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Clinician perceptions of eating disorders and treatment practices

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CLINICIAN PERCEPTIONS OF EATING DISORDERS AND TREATMENT PRACTICES

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

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by

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ABSTRACT

This study explored clinicians' perceptions of treatment practices that produce long-term recovery maintenance from eating disorders. The interview participants consisted of ten clinicians (MFTs and LCSWs) who facilitate treatment with eating disorder clients. Ten face-to-face interviews were conducted in which participants were asked about their perceptions on those treatment practices, which produce long-term recovery from an eating disorder. Following the interviews, a qualitative analysis was conducted. The results revealed that a clinician's expertise using an eclectic approach to treatment, clinician-client alliance, mindfulness practices, and follow-up aftercare were important factors to long-term recovery from an eating disorder.

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DEDICATION

I dedicate this project to my loving family who have supported and encouraged me as I pursued my educational goals. Also I dedicate this with much love and appreciation to my caring friends who gave me strength and rallied around me to completion. All of you have guided my personal development and influenced my ability to serve others.

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CHAPTER ONE

INTRODUCTION

Problem Statement

As generally recognized, eating disorders (ED) place a significant burden on our healthcare system, profoundly harm productivity, and cause mental and emotional distress in sufferers, their families, and their communities. "According to the American Dietetic Association, more than five million Americans experience eating disorders" (Kanpp, 2009, Introduction, ¶ 1). During the 1950s or early 1960s, three types of eating disorders began to proliferate over the following decades. These major eating disorder subtypes are anorexia nervosa (AN), bulimia nervosa (BN), and binge-eating disorder (BED). More important is that the effects of an eating disorder are at the least problematic and at the worst, fatal. Additional studies indicate EDs are widespread, and have been increasing on through to the present (Barlow & Durand, 2005). More troubling is the data that show eating disorders have a higher mortality rate, especially with anorexia, than any other psychological disorder even depression. More than

ninety percent of severe cases are in young females and narrowed to this smaller portion of the population, namely those living in socioeconomically upper class families in competitive environments (Barlow & Durand, 2005).

According to the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision (DSM-IV-TR) the two main criteria for anorexia nervosa are a refusal to maintain body weight at or above a minimally normal weight for age and height coupled with the intense fear of gaining weight or becoming fat, even though underweight. The main criteria for a diagnosis of bulimia nervosa are recurrent episodes of binge eating, that is foods eaten in a discrete period of time while experiencing a sense they lack control over this behavior during the episode. This behavior would then be followed with recurrent inappropriate compensatory behavior in order to prevent weight gain, which includes self-induced vomiting, misuse of laxatives, diuretics or other medications, fasting, or excessive exercise. A third type of ED is labeled binge-eating disorder (BED), though considered merely a potential disorder, it's symptoms include experiencing distress due to binge eating without

engaging in the extreme compensatory behaviors seen with bulimia (American Psychiatric Association, 2000).

Unquestionably, because eating disorders often have severe consequences they are of great concern to the individual sufferers, their families, and friends. According to the National Eating Disorders Association [NEDA] (2006), eating disorders (as many as 10 million) are more common than Alzheimer's' disease (4 million). Despite that, the research funding is inadequate for eating disorders. Moreover, anorexia nervosa is more expensive to treat ($6,054) than schizophrenia ($4,824), yet insurance coverage for treatment is exceedingly insufficient (NEDA, 2006). Additionally, employers are concerned as well due to the loss in productivity and missed days, which result from employees with ED, many not diagnosed. Although the medical community often pigeonholes patients with ED, they also have concerns due to the load this presents on healthcare and probably on the disability system as well. This problem concerns mental health professionals as social workers and marriage/family therapists who are obliged to do what they can to help individuals who suffer from ED, often without the necessary resources. Clinicians' (i.e.,

social workers and marriage/family therapists) experiences with treating EDs include the use of psychotherapy with individuals and groups and with family therapy as well (Kanpp, 2009).

Although obvious from the literature the subject of eating disorders has been heavily researched, what has not been explored is from the viewpoint of clinicians in the field on how the theories and models have been used to facilitate recovery from this destructive disorder. It follows then that obtaining the observation and viewpoints of clinicians who have the most first-hand knowledge of the processes these clients journey through to attain recovery is important. A study by Mond, Hay, Rodgers, and Owen, (2009) found that eating disorders and overweight injure the physical and psychosocial health of women, which in turn puts extra burden on healthcare systems. Furthermore, as reported in a summary of published reports suicide attempts occur in "approximately 3-20% of patients with anorexia nervosa and in 25-35% of patients with bulimia nervosa" (Franko & Keel, 2006, p. 769). Since quality treatment of EDs is so crucial, some studies have said there is a need to evaluate practices to insure patient's needs are being

met. Thus, a study conducted to gather therapist and patient outlooks on the quality of treatment found the need to converge the evidence-based knowledge, clinical practice, and patient's views in order to find the best treatment (de la Rie, Noordenbos, Donker, & van Furth, 2008). According to Jansen (2001), there is a need for better treatment practices especially for anorexia nervosa. For instance, there is pressure for evidence-based practice models to be used in mental health settings by insurance payers along with the need to understand better what conditions precede an eating disorder diagnosis.

Lastly, this problem concerns the social work academics who are researchers interested in addiction behavior and healthcare studies who also train future professional social workers as well. Certainly obtaining clinician perceptions on the treatment practices they utilize to help ED clients to recover is useful because funding for mental health issues appears to be in short supply.

Purpose of the Study

The purpose of this study was to examine the experiences, conclusions, and ideas of clinicians who facilitate recovery with patients who are in treatment for an eating disorder. These EDs included anorexia nervosa (AN), bulimia nervosa (BN), and binge-eating disorder (BED). These clinicians have five or more years experience in the field of eating disorders working directly with clients in treatment facilities. Because this study wished to interpret the experience of clinicians, which is subjective in nature, qualitative research was used by way of interviews with these professionals. This type of research is excellent because experience was defined by the "participants' interpretation of their own realities" (Grinnell & Unrau, 2008, p. 84). Interviews were conducted asking participants about their experiences with treatment modalities they used with eating disorder clients. Although eating disorders are diagnosed using defined behaviors, the way in which they impair the client differs by their individual personalities. It is also important to understand that since there are many different treatment models and methods used to assist

clients to find recovery, the ideal way to measure progress was to use subjective measures such as interviews.

