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Engaging Clients in Eating Disorder Treatment; Reducing Dropout

Lauren Ribnick
St. Catherine University

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Running Head: Engaging Clients in Eating Disorder Treatment

Engaging Clients in Eating Disorder Treatment; Reducing Dropout

Submitted by Lauren E. Ribnick
May 2012

MSW Clinical Research Paper

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

School of Social Work
St. Catherine University & University of St. Thomas
St. Paul, Minnesota

Committee Members:
Dr. Michael Chovanec, Ph.D., (Chair)
Rebecca Rand, LICSW
Amanda Thooft, LICSW

Abstract

The purpose of this study was to explore how to successfully engage clients in eating disorder treatment and reduce dropout. This study collected qualitative data from five female therapists and one male therapists working in outpatient settings with individuals with eating disorders. Qualitative interviews were conducted over a period of two weeks. Interviews were audio recorded to assist in data analysis. The strongest themes found in this study were *low dropout*, *anorexia has the highest dropout rate*, and *educating the family*. Themes that coincided with the literature included *participants having no experience asking clients to leave treatment* and *providing family support*. Social work implications were also discussed. Given the high mortality rate with this population, it is important that we continue to research this issue with the hope of reducing dropout.

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Introduction

According to Campbell, 29% of participants in eating disorder treatment (i.e. psychological therapies for eating disorders) dropout across various stages of treatment. The dropout rate of eating disorder treatment more than doubled between 1991 and 2007; In 1991 82% of individuals completed treatment, that number fell to just above 60% in 2007 (Campbell, 2009). A current problem that is being addressed in the research is the high dropout rate in eating disorder treatment. The research aims to explore what aspects of treatment and personal characteristics of patients do clinicians identify that contribute to engaging clients in treatment and reducing dropout?

A significant number of individuals never recover from their eating disorder symptoms (Geller, Williams & Srikameswaran, 2001). The South Carolina Department of Mental Health estimates that 8 million Americans have an eating disorder and that eating disorders have the highest mortality rate of any mental illness. The South Carolina Department of Mental Health published some grueling statistics on eating disorders, 5 – 10% of people with anorexia die within 10 years after contracting the disease; 18-20% of anorexics will be dead after 20 years and only 30 – 40% ever fully recover. The mortality rate associated with anorexia nervosa is 12 times higher than the death rate of ALL causes of death for females fifteen – twenty-four years old. 20% of people suffering from anorexia will prematurely die from complications related to their eating disorder, including suicide and heart problems (South Carolina Department of Mental Health, 2006). In comparison to the 29% of individuals who dropout from eating disorder treatment,

22-99% of individuals in domestic violence treatment and 30-60% of individuals in out-patient community mental health clinics discontinue treatment before completion (Daly & Pelowski, 2000). If the millions of Americans struggling with eating disorders continue to dropout of treatment at these rates, this disease will continue to claim a high amount of lives each year. Chronic eating disorders also cause a large number of medical complications. According to Rome and Ammerman, eating disorders can cause; abnormalities in vital signs, irregular heartbeat, decrease blood pressure and volume, enamel erosion, magnesium deficiency, esophageal and gastric rupture, decrease in bone density and many more (Rome & Ammerman, 2003).

When weight restoration was a focus in treatment as opposed to cognitive functioning, the rate of dropout decreased to between 12 and 16% (Campbell, 2009). Various efforts have been taken in order to reduce dropout rates in addition to focusing on retention. Some of these efforts include; trying different treatment modalities, theoretically driven interventions and investing equally in getting patients to treatment and keeping them there (Campbell, 2009).

It is important that we research helpful and harmful treatment modalities so that dropout rates will begin to decrease resulting in a lower death rate among eating disordered clients. Eating disorder treatments are very expensive and time consuming, it is important that this research is done so that the inefficient use of these expensive services does not continue. Along with physicians and psychologists, social workers are a key part of the recovery process for many who suffer from eating disorders. Social workers facilitate individual therapy, group and

family therapy and work in group homes. Social workers are present in every step of the recovery process. Further research on factors in dropout of eating disorder treatment will help to inform social workers and others working with this population what specific aspects of treatment are successful in preventing dropout.

The purpose of this study is to examine what aspects of treatment and personal characteristics of patient's clinicians identify that contribute to engaging clients in treatment and reducing dropout. With this information future clinicians can practice effective, life saving treatment with their clients and decrease the mortality rate of this devastating illness. The research question will be answered through qualitative interviews with clinicians who are involved in the treatment of eating disorders.

Literature Review

Dropout of eating disorder treatment can be attributed to many variables. The aim of this research is to identify those variables. The main topics that will be explored in this section are: diagnosis, statistics, characteristics associated with eating disorders, clinician duties, specific treatment modalities used to treat eating disorders, and a comparison of dropout rates amongst various populations. The topics presented in this section are the topics that had a significant presence in the research.

Defining Dropout

Eating disorder treatment dropout can be defined in a number of ways. The term "dropout" has been used to describe both the independent ending of regular treatment by a patient and the decision for administrative discharge made by a treatment team. Clinicians and researchers working with eating disorders have long recognized the problem of treatment dropout and its implications for long-term recovery (Fassino, Piero, Tomba, & Abbate-Daga, 2009). This study looks at both patient decision based dropout and administrative dropout.

Diagnosis

The Diagnostic and Statistical Manual IV includes three different eating disorder diagnosis; Anorexia Nervosa (AN), Bulimia Nervosa (BN), and Eating Disorder Not Otherwise Specified (EDNOS) (DSM IV). Anorexia Nervosa has two

specific subtypes, Restricting type and Binge-Eating/Purging type. To meet the criteria to be diagnosed with Anorexia Nervosa, The American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders 4th edition Text Revision states that an individual must present the following characteristics:

- Refusal to maintain body weight at or above a minimally normal weight for age and height
- Intense fear of gaining weight or becoming fat, even though underweight.
- Disturbance in the way in which one's body weight or shape is experienced
- Denial of the seriousness of the current low body weight
- The absence of at least three consecutive menstrual cycles. (DSM-IV-TR 4th ed., text rev., 2000)."

Bulimia Nervosa has two specific subtypes, Purging and No purging subtype. The diagnostic criteria, as stated in the DSM IV is,

- Recurrent episodes of binge eating.
- Recurrent inappropriate compensatory behavior in order to prevent weight gain (self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise)
- The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months
- Self-evaluation is unduly influenced by body shape and weight. The

disturbance does not occur exclusively during episodes of Anorexia Nervosa (DSM-IV-TR 4th ed., text rev., 2000).

Bulimia Nervosa purging subtype adds that during the current episode, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas (DSM-IV-TR 4th ed., text rev., 2000).

Eating Disorder NOS does not meet any specific criteria for any previously mentioned eating disorder. Individuals with this diagnosis may demonstrate one of more of the following; Females meet criteria of Anorexia Nervosa but have not lost their periods, all criteria for AN are met, however, the individuals weight is still within the normal range, or all criteria for BN are met, however, inappropriate compensatory mechanisms occur less than twice a week or for less than three months (DSM-IV-TR 4th ed., text rev., 2000).

