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Southern Californian Clinicians' Perspectives of Online Treatment for Adolescents with Eating Disorders

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Walden University

College of Psychology and Human Services

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Sandra McIntyre

has been found to be complete and satisfactory in all respects,
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the review committee have been made.

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Walden University

2025

Abstract

Southern Californian Clinicians' Perspectives of Online Treatment for Adolescents with

Eating Disorders

by

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MSW, University of Southern California, 2021

BA, University of California, Riverside, 2018

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Human Services

Walden University

February 2025

Abstract

Treatment for eating disorders in adolescents is constantly changing and improving. With the recent COVID-19 pandemic, there has been a major transition to telehealth treatment. Studies on the efficacy and experience of telehealth have mainly focused on clients and families, leaving out clinician perspectives. Little research has also been done on how telehealth can be improved on now that it is more commonly used. Lewin's field theory formed the framework for this qualitative study to explore clinicians' suggestions to improve telehealth treatment for eating disorders. Ten specialized mental health clinicians provided data collected using two sequenced questionnaires. Analysis of the data showed that all clinicians are utilizing telehealth when treating adolescents with eating disorders and feel that it is effective but also feel that in-person treatment cannot be replaced. Clinicians recommended systemic improvements to licensing and practice across state lines as well as technological advancements to increase the efficacy and accessibility of telehealth care. Clinically, participants identified that they could work toward setting strong boundaries and expectations prior to and during sessions, preparing for difficult scenarios, and continuing their own education on best practices when utilizing telehealth modalities. This study contributes to social change by highlighting the current drawbacks to telehealth treatment and proposing changes that can minimize these drawbacks. The use of telehealth will only increase in the future, and it will be important to fully understand how to maximize its benefits to provide the best possible care for clients.

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Section 1: Introduction to the Problem

Background of the Human Services Program

Eating disorders are a category of psychiatric disorders that includes anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), avoidant restrictive food intake disorder (ARFID), and other specified feeding and eating disorders (OSFED) that can have severe physical consequences (American Psychiatric Association, 2013). These disorders can affect individuals of all ages, genders, socioeconomic backgrounds, races, and ethnicities. However, there is a higher prevalence of eating disorders in young people and women (Silen & Keski-Rahkonen, 2022). The guidelines for treatment in the United Kingdom, Australia, and New Zealand recommend starting at the lowest level of care and transferring to higher levels if a patient demonstrates low responsiveness (Anderson et al., 2017). However, the American Psychological Association recommends that treatment providers take multiple factors into consideration, such as medical status, percentage of ideal body weight, co-occurring disorders, motivation for recovery, environmental stress, and suicidality, when deciding on a level of care (Anderson et al., 2017).

Specific psychological therapies may also be used such as cognitive behavioral therapy (CBT), dialectical behavior therapy (DBT), and family-based treatment (FBT). In children and adolescents, family-based treatment has emerged as the leading evidence-based treatment and is recommended by professionals as the first line of treatment for medically stable patients (Rienecke & Le Grange, 2022). Research has also shown the effectiveness of dialectical behavioral therapy for adolescents who respond poorly to

family-based therapy as well as the effectiveness of a blended family-based therapy/dialectical behavioral therapy approach (Reilly et al, 2020). Typically, eating disorder treatment has been primarily in-person as indicated by the different levels of care. However, online versions of different psychological treatments have been developed and implemented in recent times (Baudinet et al., 2023). This will be further discussed in the literature review portion of this document.

Social Problem

The COVID-19 pandemic has affected mental health in the general population (Monteleone et al., 2021). Individuals suffering from mental illnesses prior to the pandemic were even more vulnerable to effects on mental health including increased levels of distress, anxiety, depression, post-traumatic stress, and suicidal ideation (Monteleone et al., 2021). The negative effects of the pandemic have also been noted in people with eating disorders. One study determined that 40% of individuals reported worsening of eating disorder symptoms within the first few weeks of lockdown, and approximately 60% of individuals reported increased anxiety symptoms (Maglia et al., 2021). One study conducted in Italy showed that there was a worsening of eating disorder psychopathology both when the lockdowns began and the subsequent reopening period (Monteleone, et al., 2021). A similar study conducted in Ontario, Canada found that acute care visits increased immediately after the start of the pandemic and remained above the pre-pandemic average through the end of 2020 (Toulany et al., 2021). Additionally, there was a 37% increase in adolescent hospitalizations through the end of 2020. Adolescents are at an increased risk for worsening or new eating disorders due to disruptions to

routines, increased social anxiety, increased time spent on social media, and interruptions to existing treatment (Rodgers et al., 2020). Similarly, researchers also found that the average number of admissions per month was higher, and the average length of stay was significantly longer during the pandemic than pre-pandemic at one pediatric healthcare organization in the United States (Schlapfer et al., 2023).

The COVID-19 pandemic also affected how treatment was accessed, with many services transitioning to an online format. Prior to the pandemic, research on the efficacy of telehealth in eating disorder treatment has been limited, but there have been studies showing that it could be useful in certain scenarios. Advances in technology have led to advances in telemedicine and the use of the Internet and online interventions for psychiatric illnesses has increased (Maglia et al., 2021). Online treatment options have been shown to be easier to disseminate, cheaper, and more accessible as well as more appropriate for an adolescent population (Monteleone et al., 2021). However, with the beginning of the pandemic and lockdowns enforced, many programs and providers were forced to move online in an unprecedented way. Due to the COVID-19 crisis, telehealth has become standard in psychotherapy and in eating disorder treatment specifically (Monteleone et al., 2021). Preliminary research that has been conducted during the pandemic has shown that telehealth is a tangible and promising alternative to in-person treatment in an outpatient setting (Monteleone et al., 2021).

Local Problem

In southern California, statistics show that mental illnesses are highly prevalent, with nearly 1 in 7 adults and 1 in 14 children experiencing a mental illness or emotional

disturbance (Holt, 2022). For eating disorders specifically, California ranks in the top 10 states with the highest rates of eating disorders (Jawaid, 2024). Eating disorders cost an estimated \$7.8 billion to Californians and more than 6,500 emergency room visits (Deloitte Access Economics, 2020). During and following the COVID-19 pandemic, experts working in hospitals saw a steep increase in adolescents and adults seeking admission for medical complications due to eating disorders (Hartman-Munick et al., 2022). It can be assumed that other treatment programs across the country are similarly affected by increased need.

In southern California, many in-person treatment options had to cease due to the lockdowns and move to virtual formats. Focus of research has predominately been on the efficacy of telehealth eating disorder treatment and whether it works for patients. This research, supported by the literature review, shows that telehealth does work for patients and helps in other aspects such as increasing access to care as well as decreasing costs. Telehealth treatment has existed long before the COVID-19 pandemic, however the pandemic forced many clinicians to move online even if they were not prepared for it. Looking specifically at eating disorders and the treatment of eating disorders, telehealth was rare prior to the pandemic and global shutdowns. Clinicians at day treatment programs that have historically always been in-person had to transition very quickly to an online format. Although preliminary research has shown that telehealth treatment may be a good alternative to traditional in person options, more research needs to be done on how clinicians are adapting to this change.

Purpose of the Study

The purpose of this qualitative study was to explore eating disorder clinician perspectives related to online treatment of adolescents between the ages of 10-18 with eating disorders, focusing on what clinicians identify as barriers to online treatment and what solutions they think would help alleviate those identified barriers. The study focused on southern California, specifically Santa Barbara County, Los Angeles County, Orange County, and San Bernardino County. Virtual eating disorder treatment is a relatively new concept, and the COVID-19 pandemic really accelerated the growth of virtual treatment options. Studies have been done and are continuing to be done on the efficacy of different types of virtual treatments; however, little research has been done focusing on clinician perspectives. Looking at clinician perspectives and gaining an understanding of what they see as barriers and solutions is particularly important since they are the experts in providing treatment. Clinicians have a unique view of how virtual treatment works and how it can be improved on, which can lead to better overall recovery for the patients. Not only will better understanding clinician perspectives help the patients, but it will also help in understanding what clinicians need to be more effective in their jobs.

Research Questions

1. What do eating disorder clinicians in southern California see as the most important benefits and drawbacks to online eating disorder treatment?
2. What recommendations do these clinicians have to reduce the identified drawbacks to online eating disorder treatment?

3. What recommendations do these clinicians have to enhance the identified benefits to online eating disorder treatment?

Theoretical Framework

The framework that grounds this force field analysis study is field theory, which was introduced by Kurt Lewin (1951). The theory assumes that all living systems are in a state of change and that all systems are trying to move towards some level of equilibrium, also known as homeostasis. Lewin theorized that equilibrium in a system is maintained by a field of forces acting in different directions, with some forces moving toward change and some forces moving toward stability. If one set of these forces is stronger than the other, change either takes place or is resisted. According to Lewin, change happens with three stages. The first stage is to unfreeze, which deals with looking at what change needs to occur and accepting that change needs to happen. The second stage is to start enacting change, where those involved begin to look for new ways to do things in order to move in a different direction. The third and final stage is to refreeze, which is when the changes made in stage two are fully incorporated and internalized. Although this three-step change model may sound simple, Lewin's original theory did not view change as a linear pathway but rather a dynamic interplay between relationships, capacities, forces and movement (Malik, 2022).