One principal justification to understand more about eating disorders is for prevention purposes. Especially because these destructive behaviors often begin at a young age when they could be prevented or modified. Therefore, any research that facilitates the amelioration of EDs would be very valuable. Moreover, finding solutions that arrest the damaging effects these disorders produce benefits society as a whole (Fairburn, 1995). Therefore, seeking out the professionals in the field of treatment for EDs has shed light on which treatment model(s) or combination of treatments is the most effective. Essentially, if there is a chance to obtain additional resources, more research on shorter treatment models is required. Obviously if we are to implore the government or the health insurance industry to understand the bigger picture and provide coverage we need solutions with the best effectiveness.

Qualitative research methods are used when studying complex human behaviors as these are not so easily interpreted especially to understand social phenomenon.

With eating disorders, their etiology and responses to treatment options there will be a multitude of perspectives. "Social scientists often look subjectively for pattern in the complex phenomena they observe" (Leedy & Ormrod, 2005, p. 134).

This research project was best served by a qualitative research design, using interviews, which were conducted with ten eating disorder treatment clinicians who have had five years experience or more in the eating disorder treatment field. Clinicians were asked about their perception of recovery achievement and the maintenance in relief of symptoms for their clients. In the interview, they were asked a series of questions, which included their opinions and observations concerning the effectiveness of the treatment practices they have utilized, what changes, if any, they would make in services, and their thoughts on the importance of therapist and client alliance. Additionally, ideas or concepts for aftercare programs were collected from the clinicians for possible future research plans.

Significance of the Project for Social Work

Customarily, good research has the propensity to improve social work practice. To be effective, the manner in which social workers interact with ED clients is vitally important. For that reason, they need the best education and up to date information available on these disorders. Still much needs improvement in the edification of professionals who encounter clients suffering with an eating disorder. Regularly repercussions of these disorders effect the family environment, especially in abuse cases because persons with an eating disorder will often have problems with rage. Whereas substance abuse issues are often more obvious to social workers, EDs equally render a person altered producing a range of dysfunctional characteristics, which often requires an intervention as well.

Moreover, social workers are often employed in places such as schools where they encounter those at risk of developing an eating disorder therefore in a position to intervene if needed. Gathering information from clinicians who are working in treatment facilities is especially useful. The knowledge gained concerning

indicators and vulnerabilities to eating disorders will help those in the field recognize the symptoms and precursors. This is important information for social work practice when early preventive measures are needed when working with vulnerable populations. Therefore, this study will inform the assessment, implementation, and evaluation phases of the generalist intervention process. Furthermore, this study will contribute to social work policy by furthering knowledge on the effectiveness of treatment practices in order to advocate for more services to individuals who are in dire need of this care.

For the above reasons, additional research is needed in the area of eating disorders, both in their etiology, and in the treatments currently available. Therefore, this research project proposed to interview clinical facilitators to determine several things. One was their ideas about how eating disorders develop and if any commonalities exist in patients. Another is what effect treatment practices had with eating disordered inpatients, on their recovery and maintenance of relief in core symptoms (i.e. destructive eating behaviors) after they have completed the program.

CHAPTER TWO

LITERATURE REVIEW

Introduction

The following chapter will provide literature, which is relevant to eating disorders. Therein is an overview on eating disorders and the etiology of symptoms and behaviors. Also included is a sample of the related literature on current options for treatment of the three main categories of the eating disorders, anorexia nervosa, bulimia nervosa, and binge eating disorder.

Eating Disorder Treatment Interventions

In an overview of the psychological treatments for eating disorders, Wilson, Grilo, and Vitousek (2007) reviewed current conceptual and clinical innovations designed to improve on existing therapeutic efficacy. Here available evidence-based research on the efficacy of psychological treatments currently utilized with eating disorders is evaluated with the aim of discovering possible ways their application and effectiveness in practice might be improved. Thus far, the evidence-based research that has produced the best results has been done with cognitive-behavioral therapy (CBT). Thus, it is the

standard practice of treatment for all eating disorders. Unfortunately, research and treatment evidence on anorexia nervosa is negligible especially for comparative trails completed and published. Still, the severity of the condition warrants additional attempts to offer hope to those suffering along with their loved ones. Fortunately, there is one heavily studied research, the Maudsley model, which is a specific form of family therapy that showed very successful results with adolescent patients with anorexia nervosa.

On the other hand, the authors found much more evidence-based treatment research on bulimia nervosa and binge-eating disorder where more recovery success is evident. Studies on guided and self-help treatment for binge-eating disorder, found a fifty percent remission rate with self-help guided by CBT as well. These treatment results were found significantly superior to self-help behavioral weight loss treatment and to a second control condition. To sum up, this team asserts that finding better treatments for eating disorders "will depend on improved understanding of the mechanisms whereby psychological treatments produce therapeutic change and the identification of robust moderators of

outcome" (Wilson et al., 2007, p. 205). The necessity of this discovery, they posit, is the only way "to match specific interventions to particular patients on a scientific basis" (Wilson et al., 2007, p. 205). In this review, they evaluated three treatment options as possibilities for developing more effective treatments than CBT alone. For example, they suggest research on 1) combining CBT with antidepressant medication, 2) integrating CBT with other psychological therapies, and 3) enhancing manual-based CBT (Wilson et al., 2007).

In general, poor motivation is high in persons who suffer from eating disorders. Therefore, Casanovas, Fernandez-Aranda, Granero, Krug, Jimenez-Murcia, Bulik, et al. (2007) conducted a study to ascertain what the clinical impact of motivational stage of change has on the psychopathology and symptomatology of patients diagnosed with eating disorders. Subsequently these researchers analyzed 218 female hospital patients diagnosed with anorexia nervosa (AN), bulimia nervosa (BN), and eating disorders not otherwise specified (EDNOS). To assess the patients they applied assessment measures that included the Eating Disorders Inventory (EDI), the Bulimic Investigation Test Edinburgh (BITE),

the Beck Depression Inventory (BDI), and four similar scales of motivational stage, plus a number of other clinical and psychopathological indicators as well. With this they found that the patients with BA had the most motivation to change when compared with the AN and EDNOS patients. Not surprisingly, they observed that the younger the patients were the less motivation they had to change.

