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THE COMPETENCY AND LEVEL OF COMFORT MENTAL HEALTH PRACTITIONERS HAVE WHEN TREATING CLIENTS WITH DISORDERED EATING AS A COPING MECHANISM RESULTING FROM SEXUAL TRAUMA

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THE COMPETENCY AND LEVEL OF COMFORT MENTAL HEALTH
PRACTITIONERS HAVE WHEN TREATING CLIENTS WITH DISORDERED
EATING AS A COPING MECHANISM RESULTING FROM SEXUAL TRAUMA

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

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

by
Arianna Fuentes
Ángeles Jiménez

May 2021

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ABSTRACT

The study addressed the competency and level of comfort mental health practitioners have when treating clients with disordered eating as a coping mechanism resulting from sexual trauma. Acquiring knowledge on disordered eating as a coping mechanism to deal with the psychological stress of sexual trauma is important to the social work field because addresses underlying issues of disordered eating and introduces individuals to new coping mechanisms. This study will also be useful to clinicians in helping them evaluate current interventions to ensure that clients are receiving the best treatment possible.

For this qualitative research study, the research method that was used were interviews. The data received from the audio recordings was transcribed and studied using thematic analysis by identifying common themes. The themes created were: competency, comfort, and treatment. Based on the data it was quite evident there was a wide range of preparation held by these practitioners, with some having extensive, specific knowledge, and others having little to no specialized training. Regarding the participants' comfort level; 5 participants expressed that they are equally comfortable with treating both populations; and 2 participants mentioned that they are more comfortable with treating eating disorder clients with sexual trauma.

The interviews illustrated there is not one specific theory used to treat individuals with an eating disorder who also have a history of sexual trauma, however, trauma focused treatment is the most common modality implemented

by clinicians. The findings from the study demonstrate there is still more to be researched when treating individuals who suffer from an eating disorder and who also have a history of sexual trauma.

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CHAPTER ONE

INTRODUCTION

Problem Formulation

The Institute of Mental Health declared that an eating disorder is classified as a severe interference with a person's eating habits. Amongst other mental illnesses, anorexia nervosa has the highest mortality rate, estimated at around 10% (Insel, 2012). According to Fuemmeler and colleagues, (2009) children who experience adverse experiences are more likely to experience obesity and disordered eating. It is also found that in comparison, middle-aged women were two times more likely to be obese if they were sexually abused as children compared to individuals who were not sexually abused as children (Rohde et al., 2008). Although there are different classifications of eating disorders, the development as to why a person is diagnosed with disordered eating can be similar, such as sexual trauma. Connors and Morse (1993) state that a risk factor to developing an eating disorder is sexual abuse, according to the biopsychosocial etiological model. Thus, noting that there is a direct link between sexual trauma and disordered eating.

When studying the likelihood of developing an eating disorder, the topic of concern generally gravitates toward the individual's perception of body image and influences from Western media and the desire for thinness. However, there are conflicting studies showing the relationship that is associated with the development of an eating disorder. Polivy and Herman (2002) found that factors

such as family, negative affect, low self-esteem, body dissatisfaction, and sociocultural factors such as media and peer influences were not enough to conclude the development of eating disorders. Similar research suggests that eating disorders appear to develop due to a traumatic event or circumstance, including but not limited to sexual abuse as a child (Chen, 2018). There are significant relationships between increased odds between a child being maltreated, such as child sexual abuse, and later developing an eating disorder (Afifi et al., 2017). However, sexual trauma in later stages of life, such as in an individual's adult years, were also congruent in the development of an eating disorder (Blais et al., 2017).

The problem with only addressing disordered eating for the behaviors and patterns of food consumption or lack thereof puts the overall wellbeing of the client in jeopardy. Limiting disordered eating to the treatment of only such, disregards problems and issues that may be deeper rooted than the projecting behaviors revolving around eating disorders. There will be recurring problems if a client is only treated for an eating disorder and not the sexual trauma that may have caused the onset of eating pathology. This can result in malpractice, which is not only harmful to the client but to the clinician as well. By understanding that sexual trauma is a key factor in the development of disordered eating, the proper steps can be taken to ensure that clinicians are properly trained for handling and treating clients who possess both sexual trauma and disordered eating. To ensure that an agency is properly competent to handle dual diagnosis clients'

initiatives can be taken at the macro level, such as mandatory trainings for clinicians.

Purpose of the Study

The goal of this study was to further explore eating disorders as a coping mechanism among individuals who have experienced sexual trauma. For these individuals, their disordered eating is used as a form of emotion regulation for their past trauma. The study also hoped to gain some insight regarding the comfortability and competency level of mental health practitioners who serve individuals with eating disorders to cope with their sexual trauma. While most practitioners' assist individuals with eating disorders as the main problem, this study focused on understanding eating disorders as a solution to the underlying problem of sexual trauma. This study gained more knowledge on how these practitioners assist this vulnerable population and how they can be better served.

