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A Hermeneutic Exploration of the Therapeutic Process of Clinicians
at an Eating Disorder Treatment Center

Sabree Anne Crowton

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

A Hermeneutic Exploration of the Therapeutic Process of Clinicians at an Eating Disorder Treatment Center

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Doctor of Philosophy

Eating disorders remain extremely difficult to treat and investigation has revealed that manual-based eating disorder treatment outcomes have failed to improve over the second half of the last century. Various studies have observed that clinicians use evidence-based treatments for eating disorders inconsistently and often exclude fundamental theoretical techniques. Some argue that this departure from evidence-based practice may in some cases be the efforts of clinicians to develop methods more sensitive to real world situations. It stands to reason that some of the techniques currently being used by clinicians are promising treatment approaches. The purpose of this study was to explore the therapeutic process of a select group of clinicians at one eating disorder treatment center. Semi-structured interviews were conducted with 16 clinicians. A hermeneutic analysis of the interview transcripts revealed a common treatment approach with nine areas of focus: (a) stabilizing behaviors, (b) relationship building, (c) providing education, (d) increasing motivation, (e) challenging cognitions, (f) understanding emotions, (g) finding purpose and meaning, (h) improving body image, and (i) preventing relapse. Insights acquired from the clinicians in this study could contribute to the development of more effective treatments for clients* with eating disorders.

*Author's Note: It is common for individuals with eating disorders to be referred to as "patients" because of the medical implications of the disorder. However, in an attempt to promote a more humanistic view of individuals with eating disorders, the term "clients" is used throughout the study, except when cited by published research or the participants in this study.

Keywords: eating disorders, psychotherapies, treatment provider's experiences, theoretical orientations, therapy process

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INTRODUCTION TO THE STRUCTURE

This dissertation, *A Hermeneutic Exploration of the Therapeutic Process of Clinicians at an Eating Disorder Treatment Center*, is written in a hybrid format. This hybrid format combines traditional dissertation and journal publication layouts. The preliminary pages reflect requirements for submission to the university. The dissertation report is presented as a journal article and conforms to length and style requirements for submitting research reports to psychology and education journals. The literature review and additional findings sections are included in Appendix A and B, respectively.

Article Abstract

Eating disorders remain extremely difficult to treat and investigation has revealed that manual-based eating disorder treatment outcomes have failed to improve over the second half of the last century. Various studies have observed that clinicians use evidence-based treatments for eating disorders inconsistently and often exclude fundamental theoretical techniques. Some argue that this departure from evidence-based practice may in some cases be the efforts of clinicians to develop methods more sensitive to real world situations. It stands to reason that some of the techniques currently being used by clinicians are promising treatment approaches. The purpose of this study was to explore the therapeutic process of a select group of clinicians at one eating disorder treatment center. Semi-structured interviews were conducted with 16 clinicians. A hermeneutic analysis of the interview transcripts revealed a common treatment approach with nine areas of focus: (a) stabilizing behaviors, (b) relationship building, (c) providing education, (d) increasing motivation, (e) challenging cognitions, (f) understanding emotions, (g) finding purpose and meaning, (h) improving body image, and (i) preventing relapse. Insights acquired from the clinicians in this study could contribute to the development of more effective treatments for clients with eating disorders.

Introduction

The immense size of the eating disorder literature, over a hundred thousand journal articles, books, and dissertations, is evidence of the significant efforts researchers have made to develop better eating disorder treatments. These activities have been essential in light of the fact that eating disorders affect an estimated 30 million people in the United States and have a mortality rate higher than any other mental illness (Anorexia Nervosa and Associated Disorders, n.d.). Despite increased attention by researchers and clinicians alike, eating disorders remain extremely difficult to treat and investigation has revealed that manual-based eating disorder treatment outcomes have failed to improve over the second half of the last century (Steinhausen, 2002; Steinhausen & Weber, 2009). This may be attributed in part to how research has been approaching the problem. It has been discovered that when psychotherapies are compared with each other there are small to zero differences in outcomes (Wampold & Imel, 2015). Eating disorder treatments are no exception, with most meta-analyses showing similar benefits among therapies (Spielmanns et al., 2013). Yet, in what seems counterintuitive, a substantial portion of research continues to compare therapy types in an attempt to find the best treatment. Based on the disappointing progress of the last half-century, it is obvious that this method is not effective in improving outcomes. If better eating disorder treatments are to be found, research needs to shift its current focus.

Though evidence-based practice is not without errors, it does represent the best available research on the effectiveness of current treatments (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006). It appears, however, that clinicians in general do not adhere to established guidelines. Various studies have observed that clinicians use evidence-based treatments for eating disorders inconsistently and often exclude fundamental

theoretical techniques (Cowdrey & Waller, 2015; Kosmerly, Waller, & Robinson, 2015; Pederson Mussell et al., 2000; Shafran et al., 2009; Waller, String, & Meyer, 2012). Many eating disorder clinicians report not using treatment manuals and those who do often make changes to the protocol (Addis & Krasnow, 2000; Haas & Clopton, 2003; Lilienfeld et al., 2013; Simmons, Milnes, & Anderson, 2008; Tobin, 2007). Further, though most clinicians support the use of empirically based psychotherapy techniques, many report not having received any training in such treatments (Pederson Mussell et al., 2000). Consequently, the eating disorder treatment provided in the community seems to differ substantially from the interventions being used in randomized control and other clinical trials (Bulik, Berkman, Brownley, Sedway, & Lohr, 2007; Hart, Granillo, Jorm, & Paxton, 2011; Hay et al., 2014).

One group of researchers argue, “Practitioners’ perceived need for these modifications may in some cases reflect the failure of researchers to develop interventions that are sufficiently sensitive to the pragmatic exigencies of real-world clients” (Lilienfeld et al., 2013, p. 388). This aligns with statements from clinicians that manual-based treatments are “too rigid” and fail to address common issues in clinical practice such as comorbid diagnoses (Haas & Clopton, 2003, p. 347; Simmons et al., 2008). In contrast to randomized control trials, clinicians in community practice are more likely to work with more complex and extreme clinical issues (Haas & Clopton, 2003). This may be why there is a trend toward eclecticism in the eating disorders field (Simmons et al., 2008). If eating disorder clinicians do not feel that manuals and clinical guidelines are relevant, they may choose to draw from multiple theoretical orientations to meet the unique needs of their clients.

It stands to reason that some of the techniques being used by clinicians are promising treatment methods. Other researchers assert, “Delineating untested psychotherapies is important

because it may help identify promising treatments and expand the theoretical base of treatment for eating disorder clients” (von Ranson & Robinson, 2006, p. 28). Rather than compare different therapies, which is what is currently being done, it may be more productive to identify and explore the common elements contributing to successful eating disorder treatment (Macdonald, Hibbs, Corfield, & Treasure, 2012). Unfortunately, “little is known about the views of therapists working in the fields of EDs on what contributes to the quality of treatment in their day-to-day practice” (de la Rie, Noordenbos, Donker, & Furth, 2008, pp. 307–308). The “decision-making processes used by psychologists ‘in the trenches’ are largely absent from the literature” (Pederson Mussell et al., 2000, pp. 235–236).

The processes of eating disorder treatment centers are likewise undocumented. Many nationally recognized eating disorder facilities advertise unique therapies that have been neglected by research. One example is spiritually oriented therapy. Eating disorder treatment centers like Avalon Hills, Canopy Cove, Carolina House, Center for Change, Monte Nido, Rebecca’s House, Timberline Knolls, and the Renfrew Center incorporate spirituality into their treatment programs. Preliminary evidence shows positive results with spiritual interventions during eating disorder treatment (Lea, Richards, Sanders, McBride, & Allen, 2015; Richards, 2009; Richards, Berrett, Hardman, & Eggett, 2006; Spangler, 2010). Consequently, it would be valuable for research to explore more of these types of interventions.

As demonstrated, there is a significant need for process studies detailing the therapeutic process of community clinicians. Understanding why and how clinicians are tailoring their approaches in their work with clients with eating disorders may help in the development of more viable and effective treatments. Establishing partnerships with clinicians will provide researchers with valuable feedback as to the effectiveness of new treatment methods.

Purpose of the Study

The purpose of this study was to explore the therapeutic process of a select group of clinicians at one eating disorder treatment center. I assessed what these clinicians perceive as the most effective treatment approach for clients with eating disorders in individual therapy and how they implement it. Further, I inquired about their use of spiritual interventions in individual therapy and perceptions of evidence-based practices. This examination provides rich insight into the therapeutic process of one group of experienced clinicians and offers direction for research projects of a larger scale.

Research Questions

The following research questions were addressed in this study:

Research Question 1: How do clinicians at one eating disorder treatment center describe their process with clients with eating disorders in individual therapy?

Research Question 2: How do clinicians at one eating disorder treatment center integrate spiritual interventions into individual therapy with clients with eating disorders?

Research Question 3: What do clinicians at one eating disorder treatment center think of evidence-based treatment for eating disorders?

Research Question 4: What published resources do clinicians at one eating disorder treatment center report as valuable to therapeutic work?

Method

Research Design

Data was analyzed using a hermeneutic methodology. This is a qualitative research design developed for the interpretation of texts. Hermeneutics is based on the assumption that texts are representations of the experience and social context of the author. McLeod (2011)

explains, “Hermeneutics involves the appreciation that a successful interpretation is from a perspective, takes place from a position within history, requires sensitivity to the use of language, and leads to a shift (or learning) on the part of the person making the interpretation” (p. 28). Thus, hermeneutics is against the notion that an interpretation can be inclusive of all possible meaning; it is only intended to reveal additional meaning. It is this aspect that makes hermeneutics so valuable because it allows dialogue to not only continue but deepen as well.

One process within hermeneutics is the hermeneutic circle. The circle comes from the principle that the text as a whole can only be understood in reference to the individual parts and that the individual parts can only be understood in reference to the text as a whole. This back and forth process, sometimes described as a spiral, constitutes the hermeneutic circle. Interpretations for the data in this study are based on the hermeneutic circle. These are guided by the following hermeneutical canons:

1. The back and forth process defines the hermeneutic circle as the researcher progresses in understanding with each reading. Provisional interpretations are formed throughout the reading and are tested against the text in its entirety.
2. Analysis ends when a congruent and harmonious understanding of the text is achieved.
3. Interpreted segments of the text are compared and contrasted to the overall interpretation of the text.
4. The text is to be interpreted in its own context without supplemental information.
5. In the development and analysis of the text, knowledge surrounding the central themes is assumed.
6. The researcher is not without assumptions or preconceptions. Nonetheless, every effort is made to elucidate the beliefs of the researcher and how it might influence interpretation.

7. Interpretation should move beyond the obvious to provide new understanding and dimensions to the text. This requires sensitivity and ingenuity on the part of the researcher. (Paraphrased from Kvale & Brinkmann, 2015, pp. 238–239).

