

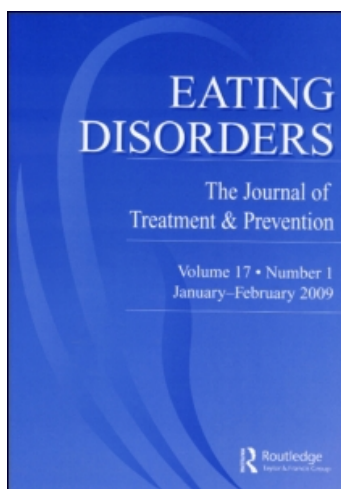
This article was downloaded by: [Weber, Sara]

On: 17 June 2009

Access details: Access Details: [subscription number 912507921]

Publisher Routledge

Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK



Eating Disorders

Publication details, including instructions for authors and subscription information:

<http://www.informaworld.com/smpp/title-content=t713666342>

Treating Patients with Eating Disorders: An Examination of Treatment Providers' Experiences

Cortney S. Warren ^a; Mary Ellen Crowley ^b; Roberto Olivardia ^b; Andrea Schoen ^a

^a Department of Psychology, University of Nevada, Las Vegas, Nevada, USA ^b Department of Psychiatry, Harvard Medical School, Boston, Massachusetts, USA

Online Publication Date: 01 January 2009

To cite this Article Warren, Cortney S., Crowley, Mary Ellen, Olivardia, Roberto and Schoen, Andrea(2009)'Treating Patients with Eating Disorders: An Examination of Treatment Providers' Experiences',*Eating Disorders*,17:1,27 — 45

To link to this Article: DOI: 10.1080/10640260802570098

URL: <http://dx.doi.org/10.1080/10640260802570098>

PLEASE SCROLL DOWN FOR ARTICLE

Full terms and conditions of use: <http://www.informaworld.com/terms-and-conditions-of-access.pdf>

This article may be used for research, teaching and private study purposes. Any substantial or systematic reproduction, re-distribution, re-selling, loan or sub-licensing, systematic supply or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The accuracy of any instructions, formulae and drug doses should be independently verified with primary sources. The publisher shall not be liable for any loss, actions, claims, proceedings, demand or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.

Treating Patients with Eating Disorders: An Examination of Treatment Providers' Experiences

CORTNEY S. WARREN

Department of Psychology, University of Nevada, Las Vegas, Nevada, USA

MARY ELLEN CROWLEY and ROBERTO OLIVARDIA

Department of Psychiatry, Harvard Medical School, Boston, Massachusetts, USA

ANDREA SCHOEN

Department of Psychology, University of Nevada, Las Vegas, Nevada, USA

Patients with eating disorders bring unique challenges to treatment providers. The purpose of this study was to explore treatment providers' experiences working with patients with eating disorders. Specifically, we investigated 1) the frequency and management of commentary about the treatment providers' appearance from patients, 2) personal changes in affect, vigilance around appearance, and eating behaviors in treatment providers, and 3) feedback and suggestions about effectively working with these patients. Using quantitative and qualitative methods, 43 professional eating disorder treatment providers attending the Multiservice Eating Disorder Association (MEDA) annual conference completed a questionnaire created for this study. Results suggest that most treatment providers experienced direct and indirect commentary about their appearance from patients and experienced notable changes in their view of food, eating behaviors, and vigilance of their own and others' appearance while working with these patients. Recommendations and suggestions from treatment providers about effectively treating these patients and managing personal changes are explored.

Address correspondence to Cortney S. Warren, Department of Psychology, University of Nevada, Las Vegas, 4505 Maryland Parkway, MS 5030, Las Vegas, NV 89154. E-mail: Cortney.warren@unlv.edu

Patients with eating disorders have a notorious reputation for being difficult to treat and undesirable as patients (Hughes, 1997; Kaplan & Garfinkel, 1999; Matz & Frankel, 2005; Williams & Leichner, 2006). In a sample of 225 Canadian psychiatry residents, for example, 28% reported that they had encountered negative attitudes towards patients with eating disorders in their training environment by fellow students, nursing staff, physicians, or other health professionals (Williams & Leichner, 2006). In a sample of 90 therapists, 31% indicated that they did not want to treat patients with eating disorders (Burket & Schramm, 1995).

Various characteristics of patients with eating disorders make them particularly challenging to treat and likely add to their undesirable reputation. First, health consequences and correlates of eating pathology include a range of sometimes lethal complications that can harm every organ system in the body, including cardiac problems, reduction of bone density (osteoporosis), muscle loss, severe dehydration, kidney failure, hair brittleness, electrolyte imbalance, gastric rupture, tooth decay, ulcers, and inflammation of the esophagus (Katzman, 2005; Mehler, Crews, & Weiner, 2004). Second, eating disorders are highly comorbid with other psychological disorders, including depressive, anxiety, substance abuse, and personality disorders (Brewerton, 2007; Godart et al., 2007; Strober, Freeman, Lampert, & Diamond, 2007). Relapses in treatment are common (Berkman, Lohr, & Bulik, 2007; Signorini et al., 2007).

Third, anorexia nervosa (AN) and bulimia nervosa (BN) are associated with suicide attempts and mortality rates considerably higher than the general population (Berkman et al., 2007; Crisp, 2006; Franko & Keel, 2006; Herzog & Greenwood, 2000) and many other psychological disorders (Newman, Moffitt, Caspi, & Magdol, 1996). An 11-year longitudinal study investigating mortality rates of eating disordered women found that women with AN were over 9 times more likely to die, with a 58 times greater suicide rate than healthy females (Herzog & Greenwood, 2000). Suicide attempts occur in approximately 3–20% of patients with AN and in 25–35% of patients with BN (Franko & Keel, 2006). The serious health consequences, high rates of suicidality, and co-morbidity in patients with eating disorders force treatment providers to constantly monitor each patient's psychological and physical functioning. This can be taxing on treatment providers' time and energy as they often must organize inpatient stays, be on-call for emergencies, stay in constant contact with additional treatment providers, and barter with insurance companies for services for their patients (Franko & Erb, 1998; Kaplan & Garfinkel, 1999).

