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Psychotherapies provided for eating disorders by community clinicians: Infrequent use of evidence-based treatment

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Abstract
This study describes the psychological interventions used for eating disorders (EDs) by community practitioners. Of 573 clinicians we screened across Alberta, 130 (22.7%) had treated EDs; 118 (90.8%) were interviewed. Clinicians reported varied reasons for psychotherapy choice and diverse training experiences; the primary approaches used varied by education and field. The most common primary approach was eclectic (43.2%), followed by cognitive-behavior therapy (CBT; 22.9%). However, self-reported CBT clinicians used specific CBT techniques infrequently. Half of clinicians incorporated addictions-based techniques. These results indicate that ED treatment provided by community clinicians is varied and generally does not align with evidence-based practice guidelines.

Keywords: eating disorders; evidence-based practice; clinical practice; treatment; cognitive-behavior therapy; health personnel

Awareness of current trends in the use of psychological interventions is vital to those interested in promoting evidence-based practice in mental health. This information may help to bridge the gap between researchers who promote empirically supported treatments (ESTs; i.e., treatments that have been demonstrated to be efficacious through controlled research trials) and front-line clinicians who provide treatment, to evaluate the need for improved dissemination into clinical settings of ESTs, and ultimately increase the effectiveness of treatments provided to individuals in need. For example, some of the better-established ESTs for eating disorders (EDs) include cognitive-behavior therapy (CBT) and interpersonal psychotherapy (IPT) for bulimia nervosa (BN) and binge eating disorder (BED), and family-based therapy for anorexia nervosa (AN) (Wallace & von Ranson, 2012). Although recovery rates remain far from perfect and there is still room for improvement of ED psychotherapies, randomized controlled trials have demonstrated that these treatments perform better than wait-list, placebo, and/or active treatment control groups, suggesting greater likelihood of symptom improvement when these treatments are provided (Wilson, Grilo, & Vitousek, 2007). However, multiple factors beyond evidence from research trials influence treatment decisions. In the field of EDs, studies examining psychotherapy use have indicated that ESTs for EDs are underused in clinical practice (e.g., Crow, Mussell, Peterson, Knopke, & Mitchell, 1999; Haas & Clopton, 2003; Herzog, Keller, Strober, Yeh, & Pai, 1992; McAlpine, Schroder, Pankratz, & Maurer, 2003; Mussell et al., 2000; Simmons, Milnes, & Anderson, 2008; Tobin, Banker, Weisberg, & Bowers, 2007; von Ranson & Robinson, 2006; Wallace & von Ranson, 2012). Although an expanded conceptualization of what constitutes evidence has been endorsed by the American Psychological Association (APA; APA, 2005), lack of use of ESTs in clinical practice suggests that the type of treatment provided in clinical practice may not be as effective as possible. Dissemination of ESTs into general clinical practice is key to improving client outcomes, including for EDs (McHugh & Barlow, 2010).

Notable gaps in our understanding of current practice remain. First, previous research has largely ignored treatment provision by *community* clinicians from whom clients with EDs regularly seek services, instead focusing on selected groups, such as specialists in EDs (e.g., Herzog et al., 1992; Simmons et al., 2008; Tobin et al., 2007; Wallace & von Ranson, 2012), affiliates of academic medical centers (McAlpine et al., 2004), and psychologists (Haas & Clopton, 2003; Mussell et al., 2000). However, clinicians in the

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community with various levels and types of training—including psychologists, social workers, nurses, psychiatrists, counselors, and others—often provide psychological interventions, or psychotherapy, for EDs (von Ranson & Robinson, 2006). It is important to describe the psychotherapies for EDs that are in use by the range of front-line practitioners to develop a more complete picture of how EDs are commonly treated, not just by specific subgroups of clinicians.

Second, little research has explored *why* clinicians choose the psychotherapies that they provide in clinical practice. To increase the use of ESTs, we need not only to refine our understanding of the psychological interventions that are used, but also to better understand the reasons for their use. To date, only a limited number of studies have identified predictors of use of ESTs for EDs. Results suggest that clinicians who use ESTs tend to read journal articles about EDs more frequently (Haas & Clopton, 2003) and to be involved in conducting ED research (Wallace & von Ranson, 2012). Likewise, use of manual-based psychological interventions has been associated with clinicians' previous training and education, duration of practice, and the proportion of ED clients in a clinician's typical caseload (Simmons et al., 2008). Two studies have directly queried clinicians as to why they did *not* use ESTs for EDs, concluding that the most common reasons are that ESTs are perceived as too rigid or constraining as well as inadequate for the complexity of clients seen in clinical settings (Haas & Clopton, 2003; Simmons et al., 2008). Research that directly queries clinicians as to why they chose to use the psychotherapy that they *do* provide, whether or not it is empirically supported, is largely lacking. For similar reasons, it is important to investigate perceived barriers to use of ESTs for EDs.

Third, there is a continued need to refine our knowledge of frequently used psychotherapeutic approaches used with ED clients of varying ages and diagnoses. Although the use of eclectic and addictions-based psychotherapies with ED clients is common (von Ranson & Robinson, 2006), detailed descriptions of these approaches are lacking. As most clinicians integrate treatment techniques from a variety of sources (e.g., Tobin et al., 2007; von Ranson & Robinson, 2006), a better understanding of the components that make up clinicians' treatment of EDs is critical. A finer-grained description of eclectic and addictions-based approaches to the treatment of EDs and reasons for their use may suggest potentially fruitful approaches to investigate empirically.