Nature of the Study

To address the research questions in this qualitative study, a force field analysis was conducted. Force field analysis is a tool that is used to analyze decisions and manage organizational change in a systematic way. It can be applied in many different ways, from

reaching a specific identified desired state or seeking to create change at a structural or systematic level (Cohlan & Brydon-Miller, 2014). The main purpose of force field analysis is to identify two types of factors or forces, driving forces and restraining forces. Driving forces are those that promote change while restraining forces are those that support the existing situation. When starting a force field analysis, one needs to identify the current state (where you are now) and the ideal state (where you are trying to get to; Graf, 2021). Currently, eating disorder treatment has been predominately in person but has been moving toward more virtual formats. In the current situation, the move to an online treatment format has been progressing with little to no input from the clinicians who are treating patients. In the ideal state, the perspectives of clinicians are incorporated in creating more effective virtual treatment options. This study was conducted to identify the driving forces for change towards the ideal situation as well as the restraining forces by directly surveying clinicians who are in the field. By identifying these forces, an action plan can be created to increase facilitators of change and to decrease the barriers.

Defined Terms

Eating disorder: Behavioral conditions characterized by severe and persistent disturbance in eating behaviors and associated distressing thoughts and emotions (American Psychiatric Association, 2023).

Anorexia nervosa: An eating disorder characterized by self-starvation and weight loss resulting in low weight for height and age (American Psychiatric Association, 2023).

Bulimia nervosa: An eating disorder characterized by an individual alternating in binge eating followed by compensatory behaviors, such as over-exercising, severe calorie

restriction, purging, or using laxatives (American Psychiatric Association, 2023).

Binge eating disorder: An eating disorder characterized by episodes where they consume large quantities of food in a brief period, experience a sense of loss of control over their eating and are distressed by the behavior (American Psychiatric Association, 2023).

Force field analysis: A framework developed by Kurt Lewin that is used to identify factors that hinder and drive any given process within social sciences (Graf, 2021).

Field theory: A theory developed by Kurt Lewin that proposed behavior is the result of an individual and the environment they are in (Coghlan & Bydon-Miller, 2014).

Driving force: Also known as a facilitating factor and refers to the act of a situational or individual factor moving the process toward the ideal situation (Graf, 2021).

Restraining force: Also known as a hindering factor and refers to the forces or factors that keeps a process from moving towards the ideal situation (Graf, 2021).

Telehealth: Health care provided remotely to a patient in a separate location using two-way voice and visual communication, such as a cell-phone or computer (Merriam-Webster, n.d.)

Qualitative methods: process of naturalistic inquiry that seeks to understand the “why” instead of the “how” of social phenomena and relies on the direct experiences of human beings (Graf, 2021).

Significance of the Study

Significance of the Study for Community or Organization

This study has the potential to open a discussion among clinicians regarding the rapid transition to virtual/telehealth treatment for adolescents with eating disorders. Often, research surrounding eating disorder treatment, whether in-person or virtual, focuses on the patients and the success of the treatment. These studies tend to focus on how effective the treatment is and what can be done to make the treatment more effective. The experiences of the clinicians are rarely looked at or talked about even though they are an integral part of the success or failure of treatments. Not only will examining the experiences of clinicians help improve the treatment options themselves, but it will also encourage discussion on how to better support clinicians and prevent things like burnout.

Significance of the Study for Human Services

Eating disorders are an extremely common mental illness with many dangerous consequences. This study has the potential to change how treatment is delivered for adolescents struggling with eating disorders. Access to care is a large issue in eating disorder treatment as there are limited specialized resources, especially in remote areas. Virtual treatment options have the potential to increase access to care for those who may be unable to get treatment any other way. By learning directly from clinicians who are experts in the care of eating disorders, this study can help fine-tune virtual treatment and make it a more effective way for adolescents to get the help they need.

Literature Review

Literature Search Strategy

When conducting the literature search, I started using broad terms such as *eating disorders*, *eating disorder treatment*, and *online treatment* to establish a foundation.

Other key terms included *online mental health treatment*, *eating disorders and covid 19*, *eating disorder and the pandemic*, *adolescent eating disorders*, *treatment of adolescents with eating disorders*, *online day treatment programs for eating disorders*, *online day treatment programs for mental health*, *clinical perspectives of online eating disorder treatment*, *patient perspectives of online eating disorder treatment*, *parent perspectives of online eating disorder treatments*, *effectiveness of online eating disorder treatment*, *eating disorder treatment seeking*, *family-based treatment*, *eating disorder statistics*, *eating disorder etiology*, *background of eating disorders*, *field theory*, and *Kurt Lewin, force field analysis*. Two main databases were used: Walden University Library and Google Scholar. Advanced search was used in each database to select the publication date ranges (2019–2024) and to select only peer-reviewed scholarly articles. When there was a need for more context, I would occasionally search further into the past for articles. I also looked at references in each article found in order to identify more papers to review. The main themes focused on surrounded the treatment of eating disorders and how virtual treatment emerged in recent times.

Theoretical Framework

Field theory was developed by Kurt Lewin to better understand individual behavior. It is now used to analyze and change group behavior (Burnes & Cooke, 2013).

Lewin was influenced by gestalt psychology when developing field theory. A gestalt is defined by psychologists as a perceptual pattern or configuration that is the construct of the individual mind (Burnes & Cooke, 2013). It is a coherent whole that has specific properties that cannot be derived from individual elements or considered just a sum of them. Gestalt psychology challenged the existing beliefs set in place by structuralist and behaviorist theories which state that an individual is merely a sum of the whole. When looking at an individual's behavior, gestalt psychologists take into account their actions as well as their responses to these actions and also take into account the interpretation the individual places on these actions and responses (Burnes & Cooke, 2013).

Six fundamental characteristics underpin Lewin's field theory. First, Lewin noted that the meaning of any concept is derived from its relationship to other concepts. Second, Lewin saw equilibrium in social life as a dynamic process, where change occurs but a recognizable form is maintained. He called this quasi-stationary equilibrium. Third, Lewin argued that the elements of an individual's or group's life space must be based on their perception of their reality rather than trying to construct it from the objective viewpoint of an observer. Fourth, Lewin suggested that one needs to consider the situation as a whole rather than attempting to understand the situation by only focusing on one or two elements in isolation. Fifth, Lewin indicated that behavior is not caused by something in the past or future but grounded in the present situation. He focused on the psychological forces that impinge on the behavior of an individual in the here and now. Finally, Lewin noted that psychology should represent behavior in mathematical terms (Burnes & Cooke, 2013).

Field theory comes from the belief that all behavior arises from the psychological forces in an individual's life space and that behavioral change comes from changes in these forces (Burnes, 2019). To understand, predict, and begin to change an individual's behavior, one needs to take into account everything about that individual and their environment in order to construct their life space. Field theory allows an individual or group to map out and better understand their life space in which their behavior takes place and appreciate how forces that make up their life space can be changed to modify their own behavior. Change is seen as a gradual and slow process, and sustained and successful change can only occur if individuals and groups reflect and understand the forces that affect their lives (Burnes, 2019).

Recently, a variation of field theory called force field analysis has been used and applied to a wide range of organizational issues including leadership, gender, professional boundaries in medicine, and IT implementation (Burnes & Cooke, 2013). In field theory and force field analysis, driving forces are needed to support the initiation of change. However, the driving forces alone are not enough to support and sustain change. A three-step model was developed to make recommendations on how change can be mastered. The first step is unfreezing, which is when a plan for change is prepared. The second stage is the actual movement that individuals and those in an organization start to make toward change. The last phase is refreezing in which individuals are allowed time to practice the changed behavior until it is internalized and normalized (Rosca, 2020).

Themes and Subthemes of Literature Related to Human Services Problem

Etiology of Eating Disorders

Eating disorders significantly impair psychological and physical health and can affect people of all ages, genders, sexual orientations, ethnicities, and socioeconomic status. In the past, professionals viewed eating disorders as diseases that predominantly affected White, upper-class women and girls. However, more recent research has shown that eating disorders are prevalent among people in lower income groups, non-Western cultures, and all genders (Hay et al., 2023). More recent research has shown that boys who are hospitalized for anorexia have more severe medical conditions and longer hospital stays compared to girls (Nagata et al., 2024). Gay, bisexual, and transgender individuals are also much more at risk of developing an eating disorder compared to their heterosexual and cisgender counterparts (Parker & Harrier, 2020). Eating disorders are also found in all ethnicities in similar rates to white populations and can also affect those of all different body types (Cheng et al., 2019).

Many eating disorders can be chronic, with an early age of onset and periods of recovery and relapse. Research has shown that teenagers and young adults are particularly at risk for developing eating disorders, with the peak age of diagnosis estimated at around 15-24 years old (Chan et al., 2023). However, disordered eating and thoughts may start as early as 11-12 years of age (Chan et al., 2023). More recent evidence has suggested that the age of onset of eating disorders has been getting younger (Hay et al., 2023). There has also been a recent increase in eating disorder diagnoses, from a prevalence of 3.5% from 2000–2006 to 7.8% in 2013–2018 (Pelc et al., 2023).

Although the lifetime prevalence of a diagnosed eating disorder is relatively low in U.S. adults, a much higher number (19% of women and 14% of men) report subclinical eating disorder symptoms (Romano et al., 2021).

Although there are different forms of eating disorders, they share common behavioral symptoms as well as psychological characteristics. Negative emotions can lower self-esteem which can increase a lack of control in eating behaviors (Pelc et al., 2023). Further, eating disorders are more common among obese or overweight adolescents compared with those at a normal weight. The following are risk factors for developing an eating disorder: body dissatisfaction, pursuit of an ideal appearance, dietary restrictions, and various psychosocial factors (Pelc et al., 2023).