This study was carried out using qualitative data. The research method that best fitted this study was interviews. The interview guide was designed by the researchers since there is not much information pertaining to this area of study. Interviews were beneficial in this study because there is much that needs to be learned from current mental health practitioners such as how they treat this population and their level of competency when helping these individuals. Although interviews are very time consuming compared to other research

methods, they were the best method for collecting the data that was needed for this study.

Significance of the Project for Social Work Practice

The study is needed to better understand the competency levels of clinicians who are treating clients with eating disorders to cope with sexual trauma. This directly affected the way clinicians view and treat individuals who have both an eating disorder and sexual trauma. When the perception of an eating disorder is changed from the issue of concern to a coping mechanism, the underlying problem can then be addressed. Thus, identifying and addressing the underlying problem and developing safe and healthy coping mechanisms would be beneficial to those who are suffering from an eating disorder as a means to cope. Ergo, it is critical for mental health practitioners and counselors to acquire knowledge of treating individuals with eating disorders, but more severely, individuals who use disordered eating to cope with sexual trauma. Acquiring knowledge on disordered eating as a coping mechanism to deal with the psychological stress due to sexual trauma is important to the social work field because it will address underlying issues of disordered eating, and can introduce individuals to new coping mechanisms. It is also beneficial to mental health practitioners and counselors by providing direct knowledge on the co-existing relationship between sexual trauma and using disordered eating as a coping mechanism. The phase of generalist intervention process that was informed by

the study was the evaluation phase. The study is useful to clinicians who need to evaluate interventions that will be beneficial to clients who use eating disorders to cope with sexual trauma.

The question this current study addressed was: do mental health practitioners and counselors feel confident in their competency to treat clients who use disordered eating, such as binge eating, anorexia, or bulimia, as a coping mechanism related to sexual trauma at any stage in life?

CHAPTER TWO

LITERATURE REVIEW

This section highlights some of the prior research conducted in this field of study and some of the gaps that are most evident. The topics that will be discussed include the prevalence of disordered eating resulting as a coping mechanism to sexual trauma and disordered eating used as a coping mechanism for emotion regulation. Lastly, the two theories that guided this study will also be explained.

Prevalence of Disordered Eating Resulting as a Coping Mechanism to Sexual Trauma

The prevalence of sexual assault victims is a widespread epidemic that results in negative symptoms associated to the sexual trauma. Disordered eating occurs in all populations, regardless of age, gender, or race. A more accurate indicator of who is more vulnerable in developing an eating disorder would be the presence of sexual trauma in an individual's life. According to Collins, Fischer, Stojek, and Becker (2014) sexual trauma influences the occurrence of disordered eating. Prior research also demonstrates that the relationship between sexual trauma as a child and sexual trauma as an adult both increase the risk of developing disordered eating behavior (Holzer et al., 2008). According to Hicks White, Pratt, and Cottrill (2018) regardless of age population, (child, adolescent, or adult populations) a predictor for developing an eating disorder is experiencing

some sort of trauma. The co-existing relationship between disordered eating and sexual trauma needs to be examined more closely as the two are very intertwined and affect one another.

It is important to note that previous studies often explore disordered eating as a problem and not as a solution for an underlying problem. This can cause gaps in literature such as not exploring the behavior in its entirety. It is also noted that it is harder to study children as they are young, and most data when exploring disordered eating as a coping mechanism for individuals who experienced some sort of childhood sexual trauma are studied as adults. There are gaps when exploring the relationship between disordered eating and sexual trauma for individuals at any point in time. The problems are viewed as two separate entities rather than one. This study aimed to gain insight information provided by mental health practitioners who are able to treat individuals of all age populations. The level of comfortability and competency of mental health practitioners who treat clients who struggle with sexual trauma and disordered eating needs to be explored further. There are little to no studies that focus on mental health practitioners regarding disordered eating and sexual trauma.

Age and Gender

According to Mitchison, Hay, Slewa-Younan and Mond (2014) being the age of 45 or higher increases the prevalence of purging. Rohde and colleagues (2008) state that middle aged women are also at risk of becoming obese, due to childhood sexual trauma. However, disordered eating is becoming more

prevalent in children and preadolescent children (Pike, Dunne, & Addai, 2013). Eating disorders can develop at any age if there are previous risk factors prior to the onset of eating pathology. According to Pike, Dunne, and Addai (2013) there is a higher prevalence of disordered eating in girls than in boys. However, males are more likely to engage in extreme dieting and purging (Mitchison et al., 2014). Overall, disordered eating affects more women than men, although, there needs to be further studies exploring disordered eating due to sexual trauma in males. However, sexual assault incidents in males typically are underreported in comparison to the female counterparts.

