Evaluation of the TEASPOON METHOD performed with children with AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER

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Abstract
Background: Eating problems are a relatively rare in children and usually rely on a phase. Sometimes, this phase does not pass and serious problems such as an Avoidant Restrictive Food Intake Disorder (ARFID) can arise. ARFID is a new understanding in feeding problems, and replaces the DSM-IV diagnosis 'Nutritional disorder in infant or early childhood'. To treat children with ARFID, the teaspoon method was developed. In the teaspoon method, both positive and negative reinforcement is used in combination with an escape extinction (a 15 minute break), since positive reinforcement alone did not contribute to an improved diet pattern of the children. The teaspoon method is quite a drastic method to execute for the whole family, and whether it succeed depends on how the parents implement the method. Therefore, it is important to investigate what changes parents have observed in their child, themselves, and their family situation since the start of the method and what their experiences with the method were.
Objectives: 1. To describe what changes parents have noticed in their child, in themselves, and in their family situation after performing the teaspoon method. 2. To examine the positive and negative experiences of the parents with the execution of the teaspoon method. 3. To describe what characteristics have helped the parents to implement the method, and what they recommend to other parents when implementing the method. 4. To describe what the improvement points regarding the method are according to the parents.
Method: A semi-structured interview was conducted in twelve parents of children with ARFID. The interview was based upon the Client Change Interview (CCI).
Results: The results of this study indicate that parents were predominantly positive about the method. The most obvious change the parents observed in their child was that a "button turned" in the head of their child and that it started to eat what was cooked. According to the parents, the method contributed to a better diet pattern in nine of the twelve children. The most common change in the parents and in the family situation is that the atmosphere during dinner was improved and that parents began to look forward to dinner, where they did not before. Parents noted that whether the method will be successful or not, depends on how parents implement the method and how they handle the executing of the method. Being consistent, executing the method as a team, and persevering even when it is difficult were mentioned as most important characteristics of the parents. The paediatrician played an important role for the parents, because she was the one who made the agreements with the child, an element that, according to the parents, took away a lot of struggle between the parents and the child. Characteristics which have helped the parents the most in executing the method were being consistent and working together as a team. The parents recommend to other parents to stay consistent, even when it is hard, and to make appointments beforehand with each other about how to execute the method. Furthermore, parents noted that you have to support the idea of the method. According to the parents, the method can be improved by giving it more publicity, by receiving information about how to deal with other children during dinner, by follow-up consultations with healthcare professionals as a reminder that the agreements do still exist, and by information evenings where the parents can share experiences with each other about the method.
Conclusion: The teaspoon method seems the first method that specifically focuses on the treatment of children with ARFID. Despite the notion that the teaspoon could be a tough method to execute, most parents indicated positive experiences with the method and positive changes in their child, themselves and their family situation. In order to make the method work, it seems to be most important that all care providers draw the same line to the child, and that they support the idea of the method. Further research should indicate if the execution of the teaspoon method is also perceived as positive on a larger scale in parents with children with ARFID.
Keywords: Eating problems, Avoidant/Restrictive Food Intake Disorder (ARFID), teaspoon method.

Content

Introduction

Eating problems

Eating disorders are relatively rare in young children, while feeding problems tend to be quite common. Most children go through periods of food refusal, playing with food and using food as a means of power. Usually, these difficulties resolve themselves. For some children, these difficulties do not resolve themselves and can result in health problems for the child and great concerns about their child by the parents. Without professional help, the eating problem can even become life-threatening in some cases (Southall and Schwartz, 2000). When the periods of refusing food do not pass and the child continues to eat both restrictively and selectively, Avoidant Restrictive Food Intake Disorder (ARFID) can arise. ARFID is a quite new understanding in eating disorders, and currently there is as yet no specific treatment method for ARFID.

Avoidant Restrictive Food Intake Disorder

ARFID replaces the DSM-IV diagnosis 'Nutritional disorder in infant or early childhood', and is a quite new understanding. According to the American Psychiatric Association (2013), the main feature of ARFID is avoidance and/or restriction of food intake, manifested by significant failure to meet requirements for nutrition or insufficient energy intake through oral intake of food. Features of ARFID are: significant weight loss, significant nutritional deficiency, dependence on enteral feeding or oral nutritional supplements, or marked interference with psychosocial functioning. Individuals with this disorder do not have a fear of gaining weight or of becoming fat, nor do they have a disturbance in the way they experience their body shape and weight. The diagnostic criteria of ARFID according to the DSM-V can be found in Appendix A.

Because ARFID contains a new category, no studies have yet been performed into the incidence and prevalence of ARFID in the Netherlands. However, there are indications that incidence and prevalence differ across the various age categories. In young children, the prevalence of food avoidance can reach over fifty percent. In a recent Dutch cohort study, 2230 young people were followed from the age of eleven years. 884 young people were screened eight years later in two phases for the presence of eating disorders. Of the 312 young people who were identified as "high risk", there were three children who met the criteria of ARFID according to the DSM-V (Smink et al, 2014).

There is increasing evidence for a link between ARFID and neurological developmental disorders, especially when this goes together with reduced oral motor activity. Comorbidity of ARFID occurs with autism spectrum disorders, especially if there is a strongly restrictive eating pattern (Bryant-Waugh, 2013). In a Swedish twin study of Norris et al. (2014), forty percent of the nine to twelve year olds with nutritional problems scored positively on a screening for ASD. Comorbidity with anxiety disorders, especially generalized anxiety disorder, is common (approximately 50% based on limited literature data); this is more often than in comparison with anorexia nervosa (AN). Mood disorders are also described as comorbidity in ARFID, but this percentage is slightly lower compared to the patients with AN. Approximately half of the ARFID patients also have a different medical problem, either as a direct result of the disorder (e.g. malnutrition or low heartbeat), or related to dietary and eating patterns, such as diabetes or food allergies.

Because ARFID is a relatively new understanding, effective treatment methods are still being studied. Currently, there are no evidence-based treatment recommendations for ARFID. However, clinical experience suggests that patients' needs might differ depending on what factors are thought to be driving the distress and eating disturbances (Norris et al., 2016). Methods that mainly have been used in the treatment of ARFID include forms of cognitive behavioural therapy and exposure therapy (Karges, 2016). Van der Gaag and Snijders (2017) recently developed the teaspoon method, which might contribute to the treatment of ARFID.

Teaspoon method

To improve the diet pattern and decrease selectivity of children with ARFID, Van der Gaag and Snijders (2017) developed the teaspoon method and pilot tested it. The teaspoon method is used when

no other intervention such as nutritional advice or a two-day observation helped, and when the children did not respond to any kind of positive approach. The teaspoon method added a combination of positive and negative reinforcements, because previous research of Piazza et al. (2003) in four children of the ages of 23 months to 4 years old, who had been diagnosed with a paediatric feeding disorder, showed that reinforcement alone did not result in increases in mouth clean or decreases in inappropriate behaviour, while negative reinforcement in combination with an escape extinction did.

The basic principle of the teaspoon method is that eating is a normal and natural requirement. When the parents ask the child to eat, this is a normal activity – nothing special, nothing worth a big reward or present when the child starts eating (Van der Gaag and Snijders, 2017). During the teaspoon method, parents and their children are taught the basic principles of the need for nutrition. The training is explained to the child and parents at the same time by the paediatrician, they will be given the same information. The training starts with the food group the child needs the most. The parents are taught that the approach to the child should be neutral, that it can be tough to implement the method and that being consistent is very important.