In a previous study, we explored the types of psychological interventions provided by 52 community clinicians working in Calgary, Alberta, Canada, all of whom regularly treated clients with EDs (von Ranson & Robinson, 2006). This study used several recruitment strategies and broad inclusion criteria to identify and include a diverse group of community clinicians (e.g., psychologists, social workers, nurses, counselors, psychiatrists, etc.) and directly queried participants about why they chose the psychotherapeutic approach that they provided.

Building upon that pilot study, in the present study we have expanded the region from which participants were drawn to include the province of Alberta. As a result, this study includes a larger, more geographically diverse group of clinicians working in both urban and rural communities than previously studied, potentially yielding more widely generalizable results. In addition, we have (a) included questions specific to treatment of particular EDs, e.g., AN, BN, and BED, rather than EDs in general, as different psychotherapies are considered ESTs for each disorder (see list of ESTs in Wallace & von Ranson, 2012); (b) asked clinicians to specify psychological interventions used with different ages of clients; (c) asked clinicians to describe eclectic approaches in detail; (d) gathered information about use of addictions-based/12-step interventions; and (e) inquired about perceived barriers to the use of ESTs. Finally, we sampled a wide swath of clinicians by inviting participation by those who had any experience providing psychotherapy or counseling for an ED, rather than including only those who had regularly treated EDs. Although the primary aims of the study were descriptive, on the basis of previous findings (Simmons et al., 2008; von Ranson & Robinson, 2006), we also hypothesized that more highly educated clinicians would be more likely to use CBT for BN and BED, and less highly educated clinicians would be more likely to use treatments without empirical support.

In sum, in the current study we sought to identify which psychological interventions community clinicians provided to clients with EDs and why they chose these treatments, as well as specific details of both the treatments provided (e.g., specific techniques used, frequency of use) and about the clinicians who provided them (e.g., demographics, training). By directly querying therapists about reasons for their choice of therapeutic approach for ED clients, influences in clinical decision-making and treatment selection may be identified and potentially targeted in efforts to improve quality of care.

Methods

Participants

Eligible participants included Alberta clinicians who had experience providing psychotherapy or counseling to individuals with EDs. There were no exclusion

criteria, and no time frame was provided. We sought to be inclusive in our sampling procedure, as previous research has indicated that psychotherapy is provided by various professionals in community settings (e.g., von Ranson & Robinson, 2006). Thus, we recruited clinicians from a range of educational and training backgrounds (e.g., psychologists, social workers, nurses, etc.). However, to meet eligibility criteria, participants' clinical work with ED clients must have included psychotherapy or counseling. We used several methods to develop a comprehensive list of potential participants: (a) we identified individuals and agencies listed in the Counseling Services and Psychologists sections of the Yellow Pages for the 15 largest population centers in Alberta: Calgary, Edmonton, Red Deer, Lethbridge, St. Albert, Medicine Hat, Grande Prairie, Airdrie, Lloydminster, Spruce Grove, Camrose, Leduc, Fort Saskatchewan, Cold Lake, and Wetaskiwin; (b) we contacted provincial licensing bodies and organizations for social workers, psychologists, and physicians, as well as regional counseling agencies and organizations for clinicians specializing in ED treatment, to request names of clinicians who provided ED treatment; (c) we solicited names of clinicians conducting ED treatment from respondents as well as those who were ineligible to participate (i.e., "snowball" recruitment). For the largest Alberta city—Calgary—we cross-checked this list against a list of eligible clinicians derived from pilot research (von Ranson & Robinson, 2006) to ensure it was comprehensive. We targeted the largest urban and rural communities in Alberta because we expected to find more clinicians in more heavily populated areas and because research indicates EDs tend to occur more frequently in urban areas (van Son, van Hoeken, Bartelds, van Furth, & Hoek, 2006).

Materials

We adapted and expanded a survey that was originally developed by Mussell et al. (2000) and subsequently revised by von Ranson & Robinson (2006) into a 25-item, semi-structured interview. The survey contained four sections. Section one included questions regarding the clinician's ED clients, the treatment modalities and settings used by the clinician, specific training received in the treatment of EDs, and interactions with physicians or other professionals. Section two assessed the participant's primary treatment approach for EDs as well as the frequency of use of 16 specific psychotherapeutic approaches, presented in alphabetical order: addictions-based (including 12-step), alternative approaches such as naturopathy, meditation, and guided imagery, CBT, eclectic, eye movement desensitization and reprocessing (EMDR), family therapy, feminist therapy, hypnotherapy, IPT, narrative therapy, play therapy, psychodynamic therapy, psychoeducation, self-disclosure, solution-focused therapy, and supportive therapy. The development of this list of psychotherapeutic approaches was previously described (von Ranson & Robinson, 2006). Participants were asked to describe any other approaches they used that had not already been mentioned, as well as their eclectic and addictions-based approaches, if used; the use of specific CBT techniques; and whether their primary treatment approach varied as a function of their client's age and diagnosis. Section three assessed reasons for the participant's primary treatment approach and, if ESTs (i.e., CBT and IPT) were not used, perceived barriers to their use. Section four assessed demographic information. Participants in southern Alberta were offered the opportunity to be listed in the Calgary Eating Disorder Program's (CEDP) community resource directory for individuals seeking outpatient ED clinicians. If they responded positively, their contact information was forwarded to the CEDP. No monetary compensation was provided for participation.