Risk Factors Contributing to Eating Disorders

Many studies have been done to identify risks factors for an eating disorder. Three common characteristics are body dissatisfaction, negative emotional reactivity, and lack of/low self-esteem (Curzio et al., 2018; Espinoza et al., 2019; Kenny et al., 2022). The transdiagnostic cognitive behavioral model of eating disorders, developed by Fairburn et al. (2003), also states that the common psychopathology of eating disorders can be thought of as a dysfunctional system of evaluating self-worth based on eating habits, body size and weight, and one's ability to assert control over these things. This model theorizes that this system is maintained by four psychological processes: mood intolerance, interpersonal difficulties, clinical perfectionism, and pervasive low self-esteem. For example, studies have shown that eating disorder symptoms in adolescents were associated with perfectionism, low self-esteem, mood intolerance, and over-

evaluation of body shape and weight (Curzio et al, 2018). Another study found that elevated body dissatisfaction at ages 13-16 increased likelihood of the development of an eating disorder in a 4-year period after the initial assessment (Rohde et al, 2015). Many studies have also reported that a pervasive negative self-view predicts the engagement of weight controlling behaviors in many individuals diagnosed with an eating disorder (Chan, et al., 2023; Cervera et al., 2003; Gual et al., 2002). However, one study found that body dissatisfaction at ages 10-11 was associated with less likelihood of a probable eating disorder at ages 16-17 as well as no significant association between negative reactivity and self-esteem at age 10-11 and probable eating disorder at age 16-17. It is possible that body dissatisfaction is a good predictor of eating disorders in the short term but not as robust a predictor in the longer term (Chan et al., 2023).

Several theories have been posited to explain the development of eating disorders. One of these theories is the self-esteem theory, which states that individuals with low self-esteem will also maintain an inflated sense of concern regarding their body shape which then leads to disordered eating (Zanella & Lee, 2022). Self-esteem is most typically defined as someone's subjective view of themselves, specifically their self-worth and self-confidence. Studies have connected the lowest levels of self-esteem with individuals with eating disorders (Espinoza et al., 2019; Silverstone and Salsali, 2003; Zanella & Lee, 2022).

Emotional regulation theory has also been used to help understand the development of eating disorders (Zanella & Lee, 2022). Studies have found that emotion regulation differs between types of eating disorders. For example, Dallman (2010) found

that individuals diagnosed with bulimia nervosa tend to numb negative emotions through binge eating and compensatory behaviors such as purging. Conversely, Hatch et al. (2010) found that those with anorexia nervosa will attempt to enhance their sense of emotion regulation as well self-regulation through extreme restriction.

One more theory that gives insight into eating disorders is the transdiagnostic theory. This theory states that the core cognitive concern for all the different types of eating disorders is the hyper fixation on body shape and weight (Fairburn et al., 2003). Recent evidence has also shown that perfectionism and over-vigilance play central roles in eating disorders (Vervaet et al., 2020).

One major limitation in the treatment of eating disorders is the overall lack of understanding surrounding why eating disorders occur and what specific risk factors suggest the presence of eating disorders. Solmi et al. (2021) examined nine different meta-analyses showing that there was a lack of evidence supporting any specific eating disorder risk factors. This study showed that there is likely some genetic risk for anorexia nervosa, similar to other psychological disorders. It also showed that appearance related teasing could be a risk factor but most likely suggests that interpersonal and social functioning could be the overlying risk factor. Solmi et al. suggested future research in better understanding risk factors for eating disorders as it can lead to earlier detection and treatment.

Over the last decade, more research has been done to better understand the genetic, epigenetic and neurobiological underpinnings of eating disorders. According to a literature review by Trace et al. (2013), twin and family studies have consistently shown

that there is a strong genetic component to eating disorders and that they are highly heritable diseases. There is also evidence through neuroimaging that confirmed the notion of an anorexia nervosa temperament that is genetically driven and neurobiologically based that influences vulnerability to the disorder as well as persistence of the illness (Kaye et al., 2009). More research has also been done looking at the connection between the gut microbiome, gastrointestinal disturbances and eating disorders. Anorexia nervosa associated genes were found to impact the brain as well as the gut and metabolic processes of individuals (Igudesman et al., 2019). Watson et al. (2019) found significant genetic correlation between eating disorders and other psychiatric illnesses such as obsessive-compulsive disorder, anxiety, and depression. Not only is there a significant overlap of eating disorders with other psychiatric illnesses, but there is also an overlap with neurodivergent presentations such as autism and attention deficient hyperactivity disorder (Christiansen et al., 2024). Serotonin (5-hydroxytryptamin, 5HT), a neurotransmitter in the brain, is believed to play a part in regulating mood and appetite (Yokokura et al., 2019).

Social and Economic Costs of Eating Disorders

On a national and global scale, eating disorders affect not only the diagnosed adolescents but also their families, the community, and the economy (Deloitte Access Economics, 2020). Total tangible costs in the United States associated with eating disorders in the fiscal year of 2018 to 2019 were approximately \$64.7 billion with individuals bearing 29% of those costs and the remaining costs shared by the government, employers, society, and family or friends (Streatfeild et al., 2021). The

approximate cost per diagnosed person was found to be highest for those with anorexia nervosa at \$2615 and the total health system cost for all eating disorders averaged at \$4.6 billion from 2018 to 2019 in the United States. (Streatfeild et al., 2021). Health system costs include services delivered in a primary care setting, hospital and emergency visits, diagnostic tests, medications, and medical research. There are also economic costs outside of the healthcare system such as reduced individual productivity, lost caregiver productivity costs, and efficiency losses.

Caregivers are a critical component in caring for adolescents and adults with eating disorders. The role of a caregiver, such as a parent, includes first identifying signs of the disorder, pursuing initial diagnosis and treatment, navigating the physical and mental challenges in their child/loved one, and participating in active treatment (Wilksch, 2023). On top of caring for their sick child, parents are also expected to manage their other roles such as caring for other children, working, and maintaining finances. Parents, specifically, report high caregiver burden, with over 30% of them reporting moderate to severe levels of distress (Wilksch, 2023). Overall, caregivers in the United States were estimated to spend an average of 4.45 hours per week caring for their loved ones, which added up to 232 hours per year (Deloitte Access Economics, 2020).

Research has also been done to look at the productivity costs of eating disorders in the United States. Eating disorders can have a negative effect on an individual's ability to function in relation to their engagement in work. One study showed that individuals with eating disorders are 10.8% less likely to be employed (Samnaliev et al., 2014). It is estimated that from 2018 to 2019 in the US, reduced employment as a result of eating

disorders cost \$15.2 billion (Deloitte Access Economics, 2020).

Another productivity cost is that of premature mortality. Anorexia nervosa has the highest mortality rate of any other mental illness, with suicide being the main causes of death (Forcano et al., 2011). A study conducted in Denmark by Soeby et al. (2024) showed that individuals diagnosed with anorexia nervosa had a 4.5 times increased mortality rate compared to the general population. The results from this study were consistent with studies done in the past regarding the mortality rates of anorexia. Another study showed that requiring hospitalization for anorexia was associated with an increased risk of death up to 20 years later (Auger et al. 2021). From 2018 to 2019, it is estimated that there were 10,200 deaths as a result of eating disorders, and the annual cost of lost productivity due to premature death was estimated at \$8.8 billion (Deloitte Access Economics, 2020).

COVID-19 Effects on Eating Disorders

The COVID-19 pandemic had a major adverse effect on children, adolescents and families struggling with eating disorders. Research has shown that individuals with eating disorders reported a worsening of eating disorder symptoms and behaviors as well as an increase in stress, anxiety and depression during the beginning of the pandemic (Termorshuizen et al., 2022). Rodgers et al. (2020) proposed three possible reasons for how the pandemic could lead to an increase in eating disorder symptoms: disruption of daily routines and constraints in social activity, exposure to eating disorder-specific and anxiety provoking content in media, and emotional distress caused by fears of health problems and contagion. These three factors combined with social isolation, possible lack

of access to support systems, and difficulty obtaining professional help have the potential to affect individuals with eating disorders in a dangerous way.

One study conducted by Machado et al. (2020) aimed to examine these factors and see if those with eating disorders were truly affected by the pandemic. This study found that most participants (all with diagnosed eating disorders) reported that the pandemic changed their lives in terms of routines, levels of stress, physical exercise, and eating habits. The study also suggested that the higher reported impact of the pandemic was significantly correlated with eating disorder symptoms, associated psychopathology, impulsivity, and difficulties in emotion regulation.

Historically, pandemics and periods of mass quarantine are linked with increased psychological distress and those with pre-existing psychological illness are especially affected. The pandemic fueled additional feelings of depression, anxiety, uncertainty, and psychological distress (Di Blasi et al., 2021). Eating disorder behaviors may arise and worsen due to maladaptive emotional regulation strategies and the pandemic increased the likelihood of using these maladaptive strategies to cope. Further exploration has shown that the recent COVID-19 pandemic led to a marked worsening of eating disorder symptoms such as restriction, binge eating and compulsive exercise (Haghshomar et al., 2022; Spigel et al., 2021).

One study that was conducted at the start of the pandemic reported that over 60% of their participants, all individuals struggling with eating disorders, experienced comorbid generalized anxiety disorder and reported increased anxiety specifically related to COVID-19 (Vuillier et al., 2021). This same study also found that 83.1% of their

participants indicated their eating disorder symptoms worsened. The three most important factors identified in this study were: changes to routine, physical activity, and difficulties around their emotions. Study participants expressed experiencing increased emotional distress, such as increased fear and uncertainty, during the pandemic which negatively impacted their eating disorders. They also reported changes to their routine which resulted in accessibility to safe foods, engagement in exercise, and overall flexibility to engage in eating disorder behaviors. Participants living alone reported increased feelings of isolation and a lack of social connection which worsened eating disorder behaviors. On the other hand, participants who had to lockdown with family, partners, or friends reported increased stress from lack of privacy and feeling constantly monitored. More time spent at home also resulted in more time spent consuming various forms of media. Many participants reported seeing triggering content on media promoting weight loss, workouts, and diets (Vuillier et al., 2021).

