Evidence-Based Practices in Outpatient Treatment for Eating Disorders

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Abstract

This study examined the current issues relevant to implementing evidence-based practices in the context of outpatient treatment for eating disorders. The study also examined the effectiveness of an outpatient treatment program for eating disorders among a group of 196 patients presenting with anorexia nervosa, bulimia nervosa, or eating disorder not otherwise specified. Results indicated that the program was effective in significantly reducing eating disordered symptoms, anxiety symptoms, and depressive symptoms. The author discusses implications of the research and potential directions for future research.
Keywords: eating disorders, evidence-based treatment, outpatient therapy, anorexia, bulimia.

Eating disorders remain a significant concern in a culture where thinness is unduly emphasized, and where anorexia nervosa is the disorder with the highest premature fatality rate of any mental illness (Sullivan, 1995). Four out of five women in the United States are dissatisfied with their appearance (Smolak, 1996), and forty percent of Americans have experienced an eating disorder or know someone who has (NEDA, 2005). Eating disorders often go unrecognized and undiagnosed due to lack of education and awareness about signs and symptoms of eating disorders in the general public, an absence of societal sanctions for maintaining an unhealthy weight, and minimizing or denial of symptoms among people with eating disorders and their loved ones. In the current economic climate, many individuals are finding the cost of treatment to be an additional, significant obstacle. As mental health professionals, it is becoming more important than ever to make available effective treatment options that yield promising results in a relatively short time period.

This study examines current issues related to implementing evidence-based practice in psychology for people with eating disorders, and examined the effectiveness of a day treatment program for people with eating disorders.

Evidence-Based Practice

According to the APA Presidential Task Force on Evidence-Based Practice (2006), the field of psychology is fundamentally committed to evidence-based practices. The APA Task Force defined evidence-based practice in psychology (EBPP) as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (2006, p.273). Thus, evidence-based practices are derived from three components, which are all relevant to good outcomes in psychotherapy: 1) research, 2) clinical expertise, and 3) individual patient characteristics. Therefore, when treating patients with eating disorders, it is best to keep in mind all three components.

First, a thorough knowledge of outcome research is critical in deciding which interventions to use with eating disorder patients, and research offers a way to keep common human errors in judgment (e.g., confirmatory bias, self-enhancement bias, availability heuristic) in check. Yet, while one typically thinks of high-quality research as the foundation for identifying true evidence-based interventions, clinical expertise is also essential for identifying and integrating the best research evidence with clinical data, which is obtained through a relationship with the patient over the course of treatment (APA Task Force, 2006). Evidence-based treatments for eating disorders include cognitive-behavioral therapy for bulimia nervosa (Fairburn, 1985) and binge eating disorder (Wilson, Grilo, & Vitousek, 2007), and the Maudsley approach to family-based treatment for adolescents with anorexia nervosa (Lock et al., 2001; Wilson, Grilo, & Vitousek, 2007).

The second component, clinical expertise, is a less quantifiable, but equally important component that may include informal analysis, clinical experience, clinical observations, psychological theory, and consultation with colleagues (Shapiro, Friedberg, & Bardenstein, 2006). Though both research and clinical expertise have susceptibility to error, they can be integrated in such a way so as to maximize our overall understanding of both the internal and external validity of a particular treatment intervention for people with eating disorders. In addition, research and practice share a commitment to providing the best knowledge about psychological methods and treatment in order to improve patient care (Kazdin, 2008). According to the APA Task Force, clinical expertise includes components such as a) assessment, diagnostic judgment, systematic case formulation, and treatment planning, b) clinical decision making, treatment implementation, and monitoring of patient progress, c) interpersonal expertise, d) continual self-reflection and acquisition of skills, e) evaluation and use of research evidence, f) understanding the influence of individual, cultural, and contextual differences on treatment, g) seeking available resources as needed through consultation or alternative services, and h) a cogent rationale for clinical strategies. In treating eating disorders, it is essential to integrate and nurture each of these components as an integral part of any intensive treatment program, and the program described in this study has implemented methods to address each one.

