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# Spiritual Pathways to Healing and Recovery: An Intensive Single-N Study of a Patient with an Eating Disorder

Troy William Lea

A dissertation submitted to the faculty of
Brigham Young University
in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

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ABSTRACT

Spiritual Pathways to Healing and Recovery: An Intensive
Single-N Study of an Eating Disorder Patient

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Doctor of Philosophy

This study presents an in-depth case study of eight sessions of spiritually integrated psychotherapy with a 20-year-old woman recovering from an Eating Disorder. The inclusion and utility of session-to-session outcome data as well as systematic follow up data in conjunction with in-depth qualitative interviews are shown. The therapist and client's perspectives are highlighted over the course of treatment. Three clinical areas of focus (renewing identity, reducing self-contempt, and fostering hope) are extracted from the qualitative interviews and the therapeutic process of weaving them together is highlighted. The Tau-U and SMA single case study statistical analyses are used to highlight clinical gains and maintenance.

Keywords: eating disorders, spirituality, religiosity

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First and foremost I would like to thank my wonderful wife, whose help, love, support, guidance, encouragement, and wisdom have made this process possible. You are everything to me, and I am eternally grateful you took a chance on me. Secondly, I wish to thank Scott, whose guidance, encouragement, and friendship have meant the world to me. You always seemed to know the right thing to say as I struggled to finish this daunting project. Thirdly, I am indebted to the therapist and client who bravely agreed to allow me to peer into their realities. I was honored to be asked to participate in this project and humbled by your openness and courage. It is also important that I thank my committee whose wisdom and care showed through in their direct and wonderful feedback. I am grateful for my three wonderful children whose encouragement and enthusiasm was never ceasing. I hope one day to be half as good as you make me feel I am. Finally, I wish to thank my wonderful parents, without whom this journey could never have been possible.

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# DESCRIPTION OF DISSERTATION STRUCTURE AND CONTENT

This dissertation, *Spiritual Pathways to Healing and Recovery: An Intensive Single-N Study of an Eating Disorder Patient,* is written in a hybrid format. This hybrid format integrates traditional dissertation requirements and journal publication formats. The initial pages of this dissertation are for the purpose of fulfilling requirements for submission to the university. The remainder of the dissertation is written in a format that will allow it to be converted for a journal submission. The review of the literature is included in Appendix A. There are two reference lists contained in this dissertation. The first reference list contains references included in the journal-ready article. The second reference list includes all the references for the review of the literature.

## Introduction

It is now widely acknowledged in the medical and psychological professions that faith and spirituality are often positively associated with physical and mental health (Koenig, McCullough, & Larson, 2001). Despite this, professionals in the field of eating disorders have largely neglected faith and spirituality in treatment and recovery (Richards, Weingarten-Litman, Berrett, & Susov, 2013). If eating disorder treatment programs were more successful at helping women heal and recover, perhaps there would be no reason to investigate the potential role of spirituality in facilitating recovery. However, success rates of most contemporary eating disorder treatment programs are relatively low (Richards et al., 2000; Steinhausen, 2002; Steinhausen & Weber, 2009). There is clearly a need for the development and evaluation of new interventions that show promise for helping more women recover successfully.

There are both theoretical and empirical supports for the hypothesis that faith and spirituality may contribute to better treatment outcomes among women with eating disorders. Some professionals have theorized that eating disorder patients struggle with several core issues that are spiritual in nature, and that spiritual interventions are the most effective way to address them (Richards et al., 2013). Empirical findings which support the hypothesis are as follows: (a) survey and interview studies of recovered eating disorder patients have found that sizable percentages of such women report that faith and spirituality were very important in their recovery (e.g., Hall & Cohn, 1992; Marsden, Karagianni, & Morgan, 2007; Mitchell, Erlander, Pyle, & Fletcher, 1990; Richards et al., 2008; Rorty, Yager, & Rossotto, 1993); (b) a quantitative correlational study of eating disorder inpatients revealed that improvements in spiritual well-being during treatment were associated with reductions in eating disorder symptoms and psychological disturbance (Smith, Richards, Fischer, & Hardman, 2003); and (c) a phase one

clinical trial revealed that women in an eating disorder inpatient treatment program who participated in a spirituality group intervention enjoyed better treatment outcomes than patients in other treatment conditions (Richards, Berrett, Hardman, & Eggett, 2006).

Despite these supportive empirical findings, the evidence-based support for the use of spiritual treatment approaches for eating disorders remains provisional (Richards et al., 2013). There is a need for additional treatment outcome studies to further document the effectiveness and efficacy of various types of spiritual approaches in the eating disorders field. There is also a need for more insight into how clinicians can effectively integrate spiritual approaches into eating disorder treatment and into the reasons that spirituality can facilitate recovery. More practice-based, process, case report, and qualitative studies about spiritual approaches are needed to answer these questions.

The American Psychological Association (APA) task force's report on evidence-based practice in psychology defined evidence-based practice as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA, 2006, p. 273). The task force also affirmed that multiple types of research designs could contribute to the evidence-based practice, including randomized controlled trials, practice-based designs, qualitative research, individual case studies, systematic case studies, single-n studies, and process-outcome studies. The task force pointed out that "different research designs are better suited to address different types of questions" (p. 274). The report confirmed the value of case study, single-n, and qualitative designs for innovating in a clinical setting, generating hypotheses, giving insight into the lived experience of clients, demonstrating the ecological validity of interventions, and establishing causal relationships in the context of individual clients (APA, 2006).

Encouraged by the APA task force's recommendations, the present study used an intensive single-n case design using both quantitative and qualitative methodologies to explore how and why religious beliefs and spirituality can facilitate eating disorder treatment and recovery. The overall purpose of the study was an in-depth exploration of the processes and outcomes of a spiritually oriented therapy approach for an eating disorder client in an outpatient treatment setting using the following research questions:

1. What spiritual perspectives and interventions were used in the treatment of the client and how did they interplay with traditional therapy approaches?
2. What was the overall experienced process of the client during her spiritually oriented treatment approach?
3. What were the therapist's treatment goals and how were they received and incorporated (or not) into the client's life?
4. Based on the quantitative and qualitative evidence collected during the study and during the post-treatment follow-up, what improvements did the client experience?

## Method

### Participants

**Client**. The client participant was selected from a large outcome study conducted at the Brigham Young University – Idaho Counseling Center. The selection of the client was made by one of the participating therapists, who identified the client as having (a) made exceptional therapeutic gains given her history, presentation, and diagnosis and (b) desired a spiritually focused treatment approach. This type of biased participant selection process has the potential to introduce confirmation bias, but due to the fact that we are addressing *how* the treatment was effective instead of *if* the treatment was effective, this bias becomes irrelevant.

Stephanie (a pseudonym) was in her early 20s, single, and without children at the time of treatment. She had previously been treated with outpatient therapy and dietary counseling for several years at an eating disorder treatment center. She was referred to the clinician at the Counseling Center by that same eating disorder treatment facility. The client reported having developed her eating disorder when she was 16. She reported primarily restricting but also reported occasional episodes of binging and purging. The client also reported a history of excessive exercise.

At the beginning of treatment, the client started the anti-depressant medication Zoloft but reported not taking her medication consistently throughout therapy. The client's diagnoses were 296.32 major depressive disorder recurrent moderate, 307.50 unspecified eating disorder, 300.00 unspecified anxiety disorder, and 301.9 personality disorder NOS. The client participated at the Counseling Center in a total of eight sessions over a three-month period.

The therapist reported Stephanie struggled with feelings of "being stuck, unhappy, not feeling good enough, difficulty with self-judgment, shame, self-contempt, loneliness, emptiness, and emotional fluctuations." The client reported difficulty trusting others and problems with impulsivity. She also felt dependent on others. The therapist reported the client had no history of suicidality or suicidal gestures.

The client reported being a member of the Church of Jesus Christ of Latter-day Saints. However, she reported only being partially involved in her religion the past couple years before treatment. She stated that she had "never stopped attending" her church services but struggled to participate or to feel a sense of belonging.

**Therapist**. The licensed psychologist who saw Stephanie had 30 years experience as a full-time practitioner. The therapist reported integrating theistic perspectives with cognitive

behavioral therapy and family systems approaches. In his 30 years of work experience he has worked at a family practice clinic and then co-founded a large inpatient eating disorder clinic. He currently works in the Counseling Center at BYU-Idaho. The therapist adheres to an integrated spiritually focused cognitive behavioral approach.

**Researcher**. The primary researcher is a graduate student at Brigham Young University seeking a doctorate degree in counseling psychology. He self-identifies as highly religious and actively involved in the Church of Jesus Christ of Latter-day Saints. The researcher has three combined years of clinical work experience at two different university counseling centers, nine months experience at a Veterans Affairs hospital, nine months experience at a local community mental health treatment facility, and is currently completing a 12-month pre-doctoral internship. From a theoretical perspective, the researcher approaches therapy from what can best be described as a research-informed, Existential-Integrative perspective (Schneider, 2011; Yalom, 1980). As a therapist, the researcher defines his goal as being able to facilitate and empower clients in the creative act of "expanding [their] sense of self, specifically an enhanced capacity for intimacy, meaning and spiritual connection in…life" (Schneider & Krug, 2010, p.16). The researcher received additional qualitative interviewing and analysis training in his doctoral program. The researcher was drawn to the single-n research paradigm for two reasons. The first is a deeply felt sense that spirituality and psychotherapy, when integrated sensitively and properly, can improve the clinical outcomes of religiously and spiritually oriented clients. Secondly, the research paradigm of single case studies (Kazdin, 2011; Yin, 2014) is especially fascinating and is an informative contribution in constructing evidence-based practice in psychology.

**Procedures**

This single-n case study occurred in the context of a larger outcome study of spiritually oriented psychotherapy at the Counseling Center at Brigham Young University-Idaho from March 11, 2013 to February 28, 2014. As part of the study, Stephanie completed a Spiritual Intake Questionnaire Theistic Spiritual Outcome Survey (TSOS; Richards et al., 2005) and a Clinically Adaptive Multidimensional Outcome Survey (CAMOS; Richards, 2012) before each of her therapy sessions. One year after the termination of treatment, Stephanie completed the CAMOS measure and the Eating Attitudes Test (EAT; Garner, Olmsted, Bohr, & Garfinkel, 1982) as a follow-up for treatment and as a gauge of the amount of therapeutic progress she had maintained. At the conclusion of each therapy session, the therapist completed the Therapist Session Checklist (Richards, 2012). The therapist also received summaries of the outcome assessment results for Stephanie each week to assist in treatment planning.

The TSOS was developed internationally in both clinician and non-clinician populations. Richards et al., (2005) reported the internal consistency reliability estimates at .90. The TSOS also correlated relatively high with other religiousness and spiritual well-being measures, namely the intrinsic subscale of the Religious Orientation Scale (ROS; Allport & Ross, 1967) and the Spiritual Well-Being Scale (SWBS; Ellison, 1983; Ellison & Smith, 1991). The TSOS also correlated with psychological functioning and disordered eating measures. The correlations were low but significant when compared with the Outcome Questionare-45 (OQ-45; Lambert et al., 1996), the Symptom Checklist (SCL-90- R; Derogatis, 1983), the Freiburg Personality Inventory (FPI; Schowalter, Richard, Murken, Senst, & Ruddel, 2003), and the Body Shape Questionnaire (BSQ; Cooper, Taylor, Cooper, & Fairburn, 1987). The version of the CAMOS that was administered for this study had two phases. First a 51-question intake questionnaire assessed

clients across all eight clinically relevant dimensions, including self-reports of their spirituality, physical health, relationships, behaviors, thinking, work/school, emotions, and therapy progress. Phase two, or the adaptive version of the measure, was administered after the initial intake. This version asked a level-one global question for each of the eight dimensions. Then, depending on the client's answers, would or would not display the additional items of each dimension. This adaptive feature helped reduce the amount of time and redundancy in the CAMOS administration. However, due to the inconsistency of the data in the level-two responses, only level-one questions were utilized for this study.

Table 1
*Validity Scales for TSOS*

| Scale | TSOS |
|---|---|
| ROS | |
| Intrinsic | .37*** |
| SWBS Existential Well-Being | |
| Religious Well-Being | .57*** |
| Existential Well-Being | .49*** |
| Outcome Questionnaire OQ-45 total | -.35*** |
| BSQ | -.27** |
| Global Self-Esteem (MSEI) | .33*** |
| SCL-90-R Global Severity Index | -.24** |
| FPI Satisfaction With Life | .32** |

*Note.* TSOS=Theistic Spiritual Outcome Survey; ROS=Religious Orientation Scale; SWBS=Spiritual Well-Being Scale; BSQ=Body Shape Questionnaire; MSEI=Multidimensional Self-Esteem Inventory. *p <.05. **p <.01. ***p <.001.

The CAMOS was in the early stages of development during the time of this study. However, according to follow-up studies (Mcbride, 2014; Sanders, 2014), the CAMOS has proven to be both clinical relevant and empirically valid. Table 2 shows the reliability coefficients and validity correlations of a shortened version of the CAMOS taken from the two sites, BYU-Idaho and the Center for Change.