There was a major spike in the number of new diagnoses as well as a spike in the acuity of pre-existing diagnoses. Higher rates of emergency room visits and hospital admissions have been recorded since the beginning of the pandemic (Haripersad et al., 2021). For example, one Canadian study looked at the rates of hospitalizations for anorexia at two separate hospitals and found that there was a substantial increase in admissions at both hospitals (Vyver et al., 2023). Studies conducted in Australia, New Zealand and the United States show similar results (Hansen et al., 2021; Jones et al., 2020; Otto et al., 2021). Adolescents already in treatment also reported increased eating disorder-related thoughts and behaviors as well as decreased motivation for recovery

(Vitagliano et al., 2021). The high demand for care as well as the high acuity of cases combined with disruptions in services due to global shutdowns has led to extremely long waitlists for treatment (Devoe et al., 2023).

Clinicians and caregivers were also affected by the impact of the pandemic on eating disorders. Obeid et al. (2024) found that caregivers reported increased rates of depression and anxiety reported. The study also found that professionals in the field reported increased workloads, lack of support, and needing to shift practices suddenly. These same professionals also reported high levels of moral distress and burnout while providing care during the pandemic. Youth, caregivers, and health professionals that participated in this study all brought up the increased waitlist times and lack of access to treatment that were exacerbated by the pandemic.

Eating Disorder Treatment

There are many ways to treat eating disorders, ranging from traditional talk therapy to hospitalization. Research continues to be done regarding the most effective ways of treating individuals with eating disorders. The most common treatment offered to individuals is enhanced cognitive behavioral therapy (CBT-E) which works by directly targeting thoughts related to eating disorders behaviors and is the recommended as the first line of treatment for bulimia nervosa and binge eating disorder (Kaidesoja et al., 2022). A systematic literature review of the effectiveness of enhanced cognitive behavioral therapy on treating eating disorders showed that it produces good outcomes in reducing eating disorder symptomology for those with bulimia and binge eating disorder when delivered face-to-face, individually (Kaidesoja et al., 2022). However, for those

with anorexia nervosa, this review found that there was very limited evidence supporting enhanced cognitive behavioral therapy as an effective treatment modality.

More recent research has been focused on dialectical behavioral therapy as an alternative treatment modality for eating disorders. Dialectical behavioral therapy was originally developed for use in those with borderline personality disorder and has been an effective treatment approach for individuals with chronic suicidal behaviors (Linehan, 1991). Skills are separated into the following four modules: distress tolerance, emotional regulation, mindfulness, and interpersonal effectiveness (Linehan, 1991). More recently, DBT has been tailored to treat individuals with eating disorders and specifically adolescents with eating disorders (Reilly et al., 2020). This form of therapy targets the emotions that are seen as the underlying cause of the eating disorder symptoms.

A link between difficulties with emotions and eating disorders has been widely established in past research (Vuiller et al., 2024). Individuals with eating disorders tend to struggle with identifying and describing their emotions which is also known as alexithymia (Westwood et al., 2017). They also struggle with regulating their emotions and will over-rely on maladaptive emotional regulation strategies (Vuiller et al., 2021). Individuals with eating disorders will also differ in their beliefs about emotions, such as whether emotions are controllable and whether emotions are good or bad (Ford et al., 2019). These individuals tend to believe that they are unable to control or manage their emotions which is linked to more severe eating disorder symptomology (Vuiller, Joseph, et al., 2021).

In treating eating disorders, DBT focuses on emotional non-acceptance and offers

strategies for managing emotions using a combination of individual therapy, skills groups, and phone coaching (Vuiller, Greville-Harris, et al., 2024). In working with adolescents, DBT includes a focus on increasing validation and effective family communication, which can be very helpful in eating disorder treatment (Reilly et al., 2020). Preliminary research has shown success in the use of DBT as the primary modality for treating both adults and adolescents with eating disorders (Rozakou-Soumalia et al., 2021). It has also been shown to be equally effective as cognitive behavioral therapy and less associated with relapse at the 6-month follow-up time point. (Lammers et al., 2022). Studies have shown results such as a significant improvement in BMI and cognitive symptoms as well as an increase in adaptive skills and decrease in depressive symptoms (Fisher & Peterson, 2015; Safer et al., 2007; Salbach-Andrae et al., 2007, 2008). In addition to DBT on its own, an integration of DBT and family-based treatment has been shown to be effective for treating adolescents with eating disorders (Johnston et al., 2015; Murray et al., 2015; Pennell et al., 2019; Peterson et al., 2019).

Family-based treatment is typically seen as the gold standard of treatment for children and adolescents with eating disorders (Hay et al., 2014; National Institute of Mental Health, 2020; Resmark et al., 2019). The central tenant of FBT is to focus on the family as a resource to bring about behavioral change rather than exploring the underlying causes of the disorder (Rienecke & Le Grange, 2022). Traditional FBT is delivered by a trained psychologist and involves weekly family sessions. Lock and LeGrange (2002) developed the treatment manual for FBT, organizing it into three phases which are primarily symptom oriented. Phase one focuses on empowering parents

to take charge of refeeding their children. Phase two focuses on the gradual return to age-appropriate control of nourishment to the child. Finally, phase three focuses on relapse prevention and the return to normal family life.

Several studies have shown that the use of this modality in an outpatient setting has been shown to lower the number of days patients need to spend in the hospital and lower the cost of treatment per patient (Agras et al., 2014; Hughes et al., 2013; Lock et al., 2016). However, research has shown the importance of implementing this treatment from the start, as a key predictor of FBT failure is having any history of receiving a different form of eating disorder treatment prior (Datta et al., 2022). Although higher levels of care such as residential or partial hospitalization may be necessary for some individuals, it may not always be a viable option for patients or families for a myriad of reasons. For some families, higher levels of care may not be accessible in their communities or may be too expensive. Hughes et al. (2013) found a 56% decrease in the need for medical hospitalization when an FBT outpatient program was implemented first. However, a study conducted by Lau et al. (2024), which compared medical centers that reported a high adherence in FBT and those who reported a low adherence in FBT, showed that there were no significant differences in higher level of care utilization. Researchers have proposed the need for studies looking at whether the early implementation of outpatient FBT could reduce the need for a higher level of care.

There are also different levels of care for eating disorder treatment, ranging from medical stabilization in a hospital to weekly outpatient visits. Medical stabilization programs, which are inpatient hospital programs, are suggested for adolescents who are

facing imminent physical risk as a consequence of their eating disorders (Anderson et al., 2017). This level of care is necessary because eating disorder behaviors, such as severe restriction, binge eating, and/or purging, can cause acute medical risks. These risks include malnutrition, electrolyte imbalances, abnormal heart rates, and dehydration that necessitate the need for close medical observation (Anderson et al., 2017). Residential programs are characterized by the adolescents living in a home-like facility, receiving around-the-clock psychological and nutritional support as well as therapeutic recreational activities (Peckmezian & Paxton, 2020). Unlike inpatient programs, residential programs offer less medical oversight, and individuals need to be cleared as medically stable prior to admission (Peckmezian & Paxton, 2020). The next step down is partial hospitalization programs (PHP), or day treatment programs where adolescents no longer live at the facility but continue to receive treatment in the form of psychological support and meal support anywhere from 6 to 10 hours a day. (Anderson et al., 2017). Once an adolescent has completed partial hospitalization program, they move on to intensive outpatient programs (IOP), where they attend scheduled group and individual sessions for approximately 3 hours daily (Anderson et al., 2017). As the adolescent progresses through the partial hospitalization program and the intensive outpatient program, the number of days of treatment starts to decrease along with the number of hours spent in treatment. This is to allow the adolescent to practice skills learned in sessions in a real-life format while still receiving the necessary supports. Once the intensive outpatient program is completed, adolescents will return to an outpatient setting where they are followed by a multidisciplinary team made up of a dietitian, psychologist and medical

doctor (Pehlivan et al., 2022).

The field of eating disorder treatment is always changing and adapting to new research. Treatment modalities such as cognitive behavioral therapy and family-based treatment are constantly being refined as new research becomes available. Personalizing treatment is something that has been increasingly recommended. Clinicians are recognizing that it is important to adapt treatment modalities to the patients. According to Byrne & Furland (2024), the original treatment manuals for CBT and FBT promoted treatment by a single provider, usually a mental health professional. Now, clinical practice guidelines recommend treatment with a multidisciplinary team consisting of a physician, mental health professional, and registered dietitian.

The Transition to Telehealth Eating Disorder Treatment

In the post-pandemic era, online forms of treatment for various mental illnesses have started to rise in popularity. This includes various online forms of treatment for eating disorders, such as mobile apps and virtual therapy sessions. Evidence shows that internet-based self-help interventions can be effective in reducing eating disorder symptoms and offer a way to provide faster help to those currently waiting for treatment (Rohrbach et al., 2022). One study was conducted in the UK showing that an online emotion self-help intervention was promising in reducing eating disorder psychopathology and changing emotion regulation processes (Vuiller et al., 2024) This study also found that individuals reported being able to form new beliefs about emotions which helped them deal with their feelings in healthier ways. Although this was only a pilot study with a small sample size, it shows that online interventions could be a game

changer in the field of eating disorder treatment.

A study conducted by Heinecke et al. (2007) evaluated the effects of an online treatment group aimed at improving body image and reducing symptoms associated with eating disorders. It was shown that there were significant improvements in body image and eating disorder symptoms in those who received the online treatment, with 65% of participants reporting they referred the online group to an in-person option. This study was conducted long before COVID and the sweeping switch to telehealth options but is useful in showing that telehealth can be very beneficial in eating disorder treatment. In 2019, Anastasiadou et al., evaluated the efficacy of a telehealth mobile app intervention for eating disorder treatment. This study showed no significant differences between the mobile app group and the in-person treatment group for reduction in eating disorder symptoms but did show that those in the mobile group app had a reduced number of visits to a mental health unit which suggests that telehealth could lead to a reduction in healthcare costs associated with in-person visits.

