THE IRISH HEALTH PROFESSIONAL AND EATING DISORDERS:
Their Understanding of the Eating Disordered Patient

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“There’s always a time at the beginning when a person develops an eating disorder and it serves its purpose, but once they get caught up in it and entrenched in it, then that’s when it starts to become destructive for them”.

(Patti, Psychotherapist, 2012).
Participant from research
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Abstract.

Eating disorders (ED) are characterised by maladaptive eating behaviours that effect an individual’s physical status and their psychosocial functioning. Therefore, treatment of eating disorders is difficult and it involves the participation of healthcare professionals from various disciplines. The principal objective of this qualitative study was to investigate the understanding of the Irish healthcare professional towards the individual with ED. Nine healthcare professionals’ experiences were elicited via semi-structured interviews with questions focusing on their experience in treating individuals with eating disorders. The nine healthcare professionals, seven females and two males, were chosen because of their diverse roles; psychiatrist, clinical nurse specialist, nutritionist and psychotherapist, and all had a varied amount of experience (4 to 20 years) in the field. Results, obtained through NVivo and thematic analysis, showed that the Irish healthcare professional displayed a good deal of understanding of the ED patient/clients’ experience in treatment, especially relapse, recovery and ED with comorbidity. In addition, attitudes of the healthcare professionals toward the ED disputed the claim of "the undesirable patient" (Warren, et al., 2009, p.28).
Chapter 1: INTRODUCTION

Eating disorders (ED), which include Anorexia nervosa (AN), Bulimia nervosa (BN), Binge eating disorder and eating disorders not otherwise specified (EDNOS) (DSM-IV) share a common core psychopathology: a preoccupation with weight and body shape (American Psychiatric Association, 1994) and a continual disturbance of eating behaviours, which can affect physical health and psychosocial functioning (Lamoureux & Bottorff, 2005). Despite treatment, prognosis is generally poor in BN (Hay & Bacaltchuk, 2000) and AN (Kaplan & Garfinkel, 1999).

Difficulties in the classification of the various eating disorders also add to confusion at the diagnosis stage (Fairburn & Harrison, 2003). In addition, ED are highly comorbid with numerous psychological disorders, ranging from anxiety, Bipolar disorder (BD), depression, OCD (Obsessive Compulsive Disorder), which can make a final diagnosis very difficult (Kaplan & Garfinkel, 1999). Therefore, treatment of eating disorders is difficult and it involves the participation of healthcare professionals from various disciplines.

ED patients are viewed as extremely challenging and difficult to treat. This is down to the various attributes of the ED patient. These include; their health status, the highly comorbid nature of the ED with other disorders, high mortality rates, time consuming aspect of recovery, high relapse rates, difficulties maintaining a therapeutic relationship and impaired cognitive thought (Warren et
These factors must be considered when treating an ED patient/client. Due to these inherent difficulties, many healthcare professionals avoid treating this particular population (Williams & Leichner, 2006; Burket & Schramm, 1995).

EDs have the highest morbidity of all psychiatric disorders. Lifetime prevalence estimates that the DSM-IV categorization of Anorexia nervosa, Bulimia nervosa and binge eating disorder are 0.9%, 1.5% and 3.5% among women respectively, and among males, it is 0.3%, 0.5% and 2.0%. (Hudson et al 2007). According to the Department of Health and Children, it is estimated that the incidence rate of eating disorders in Ireland is 10 per 100,000 of population. 400 new cases are diagnosed each year and 80 lives are claimed annually (A Vision of Change, 2006). So this is an issue for the Irish healthcare professional.

The importance of the health professional in the treatment of ED was recognised in a quantitative and qualitative Canadian study by Gilbert et al (2000). When parents were asked about the impact of eating disorders on family relationships, they emphasised the importance of locating a service provider who has prior knowledge, good understanding and experience in the field (Gilbert, et al., 2000).

The ED patient poses many challenges to the healthcare professional. It is documented that patients with ED incur “intense feelings of hostility, anger, hopelessness and stress” in therapists more than any other psychiatric disorder (Kaplan & Garfinkel, 1995 p. 667). This idea will be investigated in the study. This research aims to explore the healthcare professionals’ understanding of ED patient in terms of the issues that can arise in treatment.
CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

The review of the current literature presented many research studies, both qualitative and quantitative or a mixture of both. The main themes for this study concerned attitudes of the healthcare professional towards the ED patient, issues of comorbidity, and recovery and relapse in ED treatment. For some themes, the literature was mainly quantitative and for others, it was mainly qualitative. Given the qualitative nature of this study, the researcher would have found the qualitative research preferable, but to obtain an overall picture both methods of research were considered.

2.2. Attitudes of the Healthcare Professional.

“Patients with eating disorders have a notorious reputation for being difficult to treat and undesirable as patients.”

(Warren., et al., 2009, p.28)

There are often negative attitudes towards treating clients with eating disorders; 31% of 90 therapists questioned desired not to treat such patients (Burket & Schramm, 1995) and some healthcare professionals avoided working with individuals with eating disorders (Linville, et al, 2010).
2.2.1. The ED patient is difficult to diagnose

Primary health care physicians may find it hard to diagnose the disorder in its early stages before obvious physical symptoms are apparent due to its subtle psychological symptoms (Noordenbos, 1998). This was also reflected in Reid’s study with one GP stating that without the individual “coming forward and saying it”, GPs “may well be missing them”(Reid, et al., 2010 p. 8). Despite Flahavan’s (2006) study stating that GPs should “remain alert for these diagnoses”, GPs have described how difficult this can be, especially in issues of comorbidity as the individual can “hide their symptoms” or else the eating disorder “can be buried amongst all sorts of psychiatric morbidity” (Reid, et al., 2010 p. 7). This can be prove to be “frustrating” for the primary care physician.

Williams & Leichner’s (2006) meta-analysis study on healthcare professionals’ experiences regarding ED in their training/work environment also reflect this. 83% of the participants stated that specialised education should be mandatory. This was due to the difficulty in treating ED in terms of its comorbidity, its prevalence and its life threatening potentials (Williams & Leichner, 2006).

2.2.2. The ED patient is challenging.

“This condition is all in their heads”

This was seen across the disciplines in Williams & Leichner’s 2006 study with 28% of the participants registering negative attitudes towards ED in their training and working environments (16.3 % of the nursing staff, 10.2% of the psychiatrists and 12% of the physicians). Reasons for this negativity ranged from ED patients being difficult and exhausting to work with, being controlling and manipulative and to blaming the patient for their condition. However, it should be
noted that these are the opinions of the participants with regard to how their colleagues in other disciplines perceive ED.

This is also reflected in research by Flemin & Szmukler (1992) where some healthcare professionals felt that the responsibility for the disorder lies with patient’s attitude and lifestyle (Flemin & Szmukler, 1992). This notion is also echoed by Vandereycken, where individuals with eating disorders are compared to “impostors, who have no genuine illness, deliberately harm themselves and don’t cooperate” (Vandereycken, 1993 p.13). These attitudinal biases can affect the healthcare professional-patient relationship by evoking hostility, mistrust and resentment (Noordenboos, 1998).

In research by Burket & Schramm (1995), 87% of the participants cited frustration as the most common emotion when dealing with ED patients. (Burket & Schramm, 1995). The annoyance of the healthcare professional is evident; “they’re so frustrating because they just don’t see they have a problem. They see that we think they’ve got a problem, but they just don’t see they have a problem” (Reid, et al., 2010).

Treating individuals with eating disorders was considered “difficult” and “an awful lot of hard work” due to the heavy amount of psychological and emotional support required plus “monitoring their weight and their physical state” (Reid, et al., 2010, p.6). Participants in the study remarked how “one thing that really stuck out was just how difficult it was to treat them.... we had two patients that died that were young otherwise healthy folks” (Linville, et al., 2010).

Some healthcare professionals also stated that they were uncomfortable in discussing eating disorders with the patient as they considered many of the personal questions they had to ask were intrusive and probing (Linville, et al, 2010). However, in research by Ward, et al. (2009), healthcare
professionals considered it to be important to “find a balance that allows some exploration... without them feeling abandoned or intruded upon” (Ward, et al., 2009 p.40).

2.2.3 The ED patient is time consuming

According to healthcare professionals, screening for eating disorders was time consuming in comparison with other illness and disorders (Linville, et al., 2010). This led healthcare professionals to “pick and choose [their] battles with people with multiple issues”. As a consequence “eating disorders often fall to the bottom [of] mental health [considerations] in general” (Linville, et al., 2010). This point was reflected in a qualitative study, where participants with ED felt they “were on a conveyor belt” and that the GP had a lack of awareness about their condition (Reid, et al., 2010).

Participants in Reid and Williams’ research highlighted the time consuming aspect of ED in comparison with other patients, the demand on the GPs time for ED individuals was high because numerous visits were required (Reid, et al., 2010)

“You’ve got a certain pressure of seven minutes and .. you can’t even scratch the surface” (Reid, et al., 2010 p.7).

It takes time for a healthcare professional-patient relationship to develop. Most therapies used in the treatment of ED require a considerable amount of sessions in order to be effective (Franko & Erb, 1998). Qualitative research relating to family therapy showed that only after a good deal of sessions would a participant start to trust the healthcare professional because they “remained neutral” and “didn’t stand on my parent’s side, nor would she [the therapist] side with me” (Joyce,
The approach the service provider takes to treat the individual with an eating disorder is paramount.

2.2.4 The ED patient is in denial

“Medicine is easy when you can just prescribe something and then they get better.... but difficult sometimes when you put a lot of work into looking after them and sometimes you don’t seem to get anywhere”.

Healthcare Professional participant, (Reid, et al., 2010 p.6).