In analyzing how the duration of their disorder contributed to their actual motivation levels, they looked at each diagnostic condition separately and included the total sample as well. What was found was that in the BN and AN patients the duration did not have an influence on their motivational levels. Likewise, Body Mass Index (BMI) did not function as motivation on the ED patients' desire for change. Nevertheless, the EDNOS patients showed higher motivation with each additional year they suffered with the symptoms of this disorder. An interesting observation the data revealed was that their participation in treatment produced an anxiety, which acted to override the patient's incentive to change even though they expressed a strong desire to change. Moreover, in AN patients it was posed that the ED

behaviors may help alleviate symptoms of the anxious temperament they have always lived with. What's more, they speculate that across all ED subtypes the resistance to treatment could be related to their low self-competence, their doubts about their capacity to change, and to the method they use to weigh the pros and cons of change (Casasnovas et al., 2007). Of course, when they have thus far been unable to stop the behaviors on their own that negative mind-set would naturally follow.

In the same way, Dean, Touyz, Rieger, and Thornton (2008) were interested in exploring if a motivational intervention would strengthen the attainment of recovery in eating disorder patients. Hence, they chose 23 female inpatients who met the diagnostic criteria for an eating disorder to complete four sessions of Motivational Enhancement Therapy (MET). These subjects were part of a group of 42 total consecutive patients of which the other 19 patients were selected for the treatment as usual (TAU) group. The MET intervention had four sessions in which the MET group subjects also participated in the TAU intervention as well. In order to focus on the patient's ambivalence about change and recovery, these researchers planned a discussion on the stages of change model and

used a group exercise on decisional balance to weigh the costs and benefits of giving up their ED behaviors or maintain them. In addition, they encouraged the participants to become conscious of how their behaviors did not correspond with the values (Dean et al., 2008).

In general, the MET group that participated in both groups appears to have better results than the TAU group alone at follow-up. At the end, there was not much difference between the groups. However, the difference came at follow-up when the MET patients were still seeking treatment at 84 percent and the TAU group was then only at 44 percent. Most of all, patients reportedly enjoyed attending the groups and since resistance is typically high with inpatient treatment this could help to foster participation and longer-term motivation (Dean et al., 2008).

While cognitive-behavioral therapy (CBT) is considered the most suited treatment for eating disorders, especially for binge-eating disorder (BED), yet these sufferers' experience difficulties associated with social and interpersonal deficits. With this in mind, Wilfley, Welch, Stein, Spurrell, Cohen, Saelens, et al. (2002) decided to examine previous studies on the use

of interpersonal psychotherapy (IPT) which is designed specifically to address these issues with BED. They conducted a randomized comparison of groups using either cognitive-behavioral therapy (CBT) or interpersonal psychotherapy (IPT) which sought to assess and compare these treatments with overweight individuals diagnosed with BED. For their study, they found 162 overweight patients meeting criteria for BED and then randomly assigned them to twenty weekly sessions of either group CBT or group IPT. What they found was that both treatment modalities have comparable results in overweight persons with BED. For the results, they assessed the associated eating disorder psychopathology (i.e. extreme concerns about eating, shape, and weight), general psychological functioning, and weight, before and at post-treatment, then again at the four month interval, and finally at the twelfth month after treatment was completed. Although it takes a little longer for the benefit of IPT to show the same results as CBT, it was found to be an equivalent treatment to CBT treatment for BED (Wilfley et al., 2002).

Traditionally delivery of psychological interventions has been face-to-face, though recently the

internet has rapidly gained popularity as a means to increase access for consumers. In order to study this extension and compare outcomes between the two methods, Paxton, McLean, Gollings, Faulkner, and Wertheim (2007) followed an eight-session, therapist-led small group intervention for body dissatisfaction, and disordered eating in adult women. For this study, they recruited 116 female participants. To accomplish this, they advertised for either face-to-face or internet based group treatment for the body dissatisfaction and disordered eating program, called "Set Your Body Free." After screening applicants, they randomly placed 42 women in a face-to-face (FF) group and selected 37 women for the internet (INT) group, with an additional delayed treatment control (DTC) group of thirty-seven women, all participants were between 18 and 35 years of age. Subsequently to gauge differences, Paxton et al. used a constellation of assessment instruments to measure many facets in body dissatisfaction, body attitudes, and body size, eating attitudes and behaviors, and psychopathology. For the intervention program, they conducted eight weekly sessions with six to eight participants per group. The many features of this program

included a treatment manual containing psychoeducational material about risk factors for body image and eating problems, which factors contribute to maintaining these problems, and strategies for behavioral change. To enhance motivation for making changes they provided week-by-week topic guides and activities to do outside of sessions to discuss at the group session as well (Paxton et al., 2007).

For instance, one of the topics/activities, a rationale for the cognitive-behavioral therapy (CBT) approach, they explored the client's relationship with body image, self-esteem, emotions, and relationships, and many more topics related to this disorder. Correspondingly, the FF and INT group modes received the same intervention program, both for weekly sessions whether in person or in real time in a chat room, including an online discussion board, offered so participants could post messages to each other. These researchers concluded the outcome was positive for the "Set Your Body Free" program for both the face-to-face and the internet groups when compared to the delayed treatment control group. At first, in the many given measurements, the participants in FF group appeared to

have slightly larger gains, yet at the six-month follow-up, they both showed the same general gains (Paxton et al., 2007).

Providing another approach to treatment, Prestano, Lo Coco, Gullo, and Lo Verso (2008) considered what effect group analytic therapy would have on eating disorders. For this, they enlisted eight female subjects who consisted of three anorexic and five bulimic patients. These patients participated in weekly meetings for two years, which employed group-analytic treatment with a female group therapist. Group-analytic treatment originated from "a theory which de-emphasizes the importance of the therapist and encourages the whole group to be active in the treatment of the individual" (Prestano et al., 2008, p. 304).

