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## EATING DISORDER TREATMENT: WHAT FORMER PATIENTS ATTRIBUTE TO THEIR PERSONAL RECOVERY

Wendy Ingram

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TO THEIR PERSONAL RECOVERY

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A Project  
Presented to the  
Faculty of  
California State University,  
San Bernardino

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In Partial Fulfillment  
of the Requirements for the Degree  
Master of Social Work

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by  
Wendy Sue Ingram

June 2020

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## ABSTRACT

The purpose of this study was to explore the personal experience of people who have an eating disorder with a specific focus on what they attributed to their recovery. Eating disorders are a mental illness that affect one in 20 people. Thus, this prevalence coupled with a lack of significant research about eating disorders in the field of social work uncovered the need for this study.

Qualitative interviews were completed with five female students from a university in California. Each transcript was coded using conventional content analysis to uncover themes and subthemes, which included barriers to recovery, the need to uncover the root cause of the eating disorder, the value of support, and hope and resilience. The findings indicated that control is an important component in eating disorders and that change in weight should not be indicative of full recovery because recovery is an ongoing process. Furthermore, stigma and shame attached to eating disorders, a lack of knowledge by professionals, and access to care all served as detriments to seeking or receiving treatment.

The study provided valuable insight into the field of social work for those who service clients in the most prevalent age group for eating disorders, adolescents, and young adults, which includes child protective services. It is extremely important for social workers to know the risk factors and behaviors of an eating disorder and include them in their assessment because increasing

knowledge and decreasing stigma will help strengthen social work practice by increasing awareness, a greater understanding, and access to treatment.

## ACKNOWLEDGEMENTS

I wish to acknowledge my child, my greatest gift and teacher. My life is better because of you and I am so grateful for the journey we share.

My gratitude to my family on this earth and the other side. I appreciate the love, support, lessons, and guidance.

I would like to acknowledge California State University San Bernardino and the many professors and professionals in the School of Social Work who have supported my educational journey. Finally, gratitude to my research advisor, Dr. Simon for your expertise and guidance in my hope of making a greater contribution with this research project.

## DEDICATION

This research project is dedicated to the courageous people who battle an eating disorder.

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## CHAPTER ONE

### INTRODUCTION

#### Problem Formulation

One in twenty people will be affected by an eating disorder at some point in his or her life (National Alliance on Mental Illness [NAMI], 2019). Factors tied to eating disorders include genetics, environment, peer pressure, and emotional health. Eating disorders are not about food but rather a mental illness people experience as they attempt to cope with feelings that can be overwhelming and painful. Consequently, controlling food becomes a coping mechanism for dealing with uncomfortable feelings and emotions (NAMI, 2019).

The most prevalent and known eating disorders are anorexia nervosa and bulimia nervosa. Anorexia nervosa (AN) includes extreme food restriction with an intense fear of weight gain coupled with constant self-evaluation. Additionally, those that suffer from AN do not recognize how serious their low body weight is (American Psychiatric Association [APA], 2013). Bulimia Nervosa (BN) includes ongoing episodes of eating more copious amounts of food than most people would followed by behaviors such as vomiting, use of laxatives, fasting, or excessive exercise to prevent weight gain. Like AN, people with BN suffer constant and critical self-evaluation. Without treatment, both AN and BN can cause significant mental and physical damage. Generally, the onset occurs in adolescence or young adulthood (APA, 2013).

Stereotypically, eating disorders are linked predominantly to young, straight, White women. However, eating disorders impact people at similar rates regardless of gender, race, or socioeconomic status (National Eating Disorders Association [NEDA], 2019). Similar rates exist among Asian, Black, Hispanic, and White youth trying to lose weight, with Asian teens reporting 32.7 %, Black teens slightly lower at just below 32%, followed by White adolescents at nearly 35% and the highest reported percentage was just over 36% by Hispanic adolescents. The highest incidence was reported among Native American teens, who reported almost 50% (Kilpatrick, Ohannessian, & Bartholomew, 1999). In contrast, there is a 50% greater chance of a Black teen than White to participate in bulimic behaviors (NEDA, 2019). Additionally, NEDA (2019) reported a higher incidence of BN in Hispanic teens than non-Hispanic.

Although the cause is unknown, NEDA (2019) highlight multiple stressors faced by women of color, including but not limited to racism, low socioeconomic status, and abuse and suggest that those may create higher vulnerability to experience an eating disorder. Also, eating disorders in that population may be a coping mechanism. Despite the incidence among this group, diagnosis and treatment are less likely. Gordon, Brattole, Wingate, and Joiner (2006) present disproportionality in identifying eating disorder behaviors in women of color, considering the behavior as a problem, or recommending treatment. Thus, African American women are the least likely to be referred for treatment; or have their eating disorder behaviors identified as an issue.

Another population that experiences disadvantage and increased stressors is the LGBTQ+ community. NEDA (2019) states that there is a significant need for research in people identifying as LGBTQ+ to compensate for the lack of representation in this population. In the limited research that exists, 42% of men with an eating disorder identified as gay. Heterosexual males compared to bisexual or gay showed increased rates of bulimia and eating disorders among gay and bisexual males. Those who identified as bisexual, gay, or lesbian had higher incidence of bingeing and purging behaviors than their heterosexual counterparts. People of color in the lesbian, gay, and bisexual community experience at least the same incidence of eating disorders as their White peers. Finally, those who felt connected to a LGBTQ+ community experienced fewer eating disorders which presumes that is a protective factor against eating disorders in the LGBTQ+ population.

Given the significant statistics of people of all walks of life experiencing eating disorders, there is a need for effective forms of treatment. Significant research in the field of social work and treatment for eating disorders is limited. Further, little research exists as to the impression, opinion, or view of what clients experienced in the treatment of his or her eating disorder in the field of social work. Cowdrey & Waller (2015) surveyed 157 people, mostly females in the mid-twenty age range with anorexia nervosa as to their experience with Cognitive Behavioral Therapy (CBT). First, they reported that according to (National Institute for Health and Clinical Excellence [NICE], 2004) that CBT is

recommended as treatment in adults with an eating disorder. Turner (2017) presents CBT as an evidenced based approach therapy with assessment and planning as critical components. Additionally, interventions are specific to each client's behavioral or mental health and created with collaboration between the clinician and client. Thus, a relationship between the therapist and client is important, in addition to cultural humility. Turner (2017) notes that CBT can be viewed as a quick and simple approach to providing treatment by therapists and non-professionals. It is neither, but rather a specific approach to treatment with the potential to be effective by tailoring steps and interventions to each client. In conclusion, CBT is not a one size fits all approach to therapy but rather specific steps that require incorporation of the client's individuality and needs with a relationship forming between the client and therapist.

Cowdry & Waller (2015) noted clinicians reported CBT as a component in an 'eclectic' approach. They summarize that of the participants surveyed, evidence-based CBT was the least likely intervention to be provided to them which supported the research they found prior to their study. Therapeutic interventions not including evidence-based CBT as the recommended treatment were not recalled by participants. Additionally, while a clinician may say they use CBT, that may not be accurate. Noteworthy was the time frame of treatment being longer than suggested for CBT. Also found was the need for therapists to assess the progress and outcome of clients coupled with the clinician's

knowledge and correct use of treatment techniques not aligning with CBT guidelines (Cowdry & Waller, 2015).

In summation, eating disorders impact a large number of people and research indicates they are present in a wide range of demographics. Noteworthy is the need to include wording in future research inclusive of the LGBTQ+ community as that population is understudied. CBT was presented as an effective evidence-based treatment, yet research uncovered it may not be being used or reported by clinicians appropriately. It was found that research directly tied to social work regarding eating disorders is lacking. The need exists to include research directly related to social work in the area of eating disorders. This research project will provide that and uphold social work values and ethics in self-determination by asking individuals who have sought treatment and experienced recovery from an eating disorder about their experience and what factors they attribute to experiencing recovery from an eating disorder.

#### Purpose of the Study

The purpose of the study was to examine the views of people who have had an eating disorder, participated in treatment, and experienced recovery. The research design of this study was qualitative and participants included students that were enrolled at a university, that self-reported experiencing an eating disorder, and that received a therapeutic treatment intervention of some kind.

The data was collected by conducting interviews with students. The data that was collected included age, gender, ethnicity, identifying in LGBTQ+ population, eating disorder type, method of treatment, if treatment was inpatient or outpatient, and the perception of treatment by those surveyed. The instrument was created by the researcher and evaluated for understandability and value by the research advisor.

#### Significance of the Project for Social Work Practice

Given the figure of one in twenty experiencing an eating disorder, knowledge about eating disorders and treatment is critical to social workers. Considering the typical age onset of an eating disorder, specifically AN or BN being adolescence and young adulthood, this study is relevant to child welfare practice and children in the foster care system, including those age 18-21 receiving extended foster care services and their social workers providing case management.

The findings will potentially expand the knowledge in the field of social work regarding treatment outcomes as experienced by clients having participated in treatment. Additionally, the findings of this project may influence policy and case management in child welfare practice to expand knowledge and awareness to agencies and social workers about eating disorders. The potential to include questions during assessment to indicate possible eating disorder behaviors or

characteristics would be beneficial in client evaluation in social work and specifically child welfare.

On a micro level, results may prove useful in social workers providing therapy to clients. Access to the experience of individuals that they relate to their personal recovery from an eating disorder has potential value in multiple areas. First are therapeutic interventions provided to clients. Next, eating disorders as an area social workers may seek further knowledge or training in working with clients with eating disorders or groups at high risk. Finally, insight from the client's perspective including what they want treatment providers to know is an important evaluation component in social work. Thus, the researcher sought to answer the question, what is the client perspective on effective treatment in recovery from an eating disorder.

## CHAPTER TWO

### LITERATURE REVIEW

#### Introduction

Significant research in the field of social work and treatment for eating disorders was not available, consequently, client perception of treatment was also lacking. Therefore, research for treatment in the field of social work was relevant and necessary. Included in this literature review are articles on family-based treatment, barriers to treatment and alternative treatment options, foster youth and eating disorders, social work and eating disorder treatment, policy, and ethics, and client experiences of eating disorder treatment. In conclusion of this literature review, theories guiding conceptualization are presented.