“[ED patients have] a poor success rate. I don’t want to work with patients who aren’t motivated to recover”. Participant in Williams & Leichner (2006) p.332

Healthcare professionals should be aware that individuals with eating disorders are ambivalent about receiving treatment (NICE, 2004) and recovery (Geller & Drab, 1999). It is demanding and challenging work as the clinician has to motivate the patient/client to change (Hoek & Van Hoeken, 2003). Usually, the patient does not view their disorders as being a problem and therefore are seen as treatment resistant (Vitousek, et al., 1998). This is particularly the case with individuals with AN, where symptoms are cast in a positive light making it hard to relinquish them as they serve a purpose (Nordbø, et al., 2006). In research by Warren, et al., (2009), it was noted by 55% of the participants that one of the most difficult aspects of treating ED was the “resistance of severe chronic symptomatology to change” (Warren, et al., 2009, p. 39).
This results in many healthcare professionals finding it difficult to establish a working therapeutic relationship with eating disorder patients/clients, which can then lead to patient noncompliance and treatment refusal results in the patient withdrawing from treatment prematurely (Hamburg, et al., 1996; Kahn & Pike 2001).

In one qualitative study by Reid and Williams (2010), one GP compared treating the patient to treating an alcoholic in that “they’re rarely straightforward” and there is “a certain amount of denial” present (Reid, et al., 2010). This can prove to be a “major disability” in managing the individual (Reid, et al., 2010).

2.2.4 The ED patient and the Healthcare Professional.

“The patient may also affect and change the therapist”


The discomfort and lack of patience felt by healthcare professionals around managing an individual with ED is also apparent (Linville, et al., 2010). One participant in the research talked about dealing with the aftermath when the patient has died and how it can cause you to become “a lot more brittle” with new patients (Linville, et al., 2010). So this suggests that there is a reluctance on the side of the healthcare professionals to engage in the area of eating disorders.

According to research by Warren, et al. (Warren, et al., 2009), 33% of the participants felt it was difficult to handle the worry, sadness and frustration that is usually involved when treating someone with ED. As one participant noted that “it is hard to acknowledge that some might die” and knowing that made her feel powerless (Ward, et al., 2009)
This is also seen in research by Linville et al. (2010) where the healthcare professional would experience sadness and disappointment at the patients who lack motivation to recover (Linville, D. et al, 2010). One healthcare professional spoke about how for years a patient kept returning “for rehydrating.. till they drop off the face of the earth”, and how she does not get to see the success stories, the patient who has recovered (Linville, et al., 2010).

Research by Shisslak, showed how 20% of the healthcare professionals involved with treating EDs were affected by their work in terms of having an increased awareness of food and body image. (Shisslak, Gray, & Crago, 1989). This was also seen in research by Warren, et al. (2009) where 70% of the healthcare professionals indicated that their own relationship with food has changed since working with ED patients. Some said that they were more aware of nutritional values in food, of dieting and had more appreciation of food. One healthcare mentioned how she used this new relationship with food to be more vigilant in addressing food issues in the family home (Warren, et al. (2009).

In research by Burket & Schramm (1995), feelings of countertransference were explored. It was found that frustration was the most common emotion and empathy was noticeably evident with therapists who had an interest in ED. In a quantitative study by Burket & Schramm (1995), 39% of the participants involved cited the issues of transference and counter transference as reasons to avoid treating ED patients. The main countertransference issues were feelings of frustration, anger, helplessness, anxiety and empathy. The fact that countertransference was listed as a reason for not engaging in treatment with an ED patient shows that the healthcare professional realises the importance of this when working with this cohort.
Research by Warren et al. (2009) found that 20% of healthcare professionals considered relationship issues; as in building relationships, maintaining distinct boundaries and handling countertransference, as especially challenging in the treatment of ED. However, research by Ward, et al (2009) shows that healthcare professionals working in the ED field encourage personal supervision to improve self care and to help process the challenges that arise from working with ED clients (Warren, et al, 2009).

However, other research has noted that a lack of understanding by the healthcare professional is a key feature in hindering treatment (Walker, Lloyd & Aharoni, 2011).

According to Burket & Schramm (1995), the healthcare professionals consider a healthy rapport important for a successful therapeutic relationship. This has also been stressed by the patient/client themselves (Button & Warren, 2001). The truth of the matter is that this relationship may come under strain when feelings of mistrust and resentment emerge, or when rules and regulations are enforced pertaining to weight gain, eating behaviours and exercise (Burket & Schramm (1995).

2.3. Comorbidity in ED.

“It is very rare that ED patients are simply that - individuals with eating disorders”

Timothy D. Brewerton.

Comorbidity is an issue that has to considered when treating eating disorders; at the point of diagnosis and when deciding on the form of treatment. Comorbidity is effectively the “rule rather than the exception” (Brewerton, pp.286, 2007). This is especially apparent with BN (Lilenfeld,

2.3.1 Psychiatric disorders.

Psychiatric disorders are seen to be associated with eating disorders and more importantly they have a tendency to be significantly more evident than with individuals who do not have eating disorders (Touchette, et al, 2011). This can be applied to AN, BN and BED (binge eating disorder); with AN having more major depressive and generalised anxiety disorders and BN having more major depressive and mood disorders (Touchette et. al, 2011). Research has also seen social phobia, agoraphobia and manic depression are also found with eating disorders (Gadalla, 2008). Epidemiological research has shown that there is an association between eating disorders and bipolar disorder (McElroy, et al, 2001). Anxiety and substance use disorders are the most common comorbid lifetime disorders associated with bipolar disorders (BD), closely followed by eating disorders.

BD is usually treated pharmacologically with mood stabilising agents; Lithium, anticonvulsants, antipsychotics and anti-depressants (Keck, et al., 2004) While psychotherapy for bipolar disorders is proving effective, it is seen to be extremely beneficial when other disorders, like ED, are evident (Keck et al, 2004). Both disorders require specific treatment processes, so it is important for the healthcare professional to realise this and combine the treatments to tackle both disorders.
Research has produced evidence that anxiety, alcohol and drug disorders coexist strongly with BD (Kessler, et al. 1994). Similarly, this is seen with ED (Braun, et al., 2004) and has important implications for treatment. Medication for BD, especially mood stabilising and anti-manic drugs can exacerbate the eating disorder, especially BED (Brewerton, et al., 2002). Similarly if antidepressants are prescribed to manage BN or BED this could lead to hypomania, which is symptomatic of BD, as antidepressants and mood stabilising drugs are generally used in combination (McElroy et al., 2006). Therefore, it is imperative that the healthcare professionals have some understanding and working knowledge of the effect pharmacological treatment can have in order to tailor a treatment specific to the comorbid disorders.

2.3.2 Obsessive Compulsive Disorder (OCD)

OCD has long been seen as sharing a psychopathology with eating disorders. The pathological characteristics of both are similar. The obsession can be associated with food patterns and behaviours; in the case of AN the compulsion to food restriction and in the case of BN and BED, overeating and purging (Sallet, et al., 2010). The individual’s personality traits are also common; meticulousness, perfectionism and rigidity (Halmi, et al., 2005). However, research has shown that despite similarities between the the two disorders, they are clinically and psychologically distinct (Sallet, et al., 2010). Similarities were still evident at the personality level between OCD and AN patients, which suggests a possible diathesis (Jimenez-Murcia, et al., 2007). This could have implications for the healthcare professional in terms of treatment, where Cognitive Behavioural Theory (CBT) could be used to manage both disorders symptomatology.
Research has shown that 10-40% of patients with AN and 40% of patients with BN have a diagnosis of OCD (Sallet, et al., 2010, Halmi et al., 2005). It was also noted that when OCD was the primary diagnosis with comorbid ED, it had a higher clinical severity than OCD without ED (Jimenez-Murcia, et al., 2007). Other quantitative research (Milos, et al, 2001) concludes that using a structured clinical interview for DSM-IV Axis I disorders (SCID-I), the prevalence rate of OCD comorbidity in the sample population of females with ED was determined to be 28.6% for individuals with AN and 30.1% for those with BN. Hence showing, there was not a significant difference in OCD comorbidity rate between the two ED types. These findings are reinforced by a further investigation into comorbidity rates, which found OCD comorbidity rates of 37% with individuals with AN and 40% with BN (Milos, et al. 2001). Because of the issue of comorbidity, healthcare professionals must investigate those who present with anxiety disorders, depression and OCD for eating disorders and vice versa.

Treatment strategies should be put in place that address the co-occurrence of eating disorders and psychiatric disorders. In particular, the focus should be on the disorders that are highly connected to eating disorders.

2.4 Recovery in ED

“Recovery is an unique and subjective process”

Patients and clients with eating disorders can prove to be very challenging to service providers. Individuals with ED must decide to willingly engage in treatment for recovery to be possible (Hsu, Crisp & Callender, 1992). A “strong, but ambivalent, hesitance toward recovery” exists when treating individuals with AN (Nordbo, et al, 2008). Resistance to recovery and change
is common in ED (Kaplan, & Strasburg, 2009, Wright & Hacking, 2012). This is an ongoing concern for the service providers in the field.

ED patients may take many years to recover. According to research by Quadflieg & Fichter, 25% of patients still maintained BN after a 10 year follow up. Although research by Strober (1997) found that 76% of individuals were free of their physical and cognitive behavioural symptoms of the eating disorder some 10-15 years after their initial diagnosis.

According to Steinhausen, more than half of the individuals with ED do not recover and hence are in danger of developing a chronic disease (Steinhausen, 2002). Treatment traditionally incorporates a normalisation of eating disorder behaviours and patterns, weight restoration and a lengthy and intensive course of psychotherapy (Geller, Williams & Srikameswaran 2001). Although patients/clients benefit from these treatment programmes, there is a certain amount who do not (Ratnasuriya, et al., 1991).

