lawrence V. The experience of patient dropout from eating disorders treatment: a systematic review and qualitative synthesis. *BJPsych Open*. 2021;7:S299.
30. Giel KE, Behrens SC, Schag K, Martus P, Herpertz S, Hofmann T, et al. Efficacy of post-inpatient aftercare treatments for anorexia nervosa: a systematic review of randomized controlled trials. *J Eat Disord*. 2021;9:129.
31. Hauber K, Boon A, Vermeiren R. Therapeutic relationship and dropout in high-risk adolescents' intensive group psychotherapeutic programme. *Front Psychol*. 2020;11:533903.
32. American Psychological Association. Evidence-based practice in psychology. *Am Psychol*. 2006;61:271-85.
33. Clinton DN. Why do eating disorder patients drop out? *Psychother Psychosom*. 1996;65:29-35.
34. Fassino S, Pierò A, Tomba E, Abbate-Daga G. Factors associated with dropout from treatment for eating disorders: a comprehensive literature review. *BMC Psychiatry*. 2009;9:67.
35. Constantino MJ, Arnkoff DB, Glass CR, Ametrano RM, Smith JZ. Expectations. *J Clin Psychol*. 2011;67:184-92.
36. Lambert MJ, Cattani K. Practice-friendly research review: collaboration in routine care. *J Clin Psychol*. 2012;68:209-20.
37. Lambert MJ, Shimokawa K. Collecting client feedback. *Psychotherapy (Chic)*. 2011;48:72-9.

38. Miller SD, Hubble MA, Chow D, Seidel J. Beyond measures and monitoring: realizing the potential of feedback-informed treatment. *Psychotherapy (Chic)*. 2015;52:449-57.
39. Sousa D. *Investigação científica em psicoterapia e prática psicoterapêutica*. Portugal: Fim de Seculo; 2017.
40. Almeida F, Superior I, Gaya P, Queirós A, Faria D. Strengths and limitations of qualitative and quantitative research methods. *Eur J Educ Stud*. 2017;3:369-87.
41. Palinkas LA. Qualitative and mixed methods in mental health services and implementation research. *J Clin Child Adolesc Psychol*. 2014;43:851-61.
42. Zanatta JA, Costa ML. Algumas reflexões sobre a pesquisa qualitativa nas ciências sociais. *Estud Pesqui Psicol*. 2012;12:344-59.
43. Zimmermann JJ, Tiellet Nunes ML, Fleck MP. How do depressed patients evaluate their quality of life? A qualitative study. *J Patient Rep Outcomes*. 2018;2:52.
44. Godoy AS. Pesquisa qualitativa: tipos fundamentais. *Rev Adm Empresas*. 1995;35:20-9.
45. Hauschild A, Laís M, Paulina P, Mantovani C. A percepção do paciente quanto ao processo de mudança psicoterápica. *Aletheia*. 2009;30:158-71.
46. Maguire M, Delahunt B. Doing a thematic analysis: a practical, step-by-step guide for learning and teaching scholars. *All Irel J High Educ*. 2017;9. 3351-33514
47. Clarke V, Braun V. Thematic analysis. *J Posit Psychol*. 2017;12:297-8.
48. Fereday J, Muir-Cochrane E. Demonstrating rigor using thematic analysis: a hybrid approach of inductive and deductive coding and theme development. *Int J Qual Methods*. 2006;5:80-92.
49. McAdams DP. Narrative identity: what is it? What does it do? How do you measure it? *Imagin Cogn Pers*. 2018;37:359-72.
50. Neiva S. *Adultos com experiências precoces de vitimação e resiliência : estudo qualitativo* [Universidade Fernando Pessoa] 2016. <http://hdl.handle.net/10284/55472016>.
51. Alea N. Does the life story interview make us make sense? Spontaneous and cued redemption and contamination in life story scenes. *Imagin Cogn Pers*. 2018;37:271-92.
52. McAdams DP. The psychology of life stories. *Rev Gen Psychol*. 2001;5:100-22.
53. Manti S, Licari A. How to obtain informed consent for research. *Breathe (Sheff)*. 2018;14:145-52.

54. Nijhawan LP, Janodia MD, Muddukrishna BS, Bhat KM, Bairy KL, Udupa N, et al. Informed consent: issues and challenges. *J Adv Pharm Technol Res.* 2013;4:134-40.
55. Braun V, Clark V. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology*, 2006;3(2), 77–101.
56. Norcross JC, Wampold BE. Evidence-based therapy relationships: research conclusions and clinical practices. *Psychotherapy (Chic).* 2011;48:98-102.
57. Beutler LE, Someah K, Kimpara S, Miller K. Selecting the most appropriate treatment for each patient. *Int J Clin Health Psychol.* 2016;16:99-108.
58. Chow DL, Miller SD, Seidel JA, Kane RT, Thornton JA, Andrews WP. The role of deliberate practice in the development of highly effective psychotherapists. *Psychotherapy (Chic).* 2015;52:337-45.
59. Constantino MJ, Ametrano RM, Greenberg RP. Clinician interventions and participant characteristics that foster adaptive patient expectations for psychotherapy and psychotherapeutic change. *Psychotherapy (Chic).* 2012;49:557-69.
60. Anderson T, Crowley ME, Himawan L, Holmberg JK, Uhlin BD. Therapist facilitative interpersonal skills and training status: a randomized clinical trial on alliance and outcome. *Psychother Res.* 2016;26:511-29.
61. Eubanks-Carter C, Muran JC, Safran JD. Alliance-focused training. *Psychotherapy (Chic).* 2015;52:169-73.
62. Goldberg SB, Hoyt WT, Nissen-Lie HA, Nielsen SL, Wampold BE. Unpacking the therapist effect: impact of treatment length differs for high- and low-performing therapists. *Psychother Res.* 2018;28:532-44.
63. Lutz W, Rubel J, Schiefele AK, Zimmermann D, Böhnke JR, Wittmann WW. Feedback and therapist effects in the context of treatment outcome and treatment length. *Psychother Res.* 2015;25:647-60.
64. Laska KM, Gurman AS, Wampold BE. Expanding the lens of evidence-based practice in psychotherapy: a common factors perspective. *Psychotherapy (Chic).* 2014;51:467-81.
65. Timulak L, Keogh D. The client's perspective on (experiences of) psychotherapy: a practice friendly review. *J Clin Psychol.* 2017;73:1556-67.
66. Owen J, Hilsenroth MJ. Treatment adherence: the importance of therapist flexibility in relation to therapy outcomes. *J Couns Psychol.* 2014;61:280-8.
67. Gelso C. A tripartite model of the therapeutic relationship: theory, research, and practice. *Psychother Res.* 2014;24:117-31.
68. Horvath AO, Del Re AC, Flückiger C, Symonds D. Alliance in individual psychotherapy. *Psychotherapy (Chic).* 2011;48:9-16.