Children have several reasons not to eat, especially fears, sensory problems, absence of appetite and/or rigid patterns. These reasons can become thresholds for starting to eat. The fears of the children can be eased by taking very small steps; eating the amount of a teaspoon. These small steps are used in the teaspoon method to prevent children from panicking and to help them overcome their thresholds (Van der Gaag and Snijders, 2017). Zarcone, Fisher, and Piazza (1996) examined the effects of escape extensions and found that a break plus access to preferred items resulted in greater increases in compliance than a break alone. In the teaspoon method, a combination of positive and negative reinforcement in combination with an escape extension is used as a consequence, since positive reinforcement alone did not work in the children in previous treatment methods (Van der Gaag and Snijders, 2017). The negative reinforcement in the teaspoon method is not an escape from mealtime, but turns into an avoidable situation for the child. This situation will be made very unattractive, and the mealtime easier and more attractive by offering really small amounts of food and a positive reinforcement afterwards. For example, when a child refuses to eat the vegetables, they will be sent to bed without reading a story or watching television with the explanation that they ate insufficient food, and their body needed to rest. Since the child is made clear that eating is a normal everyday habit, the negative reinforcement does not have to be seen as punishment, but more as a consequence of not giving enough energy to the body. In their bedroom, the children receive a cooling-off period of fifteen minutes. When they then decide to eat the vegetables, they go out of bed and continue the meal. They then continue with the standard bed-time routine. This is then not a reward, since eating is a normal everyday habit that does not need rewarding. When using the consequence, it is important to ensure that eating a teaspoon is always a smaller step for the child than performing the consequence. Furthermore, it is important to consider the situation of the child, it is never the intention that the consequence is seen as punishment or arouses fear in the child. In most cases the consequence of going to bed is used, but the consequence may also be that the child is no longer allowed electronics the rest of the evening and/or the next day.

The paediatrician plays an important role in the procedure of the method. The paediatrician makes arrangements with the child about what he or she is going to eat in the next weeks. The assignments come from the paediatrician, not from the parents. In this way, conflicts between the child and parents will be decreased, because a stranger is in the lead. This gives the parents more space to perform the training, because when their child gets angry, they could not blame their parents and the parents could refer to the paediatrician. The teaspoon assignment takes place one time a day, during dinner time, every day for one month, until the next appointment with the paediatrician. The method starts with the agreement of eating one teaspoon of food the child refused to eat so far. The other eating habits of the child remain unchanged at that point. The following month, the child and parents receive a new assignment. When the child did not succeed in the first assignment (having fulfilled less than 50% of the first assignment), they will repeat the same assignment with different consequences. When they did succeed, the amount of vegetables, for example, will be increased to one tablespoon. In the third

month, the amount of vegetables will be increased to two tablespoons and in the fourth month to three tablespoons of vegetables. In the fifth month, another food group which the child does not eat will be addressed. Because the child is now used to eating food they do not prefer, it is not necessary to use the small amounts any more. The assignments now consist of drinking a glass or half a glass of natural milk or eating half a portion of fruit (Van der Gaag and Snijders, 2017). In addition to the element that the child is made responsible for its own behaviour by making agreements with the paediatrician, the parents also play an important role in the implementation of the method since the method's success depends on how the parents execute the method.

This research

Results of Van der Gaag and Snijders pilot study (2017) showed that in the before and after measurement, the quantitative intake of fruit, potatoes and vegetables increased significantly. Food selectivity decreased, expressed by an increase in variation of consumed fruit, meat, potatoes and sandwich filling. The costs of the training are low, and the children stay in their home environment. However, carrying out the method can be pretty drastic and may have a lot of impact on the family. The method's success depends on how the parents handle with the execution of it. Parents are expected to fully support the idea behind the method, and to be and remain consistent during the execution of the method. Therefore, it is important to investigate what the parents' experiences were with the execution of the method and what changes they noticed in their child, themselves and their family situation. Since the methods' success depends on how the parents handle with the implementation of the method, it is also interesting to investigate what the strong characteristics of the parents were during the implementation, and what they recommend to other parents who are at the start of implementing the method. At last, it is interesting to investigate what improvement points the parent note according to the method.

Research questions

The research question of this research is:

1. What are the experiences of the parents with the teaspoon method?

Sub questions that will be addressed are;

2. What are the observed changes in the children after performing the teaspoon method?
3. What are the experienced changes for the parents and in the family situation after performing the teaspoon method?
4. What are the positive and negative experiences of the parents with the execution of the teaspoon method?
5. Which characteristics have helped the parents and which characteristics do they recommend to other parents in the implementation of the method?
6. Which improvement points do the parents have according to the teaspoon method?

Methods

Design

A semi-structured interview was performed, since an interview is an appropriate way to clarify the experiences of the parents who executed the teaspoon method. This study has been approved by the Assessment Ethics Committee (ETC).

Participants and procedure

In 2014 and 2015, several parents came with their children at the paediatrician's consultation hour to talk about the eating problems of their children. The paediatrician decided at that time which parents and children were going to carry out the teaspoon method and which parents and children required a different approach. All participants of Van der Gaag's study, nineteen in total, were invited to be involved in this study by an information letter, which can be found in Appendix B.

A few weeks after receiving the information letter, the researcher called the parents by phone to ask whether they have read the information letter and whether they wanted to participate in the study. When parents refused to participate, the researcher asked for their reasons and then asked if they gave

permission to note their reasons in this study, which all parents did. At last the researcher thanked them for their time.

Twelve of the nineteen parents actually participated in this study, and seven parents refused to participate. Reasons to not participate were the time between the method and the study, and personal circumstances. Another reason was that the parents had a lot of other assistance for the child, and therefore chose to pass this study to them. One of the parents could not be reached after several attempts.

When the parents indicated that they wanted to cooperate with the interview, the researcher made an appointment to come over to conduct the interview in the home environment of the parents. All parents signed informed consent. All parents who participated in the study lived together as a family. The interview was taken with the mother in ten out of twelve times, in two cases both the father and the mother were present. One parent indicated that taking the interview was too time-consuming for her, but that she and her husband were prepared to answer the questionnaire by e-mail. Because the explanation of these parents was very clear, it was decided to include the interview in this study. The basic characteristics of the children at the start of the teaspoon method can be found in table 1.

Table 1. *Basic characteristics of the children at the start of the teaspoon method (n=12)*

Resp. nr.	Sex	Age
Resp. 1	Boy	7
Resp. 2	Boy	4
Resp. 3	Girl	12
Resp. 4	Boy	10
Resp. 5	Girl	6
Resp. 6	Boy	8
Resp. 7	Boy	7
Resp. 8	Boy	7
Resp. 9	Girl	4
Resp. 10	Girl	3
Resp. 11	Boy	9
Resp. 12	Boy	7

Data collection

Client Change Interview

In this study, the Client Change Interview (CCI) was used to reflect the experiences of the parents. The Client Change Interview (CCI) is a 60 to 90-minute interview consisting of ten questions with sub questions. The CCI can be administered at the end of a therapy and at regular intervals throughout the therapy (Elliot, 2008).

The questions asked in this study, identified which changes the parents have noticed in their children, in themselves, and in their family situation. Parents were also asked to identify which characteristics of themselves have helped them in the execution of the method and what aspects made it more difficult for them to execute the method. In addition to the ten standard questions, two additional questions have been added in this study; 11. “Do you have tips/suggestions for parents who start the teaspoon method or who are at the beginning of this process and might have doubt about implementing the method?”, and 12. “Do you have any other comments/things you want to tell us?”.

In Appendix C, the original CCI is added. For this study, the CCI was translated to Dutch, two questions were added and the CCI was set in the perspective of the parents. The translated CCI, together with the information letter the parents have received a few weeks before the phone call, can be found in Appendix B.

Analysis
Eleven of the twelve interviews were voice recorded. One participant returned the interview by e-mail. All interviews were transcribed in Word. Relevant quotes were selected and coded in Atlas.ti.

Deductive coding was used on the basis of the research questions. In the first instance, the data was coded according to the following six subjects: observed changes in the children after performing the teaspoon method; experienced changes of the parents and in the family situation after performing the teaspoon method; positive and negative experiences of the parents with the teaspoon method; helpful characteristics of the parents to help the method succeed; suggestions for other parents to let the method succeed; suggestions and improvement points regarding the method. Relevant quotes from the parents were selected for each subcategory. Criteria for the quotes were that they clarified the subcategory and reflected as briefly as possible what the parents said about the subject. To make the results of this study easier to read, a number of quotes have been made more readable by shortening them or by formulating them differently.

