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TWO PERSPECTIVES: METHODOLOGICAL APPROACHES TO TREATING
ADOLESCENT ANOREXIA NERVOSA FROM THE STANDPOINT OF A SCHOLAR AND
PATIENT

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ABSTRACT

Eating disorders, specifically anorexia nervosa, have become increasingly prevalent in Western Society. Old and modern-day treatment programs for anorexia nervosa will be discussed, including the efficacy of those treatments. Additionally, three separate residential eating disorder treatment centers and their methodological approaches to treating anorexia nervosa in adolescents will be discussed and examined. Journal segments from patients' experience will also be included and analyzed. Lastly, a proposed model treatment plan for anorexia nervosa will be identified and described.

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INTRODUCTION/PRELIMINARY REVIEW OF LITERATURE

With our Western infatuation with an extreme pursuit of thinness, it is evident that eating disorders are influenced by social and cultural factors. Eating disorders have sharply increased in the United States, the United Kingdom and many Western European countries for the last 60 years (Gordon 2001). There has been a rise in incidence of anorexia in young women, ages 15-19, in each decade since 1930 (Currin 2005). Between 1995 and 2005 the prevalence of disordered eating behaviors doubled among both males and females, and this rate only increases today.

Eating disorders are an important cause of physical and psychological morbidity in women, especially during the age of adolescence. Adolescent girls are particularly susceptible to influences from peers and media as they are physically and emotionally developing (Peterson 2007). Many scholars believe that the physical, cognitive and social changes of the adolescent developmental period make it a particularly troublesome time for individuals, as adolescence is considered a time of vulnerability for the development of eating disorders (Keating 1990).

There are four diagnostic subtypes of eating disorders: anorexia nervosa, bulimia nervosa, Binge-Eating Disorder (BED) and OSFED (Other Specified Feeding or Eating Disorder). As of 2013, the DSM-5 also includes the diagnosis of Avoidant/Restrictive Food Intake Disorder (ARFID), which represents dysfunctional to eating disorder behaviors and attitudes but does not specifically meet the criteria for the other specified eating disorders.

Anorexia nervosa was the first eating disorder identified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-I) in 1952. According to the current edition of this professional manual, the DSM-5, anorexia nervosa is characterized by distorted body image and excessive dieting that leads to severe weight loss with a pathological fear of gaining weight

(American Psychiatric Association, 2013). Physical symptoms include radical weight loss and/or a thin appearance, fatigue, dehydration and an absence of menstruation (amenorrhea).

Amenorrhea was removed from the DSM-5 as a critical symptom of anorexia nervosa, as not all women lose their menstrual cycle as a result of the eating disorder. Removing the symptom also reduced the stigma of men struggling with anorexia nervosa. According to the DSM-IV, additional diagnostic criteria of anorexia nervosa is disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight (American Psychiatric Association 2013). Approximately .05-1% of American women struggle with anorexia nervosa (Faltinek 2012).

Bulimia nervosa was acknowledged in the DSM-III in 1980. Bulimia nervosa is characterized by a cycle of bingeing and compensatory behaviors such as self-induced purging to undo or compensate for the effects of binge eating. Indicators of this disorder include frequent trips to the bathroom after meals, unusual swelling of the jaw or cheeks area, discoloration of teeth, withdrawal from friends and activities, and an attitude that indicates an obsession with weight loss, dieting, and control of food. Bulimia nervosa affects 1-2% of adolescent and young adult women (Faltinek 2012).

In 2013 with the publication of the DSM-5, BED was no longer a subcategory of EDNOS (Eating Disorder Not Otherwise Specified), as published in the DSM-IV in 1994. Binge-Eating Disorder (BED) is an eating disorder characterized by recurrent episodes of eating large quantities of food (often to the point of discomfort). BED is correlated to a feeling of a loss of control during the binge; experiencing shame, distress or guilt. BED is different from bulimia nervosa because those with BED do not use unhealthy compensatory measures (i.e. purging) to

counter the binge eating. BED patients can involve extreme restriction and rigidity with food and periodic dieting. BED affects 3.5% of American women, 2% of men and 1.6% of adolescents (Swanson 2011).

The prevalence of eating disorders has sharply increased since the recent “globalization” of the ideal of thinness that occurred in 20th century Western media (Lee 1996). Many individuals believe that anorexia is a ‘fad’ or a diet gone wrong in pursuit of thinness and social acceptance. The ambivalence about the severity of eating disorders may prohibit patients from receiving adequate treatment (Cockell 2003). Additionally, sociocultural theories that hypothesize factors that lead to anorexia nervosa focus on the Western cultural pressure on young girls to be thin. While virtually all young women are exposed to these cultural risk factors, only a small fraction of them develop anorexia nervosa (Tozzi 2003). This is because of the genetic, social and environmental risk factors that make certain individuals susceptible to the development of an eating disorder (Wade 2000).

It has also been shown that psychological stress or stressful events can trigger the onset of anorexia nervosa. Unfortunately, these stressful events can vary greatly and are not well defined. Some examples include but are not limited to sexual assault, divorce and/or death in the family, or an end to a romantic relationship (Troop 1997).

Additionally, the home life of one with anorexia has been linked to the pathogenesis of their eating disorder. Specific family interaction patterns have been recorded such as excessive control, overprotectiveness, marital discord and rigidity. While these characteristics have been observed among many families with a child with an eating disorder diagnosis, there is no evidence of a “typical” anorexia family (Palmer 1990).

Specific personality features found in patients with anorexia have been identified. These characteristics include obsessionality, perfectionism and low self-esteem (Bulik 2000). Similar to family dynamics in the home, there is no “typical” personality of a patient with anorexia.

The past 200 years of anorexia nervosa treatment have contributed to the forms of treatment we use today. In the 19th century, the diagnosis of anorexia nervosa implied a “moral or mental aberration rooted in the nervous system” (Brumberg, 1988). Home remedies included warm baths and massages to stimulate the appetite. In extreme cases, forced feeding was implemented, and some families resorted to electroshock therapy. 19th century medical literature expressed the puzzlement behind anorexia nervosa. Physicians wrote about the characteristic cry of the anorexic, “I will not eat”, but they rarely provided the text with the subordinate clause, “I will not eat because...” The Victorian’s understanding of the mental illness remained a mystery; however, it was considered a milestone that anorexia nervosa was now considered a mental illness, rather than a physical ailment. Food refusal, while an emotionally charged behavior, was also quiet, discrete and ladylike (Brumberg 1988). The public view of female fasting shifted from a sign of religious devotion to “wonders of science” to a demonstration of extreme willpower in pursuit of thinness. Physicians chose to remove the patient with anorexia nervosa from her home, advocating what is now called a ‘parentectomy’. The hope was the patient would recover when she was not under the watchful eyes of her mother and father (Vandereycken 1990).