Fourth, patients often experience interpersonal difficulty trusting therapists and may struggle sharing power and control with the therapist (Burket & Schramm, 1995; Kaplan & Garfinkel, 1999; Sallas, 1985). Fifth, given that eating disordered patients often overvalue appearance and body to interpret the world, they may be hyperaware of the treatment providers' appearance. These factors force treatment providers to assess and treat symptoms of

multiple, often intertwined diagnoses while continuing to work with patients through multiple bouts of their illness.

Finally, Western sociocultural values of appearance significantly contribute to eating pathology through the promotion and ascription of value to a virtually unattainable thin physique while stigmatizing fatness (Delucia-waack, 1999; Stice, 2002; Striegel-Moore, Silberstein, & Rodin, 1986). Treatment providers living in Western cultures receive the same strong sociocultural messages about beauty, bodies, food, and attractiveness as their patients (Matz & Frankel, 2005). Consequently, treating patients with eating disorders requires that therapist's examine their own feelings about bodies, appearance, and food on a regular basis (Delucia-waack, 1999).

Given the difficulty inherent in treating patients with eating disorders, researchers and clinicians have started to explore the experience of treatment providers when working with patients with eating disorders (Burket & Schramm, 1995; Emmett & Rabinor, 2007; Hamburg & Herzog, 1990; Hughes, 1997; Jarman, Smith, & Walsh, 1997; Lowell & Meader, 2005; Orbach, 2004; Shisslak, Gray, & Crago, 1989; Toman, 2002). The majority of existing literature are case studies and conceptual reviews (e.g., Hughes, 1997). Existing research suggests that a large number of treatment providers experience more worry, anxiety, and angst in treatment with eating disorder patients compared to non-eating disordered patients (Brotman, Stern, & Herzog, 1984). In one of the most descriptive empirical studies to date, health care professionals reported changes in eating habits, body image, and appearance as well as heightened awareness of food and physical health when working with patients with eating disorders (Shisslak et al., 1989). In another study, medical residents reported feeling more anger, helplessness, and stress treating patients with AN than when treating patients with other disorders (Brotman et al., 1984).

Despite common colloquial understanding that treating patients with eating disorders can be quite daunting and difficult, very little systematic research has empirically examined how treatment providers are personally affected by and effectively manage treatment with patients with eating disorders. Understanding common experiences can better prepare clinicians for common interpersonal interactions, create a forum to explore, process, and discuss common personal reactions, and provide data that normalizes potentially difficult experiences when working with patients with eating disorders.

Building on existing research, the overarching purpose of this study was to explore treatment providers' personal experiences working with patients with eating disorders. Using qualitative and quantitative data collection methods, the primary research questions investigated 1) the frequency and management of feedback from eating disordered patients about the treatment providers' appearance, 2) personal change in affect, vigilance around appearance, and eating behaviors in treatment providers after working

with patients and, 3) recommendations about effectively and constructively working with this population.

METHODS

Participants

Professional treatment providers attending the Multi-service Eating Disorder Association's (MEDA) annual meeting in October, 2006, participated in the study. Participation was voluntary and participants received no compensation for participation. Of the approximately 125 members of MEDA who attended the conference, 43 returned the survey (34%). Although this was only 1/3 of conference attendees, these completion rates are comparable to other treatment provider-based studies (Burket & Schramm, 1995; Franko & Rolfe, 1996; Johnston, Smethurst, & Gowers, 2005). This research project was reviewed and approved by necessary institutional review boards prior to participant recruitment and participation.

Measures

Participants completed a questionnaire designed by the authors for the purposes of this study. Questions evaluated treatment providers' experiences treating patients with eating disorders in three main areas: 1) the frequency and management of commentary (direct or indirect) from patients about the treatment providers' appearance, 2) personal change in affect, body image, and eating behaviors and, 3) suggestions for others in the field. Questions were both quantitative (e.g., yes or no, k-scale questions) and qualitative (e.g., open-ended questions about treatment providers experiences).

Procedure

Treatment providers attending the annual meeting of MEDA received two consent forms (one for them to keep and one for the researchers) and the study questionnaire with their conference materials. During the welcome ceremony and at lunch, the director of MEDA made an announcement about the study and encouraged members to participate. Two study authors (CSW and MC) attended the conference, introduced themselves during the opening ceremony, and stated that they were available to answer any questions about the study. Participants were told that they could leave completed questionnaires in a secure box (labeled STUDY QUESTIONNAIRES) before leaving the conference or mail them to the address on the consent form (CSW). Participants were assured that, once received, the completed

consent form and questionnaire data would immediately be separated to protect participant confidentiality.

Analyses

Quantitative data were examined using descriptive statistics in SPSS. To summarize and evaluate qualitative data, we used a general inductive approach as described by Thomas (2006). This systematic procedure for condensing qualitative data into brief, summarizing themes entails 1) closely reading qualitative text, 2) extracting the core meanings from responses, 3) identifying themes common across responses, and 4) creating labels that best describe emergent themes.

The coding process was undertaken by the primary investigator (CSW) and two graduate students. Independent parallel coding occurred such that each investigator was given the study objectives and raw data, and asked to develop preliminary findings (Thomas, 2006). Upon completion of initial independent results, the investigators met as a group and compared findings. Any discrepancies in emergent theme categorization were discussed until agreement among all was reached (Bruce, 2007; Ryan & Bernard, 2003). When a participants' response fit into multiple qualitative themes, their response was scored as lending support for all applicable themes. In other words, participants' responses could support multiple themes. When data from a given item were missing or not applicable for a given participant, they were excluded from analysis and the valid percentage of answers fitting a given response was calculated.