Inductive coding was then used by integrating the categories regarding the strong characteristics of the parents to execute the method, and the recommendations they gave to other parents about how to execute the method. This was done because the answers given by parents regarding the questions in the interview about these topics mostly came down to one thing, namely: the subject 'Helpful characteristics of the parents- and suggestions for other parents to let the method succeed', was created. The researcher critically observed the coded quotes again and created categories and subcategories based on the five subjects. After coding, all audio files of the interviews were deleted.

Results
Observed changes in the children
Table 2 summarizes the changes the parents observed in the children after performing the teaspoon method. The changes the parents have noticed in their child are commonly positive and can be divided into four categories. The first category represents that the teaspoon method, according to nine of the twelve parents, contributed to an improved diet pattern of their child. The second category is about the observation that their child eats and tastes more food. Parents indicated that their child nowadays eats what is cooked, and that their child eats more easily in the presence of someone else. Furthermore, parents noted that their child asks for food themselves. The third category is that parents noted their child has better health than it had before, because the child is less ill and feels more calm around dinner time. The fourth category is that parents indicated that their child knows better why good nutrition is important. What parents particularly indicated here was that at the moment that the paediatrician explained the method to their child, a "button turned" in the child's head and that they started eating since then.

Negative changes for the child after performing the method were that parents indicated that their child had a relapse to their old diet pattern. Two parents indicated that their child is busier with food nowadays and described this as almost an obsession, so they saw it as a negative outcome for their child. In one case this was due to the mouth sensitivity of the child, and in the other case this was probably caused by the child hearing voices in his head that stops him from eating.

Table 2. *Observed changes in the children after performing the teaspoon method*

Category	Subcategory	Resp. (n=12)	Quotations
Positive			
Improved diet pattern		9	Resp. 2: "When I look at what he now eats in comparison with when we started, that is really not comparable, I could not have hoped for this"
Eat/taste more	Eat what is cooked	8	Resp. 11: 'She eats what we have cooked. We do not longer have to cook separately for her anymore'
	Eat with others	6	Resp. 3: 'She also eats better with others'
	Asks for food themselves	6	Resp. 5: 'They may once a week choose what they eat, yesterday was kale with smoked sausage, fine! And then she really enjoys the food, and then she says: for me just one more scoop please!'
Better health	Less ill	9	Resp. 2: 'Sick less often and he looks better' Resp. 11: 'She got better hair, and she got colour in her face again. And she had more energy again, she was not tired anymore'
	More calm	2	Resp. 2: 'He became calmer. Especially around dinner. That was just better'
Child knows better why good nutrition is important	Button turned	8	Resp. 3: 'Our daughter understood what the method means, and she has autism so that is also very black and white. (..) So she understood immediately, that button went around and she understood that we had to force her to eat a teaspoon and later on a tablespoon and, yes she did'
	Knew what was expected	4	Resp. 2: 'He just knows what is expected of him, it is just better, it is just clearer'
	Understands what food does to the body	2	Resp. 5: 'They now know what is important, that vegetables are very important and what can happen if you eat too little of them. That you become sick more quickly, that you are tired more quickly, she is more aware of what food does'
Negative			
Relapse		2	Resp. 8: 'That I regret that he has fallen back with some things in his old diet, and yes that monotonous food has fallen back in the sense that he is also at the table again and that I sometimes see that he throws it out again'
Busier with food		2	Resp. 11: 'Which I myself am afraid of, she is very busy with food, and that comes, of course, that is poured into the spoon. (..) But she is concerned about it and a niece of mine died on anorexia, she did not make it. And then I'm a bit worried that I think, you are so busy with it, so, you're still so small, and with your appearance, that you're afraid, if you do not get fat, yes, where is that going, he, if it will not be something like that later'

Changes in the parents and in the family situation

Table 3 summarizes the changes of the parents and in the family situation after performing the teaspoon method. These changes were mainly positive and can be divided into four categories. The first category is that the ambiance in the family is improved. What is striking is that many parents indicate that the atmosphere during dinner is more enjoyable than before, and that it is cosier to have dinner with each other. Thereby, parents indicated that they began to look forward to dinner, where they did not before. The second category concerns that seven parents have indicated that they still make use of the method in their daily life. The parents indicated that they mainly use the method when their child feels mentally less well. As a parent indicated, the method is the safe basis to go back to. Other parents used it especially if their child had never had the food they cooked that day and did not want to taste it, then they initially gave a teaspoon to the child. The third category concerns that going out for dinner is easier than it was before. The fourth category is that parents became aware about the thinking pattern of their child. Parents hereby indicated that they have more insight into the thinking pattern of their child after performing the teaspoon method, and that they are less worried about the health of their child than they were before.

What can be seen as negative outcome is that the negative reinforcement did no longer work for one child, because the child experienced the consequence as a less severe experience than eating the teaspoon. The parents of this child did not proceed to another consequence at that time, this resulted in the child having a relapse to his old diet.

Overall, it can be concluded that the parents mainly mentioned positive changes for themselves and their family situation after performing the teaspoon method. The change that is most obvious is the feeling that there is less struggle at the dining table and that every family member enjoys the dinner more than they did before.

Table 3. *Experienced changes of the parents and in the family situation after performing the teaspoon method*

Category	Subcategory	Resp. (n=12)	Quotations Respondents
Positive			
Ambiance is improved		8	Resp. 5: 'The atmosphere at the table is just fun, no more grumbling, no nagging' Resp. 6: 'Before, I did not look forward to go home, because I knew there would be a fight at the table. Now I am really looking forward to dinner, it really has become a family moment again.'
Still use the method		7	Resp. 11: 'I say you always have to taste, that is then the teaspoon I think of, just such a little bit, we start with that'
Going out for dinner is easier		5	Resp. 6: 'What we have achieved is that we can just eat out with each other. And that everyone enjoys it, although he grabs the standard things like baked potatoes and a snack, but the point is that you are cosy eating out together'
More awareness	Parents have more insight into thinking and doing of their child	2	Resp. 1: 'That we got insights to what is it about with the food with him'
	Less worried about health	2	Resp. 6: 'Of course you also worry less about that area in any case'
Negative			
Consequence did not work anymore		1	Interviewer: 'The consequence actually passed its goal in that respect?' Resp. 8: 'Yes, then he took his things and he choose eggs for his money and then he went upstairs to do something. So eh, that was actually not what we fancied he'

Positive and negative experiences with the teaspoon method

In table 4, results according to the positive and negative experiences of the parents with the teaspoon method are summarized. In general, the parents indicated positive experiences which can be divided in three categories. The first category concerns that the parents indicated that they found the method clear. Parents indicated that the structure of the method was clear and that it was easy to implement. The second category indicates that parents noted that it was useful for them that the paediatrician was in charge of the process, as this took away a lot of struggle between the parents and the child. The third category indicates that results came fairly quickly according to the parents.

The barriers that parents have encountered can be divided into five categories. The first category indicates that most parents found the initial period especially tough. Secondly, the parents noted that they found it difficult to remain consistent. The third category concerns the fact that some parents indicated that they have a difficult family situation, in which it was hard for them to execute the method as was meant. The fourth category is about the given that one parent indicated that he found it difficult to use his experiences of his work in his home situation. The fifth category indicates that one parent could imagine that not all parents would be able to perform the method when their child physically goes into defence.