Procedure

The institutional research ethics board provided approval for the current study; all individuals provided informed consent prior to participation. Potential participants were contacted by telephone and invited to participate in the study if they met eligibility requirements. If they agreed to participate, a convenient time for an interview was arranged. If the researcher could not contact the clinician directly, a message was left, and the researcher attempted to contact the clinician again after 2 weeks if no response was received.

Data Analysis

After data collection was completed, responses to open-ended questions were coded to enable analysis. We used descriptive statistics to describe response frequencies. Chi-square analyses were conducted to examine differences in chosen psychotherapeutic approaches and the reasons given for the use of specific approaches in groups, cross-classified by level and field of education.

Results

Sample composition. In 2006 and 2007, we identified and attempted to contact all 1,131 clinicians across Alberta. We contacted and screened 573 (50.7%) clinicians. Of 130 (22.7%) screened who had treated individuals with EDs, 118 (90.8%) participated. Thus, we completed interviews with 20.6% (118/573) of Alberta clinicians screened. By the end of data collection, snowball recruitment had

resulted in no new referrals of clinicians who treated EDs, suggesting that our recruitment strategy was reasonably comprehensive.[1]

Sample demographics and description of ED clients. Participants' mean age was 48.7 years (*SD* 9.6; range 27 to 69); 83.1% were female and 94.9% were Caucasian. Clients with EDs averaged 25.8% of participants' clinical caseloads (*SD* 30.7%; mode 5%; range 1% to 100%). Most commonly, clinicians treated clients with BN (94.9%), followed by AN and eating disorder not otherwise specified (EDNOS; 83.9% each), and BED (75.4%). Almost all (96.6%) treated adult ED clients (18 years and older); 77.1% treated adolescents (13 to 17 years) and only 36.4% treated children with EDs (age 12 and under). Half (49.2%) reported currently working in a team with professionals from other disciplines to provide ED treatment. However, participants reported collaborating—i.e., having repeated communications about the client's care or health status—specifically with a physician only 39.5% of the time (*SD* 40.2%; range 0% to 100%) in the care of an ED client, rising to 47.8% (SD 42.4; range 0% to 100%) when the client had AN.

Education, licensing and training of clinicians. The mean number of years since clinicians had received their most advanced degree was 16.0 (*SD* 10.0; range 0 to 41). Level of highest educational degree varied widely: 30.5% held a doctoral degree, 54.2% held a master's degree, 13.6% had a bachelor's degree, and 1.7% had not received a bachelor's degree. Similarly, the field of participants' highest degrees varied: 31.4% were counseling psychologists, 22.9% were social workers, 10.2% were clinical psychologists, 4.2% were nutritionists, 3.4% were nurses, 4.2% were physicians, and the training of 23.7% was in another field, such as educational psychology or marriage and family therapy. Almost all participants (93.2%) reported they were registered with a regulatory body, most commonly the College of Alberta Psychologists (50.8%) or the Alberta College of Social Work (25.4%).

Most participants (85.6%) responded positively to a question about whether they had received "specific training in the treatment of EDs." However, when we sought details, only 43.5% reported having received clinical training, formal supervision, or both; an additional 11.1% reported having received informal supervision. By contrast, 69.4% reported having attended a workshop or seminar, 25.9% had read books or viewed tapes, and 10.2% had received intensive training provided by their workplace (due to multiple responses, these figures sum to more than 100%). In summary, the quality of specific training in the treatment of EDs received by most community clinicians appears questionable.

Psychotherapeutic approaches used. All but two of the 17 categories of psychotherapeutic approaches and techniques listed (16 specific approaches plus "other") were endorsed by at least one participant as their primary approach for treating EDs (see Table I). The most common primary psychotherapeutic approaches clinicians reported using with their ED clients were eclectic, CBT, and "other." Clinicians described the latter category as including dialectical behavior therapy, motivational, art and spiritual therapies, and others.

We also examined frequency of use of psychotherapeutic approaches and techniques by clinicians for ED clients, which provides a finer-grained picture of the breadth of treatment techniques used by clinicians, including both those whose primary approach was eclectic and those who had endorsed using a more specific primary approach. Table I includes the frequency with which clinicians reported they had used each category of psychotherapeutic approaches. These columns do not total 100% because participants could have endorsed the use of any or all of these approaches; however, each row totals 100%, as each clinician was asked to provide the frequency of their use of each approach. We observed great variability in approaches used, as well as their frequency of use. Most clinicians reported always using supportive and eclectic approaches, whereas most reported never having used the specialized approaches of EMDR, play therapy, hypnotherapy, and self-disclosure.

Primary approaches used with clients' age groups and ED diagnoses. The primary approaches used with adult ED clients were distributed similarly as clinicians' overall approach, with slight differences in the approaches reported used with adolescent clients (Table I). However, primary approaches for ED clients who were children included play and family therapy. Patterns of primary approaches used for each specific ED diagnosis varied minimally.