69. Zilcha-Mano S, Muran JC, Hungr C, Eubanks CF, Safran JD, Winston A. The relationship between alliance and outcome: analysis of a two-person perspective on alliance and session outcome. *J Consult Clin Psychol.* 2016;84:484-96.
70. Tryon GS, Winograd G. Goal consensus and collaboration. In: *Psychotherapy relationships that work.* New York, NY: Oxford University Press; 2011. p. 153-67.
71. Wampold BE. How important are the common factors in psychotherapy? An update. *World Psychiatry.* 2015;14:270-7.
72. Halmi KA. Perplexities of treatment resistance in eating disorders. *BMC Psychiatry.* 2013;13:292.
73. Sassaroli S, Gallucci M, Ruggiero GM. Low perception of control as a cognitive factor of eating disorders. Its independent effects on measures of eating disorders and its interactive effects with perfectionism and self-esteem. *J Behav Ther Exp Psychiatry.* 2008;39:467-88.
74. Kohn JB. What is ARFID? *J Acad Nutr Diet.* 2016;116:1872.
75. Imel ZE, Sheng E, Baldwin SA, Atkins DC. Removing very low-performing therapists: a simulation of performance-based retention in psychotherapy. *Psychotherapy (Chic).* 2015;52:329-36.
76. Roos J, Werbart A. Therapist and relationship factors influencing dropout from individual psychotherapy: a literature review. *Psychother Res.* 2013;23:394-418.
77. Coverdale GE, Long AF. Emotional wellbeing and mental health: an exploration into health promotion in young people and families. *Perspect Public Health.* 2015;135:27-36.
78. Shelley D, Craig WM. Attributions and coping styles in reducing victimization. *Can J Sch Psychol.* 2010;25:84-100.
79. Wille N, Bettge S, Ravens-Sieberer U. Risk and protective factors for children's and adolescents' mental health: results of the BELLA study. *Eur Child Adolesc Psychiatry.* 2008;17 Suppl 1:133-47.
80. Chisholm K, Patterson P, Torgerson C, Turner E, Jenkinson D, Birchwood M. Impact of contact on adolescents' mental health literacy and stigma: the SchoolSpace cluster randomised controlled trial. *BMJ Open.* 2016;6:e009435.
81. Fang Q, Zhang TM, Wong YLI, Yau YY, Li XH, Li J, et al. The mediating role of knowledge on the contact and stigma of mental illness in Hong Kong. *Int J Soc Psychiatry.* 2021;67:935-45.
82. Ran MS, Peng MM, Yau YY, Zhang TM, Li XH, Wong IYL, et al. Knowledge, contact and stigma of mental illness: comparing three stakeholder groups in Hong Kong. *Int J Soc Psychiatry.* 2022;68:365-75.
83. Schnyder N, Panczak R, Groth N, Schultze-Lutter F. Association between mental health-related stigma and active help-seeking: systematic review and meta-analysis. *Br J Psychiatry.* 2017;210:261-8.

84. Alckmin-Carvalho F, Dos Santos DR, El Rafihi-Ferreira R, Soares MRZ. Análise da evolução dos critérios diagnósticos da anorexia nervosa. *Aval Psicol.* 2016;15:265-74.
85. García EG. Anorexia nerviosa: ¿ la rata o el diván? *Acción Psicol.* 2011;8:57-70.
86. Hay P. Current approach to eating disorders: a clinical update. *Intern Med J.* 2020;50:24-9.
87. Jansen A. Eating disorders need more experimental psychopathology. *Behav Res Ther.* 2016;86:2-10.
88. Pennesi JL, Wade TD. A systematic review of the existing models of disordered eating: do they inform the development of effective interventions? *Clin Psychol Rev.* 2016;43:175-92.
89. Norris ML, Katzman DK. Change is never easy, but it is possible: reflections on avoidant/restrictive food intake disorder two years after its introduction in the DSM-5. *J Adolesc Health.* 2015;57:8-9.
90. Reynolds DJ, Stiles WB, Bailer AJ, Hughes MR. Impact of exchanges and client-therapist alliance in online-text psychotherapy. *Cyberpsychol Behav Soc Netw.* 2013;16:370-7.