In the second half of the 20th century, treatment for anorexia nervosa shifted from a purely medical standpoint, focusing on the vitals of the body, to a strong emphasis on the psychological health of the patient. Treatments included psychotherapy and accentuated the necessity of a behavioral and cognitive aspect in treatment programs. While medications were

used in the treatment of some patients with anorexia nervosa, they were rarely the only form of treatment (Steinhausen, 2002). The 20th century was the first time that anorexia nervosa was fully documented as a mental illness (Andersen 1983).

In late 20th century, new treatments were tried. The combination of overfeeding and hormone therapy was common. Overfeeding is the process of exceeding daily caloric intake in order for the body to restore weight. While the average individual consumes 1800-2500 calories a day, the overfeeding process would implement diets of 3000-4500 calories daily (Elkin 1973). In addition to this, hormones were injected into the patient in hopes of stimulating the appetite. This form of treatment was not successful (Boyar 1974). Hormone therapy was used in a group of ballerinas during a longitudinal study conducted from 2001-2003. Doctors gave ballet dancers with osteopenia and amenorrhea estrogen therapy with the intent to restore their bone density and menstrual cycle. Despite the hormones, the ballet dancer's weights were too low for any significant changes to occur from the estrogen alone (Warren 2003).

PURPOSE OF THE STUDY

The purpose of this study will be to examine three different residential eating disorder treatment centers providing current treatments for anorexia, and identify the core components of their method of intervention with the intent to propose a comprehensive treatment model that integrates research or treatment and contemporary practice in the field. By interviewing the chairmen of each treatment center, I discovered and studied what they believe are the key factors to eating disorder recovery. I examined how The Redeeming Center, Meadowland and Fishford Eating Disorder Unit focused on different treatment practices to treat the patient as a whole, while I discussed my own experiences at each facility. The three treatment settings identified in this paper have pseudonyms to protect their identity, and the names of persons listed in diary excerpts have been changed for privacy and protection of identity.

After interviewing and researching each eating disorder treatment center and conducting a review of the eating disorder treatment research literacy, I developed a proposed treatment plan that would be the most effective for patients struggling with anorexia nervosa.

THE REDEEMING CENTER

The Redeeming Center, established in 1985, was the nation's first residential eating disorder facility. The center promotes their 16 locations across the country that have provided treatment for more than 65,000 adolescent girls and women with eating disorders. Because of its credentials and years of experience, the Redeeming Center, which started as a single residential center, has several locations and continues to grow as the need for residential eating disorder care increases.

Its location is quaint and woodsy; the adult building holding up to 40 women, and the adolescent building ("The Pink House") holds up to 25 girls.

At The Redeeming Center's Residential Program, there is structure and support given to patients to assist in stabilizing medically, change problematic behaviors and normalize eating patterns. With the treatment team and the patient community's help, patients are encouraged to take the necessary risk to change the behaviors attributed to the eating disorder. This two-fold focus is called Connection and Change, and it is one of the key characteristics to the Redeeming Center approach.

The Redeeming Center does not solely treat anorexia nervosa and bulimia nervosa. They have specialized tracks geared towards the specific needs of women suffering from compulsive overeating (Binge Eating Disorder), trauma and/or substance abuse disorders. The tracks differ according to the age of each patient and how long they have been struggling with their eating

disorder. The longer the abnormal eating patterns continue, the more deeply ingrained they become and the more difficult they are to treat.

Primarily, patients are helped to reestablish nutritional and physical health. The nutrition program incorporates three basic meal plans and modifies those meal plans based on caloric and diet necessities. The Redeeming Center accommodates those with religious and medical dietary limitations. The calorie-counting system Redeeming Center uses is the Exchange System that is used for those with diabetes, but is broken down even further into six food groups: carbohydrates, fats, proteins, fruits, vegetables and dairy. Patients must eat a certain number of each exchange each day to meet caloric needs.

Another key characteristic of The Redeeming Center is the emphasis on psychotherapy. Psychotherapy groups focus on topics such as family patterns, belief systems, body image and nutrition to help participants develop insights and enhance their adaptive cognitive skills. Psychotherapy takes place three times a week and it is mandatory for patients to attend at least weekly. However, it is frequent for patients to have therapy or nutritionist appointments during psychotherapy groups and other patient meetings. This is a crucial flaw in the treatment system, as patients can be missing productive and helpful group classes by having to individually meet with other specialists. Psychotherapy also allows patients to learn how to combat compulsive thoughts and behaviors by reinforcing positive thinking and the need to realize the irrationality of eating disorder thoughts.

Patients are not allowed access to cell phones or laptops, but can sign out specific times to use a computer. Telephones can be found on the walls of each building, where patients have a 20-minute time slot to call loved ones. The limited access to technology is enforced to help the patient focus on their experience in treatment, rather than being absorbed in their usual lifestyle.

Limited hours of television are permitted. When the television is on, patients convene to the area and then begin conversations. Because TV and TV shows were something many patients experienced when outside of treatment, television is used to provide a sense of familiarity and a conversation starter to many.

Limited exercise is permitted when patients' vitals were stable. Yoga classes are offered, as well as a light cardio course. If a patient were to show overall improvement both mentally and physically, they are allowed to leave the center's premises for 60 minutes to go on a run. This is a rare occasion but is permitted.

In addition to exercise, patients are allowed to go on outings 1-2 times/week with loved ones. Outings can include a meal off campus, either at home or at a restaurant. Patients are required to write down what they ate, in addition to a signature by a loved one confirming that the food was eaten. Outings are used to help patients acclimate to a variety of foods and unmeasured quantities served at restaurants. In addition, outings identify food's ability to connect people and create a socially inviting environment.

The Redeeming Center was the first residential treatment institution that I attended. I was unprepared for the other residents I would encounter; I was shocked to see emaciated women with feeding tubes, in addition to those struggling with psychological disorders. At this time, I had just turned 16.

5/5/10

First day in. And I want out. SO BAD. I know they all want to help me, but eating full meals that complain every other word. Can't I just stay for a little bit? A week? Two weeks? They all know each other so well. I want to go home. But just fix my head quick, because I miss my family. I feel

so alone, the meals seem impossible, I'm not like the other girls. They're better anorexics than me. Please, let me go. I'm so scared.

Man I'm going to HATE Gatorade...

It is very common for those with anorexia nervosa to view other patients as “better anorexics” than them. Social comparison is a critical and complex factor of anorexia, but it is evident that patients restrict their eating as a result of comparing themselves with the successful (Morrison 2003). Patients also tend to characterize the severity of their eating disorder by comparing themselves to the physicality of the patients in the same unit (Colton 2004). This implies that they believe their peers are overall skinnier or sicker, which typically means that they are a ‘successful’ anorexic (Bruch 2001). This leads the mind to believe that they are not “sick enough” to be in residential treatment, when in retrospect they are in as much need of treatment as the other patients.

5/6/10

“Still pretty hopeless. Couldn't finish lunch, and man I HATE supplements. 20oz of Gatorade at 3 and 9PM, and 6 ounces in the morning. I am going to get fat.”

