Received: 17 August 2023 | Revised: 22 December 2023 | Accepted: 23 December 2023

DOI: 10.1002/eat.24139

ORIGINAL ARTICLE

International Journal of EATING DISORDERS WILEY

Acceptability of Specialist Psychotherapy with Emotion for Anorexia in Kent and Sussex (SPEAKS): A novel intervention for anorexia nervosa

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Funding information
Integrated Clinical Academic Fellowship-Clinical Lectureship, Grant/Award Number: ICA-CL-2015-01-005

Action Editor: Tracey Wade

Abstract

Objective: Investigate the acceptability of Specialist Psychotherapy with Emotion for Anorexia in Kent and Sussex (SPEAKS), a novel intervention for anorexia nervosa (AN), conducted as a feasibility trial to provide an initial test of the intervention.

Methods: SPEAKS therapy lasting 9–12 months was provided to 34 people with AN or atypical AN by eight specialist eating disorder therapists trained in the model across two NHS Trusts in the UK (Kent and Sussex) during a feasibility trial. All participants were offered a post-therapy interview; sixteen patients and six therapists agreed. All patient participants were adult females. Interviews were semi-structured and asked questions around individuals' experience of SPEAKS, the acceptability of the intervention and of the research methods. Interviews were analyzed using thematic analysis.

Results: Key areas explored in line with research questions led to 5 overarching themes and 14 subthemes: (1) shift in treatment focus and experience, (2) balancing resources and treatment outcomes, (3) navigating the online treatment environment, (4) therapist adaptation and professional development, and (5) research processes.

Discussion: SPEAKS was found to be an acceptable intervention for treating AN from the perspective of patients and therapists. The findings provide strong support for delivery of a larger scale randomized control trial. Recommendations for future improvements, particularly pertaining to therapist understanding of the treatment model are detailed, alongside broader clinical implications.

Public Significance: We aimed to evaluate the acceptability of a new anorexia nervosa treatment called SPEAKS. Interviews were conducted with patients and therapists involved in the pilot study and responses were analyzed. Results showed that both patients and therapists found SPEAKS to be an acceptable treatment for anorexia nervosa. The study suggests that SPEAKS meets the criteria for moving forward with a larger trial to assess its effectiveness.

KEYWORDS
anorexia nervosa, eating disorders, emotion focused therapy, psychotherapy, SPEAKS

1 | INTRODUCTION

Anorexia nervosa (AN) is a mental disorder characterized by severe restriction of nutritional intake, fear of weight gain, and distorted body image perception, despite being significantly underweight (American Psychiatric Association [APA], 2013). AN has extensive implications on physical and mental health, and a standardized mortality ratio of more than 5 compared to the general population (Himmerich et al., 2019), meaning developing a successful treatment is imperative. The National Institute for Health and Care Excellence (NICE, 2020) guidelines recommend outpatient psychological therapy for adults with AN, but no specific intervention shows superiority in clinical trials (Zeeck et al., 2018). This has led to urgent calls for improved and innovative interventions for adults with AN (Solmi et al., 2021).

The role of emotions within AN has long been documented (e.g., Bruch, 1985). The benefit of targeting emotional processing has been gradually recognized (Sala et al., 2016) and incorporated into models of AN (e.g., Hibbs et al., 2021; Schmidt & Treasure, 2006). However, it is argued that application difficulties in mental health can arise from taking an "everything is relevant" approach, resulting in a lack of clarity around how desired change is achieved, or sufficient targeting of the identified variables (Kendler & Campbell, 2009). As such, the impact of adding some focus on emotions within a much broader therapy for people with AN is unclear and indeed whether such interventions do facilitate the emotional changes they set out to remains unknown.

SPEAKS (Specialist Psychotherapy with Emotion for Anorexia in Kent and Sussex) is a newly developed intervention for adults with AN, recently evaluated in a feasibility trial (Oldershaw et al., 2023). Drawing on research pertaining to genetic, biological, psychological, and socio-environmental risk and maintenance factors for AN, SPEAKS is based on the theory that these factors may be unified by explaining AN as arising from emotional processing difficulties, leading to a lost sense of "emotional self" (Oldershaw et al., 2019). A detailed program of development research gained patient perspectives on change processes associated with recovery and how these were best facilitated (Oldershaw et al., 2023). The resulting intervention combines elements of emotion focused therapy (Elliot et al., 2004) and schema therapy (Young & Klosko, 1994), in addition to incorporating experiential techniques to achieve connection with emotions and associated (unmet) needs.

The intervention involves individual outpatient psychotherapy with weekly sessions for 9–12 months (40 sessions), with two follow-up sessions within 3 months. Throughout this time, patients work through five phases of the intervention. These are (1) engagement and formulation, (2) seeing through and moving past the facade, (3) deepening to core pain, (4) resolving core pain, and (5) consolidation of the "Real Me." Therapists were provided with a guidebook for the purpose of the feasibility trial, which articulated hypothesized change processes and mechanisms of change, including useful therapeutic "tasks" which could be used flexibly to target specified change. A detailed explanation of the psychotherapy approaches is available elsewhere (cf. Oldershaw et al., 2023; Oldershaw & Startup, 2020).