Furthermore, this therapy relies on the assertion that if a person recognizes, accepts, and can endure their intra-psychic conflicts, they will change their dysfunctional eating behaviors. Likewise, the focus is on an emphasis of here-and-now interactions between the group members and the therapist, yet pertinent historical data is also included. Emphasized in this therapy are the goals of rebuilding self-esteem, raising the group's

homogeneity, mutually mirroring, and facilitating them in finding the link between their emotions and their behaviors. Although these authors suggest that due to the small sample size in their study, the results may be an outcome of spontaneous recovery over the two-year treatment period. In spite of this, they suggest that the connection shown in recovery to perceptions of a positive alliance to the patient's facilitator bears further study. In the end, they suggest that longer-term treatment plans rate further exploration (Prestano et al., 2008).

Given that, eating disorders are rather prevalent in young women and that bulimia nervosa occurs in 1 to 4 percent of American college age women, Proulx (2008) decided to see how Mindfulness Based Stress Reduction (MBSR) would affect the women's recovery process and outcome. Therefore, she documented the experiences of six women diagnosed with bulimia nervosa of college ages as they participated in an eight-week mindfulness based eating disorder treatment group. Receiving treatment is vital to the health of those with bulimia nervosa yet "up to forty percent of bulimics are resistant to current known treatment interventions including cognitive

behavioral treatment (CBT), medications, and interpersonal psychotherapy" (Proulx, 2008, p. 53). With that in mind, Proulx, an experienced MBSR practitioner led a Mindfulness-Based Eating Disorders Treatment Group (M-BED Group) for eight sessions held with a sample of six women who had suffered with bulimia nervosa for many years. These sessions were composed of four elements as experiential mediation practice, psychoeducation (handouts), discussion, and assigned home practice, which utilized guided 10 to 30 minute body scan or sitting meditation CDs (Proulx, 2008).

Additionally, each participant created two self-portraits made in an art medium of their choice, one created at the beginning and another at the end of the sessions. Then, the portraits acted to express their impressions of their initial and final self-portraits separately and in relation to one another. Moreover, the influence of the M-BED group on the women's relationships with their bodies' was assessed as well. Following the groups, one on one interviews occurred with the researcher/therapist to gain understanding of the parts of the M-BED group that were helpful, unhelpful, or stressful. The interview also served to ascertain the

affect the M-BED group had on the women's self-awareness, affect regulation, and impulse-control because these are all elements for which bulimics have great difficulties. Interviews were then organized into five themes, 1) sense of self before the group, 2) coping strategies before the group, 3) connection with one another in the group, 4) connection with themselves through meditation, and 5) shifts in relationship to self and others resulting in new coping strategies at the conclusion of the groups, and the results overall were positive. Although this study was small, the author asserts that this method of treatment would greatly enhance traditional eating disorder programs (Proulx, 2008).

Although current disputes exist over the definitions and clinical significance of night eating syndrome (NES), Striegel-Moore, Franko, Thompson, Affenito, May, and Kraemer (2008) conducted a study to delve into possible personality subtypes of those describing patterns and traits of night eating said to be associated with NES. NES emerged as a term to describe a set of symptoms seen in severely obese patients who stated that they were eating the majority of their daily food intake at nighttime and that they never ate breakfast and usually

not during the daytime, adding that they were also having sleep disturbances. Hence, this behavior was coined *night eating syndrome* and posed as a possible cause or contribution to the maintenance of a subset of those severely obese patients. With the meaning of NES in flux, these researchers set out to clarify whether they could mete out any subtypes from the clinical features they observed. For instance, obesity is perhaps a feature of NES, rather than a characteristic of everyone with night eating behavior. They obtained their sample from the large participation in the National Health and Nutrition Examination Survey II (NHANES-IIII). Subsequently they found four classes of night eaters, two who eat very late or ate a large proportion of their daily intake after seven in the evening, and the other two groups were classified by the rates of depressive symptoms. Surprisingly a link between NES and obesity did not exist (Striegel-Moore et al., 2008).

Theories Guiding Conceptualization

Largely, the major theories on the cause of eating disorders (ED) are biological, developmental, psychological, and psychosocial. Additionally, there are

many theories on treatment for ED. Thus, an integrative model in viewing eating disorders is generally accepted (Barlow & Durand, 2005). In spite of that and based on cognitive theory, the treatment of choice is cognitive-behavioral treatment (CBT) for bulimia nervosa and binge eating disorders (Barlow & Durand, 2005; Wilson et al., 2007). Alternately, turning the focus on improving interpersonal functioning and reducing interpersonal conflict, interpersonal psychotherapy (IPT) had good results matching its efficacy at the one-year follow-up measures (Barlow & Durand, 2005). In addition, the theory of Psychodynamic therapy or object relations theory has very good concepts that explain reasons for the patterns that develop into an eating disorder (Herzog, 1995). Although not a theory, in her article, Wooley (1995) considers some valid points on its influence on the treatment for EDs the Feminist Perspective brings. Given that such varied theories are used to produce practice models, it is important to get the prospective of the clinicians who facilitate recovery because treatment should be as productive as possible. Therefore, further investigation on this would benefit this research as well.

Summary

This chapter included a review of the literature on eating disorder interventions, treatment models, and recovery. In addition, the theories guiding conceptualization for this study was also included.

CHAPTER THREE

METHODS

Introduction

This section presents the methods used in carrying out this research study. Included here are the research design, sampling, an interview instrument, the data collection, and procedures. Along with this, the protection of human subjects during the course of this research is described. An overview of the issues concerning qualitative data analysis will conclude this chapter.

Study Design

The purpose of this study was to examine the ideas, experiences, and conclusions of clinicians (i.e., licensed clinical social worker (LCSW) and marriage-family therapist (MFT)) that facilitate recovery with patients who are in treatment for an eating disorder (ED). Since this research sought to garner the interpretations of practitioners, which is subjective in nature, a qualitative design method was used. Qualitative research methods are useful when studying complex human behaviors that are not easily interpreted as with those

found in ED diagnoses. This study design consisted of face-to-face interviews with ten clinicians (LCSW and MFT) who are facilitators in ED treatment centers. These questions were asked face-to-face in order to uncover the rich practical experience of these professionals. Due to the small size of the sampling, the generalizability to the larger society is limited. These methods were used to determine how eating disorders develop and what commonalities existed among ED patients. In addition, what effect does the treatment practice have on ED client's recovery and the maintenance of relief in core symptoms (i.e. destructive eating behaviors) after they completed treatment.