Results are organized into 4 sections. First, participant demographic information is presented. Second, we review data regarding the frequency and management of feedback from patients about treatment providers' physical appearance. Third, we review data regarding personal changes and experiences in treatment providers with regard to: 1) food and eating behaviors, 2) vigilance of others' appearance, and 3) vigilance about oneself. Finally, recommendations from treatment providers about effectively working with this population are discussed.

RESULTS

Demographic Information

Participants included 4 men and 39 women. The mean age was 50 years ($SD = 10.07$). Over 95% of participants described their race and ethnicity as Euro-American/Caucasian. With regard to their educational background, the largest subgroup of participants had social work degrees ($n = 13$), followed by PhD's ($n = 8$, in clinical or counseling), Masters

degrees ($n = 8$; included M.Ed., M.A., M.S.), mental health counseling degrees ($n = 7$), Bachelors degrees ($n = 7$; included B.A. or B.S.), PsyDs ($n = 4$), nursing degrees ($n = 4$), dietetics degrees ($n = 3$), and MDs ($n = 2$)¹.

Experience treating patients with eating disorders ranged from 6 months to 31 years ($M = 129.37$ months, $SD = 112.56$). More than 30% of participants had 15 or more years of experience. The majority of participants indicated that 50% or more of their current patients have an eating disorder (range 5%–100%, $M = 58.21$, $SD = 33.93$). Although the majority of participants noted adherence to more than one theoretical orientation, most reported using cognitive/behavioral/cognitive-behavioral ($n = 17$) and psychodynamic/psychoanalytic approaches ($n = 15$). Other noteworthy orientations (endorsed by 3 or fewer participants) included family systems, dialectical-behavioral, feminist, feminist/queer theory, gestalt, integrative, interpersonal, mind/body, motivational interviewing, psychopharmacology, and narrative therapies. Participants worked in multiple venues: 31 worked at least part-time in a private practice setting and 16 worked at least part-time in a hospital setting. Other work venues included educational settings (high schools, college counseling centers) and mental health clinics.

Although no participants reported having a current eating disorder diagnosis, 13 (over 30%) reported that they had an eating disorder in the past. Although this is almost 1/3 of participants, other research notes similar rates of past eating pathology among eating disorder treatment providers (Barbarich, 2002; Costin & Johnson, 2002). Of the participants with historical eating disorder diagnoses, 5 were diagnosed with bulimia nervosa (BN), 3 with anorexia nervosa (AN), 1 with multiple diagnoses, 3 with eating disorder not otherwise specified (EDNOS), and 1 did not disclose the type of eating disorder.

Patient Commentary Regarding Treatment Providers' Appearance

Tables 1 and 2 summarize quantitative and qualitative results, respectively. As shown on Table 1, on average, treatment providers estimated that about 25% of their patients with eating disorders have commented on their general appearance (range = 0–90%, $SD = 28.34$). Of those who had received comments, about half reported that appearance-related comments occurred *frequently* or *sometimes* (46%; $n = 18$) whereas the other half reported that they occur *rarely* or *very rarely* (54%; $n = 21$). The majority of treatment providers indicated that such comments were discussed in session when they were made (65%; $n = 24$). Over half of respondents felt *comfortable* or *very*

¹ Note: Many participants indicated that they held multiple degrees. When this occurred, all degrees noted by treatment providers are listed.

TABLE 1 Summary of Quantitative Data

Question Sub-question(s)	Response
1. About what percentage of your eating disordered clients/patients have commented on your general appearance?	<i>Range = 0–90%, M = 25.56, SD = 28.34</i>
a) How frequently did they make such comments?	
“frequently” or “sometimes”	46% (<i>n</i> = 18)
“rarely” or “very rarely”	54% (<i>n</i> = 21)
b) How comfortable were you discussing the comments?	
“comfortable” or “very comfortable”	52% (<i>n</i> = 20)
“neutral”	21% (<i>n</i> = 9)
“uncomfortable” or “very uncomfortable”	12% (<i>n</i> = 4)
2. About what percentage of your eating disordered clients have commented on your body shape and weight?	<i>Range = 0–50%, M = 7.70, SD = 11.75</i>
a) How frequently did they make such comments?	
“rarely” or “very rarely”	73% (<i>n</i> = 25)
b) How comfortable were you discussing the comments?	
“comfortable” or “very comfortable”	44% (<i>n</i> = 14)
“neutral”	37% (<i>n</i> = 12)
“uncomfortable” or “very uncomfortable”	19% (<i>n</i> = 6)
3. Have you felt or thought that your appearance was being monitored, examined, or evaluated by your eating disordered patients, even when the patient did not verbalize that this was happening?	Yes = 83% (<i>n</i> = 35)
4. Has a patient ever given you a compliment on a body area, appearance trait, or aspect of your appearance that surprised or offended you?	Yes = 86% (<i>n</i> = 36)
5. Has an eating disordered patient ever criticized you on your appearance or aspect of your appearance?	Yes = 13% (<i>n</i> = 5)
6. Have you experienced significant weight changes during the course of treatment with an ED patient (e.g., a pregnancy, general weight loss or gain)?	Yes = 32% (<i>n</i> = 13)
a) If yes, did the weight change influence your treatment?	Yes = 68% (<i>n</i> = 8)
7. Has your view of food changed since working with eating disordered patients?	Yes = 70% (<i>n</i> = 30)
8. Have your eating habits been affected by working with patients with eating disorders?	Yes = 54% (<i>n</i> = 22)

(Continued)

TABLE 1 (Continued)

Question Sub-question(s)	Response
9. Have you felt that you were more vigilant or aware of other people's appearance after working with a patient with eating disorders? (e.g., evaluating other peoples clothing, body shape, weight with more frequency or criticalness after leaving a session with an eating disordered patient)?	Yes = 50% (n=19)
10. Have you ever been self-conscious about your appearance or an aspect of your appearance (such as weight, haircut, clothing, skin, etc.) during treatment with an eating disordered patient?	Yes=72% (n=31)

comfortable discussing these comments (52%; $n = 20$), whereas 21% ($n = 9$) felt neutrally and 12% ($n = 4$) felt *uncomfortable* or *very uncomfortable*.