Table 2
*Reliability Scales for CAMOS*

| Scale | Reliability | Validity Correlations |
|---|---|---|
| Psychological Distress<br>I felt worried, agitated, fearful, or tense<br>I felt sad or depressed<br>I felt stressed out<br>I thought about past personal failures/mistakes<br>I felt powerless or stuck in my problems | CFC: .90,<br>BYUI: .87 | OQ-45: .76, MMPI-II Depression: .62,<br>MMPI-II Anxiety: .65<br>OQ-45 = Outcome Questionnaire |
| Spiritual Distress<br>I felt a loss of inspiration or spiritual direction<br>I felt distant in my relationship with God<br>I felt concerned about my religious or spiritual life<br>I felt guilt and regrets over mistakes that were inconsistent with my religious beliefs | CFC:.80,<br>BYUI: .84 | TSOS Total: -.58,<br>TSOS G: -.55, TSOS-S: -.66<br>TSOS = Theistic Spiritual Outcome Survey |
| Relationship Distress<br>I argued with my loved ones or friends<br>I felt irritated and angry towards others<br>I felt hurt or disappointed by how my loved ones or friends behaved<br>I felt misunderstood by my loved ones and friends | CFC: .80,<br>BYUI: .79 | MMPI-II FAM: .44,<br>MMPI-II- Paranoia: .47 |
| Physical Distress<br>I felt physically well and healthy<br>I experienced physical pain or discomfort<br>I felt light-headed, weak, or fatigued<br>I had a stomach ache or other gastro-intestinal problems | CFC: .82,<br>BYUI: .80 | MMPI-II Hs: .67,<br>MMPI-II Health: .62 |
| Work Distress<br>I felt over-burdened with too many responsibilities<br>I felt concerned about my work (i.e., employment, school, volunteer work, etc.)<br>I worried about not meeting expectations or requirements.<br>I wanted a change in my responsibilities | CFC: .74,<br>BYUI: .78 | OQ Social Roles: .50, |
| Therapy Expectations/Progress<br>I had concerns about beginning/continuing therapy<br>I felt anxious about beginning/continuing therapy<br>I felt uncertain about whether I can be fully honest and open with my therapist<br>I had doubts about whether my therapist will understand my concerns | CFC: .84,<br>BYUI: .80 | MMPI-II: Neg Treatment Indicators: .50 |

**Quantitative Data Analysis**

We analyzed the session-to-session outcome data collected from Stephanie, investigating two main questions:

1. Is the clinician's belief that this client-improved significantly over the course of therapy supported by the session-to-session outcome data?
2. Does the session-to-session outcome data support or contradict the qualitative analysis?

To test these questions, we first calculated the percentage of change attributed to the addition of psychotherapy using the Tau-U (Parker, Vannest, Davis, & Sauber, 2011). Using the AB model, we compared the first two CAMOS surveys to the following six therapy sessions. Due to the fact that no intervention was reported during the first session, the first two sessions formed a good baseline. Second, we conducted a two-phase-effect (Parker et al., 2011) analysis using Simulations Modeling Analysis Software (SMA; Borckardt, Nash, Balliet, Galloway, & Madan, 2013; Borckardt, Nash, Murphy, Moore, Shaw, & O'Neil, 2008) in order to calculate for which of the eight therapeutic dimensions the client reported a significant change.

**Qualitative Interviews and Data Analysis**

*"Contemporary ontological hermeneutics, or hermeneutic ontology, tries to work out a conception of humans as self-interpreting beings whose being is shaped by a shared background of meanings."* (Guignon, 2002, p. 84)

The qualitative interviews and data analyses followed the hermeneutic philosophy (Gadamer, 2004). In the beginning, hermeneutics was closely tied to its Greek origin. Directly translated from Greek, hermeneutics means interpretation. During the sixteenth century hermeneutics was used to interpret the meaning of texts, mostly sacred texts. However, as Guignon points out, currently hermeneutics is considered an ontology.

Hermeneutics explains that language is understood as the most real form. Language is defined as "everything that is handed down through this language, from the day we are born into a family, a society, a culture and tradition" (Austgard, 2012, p. 830). This understanding of language is also know as *zugehörigkeit,* or belonging to a tradition. Under the hermeneutic ontology, this means that those who wish to understand a topic already have a relationship to that topic. Furthermore, that relationship is a main point in the enterprise of understanding. Therefore, reality is co-constructed between a person's experience with reality and the context in which that experience is taking place.

Hermeneutics states that the interpreter cannot transcend the tradition of understanding in which he or she lives (Kvale & Brinkman, 2009). As Austgard (2012) points out, the prejudices and fore-meanings described by Heidegger are as much a part of the interpretation of the subject as is further study. Therefore, it is impossible to observe from an objective reality within the hermeneutic ontology. Guignon (2002) points out that, "In Heidegger's view, when we step back and adopt the cool, disengaged spectator's perspective of theoretical reflection, the world, so to speak, goes dead for us, with the result that we encounter an objectified reality in which thick ethical concepts lose their meaning. Given such a view, it becomes hard to see how anything can really *matter* for us" (p. 94). Under the hermeneutic ontology, if we the interpreter were to ignore our own context and background, we would lose sight of anything that would otherwise give meaning to the situation. Kvale and Brinkmann (2009) explain that "knowledge of what others are doing and saying, of what their actions and utterances mean, always depend upon some background or context of other meanings, beliefs, values, practices, and so forth" (p. 51). Therefore, for this study, the researcher has "provoked" individual prejudices in order to research from the right "horizon," with horizon being understood as a metaphor for how the researcher

will "perceive and interpret reality" (Austgard, 2012, p. 830). Kvale and Brinkman (2009) add, "qualitative researchers can learn to analyze their interview as texts and look beyond the here and now in the interview situation, for example, and pay attention to the contextual interpretive horizon provided by history and tradition" (p. 51). Hermeneutics accomplishes this horizontal perspective with the hermeneutic circle, which has been described as "a movement from the entirety of the text to its parts and back to the entirety" (p. 46). Kvale and Brinkman go on to clarify that "this circularity is not viewed as a 'vicious circle,' but rather a 'circulus fructuosis' or spiral, which implies a possibility of a continuously deepened understanding of meaning" (p. 46). The culmination of this process is what is termed an event or the evidence of truth. Austgard (2012) states "that [it] occurs when the interpreter understands the concepts of the text in such a way that they also include the interpreter's own comprehension (begreifen) of them" (p. 831). Horizontverschmelzung, or the fusion of horizons, is used to describe this process.

Austgard (2012) points out that Gadamer believed "understanding here is always application" (p. 831). This means that understanding of the text must be applied to the here and now or "case (die sache)" (p. 831). From this point, hermeneutics does not arrive at truth through observation, but through the interval shift or clarity experienced by the researcher. This manner of investigation does not limit the researcher to test only their own biases and knowledge but subjects them to the fact that they do not know what they wish to know. Hermeneutics gives an ontology and process open to new truths and discovery that other empirical or rational ontologies do not allow.

The ontology of hermeneutics posits that reality is created in any form of dialogue between two people, such as vocal, textual, or any other method of communicating. This fits well with the research question investigated by this study, as well as the diverse data forms collected.

Using this ontology, the quantitative data "embedded" in the qualitative data also became part of the qualitative data analysis (Creswell, 2007, p. 7), which included two semi-structured interviews conducted with the therapist two and four months after the termination of treatment. Additionally, qualitative analyses were conducted on four written explanations that the therapist provided about his treatment approach. Ten months after Stephanie terminated treatment, we conducted a semi-structured qualitative interview with her.

The qualitative interviews were conducted after termination of treatment due to the participant selection criteria as well as to avoid any potential for harm during the therapy process. The topics covered during the therapist's interviews were (a) the client's presenting concerns, (b) the therapist's therapeutic approach, and (c) the overall narrative of the treatment as experienced by the therapist. The interview with Stephanie focused on (a) what she felt was impactful and meaningful from her treatment experience, (b) what she experienced as ineffective or not helpful, and (c) the overall narrative of her experience of treatment. Neither interview was constrained to these topics. Instead, the topics were used as beginning points in order to understand the overall narrative of the treatment experience. The researcher, aware of his religious biases, attempted to maintain an open and inquisitive stance toward the potential that the interaction between the client's religiosity and spirituality with the spiritually oriented psychotherapy she received had little or no effect on her positive treatment outcome. The primary researcher also completed memo writing and journal entries during the interview and analysis processes.

The qualitative data was first was transcribed by an outside transcription source. The transcripts next underwent review checks to correct their accuracy according to the original recordings. As Gibbs (2008) suggested, this is an important step for the research to reorient to

the content and context again as well as to check for accuracy. During the transcript checks the researcher followed the qualitative technique of memo writing to record initial impressions and potential coding themes that were emerging. According to Glaser (1978), memos are "the theorizing write-up of ideas about codes and their relationships as they strike the analyst while coding…it can be a sentence, a paragraph or a few pages…it exhausts the analyst's momentary ideation based on data with perhaps a little conceptual elaboration" (pp. 83-84). The memos serviced as the foundation for the thematic coding that eventually emerged later in the coding process. Aligning with Gibbs (2008), the coding process was approached as a "concept-driven coding" system (p. 44). This meant that the coding process represented "research literature, previous studies, topics in the interview schedule, hunches you have about what is going on, and so on" (p. 44). However, the coding process was not limited to these preconceived concepts. Instead, it flowed with and out of the qualitative interviews. The codes were then peer-reviewed by additional researchers. Multiple data points obtained through quantitative and qualitative methods result in a more complex picture of treatment.

## Results

### Quantitative Findings

Figure 1 presents the client's score on each of the CAMOS dimensions during the eight sessions of treatment and at the 12-month follow-up. Stephanie indicated a decreasing level of distress over the course of therapy in all dimensions except that of relationship concerns, which saw a slight climb in the eighth and final session. This can be attributed to the relationship strain of termination. Of particular note is the systematic drop of reported distress with regard to concerns about therapy beginning at the second session. This is followed in the fourth session with the drop of work/school and relationship concerns. Distressing emotions, spiritual concerns,

and self-defeating behaviors abated in the sixth session. In the seventh session the distressing thoughts dimension finally subsided. The only dimension to not be marked as "rarely" during the eight therapy sessions was the physical health concerns dimension, which was marked as rarely during the 12-month follow up. The addition of the Therapist Session Checklist (TSC) data adds interesting information, as the therapist seemed to focus early on distressing thoughts, self-defeating behavior, spiritual concerns, and distressing emotions, but shifted focus later in treatment to relationship concerns and physical health concerns.

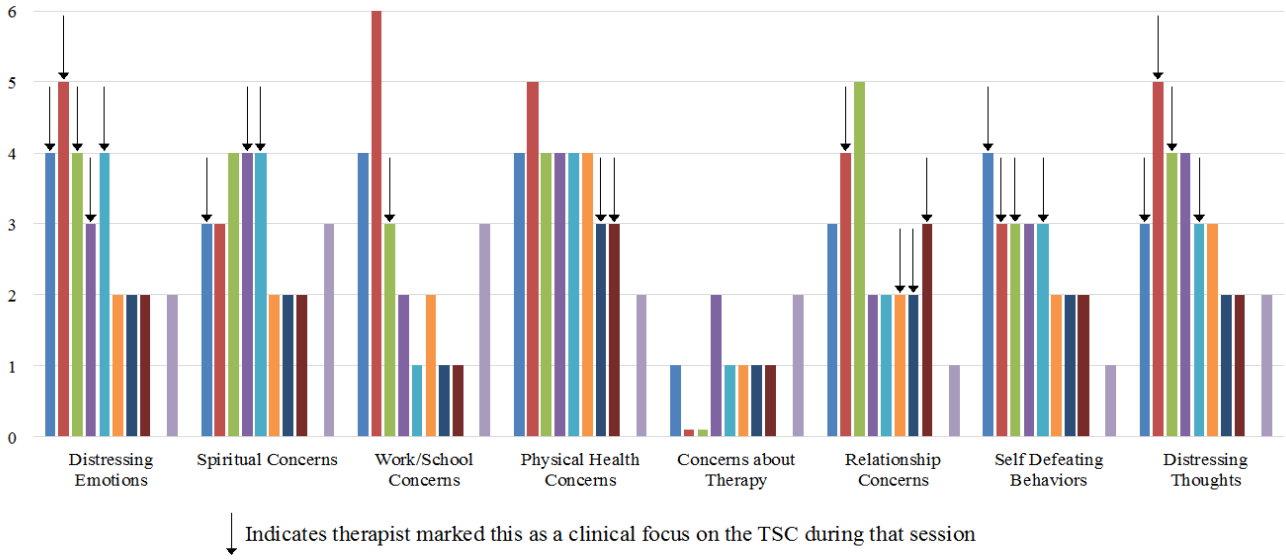


*Figure 1*. Eight dimensions of the CAMOS represented across eight sessions + 12-month follow up and the Therapist Cliental Focus as marked on the TSC across sessions.

The Tau-U estimate (Parker et al., 2011) is a statistical analysis that measures non-overlap between two phases, usually a baseline and an intervention phase, in single case designs. It is a nonparametric analysis that works well with the typical distribution free single case data. This measure uses the "S" sampling distribution similar to Mann-Whitney U and Kendall's Rank Correlation, which also yields a p-value and confidence intervals.