Several studies have also been conducted looking at the experiences of adolescents and parents moving online for eating disorder treatment. One study examined the experiences of adolescents and parents who transitioned to an online eating disorder day treatment program (Brothwood et al., 2021). It was found that adolescents felt that online day treatment was slightly less helpful than their parents. However, while both adolescents and parents did express that they appreciated the flexibility that accompanied online treatment, adolescents found that there was a disruption in the therapeutic alliance. Shaw et al. (2021) examined how patients, families, and staff members of a specific

eating disorder treatment program in the UK felt about the changes made during the pandemic. This study showed that more referrals were accepted in 2020 than in 2019, the percentage of increase was higher for urgent referrals and there was an increase in the number of admissions for eating disorder patients in the general pediatric ward. Overall, Shaw et al. found that the use of virtual platforms for treatment increased the ease of access for staff, patients, and families. Staff reported they could work with more autonomy and offer increased contact to patients without space constraints. However, staff also reported that working from home made it harder for them to disconnect and made work feel less satisfying. They also expressed concern regarding the lack of ability to monitor the physical well-being of patients since they could not assess the patients in-person. Patients and families reported that being able to use virtual treatment options lowered the cost of travel and helped them feel less drained. However, parents also reported that it was much more intense offering support to their child during the lockdowns as they needed to juggle care giving as well as working from home.

Research has been done and is currently being done regarding the efficacy and development of online treatment methods for eating disorders as well as other psychiatric illnesses. However, there are very few studies looking at the perspectives of mental health professionals and their views of digital mental health interventions (DMHIs). A study was recently conducted in Germany by Mayer et al. (2024) that aimed to better understand how clinicians feel about digital mental health interventions. The study found that all the clinicians sampled had some experience with digital mental health interventions for general mental health, mostly in conducting video-based psychotherapy

sessions. Clinicians shared that they appreciated that being able to connect with patients and families via video was more convenient and cost-effective. However, they also expressed that video visits could not replace face-to-face therapy. Very few of the sampled clinicians had experience with eating disorder-specific digital mental health interventions prior to the pandemic. Those who had some knowledge expressed that digital mental health interventions could be effective when used in adjunct with traditional treatment. Concerns included the potential harm DMHIs could do to the therapeutic alliance, especially if patients used DMHIs as a substitution for face-to-face therapy. Clinicians were also concerned for the safety of patients and not being able to intervene in time if a crisis did arise. In general, this study states DMHIs should never be “one size fits all”. Although some aspects can be generalized to all eating disorders, there is also a need to build in specifics based on the diagnosis.

Eating Disorder Treatment Seeking

Individuals with eating disorders are not likely to seek treatment and this varies within different cultural groups. Data has shown that those who identify with a racial/ethnic minority, as being male, and those who are younger are less likely to seek treatment than those who identify as White, female and are older (Romano et al, 2021). A literature review conducted by Bomben et al. (2021) looking at help-seeking attitudes in men with eating disorder showed that men much less likely to seek help for mental health conditions, including eating disorders, and are more likely to view mental health interventions more negatively. This review also found strong evidence that men who conform more to masculine norms are more likely to hold a negative attitude towards

help seeking.

Overall, it is estimated that only 19-36% of individuals with an eating disorder will receive any type of treatment (Hart et al., 2011). Out of those who do receive treatment, only 35-40% will receive targeted treatment for their disorder (Mond et al., 2007). A study conducted by Hamilton et al. (2022) found that there is a significant delay that is often seen between the onset of symptoms and eventual treatment access. Individuals with binge eating disorder and bulimia experienced a significant longer delay in treatment-seeking from the onset of symptoms compared to those with anorexia. They found that average delay for individuals with anorexia is 2.5 years, 4.4 years for those with bulimia, and 5.6 years for those with binge eating disorder. Stigma and shame were identified as the key barriers to treatment seeking in several studies. Other barriers include denial or failure to perceive the seriousness of the disorder, practical barriers, and negative attitudes towards treatment. One American study found that only 20% of adolescents sought out eating disorder treatment and this percentage was even lower in a similar Australian study (Fatt et al., 2020; Forrest et al., 2017). Further research in the future will likely focus on continuing to identify causes of delays in treatment seeking and how to mitigate these factors.

Summary

This section set the stage for the current research project by outlining the social and local problem that this study hopes to target. This section also details the nature of the study, significance of the study, and the theory that serves as the framework to the development of the study. An extensive literature review was also conducted in this

section, providing background on the problem and highlighting the gaps in previous research that this study hopes to target. The next section will provide details on the actual research project, including the research design and methods as well as the plan for data analysis.

Section 2: The Project

This section will cover the research project, starting with restating the purpose of this study followed by an explanation of the project design. Next, this section will include a detailed description of the method of data collection. The role of the researcher will be explained along with the recruitment and sampling strategy. Finally, this section will cover the data analysis plan and ethical considerations.

Purpose Statement

The purpose of this study was to gain insights into telehealth eating disorder treatment from the perspectives of the clinicians. This study aims to determine what clinicians feel are benefits and drawbacks to telehealth treatment as well as what clinicians feel can be done to enhance the benefits and reduce drawbacks.

Project Design

The primary design of this research study was a force field analysis. The clinicians were asked their thoughts around the benefits and drawbacks of telehealth treatment and what they feel should be done to improve telehealth treatment using open-ended questions delivered via surveys. Once the answers to the first survey were analyzed, a second survey was sent out asking clinicians to rank the proposed suggestions for change. The results of this study informed a white paper, which highlight the findings from this study as well as discuss the implications of these findings for the field of eating disorder research (see Appendix). This white paper will also include recommendations for improvements to virtual eating disorder treatment based on the results of the current study and discuss implications for social change.

Methods

Role of the Researcher

The main role of a researcher in a qualitative study is to create a connection with participants in which their thoughts and feelings can be accessed (Sutton & Austin, 2015). Initially, the researcher needs to have a solid understanding of the study and what they hope to achieve from conducting this study. The first thing the researcher needs to do is identify who their study participants will be and how they plan to recruit for the study. Next, the researcher will reach out to the participants to obtain informed consent and will make sure participants understand the purpose and goals of the study. Once the participants are recruited, the researcher will begin data collection followed by data analysis.

Participant Recruitment and Sampling Strategy

For this study, the population was all clinicians who work in the field of eating disorders. To narrow the population down to the sample, I only selected social workers, marriage and family therapists, professional clinical counselors, and psychologists. These clinicians are the ones who work the most closely with individuals diagnosed with an eating disorder who are currently in treatment. Typically, while in treatment, an individual is expected to see their mental health provider (social worker, marriage and family therapist, or psychologist) at least once a week. If the individual is in a higher level of care, they may see the mental health provider multiple times a week in both private and group sessions. These clinicians are also the ones who had to transition to telehealth once the pandemic began.

A participant was chosen based on the following criteria: licensed to practice in the state of California, currently working with adolescents diagnosed with an eating disorder, is a social worker, marriage and family therapist, psychologist, or registered dietitian, and has utilized telehealth treatment in the past with clients and/or are currently using telehealth treatment.

I gathered participants from the nation's leading eating disorder treatment provider directory (FindEDHelp.com). This guarantees that they have some expertise in working with individuals diagnosed with eating disorders. I was also able to narrow the search down to providers who are social workers, marriage and family therapists, licensed professional clinical counselors, and psychologists as well as where these providers practice. The directory also gives a brief description of each treatment provider, which typically includes whether they utilize telehealth in their practice as well as what age range they work with.

For this study with this specific population, eight to 12 participants were needed. This was determined by using the concept of saturation, which can be defined as the criteria for judging when to stop sampling different groups and when no additional data are being found. Essentially, saturation argues that, at some point during data collection, the research will see participants starting to say the same things over and over. For interviews specifically, experts argue that saturation is often reached between the ninth and 17th participant (Mwita, 2022).

I accessed the directory of treatment providers from FindEDHelp.com and then selected California when asked for a location of the providers. From there, I accessed a

comprehensive list of all providers and what the role is of each provider. I was able to select participants who fit the sample criteria and contact these providers through the email that is included in the description of the provider. An initial email was sent to these clinicians explaining the study and asking if there is any interest in participating. Those who responded with a positive response were recruited as participants for the study.

According to FindEDHelp.com, there are a total of 2,147 treatment providers registered. When narrowed down to just California, there were 442 providers. Since this population consists of professionals in the same field, with similar educational backgrounds, it would be reasonable to estimate that eight to 12 participants will provide ample data.

Data Collection

For this study, data were collected through surveys consisting of open-ended questions. The initial survey gathered data regarding what clinicians identify as benefits and drawbacks to virtual eating disorder treatment based on their own experience with it. This survey also asked the participants what they think will enhance the benefits of virtual treatment and what they think will reduce the drawbacks. Once the data from the first survey were analyzed, a second survey was sent to participants to rank the proposed methods of enhancing treatment and methods of reducing drawbacks. Participants were asked to rank the methods from most important to least important as well as from most achievable to least achievable. After the study is complete, I reached out to their participants to thank them for their participation as well as to ask participants whether they are interested in receiving information on the findings of the study.

I used SurveyMonkey, an online survey tool, to collect data. I used background literature to create unique survey questions. To establish content validity of the survey questions, I shared survey questions with the doctorate committee as well as with several other professionals in the field of eating disorders who will not be participants in the study. There were two surveys sent out for this study with a 2-to-3-week response time after each survey. If recruitment resulted in too few participants, the plan was to broaden the search for participants through other eating disorder professional organizations outside of FindEDhelp.com.