Studies on Disordered Eating Used as a Coping Mechanism for Emotion Regulation

Often when individuals think of disordered eating, it is thought to occur to try to fulfil a certain body image that is deemed desirable. However, less studied is viewing disordered eating as a coping mechanism. Using disordered eating to cope is generally associated with some sort of trauma. By doing so, the disordered eating is said to regulate strong negative emotions. Breland (2016) found correlations between the inability to properly regulate emotions, exposure to a traumatic event, and disordered eating. Along with being at risk of developing disordered eating behaviors, when an individual has experienced some sort of traumatic event, he/she may develop obesity due to being unable to cope with stressors and negative emotions thus resorting to food to regulate emotions (D'Argenio et al., 2009). Goncalves and colleagues also found that

purging is used as an emotion regulation function in clients who are experiencing disordered eating.

Theories Guiding Conceptualization

Previous studies have explained disordered eating through Objectification Theory. Although this theory is valid, especially in a society that focuses heavily on body image, it is only one theory when the levels of disordered eating has many layers. Slater and Tiggemann (2010) explore how the theory is supported for both male and female populations in adolescent children. Fredrickson and Roberts (1997) formulated the term 'self-objectification' which is stated to be developed by an individual continually surveilling one's appearance due to self-consciousness. The theory of objectification leads individuals to experience outcomes such as negative thoughts and feelings about one's body, which then results in disordered eating. The Objectification Theory focuses on the individual and their feelings and thoughts based on the perception they view themselves in. This will result in a treatment plan that is aimed towards the self-esteem of a client and changing their perception towards themselves and society norms. However, through Trauma Theory it focuses on the individual treating disordered eating as a behavior for an underlying issue.

Hund and Espelage (2005) explore how disordered eating is used to overcome negative memories and emotions that resulted from sexual trauma. When viewing disordered eating through the lens of disordered eating being a solution and coping mechanism rather than a problem it changes the overall

treatment that is appropriate for the client. Having the knowledge of Trauma Theory and how it relates and results in disordered eating can be utilized for prevention programs and being able to identify early symptoms. Being able to limit the use of disordered eating as a coping mechanism and introducing healthy new coping mechanism can help save many individuals who suffer from disordered eating, which is a rising epidemic. Using Trauma Theory to explore disordered eating patterns and symptoms can limit and prevent disordered eating to developing as a classified eating disorder. This study aims to address mental health practitioners and their ability to identify symptoms of eating disorders and their level of competency and comfortability when treating individuals with disordered eating. By exploring disordered eating from a different theory approach, it can increase the knowledge on how to appropriately address disordered eating to better help serve this vulnerable population.

Summary

Eating disorders have been studied but not many studies have been carried out regarding eating disorders in relation to sexual trauma. It is evident that eating disorders need to be treated along with sexual trauma instead of being treated as an isolated problem. Mental health practitioners need to be equipped with the right education and training so that they fully understand and are comfortable enough to treat these niche population of clients with coping mechanisms such as eating disorders. In conclusion, this study aimed towards

highlighting the importance of eating disorders used as a coping mechanism among individuals with sexual trauma and how practitioners currently assist these individuals and what can be done to ensure that the most appropriate treatment is administered.

CHAPTER THREE

METHODS

This chapter will discuss the methods used to carry out this study. The sections that will be explained in detail include study design, sampling, data collection and instruments, procedures, protection of human subjects and data analysis.

Study Design

The purpose of this study was to explore the comfortability and competency level of mental health practitioners who serve individuals with eating disorders to cope with their sexual trauma. There is not much previous research pertaining to this specific niche of individuals; therefore, this study aimed to further explore how these clinicians currently treat this population. Since this was a qualitative research study, the research method that was used were online interviews. Interviewees were asked a series of open-ended questions in order to understand their level of comfort and competency when helping clients that have eating disorders to cope with sexual trauma.

Using online interviews to collect data resulted in some strengths and limitations. One strength was that the interviewer was able to gather a lot of information and details by asking multiple open-ended questions as opposed to administering a survey. Another strength was that the interviewer was able to take notes of the valuable non-verbal behavior of the interviewee. While

interviews have their strengths there were some limitations as well. Some limitations of using interviews were that they were very time consuming, such as conducting the interview and analyzing the data afterward. One other limitation was accessibility of the number of interviewees because interviews require that both participant and researcher coordinate and schedule a suitable time for both to meet.

Sampling

The participants of this study were mental health clinicians and students who treat individuals with eating disorders as a coping mechanism for sexual trauma and or individuals who only have an eating disorder. The goal was to find about 6-12 of these clinicians who were willing to be interviewed. At about half way through the interviews the recordings were reviewed and based on the amount of data that was collected from the clinicians as well as the quality it was determined that more data was still needed to answer the research question, therefore the interviews were continued. The final sample size of the study resulted in 10 clinicians.