Not yet classified in the DSM is Binge-Eating Disorder (BED). Binge Eating Disorder is not currently a diagnosis in the DSM but is often used and treated in practice of eating disorders. Although it is not currently a diagnosis, Binge Eating disorder is the most common of all eating disorders in the United States (Hudson, Hiripi, Pope, & Kessler, 2007). Binge Eating Disorder was first described in 1959 by psychiatrist Albert Stunkard as Night Eating Syndrome. The term Binge-Eating was later coined meeting the same criteria as night eating syndrome excluding the nocturnal piece (Hudson, Hiripi, Pope, & Kessler, 2007). There are a number of criteria that an individual with Binge Eating Disorder can possess including; does not exercise control of food consumption (periodically), eats more quickly during binge episodes than normal periods, eats when depressed or bored, feels depressed

or guilty after binge eating, displays rapid weight gain or sudden obesity and has severe depression (Hudson, Hiripi, Pope, & Kessler, 2007).

When looking at the dropout rates of eating disorders, many researchers have come to the same conclusion that individuals suffering from Binge Eating Disorder are less likely to discontinue treatment than those with any other diagnosis (Ho, 1995). Ho conducted a study in which 156 obese, nonpurging women receiving treatment were monitored for dropout during a six-month period. According to Ho, Binge Eaters are half as likely to dropout of eating disorder treatment than individuals with AN, BN or EDNOS (Ho, 1995). Ho goes on to clarify that because the diagnostic criteria for binge eating changed from the DSM-III to the DSM-IV, it is possible that in previous studies researchers misclassified nonbinge eaters as binge eaters using DSM-III criteria that were dropping out at a higher rate. Surgenor conducted a study in which data was collected at point of admission for 213 inpatient treatment episodes of individuals with eating disorders and later compared to data on treatment conclusion or termination. Similarly to Ho, Surgenor discovered that while Binge Eaters are less likely to discontinue treatment, those with Anorexia Nervosa purging subtype are more likely to do so (Surgenor, 2003). A study conducted by Franzen identified clinical variables and personality factors that could predict completion or non-completion of a 125 patients in a day treatment program. Converse to what Surgenor and Ho found, Franzen found that non-completion of treatment is often associated with more severe bulimic symptoms (Franzen, 2004).

Statistics

The dropout rate of eating disorder treatment in the last two decades is astonishing, especially considering the numbers of Americans that suffer from this deadly illness. According to the South Carolina Department of Mental Health, eating disorders have a higher mortality rate than any other mental illness. Approximately 5-10% of individuals with anorexia die within ten years of contracting the disease. 18-20% of anorexics will be dead after 20 years, and only 30-40% will ever fully recover. The mortality rate associated with anorexia is 12 times higher than the death rate of all causes of death for females 15-24 years old (South Carolina Department of Mental Health, 2006). Approximately .5% of American women suffer from Anorexia Nervosa and 2-3% of American women suffer from Bulimia. In total, eight million Americans have an eating disorder of some type (South Carolina Department of Mental Health, 2006).

Current dropout rates of eating disorder treatment continue to rise. Campbell conducted research that looked at previous studies on eating disorder dropout from as far back as 1991 and took into account the changes in dropout rates. According to Campbell, dropout rates have more than doubled in a 16-year period (Campbell, 2009). Dropout rates also vary depending on the different treatment modalities used. In a study conducted by Dalle Grave, Calugi, Brambilla & Marchesini, 23.4% of patients discontinued treatment in cognitive behavioral therapy used with the eating disorder population. (Dalle Grave et. al, 2007).

Voluntary termination is not the only problem faced in eating disorder treatment, administrative discharge is also a growing problem for many individuals seeking treatment for their eating disorders (Masson & Sheeshka, 2007). Administrative Discharge is when a patient is asked to leave treatment for a number of reasons including behavior, insurance issues and inability to follow rules. In 2007 Masson conducted a study that looked at premature termination in eating disorder treatment. This study was conducted with clinicians from a 15-bed inpatient eating disorder program. The time frame of this study is unknown. The program treats adults, 18 years of age and older, who are medically stable and have a diagnosis of anorexia nervosa, bulimia nervosa, or eating disorder not otherwise specified. In the study, 37.6% of patients terminated treatment in some form or another. Of the 37.6% of terminations, 22.1% voluntarily dropped out and 15.5% were administratively discharged (Masson & Sheeshka, 2007).

Specific Treatment Modalities

There are a number of different treatments used for eating disorders discussed in this research. One modality used is residential treatment. Residential treatment is, According to Frisch, Herzog and Franko (2006), a live-in treatment center that provides therapy for eating disorders. The treatment modality varies depending on the facility. The average length of stay in a residential treatment facility for eating disorders is 83 days while the average cost per day is \$956 U.S. dollars (Frisch et al., 2006). Another treatment used to treat eating disorders is outpatient therapy. Outpatient therapy is any model used in a traditional outpatient

setting discussed later in the research. The final discussed in the research is intensive outpatient therapy. Intensive outpatient therapy, or programming (IOP) is defined by the Emily Program as,

“Our Intensive Outpatient Programs (IOP) provide regular, structured group and individual programming throughout the week for people with any eating disorder diagnosis. We emphasize maximum involvement of family members, friends, and other loved ones. IOP clients also see an individual therapist and registered dietitian weekly, and a physician as needed” (The Emily Program, 2012).

There are a number of different treatment modalities used to treat eating disorders, one of the most widely utilized is Cognitive Behavioral Therapy (CBT). CBT is a “form of psychopathology that emphasizes the significant task of thinking in how we feel and what we do” (National Association of Cognitive Behavioral Therapists, 2007). A study conducted by Grilo, Masheb, Gueorguieva, Wilson and White concluded that CBT produced significantly greater reductions in binge eating than behavioral weight loss programs (Grilo et. al, 2011). When looking at remission rates of those treated using CBT, Grilo found that 51% of consumers were in remission twelve months after completing treatment compared to 49% who were still experiencing some eating disorder symptoms.

Because of the success of CBT in eating disorder treatment in the 80’s, an enhanced model of CBT was developed specifically for treating Bulimia Nervosa

(Cooper and Fairburn, 2011). The enhanced model of CBT addresses psychopathological processes external to eating disorders including; low self esteem, clinical perfectionism, interpersonal problems and mood intolerance. Both perfectionism and low self esteem were associated with weight concern, which in turn was associated with increased dietary restraint. The enhanced model suggests that individuals with mood intolerance may engage in binge eating and purging in order to cope with the experience of intense mood states. The enhanced CB-BN model proposes that, for some patients, interpersonal problems may maintain eating disorders by, for example, magnifying concerns about shape and weight, acting as a trigger for binge eating episodes, or exacerbating self esteem concerns (Lampard, Byrne, McLean and Fursland, 2011). The enhanced model focuses on the additional four mechanisms (low self esteem, clinical perfectionism, interpersonal problems, mood intolerance) because in previous studies these mechanisms were associated with premature termination of treatment and over evaluation of weight and shape (Lampard et. al, 2011). The enhanced model has yet to be directly evaluated as a whole in a clinical sample.