Data Analysis

Data Analysis Plan

Once the data were collected, I organized and categorized the answers in order to best understand what participants are identifying as the benefits and drawbacks to telehealth treatment as well as what they are identifying as solutions and barriers. Coding is a qualitative data analysis strategy in which some aspect of the data is assigned a label that allows the researcher to easily identify related categories across the data (University of Illinois, 2024). This also helps the researcher to identify various themes and patterns in the data. For this study, I used inductive coding, which is a ground-up approach. This means that the codes were derived from the data with no preconceived notions of what the codes should be. Typically, there will be several coding passes. The first round of coding is about starting the process of organizing the data while the next several passes focus on reanalyzing, finding patterns, and identifying themes which brings the researcher closer to developing theories.

Ethical Considerations for Data Collection

Informed consent is an important part of any research study. The informed consent covers information on what the study is about, what is expected of participants, and how the researcher plans to protect the participants (US Department of Health and Human Services, n.d). I asked participants to disclose their email addresses on the first survey for them to receive the second survey, which was included in the informed consent. I informed participants that their email addresses would be recorded on SurveyMonkey with the rest of the data and that I would only send the participants emails that pertain to the study (sending out the second survey, concluding remarks, and sending out the study findings to those interested). If a majority of participants are against providing their email addresses, I planned to collect data for the second survey from a new group of participants. Early withdrawal from the study could also be a potential concern. This would mean that participants who completed the first survey decide not to return to complete the second survey. To avoid not having an ample amount of data by the end of the data collection time period, I recruited more participants than the necessary saturation amount to ensure enough data were collected.

To gain access to collecting data from human participants, I had approval from the Institutional Review Board (IRB; approval no. 10-25-24-1174439). The IRB is responsible for ensuring that all research studies comply with the university's ethical standards as well as United States federal regulations. I also completed the CITI training course on human subjects' protections (ID number 54899880).

Any personal or identifying information provided by participants, such as their

name and email address, will be kept completely confidential. I only used this information to identify the participants who will be sent a second survey and who want to know the findings of the study. All surveys will be kept online via the SurveyMonkey website, and I was the only one who can assess the data. The final study does not include any identifying information regarding participants and will only include the final analyzed data. The data will be kept for no longer than 5 years before it is destroyed. With regards to participant email address, I used my university email to send correspondences and will erase all emails from their inbox/outbox after sending out the findings of the study to those interested.

Preconceived ideas about the topic of virtual treatment for eating disorders include (a) clinicians who believe virtual treatment is not effective at all and worthless and (b) clinicians who feel very strongly about continuing virtual treatment with little interest in returning to in-person modalities. Due to the nature of this study, these biases were a helpful addition to the data. Part of the analysis portion was focused on looking at why some clinicians felt so strongly against virtual treatment and why some feel like they no longer want to work in person. The assumption is that those who originally held negative views of telehealth will most likely report negative experiences. The plan was to collect data on the initial clinician views of telehealth, prior to the pandemic, so that can be incorporated when results are interpreted.

As a researcher on this topic who also currently works in the field, the main ethical concern was maintaining clear boundaries. It is possible that I know and have a personal relationship with some of the clinicians sampled. It was important to maintain

professionalism and not show any type of favoritism to those participants. I also made sure my opinions regarding telehealth treatment did not influence the survey questions that are created.

Summary

This section provided details on how the researcher plans to conduct the present study, including the plan for recruiting participants, how the data were collected and how the data were analyzed. This section also discussed the purpose of this study, the role of the researcher, and what ethical concerns. The next section will look at the results of the study.

Section 3: Results of the Study

This section will begin by restating the original research questions and then delve into the results of the study. The results will be presented followed by an explanation will be given of whether the results align with the literature and conceptual framework.

Research Questions

The research questions for this study were:

1. What do eating disorder clinicians in southern California see as the most important benefits and drawbacks to online eating disorder treatment?
2. What recommendations do these clinicians have to reduce the identified drawbacks to online eating disorder treatment?
3. What recommendations do these clinicians have to enhance the identified benefits to online eating disorder treatment?

Presentation of the Results

Initial Survey Results

A total of 10 responses were collected for the initial survey in this study. Responses were collected over a 4-week period. All participants work in private practice ranging from 3 to 24 years of experience in the eating disorder field. Out of the 10 participants, only one had experience with telehealth prior to the pandemic. There was an even split among participants regarding the transition to telehealth; half the participants felt the transition was smooth and seamless while the other half felt that there were some difficulties for themselves and their clients. Only one participant expressed preference for telehealth treatment, with the other nine participants stating that they prefer in-person

sessions. However, all 10 participants are still utilizing telehealth with clients.

Participants noted the following benefits to telehealth treatment: convenience, accessibility, and flexibility for providers (moving to a new area, life changes). Every single participant included convenience and accessibility as part of their response when asked about benefits to telehealth treatment. Participants noted that telehealth treatment meant that they would no longer need to commute to an office and that clients no longer needed to travel to appointments. This meant less cancellations and less missed appointments. It was also noted that telehealth lightened the load for parents of younger clients since they did not have to drive their children anywhere or figure out childcare for other children in the home. Participants noted that clients in more remote areas were also able to access care more easily with the introduction of telehealth sessions. Continuity of care was also improved as clients could be seen virtually even if they were out of town, on vacation, or admitted to a hospital. Participants also noted that they felt that telehealth increased flexibility by allowing them to work in their own homes, on their own schedules. One participant noted that they were still able to see their clients remotely while moving homes. Another participant noted that it made returning to work from maternity leave easier and gave them more time to spend with their new baby.

The following suggestions were made by participants on how to enhance these benefits: the ability to easily get licensed among multiple states, being able to practice across state lines, improvements to insurance coverage for telehealth treatment, improvements to technology, and better integration between telehealth platforms to reduce the need to go between multiple platforms. There are many rules around licensing

as a mental health clinician and telehealth treatment across state lines that can impede upon accessibility and continuity of care for clients. In most cases, practitioners must meet licensing requirements in a specific state to practice with clients in that state. For example, a California clinician would not be able to provide telehealth treatment to a client that moves to another state (in most cases). Licensing requirements are typically different in each state, with some states only requiring a passing score on a board exam. However, some states may require clinicians to obtain a certain number of supervised hours in the state they wish to get licensed in. There are some states that have temporary practice laws in place that allows a clinician to continue seeing their client in a different state for a limited time. Some states may also allow clinicians to provide telehealth services in a state that borders the one they are licensed in. There may also be an option of telehealth registration in a select number of states that allows a clinician to practice virtually if they meet certain requirements (Department of Health and Human Services, 2024).

There are also many different types of platforms that telehealth services can be provided on. One participant noted that switching back and forth between multiple platforms can be a hassle and can also lead to things slipping through the cracks. For example, a clinician may use Google Calendar to keep track of client sessions, Zoom to conduct the sessions, and Simple Practice to bill clients and maintain detailed notes/documentation. Better integration between the platforms and improvements to technology would mean everything can be easily accessed in one place, which would further increase the convenience of telehealth. Finally, better insurance coverage would

also enhance the convenience and accessibility of telehealth. Many clients would not be able to access therapy services without insurance coverage due to high costs. One participant noted that they feel that insurance companies still view in-person sessions as the “gold standard.” They shared that requesting for an insurance company to cover telehealth sessions led to push back due to the company wanting the client to receive in-person services instead.

Participants noted the follow drawbacks: less focus from clients, more distractions, feeling disconnected, less engagement, limited privacy, harder to connect/build rapport, and technological issues. Every participant included difficulty in building rapport and maintaining focus with clients when asked about drawbacks to telehealth treatment. Multiple participants observed that clients get more easily distracted during telehealth sessions, typically from things in their environment, such as a noisy house, other people walking in on the session on accident, or things on the clients’ phones/computers. Clients are more likely to look at their phones during sessions or see a notification pop up on their computer screens when in telehealth sessions. There is also a lack of privacy when clients join sessions from their own homes. Sometimes, the client may not have their own private space for sessions, which increases the risk of someone overhearing a confidential setting. Clients may also be less willing to open up to a clinician if they suspect someone else may be listening in. Participants also noted that it harder to engage a patient via telehealth because of the inability to incorporate certain treatment modalities such as taking a walk, throwing around a ball, or trying fear foods together. Specifically, multiple participants noted that it is hard to gauge a client’s weight

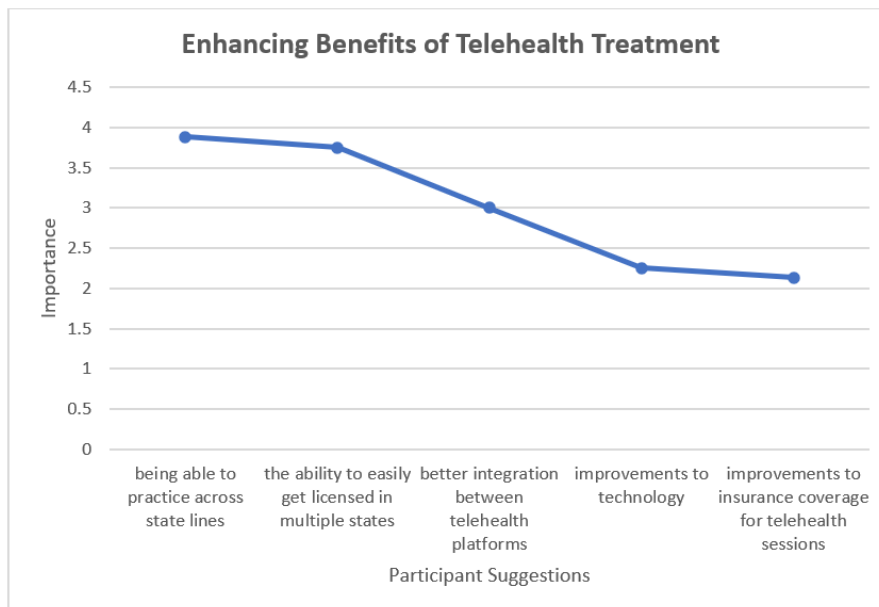
via telehealth, which is a very important aspect of eating disorder treatment. Regarding technology, one participant pointed out that there would sometimes be Wi-Fi issues that could affect the continuity of a session. Finally, rapport building was the most impacted with regard to telehealth treatment. Participants shared that it feels harder to connect with clients via telehealth due to all the other reasons noted. They also shared that it took more time to build a relationship and trust with a client when seeing them virtually compared to in-person. Body language and difficulty reading body language was noted to be a factor in the slower rapport building between clinicians and their clients.