Data Collection and Instruments

The qualitative data was collected via an online meeting platform called Zoom. This study further explained how mental health practitioners treat clients who have an eating disorder to cope with sexual trauma. In order to assess the

comfortability and competency the mental health practitioners were asked a series of questions to determine the differences in treating clients who have an eating disorder and clients who used disordered eating to cope with sexual trauma. Questions this study addressed were topics pertaining to the comfortability and competency of mental health practitioners when treating individuals with an eating disorder and a history of sexual trauma. Information such as the level of comfortability practitioners feel when they treat both populations plays into account to determine the treatment of the different aspects of an eating disorder. The prevalence of individuals with an eating disorder who have a history of sexual trauma compared to individuals who solely have an eating disorder can also play a distinct role on how comfortable a practitioner may feel when providing services. Noticing patterns in symptoms of the populations is also important for the treatment of the client. Patterns in symptoms can lead to using certain treatment methods and theories. Monitoring the progression of both populations can also differ between the populations. The interview guide is found in Appendix A.

The study was used to identify patterns between the similarities and differences in treating populations who have an eating disorder with a history of sexual trauma. The strengths from doing a qualitative study allowed each practitioner to explain in their own words the levels of comfortability and feeling of competence between a client who has an eating disorder compared to a client who uses disordered eating to cope with sexual trauma. However, the limitations

to interviewing mental health practitioners was that some practitioners may not have admitted to not feeling competent when treating a certain population. Which may have skewed the level of honesty when answering certain questions.

Procedures

Mental health practitioners were solicited via social media platforms, including LinkedIn, Reddit, and Facebook. Posts were made on these platforms seeking professionals who work with clients who have eating disorders as well as patients with an eating disorder and sexual trauma. This was voluntary and at the discretion of the practitioner. Once mental health practitioners were read the informed consent and agreed to participating in the study, they were asked a series of questions. Interviews were conducted online and audio recorded. Data was collected by Master of Social Work graduate students, Angeles Jimenez and Arianna Fuentes. Data collection was collected throughout Spring and Fall 2020.

Protection of Human Subjects

Confidentiality and anonymity of practitioners participating in the research surveys was protected by collecting de-identified data. Meaning, no identifiable information of the mental health practitioners or their clients was used throughout the study. Through interacting online with practitioners, their privacy was protected through direct emailing via a university encrypted email so the dialogue between the researcher and the participant was kept secure. All participants

were read a consent form and provided verbal consent before partaking in the interview. The consent included confidentiality and anonymity agreements meaning that the participants agreed that researchers use the information provided by the participants in the study. However, stating to the agreement that participants personal information, such as identifiable information remain confidential and anonymous so that it remained private.

The data collected was stored and protected in a personal computer that was password protected. Initial communication was via encrypted university email address. Upon interviewing, the data collected was non-identifiable information and interviewees were identified through numbering such as interviewee one, interviewee two, and so forth. The data collected was anonymous data. Audio recordings were gathered via Zoom. The digital recording was then transcribed and saved into a password protected computer and saved into a document file that was only attainable through password. After the data was transcribed, the audio file was deleted. The document of the downloaded transcribed data was also erased from the computer once it was no longer needed. Along with the consent form, there were debriefing statements for practitioners that disclosed the nature of the study and who to contact if they had questions regarding the study. The debriefing statement also informed participants that there was no deception involved in the study. The informed consent form also stated the age requirement in order to participate in the study,

description and purpose of the study, participation guidelines, duration, and risks and benefits of the study. This form can be viewed through Appendix B.

Data Analysis

Once all the interviews were completed, the data received from the Zoom audio recordings were transcribed. The participants recordings were labeled by number for anonymity and organization. After all the data was in written form it was studied using thematic analysis by identifying common themes. Some themes that emerged included: the type of treatment that is used for clients with an eating disorder as a coping mechanism for sexual trauma; the type of treatment used for clients with an eating disorder as the main problem; how well equipped and prepared mental health practitioners feel when treating an individual with an eating disorder; and lastly, the level of comfort mental health practitioners have when treating clients with an eating disorder.

Other variables that were used for descriptive analysis included the participants' age, ethnicity, sex, income level, education level, and years of experience in the field.

Summary

This study further explored the level of competency and comfortability of mental health practitioners who are treating clients who have both an eating disorder as well as sexual trauma. This study furthered the knowledge of the

different theories and treatments used to help treat individuals who have experienced sexual trauma who also have an eating disorder. This study highlighted the differences in treating individuals who possess both sexual trauma and an eating disorder compared to treating individuals who have one or the other. This study also highlighted the differences in treatment for the niche population by implementing qualitative research methods.