#### Client Perspectives

It is presumptuous to expect a client who has received treatment for an eating disorder to be able to discern the therapeutic method used except for a broad understanding such as individual or group therapy. Additionally, in the area of competency, a strong knowledge and set of skills in treating clients with methods such as Cognitive Behavioral Therapy (CBT), Solution Focused Brief Therapy (SFBT), or Seeking Safety (Najavits, 2018) is important. Three articles are presented here that include the experiences of individuals who received treatment for an eating disorder. One, (Harrop, 2019) was a personal narrative by

an individual who earned an MSW and began work on a Ph. D after treatment, so her personal experience coupled with her education and hindsight offer a unique perspective. Next, presented by Matoff & Matoff (2001) was a single case study related to feminist theory. Finally, Sheridan & McArdle (2016) included self-determination theory in their analysis of 14 patients who had treatment.

Harrop (2019) presented a personal narrative that included experience, insight and opinion having experienced treatment for anorexia nervosa first while severely underweight, and ten years later when considered overweight by medical standards. She used the phrase “weight bias” and suggested it is dangerous to judge or diagnose a patient based on physical appearance. Harrop (2019) concluded that body shame is considered a problem in a thin person but not in someone overweight, and that “fat” people should feel shame for their size. She stated that those experiences created discomfort and misunderstanding in her treatment and how she was approached by the therapist. In conclusion, she expressed an understanding that therapists do not want to cause harm by instigating conversations about body image and weight because they could be uncomfortable for the client. However, she suggested the need for therapists to gain knowledge in oppression tied to weight including social intersectionality. By doing so, she said there is the potential for meaningful and helpful conversations possibly occurring between the therapist and client leading to effective treatment and recovery, despite the difficulty of the topic (Harrop, 2019).

Matoff & Matoff (2001) presented a case study of one woman and related it to feminist theory. Several turning points were articulated by the participant as instrumental in recovery from her eating disorder and included her marriage, career, and personal power being threatened as paramount. Also, ongoing treatment was not something she wanted in her life. She also expressed experiencing trust and acceptance by her psychiatrist following a suicide attempt, in addition to accepting the imperfections of her spouse and no longer participating in self-blame for him as valuable in her treatment and recovery. Next, Matoff & Matoff (2001) reported critical points highlighted by the interviewee regarding her recovery: seeking professional help, avoiding destructive relationships, silencing the critical inner voice within, and the feeling of becoming empowered. Interventions for the case included individual therapy, medication prescribed by a psychiatrist, an eating disorder group Overeaters Anonymous, and couples therapy. In conclusion, it was summarized that recovery from an eating disorder is a lengthy process that occurs over time and despite early signs of restoration of physical health or weight, the mental aspect of recovery is a long-term process (Matoff & Matoff, 2001).

Self-determination theory was used by Sheridan & McArdle (2016) in their analysis of qualitative data that studied the perspectives of 14 patients with an eating disorder who received treatment. Their findings proposed more effective treatment methods and meeting the needs of clients. Participants in the study reported that treatment in institutional settings including medical or psychiatric

hospitals caused participants to feel stressed, controlled, and like they were the illness not a person. Treatment in a setting more like a home were preferred and participants reported feelings of inclusion, empowerment, autonomy, and calm which encouraged their desire for positive change. Clients felt motivated in smaller group sizes whose therapeutic activities were meaningful, intellectually stimulating, and fun. Completion of treatment was correlated to clients feeling engaged with their treatment professionals in addition to being recognized as a unique person and not an illness. In conclusion, Sheridan & McArdle (2016) reported that their findings suggest that the salutogenesis approach of working from a personal, humanistic well-being approach rather than focusing on a person's pathology or illness is beneficial.

### Family Based Treatment

Multiple theories in social work exist that include the importance and role families play in the development of people and how they function. Ecosystem, person in environment, and systems perspectives are foundational in human behavior in the social environment and social work practice (Green, 1999, Sheafor & Horejsi, 2012; Kirst-Ashman & Hull, 2019). Theoretical knowledge coupled with social workers valuing the importance of human relationships suggest the need for including families in the treatment of an individual with an eating disorder. This paper presents three articles with information and findings supporting family-based treatment.

Ganci, Prade, and Hughes (2018) found that family-based treatment (FBT) presented early in treatment was strongly tied to adolescents in treatment for anorexia nervosa (AN) experiencing favorable outcomes. Their method included forty-five families with at least one parent attending a skills and education workshop in the first four weeks of their adolescent receiving treatment. They compared a control group of similar families who had completed FBT prior to the creation of their workshop. Measures included parents completing questionnaires and weight monitoring of patients. Upon completion of the workshop, satisfaction was expressed by the parents who attended. Additionally, at week four, the adolescents who entered treatment with a below baseline weight had more significant weight increase with parental participation than those who did not (Ganci et al., 2018).

Early response was associated with positive outcomes in remission of anorexia nervosa, which is why Ganci et al. (2018) designed their study as such. Based upon positive response by participants, their findings suggest that participation in the workshop coupled with FBT may have provided support and better communication between patients and their parents. Further, they saw value in their findings because parents being critical of their child has been tied to poor FBT outcomes (Ganci et al., 2018). They concluded that the workshop was feasible in conjunction with FBT in improving the treatment and outcomes of anorexia nervosa.

LeGrange, Lock, Agras, Moye, Bryson, Jo, and Kraemer (2011) studied a sample of 121 adolescents with anorexia nervosa comparing family-based treatment (FBT) and adolescent focused treatment (AFT) after participating in randomized controlled trials (RCT). Remission of AN in the participants was evaluated in relation to moderators and mediators. The value in specifying moderators allowed the best treatment option for clients. Eating related obsessionality was identified as a moderator in participants with AN. As for mediators, those were used to provide improved outcomes for participants. LeGrange et al. (2011) noted that weight gain often happened before cognitive changes while participating in FBT. They concluded that targeted behavior focus in FBT is more beneficial to patients with higher psychopathology levels.

Criticism of the child by the parent and older children was addressed by LeGrange et al. (2011) as factors that might indicate AFT as a preferred method. The study did not confirm that, but rather that FBT was beneficial to both, especially patients with higher eating related psychopathology. Assessing the eating disorder psychopathology was imperative in forming treatment plans. In conclusion, AFT and FBT were effective in adolescents with lower psychopathology, whereas adolescents with higher levels of psychopathology benefitted from FBT.

Gerstein & Pollack (2015) presented an article evaluating two case studies as they outlined the need for therapists to address family issues and dynamics in the treatment of eating disorders. Family sessions included dialogue of cases

and the use of family systems, structural, and experiential family therapy models. Further, Gerstein & Pollack (2015) suggested that therapists mainly focus on understanding the development of eating disorders, treatment methods, and how family members should behave toward the family member with the eating disorder. Additionally, they presented the need for an eclectic model, and the cases showed validity in that. The safety of a therapist's office was presented as effective to treatment. Thus, given that people return home to their family environment, they need to experience safety and support there, too.

#### Barriers to Treatment and Alternative Treatment Options

There were various reasons that people do not seek or receive treatment for an eating disorder. Anorexia nervosa (AN) was easier to identify due to the outward physical appearance of low body weight than bulimia nervosa (BN). People with BN often appeared physically healthy. Both forms of eating disorders can be suffered in silence for a variety of reasons including financial issues, lack of knowledge, and shame. Competency on issues affecting the population social workers serve in addition to knowledge of available resources was critical. Two articles presented in this literature review include non-traditional yet innovative forms of treatment. First, Thompson & Park (2016) were reviewed for information and solutions presented as being valuable to social workers for clients with an eating disorder.

Thompson & Park (2016) reviewed multiple barriers that kept people from accessing and utilizing treatment for an eating disorder. One was the perception of the severity of the illness, coupled with shame. Findings indicated people with an eating disorder lacked trust in treatment facilities or the effectiveness of treatment. One study determined that many physicians lacked a full understanding of the multiple physical and emotional aspects of an eating disorder. Finances prevented many from seeking treatment, even though they were diagnosable mental disorders. Inpatient treatment averaged \$30,000.00 a month, with only ten states requiring private insurance companies to provide treatment (Thompson & Park, 2016).

Treatment centers were typically found in large metropolitan areas with California and Florida having the most, across each state. Thompson & Park (2016) revealed that developing an eating disorder following a person being abused sexually or physically assaulted became a source of power and control for that individual. Additionally, ethnic minorities were less likely to seek or be referred for treatment due to scoring lower on body dissatisfaction surveys and wanting to keep their issues a secret. In conclusion, multiple barriers existed, and the need for access to treatment, including comprehensive care, must be considered (Thompson & Park, 2016).

Stice, Rohde, Shaw, and Gau (2019) randomized a group of 84 young women who fit eating disorder criteria as presented in Diagnostic and Statistical Manual of Mental Disorders (APA, 2013) for an eight-week dissonance-based

Body Project Treatment, also called supportive mindfulness treatment. Their objective was to evaluate a cost-effective treatment more easily available than current intensive and expensive treatments. Participants were recruited in Oregon and Texas at universities and their surrounding communities. Thus, Stice et al. (2019) created a model similar to on campus mindfulness support groups which proved both cost effective and had meaningful behavior reduction outcomes. This article had public health significance in that results indicated the value in continuing efforts to provide lower cost treatment options for eating disorder patients. Stice et al. (2019) presented limitations to consider while concluding that evidence indicated that favorable outcomes supported the benefit of continued refinement of this model in future studies. The possibility of access to treatment in a broad range highlighted potentially decreasing barriers to eating disorder treatment.

Tregarthen, Lock, and Darcy (2015) created a mobile phone application for people with eating disorders. The cognitive behavior therapy (CBT) method of self-monitoring was used and also included positive reinforcement. Tregarthen et al. (2015) presented the need to improve access to treatment for a variety of reasons including prevalence, cost, physical and psychiatric symptoms, and risk or death. They also pointed out factors such as shame in seeking treatment and lack of access to care due to geography or finances were noted. The application was available on two Internet application stores with over 100,000 users participating over a two-year time frame. Nearly half of the users reported not

receiving clinical treatment or disclosure of their eating disorder to anyone.

Therefore, the application was valuable in that it provided a form of treatment for a population that may not have sought treatment for a variety of reasons.