For instance, using assessment instruments with high reliability and validity and a systematic procedure for setting goals and establishing a treatment plan enhances clinical expertise. Regular monitoring of eating disorder symptoms on a weekly log, and making treatment decisions in the context of a multi-disciplinary treatment team improves clinical decision-making. A commitment to clinical staff's personal and professional growth and training opportunities encourages continued acquisition of skills needed to enhance patient care. Clinicians' review professional literature on eating disorders and present a summary of the literature for other treatment team members, helping the treatment team to stay informed of current research. Treatment team training on current issues related to diversity helps to maintain a commitment to culturally competent therapy. Frequent consultation and open communication with other professionals in the community, and periodic treatment reviews for each patient help ensure that there is an informed rationale behind the interventions being implemented for each patient.

Making specific refinements in clinical practices can help enhance patient care and refine clinical expertise. Kazdin (2008) proposed two such changes. First, he suggested using systematic measures to evaluate patient progress. He recommended monitoring treatment effects in an ongoing fashion and utilizing this data to make decisions about continuing, altering, or terminating treatment based on the patient's improvement or lack thereof. Second, he proposed viewing clinicians as researchers who can contribute uniquely to our knowledge base. He noted that since clinicians hypothesize that a particular treatment combination will have a specific effect, and then test the hypothesis with the individual case, they are doing research. He also proposed direct collaboration between those who identify primarily as researchers and those who identify primarily as clinicians (Kazdin, 2008).

As Shapiro (2009) noted, there are some specific circumstances where therapeutic interventions may advisably vary from research-based guidelines. For instance, when the client is demographically or culturally different than the samples included in the research, it is wise to rely on culturally competent clinicians to use their clinical experience and expertise to adapt interventions accordingly. Second, when assessment reveals that the etiology of the patient's eating disorder varies from the factors addressed by evidence-based treatments, clinicians need to accommodate and address the relevant etiological issues for that particular patient. Additionally, when the use of evidence-based treatments yields a lack of progress in the patient's eating-disordered symptoms, clinicians would be wise to rely on expertise and knowledge of the patient's unique characteristics that may call for different types of interventions than are typical (Shapiro, 2009).

The third component of EBPP presented by the APA Task Force (2006) regards individual differences among patients. When considering whether to use an empirically validated treatment with an eating disordered patient, the clinician must consider how similar or dissimilar the patient is to the majority of research participants who improved in response to the intervention (Shapiro, 2009). For instance, the gap between research and practice is evident when a patient presents with atypical features and is unlikely to have been well-represented in research samples (Shapiro, 2009). One example is a patient who presented at our center meeting most of the criteria for anorexia nervosa and a specific phobia, but who exhibited self-confidence and little fear of weight gain. She did not respond well to our intensive program and became defensive and distressed about the significant differences between her and other patients in the program, but she experienced a decrease in symptoms and significant weight gain after a schedule change where she participated in the anxiety skills group in combination with intensive individual sessions twice per week focused on decreasing anxiety and addressing her specific phobia. The Task Force asserted that patient values and preferences, which are reflected in patient goals, beliefs, preferred modes of treatment, are a central component of EBPP. Thus it is important when treating individuals with eating disorders to be sensitive to patients' healthy subjective goals at the onset of treatment and during the course of their treatment, rather than merely dictating our own goals for them. In our clinical experience, when patients feel personal investment in a goal, they seem more likely to follow through with the specific behavioral goals outlined in the course of therapy.

It is also important to respect and accommodate a wide range of patient values and preferences in the development of an individualized program of treatment, and to remain flexible in this regard throughout the course of treatment, as each patient and each patient's path toward change is unique. Individual differences which may influence personality, values, worldviews, relationships, psychopathology, and attitudes toward treatment (APA Task Force, 2006) include development and life stage, gender, culture, ethnicity, race, age, family context, religious beliefs and practices, and sexual orientation (American Psychological Association, 2003). Patients' and psychologists' values interact and influence patients' help seeking behaviors and disclosure of symptoms and feelings about treatment as well (APA Task Force, 2006).