Eye Movement Desensitization and Reprocessing (EMDR) is another treatment modality being used by some clinicians to treat eating disorders. EMDR is a form of psychotherapy that was developed to resolve symptoms resulting from trauma (EMDR International Association, 2011). Bloomgarden and Calogero studied 86 women in an inpatient eating disorder facility to compare the success rates between EMDR and Standard Residential Eating Disorder Treatment (SRT). In the study, 43 women were in SRT alone and 43 were receiving EMDR services to

treat past trauma while in SRT. Standard residential eating disorder treatment is inpatient or residential treatment that focuses on eating disorders using ordinary techniques such as, CBT, Psychoanalysis, etc. The study found that women who received both EMDR to focus on past trauma and SRT were less likely to terminate treatment before completion and reported less distress about negative body image memories and lower body dissatisfaction at post treatment (Bloomgarden & Calogero, 2008). Similar to the findings of Bloomgarden and Calogero, Gross and Ratner found that most treatments (especially EMDR) including hypnosis and EMDR are virtually ineffective when used alone (Gross & Ratner, 2002). This study found that treatment termination became less likely when EMDR was used to treat trauma in combination with hypnosis. There are a number of treatments that could go along with EMDR but according to Gross and Ratner; it is imperative that it is not used as a stand-alone therapy to ensure therapy completion.

Dialectical Behavior Therapy, when used for binge eating disorders (DBT-BED) aims to reduce binge eating by improving emotion regulation skills (Safer, Jo & Robinson, 2010). Safer compared DBT-BED to group therapy in eating disorder patients. The group therapy in this study was modeled after a supportive model of group therapy and was modified to address binge eating. In the group therapy, self-esteem and self-efficacy are bolstered to enhance the ability to stop binge eating. The research found (n=101) that while DBT-BED had a dropout rate of 4%, group therapy had a dropout rate of 33.3%. The findings in this study were attributed to the fact that DBT uses an emotion regulation approach while group therapy often focuses on the prevailing problem.

Characteristics Associated with Dropout

There are many factors to consider when evaluating the different characteristics that are associated with dropout of eating disorder treatment. Genetic, biological and environmental factors all contribute to dropout of such treatment (Dalle Grave, 2010). A study conducted by Dalle Grave in 2010 compared articles on eating disorders using a database that has published articles on eating disorders since 1980. Dalle Grave (2010) found that family makeup plays a significant role in the dropout of eating disorders. Dalle Grave states that those who dropout from treatment were reported to have a higher prevalence (21% of 145 participants) of separation and divorce in their immediate families while those who completed treatment had a separation of divorce rate of 6% (Dalle Grave et. al, 2007). Hoste, Zaitsoff, Hewell & Le Grange conducted a study in which 80 adolescents with Bulimia Nervosa completed a demographic questionnaire, the Eating Disorder Examination, Rosenberg Self-Esteem Scale, Family Adaptability and Cohesion Evaluation Scales, and Beck Depression Inventory prior to beginning treatment. Of the 80 participants, 6 (7.50%) voluntarily dropped out, while 3 (3.75%) were asked to leave treatment. According to Hoste's findings, 62% of individuals who completed eating disorder treatment and 22% of those who discontinued treatment came from intact families (Hoste et. al, 2007).

History of sexual abuse also plays a key role in treatment dropout. According to research conducted by Carter Bewell, Blackmore, & Woodside among women admitted to an inpatient eating disorder unit, 48% reported a history of childhood

sexual abuse prior to the onset of their eating disorder (Carter et. al, 2005).

Cachelin, Moore, Elder, Pike, Wilfley. & Fairburn (1997) conducted a study consisting of 31 participants with eating disorders. In this study, Cachelin et. al conducted baseline assessments as well as assessments at three and six months examining the following variables; eating disorder symptomology, importance of weight or shape, psychopathology, social adjustment, childhood sexual abuse, childhood obesity, parental obesity, and parental psychopathology. When looking at the prevalence of sexual abuse and dropout, Cachelin et. al found that those who dropped out from eating disorder treatment were more likely to have reported a history of sexual abuse (Cachelin et. al, 1997).

Along with history of sexual abuse level of education also plays role in treatment dropout. According to Tasca, who conducted a study of 139 women with Bulimia Nervosa and Binge Eating disorder in an outpatient setting, 34.3% of those with Binge Eating Disorder and 31.7% of those with Bulimia Nervosa had completed college or university (Tasca et. al, 2003). Those who terminated eating disorder treatment were also more likely to have obtained a lower level of education (Dalle Grave et. al, 2007).

A study conducted by Huas, Godart, Foulon, Pham, Divac, Fedorowicz, Peyracque, Dardennes, Falissard and Rouillan identified aimed to identify predictive factors for dropout among anorexia nervosa inpatients. The study was conducted between 1998 and 2004 and consisted of 601 females. Six predictive factors in premature termination of treatment similar to those found by Dalle Grave were found in this study. The six factors found include; having one or more children, low

desired Body Mass Index, a low minimum BMI, high levels of paranoid ideation, impulsive behaviors and lower levels of education (Huas et. al, 2011).

Clinician Duties

Because of the significant dropout rates of eating disorder treatment, much of the responsibility for retention falls in the hands of the clinicians. Clinicians need to invest equally in not only getting patients to treatment but also in keeping them in treatment (Campbell, 2009). One of the many focuses of clinician duties is the varying types of treatment that are made available for eating disorders. Clinicians need to consider the differences that are due to types of therapy, therapists and relational values when looking at dropout statistics (Campbell, 2009). Geller (2001) notes that when clinicians used a symptoms focused approach in the treatment of eating disorder the problem was usually exasperated. Rather than focusing on symptoms, focusing on client self-awareness has been shown to give clients the opportunity to examine their problem with eating from a new perspective.

Making the client self-aware is just one of many tasks of the clinician. Giving the client a choice about their participation at the beginning of treatment has been shown to significantly reduce the rate of dropout during the first weeks of inpatient treatment. When patients fully stand behind their decision to initiate and remain in treatment they are less likely to dropout. (Vandereycken, 2009). These findings are based on a quasi-experimental study conducted with 87 patients with eating disorders. Masson notes that in order to assure patient retention the patient needs to trust the staff and the program that they are a part of (Masson et. al, 2007). In

order for a trusting relationship to be built, the clinician needs to encourage parental involvement in treatment as well as practice prompt rescheduling when sessions are cancelled (Hoste, 2007). Prompt rescheduling has been shown to greatly reduce the rate of dropout.