As part of their discussion, Tregarthen et al. (2015) noted that while the application was not intended to replace treatment, that may have occurred when the need for clinical treatment was warranted. Links to eating disorder hotlines were provided to mitigate risk. The nature of the study did not allow for the role the application could play post or in conjunction with treatment but, Tregarthen et al. (2015) highlighted that as an area for future research. A potential financial gain in the future for one of the researchers was disclosed in addition to the application targeting White English-speaking people. However, the potential benefit smartphone technologies offered people with eating disorders supported the feasibility and value of the future refinement and development that included adaptations to evidence-based treatments via smartphone applications.

### Foster Youth and Eating Disorders

Advocacy and social justice for vulnerable populations is critical in social work because children in the foster care system have often experienced multiple traumas. That coupled with an eating disorder, which is often a coping mechanism following sexual assault or abuse, creates a significant need for treatment and resources. Findings were limited but one article is presented which

reinforced the need for social workers working with children, especially in the foster care system, to be competent.

Casey, Cottone, and Joslyn (2012) presented a review of concerns specific to children in foster care with eating disorders. The problem was significant, with 77% of foster parents (N=300) reporting children in their care exhibiting eating or food-related issues (Thompson et al., 1994). Children in the foster care system have often experienced multiple traumas which are associated with eating disorders. The need for appropriate assessment was stressed. Prevention efforts are critical to this population with family psychoeducation a suggested component.

Foster children exhibiting eating disorder behaviors need to be referred to a pediatrician. Most effective in treatment for these youth was a treatment team with a range of professionals, including social workers (Casey et al., 2012). In conclusion, Casey et al. (2012) reported that they found no data on the awareness of this subject by social workers in child welfare services. They suggested the need for the field of child welfare to develop ways for workers to assess children in the foster care system for eating disorders and intervene if necessary. Noteworthy was that outward physical appearance was not always indicative of a person suffering from eating disorder behaviors, especially bulimia nervosa. The need for future research, including evidence-based assessment and treatment was discussed.

## Social Work and Eating Disorder Treatment, Policy, and Ethics

Eating disorders are complex and not about food but rather coping and control mechanisms. The role of a social worker in the field of eating disorders is necessary and multi-faceted. Three articles are presented that discuss ethics social workers face working with this population. First, many clients are involuntary, especially with anorexia nervosa. A key component in social work is self-determination. When an individual is too ill to make life saving health decisions or declines treatment, there are ethical ways a social worker can guide or support that individual and his or her family. The social worker's awareness and use of stages of change theory is important here. Building trust and rapport may lead to a client at least contemplating change. Also, given the secrecy often seen in eating disorders, a social worker must be aware of indications and how to address behaviors and treat the person. Finally, personal disclosure is highly cautioned in the field of social work, but Daly (2014) presented the value in body image awareness and openness by the clinician when working with clients with an eating disorder.

Bernacchi (2017) analyzed treatment, policy, and social work ethics regarding bulimia nervosa (BN). Recurrent episodes of binge eating followed by purging behaviors to avoid weight gain are the main diagnostic criteria of BN. It is often unnoticed, and the behaviors occur in secrecy. Major treatment methods included cognitive behavioral therapy intended to stop disordered eating behaviors and interpersonal therapy, which suggested dysfunctional food

resulted from anxiety and depression in interpersonal relationships. Energy balance training (EBT) was also combined with CBT. The goal of EBT was intuitive eating or eating regularly when feeling hungry to avoid hunger episodes from restricting that resulted in bingeing behaviors (Bernacchi, 2017). Also presented was exposure therapy where a client binge ate in the presence of the therapist. The therapist helped the client deal with cognitive distortions until the urge to purge had passed. Finally, mirror exposure therapy placed a client in front of a mirror in tight clothes while the therapist challenged negative thoughts and cognitive distortions that the client disclosed (Bernacchi, 2017).

Ethically, Bernacchi (2017) stressed the need for social workers to be competent in treating people with eating disorders, especially given their cooccurrence with other more prevalent issues such as depression or anxiety. If a client presented with anxiety, and an eating disorder was uncovered, the social worker needed to be competent to treat both. Finally, the importance of reducing the stigma in BN that prevented people from seeking treatments need to be an advocacy piece for social workers (Bernacchi, 2017).

Kendall & Hugman (2014) addressed the social work values of promoting social justice and empowering people. The best interest of people in treatment involuntarily for anorexia nervosa (AN) was considered. The focus of research by Kendall & Hugman (2014) stressed the need for making decisions about the best interest of the patient who was being treated primarily against their will. The

treatment option must have had the least restriction while evaluating the necessity of care, treatment, and control.

Given that recovery is a complex process, Kendall & Hugman (2014) uncovered that positive relationships between client, family, and professionals were critical to the recovery process. Integral to social work is empowerment, self-determination, and dignity and worth of the person. Therefore, when working with involuntary clients, concerns and conflict arose. Supporting the dignity of the person was maintained when the patient was allowed to voice their opinion when the treatment team discussion was shared with the client. Transparency in “the why” behind decision making allowed the opportunity for trust and respect to be established.

Daly (2014) explored object relations theory in the treatment of patients with eating disorders and the role of countertransference. Despite social work guidelines of limiting personal disclosure, Daly (2014) suggested that a client experiencing disordered eating coupled with body image issues was better served when acknowledgement of the therapists’ body was part of the process. Clinicians who were aware of their own body experience could remain subjective yet share experiences. She suggested that lead to better outcomes as it built a relationship and trust. Finally, the need for the therapist’s self-care and awareness allowed this process to benefit the recovery of the client without becoming uncomfortable in being physically scrutinized during the therapeutic process (Daly, 2014).

## Theories Guiding Conceptualization

Maslow's hierarchy of needs and the stages of change, which is part of Prochaska & Diclemente (1982) transtheoretical model of change (as cited in Kirst-Ashman, 2016) was used for this research project. Kirst-Ashman (2016) presented Maslow's view that human beings are all good and striving to live their best and fulfilling life, including being contributing members of society. Ultimately, he felt self-actualization was what people worked toward, but few attained. He created a hierarchy of needs believing that the multiple layers of needs needed to be met. A pyramid shape serves as an illustration that various levels need to be met, from the bottom up, to build upon. The foundation is *physiological*, including the basic needs of food, water, shelter, and sleep. Next is *safety*: feeling grounded, secure, and free of feelings of anxiety or fear due to turmoil. Following *safety* is *belongingness and love* with friends, family, and romantic partners providing close and caring relationships. The next phase is *self-esteem* when one has the respect of self and others, coupled with attaining accomplishment and gratitude. Finally, *self-actualization* is when a person reaches the ultimate level of self-acceptance coupled with acceptance of the world around him or her. Additionally, strong values, emotional stability, and meaningful relationships are achieved. He believed that attempting to reach self-actualization was not age specific, but something everyone strives to reach. However, once a person reached financial security, reaching self-actualization

became more of a focus. Maslow's hierarchy of needs suggested that until one level is met the next cannot be achieved in building a pyramid of needs fulfilled.

This theory was related to people with eating disorders. For those suffering from anorexia nervosa, their physiological need of food was not being met. Kirst-Ashman (2016) relates this to social work and the role of the social worker in helping people fulfill their basic needs. While it is important to note that people with an eating disorder do not necessarily lack food availability, they lack the overall value of their basic needs being met. This paper addressed treatment methods but considering Maslow's theory, until a client is stable physiologically, therapeutic interventions striving for self-esteem may be less effective.

The Prochaska & DeClemente' (1982) stages of change model, (as cited in Kirst-Ashman, 2016) can be used to understand the experience of eating disorder clients and includes five steps. Outlined as cited in Kirst-Ashman (2016), the first step is *precontemplation*; with a person seeing no need for a change in his or her life. Second is *contemplation* when a person is pondering the making of a change without a commitment or plan to do so. Preparation is third, the decision to make a change is made and options on how to change are taken into consideration. Next is the fourth stage, *action* when the person is actively taking steps to change. Finally, *maintenance* is the final stage. This stage can include minor setbacks or relapses into old behavior patterns, but on the whole, the person is working to maintain the changes made in his or her life.

NEDA (2019) recommends an understanding of the stages of change as part of the recovery process for eating disorders as it is a long process that includes professionals such as social workers and the love and support of the family and friends of the person receiving treatment and recovering. Further, NEDA (2019) suggests that recovery is complex with many stages existing at the same time. For example, while a client may be in the action stage regarding restricting food intake, in the area of body image they may be experiencing precontemplation.

In summation, eating disorders are complex mental health issues. Limited research exists and this literature review presented a brief look into a variety of methods of treatment. No single conclusive method of treatment stood out as evidence-based for a successful outcome. However, the significant number of people who took advantage of a free mobile phone application indicated that people want or seek help for their eating disorder. Also, a broad range of the population experience eating disorders with significant statistics represented in people of color. People in the LGBTQ+ community suffer and are underreported. Shame emerged as something individuals experienced both internally and by clinicians and may be a barrier to seeking treatment. Thus, the necessity for further research existed and was suggested in literature reviewed, which led to the need for this study.

## CHAPTER THREE

### METHODS

#### Introduction

This chapter provides a description of the research methods used in the study to gather and understand the perspective of people who have received treatment for an eating disorder and their thoughts on what part of treatment they attributed to their personal recovery from an eating disorder. Included in this section is the study design used, description of the sample for gathering data, an explanation of the data that was collected, general questions related to the qualitative study, the procedures used to collect data, the protection of human subjects, and the qualitative procedures used in data analysis.

#### Study Design

The purpose of the study was to collect data from people who have received treatment for an eating disorder to explore their personal experience. Specifically, this study presents findings of what people attributed their personal recovery outcome from an eating disorder in relation to treatment. It inquired as to what the people surveyed would like their practitioner, treatment center, or specifically social workers know about treatment experience and outcome. Additionally, it asked participants what they would like to share about their experience with others suffering from an eating disorder, and concluded with an

open ended question if there was anything else the participant would like to share about their recovery.

This study used a qualitative research design. This method was chosen in line with social work values and the belief that each person is an expert in his or her own life experience. Collecting data and having an in-person interview allowed the researcher to build rapport and engage the participant prior to personal disclosure in the interview and potentially create an environment where the individual being interviewed disclosed valuable experience information that may benefit the field of social work and treatment of people with an eating disorder. Methodological limitations of the study included a potentially small sample size and focus at one university campus. Additionally, the age of participants was likely be younger as is typical of college students, therefore not a broad range of participant ages.