2.4.1 Definition of Recovery- a marriage of the Psychological and the Medical.

The usual diagnostic criteria of recovery for AN has been maintaining an acceptable weight and the resumption of menses (Pike, 1998). As regards BN, the focus was on the behaviour; the absence of binge eating and purging (Jarman & Walsh, 1999). The healthcare professional and the patient are sometimes at odds regarding recovery. The healthcare professionals focus is on physical recovery and normalised eating patterns, while the patients regarded self acceptance, positive body image and the ability to express emotions as paramount (Noordenbos & Seubring 2006).
A more inclusive definition concerning recovery would be that of Peters and Fallon (1994) who “describe a multidimensional change in relation to one’s self, body, family and mind (Vanderlinden, 2007) p.927 )

Recovery is usually evaluated from a clinical perspective, mainly the reduction in medical symptoms associated with the eating disorder (Kordy, 2002) and the absence of disordered eating patterns and behaviours (Noordenbos & Seubring, 2006). A study in 1993 investigated into the wellness of the “cured” anorexic patient (Windauer, et al., 1993) by analysing the eating patterns, nutritional intake and psychopathology of sixteen weight-recovered anorexics. Windauer, et al. found that body fat and psychosocial adjustment had reverted to normal in most of the patients, but twelve still had a restricted eating pattern with a nutritional intake below 90% of their energy requisites (Windauer, et al., 1993). It was therefore concluded that the criteria that are used in determining full recovery, namely weight, menses and psychosocial conditions were not sufficient, and changes in behaviour and attitudes should also be considered. This research makes an important point for the health professional to examine all aspects of eating disorders and not just the physical. Other research has focused on the psychological aspect in recovery (Lamoureux & Bottorf, 2005).

However, research has turned its focus on the patient’s perspective of what recovery means to them.

2.4.2 Patient’s definition of recovery.

“If your weight goes up, it’s not the end of the world. It’s not so deadly serious”

Isabel, Participant in research (Bjork & Ahlstrom, 2008)

Numerous studies have been completed regarding recovery from ED, both quantitative and qualitative. Recovery as seen from the patient’s perspective revealed that the willingness to change,
professional treatment, nonprofessional care and support were factors in the recovery process (D’Abundo & Chally, 2004, Pettersen & Rosenvinge, 2002). The patient themselves defined recovery as involving body satisfaction, self acceptance and improved interpersonal relationships (Bjork & Ahlstrom, 2008). It is imperative for healthcare professionals to note that these characteristics of recovery are unique in that they differ from those of other mental disorders (Bjork & Ahlstrom, 2008). Healthcare professionals in treating ED have a tendency to emphasise the clinical and cognitive symptoms and assess recovery in an objective way rather than the subjective, and place a large emphasis on weight gain (Jenkins & Ogden, 2011). Using the research into the patient’s perspective can inform and enhance the criteria for recovery.

“I can’t run away any longer, I have to deal with many difficult situations and emotions that I previously could control with my food intake, and that can sometimes be hard.”

(Participant in Pettersen, & Rosenvinge, 2002 p. 66).

Recovery involves letting go of maladaptive coping strategies and replacing them with new ones. This involves not using binges to deal with problems and negative life events (Pettersen & Rosenvinge, 2002 p. 66).

It is imperative that healthcare professionals realise that some individuals with an ED who embark on recovery find life very difficult without their ED. This is also seen in the qualitative study by Bjork and Ahlstrom (2008), where a participant recognised that recovery involves managing emotions. Because she had “turned her feelings off” with ED, she now experiences them all, “up and down”, which can at times made her feel worse (Bjork and Ahlstrom, 2008)

The research on the patients’ perspective found that a good therapeutic relationship, which was based on empathy and understanding and “seeing the individual behind the symptoms” aided in the
recovery process (Pettersen & Rosenvinge, 2002 p 66). However, if therapy was focused on weight, this could exacerbate the disorder (Jenkins & Ogden, 2012).

Research by Vanderlinden, Buis, Pieters & Probst (2007), has shown that the healthcare professional, in this instance the therapist, is aware of what the patient/client needs as regards to treating during the recovery process treatment.

2.4.3 Full recovery in ED?

“I find the hardest part is staying hopeful and optimistic about recovery with the more entrenched eating disordered patients”


Research has questioned whether full recovery is possible in ED (Noordenbos & Seubring, 2006). According to research by Jenkin and Ogden, recovery also meant controlling the “anorexic voice” (Jenkin & Ogden, 2012, p.26), which one individual in recovery said that she believes is always present. All of the individuals in the qualitative study believed that one could attain full recovery, both physical and psychological, but they all defined the psychological recovery in different ways and expressed that full recovery means an end to obsessing about food and weight (Jenkin & Ogden, 2012). This was also the case with the Pettersen & Rosenvinge 2002 study, where despite the presence of symptoms and behaviours of ED, the participants still considered themselves recovered, hence implying that they regarded recovery as more of an ongoing process rather than a destination (Pettersen & Rosenvinge, 2002). In the same study, it was found that some individuals consider ED to be part of their life. Considering the long duration of illness, in some
instances 11 years, ED would always be there as part of “their life history” (Pettersen & Rosenvinge, 2002 p.68).

Healthcare professionals should be aware that while weight gain might be seen as a sign of recovery, it does not necessarily translate that the psychological well being of the patient has recovered (Jenkin & Ogden, 2012).

2.5 Relapse in ED.

"Once you’ve been in a bad state, you don’t want to return to it for anything in the world....but what is going to happen when I start gaining weight”


Due to the complex nature of the ED, high relapse rates are understandable in the recovery process. In some cases, the recovered individual has to be conscious of this and be aware of casual triggers (Pettersen & Rosenvinge, 2002). According to research by McFarlane, Olmsted & Trottier, a relapse rate of 41% at 12 months was observed, which is comparable with relapse rates associated with addiction, namely alcoholism and substance abuse (McFarlane et al., 2008).

Research has been completed mostly on relapse rates with regards to BN and AN. In research relating to BN, a relapse rate of 30% was found, with the vast majority of relapses occurring in the first 6-7 months of treatment (Olmsted, et al, 1994). A study undertaken in 2005 discovered that relapse rates were 32.6% for AN and 37.4% for BN. The highest risk of relapse for both ED was the same as the aforementioned study; it occurred within the first 6-7 months of
treatment (Matthias, et al, 2005). This study also attempted to identify predictors of relapse for both disorders. These predictors differed for both, with AN focusing on the degree of specialisation of the service and duration of illness whereas for BN motivation for treatment and additional treatments are highlighted (Matthias, et al, 2005).

This was also investigated in a qualitative study by Cockell, Geller & Zaitsoff, (2004) which examined the recovery after a period of hospitalisation. The clients identified several factors that hindered recovery, which included loss of structure upon returning to regular life, lack of specialised professional support, self defeating beliefs and dealing with real life. This study advocated for healthcare professionals to provide follow up care after treatment to empower and support the client and prevent them from “going back to their old ways” (Cockell, et all, 2004). Further research on relapse rates shows the complex cycle of ED and how it becomes apparent in relapse. AN individuals who were restricters tended to develop bulimic symptoms during relapses whereas BN individuals tended to retain the bulimic behaviours during relapse (Keel, et al, 2005). The outcome for recovery improved with clinicians engaging in follow-up sessions with the patient (Steinhausen & Hans-Christoph, 2002). These are factors that must be taken into consideration by health professionals when dealing with individuals afflicted with this illness. If healthcare professionals are aware of these indicators, a customised course of treatment and a strategy to prevent relapse can administered to the individual’s requirements. Relapse after remission can signify distressing and anxious times for the individual involved, that can result in a poor prognosis. It is imperative that the level of risk to a patients mental health and physical health be constantly monitored as the treatment programme develops, particularly with regards to weight changes. A healthcare professional must be sensitive to and aware of this.
In qualitative research by Bjork & Ahlstrom (200*), the risk of relapse is discussed by recovered individuals. Some participants in the study considered themselves recovered, “the eating disorder is a closed chapter” (Bjork & Ahlstrom, 2008 p. 933), and would not allow relapse to occur, while others acknowledged that while they were recovered, some crisis in the future would show if they would relapse or not. An emphasis was placed on having skills to be able to recognise that the relapse is occurring and also having support.

2.6 Conclusion of Literature review

The objective of this research is to investigate the healthcare professionals’ understanding of the ED patient and to investigate the experiences of the healthcare professional in the treatment process. With that in mind, the literature review focused on research concerning the main themes that would arise in ED treatment. This took the form of researching from the healthcare professionals’ perspective and that of the patient/client. The implication was that this would form a better understanding and insight into the area of ED for healthcare professional.

The literature review focuses on research concerning the main themes that would arise, themes that a health professional would experience in their treatment of ED.

Many themes occurred while reviewing the literature. Some of which are outside the scope of this research project. The main themes that arose were the attitudes of the healthcare professional towards engaging in treatment with the ED patient, the issue of comorbidity with ED, the experience of recovery in treatment and the experience of relapse.
A number of qualitative studies concerning the attitudes of the healthcare professional were found. These focused on the dynamic between the healthcare professional and the ED patient.

The research pertaining to comorbidity was quantitative in nature and focused on OCD and depression, where OCD was seen to coexist at a equal prevalence rate with AN and BN. The effects of pharmacological treatment of OCD and BD on ED were also investigated.

A number of qualitative studies revolve around the recovery process and the contrast between what it means to the healthcare professional and what it means to the patient.

As regards the relapse, the majority of the research regards relapse as a negative aspect of recovery. The triggers of relapse from the patient’s perspective were also examined.