Frameworks commissioned and outlined by the National Institute of Health Research and the UK Medical Research Council call for a phased approach to research into complex interventions, including intervention development, feasibility, evaluation, and implementation (Skivington et al., 2021). SPEAKS research programme included a detailed intervention development phase, followed by a feasibility phase to examine initial outcomes and acceptability. SPEAKS feasibility study employed a multisite, single-armed, within-group mixed-methods trial design (Oldershaw et al., 2022). The trial feasibility aims were to examine acceptability, reach and recruitment, adherence and compliance, sample size and economic evaluation, to establish parameters and financial feasibility of a potential future efficacy/effectiveness trial, alongside change process analysis. SPEAKS was provided instead of treatment as usual, and all other risk or physical health appointments were delivered in line with local and national guidance, including dietitian or psychiatrist appointments.

Acceptability plays an important role when evaluating an intervention's feasibility, as it examines the perception of appropriateness by those involved in delivering or receiving healthcare (Sekhon et al., 2017). Combined with qualitative outcomes, a rounded view of an intervention and its future potential is provided. Considering stakeholders' views importantly informs feasibility, acceptance, and impact of an intervention.

The present study aims to examine the acceptability of SPEAKS as a new intervention for AN. By analyzing data obtained in qualitative interviews post-therapy, we consider the acceptability of SPEAKS to both patients and therapists. It represents the first of two analyses of the SPEAKS post-therapy interviews; the second paper focusing on a process evaluation of perceived "helpful factors" and "active ingredients" of SPEAKS in facilitating change (Papastavrou Brooks, in prep). This article seeks to assess the acceptability of SPEAKS across clinical and practical aspects of the intervention and the research processes, ensuring space is given to minority and diverging views to highlight all potential future adaptations and improvements. Findings are hoped to have wider implications for the treatment of adult AN across models, particularly pertaining to the use of experiential psychotherapeutic techniques with this client group.

2 | METHODS

2.1 | Participants

All 46 patient and therapist participants in the SPEAKS trial provided written informed consent before starting the intervention, including consent to post-therapy interviews. All patient participants were approached for verbal consent to be contacted for post-therapy interviews following therapy completion. Similarly, verbal consent was

sought from therapists after completing therapy with their final trial participant, except for AO, who was a trial therapist, but also SPEAKS intervention co-developer and Chief Investigator on the trial.

In total, 16 patients (12 from North East London NHS Foundation Trust and 4 from Sussex Partnership NHS Foundation Trust) and 6 therapists took part in post-therapy interviews (Figure 1). A demographic breakdown of patients who received a post-therapy interview is provided in Table 1, with clinical characteristics summarized in Table 2. Of note, all patients were adult females, with half having a diagnosis of atypical AN and the other half AN. The demographic and clinical characteristic breakdown of the full sample of those who received SPEAKS can be seen in Oldershaw et al. (2023), but as an overview, both samples were predominantly White British and female. In addition, 50% of the acceptability sample were categorized as having an illness duration of 10 years or higher; similarly, in the overall sample, the average was 9 years. EDE-Q global scores for the acceptability sample decreased from 4.4 ($SD = 0.9$) pre-therapy to 2.9 ($SD = 1.7$) post-therapy, with close similarities to the overall sample who saw a decrease in their EDE-Q global scores of 4.14 ($SD = 1.11$) pre-therapy to 2.90 ($SD = 1.74$) post-therapy (Oldershaw et al., 2023). Key differences were that for the acceptability sample, only 31% had received previous psychological therapy, whereas in the overall SPEAKS sample, 80.3% had. Ethical approval was granted by London-Bromley Research Ethics Committee (Ref.: 19/LO/1530). All authors abided by ethical codes as outlined by the British Psychological Society (BPS, 2021). The trial is registered ISRCTN11778891.

2.2 | Interviews

Acceptability was qualitatively assessed using semi-structured post-therapy interviews. Interviews followed a schedule of questions pertaining to patient and therapist experience of SPEAKS, its acceptability in treating an eating disorder or facilitating change, and acceptability of the way SPEAKS was delivered. Questions came from an adapted version of the Client Change Interview (Elliott & Rodgers, 2008), with separate interview schedules used for therapists (see Supporting Information S1) and patients (see Supporting Information S2). Adaptations included editing the wording, with the rationale that it needed to be relevant to our research, and to add in questions related to acceptability. The interview also involved questions regarding helpful factors and mechanisms of change which are reported elsewhere (Papastavrou Brooks, in prep).