It is frequent for patients with anorexia to have electrolyte abnormalities. This is a result of fluid depletion and starvation (Sharp 1993). In order to rebalance the electrolytes, treatment centers frequently use sports drinks that have electrolytes, potassium and other vital nutrients. Drinking the sports drinks causes great anxiety because of the amount of sugar, or calories, that is being consumed in liquid form. Before treatment, I would frequently drink diet soda or other non-calorie drinks. Drinks with calories in them quickly became a fear and were avoided at all costs.

If a patient was unable to complete a meal, they were given 16oz of a supplemental drink: approximately 700 calories. Patients were allowed 30 minutes to complete the supplement. If the supplements were not finished, therapists and dieticians were notified for issuing of further consequences, such as being bedridden and unable to socialize with other patients, or being watched by a staff member 24/7. From the patients' perspective, supplements were punishment for not being able to eat the large quantity of food in 30 minutes.

5/8/10

I wish that I felt different or something, because I feel the same as I came here. I want to get better for the sake of getting back to my old life and behaviors. Why do I not have hope? Why can't I wait until I get home just so I can go back to my old ways? Healthy is scary. It's wrong. Feeling 'unhealthy' has control. It wasn't my choice to come here. I was forced here by people who love me. Will I change?

Refusal or questioning of treatment is common in anorexic patients (Goldner 1997). When I was admitted to the Redeeming Center, I was early in my struggle with anorexia nervosa. I was not yet able to see the consequences of the disorder and what opportunities I was missing because of it. The symptoms I used were a coping mechanism for the lack of control I felt I had in my life. When they were forcibly removed from me while in treatment, I realized how much I needed them to deal with my emotions and compulsive thoughts. At this point in time, I was unwilling to eradicate the symptoms from my lifestyle. The extreme need to control the consumption of food is a prominent feature of anorexia nervosa, and it has been associated with the maintenance of the disorder and the presence of other characteristics such as resistance to change (Fairburn 1999).

Because I was unable to resort to my eating disorder symptoms for comfort, I relapsed into self-harming behaviors. The Redeeming Center holds onto patient's razors and scissors and allows patients to use them while showering, but products such as paper clips, wire notebooks and other items that could be used for self-harm are neither confiscated nor difficult to find on the campus. During free time (about 90 minutes a day), patients are free to roam the campus or return to their rooms. I used this opportunity to isolate myself in my room and self-harm.

Patients with anorexia or bulimia nervosa have been found to be at high risk for self-injurious behavior (Garfinkel 1980). One line of research studying psychopathological features emphasizes levels of impulsivity and its correlation to obsessive-compulsive disorder. Deficits in impulsivity has also been linked to self-harming behavior; impulsivity has also been linked to eating disorder patients (Paul 2014).

5/10/15

The monster, the beast, the disease that lived in my veins all last year, the addiction that I thought I had overcome, has returned to my heart, ripping through my body to creep into my mind, my heart. The monster, the beast, the disease that comforts me in times of hopelessness. To think that destruction could be so soothing, so comforting. I'm ashamed to be in the skin I am in because I know that there is no one else that hurts me, hates me the way I do.

5/13/10

I don't think I'm strong enough still. Can I just go home? Please? I really don't think that I can do this, the negativity, the depression, the meltdowns and freak-outs, the huge meals, the calories, missing my family, my loved ones, my life that is happening outside of here...

Family therapy is an hour-long session with a therapist, the patient and the parents/loved ones either on the phone or in person. Topics usually include factors that could have contributed to the development of the eating disorder and ways in which the family and loved ones can help the patient at home. Family therapy is typically a very emotional time where secrets are revealed and arguments can occur. Despite the pain and discomfort family therapy can bring, it has shown to be more effective than individual therapy in patients under 19 (Russel 1987).

5/14/10

After Family Therapy

This is a painful process. It reminds me of stiches. This eating disorder, this cutting, all of the hideous problems that have happened, that's the wound. That's the huge, gaping, bloody wound. Coming here is the stiches. But rather than being numbed before putting them in, I wasn't given that. And they are being put in on one side. They're being put in for the healing process. Having to bring up these painful memories again, my past, my history. Bringing up/reliving the past is like ripping out the stiches from the wound. No anesthesia. Ripping them out slowly. I haven't cried so hard since I got here. No, it's too early to rip out those stiches. Please, not 20 more days. Anything but this.

Despite the pain that can be felt during family therapy sessions, this mode of therapy has been recognized as a successful form of treatment for adolescents with anorexia nervosa. According to a 5-year study conducted to study psychological treatment for adolescents with anorexia nervosa, significant improvements were found in patients who received psychological treatment, specifically family therapy. Weight restoration was achieved following the completion of a family therapy program (Eisler 2000).

5/15/10

There are three phases of pain:

The Injury-what caused the eating disorder

The Freeze- the actual eating disorder

The Thaw-the recovery

The THAW hurts the most

The Redeeming Center boasts its rigorous nutrition rehabilitation. By exposing patients to a large variety of food, the Redeeming Center aspires to eliminate labeling food as either “good” or “bad”. By challenging eating disorder beliefs and being encouraged to eat an assortment of foods, the patient’s level of comfort and trust around food can increase. Their program worked for me while I was a patient, as I became acclimated to being around food again.

5/26/15

You know, I’m actually kind of happy today. Maybe I have hope or something with my discharge date coming closer. I think I’m realizing how far I have come. The sight of food, like cottage cheese or a pita, it isn’t so scary anymore. That really encourages me. I also have exercise class today, and I’m always looking forward to that boost of self-esteem and body image it gives me.

I want my life back. Life is too beautiful to constantly be sick. And I want to live a healthy life.

Depression is known to co-occur with anorexia nervosa. Mood changes, particularly depression, are frequently found in patients with anorexia nervosa. Because anorexia nervosa is

an internalizing disorder like depression, researchers have suggested that the two mental illnesses often occur co-morbidly (Hendren 1983). There is also a positive correlation found in depressed anorexics and a disturbance of eating behavior and eating attitude (Meehan 2006).

In a recent study, levels of depression in anorexia nervosa patients were measured before and after weight restoration. The results of the study showed that moods were significantly improved after a healthy Body Mass Index was reached (Meehan 2006).

5/31/10-Last full day

Oh my goodness, I can't believe I am leaving tomorrow. Looking back on this month, I have come so far. The first day, it took me 2-3 hours to finish 8 ounces of Gatorade and I ended up pouring half of which in a plant. I can eat, but it still needs to be portioned, but nevertheless I can consume food again. I cannot see myself as beautiful or love myself yet, and I do struggle with self-loathing and self-harm still. However, I believe that it will disappear in due time. I suppose this will be possible, but it will be a battle.

Two critical components of post-treatment care include weight stabilization and relapse prevention (Hauserman 1977). The patient's motivation to recover has also been recorded as the patients normalize their behavior and achieve a sense of accomplishment over the process of recovery (Guarda 2007). Patients with anorexia nervosa have been noted to have slower cognitive functioning and overall neuropsychological abilities (Jones 1991). With this in mind, it is also known that anorexics restoring weight were recorded to have higher cognitive functioning and a clearer mind (Tchanturia 2004). With a better functioning brain, it is easier for patients with anorexia nervosa to combat the compulsive thoughts and behaviors associated with the eating disorder (Steinglass 2006).