Use of the aggregated eight dimensions of the CAMOS yielded a Tau of -0.410 (0.488) which is statistically significant at a p = 0.017, indicating a 41 percent improvement of change across the eight dimension from baseline to intervention.

The Simulations Modeling Analysis (Borckardt et al., 2013; Borckardt et al., 2008) estimated that Stephanie reported significant changes in the Distressing Behaviors (Baseline, $M = 3.5$; Intervention, $M = 2.43$; $r = +0.78$; $p = .021$), Distressing Emotions (Baseline, $M = 4.5$; Intervention, $M = 3.0$; $r = +0.88$; $p = .025$), Distressing Thoughts (Baseline, $M = 4.0$; Intervention, $M = 3.14$; $r = +0.87$; $p = .025$), and Physical Health (Baseline, $M = 4.5$; Intervention, $M = 3.57$; $r = +0.83$; $p = .038$) dimensions.

Additionally, Stephanie completed an EAT survey one year after terminating therapy. Her response of 14 was well below the normal cutoff of 30 and significantly below the 58.7 inpatient cutoff, indicating she had developed healthy eating attitudes. This was also confirmed when Stephanie calmly and causally snacked during her qualitative interview.

The quantitative findings provide evidence that Stephanie achieved significant improvements over the course of her treatment and that she maintained them for at least one year after treatment.

**Qualitative Findings**

**Therapist's story.** Eating Disorder Education: The therapist reported he spent time early in treatment providing some psychoeducation on how he believes eating disorders work. The therapist explained several themes he often relates to clients.

***Teaching client how eating disorders work.*** The first theme was an "intense pursuit of approval." The therapist explained this often plays out as a false belief system in which the client presumes, subconsciously or consciously, that if he or she is thin enough then he or she

will receive enough approval or acceptance that all other deficits or deficiencies will be over shadowed, forgotten, or erased. The therapist explained that this belief only leads the client to more perceived evidences of his or her own inadequacies as the expectation of complete and unchallenged approval is neither realistic nor obtainable. Therefore, this belief cycles back on itself, feeding the "painful self-judgments, self-criticisms, and overall self-contempt that indirectly feeds the eating disorder."

The second theme the therapist explained was an "intense pattern of avoidance." The therapist explained that eating disorders are "addictions of avoidance," specifically avoidance of intense and unwanted emotional and relational experiences. The therapist explains that, though the eating disorder begins as an avoidance tool, in time it transforms into the focal point of the client's lived experience. At this point, all other experiences or relationships that would interfere with the eating disorder are avoided or excluded. The therapist explains that the client's lived experience shrinks to the point where the eating disorder permeates all facets of the client's identity, resulting in the unwanted emotional experience of shame. Often the client feels intense shame for the quality of life they lead; only finding solace in the eating disorder. This shame then cycles back to the eating disorder as just another unwanted emotional experience. The therapist points out that this pattern also acts as another perceived piece of evidence of inadequacy that the client uses against him- or herself, thus fueling their self-contempt and the eating disorder.

The third theme noted was a "false pursuit of comparison." The therapist explained that he has often seen a "preoccupation, if not obsession," in how a client is perceived in comparison to another. The therapist explained this theme as a "false pursuit" because the criteria or structure that an eating disorder client uses to compare him- or herself to others is often

disordered as well. The criteria are often distorted to such a degree as to render any positive interpretation impossible. All interpretation, therefore, "leads to more self-contempt, which indirectly feeds the eating disorder."

The fourth theme was explained as an "over-pursuit of control." This theme seemed to permeate all symptomology present in any eating disorder. Often a client will appear, or desire to be perceived, as having all behavioral, emotional, or relational factors under their control. Yet the client will simultaneously report feeling one breath away from chaos. This creates an over-reliance on control in an effort to protect him- or herself from experiences that could potentially cause them to feel "vulnerable, stupid, or powerless." As clients exert more and more control on what they bring in and out of their lives, they slowly lose the ability to engage in intimate, personal, and vulnerable relationships with others, which leads to a "deep sense of loneliness." In turn, the loneliness is used as another perceived piece of evidence of the client's inadequacy, again fueling self-contempt, and indirectly feeding the eating disorder.

The fifth theme was an "overwhelming fear." The therapist explained that of all the energies and behaviors used to control or avoid emotional experiences, fear seems to be the only one that can or is allowed to linger. Fear is the overall sustainer of the other themes as well as of more general eating disorder symptomology. Patients have explained that they have "fears about who they are, what will happen next, how other people will react or think, whether they will be accepted, whether they will fail, or how they will come up short, etc." The therapist explained that months and years of enduring these types of relentless fears can grind out any hope that "there is anything good to hold on to in life." This hopelessness "leads to self-contempt, and the self-contempt indirectly feeds the eating disorder."

The therapist explained that, consistent with his understanding of eating disorders and the course of treatment, Stephanie and he would follow and focus on the "underlying emotions and contributors to the eating disorder." He also would take time to discuss dietary and nutritional aspects of treatment, because the center where he was employed did not provide dietician services.

***Key psychological issues targeted by treatment.*** The therapist's treatment of Stephanie focused on five key issues: addressing cognitive distortions, engaging avoidance patterns, renewing identity development, creating healthy behavior patterns, and facilitating coping. In all of these key issues, the therapist interwove spiritual concepts specific to the client's religion.

*Addressing cognitive distortions.* The therapist reported that he would engage the client's depression with "more of a cognitive behavioral model." He explained that he would help her to "challenge some of her negative thinking about herself, about life, helping her reframe things that were going on in her life so she didn't end up with the worst meaning always." He went on to explain that he would use the concept of self-kindness. In this concept, the therapist juxtaposes self-kindness and self-acceptance. He explained to Stephanie that self-kindness is choosing to be kind to one's self in the moment, even if she did not feel fully accepting of herself. Self-acceptance, on the other hand, is more a sense of total acceptance.

The therapist amplified this concept of self-kindness through a powerful experiential intervention. He stated that during one particular session the client reported feeling significantly more "down and depressed." When questioned further, the client explained that she had been "cruel and mean" to herself over what she perceived as a mishandled social situation. The therapist placed an empty chair in front of the client with her backpack in it. He explained he

knew that the client had "first started to hate her body" when she was a little girl about 7 years old. He clarified:

> This is going to symbolize your little girl you. I asked her to basically say to [the imagined little girl] everything she had just shared with me that had been going on inside of her for several days but to imagine that she was talking to that little girl self.

The therapist stated:

> It was painful, but it was profound. Because she finally realized that it was the little girl that decided that she wasn't okay. And who started this whole thing of self-judgment. But by recognizing that it wasn't only hurting her but it was hurting that little girl self…it was powerful. Then we processed it at length. I mean she was crying, she wanted to stop lots of times but I wouldn't let her. I wanted her to keep going. Then we had the little girl put some words to what she felt like.

*Engaging avoidance.* During therapy the client and the therapist examined the client's avoidance patterns. He stated that she would often "get shut down and depressed" with minor set backs or criticisms. He stated that she would attempt to be in control through "avoiding things." The therapist introduced a concept he terms the "four levels of honesty." The first level of honesty focuses on "telling" the secrets the eating disorder required the client to keep. This level acknowledges the pain associated with the telling as well as the lightness and freedom in not having secrets to keep. In this level of honesty, self-punishment and judgment are not targeted or redirected. In the second level of honesty, the client focused on accepting the truth of her behavior while maintaining a separation of current identity. This results in statements like, "It's the truth, but it is not who I am." The third level of honesty focuses the self-judgment into personal responsibility in the here and now. The goal is to create an environment where the

client can learn from life experiences without damaging personal identity. The fourth level extends the third level out of the individual and into personal relationships with others. The therapist stated, "I talked to her throughout our working together on the four levels of honesty about learning to be honest without self-judgment, self-blame, and how to start being more honest through self-kindness and choice…and that was very helpful to her."

*Renewing identity development***.** The therapist also focused the client on her own identity and how she could renew her sense of self. He used a drawn model, shown in Figure 2, which introduced two identity and religious concepts. The first is that her current identity development was so dependent on externalized information that there was no clear distinction between "who I am" and "what I do." The client clarified that, in reality, it is not "what I do" that she was struggling with, but actually "all the emphasis is on what [she] doesn't do well." The therapist introduced the "Atonement" and God's love, two key religious principles consistent with the client's religious background, as alternatives to the client's identity formation. The Atonement, as the therapist introduced it, covers the sacrifice of Jesus Christ for the salvation of mankind. The therapist explained, "God knows who you are and He also knows what you do. But we need to leave this room here [in the middle between "what I do" and "who I am"] otherwise you're left to your own devices."

In addition to these in session discussions, the therapist recommended small sections of *The Continuous Atonement,* a short book by LDS author Brad Wilcox (2009), as well as small sections of *Weakness is Not Sin* by Wendy Ulrich (2009), both of which highlighted specific fundamental focus points important to clarifying this religious principle.

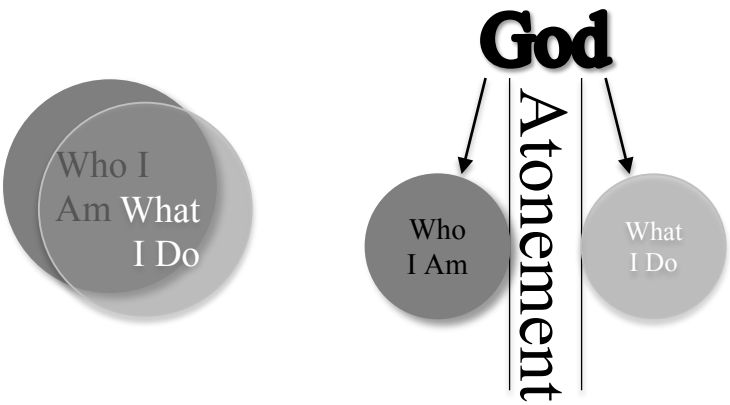


*Figure 2*. The therapist's model for incorporating the Atonement into the patient's identity formation.

The therapist then used another diagram, shown in Figure 3, to explain how the client had only been focusing on one aspect of her identity, namely the eating disorder. Instead, the therapist helped her to understand the complexity of her identity. He explained:

> So one piece of you cannot be all of who you are. And then I could also point out that how she looked was not who she was – it was only one tiny part of her. So what I was trying to do was to get her out of this very black and white emotional concreteness.

*Figure 3*. A model therapist utilizes for explaining the complexity of identity formation to a patient.

The therapist also introduced the concept of outcome vs. process living as seen in Table 3. In this concept, the therapist explained that people who base their identity on outcomes often "get stuck and over think and obsess and worry and analyze everything to death." He explained that Stephanie was completely focused on the "do" aspects of life. He stated that in order for Stephanie to recover, she needed to have a balance of both outcome and process goals. He explained that she needed to value "her experience, her learning, her understanding, her heart, her intuition, her relationship, and that that's internal or that's inside of her." He stated, "we made outside goals and inside goals for therapy."

Table 3
*Therapist's Explanation of Outcome vs. Process Ways of Living*

| Outcome | Process |
|---|---|
| DO | BE |
| Task | Experience |
| Achievements | Insight/Wisdom |
| Results | Learning/Understanding |
| Performance | Motive |
| Accomplishments | Heart – Intuitive |
| Product | Relationships |
| Outside – External | Inside – Internal |
| Focus Excellence | Focus – Acceptance |
| Outside Goals | Inside Goals |
| Spiritual | Spiritual |
| - Obedience | - Change of Heart |
| - Keep Commandments | - Be New Beings |
| Both are Important! | |

Next the therapist explained, through Figure 4, how Stephanie's identity formation depended on three important relationships, client to self, client to other, and client to God. He explained that Stephanie had placed relationships with others above her relationship with herself, which is why she was so sensitive to critical feedback from those around her and yet was unable

to provide herself with constructive feedback or to receive divine feedback. Ultimately, the therapist wanted Stephanie's relationship with God to supersede all other relationships. The therapist explained:

> We had to change the order. We had to go God first, self second, others third. And we had to work on how she connected to God and how God connected to her, how she connected to herself and how she responded to herself so that all of the focus wasn't on other people.