Components of eclectic approaches. The most frequently endorsed primary psychotherapeutic approach for EDs was eclectic. The term "eclectic" is ambiguous and suggests the integration of multiple approaches or techniques. Therefore, we inquired specifically about the elements included in each clinician's eclectic approach. The results are summarized in Table II, using additional categories of treatment approaches devised in a previous study

Table I. Clinicians' use of psychotherapeutic techniques or approaches with eating disorder clients, as endorsed by the sample overall and as cross-classified by eating disorder clients' age and diagnosis, in percent

		Frequency of use ($n=118$)				Age group of clients			Diagnosis of clients			
	Primary approach ($n=118$)	Always	Often	Sometimes	Never	Adults ($n=113$)	Adolescents ($n=90$)	Children ($n=42$)	AN ($n=96$)	BN ($n=111$)	BED ($n=88$)	EDNOS ($n=98$)
Addictions	2.5	10.2	11.0	28.8	50.0	1.8	1.1	0	1.0	1.8	3.4	2.0
Alternative	5.1	16.1	22.9	44.9	16.1	4.4	4.4	0	5.2	4.5	3.4	5.1
CBT	22.9	44.1	34.7	16.1	5.1	23.0	20.0	9.5	21.9	22.5	19.3	23.5
Eclectic	43.2	57.6	21.2	10.2	11.0	43.4	38.9	19.0	41.7	43.2	43.2	41.8
EMDR	.8	5.1	12.7	10.2	72.0	.9	0	0	0	.9	1.1	1.0
Family	0	11.0	19.5	48.3	21.2	0	5.6	21.4	0	0	0	0
Feminist	2.5	25.6	13.7	29.1	31.6	2.7	3.3	0	3.1	2.7	3.4	3.1
Hypnotherapy	.8	5.9	11.9	18.6	63.6	.9	0	0	0	.9	1.1	1.0
IPT	1.7	24.6	31.4	30.5	13.6	1.8	2.2	0	2.1	.9	2.3	1.0
Narrative	3.4	8.5	22.0	39.8	29.7	2.7	4.4	4.8	3.1	2.7	3.4	3.1
Play	0	.8	8.5	25.4	65.3	0	0	31.0	0	0	0	1.0
Psychodynamic	3.4	15.3	16.1	33.9	34.7	3.5	1.1	2.4	3.1	3.6	3.4	3.1
Psychoeducation	1.7	39.8	35.6	22.0	2.5	1.8	4.4	4.8	2.1	1.8	2.3	2.0
Self-disclosure	0	10.2	16.9	51.7	21.2	0	0	0	0	0	0	0
Solution-focused	3.4	11.9	33.9	42.4	11.9	3.5	5.6	0	3.1	3.6	3.4	2.0
Supportive	.8	59.3	24.6	13.6	2.5	.9	0	0	2.1	.9	1.1	1.0
Other	7.6	37.1	29.0	27.4	6.5	8.8	8.9	7.1	11.5	9.9	9.1	9.2

Note. Respondents could endorse having used multiple psychotherapeutic approaches, but only one primary psychotherapeutic approach. CBT, cognitive-behavioral therapy; EMDR, eye movement desensitization and reprocessing; IPT, interpersonal psychotherapy. Adults: 18 years and up; Adolescents: 13 to 17 years; Children: 12 years and under. AN, anorexia nervosa; BN, bulimia nervosa; BED, binge eating disorder; EDNOS, eating disorder not otherwise specified.

(Wallace & von Ranson, 2012). CBT was the most frequently mentioned element of an eclectic approach, followed by "other" psychotherapies (which most commonly included a systemic approach, art therapy, or spirituality), and strategic or solutions-oriented therapy. Some participants (14.3%) whose primary treatment approach was eclectic declined to specify which techniques they used.

Use of cognitive-behavioral techniques. As noted above, CBT was commonly used as a primary approach with ED clients, both on its own and as a component of eclectic therapy. In addition to asking about primary approaches, we asked all participants about the frequency with which they had used specific cognitive-behavioral techniques with ED clients. The results indicated that even many respondents who reported using CBT as their primary treatment approach ($n=27$) did not consistently use most cognitive-behavioral strategies with ED clients (% "always" using each technique): Self-monitoring, 59.3%; cognitive restructuring, 51.9%; written homework assignments, 48.1%; relapse prevention strategies, 44.4%; formal problem-solving, 37.0%; prescribing distracting activities, 29.6%; and stimulus control techniques, 25.9%. However, use of CBT techniques was not limited to those who reported primarily using CBT with their ED clients, as suggested above. Of clinicians whose primary approach with ED clients was something other than CBT ($n=91$), substantial minorities reported they "always" used relapse prevention strategies (47.3%), self-monitoring (34.1%) and cognitive restructuring (31.9%) techniques with their ED clients, highlighting the most popular CBT strategies.

Use of addictions-based/12-step approaches. Half of clinicians reported using addictions-based or 12-step approaches for clients with EDs at least sometimes (numbers vary because some clinicians treated only some types of EDs). Of the 46 clinicians who saw clients with AN, 65.2% used addictions-based approaches; 87.3%, 88.9% and 75.6% reported using addictions-based approaches with BN ($n=55$), BED ($n=45$), and EDNOS ($n=45$) clients, respectively. Overall, a quarter of respondents (26.3%) reported they integrated addictions-based approaches into their treatment of ED clients; a minority (15.8%) reported they referred ED clients to 12-step programs; and most (57.9%) reported they did both ($n=57$).