The onset of eating disorders did include the age range of college students in addition to but also younger adolescents. Collecting data from a younger adolescent population would have been beneficial. The university where the data was collected reported their Fall 2018-2019 enrollment as 19,973 students that included 12,200 female and 7,773 male students so there was the possibility of higher reporting of female than male participants.

Methodological strengths of the design was face-to-face contact which as stated had the potential to put the person participating in the survey interview at ease. The focus campus was diverse with demographics including people of

color who are marginalized in eating disorder diagnosis and treatment (NEDA, 2019). Another strength was the availability of the university Health Center and Psychological Counseling Center to participants as part of their tuition if the need arose for therapeutic or medical services post interview. The research question was to ask for the perspective of the person being interviewed on what they found as effective in treatment leading to recovery of their eating disorder.

### Sampling

The sampling method used for this study was a non-probability convenience sampling chosen for convenience and availability. The sample for the study was university students currently enrolled as an undergrad, graduate student, or doctoral candidate. Additionally, each participant must have participated in some form of treatment for their eating disorder. Participants for this study were recruited by several means. The researcher provided an email that sought participants to the School of Social Work for distribution to students. The researcher received permission from the university Office of Student Engagement to post flyers for recruitment of study participants at appropriate locations on campus with contact information. In addition, the following was done to increase the sample size:

- The researcher spoke with various organizations in the Student Union about the study in an effort to create a snowball sample.

- The researcher contacted former professors about presenting the study to their classes in an effort to seek participants with several allowing the researcher to present.
- The researcher provided a piece of candy with contact information to each student during classroom presentations in addition to leaving candy with organizations.
- The researcher emailed 42 university organizations seeking participants.

The sample size the researcher sought was 15 participants. Considering time and resources available to complete the research project, eight to ten participants was considered acceptable in completing the project. However, the ability of the researcher to distribute flyers and seek participants on campus came to a halt due to the Coronavirus outbreak, campus closures, and government mandates which resulted in a final number of five participants.

#### Data Collection and Instruments

For the purpose of this study the data was collected by face to face or a phone interview with researcher taking notes in addition to audio recording each interview. The data collected included basic demographics including gender, age, and ethnicity. In regard to gender, researcher included a transgender inclusive

option in addition to male, female, and other. Additionally, each participant was asked which pronouns they preferred to be used during the course of the interview in addition to the presentation of findings and discussion in the research project.

An interview guide was created to specifically ask the research question using information garnered in the literature review about eating disorders. Because it was a new instrument, its validity was unknown. However, the researcher tested it for understandability by providing it to the research professor and research advisor who provided their opinions and feedback on the questions, format, and understandability. The areas of inquiry included demographic questions such as age, ethnicity, and gender. The majority of the questions were open-ended. Questions similar to the following were included in the survey, “Have you been diagnosed with an eating disorder by a medical or mental health professional? Anorexia Nervosa? Bulimia Nervosa? Have you received treatment for your eating disorder? Did you participate in family therapy? Did you participate in group therapy? What form of the above treatments do you most strongly associate with your recovery? What would you like treatment providers to know about your treatment experience?”

## Procedures

Prior to collection of data, an IRB form was submitted to California State University San Bernardino for approval to interview human subjects in addition to Carolyn McAllister, Ph.D., Director of the School of Social Work. Upon receiving approval, participation was solicited via e-mail, personal presentation to classes by the researcher as a form of recruitment, and posting flyers seeking participants in approved locations and with proper approval. A small incentive of a \$5.00 Starbucks gift card was provided to the participants at the beginning of each interview. Each participant was provided an informed consent prior to the interview and the option to stop the interview at any time. Additionally, the researcher advised ending the interview would cause no repercussions and they could keep the Starbucks gift card. Participants were informed of the purpose of the study, voluntary participation, and possible risks and benefits. Upon completion each participant was provided a debriefing statement with resources to mental health services should any discomfort arise from participation.

Data collection took place on a university campus in private rooms secured by researcher in the library. Due to the Coronavirus outbreak and campus and IRB guidelines, one interview was done over the phone with screen shots of informed consent and debriefing statement sent via text message prior to the interview. The researcher collected the data in Winter Quarter 2020.

## Protection of Human Subjects

In order to protect the confidentiality of the people studied several measures were used by the researcher. First, each participant was identified as, "Participant One, Two, Three, Four, or Five." Each participant was specified as such in the researcher's password protected phone as a contact and for the audio recording and written notes during the interview by the researcher. The contact information including phone number was deleted once the research project was accepted and completed.

Additionally, the audio recording was saved by the assigned participant number on an audio recording device and deleted as specified by California State University San Bernardino research project guidelines. The written notes the researcher took during the interview only included the participant's assigned number that matched the audio recording and kept them in a sealed envelope in the possession of the researcher while on campus and in a locked file cabinet upon completion. In reporting the data, the number assigned to the participant was used, for example, "Participant One" was be used in addition to their preferred pronouns. Data was stored on a password protected computer only accessible to researcher with all data to be destroyed after 3-5 years.

Informed consent was explained to each participant prior to the interview and the researcher received formal informed consent from each participant. Their anonymity was protected by the participant marking an X, not their name. Upon completion, each participant received a debriefing statement that included

resources for mental and physical health support including but not limited to the university Health Center and Psychological Counseling Centers, university CARE Team, National Eating Disorders Association, and National Suicide Prevention Lifeline.

### Data Analysis

This study used qualitative data analysis techniques, namely conventional content analysis (Hsieh & Shannon, 2005). Univariate statistics were utilized in describing demographic statistics such as gender, ethnicity, and age.

The researcher personally transcribed the raw data from the form of audio recording to a transcript. A coding scheme was created with the goal of describing the main categories and themes in the data. Key phrases were identified and labeled with a specific code. Relationships between the main categories and themes were identified and extracted from the data using content analysis.

The researcher maintained a research journal to document the rules and procedures used in the study. This established rules specific to this research project and will allow it to be replicated. The burden of the process falls to the researcher when using qualitative data, therefore, maintaining a journal and careful documentation was critical in the integrity of the research project.

## Summary

This research study was a qualitative research design conducted with primarily face-to-face interviews with participants. Participants were recruited from university students via e-mail, flyers seeking participants, and researcher spoke to several classes on campus to recruit participants. A nominal gift card was offered as an incentive. The sample included individuals who have experienced an eating disorder, received treatment, and experienced recovery.

The survey included basic demographics and open-ended questions as to the type and location of treatment and open-ended questions about their experience. Participants were provided a de-briefing statement at the conclusion with multiple mental health resources in the event they experienced discomfort related to participating in the survey.

After data was transcribed from audio recordings, codes were assigned for data analysis. The goal was to describe the main themes from data collected and identify relationships between them using conventional content analysis.

## CHAPTER FOUR

### RESULTS

#### Introduction

Presented in this section is data that was gathered conducting face-to-face interviews with a survey designed for this study. The survey contained demographic questions providing important background information about each participant. It also included several open-ended questions designed to inquire about the participant's experience and recovery from an eating disorder. Transcription of the responses revealed the following themes and subthemes. The first theme is identifying and treating the underlying or root causes of the eating disorder with subthemes trauma, physical health, and mental health. The next theme is barriers to recovery with subthemes of stigma and judgment, lack of engagement/knowledge by physicians and professionals, and access to treatment. The third theme is the recovery experience with subthemes of control, support system, and self-determination and awareness. Finally, hope and encouragement from participants is the fourth theme with subthemes of hope, resilience, and support.

#### Demographics

As indicated in Table 1, the age range of the five participants was from 22 to 42, with an average age of 30.6 years old ( $SD=8.7$ ). They all identified as female. One participant identified as Caucasian, one as Multi-Racial, one as

Hispanic/Latino, and two participants identified as both Caucasian and Hispanic/Latino. Each participant stated their desired pronouns as “she, her.” One participant indicated that she identified with the LGBTQ community and another said she identifies with the LGBTQ community “in solidarity.” Three participants indicated that they had earned a Bachelor’s Degree and were currently in a Master’s Program. Two participants indicated that they were working toward a Bachelor’s Degree.

Table 1  
Demographic Characteristics of Study Sample

	n	M	S.D.
Age		30.6	8.7
Sex			
Male	0		
Female	5		
Race/Ethnicity			
African-American/Black	0		
Caucasian/White	3		
Hispanic/Latino	3		
Other	1		
Highest Level of Education			
High School Graduate	5		
Bachelor’s Degree	3		
Preferred Pronoun			
She/Her	5		
Identifies with LGBTQ Community			
Yes	1		
No	4		
In Solidarity	1		

## Themes and Subthemes

Evaluation of the data collected in interviews resulted in four themes and 12 subthemes. The first theme, Identifying and Treating the Underlying or Root Cause of the Eating Disorder includes subthemes in trauma, physical health, and mental health. Secondly, Barriers to Recovery emerged as a theme including stigma and judgment, lack of engagement or knowledge by physicians and professionals, and access to treatment. The third theme is The Recovery Experience with control, support system, self-determination and awareness as the three subthemes relating to that. The final theme is Hope and Encouragement from Participants with subthemes of hope, resilience, and support. This chapter includes the research participant's demographics and a description of the themes including direct quotes from participants.

Table 2

Themes Related to Findings

Themes/Subthemes	Description
Identifying and Treating the Underlying or Root Causes of the Eating Disorder <ul style="list-style-type: none"> <li>• Trauma</li> <li>• Physical Health</li> <li>• Mental Health</li> </ul>	This theme provides insight participants provided about their history and correlation to their eating disorder.
Barriers to Recovery <ul style="list-style-type: none"> <li>• Stigma and Judgment</li> <li>• Lack of Engagement/Knowledge by Physicians and Professionals</li> <li>• Access to Treatment</li> </ul>	This theme presents barriers participants experienced in receiving the care they needed or wanted for their eating disorder.
The Recovery Experience <ul style="list-style-type: none"> <li>• Control</li> <li>• Support System</li> <li>• Self Determination and Awareness</li> </ul>	This theme includes the components participants experienced and utilized in their recovery experience.
Hope and Encouragement from Participants <ul style="list-style-type: none"> <li>• Hope</li> <li>• Resilience</li> <li>• Support</li> </ul>	This theme highlights the resilience of the participants and hope they share for others experiencing an eating disorder.