Sampling

As mentioned previously, the study sample consisted of ten selected clinicians (i.e., LCSW and MFT) currently working with ED clients who agreed to be interviewed for this research. The study participants were selected using a purposive sampling method. These participants have five or more years experience in the field of EDs working directly with clients. These clinicians were selected

among the Eating Disorder field and all were located in the southern California area.

Data Collection and Instruments

As expected, the data for this study was collected from the interviews obtained from clinicians who practice independently in eating disorder treatment. At the outset, permission for the interviews to be tape-recorded was obtained from the interviewees. The interview guide consists of twenty in-depth loosely structured questions designed to explore their perceptions of the effectiveness of treatment modalities options. These questions were presented in an open-ended fashion, in order to seek the most inclusive responses from the participants (See Appendix A, for the list of questions, which appeared on the interview guide).

Procedures

The participants consisted of ten selected clinicians (i.e., licensed clinical social workers (LCSWs) and marriage/family therapists (MFTs)) that facilitate treatment with clients diagnosed with eating disorders. They were selected by having five or more years experience with this client population and

recruited by contacting them directly at their home or their respective treatment centers. The investigator contacted them through telephone calls and arranged for face-to-face interviews. Interviews took place in the interviewee's choice of place, both outside or at their treatment center. The ten interviews were conducted over a six-week period. In an interview lasting roughly one hour, the interviewees were asked twenty questions about their experiences. A data analysis and synthesis of the material were undertaken following the completion of the interviews for approximately a two-week period. No foreseeable immediate or long-term risks to participants who were interviewed were expected. If there was, any question they felt uncomfortable answering, interviewees were assured that they were free to refuse to answer those questions or to withdraw any time without penalty. There were no direct benefits for the participants to receive for participating in this study. However, indirect benefits to the participants could be foreseeable in the end. This research could help concerned individuals, researchers, eating disorder professionals to understand more clearly the current

nature of this disease and factors that affect their clients.

Protection of Human Subjects

Since the participants of this study are employed both independently and in different treatment centers, protection of their anonymity and confidentiality was given significant consideration. Furthermore, careful handling of the data ensured that the interviewees name would not be connected to their treatment location. Additionally, the data collected has been carefully protected during its analysis and once the study was completed, it was then eradicated. All of the interviewees were assigned an ID code, therefore all the information identifying them (names, addresses, and telephone numbers) had no connection to the data being recorded. The interviews were then digitally recorded. The digitally recorded interviews were downloaded to a data file and then transcribed into a text file and were kept in the investigators computer. After the study was completed, the list of the interviewees and digital audio recordings was destroyed.

Data Analysis

This study employed qualitative data analysis techniques. As such, the recorded interviews were transcribed verbatim into written form using a coding method to organize the transcriptions from the recordings into specific themes. Then the themes were analyzed for commonalities and differences in order to interpret the experiences that were expressed in the interviews.

Summary

This chapter presented the methodology utilized with this research study. Included are the study design, sampling, data collection, procedures, and the details of the interview used. Additionally, the protection of human rights was discussed which include confidentiality. Lastly, a discussion of the data analysis was included.

CHAPTER FOUR

RESULTS

Introduction

This chapter includes the presentation of the results of this research study. Included are the themes and categories, which emerged from the interviews. This chapter concludes with a summary.

Presentation of the Findings

All clinicians interviewed were between the ages of 40 and 60 years of age and had five or more years of experience in treating clients with eating disorders.

The researcher interviewed the participants using questions, which focused on their clinical experiences while treating clients with eating disorders. Each interviewee was asked twenty questions. To gain insight into the clinician's experiences with eating disorder treatment and the elements that produce the best outcomes, these questions were asked. Please see Appendix A, Interview Guide. The responses to these questions were digitally recorded, transcribed, and analyzed to provide the information on the themes that emerged.

The twenty interview questions were then condensed into five main categories. These include similarities or backgrounds in eating disorder clients; best treatment models; therapist-client alliance; motivation to change; aftercare practices.

Eating Disorder Client Similarities

Family and Background History

Nearly all of the clinicians said that there was a significant amount of clients who had some trauma or abuse in their history either physical, sexual or both. Most of the participants said that clients' had a parent or grandparent who had suffered from an eating disorder as well. One clinician had the view that there were some religion differences in types of eating disorders. For example, in this clinicians practice, "anorexics were mostly of the Christian and Catholic religion, bulimics in her care were mostly from Jewish families" (Interviewee 5, personal communication, March 6, 2010). Furthermore, she saw her anorexic clients as having "overly involved, or the appearance of overly involved, very strict fathers who were emotionally distant" (Interviewee 5, personal communication, March 6, 2010).

However, bulimics had "a lot of family chaos, lack of structure and boundaries, distance fathers, along with womanizing in the father, more divorces" (Interviewee 5, personal communication, March 6, 2010).

Personality Traits

Half of the participants said that perfectionism was a characteristic of the eating disorder clients they had treated. Three clinicians said that many of their clients had difficulties with attachment issues and a fair amount suffered from personality disorders as well. Substance abuse in one or both of the parents of their clients was common in three of the responses to this question. One third of the interviewees believed that clients had been "negatively impacted by the dieting mentality of the culture," (Interviewee 4, personal communication, March 5, 2010), along with media and body rejection as a similarity. Another observation was that in anorexics had a tendency towards "childhood onset of Obsessive-Compulsive Disorder (OCD), personalities prone to perfection, rigidity, and high achievement" (Interviewee 8, personal communication, March 9, 2010). While with bulimics, this clinician observed "there's more of a pattern of chaotic and unpredictable

interpersonal relationships, which translates to their intrapersonal relationship as well" (Interviewee 8, personal communication, March 9, 2010). Yet in persons with binge-eating disorder, they observed "a quiet desperation, periods of alcohol abuse and a mixture of addictive behaviors" (Interviewee 8, personal communication, March 9, 2010).