Another concern that has emerged in the dialogue about EBPP is the need to move from efficacy studies to effectiveness studies to examine issues of external validity. One way to do this is to conduct field studies of clinicians in applied settings (Whaley & Davis, 2007), which was one goal of the current study.

Treatment of Eating Disorders

There is a need for improved treatment approaches for people with eating disorders. Researchers have indicated a specific need for investigations assessing multimodal interventions in inpatient, outpatient, and partial-hospitalization settings and investigations incorporating alternate systems of delivery and therapeutic approaches, alone or in combination (Chavez & Insel, 2007). Moreover, the wide range of personality and comorbidity features across cases in individuals with eating disorders (Wonderlich et al., 2007) presents an ongoing challenge and a continued need for greater flexibility and consideration for individual differences in the way treatment is administered.

In addition, each patient's eating disorder is unique, and patients present with a wide array of symptoms, comorbid disorders, and variations in their behaviors. Due to the variability in presenting features of eating disorders, they are not easily classified or categorized (Schaffner & Buchanan, 2008). There are currently new diagnostic criteria being developed which will appear in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), due to be released in 2012. The new criteria may include a broader definition of anorexia and/or a separate diagnosis for binge eating disorder, to lessen the number of patients who end up with the "default" diagnosis of eating disorder not otherwise specified (EDNOS). Currently, 60-65% of patients with eating disorders have a diagnosis of EDNOS

(DeAngelis, 2009), which represents a need to acknowledge the variations in presenting symptoms, and the implications for the need to use a variety of individually-tailored interventions in treatment. The ongoing challenge is developing personalized care based on a which treatment components will be most effective for which patients (Chavez & Insel, 2007).

Trends toward relapse following inpatient treatment have been reported in several studies (Lowe et al., 2003; Oyvind et al., 2005; Williamson et al., 1989), and there is a need for good follow-up care after an inpatient stay. The day program in this study offers an intermediate level of intensive care, as patients transition back to work, school, or other aspects of their daily lives. Distinct advantages to outpatient treatment have been noted, such as less opposition to treatment since patients are less monitored (Kaplan & Olmsted, 1997), less identification with the disorder (Wilson, Grilo, & Vitousek, 2007), the ability to maintain closer contact with supportive persons in their life (Schaffner & Buchanan, 2008), and cost-effectiveness (Kaplan & Olmsted, 1997).

An Outpatient Treatment Approach for Eating Disorders

The day treatment program used with patients in this study is a day treatment program, with two levels of intensive care. The highest level of care is the partial hospitalization program (PHP), and the alternative, lower level of care is the intensive outpatient program (IOP). The PHP program involves 5 groups per day, Monday-Thursday, and 2-3 groups per day on Friday-Saturday. The IOP level of care involves anywhere from 2-14 groups per week, depending on individual patient needs. The program uses both process-oriented therapy groups and more structured and psycho-educational skills-oriented groups. In addition, meal process groups help patients learn to identify hunger/fullness cues, identify and eat appropriate portions, and challenge themselves on food-related fears in a safe, supportive, and homelike environment. Patients bring their own lunches and/or dinners and eat with other patients and one therapist, who monitors and supports the group and provides feedback and challenges tailored to patients' specific goals.

In this outpatient program, clinicians integrate research on evidence-based treatments with clinical expertise as well as patient characteristics, culture and preferences. This highly individualized treatment approach accommodates roughly 40 individuals in treatment at any given time, and allows for individuals to continue work and/or education while also receiving intensive treatment. This integrative and cost-effective approach has also shown a promising alternative to inpatient treatment as it has resulted in significant improvement in patients' eating disordered attitudes and behaviors, anxiety symptoms, and depressive symptoms in an average of 12.8 weeks of treatment (Schaffner & Buchanan, 2008).
The theoretical orientation of the treatment center is integrative, including a primary focus on cognitive-behavioral and psychodynamic interventions. A patient's treatment may alternate between periods of focusing on more behavioral goals and techniques to address eating disordered symptoms, and periods of focusing on underlying psychological and relational issues that maintain the eating disorder (Buchanan, 1994). The program utilizes an integrative theoretical approach combining evidence-based treatments with additional multimodal interventions based on individual differences and needs. For a more detailed description of the program and specific evidence-based interventions and other individualized interventions, see Schaffner & Buchanan (2008).