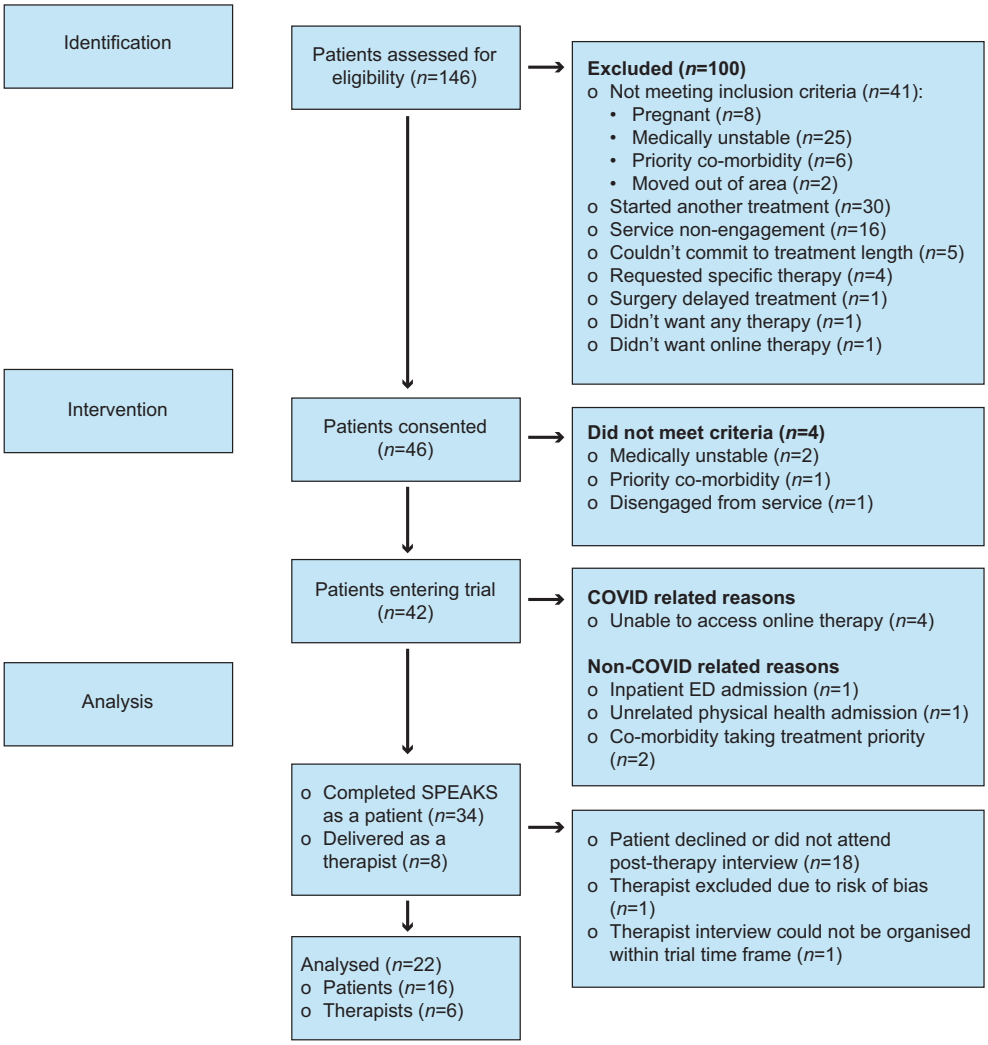

FIGURE 1 CONSORT flowchart of participants.

TABLE 1 Demographic characteristics of patients.

Characteristic		*n*	%
Gender	Female	16	100.0
	Male	0	0.0
Age	19	*	*
	20–29	7	43.8
	30–39	4	25.0
	40–49	4	25.0
Ethnicity	White—British	14	87.5
	Mixed—White and Black Caribbean	*	*
	Not stated	*	*
Employment status	Paid/self-employed	11	68.8
	Unemployed	*	*
	Student	*	*
	Volunteer	*	*
	Homemaker	*	*
	Unknown	*	*

Note: Responses with an asterisk (*) indicate a category with three or less responses and have therefore been suppressed to maintain confidentiality.

TABLE 2 Clinical characteristics of patients.

Characteristic		Mean	*SD*
BMI at start of therapy for those with AN		17.2	0.9
BMI at start of therapy for those with AAN		19.1	1
EDE-Q total score at start of therapy		4.4	0.9
EDE-Q total score at end of therapy		2.9	1.7
Characteristic		***n***	***%***
Diagnosis	Anorexia nervosa	8	50
	Atypical anorexia nervosa	8	50
Previous psychological treatment for AN?	Yes	5	31.3
	No	11	68.8
Illness duration	0–3	4	25
	3–6	*	*
	6–10	*	%
	10+	8	50

Note: Responses with an asterisk (*) indicate a category with three or less responses and have therefore been suppressed to maintain confidentiality.

2.3 | Procedure

Informed consent and demographic and clinical information were collected prior to intervention delivery by lead SPEAKS researcher (RSB). Qualitative interviews were conducted by RSB, taking place upon completion of therapy, 12 months after enrolling. The interviews were conducted in a standalone appointment, separate to collection of questionnaires. Interviews took place individually via the video call platform Zoom and lasted up to 1 h. Analysis of qualitative interview data was carried out by researchers AR and CPB, who had no involvement in the development of the SPEAKS trial or data collection, remaining blind to participant outcomes. Those who developed SPEAKS and delivered the trial had no involvement in analysis. The strength of this was to enable a truly inductive coding process whereby researchers did not interpret data with any preconceived expectations. The authors do recognize the limitations that come with being removed from the intervention, in terms of a reduced understanding (in comparison to intervention developers) of what SPEAKS involved. Qualitative data were analyzed prior to quantitative acceptability and trial data to minimize interpretations being clouded.

2.4 | Qualitative data analysis

Participant video recordings of semi-structured interviews were transcribed verbatim. Transcripts were anonymized to maintain confidentiality. Data were analyzed using a reflexive thematic analysis approach (Braun & Clarke, 2006, 2019, 2021); this was chosen as it allowed for a thorough interpretation of interviewee perspectives which was needed in order to fully assess the acceptability of the intervention. A semantic approach to coding was utilized (Braun & Clarke, 2019) meaning that researchers analyzed transcripts at face value and did not try to interpret beyond what the interviewee had said. This was to honor participants own words and interpretations. The process followed is outlined below.