Theme One: Identifying and Treating the Underlying or Root Cause of the Eating Disorder

The participants were forthcoming about their history and experience.

Although the cause or onset of the eating disorder were not part of the interview questions, each participant provided that information or insight, either directly or indirectly, of their own accord during the course of the interview. Several

expressed one or more life or health circumstances as contributing factors in their eating disorder. Such areas created the subthemes of trauma, physical health, and mental health.

### Subtheme: Trauma

Trauma can be correlated and associated with negative outcomes and a host of issues for people in general. Three shared that they had experienced trauma, or multiple traumatic experiences. They included poverty, molestation, sexual abuse, death, hyper-religiosity inflicted upon them, adults failing to protect, difficult home life, and substance abuse. Each expressed an awareness that trauma had an impact on them, their life, and associated it with their eating disorder.

Participant 1 spoke of poverty, “Even doing this recovery process I still wouldn’t be able to determine if this began because I was poor and didn’t know when I was going to eat next so I would just eat.”

Participant 2 disclosed multiple traumas including a medical procedure, voidingcystourethrogram, that she experienced as a sexual trauma at four years old, “They shove a tube up your urethra and shoot you full of dye.” Additionally, “I was traumatized, my dead grandfather, he didn’t rape me, he molested me.”

Participant 2 also spoke of lack of protective factors adding to the traumatic situations, “And what really bothered me, too about that [sexual assault by two teenage boys] was a male teacher who witnessed this and didn’t do

anything to stop it.” Adding to that, “My mom publicly ridiculed me, that was painful at the time, I’m not trying to be mean, she just isn’t tactful.”

Participant 3 was able to articulate the trauma she associates with her eating disorder, “I feel like the eating disorder was a symptom for all of my problems, so I was dealing with that and dealing like with my depression.” She connected depression with her eating disorder, “I feel like it has to do with trauma as well, because in 2013 that’s when my mom passed away and it was all of the sudden, like in the span of a month.” Participant 3 was 15 when her mom died and she gained 100 pounds in the span of one year.

#### Subtheme: Physical Health

Multiple health issues were cited by participants as components or a symptom of their eating disorder. They include childhood and adult obesity, polycystic ovarian syndrome, Type II Diabetes, high blood pressure, hypothyroidism, and Participant 5 disclosed that an “eye-opening health experience” lead her to seek health for her binge eating.

Participant 2 described herself as “skeletal” at age 14 due to anorexia and recalled talking to a doctor, “I feel like, I did talk to a pediatrician, he was trying to get me to eat differently.” For Participant 2, it was a procedure (voidingcystourethrogram) for a physical health issue that ended up being a sexual trauma experience for her.

Participant 3 shared that she had weight issues her whole life, “My mom would always be like go on this diet, now looking back it was a binge eating type

of disordered eating.” Her mom took her to a pediatrician where high blood pressure was discovered and treated. While she sees the binge eating behaviors going back to childhood, her mom and doctor attributed her excess weight to simply overeating or being lazy. “It was not being able to even get the care that I wanted from the doctor or like the professional help I needed at the time.” As Participant 3 grew into adulthood the physical health issues compounded including Type II Diabetes, polycystic ovarian syndrome, and high blood pressure.

Participant 4 recalled that from the time she was 16-19 she suffered from anorexia and did not want to eat and if she did eat, it was a small portion followed by excessive running. She said that despite her efforts she did not lose weight, so she told her mom who took her to the doctor. She was diagnosed and treated for hypothyroidism. She disclosed that her mom had an eating disorder when she was young. When asked if she was diagnosed with anorexia nervosa she said, “They did, and then they were like are you done doing it? And I said yea, but I wasn’t at the point where they could diagnose me because I wasn’t severely malnourished.”

In summation, while the participants had all been under the care of a physician at some point, the eating disorder itself was not addressed to their recollection. Participants 3 and 5 both ended up with life threatening health issues that they took as warnings to seek better physical health.

### Subtheme: Mental Health

Eating disorders are a mental illness. In addition to the eating disorder, participants disclosed additional mental health issues including addiction and depression. Participant 1 disclosed that she participates in a 12-Step Program and her sponsor is an eating disorder specialist who works in treatment. It is with that individual that she has done work specific to her “obesity and overeating.”

Participant 2 recalled talking with a therapist, but not specifically about her anorexia, “To be perfectly honest, I don’t remember the treatment, she was nice, she was good, the Psychologist.”

Participant 3 indicated she has experienced and battled depression, and attributes it to the death of her mom and described experiencing depression as she gained weight following her mom’s death. Additionally, she is aware of stress and insomnia as factors in her mental and physical health. Further, she expressed fear related to her weight and age and associated it with her mental health, “I was like there is a problem here, its not just weight, like you’re dealing with your emotions in the wrong way.”

Participant 4 disclosed that she experienced depression and was prescribed medication which she said was the least helpful component of her treatment, “I feel like the medication because I didn’t want to be on it.” She disclosed being on three medications but spoke specifically about one, “The Zoloft they gave me, it made me like numb, and even though it was supposed to increase my serotonin I felt like I didn’t want to do anything.” Participant 4, similar

to the other participants, seemed to have an understanding of the mental illness aspect of an eating disorder, “I feel like even though it didn’t like mess me up physically, it did up here,” and she motioned to her head.

## Theme Two: Barriers to Recovery

All five participants reported having been in the care of a pediatrician or physician while their eating disorder was active. Each participant acknowledged and appeared accepting of the fact that they have an eating disorder, yet some lacked, or did not recall a formal diagnosis. Most participants shared the reality of relapse or slips back into eating disorder behaviors. Three subthemes emerged and follow: stigma and judgment, lack of engagement/knowledge by physicians and professionals, and access to care.

### Subtheme: Stigma and Judgment

Each participant disclosed experiencing or recognizing judgment relating to their eating disorder. This ranged from self-judgment, feeling judged by others including health care professionals and society. Further, they articulated the stigma attached to being overweight and need for that and judgment of others to change on multiple levels.

Men experiencing eating disorders was addressed by Participant 1, “We have this idea and that society tells us, that men don’t have this thing and its only women.” Further, she said that it is while in a space of non-judgment that she experiences recovery.

Participant 2 stated, “Adults weren’t helpful” due to experiencing “a lot of judgment from adults,” specifically a pediatrician. As for stigma, she said, “Each and every one of us has the power to heal but society needs to change, we look to the pathology, but we need to look how society changed that, the pathology.”

Feeling uncomfortable about therapy and discussing her eating disorder with family members was disclosed by Participant 3. Despite that, she shared, “ I feel like it is needed and I’m open to being uncomfortable, its uncomfortable because everyone gets to see like you’re overweight.” She articulates stigma and judgment coupled with oversimplification, “There are these biases or judgments people have. It is much more complex that, like biologically and your environment has an impact on that, too. You can’t really judge a person like that and its unfair.”

Feeling judgment over food choices was stated by Participant 4 as something she encounters. Participant 5 addressed the judgment of people who are overweight, or a person by their appearance. Additionally, she felt that there is an emphasis on people who are losing weight and appear frail as opposed to those who struggle and that manifests in gaining weight.

#### Subtheme: Lack of Knowledge by Physicians and Professionals

Four of the participants received medical care and expressed a lack of understanding or acknowledgement of their eating disorder by their health care professional.

Participant 2 was seen by a pediatrician who wanted her to eat differently and a therapist, “I got counseling but not specific for an eating disorder, I don’t remember talking to the therapist about anorexia.”

Participant 3 recalls going to the doctor as a child and, “They just simply thought like oh she’s eating a lot or she’s just being lazy.”

For Participant 5, it was “an eye-opening health experience” when she received medical care. Her desire is for a healthier lifestyle and included nutrition classes where healthy food and eating was taught but eating disorder behaviors were not addressed.

#### Subtheme: Access to Treatment

Each of the five participants disclosed having an eating disorder with three answering yes to having received treatment. None received inpatient treatment. The three who received treatment experienced it as outpatient and it included individual and/or group therapy. Participants 3 and 5 both experienced severe medical issues that they were treated for. Additionally, both expressed the desire for better physical health as a motivating factor.

Participant 3 sought a health coach and group and individual therapy available as a college student, “Going out and getting help, like it has really changed my life.” When provided a list of mental health resources at the conclusion of the interview she asked if there were any eating disorder treatment centers, despite her progress she is still interested in further treatment.

In an effort to deal with her health issues, including binge eating and being overweight, Participant 5 saw a nutritionist. She disclosed that she eats healthier food, “but it hasn’t really stopped the bingeing.”

### Theme Three: The Recovery Experience

Each participant had a different recovery experience with Participant 5 being the only one to state that she does not feel she is in recovery from her eating disorder. Each person was able to articulate self-awareness in multiple areas. Additionally, they recognized the role of control in their eating disorder including regaining control, in one way or another. Each participant was forthcoming about specific tools or methods associated with seeking, experiencing, and maintaining recovery. In this area the subthemes of control, support system, and self-determination and awareness emerged and are presented.

#### Subtheme: Control

When asked about what she would like treatment providers to know about her recovery experience, Participant 1 shared, “There is freedom but sometimes it doesn’t feel like freedom,” and suggested treatment providers prepare clients for that, so that, “because at times you’re in situations where the recovery feels like more of a restriction. You have to be able to identify and know it is just situational, it’s not actually internal.”

Participant 2 stated, “It is so important talking with someone with an eating disorder to recognize that a lot of times it has to do with control. I felt out of control, honor the self-determination of clients and come from a place of non-judgment,” and she continues later in the interview with, “I thought they wanted me to be fat, everyone, they wanted to control me, it’s more than eating, abuse can affect it.”

Control emerged as a theme early in Participant 3’s interview with her disclosure that as a child with weight issues her mom was always putting her on a diet, “Like this was my whole life, I would eat a lot, and it wasn’t just to eat, you know, it’s just very complex.” When her mother died, she turned to bingeing, “It was just really connected with everything at that time, too. And I had a past with my eating and not being able to grab a hold of it or have control of it.” She stated, “It’s scary because with binge eating, I felt like I didn’t have any control, now looking back its painful.” In sharing the components of recovery including doing her own research and working with a health coach she describes a sense of regaining control.