Best Treatment Model Practices

Three clinicians reported that the first treatment for eating disorders is the act of eating in itself. Comments made were "a major component that really helps and best tool is eating, for an anorexic food is medicine, for a bulimic learning that food can be your friend," and "learning how to eat" (Interviewee 1, personal communication, February 7, 2010). In addition, when asked to describe treatment models they believed promoted lasting recovery from eating disorders, one clinician mentions the use of a technique called "neurofeedback" and this was specifically for "calming down the nervous system" done with a system called "BrainPaint™" which claims to exercise brain waves (Interviewee 8, personal communication, March 9, 2010).

Cognitive-Behavioral Treatment

Although eight of the clinicians report that Cognitive-Behavioral Treatment (CBT) is used in their practices, all of them report using a more eclectic approach with their clients. Some of the comments on using CBT with eating disorders were: "Good only in highly motivated clients," (Interviewee 1, personal communication, February 7, 2010); "It's a modality that takes a lot of effort and sophistication to understand, how your cognitions, how you relate, how you think is quite often distorted, not real, is delusional," (Interviewee 1, personal communication, February 7, 2010); "A strict CBT does not work well with eating disorders because there is too much right-brain, emotional stuff with eating disorders" (Interviewee 2, personal communication, February 13, 2010).

Dialectical-Behavioral Treatment

Although most had not had much experience using Dialectical-Behavioral Treatment (DBT) with their clients, those who did thought it was a useful practice model for treating eating disorder clients. The responses were varied: "It is excellent because it is so concrete," and "it is good for many ED patients who have borderline

traits" (Interviewee 1, personal communication, February 7, 2010); One clinician stated her preference was DBT because "it has a more sophisticated emphasis on emotional regulation," important because in her perception eating disorders are "a disturbance of chronic inability to manage stress" (Interviewee 8, personal communication, March 9, 2010).

Interpersonal Therapy

All ten participants had positive experiences with Interpersonal Therapy (IPT) in their treatment with eating disorders. Expressions they used were "it is critical," "very important," and "works hand in hand with treatment of addiction" (Interviewee 8, personal communication, March 9, 2010).

Educational Component for Teaching Coping Skills

All ten clinicians reported that "absolutely" they use an educational component in their treatment practices. Some of the responses were that education focuses on "assertiveness, learning to set boundaries, learning to communicate, learning that they matter, and believing in themselves, separation, and individuation from unhealthy relationships" (Interviewee 1, personal communication, February 7, 2010). In addition, "problem

solving, teaching emotional language and identifying feeling words" were quotations from responses made (Interviewee 3, personal communication, February 26, 2010). One clinician added, "We want to create an emotional corrective experience in therapy, this is the most powerful". (Interviewee 3, personal communication, February 26, 2010)

Group Therapy

The belief in using group therapy in treatment for eating disorders was unanimous. Comments made were "it is a necessity," (Interviewee 1, personal communication, February 7, 2010) "group support is absolutely critical for addictions," (Interviewee 9, personal communication, March 19, 2010) "there is no place to hide in a group," (Interviewee 2, personal communication, February 13, 2010) and "the clients are able to identify with each others' feelings and experiences" (Interviewee 1, personal communication, February 7, 2010).

Twelve-Step Social Model

Three of the clinicians were firm in their use of a twelve-step social model approach to treatment. One espouses that "an eating addiction is a process or behavioral disorder and not a dysfunctional coping

mechanism, and this view gets rid of the ambiguity" (Interviewee 4, personal communication, March 5, 2010). Two clinicians believe that the therapist must have their own ED experience in order to do treatment with eating disorder clients.

Mindfulness Practices

All clinicians reported mindfulness practice with eating disorders as having an impact on the client's recovery and overall maintenance of that recovery. Several responded, "It's critical, they must observe their thoughts," and "It is hugely helpful because patients are so disconnected." (Interviewee 1, personal communication, February 7, 2010). One clinician stated that it was necessary to begin with calming the nervous system using neurofeedback then the clients connect with being mindful, "they get that their feelings are not facts and therefore they don't have to act on them with ED behaviors." (Interviewee 8, personal communication, March 9, 2010).

Spirituality

Using spiritually as part of their treatment practice was varied depending on the setting of treatment. When the treatment facility was a larger

corporation, the clinicians were more cautious in offering spirituality in treatment. However, when the client already had a spiritual belief system the clinicians thought that the clients' did "extremely well" in their treatment (Interviewee 1, personal communication, February 7, 2010). Conversely, most of the clinicians who had more freedom in with their treatment practice felt that "spirituality is a huge piece" of the treatment provided (Interviewee 1, personal communication, February 7, 2010).

Creativity

All ten clinicians reported using creativity of some kind in their treatment with eating disorders.

Individual versus Individual and Group Combined

All ten clinicians reported that eating disorder treatment "must have both individual and group therapies" to be effective, saying, "having both is essential" (Interviewee 1, personal communication, February 7, 2010).

Therapist-Client Alliance

The response was unanimous on the necessity of an alliance between the therapist and their client in

treating eating disorders. Most replies were "it's a must" (Interviewee 1, personal communication, February 7, 2010).

Motivation to Change

When asked the question, does your program have an element that addresses motivation to change and do you think this is helpful? All ten clinicians said that they believed this was important and a part of their treatment. For instance, one stated, "anorexia is a disease that is so egosyntonic they have to find the leverage, whether it is financial or family" and "they have to raise the bottom" (Interviewee 8, personal communication, March 9, 2010).

Aftercare Practices

Aftercare Participation Affects on Outcome of Long-Term Recovery

When asked the affect that aftercare participation had for clients with eating disorders the ten interviewees said that it was very important. Clinicians said, "it's a must," "follow-up is critical," and "a major piece for long-term recovery" (Interviewee 1, personal communication, February 7, 2010).

Self-Help Models, Face-to-Face or Online

Most of the clinicians were to unfamiliar with online self-help models to respond to this questioning. Comments made were "may be helpful," and "could be a helpful resource" (Interviewee 1, personal communication, February 7, 2010). In response to online self-help groups, most clinicians cite their concern about the isolation, which is a large problem for persons with an eating disorder.