CHAPTER FOUR

RESULTS

Introduction

This study used the content comparative approach to analyze the data and develop themes. Qualitative data from 10 participant interviews was collected. The interview guide was designed to learn about the competency, comfort, and differences in treatment of mental health practitioners when treating individuals with an eating disorder who also have a history of sexual trauma, compared to treating individuals with solely an eating disorder. The interviews consisted of 6 demographic questions and 7 open ended questions. The themes developed included: competency, comfort, and treatment. The categories within each theme included trainings, areas of study, integrative approach, and safety first.

Presentation of the Findings

Demographics

The sample consisted of mental health practitioners who have experience in treating clients with eating disorders only and clients with an eating disorder and a history of sexual trauma. There was a total of (10) participants. (3) of the participants were male and the remaining (7) were female. Regarding ethnicity (3) reported as Hispanic and (7) reported as White. The age ranges consisted of (3) being between the ages of 25-29 years; (5) participants within the age range

of 34-38 years; and (2) between 48-55 years. The annual income levels also had a wide range. (2) participants fell into the bracket of \$0 to \$25,000 a year. (6) participants belonged to the bracket of \$55,000 to \$65,000 and (2) were in the upper tier of \$85,000 to \$100,000. Pertaining to the participants education levels, all but two participants had a master's degree and the two who did not, had a bachelor's degree and an ongoing master's degree. Of the (8) who had a master's degree, (1) also has a doctorate and (1) had an LCSW. Lastly, the years of experience that these participants had in the area of eating disorders ranged from 2.5 years to 20 plus years.

Qualitative Interview Data

After the participants answered the 6 demographic questions, they were asked 7 open-ended questions. The open-ended questions asked about the participants' comfort levels, how often they treat the two populations, the differing symptoms of the two populations, the theories they use, how they monitor progress, any specialized trainings they received, and prior areas of study. The duration of the interviews conducted ranged from 8 minutes to 33 minutes. The themes created were: competency, comfort, and treatment.

Competency

One element of this study was to explore the participants competency in treating individuals with only eating disorders and individuals with eating disorders and sexual trauma. In order to determine their competency level,

participants were asked about the trainings they had received to treat these two populations as well as previous areas of study.

Trainings

During the interviews participants were asked to share if they received any specialized training to treat these two populations. 3 of the participants mentioned that they received a few different trainings in order to prepare themselves to treat these two populations. Of these 3, 1 received training in Cognitive Processing Therapy, EMDR, DBT for eating disorders, eating disorders and OCD, psychiatric first aid, grounding skills, and food philosophy. Of these 3, 1 received training in DBT for eating disorders, Internal Family Systems Therapy, and Carolyn Costin's *The Eight Keys to Eating Disorder Recovery*. Lastly, 1 participant received training in DBT and Family Based Therapy. 2 participants stated that they only had training in Family Based Therapy. 1 participant reported receiving "continuing education in eating disorders and trauma." 2 participants stated that they did not have specialized training: 1 only had a two-week job training, shadowing, and learning from coworkers; and the other one only had generic mental health training. Lastly, one participant reported receiving no specialized training. Based on the trainings that some received it is quite evident there is a wide range of preparation held by these practitioners, with some having extensive, specific knowledge, and others having little to no specialized training.

Areas of Study

All the participants were also asked to discuss their area(s) of study. The participants all had a wide range of areas that they studied, received formal education in, gained experience in, and specialized in. One participant studied clinical psychology and sports psychology. Two participants were MSW candidates: one was working towards receiving Pupil Personnel Services Credentials (PPSC); and the other specializing in clinical work and trauma. One participant mentioned a Master in Counseling Psychology and another mentioned studying community education, further education, and teacher training. Two were regarding the transgender community: one shared that they studied special circumstances with the transgender community; and another had expertise in domestic violence, intimate partner violence, studies with victims of sex trafficking, and eating disorders and sexual abuse in the teen transgender community. Another participant reported studying dance movement therapy, mental health counseling, talk therapy, creative arts therapy, and worked with previously incarcerated woman, patients in the psychiatric hospital, and survivors of human trafficking. Lastly, one participant studied mental health with a focus on borderline personality disorder. It is evident that most of the participants worked with more challenging populations that dealt with some form of trauma or another.

Comfort

Another aspect of this research study dealt with the comfort level of practitioners. The aim was to determine if there is a difference in comfort level when treating eating disorder only clients versus clients with eating disorder and sexual trauma. 5 participants expressed that they are equally comfortable with treating both populations. 2 participants mentioned that they are more comfortable with treating eating disorder clients with sexual trauma. 1 participant stated that their comfort level was very similar but slightly less comfortable with clients with an eating disorder and sexual trauma. Lastly, two of the participants did not answer the question.