Transcribed interviews were read multiple times to ensure familiarity with content. Inductive coding was conducted by the first researcher (AR), using a systematic process considering anything related to the acceptability of SPEAKS. Initial codes included segments of raw data in the participants' words with as many codes generated as relevant. Codes were reviewed and refined multiple times, being condensed or split as necessary. To explore whether new interpretations could be made from the data, 30% of transcripts were coded by the second researcher (CPB). This was important given the reflexive thematic analysis approach used, whereby meaning is not fixed within the data and is subject to researcher interpretation (Braun & Clarke, 2020). Researchers reviewed and compared codes. Any differences were discussed to reach consensus. Codes were then grouped into higher-order themes, which expressed the meaning of what participants had communicated. Minority viewpoints were included in the analysis to achieve a comprehensive view of SPEAKS. Themes were reviewed in relation to the data within them and the whole data set, finalized, and assigned succinct names and definitions.

2.5 | Reflexivity

Both researchers shared a similar demographic background, being close in age, identifying their gender as female and ethnicity as White-British. This combination of factors was similar to the majority of participants, potentially facilitating a deeper comprehension of patient perspectives due to a shared understanding. Additionally, AR had clinical experience in an eating disorder service which may have influenced theme generation

as suggested by Braun and Clarke (2020), who noted that researchers values, skills, experience and training shape the thematic analysis process. CPB had a research background, which enabled alternative interpretations to the data, facilitated by previous experience in the research methodology. These varied experiences were considered important to the consideration and interpretation of findings within this context. With both researchers being early in their career, there was a sense of ease discussing experiences and different interpretations of data with each other, with no power imbalance experienced. This dynamic worked well when generating meaning from the transcripts.

3 | RESULTS

Five key themes were agreed upon encompassing both patient and therapist views of the acceptability of SPEAKS;

1. Shift in treatment focus and experience
2. Balancing resources and treatment outcomes
3. Navigating the online treatment environment
4. Therapist adaptation and professional development
5. Research processes

Themes were divided into 14 sub-themes to categorize data. Themes and subthemes are outlined in Figure 2 and explained below. A table is also available (see Supporting Information S3).

3.1 | Shift in treatment focus and experience

a. Appreciation for creating space from their eating disorder

The majority of patients vocalized how identifying different parts of themself (which at times involved using physical toys) allowed them to separate themselves from their eating disorder in ways not experienced previously.

> "I think it was helpful the way we would draw the different parts of me and the people in my life out. Like the different voices. So, I think that made me realise that everything wasn't just one narrative in my head, there were lots of different things going on. And it was easier to sort of deal with that I guess."—Patient, female, 27.

This distance was beneficial when unpicking maintaining factors.

> "I think identifying the different parts of me which is something that I wasn't even aware of. And the different roles that are playing, and which is keeping me stuck if you like, so that was a big eye opener…I can know when it's my critic talking whereas before I didn't. So that's a massive change."—Patient, female, 40.

FIGURE 2 Thematic map containing themes and subthemes.

b. Focus on emotions

SPEAKS holds at its core an emotions change process. Patients spoke about finding this crucial for their therapy and, although difficult, was significantly important in facilitating change. Those with prior therapy experience reflected this was a welcomed different focus.

> "Probably the only way to describe it is a little bit like an emotional rollercoaster. Some weeks would be absolutely fine. And then other weeks it would feel like you'd been hit with a brick. But you felt like you were doing really hard work which made it feel like it was worth it"—Patient, female, 27.

Patients commented how being able to externalize thought processes through the use of experiential techniques such as chairwork, evoked powerful emotions, in a way different from previous experience.

> "I loved them [SPEAKS techniques]. I really loved them…the first time was a bit strange but I found it really helpful. A lot would come out in those exercises that wouldn't come out just sitting here talking… I really felt different in each chair. Like I could be crying in one chair, switch and they just stop. Like it really worked for me, them exercises because I could fully be each one. Yeah, I really enjoyed the chairs, I really enjoyed them."—Patient, female, 28.

Patients went on to describe how they found the focus on emotions to be validating, and that experiencing or outwardly showing emotion was not a weakness.

> I think the biggest thing for me is that it's made me realise that, you know, feeling upset, feeling low in mood, being angry is not necessarily a bad thing.—Patient, female, 25.

A number of patients and therapists reflected how not primarily focusing on food was difficult, and some patients reflected that being more informed in regards to meal planning would have been useful. One therapist mentioned feeling confused about whether discussing food was in line with SPEAKS. The SPEAKS trial protocol outlines that all risk and health management should be as per usual service guidelines, and participants within SPEAKS should have received all usual physical health checks and access to dietetics. A focus on emotional processes as the mechanism of change does not mean ignoring the relevance of food, eating, weight and shape, and within SPEAKS, food and weight should always be spoken about. This indicates a gap in adherence to the model that should be addressed by further reinforcing the guidebook and training.

> Considering it's like for eating disorders I did struggle at times, especially in the beginning, when I was really struggling with food, I really had no clue what I was doing, and we didn't ever address like food in therapy and stuff. I felt a little bit lost at times there.—Patient, female, 27.

c. Uncertainty around experiential techniques

A minority of patients and therapists expressed uncertainty about the act of using toys during the activity of identifying different parts of themself. One patient felt toys were inappropriate for their age, while another felt inadequate rationale had been offered by their therapist. One therapist wondered if patients used the toys for her benefit rather than their own.

> I liked the idea of like naming different parts of me, that's fine…but it was then associating it with some inanimate object that I hadn't—I was literally like this doesn't—no, that's too simplistic….I just didn't see the connection.—Patient, female, 21.