An explanation of how data analysis was conducted based on these canons will be described in a subsequent section.

Participants

The participants in this study were 16 clinicians at an inpatient eating disorder treatment center in the Western United States. Twelve of the clinicians identified as female and four as male. All identified as European American. The highest degrees of the clinicians included: Master of Arts in Marriage and Family Therapy (1), Master of Science in Marriage and Family Therapy (6), Master of Social Work (5), Doctor of Philosophy in Clinical Psychology (1), and Doctor of Philosophy in Counseling Psychology (3). All 16 clinicians were licensed in their field of training. The average number of years spent practicing as a clinician was 12, with years ranging from 1 to 37. The average number of years spent in the treatment of eating disorders, specifically, was 10, ranging from 1 to 33. The average number of hours a week spent with clients in individual psychotherapy was 15 with a range of 6 to 25. Three of the clinicians worked in outpatient and the remaining 13 worked in inpatient/residential treatment.

The theoretical orientations of the clinicians included: client-centered therapy (1), cognitive behavioral therapy (3), dialectical behavior therapy (1), eclectic (8), emotion-focused therapy (1), family systems therapy (1), and rational emotive behavior therapy (1). The clinicians who endorsed eclectic named two or more of the following orientations as part of their approach: client-centered therapy, cognitive behavioral therapy, developmental therapy, dialectical behavior therapy, emotion-focused therapy, experiential therapy, eye movement desensitization

and reprocessing therapy, family-based treatment, family systems therapy, relational psychotherapy, and spiritually integrated psychotherapy.

Data Collection

This study was approved by Brigham Young University's (BYU) Institutional Review Board (IRB) and adhered to ethical standards. The money used to conduct this study came from an Eliza R. Snow grant to Professor P. Scott Richards at BYU. Data was collected in a three-step process. First, demographic information was collected through an online survey sent to the clinicians via email. Surveys were required to be completed before an interview could be scheduled. Second, I conducted semi-structured interviews lasting approximately 60 minutes with each of the clinicians. The interview questions served as a guideline and allowed for deviations when I considered it to be important. All of the interviews were audiotaped and later transcribed by myself for data analysis. Third, I contacted the clinicians following an initial analysis of the data. I shared with them my preliminary findings and made note of any feedback they had regarding these findings.

Investigator

In contrast to positivist and post-positivist traditions, hermeneutics not only has an awareness of, but an appreciation for the context in which interpretation takes place. McLeod (2011) explains, "From a hermeneutic perspective, we cannot step outside culture and history... [it] insists that we accept and embrace these realities" (p. 30). Further, "It is necessary for the inquirer to be *reflexive*, to develop a critical awareness of his or her own assumptions (p. 30). In an effort to be reflexive, I would like to provide relevant background information to the reader as the primary investigator of this study.

I am a doctoral student in the counseling psychology program at BYU with a research agenda focused on the treatment of eating disorders. The decision to base this study on a hermeneutic approach was influenced by my training in historical research as an undergraduate at BYU. Prior to conducting the interviews, I received training in qualitative interviewing techniques based on topics in the book *InterViews: Learning the Craft of Qualitative Research Interviewing*, 2nd ed. (Kvale & Brinkmann, 2015). It is important to note that I am not affiliated with the treatment center in this study nor do I have a connection to any of the participants. I am a member of the Church of Jesus Christ of Latter-day Saints (LDS) and I believe spirituality is a part of multicultural psychotherapy.

Data Analysis

Data was analyzed using the same theoretical foundation that guided the interviews themselves, namely, a hermeneutic method. Hermeneutic interpretation “aims to bring to light an underlying coherence or sense” (McLeod, 2011, p. 27). This is achieved through use of the hermeneutic circle. The circle involves:

(a) gaining a sense of the meaning of the whole text, and then using that as a framework for understanding fragments of the text; and (b) carrying out micro-analysis of the possible meanings of small sections of the text, and using these to challenge or reinterpret the overall sense of the total text.” (McLeod, 2011, p. 33)

In line with this method, data analysis proceeded as follows:

1. I read an interview and identified overarching meanings. I then reread the interview and identified meanings of distinct parts. This process was repeated until the overarching meanings and meanings of distinct parts were congruent (i.e., the whole and the parts together provided greater understanding of the interview).

2. After individually analyzing each interview, I compared the interviews to each other using the same circular process described in the first step.
3. I met with an auditor throughout data analysis to discuss my interpretations. This individual was a member of the dissertation committee with expertise in qualitative research and had over 25 years of experience as a psychologist.
4. After a preliminary analysis of the data, I conducted quality checks to ensure that the meanings I had identified were consistent with the experience of the clinicians. This was done by randomly selecting six clinicians who read a draft of my findings. Some minor revisions were made based on their feedback.
5. My final interpretations were organized into themes and subthemes coupled with supporting quotes for the findings section of the study.

Findings

Findings are organized into five broad themes (i.e., therapeutic process, spiritual interventions, APA guidelines, critical issues, and published resources). Each broad theme contains a number of significant subthemes which provide insight into the therapeutic processes of a select group of clinicians at one eating disorder treatment center. I have further provided descriptive quotes from clinicians which highlight what they perceive as effective in the treatment of clients with eating disorders.

Therapeutic Process

After analyzing the data using the hermeneutic circle regarding the individual therapy process of clinicians, a number of similarities between therapists emerged. Naturally, this process varied based on factors such as comfort with self-disclosure, training, theoretical orientation, personality, and experience. Be that as it may, a general process in treating clients

with eating disorders was evident from a comparison of interviews. Within this process are nine distinct areas of focus, which include the following: (a) stabilizing behaviors, (b) relationship building, (c) providing education, (d) increasing motivation, (e) challenging cognitions, (f) understanding emotions, (g) finding purpose and meaning, (h) improving body image, and (i) preventing relapse. These areas are fluid and interconnecting; however, they provide a broad overview of what individual therapy with clients with eating disorders looks like in actual practice.

Stabilizing behaviors. After evaluation by the medical staff, therapy starts with stabilization of eating disorder behaviors (i.e., restricting, bingeing, purging, and excessive movement). One clinician explained:

I know some therapists and other treatment centers think we need to form the relationship with the patient first and then they will want to stop the behaviors... I say no... That's why our patients are kind of made to eat because we are stopping those behaviors because tell me, how hopeless would it feel if you are in a treatment center and you are allowed to do your eating disorder. You feel like you are never getting better.

This means that clinicians implement consequences from the outset when clients exhibit disorder behaviors. For clients in outpatient, a similar approach is taken except with more reliance on caregivers to monitor behaviors and implement consequences. This is admittedly more difficult, however, than in inpatient treatment. The reason behind this initial emphasis on behavioral change is illustrated in the following comment: "Really it's kind of letting them heal physically to try and get cognitive functioning back." Overall, clinicians asserted that the acute exhaustion and nutritional deficiencies caused by disordered behavior makes regaining physical and mental energy the first priority of treatment.

Relationship building. Clinicians were unanimous in their opinion that a strong therapeutic relationship is an essential component of effective therapy. One clinician stated, “I want my patients to feel that they have an advocate and somebody they can trust.” Another recounted, “I am just trying to build rapport in those first few sessions especially. I don’t try to get into too much crazy deep stuff or challenge them too much because at that point I am just validating that they came.” Several clinicians noted that clients are often scared of giving up their eating disorder. Thus, establishing a meaningful connection with clients is perceived to decrease resistance in treatment, particularly when work becomes more difficult. One clinician explained:

There’s accidental reinforcement by society and family that the eating disorder becomes their identity the longer they have it... so if you attack the eating disorder, they feel attacked. So, you have to build these rappsorts so that when the eating disorder is challenged they recognize you’re challenging the eating disorder to help them.

A common saying in the treatment center is “you have to have money in the bank before you can make a withdrawal.” In other words, clinicians believe that trust and respect need to be established before clients can be asked to change.

Providing education. During the beginning stages of therapy, clinicians spend time educating clients about eating disorders specifically and mental illness in general. One clinician reflected, “I think I teach just as much as I ‘therapize,’ if you will, about how the body works, about how the brain connections work.” The need for education is based on observations that many clients, even those who have been in treatment before, come in with little understanding of the disorder and how it developed and is maintained. One clinician disclosed, “I educate [clients] about what they’re suffering with, what can be done, what treatments are available, what works and what doesn’t work, and what we may try to help them, what has helped other people, [and]

what the research shows.” Along with psychoeducation, clinicians teach clients to recognize patterns within the disorder. One clinician described, “[The eating disorder] is predictable and so the more that we can help [them] realize the predictability of it, the more [they’re] going to be able to stand up against it.” This approach is said to help clients to conceptualize the eating disorder as a mental illness that can be overcome rather than an ingrained part of themselves.

Increasing motivation. Clinicians recommended starting where clients are at in terms of readiness to change. One clinician remarked, “I think a lot of [therapy] is initially just working on increasing motivation for recovery and trying to help [clients] understand the benefits of life without [the] eating disorder.” According to clinicians, this is accomplished by identifying motivating factors. One clinician endorsed, “Find something in [the client’s] life that has more meaning to them than being thin and you really go after that.” Another mentioned, “[I try] using [the client’s] own words, things that they’ve said so it’s not coming from me or the treatment team.” Several clinicians observed that using this type of approach helps clients to feel validated and also decreases opposition. Further, the emphasis on intrinsic rather than extrinsic motivations is considered to be more influential in terms of change. One clinician noted, “A lot of the success that I think I’ve experienced is related to the patient’s motivation.” A different clinician emphasized the importance of pointing out and encouraging motivation when it is evident. This clinician reported that clients are better able to maintain progress when their efforts are recognized and reinforced during therapy.

Challenging cognitions. Based on responses, most clinicians spend a significant amount of time in therapy working with clients on cognitive restructuring. This aligned with descriptions from clinicians of eating disorders as an illness of “negative thinking patterns” and “distorted thoughts.” Accordingly, clinicians draw upon cognitive-behavioral interventions to help clients

understand “how their thoughts are translating to their feelings and to their actions.” One clinician explained that although cognitive-behavioral techniques are more task rather than process oriented, clients express a sense of accomplishment from practicing them. One of the most common cognitive interventions used in therapy is cognitive defusion or distancing thoughts and emotions from self. Clinicians teach clients how to “differentiate their thoughts and beliefs from what the eating disorder is telling them to do.” This distinction is thought to allow clients to see how they have power to choose to not act on disordered thoughts. Further, strengthening the “rational side” of the mind also works to “lessen the intensity of the emotional response” so common in eating disorders according to another clinician.