However, from the literature review a number of things arose. Firstly, because of the complexity of ED, it requires a multidisciplinary team to treat it effectively. There seemed to be a minimum amount of literature where the perspective of the various professions who work in ED were investigated. This excluded Shisslak et al(1989), where the effects of working in ED were examined. A lot of the literature focuses on one discipline at a time (Flahavan, et al, 2006; Burket & Strumm, 1995; Vanderlinden, et al., 2007).

In addition, there appears to be a lack of research in this area from the Irish perspective. The primary focus of Flahavan (2006) was the general practitioner. So this will be an opportunity to investigate the experiences of the Irish Healthcare professional in the treatment of ED.

This research attempts to investigate the multidisciplinary approach in the treatment of ED and to improve the understanding between the ED patients and healthcare professionals.
CHAPTER 3: METHODS

3.1 Aim

The main objective of this research project was to obtain an insight into the healthcare professionals’ understanding of the ED patient and the experiences that feature in treatment. The perspective of the healthcare professionals in Ireland, more specifically, the Dublin area, is investigated in this research. During the interview process, questions were asked pertaining to their understanding of the term eating disorders, their experience of working in this area, issues of comorbidity, the resources available and the impact of working in this area on themselves.

3.2 Design

The type of research employed was qualitative. Meta analysis would have been preferable, as themes arising in the interviews could have been a diving broad for further empirical investigation with psychometric tests (e.g. Likert type questionnaires), and therefore broaden the research and gain more access to a bigger sample size, but due to time constraints and lack of resources and the nature of the study, qualitative analysis was preferred. This allowed for the many diverse and subjective paradigms and perspectives of the participants involved to be represented, whereas a quantitative led analysis executed via a survey, would not account for the different roles and practices of the participants. Oevermann (1979) stated that quantitative methods are only “research economic shortcuts of the data generating process” Flick (2009). However, Cicourel (1964) views quantitative methods as those that investigate macro sociological issues, and qualitative methods as those that analyse micro issues (Flick & Uwe, 2009). Cicourel(1964) regards qualitative research as “a naturalistic interpretive approach concerned with understanding the meanings which people attach to phenomena (actions, decisions, beliefs,values) within their
social worlds” (Ritchie & Lewis, 2003, p.3). Qualitative analysis also allows for the “pluralisation of life worlds” (Flick, 2009) and according to Beck (1992) presents “the growing individualisation of ways of living and biographical patterns” (Flick & Uwe, 2009), which suits the main purpose of this study. The purpose being to focus on the experiences of the healthcare professional in this specific area and through analysis to gain a deeper understanding and insight what these experiences and perspectives mean in the treatment of eating disorders.

The research design chosen enabled the researcher to use the context-specific data collected to address the initial research question. As the research design is qualitative, inductive reasoning is used. The main tool for data collection was an in-depth semi structured interview process. Interviews are “a key venue for exploring the ways in which subjects experience and understand their world. It provides a unique access to the lived world of subjects, who in their own worlds describe their activities, experiences and opinions.” (Kvale, S., 2007)

The design will be flexible and the setting will be natural rather than experimental. In 1969, Maxwell stated that design in qualitative research may have to be modified in reaction to the research setting. Therefore, the research design here is a continuing process with constant reviews and monitoring.

3.3 Materials.

The interview consisted of about 12 open questions, which ranged from their understanding of eating disorders, their experience and the resources in the area (See appendix 3). However due to the nature of the semi structured interview, a conservational style was established, which enabled a
certain level of engagement between the interviewer and interviewee and allowed for additional
questions to be asked in a more natural style.

The interviews were recorded using a dictaphone and an iPhone. It was hoped that these recording
device would not intrude on the interview process and a naturalistic setting could be maintained

3.4 Participants

Sampling is limited to specific criteria. A specific disorder is being investigated, involving a
specific cohort who treat this specific disorder. This leads to purposive sampling, where
participants are chosen based on the fact that they reflect certain characteristics of interest (Carter,
& Henderson, 2005). In this case, the inclusion criterion was namely that they are healthcare
professionals who work in the realm of eating disorders.

The number of participants involved in this qualitative study totaled nine, one Dietician, two
Clinical Nurse Specialists, one General Practitioner (GP), two Psychiatrists, three psychotherapists.
These individuals predominantly specialise clinically and/or psychologically, in the treatment of
eating disorders. Their role in the treatment of eating disorders ranged from diagnosis to
management to recovery and education. Each of the participants are currently employed in private
practice, eating disorders counseling centres/clinics, eating disorder support organisations, or in
eating disorder units in private or public Hospitals, which cater for both inpatient and outpatient
requirements. It was important to recruit individuals who represented the diverse disciplines in the
treatment of eating disorders.
3.5 Data collection

The researcher approached a number of individuals who worked in the area of eating disorders. The researcher found these individuals usually via the internet and eating disorder support websites and through specialist services and hospitals. This was completed by email and phone. A cover letter and a letter of consent was designed by the researcher and distributed to these individuals, who expressed an interest in participating (See Appendix 2). In addition to this, a letter of access from Dublin Business School was also sent (See Appendix 1). The cover letter introduced the researcher and contained information detailing the purpose of the research. The letter of consent further outlined the research objective and the requirements of the research. The participants were contacted by email and phone and arrangements for the interviews were subsequently made. Prior to conducting the interview, the participant was asked to read and sign the letter of consent, which they retained. On the day of the interview, a second copy of the letter of consent was signed by the interviewee, which was kept by the researcher.

3.6 Procedure

The interviews were conducted at the premises of work of the participant or a location of the participants’ choosing. The interview time ranged from 40 minutes to 1 hour 30 minutes depending upon each participant, where each participant was asked the core 13 questions. The interviews were recorded using a dictaphone and an iPhone with the participant’s consent. After each interview, the researcher asked the participant to reflect and enquired about any concerns the participant may have as a result of the interview. It was repeated that they could withdraw at any stage of the research project. The interviewer followed up with the participants through email and texting and thanked them for their involvement in the study.
The interview files were transferred onto the researcher’s password protected computer and then transcribed verbatim. To ensure total confidentiality and anonymity in the research, pseudonyms were assigned to the 9 individuals. This was applied to the organisations they represented or with which they were affiliated.

3.7 Ethical Considerations.

The main ethical issue as outlined by the APA and PSI association is that one must not cause harm. It must be remembered that service providers are human too and one cannot take for granted that just because this is their role/occupation does not mean that they are not affected by it. At the same time, a distance was maintained. The researcher’s role is not one of therapist or counsellor. In an interview, when one is asking questions, an issue of power can arise. One has a duty of care and must be careful not to abuse the situation or the data collected. Before and after the interview, it was emphasised that the participants involved could withdraw at any time without giving a reason to justify themselves. Confidentiality was paramount. In the arena of Psychotherapy-therapist: client confidentiality, and Medicine, Doctor-Patient confidentiality, one would not like to threaten this bond. The information obtained would be treated with utmost confidentiality and respect, and complete anonymity would be given in terms of the participants and the organisations that they represented. The Belmont Principles were adhered to throughout the research (http://ohsr.od.nih.gov/guidelines/belmont.html). Through these measures, welfare and respect for the rights of the participant were maintained.

After the interview, the researcher contacted the participants and thanked them for their contribution.
3.8 Data Analysis

In 1969, Maxwell stated that design in qualitative research may have to be modified in reaction to the research setting. Therefore, the research design here is a continuing process with constant reviews and monitoring.

The transcribed interviews, the data set, were imported into NVivo, a qualitative programme, where the interviews were coded. The process used to extract this data is thematic analysis. Thematic analysis main purpose is to identify, analyse and disclose themes within the data. Thematic coding is a multi stage process. It involves cross checking and comparing interviews. From the hierarchical coding, through the use of free nodes, numerous themed were seen.
CHAPTER 4: RESULTS

4.1 The participants and the themes
“Everyone to a certain extent engages in some sort of disordered eating, where that crosses over to an eating disorder would be where the compulsion comes in... a person has to keep doing it in order to feel ok”
(Patti, psychotherapist & service co-ordinator).

Table I. The role of the Participants in ED treatment.

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Practice</th>
<th>Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helen</td>
<td>Psychotherapist and ED trainer</td>
<td>Private</td>
<td>Self</td>
</tr>
<tr>
<td>Hannah</td>
<td>Psychiatrist and Psychotherapist</td>
<td>Private</td>
<td>Self</td>
</tr>
<tr>
<td>Mary</td>
<td>Psychotherapist</td>
<td>Private</td>
<td>Self</td>
</tr>
<tr>
<td>Karen</td>
<td>Nutritionist</td>
<td>Private</td>
<td>Self</td>
</tr>
<tr>
<td>Tom</td>
<td>GP</td>
<td>Private</td>
<td>Self</td>
</tr>
<tr>
<td>Rachel</td>
<td>Clinical Nurse specialist and programme co-ordinator</td>
<td>Private and Public Hospital</td>
<td>Medical</td>
</tr>
<tr>
<td>Michael</td>
<td>Psychiatrist</td>
<td>Private and Public Hospital</td>
<td>Medical</td>
</tr>
<tr>
<td>Rose</td>
<td>Clinical Nurse specialist</td>
<td>Private and Public Hospital</td>
<td>Medical</td>
</tr>
<tr>
<td>Patti</td>
<td>Psychotherapist and support co-ordinator</td>
<td>Private</td>
<td>Self</td>
</tr>
</tbody>
</table>
There were a number of overriding themes that arose in the research project. Each participant spoke at length on issues pertaining to their experience of dealing with ED patient, and the complexity of eating disorders, especially concerning comorbidity and their experiences of recovery and relapse in ED.