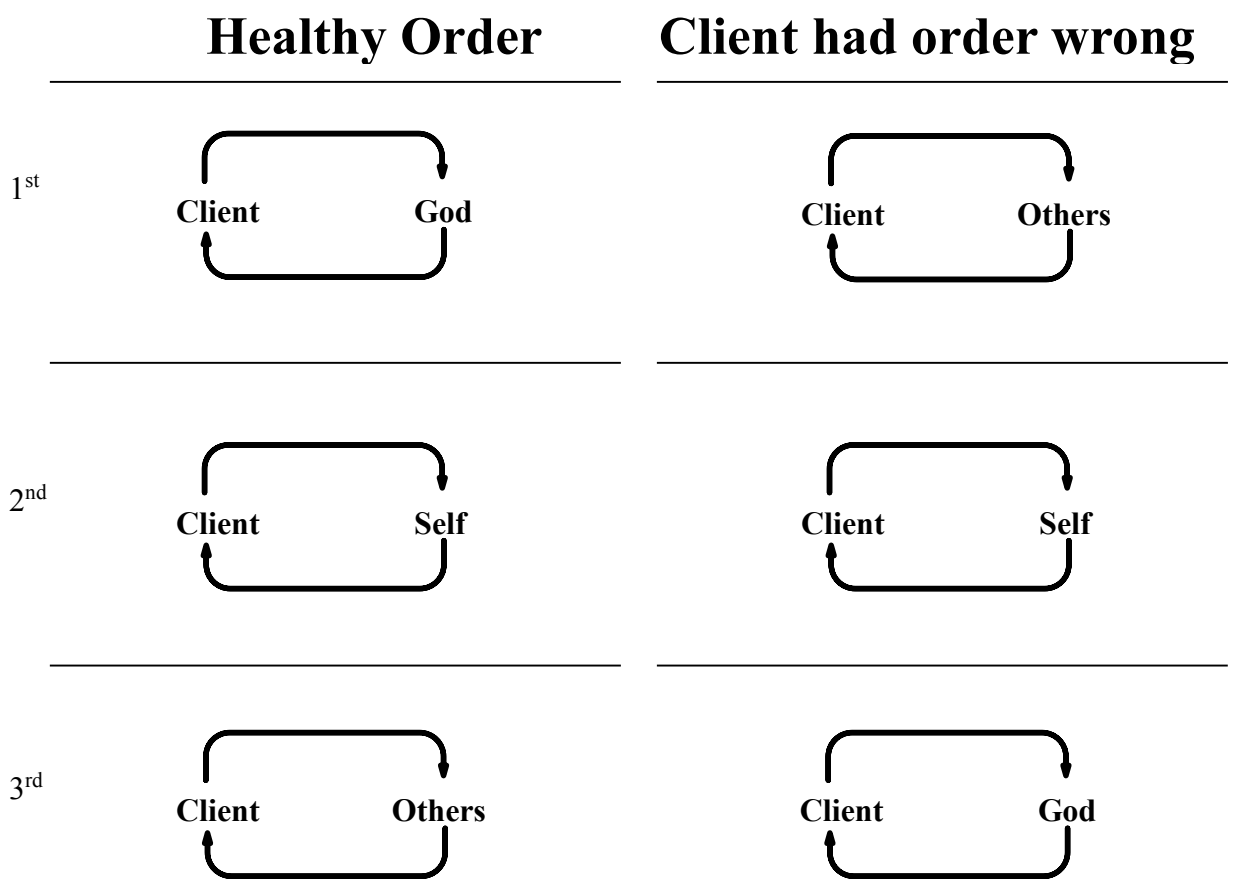


*Figure 4.* Therapist's model comparing client's healthy to unhealthy relationship priorities.

*Creating healthy behavior patterns.* The therapist described helping the client correct some bad behavior cycles. He explained:

> When I started seeing her in the semester she, at that point, was failing all of her classes, was not attending class, was not working very much on her homework…She also had a part-time job here that once she was there she did pretty well, but it was hard to get into it. We would talk about structures and strategies to kind of help her…we worked on some structure and some strategies to get her to class, to work on homework… we shortened study time so she could stay focused for longer. You know, like we would do three short periods of study instead of one big one.

***Interweaving Spiritual Interventions***. The therapist explained that with every principle they discussed he would "frame things in a spiritual context." The therapist focused on a clinical framework called "six spiritual pathways to recovery from an eating disorder."

*The first pathway.* The first pathway is a technique the therapist calls "listening to the heart." The therapist explained he had developed this spiritualty sensitive therapeutic language over the course of his work at an inpatient eating disorder clinic. At the clinic, he noticed that when the new patients would do a body tracing art project they would represent their hearts as "broken, in chains, or missing" but as the clients progressed in therapy, they began to draw different hearts in their body tracings. He described the new hearts as "vibrant, full of color, with light shooting out of them." It was because of these experiences that the therapist began to discuss heart-related experiences, which eventually developed into this technique. The therapist explains the focus of asking clients to listen to their heart:

> Helps [eating disorder patients] remember intuitively and deeply the important truths about who they really are. It helps them remember what matters most in their lives. The

> heart helps them remember who truly loves them. It also helps them remember what they really want and where they want to be.

The therapist believed that, in addition to reawaking their sense of identity and values, listening to the heart is a powerful and universal way of engaging a client's spirituality. He states:

> I believe that by listening to their hearts again [the patients] will remember that they are not alone in this world, and that they are surrounded by seen and unseen influences of good. The heart can help them remember all the good things that once spoke to their hearts.

With Stephanie, the therapist asked her to listen to her heart, highlight the spiritual impressions that came into her heart, and bring them into therapy sessions to develop them more. He explained:

> [A]nytime the spirit talks to you [Stephanie] in session or in your own life out there…write those down because those are key messages to you to help you in the change process and…we will develop them in therapy…and in session she would feel that spirit sometimes as we were talking about things and she would either tell me or I would notice it and bring it up and we kind of anchor that. We anchored these spiritual moments as kind of key…messages. So we want to make them an active part of your change process or of your strategies to help you do things better. And she liked that because it made her feel more connected to God. It helped her feel like she wasn't alone and that God was actively helping her.

*Second spiritual pathway.* The therapist utilized the second spiritual pathway as he focused on understanding and fostering a spiritual language that he and Stephanie could use in

therapy. This allowed the therapist to further develop spiritual concepts such as choosing light vs. dark. He framed the client's possible choices in terms of light and dark by explaining:

> If her choices were in light, she felt edified, uplifted, she felt peace, it felt like there was more good things available to her, it enlarged her view of things. If she chose out of darkness, then it restricted things and limited them. She felt more was missing and it felt more like that there were less good things available.
>
> I tried to teach her that a choice was not good or bad, right or wrong. It's simply to tune into her heart and say is this a heart choice? And if so, it's going to create light or more room or abundance. If it's an eating disorder choice, it's going to restrict me, make me feel bad, limit me.

In this way the therapist was able to incorporate both the psychological and spiritual into the same intervention.

*Third spiritual pathway.* The therapist also directed the client toward the third pathway, mindfulness and spiritual mindfulness. The therapist worked to help Stephanie understand how she could be mindful in putting "spiritual principles ahead of her feelings." He stated, "I gave…both a psychological and spiritual meaning of self-respect…and said we're going to put self-respect over feeling not good enough, or we're going to put self-kindness and self-respect over feeling self-doubt or feeling afraid." The therapist further utilized listening to the heart to help ground Stephanie in the present moment. As he explained using Figure 5, the mind can be in the past, the present, and the future, but the body and heart are always in the present. He explained about Stephanie that:

> Most of the time all of her—she lived her life in her mind. It was in the past, or it was in the future, but she wasn't present…and that if we can get her mind and her body and her

heart in the same spot, she'll feel connected to herself, she'll feel connected to God, she'll feel connected to others. So what I used to say to her a lot is be yourself, show up, be connected, be present, and later you can think about it if you wanted to. But I need your mind to be where your body and heart is because that's how you're going to recognize your heart speaking to you and help you to listen to it.

| | *Past* | *Present* | *Future* |
|---|---|---|---|
| *Mind* | ***X*** | ***X*** | ***X*** |
| | | *mind can be in all* | |
| *Body* | | ***X*** | |
| | | *body is here* | |
| *Heart* | | ***X*** | |
| | | *heart is always available in present* | |

*Figure 5*. Therapist's model comparing mind, body, heart a crossed past, present, and future time frames.

*Fourth spiritual pathway.* The fourth spiritual pathway the therapist used was principled living. In this pathway a client is able to courageously endeavor to align their behaviors with their deeply felt religious convictions. The therapist utilized the process vs. outcome living example explained in Table 3 to explain how the balance between process vs. outcome living also relates to spirituality. He explained, "Spiritual outcomes are obedience and keeping the commandments. And spiritual process is a change of heart and being new creatures in God." He explained how she had only focused her religious participation on the outcome aspects of religiosity and had thus become "only partially involved" in her religious community.

*Fifth spiritual pathway.* The fifth pathway the therapist utilized was the "giving and receiving of good gifts of love." In this pathway the therapist would have Stephanie go out and "look for God's love, look for love in other people, look for love, look for God out there in her day-to-day life because she had a terrible case of eating disorder tunnel vision." He went on to explain:

> I realized that most clients do not do a very good job of looking for love in their life. Because a lot of times they feel like they're broken or they're the exception of love. So that's where I said, every time you feel the Holy Ghost it's a witness of God's love. Every time somebody in your life shows you love, let it in. That's a witness that love is in your life. You're not the exception of it.

*Sixth spiritual pathway*. "Holding up a therapeutic mirror that reflects spiritual identity," the sixth and final pathway the therapist used, is a technique in which the therapist uses positive statements and praise to help the client see new and positive aspects of him- or herself. He explained that with Stephanie, he often "held up the mirror to her so she could see God's light and love in herself and how she was being with other people. I invited her to look for God's love in her life, in other people, and herself, and to connect to love."

***Spiritual guidance.*** In addition to these six spiritual pathways, the therapist also shared his own openness to spiritual guidance over the course of therapy. He stated that:

> I pray before every session. I do. I know I can't do this. We all need God's help. But when I have an impression come to my heart or my mind through the Spirit, I always say it. Even if we're doing something different I'll say it. I'll act on it. And I've found that it's almost always well received. And it's often times just what they needed. So what I'll sometimes say to them is, look I need to stop and tell you what came to my heart and

> share it with you. Or, let me tell you what I felt the Spirit wanted me to – just came to me and so I want to pass it on to you. And I often said, look we need God's help—you pray for God's help, I'll pray for it because when we're here He'll help us.

The therapist also explained how he was able to receive spiritual guidance during one experiential intervention with Stephanie. The therapist began working with Stephanie's self-contempt in the beginning of one particular session in which she reported having "a terrible body image." The therapist explained that he began exploring her thoughts and emotions in a very "CBT way," but received a spiritual impression to move the session into a more spiritual concept. He explained that he had Stephanie "imagine how God viewed her body, not how she saw her body, but how God saw her body." The therapist then placed a chair in front of Stephanie with her backpack in it and stated:

> Let's imagine that [the backpack is] your body and that God's looking at your body and you're looking at your body here together. And I want you to tune in and get through your heart or through your mind to get a sense of how God sees or views your body.

The therapist explained the results of the exercise:

> She had a powerful spiritual experience. Where she felt like she knew how God viewed her body. She got a sense of it, a spiritual sense of it…how God valued her body and that God saw her body as beautiful and acceptable and had a purpose and was important and had a role…And it was profound. I mean she was crying and the Spirit was strong.

The therapist goes on to explain that after that experience the client still struggled with feelings of self-contempt, "but that…she said okay, I know what God's perspective is now and so I want to pursue that. And it gave her hope and it gave her a deeper sense of what her body really meant." The therapist continued by recommending Stephanie seek, through prayer,

continued confirmation about how God views her body as well as ask for help aligning her own beliefs about her body with her felt sense of God's beliefs. He stated:

> We talked about how to specifically pray for that. To pray in her prayers very specifically to have God help her align her view of her body image more in harmony with His view of her body image. And that was a key turning point in the recovery. Because once she knew that then it was like I need to take better care of me and my body. I need to do recovery. And after that session, I knew that she was going to get better. And it really made a lot of momentum in recovery.

The therapist explained that this was a completely novel intervention but a powerful one. For an overview of the timing and type of spiritual interventions consult Table 4.

Table 4
*Therapeutic Interventions Used Throughout Treatment*

| | Session | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| Eating Issues | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Charitable service | | | | | 1 | | | |
| Forgiveness | | 1 | | | 1 | | | |
| Discussed scriptures | | | 1 | | | | | |
| Referral for blessing | | | 1 | | | | | |
| Spiritual journal writing | | 1 | | | | | | |
| Spiritual relaxation or imagery | | | | | | | 1 | |
| Spiritual self-disclosure | | | | | | 1 | | |
| Teaching spiritual concepts | | 1 | | 1 | | 1 | 1 | 1 |
| Prayer-silent therapist prayer | | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Use of religious community | | | | | | 1 | 1 | |
| Listening to the heart | | 1 | 1 | 1 | 1 | 1 | 1 | |
| Trusting God | | | | | | 1 | | |
| Accept God's Love | | 1 | 1 | | 1 | | | 1 |
| Client Private Prayer | | | | | | | | 1 |
| Encouraging personal prayer | | 1 | 1 | 1 | | | | |

**The client's story.** From the client's perspective we gain two interesting insights, (a) what aspects the client considers to be her problem and (b) what therapeutic solutions she feels helped in her recovery.

To begin, the client explained several factors that she considered integral to her previous development and maintenance of her eating disorder: religious community pressures, perfectionism, self-contempt, irrational thinking, body fixation, and depression spirals.

Stephanie explained that while growing up in an LDS community, she had always felt "so much pressure, to be perfect." She stated that she witnessed many of the women in her community struggle with the "ideal image of what you need to be." She stated that she would often compare herself to peers who seemed to have better grades and more academic accomplishments. She recalled feeling, "If you don't have it all together, you're not good, you're not worth anything." She explained how this religious community pressure extended into her experience at BYU-Idaho. She stated, "I have a problem with expecting so much from myself. Like the semester that I was with the department, I was working, and I was taking like more than the full, like 14 credits."