Understanding emotions. Throughout interviews, eating disorder behavior was generally conceptualized as a coping mechanism for negative emotions. One clinician observed, “I see a lot of clients do a lot of numbing out because they don’t want to deal with these things.” This avoidance of uncomfortable and distressing emotions is associated with disordered eating. In order to disrupt this cycle, clinicians first said they teach clients to discern between and describe different emotions. Once this is achieved, concepts from dialectical behavior therapy such as mindfulness, emotion regulation, and distress tolerance are introduced. One clinician explained, “A lot of our patients, the reason why they can’t handle emotion and they run from it is because they judge themselves for whatever they’re feeling.” The use of radical acceptance from dialectical behavior “takes that self-hatred most [clients] have and lets them deal with it in a way that makes it more nonjudgmental.” According to clinicians, this opens the door to helping clients to have an emotionally corrective experience in which they can express and experience the emotion in full rather than resorting to disordered eating. Moreover, the validation communicated is said to decrease some of the shame attached to these emotions.

Finding purpose and meaning. According to clinicians, as clients advance through therapy, many of them start to question who they are, where they belong, and what they want. One clinician reflected, “Something that’s really hard for [clients] is that they have had the eating disorder...and that’s been their identity for a really long time and you get to the point where you unravel it and they’re left with nothing and they’re like, who am I?” To address this concern, clinicians mentioned helping clients redefine their identity. Another clinician explained:

We’re trying to get them to connect back to everything that’s important: their spirituality, their dreams, their vision, the purpose of their life, the passion of their life, their relationships, love, all of that. We’re trying to get them connected to people again, and we’re trying to deepen the connection and make the connection more profound and more real and more meaningful.

One way this connection is reestablished is through “intuitive living.” Based on the concept of intuitive eating, one clinician described this as “rely[ing] on the information that’s coming into you provided either from yourself, or your Higher Power, or your experiences.” Clinicians described the intuition or spiritual power clients learn to rely on again as a protective factor against disordered thoughts and behaviors.

Improving body image. The consensus among clinicians was that “body image is the hardest thing for [clients] to change.” One clinician attributed societal expectations to look perfect as a major contributor to relapse. This clinician reflected, “A lot of people come back in and it was the body image that got them... that’s the last thing to kind of go.” To address body dissatisfaction, clinicians work with clients in accepting their body. One clinician stated, “Accepting your body doesn’t mean that you always have to love it or love every part of it. But can I be okay with it, can I live with it, and can it maybe consume less space in my brain.” Other

clinicians mentioned using values work to combat body image distress. For example, one reported, “I think as we become more focused in our life on living our values, I think our body image might still be there but it’s not top priority.” This clinician asks clients to identify values that have been neglected as a result of their eating disorder. The purpose of this approach is to help clients live with body image dissatisfaction without allowing it to define them.

Preventing relapse. Based on reports, clinicians follow the transitional care model outlined in the *Practice Guideline for the Treatment of Patients with Eating Disorders* by the American Psychiatric Association (APA, 2006). In this model, medical and psychological improvement or deterioration determines level of care. One clinician explained, “If we can step [clients] down gradually and slowly into successful levels of intensity of care, then we can ward against relapse and increase the probability that they will maintain the progress that they’ve been making in treatment.” A significant part of transitional care is relapse prevention. Clinicians expressed awareness of the fact that clients need to learn how to cope without their eating disorder not just during treatment but in their daily lives. One clinician concluded, “Nobody recovers in treatment. You do the training for recovery in treatment and then recovery begins when you leave.” Others observed that weight restoration and adequate nutrition during treatment is usually successfully achieved; the problem seems to occur when clients return to everyday life. For that reason, clinicians require clients to develop extensive relapse prevention plans with components such as coping skills, crisis resources, and meal plans.

Spiritual Interventions

The treatment center uses a non-denominational approach designed to accommodate various religious and spiritual frameworks. Based on interviews, most clinicians incorporate spiritual interventions to some degree into individual therapy as well. A small subset of

clinicians reported rare or no use of spiritual interventions. These clinicians were sensitive and respectful of client beliefs but did not explore them in therapy unless specifically asked.

Regardless of preference, all of the clinicians affirmed that the decision to include spirituality is always client driven and never forced in any way. The most popular spiritual interventions described by clinicians are outlined as follows: (a) conducting a spiritual assessment, (b) using spiritual language and concepts, and (c) exploring spiritual beliefs about food and the body.

Conducting a spiritual assessment. A common practice among clinicians is to conduct an informal spiritual assessment with clients with eating disorders. Though different for each clinician, the general approach used by most is exemplified in the following description:

We just have a conversation about how do you see spirituality fitting into your treatment experience and your recovery... then we decide is that something you want to talk about here in our individual sessions or is that something you want to do personally or do you want to have one of your ecclesiastical leaders come and talk to you.

It was apparent from interviews that clinicians strive to not only accommodate but also support clients in their treatment preferences, whether or not that includes spirituality. This means making it clear from the outset that any type of beliefs or values are welcome. One clinician asserted, “Refusal to be willing to [talk about spirituality] is actually a message to the patient that it’s not important and usually patient spiritual beliefs are the most important beliefs.”

Using spiritual language and concepts. More than just a common language, the majority of clinicians consider spirituality to be an aid in facilitating recovery from an eating disorder. One clinician reflected:

I think [spirituality] is a real lifeline to help in finding meaning, purpose, and value in [client’s] lives... In my personal experience, [clients] tend not to relapse as much when

they're spiritually based because they have figured out some things to soothe themselves that's a little deeper and a little more resilient in that sense than just reframing.

According to clinicians, spirituality is anything of deep and sacred meaning. One clinician described, "I had an adolescent once tell me that her Higher Power was Bob Marley and I was like awesome, let's talk about Bob Marley. So, we used a lot of Bob Marley in her therapy to talk about what's her identity and what's her purpose and what does she want out of life." Spiritual interventions are thus rooted in the spiritual beliefs that the client has expressed. Another example of this is illustrated in the following intervention: "We ask [clients] have there been books that you've used or are available to you that would help you develop a stronger spiritual connection... we encourage them to look within their own libraries... whether they're written books or scriptures or whatever."

Exploring spiritual beliefs about food and the body. While spirituality is considered a valuable resource for clients, several clinicians elaborated on how misinterpreted spiritual principles can impede recovery. One clinician described:

[Spirituality] can be the whole double-edged sword because a lot of [clients] have shame about disappointing their Higher Power if it's like a godlike figure or they feel abandoned because they haven't felt much help there. So, it can actually be problematic because it ends up adding an extra issue to have to work through.

With permission from the client, clinicians reported exploring spiritual beliefs that appear to be perpetuating disordered eating behaviors. A different clinician mentioned, "There are some people for who religion is a big trigger for them and the culture of their religion is a really big trigger." Consequently, some interventions are intended to help clients decide how to cope with

religious triggers that may be unavoidable. Other interventions involve discussing with clients how trauma or other painful experiences have impacted their spirituality.

APA Guidelines

During interviews, clinicians were asked their opinion of the *Practice Guideline for the Treatment of Patients with Eating Disorders* published by the American Psychiatric Association (APA, 2006). The consensus among clinicians is that APA guidelines are relevant and valuable but contain limitations. Clinicians expressed satisfaction with the recommended levels of care (i.e., inpatient, residential, partial hospitalization, outpatient). A common complaint was the lack of assessment criteria related to psychological functioning. These perceptions are defined as (a) approval of medical guidelines and (b) critique of psychological guidelines.

Approval of medical guidelines. Attitudes toward APA treatment guidelines among clinicians were generally positive. The criteria for levels of care and medical stabilization were praised as useful and practical. One clinician remarked, “I think the guidelines are pretty right on as far as some of the realities of what people can do, how they handle daily living, whether they need more support, and whether they are physically compromised.” Clinicians also expressed appreciation for the guidelines in terms of clinician liability. One clinician explained, “For outpatient, it helps because we can then use those APA guidelines to let patients know why I cannot continue to treat them at this level of care if... we are not seeing improvements.” Another clinician mentioned that writing a note in APA format “helps me assess a little bit more frequently for things like suicidality.” Although clinicians were aware of the limitations of the guidelines, they seemed to value the standards and common language they provide.

Critique of psychological guidelines. There were a few notable critiques from clinicians in regard to the APA guidelines. For example, many thought the assessment criteria should place

more emphasis on psychological readiness when stepping down care. One clinician pointed out, “[Clients] may be physically in weight and they may have support, but psychologically they may not have embraced what they need to... That’s where you get a lot of relapse.” Several requested a provision in the guidelines to allow for clinician discretion when clients meet medical criteria for a lower level of care but need a higher level of care due to psychological impairment. Perhaps the most vocal dissatisfaction was not with the guidelines per se but with how they have been used by insurance companies. One clinician stated, “We’re looking for success, we’re looking to get them into recovery, and sometimes I feel like the insurance is looking for failure so they can justify paying for it.” Most of the clinicians cited experiences in which APA guidelines were used so strictly by insurance that there was a compromise to treatment.

Critical Issues

According to clinicians, clinical issues absent from evidence-based treatment recommendations are (a) binge eating disorder, (b) chronic anorexia, (c) LGBT clients with eating disorders, and (d) males with eating disorders. Clinicians perceived these as critical issues in everyday practice in which there is limited guidance from scientific and professional organizations.

Binge eating disorder. During interviews, clinicians expressed interest in treatment recommendations for binge eating disorder (BED). These clinicians described several complications in treating clients with BED that are neglected in guidelines. One is that clients with BED report feeling uncomfortable in treatment settings with clients with anorexia and bulimia nervosa because of the “hierarchy of control within eating disorders.” This is worsened by the fact that most insurance companies do not cover treatment for BED which leads people to perceive it is “not a real disorder.”

Chronic anorexia. Dissatisfaction with the general lack of recommendations for adult clients with severe and chronic anorexia was also apparent. One clinician reported attending eating disorder conferences that made explicit that the interventions presented would “work for everything – except anorexia.” Another clinician lamented, “I think one of the hardest things in the entire world to treat are your rigid, strict anorexics with no trauma. They tend to be the ones that just stay sick for a really long time.”

LGBT clients with eating disorders. Other clinicians commented on the lack of recommendations for eating disorder treatment sensitive to sexual orientation and gender identity issues. A clinician active in eating disorder research remarked, “I speak around the country and people often ask about LGBT. How does this apply to LGBT? And I don’t know because the research does not tell me much.” Another clinician explained that different cultural expectations among the LGBT community make treatment a different process for these clients.

Males with eating disorders. Treatment guidelines for males with eating disorders were also considered deficient. A fact made more obvious with the increase in the number of males seeking treatment at the center, according to clinicians. One clinician commented, “It is a huge under diagnosed population of men who are looking for the silver bullet or the holy grail of body image and you can see them at the gym every day.” This clinician continued, “These men are probably doing just as much harm to their bodies as the women who purge because many of them are often taking body enhancing substances.”