When asked the percentage of patients that made a direct comment about the treatment providers' body shape and weight, responses ranged from 0–50% ($M = 7.70\%$, $SD = 11.75$). Most treatment providers reported that direct weight- and shape-related comments occurred *rarely* or *very rarely* (73%; $n = 25$). The majority of participants indicated that such comments were discussed in session when they were made (75%; $n = 24$). Most were *comfortable* or *very comfortable* discussing these comments with patients (44%; $n = 14$), although 19% ($n = 6$) reported that they were *uncomfortable* or *very uncomfortable* and 37% ($n = 12$) felt neutrally.

In addition to receiving direct commentary, 83% of treatment providers ($n = 35$) felt their appearance was being monitored, examined, or evaluated by their eating disordered patients, even when it was not verbalized. When this occurred, only 34% ($n = 12$) discussed their perceptions with the patient in session.

With regards to the valence of appearance-related comments, 86% of treatment providers ($n = 36$) had received a compliment. Qualitative data suggested 3 primary responses to receiving a compliment: 1) saying thank you and moving on ($n = 11$), 2) discussing the meaning of the comment ($n = 9$), and 3) discussing the meaning only if the theme warranted discussion ($n = 10$) (see Table 2).

Additionally, 13% of treatment providers ($n = 5$) received a criticism about their appearance. Criticisms were most frequently about the treatment providers' body features (height, weight, age) ($n = 3$), hair ($n = 2$), and clothing/fashion ($n = 2$). For example, one treatment provider stated that she has been called "old" and "fat" by some patients with AN. Most treatment providers reported that they responded to criticisms by discussing what the patient was thinking at the time the comment was made ($n = 5$). For example, one treatment provider stated that she tries to "discuss what [the patient] thinks and feels about what they are saying." Another stated

TABLE 2 Experiences Treating Patients with Eating Disorders: Qualitative Responses

Question Emergent Themes	<i>n</i> of responses
1. How do you handle it when a patient compliments your appearance in session?	
a. Thank you and move on (no discussion)	<i>n</i> = 11
b. Discuss what it meant to them, explore the comment	<i>n</i> = 9
c. Combination of thank you and discussion depending on theme	<i>n</i> = 10
2. If you have been pregnant while working with a patient with an eating disorder, how did your weight gain and appearance affect treatment?	
a. Increase in negative affect (envy, fear, anger) in patients	<i>n</i> = 6
b. Increase in body image issues in patients	<i>n</i> = 4
c. Child-related concerns in patients	<i>n</i> = 2
3. Has your view of food changed since working with eating disordered patients? How?	
a. Increased awareness of food, culture	<i>n</i> = 17
b. Food as fuel/ source of nutrition	<i>n</i> = 10
c. Enjoyment and appreciation for food	<i>n</i> = 9
4. Have your eating habits been affected by working with patients with eating disorders? How?	
a. Eat healthier, more mindfully	<i>n</i> = 12
b. More “disordered” or unhealthy eating	<i>n</i> = 8
5. Have you felt that you were more vigilant or aware of other people’s appearance after working with a patient with eating disorders? If yes, how did you feel about it and what did you do to process or cope with this situation?	
Feelings about vigilance	
a. Negative personal influence (discontent, felt hypocritical, judgmental)	<i>n</i> = 10
b. Positive personal influence (more accepting/less critical)	<i>n</i> = 3
c. More aware with no valence (curious, generally notice more)	<i>n</i> = 8
d. Resolved: part of working with ED/ coping with own issues	<i>n</i> = 2
Coping strategies	
a. supervision	<i>n</i> = 7
b. self-care activities	<i>n</i> = 7
6. Have you ever been self-conscious about your appearance or an aspect of your appearance during treatment with an eating disordered patient? If yes, please elaborate on the aspect of your appearance and how it affected you personally.	
Aspect of appearance	
a. Weight and body characteristics	<i>n</i> = 22
b. Fashion, clothing	<i>n</i> = 17
Personal Influence	
a. Increased self-awareness	<i>n</i> = 22
i. about weight	<i>n</i> = 13
ii. related to professionalism	<i>n</i> = 7
b. Strong negative emotion (offended, distracted, self-criticalness)	<i>n</i> = 7
c. Worry of envy or judgment by patients	<i>n</i> = 6
d. Change behavior (e.g., haircut, new clothes)	<i>n</i> = 5
e. Positive emotions (recognize humanity, understand patient)	<i>n</i> = 3

(Continued)

TABLE 2 (Continued)

Question Emergent Themes	<i>n</i> of responses
7. What is the hardest aspect of working with eating disordered patients?	
a. Difficulty treating/changing severe symptomatology	<i>n</i> = 22
b. General characteristics of population	<i>n</i> = 16
c. Negative affect in treater (e.g., worry)	<i>n</i> = 13
d. Relationship issues (familial and professional)	<i>n</i> = 8
e. Time and resources (insurance, team collaboration)	<i>n</i> = 7
f. Therapist health	<i>n</i> = 4
8. What advice would you give new therapists working with eating disordered patients about treating this population?	
a. Supervision	<i>n</i> = 16
b. Maintain social support	<i>n</i> = 13
c. Chronic condition-be realistic	<i>n</i> = 8
d. Stern parent	<i>n</i> = 8
e. Limit caseload	<i>n</i> = 8
f. Enjoy the challenge	<i>n</i> = 8
g. Be aware of comorbidity	<i>n</i> = 6
h. Continue your education	<i>n</i> = 6

that she tries “to understand where and how [the patient’s] ideas of fat and exercise came from.”