### 4.2 Attitudes of Healthcare Professional to ED.

“My Job is to hold up the mirror to the client so they understand exactly what they are doing, they understand that this is a choice they are making and they alone are responsible for the consequences of that choice”

(Mary, psychotherapist, 2012)

#### 4.2.1. The Healthcare professional: The opposite of ambivalent

The participants have been working in the area of ED from 2-15 years. All of the participant were quite happy in their employment. They all acknowledged that although the ED patient can be difficult and “can have a lot of baggage” (Tom, GP, 2012), it did not deter them from remaining
working with ED patients. Two of the participants said that they “just get it” (Helen, psychotherapist & Mary, psychotherapist). Patti was a psychotherapist in her own private practice, but also worked in a voluntary ED support organisation. Tom, the GP, was actively involved with an eating disorder clinic in addition to his own GP practice. Four of the individuals were also involved in maintaining support websites for ED. One of the participants worked way beyond her core hours unpaid, but accepted that because the area is short staffed, “someone has to do it”.

No ambivalence or reluctance to work with ED patients was evident. All participants displayed a great deal of understanding with the ED condition and expressed a wish of remaining in the field for the foreseeable future.

4.2.2 The ED is difficult to diagnose

“They body language is all twisted...arm, legs... trying to make themselves as small as possible and as invisible as possible”
(Hannah, psychiatrist, 2012),

“They don’t want to be here...they cannot relax and are fidgeting and jumping out of the chair” (Rose, clinical nurse specialist, 2012).

“Even if the diagnostic criteria add up, the individual with ED won’t admit it”
(Tom, GP, 2012)

Tom, GP, would sometimes find that he had to play “good cop, bad cop” with ED patient to find out what is going on for that individual. Michael referred to the fact that some usually know, “they hear what you say, process it, and then throw it away” (Michael, psychiatrist, 2012).

Tom would find that some individuals with ED would come to his practice, usually at the behest of the family, and “shout and scream... and deny, deny, deny”, others be relieved, because “they know
now it’s out, someone will be take the reins and take control” (Tom, GP, 2012). However, he also acknowledged that this may be the case one day, but the next will be different as the ED patient is very “conflicted”(Tom, GP, 2012). According to Tom, in the early stages, “the ED patient is not compliant or forthcoming with their case history”(Tom, GP, 2012). Tom believed that the way you approach the ED patient about the ED is important. He said that he does not use any Eating Disorder Examination, as there is a high risk of the ED patient lying to him, so he “uses the human touch and talk”, which he reckons that the ED patient responds to this rather than filling out a questionnaire. As Tom, the GP, stated how you deal with it depends on “how tactful you are at bringing the elephant in the room”(Tom, GP, 2012).

4.2.3 ED patient is challenging

“It is so so challenging.. you either love it or hate it. They are going to question you and tell you black is white and then black again. They will question your whole identity”

(Rose, clinical nurse specialist, 2012)

Rachel describes how the patients were“so exacting and place huge demands on you”(Rachel, clinical nurse specialist, 2012) Karen spoke of the fact that the “mistrust” that was evident when people present to her. Karen did not prescribe “a set diet”. These people are dealing with a patients/clients who are “resistant to changes in food patterns” and to put these demands on them is not a welcomed prospect.

Patti, psychotherapist, also considered herself not to be there “to fix someone”, she doesn’t give the client the solution, the solution is in them, we do not tell them what to do, we just guide them to it”

Due to the challenging nature of the work, frustration obviously was a factor with the health professionals, Tom, the GP, felt that sometimes he “was banging his head against the wall” and
Rachel, a clinical nurse specialist, said that at times it could be “a battle of wits” and that the patients could “run rungs around you”, especially around mealtimes. She recognised that they will “think of any excuse to avoid it, and it is down to you to be firm and patient” (Rachel, clinical nurse specialist, 2012). She also talked about when a client continually breaks a contract of treatment in the inpatient or outpatient setting, resulting in the patient being removed from the programme, the patient will blame it on the staff. On this Rachel said that the ED patient usually sabotages it themselves, because they are not ready to engage in treatment.

Rachel spoke of how you “don’t want to antagonise the situation, I am not looking to do battle with them, as they already have too many people nagging them”, but recognised that if they enrolled in the programme and ready for treatment, “it isn’t a holiday” (Rachel, clinical nurse specialist, 2012).

The challenging nature of the ED was acknowledged by all participants. However, they “did not take it personally” (Hannah, psychiatrist, 2012) if a ED patient was angry or resentful towards them as they expected it. Although frustration was sometimes existed, there was an overall sense of acceptance and duty of care toward the ED patient/client.

In treatment, ED patients “do enough to stay out of trouble rather than get back to a healthy weight” (Michael, psychiatrist, 2012) or “stay floating around the minimum weight” (Rachel, clinical nurse specialist, 2012). Tom also acknowledged this how the “individual would load up on water” before being weighed. Rachel, who worked in the inpatient setting, remarked that individuals with ED will try and fight the treatment by a multitude of ways. She gave the example about when a patient does Rachel would see individuals supposed to be on bed rest running up and down the corridor because they did not want gain weight.
Four participants referred to instances when they had to terminate therapy with individuals with eating disorders as they were “no longer holding up their end in the contract” (Mary, psychotherapist, 2012). And with this brings disappointment and sadness, but there remained a degree of acceptance, as ”it is all part of the process” (Hannah, psychiatrist, 2012).

Tom, GP, also gave an example how patients would manipulate treatment by declaring that “if I don’t get my own way on this, I am actually going to kill myself” (Tom, GP, 2012). Helen, does not believe that the patient is being manipulative and consider it is “the disorder that is manipulating the patient” (Helen, psychotherapist, 2012).

4.2.4 The ED patient is in denial

“For the first three, four, five stages of therapy, they will still disagree that they have an eating disorder” (Rose, clinical nurse specialist, 2012).

“There is a lot of bargaining and just keep climbing up that ladder step by step, bit by bit. You have to be careful though, because if you aim to too high, it’s not going to happen... take little steps and the eating disorder is less likely to reject it” (Tom, GP). This was also acknowledge by Patti, psychotherapist, about how “you spend your time negotiating from one situation to another” (Patti, psychotherapist, 2012).

The participants agreed that at the early stages of treatment, the ED patient does not want to engage, which shows the resistance to treatment that exists. However, Helen realises that it is hard for the ED patient to relinquish the eating behaviours, so obviously they are going “to protect the eating
disorder part of themselves” (Helen, psychotherapist, 2012). Patti, psychotherapist, is in agreement with this and said that “the behaviours are coping mechanism...when they are taken away, the individual has to face the problem” (Patti, psychotherapist, 2012). Patti said that the ED client would downplay the situation. Patti also stated that other psychotherapists, who are not used to working in the ED area, would get extremely frustrated and angry, and she could understand this as the patients “can take their toll on you” (Patti, psychotherapist, 2012) and would not realise the serious medical and psychological implications of the ED.

Patti, psychotherapist, emphasised how important it was to “be grounded and comfortable in your own skin”, because the very nature of ED is to avoidance and to deflect everything back to the therapist, so it can become extremely challenging. Hannah, psychiatrist, also agreed with this and said that you would be “tested to the max” and “every word you say will be scrutinized” (Hannah, psychotherapist, 2012).

Six of the participants spoke how during treatment the ED patient/client would question their ability in dealing with ED and even go so far as to ask whether they have had ED. However, most of the participants realised that this was down to projection, and that they “have to hit out at someone, so why not me” (Helen, psychotherapist, 2012).

4.2.5 The ED patient is time consuming

All the participants agreed that there was “no quick fix” (Tom, GP, 2012) and that whatever form of treatment was used that it was “a very long process, ” which required a lot of effort and commitment from them, possibly their family and the therapist. The majority of the participants spoke on how
they were seeing some patients/clients for years. Michael stated that when he see someone come in that has an eating disorder, “you know that you will still be seeing them in a years time, prepare yourself for a long haul” (Michael, psychiatrist, 2012).

Tom, the GP referred to the fact that for some GPs, as the initial primary care physician seen by the patient, it can be hard as someone with an eating disorder may need at least an hour “rather than 10 minute slots”. This was also registered with Rachel, the clinical nurse specialist, who spoke how patients’ attitudes to GPs were that they did not “understand them” and they “only give them five minutes” (Rachel, Clinical nurse specialist, 2012). This was similarly expressed by Helen, who remarked on the ED training GPs get “ a half an hour in the whole course”, this in turn leads to individuals going “what’s the point in going?” (Helen, psychotherapist, 2012).

4.2.6 ED and healthcare professional relationship

It’s not really about what I think an eating disorder is, it’s about me being able to occupy a position of ignorance in terms of what other people’s stories are, because only then will they tell me what it is like for them” (Patti, psychotherapist, 2012).

Rachel considered her patients as “really inspiring people, who are in a distressed place at this point in her life” and she from them and they learns from me. (Rachel, clinical nurse specialist, 2012). Michael (psychiatrist, 2012) talked about how he was continually learning something new and his job was”never boring”(Michael, psychiatrist, 2012).
Patti believed that treating individuals with ED is about believing in a dynamic that allows people to not feel threatened to understand we can listen, and validate their feelings.

Patti, Helen, Mary, Rachel and Karen all spoke of the impact of working in ED on themselves. Patti considered herself to be more aware about nutrition and people’s eating behaviours to the point that maybe she is “too sensitive” about it. She referred to her young daughter in this respect. Mary also spoke of family life and how you have to represent what a real life looks like to a ED client, in that while she retained her boundaries, she did not exactly hide things about her personal life from the patient. She gave an example of a wedding ring or discussing pregnancies. Helen commented on how consuming ED work can be, and that she has to remind herself to take a step back.