The 2 participants that expressed being more comfortable with treating eating disorder clients with sexual trauma had similar reasons. One participant's rationale was "In some regard I sort of prefer working with sexual trauma just because early childhood trauma is like a specialty for me" (Participant B, September 2020). It is clear that because it is the participant's specialty, they feel more confident in treating this client and therefore, more comfortable. The other participant's reasoning was that they had more experience with sexual abuse than eating disorders. The participant also mentioned that "it's a lot harder to identify eating disorders" and they "are more complicated" (Participant E, January 2021). Evidently, this participant's comfort level stems from having more experience in one area versus another. Here the comfort level is also connected

to the area of expertise and the competency with treating eating disorder clients who also have sexual trauma.

Treatment

As stated above only 3 participants reported that they had a variety of trainings regarding eating disorders and sexual trauma, however, when asked about treatment, all 10 participants used more than one theory and method to treat their clients. And despite receiving a variety of trainings and using different therapies all participants unanimously agreed on treating any severe eating disorder symptoms first.

Integrative Approach

When participants were asked what sort of theories and methods, they use to treat eating disorder clients and eating disorder clients with sexual abuse, 100% of the participants mentioned that they use two or more theories and or methods. It was evident that they all use an integrative approach. 50% of participants use DBT along with other methods to treat eating disorder clients. 50% stated that they also use CBT along with other methods to treat eating disorders. 30% use FBT to treat clients and 20% said they use Motivational Interviewing along with other methods. The three least common therapies were Narrative Therapy, Internal Family Systems Therapy, and Acceptance Commitment Therapy, only 3 participants used one or the other. Other methods used to treat eating disorder clients included mindfulness, relational approaches,

harm reduction model, meal support, dance movement therapy, talk therapy, person-centered approach, exposure response prevention, relapse prevention, and distress tolerance.

Regarding the treatment for eating disorder clients with sexual abuse history, all participants claimed using more than one theory and method as well. 50% of the participants use DBT along with other methods. 40% reported using CBT in combination with other theories and methods. TFCBT was used by 20% of the participants. FBT was also utilized by 20% of the participants. 20% also used EMDR. The two least common therapies were Narrative and Cognitive Processing Therapy. Along with these therapies other methods used included trauma processing, trauma informed care, somatic experiencing, and support groups. It is evident that the best treatment is created by using an integrative approach. Also, the most common treatments for both populations included CBT and DBT.

Safety First

When analyzing the data, it was clear that all participants agreed that the severe eating disorder symptoms had to be treated first. Behaviors such as “purging, no eating at all, suicidal ideation, self-harm, cutting,” etc. (Participant H, February 2021). should be addressed first. 70% of the participants shared that it was important first to have the client become medically stable and safe. Safety is always a priority because severe “eating disorder behaviors can easily kill a client” (Participant E, January 2021). Next, 60% of the participants claimed that

after becoming medically stable the client then had to become “mentally strong enough” before moving on to trauma processing or other issue areas (Participant B, September 2020). The participants stated that often times a client is so undernourished that they cannot even process or retain new information (Participant A, September 2020). Therefore, it is important that the client is fed enough so that they are mentally capable of delving into the deeper issues of their disorder.

Summary

This chapter discussed the data that was collected from all the interviews. First, some demographic information regarding the participants was given. Then the open-ended interview questions were discussed. Lastly, the themes that were created were explored and shared to demonstrate the comfort level of practitioners’, their competency in this specific field, and how treatment compares between eating disorders clients and eating disorder clients with sexual trauma.

CHAPTER FIVE

DISCUSSION

Introduction

This chapter discusses the findings and major themes extracted from the interview study. The findings reveal the patterns as it relates to mental health clinicians and the treatment method and modalities when treating individuals with an eating disorder/ disordered eating who also have a history of sexual trauma. This chapter briefly discusses the different limitations of the study as well as the possible influences on the findings. Lastly, the chapter will also introduce recommendations as it relates to social work practice, as well as areas that need to be further explored for the treatment of the niche population.

Discussion

Trauma Theory

To further understand the niche population of individuals who suffer from both an eating disorder and sexual trauma, the Trauma theory was used throughout the study to conceptualize the treatment modalities used by different mental health practitioners. Throughout the study multiple practitioners stated that the disordered eating could have stemmed as a result of the sexual trauma, therefore learning to implement healthy coping mechanisms in lieu of the maladaptive coping mechanism is an important part of the treatment process.

One clinician stated, “I see a lot of those clients developing eating disorders as a coping strategy later in life” (Participant H, February 2021). Another clinician also stated,

When there's sexual trauma, there's usually that feeling of not being safe in their bodies. Not being able to control what happened to their bodies. So, an eating disorder can kind of give that false sense of control. And so, I would say it's pretty difficult for people who have had sexual trauma to relinquish some of those behaviors, because it feels like that's the thing that's keeping them safe. That's the adaptive coping mechanism that they're using to feel safe in their body. (Participant I, February 2021)

Treating eating disorders from a perspective of the disordered eating being a result of trauma and used as a coping mechanism is important to note for the different treatment methods and approaches. Although disordered eating is used as a coping mechanism there was a common theme amongst the study: that is safety is the first concern when treating individuals with an eating disorder. In order for the clinicians to tend to the trauma, the client needs to be safe above all else. Because of the severity and how detrimental eating disorders can be, clinicians will tend to the client's safety first, whether it be suicidal ideation, malnourishment, starvation, underweight or overweight etc., before addressing the trauma. Clinicians also stated that an appropriate coping mechanism needs to be replaced with the disordered eating behavior before tackling the trauma history.