When asked about whether they had experienced any weight gain or change in appearance while working with eating disordered patients, 13 respondents (32%) reported that they had significant weight change, all due to pregnancy. Of those individuals, 68% (*n* = 8) reported that their pregnancy influenced treatment. As shown on Table 2, qualitative analysis suggested that pregnancy influenced treatment in the following ways: patients experienced 1) increased negative affect (fear, envy, anger), often directed towards the therapist (*n* = 6), 2) increased body image issues (*n* = 4), and 3) child-related concerns (*n* = 2). As one treatment provider stated, pregnancy “affects everything [about] treatment—rivalry, disgust/shame issues, and anxiety about maternity leave.” Another stated that her patients asked her how it felt to gain so much weight and commented that she was “lucky” that she was “allowed” to gain weight and eat anything. A third reported that her patients feared not being able to have children and stated that “themes of envy and fear were prominent” in session.

In the most extreme case, one treatment provider thought that her pregnancy may have influenced the patient’s willingness to continue in treatment. She stated: “When I became pregnant, my body obviously changed. This brought up many issues regarding body image concerns/dissatisfaction in patients. I also had a number of patients not return to treatment after my maternity leave, but it’s hard to know the complex reasons why.”

Effects on Treatment Providers

FOOD AND EATING

Seventy percent ($n = 30$) of treatment providers indicated that their view of food has changed since working with patients with eating disorders. As shown on Table 2, views of food changed in three main ways: 1) increased awareness and consciousness of food (e.g., dieting, the meaning of food, messages about food, eating choices, sociocultural messages) ($n = 17$); 2) view of food as fuel/ source of nutrition ($n = 10$); and, 3) increased enjoyment and appreciation for food (e.g., more kind to self around eating, enjoy eating more) ($n = 9$). For example, one participant stated, "I see the way so many people, especially women, use food to serve a variety of purposes: To control, numb, distract, comfort . . ." Another participant stated, "I certainly enjoy food and think of its pleasure factor as well as its nutritional/fuel factor. I am more tuned into my choices than earlier in my life. I have 2 daughters and I am aware of being more vigilant to the messages I give them about the value of food as pleasurable experience and a nutritional necessity."

In addition to changing their views of food, 54% of participants ($n = 22$) reported that their actual eating behaviors have changed since treating patients with eating disorders. As shown on Table 2, on one hand, many treatment providers think that they eat healthier, more mindfully, moderately, and deliberately ($n = 12$). For example, one treatment provider stated, "I've learned more about eating/food issues. I've gained insight into my own issues with food through working in this field and I have a healthier relationship with food as a result." On the other hand, a large minority indicated that they engage in more "disordered" or unhealthy eating (e.g., emotional eating, occasional over-eating; $n = 8$). In fact, 3 treatment providers (7%) reported that they had engaged in disordered eating behavior after a session. One treatment provider stated: "I find myself going to an extreme, at times, of eating whatever I want and thinking it is bad to 'eat healthy.' I feel like I try to compensate for my clients' eating disordered views and forget that it's okay to exercise and eat healthy and it's not a sign of a disorder." Another participant stated: "I think I eat more often working with clients, especially [those] with anorexia. I'll also go to an extreme of thinking it's not okay to eat healthy and eat more junk food in an effort to practice what I preach to clients about all food being okay. I lose sight of moderation and go to an extreme of my clients distorted views."

VIGILANCE ABOUT OTHERS PEOPLES' APPEARANCE

Fifty percent of treatment providers ($n = 19$) reported that they have felt more vigilant and/or aware of other people's appearance after leaving a session with a patient with eating disorders (e.g., evaluating other people's

clothing, body shape, weight). When asked how they felt about this, the majority of respondents reported that it influenced them negatively ($n = 10$). One participant stated that the hyper-vigilance “feels uncomfortable and intrusive.” Another stated, “I feel a bit hypocritical sometimes whenever I preach one thing and do another. I wish I didn’t focus so much on appearance (especially when working with eating disordered patients.)”

Other treatment providers indicated that working with this population increased their awareness and vigilance without having a negative or positive valence ($n = 8$). For example, one treatment provider stated that working with this population “definitely heightens awareness/noticing, but not necessarily ‘criticalness’. . . it also can depend on my own mood/feelings about my own body on any particular day.” Another participant commented: “I often wonder about people in the general population who appear visually anorexic or, in the grocery store, [people who are carrying] a basket of possible binge food (i.e., clearance bakery items).” Many matter-of-factly noted that it is just “part of working with this population” to be more vigilant of others.

Finally, a few participants, all of whom reported that they had an eating disorder in their past, reported that since working with this population they feel less vigilant ($n = 3$). For example, one participant stated that she had “already spent all of [her] younger years examining all the bodies around [her]” such that now she is less critical and aware.

When asked what they did to process or cope with the increased vigilance and awareness, the majority of treatment providers indicated that they engage in self-care activities (e.g., cognitive reframing, social interaction with friends, reading, exercise) ($n = 11$) and/or seek supervision/consultation ($n = 7$). For example, one treatment provider stated, “I discuss with my peer supervision groups, reflect on my own experiences, [and] use some of the ‘skills’ I teach my clients!” Another respondent stated, “I usually tell myself that ‘this is one of the hazards of working in the ED field’. . . and talk about it with my colleagues.”

VIGILANCE ABOUT OWN APPEARANCE

As shown on Table 1, 72% of treatment providers ($n = 31$) reported that they have felt self-conscious about their own appearance or an aspect of their appearance during treatment with an eating disordered patient. The majority of participants were self-conscious about their body characteristics (height, weight, features; $n = 22$) or their clothing/fashion sense ($n = 17$). As shown on Table 2, when asked how the self-consciousness affected them, 71% of participants described increased awareness and hypervigilance around their own appearance, particularly with regard to their weight and appearance-related professionalism. Specifically, 39% noted strong negative feelings (e.g., feeling offended, angry, vulnerable, self-critical, incompetent),

and 33% described worry about judgment or envy of them by their patients. For example, one treatment provider stated: "I am sometimes self-conscious of being robust and curvy when I'm sitting with anorexic teenagers. I feel like they are looking and judging." Another participant stated: "I sometimes feel self-conscious about my weight (thinness). Makes me feel like an impostor. Makes me doubt my ability to empathize with clients, makes me feel hypocritical and doubt myself as a professional."