#### Subtheme: Support System

Participant 1 shared that she was not alone in her recovery and, “being vulnerable enough to talk to others about it, because in my experience, I’ve had the courage to open up about it and other people have been able to open up about it.” She expressed the value in not feeling alone and being a support system for others helps her recovery in addition to theirs.

Participants 2 and 3 both attributed a new activity, sports to recovery. For Participant 2 it was while in junior high, she said the sport was the means to build a connection to the coach and teammates which made a world of difference for her. Additionally, she came to realize the need to provide nutrition for her body to be able to participate in the sport that perpetuated the connection. She said, "I've participated in women's circles as an adult," and concluded that having those and rites of passage for girls are things she believes would have been beneficial to her in the past and suggested them as valuable for girls today.

Working closely with her health coach and trainer helped Participant 3 and lead her to, "Celebrating what your body can do is what I find important,...power lifting keeps me anchored and sane,...I do it for fun most importantly." She said her exercise, bench, and power lifting, "essentially saved my life."

Participating in group therapy with people sharing the same experience was beneficial to Participant 4, "It was like a group where you bring each other up." Additionally, she considers her mom her strongest support, "She helped me because she used to have it [eating disorder] too, when she was little." Family therapy was offered to Participant 4 and her mom while in treatment, but her mom declined. Despite lacking the family therapy piece, which she said would have been helpful Participant 4 said, "She's been like a big support," about her mom.

### Subtheme: Self-Determination and Awareness

Each participant vocalized self-determination and awareness in varying degrees and areas. The work Participant 1 has done in her recovery, including mindfulness, have helped her become aware of situations that trigger emotions and stated, “I know all of the stuff of being able to really identify the feelings, and if you identify them it’s not that you will avoid them, right, it’s that you will come up with a plan that you’ve created with your provider.”

Participant 2 was aware of a turning point in her eating disorder journey. It was when her friend asked her why she did not eat normally, she said she wondered, “Why don’t I?” Her self-determination is evident in nurturing her spirituality and utilizing Emotion Code as a form of healing, “Healing is not instant gratification, emotion code isn’t. You go to a session and then rest, self-care, it takes the negative energy of trapped emotions and they are replaced with something you choose, something good, self-care. It is astonishing.”

“Just going out and getting help, like it really helped me change my life, like change the lenses of how you view food. Like before, food was my drug and before I felt really numb and its weird, it was just me using that as a drug to heal from my past trauma.” Participant 3 articulates both self-determination and awareness in that statement.

Participant 4 disclosed the potential for relapse due to recent weight gain and has turned to her journals and mom for support, “You can’t let yourself get too low because it will just happen all over again and you won’t even know it is

happening.” Her awareness of reaching low points and seeking support is indicative of self-determination.

#### Theme Four: Hope and Encouragement from Participants

Several of the participants stated that their participation in the research project was to help others learn from their experience. One of the questions each participant was asked was what they would like to say to other people struggling with an eating disorder. The final question was open-ended with a general opportunity for them to share anything related to their recovery. The theme of the responses to the final two questions were hope, resilience, and support.

##### Subtheme: Hope

All of the participants expressed positive outlooks regarding their eating disorder recovery. Three of the participants expressed statements of hope to relay to others who are experiencing an eating disorder.

Regarding recovery Participant 1 said, “That it’s not perfect, that feelings still come and go, but they come and go.”

Participant 2 said that healing is an ongoing journey, “Women are the greatest power, women and the two spirit [third gender, alternative spiritual path] are the most powerful.”

Participant 3 stated, “I’m happy to be here, that’s nice, two know your worth and know that you’re enough.”

### Subtheme: Resilience

Each participant demonstrated resilience in overcoming difficult life or health experiences in addition to their eating disorder. Three participants expressed resilience in their message to others experiencing an eating disorder.

Participant 2 stated, “This [recovery] is bigger than the eating disorder, it is the whole picture of your life,” and further, “Each and every one of us has the power to heal but society needs to change.”

Participant 3 said, “I feel like I’m starting to realize that I have a voice, I have power. I felt like I was in a hole I was never going to get out, but there is a way out.”

Participant 4 offered, “Don’t let yourself get very low or feel bad about yourself because you are perfect.”

### Subtheme: Support

Support emerged as a subtheme again in four of the participants offering their thoughts to others experiencing an eating disorder. Participant 1 embraces her vulnerability and wants to show people that they are not alone and said, “Just knowing it [the eating disorder] is not something we created or did wrong, that the disorder itself is not our responsibility but what we do in response to it is.”

Participant 3 spoke of compassion for self and others and said that recovery allowed her to no longer feel empty and the realization, “I used to think I was a broken person but I’m not, I’m me, I’m great.”

Participant 4 encouraged, “It’s going to get better and you need to seek help, even if you don’t want to,” and stressed the need for support, “You need to tell somebody because you can’t go through that kind of stuff alone.”

Participant 5 talked about the value in a support system, despite the difficulty in not wanting friends and family to know about the eating disorder behaviors, to find one person to confide in, “I think that not to be ashamed, part of it is the shame behind it.”

### Summary

This chapter included the demographics of the participants interviewed and the themes that were identified in the data collected. The study identified the following themes and subthemes in relation to the experience of treatment and recovery for an eating disorder by the participants interviewed: Theme One: Underlying or Root Cause of the Eating Disorder, with subthemes: trauma, physical health, mental health, Theme Two: Barriers to Recovery, with subthemes: stigma and judgment, lack of engagement/knowledge by physicians and professionals, access to treatment, Theme Three: The Recovery Experience with subthemes: control, support system, self-determination and awareness, and Theme Four: Hope and Encouragement from Participants. The themes emerged as the researcher transcribed the interviews and then analyzed and coded the transcribed interviews. Additionally, analysis and coding was evaluated by the research advisor. The themes represent the experiences of the participants

interviewed in addition to their messages of hope and encouragement to others who are struggling with an eating disorder.

## CHAPTER FIVE

### DISCUSSION

#### Introduction

The purpose of this study was to explore the personal experience of individuals who have an eating disorder and their treatment for it. Concisely, the study was designed to gain insight into the perception of the individuals interviewed as to what they attribute to their recovery from an eating disorder. This section of the paper will discuss the findings, limitations, and strengths of the study based upon data collected. Additionally, recommendations for social workers in general and specifically those who specialize in the area of child welfare are discussed in working with clients who have been diagnosed or are at risk of an eating disorder. Recommendations for further research are included, and a discussion of the findings of this study with respect to the literature review are presented in support of the researcher's discussion and recommendations.

#### Discussion

Each participant disclosed their personal experience about their eating disorder during the course of the interviews, and the candor in which some participants disclosed their trauma history was unexpected, but not the trauma itself. What emerged was similar to existing literature suggesting that individuals who have an eating disorder have often experienced a trauma (NEDA, 2019),

which left untreated can increase the future risk of substance abuse, suicide attempts, anxiety, depression, and early death (Stice et al., 2019). Participants shared their experience, insight, and expressed the need for professionals, including social workers, to engage clients effectively. This is similar to prior studies highlighting the importance of client engagement and a supportive environment for individual with an eating disorder (Sheridan & McArdle, 2016). Further, participants stressed the importance of not judging a person based on their appearance and not being afraid to inquire about eating disorder behavior. That relates to a finding, clinicians should not approach clients with weight bias, either under or overweight and not being afraid to introduce weight and eating disorders into a conversation (Harrop, 2019).

The study was designed to focus on treatment and recovery, but the participants were forthcoming about their underlying or root cause and experience with a diagnosis or lack of one by health care professionals. Again, their disclosure was unexpected but insightful. It led to the emergence of identifying and treating the underlying or root cause of a person's eating disorder. This was echoed in the disclosure of the participants interviewed. Four of the five interviewed had at one point been in the care of a physician with their eating disorder not being addressed or diagnosed. All participants voiced the need for getting to the root of the problem, the existence of an eating disorder, and its origin rather than treating the symptoms.

That led to uncovering trauma as a subtheme. Insight gained from data include the need for social workers to look into the root cause including possible mental health issues related to trauma with their clients with weight related issues. This aligns with the literature presented by National Alliance on Mental Illness [NAMI] (2019), that eating disorders are a mental illness experienced by people attempting to cope with uncomfortable and overwhelming emotions by controlling food. While none of the participants disclosed any involvement in the child welfare system, for some the nature and age of their trauma may have been reportable to children and family services for investigation at the time. The importance of social workers in child welfare needing an understanding of eating disorders as coping mechanisms for their clients is noteworthy. Foster youth have a high incidence of trauma history and eating disorders and problematic disordered eating (Casey et al., 2010). Thus, increasing awareness of eating disorders and coping behaviors related to controlling food among foster youth is important because many have experienced multiple traumas.

Physical health emerged as the next subtheme. According to NAMI (2019), eating disorders left untreated can lead to serious physical health issues, in extreme cases even death. The findings from this study uncovered individuals being treated for a physical health issue without the eating disorder being discovered, discussed, or diagnosed. Based on the presented findings of NAMI (2019) that left the participants in an especially vulnerable position. Had their

eating disorder been diagnosed, addressed, or treated some of their physical health issues may have been avoided or prevented.

The final subtheme in uncovering the root cause was mental health. Several participants expressed experiencing anxiety and depression. According to Bernacchi (2017), anxiety and depression in interpersonal relationships resulted in dysfunctional eating. That echoes NAMI (2019) that eating disorders are a mental illness and lack of treatment can cause serious mental damage. Collectively, the voice of the participants in getting to the underlying issue related to their eating disorder speaks to the need to uncover what is causing the negative emotions or feelings causing the eating disorder behaviors.

The second theme that the researcher uncovered was barriers to recovery. Primarily, the participants who had been under the care of a pediatrician or physician felt they had received treatment for symptoms related to their eating disorder rather than the eating disorder itself and its underlying cause. Therefore, effective engagement is necessary to address root causes, and trauma needs to be addressed with appropriate treatment.