According to the experiences of the parents with the teaspoon method, it can be concluded that the parents were mainly positive about the method, and that the clear structure of the method, the contact with the paediatrician and the element that the paediatrician was in the lead, was often reflected in the interviews. Parents have indicated that they have experienced the initial period as tough, but that it is definitely worthwhile to continue, because they quickly achieved the desired results. Aggregating, the useful aspects of the method can be summarised as a parent did:

> Resp. 6: *'The shortest thing we can say about it, I think is really the fact that you have that cooperation and the guidance of the doctor, and you as a parent are not the wicked, but the executor. That you can always fall back on the agreement between your child and the doctor, he makes the appointment, we do not. We think it is necessary, we also want it to went well, but he makes the appointment with the doctor. I think that is really the red thread in the method. We could have thought of everything and anything. But if we did not have had that element, it would not have been possible. I think that was the most important of the whole therapy.'*

Table 4. *Positive and negative experiences of the parents with the teaspoon method*

Category	Subcategory	Resp. (n=12)	Quotations Respondents
Positive			
Clear method	Step-by-step	9	Resp. 5: 'It is step by step, so you keep an overview'
	Easy to implement	8	Resp. 8: 'Good to do, easy to understand'
Paediatrician is responsible	Paediatrician in lead	8	Resp. 6: ' I think it is good that he made the appointment with the doctor and that he himself was very involved and therefore responsible for whether it went well or not. As a parent you really only have to use the rule, and as a parent you could easily say that he should call the paediatrician if he does not agree with it'
	Interaction with paediatrician	7	Resp. 2: 'And also a lot of credits to the paediatrician that she thought along with us'
	Child has awe for the paediatrician	6	Resp. 2: 'By how the paediatrician explained to him what it delivers to him and because we have also remained consistent, that has helped enormously that he has had something like; if I put down, it really costs me a lot if I do not eat it'
Results came fairly quickly		2	Resp. 2: 'It really was the first couple of months I think, those were a little bit spicier, two, yes four till five weeks. Six weeks maybe, and then it becomes more your own'
Barriers			
Initial period is tough		7	Resp. 10: 'In the beginning, we certainly found it difficult. We saw his trouble with (and also tears) eating fruit and vegetables. It is difficult to change from one day to another, to a 'strict' approach. But we found this necessary after having eaten little or no fruit and vegetables for several years'
Being consistent is though	Carry out consequence	5	Resp. 5: 'That you really have to implement the consequences, that is in the beginning. The first time was really oops, swallow, and the first time she went really well into the defence physically, that has stuck'
	Saw the child's trouble	3	Resp. 1: 'But I found it very sad sometimes. That is what hurt me, really. For example, he had to eat a teaspoon with a carrot, he gagged in advance so terrible that I thought what do I do to him, you know'
Difficult family situation	Carried out on my own	2	Resp. 11: 'My husband has not been with me to the paediatrician, I have been with my son, my husband has a very busy job. But that did result in we ourselves also had a fight with each other'
	Other children	2	Resp. 7: 'What I find difficult is that you have another child who does not have autism, so that automatically other rules apply'
	Babysitters must draw the same line	2	Resp. 8: 'The grandmothers I have here, and that we both, that everyone does the same thing. I also had to demand a bit from my mother, which I found difficult. Because yes, my mother came then to babysit and came to make food and then I had to say that to her, and yes I know she still found it more difficult than I myself of course'
Experiences of work difficult to execute at home		1	Resp. 6: 'I have worked for years with mentally disabled people with autism who eh, there where you give a millimetre of space, then you just do not have life as a supervisor on such a living group. And as good as I did there, I can do it so badly at home. I cannot do that in one way or another. That is, yes, I do not know, there are certain emotions that I think that block me, I also find it sad quickly'
Physically not able to perform the consequence		1	Resp. 2: 'I can also imagine that there are also parents who cannot physically do it. (..) Maybe you can come up with something on that, because I do not have the solution for that either'

Characteristics of the parents that were helpful

Table 5 summarizes the characteristics of the parents which helped them to perform the method and which recommendations they have for other parents to let the method succeed. The characteristics can be divided into four categories. The first category indicates that parents stated that being consistent is the most important while executing the method. The second category concerns that parents indicated that you have to execute the method as a team, in which parents stated that it is very important to go for it together, to draw one line with each other, and to make appointments in advance about how to deal with several situations. The third category concerns the given that parents indicated that you have to carry on, even when it is difficult, because in the end, the method delivers a lot. The fourth category concerns that the parents have indicated that they have been able to use their work experiences in the home situation, because they were already accustomed to similar situations in their work.

Table 5. *Helpful characteristics of the parents- and suggestions for other parents to let the method succeed*

Category	Subcategory	Resp. (n=12)	Quotation Respondent
Consistent	Being consistent	9	Resp. 11: 'To be consistent, very important, consistent'
	You have to support the idea	5	Resp. 3: 'You really have to stay behind. You do not need any other things which you think will work, then you should try that first. You must be hundred percent convinced. It depends on the determination of the parents. If the parents have something like leave it, yes, you really have to be hundred percent behind it'
	Not being afraid	2	Resp. 1: 'I am not that scared about that. I do not have the idea that I am not doing well, and I really do not have that feeling'
	Keep calm	5	Resp. 4: 'You have to be able to keep that peace'
	Keep structure	3	Resp. 11: 'Regularity, then you eat something, at that time, and we eat that'
	Have one parent in lead during diner	2	Resp. 7: 'That there was one parent who interfered with him. Also to ensure that no confusion arises'
Work together as a team	Go for it together	9	Resp. 2: 'You really have to go full for it together'
	Draw one line	8	Resp. 10: 'As parents, you have to draw one line together and be consistent, both against your child and the environment, which sometimes has problems with it'
	Make appointments in advance	6	Resp. 2: 'That you have agreed a little in advance if this goes wrong, how do we say that and how are we going to do it?'
	Involve child while cooking	1	Resp. 8: 'Involve the child in the cooking, it is also a handy thing to start looking for recipes together'
	Discuss your doubts with the paediatrician	2	Resp. 2: 'Tell the doctor clearly what your doubts are, what are you afraid of. Because she can take away a great deal. Yes, what is it that holds you back, and what makes it debatable. I think that will create a lot of clarity'
Carry on	It delivers a lot	5	Resp. 6: 'Certainly in the beginning I think, you get more misery because you go a little further in the pit than you will get out, so I think you really have to be aware of that'
	Continue even when it is difficult	5	Resp. 7: 'That you also know that it can be difficult, but even then do not admit it'
	Consider what is most important	2	Resp. 3: 'How sad is it for your child, I think if it eats very badly and goes back in health in the coming years, I think that is worse than being very consistent now. (..) With which you do more damage to your child'
Work experience	Experiences with target group	2	Resp. 1: 'I have worked for seven years on a residential group for people with autism, there you also get a lot of away'

Suggestions and improvement points

Table 6 summarizes the suggestions and improvement points the parents described regarding the method, which can be divided into four categories. The first category describes that parents have indicated that they would like more publicity for the method. The second category concerns that the parents would like to receive tips about how to deal with the method in the family situation, especially when there is another child at the table during dinner. The third category indicates that parents would like to have follow-up consultations with a healthcare professional after executing the method, so that the agreements about the food remain, and the parents do no longer come into conflict with their child about the agreements. The last category indicates that parents would like to share their experiences with other parents.

Table 6. *Suggestions and improvement points regarding the method*

Category	Subcategory	Respondent (n=12)	Quotation Respondent
Give more publicity to the method	Spread the word	3	Resp. 7: 'There can get a lot more known if I hear how little is known to others, and I do not know if we are the only success story, but I think, oh spread the word, spread the word'
	Build a website/write a book	2	Resp. 1: 'I would say make a very nice website where all those parents can go for eating problems. Because there are many! Really a lot'
	Make it known at an earlier stage	1	Resp. 7: 'At a consultation desk, you know, that it is known earlier, yes how simple it can be, how helpful it can be, that would have saved us four years of trouble'
Tips family situation	Other children	2	Resp. 12: 'We had something like maybe do you have tips and advices for when you are sitting at the table with several children'
Period after method	Yearly check-up	2	Resp. 6: 'I wonder if a moment comes when you are no longer under control of the paediatrician how things are going. (..) A yearly check-up or something'
Sharing experiences		1	Resp. 3: 'But I'm curious how that went with other parents. That perhaps you come together with other parents and you can exchange experiences there, that could be helpful too, maybe for parents who find it very difficult to implement these consequences'

Discussion

This study had the following aims:
1. To describe what changes parents have noticed in their child, in themselves, and in their family situation.
2. To examine the positive and negative experiences of the parents with the execution of the teaspoon method.
3. To describe what characteristics have helped the parents to implement the method, and what they recommend to other parents when implementing the method.
4. To describe what the improvement points regarding the method are according to the parents.