Other noteworthy responses included changing ones appearance behaviorally (e.g., getting a haircut, buying new clothes; 28%) and using the self-consciousness to understand oneself and the patient (17%). One participant stated, "I often feel fat, sloppy or not well-dressed in comparison with a few of my patients. Sometimes I just notice it other times I find myself trying to dress better or get a hair cut, etc."

Recommendations for Trainees and Other Treatment Providers

Treatment providers were asked to openly write about the hardest aspects of working with patients with eating disorders. Numerous themes emerged from qualitative analyses (see Table 2). The most common theme, noted by 55% of treatment providers ($n = 22$), was the resistance of severe, chronic symptomatology to change (e.g., severe body image distortion, rigid thinking, lack of readiness to change, confrontational personalities, multiple diagnoses, medical complications). One treatment provider stated that "delusional beliefs around shape/appearance and intense fears of letting go of behaviors" are the most difficult aspects of the disorder to treat. Another wrote that "the resistance of the symptoms to change or the level of readiness for change by the client" is hard.

A second theme, noted by 40% of respondents ($n = 16$), was the nature of the illness and its prognosis. This theme encapsulated comments about high relapse rates, risk for death due to medical complications and suicidality, chronicity, and the slow process of recovery. A related theme, noted by 33% of respondents ($n = 13$), was managing the personal negative affect (worry, fatigue, sadness, frustration) that often accompanies treating difficult, treatment resistant symptoms. For example, one respondent wrote: "it is hard to acknowledge that some may die. I can be scared and sad for not only their quality of life but the risk of a patient dying. I worry about who might/could die from this disorder and have to sit with my powerlessness (at times) to help."

Relationship issues, such as building therapeutic and familial relationships, maintaining healthy boundaries, and managing counter-transference reactions, were noted by 8 respondents (20%) as being particularly challenging. One treatment provider wrote that her patients tend to increase her desire to reassure: She wrote that she strives to "find a balance that allows some exploration . . . without them feeling either abandoned or intruded

upon. Generally, their tendency to retreat from relationships can be very challenging.” In working with families, one treatment provider stated that “dealing with the family’s expectations that I will ‘fix’ the client and their frustration and fear for client” is extremely difficult.

The final two themes that emerged as being particularly difficult about working with patients with eating disorders were 1) time and resources, which includes practical issues around insurance, team collaboration, organizing an integrated care team, treatment team disagreements ($n = 7$) and maintaining therapist health by staying optimistic, continuing to work hard independent of client progress, staying personally confident and healthy ($n = 4$). One treatment provider wrote: “I find the hardest part is staying hopeful and optimistic about recovery with the more entrenched eating disordered patients.”

Treatment providers were also asked what advice they would give trainees and other eating disorder treatment providers about effectively treating this population. The most popular theme in respondents answers was to receive supervision and consultation on a regular basis ($n = 16$). A second, related theme was to remember that eating disorders are serious, chronic illnesses ($n = 8$). Respondents commented that it is essential to get supervision, be prepared for relapses, have patience, be realistic, and not to take responsibility for success or failure of patients in recovery. Practically, treatment providers also recommended limiting the number of eating disordered individuals on a caseload and working with a multi-disciplinary team ($n = 8$). Treaters noted that it is critical to be aware of comorbidity with other disorders ($n = 6$) and to continually learn and read incoming research and innovative materials (e.g., about medical issues, treatment outcome studies, attend conferences) ($n = 6$).

Treatment providers also noted that it is critical to utilize outside social support and engage in self-care ($n = 13$). Self-care, self-knowledge, and maintaining a positive personal relationship with one’s body and eating behavior was cited by many as critical to effective treatment and personal survival in the field. As one treatment provider stated, “be sure to have support in your own life and take time to nourish and care for yourself.” Another noted that it is critical to “feel confident about your own eating behaviors and body image” and “directly address your own food, body image issues, judgments, and feelings.”

Another common theme related to the style of relationship most effective with eating disordered patients: a theme we titled *stern guide*. Eight treatment providers talked about pushing patients, even if they resist, and to be proactive, direct, and clear even when progress is stunted. For example, one treatment provider stated: “you must be stern and direct. Set clear boundaries. There needs to be a balance between support and encouragement and assertive directiveness.” Another provider stated: “If I don’t push my patients to try new things and I give in to their resistance, I’m not helping

them.” A third respondent stated: “Be attentive to the balance between attending to symptoms and attending to the person and the relationship. These patients tend to want to be known and are terrified of being known at the same time—more than other patients, I think.”

Another theme that emerged we titled, *enjoy the challenge*. Eight treatment providers noted that although challenging and frustrating, treating patients with eating disorders can be extremely rewarding and to maintain a positive attitude. One treatment provider stated, “slow and steady wins the race! For real change—stay in touch w/ your own optimism. Remember you are on this journey with your client as a support, a witness, a coach, and there is no ‘right way.’” Another noted: “It can be challenging and frustrating but it’s also a complex interesting disorder to deal with and an opportunity to experience a challenging but also deep relationship with clients. To me, this population allows me to appreciate the complexity of the work.”

DISCUSSION

The overarching purpose of this study was to explore treatment provider’s personal experiences working with patients with eating disorders. Using quantitative and qualitative data from a sample of 43 professional treatment providers who treat patients with eating disorders, we examined 1) the frequency of commentary about physical appearance, 2) changes in affect, vigilance about appearance, and eating behavior, and 3) recommendations for effectively working with this population.