In addition, a minority of patients reported not liking chairwork. They described feeling embarrassed or silly, potentially pertaining to the stage in therapy it was carried out; how it was explained by their therapist; or the relationship with their therapist and whether they perceived the session as a safe, contained space. Therapists who witnessed patients feeling uncomfortable commented on this in interviews, and how chairwork seemed to work less effectively for them. Future SPEAKS training should emphasize that chairs need not be used if inappropriate, and to utilize alternative methods as already detailed in the guidebook.

> I didn't like the chairs, I couldn't get on with that. It felt, to me, it felt a bit contrived and a bit, it made me feel quite awkward and embarrassed doing it… I didn't enjoy that—Patient, female, 47.

3.2 | Balancing resources and treatment outcomes

d. Worries over amount of resource needed to deliver SPEAKS

The majority of therapists expressed concerns over delivering SPEAKS in a non-trial context, considering the current picture of NHS eating disorder services in terms of staffing provision, support available and funding. This related to increased resources of offering this length of therapy, and the emotional toll on therapists.

> It's a huge amount of resource, for every patient, a lot of our patients will only get 20 sessions, this could be double. So, I think that is something that needs to be thought about in these sort of trials and ongoing with the therapy.—Therapist 001.

> As a therapist it kind of feels like you have to be prepared to emotionally invest quite a bit more than you would in some other models, that's for sure.—Therapist 006.

e. Frequency and duration allowing for long term change

Despite the above worries, most patients found the weekly sessions beneficial; changes could be trialed independently and implemented without too much time passing. One noticed a difference in themselves on weeks they had missed sessions, naming regularity as an important factor.

> I liked them being weekly because there's not too much time passed, so you can just pick up, just like a conversation, I suppose. But I think if there was a bigger gap, you'd feel like you were starting again every time or having to recap.—Patient, female, 28.

In addition, SPEAKS duration of nine to 12 months appealed to patients when offered the therapy. Some had experienced therapy before and felt the duration of these interventions had been too short to facilitate long term change.

> To be offered to see someone for a year, it was like, 'Oh my God, yes please.' Because I just knew that that was going to be so much more promising than only seeing someone for a couple of weeks. So that about it is brilliant.—Patient, female, 20.

f. Confidence with moving forwards independently

Most patients voiced confidence in their ability to continue recovery independently after finishing SPEAKS. Patients spoke about tools they had gained and differences they observed in themselves such as increased inner strength. The minority who expressed worries over SPEAKS ending were patients who wanted a longer duration or a more tapered ending.

> I was nervous about it coming to an end and, you know, she made me realise that it doesn't matter that it's coming to an end because I've got all the tools now. For the past six months or so I've gained all the tools and I've done it by myself.—Patient, female, 31.

3.3 | Therapist adaptation and professional development

Two topics spoken about during interviews were specific to therapist experience of delivering SPEAKS.

g. Confidence with new techniques takes time

Most therapists spoke about the new techniques and ways of working which they learnt as part of SPEAKS, and how these involved getting used to. It was common for therapists to say that delivering SPEAKS felt like a "˜learning curve"; feeling deskilled initially due to being different from interventions they were used to delivering, but with practice and supervision, seeing an increase in feelings of confidence.

> I think it was quite new for me going in with no agenda, and really trying to be completely open to the process in the moment, what the patient brings, where the patient is at. Where the patient's emotions are. So, I think having been able to build confidence in doing that.—Therapist 001.

They also spoke about the opportunity to rely on existing core therapy skills which further assisted with feeling confident during delivery.

> There's loads of core therapy skills in the SPEAKS kind of model, the kind of empathic reflecting and the building a rapport at the beginning. And then there was some of the SPEAKS specific stuff that kind of went on top of that, like the chair work and the formulations and the toys. So you've got kind of the new bits that kind of felt like they stacked on top—Therapist 002.

h. Appreciation for regular supervision and training

The majority of therapists raised how appreciative they were for the individual and group supervision and training received, feeling it helped to lay good theoretical foundations and provide support when needed. This was in addition to facilitating a connection with colleagues delivering the same intervention.

> I couldn't fault the supervision with [supervisor], it was incredibly helpful, very containing, very reassuring. Those early times when I felt de-skilled, kept me going, you know, in a way that without it, I don't know, I might have had to say "I'm sorry I can't do this trial". So it was really good, really, really good.—Therapist 003

There were differing views in terms of supervision frequency, with most feeling happy with the amount received, whereas a small number of others wanted more. Those who supported an increase in supervision wanted this in a group format, to enable discussion and roleplay.

> I think just more frequent getting together, practising certain, you know, techniques, certain aspects of the

work, that you know, that would be a really good thing—Therapist 006.

3.4 | Navigating the online treatment environment

Despite SPEAKS originally being developed as an in-person intervention, COVID-19 pandemic measures in the UK meant most sessions were delivered remotely via video call. All patients received at least part if not all of their intervention online.

i. Not being able to immerse in the therapy experience

Both patients and therapists voiced confidentiality worries for sessions delivered via video, not knowing who might hear the session, and patients not feeling able to fully engage in the process as a result.

> It was very hard given that we were doing it all online. She was living with her parents and doing most of it in her bedroom. I think there were other people in the house. I think perhaps it would have been a different experience had it been in a more confidential space away from the family.—Therapist 002.