Several suggestions were made in how these drawbacks could be reduced. In order to target dissociation and dysregulation during sessions, clinicians can create a catalog of clearing coping skills that they can engage a client with. Clinicians should also make sure to set clear boundaries and expectations with the client at the beginning of each session. Since one major drawback to telehealth was noted to be lack of focus, clinicians can try to reduce this by asking clients to remove distractions from around them as well as removing themselves from a distracting environment. Clinicians can also ask clients to show themselves and their surroundings on camera so that body language can be better monitored. In addition to things that clinicians can do in sessions, suggestions were also made for more general learning related to telehealth. Since telehealth and therapy are fields that are constantly changing and growing, it is important for clinicians to keep up to date on the latest research on conducting successful telehealth sessions. This also includes finding resources on how to better engage with clients in a virtual format, such as with online games or screen sharing activities. Finally, clinicians

can always refer a client to in-person treatment instead if they feel that telehealth is not showing signs of success.

Follow-up Survey Results

The second survey asked the same participants to rank the suggestions on how to enhance benefits and decrease drawbacks. Participants were asked to rank the suggestions for enhancing benefits from most important to least important. Five items were provided to participants for ranking: the ability to easily get licensed in multiple states, being able to practice across state lines, better integration between telehealth platforms, improvements to technology, and improvements to insurance coverage for telehealth sessions. Figure 1 shows a representation of how the suggestions were ranked. The ability to easily practice between state lines was ranked as the most important suggestion, showing that clinicians feel telehealth can improve if they are able to expand their practice range. Similarly, participants ranked the ability to easily get licensed in multiple states as the second most important. Better integration between telehealth platforms and improvements to technology were ranked lower in importance to clinicians. This may indicate that, even though technological advances are necessary to enhance telehealth, many clinicians feel that is not the top priority right now. Improvements to insurance coverage for telehealth treatment was ranked as least important by participants. This may indicate that a majority of clinicians are not having issues with insurance coverage for their clients in telehealth treatment.

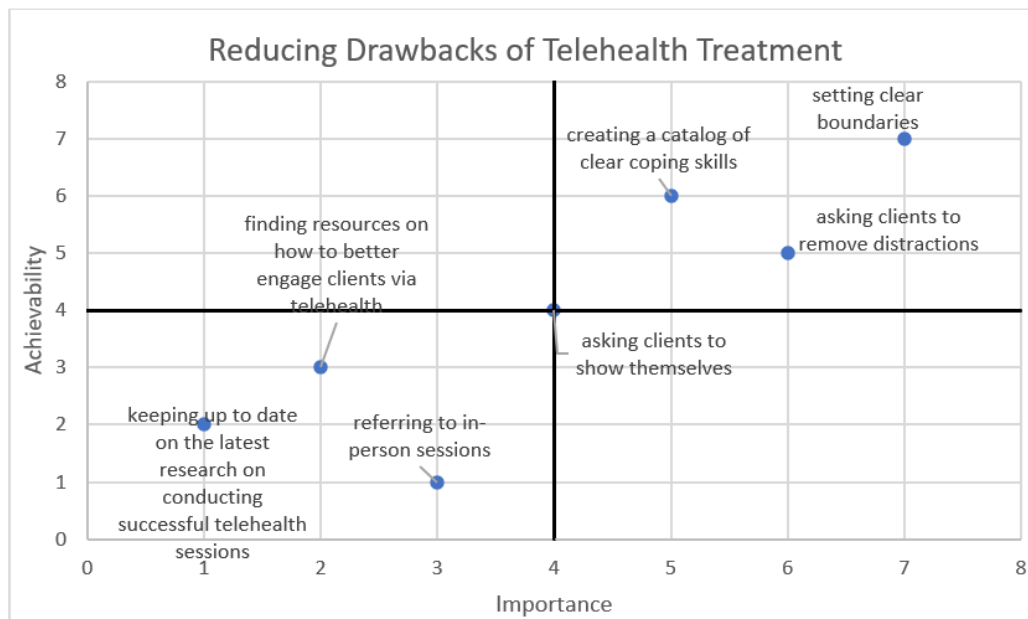
Figure 1*Enhancing Benefits of Telehealth Treatment*

Participants were also asked to rank the suggestions for decreasing drawbacks on two scales, most important to least important as well as most achievable to least achievable. The following items were provided to the participants to be ranked: setting clear boundaries and expectations with clients at the beginning of sessions, creating a catalog of clear coping skills that can be used via telehealth with clients in case of dissociation and/or dysregulation, asking clients to remove distractions from around them and/or remove themselves from a distracting environment, finding resources on how to better engage clients via telehealth, keeping up to date on the latest research on conducting successful telehealth sessions, asking clients to show themselves/their surroundings on camera so that the clinician can get a better sense of their body language/environment, and referring to in-person sessions if telehealth sessions are not

showing signs of success. Figure 2 shows a representation of how the suggestions were ranked.

Figure 2

Reducing Drawbacks of Telehealth Treatment



Setting clear boundaries and expectations for clients at the beginning of sessions was ranked as both the most important as well the most achievable by participants. Referring to in-person treatment was ranked as least achievable, but towards the middle in importance while keeping up to date was ranked least important but more achievable than referring to in-person treatment. The most achievable suggestions are the ones that participants feel like they can implement in their day-to-day practice and includes setting clear boundaries, creating a catalog of clear coping skills for dealing with dysregulation/dissociation, asking clients to remove distractions and/or remove themselves from a distracting environment, and asking clients to show

themselves/surroundings on camera. Not only did participants feel that these were the most achievable suggestions, but they also felt these were the most important suggestions.

Alignment with Literature and Framework

The results of this study showed that clinicians almost unanimously prefer in-person treatment to telehealth but still utilize telehealth more frequently due to convenience and accessibility. Past studies have shown similar sentiments from both clinicians and clients regarding telehealth treatment. Shaw et al. (2021) found that the use of telehealth for eating disorder treatment increased accessibility for clinicians, clients, and families. They also found that clinicians expressed that, even though they appreciated the ease of access that came with telehealth, there were still concerns regarding being able to monitor the physical health of clients. This concern was also voiced by clinicians in this current study. Mayer et al. (2024) also found that clinicians expressed that video sessions with clients are not able to replace face-to-face therapy. Clinicians in the Mayer et al. study voiced concerns regarding the safety of clients in a crisis situation. The same concerns were voiced by clinicians in this current study.

Both clients and clinicians agree that telehealth has benefits and can achieve the same results as in-person treatment. However, they also agree that there is a certain level of rapport building and human connection that happens in-person that cannot be replicated via telehealth. There have been no other studies that have asked for clinician suggestions on how telehealth can be improved upon to compare results to. Previous studies like the ones conducted by Shaw et al. (2021) as well as Mayer et al. (2024)

focused solely on the perceptions clinicians have towards telehealth treatment but did not investigate what can be done to improve the treatment. The results of this study show that there are things that can be done not only by clinicians themselves to improve telehealth, but organizational changes that can be made as well.

Force field analysis was derived from Kurt Lewin's field theory, which comes from the belief that behavioral change comes from changes in psychological forces in an individual's life. Although the original concept was centered on an individual's psychological change, the theory has been adapted in recent times and applied in a wide variety of organizational issues. By following the concept of a force field analysis, this study was able to identify the restraining forces against change, including difficulties with technology, difficulties with keeping clients focused and maintaining/creating meaningful client rapport as well as driving forces for change including setting better/clearer boundaries with clients, being prepared for scenarios of dysregulation/dissociation during telehealth sessions, and taking time to learn more about how to be a more effective clinician while using telehealth.

Summary

In this section, the results of the study were presented in a narrative format as well as in two different charts (Figures 1 and 2). An explanation of the results and how they aligned with the literature and conceptual framework was also presented in this section. Section 4 will include a reflection of self and a reflection of the scholar/practitioner as well as a discussion of recommendations for the eating disorder field.

Section 4: Conclusion and Reflections

This section begins with a brief reflection of self as well as a reflection of my journey as a scholar-practitioner. Following the reflections, recommendations for the eating disorder telehealth treatment field will be outlined. These recommendations will be based on the results of the current study and opportunities for advocacy will be identified.

Reflection of Self

Pursuing a doctorate degree has always been one of my life goals. As someone who loves education and learning, I always knew that I would want to pursue a higher education degree. When I started my doctoral journey, I was also starting a brand-new job in a brand-new city. It was my first time moving out of my family home and my first time living alone so there were a lot of changes to adapt to. Since I have always excelled in academics and school, I thought a doctorate degree would be a similar experience. However, working full-time while also keeping up with schoolwork turned out to be more challenging than anticipated.