Overeaters Anonymous

The response to the question of Overeaters Anonymous (OA) participation after treatment was mixed. Four clinicians believe that it was "a must" (Interviewee 9, personal communication, March 19, 2010). Three clinicians stated that they thought the OA groups were not equipped to handle the "complex phenomena" that comes with an eating disorder (Interviewee 2, personal communication, February 13, 2010). Two interviewees did not have an opinion on the use of OA. However, one clinician, a long time member of Overeaters Anonymous, states that her clients must attend 12-step meetings and use the program or she does not treat them. Yet, she stated, "different programs work better for different people, OA is good for

the vast majority but not for all" (Interviewee 8, personal communication, March 9, 2010). For instance, "Eating Disorders Anonymous (EDA) is the most effective fellowship for people with anorexia because there is no bottom line" (Interviewee 8, personal communication, March 9, 2010).

Summary

This chapter examined the results taken from the interviews of ten clinicians who treat eating disorders. The opinions of these clinicians were studied in order to enhance understanding of the elements that produce long-term recovery from an eating disorder from the clinician's perspective.

CHAPTER FIVE

DISCUSSION

Introduction

The objective of this study was to discover what methods produce effective long-term recovery from an eating disorder from the clinician's perspective. In this chapter, research results are discussed and the limitations of the study are addressed as well.

Discussion

Gaining an understanding from the experience of clinicians who treat eating disorders provided a profound awareness of the complex nature involved in the origin of and the treatment of an eating disorder.

Commonalities among Eating Disorders Clients

Since it was the clinician's observations that many ED clients have had trauma histories (i.e., physical, sexual, or both), this could suggest a connection with post-traumatic stress disorder (PTSD). In a study on the links between stress and eating disorders, Rojo, Conesa, Bermudez, and Livianos found that "stress is considered an important precursor of EDs" (2006, p. 628) This thought could facilitate treatment decisions to address this

substantial feature of a client's condition. Considering the use of neurofeedback in ED treatment would be helpful in calming the nervous system to prepare a client for more in-depth treatment practices (Pop-Jordanova, 2000). One study found favorable results using neurofeedback with eating disorder clients (Smith, 2002). As one clinician had positive experiences using this modality as a part of treatment, it merits consideration. Similarly, Hammond (2005) presents literature validating the biological predispositions present with depression, Obsessive-Compulsive Disorder (OCD), and anxiety and suggests neurofeedback "as a method for modifying biological brain patterns" associated with these conditions. Often these conditions are associated together with elements of both PTSD and eating disorders (Brewerton, 2007; Stice, Burton, & Shaw, 2004; Swinbourne & Touyz, 2007, p. 135).

Regarding other common personality traits mentioned such as perfectionism, rigidity, and high achievement, any of these characteristics could indicate a coping response to reduce stress by an attempt to control their environment. Furthermore, a family history of substance abuse or addictive behavioral patterns has a possible

connection to psychological developmental stage disruptions that may contribute to eating disorder conditions. Given that issues with attachment were pointed out with eating disorders illustrates how vulnerable individuals are to the relationships in their environment. In general, dysfunctions within the family system (i.e. overly strict or chaotic, too rigid or loose boundaries, lack of structure, and/or substance abuse) create environments where the child or adolescent is merely doing their best to acquire ways to cope with conditions.

Treatment Model Practices

The responses to questions on treatment models were similar in nature yet differed in the application by clinicians. For example, CBT has been widely researched as a standard therapy model for eating disorders. Yet most of the clinicians perceived CBT as a therapy model that presents resistance issues with these clients because of their denial. This may indicate that using any strict treatment practice is impractical for such complex sets of behaviors. In addition, IPT was thought a necessity by most clinicians interviewed which suggests that relationships are challenging for these clients.

Further, this may indicate that disruptions in childhood development where people learn interpersonal skills have a link to eating disorders. Additionally, DBT was not widely used by this group of clinicians, yet it was clear many thought this to be a valid treatment option. Thus, this suggested that they only lacked the proper training for this model.

In effect, treatment models for eating disorders vary widely and depend profoundly on the treating clinician and type of eating disorder (anorexia, bulimia, binge eating disorder). For that reason, the clinicians in this study all revealed the need to be flexible in their practices and have an eclectic approach in their treatment. Essentially, the concept of learning how to eat as a form of treatment reveals one disconnection ED clients have with its relationship to their basic requirement for nourishment. Since utilizing mindfulness practice in treatment emerged as a useful skill in the interviews, it indicates a need for available modalities. One study examined yoga as a complementary treatment for depression that could be translated to eating disorders (Shapiro et al., 2007).

Most of all, the importance of the training and direct experience of the clinician was a recurring theme that emerged from the interviews. Hence, this may explain why there was such a range in the responses about treatment models. Moreover, the clinician's use of self and their sensitivity to the client is essential with this population. As expected, this might be one reason that some clinicians felt strongly that to treat eating disorders one must also be in recovery for an eating disorder. This view falls in line with the use of a twelve-step social model in their treatment. This suggests that eating disorders are addictions requiring a different take on treatment. Some research suggests that there are biological reasons for food addictions (Taylor, Curtis, & Davis, 2010). Finally, the use of spirituality as part of treatment was desired by most yet only a few used this as an integral part of their treatment. That fact suggests that there is ambiguity about this issue because of political correctness. It was clear that the larger the organization was where they practiced the more cautious they were to use spirituality as a tool, whereas the clinicians in smaller organizations who work more independently perceived spiritually to be an essential

ingredient in their treatment strategy for long-term recovery.

In view of all the above, the multiple systems that require treatment attention are evident. Therefore, the necessity of a multidisciplinary team approach is fundamental for long-term recovery from eating disorders.

Clinician and Client Alliance

In essence, the interviewees' agreement on the necessity of an alliance between them and their clients reveals something of how change is facilitated. As previously mentioned, use of self is a significant instrument of any clinician especially when establishing a relationship with a client who has been isolated by their disease. Thus, when it is successful, this connection allows for the possibility of the client opening themselves to important realities they may be denying which may be threatening their life.