A minority of patients commented on not having space to decompress at home after sessions. This is an important consideration when thinking about SPEAKS being implemented on a larger scale. The eliciting of and focus on emotions may be more difficult when the intervention is carried out in a patient's home where they may continue the rest of their day, rather than changing location as you would after an in-person session.

> When I first did it online I felt a little bit—it felt a bit daunting because I kind of just would come away from the session and be at home, and not really have that time to process.—Patient, female, 25.

> At the beginning she said to me, "I can't do this here because my bedroom's my safe space and…you're asking me to bring really difficult emotions into my safe space—Therapist 002.

j. The ease of online sessions

Despite the difficulties, a third of patients felt no difference with online delivery compared to in-person. Many reported appreciating the benefits of remote sessions, including not having to travel, feeling comfortable at home, and convenience.

> Not having that travelling and the stress about being on time or parking the car or whatever meant that I could start a meeting fresh and considered and prepared and everything like that. So I probably got more out of the meetings.—Patient, female, 40.

The quote below was from a patient who received a mixture of face-to-face and online, starting in person, moving to online for the bulk of their therapy under COVID-19 lockdown, and finishing with several in person sessions.

> I would have got just as much out of doing it online as I would have done in a session—Patient, female, 25.

k. Valuing the opportunity to collect with colleagues

A third of therapists highlighted the value of connection with other SPEAKS therapists. Reasons included practicing techniques via video, or feeling part of a SPEAKS team. Ensuring facilitation of this is important, particularly given the increase in working remotely since COVID-19.

> Linking in with the [other location] team as well, kind of, more widely and just kind of sharing those experiences, I think that's been really valuable, to feel like you're part of, kind of, the SPEAKS project.—Therapist 004.

3.5 | Acceptability of research processes

l. Emotional responses to involvement in a new intervention

Being part of a research trial was generally a positive experience for patients and therapists. Patients reported feeling excited about participating in something pioneering and found it motivating to be part of a process that could have a positive impact on others.

> I felt quite special—to be given the chance to take part. Quite excited about it, and quite optimistic because… the benefit of having somebody there that has created something and really thinks that this different way of doing something can have a positive impact on people, and offer them more chance of change and improvement than what's currently available is a real opportunity for myself, but then also for other people to have that help and to change.—Patient, female, 40.

Despite echoing patient sentiments regarding valuing their involvement, therapists experienced initial anxieties. These were largely due to increased responsibility and scrutiny arising from being part of a trial, such as recording sessions and opening themselves up to constructive criticism from colleagues.

> I've never done anything like this before. At times a bit scary because you're being more scrutinised than you would be. For example, I have had to record my sessions and know that [name] has looked at them and other people in my team have looked at them and we shared them in supervision. So there's a lot of vulnerability in that as a clinician to exposing yourself to being imperfect.—Therapist 005.

The majority of therapists felt that being able to learn, practice and deliver a new intervention was something they were pleased to have accomplished, and felt satisfaction from engaging with the intervention.

> Initially it's sort of quite exciting really, it's quite sort of, again it's quite a honour in some ways and it's, yeah, it's kind of, it gives you a bit of a buzz to be involved with something that's new and quite counter, you know, quite sort of revolutionary in some ways compared to many of the standard treatment models.—Therapist 006.

m. Research components

Patients reported a range of feelings regarding the questionnaires they were asked to complete. Some felt that specific questionnaires resonated more than others; one felt the Young Schema Questionnaire (Young & Brown, 1994) was particularly salient. Several patients expressed it would be beneficial to receive more feedback on how they'd answered the questionnaires, to enable additional understanding of how therapy was affecting everyday life. Only one patient seemed to compare their answers against previous completions independently. This is an important consideration for a larger scale trial of SPEAKS to ensure that patients feel informed, and understand that completing the measures are worthwhile.

> They really helped me see my progress. Really helped. I think that sort of regular check-in outside of therapy, it was almost like a stock-take that I didn't realise I was sort of having with myself. So that's good.—Patient, female, 29.

> Having almost like a sort of report at the end to say, "Well, this is how you've developed," or "This is how you've changed" would be quite useful.—Patient, female, 40.

Approximately half of patients expressed difficulties with the length of the questionnaires, and despite making time for them, found them tiring. One suggested streamlining them could minimize repetition. This is key, particularly when working with a population who can experience reduced motivation and sustained attention caused by lack of nutrition.Only one patient discussed the recording element of their sessions and how they didn't like knowing others had watched the recording and given feedback to their therapist. It isn't usual practice in therapy, including SPEAKS, to discuss supervision processes explicitly with clients, which suggests a deviation from the SPEAKS approach.

> [The] idea that someone was watching back the recording and saying you need to do more of this work…I can understand it, but I think I wouldn't want to know that there was feedback. Like I'd rather she'd just implemented the feedback than said [supervisor] wants me to do this… I personally wouldn't have mentioned it. Because then it made it feel a little prescriptive.—Patient, female, 21.

Many therapists had experience of recording their sessions prior to SPEAKS, with this familiarity felt to make the process easier. For others, the recording element was described as more difficult.

> To be honest I'm used to recording all my sessions. People listen to it. I didn't really think about it in that way. It didn't—I'm used to live supervision.—Therapist 001.