Published Resources

Published resources play an influential role in how clinicians conceptualize and treat eating disorders. According to clinicians, the resources that inform and guide their therapeutic process are treatment manuals and professional journals. Resources that clinicians recommend to

clients include non-academic books and online materials. These resources are elaborated on in the following subthemes: (a) treatment manuals, (b) professional journals, (c) non-academic books, and (d) online materials.

Treatment manuals. Treatment manuals, for eating disorders and comorbid disorders, are commonly used by clinicians in their therapeutic work with clients. Manuals were described, however, as valuable in terms of specific interventions rather than as a protocol for treatment. Others expressed dissatisfaction with treatment manuals. One clinician commented, “I don’t think I’ve found [a manual] that fits generally enough that I can use it with all of the different patients I see.” Another stated, “I have been a part of programs in the past where there is a lot more manualized treatment... it’s evidenced based... but sometimes it was a little depersonalized.”

Professional journals. A few clinicians reported efforts to stay informed of current scholarly research. The academic journals these clinicians consult include *The International Journal of Eating Disorders* and *Eating Disorders: The Journal of Treatment and Prevention*. One clinician described consulting scholarly articles when working with less familiar issues. This clinician reflected, “I had a client with Avoidant/Restrictive Food Intake Disorder (ARFID)... so that was when I went online and I did more reading about that because it’s a newer one for me.” In contrast, another clinician, despite interest in research, remarked, “I don’t base a lot of my therapy on research articles.” This clinician continued, “I don’t think of reading it to get that information. It could be a deficit in what I do.”

Non-academic books. A common practice among clinicians is to supplement therapeutic work with assigned reading. Books are considered to be an effective way of addressing problems or emphasizing concepts discussed in therapy. One clinician explained, “I always want clients to

be reading a book at all times... I think there are ways that these authors can convey their ideas that I cannot no matter how hard I try.”

Online materials. As would be expected, online materials are influential in the therapeutic process of clinicians. Ted Talks and YouTube videos are shown to clients in order to emphasize or explain certain topics or concepts. For example, one clinician mentioned showing video clips from *The Lord of the Rings* films to illustrate the battle between an eating disorder and purposeful living. Another online source cited is self-help worksheets for clients. One clinician stated, “I Google DBT a lot because I have to do the DBT group and I’m always looking for ideas that way.” Another related, “There are a couple of resources online that are cognitive behaviorally focused and so I will print off worksheets to help with thinking errors. There are a lot of good ones on negative self-concept and changing it.” This clinician cautioned, “I think especially with eating disorders you have to be really careful because there’s well-intended stuff but they may not be super effective.”

Discussion

Studies over the past two decades demonstrate that clinicians in everyday practice do not follow evidence-based practice in treating eating disorders (Cowdrey & Waller, 2015; Kosmerly et al., 2015; Pederson Mussell et al., 2000; Shafran et al., 2009; Waller et al., 2012). The most common explanation among clinicians for this neglect is the discrepancy between conditions in randomized clinical trials and clinical practice (Haas & Clopton, 2003). Researchers, on the other hand, argue that the problem is not randomized clinical trials but deficits in training and misperceptions about the value of evidence-based practice (Lilienfeld et al., 2013; Simmons et al., 2008). While there are indeed studies to support these claims by researchers, there is also “little data to determine whether manualized treatments maintain efficacy or produce results that

exceed treatment as usual when applied in a clinical setting outside of controlled research parameters” (Pederson Mussell et al., 2000, p. 235). Thus, “It is possible that untested strategies in clinical practice would fare well if empirically tested” (p. 235).

It has been well established what clinicians are not doing in terms of eating disorder treatment (Addis & Krasnow, 2000; Haas & Clopton, 2003; Lilienfeld et al., 2013; Simmons et al., 2008; Tobin, 2007), but few studies have determined what clinicians actually are doing. Thus, the purpose of this study was to better understand what experienced clinicians consider to be effective eating disorder treatment and how they implement this treatment in practice. This was accomplished through semi-structured interviews with 16 clinicians at an eating disorder treatment center in the Western United States. What follows is a reflection on the findings of this study, a discussion of its limitations, and recommendations for future research.

Reflection on Findings

The findings of this study both support and expand upon the current body of literature. Data from online surveys revealed that most clinicians identify with an eclectic therapeutic approach. This is consistent with research showing that eating disorder clinicians rarely identify with a single theoretical orientation (Pederson Mussell et al., 2000; Simmons et al., 2008; Tobin et al., 2007; von Ranson & Robinson, 2006). One explanation for this trend is the high occurrence of comorbid disorders (e.g., mood, anxiety, substance abuse, posttraumatic stress, obsessive-compulsive) among clients with eating disorders (Blinder et al., 2006). When faced with these complications, clinicians may feel that one therapeutic approach is insufficient. Moreover, clinicians are increasingly under pressure to prove to insurance companies that their method of choice is empirically validated. It seems that eclecticism would best allow clinicians to select therapeutic interventions compatible with multiple presenting concerns. On the other

hand, attempts to combine incompatible theoretical views may be disruptive in treatment. A search of the literature provides no direction as to whether or not an eclectic approach is as effective as a single approach.

Despite differences in training and experience, clinicians in this study described a similar therapeutic process for treating eating disorders. All seemed to agree on a general process to effectively intervene with clients with eating disorders. The first of this process is stopping disordered behaviors and building a strong therapeutic relationship. Clinicians were in consensus that medical stabilization takes precedence over establishing trust with clients. This seems reasonable due to the fact that eating disorders have a higher mortality rate than any other mental illness (National Eating Disorders Association, n.d.). Research has found, however, that dropout among clients with eating disorder is related to deficits in the therapeutic relationship, placing clients at risk in the long-term if the relationship fails to develop (Clinton, 1996). How to balance the medical and emotional needs of clients during the early stages of treatment deserves thoughtful consideration.

The next intervention is teaching clients about eating disorders. Naming and describing the illness seems to depersonalize it and thus enable clients to extricate themselves from it. Though not mentioned during interviews, it may be useful to incorporate identity work based on the fact that many clients define themselves by their disordered eating (Stein & Corte, 2007). Having other sources of identity to turn to when the eating disorder is challenged may help clients feel less threatened. Throughout this and other interventions, clinicians also encourage and point out the motivation of their clients. This seems appropriate in light of the fact that client readiness for change predicts the success of eating disorder treatment (Bewell & Carter, 2008). It

also speaks to the value of established techniques such as motivational interviewing for clients with eating disorders (Macdonald, Hibbs, Corfield, & Treasure, 2012).

After cognitive and physical restoration, clinicians address illogical patterns of thinking. The decision to address cognitive distortions aligns with evidence-based guidelines that recommend cognitive-behavioral therapy as the first line treatment for bulimia nervosa and binge eating disorder (American Psychiatric Association, 2006). In conjunction with this intervention, clinicians help clients develop an awareness of and appreciation for their emotions. Research shows that many clients with eating disorders have a comorbid diagnosis of alexithymia (Speranza, Loas, Wallier, & Corcos, 2007) and that the majority have difficulty emotion regulating (Harrison, Sullivan, Tchanturia, & Treasure, 2010). Despite these findings, emotion-focused therapy (EFT) is not included in the list of evidence-based therapies for eating disorders. Control studies on EFT for eating disorder treatment, however, are limited (Sala, Heard, & Black, 2016).

An additional intervention used during treatment is exploring sources of purpose and meaning with clients. Purpose and meaning are considered preventative resources against disordered eating behaviors. Research supports this with evidence that spiritual beliefs and practices confer behavioral protection against body image concerns and eating pathology (Henderson & Ellison, 2015; Zhang, 2013). One group of researchers argue that religion and spirituality are underutilized resources for body image dissatisfaction (Jacobs-Pilipski, Winzelberg, Wilfley, Bryson, & Taylor, 2005). In many cases, this is an aspect of treatment and recovery that appears to be ignored, despite being a critical aspect of multiculturalism.

The final intervention in the process of eating disorder treatment is preventing relapse. Although relapse plans are intended to be as realistic and thorough as possible, it is difficult to

know whether or not clients implement them in times of crisis. Relapse prevention is based on a cognitive-behavioral framework with the twofold purpose of “maintaining abstinence” and “providing lapse management if a lapse occurs” (Marlatt & Donovan, 2005, p. 1). This framework is applied primarily to addictive illnesses. Whether or not conceptualizing and treating eating disorders as an addiction, however, is an issue of contention among researchers (Benton, 2010; Goodman, 2007; Wilson, 2008).

In addition to general therapeutic interventions, this study provides a description of the spiritual interventions used among clinicians to facilitate eating disorder recovery. The decision to incorporate spiritual interventions can be explained in part by client demographics. According to clinicians, a significant portion of the clients treated identify as Christian. Studies show that religious clients have higher expectations of and preferences for therapy with spiritual interventions than secular clients (Bannister, Park, Taylor, & Bauerle, 2015; Saenz & Waldo, 2013). Thus, it is likely that clinicians have adopted the use of spiritual interventions to better accommodate the needs of their clients.

One spiritual intervention mentioned during interviews was assessment of spiritual and religious beliefs. Research supports this as a valuable tool with evidence that clinician sensitivity to religious and spiritual beliefs during eating disorder treatment impacts client motivation and by association clinical outcomes (Marsden, Karagianni, & Morgan, 2007). Another spiritual intervention described was using spiritual language and concepts in therapy. Despite a historical bias against spirituality in the field of psychology, spiritual interventions for the treatment of eating disorders are associated with positive outcomes (Lea, Richards, Sanders, McBride, & Allen, 2015; Matussek & Knudson, 2009; Richards, Berrett, Hardman, & Eggett, 2006; Tonkin, 2005; Wasson & Jackson, 2004). A final spiritual intervention that emerged was exploration of

the connection between disordered eating and religious beliefs about food and the body. This likewise appears apt given findings that in many cases clients use religious practices to rationalize disordered eating (Brytek-Matera & Schilitz, 2013; Hardman, Berrett, & Richards, 2003; Graham, Spencer, & Andersen, 1991; Marsden et al., 2007).

In this study, the opinions of clinicians on APA's practice guidelines for eating disorders were collected. Most clinicians described positive experiences with the medical recommendations. Given the high risk associated with eating disorders, this is important feedback. These experiences seem to suggest that in many ways the guidelines are a valuable aid in treatment decisions. Alternatively, many clinicians felt that psychological functioning should be more of a consideration in the guidelines. This seeming absence may stem from the fact that APA guidelines are "addressed to psychiatrists and pay little attention to the US health care system as a whole" (Yager, 2001, p. 190). Guidelines that speak more to the therapeutic side of treatment would perhaps feel more relevant to social workers, marriage and family therapists, and psychologists.