The day program mentioned above seeks to integrate the aforementioned sources of evidence-based practices (best available research, clinical expertise, and patient characteristics). See Table 1 for an overview of how each of the areas is addressed in the program, and the benefits that have been noted. Clinicians in this day treatment program sought to focus on patient goals by collaborating during the first session on a treatment plan which places a strong emphasis on client's goals, stated in their own words, accompanied by current symptoms and specific, measurable, and behavioral treatment planning which creates a map for helping the patient reach his or her stated goals. The treatment plans are individualized

and the treatment program is individualized, so that each patient does a unique combination of treatment groups and sessions.
Treatment at the outpatient facility begins with an initial psychological assessment, which has been noted as essential to effective treatment (APA Task Force, 2006). The assessment battery includes a clinical interview, the *Eating Disorder Inventory- Second Edition* (EDI-2; Garner, 1991), the *Eating Disorder Inventory- Symptom Checklist* (EDI-SC; Garner, 1991), the *Beck Depression Inventory- II* (BDI-II, Beck, Steer, & Brown, 1996), and the *Sheehan Patient Rated Anxiety Scale* (SPRAS; Sheehan, 1990). Based on the initial assessment, and taking into consideration each patient's availability and financial resources, a psychologist recommends an individualized program schedule. There are roughly five groups per day offered, six days per week, but patients may elect to do anywhere from one to twenty-three groups per week, based on their individual needs and preferences and the recommendation of the intake clinician. Thus, the program is flexible, individualized, and creates an opportunity for patients to continue work or school in addition to intensive treatment if they choose to do so.

The current study examines the effectiveness of a day treatment program for people with eating disorders. Specifically, this study evaluates the program's outcome on self-reported measures of patients' eating disordered attitudes and behaviors, depressive symptoms, and anxiety symptoms, by comparing patients' self-reported symptoms at pre-treatment and post-treatment.

Table 1. Methods Used in the ACE Program for Integrating Evidence-Based Practices

Components of EBPP	Methods Used in the ACE Program to Integrate EBPP	Outcomes Observed as a Result of Using the Methods
Best Available Research Evidence	Regular clinician review of journal articles Presentation of current research with colleagues at weekly treatment team Discussion of professional readings in group supervision	Informed and current integration of research and practice Clinicians' use of the most current and effective interventions Clinicians' contribution to research literature
Clinical Expertise	Use of valid and reliable assessments Regular monitoring of patient progress Commitment to personal growth & self-reflection Team approach	Cohesive team Informed decision-making Ongoing learning and exchange of ideas/input Built-in support and lower risk for burnout
Patient Characteristics, Culture, & Preferences	Individualized treatment recommendations Individualized program schedule, modified as needed on ongoing basis Diversity chairperson presents current issues for maintaining cultural competence	Flexibility with patient schedules Patient-reported satisfaction with program Patient ability to integrate treatment with other life goals/activities (e.g., school, work)

Method

Participants

Participants in the study included 196 people. Ninety-eight percent of participants were women and all participants were diagnosed with an eating disorder (anorexia nervosa, bulimia nervosa, or EDNOS) at the onset of treatment. All participants received treatment at a partial hospitalization or intensive outpatient level in the program described above. These women attended the program between 2001 and 2009.