The self-paced course work portion of the program was relatively smooth. However, the real work started when it was time to work on my capstone. On a personal level, I started to very quickly feel fatigued and burnt out by the sheer amount of work ahead of me. The thought of reading through dozens and dozens of academic articles in order to compile a literature review felt nearly impossible after a long day at work. I felt my mental health starting to deteriorate and I notice that I was constantly making excuses for why I couldn't get my schoolwork done. On top of work and school, I also started planning my wedding around the same time as starting my capstone literature review. At

this point in time, I decided to see professional help and started seeing a psychiatrist. I knew I would need extra support to get through the journey and it was honestly the best decision I could have made for myself. The psychiatrist was able to place me on a regimen that helped lift the fog of burnout and allowed me to effectively complete my capstone project.

Reflection of Scholar-Practitioner

As someone who has always thought of themselves as a capable scholar, the doctoral journey made me question exactly how capable I was at time. There were days when I felt like I made a mistake in pursuing this program and that I would not be able to complete the degree. As a college student and masters level student, I always felt that school came naturally to me, so I assumed that this time around would be the same way. However, a capstone project required much more research, time, and commitment as well as a high level of critical thinking to identify a specific research need and how to fill it. I went into this program thinking that I had some really great research ideas only to realize that I was on the completely wrong track. However, with support from my chairperson I was able to engage in meaningful discussions that helped me narrow down my focus and find a meaningful topic to delve into.

The biggest takeaway as a human services practitioner was learning more about the field I already work in while conducting my capstone background research. I currently work as an eating disorder social worker, and I was able to further my knowledge which helped me to be a better clinician. The biggest challenge was learning to separate my professional work from my work as a doctoral candidate. Since my

research was focused on eating disorder clinicians, there was always a chance of interacting with someone I have worked with in my professional circle. I had to learn to clarify with clinicians my specific role in order to not confuse the two worlds. This would include making it clear in any correspondences related to the study that I was working independently as a student and not as a part of my actual professional role.

Recommendations for Human Services Organization or Human Services Field Advocacy

Telehealth treatment for mental health and eating disorders specifically is still considered relatively new. Prior to the COVID-19 pandemic, the gold standard of eating disorder treatment, whether through a day treatment program or just outpatient therapy, was in person. However, the worldwide shutdowns meant that many programs and clinicians needed to pivot to online options in order to continue treating their clients. Due to how quickly the landscape of treatment changed during this time, there was a lot of trial and error to figure out what worked via telehealth and what did not. Now that telehealth has been a part of eating disorder treatment for a several years, more research is being done on whether or not it is as effective as in-person treatment.

This study showed that clinicians want to continue utilizing telehealth with clients for a variety of reasons. However, there are improvements that need to be made. Past research has focused more on families and clients, but clinicians are the ones who are most qualified to determine what can be made better. The results of this study can be used as a starting point in making changes, not only on a clinician level, but on an organizational level. There is a lot of room for growth for telehealth treatment, especially

with procedures on licensing and practice as well as advancements in technology. Every effort should be made to advocate for a less complicated way for clinicians to practice between state lines as well as becoming licensed in multiple states. This would greatly improve accessibility of care for clients across the country. Technological improvements such as more streamlined ways to conduct telehealth, schedule sessions and complete documentation can also go a long way in making services much more convenient for clinicians.

Summary

This section included a brief self-reflection as well as my reflection of their journey as a scholar-practitioner followed by an outline of how the results of the current study inform recommendations as well as advocacy opportunities for changes in the field of eating disorder telehealth treatment.

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Appendix: White Paper

Suggestions for Improvements to Telehealth Eating Disorder Treatment

Eating disorders are serious mental illnesses with physical consequences that can affect individuals of all ages, genders, races, ethnicities, and socioeconomic backgrounds. California ranks in the top 10 states with the highest rates of eating disorder diagnoses (Jawaid, 2024). According to a report published by Deloitte in 2020, eating disorders cost an estimated \$7.8 billion to Californians and resulted in more than 6500 of emergency room visits. According to Project Heal, a nonprofit organization focused on advocacy for equitable eating disorder care, there are an estimated 3,000 therapists in the United States that treat eating disorders and approximately 228 eating disorder treatment centers in the United States. This means that there is one therapist for every 10,000 people diagnosed with an eating disorder and one treatment program spot for every 5,000 people diagnosed with an eating disorder. Treatment options for eating disorders are in limited quantity and high demand, making it of utmost importance to continue research on how to maximize treatment in every way possible.

Prior to the COVID-19 pandemic, eating disorder treatment was primarily conducted in-person at varying levels of care. However, the pandemic and worldwide shutdowns led to a rapid transition to telehealth treatment. Since the beginning of this transition in 2020, the efficacy of telehealth treatment for all mental health conditions, eating disorders included, has been a topic of interest. Currently, much of the research around telehealth treatment has focused only on client and family perspectives leaving out valuable information that can be gathered from clinicians. Overall, studies have found

generally positive experiences from clients and families utilizing telehealth treatment, especially highlighting increased accessibility to care and better flexibility (Brothwood et al., 2021; Shaw, Robertson & Ranceva, 2021). Although client and family perspectives on how telehealth can be expanded and improved upon is important, clinicians should also be allowed to weigh in on what they think can help. As the ones providing treatment, clinicians are uniquely qualified to speak on what can be made better so that they can provide the best possible care for their clients.

The field of eating disorder treatment is one that is always changing and adapting. Due to the relatively unresearched nature of how telehealth treatment for eating disorders can be improved upon, it is important to begin exploring this topic. Clinicians and other experts in the field need to be aware of both the benefits as well as the drawbacks to telehealth treatment. Through their own personal experiences, clinicians are able to identify ways in which these benefits and drawbacks can be worked on in order to make telehealth more effective across the board.

Participants in this study were all provided with informed consent forms detailing the requirements of the study. All participants were required to review and agree to the informed consent form prior to proceeding with the study. Participant information was kept confidential with only the researcher having access to personal information (name and email). No participant was asked to share any sensitive information for this study and were all aware that they were able to revoke consent at any time.

The primary researcher of this study current works in the eating disorder field as a licensed clinical social worker and has seen, firsthand, the transition from in-person care

to telehealth care. They were able to witness how quickly the landscape of treatment changed and how that affected not just clients but also the clinicians themselves. This made it apparent to the researcher that clinician perspectives are just as important when attempting to better understand and improve upon telehealth treatment. Prior to beginning the study, the researcher spent time conducting a literature review of eating disorder treatment, how treatment has changed over the decades, the effect of the COVID-19 pandemic on eating disorders as well as general mental health, and the effects of the pandemic on treatment modalities.

The study consisted of two sequenced questionnaires. The first questionnaire consisted of a series of open-ended questions designed to gather clinician perspectives on the transition to telehealth, what they feel like are benefits and drawbacks to telehealth, and what changes they would make to make telehealth more effective and efficient. Once an appropriate number of responses to the first questionnaire was received, the researcher used inductive coding to determine trends in the data. From there, the researcher was able to narrow down the suggestions made by clinicians for both increasing benefits as well as decreasing drawbacks. The second questionnaire asked clinicians to rank the suggestions on two scales, from most to least important as well as from most to least achievable. From all of the rankings provided, the researcher was able to average the scores for each suggestion in order to compile the final lists in order of most to least important and most to least achievable.

The initial survey found that, while all participants were still utilizing telehealth to treat their clients, a majority of them preferred in-person treatment options. The clinicians

reported the following benefits to telehealth treatment: convenience, accessibility and flexibility. They shared that it was nice to no longer have to commute to and from an office space for work, that clients were less likely to cancel sessions since they did not need to worry about transportation, that clients in more remote areas were still able to access care, and that it was easier to continue working with clients even if the clinician had a life event such as maternity leave or a move. In addition to the benefits, clinicians also noted the following drawbacks: less focus from clients, more distractions, feeling disconnected, less engagement, limited privacy, harder to connect/build rapport, and technological issues. Many clinicians shared that they noticed that clients would get distracted more easily during telehealth sessions, that it took longer to build a therapeutic connection, and that medical monitoring (such as gauging a client's weight) was much harder in a virtual format.

Of the suggestions provided on how the benefits of telehealth could be increased, clinicians felt that the ability to practice between state lines was most important. This was followed by the ability to easily get licensed in multiple states, better integration between telehealth platforms, improvements to technology, and improvements to insurance coverage. Of the suggestions provided on how the drawbacks to telehealth could be decreased, clinicians ranked setting clear boundaries/expectations with clients at the beginning of sessions as the most important and achievable. This was followed by asking clients to remove distractions, creating a catalog of clear coping skills for times of dysregulation and/or dissociation, and asking the client to show themselves and their surroundings on camera. Clinicians ranked keeping up to date on the latest research on

conducting telehealth treatment, finding resources on how to better engage clients virtually, and referring to in-person treatment as lower in importance as well as achievability.

Overall, this study shows that there are things that can be improved upon at an organizational level as well as an individual level to enhance and improve telehealth treatment. Each clinician has their own approach to conducting sessions with clients; however, it will be important for them to assess their own work on a regular basis to determine whether or not they are providing effective treatment. Clinicians can implement the suggestions in the previous paragraph and assess if this helps in connecting better with their clients and in building a stronger therapeutic relationship. On an organizational level, it is apparent that clinicians are wanting simplified pathways to licensure across state lines and more ways to practice across state lines. This should be taken into account by the various boards that are in charge of creating the requirements for licensure and practice, such as the Board of Behavioral Sciences which oversees licensed clinical social workers, licensed marriage and family therapists, and licensed professional clinical counselors. Finally, platforms used for telehealth treatment should continue to assess their effectiveness and ease of use, making adjustments and improvements wherever needed. Telehealth treatment for eating disorders, as well many other mental health conditions, is here to stay. The mental health field as a whole should continue to raise awareness of what changes need to be made in order to make sure treatment is being provided in the best possible way for the safety and general wellbeing of clients everywhere.