During interviews, clinicians also provided feedback on critical issues in everyday practice that are neglected in APA's practice guidelines. Treatment for binge eating disorder (BED) and chronic anorexia nervosa (AN) were some examples. According to interviews, the treatment center has seen an increase in the number of individuals with BED seeking treatment. Treating clients with BED alongside other eating disorders poses several complications due to the fact that most clients with BED are overweight and judged for their perceived lack of self-control by clients with anorexia and bulimia nervosa. As a newly recognized disorder, evidence-based treatments for BED are preliminary and most appear effective only for short-term reduction of symptoms (Amianto, Ottone, Daga, & Fassino, 2015). In contrast, despite extensive

research on AN, no treatment of choice has emerged and clinicians in this study expressed frustration with the lack of direction for chronic and severe cases.

Another issue described by clinicians in this study is treatment sensitive to LGBT clients with eating disorders. The difficulties of treating this population is consistent with research indicating that lesbian, gay, and bisexual youth exhibit more disordered eating than their heterosexual counterparts (Watson, Adjei, Saewyc, Homma, & Goodenow, 2017). A search of the literature, however, produces only a few treatment guidelines specific to LGBT clients (Feldman & Meyer, 2007; Minaiy, Johnson, Ciochon, & Perkins, 2017; Walloch, Cerezo, & Heide, 2012). Guidelines for males with eating disorders were likewise cited by clinicians as limited. This seems particularly important given that males with eating disorders often report feeling misunderstood (Strother, Lemberg, Stanford, & Turberville, 2012) and attempt suicide more often than females with eating disorders (Bramon-Bosch, Troop, & Treasure, 2000). Examining concerns such as the drive for muscularity (Parent & Bradstreet, 2017) and the gay ideal (Yelland & Tiggemann, 2003) may be useful in the development of treatment guidelines.

This study is one of the first to gather data on the published resources that influence the therapeutic work of clinicians who treat eating disorders. According to findings, non-academic books are the resource that play the largest role in therapy. Internet resources such as YouTube and Ted Talks were also described as an influential resource. This is not surprising given that these resources are typically accessible, enjoyable, and relatable. It is reasonable to conclude that these resources communicate therapeutic principles in a more emotional and personal way than other didactic approaches. Nonetheless, research on these resources as interventions in eating disorder treatment are non-existent. Why and how these are effective are in need of further examination, especially from the perspective of clients in treatment.

Another resource identified by clinicians was treatment manuals. Based on responses, clinicians utilize these for eating disorders as well as comorbid illnesses. Clinicians made clear, however, that manuals are utilized when deemed relevant and are not a guiding source for treatment. This is consistent with previous studies indicating that treatment manuals are adapted to fit circumstances (Addis & Krasnow, 2000; Haas & Clopton, 2003; Simmons et al., 2008). Professional journals were mentioned as a resource but only by a few clinicians, most of whom held doctoral degrees. The fact that the highest level of education among most of the clinicians was a master's degree perhaps explains this finding. It is a well-known fact that master's level programs devote less time to research than doctoral programs because of differences in focus. It was apparent from interviews that academic articles would be sought after more frequently if the interventions used in studies better explained their application to everyday practice.

Limitations of the Study

This study had some limitations. For example, 12 of the clinicians held a master's level degree while the remaining four held a doctoral level degree. Furthermore, 13 of the clinicians worked in inpatient/residential treatment and only three worked in outpatient. Consequently, the approaches detailed in this study may be more typical of clinicians working in more intensive treatment settings. Moreover, given that the client population at the treatment center is predominantly female, it is difficult to determine how these results relate to male clients. Therefore, the processes described in this study are based on the experiences of European American clinicians who work almost exclusively with females. Clinicians of different ethnicities and religious groups were not available to examine. Finally, as with all interview studies, the data acquired in this study was self-report and subject to introspection errors. As a

result, some of the information provided may not be completely reflective of the therapeutic approaches used by clinicians on a consistent basis.

Recommendations for Research

This study expands research on the therapeutic process of eating disorder clinicians and lends direction for future research. As was mentioned, most of the clinicians worked exclusively with clients in inpatient/residential treatment. There is a need for accounts from clinicians in different treatment settings (i.e., hospitals, private practices, college counseling centers). It would also be beneficial to have perspectives from clinicians of different racial and educational backgrounds than those in this study. A comparison of approaches across settings could contribute to the development of a more effective treatment process for eating disorders. Furthermore, there is a need for studies exploring the experiences of clients in eating disorder treatment. Perspectives from clients who are male and clients in the LGBT community, in particular, are very limited.

There is a need for an honest dialogue between researchers and clinicians concerning the advantages and disadvantages of manual-based treatments for eating disorders. Findings from previous research as well as those in this study confirm that manualized treatments are not being used in everyday practice. An open exchange of information would allow clinicians to provide feedback on the acceptability of treatments based on real world experiences. It is also recommended that professional journals publish more studies that focus on how to implement interventions used in scientific articles or provide website links to such descriptions. This would provide incentive for clinicians to consult current research and improve dissemination of evidence-based treatments.

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APPENDIX A: LITERATURE REVIEW

Introduction

In 1950, a committee of members from the American Psychiatric Association convened in order to address the need to standardize diagnosis of mental illness. The result of their efforts was the first publication of *The Diagnostic and Statistical Manual of Mental Disorders* (DSM-I) (American Psychiatric Association, 1952). At a modest 130 pages, it included a list of 106 mental disorders. It is in this context that eating disorders started to receive more serious consideration. Anorexia nervosa (AN), the only eating disorder mentioned at the time, was categorized as a psychophysiologic autonomic and visceral disorder. Essentially viewed as a dysfunction of the nervous system either caused or exacerbated by emotional upset, this classification was to change in subsequent editions. The next eating disorder to receive recognition was bulimia with the DSM-III in 1980, later revised to bulimia nervosa (BN) in the DSM-III-R (American Psychiatric Association, 1980; American Psychiatric Association, 1987). Distinct from AN, BN was characterized by its association with the use of vomiting, laxatives, and diuretics in response to binge eating.

The most recent development in eating disorder diagnosis was the acceptance of binge eating disorder (BED) with the DSM-V in 2013 (American Psychiatric Association, 2013). Though it received considerable resistance, BED was distinguished by episodic binge eating accompanied with feelings of loss of control. These historical milestones are significant because they shed light on how eating disorders have been conceptualized and treated in clinical psychology. The revision of definitions and addition of new disorders demonstrates the changing state of the field based on increased understanding and awareness from research and clinical practice.

AN is no longer considered a breakdown of the nervous system. Though the exact cause remains unknown, criteria for AN includes: “persistent energy intake restriction; intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain; and a disturbance in self-perceived weight or shape” (American Psychiatric Association, 2013, p. 339). Individuals with AN refuse to maintain a body weight that is appropriate for their age, sex, development, and physical health. Food restriction is employed to achieve a low body weight. Though prevalence rates are difficult to determine because of the shame and secrecy of the disorder, research estimates 0.4% of females are affected (p. 341). Rates for males are far less reliable though generally believed to be much lower (p. 341). AN is a life-threatening condition with the highest mortality rate of any mental illness (National Eating Disorders Association, n.d.–b).

The symptoms of BN comprise of: “recurrent episodes of binge eating; recurrent inappropriate compensatory behaviors to prevent weight gain; and self-evaluation that is unduly influenced by body shape and weight” (American Psychiatric Association, 2013, p. 345). It shares similarity with AN on two criteria, namely, anxiety over weight gain and overemphasis on body image. The distinguishing feature of BN, however, is the persistent cycle of bingeing and purging. Purging consists of compensatory behaviors for overeating such as vomiting, laxative and diuretic use, exercising, and fasting. Like AN, BN is believed to be less common in males and affects approximately 1%–1.5% of females (p. 347). Risk of suicide is particularly elevated for this population.

As mentioned earlier, BED is newly recognized as of the DSM-V. Its essential feature is “recurrent binge eating that must occur, on average, at least once per week for 3 months” (p. 350). Bingeing is defined as “eating, in a discrete period of time (e.g., within any 2-hour period),

an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances” (p. 350). The binge period is characterized by a sense of lack of control. Individuals eat in response to emotional rather than physical cues and experience feelings of guilt and disgust with themselves. In contrast to BN, however, there is no attempt to use compensatory behaviors after a binge. Estimates place the prevalence of BED at 1.6% for females and 0.8% for males (p. 351). Though difficult to treat, remission is higher than for AN and BN.

In an attempt to prevent and treat eating disorders, research has investigated potential biological, psychological, and sociocultural risk factors. Among the most prevalent risk factors are body dissatisfaction, negative affect, thin-ideal internalization, dieting, and family social support deficits (National Eating Disorders Association, n.d.–a). Other influences include low body mass index, social pressure for thinness, low self-esteem, social withdrawal, and prior psychiatric illness. These factors are complex and are only some of many possible contributors. In an analysis of eating disorder influences, Culbert and colleagues created a working model of eating disorder risk based on a biopsychosocial perspective (Culbert et al., 2015). A number of variables were examined based on support from previous literature. Sociocultural influences such as thin idealization, expectations for thinness, and thin media exposure were one aspect of the examination. Research on personality traits such as perfectionism, negative emotionality, neuroticism, perfectionism, impulsivity, and negative urgency was assessed. Genetic components and the interplay with environmental factors were considered in addition to studies on cognitive flexibility and inhibitory control. Analysis revealed that the interaction among many of these variables contribute to the development of eating disorders. Specifically, the most significant impact came from the interaction between the thin ideal and neural/behavioral plasticity, the

interplay of personality and neurocognitive processes, and the effect of environmental influences and developmental changes.

Today, approximately 20 million women and 10 million men in the United States suffer from an eating disorder (National Eating Disorders Association, n.d.–b). Furthermore, 13% of youth will have at least one eating disorder by age 20 and 15–47% of youth show symptoms of disordered eating (Culbert, Racine, & Klump, 2015). Though eating disorders are indeed more prevalent in Western countries, non-Western countries have troubling rates that are increasing (Makino, Tsuboi, & Dennerstein, 2004; Qian et al., 2013). Despite the severe and often fatal nature of eating disorders, the misconception that eating disorders are “lifestyle choices” persists in society (National Institute of Mental Health, n.d.). Furthermore, the perpetuation of the idea that eating disorders only affect females prevents males from receiving treatment. Efforts for awareness, prevention, and treatment have encountered a serious stumbling block, that is, lack of funding. The National Eating Disorders Association (n.d.–b) explains, “Research dollars on Alzheimer’s Disease average \$88 per affected individual in 2011. For Schizophrenia the amount was \$81. For Autism \$44. For eating disorders the average amount of research dollars per affected individual was just \$0.93.” A tragically small amount when the physical and emotional devastation of eating disorders is considered.