It is important to note that although there was not one exclusive specialized theory that clinicians were trained on, multiple clinicians stated that they use similar methods and theories that are trauma focused, such as trauma focused DBT, EMDR, and trauma focused CBT.

Limitations

There are multiple limitations to be noted throughout the study. First, there was a sample size of 10. Although there were significant themes as it relates to client safety, there needs to be further research to form more significant patterns as it relates to treatment methods and theories. The sampling of the study was done via online platforms which limits the participants to clinicians who are fluent and active on online platforms.

Another limitation is that due to soft sciences being unique from person to person there is no one set way that clinicians treat clients with an eating disorder and sexual trauma. Therefore, clinicians stated that depending on the client there will be different treatment methods based on the individual's needs.

Recommendations

Specialized Trainings

Individuals who suffer from both an eating disorder as well as sexual trauma will benefit from treatment more if clinicians are well equipped with proper training for the niche population. If clinicians are solely treating the eating

disorder, without also treating the sexual trauma the root cause of the maladaptive coping mechanism will not be addressed. Therefore, the client is not fully benefiting from treatment. Clinicians as well as clients will have a higher chance of successfully completing treatment if clinicians are knowledgeable of both treating eating disorders but also have knowledge on how trauma, sexual trauma, play a role in the disordered eating behaviors. It is important for clinicians to practice within their scope; thus, clinicians need to continue to learn about how sexual trauma affects disordered eating in order to better serve the niche population.

Recommendations for Research

An area that would benefit from further research would be to ask a larger sample size. Although there are some slight patterns throughout the study, having a larger population can help form more definitive patterns for methods and theories. Another recommendation would be to interview clinicians who solely treat eating disorders. Interviewing clinicians who solely treat eating disorders can help form more definitive patterns between the two populations.

Conclusions

This study explored the different treatment modalities, theories, and symptoms for populations who suffer from an eating disorder and have a history of sexual trauma, as well as exploring the different specialized training for treating the niche population. Ten clinicians provided information through

interviews about their personal methods used to treat the niche population. Clinicians noted the different symptoms and which are treated first, the level of comfortability treating both populations, specialized training as it relates to eating disorders, as well as the theories and methods used. Through the interviews it was found that there is not one specific theory used to treat individuals with an eating disorder who also have a history of sexual trauma, however, it is common that the safety procedures are precedent above all other symptoms and treatment methods. Trauma focused methods is the most common modality implemented by clinicians.

The findings from the study make it apparent that there is still more to be researched when treating individuals who suffer from an eating disorder and who also have a history of sexual trauma. There needs to be further research about effective theories and methods to implement when treating the niche population. Further exploring the topic will make clinicians more equipped to successfully treat the fatal disorder as well as the underlying cause for the maladaptive coping mechanism.

APPENDIX A
INTERVIEW GUIDE

INTERVIEW GUIDE

1. How comfortable are you when you treat clients with an eating disorder compared to treating clients with an eating disorder and sexual trauma?
2. How often do you treat individuals who have an eating disorder and a history of sexual trauma? How often do you treat individuals who only have an eating disorder and no history of sexual trauma?
3. How do the symptoms differ when treating clients who use disordered eating as a coping mechanism compared to clients with no history of sexual trauma? What symptoms do you treat first for both populations?
4. What methods and theories do you use when treating clients with an eating disorder compared to the methods and theories used when treating a client with an eating disorder and a history of sexual trauma?
5. How do you monitor progress in treatment for both populations?
6. Do you have any specialized training for treating eating disorders? If so, what trainings did you receive?
7. What is your level of education? And what areas did you study?

Developed by Arianna Fuentes

APPENDIX B
INFORMED CONSENT FORM

INFORMED CONSENT

The study in which you are asked to participate is designed to explore the competency and different treatments when providing therapy for individuals with an eating disorder, compared to treating individuals who are solely being treated for an eating disorder. The study is being conducted by Arianna Fuentes and Angeles Jimenez, both Master of Social Work students working under the supervision of Dr. Carolyn McAllister, Associate Professor and Director of CSUSB School of Social Work. This study has been approved by the Institutional Review Board Social Work Sub-Committee, California State University, San Bernardino.

PURPOSE: The purpose of the study is to explore the competency and differences in treatment when treating individuals with an eating disorder who also has a history of sexual trauma, compared to treating individuals with solely an eating disorder.