Despite the importance and contributions of this study, we need to recognize its limitations. The sample was small and consisted of individuals attending an eating disorder focused conference. Although all participants were professional treatment providers, these results may not be representative of all treatment providers who work with eating disorders. Self-report of a taboo topic such as the personal effects of work on treatment providers, may have influenced responses. Seeing that providers admitted to personal experiences, such as a history of an eating disorder, it is likely that these responses may represent “the tip of the iceberg.”

Despite these limitations, there were many interesting insights into the experiences of treatment providers who work with patients with eating disorders. Direct and indirect patient commentary about the physical appearance of treatment providers is normative: the large majority indicated that they received direct comments or felt their appearance was being monitored by their patients with eating disorders. Most treatment providers indicated that appearance-related comments were discussed in session when they were made, although a considerable number did not and many reported that they were not comfortable having such conversations. Comments took the form of compliments more often than criticisms, although both occurred.

Results also support past findings that working with this population commonly influences treatment providers' relationships with food, eating, and vigilance of appearance in themselves and others (Franko & Rolfe, 1996; Kaplan & Garfinkel, 1999; Shisslak et al., 1989). Seventy percent of treatment providers reported their view of food changed, 54% indicated their eating changed, 50% noted that they are more vigilant and/or aware of other people's appearance after leaving a session with a patient with an eating disorder, and 72% reported that they have felt self-conscious about their own appearance or an aspect of their appearance during treatment with an eating disordered patient. Changes in eating behavior ranged from eating in a more disordered, unhealthy way to seeing food as necessary nutrients to feed the body. Emotional reactivity ranged from feelings from anger, irritation, and incompetence to confidence, care, and compassion. Smaller micro-changes in behavior were also noted, such as wearing a certain type of clothing when seeing patients with eating disorders, paying more attention to ones appearance when seeing a particular patient, and not displaying food in their office around some patients.

It is clear from these data that many treatment providers experience substantial personal changes in affect, cognitions, and behaviors when treating patients with eating disorders. Given that these changes seem to be common among treatment providers, it is critical that trainees and existing treatment providers are aware that themes of appearance, beauty, value, and eating will almost undoubtedly arise in treatment and likely have some personal influence. Treatment providers made many important recommendations for others in the field with regard to effectively personally and professionally managing interactions and personal reactions. The eight primary recommendations that emerged were: 1) receive supervision and consultation on a regular basis; 2) acknowledge that eating disorders are serious, chronic illnesses that even the best therapists cannot always successfully treat; 3) limit the number of individuals with eating disorders on one's caseload and work in a multi-disciplinary team; 4) be aware of comorbidity with other disorders; 5) continually read incoming research materials; 6) utilize outside social support and engage in self-care; 7) be a *stern guide*, proactively directing progress while maintaining clear boundaries and a healthy amount of support and encouragement; and, 8) *enjoy the challenge* by remembering that treating these patients can be extremely rewarding.

These results have various implications for clinical practice and training. Patients' comments regarding treatment providers' appearance are common and can serve various functions. They may be an attempt to strengthen the therapeutic alliance. For example, a patient may give a compliment to connect with the therapist. Conversely, implications about one's appearance can be a way to disconnect from the relationship. For example, a patient may assume that because of the treatment providers' appearance (positive or

negative), the person can't understand them because they have so many valuable traits (e.g., smart, have a college degree, have a perfect life, are attractive). For example, a patient may assume that an attractive therapist would not be able to empathize with them. A patient may also correlate a positive appearance with other valuable traits, such as a good education, career, and a perceived "perfect life."

Comments may also be reflective of an attempt to neutralize the power hierarchy or elicit a reaction in the treatment provider. For example, a patient may mention that the therapist has gained weight or looks tired. Patients with eating disorders can also harbor competitive thoughts about their same-sex therapist. They may compare their skin, hair, and clothing in session, sometimes distracted by what the therapist may be saying or the process of the therapy. Furthermore, there may be therapy interfering judgments made by the patient as a result of these comparisons. For example, a patient may see her therapist as incompetent if the therapist is overweight or does not dress fashionably, yet never voice these concerns. Instead they may manifest as a generalized resistance. A patient may also compliment a therapist as an attempt to get a compliment back, a subtle form of reassurance.

Independent of the purpose or valence of a comment, a patient commenting on the treatment providers' appearance inherently creates a platform for discussion that, we argue, can be critical to understanding the patient and relationship building. The treatment provider can use such comments as an opportunity to model how competition in this area has influenced other interpersonal relationships negatively. Such conversation can help establish a collaborative therapeutic alliance that reduces the emergence of power struggles and control issues.

As an initial study, this qualitative exploration and feedback from treatment providers invites further investigation. Future research investigating the experience of losing patients (to death or drop-out), feminist-centered and empowerment based perspectives in treatment, and culturally-competent treatment approaches/aspects with people of color and men were all noted as critical. Additionally, creating a forum and future opportunities to process "taboo" discussions about the effects of working with these patients on treatment providers is imperative, particularly for trainees who aspire to work with this population.

REFERENCES

- Barbarich, N. C. (2002). Lifetime prevalence of eating disorders among professionals in the field. *Eating Disorders, 10*, 305–312.
- Berkman, N. D., Lohr, K. N., & Bulik, C. M. (2007). Outcomes of eating disorders: A systematic review of the literature. *International Journal of Eating Disorders, 40*, 293–309.