Mary talked about how she “could not do this job in isolation”and how she could not maintain this job if she had a family. Her role was that demanding. Tom, the GP, said he “has heard every story, every lie” and he now “knows every trick in the book”. While he can accept “this is part of the illness, he know does not believe everything he hears”(Tom, GP, 2012)

All of the psychotherapists and one of the psychiatrists were very active with their formal supervision, which they found extremely useful, especially, if an issue of transference arose in a therapy session. The remainder of the participants had the support of the multidisciplinary team, which they considered vital to their work and their own well being. Rachel said that it is this support that keeps her sane.
4.3 Comorbidity in ED

“It’s a question of which comes first, the chicken or the egg”


All of the participants involved had experience in comorbidity. Clinical depression, OCD, anxiety disorders and Aspergers syndrome (Rose, clinical nurse specialist, 2012) were the main disorders mentioned that would coexist with the eating disorder. Because depression, anxiety, and obsessional behaviours are characteristic of ED, all of the participants would monitor the situation, before using intervention in the form of medication. Michael talked about his experiences of comorbidity with ED and was of the opinion that though the disorders may evolve in tandem, the eating disorder would probably be “the most alarming one” and therefore would present first.

4.3.1 Psychiatric disorders

Tom, GP, in his experience he has seen BN, BED and AN coexisting, with depression, he sees them as going “hand in hand with each other” (Tom, GP, 2012). He referred to how with BN and BED, usually have depressive symptoms as with these particular patients, there is a considerable amount of self punishment present. Michael agreed that as regards clinical depression, this was more likely to coexist with BN.

In Mary’s experience, depression would feature, especially with AN. Mary, who mostly works with adults, also referred to times when “someone is in such a low state that cognitively they cannot take onboard what we’re talking about” and that there could be “no change for a long period of time... with the low mood persisting”. That is when Mary would suggest a visit to the GP so it can be investigated if it is the symptom of the ED or if it is a coexisting illness.
Rose, a clinical nurse specialist, spoke on how they try to work with medication “as little as possible”, but if someone was “absolutely stuck in depression” whether it is the result of the eating disorder or seen to be the primary illness, antidepressants, such as SSRIs might be required in order “to take the edge of that intense anxiety that is preventing them from working ... and allowing them to be more available for therapy” (Rose, Clinical Nurse Specialist, 2012).

However, Mary would be more interested in using “the food is medicine approach”, as she is of the opinion that these coexisting disorders could be due to the lack of food and “obsessing ritualistic eating habits” (Mary, psychotherapist, 2012).

Michael, the psychiatrist, would have more experience with Bipolar disorders and ED, most particularly with Bulimia. In some cases would prescribe Prozac or Zoloft and/or Lithium, depending on the stage in the Bipolar disorder. If he is administering an antidepressant for BD, although it might be beneficial for BN, it could prove to be detrimental to BD. “A happy balance of medication” has to be achieved. (Michael, psychiatrist, 2012).

In some cases Michael would feel the need to administer anti-psychotics, but if a patient with AN and acute depression, he acknowledged that one of the side effects is that it increased appetite, so weight gain for an AN patient or even a BN, BED patient would be an issue for the patient and increase anxiety.

Depression and panic attacks are side effects of the disorders, so all participants opted to monitor the eating disorder situation to see if the other disorder would dissipate. Patti, psychotherapist, remarked that when the eating disorder, especially AN, “stops working for you, then you will see the depression” (Patti, psychotherapist, 2012), and in that case antidepressants, such a SSRI have to be administer to tackle the clinical depression, so “that the ED part of the individual can be engaged” (Rose, clinical nurse specialist, 2012).
4.3.2. Obsessional Compulsive Disorder

“Starvation does awful things to you”
(Rose, clinical Nurse Specialist, 2012)

Rose has seen a lot of patients who have presented with ED and have very severe obsessional traits. However, she recognised that this could be down to the type of ED. With AN, traits that were previously present, become more severe as a result of the starvation and “are amplified by 1000” (Rose, clinical nurse specialist, 2012). Michael, also talked about OCD and AN presenting together, and “sometimes CBT is not enough”, especially when the OCD appears to be the primary illness.

Tom, the GP, received many ED patients in his practice that have obsessional compulsive traits. In these cases, if psychotherapy, has not resolved the obsessional traits, he would medicate using Olanzapine. He has had a lot of mixed diagnosis and with medication, “this can be a minefield as you don’t want to prescribe a drug to counteract the side effects of another drug” (Tom, GP, 2012)

4.3.3 Reluctance to Medicate.

Five participants out of the ten could actually prescribe medication; Two psychiatrists, two clinical nurse specialists and the General practitioner. Although the psychotherapists could not prescribe medication, they would suggest that the client should visit the GP.

Mary, psychotherapist, expressed her frustration at the over diagnosing and overmedicating that exist, particularly at the primary care level, before any underlying investigation is done. Helen stated that medicating the patient/client was akin “to dulling the signal and masking the problem” (Helen, psychotherapist, 2012). Helen gave the example of a client presenting with AN
and acute obsessional compulsive symptoms, where she would engage in intense behavioural therapy to treat the OCD.

Hannah, the psychiatrist, though she was reluctant in prescribing medication before the coexisting disorder has been investigated, “You can’t be prescribing for the sake of it…what is it going to achieve?” (Hannah, psychotherapist and psychiatrist, 2012) She gave the scenario of an individual presenting with a BMI of 14 and displaying extreme depressive symptoms and expressing how they “can’t do anything…. have no energy” and their “life is nothing anymore” (Hannah, Psychiatrist, 2012), she would certainly consider it, but then again “the body lacking in energy might not be able to metabolise this medication” (Hannah, psychiatrist, 2012), but as the individual was so severe in her presentation, she would administer the drug anyway “as a trial run for the short term”.

Rachel was also of the opinion that food is medicine as “starvation is a big thing, so you have to re-feed them in order to help them to work psychologically so you can see what is going on” (Rachel, Clinical Nurse specialist, 2012). She favoured the “food is medicine” approach and referred to the Ancel Keys Minnesota Starvation Study, where starvation resulted in significant increases in depression and hysteria. After this treatment, if one needs to go down the pharmacological route, “the body is now in a position to work with the drug” (Rachel, psychotherapist, 2012).

Karen, nutritionist, and Rose, clinical nurse specialist, also mentioned other disorders, schizophrenia and Aspergers.

There was general consensus among the participants that OCD and anxiety disorders were the most prevalent disorders that coexisted with the ED. Two participants, Rose and Karen, referred to other disorders, Aspergers and schizophrenia.
4.4 Recovery in ED.

“Recovery progress isn’t straightforward at all., things can happen, which are challenging for the person, life can and does happen” (Rachel, clinical nurse specialist, 2012).

Recovery is seen as “building up a sense of themselves that is strong enough that they don’t slip back to eating disorder part” (Patti, psychotherapist, 2012)

4.4.1 The Healthcare Professional’s definition of Recovery.

Everyone had their own definition of what recovery is and what is involved. This was voiced by Rose, clinical nurse specialist. “The harsh reality is that recovery takes a long time, and what works for one, might not work for another” (Rose, Clinical Nurse Specialist, 2012). This was shared by the majority of the participants. There is “no quick fix with eating disorders” (Mary, psychotherapist, 2012). All agreed that the recovery process was different and there was not one standard treatment that he individual could follow. In that sense it seen as very individualistic.

With regards to recovery, the participants discussed two main aspects; the medical and the psychological. There are two aspects to recovery, one is physical “healthy weight, blood and cardiac, endocrine functions and an absence” (Michael, psychiatrist, 2012).

When asked for a definition of recovery, while mentioning the medical aspect, most of the participants focused in the psychological aspect of the eating disorder, a change in the behaviours, especially concerning bingeing and purging, a reduction in the negative thinking, being more relaxed, an increase in self acceptance (Helen, psychotherapist, 2012) being more spontaneous (Patti, psychotherapist, 2012), being more social, “wearing a pair of jeans” (Mary, psychotherapist, 2012), not caring or remembering what you ate two weeks ago” (Rachel, Clinical Nurse specialist, 2012). All participants across the disciplines did cite some example of normal living. Helen viewed the endpoint of recovery as when the “person does not react to their life by using food and their body”. Most of the participants used CBT when dealing with individuals with ED. This was
reflected in the fact that seven of the participants spoke of recovery as learning new coping mechanisms and “reprogramming oneself” (Hannah, psychiatrist, 2012).

The participants from the inpatient and outpatient hospital setting emphasised the importance of the clinical picture in recovery; weight normalisation, menstrual regularity, normal ECG, blood results, and reduction on physical symptoms. The importance of healthy cognitive functioning was also vital to the recovery process. However, this emphasis on weight could be due to those particular participants exposure to more severe cases, which involve a certain amount of re-feeding and intense treatments.

4.4.2 Full Recovery in ED?

Most of the participants were of the opinion that an individual can gain recovery. However, the participants definition of full recovery differed. Karen, a nutritionist believed that the eating disorder, especially BN, is “still there in the background” and that clients, who “are well enough” say that “it is always there” as there is “an awareness not to put on weight” so recovery isn’t “100%” (Karen, Nutritionist, 2012). Karen compared it to an addiction; “the ED behaviour is always there even though you’re not doing it anymore” (Karen, nutritionist, 2012) Tom, GP, agreed with this “trait” concept and in his experience he found individuals with AN to recover more than those with BN or BED. (Tom, GP, 2012).

Patti also viewed the eating disorders like “an addiction” in that they have that “progression, the preoccupation and the social isolation” (Patti, 2012). However, Patti considered eating disorders as being different from the disease model of addiction, where “once an alcoholic, always an alcoholic” (Patti, 2012). She disagreed with Karen, and is of the opinion that an individual with an eating disorder can reach recovery, and “not in the sense that they will always be a person with an eating disorder, who just does not engage in the behaviours... they would be fully recovered” (Patti, 2012). She acknowledged that recovery is very difficult as there is “huge anxiety
and panic around taking this step toward recovery.” (Patti, 2012). Hannah believed that recovery is possible, but individuals with ED, particularly AN, resist the idea. She calls it “a balancing act between the anorexic voice and the individual themselves” (Hannah, psychiatrist, 2012).