DESCRIPTION: Participants will be asked several questions regarding the level of comfortability in treating clients with both an eating disorder and sexual trauma, the frequency of treating the niche population, the methods used for treating clients with an eating disorder and sexual trauma compared to treating clients with only an eating disorder, how long individuals have been working with the populations, specialized training pertaining to sexual trauma and eating disorder, as well as demographic information.

PARTICIPATION: The participation in the study is voluntary. Any individual may refuse to participate in the study or to discontinue participation at any time without any consequences.

ANONYMITY: Your responses will remain anonymous and data will be transcribed and stored through a password encrypted university drive.

DURATION: It will take 30 minutes to 1 hour.

RISKS: There are no foreseeable risks to the participants. However, if questions arise that create discomfort, you may choose to not answer and can skip the question or end your participation.

BENEFITS: There will not be any direct benefits to the participants during the study. However, findings from the study will contribute to the knowledge of mental health practitioners and the field.

CONTACT: If you have any questions about this study, please feel free to contact Dr. Carolyn McAllister at (909) 537-5559 or through email at cmcallis@csusb.edu

RESULTS: Results of the study can be obtained from the Pfau Library ScholarWorks (<http://scholarworks.lib.csusb.edu>) at California State University, San Bernardino after July 2021.

I agree to have this interview be audio recorded: _____ YES _____ NO

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

Place an X mark here

Date

APPENDIX C
DEBRIEFING STATEMENT

DEBRIEFING STATEMENT

This study is to explore the competency of mental health practitioners when treating clients with an eating disorder who have also experienced sexual trauma. The differences in treatment for individuals with an eating disorder and sexual trauma compared to individuals with only an eating disorder is further explored. We are interested in the different methods used to approach the niche population. This is to inform you that no deception is involved in this study.

If you have any questions about this study, please feel free to contact Dr. Carolyn McAllister at (909) 537-5559 or through email at cmcallis@csusb.edu.

Results of the study can be obtained from the Pfau Library ScholarWorks (<http://scholarworks.lib.csusb.edu>) at California State University, San Bernardino after December 2020.

APPENDIX D
IRB APPROVAL LETTER

April 29, 2020

CSUSB INSTITUTIONAL REVIEW BOARD

Expedited Review

IRB-FY2020-253

Status: Approved

Angeles Jimenez, Carolyn McAllister, Arianna Fuentes

CSBS - Social Work

California State University, San Bernardino

5500 University Parkway

[San Bernardino, California 92407](#)

Dear Angeles Jimenez, Carolyn McAllister, Arianna Fuentes:

Your application to use human participants, titled “The Competency and Level of Comfort Mental Health Practitioners Have When Treating Clients with Disordered Eating as a Coping Mechanism Resulting from Sexual Trauma ” 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. You are required to keep copies of the informed consent forms and data for at least three years.

The study is approved from April 28, 2020 through --.

Your IRB application must be renewed annually and you will receive notification from the Cayuse IRB automated notification system when your study is due for renewal. If your study is closed to enrollment, the data has been de-identified, and you're only analyzing the data - you may close the study by submitting the Closure Application Form through the Cayuse IRB system.

You are required to notify the IRB of the following as mandated by the Office of Human Research Protections (OHRP) federal regulations 45 CFR 46 and CSUSB IRB policy. The forms (modification, renewal, unanticipated/adverse event, study closure) are located in the Cayuse IRB System with instructions provided on the IRB Applications, Forms, and Submission Webpage. Failure to notify the IRB of the following requirements may result in disciplinary action.

- Ensure your CITI Human Subjects Training is kept up-to-date and current throughout the study.
- Submit a protocol modification (change) if any changes (no matter how minor) are proposed in your study for review and approval by the IRB before being implementing in your study.
- Notify the IRB within 5 days of any unanticipated or adverse events experienced by subjects during your research.
- Submit a study closure through the Cayuse IRB submission system once your study has ended.
- Keep your CITI Human Subjects Training up-to-date and current throughout the study.

The CSUSB IRB has not evaluated your proposal for scientific merit, except to weigh the risks and benefits to the human participants in your IRB application. 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 number IRB-FY2020-253 in all correspondence. Any complaints you receive regarding your research from participants or others should be directed to Mr. Gillespie.

Best of luck with your research.

Sincerely,
Donna Garcia

Donna Garcia, Ph.D., IRB Chair
CSUSB Institutional Review Board

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ASSIGNED RESPONSIBILITIES PAGE

Both partners divided up the work that was needed to complete the IRB Human Subjects Application. Each partner helped in recruiting participants by posting on their LinkedIn, Reddit, and Facebook accounts. For the interviews each partner interviewed half of the participants or 5 each. After the interviews were completed, each partner transcribed exactly half of the participants' audio recordings. Lastly, the data analysis section was conducted together; the results and findings were completed by Angeles; and the discussion section was completed by Arianna.