The Redeeming Center has been commended for their real-world approach and extensive therapy opportunities that show promise of efficacy (Lowe 2011). Having the treatment experience simulate life outside of the treatment center can decrease the likelihood of a relapse.

On the Redeeming Center's website, they state that they conduct follow-up studies which indicate a significant reduction in the intensity of symptoms for the majority of participants in their residential program. However, the Redeeming Center typically calls 48 hours after discharge, when patients may have not yet had the opportunity to engage in symptoms. Additionally, there may be a high level of reactivity in the study because patients may not feel led to tell the truth. There is no found purpose in telling the researchers the truth, and it can be easier to lie than to admit to struggling.

After becoming accustomed to a routine schedule found in a treatment center, it can be difficult for a patient to prepare for life's spontaneity. Food will no longer be measured and portioned out, but 'eyeballed' for appropriate servings. While the Redeeming Center encourages patients to see a therapist and nutritionist, the structure and strength of two professionals is not as sound and comforting as a treatment center and the multitude of services it can provide.

MEADOWLAND

Meadowland Residential Center was developed by a private businessman. His adolescent daughter struggled with anorexia and he sought treatment, but the only form of treatment was in a hospital setting, where the focus was primarily on rapid weight gain. In 1988, he bought a ranch and transformed it into an eating disorder residential treatment center. The concept took hold and beds were quickly filled. In 1994, there were 65 employees and 28 patients; in 2001, there were 550 employees and over 120 patients.

Meadowland identifies what components they believe are necessary for a client's recovery. The first and foremost factor is nutrition rehabilitation. The program stabilizes the eating patterns of all patients. Most patients' weights are increased up to the 90th percentile. During the weight restoration process, patients are exposed to fear foods, which are types or amounts of food that individuals fear will lead to instant and discernible weight gain. Second, a culinary training program is included twice a week. Patients learn how to cook, prep, and store food products, as well as learn how to cook a variety of food. The Clinical Director of Meadowland explained that this is to familiarize the patient with food and to focus on exposure response prevention. If a patient is exposed to a fear food (ex: spaghetti) and has no option but to cook it and eat it, the anxiety and fear are bound to come up. It is better for this to happen in a safe, controlled environment where therapists and nutritionists are available.

Patients are not told what their caloric intake is; however, they have the freedom to choose between two meal options per meal. They are told they need to eat a certain amount of supplements (called EQ's, or exchanges) to aid in the weight gaining process. These are eaten together in groups and can range from canned peaches to king-size candy bars. If patients are

physically uncomfortable with the amount of food, they can have a feeding tube installed that runs at nighttime while they are asleep.

Part of what makes Meadowland's approach so unique is its separation of the patient from the outside world. No laptops, iPods, cellphones or TV's are permitted on its campus. This helps the patients focus on their recovery and prohibit access to eating disorder-promoting websites. This also helps them disengage from normal life. While I was a patient in April-June of 2011, it was a strictly Christian facility. Chapel was mandatory, along with morning devotions and grace before each meal. Since Meadowland was renewed to become Meadowland Health and Hope Center, the program developed two tracks for the patients to choose from. There was the Christian track, which included the 12-step approach with the implementation of faith, biweekly chapel services and consultations with the center's pastor. The other track was more standard and offered the 12-step approach similar to tracks used for substance abuse. The average residential stay for a patient is 6 weeks.

As a patient, being stripped of communication and belongings can be traumatizing. The first few days are the most difficult, and that was certainly evident in my journal entries.

On the day of my admittance on 4/19/11, I wrote,

"I have stepped into hell. They stripped me of everything. I can't call home for 72 hours. They took the wire coil out of this journal and replaced it with string in case I wanted to cut myself (which I probably would do). They took my guitar and my shorts and need to get Woofie [my plush dog that I brought with me for comfort] examined by my therapist. They dumped my clothes and belongings out of my suitcase and examined it like it was science. I am devastated. I cannot stop crying."

Upon admittance, while the patient's belongings are being searched, patients are given encouraging books to read throughout their stay. One book is Beyond the Broken Image, which holds the stories of other women who were patients at Meadowland and their journey through recovery. Additionally, patients were given The Ritteroo Journal for Eating Disorder Recovery, which allows patients to develop an honest, caring relationship with their bodies. Patients are also given celebrity Demi Lovato's encouraging book Staying Strong, that provides daily affirmations and commitment to self-love.

As my clothes and my comfort items were being scrutinized for any possible narcotics, diuretics or diet pills, I was told that I would be placed on a 1200-calorie meal for the first few days. Meadowland starts their patients on a low-calorie plan to help reintroduce food into her schedule; it is named "the gentle diet". Every few days, the meal plan increases by 300-calorie increments. Before admittance, I was eating approximately 400-500 calories a day.

Beginning the patient at a low-calorie diet can save their body from experiencing the refeeding syndrome. This is a potentially lethal condition that can occur when severe electrolyte and fluid shift quickly and rapidly from the refeeding process (Crook 2001). If nutrition rehabilitation does not begin slowly and gently, the patient's body can experience severe metabolic and cardiac complications.

At the time of my admittance, I was unable to express my feelings to anyone in power, and I believed that my thoughts and behaviors were valid. At this point, I was unable to express my fear in a proper coherent way. I would frequently whisper the same phrase repeatedly, in hopes that it would lead to my release.

4/20/11

“Please get me out. Please get me out.”

As a patient, it was extremely important to have my voice heard. I met with my nutritionist, Kristen, on my second day.

4/20/11, 4:23PM

“I met with my nutritionist Kristen who wants to put me on 3 ensures on Sunday and have me gain 2-3 pounds A WEEK. I’m so terrified, but I actually got the guts to tell her so. I really like her; she listens and responds to me like I am a person, not a patient. She said it IS a very scary thing to do, but I’m in a safe environment with staff 24/7 to talk to or cry with. It eases the panic somewhat.”

A significant factor of Meadowland’s treatment program focuses on forcing the patient to relinquish control and give it to a professional. Giving up control (of food, environment, weight, etc.) can be stressful and very upsetting. The professionals at Meadowland assured me that I was in safe hands, which allowed my mind to toy with the idea that I could be all right, even with someone else in control of my body.

4/22/11

“Kristen has set me on 3 meals and 3 snacks a day, which every patient must do. It’s amazing, actually, eating what feels like huge meals and snacks but keeps me only on (weight) maintenance. The point here is to gain weight through supplements, not food, so food does not equal weight gain in our minds. Still, I am incredibly anxious about it. On Easter Sunday, my

Ensures will be starting. It will start on one a day and eventually will go up to 3-4 a day, as I said.

The food is catching up to me. Like last night, I had my challenge food (while on the gentle diet) of turkey and noodle casserole. It was horrifying, and that and loneliness and the idea of staying for 60 days made cutting so tempting. I cried some, which did help. I did not actually cut, which was good.”