Observed changes in the children

The most obvious changes the parents have noticed in their child, is that the child, after performing the method, eats what is cooked and even asks for food themselves. The outcomes in this study are in line with previous research of Piazza et al. (2003) in the treatment of four children of the ages of 23 months to four years old, who had been diagnosed with a paediatric feeding disorder. In their study, the effects of three approaches were compared: the effects of positive reinforcement alone, escape extinction alone (which was a 15 minute break), and positive reinforcement with escape extinction. Outcomes of Piazza's et al. (2003) study show that the consumption did not increase when positive reinforcement was implemented alone. By contrast, consumption increased for all participants when escape extinction was implemented, independent of the presence or absence of positive reinforcement. For the continuation of the teaspoon method it is advisable to continue using the escape option (the 15-minute break) in combination with the negative reinforcement element, because this study has confirmed that it is important to make the consequence (the negative reinforcement) for the children bigger than eating a teaspoon of the food group they want to avoid.

In this study two parents expressed their concerns about the fact that their child is more concerned with food compared with the period before the method, and in particular that their child was more busy with only eating healthy foods. One parent in this study noticed that her child had a relapse to his earlier diet pattern and in the end, the method did not work out for this family. This was mainly due to the fact that the child no longer experienced the consequence as negative. During the execution of the teaspoon method, it is important at all times to ensure that the child experiences the threshold for eating as being lower than performing the consequence. Another parent expressed her concerns about the development of an eating disorder in her child. At this moment, it is unknown whether ARFID at a young age predisposes to the development of e.g. anorexia nervosa (AN) or bulimia nervosa (BN) later in life. In one recent study of Norris et al. (2014), it is described that four out of 34 children and adolescents with the initial diagnosis ARFID finally met the criteria of AN. To determine whether the parents' concerns in the current study are justified, and to establish if ARFID and/or the execution of the teaspoon method can indeed contribute to the development of AN or BN, longitudinal studies must

be done to establish this.

Experienced changes for the parents and in the family situation
Because the teaspoon method is not a simple method to execute for parents, it was important to look at the experiences of the parents with the execution of the method. What stands out in the outcomes of this study is that most parents conclude that the atmosphere during dinner time is much better than it was before. Having dinner together no longer costs the parents effort. Most parents in this study indicated that they still make use of the method, which indicates that the teaspoon method has contributed to a lasting change in their family life.

Prior studies of Piazza (2003 and 2015) noted the importance of parent training. According to Piazza (2015), parent training is the most important thing to do when a child has eating problems, so that the child learns to eat in the natural environment. In another study, Piazza (2015) notes that it is important to train everyone who will feed the child, this means that caregivers, teachers and grandparents also have to be involved in the training. For example, the parents and caregivers should learn that caregiver consequences such as removal of the spoon or cup, adult attention, and giving the child a tangible item, affects the child's behaviour during mealtimes (Piazza et al, 2003). In the current study, some parents found it hard that the babysitters had to draw the same line to the child, especially in the case when the babysitter was a grandparent and felt pity for the child. For the teaspoon method, it is advisable to inform everyone who has authority over the child during dinner about the idea behind the method, about how to execute the method, and about how they have to deal in various situations with the goal that all caregivers will show more commitment to the method.

Experiences with the execution of the teaspoon method
In this study, the parents overall noticed positive experiences with the execution of the teaspoon method, despite that they indicated that the initial period was though. What stands out in the experiences, is that parents indicated that the role of the paediatrician played an important role for them during the execution of the teaspoon method. Because the paediatrician made the agreements with the child and involved the parents in this, the paediatrician took away a lot of struggle between the parents and the child about this topic. Furthermore, by doing this, the paediatrician applied shared decision making. According to Michael, Barry and Edgman-Levitan (2012), clinicians can help patients through shared decision making to let them understand the importance of their values and preferences in making the decisions that are best for them and their child. In this study, parents have emphatically stated that this was an important aspect of the method for them, because the fight was taken away from the parents and the child himself was made responsible. In follow-up research it is therefore certainly advisable to keep this element.

Helpful characteristics
Although the teaspoon method is a tough method, the parents were predominantly positive and were able to name several properties of themselves that helped them to carry out the method. Through the consistency of the parents the child knew what was expected of him or her. Neve (2010), did research into positive and creative education. According to Neve (2010), all children need clear and consistent agreements, rules and boundaries in the basis that gives them guidance and rest. It ensures that they know where they stand, they do not always have to seek for the boundaries. When parents are consistent and clear, they are reliable for a child. By explaining the teaspoon method, it is up to the paediatrician/practitioner of the method to make clear to the parents that the method is not always easy to carry out and that the results mostly depend on how the parents execute the method. Parents must be consistent and need to support the idea of the method. Parents in this study also indicated that the guidelines of the method helped them to carry on, even when it was hard sometimes. They also indicated that it was helpful to make appointments in advance with each other. These findings are also in line with the findings of Neve (2010), who notes that it is important that partners agree on the limits and rules in the family, and that both are consistent and treat the child in the same way. This means that in the execution of the teaspoon method, partners can discuss together beforehand when to give which consequence, but also when the child receives a reward. It is also important that parents clearly

agree in advance how long the child has the time to eat what is on the teaspoon, and when the consequence will be executed.

What in this study also can be seen as a helping characteristic from the parents, is that all parents who participated in this study lived together as a family. Because of this, the children did not have to switch between different family situations, and parents could quickly make agreements about how to implement the method and about how to react in several situations. In a follow-up study it would also be interesting to include children from broken families, to find out how these parents experience the execution of the teaspoon method and what they encounter during the implementation.

Improvement points regarding the teaspoon method
In this study it clearly emerged that parents indicated that there was little information outside the paediatrician available about the method and that there is an urgent need for more information, to make sure that parents are informed about what the method is about, and that it can be tough to execute. To give more publicity to the teaspoon method, the method must be known in an earlier stage. To achieve this, consultation desks and GPs must become familiar with the method so they can make parents aware of the method at an earlier stage. GPs and employees of consultation desks need to get information about what the method looks like, and when they should think about referring parents and their child to the paediatrician. Early referral can ensure that parents engage in less searching for a method which works for their child and can save years of struggle in the family. In addition, informed decision making will be applied in this way. What also can be done to give the teaspoon method more publicity, is that a website can be built or a book can be written, whereupon the parents can find all information about eating disorders in children with ARFID at the same place. This site or book can also provide a description of the method and a description about what the parents can expect when they plan to implement the method. In this way, parents are faced with fewer surprises and are informed that execution of the method can be tough. In addition, parents in this study indicated that it would have helped them if they had received tips about how to deal with another child in the family. Because dinner mostly is a social affair and the whole family is often present, the parents indicated that it was sometimes difficult to deal with another child at the dining table. Therefore, the site or book should provide a manual, in which the method will be described and in which parents will find tips according to subjects such as how to deal with other children during dinner.