Despite these barriers, psychology and medicine have made important strides in the treatment of eating disorders. It is evident that “the most effective and long-lasting treatment for an eating disorder is some form of psychotherapy or counseling coupled with careful attention to medical and nutritional needs” (National Eating Disorders Association, n.d.–c). An exploration of eating disorder treatment based on current research and practice will be explored further.

Current Research Trends

Anorexia Nervosa

Meta-analyses and clinical guidelines offer important insight into the complications of eating disorder treatment. For example, it has been found that AN is one of the most challenging mental illnesses to treat with fewer than 50% of patients recovering fully (Galsworth-Francis & Allan, 2014). Factors associated with poor outcomes include: depression, mood and anxiety disorders, social functioning, longer duration of disease, and substance abuse (Berkman et al., 2007). Even though there has been extensive research on AN, there is still no treatment of choice for this disorder (DeJong, Broadbent, & Schmidt, 2012; Galsworth-Francis & Allan, 2014). Moreover, understanding of severe AN is woefully inadequate (Hay, Touyz, & Sud, 2012). For adolescents with AN, family based therapy (FBT) is the most frequently used treatment method (Couturier, Kimber, & Szatmari, 2013). It is also the only intervention specifically endorsed by the American Psychiatric Association (2006). In clinical trials, adolescent clients appear to respond better to FBT than adults (Bulik, Berkman, Brownley, Sedway, & Lohr, 2007; Hay, 2013). Evidence supporting the use of cognitive behavioral therapy (CBT) for this population is limited (Gowers, 2006).

The American Psychiatric Association (2006) does not endorse a particular treatment for adult clients with AN citing a lack of evidence from controlled trials though they do favor cognitive behavioral, interpersonal, and psychodynamic therapy. CBT seems to reduce the risk of relapse in adults, though only after weight gain has been accomplished (Bulik et al., 2007; Hay, 2013). The use of CBT for severely underweight clients has not been adequately studied. In terms of medication, several studies indicate that the use of antidepressants only for AN is insufficient. Interpersonal therapy (IPT), though not as popular, is moderately effective when

compared to non-specific clinical care (Hilbert & Brähler, 2012). Long-term improvements with IPT have been confirmed though larger outcomes studies are needed. There have been no pharmacological interventions that have significantly restored weight gain or improved the psychological symptoms of AN. As of current guidelines, no pharmacotherapy for AN is recommended (Herpertz et al., 2011).

Bulimia Nervosa

In contrast to AN, BN and BED have higher success rates though present their own unique challenges. The most accepted treatments for BN are cognitive behavioral, dialectical behavior, and interpersonal therapy (Allen & Dalton, 2011). The American Psychiatric Association (2006) likewise endorses these therapies in official guidelines. When compared to medication, CBT more effectively reduces bingeing and purging and improves eating attitudes (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012; Whittal, Agras, & Gould, 1999). CBT also appears to bring about more rapid symptom change than IPT even though both have established effectiveness (Shapiro et al., 2007). A version of CBT specifically developed for bulimia (CBT-BN) has proven successful with approximately 40% of patients free of binge eating symptoms at the end of treatment (DeJong et al., 2012; Whittal, Agras, & Gould, 1999).

IPT and psychodynamic therapy for BN in randomized clinical trials shows moderate to good effectiveness lower than CBT in the short term but equal in the long-term (Hilbert et al., 2012; Thompson-Brenner & Westen, 2005b). Though still relatively new in the treatment of eating disorders, dialectical behavior therapy (DBT) has demonstrated value in several studies, with abstinence rates ranging from 29% to 89% at the end of treatment (Bankoff, Karpel, Forbes, & Pantalone, 2012). A lack of comparisons to other therapies, however, prevents complete understanding of how and when DBT should be used. Other research indicates that counseling

for BN is initially effective but shows diminished outcomes in the long-term (Erford et al., 2013). Factors associated with worse outcomes include depression, substance use, and poor impulse control (Berkman et al., 2007). The only medication approved by the Food and Drug Administration (FDA) for BN is Prozac, in order to minimize binge and purge frequency (Mayo Clinic, n.d.). Some researchers argue that the “the bulimia nervosa literature underscores the utility of antidepressants, particularly, SSRIs, in improving the symptoms of the disorder” (Mitchell, Roerig, & Steffen, 2013, p. 470).

Binge Eating Disorder

Like BN, CBT, DBT, and IPT are the most widely used treatments for BED (Allen & Dalton, 2011). Relapse rates for BED remain high despite positive short-term results with the previously mentioned therapies (Bankoff et al., 2012). Research suggests that CBT, the standard treatment for BED, may be insufficient for many patients, especially those seeking weight loss (Godfrey, Gallo, & Afari, 2015). Multiple meta-analyses of CBT interventions for BED have shown, however, reduction in binge behaviors as well as improvement in alleviating concerns about eating, body weight, and body shape (Brownley, Berkman, Sedway, Lohr, & Bulik, 2007; Duchesne et al., 2007; Vocks et al., 2010). These discrepancies necessitate further research on why CBT is helpful for some clients and not for others. Interventions that promote healthy weight loss are another important area that deserves future development.

In contrast to other eating disorders, IPT shows more promise for BED. Significant short and long-term therapeutic gains have been established with IPT (Hilbert et al., 2012). DBT has also been utilized with success leading to abstinence rates ranging from 29% to 89% at post-treatment (Bankoff et al., 2012). A range of medications for the treatment of BED has included SSRIs, SNRIs, anticonvulsants, and obesity medication. These drugs have shown a modest

positive effect on binge eating and associated depression symptoms (Vocks et al., 2010). Mitchell et al. (2013) assert that the literature has disregarded much of the potential use of antidepressants for BED. Nonetheless, current guidelines do not recommend the use of any specific pharmacotherapy (Herpertz et al., 2011). Due to the relative newness of BED as a recognized mental illness, research is still in the beginning stages and more high-quality studies are crucial, especially as dropout rates for existent studies are quite high.

New Therapies

Eating disorder treatment is costly and the stigma associated with mental illness deters many clients from seeking help. Even for clients interested in treatment, it can be difficult to find qualified clinicians in their community. A number of innovative approaches have thus been designed in recent years in an attempt to address some of these problems. Self-help, for instance, has been proposed as a low cost, easily accessible solution. Allen and Dalton (2011) reviewed studies involving cognitive behavioral based treatments for BN and BED using self-help books. Analysis indicated that self-help in general was helpful though guided self-help (i.e., self-help coupled with provider guidance) was superior (p. 1168). One exception was a study in which fluoxetine showed decreases in bingeing and purging and not self-help (Walsh, Fairburn, Mickley, Sysko, & Parides, 2004). Although the findings are worth note, there were a few significant issues, namely, that none of the studies had been replicated as of publication and there was no standardization between the treatment protocols. The authors believe that these types of treatment would be more realistic in the future if standardized manuals were used.

Other meta-analyses of self-help for BN and BED were conducted except focused on studies with internet-based interventions. Dropout rates were high though comparable to internet therapies for other mental disorders and clients with BN had higher dropouts than clients with

BED (Beintner, Jacobi, & Schmidt, 2014; Dölemeyer, Tietjen, Kersting, & Wagner, 2013). As in the case of self-help via a book, provider direction throughout treatment led to improved adherence and outcomes. Most studies did show reductions in disordered eating behaviors as well as weight concern from pre to post treatment (Loucas et al., 2014; Stefano, Bacaltchuk, Blay, & Hay, 2006). Beintner and colleagues emphasize the need for “the use of consistent terminology as well as uniform standards for reporting adherence and participation in future self-help trials” (p. 158). Thus far, there are no definitive answers on the effectiveness of self-help treatments indicating a need for additional research if these are to be a primary method of treatment. Notably absent from these analyses were studies with clients with AN, perhaps due to the higher threat of mortality making internet interventions less realistic. Interestingly, the majority of interventions had cognitive behavioral foundations indicating the opportunity for exploration of other therapy types in an internet format for eating disorder treatment.

Mindfulness based treatments for eating disorders are another area of research that has come to the fore with techniques drawn from DBT, acceptance and commitment therapy, and mindfulness-based stress reduction (MBSR). In the first systematic review and meta-analysis of mindfulness-based psychological interventions for binge eating, Godfrey and colleagues found effects sizes of medium-large to large (Godfrey et al., 2015, p. 358). It is important to note that the participants in these studies may or may not have been diagnosed with BED limiting the generalizability to clients with eating disorders. Another meta-analysis looked at mindfulness meditation for binge eating (Katterman, Kleinman, Hood, Nackers, & Corsica, 2014). Mindfulness meditation was associated with decreases in bingeing and emotional eating though effects on weight loss were inconclusive. Populations with AN or BN were specifically excluded in this data analysis. A review that examined mindfulness for clients with eating disorders

specifically was unable to make any definitive statements because of small sample sizes and variability in design quality (Wanden-Berghe, Sanz-Valero, & Wanden-Berghe, 2011). Each study in this review did, however, report positive outcomes. It thus appears that there is a small but promising body of research supporting mindfulness-based interventions for binge eating. How and when these interventions should be used for clients with eating disorders should be the focus of future investigations.

Though in the early stages, there are some other areas of interest in the treatment of eating disorders. For instance, researchers have observed that clients with eating disorders often struggle with core religious and spiritual issues such as feelings of spiritual unworthiness and shame before God (Marsden, 2007; Richards et al., 1997). Spiritually oriented interventions have been proposed as a way to address these problems. The few studies using spiritual interventions for eating disorder treatment have demonstrated meaningful results (Lea, Richards, Sanders, McBride, & Allen, 2015; Richards, 2009; Richards, Berrett, Hardman, & Eggett, 2006; Spangler, 2010). Spirituality offers clients a powerful source of healing and merits further study. Another focus of research has been on exercise therapy, something that has been traditionally contraindicated for clients with eating disorders. Meta-analyses show however, that yoga, aerobic exercise, and even biofeedback may be effective adjuncts to treatment (Moola, Gairdner, & Amara, 2013; Schoenberg & David, 2014; Vancampfort et al., 2013; Vancampfort et al., 2014). These interventions have outcomes such as enhanced quality of life, improved psychological wellbeing, increased body awareness, and decreased disordered eating. These therapeutic practices show a trend toward a holistic mind, body, and spirit approach in treatment.