Helen believed in full recovery. She was talking from experience as she had an eating disorder and she has “never gone back”. She disagreed with the concept of “an anorexic voice” and the view of the ED as “a life sentence” (Helen, 2012). She considered it harmful to the client if “a dynamic is set up with the therapist or doctor does not believe you can recover” (Helen, psychotherapist, 2012).

Rachel has has experiences of recovery. However, she emphasises the amount of time it can take, especially in the hospital environment, which can be compared to “a revolving door” (Helen, psychotherapist, 2012) in terms of treatment. All of the participants had experiences of patients and clients’ recovery, but it has to be noted what their idea of recovery, despite fulfilling the diagnostic criteria, might be completely different one to another.

4.5 Relapse in ED

4.5.1 Relapse as part of ED recovery

“You nearly wait for the relapse” (Mary, psychotherapist, 2012)

“Personally, I would see the relapse as part of the picture of having an eating disorder..... it just shows the complexity of the disorder” (Rachel, clinical nurse specialist, 2012)
As the above statements show, there was general consensus amongst the participants that relapse was a feature of the recovery process. All the participants expected it and Karen, a dietician, even remarked that if a person was not talking about a relapse, that she “would think something was amiss” (Karen, dietician, 2012). Patti also considered that once a client started to talk about having a relapse, she would take that as a sign of a progress and of a healthy therapeutic relationship, where the therapist: client dynamic was not set up where the client was “trying to please the therapist” (Patti, psychotherapist, 2012) The idea of having “the perfect recovery” was discussed by five of the participants (one clinical nurse specialist, the GP, one psychiatrist and two psychotherapists) This was common behaviour with ED clients, especially those with AN, where perfectionism is key, so these participants would catch out for “subtle signs of relapse” (Hannah, psychiatrist, 2012).

All participants said that it was important that once a relapse occurs, “draw a line under it and move on” (Mary, psychotherapist, 2012), but it is important to see how the patient handles the relapse. The important aspect of the relapse is not the relapse itself, but what to do with it. As Helen stated “Don’t let the relapse become a collapse” (Helen, psychotherapist, 2012).

Relapses can happen and there would be “a waxing and waning, where a person can well for a period of time, then return to certain behaviours and psychopathology, but it important they realise it and get “a top up treatment” (Michael, psychiatrist, 2012)
4.4.2 Relapse - The Positive

“I expect people to lapse because lapsing is quite motivational because it’s just another tool to be put in the toolbox, it’s another opportunity to learn something about yourself.”
(Helen, psychotherapist and ED trainer, 2012).

Relapse can happen at any stage and most participants thought it was important to frame it in a positive light in that the patient/client has been presented with “an opportunity to learn about themselves” (Tom, GP, 2012) and how “one purge does not mean that you have ruined your life” (Hannah, psychiatrist, 2012). Four of the participants referred to the lapse management model and all were in agreement that relapse was essential to the road to recovery. “They have to relapse within the treatment because we have to work out how they deal with that lapse and relapse” (Mary, Psychotherapist, 2012). Relapses present the opportunity for the Healthcare professional to teach lapse management to the client/patient. This was seen as “vital” for recovery and “an important skill” (Helen, psychotherapist, 2012) for the client/patient to employ, especially with triggers, in high times of stress or emotion, there is always a danger that they will relapse, so we have to equip them with the appropriate tools” (Mary, Psychotherapist, 2012). Lapses in recovery should be viewed as “a positive learning experience rather than a negative one” (Helen, psychotherapist, 2012).

4.4.3 Relapse - The negative

“The patient shouldn’t panic as we have worked through this before and we can work through it again... it might even be easier the second time round”.
(Tom, GP, 2012)
However, seven of the participants discussed how the patient/client would feel like they have “failed” (Rose, clinical nurse specialist, 2012) and that feel frustrated because they find it hard to motivate themselves and “get back on that road again” (Michael, psychiatrist, 2012). Karen noted that for some patients relapse was very “demoralising” (Karen, dietician, 2012). Tom, GP, discussed how if a pattern of relapses occurred, that would cause him to “worry” and he would investigate what is triggering the patient’s relapse (Tom, GP, 2012).

4.4.4 Relapse and types of ED

The majority of the participants spoke about relapse and BN or BED. Six out the nine participants spoke about AN, but it was observed that BN and BED were the most common types of that were prone to relapse.

Helen noted that in her experience, when patients who have recovered from AN relapse, they feel compelled to binge and purge. “It’s almost like the body remembers that restriction happened in the past, and when the person starts eating, the body wants her to keep eating in case there is a time when she restricts again” (Helen, psychotherapist, 2012).

4.4.5 Causes of Relapse

Tom spoke about how “changes in routine or going from one job to another” could trigger relapse in the ED patient. Helen equated relapse with major life events, “marriage, a death in the family or anything that will cause anxiety” (Helen, psychotherapist, 2012). Patti referred to lack of support from the family and “stress in daily life, be it financial or otherwise” as contributing to relapse.

Rachel, clinical nurse specialist, referred to the high rates of relapses on the hospital programmes. While she accepted relapses, she also made the distinction between “a proper relapse”
and one where the patient is being uncooperative and not agreeing to the terms of the contract of treatment (Rachel, clinical nurse specialist, 2012). She also remarked that a patient may leave the programme, and then return six months later as they cannot deal with the problems in the outside world (Rachel, clinical nurse specialist, 2012). Mary, psychotherapist, also acknowledged how some people can get “comfortable relapsing”, but this was not seen as surprising as it is similar to “going back to an friend who you realise is also your enemy” (Mary, psychotherapist, 2012).

Therefore the research has shown it is acknowledged by all participants, that relapse happens, and especially, “in times of high stress and emotion”(Karen, dietician, 2012), life events can occur and the individual has to learn to deal with them accordingly and be comfortable in looking for support.

CHAPTER 5 : DISCUSSION WITH REGARDS TO THE LITERATURE REVIEW

5.1 Attitudes of the Healthcare Professional

Contrary to Burket and Schramm’s (1995) research, the participants in this research do not have a negative attitude to working with ED patients/clients. The individuals have been working in the area from 2-16 years. However, Burket and Schramm’s (1995) research dealt with therapists, where as this research deals with people from various disciplines who play a role in the treatment of ED. According to research by Flahavan’s(2006), the diagnosis of ED is difficult. This is in agreement with this research. However, the primary care physicians were the main focus in Flahavan(2006) research.
The findings in Williams and Leichner (2006) research counteract what is evident in this research. Despite the challenging aspects of the participants’ work, they still found it interesting and informative. However, the individuals in the Williams and Leichner (2006) research, were also working with general caseloads in the hospital environs. All the participants in this study had a special interest in ED. That is not to say that they were solely confined to treating individuals with ED, but they were chosen specifically because they were known to work in the ED area.

The findings did not support Vandereycken (1993) view that ED patients were impostors. The participants in this study expressed how the ED was a serious illness.

All of the participants experienced frustration at one time or another, but there was also an understanding what the ED entailed. Although this study agrees with Linville et al., (2010) research as regards the time consuming aspect of ED, it disagrees with the idea using that reason to avoid working in ED. This study concurs with the research (Warren, et al, 2009) pertaining to treatment resistance.

Another aspect of Linville et al (2010) research dealt with the healthcare professional being uncomfortable with the ED patient. This was not apparent in this study, with all participants appearing comfortable and having good therapeutic relationships with their patients/clients.

In keeping with research by Warren et al (2010), all participants in this study had a support network that was important to them, be it in the guise of formal supervision or a colleague. In the case of transference, some of the participants acknowledged that it did exist.
5.2 Comorbidity

All of the participants involved were aware or had experience dealing with comorbidity in ED. The fact that all of the participants had first hand experience with these disorders supports Brewerton’s (2007) research where comorbidity and ED is more “the rule rather than exception”. The disorders that were most prevalent in the clinical and therapeutic setting were OCD, depression and bipolar disorders. These present findings are in line with retrospective and current research (Touchette, et al, 2007).

However, despite research (Milos, et al, 2001) showing that there was no significant difference in the prevalence of the OCD between AN and BN, the researcher found that the participants were more exposed to treating individuals with OCD and AN.

As regards medication, it should be noted that three of the participants wanted to do adopt the “food is medicine” approach, particularly in the case of AN, before medication was administered.

5.3 Recovery in ED

All of the participants spoke how recovery was very individualistic and depended on the individual themselves as well as the type of ED. This was in keeping with research which dealt with the patients perspective of ED (Pettersen & Rosenvinge, 2002).

In accordance with (Noordenbos & Seubring 2006), all the participants displayed a good insight into what recovery means for the ED individual. It was evident with regards to how the therapists in that study and the therapists in this study agree that some criteria for recovery, for example, regular menstruation was considered to be last important, where in this study, it was listed
by one of the psychiatrist’s as being one of the criteria for recovery. It has to be noted though that
the study by Noordenbos & Seubring (2006) focused on the therapist’s idea of recovery, while in
this study, a multidisciplinary view was investigated in terms of therapists, general practitioner,
clinical nurse specialists and psychiatrists.

In this study, the participants who worked in a hospital setting, focused mainly on the weight
normalisation and secondly on the psychological aspect and this correlates with research on the
diagnostic criteria of recovery of AN (Pike, 1998). There was an acknowledgement by all
participants that both aspects have to be investigated for a successful recovery and this relates to
research by Windauer et a, (1993). The research by Bjork and Ahlstrom (2008) is also relevant as
the participants displayed having a understanding of the unique characteristics of recovery as
expressed by the ED recovered patient.