Clinicians provided numerous reasons for using addictions-based approaches with ED clients. The most commonly endorsed most important reasons

Table II. Categories and endorsement rates of eclectic treatment approaches used by clinicians with eating disorder clients, in percent ($n = 105$)

	Rate of endorsement
Cognitive-behavioral therapy	46.7
Other psychotherapy (e.g. art, attachment)	32.4
Strategic/solutions	17.1
Narrative	16.2
Alternative (e.g. meditation, guided imagery)	12.4
Psychodynamic	11.4
Humanistic/existential	9.5
Psychoeducation	9.5
Interpersonal psychotherapy	7.6
Family	7.6
Eye movement and desensitization reprocessing (EMDR)	6.7
Feminist	6.7
Hypnotherapy	6.7
Supportive	6.7
Motivational	4.8
Addictions	3.8
Acceptance/acceptance and commitment therapy	2.9
Behavioral	2.9
Dialectical behavioral	2.9
Mindfulness	2.9
Play therapy	1.0
Self-disclosure	1.0
Not specified	14.3

for using an addictions-based approach for EDs were to give clients additional support (26.4%), because their personal experience indicated it is effective (22.6%), and because they viewed behavior patterns in EDs as similar to those of behavioral addictions (11.3%). Various other reasons (24.5%) were given, including that it provided a model consistent with the client's view of the ED and that it is useful for ED clients who have had (other) addictions.

Reasons for use of primary approach. Clinicians most commonly endorsed the following reasons for selecting their primary treatment approach with ED clients: The approach was consistent with their theoretical orientation; their clinical experience indicated its effectiveness; and it was compatible with their clinical style (see Table III). However, when asked to provide the *most important* reason for using their primary approach, clinicians gave a diversity of responses ("other" in Table III), such as fit with/respect for client, to target underlying causes, to build on client strengths/empower the client, and other, idiosyncratic reasons. In addition, many clinicians believed the most important reason for using their primary approach was that their clinical experience indicated its effectiveness and that it could be tailored to clients' needs. Only a small minority of clinicians reported that the most important reason for using their approach was that it was supported by research.

Table III. Main reasons and the single most important reason endorsed by clinicians for use of their primary psychotherapeutic approach with eating disorder clients, in percent ($n = 118$)

	Main reason	Most important reason
Supported by research	55.9	12.4
Recommended by others	38.1	0
Consistent with theoretical orientation	83.1	5.3
Compatible with own clinical style	78.8	3.5
Flexible; can be tailored to clients' needs	70.3	18.6
Clinical experience indicates effectiveness	81.4	27.4
Received training in approach	59.3	1.8
Worked for own recovery	16.1	1.8
Other	55.1	29.2

Perceived barriers to use of ESTs. Those participants who reported never using CBT or IPT with BN or BED clients provided their main reasons as well as the most important reason for not using each of these ESTs (CBT: $n = 6$; IPT: $n = 16$). Sixty percent reported the most important reason they did not use CBT was that it was inconsistent with their personal theoretical orientation; in addition, 100% of respondents endorsed this as one of the main reasons they did not use CBT. The most frequently endorsed reasons were that CBT was incompatible with their own clinical style (83.3%), that their personal clinical experience indicated CBT lacks effectiveness (83.3%), and that CBT was inflexible (33.3%).

Different reasons were given for not using IPT. The most important reason provided for not using IPT was that the clinician had not received training in this approach (68.8%). This reason was endorsed by 87.5% of respondents. Other frequently endorsed reasons were that they were uncertain how to learn to use IPT (12.5%), lack of compelling research (6.3%), that it was inconsistent with their own theoretical orientation (6.3%), and "other" reasons (26.7%), including that they had not heard of the approach before, that it was vague, and that other approaches were believed to be more effective.

Use of primary approaches according to clinician level and field of education. Clinicians were divided into three groups based on their highest educational degree: doctoral, master's, and bachelor's or less education. The frequency of use of psychotherapeutic approaches, as shown in Table IV,

Table IV. Clinicians' primary psychotherapeutic technique used with eating disorder clients, cross-classified by clinicians' level of education, in percent

	Bachelor's or less ($n=18$)	Master's ($n=64$)	Doctorate ($n=36$)
Addictions/12-step	0	1.6	5.6
Alternative	22.2	0	5.6
Cognitive-behavioral therapy	16.7	26.6	19.4
Eclectic	38.9	40.6	50.0
Eye movement desensitization and reprocessing	0	1.6	0
Family	0	0	0
Feminist	0	4.7	0
Hypnotherapy	5.6	0	0
Interpersonal psychotherapy	0	1.6	2.8
Narrative	5.6	4.7	0
Play	0	0	0
Psychodynamic	0	0	11.1
Psychoeducation	5.6	1.6	0
Self-disclosure	0	0	0
Solution-focused	0	4.7	2.8
Supportive	0	1.6	0
Other	5.6	10.9	2.8

varied by clinicians' education level, χ^2 (26) $=43.61$, $p<.05$. Specifically, bachelor's level clinicians used alternative therapies more often than more highly educated clinicians, χ^2 (2) $=14.40$, $p=.001$, whereas doctoral clinicians used psychodynamic approaches more often, χ^2 (2) $=9.43$, $p<.01$. However, no significant group differences emerged in use of addictions-based, CBT, eclectic, feminist, psychoeducation, or "other" approaches according to clinicians' education level.