Future Directions

In what is known as the “Dodo Bird Verdict,” equivalent outcomes are observed when psychotherapies are compared with each other (Wampold, & Imel, 2015). Therapies for eating disorders are not immune to this phenomenon as analysis shows eating disorder treatments are equally effective (Spielmans, Benish, Marin, Bowman, Menster, & Wheeler, 2013). Further, dropout rates from therapy do not appear to be significantly influenced by treatment type either (Swift & Greenberg, 2014). This does not necessarily mean, however, that every therapy used in research studies is valuable. Spielmans and colleagues (2013) contend that many clinical trials do not have sound theoretical rationales, an argument that has been made by other researchers (Pennesi & Wade, 2015). They point out that most meta-analyses do not include dissertations, leaving out interventions that may have superior outcomes. Moreover, equivalence between therapy types does not mean there is no room for improvement. Long-term recovery rates for clients with eating disorders are alarmingly low and there is substantial work to be done if we are to help these individuals. Some researchers argue that studies should focus on an “integrationist approach to therapy” that is influenced more by other therapy variables such as “common factors, client characteristics, and therapist characteristics” (Swift & Greenberg, 2014, p. 193). This is a convincing argument that deserves further attention if research is to innovate and improve eating disorder treatments.

Current Clinical Practices

Case Differences

It has become increasingly obvious that there are major discrepancies between the eating disorder treatments being used in clinical trials and in everyday practice. Part of this divide seems to stem from the fact that researchers and clinicians are working with very different cases.

Haas and Clopton (2003) found several distinctions between clients in outcome studies and clinical practice. One was the extent of comorbid diagnoses. “Comorbidity is the norm rather than the exception” in the community (Thompson-Brenner & Westen, 2005, p. 581). Most cases contain Axis I and Axis II diagnoses based on DSM-IV criteria in contrast to treatment studies that very seldom allow participants with multiple issues. Another difference Haas and Clopton (2003) observed was that clients in clinical practice are more likely to be treated individually and for more sessions. Subjects in outcome studies, on the other hand, are more likely to receive group therapy and for fewer sessions. Lastly, it was discovered that clinicians usually work with clients with more extreme and complex problems. These can be anything from financial difficulties to legal complications to family drama.

Furthermore, a devastatingly low number of individuals with eating disorders receive appropriate treatment in the community. In one meta-analysis, it was discovered that 67% to 85% of eating disorder cases have unmet needs for treatment (Hart, Granillo, Jorm, & Paxton, 2011, p. 732). Ethnic minorities, in particular, are less likely to be diagnosed and receive therapy (Sinha & Warfa, 2013). This is despite the fact that individuals with eating disorders are more frequent users of health care services. According to Hart and colleagues (2011), “Medical treatment for weight loss was found to be much more common than mental health care for an eating problem, which suggests that many treatment services are not adhering to clinical practice guidelines” (p. 732). These findings are disturbing due to the serious and sometimes fatal nature of eating disorders. If clinicians are being confronted with different and often more challenging cases, it is vital that studies reflect these conditions.

Theoretical Orientations

Several studies have investigated the main theoretical orientations that influence the work of eating disorder clinicians. In surveys with providers from the Multi-Service Eating Disorder Association and the Academy of Eating Disorders, most participants reported using CBT and psychodynamic therapy with clients with eating disorders (Tobin, Banker, Weisberg, & Bowers, 2007; Warren, Crowley, Olivardi, & Schoen, 2009). Another assessment of the primary orientations used by doctoral level psychologists in clinical settings resulted in similar findings (Pederson Mussell et al., 2000). CBT was the most frequently endorsed approach and second was eclectic therapy. Those who identified with an eclectic approach employed techniques primarily drawn from CBT. 78.3% of the psychologists, however, had never received training in the use of CBT with clients with eating disorders though most expressed interest in such training. When von Ranson and Robinson (2006) conducted telephone interviews with Canadian mental health clinicians, eclectic therapy was the most common therapeutic orientation and second was CBT. 87% said they used CBT techniques with their clients with eating disorders. The foremost response by clinicians for the selection of their primary approach was clinical experience.

In another study, 265 eating disorder clinicians were interviewed about the specific therapeutic strategies they most frequently used in therapy (Tobin et al., 2007). Factor analysis revealed seven areas: psychodynamic interventions, coping skills training, family history, CBT, contracts, therapist disclosure, and patient feelings (p. 754). This is in line with the previous research indicating that CBT and psychodynamic therapy play a large role in community therapy. Clinicians in a different examination were solicited for their recommendations in regard to eating disorder treatment (Warren et al., 2009). They offered the following suggestions: (1) receive frequent supervision and consultation; (2) recognize the seriousness of eating disorders;

(3) avoid heavy caseloads; (4) understand comorbidity; (5) stay informed of new research; (6) practice self-care; (7) be firm and encouraging with patients; and (8) appreciate the opportunity to help (p. 42).

CBT, eclectic, and psychodynamic are the most popular therapy approaches of community clinicians when working with clients with eating disorders. Studies with different populations, however, are desirable in order to substantiate these findings. It appears that clinicians use a style that is more often based on their personal judgment rather than empirical support. Though part of good clinical practice involves adapting treatment to individual client needs, relying solely on experience may cause clinicians to ignore established research and make decisions that are not in the best interest of their clients. Finding a balance between the two is thus continual challenge.

Barriers in Treatment

On the surface, it looks as though many clinicians implement evidence-based therapies. In interviews with 423 healthcare clinicians of clients with BN, 83% reported satisfaction with CBT (McAlpine, Schroder, Pankratz, & Maurer, 2004). 70% of 73 clinicians in specialized eating disorder treatment agreed that evidenced-based treatments are important, and that CBT is the ideal (de la Rie, Noordenbos, Donker, & van Furth, 2008). Even with these beliefs, however, there is evidence that many clinicians do not necessarily apply these treatments. Waller and colleagues explored the extent 80 CBT clinicians used CBT techniques with their clients with eating disorders (Waller, Stringer, & Meyer, 2012). According to the authors, “Reported adherence was poor with no single core CBT technique routinely used by even 50% of the sample” (p. 174). One of the most commonly reported techniques was pretherapy motivation work, an intervention that is without empirical support. A similar study was conducted to note

the frequency that practitioners of FBT used core FBT techniques (Kosmerly, Waller, & Robinson, 2015). The clinicians, 117 in total, “fell into two clusters – about two-thirds using manual-recommended FBT techniques, and a third deviating substantially from those recommendations” (p. 227). These studies uncover a significant problem, namely, that identification with an evidence-based therapy does not equate with consistent use. This raises the question as to why there is incongruence between beliefs about treatment and actual practice.

Variance in adherence to core theoretical techniques has been linked to a number of factors. In the previously mentioned study, “clinician caseload and anxiety were associated with differences in the use of FBT tasks” (p. 223). Clinicians were less likely to use FBT when working with older clients and clients with BN. Those with higher anxiety often avoided weighing clients on a regular basis, perhaps from fear of distressing the client. Another factor that affects delivery is age. In one investigation, younger clinicians (between the ages of 21 and 30) were more likely to use CBT (Cowdrey & Waller, 2015). Clinicians between the ages of 31 and 40 were more likely to use CBT variably and clinicians over age 40 were more likely to use a general approach. One explanation for this may be that as clinicians advance in age they are more prone to trust their experience over research. An additional factor that accounts for deviation is education. Of 271 doctoral level psychologists, 62.5% cited lack of training as the primary reason for not using empirically based psychotherapy (Pederson Mussell et al., 2000, p. 233).

In summary, many clinicians have not received sufficient instruction on evidence-based therapies though there seems to be a significant number of clinicians interested in receiving such training. Clinicians are balancing multiple demands and are often forced to cope with circumstances beyond their training. This situation, however, can be remedied with efforts to

better prepare students to work with clients with eating disorders and help them to understand the evidence supporting certain treatment options. Several factors have been associated with the delivery of treatment. Additional research, however, would be beneficial to understand the interplay of these and other factors.

Treatment Manuals

Treatment manuals have become a fundamental component of evidenced-based treatment. Wilson (2007) notes, “The advantages of manual-based treatment include well-documented efficacy, less reliance on intuitive clinical judgment, and greater ease in training and supervising therapists in specific clinical strategies and techniques” (p. 105). Even with evidence that manuals are effective with various client populations and disorders, many clinicians lack understanding of treatment manuals (Addis & Krasnow, 2000). Some believe that manuals are simply an assortment of techniques or the agenda of third parties. These sentiments seem to be felt among eating disorder clinicians as well. Psychologists from the National Register of Health Services were asked whether or not they believed eating disorder treatment manuals are useful (Haas & Clopton, 2003). According to the authors, “The two most common responses to this question were that manuals are helpful when they are flexible enough to meet client’s individual needs (38.3%) and that such manuals are not helpful because they do not address comorbidity and other individual needs of clients (29.7%)” (p. 415). This aligns with a similar investigation in which 67% of 265 clinicians thought eating disorder manuals were important but made adjustments based on individual cases (Tobin, Banker, Weisberg, & Bowers, 2007).

In a survey of 268 clinicians from the Academy of Eating Disorders, 50% admitted to not using manual-based therapies for eating disorders (Simmons, Milnes, & Anderson, 2008). The predominant reasons mentioned for not using manuals were that they are overly structured and

not applicable to most cases. In fact, “Clinicians report treating patients for much longer than 16 to 20 sessions prescribed in widely tested manuals, and they report that durable change typically emerges long after 20 sessions. The average length of treatment in the community for BN is about 2 years, with CBT treatments lasting 68 sessions on average” (Thompson-Brenner & Westen, 2005a, p. 581). It is important to consider, however, that although clinicians perceive manuals as ineffective, it does not mean that manuals are useless. For example, Brown and colleagues found that “clinicians who used manuals reported focusing on structured eating and being more likely to have patients who achieve NICE guidelines on weight gain (0.5 kg/week)” (Brown, Mountford, & Waller, 2014, p. 9). In this study, emphasis on the therapeutic alliance over change in eating actually delayed weight gain in clients with AN. These inconsistencies between practice and research are complex. It may be that clinicians are biased toward treatment manuals and lack proper training, but it does not negate the fact that clinicians have valuable insights into real world practice that can inform research. If closer adherence to manuals would indeed enhance outcomes, then better communication and trust between clinicians and researchers needs to be established.

Client Perspectives

Client perspectives provide further evidence that established clinical guidelines are not being reliably used by clinicians. In one study, 157 clients with eating disorders were asked about their experience of receiving CBT (Cowdrey & Waller, 2015). According to this study, “fewer than 20% of patients received a pattern of intervention that resembled the evidence-based version of CBT” (p. 76). Techniques from different theoretical orientations, including many that lack empirical evidence, were more often used than core CBT techniques. The authors speculate that one reason for the departure is that “when presented with patients with anorexia nervosa,

clinicians modify their approach in response to the limited success rates for treating this clinical group” (p. 76). Other reasons for the drift from protocol may be related to lack of training, negative attitudes toward research, or fear of distressing the client. Likewise, in interviews with clients with BN, descriptions of substandard treatment were recounted (Crow, Mussell, Peterson, Knopke, & Mitchell, 1999). Specifically, 96.8% had received psychotherapy but only 6.9% involved CBT. 63.7% of clients underwent some type of pharmacotherapy but only 46.2% had been prescribed an adequate antidepressant dose (p. 42). Discussing these findings, the authors concluded that adequate pharmacotherapy and empirically supported psychotherapies for BN are not being adequately applied.