Motivation to Change

In the same way, the interviews indicated that motivation to change is in fact an important factor in ED treatment from the clinician's perspective. This means that they understand the value this concept has on any treatment success with ED clients. In spite of that, none

indicated that there was any formal way to evaluate a client's readiness for treatment or use of methods to improve outcome. One study on change motivation suggests methods, which could be useful in this, regard (Vitousek, Walson, & Wilson, 1998).

Aftercare Practices

Although clinicians unanimously favored using aftercare practices, the manner in which they thought clients should receive it varied. Perhaps indicating that this is truly a clinician preference and needs more investigation to reveal which approaches have the most effectiveness. For instance, 12-step self-help models such as Overeaters Anonymous have great value for ED clients because of its substantial accessibility. Yet the success rate has not been widely researched.

Limitations

The first limitation of this study comes from the small sample size, which will not generalize well to the larger population. Secondly, observations on any human behavior are subjective and limit the study.

Recommendations for Social Work Practice, Policy and Research

Generally, the recommendation for social work practice, policy, and research is that social work education should always include more emphasis on the use of self in the classroom and not only at clinical internships. Additionally, social work in all areas should be well informed on all addictive behaviors, not just alcohol and drug abuse. In fact, process addictions have detrimental effects on individuals, families, and communities and need more attention from the professionals who are direct service to the public.

Conclusions

Principally, the purpose of this study was to gain insight into what clinicians who provide treatment to eating disordered clients perceive imparts long-term maintenance of recovery after ED treatment. In retrospect, this investigator would make a few changes in the study. For example, it might have been more productive to focus less on questions about specific treatment practice models, replaced by inquiry that would have allowed clinicians more narrative answers. This would have enriched the data. Another area not addressed

in this study is a question of how coping styles of individuals fit into assessments and treatment of eating disorder clients (Villa et al., 2009). Another possible question that could have enlightened the study was in the area of addiction. There is some controversy around the debate of whether eating disorders fall into the addiction category and this produces differences in treatment practices. Hence, questioning along this line may have produced a clearer view of their perceptions about the nature of eating disorders. Lastly, it appears that more research is needed in the area of spirituality practices as a viable modality for equipping ED clients with something that is developed by them and within them that can be used throughout their recovery. Most clinicians are somewhat constrained to using evidence-based practices therefore more evidence is needed.

Clearly the responses indicated how serious these clinicians are about their individual responsibility to the clients they serve.

APPENDIX A

INTERVIEW GUIDE

Interview Guide

1. Can you describe any similarities you observe in the histories eating disorder clients?

2. If used, how is the Eating Disorder Examination (EDE) assessment tool useful in your practice?

3. If used, does the eating disorder examination self-report questionnaire (EDE-Q) help you to make treatment plans?

4. From your experience, can you describe which treatment models you believe promotes the most lasting recovery from an eating disorder?

5. From your experience, can you describe any treatment models you believe do not work well with eating disorders and why?

6. In your treatment plan, is there an educational component to teach coping skills and what does that include?

7. What are your thoughts on therapist-client alliance?

8. What are your experiences using spirituality as a part of the treatment program?

9. What are your thoughts about the length of stay for inpatient treatment?

10. How you think aftercare participation affects the outcome in long-term recovery?

11. What are your thoughts on participation in Overeaters Anonymous after inpatient treatment? Is it effective?

12. Do you believe cognitive-behavioral therapy is the best treatment model for eating disorders?

13. What are your observations of the use of interpersonal psychotherapy with eating disorders?

14. What are your opinions and/or experience using group analytic therapy with eating disorders?

15. What are your opinions and/or experience using dialectical behavioral therapy with eating disorders?

16. What impact do you think mindfulness practices have on the recovery and maintenance for eating disorders?

17. Do you believe that either guided or unguided self-help models, which are done either face-to-face or online, are helpful to the recovery and maintenance process?

18. Does your program have an element that addresses motivation to change and do you think this is helpful?

19. What are your thoughts on individual therapy compared with the combination of group therapy and one-on-one therapy?

20. Do you think that incorporating creativity practices or art therapy has a place in eating disorder treatment?

APPENDIX B

INFORMED CONSENT

INFORMED CONSENT

The study in which you are being asked to participate is designed to examine the experiences, conclusions, and ideas of clinicians who facilitate recovery with patients who are in treatment for an eating disorder. This study is being conducted by Ms. Katrina Bullard, a Master of Social Work graduate student under the supervision of Professor Tom Davis, PhD., School of Social Work, California State University, and San Bernardino. This study has been approved by the Social Work Human Subjects Sub-Committee of the Institutional Review Board, California State University, and San Bernardino. This study has been approved by the Social Work Human Subjects Sub-Committee of the Institutional Review Board, California State University San Bernardino.

PURPOSE: The purpose of the study is to examine the experiences, conclusions, and ideas of clinicians who facilitate recovery with patients who are in treatment for an eating disorder.

DESCRIPTION: You are being asked to take part in a face-to-face interview. You will be asked about a few questions about your experiences, conclusions, and ideas on your facilitation of treatment with eating disorder clients.

PARTICIPATION: Participation is voluntary, refusal to participate will involve no penalty or loss of benefits that you are entitled to, and you may discontinue participation at any time without penalty.

CONFIDENTIALITY: The information you give during the interviews will be recorded.

DURATION: The interview will approximately take about 1 hour.

RISKS: No foreseeable risks to your participation in the research.

BENEFITS: A benefit of taking part in this study will be to have a role in informing clinicians working with eating disorder clients.

VIDEO/AUDIO/PHOTOGRAPH: I understand that this research will be audio recorded. Initials and data from the recording will be used to inform clinician on best practices_____.

CONTACT: If you have questions about this project, please contact my research supervision, Dr. Tom Davis, Professor, School of Social Work, California State University San Bernardino, 5500 University Parkway, San Bernardino, CA 92407, tomdavis@csusb.edu 951-537-3839.

RESULTS: The results of this research will be available at the Pfau Library, California State University, San Bernardino after September 2010.

Signature _____ Date _____

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