Campbell recommends that clinicians need to consider the lack of interventions that lack theoretical backing as well as consider the difference between those who drop out while still suffering from the eating disorder and those who dropout because they are doing well and no longer need treatment. (Campbell, 2009).

Eating Disorder Dropout Compared to Other Populations

When looking at dropout rates of individuals in eating disorder treatment, it is important to look at the dropout rates of other populations in order to gain a broader perspective of the magnitude of these rates. A study by Daly and Pelowski focused on the treatment dropout rates of male perpetrators of domestic violence. The study found that dropout rates are consistently high and range anywhere from 22-99%. The findings vary greatly based on the treatment technique used. Along with looking at domestic abuse drop out rates, Daly and Pelowski compared their findings to the dropout rates of outpatient community mental health centers. The dropout rate at these centers ranged from 30-60%. Dropout rates in medical treatment ranged from 50-80% (Daly & Pelowski, 2000). Campbell (2009) found that eating disorder treatment has a dropout rate of 29% compare to these findings.

Duwe conducted a study of the efficacy of prison based chemical dependency programs. The study consisted of 1,852 offenders released from Minnesota correctional facilities in 2005 who received chemical dependency treatment while incarcerated. Of the 1,852 individuals who received treatment, 17% dropped out, or never completed treatment (Duwe, 2010).

Summary

Treatment modalities, specific diagnosis, characteristics associated with dropout and clinician duties are key points of the literature reviewed. It is important to keep these specific variables in mind when reviewing the research in this study. Specific treatment modalities including residential treatment, outpatient treatment, and intensive outpatient are also important to keep on mind when going through the research. Also important to keep in mind is treatment dropout rate of 29% and the consequences that go along with that including the 20% mortality rate that goes along with anorexia nervosa (20%). All of the variables previously discussed play a key role in the determination of eating disorder treatment dropout.

Conceptual Framework

Framework Chosen and Rationale

The framework that was chosen for this research was the ecological model. According to McClaren and Hawe (2004), “An ecological perspective on health emphasizes both individual and contextual systems and the interdependent relations between the two” (p.6). This is important when examining eating disorder treatment dropout because the relationship between individual and contextual relationships plays an important role in treatment dropout. According to Catalano, the ecological model focuses totally on the environment and community (Catalano, 1979). In this research the ecological model focuses on the eating disorder patient as well as their surrounding environment to distinguish what can be done to reduce dropout in future treatment of clients with eating disorders. This model was chosen because eating disorder treatment has a number of components and the ecological model makes focusing on all of these components possible.

Strengths and Limitations

A strength that is present in adapting the ecological perspective to this research is that it can be applied to many different areas of eating disorders and eating disorder treatment and is helpful in the analysis of the two. A limitation present is that the eating disorder treatment process is not completely encompassed by the ecological perspective.

Key Concepts

The ecological model provides a wide lens by which to view the problem and includes six key concepts; micro-system, meso-system, macro-system, adaptation,

transaction and goodness of fit. Micro-system looks at the setting of the individual (Forte, 2007). In the instance of this research the micro-system of the individuals being studied would be eating disorder treatment. Meso-system looks at the process involving the individual between two or more settings (Forte, 2007). In the case of this research those settings could be working on family relationships while participating in treatment or it could look at clinician-patient relationship. Macro-system looks at the patterns of cultures in a social context (Forte, 2007). This research may look at different religious or cultural backgrounds in relation to treatment dropout rates. Adaptation focuses on how the person and the environment play an equal role in their influence and response to each other to achieve the best results. An example of this includes focusing on the client with an eating disorder seeking treatment and focusing on how the client's characteristics and the treatment environment are equally important factors in determining the likelihood of treatment dropout. The same example can be applied to transactions, which looks at the exchanges between the individual and their environment. Goodness of fit looks at the extent to which there is a match between the individual's needs and the qualities of their environment over time. An example of this would focus on whether or not the treatment setting is addressing the issues that each individual client presents rather than focusing on one overarching problem shared by many clients. In this research adaptation, transaction and goodness of fit will be applied by looking at how different aspects of treatment and patient characteristics influence treatment dropout rates. The framework being used in this research will help the researcher develop interview questions for the qualitative interviews.

Methods

Research Design

The purpose of this study was to explore what aspects of treatment and personal characteristics of patient's clinicians identify that contribute to engaging clients in treatment and reducing dropout. The research design used in this study was exploratory and qualitative. This research design was chosen because by choosing qualitative research the respondents were not limited to specific answers but were able to elaborate on the questions being asked. The research was exploratory because its' aim was to explore various techniques used by clinicians when working with clients with eating disorders. The research explored data and techniques about eating disorder treatment and dropout through qualitative interviews with clinical professionals in the field of eating disorders.

Sample

The sample technique used in this study was a snowball sample. The researcher contacted various clinical professionals and got contact information for additional professionals through the contacts already made. The estimated sample size was between eight and ten clinicians. Mental Health clinicians who have worked with individuals with eating disorders for at least two years in the Minneapolis-St. Paul metropolitan area were interviewed to obtain the necessary data for the purposes of this research. The respondents all worked in the field of eating disorders with a wide range of experiences and had skill in working with eating disordered clients. The respondents' experiences with eating disorders included, working with patients in a voluntary outpatient program, working with

patients in a residential facility and working with patients in an intensive outpatient program.

Protection of Human Subjects

The respondents agreed to the interview and the terms outlined with recording of the interview, which included maintaining their confidentiality and destroying the audiotape and any identifying data subsequent to the completion of the research. The participants confidentiality was maintained by storing recorded data on a password secured computer until the research had been submitted. Once the research had been submitted all recorded interviews were destroyed. A consent form attached in Appendix B, was given to the respondents prior to the interview to ensure subject privacy and protection. The consent form was approved by the St. Catherine University Institutional Review Board and contained the appropriate information on the respondent's privacy and confidentiality. The interviewer decreased coercion by distributing consent forms and interview questions prior to potential participants decision. The agency that the respondents are employed by was not be made aware of who did and did not participate.

Instrument

Appendix C contains the questions that were used for this interview. The questionnaire also tracked the participant demographics of, years experience, gender, ethnicity, and profession. The interviews were transcribed by the researcher for data analysis and reliability. All questions were reviewed by the

research committee prior to the interview to reduce research bias and ensure appropriate content. The interview consisted of twelve questions. In addition; the questions were open-ended to ensure that few restrictions were placed on the respondents' answers and for the exploratory nature of this study. The questions covered a variety of topics including client characteristics, clinician duties, drop out rates and treatment modalities used. Questions were not be personally sensitive in nature. The questions began by gaining an understanding of the respondents' experiences working with clients with eating disorders, then gained complexity by addressing various factors and characteristics associated with treatment dropout.