- Brewerton, T. D. (2007). Eating disorders, trauma, and comorbidity: Focus on PTSD. *Eating Disorders, 15*, 285–304.
- Brotman, A. W., Stern, T. A., & Herzog, D. B. (1984). Emotional reactions of house officers to patients with Anorexia Nervosa, Diabetes, and Obesity. *International Journal of Eating Disorders, 3*(4), 71–77.
- Bruce, C. D. (2007). Questions arising about emergence, data collection, and its interaction with analysis in a grounded theory study. *International Journal of Qualitative Methods, 6*(1), 1–12.
- Burket, R. C., & Schramm, L. L. (1995). Therapists' attitudes about treating patients with eating disorders. *Southern Medical Journal, 88*, 813–818.
- Costin, C., & Johnson, C. L. (2002). Been there, done that: Clinicians' use of personal recovery in the treatment of eating disorders. *Eating Disorders, 10*, 293–303.
- Crisp, A. (2006). Death, survival and recovery in anorexia nervosa: A thirty five year study. *European Eating Disorders Review, 14*(3), 168–175.
- Delucia-waack, J. L. (1999). Supervision for counselors working with eating disorders groups: Countertransference issues related to body image, food, and weight. *Journal of Counseling & Development, 77*, 379–388.
- Emmett, S. W., & Rabinor, J. R. (2007). The therapist's voice: The sated starver. *Eating Disorders, 15*, 81–84.
- Franko, D. L., & Erb, J. (1998). Managed care or mangled care?: Treating eating disorders in the current healthcare climate. *Psychotherapy: Theory, Research, Practice, Training, 35*(1), 43–53.
- Franko, D. L., & Keel, P. K. (2006). Suicidality in eating disorders: Occurrence, correlates, and clinical implications. *Clinical Psychology Review, 26*, 769–782.
- Franko, D. L., & Rolfe, S. (1996). Countertransference in the treatment of patients with eating disorders. *Psychiatry: Interpersonal & Biological Processes, 59*(1), 108–116.
- Godart, N. T., Perdereau, F., Rein, Z., Berthoz, S., Wallier, J., Jemmet, P., et al. (2007). Comorbidity studies of eating disorders and mood disorders. Critical review of the literature. *Journal of Affective Disorders, 97*(1–3), 37–49.
- Hamburg, P., & Herzog, D. (1990). Supervising the therapy of patients with eating disorders. *American Journal of Psychotherapy, 44*, 369–380.
- Herzog, D. B., & Greenwood, D. N. (2000). Mortality in eating disorders: A descriptive study. *International Journal of Eating Disorders, 28*(1), 20–26.
- Hughes, P. (1997). The use of the countertransference in the therapy of patients with anorexia nervosa. *European Eating Disorders Review, 5*, 258–269.
- Jarman, M., Smith, J. A., & Walsh, S. (1997). The psychological battle for control: A qualitative study of health-care professionals understandings of the treatment of Anorexia Nervosa. *Journal of Community & Applied Social Psychology, 7*, 137–152.
- Johnston, C., Smethurst, N., & Gowers, S. (2005). Should people with a history of an eating disorder work as eating disorder therapists? *European Eating Disorders Review, 13*, 301–310.
- Kaplan, A. S., & Garfinkel, P. E. (1999). Difficulties in treating patients with eating disorders: A review of patient and clinician variables. *Canadian Journal of Psychiatry, 44*, 665–670.
- Katzman, D. K. (2005). Medical complications in adolescents with Anorexia Nervosa: A review of the literature. *International Journal of Eating Disorders, 37*, 52–59.

- Lowell, M. A., & Meader, L. L. (2005). My body, your body: Speaking the unspoken between the thin therapist and the eating-disordered patient. *Clinical Social Work Journal, 33*, 241–257.
- Matz, J., & Frankel, E. (2005). Attitudes toward disordered eating and weight: Important considerations for therapists and health professionals. *Health at Every Size, 19*(1), 19–30.
- Mehler, P. S., Crews, C., & Weiner, K. (2004). Bulimia: Medical complications. *Journal of Women's Health, 13*, 668–675.
- Newman, D. L., Moffitt, T. E., Caspi, A., & Magdol, L. (1996). Psychiatric disorder in a birth cohort of young adults: Prevalence, comorbidity, clinical significance, and new case incidence from ages 11–21. *Journal of Consulting and Clinical Psychology, 64*, 552–562.
- Orbach, S. (2004). What can we learn from the therapist's body? *Attachment & Human Development, 6*, 141–150.
- Ryan, G. W., Bernard, H. (2003). Techniques to identify themes. *Field Methods, 15*(1), 85–109.
- Sallas, A. A. (1985). Treatment of eating disorders: Winning the war without having to do battle. *Journal of Psychiatric Research, 19*, 445–448.
- Shisslak, C. M., Gray, N., & Crago, M. (1989). Health care professionals' reactions to working with eating disorder patients. *International Journal of Eating Disorders, 8*, 689–694.
- Signorini, A., De Filippo, E., Panico, S., De Caprio, C., Pasanisi, F., & Contaldo, F. (2007). Long-term mortality in anorexia nervosa: A report after an 8-year follow-up and a review of the most recent literature. *European Journal of Clinical Nutrition, 61*(1), 119–122.
- Stice, E. (2002). Risk and maintenance factors for eating pathology: A meta-analytic review. *Psychological Bulletin, 128*(5), 825–848.
- Striegel-Moore, R. H., Silberstein, L. R., & Rodin, J. (1986). Toward an understanding of risk factors for bulimia. *American Psychologist, 41*, 246–263.
- Strober, M., Freeman, R., Lampert, C., & Diamond, J. (2007). The association of anxiety disorders and obsessive compulsive personality disorder with anorexia nervosa: Evidence from a family study with discussion of nosological and neurodevelopmental implications. *International Journal of Eating Disorders, 40*, S46–S51.
- Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation, 27*, 237–246.
- Toman, E. (2002). Body mass index and its impact on the therapeutic alliance in the work with eating disorder patients. *European Eating Disorders Review, 10*, 168–178.
- Williams, M., & Leichner, P. (2006). More training needed in eating disorders: A time cohort comparison study of Canadian psychiatry residents. *Eating Disorders, 14*, 323–334.