> I think I found the camera quite hard. I would try and switch off from it, but there's something about being recorded I think that was quite tricky.—Therapist 002.

n. Future randomized control trial (RCT) of SPEAKS

Most participants were incredibly supportive of an RCT for SPEAKS. This stemmed from positive appraisals of SPEAKS' impact, and the potential of enabling more people to access it. No-one requested changes (beyond changes to questionnaires outlined above), and there was a feeling that SPEAKS was "one of those why fix it if it's not broken things" (patient, female, 31). A minority of patients felt SPEAKS had not been beneficial but were still supportive of an RCT, imagining it could be helpful for others with different needs.

> I really hope that you can, and you get the funding or whatever you need to do it, because for me my only regret is I didn't do this years ago, because obviously it wasn't available then. I think the more people this can help, the better […], it's great. I really hope it does get to be cascaded out further—Patient, female, 40.

Therapists were asked about essential variables to capture during a future trial. There was consensus that weight gain was important, not necessarily as the primary outcome, but alongside other eating disorder behaviors captured in the Eating Disorder Examination

Questionnaire (EDE-Q; Fairburn & Beglin, 1994). This was in addition to capturing qualitative outcomes, in terms of how people felt about themselves, as this is what the intervention had been targeting.

> I guess with SPEAKS there may be some more interpersonal and emotional constructs that you'd want to tap into because that's what the therapy is tapping into. And it's very relevant, we know that one of the huge areas of difficulties that people with eating disorders have is their emotional recognition, expression, management—Therapist 001.

Both patient and therapists queried whether it would be possible to allocate future participants based on their suitability for SPEAKS or treatment as usual, as opposed to random assignment. There was an understanding that random allocation was important in trials methodology, despite it removing individual choice. Some patients expressed negative feelings over randomization due to previous therapy experience.

> I would have been really disappointed. I would have been devastated… and I would have known. I don't know if you're going to tell them or not, but I would have known, "This is CBT again," from the way that I was being spoken to. I would have recognised it and I would have been really disappointed because I've done that before and I know that that doesn't work for me—Patient, female, 20.

4 | DISCUSSION

This study sought to assess acceptability of the SPEAKS intervention for AN, and highlight areas for development by giving space to divergent views even where expressed by a minority.

The majority of interviews conveyed a clear message: SPEAKS was seen as an acceptable intervention for AN, offering patients a new way to think about and address their difficulties. Most patients found the techniques which SPEAKS utilizes powerful and empowering. They were often described in the context of a journey, feeling emotionally demanding in the moment but resulting in change. In general, the focus on emotions was welcomed by patients, who acknowledged the importance of this for being able to create long lasting change. Therapists valued being able to work with patient's presenting processes in sessions. This aligns with previous research, where experiential techniques, such as chairwork, were described as being "emotionally evocative… demanding, painful and helpful" (Stiegler et al., 2018).

Some participants found chairwork more challenging. This is in keeping with other acceptability assessments of interventions using chairwork techniques where as many as two third of participants have reflected that initial engagement in chairwork is difficult and impeded by embarrassment, finding it hard to take it seriously, and difficulties with emotions (Josek et al., 2023). For patients who found the techniques less suited to them, SPEAKS guidance suggests that therapists can adjust the approach or guide and hold these initial difficulties within the therapeutic relationship.

Patients appreciated the weekly frequency of sessions as this kept momentum; this frequency is comparable to current NICE recommended treatments (NICE, 2020). The duration of nine to 12 months (40 sessions; Oldershaw et al., 2023) appealed particularly to those with previous therapy experience, eliciting feelings of hope, as it was deemed longer than current interventions for anorexia. This duration is in keeping with findings that treatments of standard length (20–30 sessions) are less effective for those with longer illness durations (Ambwani et al., 2020). This viewpoint on length of therapy was not unanimously shared by therapists, with some expressing concerns—particularly in terms of staff practical and emotional resource—with delivering SPEAKS outside of a trial within the current NHS. This highlights the importance of providing effective support for therapists delivering aspects of an emotion focused intervention (Qiu et al., 2020), but also may highlight a broader concern over current demands and levels of support for staff generally in NHS eating disorder services. The interplay of these findings; that the length of SPEAKS was deemed as preferable to patients, but that therapists had concern about resource, indicate a balance needs to be achieved to ensure successful outcomes are achieved as in the SPEAKS trial, but with current levels of staffing and funding. It highlights a potential conflict and gap between patient needs and current NHS provision and resources relevant across patients with complex needs.

Despite being designed as an in-person intervention, elements of SPEAKS worked well being delivered online, but for the experiential sessions, it was widely felt by patients and therapists that in-person sessions were preferable. Research specific to AN treatment delivery and outcomes, such as findings from Carr et al. (2022), found no significant advantage for either in-person or online delivery. Furthermore, experiential methods such as chairwork are reported to be feasibly delivered online (Pugh et al., 2021), suggesting that factors such as patient preference and therapist confidence in delivery have influence over how these are received This study adds to those previous findings by highlighting views of online therapy for this specific patient group. Ideally, delivery mode must always be in line with a patient's preference, taking into consideration whether remote delivery is feasible and a patient has a suitable environment where they can relax and fully engage. If this is not possible, comments from patients and therapists reflect that these sessions are felt to be less helpful.

Therapist viewpoints gave an insight into what SPEAKS was like to deliver. Some felt de-skilled initially, but these feelings reduced over time with peer support through group supervision, alongside individual supervision. Neither of these are new concepts and therefore, it seems unlikely they would add significant extra burden onto staff, but instead act as a familiar space to feel contained and advance learning. Additionally, therapists were able to draw on their core therapeutic skills, developed over their training and

subsequent career. Once this was recognized, therapists reported increased confidence levels with SPEAKS delivery.