Data Collection

The data was collected using the following steps: first, flyers were given to each research committee member to give to 2-3 additional clinicians. The flyer included a brief description of the study as well as a consent form and a list of interview questions. If the potential participants did not respond, the researcher followed up with the committee members. Next, the researcher followed up with the potential participants and answered any questions that they may have had. Third, the researcher followed up again to answer questions and schedule the interview if the potential participant was interested. The interviews were 45-60 minutes in length and were audio taped. Finally, the interviews took place in the participant's professional office or a place determined by the participant.

Data Analysis

All data collected from the interviews were transcribed by the researcher and a content analysis was conducted where the researcher looked for codes and themes (Berg, 2009).

Researcher Bias

The researcher had bias concerning eating disorders because of past family experiences. The bias was addressed by reviewing interview questions with committee members to ensure that the questions are not leading or too narrow in focus.

Findings

Sample

A snowball technique was used to collect the sample for this research. A flyer was sent out February 1st to clinicians in the eating disorder field. Six clinicians chose to participate in the study. Approximately 25 clinicians were offered to participate in the study. All interviews took place in the month of February. Two of the clinicians interviewed were Licensed Independent Clinical Social Workers. The Remaining four clinicians interviewed were Licensed Psychologists, while one additionally had her doctorate in psychology. Five of the clinicians interviewed were female while one was male. All of the clinicians worked in outpatient mental health settings. The clinicians had between 7 and 34 years of experience. The average years of experience the clinicians had working with eating disorders was 13. The clinicians were asked to indicate which treatment modalities they used with their patients at the time of the interview. The modalities indicated included: Cognitive Behavioral Therapy (CBT), Eye Movement Desensitization and Reprocessing (EMDR), Family-Based Treatment (FBT or Maudsley), Dialectical Behavioral Therapy (DBT), Narrative therapy and Solution focused therapy. The following themes were identified by a minimum of three participants. The following quotes were chosen to best represent the themes and will be italicized.

Low Dropout

Low Dropout was one themes identified through the analysis of interview data. Four out of six clinician's interviewed identified having low client dropout.

This theme was related to the clinician's responses to the question, what is your experience with the eating disorder population and dropout? The following quote highlights one of the respondent's thoughts on this topic: *"I have a really low dropout rate. I have actually tracked this and in 6 months my dropout rate is less than 5%"* (Case 3, Page 1, Lines 11-12). Another clinician reflected on the fact that dropout has become less prevalent in recent years:

"I think we used to have a lot more dropout. In my experience, I had a lot more dropout because we didn't really know anything about treating people with eating disorders when we first started. We were really the blind leading the blind" (Case 2, Page 1, Lines 10-13).

No Experience With Asking Clients to Leave Treatment

Another theme that emerged from the data analysis was asking clients to leave treatment. This theme was identified when the clinicians were asked if they had any experience with patients being asked to leave treatment. Three clinicians stated that they had never asked anyone to leave treatment. One clinician said: *"I don't think that I have ever asked a client to leave"* (Case 2, Page 3, Line 53). Three other clinicians reflected on the fact that they have had clients come to them after being asked to leave other treatment facilities. None of the six clinicians had ever asked a client to leave treatment. One clinician reflected:

"Sometimes it can be fairly dramatic, that they have broken significant rules from another treatment center or have been

asked to not return to a center for whatever reason. If they have just plain and simple broken some basic and non-negotiable rules of another center” (Case 5, Page 2, Lines 37-40).

Insurance Limitations/Financial Struggles

A third theme that emerged in the data was insurance limitations and financial struggles. When asked what factors impact the clients’ ability to stay engaged in treatment and not dropout, three of the clinicians interviewed relayed that one of the primary factors impacting client engagement was insurance limitations. One clinician stated:

“Well, I think insurance is a big one. You know, it’s expensive, treatment, If the insurance limits the number of sessions or refuses to pay for nutrition counseling or something, that will often times precipitate because, you know, it’s expensive” (Case 1, Page 2, Lines 47-49).

Another clinician stated that financial struggles were a factor that impacted clients’ ability to stay engaged in treatment. The clinician noted that:

“ I have noticed that financial reasons are a lot of what brings clients in or has them slow down or stop treatment. ‘My gosh how much is the co-pay, or insurance only pays that much?’ And it’s very real. So I see that kind of thing lead to drop out as well” (Case 5, Page 1, Lines 22-25).

Family Support

A theme that emerged from three of six clinicians when asked what factors impact a clients' ability to stay engaged in treatment and not dropout on a family level was support. All three clinicians agreed that without the families' support it is difficult for the client to stay engaged in treatment. One clinician stated:

"Family is really important. So, having support is extremely important and I think that more involved families are, the more involved the primary people in their life are, the better chance they have at recovery. Where as if someone comes in and they are very alone and isolated, where a lot of people are, and they don't have much support, where they are in an environment that actually promotes the eating disorder, then that's a deterrent"

(Case 4, Page 4, Lines 92-97).

Relationship as a Role in Preventing Dropout

When asked what they see as their role in preventing dropout, three of the six clinicians interviewed said that they believe that building a relationship between clinician and client is a key factor in preventing treatment dropout. A clinician interviewed said: *"I think it's the relationship. It's all about the relationship. In therapy, you know that's the number one factor that is a predictor of success, building that relationship"* (Case 1, Page 4, Lines 74-75). Another clinician's response to the question, "what is your role in preventing dropout" was: *"My role is to develop a relationship with the client and the family"* (Case 2, Page 5, Line 116).

Family-Based Treatment

Another theme that emerged through the data analysis process was family-based treatment (FBT). When asked if they had noticed a difference in dropout rates between different modalities, three of the six clinicians interviewed noted that when they used FBT, or Maudsley method, they had a much lower dropout rate than when they used other treatment modalities. One clinician reflected:

“I would say using FBT makes a hug difference. I don’t know in terms of numbers but I think that I see people get better and it happens much more quickly. Within a year, you come in and you prepare the family that you are going to be in treatment for a year and I see the kids get on board within months with eating again and normal eating. It’s like just in my past, it doesn’t have to be part of who they are for years” (Case 4, Page 9, Lines 203-208).

Anorexia has the Highest Dropout Rate

A theme that emerged from the data analysis was anorexia has the highest dropout rate. This theme emerged when the clinicians interviewed were asked if they had noticed a difference in dropout rates between different eating disorder diagnoses. Four of the six clinicians interviewed said that they have noticed that clients with anorexia have a higher tendency to dropout than clients with other eating disorder diagnosis. One interviewee stated:

“You do see a greater propensity to dropout among people who have anorexia because people with bulimia and people with binge eating disorders are in more pain, they are more connected to their pain, Where as people with anorexia are more successfully able to disconnect from being in any pain and they are really all too often ‘just fine’” (Case 2, Page 8, Lines 168-172).