She explained how this religious community pressure to perform had left her with a need "to be perfect." She stated that her depression was partly due to that fact that "I ended up failing because I expect too much of myself."

Stephanie went on to explain that all of this pressure and self-criticism caused her to foster a great deal of self-contempt. She explained, "I just didn't like myself, as a person, I didn't think I was good, I thought I was bad." Stephanie explained how these feelings of depression spiraled into her eating disorder:

> I just felt bad about myself. I knew there was just this thing that was like bringing me down, I was so depressed, like I was always down and just even my thoughts were bad you know? You let it control your thoughts and then control your whole body and then you don't know you're in a bad place, but sometimes it's easier to just stay there than it is to like improve.

Stephanie explained that these feelings of depression would be focused in on her body. She explained:

> I had a huge problem with my body, but the bigger problem was I just didn't like myself… I'm not good at going to church all the time, and I have depression, and I have these spirals out of control and I don't have that many friends and all these little things pile up and then I would take it out on my body. I would say the whole problem here is I'm not fit enough. Because if I was thinner, everything would be perfect.

As Stephanie revealed, this fixation became more and more set until she had lost touch with who she was or what she wanted. All she had room for was her eating disorder. She stated that, "for a long time, I don't think I really knew who I was. And being that person, like, I didn't like who I was…I was always bad and I was always fixated on you know my body and all those things."

Stephanie noted that there were several parts of her eating disorder solution. She explained that the therapist and his modality were a big part of her healing. She also explained that she learned some important skills during treatment like the ability to resist comparing herself to others and to impart self-kindness. She also developed a deeper sense of her own identity, connection to what she loves, a consistency with her medication, and an ability to be present in a relationship despite having imperfections.

Stephanie recalled that when she began treatment, she did not have a good impression of the therapist. She explained, "he does have a strong personality, and so at first I didn't really like that." She explained that she stuck with therapy because of the relationship she was able to form with the therapist. She described how "he always wanted to listen and hear everything I had to say." She went on to explain that, "I just believed him more, because I trusted him." She explained that trust had developed because she always felt her therapist wanted to listen to her. She stated how his interest in her opened "the floor up and so I would talk, and then he would kind of analyze it, and he would tell me what he thought you know and yeah, I always believed when he said things spiritual because…I just, I trust him." She also explained she felt she could rely on the therapist's clinical experience. She did not recall the therapist ever using his position or experience to tell her "a story about himself for every little thing I had to say." Stephanie also explained that it was important to her trust in her therapist that he would "tell me things that were really hard to hear… like, 'you think you're fat' or 'you don't like your thighs'."

Stephanie pointed out that the therapist had a positive way of responding to her failures. She explained, "He was just so light about it." She recalled several examples of when the therapist would say things like, "it's okay, you did something, now let's just keep going, let's just keep working on it," or, "okay, so you skipped class, that doesn't make you a bad person." These statements helped her trust the therapist and the therapy process. She explained that the therapist would reinforce positive aspects about her like, "you are a really loving person." She explained how important it was for her to feel "someone notices me, someone notices the good about me and someone was telling me the stuff that I needed to hear about myself, you know." She believes that her therapist was a great example of "someone who loves you, that you can

trust, who will be honest with you and that will help you come into yourself," and that for her was one of the factors that led to her embracing recovery.

Stephanie recalled how important for her it was that her therapist was "in tune with the Spirit" and was able to "relate to all my beliefs." She explained that her therapist's spiritual sensitivity also played out in a priesthood blessing she received from him toward the end of her treatment. This is a practice that is common in the LDS religious tradition, but it is not a common spiritual therapeutic intervention. She highlighted how this spiritual experience had greatly impacted her during her time outside of treatment. She stated that during the blessing, the therapist promised her that she was "going to recover." He also explained that she would continue to progress spiritually and that she would soon find her spouse. She stated that this blessing had special importance in her life after treatment. She would often recall it when she needed hope.

Stephanie talked at length about the impact the therapist's integration of spirituality had on her own spirituality. She explained how she was able to gain a sense of what God knows about her, help challenge incorrect feelings with correct spiritual principles, and increase her measure of faith that God believed in her and would help her. She explained, "When you're down on yourself all the time, that's **NOT** how [God] sees you…because you are putting yourself down so much, it feels real. It makes everything that you're saying feel very real, but it's not…it's not true." She went on to explain that the work she did with her therapy impacted her faith:

> I think the feeling that he gave me was just faith, and that [God] believed in me, and [God] believed that I could change. And that [God] was there to help me, and you know, pulling me up.

Looking back over the course of her recovery, Stephanie explained that "God really does have a plan for me and I was meant to go through everything that I had to go through."

Stephanie recalled how important it was for her to learn how to stop comparing herself to others. She explained that the key to this skill is being able to recognize her limits and realize that the consequence of failing is "nothing! Life goes on, you move on, you figure it out, you get better, you become a better person, you learn."

Stephanie went on to explain how she felt she had to "start taking care for myself…I had to learn how to love myself, which is really hard." She explained how her therapist helped her by asking her to create a list of things she liked about herself "that [weren't] physical." The therapist wanted her to read it to him in the subsequent session. She recalled, "that was really good for me, because you don't often tell yourself, you don't look in the mirror and tell yourself good things about yourself, you tell yourself bad things." Next, she recalled her therapist wanted her to "practice hugging." She recounted how "weird" this request was but she complied and stated that it helped. She summarized:

> Just like telling myself that I was okay…and that there were things that I did like about myself. Like even if I didn't like my legs I could look in the mirror and see there were twenty other things I liked about myself that aren't…physical things…and then learning to respect and take care of yourself.

She explained that she started to build on these small acts of self-kindness by "get[ting] to class on time, and eat[ing] enough so that you're not starving so that you can focus more on your classes, so that you can do all these different things." Stephanie goes on to explain that slowly she began taking control of her own self-care. In this process she was:

> Learning how to love myself and accept myself for who I was and then, I don't know, I just kind of grow from this, like once I went to that place of being able to love myself, like I was so open to growth. But before that I couldn't, because there was nothing to grow on.

Stephanie explained how this growth began to blossom into a renewed sense of identity. She proclaimed, "I'm finally to the point where I'm more okay with myself. And I'm like you know what, this is who I am, and I like who I am." She furthered her process of discovery after leaving treatment. She started working with a dietician. She recalled that the dietician asked her to make a list of all the foods she liked. Distraught she stated:

> I was like, oh my gosh, what kind of food do I even like? I didn't even know. I didn't even know what kind of food I liked because all it was was this stuff I put down my throat and then throw up.

She stated she embarked on a food-tasting quest to find her favorite foods. She described the experience as "empowering." She noted that she felt this journey of discovery was possible only because she had stopped "being obsessed over myself" and was able to "like herself."

Another key feature of her recovery was opening up to her own values and passions. She explained that she started doing floral arrangements again after leaving treatment. She explained that she had done it before and had really enjoyed it, but she had given it up because her parents had told her she would "never make any money." She explained that as she reengaged in creating floral arrangements she had greater fulfillment. She joyfully said, "I wasn't weighing myself every day, I wasn't like so concerned about stuff, I was who I was."

Stephanie also explained how during her treatment she was able to gain a new perspective on medication. She explained that before her treatment she had struggled to take her

depression medication regularly. She recalled struggling with the stigma that surrounds psychotropic medication. She came to realize that "when you're off your medication, that's not who you really are." She stated that as she was finally able to take her medication at "regular increments" she would "get to bed on time, take care of myself, eat enough food." She concludes the thought with, "When I do all that it just enables me to be who I really am and just help you grow."

Lastly, Stephanie explained how treatment had allowed her to engage in meaningful and sincere relationships. Before treatment she felt she had to "figure it all out" before getting into a relationship. Stephanie describes the process of engaging in dating her now husband:

> I think something that was good for me was finding him, and it's so cheesy to say it, but, my other half, and him loving me so much that he was willing to stand by me while I go through all of this, while I figure out who I am, and I figure out what I like and become more confident in myself.

Table 5
*Similar Quotes from Therapist and Client*

| Therapist | Client |
|---|---|
| "Get through your heart or through your mind…a sense of how God sees or views your body" | "you have to be able to see yourself the way that [God] sees you". |
| "I asked her to basically say to [the imagined little girl] everything she had just shared with me that had been going on inside of her for several days." | "and then he asks me to tell a little girl that, well then I'm like they're not true, well then, wait a minute, then it's not true altogether." |
| "Every time somebody in your life shows you love, let it in. That's a witness that love is in your life. You're not the exception of it" | "Like people show you love all the time, like someone opens the door for you, or someone smiles at you, like if you really think about it, you can let all that love in, but people don't let that love in, they blow everything off" |
| It helped her feel like she wasn't alone and that God was actively helping her which He was. | What I've been through was worth it, and God really does have a plan for me and I was meant to go through everything that I had to go through, and that's when I knew, for real, that this was my purpose you know, and God blesses you. You know, you think that we go through all this hard stuff and it's not gonna get any better but it does |

She explains how she feels one of the best things she has been able to accomplish since treatment is to be vulnerable and engaged in her relationship with her husband. Equally

remarkable was the permanence of the effects of Stephanie's treatment on her own beliefs and life as evidenced in the themes and phrases covered in her and her therapist's interviews. Equally fascinating was the frequency with which Stephanie used the same stories and phases as her therapist while describing her treatment. Some examples of this can be found in Table 5.

## Discussion

Within the context of the larger eating disorder field, Stephanie's progress is something of an outlier. It has been reported that only about 27% of bulimia patients report "bingeing and purging less than once per month" after follow up (Richards et al., 2000). Other publications have stated that roughly only 45% of patients diagnosed with bulimia ever report achieving recovery (Steinhausen & Weber, 2009). These disheartening statistics show just how rare it is for a client to have the type of improvement Stephanie reported through session-to-session quantitative outcome data, the EAT, and qualitative interviews.

The single-n case study research design has proven an informative and rich methodology in the examination of Stephanie's treatment experience. In this intensive single-n case study (Creswell, 2009; Kazdin, 2011; Merriam, 1988; Stake, 1995; Yin, 2014) we provided an in-depth qualitative study that plumbed the depths of clinical expertise within an actual therapy experience, providing important insight into why and when spiritually oriented interventions are helpful in the treatment of eating disorders.

Due to the non-evasive nature of the single case study design, we were able to examine treatment as usual, giving us a "descriptive foundation for a science that suits the nature we are trying to comprehend" (Peterson, 2004, p. 205). We have also unitized "multiple sources" of evidence (e.g., session to session outcome data, qualitative interview, video recordings; Yeh & Inman, 2007, p. 374), which provide rich detail to the insights and findings. We have

collaborated with skilled and seasoned clinicians in the development of clinically relevant outcome measures, which not only added to the treatment (Lambert, 2013), but also increased the clarity with which we could understand Stephanie's progress. This methodology could continue to expand our understanding of the techniques, foundations, and limitations of spiritually oriented psychotherapies as applied by those with valuable clinical expertise and, of equal importance, it could give voice to the client's themselves as they teach what healing means (Barkham, Stiles, Lambert, & Mellor-Clark, 2010; Evans, Connell, Barkham, Marshall, & Mellor-Clark, 2003; McGilley & Szablewski, 2010).

Two of the major drawbacks of single case methodology are limited generalizability and internal validity (Kazdin, 2011; Yin, 1981). As Barkham, Stiles, Lambert, and Mellor-Clark (2010) explain, "no single study can yield a definitive answer" (p. 22). Therefore, this study should not be generalized beyond these specific contexts. However, this weakness can be addressed by continuing to repeat rich single case studies across varied contexts and conditions. Thus, the present study should be viewed as one link in a chain of several studies. An additional limitation experienced in this study was the broadness of the assessment measures used. Because Stephanie was selected from a large outcome study after the course of her treatment, she was not given specific tracking measures for disordered eating before or during her treatment. It was not until after she was selected for this study that she completed the EAT. In conjunction with the lack of symptom specific measures, we feel that the selection criteria for this study prevented us from establishing a clear baseline. Had we been able to provide several interactions with the CAMOS before treatment began, the baseline would have been much more clear. Lastly, as can often be the case, additionally qualitative interviews with the therapist and the client would have added depth and detail to our findings. However, due to the limited access we

had to the client and the therapist, as well as the data we were able to gather, we believed we had sufficient to proceed with our data analysis. Despite these limitations, we feel this case study provides ample insight into the process and outcome of Stephanie's treatment.

This case illustrates how a patient's religious community and religious misinterpretations can influence the development and retention of an eating disorder. In Stephanie's case, she reported her eating disorder developing out of struggles with perfectionistic tendencies consistent with religious beliefs of constant improvement toward perfections that she misunderstood and misapplied in her life. Stephanie's therapist's "denominational therapeutic stance" (Richards & Bergin, 2005, p. 158) was powerfully effective in this case study. He was able to provide "more directive, challenging, and educational" (p. 158) spiritual interventions through correcting the client's misunderstandings about specific religious principles like the Atonement, helping Stephanie put those correct spiritual principles ahead of her negative and self-judgmental feelings, and providing critical feedback about the poor state of Stephanie's relationship with Christ. Stephanie recalled her therapist's ability to incorporate spirituality and religious topics into therapy saying, "[He] knows what he's supposed to say."