Challenge foods, more commonly known as ‘fear foods’ are certain food products that an eating disorder patient finds especially anxiety inducing. Common foods include cheese, pasta, ice cream, butter, and fried foods. These fear foods vary according to each patient.

4/22/11

“I couldn’t finish lunch. It was a bean and cheese burrito, rainbow sherbet and a sugar cookie. I finished half of the burrito. To make up for the calories I didn’t eat, Cheryl gave me an Ensure. I didn’t finish that either.”

This meal is an example of a combination of fear foods for me - primarily, cheese and starches. If a patient is unable to complete a meal, behavior therapists (BHT’s) offer them an Ensure, a supplemental nutritional shake. If the Ensure is not completed, the patient can be dismissed, but these behaviors are reported to the nutritionist and therapist who can take further action.

One week into treatment, while still on the weight maintenance plan, I have a meeting with my nutritionist.

4/25/11

“Today, I had a one-on-one with Kristen. Even before I went on the Ensures, I was gaining weight. She said it was due to replenishing my body with fluids. I do not know how much, but it frightens me beyond belief. I cried a lot. Kristen tried to dig deeper to know where the fear came from. Gaining weight (to me) means losing control. Losing control means getting bigger. Getting bigger means...I’m not sure. The lack of knowing anything made me get so entangled in an eating disorder frame of mind. I still feel so fat and HUGE-probably didn’t help that I’m wearing jeans and a small t-shirt that actually fits along my body.”

Meadowland strives to control as much of the patient’s environment as possible. They take precautions with every individual, no matter what their background of self-harm is. I vividly remember having “shaving parties” twice a week with the other patients. We were not allowed to own a razor to shave our legs. Before our admission, our parents/guardians had to purchase an electric razor, which we could use for 10 minutes, twice a week. Meadowland’s program protects the patient from herself before she can think of self-harm.

“This is so weird. I’m in a tank top and Soffee shorts, shaving my legs dry (with no water) with 10 other girls. There are two BHT’s watching us. Like we could actually hurt ourselves with an electric razor. Sandra is watching my every move--she probably knows that I tried to throw away my Ensure.”

Minute symptoms are scrutinized and prohibited by the behavioral therapists. Micro-symptoms can include food rituals (cutting food in very small pieces, eating food/fluids with a teaspoon), hand tremors or leg shaking. As a patient, I was guilty of all of these symptoms. They were a coping mechanism I used to feel as though I still had control in the environment. The

therapists encouraged us to avoid coping with our anxieties through physical symptoms and to discuss them with our therapist.

5/7/11

I got such a lecture from Carla for standing again. I fought back at her. I explained that I wasn't standing to burn calories, that I was actually getting an envelope. She asked "how long have you been here" and "do you want to stay forever" in her manner that makes me want to scream and cry and flip her off. But I did not...just got in the back of the room and cried. And I don't give a s*** if she sees my foot thumping".*

Another food ritual is eating food abnormally slowly. Patients are given 30 minutes to complete each meal. During treatment, most patients take all 30 minutes to eat their food. Some behavioral therapists urged us to eat in 20-25 minutes; assuring us that it was normal behavior. One BHT made all of the patients eat all of our food in 15 minutes. We were all on weight-gain meal plans, so the amount of food that we had to eat in such a short amount of time was extremely uncomfortable.

5/9/11

"I finished dinner in 15 minutes for Carla today. I nearly threw up from indigestion, but I did manage. She was so proud of me...but I found it all unnecessary. All I could focus on was the food and how quickly I could get it down. It felt like I was bingeing. I can't remember anything that we talked about."

The physical discomfort and anxiety that I experienced was reflected by several other patients. In a Scotland residential eating disorder treatment center, patients complained of feeling

constrained by the clock and had to rush in order to complete all of the food in the allotted time (Long 2012).

Normalization of weight in patients with anorexia exhibits greater extraversion and self-doubt and discomfort. The intensity of the discomfort can lead the patient to behave in ways they would not normally act in any given environment.

5/18/11

“Sarah caught me trying to dump Ensure. What is wrong with me? The guilt, the shame is so awful. I am afraid that people will now judge how motivated I am, truly. She said that she saw me dump it yesterday. Oh my word...I feel like I can't do anything. Why am I such a lying, deceitful person? I don't want this anymore. Enough is enough.”

Compulsivity is a common symptom of anorexia nervosa. The persistency of the compulsive thoughts and behaviors aids to the maintenance of the eating disorder and makes it more difficult for symptoms to be eradicated (Godier 2014). The erratic and compulsive behavior accompanying the weight gain process in anorexia nervosa patients has been deemed “Dietary Chaos Syndrome” by Robert Palmer of the British Journal of Medical Psychological in the late 20th century. This syndrome consists of the symptoms listed above in addition to a grossly disordered pattern of eating and behaviors such as secret eating, chewing food without swallowing and spitting out food (Palmer 1979).

Moments like these can help the patient realize how far away they are from their actual selves. The eating disorder frequently leaves nothing but a shell of a person, someone who throws food away and disengages the emotions of the victim. During the recovery process, surges of hope break through the apathy.

“Surprise...I had a restaurant outing at Screamer’s with the other patients. I found out about two hours prior. Surprisingly, it was a good experience. I got fried chicken tenders and onion rings/fries and...honestly, it was good. The chicken made the napkin underneath it wet with grease, which sent my thoughts racing. However, I reminded myself that it was part of the meal. The onion rings were so good. I cannot believe that I’m saying that.

And at snack, I first was going for peaches, but then I turned around and got a Rice Krispie treat.

A day of progress, a day with one step forward.”

At this time, there is no follow-up treatment offered by Meadowland. However, they have a Meadowland representative contact the patient via phone approximately one week after discharge. 100% of all clients have a therapy appointment (set up by Meadowland) within one week of discharge. The development of a follow-up program is in progress, but it is not yet available.

At the time, my experience at Meadowland was excruciatingly difficult. Looking back, I can now see that the rigidity of the program at Meadowland helped me eradicate more symptoms.

FISHFORD

Fishford Eating Disorder Unit was founded in the late 20th century with a purpose to provide its patients with a comprehensive treatment program to create the foundation for a full recovery. The EDU is located in a large wing of the Fishford Hospital in the Northeastern US. Their inpatient program features 24/7 nursing care and access to specialists such as psychotherapists, psychiatrists and nutritionists. In 2012, they could accommodate roughly 16 patients. As the hospital built a new eating disorder center, the number of beds increased slightly to 22, while the space provided a more comfortable atmosphere and less of a 'hospital' feel. In order to be admitted to Fishford's Eating Disorder Unit, patients must go through a phone screening, an online screening, insurance verification and medical clearance. There is frequently a waiting list of patients to be admitted. The wait for a bed can range from 2-6 weeks. If a patient is severe enough, they are admitted into Fishford Hospital's ICU unit until a bed opens up in the Eating Disorder Unit.