Furthermore, parents in this study indicated that they would like to exchange experiences with other parents to hear how others handled the executing of the method and how they acted in different situations. As noted before, Piazza (2003) stated that all caregivers should be trained on how to execute the method. Both experience exchange and information provision about the teaspoon method to other caregivers than the parents, can be done during information evenings. During the information evenings, a professional in the field of the teaspoon method would speak about the method, and parents and caregivers would have the opportunity to ask questions to the professional, and to exchange experiences with each other. Because other caregivers also get familiar with the idea behind the teaspoon method and hear what the idea behind the method is, they will become less sceptical about the implementation and hopefully support the parents in the execution of the method. Furthermore, the combination of information provision and sharing experiences can help to ensure that parents and caregivers, especially in difficult periods, continue the execution of the method and do not give up. The information evenings can also be helpful for parents who still doubt whether they want to implement the method or who are in doubt about their own capacities. The information evening will also be a good opportunity to hear from others parents how they experienced the execution of the method. When giving an information evening, the aspect of informed decision making will also be approached.

In addition, parents indicated that they would like to have follow-up consultations with healthcare professionals, even if only once a year. The parents indicated that they are afraid that when they are no longer under control, the child will think that the appointment would no longer exist and would fall back into his old diet pattern, and that the battles during dinner will come back. Therefore, it is

advisable that the children and parents have an appointment at least once a year as a reminder to the agreements according to the teaspoon method. When the child is old enough, the paediatrician or healthcare professional also makes an appointment with the child explaining that the appointment remains valid and explains to the child that it is old and wise enough to deal with it independently; and that at the moment that the child threatens to return to the situation before the method, the parents should call right away to make an appointment with the paediatrician.

Strengths and limitations of this study

As far as known, this is the first study that has specifically focused on a treatment method for children with ARFID. Prior to this study, Rapley (2006) invented the so called Rapley method to support children in the transition from bottle to solid food, used in babies from six months. The principle of the Rapley method is that different foods are deposited and that the child can decide for himself what he wants to pick and taste, allowing the child to discover the food. The solid food is not a substitute for the breast or bottle food, but is offered alongside to make the child familiar with solid food. Besides, Seys (2000) introduced sensory integration (SI) therapy that assumes that the avoidant or selective diet pattern of children is often attributed to anxiety or post traumatic nutritional disorder. Nowadays the treatment often consists of EMDR. Children with ASD often experience problems with stimulant processing (SI), which makes it difficult to interpret new (nutritional) stimuli and raise anxiety. There may then be a hypersensitivity to the touch, smell and taste stimuli. The latter SI problem can also occur separately from the ASD problem and cause selective food acceptance. The treatment in this children usually consists of a combination of a behavioural therapeutic intervention, supplemented with cognitive techniques and SI therapy (Seys, 2000). The therapeutic intervention consists of the SLIK (swallow) program, an approach that allows the child to get acquainted with food by means that the practitioner puts custard on a fingertip and touches the mouth of the child, acceptance is then rewarded. The studies of Rapley and Seys mentioned above, indicate that there are already methods to support children in the transition from bottle to solid food, and with problems with stimulant processing and a selective and restrictive diet. However, the teaspoon method is based on negative reinforcement in combination with an escape extinction (a 15 minute break) and does not assume that the avoidant or selective diet pattern of children is attributed to anxiety or post traumatic nutritional disorder. In addition, the teaspoon method is carried out at the home environment of the child with the supervision of the paediatrician, what saves costs in comparison with a (semi) clinical treatment in a treatment centre or hospital. Furthermore, the children could stay in their familiar surroundings and did not have to get used to another environment or a stranger at the table who carried out the method with them. In addition, the above studies do not specifically focus on children with ARFID, where the teaspoon method does.

As far as known, this is the first medical context in which the CCI is used. So far only studies have been published that have used the CCI in the field of psychology and behavioural analyses (Kanfer and Grim, 1977, de Jong and Miller, 1995, and Hatfield et al., 2010). The structured questions in the Client Change Interview (CCI) were a strength of this study. In addition to the structured questions, the parents also had the opportunity to give a free answer and to deviate from the question itself. Because the parents received an information letter including the CCI in advance, the questions that were asked were clear for both the researcher and the parents. In addition, parents had time to prepare answers for the questions. The researcher tried as much as possible to keep the same structure for each parent, and when a parent went through a later question in the interview, the researcher then always tried to return to where they had stopped. The question that was asked during the interviews that needed the most clarification, was the question; ‘What things in your current life situation have helped you make use of therapy to deal with your problems? (family, job, relationships, living arrangements)’. Most parents did not understand what was meant by this question. The researcher then asked the parents if they still make use of the method, and what in their daily life helps them in making use of the method or how they deal with problems. In further research it is advisable to formulate this question differently so that there is no confusion. The question could be replaced into the following: ‘Do you still use the method in your daily life? If so, in what way?’ Another question that was confusing for the parents was the question about what it has been like to be involved in the

study according to the method (initial screening, research interviews, completing questionnaires etc). Parents often asked for clarification if this was not about executing the method but purely about the things around it, completing the questionnaires, blood sampling and visits to the doctor. In future research, it is advisable to make clearer that this question is about the study instead of the execution of the method. This question could also be omitted in follow-up research, because it did not contribute to relevant results in this study.

The small research group of this study can be seen as a limitation. The study of Van der Gaag and Snijders (2017) consisted of a pilot and did not rely on random assignment. However, the results of the current study show that parents were mainly positive about the execution of the method. To indicate whether the teaspoon method will also be perceived as positive on a larger scale, further research with a bigger research group that is randomly assigned is advisable.

The fact that only twelve of nineteen parents participated in this study can be seen as a limitation, because one can ask whether only the parents who were mainly satisfied with the method took part. Although, only one parent indicated on the telephone that the eating problems of their child were resolved by themselves. Other parents had other (personal) reasons not to participate, but they mainly indicated that they were satisfied with the outcomes of the method.

Recommendations for research and practice

This study showed that parents were mainly positive about the execution of the teaspoon method and that they have noticed positive changes in their child, themselves, and their family situation. For follow up studies, it is recommended to do a random study to see if the teaspoon method is also perceived as positive on a larger scale in parents with children with ARFID. It would be also interesting to include children from different family situations in follow up studied. It is important to always consider the situation of the child in the agreement of the negative reinforcement. Eating the food on the teaspoon always have to be a smaller step for the child than executing the consequence, and the consequence may never evoke fear in the child. To make the teaspoon known at an earlier stage, GPs and employees of consultation desks must become familiar with the method. It is advisable to provide them with information about what the method entails and when the GPs and employees of the counselling centres should think about referring parents and their child to the paediatrician. Additionally, it is advisable to develop a manual about the teaspoon method online or in a book, which can help as a reference work for the parents and other caregivers when they want to achieve information about the method or to reread how the method works. In this manual, information can also be given about how the parents should deal with any other children during dinner. Furthermore, it is advisable to organise information evenings in which a professional speaks about the method, in which experiences can be exchanged, and where all caregivers who have responsibility for the child during mealtimes come together to obtain information about the method and to learn how they can react in different situations. In addition, it is advisable that the children have follow-up consultations with healthcare professionals, even if only once a year, until the child is old enough to understand that it can handle a healthy diet pattern themselves. This provides a basis for the parents and a reminder for the children that the appointment will continue to apply.

Conclusion

The teaspoon method seems the first method that specifically focuses on the treatment of children with ARFID. Despite the notion that the teaspoon could be a tough method to execute, most parents indicated positive experiences with the method and positive changes in their child, themselves and their family situation. The most positive changes that are found are that the ambiance during dinner is improved and that the child eats the same as the rest of the family. The element that the paediatrician made the agreements with the child and hereby took away a lot of struggle between the child and the parents, was seen as one of the most important aspects of the method. Parents note that whether the method is successful depends on how the parents deal with the execution of the method. Being consistent, executing the method as a team, and persevering even when it is difficult were mentioned as most important characteristics of the parents in the execution of the method. In order to make the

method work, it seems to be most important that all care providers draw the same line to the child, and that they support the idea of the method. Further research should indicate if the execution of the teaspoon method is also perceived as positive on a larger scale in parents with children with ARFID.