Stephanie's case also provided clear insight into the therapeutic processes that were most effective in her healing. She acknowledged a powerful triad of attributes in the therapeutic alliance. Specifically, she credited her therapist's openness to listen, his patience with her in the process, and his spiritual sensitivity as primary contributors to her ability to overcome her initial hesitancy about the therapist's effectiveness. She recalls thinking, "this guy can't help me." She explained that, through these attributes, she gained "trust" in the therapist, which added even more power to her treatment experience. The therapist explained that he felt his ability to foster these therapeutic alliance attributes is related to his theistic framework of human nature and

recovery, which have been written about in several sources (Richards & Bergin, 2005; Richards, Hardman, & Berrett, 2007).

Material to the successes realized was the therapist's recognition of time and other logistical limitations. More specifically, the therapist knew he was only going to be able to provide therapy for a relatively short period. Therefore, his treatment was brief and strategic. Despite the complexity of the therapist's theoretical framework, he focused on three therapeutic areas, which we conceptualized as: reawakening identity, reducing self-contempt, and fostering hope. These three clinical focuses were not systematically addressed in succession; rather, the therapist wove them into the therapy simultaneously, demonstrating an understanding of the delicate interaction between the three areas and a reliance that each would progressively support the other two. For example, as the therapist worked with the client in developing the skill of "listening to the heart," Stephanie became receptive to small spiritual impressions of self-kindness and also engaged feelings of hope and faith that God could help and that spiritual healing should be part of her recovery. This in turn helped restore her spiritual identity, which she had lost over time due to the incongruence of her behavior and her religious beliefs. Renewing her spiritual identity opened a small portal to self-empathy that the therapist expertly wove back into acts of self-kindness and hope. In this way, the therapist slowly breathed life back into Stephanie's spiritual identity, and with a renewed confidence she began seeking spiritual connections that would eventually replace her eating disorder (Berrett, Hardman, O'Grady, & Richards, 2007; Richards, Smith, Berrett, Grady, & Bartz, 2009; Richards, Weinberger-Litman, Susov, & Berrett, 2013).

Of greatest surprise to the researchers of this study was the extent to which the client's and the therapist's qualitative interviews corroborated with fidelity. We anticipated that, due the

large amount of time between therapy and our follow up interviews, only basic themes or principles would carry over between the therapist's and the client's tellings of their experiences. However, the client's vernacular matched the therapist's to an extraordinary degree. One of the potential contributors to this level of cohesion between therapist and client is the transcendent nature of the therapy they completed together. Theistic treatments, unlike more individualistic treatments, redirect the client's focus out of themselves, placing that focus on a loving higher power (Richards & Bergin, 2005). This, coupled with the experiential nature of the interventions employed by the therapist, fostered a transcendent experience consistent with self-transcendence, Maslow's highest level of human needs (Maslow, 1969), which seems to have the ability to reach deep into individuals' lives, providing a sustainable altered view of themselves and their pathology. Further study on this phenomenon is merited.

As we studied this case further, we came to believe that perhaps the most significant element of permanence in Stephanie's recovery is her practiced ability to honestly and hopefully self-evaluate and self-correct. Before a series of treatment successes, this ability had been mercilessly crushed by Stephanie's overwhelming sense of self-contempt. As the therapist explained, Stephanie's reduction in self-contempt hinged on the experiential interventions in which Stephanie was asked to express to her seven-year-old self all of her negative body image beliefs. As Stephanie recalled, through the power and spiritual component of those experiences, it became clear how effective it is to develop an appropriate spiritual language in therapy such as "listening to the heart" (Berrett, Hardman, & Richards, 2010, p. 373). Stephanie clarified, "I would never tell a little kid that you know? So it just, it spiritually, it touched me…to be able to know that I wasn't right, or that I shouldn't be doing that or shouldn't be saying that [to me either]."

Upon termination of services with Stephanie, the therapist noted:

> "Stephanie still had work to do… But…what made it different for her now is that she had hope. She knew she could recover. She knew God would help her recover. She knew that her view of herself had changed because she had felt God's kindness."

The client's echo of this statement is both awe inspiriting and hopeful as she is able to bring all the pieces of her treatment together:

> It still wasn't good when I left him, but as I worked on it, I knew…this was the happiest I have ever been in my entire life and…God really does have a plan for me and I was meant to go through everything that I had to go through, and that's when I knew, for real, that this was my purpose and God blesses me. You think that we go through all this hard stuff and it's not gonna get any better but it does.

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APPENDIX A: Literature Review

**Evidence-Based Practice of Psychology**

The concept of evidenced-based treatment in psychology is not new. From the time of the earliest mental health clinics, "psychologists have been deeply and uniquely associated with an evidence-based approach to patient care" (APA, 2006). However, defining what constitutes evidence-based, empirically validated, or empirically supported treatment, as well as helping establish the evidence base in the practical application of therapy, has been a source of difficulty in the profession (Wampold, 2010). Some have hypothesized (Castonguay, Barkham, Lutz, & McAleavey, 2013; Castonguay et al., 2010) "empirical imperialism" as being central to this difficulty, which is to say those who direct therapy research are often far removed from the actual administration of therapy. One example of this type of discrepancy can be found in the research and treatment of eating disorders. Berrett, Hardman, and Richards (2010) reported that, "A systematic review of the *International Journal of Eating Disorders* found that only 0.8% (N=8) of over 1033 empirical studies published from 1993 to 2004 included religion or spirituality as a variable." As well, "Only 2.2% (N=4) of 186 empirical studies published from 1999 to 2004 in *Eating Disorders: The Journal of Treatment and Prevention*, included religion or spirituality as a variable" (p. 368). Despite this seeming lack of interest within the field of research, an exhaustive internet search of eating disorder treatment facilities showed "67 of [the 150 treatment sites found] (44.7%) indicated that they address religious or spiritual issues in some way" (p. 368). McGilley and Szablewski (2010) also explain, "spiritual issues have long been underscored in the recovery literature despite being more newly emphasized in academic forums" (p. 209). In the small amount of research that has been done on spirituality and eating disorder, there is resounding evidence that the dimension of spirituality needs to be included in

the etiology and treatment of eating disorders (Richards, Weinberger-Litman, Susov, & Berrett, 2013).

In response to this and other similar discrepancies across the psychological field, the American Psychological Association (APA) appointed a Presidential Task Force on Evidence-Based Practice in Psychology to study the issues and to write a position paper. The APA Task Force report (APA, 2006) unsurprisingly calls for "mutually respectful collaboration between researchers and expert practitioners" with the belief that they "will foster useful and systematic empirical investigation of clinical expertise" (p. 278). The report explained that one of the ways this collaboration could take place is through "qualitative research," which could "be used to describe the subjective, lived experiences of people, including participants in psychotherapy" (p. 274). The report goes on to explain, "clinical observation (including individual case studies) and basic psychological science are valuable sources of innovations and hypotheses (the context of scientific discovery)." (p. 274).

## Single Case Study

An intensive single-n case study (Creswell, 2007, 2009; Kazdin, 2011; Yin, 2014) can provide an in-depth study that plumbs the depths of clinical expertise within an actual therapy experience and provides important insight into why and when interventions are helpful in treatment. Due to the close relation between the single case study and actual therapy, it is fairly easy to institute this research paradigm. As Peterson (2004) explains, the naturalistic settings add strength to the findings as they are creating "databases grounded in the actual experiences practitioners encounter will provide a descriptive foundation for a science that suits the nature we are trying to comprehend." The single case study also relies on "multiple sources" (Yeh & Inman, 2007, p. 374) of both qualitative and quantitative evidence (e.g. session to session

outcome data, qualitative interview, video recordings, etc.) in drawing rich and in-depth intrasubject findings (Mcmillan & Morley, 2010).

## Eating Disorders

As stated in the report for the Academy for Eating Disorders (Banker et al., 2012), "Eating disorders are serious disorders with life-threatening physical and psychological complications" (p. 5). Eating disorders have been broadly understood to encompass disrupted eating practices, intense fear or anxiety of gaining weight, and disturbances in how one perceives their size and body weight (APA, 2000). However, the changes found in the recent update of the Diagnostic and Statistical Manual of Mental Disorders (DSM) show the nuanced complexity of disordered eating.

The first disordered eating diagnosis appeared in the third edition of the DSM in 1980. Eating Disorders were specified by two categories: Anorexia Nervosa (AN) and Bulimia Nervosa (BN). It was not until 1994 that, with the publishing of the forth edition of the DSM, Eating Disorder Not Otherwise Specified (EDNOS) was recognized and Binge Eating Disorder (BED) was introduced as an example in the appendix under the EDNOS category (Walsh & Sysko, 2009). This was a much-needed addition as the two main eating disorders, anorexia and bulimia, have been documented as existing on a continuum and are not often mutually exclusive (APA, 2006; Fairburn et al., 2007). This has led to EDNOS becoming the most common eating disorder diagnosis. Some have estimated that 50-70% of all eating disorder cases are diagnosed as EDNOS (Fairburn & Bohn, 2005; Fairburn et al., 2007; Walsh & Sysko, 2009). In 2013, the fifth edition of the DSM introduced binge eating disorder as a separate diagnosis (Striegel-Moore & Franko, 2008). DSM-5 also now includes pica, rumination, and avoidant/restrictive food intake disorders in the "Feeding and Eating Disorders" category. These last three disorders were

included in the DSM-IV, but only in the "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence" category.

The DSM-5 made some significant changes to the diagnosis criteria of AN. The changes included removing the word "refusal" from criterion A, which denoted an intention and was difficult to assess. Also, criterion D in the DSM-IV, which required an absence of at least three menstrual cycles, was deleted. The diagnostic criteria for BN were also changed. The frequency of binge eating and compensatory behaviors required for the diagnosis was reduced from twice weekly to once weekly (APA, 2000, 2013).

Where normal identity is informed by relationship, employment, spirituality, etc., AN and BN do share a common psychopathological theme in the placement of identity solely on a person's "shape and weight and their ability to control them" (National Collaborating Centre for Mental Health, 2004, p. 407).

**Anorexia Nervosa**

Anorexia Nervosa, as highlighted in Figure 6, focuses primarily on three main criteria: persistent restriction of energy intake, intense fear of gaining weight or persistent behaviors that prevent weight gain, and disordered perception of one's own weight or body shape. Criteria A utilizes a person's body mass index (BMI; calculated as weight in kilograms/height in meters2) in comparison to others of a similar age, sex, developmental trajectory, and physical health to judge if the individual's restricting of food energy intake has placed them in the low 15%. BMI is not a definitive measure in determining healthy body type in adults (Prentice & Jebb, 2001). The World Health Organization (WHO) and Centers for Disease Control and Prevention (CDC) have indicated 18.5 kg/m2 as the threshold for a normal BMI in adult populations. As

Figure 6 explains, severity of AN begins at 17 kg/m$^2$, which the WHO and CDC classify as moderate to severe thinness. In children and adolescents, the BMI standards are also not a definitive standard. Clinicians should include "body build, weight history, and any physiological disturbances" (APA, 2013) the child may have experienced when making a diagnosis. Although restricting behavior is usually paired with an intense fear of becoming fat, this is not always universal; some have estimated that 20% of inpatient clients with AN do not report either this fear or a distorted body image (Strober, Freeman, & Morrell, 1999).

A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.
B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.
C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

*Specify Whether:*

**Restricting type:** During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.

**Binge-eating/purging type**: During the last 3 months, the individual has engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

*Specify if:*

**In partial remission**: After full criteria for anorexia nervosa were previously met, Criterion A (low body weight) has not been met for a sustained period, but either Criterion B (intense fear of gaining weight or becoming fat or behavior that interferes with weight gain) or Criterion C (disturbances in self-perception of weight and shape) is still met.

**In full remission**: After full criteria for anorexia nervosa were previously met, none of the criteria have been met for a sustained period of time.

*Specify* current severity

**Mild**: BMI ≥ 17 kg/m2
**Moderate**: BMI 16–16.99 kg/m2
**Severe**: BMI 15–15.99 kg/m2
**Extreme**: BMI < 15 kg/m2

*Note.* From *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., pp. 338-339), by the American Psychiatric Association, 2000a, Washington, DC: Author.

*Figure 6*. Diagnostic criteria for anorexia nervosa.

AN has one of the largest gender discrepancies when compared with other psychological disorders. AN is 10 times more prevalent in females than in males, and it is the third most common illness in adolescent females (Maine & Bunnell, 2010). The prevalence of AN has been estimated between 0.3-3.7% in females, with little research having been completed for males. However, some have estimated national prevalence in males below 1.0% and some as low as 0.1% (Hoek & van Hoeken, 2003; Hudson, Hiripi, Pope, Harrison, & Kessler, 2007; Preti et al., 2009). Culturally, AN seems to be more present in white adolescent girls and women more than in any other ethnicity (Striegel-Moore et al., 2006). The common consensus among researchers is that the overall prevalence of AN has been increasing, especially over the course of the latter have of the 20th century, with the most prevalence in industrialized cultures with a link between thinness and attractiveness (Hoek & van Hoeken, 2003; Hudson et al., 2007). Age of onset for AN is typically late adolescence (Stice, Marti, & Rohde, 2013).