Stigma and judgment appeared as a subtheme. Bernacchi (2017) presented the need for reducing stigma related to eating disorders, specifically as it prevents individuals from seeking treatment as a critical advocacy piece for social workers. Judgment presented multiple times, including micro, mezzo, and macro levels. It was also tied to an oversimplification of the complex mental health aspect of eating disorders. That corresponds with findings by Harrop

(2019), and her personal experience with weight bias and the danger in diagnosing a person based on their personal appearance. This is tied to one participant who appeared “normal” in weight despite her anorexia because of hypothyroidism. Further related to this theme, Harrop (2019) presented that based upon her experience, body shaming [personal judgment] is considered problematic for a thin person but acceptable in someone overweight. Harrop (2019) includes intersectionality as a component which relates to the experiences of the participants interviewed. There is nothing simplistic about an eating disorder and it intersects on many levels including stigma and judgment. Therefore, social workers need to consider many aspects as contributing factors intersecting as components or risks associated with an eating disorder.

The final subtheme relating to barriers to recovery is access to treatment. Thompson & Park (2016) list social factors, financial barriers, and provider’s attitudes as barriers to treatment. Noteworthy is the provider’s attitude presented by Thompson & Park (2016) attributed to lack of knowledge which is similar to findings of this study. While none of the participants vocalized cost as a barrier, according to NEDA, inpatient treatment can run \$30,000 a month on average and from \$500.00 to \$2,000.00 per day for outpatient treatment. Bernacchi (2017) presented insurance as an issue for many clients including eating disorders not being covered as a mental health condition. The researcher concludes that a variety of barriers exist, as articulated by participants and research findings. Advocacy for access to treatment by social workers is critical in this area. That

being said, a variety of paths to recovery and overcoming barriers to recovery is not uncommon in people with eating disorders. A mobile phone application was created by Tregarthen, Lock and Darcy (2015) for people with an eating disorder with wide-spread usage, over 100,000 users over two years. It was valuable in providing treatment for individual who may not have sought or had access to treatment. Considering the barriers, the findings that recovery is a lengthy process, and desire of the participants for recovery for their eating disorder, a mobile phone application may be a valuable option for a confidential, low-cost, and accessible intervention. Given the timing of this study and the COVID-19 pandemic and the impact it has had on access to care, a mobile phone application is especially relevant.

The third theme uncovered was the recovery experience. Sheridan & McArdle (2016) found that clients fared best when engaged with their treatment provider and the provider approaching clients in a personal, humanistic manner focusing on their well-being rather than on their illness or symptoms. That was articulated by participants of this study who spoke positively of mental health professionals they had worked with. Despite that, conventional therapy was not cited as the main component of recovery for the participants. This suggests the importance of social workers remaining open minded to what the person determines recovery to look like coupled with it not always being a result of traditional therapy or treatment.

That led to the subtheme of control. Eating disorders are about control, an unhealthy coping mechanism (NAMI, 2019). Control was disclosed through the course of each interview, but most prevalent in recovery. Control was disclosed through many interviews, but interestingly enough it was most prevalent in recovery. This was unexpected but in social work it speaks to self-determination. While spirituality was not uncovered in research, it did in one interview. Emerging from religious and patriarchal familial patterns to discover her own spiritual path was the greatest shift in control for one participant. What emerged were many paths to regaining control of physical and emotional health. This suggests the value in social workers engaging their clients to support their self-determination in discovering and pursuing a healthy activity or interest as a means of gaining control of their overall well-being and potential recovery from an eating disorder.

Next, the value of a support system was uncovered as a theme. The participant who identified with the LGBTQ+ community shared the value in her support system and not feeling alone which echoes what was presented by National Eating Disorders Association [NEDA](2019). Group therapy that included similar ages and sharing experiences and positivity were expressed as valuable support systems by two participants. That aligns with small group sizes including meaningful and engaging activities being beneficial in group therapy (Sheridan & McArdle, 2016). Support systems presented as beneficial to the participants. That relates to the field of social work and the importance of human relationships. This also stresses the importance of finding the best modality for

people struggling with eating disorders as some may prefer to be in a group with others whereas others may prefer individual treatment.

Finally, self-determination and awareness presented as a theme. Self-determination is a critical component in social work and this theme will prove useful for social workers working with clients with an eating disorder as presented by Kendall & Hugman (2016). Awareness is a two-way street, the participants expressed individual awareness and the need for health care practitioners, and specifically social workers to also be aware. Attached to awareness by the social worker is the ethical piece, social workers need to be competent in eating disorders, especially because they are often cooccurring with other more common issues including anxiety and depression (Bernacchi, 2017). An awareness of the turning point in their eating disorder was expressed by most participants. That was also the case for Harrop (2019).

The final theme is the hope and encouragement from participants. Ultimately, the collective voice of participants suggests that recovery is possible, comes when a person is ready, includes self-determination, resilience, and the need for a form of support. This ties to Maslow's hierarchy of needs and the quest of people is striving to live their best life (Kirst-Ashman, 2016). Specific to the participants disclosing the timing of their individual recovery is related to NEDA (2019) recommending and understanding the stages of change. The Prochaska & DeClemente' (1982) Stages of Change, (as cited in Kirst-Ashman, 2016) includes precontemplation, contemplation, preparation, action, and

maintenance. This is important for social workers to be aware of in working with any clients, but specifically those with an eating disorder who do not yet accept its presence or a willingness to seek or participate in treatment.

The participants each disclosed difficult experiences that they attribute as components of their eating disorders, and disordered eating behaviors. That leads to their transparency that recovery is not easy and is an ongoing journey with relapse as a possibility. However, resilience that emerged from each participant sharing their insight for this project, coupled with their encouragement to others who suffer from an eating disorder is valuable and meaningful in the hope of recovery for individuals. It also provides insight for social workers who will likely work with clients with an eating disorder. The voice of the participants presented through data attached to the theories, and research presented have the potential to help social workers in this area of practice and encourage them to seek further knowledge and advocate for clients battling an eating disorder.

### Limitations and Strengths

Sample size was a major limitation for this study with only five participants; thus, caution should be made in generalizing these findings outside of the setting in which the data collection took place. The greatest limitation was a broad range of experiences not being gathered and therefore no possibility for significant data to compare to research or experiences within the population surveyed.

Only women responded and participated, so the sample does not reflect the experiences of men or anyone identifying as transgender. Future research including a broader range of participants would be valuable, but the researcher stands by having access to care available to participants in future research.

The qualitative design was a strength for this study as was the diversity of the participants. This approach allowed participants to share their experience without any limits. The design resulted in the participants disclosing more information than was part of the survey which resulted in meaningful data. Despite the small sample size, there is a range of backgrounds including race, age, education level, and the LGBTQ+ community. Another strength was the researcher's knowledge and experience in building rapport, engagement, and assessment with participants. The researcher attributes those skills to a BASW degree, course work in the MSW program, and being a Title IV-E student with internship experience in Children and Family Services. Participants appeared at ease with the researcher, as indicated by extensive disclosure. Additionally, the researcher has and proved the ability through the IRB process to assess and provide crisis intervention should the need arise during an interview. No participant exhibited signs of distress as a result of the interview.

## Recommendations for Social Work Practice, Policy, and Research

Eating disorders are a mental illness experienced by a significant number of people, one out of 20. Therefore, it is important for social workers to have knowledge of them and be competent in providing treatment or resources. The results of this study, coupled with the literature review highlight the need for social workers to engage with clients, honor their self-determination, and get to the root cause of the symptoms that clients present with. Considering that many children in child welfare experience trauma, social workers in this field should assess for weight fluctuation and educate caregivers about this possibility. However, a change in weight is not always indicative of an eating disorder, so social workers need to be aware of other indications of eating disorder behaviors such as rituals surrounding food, extreme concern over body weight, loss of menstrual cycle, bloated or facial puffiness, callouses on back of hands and knuckles from self-induced vomiting, social withdrawal, and avoidance of situations including food.

Assessment is critical for social workers, and inclusion of assessing for signs of an eating disorder should be a component. Some individuals may present with known risks, specifically a traumatic experience. This is often the case for children in the foster care system. But many do not, thus it is important for their social worker to be assessing for risks or behaviors. The most effective form of assessment is conversations and as articulated by each participant, find out the reason behind the symptom, not just the symptom. That conclusion of

participants echoes a finding in the research that clients with eating disorders who show positive changes in weight restoration and management early in treatment does not imply full recovery, that is an ongoing process. Therefore, assessment needs to be ongoing.

Another recommendation is for Schools of Social Work providing information about eating disorders in their curriculum. Certainly, eating disorder treatment is an area of specialty, but given the high incidence of them and the co-occurrence with more common diagnosis of anxiety and depression it is important to include assessment and evaluation for eating disorders related to those. Children and Family Services offering training to social workers and foster families regarding eating disorders would be valuable.

Participants disclosed the shame and secrecy they experienced with their eating disorder so steps to reduce stigma and helpful ways to provide support for individuals experiencing an eating disorder is important. Recommendations include the micro level and having the conversation with people that “normalize” difficulty with eating following trauma for some individuals. A step further is at the mezzo level in locations such as schools and agencies. Finally, from a macro or societal level reducing stigma and recognizing that many suffer in silence experiencing an eating disorder could prove helpful.

The need for further research, especially in the field of social work exists and is recommended. The study could be repeated at other universities or locations. Another suggestion for further research is to work with mental health

care providers that provide treatment specific for eating disorders and their clients to compare the perception of treatment and recovery between the clinician and the client. This study could also be replicated in child welfare to assess whether foster youth display similar struggles with eating disorders considering their shared trauma history.

### Conclusion

This study provided insight into the experience of five individuals who have an eating disorder and the recovery of four of the participants. Many of the experiences shared related to the literature reviewed. Participants were forthcoming and several vocalized that their participation was in hope of reduction of stigma and access to care in the future. Findings indicate a connection between trauma and eating disorders and that control is a component of eating disorders. While it was a small sample size, strong themes emerged, and the data showed that there are many paths to recovery from an eating disorder.

APPENDIX A  
INFORMED CONSENT



College of Social and Behavioral Sciences  
School of Social Work  
**INFORMED CONSENT**

The study you have been asked to participate in is designed to gain knowledge of what individuals who have participated in treatment for an eating disorder attribute to their personal recovery from an eating disorder. The study is being conducted by Wendy Ingram, a MSW student under the supervision of Dr. James Simon, Assistant Professor in the School of Social Work, California State University, San Bernardino. The study has been approved by the Institutional Review Board at California State University, San Bernardino.