Meeting the Client Where they are

Another theme that emerged was meeting the client where they are. This theme emerged from asking the clinicians the question, “What recommendations do you have to increase engagement and reduce dropout on an individual level?” Three clinicians made reference to the importance of meeting the client where they are in the treatment process as an answer this question. One clinician answered:

“I would just say, being ready to meet them where they are at when they walk in the door, really listen to what they want, and maybe they say they want something but what is their body language, what are they really speaking to you, saying that they want or need at that time and truly being able to hear what that is accurately, and being able to honor that and respect it and not push it. I think that is less intimidating, makes them feel less vulnerable. They are human beings that need time to trust the

stranger who is going to be guiding them through this” (Case 6, Page 9, Lines 203-209).

Educating the Family

A theme that emerged from the question “What recommendations do you have to increase engagement and reduce dropout of clients in eating disorder treatment on the family level?” was educating the family. Four of the clinicians interviewed alluded to the fact that an important factor to engaging clients’ and their families in treatment is educating the entire family on eating disorders and the treatment process. One clinician said: *“I think we have to give families as much information as they need and I think we have to make that available. I think we have to offer lots of educational kinds of things for families” (Case 1, Page 9, Lines 193-196).*

Community Awareness of Eating Disorders

The final theme that emerged from the data analysis was community awareness of eating disorders. This theme emerged when the clinicians were asked what could be done in order to engage clients’ in treatment and reduce dropout on the community level. Three of the six clinicians interviewed stated that a key factor to this was community awareness brought upon by the clinicians themselves or the agencies that they worked for. The following quote illustrates this theme:

“Just keeping up with the awareness, and the different eating disorder awareness programs that are out there, and news stories and body image stuff. Kind of breaking down the media

adds that are out there and just really realizing the contributions that our community, our culture adds to this disorder becoming as common as it is” (Case 6, Page 11, Lines 243-247).

Discussion

Sample

The sample that was used to collect the data for this research appears to be representative of clinicians working with eating disordered patients in the community. The majority of the sample in this research was women, which is reflective of the clinicians that are currently treating eating disorders. The clinicians that participated in this sample were well seasoned, with an average of 13 years of experience with the eating disorder population.

Low Dropout

Four out of six clinicians identified low dropout as a major theme in this study. This theme is not supported by the literature. The literature suggests that over the past sixteen years, the number of patients who have dropped out of eating disorder treatment has more than doubled (Campbell, 2009). This research however, was conducted at an inpatient treatment facility. None of the clinicians interviewed for this study work in inpatient settings. The clinicians that participated in this study were experienced in the field of eating disorder and are likely skilled at engaging clients. It is probably that those who volunteered for this study feel more successful in their work.

No Experience With Asking Clients to Leave Treatment

No experience with asking clients to leave treatment was another theme that was identified in the data analysis. None of the six clinicians that participated in this

study had ever asked a client to leave treatment. This theme was supported by the literature. The literature demonstrated this theme through a study that discussed administrative discharge from treatment. In the study, 15.5% of clients at an inpatient treatment facility were administratively discharged, or asked to leave treatment (Masson & Sheeshka, 2007). This is in keeping with the data analysis, where three clinicians stated that they had clients who came to them for services after being asked to leave another treatment setting. It is likely that the findings in the data analysis differed from those in the literature because the clinicians that participated in this study were all in private practice and therefore may be more conscious about engaging clients. It can also be said that outpatient facilities have less strict rules and regulations than inpatient facilities.

Insurance Limitations/ Financial Struggles

Three out of six clinicians identified insurance limitations and struggles as another theme in the analysis of the data. This theme was minimally supported by the literature. The literature briefly touches on how insurance issues are often a factor that cause administrative discharge from eating disorder programs, but does not further discuss the issue (Fassino, Piero, Tomba, & Abbate-Daga, 2009). The literature also states that the average cost for one day in a residential eating disorder treatment facility in the United States is \$956 (Frisch et al., 2006).

Family Support

Three out of six clinicians identified family support as an important factor for clients staying engaged in treatment. This theme was supported by the literature. Hoste et al. (2007) suggested that if a client comes from a supportive, in-tact family, they are more likely to complete treatment. Sixty-two percent of individuals who completed eating disorder treatment and 22% of those who discontinued treatment came from intact families (Hoste et. al, 2007). Based on a study of 80 adolescents with Bulimia Nervosa.

Relationship as a Role in Preventing Dropout

The theme of the clinician building a relationship with the client in order to prevent treatment dropout was also identified in the data analysis by three out of six clinicians. This theme is minimally supported by the literature in the clinician duties section. Campbell (2009) states that, Clinicians need to consider the differences that are due to types of therapy, therapists and relational values when looking at dropout statistics Campbell also notes that in order to build a trusting relationship with the client, parental involvement must be a part of the treatment process.

Family-Based Treatment

Three of the six clinicians that participated in this study identified family-based treatment as a theme in this study. This theme was not supported by the literature. This theme was present when discussing a difference in dropout rates

between treatment modalities. The model of FBT was not researched in the literature; therefore this theme is not supported. Because FBT is a somewhat new and controversial model, it did not show up in the literature as much as other treatment modalities.

Anorexia has the Highest Dropout Rate

When asked if there was difference in dropout between different eating disorder diagnoses, four of the clinicians stated that individuals suffering from anorexia had a higher rate of dropout. This theme is supported by the literature. The literature states that while Binge Eaters are less likely to discontinue treatment, those with Anorexia Nervosa purging subtype are more likely to do so (Surgenor, 2003). Surgenor's study collected data on 213 individuals in an inpatient facility at the time of admission and compared it to data at the time of completion or termination. It is likely that anorexia is found to have the highest dropout rate because those suffering from the disorder are often dealing with more physical issues than those with other eating disorders.

Meeting the Client Where They Are

Three out of six clinicians identified meeting clients where they are as a theme in this study. This theme is minimally supported by the literature in the section clinician duties. Vandereycken (2009) states that giving the client a choice about their participation at the beginning of treatment has been shown to significantly reduce the rate of dropout during the first weeks of inpatient

treatment. When patients fully stand behind their decision to initiate and remain in treatment they are less likely to dropout. (Vandereycken, 2009). The clinicians interviewed for this research worked in outpatient setting while the study previously noted took place in an inpatient setting. It is likely that this theme is minimally supported in the literature because studies focus more on outcomes rather than on the engagement process early in treatment.

Educating the Family

The theme of educating the family, in order to increase engagement and reduce treatment dropout was identified by four out of six clinicians participating in this study. This theme is not supported by the literature. The Emily Program (2012) does suggest, however, that family involvement is important when discussing specific treatment modalities (The Emily Program, 2012). It is likely that this theme did not appear in the literature because often, the individual is the main focus of treatment.

Community Awareness of Eating Disorders

Three out of six clinicians identified community awareness of eating disorders as key factor in engaging clients in treatment and reducing dropout. This theme is not supported in the literature. The literature did not explore what can be done on a community level in order to engage clients' in treatment and reduce dropout, therefore this theme was not supported by the literature. Similar to

education the family, often, the individual is the main focus of eating disorder treatment.