Persons with AN often experience a wide array of related medical problems, which include amenorrhea, constipation, abdominal pain, cold intolerance, lethargy, excess energy, hypotension, hypothermia, bradycardia, hypoglycemia, and lanugo (a fine downy body hair). Some individuals will develop acrocyanosis, the bluish coloring of the hands and feet caused by poor circulation (APA, 2013; Anderson, Lavender, & De Young, 2010; Tyson, 2012).

The course, treatment, and outcome of AN varies greatly in severity and intensity. Some individuals find full recovery after only one episode, where others do not recover over the course of their lifetime. The standardized mortality ratio for AN is 5.86, with one in five individuals who died having had committed suicide (Arcelus, Mirchell, Wales, & Nielsen, 2011). The treatment options also vary from outpatient to intensive inpatient, and some may require

hospitalization to restore weight and stabilize fluid and electrolyte imbalances (Hudson et al., 2007; Watson & Bulik, 2013).

**Bulimia Nervosa**

The main difference between AN and BN, as outlined in Figure 7, is that the restricting of energy intake in BN is interrupted by repeated binge eating episodes followed by compensatory behaviors used to reduce weight gain. Binge eating episodes are defined by a sensed loss of control in consuming an unusually large amount of food in a limited time frame, usually less than 2 hours. The large amount of food criteria, as defined by the DSM-5, consists of a meal "definitely larger than most individuals would eat in a similar period of time under similar circumstances." This definition has remained a point of controversy due to its subjective nature. Additionally, some studies have shown persons who binge eat small or moderate amounts experience the same levels of distress as those who meet the "unusually large" amount criteria (Wolfe, Baker, Smith, & Kelly-Weeder, 2009).

Compensatory behaviors can include both purging and non-purging methods. Some examples are self-induced vomiting; misuse of deistic, laxative, or enema; excessive exercise; and inappropriate use of diabetic and thyroid medications. Some other common but not universal symptoms are consuming foods a person would otherwise normally avoid, experiencing dissociative symptoms during or after the binging episode, feeling shame because of eating behaviors, and experiencing an excessive amount of fear of gaining weight.

BN, as with AN, is gender discrepant. Women are 10 times more likely to be diagnosed than men (Maine & Bunnell, 2010). The prevalence of BN in females has been estimated between 1% to 3.7% in the US, several European nations, and New Zealand (Hoek & van Hoeken, 2003; Preti et al., 2009; Smink, van Hoeken, & Hoek, 2012; Stice et al., 2013). As is

the case with AN, males represent a very small portion of the BN samples. Estimates for male prevalence of BN have been estimated between 0.08-0.12 (Preti et al., 2009; Stice et al., 2013). As with AN, it appears that BN is more prevalent among white adolescents girls and women than among other ethnicities (Striegel-Moore et al., 2006). The typical age of onset for BN is late adolescence (Stice et al., 2013). BN has been found in higher levels among those with type I diabetes than AN (Mitchell & Crow, 2006).

A. Recurrent episodes of binge eating.
B. Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.
C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.
D. Self-evaluation is unduly influenced by body shape and weight.
E. The disturbance does not occur exclusively during episodes of anorexia nervosa.

*Specify if:*

**In partial remission**: After full criteria for bulimia nervosa were previously met, some, but not all, of the criteria have been met for a sustained period of time.

**In full remission**: After full criteria for bulimia nervosa were previously met, none of the criteria have been met for a sustained period of time.

*Specify* current severity

**Mild**: An average of 1–3 episodes of inappropriate compensatory behaviors per week.

**Moderate**: An average of 4–7 episodes of inappropriate compensatory behaviors per week.

**Severe**: An average of 8–13 episodes of inappropriate compensatory behaviors per week.

**Extreme**: An average of 14 or more episodes of inappropriate compensatory behaviors per week.

*Note.* From *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., p. 345), by the American Psychiatric Association, 2013, Washington, DC: Author. Copyright 2014 by the American Psychiatric Association.

*Figure 7*. Diagnostic criteria for bulimia nervosa

Individuals with BN often experience medical complications due to the compensatory behaviors and nutritional, fluid, and electrolyte imbalances. Some common and potentially fatal medical conditions are hypokalemia (potassium deficiencies which can cause heart and cardiac arrhythmias), hypochloremia (electrolyte imbalance), and hyponatremia (sodium deficiencies). Additionally, the compensatory behavior of vomiting can lead to metabolic alkalosis (increased serum bicarbonate in the blood stream), tears in the esophagus or stomach, and potentially permanent loss of dental enamel. Abuse of laxatives and diuretics can lead to metabolic acidosis

(body producing too much acid) and cause chronic and severe constipation (APA, 2013; Mitchell & Crow, 2006; Tyson, 2010).

As with AN, the courses, treatments, and outcomes for BN vary in severity and intensity. Treatment for BN can include individual or group psychotherapy and psychotropic medication. Depending on the severity of symptoms, these treatments may be coupled with multidisciplinary medical teams who oversee the re-feeding and medical stabilization of the patient. Clinical experience, more than empirical studies, has highlighted the benefits of working with a dietician to provide education in meal planning, self-monitoring, and ongoing nutritional rehabilitation (Croll, 2010; Maine, Davis, & Shure, 2008; Richards et al., 2009).

**Binge Eating Disorder**

Binge Eating Disorder, as outlined in Figure 8, differs from BN in that it does not include the compensatory behaviors after the binge eating episodes. In the case of BED, the binging episode must include three of the following features: "eating much more rapidly than normal; eating until feeling uncomfortably full; eating large amounts of food when not feeling physically hungry; eating alone because of feeling embarrassed by how much one is eating; and feeling disgusted with oneself, depressed, or very guilty afterward" (APA, 2013). As with BN, the variable and subjective nature of many of the diagnostic criteria makes it hard to diagnose. One of the more common and salient diagnostic criteria is the subjective sense of having lost control of one's eating behavior. Others have found that, in place of a typical binge eating episode where a person takes in a large amount of food in a short time, some individuals with BED report feeling a similar lose of control while engage in "grazing" behavior where they frequently consume small amounts of food over a longer period of time with limited breaks between eating (Anderson et al., 2010; Wolfe et al., 2009).

The prevalence of BED does not reflect the drastic gender disparity present in AN and BN. However, a disparity does exist. The lifetime prevalence of BED has been reported in females as 3.5% and as 2.0% in males. The age of onset has been reported as mid-20s, which is several years after late adolescence, the typical age of onset in BN and AN (Hudson et al., 2007).

A. Recurrent episodes of binge eating.

B. The binge-eating episodes are associated with three (or more) of the following:
   a. Eating much more rapidly than normal.
   b. Eating until feeling uncomfortably full.
   c. Eating large amounts of food when not feeling physically hungry.
   d. Eating alone because of feeling embarrassed by how much one is eating.
   e. Feeling disgusted with oneself, depressed, or very guilty afterward.

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least once a week for 3 months

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

*Specify if:*

**In partial remission**: After full criteria for binge-eating disorder were previously met, binge eating occurs at an average frequency of less than one episode per week for a sustained period of time.

**In full remission**: After full criteria for binge-eating disorder were previously met, none of the criteria have been met for a sustained period of time.

*Specify* current severity

**Mild:** 1–3 binge-eating episodes per week.
**Moderate:** 4–7 binge-eating episodes per week.
**Severe:** 8–13 binge-eating episodes per week.
**Extreme:** 14 or more binge-eating episodes per week.

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*Note.* From *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., p. 350), by the American Psychiatric Association, 2000a, Washington, DC: Author. Copyright 2014 by the American Psychiatric Association.

*Figure 8*. Diagnostic criteria for binge-eating disorder.

## Research About Eating Disorder Treatment

The treatment of eating disorders has its roots in psychodynamic theory, but was not systematically studied until the introduction of behaviorism in the 1960s. With the rise of behavior therapy during the 60s, the use of operant conditioning became a popular form of treatment for eating disorders. The basic premise was to isolate the patient from social and material reinforcers and then systematically reinstate them contingent on weight gain. For a

time, this technique was so widely accepted that it was instituted in several inpatient treatment centers as the treatment of choice (Bemis, 1987). With time, the technique was criticized as controlling and coercive. Most importantly, long-term gains were scarce. In the 70s, Minuchin et al. (1975) introduced the use of family interventions into the treatment of eating disorders. The theory was based largely on the concept that the patient was not anorexic, but rather that the family was "anorexogenic." This treatment is still in use today, but with a shift away from family blaming. Instead, the treatment attempts to mobilize the family's resources to help support the patient. Despite several decades of research and development, no clear standout treatment has emerged for eating disorders (Watson & Bulik, 2013). Some common treatments for eating disorders include "behavioral, cognitive-behavioral, psychodynamic, supportive-expressive, interpersonal, family, group, and a wide variety of pharmacological therapies" (Richards et al., 2000, p. 189). The evidence base for these treatment approaches has been scarce due to the difficulty of patient or clinician withdrawal and the complexity of addressing common multidisciplinary treatments. However, recently the research base has been growing (National Institute for Clinical Excellence, 2013; Treasure, Claudino, & Zucker, 2010; Watson & Bulik, 2013).

**Current Treatments for Anorexia**

Currently the treatment approach most common for AN is inpatient hospitalization where a patient receives medical, nutritional, and psychological treatments. Richards et al. (2000) found in a review of eating disorder literature that, under these circumstances, 50-60% of clients with AN are able to stabilize their weight and experience regular menstruation during treatment, 40-50% show normalized eating behaviors, 30-40% experience full recovery after treatment, 30-35% report improvements in their disordered eating, and 20-25% continue with a chronic

disorder. They go on to explain that some 50% of underweight patients may be treated in outpatient treatment settings, but that this setting requires a patient to have high motivation, a active support structure, and good prognostic markers (i.e. short duration between onset of symptoms and receiving treatment).

Research has not been able to highlight a common consensus about which psychotherapeutic treatment approach is preferable above others. Watson and Bulik (2013) explain that between specialist supportive clinical management, cognitive behavioral therapy, or interpersonal psychotherapy, no clear therapeutic approach stands out above the others. However, Hays (2004), in a review of randomized controlled trials between 2005-2012, explains that CBT and family-based treatment have established themselves as "first-line therap[ies]" in the treatment of AN. Lock (2015) explains that the empirical support for psychological treatment for children or adolescents is more limited than that for adults. However, he reported that family-based treatment has meet criteria as "well established treatment[s]." He goes on to explain that insight-oriented individual psychotherapy (IOP) rates as "probably efficacious" and Cognitive-Behavioral Therapy-Enhanced (CBT-E) rates the lowest as an "experimental treatment" in children and adolescents.

**Treatment for Bulimia Nervosa**

As with AN, the treatment of BN is primarily individual psychotherapy and medication. Additionally, group therapy has shown some success in treating BN. Cognitive-Behavior therapy has been widely recognized as the treatment of choice for BN (Fairburn, Zafra, & Shafran, 2008). However, several reviews of the literature have show that only about 45% of patients show full recovery after diagnosis and treatment. In some situations, that number was seen to increase over the course of seven years to 73% being classified as in recovery.

Additionally, 27% of individuals with BN have been shown to only gain partial recovery after a course of treatment. However, 30-35% of individuals with BN do not recover after treatment or in seven-year follow ups (Berkman, Lohr, & Bulik, 2007; Steinhausen & Weber, 2009). Steinhausen and Weber (2009) found in their review of 25 years of research on BN that no clear theoretical orientation held greater outcomes, but that psychotherapy was clearly more effective then behavior therapy or medical therapy.

## Research on Spiritually Oriented Treatments

### A Brief History

Richards and Bergin (2005), in describing the history of religion and spirituality in psychology, wrote that “strong forces of historical inertia” (p. 11) prevented certain research questions from being explored. This resistance has ranged from an overt criticism of religiosity, referring to it an “inferior or pathological state,” to an apathetic exclusion of religious or spiritual content in the research and training literature in psychology (Hood, 2012, p. 9). Richards and Bergin (2005) point out that the early founders of the psychological sciences may have needed to remove psychology and psychiatry from the perceived contamination of mysticism that was present during their time and move the field into the more accepted scientific philosophies. They go on to explain that Freud referred to religion as “the universal obsessional neurosis of humanity," and Watson (1919) was known to have said "psychology, up to very recent times, has been held so rigidly under the dominance both of traditional religion and of philosophy—the two great bulwarks of medievalism—that it has never been able to free itself and become a natural science" (p. 1). Albert Ellis (1980) has also cast religiosity as “significantly correlated with emotional disturbance” (p. 637). He later (1992) emended his views by explaining that he believed only “pietistic, rigid, dogmatic belief in and reliance upon some kind of supernatural,

divine, or 'higher' power and as strict obedience to and fanatical worship of this hypothesized power" (p. 428) as being connected with emotional disturbance.