**PURPOSE:** The purpose of the study is to gain knowledge of what people who have participated in eating disorder treatment attribute to their personal recovery from an eating disorder.

**DESCRIPTION:** Participants will be asked several questions about their personal experience and recovery from an eating disorder.

**PARTICIPATION:** Your participation in the study is completely voluntary. You can decline participation in the study or stop your participation at any time without any repercussions.

**ANONYMITY:** Your responses will remain anonymous and data will be reported anonymously with no identifying factors.

**DURATION:** It will take approximately 30 to 60 minutes to complete the interview.

**RISKS:** Foreseeable risks to participants include discomfort as some questions associated with an eating disorder, treatment, or trauma related to either may bring up uncomfortable feelings. Each participant will be provided a list of mental health services.

**BENEFITS:** There will be no direct benefits to the participants. However, there is the possible future benefit if this research project contributes to furthering the knowledge of what individuals who have participated in treatment for an eating disorder attribute to success in the field of social work.

**CONTACT:** If you have any questions about the study, you are welcome to contact Dr. James Simon at 909-537-7224 or James.Simon@csusb.edu

**RESULTS:** Study results can be accessed from the Pfau Library ScholarWorks (<http://scholarworks.lib.csusb.edu>) at California State University, San Bernardino after July 2020.

This is to certify that I must be 18 years of age or older to participate in your study, and I have read and understand the consent document and agree to participate in your study.

Place an X mark here: \_\_\_\_\_ Date: \_\_\_\_\_

I agree to be audio recorded: YES \_\_\_\_\_ NO \_\_\_\_\_

909.537.5501 · 909.537.7029

5500 UNIVERSITY PARKWAY, SAN BERNARDINO, CA 92407-2393

The California State University · Bakersfield · Channel Islands · Chico · Dominguez Hills · East Bay · Fresno · Fullerton · Humboldt · Long Beach · Los Angeles · Maritime Academy · Monterey Bay · Northridge · Pomona · Sacramento · San Bernardino · San Diego · San Francisco · San Jose · San Luis Obispo · San Marcos · Sonoma · Stanislaus

APPENDIX B  
DATA COLLECTION INSTRUMENT

## **INTERVIEW GUIDE**

### **DEMOGRAPHICS**

Age:

Ethnicity:

African American    Hispanic/Latino    Caucasian    Native American    Other

Gender:

MALE    FEMALE    OTHER

Which pronouns do you prefer?

Do you identify with the LGBTQ community?

What is your highest level of education completed?

### **EATING DISORDER QUESTIONS**

Have you ever been diagnosed with an eating disorder by a medical or mental health care provider? Please elaborate.

Were you diagnosed with anorexia nervosa?

Were you diagnosed with bulimia nervosa?

### **TREATMENT AND RECOVERY QUESTIONS**

Have you received treatment for an eating disorder?

Inpatient?

Outpatient?

Individual Therapy or Counseling?

Family Therapy?

Group Therapy?

What was the most helpful component of your treatment?

What was the least helpful component of your treatment?

Have you experienced abstinence/recovery from an eating disorder?

What do you most strongly associate with your recovery?

What would you like treatment providers to know about your treatment experience?

What would you like treatment providers to know about your recovery experience?

What would you like other people struggling with eating disorders know about your recovery experience?

Is there anything else you would like to share about your recovery?

Created by Wendy Ingram

APPENDIX C  
DEBRIEFING STATEMENT

## DEBRIEFING STATEMENT

The study you just completed was designed to gain knowledge from individuals about what they attribute to their personal recovery from an eating disorder. The researcher is interested in contributing information related to the personal experience of individuals who have experienced recovery from an eating disorder to the field of social work. This is to inform you that no deception is involved in this study.

Thank you for your participation. If you have any questions about the study, you can contact Dr. James Simon at 909-537-7224. If you would like to know the results of this study it will be available at the Pfau Library ScholarWorks database (<http://scholarworks.lib.csusb.edu/>) at California State University San Bernardino after July 2020.

While no foreseeable immediate or long-term risks to participants are anticipated, should you experience any discomfort following your interview this form includes resources for mental or physical health support.

California State University San Bernardino (CSUSB) Health Center 909-537-5241

CSUSB Suicide/Crisis Help Line 951-686-4357 or 800-784-2433

CSUSB Counseling & Psychological Services 909-537-5040

CSUSB CARE Team 909-537-2273

National Eating Disorders Association (NEDA) [nationaleatingdisorders.org](http://nationaleatingdisorders.org)  
NEDA Helpline 800-931-2237 or for 24/7 crisis support text "NEDA" to 741741

National Suicide Prevention Lifeline 800-273-8255  
[www.suicidepreventionlifeline.org](http://www.suicidepreventionlifeline.org)

The Trevor Project 866-488-7386 [thetrevorproject.org](http://thetrevorproject.org) or text "START" to 678678

APPENDIX D  
INSTITUTIONAL REVIEW BOARD APPROVAL

JANUARY 17, 2020

CSUSB INSTITUTIONAL REVIEW BOARD  
EXPEDITED REVIEW  
IRB-FY2020-122  
STATUS: APPROVED  
WENDY INGRAMJAMES SIMON  
CSBS - SOCIAL WORK  
CALIFORNIA STATE UNIVERSITY, SAN BERNARDINO  
5500 UNIVERSITY PARKWAY  
SAN BERNARDINO, CALIFORNIA 92407

DEAR WENDY INGRAMJAMES SIMON:

YOUR APPLICATION TO USE HUMAN SUBJECTS, TITLED "EATING DISORDER TREATMENT: WHAT FORMER PATIENTS ATTRIBUTE TO THEIR PERSONAL RECOVERY" HAS BEEN REVIEWED AND APPROVED BY THE INSTITUTIONAL REVIEW BOARD (IRB). THE INFORMED CONSENT DOCUMENT YOU SUBMITTED IS THE OFFICIAL VERSION FOR YOUR STUDY AND CANNOT BE CHANGED WITHOUT PRIOR IRB APPROVAL. A CHANGE IN YOUR INFORMED CONSENT (NO MATTER HOW MINOR THE CHANGE) REQUIRES RESUBMISSION OF YOUR PROTOCOL AS AMENDED USING THE IRB CAYUSE SYSTEM PROTOCOL CHANGE FORM.

YOUR APPLICATION IS APPROVED FOR ONE YEAR FROM JANUARY 17, 2020 THROUGH --.

PLEASE NOTE THE CAYUSE IRB SYSTEM WILL NOTIFY YOU WHEN YOUR PROTOCOL IS UP FOR RENEWAL AND ENSURE YOU FILE IT BEFORE YOUR PROTOCOL STUDY END DATE.

YOUR RESPONSIBILITIES AS THE RESEARCHER/INVESTIGATOR REPORTING TO THE IRB COMMITTEE INCLUDE THE FOLLOWING FOUR REQUIREMENTS AS MANDATED BY THE CODE OF FEDERAL REGULATIONS 45 CFR 46 LISTED BELOW. PLEASE NOTE THAT THE PROTOCOL CHANGE FORM AND RENEWAL FORM ARE LOCATED ON THE IRB WEBSITE UNDER THE FORMS MENU. FAILURE TO NOTIFY THE IRB OF THE ABOVE MAY RESULT IN DISCIPLINARY ACTION. YOU ARE REQUIRED TO KEEP COPIES OF THE INFORMED CONSENT FORMS AND DATA FOR AT LEAST THREE YEARS.

YOU ARE REQUIRED TO NOTIFY THE IRB OF THE FOLLOWING BY SUBMITTING THE APPROPRIATE FORM (MODIFICATION, UNANTICIPATED/ADVERSE EVENT, RENEWAL, STUDY CLOSURE) THROUGH THE ONLINE CAYUSE IRB SUBMISSION SYSTEM.

1. IF YOU NEED TO MAKE ANY CHANGES/MODIFICATIONS TO YOUR PROTOCOL SUBMIT A MODIFICATION FORM AS THE IRB MUST REVIEW ALL CHANGES BEFORE IMPLEMENTING IN YOUR STUDY TO ENSURE THE DEGREE OF RISK HAS NOT CHANGED.
2. IF ANY UNANTICIPATED ADVERSE EVENTS ARE EXPERIENCED BY SUBJECTS DURING YOUR RESEARCH STUDY OR PROJECT.
3. IF YOUR STUDY HAS NOT BEEN COMPLETED SUBMIT A RENEWAL TO THE IRB.
4. IF YOU ARE NO LONGER CONDUCTING THE STUDY OR PROJECT SUBMIT A STUDY CLOSURE.

PLEASE ENSURE YOUR CITI HUMAN SUBJECTS TRAINING IS KEPT UP-TO-DATE AND CURRENT THROUGHOUT THE STUDY.

THE CSUSB IRB HAS NOT EVALUATED YOUR PROPOSAL FOR SCIENTIFIC MERIT, EXCEPT TO WEIGH THE RISK TO THE HUMAN PARTICIPANTS AND THE ASPECTS OF THE PROPOSAL RELATED TO POTENTIAL RISK AND BENEFIT. THIS APPROVAL NOTICE DOES NOT REPLACE ANY DEPARTMENTAL OR ADDITIONAL APPROVALS WHICH MAY BE REQUIRED. IF YOU HAVE ANY QUESTIONS REGARDING THE IRB DECISION, PLEASE CONTACT MICHAEL GILLESPIE, THE IRB COMPLIANCE OFFICER. MR. MICHAEL GILLESPIE CAN BE REACHED BY PHONE AT (909) 537-7588, BY FAX AT (909) 537-7028, OR BY EMAIL AT MGILLESP@CSUSB.EDU. PLEASE INCLUDE YOUR APPLICATION APPROVAL IDENTIFICATION NUMBER (LISTED AT THE TOP) IN ALL CORRESPONDENCE.

BEST OF LUCK WITH YOUR RESEARCH.

SINCERELY,

DONNA GARCIA

DONNA GARCIA, PH.D., IRB CHAIR

CSUSB INSTITUTIONAL REVIEW BOARD

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