Instruments

The participants' eating disorder symptoms, depressive symptoms, and anxiety symptoms were measured in the initial assessment and again at the time of discharge from the program. The instruments used included the *Eating Disorder Inventory- Second Edition* (EDI-2; Garner, 1991), the *Eating Disorder Inventory- Symptom Checklist* (EDI-SC; Garner, 1991), the *Beck Depression Inventory- Second Edition* (BDI-II; Beck, Steer, & Brown, 1996), and the *Sheehan Patient Rated Anxiety Scale* (SPRAS; Sheehan, 1990). The EDI-2 has been shown to have high reliability and construct validity (Espelage et al., 2003), and the BDI-II has also demonstrated high reliability (.92). The EDI-SC includes items addressing the patient's current weight, weight history, and use of eating disordered behaviors such as binge eating, purging, and restricting food intake. The patients' weight and use of various eating disorder symptoms were also logged weekly throughout treatment by the therapist or nutritionist.

Design and Procedure

This analysis involved a repeated measures design, with each participant as his or her own control. The data that were gathered prior to treatment for each participant were compared to the post-treatment data in order to examine the outcome of treatment at the center on measures of anxiety, depression, and eating disordered behaviors and attitudes. Each case was assigned a number to maintain confidentiality and files were kept locked in a chart room at the center. Pre-treatment and post-treatment data were obtained from patient charts on measures of eating disordered attitudes and behaviors, depressive symptoms, and anxiety symptoms. Paired sample t-tests were used to compare mean scores on pre-treatment and post-treatment measures.

Results

Among the entire sample of participants, the average age was 22.6 years (SD = 7.8), and ranged from 13-51 years old. The mean number of weeks the individuals participated in the program ranged from 1 to 60 weeks, with a mean length of stay of 13.6 weeks (SD = 10.3). Most patient (65.1%) participated in the IOP level of care in the program, in comparison with 10.3% of patients who did the PHP program, and 24.6% of patients who did some combination of PHP and IOP treatment. All patients in the program received individual therapy, and the average number of individual therapy sessions patients received during the program was 14.4 (SD = 11.8). Sixty percent of individuals in the program participated in at least 1 session of family therapy. Twenty-two percent of participants participated in six or more sessions of family therapy.

Of the patients in the study, 81.5% reported purging symptoms at the onset of treatment or during treatment, and 77.4% reported bingeing symptoms during at the onset of treatment or during treatment. The mean number of binges per week that patients reported at the intake was 4.7 (SD = 9.1), and the mean number of reported binges per week at post-test was .7 (SD = 2.0). The mean number of purges per week at pre-test was 6.6 (SD = 10.8), compared to 1.0 purges per week (SD = 3.3) at post-test. Paired samples t-tests were used to compare patients' mean number of binge/purge symptoms per week. A paired samples t-test revealed a significantly lower number of binges at post-treatment when compared to the number of binges at pre-treatment, t (142) = 5.2, $p < .001$. Another paired samples t-test revealed a significantly lower number of purges at post-treatment when compared to the number of purges at pre-treatment, t (144) = 6.1, $p < .001$.

A paired sample t-test was also used to compare participants' mean scores on pre-treatment and post-treatment measures of eating disordered attitudes, personality features, and symptoms. This analysis revealed that patients reported a significantly lower number of eating disordered attitudes, personality features, and symptoms at post-treatment than they did at pre-treatment, t (109) = 12.8, $p < .001$. This indicates that the patients' mean score after treatment (M = 3.5) was significantly lower than their mean score before treatment (M = 8.4).

Anxiety symptoms and depressive symptoms before and after treatment were also analyzed in the same way. The analysis indicated a significant decrease in patients' mean scores for anxiety symptoms at post-treatment when compared to pre-treatment, $t(103) = 7.7$, $p < .001$, and a significant decrease in patients' mean scores for depressive symptoms at post-treatment when compared to pre-treatment, $t\ (112) = 11.5$, $p < .001$. Table 2 shows the means, standard deviations, and sample size for each of the above comparisons.