There also appears to be incongruence between what clients and clinicians value in eating disorder treatment. When comparing the responses of clinicians and clients about the quality of therapy, some critical areas of divergence surfaced (de la Rie et al., 2008). It was found that “therapists valued the focus on ED symptoms and behavioral change more highly, whereas patients underscored the importance of the relationship with the therapist and addressing underlying problems” (p. 313). Clinicians and clients did agree, however, on the overall process and structure of treatment. Arguably one of the most interesting findings was that “trust in therapist” was ranked as the number one criteria by clients. This is telling as most clinical guidelines focus on techniques and methods rather than the therapeutic alliance. If these results are correct, it is perhaps more advantageous to focus more on relationship factors and clinician characteristics than it is on specific treatments.

Rationale for the Study

After review of the literature, several themes emerged. First, eating disorder diagnosis and treatment have evolved over time. Once perceived as a biological disorder with

psychological overlap, eating disorders are now viewed as a mental illness with serious physical side effects. *The Diagnostic and Statistical Manual of Mental Disorders* (DSM-V) defines an eating disorder as a “persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning” (American Psychiatric Association, 2013, p. 329). The American Psychiatric Association recommends a treatment plan based on nutritional rehabilitation, psychosocial interventions, and appropriate medication. Second, a number of therapies have come to the fore in eating disorder treatment and more are being developed. Evidence-based practice for AN involves FBT, CBT, IPT, and psychodynamic therapy. CBT, DBT, and IPT is recommended for BN and BED. Promising areas of research include self-help, mindfulness, spirituality, and physical exercise for eating disorder treatment.

Third, clients in clinical trials are not always representative of clients in the community. Part of this discrepancy is unavoidable. Research is constrained by time and funding resulting in less than ideal conditions. Nonetheless, community clinicians are confronted with some of the most difficult cases and often lack sufficient resources. This has resulted in treatment manuals and clinical guidelines that are not always flexible enough to address the conditions in the real world. Fourth, adherence to evidence-based practice by every day clinicians is inconsistent. Factors such as lack of training, clinician anxiety, and skepticism about research explain part of the variance. Though there have been a number of important studies, the views and practices of clinicians working in the field are still largely unknown.

While the research-practice gap is not unique to eating disorder treatment, the impetus for researchers to collaborate with clinicians is just as strong. Research is most effective when the input of clinicians and clients are taken into account. Thompson-Brenner and Westen (2005a)

explain, “Clinical practice can be useful as a natural laboratory for identifying associations between patient and treatment variables (and their interactions) and outcomes and that these patterns of associations can be used to design treatments to test in the next generation of clinical trials and naturalistic studies” (p. 574). Further, “Clinicians have ready access to patient populations and data from samples of patients treated in the community which is an obvious advantage in terms of generalizability” (p. 574). The clinical setting is an underutilized resource. To bridge the research-practice gap, it is essential that researchers and clinicians develop a better relationship.

It is anticipated that this study will be a step forward in understanding how clinicians approach therapy with clients with eating disorders and what they believe contributes to quality treatment. Insights acquired from clinicians will inform research of potential treatment approaches and interventions for clients with eating disorders. Further, it will help researchers enter the minds of clinicians and reveal barriers to delivering evidence-based treatment. It is hoped that this study will be a catalyst for studies of a larger scale in order to take advantage of the collective knowledge and experience of clinicians working in the community.

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APPENDIX B: ADDITIONAL FINDINGS

The following is a list of the specific treatment manuals and non-academic books clinicians mentioned during interviews.

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APPENDIX C: LETTER OF REQUEST

Dear Participant,

My name is Sabree Crowton and I am a doctoral student in the Counseling Psychology department at Brigham Young University. I am writing to invite you to participate in a study that examines the experience of clinicians in working with clients with eating disorders. In order to participate in this study, you must meet the following criteria: 1) Must have a master's or doctoral degree and 2) Must be currently treating or have treated clients with any type of DSM-5 (2013) level eating disorder.

The study will be carried out in three phases. First, you will complete an online survey that will take approximately 10 minutes for collection of demographic information. Second, you will be asked to participate in a semi-structured interview that will last for approximately 60 minutes. The interview will be held in your office or another convenient location, and will be audiotaped and later transcribed for data analysis. Third, you will be contacted, by telephone or email, after an initial analysis of the data has been completed, so that I can briefly share with you the general findings of the study, and give you the opportunity to provide any final feedback. The total time commitment will be approximately two hours. In exchange for your participation, you will receive a reimbursement check of \$100.

Involvement in this research project is voluntary. You may withdraw at any time without penalty or refuse to participate entirely. Your experience is valuable and will help progress research for the treatment of eating disorders. In addition, at the end of the interview you will be offered the option of having this study emailed to you, once it is completed. If you have any additional questions my email address and cell phone are provided to you, and you may contact me at any time. If you have any questions regarding your rights as a participant in research projects, you may contact the IRB Administrator.

Thank you for your participation and I look forward to meeting with you.

Sincerely, Sabree Anne Crowton

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APPENDIX D: CONSENT FORM

Introduction

The purpose of this research study is to explore the therapy process of clinicians with their clients with eating disorders. Sabree Anne Crowton, a doctoral student in the Counseling Psychology department at Brigham Young University, is conducting it. P. Scott Richards Ph.D. is serving as the committee chairperson. You were selected as a potential research subject because of your experience in working with client with eating disorders.

Procedures

The research will be carried out in three phases. First, you will complete a demographic survey sent via email that will take approximately 10 minutes. Second, you will be asked to participate in a semi-structured interview that will last for approximately 60 minutes. The interview will be held in your office or another convenient location, and will be audiotaped and later transcribed for data analysis. Third, you will be contacted, by telephone, after an initial analysis of the data has been completed, so that I can briefly share with you the general findings of the study, and give you the opportunity to provide any final feedback. The total time commitment will be approximately two hours.

Risks/Discomforts

The risks of this study are minimal. Nonetheless, clinicians may experience some discomfort describing their treatment process and about this information being seen by the research team. Clinicians will be assigned an ID number to protect confidentiality. Only the primary researcher will be able to link names with ID numbers. No one outside the research team will have access to clinician names.

Benefits

One potential benefit for you from participating is that we will share our findings with you. In addition, you will be given an opportunity to examine your professional practices and contribute your knowledge and experience to other clinicians.

Confidentiality

ID numbers will be used in such a manner that your identity will not be attached physically to the data that you contribute. The master list containing your name and ID number will be kept separate from the data and stored in a file cabinet accessible only to the primary researcher and her committee chair. The audiotapes will be erased immediately after the transcripts are typed. The findings of this research may be published or otherwise reported to scientific bodies, but you will not be identified in any such publication or report.

Compensation

Clinicians will receive a check for \$100. The money will be delivered after completion of the interview.

Participation

Participation in this study is voluntary, and you are free to withdraw your consent and discontinue participation at any time.

Questions about the Research

If you have any questions regarding this research project you may contact: Sabree Crowton, 2960 N 600 E Lehi, UT, 84043; 801-358-4654; and/or P. Scott Richards Ph.D.; 801-422-4868.

Questions about Your Rights as Research Participants

If you have questions regarding your rights as a research participant contact IRB Administrator at (801) 422-1461; A-285 ASB, Brigham Young University, Provo, UT 84602; irb@byu.edu.

Statement of Consent

I have read, understood, and received a copy of the above consent and desire of my own free will to participate in this study.

Signed Participant Name

Date

APPENDIX E: DEMOGRAPHIC SURVEY

1. What is your gender?
 - a. Female
 - b. Male

2. What is your current age (in years)?

3. What is your race/ethnicity?
 - a. Asian/Asian American
 - b. Black/African American
 - c. Hispanic/Latino
 - d. Native American/American Indian/Alaskan Native
 - e. Native Hawaiian/Pacific Islander
 - f. White/European American
 - g. Other (please specify)

4. What is the highest degree or level of school you have completed
 - a. Master of Arts (M.A.)
 - b. Master of Education (M.Ed.)
 - c. Master of Science (M.S.)
 - d. Master of Social Work (MSW)
 - e. Doctor of Education (Ed.D.)
 - f. Doctor of Medicine (M.D.)
 - g. Doctor of Philosophy (Ph.D.)
 - h. Doctor of Psychology (Psy.D.)
 - i. Doctor of Social Work (DSW)
 - j. Other (please specify)

5. What is your highest degree in?
 - a. Clinical Psychology
 - b. Counseling Psychology
 - c. Marriage and Family Therapy
 - d. Mental Health Counseling
 - e. Psychiatry
 - f. Social Work
 - g. Other (please specify)

6. Are you a licensed professional?
 - a. Yes
 - b. No

7. How many years have you spent practicing as a clinician?

8. How many years have you spent working with clients with eating disorders?

9. How many hours of individual therapy with clients with eating disorders do you spend in a week?
10. Which of the following best describes your theoretical orientation?
- a. Acceptance and commitment therapy
 - b. Client-centered therapy
 - c. Cognitive behavioral therapy
 - d. Dialectical behavior therapy
 - e. Emotion-focused therapy
 - f. Existential therapy
 - g. Gestalt therapy
 - h. Humanistic therapy
 - i. Psychodynamic therapy
 - j. Rational emotive behavior therapy
 - k. Relational therapy
 - l. Spiritually integrated therapy
 - m. Systems/family therapy
 - n. Transpersonal therapy
 - o. Eclectic (please specify which approaches you combine)
 - p. Other (please specify)
11. Is there anything else you would like to tell me about your therapy approach?

APPENDIX F: INTERVIEW GUIDE

Initial questions and possible follow-up questions:

1. How do you go about treating clients with eating disorders? (What is your process from beginning to end? What is your relationship like?)
2. What types of approaches and interventions do you think are not effective with clients with eating disorders?
3. What theoretical perspectives and interventions do you include when working with clients with eating disorders?
4. Can you describe some successful experiences you have had in therapy? (Could you give me a case example?)
5. Can you share your experience with how the various components of the treatment center influence the work you do with clients during individual therapy?
6. What do you think of the American Psychiatric Association's evidence-based treatment guidelines for clients with eating disorders?
7. Are there any published resources (i.e., manuals, books, articles, websites, etc.) you frequently draw upon in therapy? (Do you use treatment manuals? If not, why?)
8. Do you integrate spiritual perspectives into your treatment approach? (How do you address spirituality in treatment? Do you believe integrating spiritual interventions enhances the outcomes of treatment?)
9. Is there anything you would like to see research focusing more on?
10. Is there anything else you have learned from your experience in treating clients with eating disorders that you would like to share with me?