Fishford takes pride in their team approach. They have multidisciplinary treatment teams, including certified psychiatrists, registered nurses, licensed psychotherapists, registered dietitians and nutrition assistants, physicians and certified teachers to provide tutoring support for patients still in secondary school. Fishford also views each patient's family to be an integral part of the team necessary for recovery; Fishford works closely with family members to facilitate their roles in their loved one's recovery. This better equips families with the tools crucial for the care of their loved one once they are discharged from residential treatment.

Fishford's primary treatment approach includes psychosocial treatment and nutrition rehabilitation. Psychosocial treatment includes psychotherapy (which focuses on moods,

thoughts and behaviors and how they can influence their lives) and support groups as well as therapy with psychologists.

In addition to this, Fishford focuses on meeting the nutritional needs of their patients. Most patients begin on a low-calorie diet (1200 calories) and gradually increase them by 350-500 calorie increments every few days in order for necessary weight gain to occur. While patients are aware of how many calories they are eating, they are not allowed to know their weight. During morning vitals, when weight and blood pressure are taken, patients must stand backwards on the scale while the nurses record the information.

Days consist of 45-minute meals and 30-minute snacks. Every patient sees a psychiatrist, a therapist and a nutritionist at least 3 times a week. Between all of this, there are support group meetings, trauma intervention groups and family therapy groups.

Once a patient's vitals are stable, they are allowed to engage in physical activities like yoga. When a healthy weight is achieved, patients are allowed to do 15-20 minutes of unsupervised stretching and toning a day.

At this point in my recovery process, I am complacent and willing to do whatever it takes to combat anorexia. However, being a residential patient is never easy.

12/13/11

It makes me devastated that I am missing so much of life. Christmas season is my most favorite time, and I'm stuck in this hospital room with no decorations or lights anywhere to be seen, even out the window. The fluorescent light bulbs are no match to the sunlight that I cannot see.

I got to call Mom and Dad after dinner (which was panko-crusted tilapia, rice and roasted vegetables), and it helped some. Merely hearing their voices makes me feel comforted. I love being able to have my phone and my iPod and Internet access because I feel connected to the world still. But being in a hospital shows me that this is a disease, a sickness, an illness, a mental disorder. Being in this setting makes me sad and uncomfortable, but opens my eyes to what this really is.

Admission to a hospital is frequently the first step before a patient with anorexia nervosa is transferred to a psychiatric facility. If the patient is at a dangerously low weight, electrolyte and hydration levels may be balanced before there is further psychological treatment done (National Collaborating Centre for Mental Health 2004).

12/14/11

The meals are so quiet and uncomfortable, but I think they will get better as time goes by. I'm only set up for 1200 calories a day right now, but I know that's definitely prone to increase considering that I need to restore weight. Apparently I'm 105 pounds and I'm below the 1st percentile for girls my height. At the 5th percentile, insurance basically asks for patients to go into some place for help. So while I can't see it, I guess I'm pretty bad off.

Patients with anorexia nervosa usually exhibit feelings of distress and concern over their physical weight and size. Additionally, studies show that the degree of overestimation of body width exhibited by patients was found to bear a relationship to their progress after discharge from hospital. When this mindset persisted after weight gain, a relapse was more likely to occur (Slade 1973).

While there are many courses and meetings throughout the day, patients are still allowed free time between events. This time can be used to call loved ones, journal, watch TV or socialize with other patients. However, this time can be used in a destructive manner by engaging in eating disorder symptoms.

12/18/11

We have a lot of free time around here, just like the Redeeming Center. Weekends are so boring around here. There were about 4-6 of us around here all day, while the patients who were more stable could visit family. I have too much free time to myself. I finished my homework, which is good, but I have no roommates. I could close the door and start exercising and I doubt that anyone would notice for a while.

It is the facility's responsibility to control or maintain its environment for its patients. Patients must relinquish control of their days, their weight and their meal plans and give it over to the professionals. However, when the environment does not feel secure, patients can either experience high levels of anxiety or engage in eating disorder behaviors (Minuchin 2009).

1/10/12

Yesterday, I was told that I may be discharged today. Apparently insurance has had enough. I don't think that I'm at a healthy weight though. My treatment team seems really upset.

Most eating disorder patients have no involvement in any decisions pertaining to their length of stay in residential treatment. However, health insurance has been cited as being the primary deciding factor in choosing a specific treatment center (Darcy 2010). Insurance frequently prematurely drops eating disorder patients as soon as their vitals show minimal signs of improvement. The same reason that individuals choose a specific treatment center is the same

reason why patients are suddenly discharged from residential treatment. It has been found that average number of days, whether inpatient or outpatient treatment, is less than the minimum recommended by standards of care (Striegel-Moore 2000).

Fishford EDU also offers a Partial Hospital Program, where patients can be given the same comprehensive services as the Inpatient Program, but on a more accommodating, outpatient schedule. The Partial Hospital Program runs Monday through Friday 8am-6pm, where they can participate in the same group activities as the inpatient residents. All three meals are eaten during the program hours, until gradually calories can be saved and eaten outside of program; these calories are called “saves” and are usually in the form of a snack. The program is still as rigorous as residential, and patients are still placed on levels based on weight gain and weight maintenance.

1/13/12

I am still doing partial here. The commute sucks (yesterday was an hour and 50 minutes to Fishford) but Mom and Dad are willing to drive me and it is helpful to have some independence at home while having the structure of Fishford. And I love being in my own bed and room again. I am in the car now, fighting sleepiness and body distortion.

1/16/12

I won't even say what meal plan I am on now. It's ridiculous. Over 3000 calories. I feel fat on my arms, my legs, my face. I don't know if I need to stay here at Fishford until I at least make my hospital goal weight.

While nutritional and weight restoration is a known component of treatment programs for anorexia nervosa, there has been little research on the quantity and quality of nutrients that are most critical to achieve the appropriate treatment goals (Marzola 2013).

If patients show strides of improvement, they can take their “saves” home to eat. However, patients, such as myself, could abuse this privilege and face consequences. I would eat the food in program, but would purposely restrict eating when at home, depriving myself of 500-1000 calories a day.

1/20/12

I am back on all food in program now. I met with Kelly (Fishford nutritionist) today, and she talked about how she didn't know when she could trust me because I was lying about how I was doing. I didn't eat what I was supposed to outside of partial.

I want trust, but I keep breaking it. I want to be honest, but I don't want change. I want recovery, but I don't want to be all right.

After being deceitful, Kelly wants me to answer this question:

Why am I attached to the eating disorder?

Well, I am attached to the eating disorder because it soothes me. I'm attached because it makes me confident in one aspect of my life. I'm attached because it's something that's there for me unconditionally. I'm attached because it's a way that I can express the bad parts of me. I can smile and be nice and give to others and be 'perfect' in the eyes of others, yet I can lie and punish and curse to myself when I know that I deserve it. I'm attached because it's the way I feel adequate in life. I'm attached because it knows just how to respond to how I'm feeling. I'm attached because it is something that is mine. I'm attached because I feel responsible and like I

PROPOSED TREATMENT PLAN

Based on a review of the published literature on treatment and my experience at these three residential treatment centers, the following core components are proposed as integral to a treatment plan that will lead to effective symptom reduction for adolescent eating disorders: an individualizing treatment plan to accommodate the different stages that those with an eating disorder might experience, an emphasis on family therapy, and a significantly increased stay in the treatment center to solidify the ideas that have been introduced to the patients.