Table 2.
Mean Differences in Eating Disorder, Depressive, & Anxiety Symptoms Between Pre-Treatment and Post-Treatment

Measure	Pre-treatment			Post-treatment		
	Mean	Standard Deviation	Sample Size	Mean	Standard Deviation	Sample Size
EDI-2	8.4	3.9	110	3.5	3.2	110
BDI-II	22.7	12.9	113	8.2	9.2	113
SPRAS	35.0	24.4	104	18.8	17.7	104
Binges/wk	4.7	9.1	143	.7	2.0	143
Purges/wk	6.6	10.8	145	1.0	3.3	145

Note. EDI-2 = *Eating Disorder Inventory-Second Edition;* BDI-II = *Beck Depression Inventory- Second Editioin;* SPRAS = *Sheehan Patient Rated Anxiety Scale.*

Discussion

This study supports the effectiveness of an outpatient treatment program for eating disorders that integrates research on evidence-based treatments with clinical expertise and individual characteristics and needs. In an average of 13.6 weeks, patients showed substantial improvement on measures of eating disordered symptoms, anxiety symptoms, and depressive symptoms. The program's unique approach utilizes a multi-disciplinary treatment team, an individually tailored treatment schedule based on an initial assessment and consideration of individual needs, and interventions based on evidence-based treatments for eating disorders.

It appears that there are promising outcomes in the arena of outpatient treatment for eating disorders, and there are effective practices in place for moving evidence-based practices into the outpatient environment. While individual patient differences call for flexibility and patience in applying research-based interventions, a program can base its overall structure and content on evidence-based treatments that have shown to be effective for groups of research participants, and at the same time vary the program schedule and combination of group therapies for any given patient. This approach lends itself to maximizing improvement in patients' symptoms by taking into account individual characteristics, cultural differences, idiosyncratic presentations of symptoms, and atypical courses of the disorders. Factors such as the makeup and interpersonal dynamics of any given therapy group in the program at any given time may also impact patients' ability to progress. There are times when one particular group or the

overall milieu has an overall tone of health and recovery, and other times when the milieu has an overall feel of competition or other dynamics that tend to perpetuate eating disordered thoughts and behaviors. In either situation, it is vital to factor in clinical expertise about an individual's motivation to recover and ability to respond appropriately to the current milieu. Communication and collaboration among members of the treatment team is also vital in resolving conflicts that arise among patients and maintaining an environment of health and recovery as much as possible.

These findings replicate those of an earlier evaluation of the same program on measures of eating disordered symptoms, anxiety, and depression (Schaffner & Buchanan, 2008), and suggest that using a combination of evidence-based treatment approaches, clinical experience, and additional interventions based on individual needs is an effective approach for the treatment of eating disorders.

The study has a few limitations. Not all participants fully completed the questionnaires at discharge, and we do not know the characteristics of the patients who did not complete the questionnaires, or the outcomes of their eating disordered symptoms, anxiety symptoms, or depressive symptoms. Future studies might examine factors related to patients' compliance with filling out questionnaires in relation to eating disordered symptoms, depressive symptoms, and anxiety symptoms. It could be that patients who were significantly depressed did not have the motivation to fill out the questionnaires, or may have felt additional discouragement if they were unable to report improvement. In addition, follow-up data is needed to examine whether patients maintained their gains in treatment six months or a year later, and if so, what helped them to do so. Some patients in the program mentioned above continued with individual and/or nutrition therapy after discharging from the program, and it would be worth examining in future studies the difference between those patients and the ones who did not continue in treatment of any kind, or who tried other strategies for relapse prevention (e.g., utilizing general social support of friends and family, reviewing materials from treatment, attending free support groups in the community, etc).

It is important to continue examining how therapy works and which methods are the most effective to improve patient care. Research findings in the field of psychology shape the standards for appropriate practice, and determine which services will be reimbursed at what rate (Kazdin, 2008). As researchers and clinicians continue to collaborate in examining the many components involved in applying evidence-based practices to the treatment of eating disorders, patients' recovery process can continually be improved and enhanced.

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