Likewise, the sample included clinicians with diverse fields of education (see Table V). Almost a quarter of respondents (categorized as "other") reported that their highest degree was in a field outside those listed, such as educational or school psychology ($n=10$), marriage and family therapy ($n=5$), experimental psychology ($n=2$), bachelor's degree in psychology ($n=2$), as well as fields such as art therapy, naturopathic medicine, pastoral counseling, and criminology ($n=1$ for each). Primary psychotherapy choice for ED clients varied by training field, χ^2 (78) $=105.69$, $p<.05$. Notably, alternative approaches were endorsed most often by nurses as well as those with degrees outside traditional mental health professions, such as educational or school psychology, χ^2 (6) $=21.62$, $p=.001$, and psychodynamic approaches were endorsed solely by physicians and those with degrees outside the health professions, χ^2 (6) $=24.65$, $p<.001$. No systematic differences in field of training were identified in use of addictions-based, CBT, eclectic, feminist, and "other" primary approaches.

Discussion

Below we discuss the study findings, describe study strengths and limitations, and present conclusions and implications based on these findings.

Who Provides Psychotherapy to Eating Disorder Clients in Alberta?

Only a minority of Alberta clinicians—one-quarter of those initially screened—reported providing psychotherapy to individuals with EDs. Our sample included clinicians with various levels of training and experience with EDs, both specialists and nonspecialists, though weighted more heavily toward the latter group as Alberta has very few specialized ED treatment programs. The diverse sample in the

Table V. Clinicians' primary psychotherapeutic technique used with eating disorder clients, cross-classified by field of clinicians' highest educational degree, in percent

	Counseling psychology ($n=37$)	Clinical psychology ($n=12$)	Social work ($n=27$)	Nutrition ($n=5$)	Nursing ($n=4$)	Medicine ($n=5$)	Other ($n=28$)
Addictions/12-step	2.7	8.3	0	0	0	20.0	0
Alternative	2.7	0	0	0	50.0	0	10.7
CBT	29.7	41.7	11.1	40.0	0	20.0	17.9
Eclectic	45.9	41.7	51.9	40.0	25.0	20.0	39.3
EMDR	0	0	3.7	0	0	0	0
Feminist	5.4	0	0	0	0	0	3.6
Hypnotherapy	2.7	0	0	0	0	0	0
IPT	2.7	0	3.7	0	0	0	0
Narrative	5.4	0	0	0	25.0	0	3.6
Psychodynamic	0	0	0	0	0	40.0	7.1
Psychoeducation	0	0	3.7	20.0	0	0	0
Solution-focused	0	8.3	3.7	0	0	0	7.1
Supportive	0	0	3.7	0	0	0	0
Other	2.7	0	18.5	0	0	0	10.7

CBT, cognitive-behavioral therapy; EMDR, eye movement desensitization and reprocessing; IPT, interpersonal psychotherapy.

present study reflects its unique focus on describing the broad range of psychological interventions provided to ED clients, mostly by non-specialists, across a relatively broad geographic area. This sample of practitioners was more diverse in many respects than those included in most previous studies of psychotherapy use with ED clients. For instance, less than one-third of participants in this study had obtained a doctoral degree, whereas half (Simmons et al., 2008) to virtually all or all participants (Haas & Clopton, 2003; Mussell et al., 2000) had obtained a doctoral degree in other studies. Unlike other Canadian jurisdictions (i.e., British Columbia, Manitoba, Ontario, and Quebec; Canadian Psychological Association, 2012) and many American jurisdictions (Association of State and Provincial Psychology Boards, n.d.) that license psychologists at the doctoral level only, Alberta also licenses psychologists at the master's degree level. Thus, the lower average level of education observed in this sample is largely attributable to the large proportion of master's level psychologists in Alberta. Furthermore, clinicians may practice psychotherapy in Alberta without being licensed as a psychologist, social worker or physician, which helps explain why several participants did not hold a graduate degree as well as the multiplicity of educational fields represented among participants.

Level and type of training in ED treatment varied considerably, but overall tended to be quite limited, leading us to conclude that the qualifications of many community clinicians treating EDs were questionable. It is important to note that a substantial minority of the sample did not appear to have the educational background to provide psychotherapy, in spite of reports that almost all were licensed. Furthermore, the finding that fewer than half of participants had *any* clinical training in ED treatment is concerning. Most clinicians reported having received some specific training in the treatment of EDs, but the intensity of training received often appeared to be minimal. Worse, 14% reported having had *no* specific training in ED treatment. It is also concerning that clinicians reported that they worked in interdisciplinary teams and collaborated with a physician in the care of ED clients only half of the time or less. Experts agree that the standard of care for EDs requires the involvement of professionals with different domains of expertise, such as a physician and nutritionist as well as a psychotherapist (e.g., Alexander & Treasure, 2011), yet the present evidence suggests that such multidisciplinary treatment of EDs occurs inconsistently, whether systematic or ad hoc. Competency of mental health professionals is an ethical obligation, and is particularly important in the treatment of EDs given the complexity and vulnerability of the population, including the risk of medical complications and death (Arcelus, Mitchell, Wales, & Nielsen, 2011; Williams & Haverkamp, 2010; Wolff & Treasure, 2008), yet the competency of many community clinicians in their treatment of individuals with EDs appears uncertain.

Which Psychotherapies Are Used for Eating Disorders?