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Appendix A: Diagnostic Criteria of Avoidant/Restrictive Food Intake Disorder, According to DSM V (American Psychiatric Association, 2013)

Avoidant/Restrictive Food Intake Disorder

Diagnostic Criteria — 307.59 (F50.8)

A. An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:
   1. Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
   2. Significant nutritional deficiency.
   3. Dependence on enteral feeding or oral nutritional supplements.
   4. Marked interference with psychosocial functioning.

B. The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.

C. The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.

D. The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

Specify if:

In remission: After full criteria for avoidant/restrictive food intake disorder were previously met, the criteria have not been met for a sustained period of time.

Appendix B: Information letter and Client Change Interview (in Dutch)

Informatie voor de patiënten

Informatiebrief Evaluatie Theelepelmethode

Beste ouder/verzorger van ……..,

Rond 2014 heeft u meegewerkt aan een eettraining van uw zoon/dochter bij dokter van der Gaag. Wij, als eetteam ZGT, zijn erg benieuwd naar uw mening over deze methode en hebben hiervoor een onderzoek opgesteld. Via deze weg willen we u vragen om deel te nemen aan dit onderzoek. Voordat u de beslissing neemt, is het belangrijk om meer te weten over het onderzoek. Leest u daarom deze brief rustig door. Heeft u na het lezen nog vragen? Op de volgende pagina vindt u de contactgegevens van de onderzoeker.

Waarom wordt dit onderzoek uitgevoerd?
Dit onderzoek wordt uitgevoerd om de eettraining, de theelepelmethode, te evalueren. Wij zijn erg benieuwd naar uw ervaringen, veranderingen die u al dan niet op heeft gemerkt en/of nog merkt bij uw kind, dingen die u hebben geholpen tijdens het uitvoeren van de methode of juist hebben belemmerd, en of u nog suggesties heeft m.b.t. de methode. Omdat dit een van de eerste keren is dat deze methode is uitgevoerd, hopen wij te leren van deze evaluatie en kunnen wij de methode na afloop van dit onderzoek waar nodig aanpassen.

Wat kan ik verwachten van het onderzoek?
Binnenkort zult u gebeld worden door de onderzoeker met de vraag of u mee wil werken aan dit onderzoek. De onderzoeker zal, indien u mee wil werken, een afspraak met u maken voor het afnemen van het interview. De voorkeur gaat ernaar uit om het interview bij u thuis af te nemen, zodat u niet naar het ziekenhuis hoeft te komen. Heeft u hier bezwaar tegen en komt u liever in het ziekenhuis voor het interview, dan is dit bespreekbaar. Om u voor te bereiden op het interview, is deze in de bijlage toegevoegd. Wij verzoeken u vriendelijk om deze alvast aandachtig door te lezen en over uw antwoorden na te denken, zodat u goed voorbereid bent op de vragen die gesteld zullen worden. Het interview zal worden opgenomen, deze opname wordt door de onderzoeker gebruikt om het interview nog eens terug te kunnen luisteren en om het interview uit te werken.

Is deelnemen aan het onderzoek belastend?
Deelname aan dit onderzoek is niet belastend. Tijdens de evaluatie zullen u vragen worden gesteld m.b.t. de theelepelmethode. In totaal zal dit ongeveer anderhalf uur van uw tijd in beslag nemen.

Wie hebben er inzage in de gegevens van het onderzoek?
De deelnemende kinderartsen, pedagogisch medewerkers, logopedisten en diëtisten van de Ziekenhuisgroep Twente (Almelo en Hengelo), de onderzoeker, de leden van de Inspectie van de Gezondheidszorg en de leden van de Medische Ethische Toetsingscommissie. Deze informatie is vertrouwelijk. Met de gegevens van uw evaluatie zal zeer zorgvuldig worden omgegaan en zal ten alle tijden anoniem blijven.

Wat gebeurd er met de (medische) gegevens van uw kind?
Eventuele medische gegevens en resultaten van dit onderzoek zullen alleen anoniem en vertrouwelijk aan derden bekend worden gemaakt. Opnamemateriaal of bewerking hiervan wordt uitsluitend voor analyse en/of wetenschappelijke presentaties gebruikt.

Zijn er voorwaarden aan deelname?
Nee, deelname aan dit onderzoek is geheel vrijwillig. U kunt ten alle tijden beslissen om te stoppen met uw deelname. U hoeft hiervoor geen reden op te geven. Stoppen heeft, indien uw kind op dit moment nog onder behandeling is, geen enkele invloed op de verdere behandeling in het ziekenhuis.

Met wie kan ik contact opnemen bij vragen of problemen?
Bij vragen en/of problemen kunt u contact opnemen met de uitvoerend onderzoeker; Iris Hudepohl, e-mailadres: i.m.h.hudepohl@student.utwente.nl

Bij klachten kunt u contact opnemen met het klachtenbureau, via het formulier op de website van de Ziekenhuisgroep Twente: https://www.zgt.nl/2753/klachtenformulier/

Wij willen u vriendelijk bedanken voor het lezen van deze informatie. Aarzel niet om contact op te nemen met vragen!

Namens het eetteam ZGT,

Iris Hudepohl
Studente Gezondheidspsychologie en -Technologie
Universiteit Twente

Mede namens EJ van der Gaag,
Kinderarts ZGT

Bijlagen:
- Client Change Interview
- Toestemmingsverklaringsformulier

Client Change Interview

Introductie:

De belangrijkste onderwerpen van dit interview zijn eventuele veranderingen die u hebt opgemerkt sinds de therapie begon, wat er uit deze veranderingen is voortgekomen, en wat u ziet als helpende- en niet helpende aspecten van de therapie. Het hoofddoel van dit interview is om uw ervaringen met de therapie met ons te delen in uw eigen woorden. Deze informatie zal ons helpen om beter te begrijpen hoe de therapie heeft geholpen en hoe we deze kunnen verbeteren. Het interview zal, indien u hiermee akkoord gaat, worden opgenomen.

1. Algemene vragen: [ongeveer 5 minuten]

1a. Hoe gaat het nu in het algemeen met uw kind?
1b. Hoe heeft de therapie er voor u tot dusver uitgezien? Hoe vond u het om deze therapie uit te voeren?
1c. Welke medicijnen gebruikt uw kind momenteel? (dosis, hoe lang al, laatste aanpassing, homeopathische middelen?)

2. Veranderingen: [ongeveer 10 minuten]

2a. Welke veranderingen heeft u bij uw kind opgemerkt sinds jullie begonnen zijn met de therapie?
2b. Is er iets negatiefs voor u en/of uw kind veranderd sinds de therapie begon?
2c. Is er iets dat u veranderd had willen zien sinds de start van de therapie dat niet veranderd is?

3. Veranderingsscores: [ongeveer 10 minuten]

3a. Geeft u voor iedere verandering aan in hoeverre u de verandering had verwacht en/of hier verbaasd over was.
(1) Ik verwachte deze verandering zeer
(2) Iets wat verwacht
(3) Noch verwacht of verrast door de verandering
(4) Een beetje verrast door de verandering
(5) Zeer verrast door de verandering

3b. Geef voor elke verandering aan hoe waarschijnlijk deze zou zijn geweest als u de therapie niet had uitgevoerd.
(1) De verandering zou niet hebben plaatsgevonden
(2) Waarschijnlijk zou de verandering niet hebben plaatsgevonden
(3) Noch waarschijnlijk noch onwaarschijnlijk
(4) Waarschijnlijk zou de verandering ook zonder therapie hebben plaatsgevonden
(5) Ook zonder therapie had deze verandering plaatsgevonden

3c. Hoe belangrijk of significant is de verandering voor u persoonlijk?
(1) Helemaal niet belangrijk
(2) Een beetje belangrijk
(3) Redelijk belangrijk
(4) Belangrijk
(5) Erg belangrijk

4. Attributen: [ongeveer 5 minuten]

Wat is volgens u de oorzaak van de veranderingen, zowel binnen- als buiten de periode va het volgen van de therapie?