Individualized Treatment Plan

A flexible individual treatment plan is vital in the recovery process of a patient with anorexia nervosa. Eating disorder treatment programs should include restoring patients to a healthy body weight, eliminating negative behaviors and learning new coping skills in order to deal with stressful situations, but I implement their treatment goals to acknowledge that every patient's needs differ and the manner in which treatment is provided must accommodate those individual differences. Kendall Hamilton established the phrase "flexibility within fidelity", which emphasizes the elimination of rigid adherence to treatment protocol in order to best treat the patient (Hamilton 2008). Treatment manuals cannot be used in a "cookie-cutter" fashion, as the need for each patient differs.

Several studies have observed the several factors that lead to the development of anorexia nervosa and it is these factors that need to be addressed in treatment; these include and are not limited to social, cognitive, emotional and family factors (Polivy 2002). With this in mind, in the initial phases in treatment, it is important to assess the individual needs of a patient in order to fully and adequately treat the disorder.

Albert Bandura's social learning theory states that learning is a cognitive process that takes place primarily in a social context and can occur through observation or direct instruction, even without motor reproduction and direct reinforcement (Bandura 1963). For example, through observation of media, individuals can learn that physical attractiveness leads to rewards. When used positively, patients undergoing social learning therapy who received an individualized treatment plan maintain their treatment gains to a greater degree than those receiving standardized treatment (Jacobson 1989). The application of social learning theory in a treatment plan emphasizes the ability to reteach patients about their preconceived thoughts of physical attraction and the malevolence of weight gain (Killen 1996). The social learning theory being applied to the treatment process indicates the importance of addressing an eating disorder with a multidisciplinary approach.

While physical recovery is a vital component of residential treatment for many patients, it is not always the primary reason they are admitted to inpatient treatment (Rome 2003). In a qualitative study, patients complained of having the physical recovery as a priority over psychological recovery. While the physical needs of an anorexic patient may be life threatening, patients felt as though the staff simply wanted to "fatten them up" and viewed their psychological and emotional needs as not important (Offord 2006). Physical health is of utmost importance; however, the multidisciplinary approach in treatment for anorexia nervosa, including weight restoration, cognitive and behavioral therapy, has been proven to be the most effective (Joy 2003).

Additionally, enforcing the limitation of contact with the outside world outside of the treatment program is vital for a patient's recovery. When restricted from contact with friends and family via cell phones or social media, the patient has no choice but to focus on themselves and

their battle against the eating disorder. The use of a “parentectomy”, or removal of contact from parents and loved ones while in inpatient treatment, was created in the early 20th century (Harper 1983). Studies have shown that despite the fact that the weight rehabilitation program was identical in the hospital and at home, patients with anorexia nervosa lost more weight at home and lost it faster than she put it on in the hospital, (Harper 1983). This can be due to the fact that despite the attempts of family members, there is more freedom and independence at home, which allows space for relapsing. While it is painful to be separated from loved ones, it is a necessary step that patients must take in order to fully grasp the treatment they receive.

Family Therapy

There is no consistent pattern of family structure in individuals who suffer from anorexia nervosa, and most families report as being “well functioning” (Eisler 2005). However, some specific characteristics have been reported in multiple studies of families with an anorexia nervosa patient: conflict avoidance, internalization of emotions, great pressure to succeed, family role rigidity and a strong focus on bodily functions (Kog 1989). Several researchers have noted an emphasis on achievement and success and less self-expression (Bruch 1973). Because there are countless factors that contribute to the development of anorexia nervosa, it is imperative that patients are offered several different approaches to family therapy so the therapy that best accommodates their situation can be used.

When an adolescent struggling with anorexia nervosa still lives with at least one parent, the role of the family is critical to recovery. Studies have demonstrated greater restoration of health with a family-based intervention versus an individualistic intervention (Lock 2006). Other studies have found that family-based therapy was significantly superior to adolescent-focused therapy and there has been a correlation found between higher body mass indexes at the end of

treatment following the use of family-based therapy for adolescents with anorexia (Lock 2010). While limitation to the outside world is encouraged, access to the family in a therapy-based setting can help the patient and family address the problems in the home environment and create a healthier environment once the patient is discharged from treatment.

Specific eating patterns have been found in families with an anorexic family member. Studies have shown that parents who think their children are overweight or at risk of becoming overweight are more likely to practice restrictive feeding behaviors for themselves (Spruijt-Metz 2002). With this in mind, it is also known that children commonly reflect their parents' eating patterns (Golan 2004). The mother's own food behaviors (such as when food was consumed, what foods were liked or disliked) were also found to be correlated with the child's food behaviors (Seagren 1991). Similarly, the parents' own dietary restraint and perceptions of her daughter's risk of overweight predicted restrictive child-feeding practices. The parent's restrictive child-feeding patterns subsequently predicted daughters' eating patterns and relative weight to be abnormal, either below or above the average (Birch 1998). This suggests that children who experience restrictive-feeding patterns from their parents are more likely to be underweight or overweight as they development their own feeding patterns.

There are several different forms of family therapy that are successfully implemented in the treatment of anorexic adolescents and their families. Structural Family Therapy centers on individual physiological vulnerability and the role the anorexic child plays in facilitating conflict avoidance. Structural Family Therapy also addresses the overall function and efficacy of family communication (Raymond 1993). The use of Structural Family Therapy and the use of behavior conditioning have been shown effective for adolescents with anorexia (Liebman 1974) in addition to children with other psychosomatic disorders unresponsive to medical management or

other forms of psychotherapy (Hodas 1978). Families that deny the existence of any problems or see “no need” to ever disagree and are highly invested in keeping consensus and harmony would respond best to Structural Family Therapy (Minuchin 2009). The structural approach discourages the therapist from verging off the central therapeutic task, which is to keep the parents focused on weight restoration for their eating disordered child in order to free her from the eating disorder (Lock 2015).

Strategic Family Therapy emphasizes the effect of the illness on all family members and focuses on inducing change in the eating disorder symptoms. This approach is contrary to other forms of therapy that may emphasize the impact of the family dynamic on the onset of the illness. The ultimate goal of this form of therapy is designing a strategy that can effectively improve or eradicate the dilemma of the patient and his/her family (Madanes 1991). Addressing and emphasizing the conflict in the family can best help family members work together to eradicate the problem (Stanton 1981). The overall goal of this model is to prevent the same conflict from repeating in the family (Gerhart 2003). One unique key of Strategic Family Therapy is the use of ‘paradoxical’ interventions (i.e. asking a patient to eat in order to have the strength to fight her parents). While creating the child’s own will and desire to fight, the injunctions support the parental efforts at weight restoration while recognizing the child’s need to resist these efforts (Lock 2015).