Given the assortment of educational and training backgrounds represented, it is not surprising that clinicians reported using a wide variety of primary psychotherapeutic approaches with ED clients. The most common primary psychotherapeutic approach used was eclectic, by almost half of clinicians, consistent with specialist (Tobin et al., 2007; Wallace & von Ranson, 2012) and other community (von Ranson & Robinson, 2006) samples. In addition, clinicians reported they frequently used CBT, eclectic, IPT, supportive, and other therapies, like previous research (von Ranson & Robinson, 2006; Wallace & von Ranson, 2012).

CBT was the second most common primary psychotherapeutic approach used with ED clients, endorsed by almost one-quarter of participants. However, there is evidence to suggest that CBT is not often provided in its entirety. By contrast, previous research found that up to two-thirds of specialist clinicians used CBT as their primary psychotherapeutic approach for EDs (Haas & Clopton, 2003). However, participants in the present study reported including CBT in their treatment at least as often as participants in previous studies (e.g., Mussell et al., 2000). Differences in reported use of interventions across studies may be influenced by factors such as methodology (e.g., asking participants to indicate their primary approach versus asking participants to indicate how often they use a range of approaches/techniques) and samples (e.g., special groups of clinicians versus community clinicians).

Contrary to our hypothesis, we observed no difference in CBT use according to clinicians' educational level, but educational level and field were linked to use of two other primary psychotherapeutic approaches. Specifically, physicians, nurses, those without graduate degrees and those with degrees outside the traditional mental health professions tended to use alternative and psychodynamic approaches more often than other clinicians. Given the relatively small subgroups on which these findings are based, we urge caution in interpreting them, and encourage replication attempts.

Overall, it appeared that many community clinicians provided elements of psychotherapies recommended by evidence-based practice guidelines (e.g., CBT), but

rarely provided ESTs in the manner in which they were originally evaluated, often preferring to combine techniques and approaches instead. More research is needed to better understand the efficacy of providing psychotherapies in this manner. In addition, clinicians often used psychotherapeutic techniques that are not endorsed by evidence-based practice guidelines. For example, approximately half of participants indicated that they had used addictions-based/12-step psychotherapeutic techniques when working with clients with EDs. Most previous research on the frequency of use of psychotherapies for EDs has not examined to what degree clinicians used addictions-based approaches. As no research to date has examined the efficacy of addictions-based treatments for EDs, the empirical evaluation of the composition, compatibility, and efficacy of using addictions-based treatments with ED clients is critical. Future research may provide empirical evidence to either support or discourage continued use of specific addictions-based treatments for EDs.

On average, psychotherapeutic approaches used did not differ greatly across ED diagnoses. This observation is inconsistent with research identifying different ESTs for different ED types (Wilson et al., 2007), which suggests that certain interventions are more efficacious than others for specific EDs. Although one interpretation is that few clinicians altered their primary therapeutic approach according to the client's specific ED diagnosis, it is also possible that individual clinicians may have altered the approach used on the basis of the client's diagnosis without any net differences in the aggregate results.

Why Did Clinicians Choose the Psychotherapies They Used with ED Clients?

Consistent with the view of treatment selection as a complex process with multiple influences, clinicians tended to endorse multiple factors as influences on their selection of a primary treatment approach. One important factor considered was the age of the client: Children were most often provided family therapy.

Characteristics of the present sample were similar to those included in von Ranson and Robinson's (2006) study in participants' level of education, field of highest degree, levels of training in EDs, and portion of ED clients in their caseload. In the present study, however, participants endorsed more reasons why they used their chosen primary psychotherapeutic approach with ED clients. Nevertheless, similar reasons appeared to influence the majority of clinicians, such as that the approach was consistent with his/her theoretical orientation and personal clinical experience indicated that the approach was effective.

The finding that only half of participants indicated that available research support was a main reason for selecting his/her primary psychotherapeutic approach, including the 10% of participants who reported that available research support was the *most* important reason, indicates that many community clinicians are not considering empirical support when selecting a psychotherapeutic approach for treating EDs. This practice does not align with the current movement toward evidence-based care. In a discussion of the complexities of integrating science across health professions, Satterfield and colleagues (2009) identified key challenges to the promotion of evidence-based practice, including different conceptual frameworks and varying definitions of "evidence" across health disciplines.

Previous studies that directly queried clinicians as to why they did *not* use ESTs for EDs found the most common reasons were that ESTs were perceived as too rigid or constraining as well as inadequate for the complexity of clients seen in clinical settings (Haas & Clopton, 2003; Simmons et al., 2008). In the present study, although just six clinicians reported never having used CBT with BN or BED clients, all agreed that CBT was inconsistent with their theoretical orientation, and most agreed that CBT was incompatible with their clinical style and that their experience indicated CBT lacks effectiveness. Thus profound differences in theoretical orientation and clinical decision-making approaches appear to underlie the lack of uptake of CBT among some clinicians. Note that the small number of non-CBT-users limits confidence in the generalizability of these findings. By contrast, IPT was less polarizing: Most of the 16 clinicians who never used IPT with ED clients reported they had not received training in its use, and many indicated interest in receiving such training if it became available.

Study Strengths and Limitations

Strengths of this study included our systematic efforts to sample all clinicians with ED treatment experience within a broad geographic area, and our inclusion of clinicians across fields and levels of training, including those without advanced degrees. To our knowledge, this study is unique in its focus on describing community practitioners. In addition, at 91%, the participation rate of screened and eligible clinicians was quite high. We explored several important topics related to psychotherapy provision, and examined psychotherapy use according to clients' age group and specific ED diagnosis.