5. Hulpmiddelen: [ongeveer 5 minuten]

5a. Welke sterke eigenschappen van uzelf hebben u geholpen om deel te nemen aan de therapie en om met de eetproblemen van uw kind om te gaan? (Waar bent u goed in, persoonlijke kwaliteiten)
5b. Welke dingen in uw huidige levenssituatie hebben u geholpen om gebruik te maken van de therapie en om met de problemen binnen het gezin om te gaan? (Familie, baan, relaties, etc.)

6. Uitdagingen: [ongeveer 5 minuten]
6a. Welke eigenschappen hebben het voor u moeilijker gemaakt om gebruikt te maken van de therapie en om met de problemen om te gaan?
6b. Welke dingen in uw levenssituatie hebben het voor u moeilijker gemaakt om gebruik te maken van de therapie en om te gaan met de problemen?

7. Helpende aspecten: [ongeveer 10 minuten]
Kunt u een samenvatting geven wat tot dusverre nuttig is geweest aan de therapie? Geeft u alstublieft voorbeelden. (Bijvoorbeeld algemene aspecten, specifieke gebeurtenissen)

8. Problematische aspecten: [ongeveer 5 minuten]
8a. Welke aspecten van de therapie waren hinderend, niet helpend, negatief of teleurstellend voor u? (Bijvoorbeeld algemene aspecten. Specifieke gebeurtenissen)
8b. Waren er dingen binnen de therapie die moeilijk of pijnlijk voor u waren, maar desondanks wel goed om uit te voeren of misschien nuttig waren? Kunt u hier voorbeelden bij geven?
8c. Heeft u iets gemist binnen de therapie?
8d. Wat zou de therapie meer effectief of meer helpend hebben gemaakt voor u?

9. Het Onderzoek : [Ongeveer 10 minuten]
9a. Hoe was het om betrokken te zijn bij het onderzoek rondom uw therapie? (Denkt u hierbij aan het invullen van de verschillende vragenlijsten, de bezoeken aan de arts, de (bloed)onderzoeken van uw kind, etc.)
9b. Kunt u aangeven wat tot dusverre nuttig is geweest aan dit onderzoek voor u?
9c. Waren er voor u dingen die het onderzoek hebben gehinderd, die niet helpend waren, negatief waren of de therapie in de weg stonden?

10. Suggesties: [ongeveer 5 min]
Heeft u suggesties voor ons met betrekking tot het onderzoek van de therapie?

11. Heeft u tips/suggesties voor ouders die beginnen aan de theelepelmethode of aan het begin staan van dit proces?

12. Heeft u nog andere opmerkingen/dingen die u wil vertellen?

Toestemmingsverklaringformulier (informed consent)

Titel onderzoek: Evaluatie theelepelmethode
Verantwoordelijke onderzoeker: Iris Hudepohl

In te vullen door de deelnemer
Ik verklaar op een voor mij duidelijke wijze te zijn ingelicht over de aard, methode, doel en [indien aanwezig] de risico's en belasting van het onderzoek. Ik weet dat de gegevens en resultaten van het onderzoek alleen anoniem en vertrouwelijk aan derden bekend gemaakt zullen worden. Mijn vragen zijn naar tevredenheid beantwoord.

Ik begrijp dat opnamemateriaal of bewerking daarvan uitsluitend voor analyse en/of wetenschappelijke presentaties zal worden gebruikt. Ik stem geheel vrijwillig in met deelname aan dit onderzoek. Ik behoud me daarbij het recht voor om op elk moment zonder opgaaf van redenen mijn deelname aan dit onderzoek te beëindigen.

Naam deelnemer: ……..

Datum: …… Handtekening deelnemer:
…..…….

In te vullen door de uitvoerende onderzoeker
Ik heb een mondelinge en schriftelijke toelichting gegeven op het onderzoek. Ik zal resterende vragen over het onderzoek naar vermogen beantwoorden. De deelnemer zal van een eventuele voortijdige beëindiging van deelname aan dit onderzoek geen nadelige gevolgen ondervinden.

Naam onderzoeker: Iris Hudepohl

Datum: …… Handtekening onderzoeker:
...…….

Appendix C: Original Client Change Interview

After each phase of counselling, clients are asked to come in for an hour-long semi-structured interview. The major topics of this interview are any changes you have noticed since therapy began, what you believe may have brought about these changes, and helpful and unhelpful aspects of the therapy. The main purpose of this interview is to allow you to tell us about the therapy and the research in your own words. This information will help us to understand better how the therapy works; it will also help us to improve the therapy. Your therapist will not be shown this information until you have finished counselling with them, and only then if you give us permission to do so. This interview is recorded for later transcription. Please provide as much detail as possible.

1. General Questions: [about 5 min]
1a. How are you doing now in general?
1b. What has therapy been like for you so far? How has it felt to be in therapy?
1c. What medications are you currently on? (interviewer: record on form, including dose, how long, last adjustment, herbal remedies)

2. Changes: [about 10 min]
2a. What changes, if any, have you noticed in yourself since therapy started? (Interviewer: Reflect back change to client and write down brief versions of the changes for later. If it is helpful, you can use some of these follow-up questions: For example, Are you doing, feeling, or thinking differently from the way you did before? What specific ideas, if any, have you gotten from therapy so far, including ideas about yourself or other people? Have any changes been brought to your attention by other people?)
2b. Has anything changed for the worse for you since therapy started?
2c. Is there anything that you wanted to change that hasn't since therapy started?

3. Change Ratings: [about 10 min] (Go through each change and rate it on the following three scales:)
3a. For each change, please rate how much you expected it vs. were surprised by it? (Use this rating scale:)
(1) Very much expected it
(2) Somewhat expected it
(3) Neither expected nor surprised by the change
(4) Somewhat surprised by it
(5) Very much surprised by it

3b. For each change, please rate how likely you think it would have been if you hadn't been in therapy? (Use this rating scale:)
(1) Very unlikely without therapy (clearly would not have happened)
(2) Somewhat unlikely without therapy (probably would not have happened)
(3) Neither likely nor unlikely (no way of telling)
(4) Somewhat likely without therapy (probably would have happened)
(5) Very likely without therapy (clearly would have happened anyway)

3c. How important or significant to you personally do you consider this change to be? (Use this rating scale:)
(1) Not at all important
(2) Slightly important
(3) Moderately important
(4) Very important
(5) Extremely important

4. Attributions: [about 5 min]
In general, what do you think has caused the various changes you described? In other words, what do you think might have brought them about? (Including things both outside of therapy and in therapy)

5. Resources: [about 5 min]
5a. What personal strengths do you think have helped you make use of therapy to deal with your problems? (what you're good at, personal qualities)
5b. What things in your current life situation have helped you make use of therapy to deal with your problems? (family, job, relationships, living arrangements)

6. Limitations: [about 5 min]
6a. What things about you do you think have made it harder for you to use therapy to deal with your problems? (things about you as a person)
6b. What things in your life situation have made it harder for you to use therapy to deal with your problems? (family, job, relationships, living arrangements)

7. Helpful Aspects: [about 10 min]
Can you sum up what has been helpful about your therapy so far? Please give examples. (For example, general aspects, specific events)

8. Problematic Aspects: [about 5 min]
8a. What kinds of things about the therapy have been hindering, unhelpful, negative or disappointing for you? (For example, general aspects. specific events)
8b. Were there things in the therapy which were difficult or painful but still OK or perhaps helpful? What were they?
8c. Has anything been missing from your therapy? (What would make/have made your therapy more effective or helpful?)

9. The Research:. [about 10 min]
9a. What has it been like to be involved in this research? (Initial screening, research interviews, completing questionnaires etc)
9b. Can you sum up what has been helpful about the research so far? Please give examples.
9c. What kinds of things about the research have been hindering, unhelpful, negative or have got in the way of therapy? Please give examples.

10. Suggestions: [about 5 min] Do you have any suggestions for us, regarding the research or the therapy? Do you have anything else that you want to tell me?