Regarding research acceptability, patients expressed receiving outcome measure feedback would have been useful. Providing feedback when using routine outcome measures is considered best practice and assigns meaning to the task, in addition to providing an alternative form of evidencing change. Update reports on key measures were provided to therapists every 3 months for each patient and were available to be shared; further emphasis could be placed on this in future therapist training.

4.1 | Research and clinical implications

In line with the aims of this article, the natural progression for future research would be for a larger SPEAKS trial. A potential area of interest within this could be to assess acceptability at a longer-term follow up point. It may be that people have an alternative view on how acceptable they found certain techniques when they have been without the intervention for more time. Changing perspectives over time from experiential techniques being more difficult to highly beneficial have been found in other research studies (Josek et al., 2023) and tracking such changes during therapy would have been beneficial here. Whilst individual preferences with regards to experiential methods should be respected, research focusing on how chairwork may be introduced or delivered in such a way as to make it more engaging or attractive for people with AN could be valuable, particularly given that the inclusion of chairwork in psychotherapies can lead to better clinical outcomes (Pascual-Leone & Baher, 2023).

This study provides wider clinical implications beyond SPEAKS, including regarding therapy length, clinician support and use of video sessions. Key learning is the positive feedback received regarding emotions and understanding different aspects of the self being a valued primary focus of the intervention. This is a different approach to the current standard treatments for AN and adds to the literature for researchers to explore further.

A valuable implication for professionals treating AN seems to be the importance of collaboration; therapists valued and enjoyed connection with their colleagues and found it beneficial to their work. This illustrates the importance of therapists not working in silo. This doesn't have to solely take place during a trial, but could be provided through protected time in therapists' working week or the scheduling of peer support groups. The act of regular supervision was reported to be important and highlights how being supported by line managers, and colleagues during peer supervision, helps to bolster confidence.

There is a wider consideration to be made when conducting randomized control trials with people with a longer illness duration, and who may have received (multiple) previous therapies. These individuals may have a preference for what type of intervention they may be after, or not after, as indicated by the patient who told us they would not want Cognitive Behavioural Therapy (CBT) again.

4.2 | Limitations

One limitation is the homogeneity of the qualitative research team and participant sample. Both researchers were young, white females; all participants were female, and 14 of the 16 participants were White. This could have resulted in biased interpretations of interview transcripts, as the researchers may have shared similar backgrounds to participants. Researchers engaged in active discussion with each other, and subsequently the wider team, including co-developers of the intervention, to mitigate this, but without alternative perspectives this may still have occurred. Future research could benefit from a diverse team and participant sample to ensure findings are representative of a broader population.

This analysis included 16 patients and 6 therapists, representing approximately half of those who completed the SPEAKS feasibility trial, although all participants were offered a post-therapy interview, including those who withdrew from the trial. There was some variability in the demographics of those who completed interviews versus those did not, such as that two thirds of those completing interviews had not received a previous therapy, whilst in the overall sample, only 20% had not. Whilst this and the sample size may somewhat limit generalizability, it is consistent, if not larger, than other qualitative studies looking into acceptability of eating disorder treatments (Hoskins et al., 2019; Juarascio et al., 2015). It is unfortunate that no interviews were conducted with patients who withdrew from the trial as alternative perspectives may have been captured; however, patients who did agree to interviews had different backgrounds in terms of length of eating disorder and prior therapy experience, thus entering the trial with different needs and expectations bringing breadth and variety to the feedback obtained.

4.3 | Conclusion

The study findings suggest SPEAKS has favorable acceptability as a novel intervention for AN. Participants expressed support for further investigation of its impact through an RCT with a larger and more diverse participant group. Moving forward, it will be important to prioritize therapist understanding of the treatment model through guidebook adaptation and comprehensive therapist training to ensure fidelity to the model and patient-centered flexible care.

AUTHOR CONTRIBUTIONS

Abigail Rennick: Conceptualization; data curation; formal analysis; methodology; writing – original draft; writing – review and editing. **Cat Papastavrou Brooks:** Conceptualization; data curation; formal analysis; methodology; validation; writing – original draft; writing – review and editing. **Randeep Singh Basra:** Data curation; investigation; project administration; writing – review and editing. **Tony Lavender:** Conceptualization; funding acquisition; methodology; writing – review and editing. **Helen Startup:** Conceptualization; funding acquisition;

methodology; writing – review and editing. **Anna Oldershaw:** Conceptualization; data curation; formal analysis; investigation; methodology; supervision; validation; writing – review and editing.

FUNDING INFORMATION

The SPEAKS intervention development and feasibility trial is independent research arising from an Integrated Clinical Academic Fellowship-Clinical Lectureship awarded to AO (ICA-CL-2015-01-005) supported by the National Institute for Health Research and Health Education England. The views expressed in this publication are those of the authors and not necessarily those of the NHS, the National Institute for Health Research, Health Education England or the Department of Health.

CONFLICT OF INTEREST STATEMENT

The authors have no conflicts to disclose.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Rennick, A., Papastavrou Brooks, C., Singh Basra, R., Startup, H., Lavender, T., & Oldershaw, A. (2024). Acceptability of Specialist Psychotherapy with Emotion for Anorexia in Kent and Sussex (SPEAKS): A novel intervention for anorexia nervosa. *International Journal of Eating Disorders*, 1–13. https://doi.org/10.1002/eat.24139