Topics Not Discussed

One treatment modality not discussed was the success rate of Cognitive Behavioral Therapy (CBT). The literature suggests that CBT has one of the highest success rates of any treatment employed to treat eating disorders (Grilo et. al, 2011). It is likely that CBT did not arise in the study because of new treatment modalities, such as FBT, and there reported success.

Researcher Reaction

A reaction I found myself having during most of the interviews was wanting to ask more questions that I had allowed for. When the clinicians answered the questions I had come prepared to ask I often found myself wanting to ask additional questions that I had not planned for. I initially had trouble conforming to the structure of the interviews, particularly the formality of the interviews.

Another reaction I found myself having was anger. When clinicians would talk about how unsupportive family members were in some situations I was angry that a family could be so cruel to each other.

A final reaction that I experienced through the interview process was panic. There were times that I was in the interview and I realized that some of the answers I was getting would not fit into my research. Over time I gained confidence as the

interviewer and became increasingly comfortable throughout the interview experience.

Limitations/Recommendations for Future Research

A limitation to the research was that the researcher did not have a coding partner. This made the coding process less reliable. Having a coding partner would minimize the impact of researcher bias. It would be recommended that a coding partner be used when coding is done.

While the expectation of this study was to interview clinicians in multiple settings to reflect the literature, the participants in this study were all from an outpatient setting. The researcher in this study contacted an agency that has a residential facility but was unwilling to participate in the study. A recommendation for future research is to include an incentive for research participants.

An additional limitation is the number of participants in the study as well as the settings of the participants. It is likely that there was a limited number of participants because of the researchers access to eating disorder clinicians in the area. It is recommended that in order to increase sample size, future research focus on one agency. All of the participants that took part in the study worked in outpatient settings. The aim of the study was to also include clinicians from residential settings. A recommendation for future research is to reach out to more clinicians to participate in the study, this can be done by conducting the study using a survey tool.

A final limitation is self-selection bias. It is likely that the clinicians that participated in this study had self-selection bias. The clinicians that participated in this study were more likely to be interested in the topic and good at the work than those who declined to participate in the study.

Implications for Social Work

Engaging clients early in treatment was a strong theme in this study. The study demonstrated the importance of the client-clinician relationship. The client-clinician relationship can be strengthened by focusing on engaging the client in treatment early on in the treatment process. Programs should pay more attention to the client clinician relationship earlier in treatment.

Another implication of the research is the need for more application of Family Based Treatment (FBT). Three out of six clinicians identified FBT as a successful treatment. This study illustrated the success of FBT. If FBT was more widely used, it is possible that dropout rates among those receiving FBT services would decrease.

Three out of six clinicians identified financial struggles as a key barrier to staying in treatment. The research demonstrated that many individuals with eating disorders discontinue treatment because of financial struggles. If there was more money available for eating disorder treatment, it is likely that the treatment dropout rate would decrease. Grant money could be used to target people with financial struggles in need of treatment.

Conclusion

The purpose of this study was to explore how to successfully engage clients in eating disorder treatment and reduce dropout. A strength of this study is that is one of the few studies that examines dropout in eating disorder programs. Another strength is that it heard from the voices of clinicians who are closest to clients struggling with eating disorders. Key findings made in this study include; family support is important to an individual's success in treatment, along with the client's relationship with the clinician. Another key finding made in this study is that Family-Based Treatment (FBT), although new, has a very high success rate, and a very low dropout rate. Given the high mortality rate with this population, it is important that we continue to research this issue with the hope of reducing dropout and improving the lives of clients and their families.

References

- American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th edition, text revision). Washington DC.
- Berg, L (2009). *Qualitative research methods for the social sciences*. Boston, MA: Allyn and Bacon, 7th edition.
- Bloomgarden, A & Calogero, R (2008). A randomized experimental test of the efficacy of EMDR treatment on negative body image in eating disorder inpatients. *Eating Disorders*, 16, 418-427.
- Cachelin, F, Moore, R, Elder, K, Pike, K, Wilfley, D, & Fairburn, C (1997). Natural course of a community sample of women with binge eating disorder. *International Journal of Eating Disorders*, 45-54.
- Campbell, M (2009). Drop-out from treatment for the eating disorder: a problem for clinicians and researchers. *European Eating Disorders Review*, 17(2009), 239-242.
- Carter, J, Bewell, C, Blackmore, E & Woodside, B (2005). The impact of childhood sexual abuse in anorexia nervosa. *Child Abuse & Neglect*, 30(3), 257-269.

Catalano, R (1979). Paradigm succession in the study of abnormal behavior. *Health, Behavior, and the Community*, 138-175. Pergamon Press.

Cooper, Z & Fairburn, C (2011). The evolution of “enhanced” cognitive behavior therapy for eating disorders: learning from treatment nonresponse. *Cognitive and Behavioral Practice*, 18(2011), 394-402.

Dalle Grave, R (2010). Eating disorders: progress and challenges. *European Journal of Internal Medicine*, 22(2011), 153-160.

Dalle Grave, R, Calugi, S, Brambilla, F & Marchesini, G (2007). Personality dimensions and treatment drop-outs among eating disorder patients treated with cognitive behavior therapy. *Psychiatry Research*, 158(2008), 381-388.

Duwe, G (2010). Prison-based chemical dependency treatment in minnesota: an outcome evaluation. *Journal of Experimental Criminology*, 6(57), 57-81.

EMDR International Association, 2011. *About EMDR*. Retrieved from

<http://www.emdria.org/>.

The Emily Program, 2012. Intensive Outpatient Programs. Retrieved from:

http://www.emilyprogram.com/ourprograms/outpatient_services/intensive_outpatient_programs/

- Fassino, S, Piero, A, Tomba, E, & Abbate-Dage, G (2009). Factors associated with dropout from treatment of eating disorders: a comprehensive literature review. *BMC Psychiatry*, 9(67), 1-9.
- Forte, J. (2007). *Human Behavior and the Social Environment: Models, Metaphors, and Maps for Applying Theoretical Perspectives to Practice*. Belmont, CA: Thomson Brooks/Cole.
- Frisch, M, Herzog, D, & Franko, D (2007). Residential treatment for eating disorders: *International Journal of Eating Disorders*, 39, 434-442.
- Geller, J, Williams, K & Srikameswaran, S (2001). Clinician stance in the treatment of chronic eating disorders. *European Eating Disorders Review*, 9(6), 365-373.
- Grilo, C, Masheb, R, Gueorguieva, R, Wilson, G & White, M (2011). Cognitive-behavioral therapy, behavioral weight loss, and sequential treatment of obese patients with binge eating disorder: a randomized controlled trial. *Journal of Consulting Clinical Psychology*, 79(5), 675-685.
- Gross, L & Ratner, H (2002). *Energy Psychology in Psychotherapy: A comprehensive sourcebook, the norton energy psychology series*, New York, NY: Norton & Co.