The question of full recovery discussed by the participants is in keeping with qualitative
research (Jenkin & Ogden, 2011 Pettersen & Rosenvinge, 2002) where it is shown that patients
define recovery in different ways. Again Pettersen & Rosenvinge (2002 ) qualitative research
showed that given the duration of the illness in some cases, some clients considered that the ED
would always be a part of their history and food intake would always have to be considered.
However, the researcher found that while the majority of the participants agreed that there would be
a “trait”, one participant strongly disagreed. The fact that this one individual had recovered from
ED might be a route worth investigating.

5.4 Relapse in ED

Most of the quantitative studies in relapse focus on the high rates in ED treatment (Matthias,
et al, 2005). This was in accordance with the participants, who all experienced high rates in the
practices. The most common type of ED to relapse was BED and BN. However, in previous research, AN and BN were seen to relapse at similar rates (Matthias, et al, 2005). However, BED was not included in this 2005 research.

Regarding the type of ED that is engaged in relapse, the research was in agreement about the AN presenting with bulimic tendencies (Keel, et al, 2005). However, it should be noted that in the researcher’s study, only one participant referred to this.

According to the literature, relapse is recognised as a negative aspect in the recovery process. It seems to represent a failure of treatment and is not seen as being essential to the recovery process. This was not the case in this present study, where the relapse was seen as motivational force as it allowed individuals to learn something new about themselves. The learning and motivational aspects of the relapse was not referred to in any literature. This could mean that the notion of a relapse would have to be defined.

The findings here relating to causes of relapse coincide with the findings of Cockell et al. However, Cockell et al dealt with patients that were recovered after an intensive inpatient programme, so some of the issues, for example the lack of specialised professional treatment and a “sense of disconnection” were not evident in the participants’ experience, except in the case of the one of the nurse specialists, where former patients would return because of failing to resolve real world issues.
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5.6 Strengths and Limitations of the Study.

This objective of this research was to gain an understanding into the experiences of the Irish healthcare professional in the treatment of eating disorders, which was completed via the use of the in depth interview, which provided a forum for each participant to speak freely about the topic at hand. This allowed the researcher to gain a valuable insight into the experiences of the healthcare professionals. Also, the interview created an opportunity for new topics to arise, that the researcher would not have considered when formulating the questions.

The interview process could also seen to be a limiting factor in the research. One of the participants felt uncomfortable with the idea of being recorded, but she still proceeded with the interview. However, the researcher noted that it took her a good ten minutes before she forgot about the dictaphone’s presence in the room. This was seen as obstructing the naturalistic setting desired by the researcher. This could have been prevented and the anonymity of the participant preserved by using quantitative means in the form of a survey or questionnaire.

Another limitation in this research relates to its small sample size of nine participants. This was due to time constraints and lack of resources. If the research was done quantitatively, this number could have been increased and the catchment area also expanded.
5.7 Implications for further research

The researcher would hope that this research would allow healthcare professionals from different disciplines to gain a better understanding of treating eating disorders. In addition, it would reveal the positive and negative aspects of this line of work, and allow people to identify with said experiences.

For the individual with the eating disorder, be they patient or client, it creates an opportunity for enlightenment over the possible problems that can arise from treating this population.
CHAPTER 6: CONCLUSION

The main objective of the research was to investigate the health professionals’ understanding of the ED patient. This means to understand ED from the perspective of the ED patient. Through the themes discussed; attitudes of the healthcare professional, issues of comorbidity, relapse and recovery, one can gauge if the healthcare professional has a clear understanding what it means to have an eating disorder.

All participants spoke frankly and enthusiastically about the area of work. Though at times, they acknowledged that it was challenging, that did not deter them from working in the area. With all of the topics involved, they were able to see it from the patient/client’s perspective. In addition, they sought to help the individual with ED as much as they could from within their own discipline. This was reflected in how they referred to the individual with ED as either a patient or a client. Both the medical and the psychological are covered.

The healthcare professionals are the antithesis of the healthcare professionals that Burkett & Schramm (1995) and Warren et al (2009) refers to as they actively engage with the ED patient/client and do not show signs of stopping.
REFERENCES


Arcelus, Jon, Mitchell, Alex J.,Wales, Jackie & Nielsen, Soren, (2011) Mortality Rates in Patients With Anorexia Nervosa and Other Eating Disorders A Meta-analysis of 36 Studies, Arch Gen Psychiatry. 68(7) 724-731


Dear Sir/ Madam,

Re: Permission to conduct a research study with students within your organisation.

Emma Pentony is enrolled as a final year social science student at Dublin Business School. DBS social science students are required to complete an independent research project during their final year of study. Emma’s final year research project aims to examine the perspective of the service provider on the topic of eating disorders.

All research conducted by final year students is done for the purpose of meeting course requirements. All results obtained are strictly confidential, and to be used for assessment of the researching student’s qualifications for receipt of a BA in Social Science. Emma is requesting written permission, as soon as possible, to collect research data.

Please feel free to address any questions regarding this research to Dr. Bernadette Quinn, Research Coordinator, Social Science Programme, Dublin Business School. Emma Pentony [ozzskie@gmail.com] can also provide further details about how she will conduct her research study. Thank you for your time.

Yours Sincerely,

Dr. Bernadette Quinn
Tel: 01 4178737
Email: Bernadette.quinn@dbs.ie
APPENDIX 2.

Informed Consent
Eating Disorders: The perspective of the service provider.
20th of November
2011

Title of Study: Eating Disorders: The perspective of the service provider.

Principal Investigator:
Name: Emma Pentony.
Address: 145 Collins Avenue west, Whitehall, Dublin 9.
Phone: 0872063625
E-mail: ozzskie@gmail.com, emmapentony@beaumont.ie

Background:

I am a final year student in a part time degree in Social Science in Dublin Business School. A research project must be submitted as part of the degree. My area of interest concerns eating disorders and the service providers’ perspective of working with, treating and counseling individuals with eating disorders.

I wish to ask you if it would be possible for you to participate in this research study. Before you decide to participate in this study, it is important that you understand why the research is being done and what it will involve. Please take the time to read the following information carefully. Please do not hesitate to ask if there is anything that is not clear or if you need more information.

Research Project:

The research project will take the form of an interview. This interview will be recorded via dictaphone. In this interview process, the service providers’ viewpoints and experiences on eating disorders will be sought. Such questions will be asked referring to the services currently available, the effectiveness of treatment, comparing the eating disorder patient/client with other patients/clients, the impact of treatment on the service provider themselves, recovery, triggers and coping mechanisms which the patient/client uses, the prevalence of the disease in society and whether it is considered medical or psychological, and what enticed the service provider into this line of work.
The expected time commitment for this study should be approximately 45 minutes.

**Risks:**

The risks of this study are minimal. You may decline to answer any or all questions and you may terminate your involvement at any time if you choose.

**Benefits:**

There will be no direct benefit to you for your participation in this study. However, I hope that the information obtained from this study may be used to reach a wider audience. There is much talk in society today about eating disorders with both positive and negative connotations. This research project may add to literature concerning this secretive illness and give the service provider operating in today’s Irish society an opportunity to voice their opinions and experiences.

**Confidentiality:**

For the purposes of this research project your comments will be anonymous. Every effort will be made by the researcher to preserve your confidentiality. Code names/numbers will be assigned to participants and will be used on all researcher notes and documents. Recordings and notes and interview transcriptions and any other identifying participant information will be kept in a password protected file on a computer which will be in the personal possession of the researcher. When no longer necessary for research, all materials will be destroyed. Information from this research will be used solely for the purpose of this study.
Informed Consent  
Eating Disorders: The perspective of the service provider  
20th of November  
2011

**Person To Contact:**

Should you have any questions about the research or any related matters, please contact the researcher, Emma Pentony, ozskie@gmail.com, 0872063625.

**Voluntary Participation:**

Your participation in this study is voluntary. It is up to you to decide whether or not to take part in this study. If you do decide to take part in this study, you will be asked to sign a consent form. If you decide to take part in this study, you are still free to withdraw at any time and without giving a reason. You are free to not answer any question or questions if you choose.

**Costs To Subject:**

There are no costs to you for your participation in this study.

**Compensation:**

There is no monetary compensation to you for your participation in this study.

**Consent:**

By signing this consent form, I confirm that I have read and understood the information and have had the opportunity to ask questions. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without cost. I understand that I will be given a copy of this consent form. I voluntarily agree to take part in this study.

Signature _______________________________ Date ___________________
APPENDIX 3.

Interview Schedule.

1. What is your understanding of the term “eating disorders”?

2. What is your experience of treating individuals with eating disorders?

3. In your experience, what sort of symptoms lead you to believe/hypothesis that an individual has an eating disorder? How does an individual respond to the diagnosis/term eating disorder?

4. How do you decide what course of treatment for the individual upon presentation? Does the eating disorder usually coexist with other illnesses/issues?

5. What is the your view on the Irish services provided in this area? Can they meet demand/? how prevalent are eating disorders in Ireland?

6. What would your view towards multidisciplinary teams working together to treat the patient/client?

7. What would you do differently/?how would you make the service more effective?

8. In your opinion, when you initially began working in this field, how prepared were you to meet the challenges posed by treating individuals with eating disorders? How do you feel about it now?

9. How would you define the term relapse with regards to eating disorders? What impact has it on you when an individual relapses?

10. How would you define the term recovery with eating disorders?

11. In your experience, what is the worst aspect of dealing with eating disorders? Positive aspect?

12. How does treating an individual with an eating disorder impact on your professional and personal life?