Additional forms of family therapy give parents full responsibility for their child’s eating patterns. Called the Maudsley Approach, this form of therapy educates the parents about anorexia nervosa and encourages parents to generate strategies for increasing food intake and limiting physical activity. Strategies to increase food intake include reintroducing high calorie-dense foods (cake, butter, cheese, etc.) and increasing portion sizes. The primary goal of this

form of therapy is weight restoration and the relinquishment of control from the anorexic adolescent. Many studies have found that adolescents with anorexia nervosa who undergo family therapy and incorporate the Maudsley Approach have reached a healthy weight and did not need hospitalization or inpatient treatment (Le Grange 2005). The Maudsley Approach is most effective, however, when the adolescent has only struggled with the disordered eating for a short duration of time.

Increased Stay

The length of the patient's stay in a residential treatment center is crucial to solidifying the strong coping mechanisms introduced in treatment and reducing eating disorder symptoms. The length of stay should differ from patient to patient due to specific needs and individual responses to treatment. It is essential that those who have struggled with anorexia nervosa for longer than 6 years, have experienced amenorrhea for over 2 years and have an overall lower body mass are in more need of a longer duration of treatment to avoid relapse (Howard 1999). Studies have shown that patients who completed an inpatient treatment program (average of 13 weeks) and achieved an average of 98% of ideal body weight were less likely to relapse after discharge than those released before they could complete the program (Baran 1995). In 2004, the average length of stay in a residential treatment program was 83 days (SD=44) (Frisch 2006). Unfortunately, with residential treatment costing an average of \$965/a day (Frisch 2006), the length of stay varies drastically per patient due to health insurance coverage limitations, the shortest stays beginning at 72 hours (Kahn 2001). The recent limitations of health care coverage have subsequently caused shorter lengths of inpatient care for patients with anorexia nervosa, thus leading anorexics to be discharged while still underweight (Kaye 1996). Patients discharged

while still underweight tend to have a 20% lower BMI than patients that were discharged at a healthy weight (Baran 1995).

The patient's motivation to recover also predicts how effective inpatient treatment will be. A study has found that readiness for change (RFC) in patients with anorexia nervosa predicted their length of stay (LOS) at a residential treatment center. Those with a low RFC had a mean treatment length of 59.4 days, whereas patients with a higher RFC stayed an average of 34.1 days (Lock 2006). While some research suggests that a longer treatment plan can be beneficial to the patients, it is imperative to consider the mental state of the patient upon admission, thus emphasizing the necessity for individualized treatment plans for patients.

In order for the healthy behaviors to solidify in the patient's lifestyle, it is necessary for the patient to be exposed to several environments, including: trying on/purchasing clothes for their weight-restored bodies, going on restaurant-outings, putting on and swimming in a bathing suit, among other situations. Cognitive inflexibility is a common characteristic of those with anorexia nervosa (Zastrow 2009), and it is known that as BMI increases in anorexic patients, their cognitive flexibility also increases. Cognitive inflexibility is correlated to the maintenance of the illness; once the weight is restored on the patient, cognitive flexibility returns to a normal state (Tchanturia 2012). Their cognitive flexibility can also increase while engaging in activities such as restaurant-outings and swimming in bathing suits. The exposure to such environments cannot take place over the course of a few weeks. These events mimic real-life situations that the patients would face once they are discharged from treatment.

CONCLUSION

There are a lot of positive attributes that most residential eating disorder centers possess. Considering how recent the birth of residential eating disorder treatments are, they have made great strides in reducing the symptoms of those with eating disorders. Unfortunately, the prevalence of eating disorders in Western society only seems to increase. With this in mind, we hope to see different forms of treatment available to patients, in addition to more education to the public about the physical, social and emotionally debilitating effects of eating disorders. The nature and severity of eating disorders is not a topic to take lightly. As a recovering victim of anorexia nervosa, I stress the importance of effective treatment plans that use a multidisciplinary approach to eradicate the symptoms and need for the eating disorder.

Only a small fraction of patients with eating disorders seek psychological treatment (Fairburn 1996). There are several stigmas attached to anorexia nervosa; in a report on the state of mental health in the US, the Surgeon General named stigma as a significant obstacle to the treatment of mental disorders (Stewart 2006). The stigmatization of people with anorexia nervosa can lead to a decrease in self-esteem and increased shame, which may prolong the recovery process and increase the likelihood for relapsing (Corrigan 1999). Additionally, there is limited pharmacotherapy for anorexia nervosa, thus reducing the extent of people to think of anorexia nervosa as a biological pathology (Agras 2004). As researchers, we have the responsibility to challenge false assumptions about the etiology of eating disorders. As stressed before, education to the public is necessary to alleviate the stigmas and realize the morbidity of this mental illness.

Additionally, it is important for individuals with an eating disorder diagnosis to realize that it is a psychological illness that requires medical attention. While every development and reaction to treatment is different for each patient, it is essential to realize the necessity of inpatient treatment if the situation is too severe to handle at home or in outpatient care. Residential treatment ultimately saved my life, and research shows it has saved countless other lives of eating disorder victims. Every treatment story is different; as the pursuit for thinness inevitably continues in Western society, one can hope that professionals can identify the key components that help victims of eating disorders to choose recovery.

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Education

Pennsylvania State University / Abington, PA 19001 / Graduation: May 2016
Bachelor of Arts / Psychological and Social Sciences
Principle Instructor: Dr. Michael Bernstein

Schreyer Honors College / Penn State University / February 2014 to present

Research Assistant / Penn State University / August 2014 to present
Orchestrated and ran online studies for underclassmen. Analyzed results and debriefed students about the next steps taken in the study.

Presenter / Eastern Psychological Association / Philadelphia / March 2015
Presented thesis on frustration and the impact on cognitive functioning. Additional presentation to be in March 2016 on social and personal body image across five racial backgrounds.

Experience

Intern/ Poverty Resolutions, Furlong, PA / July 2013 to August 2014
Volunteered as an intern for non-profit involved with helping create sustainable ways of life for the people in Haiti. Spent a total of 5 weeks in Haiti as a leader to volunteers.

Assistant Coordinator / Penn State Alumni Association / August 2013 to December 2013
Promoted alumni association on social media, helped organize alumni events, contacted alumni to inform about upcoming events

Assistant Director / Indian Crest Junior High School, Souderton, PA / October 2012 to February 2014
Volunteered as assistant director of the school's musical. In 2014, given a stipend as co-director. Helped create choreography, gave students vocal lessons, provided assistance to stage crew.

Lawn & Garden Specialist/Cashier / Harleysville Ace Hardware / December 2013 to present
Tend to store's nursery and plant section, take stock of inventory, process customer transactions

Awards

Co-President / Psi Chi Honors Society / Penn State University / July 2015 to present
Plan events and coordinate regionally known psychologists to visit campus.

The Honor Society of Phi Kappa Phi / Penn State University / March 2015 to present
Member of the nation's oldest and most selective all-discipline honor society.

Dean's List / Penn State University / August 2012 to present

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