The most important limitation of this study is that we were able to reach and screen only half of the clinicians we had identified, suggesting we may have missed some eligible clinicians. However, the fact

that by the end of recruitment no new clinician names were being suggested via a snowball sampling procedure suggests that we had identified most of the Alberta clinicians with relatively more ED treatment experience. As we did not inquire about the number of ED clients each participant had seen, we were unable to evaluate whether more experienced clinicians used different psychotherapies than less experienced ones. Although questions were worded as neutrally as possible, demand characteristics could have influenced results; furthermore, it is possible that clinicians' own perception of the treatment they intend to provide does not align with that which is actually provided. Finally, although findings are broadly consistent with previous research, it is unclear to what degree findings may generalize to other locations, particularly those with different health profession environments and regulations.

Conclusions and Implications

Like clinicians from specialized samples, the community clinicians sampled in this study reported using ESTs for EDs only rarely, and not necessarily in forms that had been previously tested. Eclectic therapeutic approaches were most commonly used, including elements of CBT. Self-reported CBT clinicians used specific CBT strategies infrequently. Surprisingly, half of clinicians incorporated addictions-based approaches into their treatment of EDs. In sum, ED treatment provided by community clinicians generally does not align with evidence-based practice guidelines.

Research on clinical decision-making indicates that decision rules often outperform idiosyncratic judgments, due to cognitive errors and heuristics (Garb, 2005; Grove, Zald, Lebow, Snitz, & Nelson, 2000). For example, such a "rule" (or default position) might be to use a manualized EST for a particular problem, such as CBT or IPT for BN, unless contraindicated. This research suggests that the exceptions clinicians make—such as using an eclectic or addictions-based approach—may actually provide worse outcomes, not better ones, on average (Garb, 2005). For example, a clinician might decide a non-EST is preferable for X client for Y reason, despite the absence of systematic research supporting its use. The use of rules in clinical decision-making as described—i.e., using manualized CBT or IPT for BN—runs counter to conventional wisdom that places high value on clinical judgment. The desire to tailor treatment to an individual client assumes mistakenly that the intent of beneficence yields improved outcomes.

Converging evidence suggests that clinicians' descriptions of psychological interventions are incomplete and inconsistent with language used in randomized controlled trials. Specifically, although clinicians may describe themselves as using "CBT," further inquiry, including in the present study, has revealed that most use only selected techniques and not the CBT package provided in randomized controlled trials (Wallace & von Ranson, 2012; Waller, Stringer & Meyer, 2012). The term "eclectic" similarly refers to any combination of therapeutic approaches and strategies. Thus there is likely disagreement across individuals in the use of terms such as "CBT" and "eclectic" unless more specific elements are specified. In future dissemination efforts, it may be important to identify and highlight essential components of various psychotherapeutic approaches so as to increase the likelihood that the critical components of treatment packages are uniformly administered in clinical practice. Psychotherapy dismantling studies may identify the treatment elements that must be included to effectively provide specific psychotherapeutic approaches.

Researchers should continue to examine education and training factors influencing treatment selection for ED clients, and future efforts to disseminate ESTs should take into account the diversity of clinicians' training backgrounds and perspectives. A better understanding of why empirical evidence does not influence some clinicians' choice of therapeutic approaches is critical to help bridge the research-practice divide and disseminate ESTs into community settings. As many of our participants had received little training in ED treatment, it is unclear to what degree clinicians did not base their approach on existing research about effective treatments because they were unaware of it, did not value or trust it, had limited resources or incompatible organizational demands, or were reluctant to adopt innovations (Gallo & Barlow, 2012; Wallace & von Ranson, 2012). Clinicians made clear their interest in obtaining training in ESTs for EDs.

Clinicians' lack of training may be due in part to a lack of clearly defined training paths and opportunities related to psychological interventions for EDs (Wilson et al., 2007), which is critical to remedy if maximally effective care is to be provided to people with EDs. Emphasis needs to be placed on both clinicians' training in EST provision and ED-related knowledge. One useful source for clinicians' self-evaluation is Williams and Haverkamp's (2012) article on core competencies for ED therapists. We also encourage licensing bodies and professional organizations to provide more opportunities for continuing education in providing ESTs for EDs, such as IPT for BN and BED.

The onus of bridging the research-practice gap lies with researchers as well as clinicians. Researchers must aim to identify clinically relevant research

questions, and to provide evidence in forms that are as readily translatable to clinical practice as possible. Researcher-practitioner partnerships are one potentially fruitful means to this end.

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Note

[1] As an index of the representativeness of our sample and because EDs most often affect a specific demographic—young women—we collected demographic information from a subset of 366 clinicians we had reached who were ineligible to participate in the study because they did not treat EDs. Analyses showed two differences between groups: Study participants who had treated EDs were more likely to be female (83.1% vs. 67.9%; $\chi^2(1) = 10.01$, $p < .01$) and slightly younger (48.3 years vs. 51.2 years; $t(458) = 2.84$, $p < .05$) than non-participants. There were no group differences in ethnicity, highest level of education obtained, field or year of highest degree, or percent registered with a regulatory body. Twelve clinicians eligible to participate declined to do so, but only two provided demographic information. We deemed this number too small for valid analysis.

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