- Hoste, R, Zaitsoff, S, Hewell, K & Le Grange, D (2007). What can dropouts teach us about retention in eating disorder treatment studies? *Wiley Interscience*, 40, 668-671.
- Huas, C, Godart, N, Foulon, C, Pham, A, Divac, S, Fedorowicz, V, Peyracque, E, Dardennes, R, Falissard B, & Rouillan, F (2011). Predictors of dropout from inpatient treatment for anorexia nervosa. *Psychiatry Research*, 185(3), 421-426.
- Hudson, J, Hiripi, E, Pope, H, & Kessler, R (2007). The prevalence and correlates of eating disorders in the national comorbidity survey replication. *Biological Psychiatry*, 61(3), 348-358.
- Lampard, A, Byrne, S, McLean, N & Fursland, A (2011). An evaluation of the enhanced cognitive-behavioural model of bulimia nervosa. *Behaviour Research and Therapy*, 49(2011), 529-535.
- Masson, P, & Sheeshka, J (2007). Clinicians's perspectives on the premature termination of treatment in patients with eating disorders. *Eating Disorders*, 17(2), 109-125.

McClaren, L & Hawe, P (2005). Ecological perspectives in health research. *Journal of Epidemiology and Community Health*, 59(1), 6-14.

National Association of Cognitive Behavioral Therapists (2007). *Nacbt online headquarters*. Retrieved from <http://www.nacbt.org/whatiscbt.htm>.

Daly, J, &Pelowski, S (2000). Predictors of dropout among men who batter: a review of studies with implications for research and practice. *Violence and Victims*, 15(2). 137-160.

Rome, E, & Ammerman, S (2003). Medical complications of eating disorders: an update. *Journal of Adolescent Health*, 33, 418-426.

Safer,D, Jo, B & Robinson, A (2010). Outcome from a randomized control trial of group therapy for binge eating disorder: comparing dialectical behavior therapy adapted for binge eating to an active comparison group therapy. *Behavior Therapy*, 41(1) 106-120.

South Carolina Department of Mental Health (2006). *Eating Disorder Statistics*. Columbia, SC: Retrieved from <http://www.state.sc.us/dmh/anorexia/statistics.htm>.

Tasca, G, Illing, V, Lybanon-Daigle, V, Bissada, H & Balfour, L (2003). Psychometric properties of eating disorders inventory 2-among women seeking treatment for binge eating disorder. *Assessment*, 10(3), 228-236.

Appendix A
Engaging Clients in Eating Disorder Treatment: Reducing Dropout
RESEARCH INFORMATION AND CONSENT FORM

Introduction:

You are invited to participate in a research study investigating the dropout of eating disorder treatment. This study is being conducted by Lauren Ribnick student in the MSW program at St. Catherine University, under the supervision of Michael Chovanec, Ph.D., Associate Professor. You were selected as a possible participant in this research because of your work with eating disorders. Please read this form and ask questions before you decide whether to participate in the study.

Background Information:

The purpose of the research is to gain a deeper understanding of clinician's views on how to engage clients in eating disorder treatment and reduce dropout. Approximately 10 people are expected to participate in this research.

Procedures:

If you decide to participate, you will be asked to participate an interview consisting of between ten and twelve questions where you will share your knowledge of working with clients with eating disorders. The interview will take place in a location specified by the respondent. This study will take approximately 60-90 minutes over 1 session.

Risks and Benefits:

The study has minimal risks. The questions you are asked may elicit an emotional response, although the likelihood of this is low.

There are no direct benefits to you for participating in this research

Confidentiality:

Any information obtained in connection with this research study that could identify you will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented.

I will keep the research results in a password protected computer and only I and our/my advisor will have access to the records while I work on this project. I will finish analyzing the data by May 14, 2012. I will then destroy all original reports and identifying information that can be linked back to you. The audio taped interviews will be destroyed when the findings of this presentation are reported on May 14, 2012.

Voluntary nature of the study:

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with St. Catherine University in any way. Participants can refuse to answer any interview questions if they choose. If you decide to participate, you are free to stop at any time without affecting these relationships, and no further data will be collected.

New Information:

If during course of this research study I learn about new findings that might influence your willingness to continue participating in the study, I will inform you of these findings.

Contacts and questions:

If you have any questions, please feel free to contact me, Lauren Ribnick at (xxx) xxx-xxxx or xxxxxxxx@stthomas.edu. You may ask questions now, or if you have any additional questions later, the faculty advisor, Dr. Chovanec (651) XXX-XXXX, will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher, you may also contact John Schmitt, PhD, Chair of the St. Catherine University Institutional Review Board, at (651) XXX-XXXX.

You may keep a copy of this form for your records.

Statement of Consent:

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time and no further data will be collected.

I consent to participate in the study. (If you are video- or audio-taping your subjects, include a statement such as "and I agree to be videotaped.")

Signature of Participant Date

Signature of Parent, Legal Guardian, or Witness Date
(if applicable, otherwise delete this line)

Signature of Researcher Date

Appendix B
Engaging Clients in Eating Disorder Treatment; Reducing Dropout
Interview Questions

Please fill out the following demographic information and complete the questions before the interview.

Demographic Information

Years experience:

Setting experience(s): (Please circle all that apply)

Inpatient Outpatient Residential Other_____

Treatment modality used: (Please circle one)

CBT EMDR DBT Narrative Therapy Other _____

Profession (license): (Please circle one)

LICSW LMFT LGSW MH LPC PsyD Other_____

Interview Questions

1. What is your experience with the eating disorder population and dropout?

2. Have you had experience with patients being asked to leave treatment? If so, what lead to this?

3. What factors impact clients' ability to stay engaged in the program and not dropout?
 - a. Individual
 - b. Family
 - c. Treatment
 - d. Community

4. What is your role in preventing dropout?

5. Have you used other modalities in the past?

6. What treatment modalities have you seen used to treat eating disorders?

7. Have you noticed a difference in the dropout rates between different modalities? If so explain.

8. Have you noticed a difference in dropout rates between different eating disorder diagnoses? If so explain.

9. What are the challenges to retaining clients in the program and how do you respond to them?

10. What recommendations do you have to increase engagement and reduce dropout of clients in eating disorder programs?
 - a. Individual
 - b. Family
 - c. Treatment
 - d. Community

11. Do you have a client example of someone who overcame challenges to complete the program?

12. Do you have anything else you think would be helpful to me and my study?

Appendix C
Engaging Clients in Eating Disorder Treatment: Reducing Dropout
Participant Recruitment Flyer

MSW CLINICAL RESEARCH PROJECT

- **What :** MSW clinical research project on engaging clients in eating disorder treatment and reducing dropout.
- **Location :** Your place of employment.
- **Time :** 45-60 minute interview.
- **Contact information :**

Lauren Ribnick

**MSW student, University of St Thomas/St. Catherine
University**

XXXXXXXXX@stthomas.edu

(XXX) XXX-XXXX

***If you are interested in participating, please contact Lauren Ribnick within 1 week of receiving this.**