However, as Richards and Bergin (2005) and others have argued, there exist several good reasons a more complete psychology will include an empirically supported psychology of religion and spirituality: (a) The culture in the United States is a religious culture, as Ellison and McFarland (2013) explain by saying, "50% to 60% of U.S. adults report that they are actually members of a religious congregation and that at least 80% maintain a religious identity, preference or affinity with some religious tradition." Pargament, Mahoney, Exline, Jones, and Shafranske (2013), supported by these statistics, argue that a "mainstream psychology that overlooks the religious and spiritual dimensions of human function remains incomplete" (p. 10). Sperry and Shafranske (2005) explain that at the core of the current shift towards a more open approach towards a psychology of religion and spirituality stands "the recognition that there is 'something more' to human experience than modifiable behaviors, intra-psychic conflicts, and serotonergic imbalances—we are more than the 'thinking meat' of neuroscience—and with this claim we are on the threshold of transcendent" (p. 12). (b) Pargament et al., (2013) explain the benefits of spirituality and religiosity have been empirically tracked over "combat veterans, divorcees, widows, physically abused spouses, parents of children with disabilities, and the medically ill." They cite studies that have pointed to "positive links between religion and spirituality with physical and mental health." Others have found similar evidence (Post & Wade, 2009; Smith, Bartz, & Richards, 2007; Worthington, Hook, Davis, & McDaniel, 2011).

These documented benefits have fueled the dialog between science and religion, and have begun changing the zeitgeist present in psychology from the once strictly naturalistic and

atheistic sciences to one more open to the spiritual and religious (Pargament, Exline, & Jones, 2013; Richards & Bergin, 2005).

**Research in Spirituality and Religion**

Research into religion and spirituality is difficult because it suffers from a definition problem (Richards & Bergin, 2005). The ideas of spirituality and religion are experienced in many different ways by many different people. This makes it hard to study as well as to implement into therapy. However, Pargament (1997) described a working definition of the difference between spirituality and religion in broad ecumenical terms. Pargament explained spiritually as "the search for the sacred." Pargament et al. (2013) goes on to explain that the focus of this definition needs to be placed on two vital words, *search* and *sacred*. Under his definition, sacred encompasses not only concepts of a divine but perceived manifestations or qualities of the divine. This multifaceted view of spirituality opens up to the myriad of diverse "sacred pathways in search of any number of sacred destinations" (p. 14). Although Pargament et al. (2013) do point out that the actual decision of which sacred path and destination is not a trivial matter and can have serious impacts on and individual's mental health. Richards and Bergin (2005) also point out that there are positive aspects of spirituality that promote mental health within therapy, while at the same time there can be attributes within a person's spirituality that work contrary to their own mental health.

Pargament (1997) goes on to explain how the word "*search"* in his definition refers to the ongoing process of seeking, knowing, building, and sustaining a connection with the sacred. Hill et al. (2000) points out that there does exist a difference between engaging in an activity for satisfaction and subjective well-being and engaging in one's spirituality. They use the example of gardening for enjoyment and gardening to experience "the creative forces of the universe" (p.

65). The latter, in helping one to approach the sacred, would meet the criteria for spirituality; the former would not. Pargament (2001) describes the spirituality process as complex, where the act of discovery transforms the "ties to what is held to be sacred," thus implying this as a journey of process and not a specific designation of arrival. The journey is not limited to a specific context however; religion is one context wherein this search may take place.

Religion, as defined by Pargament et al. (2013), builds on the work of Hill et al. (2000) and Pargament (2007). They explain that religion can be understood as "the search for significance that occurs within the context of established institutions that are designed to facilitate spirituality" (p. 15). The term search in this definition harkens back to the earlier explanation of spirituality as a journey. "Significance" in this definition encompasses not only spiritual significance, which Mahoney and Shafranske (2013, p. 15) describes as religion's most central function, but also "psychological, social, and physical" significance. Both definitions of spirituality and religion, therefore, center on the sacred. However, as the scientific community has become more open to spirituality, it seems that the old ire reserved for spirituality and religion has not shifted to strictly focus on organized religion, as was evidenced in Ellis' shifted view that not all spiritually is emotional damaging, just spiritualty that is devout or pious. This runs counter to the research that shows common church activity and beliefs positively affect health and well being in the United States (Koenig, King, & Carson, 2012; Pargament et al., 2013; Richards & Bergin, 2005; Seirmarco et al., 2012).

**Spiritual and Religious Perspectives on Treatment of Eating Disorders**

According to Slife and Richards (2001), all counseling and psychotherapy traditions assume certain theological, philosophical, and theoretical tenets. In the recent burgeoning of spiritually oriented treatment approaches, several theoretical frameworks have been proposed as

viable in the treatment of eating disorders. Richards et al. (2013) explain that these frameworks include "feminist, metaphorical, narrative, theistic, integrative–medical, Protestant Christian, and 12-step" perspectives.

The metaphorical feminist framework, as explained by Anita Johnson (1996), explains that within each person there exists a masculine and feminine spirit. She goes on to say that the obsession for thinness is perceived as a by-product of modern culture's rejection of the feminine spirit. She further explains that in order for eating disorder patients to reclaim their feminine, they must affirm the intuitive spiritual way of being and reconnect to their hungers both body and spirit. Using a mix of multicultural myths, ancient legends, and folktales, Johnson posits that through exercises of spiritual receptivity, stillness, and practice one can reclaim oneself from an image-obsessed modern culture and thereby free oneself from an eating disorder.

Manley and Leicher (2003) theorized a framework that combines narrative, feminist, cognitive, and spiritual perspectives in helping manage suicidal thoughts and impulses in adolescents with eating disorders. In their theory, getting in touch with one's spiritualty may empower a person to recognize how suicide functions outside of their ethical framework. Additionally, they explain that exploring spirituality in a group therapy setting may help support individuals in the implementation of important personal values more so than if they attempted to do so alone.

The feminist-integrative approach, as posited by Margo Maine (2009), highlights the impact image-focused media is having on patients' mental, emotional, spiritual, and medical well-being. She cites eating disorders as evidences of "spiritual disharmony." Maine explains, "spirituality is the most under researched, underestimated, and underutilized agent of change" (p. 20). She goes on to state the importance of spiritual reflection, meditation, and self-care as part

of any eating disorder treatment plan due to the formidable healing power that reawakened spiritualty can provide.

The integrative medical approach (Ross, 2007, 2009) combines integrative medicine with complementary approaches aimed at promoting the patient's own ability to self-heal. This approach views mind, body, and spirit as important targets of treatment. By embracing traditional mainstream therapeutic approaches along with alternative spiritual approaches such as guided imagery, meditation, yoga, forgiveness, inspiration, and awe, this framework looks to provide transformation on the deepest level.

The Protestant Christian Model (Cumella, Eberly, & Wall, 2008) is based on the biopsychosocial-spiritual mode. This model looks to address the medical, psychological, social, and spiritual aspects of an individual's recovery and healing. Under this framework, an individual is to be understood holistically, comprised of body, soul, spirit, and relationships. Due to the relationship this model has with Christianity, clients are asked to given explicit consent to having treatment include expressions of biblical Christianity. This framework includes a spiritual assessment of spiritual wellness, past spiritual experiences, and possible spiritual abuse. The treatment includes structured spiritual interventions that explore spiritual issues and spiritual expression.

The existential psychospiritual perspective of eating disorders (Emmett, 2009) focuses on nurturing an individual's sacred nature through spiritual teaching and inspiration while incorporating traditional psychotherapy skills such as restructuring and interpretation. This model seeks to facilitate the client in coming to know how to satisfy his or her own spiritual hungers autonomously. This model does not espouse a specific religious doctrine and respects the spiritual process of individuation from past religious or spiritual systems. This form of

empowerment is employed to help the patient "take risks, explore new directions, and adopt the faith to shed their fraudulent selves" (p. 32). At the heart of this framework is the belief that within the divine is kept unconditional love and worth that, when accessed, facilitates the faith to trust one's own "God-given abilities to heal" (p. 32).

The spiritual feminist framework (Lelwica, 2010) looks to help a patient reject the false quasi-religious obsessiveness of thinness. Lelwica explains the "obsessive, imaginary, sacrificial, ritualizing, ascetic, penitential, dogmatic, and devotional aspects of anorexia and bulimia all resemble certain features of traditional Christianity" (p. 7). Lelwica goes on to explain that eating disorders are centered on fulfilling a "spiritual hunger" more than they are a means to thinness. The spiritual hunger Lelwica is referring to is comprised of a deep hunger for meaning and wholeness. She goes on to recommend a number of spiritual interventions comprised of touching or experiencing the totality of life's experience through such examples as mindfulness, nourishing relationships, compassion to self and others, and strengthening one's connection to the sacred and to that which gives life meaning and purpose.

The 12-step group program (Wilson, 1957), which was originally developed for treating alcoholics, has been adapted to treat several compulsive or addictive behaviors. The original twelve-step program centered on the alcoholic's need to admit their own powerlessness in overcoming their alcoholism and their need to turn toward God's power to overcome their addiction. Later iterations have substituted "higher power" for God in an attempt to be more universal. Johnson and Sansone (1993) have posited an adaptation of the twelve-step approach to the treatment of easting disorders, embracing such ideas as powerlessness, abstinence, and higher power. They explain that the twelve-step program has opened the door to several spiritual interventions such as "confession, making restitution, seeking forgiveness from God and others,

prayers of petition and invocation, meditation, and service to others" (Richards et al., 2013, p. 330). Wasson and Jackson (2004) also presented a therapeutic 12-step model in the treatment of eating disorders, specifically the treatment of BN.

The theistic, spiritual approach was first articulated by Richards and Bergin (2000), and was then adapted by Richards, Hardman, and Berrett (2007) for the treatment of women with eating disorders. The theistic approach assumes first and foremost that a benevolent higher power exists. For some, that higher power is considered to be God. As Bergin explains (1980, p. 99), "God exists,...human beings are the creations of God, and...there are unseen spiritual processes by which the link between God and humanity is maintained." Richards and O'Grady (2007) point out that, even though the religions of the world encompass great diversity, there seems to be a common convergence in the majority of them around the concepts of "deity, human nature, purpose of life, spirituality, morality, and life after death" (p. 81). This grounding belief is important in clinical work as it has a direct impact on several core components of treatment. Using their theistic approach, Richards et al. (2007) address common spiritual components in eating disorder patients such as negative god image, feeling of shame and unworthiness, religious guilt associated with sexuality, difficulty experiencing love, and deception or dishonesty. Like the spiritual feminist approach, the theistic spiritual approach posits that an ED patient puts their faith in their ED to provide them meaning and happiness. They go on to explain that, as a patient is able to open their heart to God and other significant relationships, they are able to give up their faith in the ED. They give recommendations for spiritual interventions including, "religious–spiritual assessment, solo times for reflection, contemplation and prayer, reading sacred writings, spiritual journaling, creating opportunities for service, and referrals to religious leaders for spiritual direction" (Richards et al., 2013, p. 329).

## Conclusion

It is now widely recognized in the medical and psychological professions that faith and spirituality are often positively associated with physical and mental health (Koenig, McCullough, & Larson, 2012). Despite this, literature in the field of eating disorders has largely neglected the role of faith and spirituality in treatment and recovery (Richards et al., 2013). If eating disorder treatment programs were more successful at helping women heal and recover from their eating disorders, perhaps there would be no reason to investigate the potential role of spirituality in facilitating recovery. However, success rates of most contemporary eating disorder treatment programs are relatively low (Richards, Baldwin, Frost, Clark-Sly, Berrett, & Hardman, 2000; Steinhausen, 2002; Steinhausen & Weber, 2009). There is clearly a need for the development and evaluation of new interventions that show promise for helping more women recover from eating disorders.

There are both theoretical and empirical reasons to hypothesize that faith and spirituality may contribute to better treatment outcomes among women with eating disorders. Some professionals have theorized that eating disorder patients struggle with several core issues that are spiritual in nature, and that spiritual interventions are the most effective way to address them (Richards et al., 2013). In regards to the empirical findings: (a) Survey and interview studies of recovered eating disorder patients have found that sizable percentages of such women report that faith and spirituality were very important in their recovery (e.g., Hall & Cohn, 1992; Marsden, Karagianni, & Morgan, 2007; Mitchell, Erlander, Pyle, & Fletcher, 1990; Richards et al., 2008; Rorty, Yager, & Rossotto, 1993); (b) A quantitative correlational study of eating disorder inpatients revealed that improvements in spiritual well-being during treatment were associated with reductions in eating disorder symptoms and psychological disturbance (Smith, Richards,

Hardman, & Fischer, 2003); and (c) A phase one clinical trial revealed that women in an eating disorder inpatient treatment program who participated in a spirituality group intervention enjoyed better treatment outcomes than patients in other treatment conditions (Richards, Berrett, Hardman, & Eggett, 2006).

Despite the supportive clinical expertise and empirical findings, the evidence-base supporting the use of spiritual treatment approaches for eating disorders remains provisional (Richards et al., 2013). There is a need for additional treatment outcome studies to further document the effectiveness and efficacy of various types of spiritual approaches and frameworks in the eating disorders field. Of equal importance, in-depth qualitative studies investigating the clinical expertise within an actual therapy experience are needed to help understand why and when spiritual or religious interventions are helpful in treatment and to further guide clinical training and practice improvement. It is only when these two important aspects of the evidence-base for the spiritual practice of psychology movement can come together that psychology will have finally reached the same level of integration we ask of our clients.

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